# HOW BEST CAN HIV/AIDS POLICY BE MOVED TO SUCCESSFUL IMPLEMENTATION? LESSONS FROM ROUTINE HIV TESTING OF PATIENTS WITH SEXUALLY TRANSMITTED INFECTIONS IN MALAWI

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# ABSTRACT

Gift L.F. Kamanga: How Best Can HIV/AIDS Policy Be Moved to Successful
Implementation? Lessons from Routine Testing of Patients with Sexually Transmitted
Infections in Malawi.
(Under the direction of Suzanne Havala Hobbs)

Like other sub-Saharan countries, Malawi is hard hit by HIV/AIDS. Various aspects

of human development often stall because of physical and psychosocial effects resulting from

illnesses due to HIV infection. Prevention of HIV infections will avert many miseries

resulting from HIV. If HIV prevention is optimized, the efforts and resources dedicated to

treatment of HIV/AIDS ailments and impact mitigation could be directed towards improving

social economic development, which will improve the quality of life for the people.

However, execution of HIV prevention and other programs require enabling policies to move

forward. Policies are not meaningful until they are properly implemented.

This descriptive qualitative case study looked at the Malawi HIV/AIDS Policy from

2003 to 2013. I used in-depth interviews to explore the implementation of provider-initiated

testing and counseling (PITC) for Sexually Transmitted Infections (STI) patients and HIV

testing for prevention of mother-to-child transmission (PMTCT) as a contrast. Document

literature reviews were done to provide background information. This study examined

barriers and facilitators to successful implementation of HIV/AIDS policy to inform the

development of recommendations for subsequent policies.

Key barriers included lack of involvement in policy making process by healthcare

workers and some senior health workers , lack of healthcare training or sensitization about

the policy implementation plan, lack of supervision, lack of systems coordination and policy harmonization, non-accommodating infrastructure for male participation, and shortage of healthcare workers to implement the policy, supplies, and test kits. Some specific facilitators were highlighted as follows: sustained counseling to participants, supportive supervision of healthcare workers, good support from implementing partners, and good political will.

Based on the issues reported by participants and analysis of those issues, the following recommendations were made to improve policy implementation: greater involvement of healthcare workers in the policy-making process, training of all healthcare workers, community sensitization to increase male participation including making health facilities male-friendly, clear policy coordination mechanisms with defined roles, creation of a policy harmonization team, and decentralization of policy implementation supervision.

To my wife, Mydass, and children. You were all very patient and supportive with my long and tiresome studies. Behold, herewith, partake with me the fruit of that labor.

# ACKNOWLEDGEMENTS

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| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| DOT | Directly observed therapy |
| HIV | Human immunodeficiency virus |
| IRB | Institutional Review Board |
| NGO | Non-governmental organization |
| NHSRC | National Health Sciences Research Committee |
| OPC | Office of President and Cabinet |
| PEPFAR | (The U.S.) President's Emergency Plan for AIDS Relief |
| PITC | Provider-initiated HIV testing and counseling |
| PMTCT | Prevention of mother-to-child transmission |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| UNAIDS | (Joint) United Nations Program on HIV/AIDS |
| UNC | University of North Carolina |
| VCT | Voluntary counseling and testing |
| WHO | World Health Organization |

## CHAPTER 1: INTRODUCTION

### Problem Statement

There is great need to create an enabling environment for implementing policies to deal with HIV/AIDS as it continues to wreak havoc globally. Sub-Saharan Africa bears a disproportionate share of the global HIV burden. An estimated 22.5 million people (68% of the global HIV number) living with HIV resided in sub-Saharan Africa in 2009. Malawi is one of the top ten countries in southern Africa most affected by HIV (UNAIDS, 2010). The country's HIV infection has a high prevalence—over 10% in the general population. HIV/AIDS negatively affects the health and well-being of productive people. This eventually retards social and economic development (Muniyandi et al., 2006). HIV/AIDS is also exacerbated by other sexually transmitted infections (Laga et al., 1993; Simonsen et al., 1998).

Intensification of primary and secondary preventive measures is very important to mitigate this problem and the associated consequences. These have to be organized through guiding principles such as policies to achieve the intended goal. These policies need to have an enabling environment so that they are well implemented, otherwise the HIV prevention efforts will be in vain.

### Importance of the Study

Given the high burden of HIV/AIDS in Malawi, it is my intent to understand barriers that prevent policies from being implemented or facilitators that will help enhance the implementation of HIV/AIDS prevention and impact mitigation programs.

The magnitude of resources required for policy formulation is huge; this makes it important for public health policies to be well implemented so that such resources are of benefit. Understanding barriers and facilitators and their strategies will help contribute toward global health efforts, particularly good policy implementation in settings similar to Malawi.

### Background

Understanding how public health policy translates to actual interventions in the field requires recognition of several components of the policy cycle including problem identification, establishing the cause of the problem, evaluation of strategies that work to solve it, implementation of a plan for change, and then evaluation of the policy intervention (Caldwel, 2006). The process is iterative—the policy intervention evolves over time. Policies are necessary to move public health initiatives forward. HIV/AIDS and other sexual and reproductive health services will be chaotic and will fail if they are operated without guiding policies. A complete and successful public health package entails successful transition from research to policy formulation to implementation. The translation of research into policy is difficult, but once successfully done, it has a high rate of return for the huge investment in research (Askew et al., 2002). However, that is not the end of the story because there is also evidence that merely having policies in place is not a guarantee that implementation will be achieved. General barriers to successful implementation after policies are in place include stigma and discrimination, low motivation and commitment, conflicting policies, and challenges in multilevel coordination (USAID, 2009).

### Problem Overview and Rationale of the Study

In 2003 Malawi published its first ever HIV/AIDS policy—A Call to Renewed Action. The goal of the policy is to prevent the further spread of HIV infection and to

mitigate the impact of HIV/AIDS on the socioeconomic status of individuals, families, communities, and the nation. The policy's HIV testing prevention efforts focused on provider-initiated HIV testing and counseling (PITC) including diagnostic HIV testing for sexually transmitted infections (STI) patients, as well as HIV testing for pregnant women for prevention of mother to child transmission of HIV (PMTCT).

Literature from the sub-Saharan region hinted at multiple barriers and facilitators that affected implementation of health-related policies. However, there were differences in context, such as the political landscape of countries and resources. There is a paucity of literature about HIV policy from Malawi. Given the magnitude of HIV-related problems, a study to understand the local context was therefore warranted. My work provided great insights about policy implementation barriers and facilitators in Malawi. This dissertation will provide a guide and basis for other specific enquiries in this area of research such as specific evaluation programs of several health-related policy implementations.

## Purpose of the Study

The purpose of this work is to understand barriers and facilitators to implementation of HIV/AIDS policies in Malawi. This will be done through understanding various stakeholder perspectives and the consequent development of action-oriented recommendations. The outcome of this study will also help inform the implementation of other health-related policies.

## Scope of the Study

The Malawi 2003 HIV/AIDS Policy is very broad with several components where implementation problems were evident.

This dissertation evaluated routine HIV testing policy in the outpatient setting under provider-initiated HIV testing and counseling (PITC), which also covers HIV testing for STI patients. . I included HIV testing in antenatal clinics for PMTCT to act as a contrast.

I limited this study to outpatients because that is the most important point of entry for HIV prevention efforts, and almost all patients who are admitted to the wards pass through outpatient clinics. STI services are largely delivered through integrated outpatient clinic settings where other general patients are seen, and there are very few stand-alone outpatient STI clinics. Therefore assessment of the uptake of PITC for STIs was largely done through these integrated clinics. Because there is no separation of patients for STIs and other medical conditions in integrated clinics, my assessment has provided general reflection on the uptake of PITC for all general patients rather than STI patients only, as recommended by WHO in 2007.

## Overall Objective of the Study

This retrospective, descriptive analysis of the Malawi HIV/AIDS Policy from 2003 to 2013 is aimed at learning about barriers, facilitators, and strategies in implementation of HIV testing for STI patients, using PMTCT as a contrast.

## Aims of the Study

The study question sought to assess "How Best Can HIV/AIDS Policy be Moved to Successful Implementation? Lessons from Routine HIV Testing of Patients with Sexually Transmitted Infections in Malawi."

The following aims helped address this question:

1. Determine the existing status and gaps regarding policy implementation for HIV/AIDS and related health policies in sub-Saharan Africa through a literature review.

2. Determine HIV/AIDS Policy implementation barriers and facilitators in Malawi.
3. Explain which strategies for implementation of specific HIV/AIDS Policy components have succeeded and which have failed and why.
4. Develop recommendations to strengthen policy implementation.

# CHAPTER 2: REVIEW OF LITERATURE

## Purpose of the Review

The purpose of this review was to get a general overview of this type of policy implementation and also to understand different sources of barriers and facilitators affecting implementation of health-related policies and guidelines once approved or passed in Malawi and sub-Saharan Africa. To meaningfully contribute to my dissertation topic, I tailored my literature review to capture implementation of HIV/AIDS-related as well as other health-related policies.

## Conceptual Approach and Policy Analysis

Policy analysis employ a scientific approach to achieve credible and replicable findings (Sabatier, 1999). Policy analysis is often conducted using a step approach such as the six-step approach described by Patton and Sawicki (1993). These are outlined as follows:

**Step 1. Verify, define, and detail the problem**

Information is sought about the problem. The problem is well defined and properly verified by engaging with all involved stakeholders. The magnitude and extent is determined. In this case, the study of literature provided insights from various stakeholders.

**Step 2. Establish evaluation criteria**

A relevant evaluation criterion is established depending on the issue at hand and its social-political context.

**Step 3: Identify alternative policies**

Having understood the basics of the issue, the analyst needs to list predetermined or researched alternatives.

**Step 4: Evaluate alternative policies**

An optional appraisal of the policy alternatives is done and the best fit for a respective work is settled on.

**Step 5: Display and distinguish among alternative policies**

A list of alternatives is presented in different ways depending on whether qualitative or quantitative methods are employed.

**Step 6: Monitor the implemented policy**

Programs need to be monitored and their impacts measured. Policies fail because the program could not be implemented as designed or the program may have run as designed but did not produce the desired results because the underlying theory was incorrect (or a combination of both). This study will examine general issues that affect implementation of policies after they have been passed or approved.

Policy analysis is complex and does not have a single definitive approach (Patton and Sawicki (1993). The policy process has stages such as problem identification, policy formulation, policy implementation, and evaluation. Each of these steps can be further detailed for analysis. This dissertation focused issues affecting the implementation phase of the policy process.

The implementation component of a policy, too, has many dimensions. Key aspects to consider are the initiators and the implementers of policy.

It is important to know who is involved in each of these areas and how their interaction affects the overall implementation. I don't know of similar policy analysis work in Malawi, so far. I envisage that this approach is a very important starting point for future policy or program impact evaluations.

Any new enquiry needs to have a basis from existing body of knowledge, in recognition of this; I looked at some existing policy theories or perspectives to guide my work. Although theories apply in most general cases, it gives more sense and strength if they are supported within prescribed contexts (George & Jones, 1997).

Issues such as culture, political systems, and other environmental factors affect policy dynamics in a particular society, because each setting operates from a different stage of social-political and democratic development. For example, the way an issue is handled from problem identification, formulation of policy solutions, and implementation in the United States is likely to be different from how it is handled in Malawi.

In a traditional model of policymaking, the following distinct stages are recognized: (1) identification of policy problems, (2) agenda setting (focusing governmental attention to the problem), (3) development of policy proposals, (4) adoption of policies, (5) implementation of policies, and (6) evaluation of policies' implementation and impact (Porter, 1995). This theoretical framework has also been described as "Stages Heuristics." This approach helps create understanding of where some of the issues affecting implementation are coming from.

This traditional model also relates well with "diffusion technology transfer" theory, where an issue is developed and made known to other people, who, in turn, learn and understand its benefits and make a decision to buy and continue using it (Rogers, 2003).

Perhaps the difference is that in the stages heuristic, it is not clear if the adoption is followed through. In diffusion theory, the end output is assimilation into the action as evidenced in their continued use. Stakeholders might mention some success or failure of some policy process issues as contributing factors to failures or successes of the implementation.

An ecological framework can also be potentially used for piece of work like mine. It proposes a broad range of factors such as training, technical assistance, provider characteristics, and community factors that affect implementation (Durlak & DuPre. 2008). A critical unit of policy implementation discussed in this study is local healthcare workers who implement policies. This reiterates the importance of training and technical assistance the framework suggests.

Given that implementation is the springboard of public health's ultimate goal of healthy people and the basis for evaluating public health interventions, it is crucial to adequately address the important issues affecting it. Policy implementation is the carrying out of a basic policy decision, usually incorporated in a statute but that can also take the form of important executive orders or decisions.

Centrally located policy actors are seen as most relevant to producing the desired effects (Mazmanian & Sabatier, 1983). However the reality is that there are still other important players needed to make implementation a reality, and these are the healthcare workers on the ground. The list can go beyond this until we get to the communities or beneficiaries. However, we need to have a starting point to move forward, and this study will limit to factors up to the healthcare providers level.

Another important framework is "multiple streams" by Kingdon. It recognizes problems, policies (solutions), and politics as very important contextual factors (1984).

It has a problems stream that looks at the prevailing issues, a policies stream where solutions and alternatives are formulated, and finally a politics stream involving those that are responsible to drive the implementation. The Malawi HIV/AIDS policy shares some of these elements, such as having political, administrative, and local players like healthcare workers.

I found no clear theory of policy implementation but there are several aspects of different frameworks that strengthened my thinking about an approach in Malawi. Despite this lack of a straightforward approach, the top-down and bottom-up perspectives (Matland, 1995, as cited in Narendra, 2009) are very promising. "Top-down" is defined as hierarchal execution of a centrally defined or formulated policy. Such a policy is handed down from the top leadership. On the other hand, "bottom-up" involves engagement of the local players and their coalition partners in the process of policy implementation.

I used this top-down and bottom-up perspective to pursue my work because it fits well with the context of my study setting in Malawi, whose health services are structured in a hierarchal system. The initiation of policy starts higher in the hierarchy of HIV/AIDS governance.

Policy keepers for HIV/AIDS in Malawi are in the Office of President and Cabinet (OPC). These are designed to work hand in hand with the Ministry of Health (MOH), which is designed to lead implementation, and the National AIDS Commission (NAC), designed to lead coordination of the national response including resource mobilization. These three will collectively be referred to as coordinating stakeholders in other parts of this document.

Top government leadership is very instrumental in leading the process of policy making and implementation. The next most prominent level of players is the local health workers, who are the implementers of policies and programs.

Of late, there are several health interest groups emerging in Malawi. These are important stakeholders because they represent the civil society organizations who are also working in the area of HIV/AIDS, and they also act as a voice of the general public about issues of health concerns. I will use this group as a mediating group for my enquiry.

A top-down approach is driven by high political or executive leadership. The assumption is that such a level is the most important player in producing the desired policy outcome. The top-down approach is responsible for directing officials and target groups in meeting objectives and procedures outlined in that policy decision, ascertaining meeting objectives over time, assessing the impact, monitoring principal factors affecting policy outputs, and tracking the experience of the policy for necessary modifications. Narendra, 2009, quoted Elmore, Richard E. (1978) that there are four main ingredients for effective implementation in support of the top-down approach:

> (a) Clearly specified tasks and objectives that accurately reflect the intent of policy;
> (b) A management plan that allocates tasks and performance standards to subunits;
> (c) An objective means of measuring subunit performance; and
> (d) A system of management controls and social sanctions sufficient to hold subordinates accountable for their performance

The bottom-up approach focuses on the importance of local capacity. It starts by identifying the network of actors involved in service delivery at the operational level, builds necessary coalitions, and advances the cause for implementation. It capitalizes on the importance of individual motivation, the will and internal institutional commitment to influence policy outcomes at that level (Palumbo, Dennis, and Calista, 1990, as cited in Narendra, 2009).

Because moving from policy to implementation can have problems at policy/political and operational levels or with interest groups, (Kingdon, 2011) the top-down and bottom-up conceptual approach seems relevant for this work. In this type of policy model, the processes of developing policies starts from up in the hierarchy and technical people are simply implementers.

At the dawn of inclusive government, South African technocrats started HIV/AIDS policy formulation but progress toward implementation was hijacked by political dictations, which slowed progress in the HIV/AIDS policy process (Schneider, 2001). This is unlike in the United States, where once policy makers formulate policy, the duty of putting them into practice lies in the hands of technocrats. But in some instances people who are supposed to lead the implementation do not act. There are many possible reasons, including non-involvement in the process or simply resisting because of being unhappy with the processes followed by their "masters" who made the policies (Kingdon, 2011).

Several barriers have been cited by a systematic review at the guidelines level, such as lack of awareness, limited familiarity, and a lack of agreement with the guidelines (Francke, 2008). Other factors are limited time and personnel resources, as well as work pressure (Sachs, 2006). Another challenge contributing to the failure of programs to take shape is the lack of political will.

Malawi had political commitment—during the entire period of this policy implementation, the State President of the Republic of Malawi has been the minister responsible for HIV/AIDS issues.

This further aroused my curiosity as to what HIV/AIDS policy implementation barriers and facilitators would unfold in such an environment, cognizant that greater political

commitment has not led to the removal of implementation difficulties but that a good

technocratic approach with rational decision-making, good institutional capacity, and

adequate political capital does (Reich, 1995).

<p align="center">**Barriers for the Implementation of Policies**</p>

**Lack of Coordination by Key Policy Stakeholders**

Public health requires collaboration of teams or different players to achieve

meaningful advancement. There were several problems identified regarding stakeholder

coordination.

In Malawi, for example, global infant feeding guidelines faced implementation

challenges due to several factors. First, policy makers in the same area of interest had

conflicting ideas about infant feeding. Second, there was confusion due to lack of explicit

guidelines to translate the policy for providers. Finally, there was poor consensus regarding

infant feeding policy among government departments dealing with infant feeding (i.e., the

HIV/Nutrition Department at the Office of President and Cabinet (OPC), the Nutrition

Department under the Ministry of Health, and the HIV/PMTCT Department under the

Ministry of Health). There was no clear mandate of who was in charge of the policy among

key institutions regarding infant feeding (Chinkonde et al., 2010).

As another example, in 2006 the World Health Organization (WHO) issued a

recommendation for cotrimoxazole and Isoniazid preventive therapy to be used to ease the

burden of HIV-related opportunistic infections, especially in countries with a high burden of

HIV/AIDS. Widespread implementation of this policy was problematic in many countries. In

a survey conducted by the WHO in 2007, only half of the respondent countries had adopted

this recommendation as a national policy. Less than one-third implemented it on a national

scale. Some of the reasons were: lack of consensus among policy makers, logistical challenges such as consistent supplies, and insufficient healthcare worker awareness (Date et al., 2010).

As another example, a qualitative assessment of implementation of reproductive health policies in four countries (Ghana, Kenya, South Africa, and Zambia) revealed that poor implementation was due to lack of harmonization of reproductive health policies. Most of the programs' activities were not harmonized due to lack of coordination among donors. Change of political climate and dispersion of original reform actors affected implementation in Zambia. There were often multiple policies and guidelines from the same system to meet different donor requirements, and there was evident lack of coordination among implementers and policy makers (Mayhew et al., 2000).

Another example where lack of coordination affected implementation was observed after the International Conference on Population and Development (ICPD)-Cairo, 1995. Regardless of commitment to resolutions, progress was hindered by lack of consensus among participating member countries.

**Cultural/Moral/Personal Convictions and Reservations**

Some of the HIV/AIDS-related barriers to implementation may not be obvious from the perspective of healthcare workers and policy makers but may be related to recipients or clients of the services. In a typical African setting, communities are run by traditional leaders. Traditional leaders are very powerful in influencing the social-cultural practices of their subjects. It is important that HIV/AIDS programs work to gain acceptance of these local leaders. However such involvement should be well executed or coordinated to avoid doing the opposite of what the program intends to do. A South African program was instituted to

reduce AIDS stigma, build female and youth capacity on sexual health, and encourage men to take responsibility over HIV/AIDS. The chief welcomed it and spoke highly about it. However the program did not achieve the intended results—it was shunned by many people due to the chief's domineering dictation of acceptable behavior such as "no condoms for the youth" and contradictory behavior. The chief was, in practice, not a good example. He had many wives and extramarital affairs, which he publicly confessed and justified. In this case, lack of consistency in messaging between the policies and leaders' lifestyles unfortunately undermined and weakened the policy's effectiveness (Campbell, 2010).

Community's social/cultural interaction attributes are very important in determining some of the uptake of public health services. Societies or cultural pressures influence some of the important decisions in public health. Unwillingness of staff to perform abortions out of personal convictions was one of the main problems that led to lack of proper implementation of the reproductive health policy framework (Cooper et al., 2004). Sexuality and HIV/AIDS are still sensitive matters in many communities in Malawi.

Provider willingness and preparedness is one of the issues that affect implementation of health policies. In South Africa, healthcare workers resisted advocating and counseling for female condom use. Promotion of female condoms was viewed negatively and culturally not appropriate—it was seen as promoting promiscuity. When healthcare workers from all over the country were trained on HIV issues with emphasis on female condom use, knowledge and attitude toward female condoms were greatly improved (Mantell et al., 2000).

Health workers might be influenced by personal beliefs in the course of implementation of HIV/AIDS-related polices. A comprehensive school AIDS education program in Uganda was faced with some implementation problems, especially in the

teaching about condoms in schools. Strong cultural disapproval with a perception that condoms encourage immorality and teachers' personal prejudice against condom use for the same reason were some of the reasons for failure to implement teaching about condoms (Kinsman et al., 1999).

**Lack of Awareness of Policies/Guidelines and Training on Technical Issues**

In a study that assessed implementation of integrating mental health policy in three countries—South Africa, Ghana, and Uganda—the challenges identified included: service providers' lack of awareness of the existence of the policy/guidelines even though the policy had been in place for six years (Ghana), lack of clear government endorsement of these guidelines/policy endorsement (South Africa), and lack of directives on exactly how these policies were to be implemented (Uganda) (Bhana et al., 2010).

A review of literature reinforced the fact that nurses are critical healthcare workers to spearhead the current concept of provider-initiated HIV testing. Unfortunately there is lack of HIV/AIDS-related capacity building to understand HIV/AIDS issues for this cadre of healthcare workers. Undoubtedly nurses are a major healthcare service provider in most health settings. The WHO recommendation to maximize the uptake of HIV testing services so that many people benefit from timely care will see a lot of nurses being at the center of not only HIV testing but also other AIDS-related services. Their training and mentoring in HIV-related services as well as their involvement in policy development are very necessary to succeed in this endeavor (Evans, Ndirangu, 2009). Lack of capacity building in people who are supposed to implement policies will therefore be a setback to effective implementation of services.

It is important for health workers to understand the importance of the program being implemented. In South Africa, the implementation of a cervical cancer screening program faced some challenges partly because health workers did not understand the program and therefore did not support the policy. There was also poor client knowledge about cervical cancer. An intervention study that included healthcare trainings about the importance of the cervical cancer program and its policy plus proper organization of services at primary care clinic was done. Staff agreement with the policy greatly increased, as did the uptake and referral of cervical cancer screening services (Moodley et al., 2006).

In Cape Town, South Africa, a school-based HIV/AIDS educational program was positively affected by two main factors—an enabling policy environment (teachers in schools with the HIV/AIDS Policy were more likely to implement the HIV/AIDS teaching program) and teacher training on issues of HIV/AIDS because it gave the necessary confidence to teach (Mathews et al., 2006).

**Resistance to Implementing Externally (Internationally) Developed Policies**

The process of policy formulation will have an impact on its implementation. It is recognized there are three main areas for policy action: problem identification, which is done by several players of which local communities or the people to be affected should be part and parcel; alternatives setting (policy options), which is spearheaded by mainly technical experts; and finally, political streams, where institutions that hold political power are at play (Kingdon, 2011). From this theoretical base, one can see that it is very important that these factors or avenues are well connected and open to each other for effective policy formulation and eventually implementation.

WHO is renowned for spearheading international policies on various health issues.

However implementation of these internationally driven policies has been problematic. The

WHO STIs syndromic guidelines were abandoned because of conflicting philosophies among

international policy advocates and local communities (Lush et al., 2003). Another case study

analysis about STI syndromic management from South Africa and Mozambique gave further

insights on how to get internationally driven policies accepted. In this scenario, the

introduction of STI Syndromic Management was participatory between the WHO team and

national and regional staff, and thus achieved acceptance in a short space of time. (Schneider

et al. 2006)

**Lack of Political Will/Support/Environment**

South Africa's HIV/AIDS response had faced a huge problem because policy makers

did not recognize the fact AIDS is caused by HIV. This means all technical efforts to curb

HIV/AIDS were left without political support (Hasnain, 2004). Creating an enabling policy

environment is a catalyst for moving in the right direction. The South African government

was initially in a state of denial on the negative effects of HIV/AIDS. The government's

change of attitude to accept HIV/AIDS led to an increase of knowledge in HIV/AIDS-related

issues among its 27,000 medical practitioners, as opposed to only 2,000 who were conversant

prior to government acceptance (Baleta, 2002). As an operational example, an analysis by

Leon indicated that the policy of provider-initiated HIV testing and counseling is a necessary

step in increasing coverage of HIV testing uptake. This was even shown in the South African

context (Leon et al., 2010).

A case study analysis of two policy implementations for STI syndromic management

and sexual behavior change interventions for Uganda and South Africa revealed how

political will drives the institutionalization of HIV/AIDS Policies and the implementation of its programs.

Uganda achieved very good milestones in reducing HIV prevalence, presumably due to a combination of factors including clear political will and support, even from the presidency, on issues of HIV/AIDS programing, stakeholder engagement, and NGO support. South Africa, on the other hand, has seen slow progress regardless of its privileged position of technical and financial resources. Lack of political will, denial, and a non-supportive atmosphere at the level of the Office of President was a major blow to making progress (Parkhurst, 2004).

Post-apartheid South Africa was a very difficult environment to implement HIV/AIDS policies in the face of increasing HIV/AIDS incidence, given the political and social system building that was necessary in the post-apartheid era.

The new South African government responded by setting up a huge plan for HIV/AIDS response. In reality the lack of interplay, disorganization, and mistrust between post-apartheid South African civil service (mostly inherited from the apartheid era) and several political actors failed to appropriately stimulate the response into action for the benefit of their clientele. Non-implementation was further complicated by the top leadership's lesser regard for HIV/AIDS, against the recommendation of their own renowned technocrats and scientists (Schneider, 2001).

A South African TB and HIV integration program was marred by challenges of implementation due lack of political support. This eventually led to lack of proper coordination of programs and notable operational problems. The system of supervision or monitoring was also not adequate (Marrian, Loveday, & Zweigenthal, 2011).

Tensions between national and local policy governance negatively affected the implementation of an HIV/AIDS treatment program in South Africa. Although decentralization of decision making was adopted, in practice the national policy governance body either took or wanted to control implementation of decisions. For example, local policy governance as influenced by civil society–instituted task shifting of training nurses to run the treatment program due to scarcity of medical doctors was resented by the national policy governance body. Implementation was deemed "illegal" and did not go well (Evensen & Stokke, 2010). It will be interesting to get insights on how this might be reflected in Malawi because the national HIV policy governance is in a different government ministry from the largest implementer of the policy.

**Lack of Leadership**

Failure to implement policies may be a hindrance to the very activities that bring forth socioeconomic gains in countries. Policy implementation can be adversely affected by organizational, logistical, and technical challenges. In South Africa, gold mining is one of the major successes of its economy but has led to health concerns of silicosis. The South African government failed to implement its own policy for reducing mining dust levels and associated diseases. Important factors identified for the failures were financial and other resources constraints. Finally there was disorganization of the health system as it biased its focus on accident prevention, which looked more urgent but ignored the long-term effects of silicosis (Murray et al., 2011).

In Kenya, internationally developed guidelines to improve management of seriously ill children and newborn babies were not used due to several reasons, such as incomplete training coverage (senior professionals were not willing to be trained by the junior ones who

were conversant with the new skills), inadequacies in local standard setting and leadership, the leadership seemed not to be part of the new skills, leadership did not give any supportive supervision, and did not hold their subordinates responsible for implementing the same, healthcare workers were not being appreciated for the good job they do, poor communication and lack of team work (clinicians and nurses hold separate meetings and no joint meetings to iron out some issues together), limited resources, shortage of staff, lack of benefits attached to implementing the new guidelines, and lack of motivation and conflicting attitudes/beliefs (Nzinga et al., 2009).

**Resource and Logistical Challenges**

In response to Tuberculosis (TB) and HIV co-infection high prevalence, which was almost at 77%, Uganda adopted the WHO TB-HIV collaborative policy. One of the most important aspects under this policy was routine testing of all TB patients for HIV. However, the collaborative services remained poor, with only 30% of TB patients receiving HIV testing. Notable barriers to dissemination included logistical challenges and staffing shortages (Okot-Chono et al., 2009).

In Tanzania, malaria lab confirmation policy before treatment was instituted in 2008. This was expected to weed out unnecessary treatment of malaria. Good as the policy was, it was unfortunately marred with human resource constraints like shortage of healthcare workers, which made it impossible to sustain the confirmatory malaria tests. Other challenges included procurement delays due to funding challenges leading to stock outages of the confirmatory kits (Masanja et al., 2011).

**Facilitators for the Implementation of Policies**

**Collaboration among Local and International Partners**

A PEPFAR Program in sub-Saharan countries in East and Central Africa showed that collaboration with host countries, international partners, and other stakeholders led to the success of integrating TB and HIV testing services.

Such commitment and approach was also observed at the program level and led to effective integration, which provided a conducive environment for development of policy, operational guidelines, training manuals, and protocols for TB and HIV activities. PEPFAR supported the erstwhile difficult routine HIV testing of clients into a successful provider-initiated testing through guideline development, modifying recording and reporting systems, procuring test kits, developing linkages to HIV care, and training clinicians.

The Child Support Grant in South Africa was aimed at giving financial assistance to a parent if the other one was not available for assistance due to various circumstances as a way of impact mitigation for HIV/AIDS. The program was well implemented because there was good support from all levels of stakeholders; beneficiaries, community, government officials, civil society, and participatory legislative process (Budlender et al, 2008).

**Training, Supervision, and Incentives for Staff**

The other aspect that led to this success was the support for mentorship and supervision of early rollout initiatives to the Ministry of Health staff. This is in support of another finding, which showed that health worker training, consistent supportive supervision, and steady commodity distribution were important factors leading to success of implementation of new technology of malaria diagnosis rapid tests in Uganda (Asiimwe et

al., 2012). In Zambia, training and giving monetary incentives to existing nursing staff helped with successful integration of the PMTCT program (Stringer et al, 2003).

Sub-Saharan Africa is faced with shortage of health care worker staff. This hinders integration of HIV/AIDS-related services. Any ways of motivating existing healthcare workers to implement programs are a welcome development.

**Sense of Ownership of Guidelines**

Sense of control and ownership of policy guidelines seem to be important in the delivery of HIV testing services at the community level. A study with HIV testing counselors in Malawi stated that the local HIV testing counselors made a lot of modifications to internationally designed guidelines about HIV prevention and impact mitigation to suit their social cultural circumstances. Because some of the modifications sounded plausible for HIV prevention, they deviated from the "standard" (Western) HIV testing norms and ethics. Apparently some deviations were viewed positively by the communities—some of the counselor's actions were thought of as normal by the communities. (Angotti, 2010). It is important for external partners and local experts to work together towards so that such modifications truly meet the intended purpose.

**Literature Review Methods**

The literature review examined a wide range of qualitative issues on barriers and facilitators of health policy implementation. There were issues raised at different levels, such as central policy level, program directorate, local healthcare worker implementers, and other interested parties such as health rights groups. In search of implementation literature, I used the key word "guidelines" for HIV/AIDS, health, and reproductive health. This is because policy implementation is sometimes synonymous with guideline implementation. It has to be

recognized that guidelines may also be simply a technical procedural step-by-step guide for the less experienced people in a particular field.

**Sources literature review for this study.**

The main database used for my literature search was PubMed/Medline. Other databases searched included Web of Knowledge, EBSCO (PsycInfo, HealthSource), PAIS (policy), PolicyFile, and Google Scholar.

**Inclusion criteria.**

HIV/AIDS implementation policy articles and other health policy papers that discussed barriers or challenges to implementation were included. Service guidelines are synonymous policies and the articles outlining barriers and challenges of any health-related guidelines were also included. Search terms used were barriers, uptake, challenges, and implementation. I also used a publication from USAID at http://www.healthpolicyinitiative.com which describes the intended variables.

**Exclusion criteria.**

My initial search was unlimited so that I captured all relevant articles. Thereafter I selected those in the English language that were published after 1993. Luckily enough, there was only one article in French that was excluded because of language.

Articles from countries other than sub-Saharan Africa were excluded in the refined list. However there was an exception: limited literature or books by some experts on health policy issues have been used, especially in the general background section, to bring broad perspectives of policy implementation.

**Key words, search strategies, and results.**

My search constructs were based on the fact that I needed to capture as many facilitators and barriers to implementation of HIV/AIDS and other reproductive health–related policies in sub-Saharan Africa to identify lessons learned and gaps. I ran the literature search from 22–25 February 2012.

I searched PubMed/Medline using search terms outlined below. The search yielded 284 articles. When the same terms were used on Web of Knowledge, a total of 257 articles were identified. Many papers identified were duplicates of those identified through PubMed. My search on EBSCO (PsycInfo, HealthSource) and PolicyFile did not give me relevant articles but PAIS (policy) revealed one new article. I also used Google Scholar because of its high sensitivity in identifying other articles.

**Description of search terms used.**

*Barriers search.*

Barriers to implementing HIV policy
Barriers to broad implementation of health policies
Implementing HIV AIDS Policies*
Barriers to putting HIV policies into action
Scaling up HIV AIDS policies in Sub Saharan Africa
Scaling up HIV AIDS policies in poor resource setting
Implementing HIV AIDS Policies in Sub Saharan Africa
Putting into practice HIV/AIDS Policies Sub Saharan Africa
HIV AIDS policy implementation in Sub Saharan Africa
Barriers to implementation of clinical service guidelines
Implementing reproductive health policies in Sub Saharan Africa
Barriers to implementing health policies in sub Saharan Africa
Challenges in implementing health policies in sub Saharan Africa
Challenges in implementing health care and policy guidelines in sub Saharan
      Africa

**Results for literature search.**

After application of the inclusion/exclusion criteria, a list of 76 (including 8 reviews) articles remained. Specifically these remaining articles focused on guidelines, policy implementation of HIV/AIDS, health, and reproductive health guidelines. Further limitations to sub-Saharan Africa with the words *barriers* and *challenges* yielded 33 articles. Following the same process with Web of Knowledge identified 22 articles. After removing duplicates already identified through PubMed, 17 articles were unique and included accordingly.

**Facilitators' search.**

Although finding barriers indirectly implies that the opposite of these barriers may be the facilitators, I felt that leaving out facilitators in the search would be a source of potential bias. Therefore an additional search for facilitators of policy implementation was done using almost similar terms except for substituting barriers with facilitators. Most of the papers were the same as already identified through barriers. Only 4 papers were deemed unique enough and were included. The search was limited to PubMed/Medline and Web of Science. The terms were as follows:

*Facilitators to implementing HIV policy*

Facilitators to broad implementation of health policies
Implementing HIV AIDS Policies*
Facilitators to putting HIV policies into action
Scaling up HIV AIDS policies in Sub Saharan Africa
Scaling up HIV AIDS policies in poor resource setting
Implementing HIV AIDS Policies in Sub Saharan Africa
Putting into practice HIV/AIDS Policies Sub Saharan Africa
HIV AIDS policy implementation in Sub Saharan Africa
Policy implementation facilitators
Implementing reproductive health policies in Sub Saharan Africa
Facilitators to implementing health policies in Sub Saharan Africa
Facilitators in implementing health policies in Sub Saharan Africa
Facilitators in implementing health care and policy guidelines in Sub Saharan
        Africa

What factors facilitate implementation of policies?
Facilitators of implementation of health policy in Sub Saharan Africa

## Summary of Major Literature Review Findings

Implementation of public health policy requires several players working together. These include community and service providers implementing the policies (including program directors and policy makers, higher technical or political key players). Based on this literature review, it was apparent that problems with policy implementation were operating at various levels and in different forms. At higher technical and/or policy level, the problems were leadership's (key policy players) failure to coordinate among themselves. At the community level, it was clear that society's interaction and sharing of beliefs and culture affect the moral conviction of service providers. Implementation of certain policies will be negatively affected, especially if they are viewed as against cultural norms. Lack of awareness also led to not being confident about policies at the service provider level. It was noted that even leaders were affected by this and consequently failed to provide the most needed guidance and supervision to policy implementation. It was also apparent that policies without input, acceptance, involvement, or adaptation by local stakeholders faced resistance or implementation challenges (especially internationally developed policies). Similarly, lack of political will was another challenge to the success of implementation of policies. At the provider level, there were a combination of leadership, human capacity, resource, and logistics constraints, all important factors affecting implementation. It is evident from this review that resource and logistics constraints are crosscutting policy implementation. They seem to be important generic problems that need to be looked at together with other context-specific factors.

The findings have been put in some thematic areas or categories. However there are so many interactions between findings, and the categorization is based on what the author considers to be the strongest or most unique finding in a particular paper. Understanding different contextual situations in terms of country politics, human resource challenges, actual practice, and government commitment is very important to move in the right direction.

Factors that seemed to facilitate implementation of policies or guidelines were: collaboration of international partners with host countries and other stakeholders, support for mentorship or supervision of early rollout initiatives, and finally, sense of ownership of policy guidelines. The all appeared to drive implementation in the positive direction.

## Strength of the Literature Review

Although there was lack of literature from Malawi and the bulk of literature was from South Africa, there was at least some similarity of general issues from other countries from within sub-Saharan Africa. The findings in this review captured perspectives of top-level and bottom-level policy players.

## Weaknesses of the Literature Review

The ultimate goal of this work is to build enough information toward finding solutions to Malawi policy implementation challenges. Unfortunately there was only one relevant piece of literature cited from Malawi; most literature was from South Africa. It is therefore difficult to deduce definitive reasons in the Malawi context. South Africa did undergo a somewhat different political background and awakening, which may have had some influence on certain policy implementation experiences. The search did not find good local research to see if the implementation uptake would be different to the internationally driven policies, which generally faced a lot of resistance to be implemented.

The literature selected was in various combinations such as commentaries, analysis, and editorials and did not specify type of research such as randomized trials. The use of only English-language articles is a potential source of bias, because I may have omitted some pertinent articles. However, because I first used a general search followed by targeted, I noted only one French article that was left out. The literature review was done predominantly using two major databases, PubMed and Web of Knowledge. Generally the same spectrums of papers were generated. Some of these sources may have given subjective interpretations on the importance of policy implementation issues being presented, which could have been mitigated if one defined type of study were chosen. The challenge is that there is general paucity of the unique body of research in this area.

## Contribution of the Literature Review

The understanding of Malawi-specific challenges for policy implementation is crucial in driving the fight for HIV prevention through policy implementation. This review has helped with understanding general key issues related to implementation of health-related policies. This review dwelt on barriers, but the actual dissertation explored motivators of policy implementation so as to provide complete and realistic recommendations for public health practice. The exploration of HIV/AIDS Policy implementation barriers and motivators will be important for Malawi and similar settings. A summary of literature review papers is presented in Tables 1 and 2.

Table 1.

Summary of Literature Review Papers

| Author Details | Status √=included x=excluded | Type and Description of Source | Remarks |
|---|---|---|---|
| Askew, I, Matthews, Z., & Partridge, R. (2002). Going beyond research: A key issues paper raising discussion points related to dissemination, utilization and impact of reproductive and sexual health research. [On-line]. Available:http:www.socstats.soton.ac.uk | √ | Meta-review | There was systematic selection of peer reviewed articles |
| Baleta, A. 2002, "South Africa hints at HIV/AIDS policy rethink", Lancet, vol. 360, no. 9341, pp. 1232. | √ | Non research (Brief historical perspective) | Presents a vivid example about the importance of political role towards policy implementation |
| Bhana, A., Petersen, I., Baillie, K.L., Flisher, A.J. & The Mhapp Research Programme, C. 2010, "Implementing the World Health Report 2001 recommendations for integrating mental health into primary health care: a situation analysis of three African countries: Ghana, South Africa and Uganda", *International review of psychiatry (Abingdon, England),* vol. 22, no. 6, pp. 599-610. | √ | Situation analysis of policy implementation | Good analysis of policy implementation in three countries following similar methodical approach |
| Caldwell, Glyn G. MD, December 13, 2006, Lecture notes, Department of Epidemiology in the University of Kentucky, College of Public Health.[*] | √ | Lecture notes | Presents general meaning of public health approach. (Used for the purpose of reiterating importance of the topic under study) |
| Chinkonde, J.R., Sundby, J., de Paoli, M. & Thorsen, V.C. 2010, "The difficulty with responding to policy changes for HIV and infant feeding in Malawi", International | √ | Qualitative research- difficulties in implementing internationally | They conducted 5 interviews with policy makers and 11 purposefully selected providers. I think the study participants |

breastfeeding journal, vol. 5, pp. 11.

Cooper, D., Morroni, C., Orner, P., Moodley, J., Harries, J., Cullingworth, L. & Hoffman, M. 2004, "Ten years of democracy in South Africa: documenting transformation in reproductive health policy and status", Reproductive health matters, vol. 12, no. 24, pp. 70-85.

√

driven infant feeding guidelines

needed to be more varied given the implication of this magnitude of interpretation

Not a study but historical analysis of policy implementation citing good governance as one of the important elements along with other factors

Does not give an empirical evidence and therefore it may be argued that it's application may be limited

Evans, C. & Ndirangu, E. 2009, "The nursing implications of routine provider-initiated HIV testing and counselling in sub-Saharan Africa: a critical review of new policy guidance from WHO/UNAIDS", International journal of nursing studies, vol. 46, no. 5, pp. 723-731

√

Review of policy guidance from WHO/UNAIDS

The review looked at the role of nurses in helping with scale up of HIV testing. The reviewers argued that nurses are a very big cadre in offering medical services. The review could have done better to do relative analysis with other cadres in the sub-Saharan Africa which are doing a lot of HIV testing (more than the nurses), these are lay HIV testing counselors specifically trained to offer such services. The inclusion of non-published reports are both strength and weakness as publications which merely didn't not have opportunity to published were included but quality may be compromised at the same time.

Evans, C. & Ndirangu, E. 2011, "Implementing routine provider-initiated HIV testing in public health care facilities in Kenya: a qualitative descriptive study of nurses' experiences", *AIDS Care,*

X

No real policy/implement challenges

vol. 23, no. 10, pp. 1291-1297

| Reference | | Type | Comments |
|---|---|---|---|
| Francke Anneke L, Smit Marieke C, de Veer Anke JE and Mistiaen Patriek. Factors influencing the implementation of clinical guidelines for health care professionals: A systematic meta-review. BMC Medical Informatics and Decision Making 2008, 8:38[*] | √ | Systematic meta review | Methods of the review well described only peer reviewed articles included |
| Gift Kamanga et al, Malawi National AIDS Commission, Best Practices Conference 2007[*] | √ | Peer reviewed abstract presentation at National Dissemination Conference | Single program success of policy implementation for routine HIV testing. Difficult to generalize it for programs because other settings may have different environment, leadership and resources to this single context. |
| Goyer, K.C. & Gow, J. 2002, "Alternatives to current HIV/AIDS policies and practices in South African prisons", Journal of public health policy, vol. 23, no. 3, pp. 307-323. | X | | No direct reference to policy implementation challenges discussed |
| Habte, D., Dussault, G. & Dovlo, D. 2004, "Challenges confronting the health workforce in sub-Saharan Africa", World hospitals and health services : the official journal of the International Hospital Federation, vol. 40, no. 2, pp. 23-6, 40-1. | X | | No direct reference to policy implementation challenges discussed |
| Hanefeld, J. 2010, "The impact of Global Health Initiatives at national and sub-national level - a policy analysis of their role in implementation processes of antiretroviral treatment (ART) roll-out in Zambia and South Africa", AIDS Care, vol. 22 Suppl 1, pp. 93-102 | X | | No direct reference to policy implementation challenges discussed |
| Harding, E., Pettinari, C.J., Brown, D., Hayward, M. & Taylor, C. 2011, "Service user involvement in | X | | Outside Sub Sahara Africa |

clinical guideline development and implementation: learning from mental health service users in the UK", *International review of psychiatry (Abingdon, England),* vol. 23, no. 4, pp. 352-357.

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|---|---|---|---|
| Hasnain, M. 2004, "Antenatal HIV screening and treatment in South Africa: social norms and policy options", African Journal of Reproductive Health, vol. 8, no. 2, pp. 77-85. | √ | Policy analysis discussing how HIV/AIDS and sexual reproductive health policies are affected by high level policy decisions | Not empirical research but discusses recommendations as learned from previous policy decisions |
| Kingdon JW. Participants on the inside of Government. In Kingdon JW. Updated Second Edition; Agendas, Alternatives and Public Policies. Washington DC:Longman, 2011: Page 30-32[*] | √ | Book Chapter | Although this book is written in the US perspective of policy development and implementation, it gives a general generic theoretical and practical perspectives on policy implementation which other settings can learn from |
| Kinsman, J., Harrison, S., Kengeya-Kayondo, J., Kanyesigye, E., Musoke, S. & Whitworth, J. 1999, "Implementation of a comprehensive AIDS education programme for schools in Masaka District, Uganda", AIDS Care, vol. 11, no. 5, pp. 591-601. | √ | Operational research to asses WHO/UNESCO 's School HIV/AIDS program | - |
| Laga M, Manoka A, Kivuvu M, Malele B et al; Non-ulcerative sexually transmitted diseases as risk factors for HIV-1 transmission in women: results from a cohort study. AIDS. 1993 Jan;7(1):95-102 | √ | Clinical trial whose findings are relevant for policies in the fight against HIV | - |
| Leon, N.H., Colvin, C.J., Lewin, S., Mathews, C. & Jennings, K. 2010, "Provider-initiated testing and counselling for HIV - from debate to implementation", South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde, vol. 100, | √ | Editorial | - |

no. 4, pp. 220-221

| Reference | | Type | Comments |
|---|---|---|---|
| Lush, L., Walt, G. & Ogden, J. 2003, "Transferring policies for treating sexually transmitted infections: what's wrong with global guidelines?", Health policy and planning, vol. 18, no. 1, pp. 18-30. | √ | Policy analysis-review | The inclusion of non-published literature is good to include other potentially good work which did not find its way to publication for some valid reasons but may also compromise quality in certain cases as they may not be peer reviewed. The long span of review (30 years) of paper in this analysis is a historical opportunity to learn from many scenarios but at the same time there may be loss of historical relevance on some issues. |
| Mahajan, A.P., Colvin, M., Rudatsikira, J.B. & Ettl, D. 2007, "An overview of HIV/AIDS workplace policies and programmes in southern Africa", AIDS (London, England), vol. 21 Suppl 3, pp. S31-9. | **X** | | Does not discuss challenges of policy implementation issues |
| Mantell, J.E., Scheepers, E. & Karim, Q.A. 2000, "Introducing the female condom through the public health sector: experiences from South Africa", AIDS Care, vol. 12, no. 5, pp. 589-601. | √ | Operational research assessing the implementation of a new " socially sensitive" program | - |
| Masanja, I.M., de Bethune, X. & Jacobs, J. 2011, "Implementing ideal health policy in a fragile health system: the example of expanding the use of malaria rapid diagnostic tests in mainland Tanzania", Malaria journal, vol. 10, pp. 322. | √ | Commentary about policy implementation | - |
| Mathews, C., Boon, H., Flisher, A.J. & Schaalma, H.P. 2006, "Factors associated with teachers' implementation of HIV/AIDS education in secondary schools in | √ | Descriptive study on program implementation | Low response rate (56%) |

| Reference | | Type | Notes |
|---|---|---|---|
| Cape Town, South Africa", AIDS Care, vol. 18, no. 4, pp. 388-397. | | | |
| Mayhew, S.H., Lush, L., Cleland, J. & Walt, G. 2000, "Implementing the integration of component services for reproductive health", Studies in family planning, vol. 31, no. 2, pp. 151-162. | √ | Qualitative research evaluating implementation of HIV/AIDS, STI and other reproductive health service integration in several countries | - |
| McKillop A, Crisp J, Walsh K. | **X** | | Outside Sub Sahara Africa |
| Moodley, J., Kawonga, M., Bradley, J. & Hoffman, M. 2006, "Challenges in implementing a cervical screening program in South Africa", Cancer detection and prevention, vol. 30, no. 4, pp. 361-368. | √ | Policy implementation study | Study methods well described |
| Murray, J., Davies, T. & Rees, D. 2011, "Occupational lung disease in the South African mining industry: research and policy implementation", *Journal of public health policy,* vol. 32 Suppl 1, pp. S65-79 | √ | Policy implementation commentary | - |
| Myer, L. & Akugizibwe, P. 2009, "Impact of HIV treatment scale-up on women's reproductive health care and reproductive rights in Southern Africa", Journal of acquired immune deficiency syndromes (1999), vol. 52 Suppl 1, pp. S52-3. | **X** | | Discusses policy formulation than implement |
| Narendra, RP. (2009). A Critical Account of Policy Implementation Theories: Status and Reconsideration. *Nepalese Journal of Public Policy and Governance*, Vol. xxv, No.2. | √ | Theoretical overview of policy implementation | Provides broader framework in which policy implementation falls |
| Nzinga, J., Mbindyo, P., Mbaabu, L., Warira, A. & English, M. 2009, "Documenting the experiences of health workers expected to implement guidelines during an | √ | Qualitative implementation research | - |

intervention study in Kenyan hospitals", Implementation science: IS, vol. 4, pp. 44.

| | | | |
|---|---|---|---|
| Okot-Chono, R., Mugisha, F., Adatu, F., Madraa, E., Dlodlo, R. & Fujiwara, P. 2009, "Health system barriers affecting the implementation of collaborative TB-HIV services in Uganda", The international journal of tuberculosis and lung disease : the official journal of the International Union against Tuberculosis and Lung Disease, vol. 13, no. 8, pp. 955-961. | √ | Qualitative policy implementation research | - |
| Parkhurst, J.O. & Lush, L. 2004, "The political environment of HIV: lessons from a comparison of Uganda and South Africa", *Social science & medicine (1982),* vol. 59, no. 9, pp. 1913-1924. | √ | Political-policy analysis from two countries | - |
| Reich, M. R. (1995). The politics of health sector reform in developing countries: Three cases of pharmaceutical policy. In: Berman, P. (Ed.). Health sector reform in developing countries: Making health development sustainable, Chapter 3. Harvard School of Public Health, Boston, MA: Department of Population and International Health[*] | √ | Book Chapter | - |
| Rowa, Y., Abuya, T.O., Mutemi, W.K., Ochola, S., Molyneux, S. & Marsh, V. 2010, "Factors influencing implementation of the Ministry of Health-led private medicine retailer programmes on malaria in Kenya", BMC public health, vol. 10, pp. 93. | **X** | Qualitative research assessing program implementation | - |
| Sachs M: Successful strategies and methods of nursing standards iplementation). Pflege 2006, 19:33-44[*] | √ | Policy analysis | - |
| Schneider, H. & Stein, J. 2001, "Implementing AIDS policy in | √ | Historical policy analysis | - |

| | | |
|---|---|---|
| post-apartheid South Africa", *Social science & medicine (1982),* vol. 52, no. 5, pp. 723-731. | | |
| Schneider, H., Gilson, L., Ogden, J., Lush, L. & Walt, G. 2006, "Health systems and the implementation of disease programmes: case studies from South Africa", Global public health, vol. 1, no. 1, pp. 49-64. √ | Historical policy analysis | Good historical analysis of two case policy case studies implementation challenges. Since there is lack of scientific collection of information to inform such an analysis, the strength of its evidence for general application can be questionable |
| Simonsen J. Neil, M.D., D. William Cameron, M.D., Human Immunodeficiency Virus Infection among Men with Sexually Transmitted Diseases. N Engl J Med 1988; 319:274-278[*] √ | Clinical trial whose findings are relevant for policies in the fight against HIV | - |
| Thomson, H.I. 1999, "A prioritized implementation plan. Malawi. The Hague Forum", *Integration (Tokyo, Japan),* vol. (60), no. 60, pp. 24. **X** | | Policy implementation commitment |
| UNAIDS; Global Report 2010 Fact sheet: Sub-Saharan Africa[*] √ | Global HIV fact sheet | - |
| USAID, 2009. Policy Implementation Barriers Analysis: Conceptual Framework And Pilot Test In Three Countries. Accessed at http://www.healthpolicyinitiative.com[*] √ | Qualitative analysis | - |
| Wachira, C. & Ruger, J.P. 2011, "National poverty reduction strategies and HIV/AIDS governance in Malawi: a preliminary study of shared health governance", *Social science & medicine (1982),* vol. 72, no. 12, pp. 1956-1964. **X** | | No direct reference to policy implementation challenges |
| Watts, C. & Kumaranayake, L. 1999, "Thinking big: scaling-up HIV-1 interventions in sub-Saharan Africa", *Lancet,* vol. 354, no. 9189, pp. 1492. **X** | | Scaling Up Interventions |

*The article was not sourced through primary search in PubMed

Table 2.

An Addendum to Literature Review for Additional 17 Articles from Web of Knowledge

| Paper Details | Inclusion Status in the Review | Reason for Exclusion |
|---|---|---|
| Budlender, Debbie, Proudlock, Paula and Jamieson, Lucy. Formulating and Implementing Socioeconomic Policies for Children in the Context of HIV/AIDS: A South African Case Study 2008 | Included | N/A |
| Cabana, M., Brunton, S., Jacobs, RP, et al., Barriers to guideline adherence 1998 | Not included | Outside the setting of my review |
| Campbell, Catherine. Political will, traditional leaders and the fight against HIV/AIDS: a South African case study 2010 | Included | N/A |
| Church, Kathryn, de Koning, Korrie, Hilber, Adriane M., Ormel, Hermen and Hawkes, Sarah. Integrating Sexual Health Services Into Primary Care: An Overview of Health Systems Issues and Challenges in Developing Countries 2010 | Included | Does not discuss implementation barriers and facilitators of health policy but general issues of high burden of sexual and reproductive health |
| Clarkson, JE. Getting research into clinical practice - Barriers and solutions 2004 | Not included | Outside the setting of my review |
| Evensen, Jane V., Stokke, Kristian. United Against HIV/AIDS? Politics of Local Governance in HIV/AIDS Treatment in Lusikisiki, South Africa 2010 | Included | N/A |
| Grimshaw, JM, Thomas, RE, MacLennan, G., et al., Effectiveness and efficiency of guideline dissemination and implementation strategies RID G-7338-2011 RID D-3998-2009 2004 | Not included | Outside the setting of my review |
| Hardon, A. Confronting the HIV/AIDS epidemic in sub-Saharan Africa: policy versus practice 2005 | Not included | Does not discuss implementation barriers and facilitators of health policy but policy shift over time |
| HEIDENBERGER, K., FLESSA, S. A System Dynamics Model for Aids Policy Support in Tanzania 1993 | Not included | Outside the scope of years |
| Jensen, Kipton, Gaie, Joseph B. R. African communalism and public health policies: the relevance of indigenous concepts of personal identity to HIV/AIDS policies in Botswana 2010 | Not included | Does not discuss implementation barriers and facilitators of health policy |

| | | |
|---|---|---|
| Kurowski, Christoph, Wyss, Kaspar, Abdulla, Salim and Mills, Anne. Scaling up priority health interventions in Tanzania: the human resources challenge 2007 | Not included | Does not particularly discuss implementation barriers and facilitators of health policy but rather general human resource constraints |
| Loveday, Marian, Zweigenthal, Virginia. TB and HIV integration: obstacles and possible solutions to implementation in South Africa 2011 | Included | N/A |
| Mamdani, Masuma, Rajani, Rakesh and Leach, Valerie. How Best to Enable Support for Children Affected by HIV/AIDS? A Policy Case Study in Tanzania 2008 | Not included | Does not discuss implementation barriers and facilitators of health policy |
| Meessen, Bruno, Hercot, David, Noirhomme, Mathieu, et al., Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries 2011 | Not included | Does not discuss implementation barriers and facilitators |
| Stringer, E. M., Sinkala, M., Stringer, J. S. A., et al., Prevention of mother-to-child transmission of HIV in Africa: successes and challenges in scaling-up a nevirapine-based program in Lusaka, Zambia 2003 | Included | N/A |
| Vassall, Anna, Compernolle, Phil. Estimating the resource needs of scaling-up HIV/AIDS and tuberculosis interventions in sub-Saharan Africa: A systematic review for national policy makers and planners 2006 | Not included | Does not discuss implementation barriers or facilitators but resource estimates |
| Whelan, Ronald, Dickinson, David and Murray, Tessa. Use and neglect of best-practice HIV/AIDS programme guides by South African companies 2008 | Not included | Does not discuss implementation barriers and facilitators |

## CHAPTER 3: STUDY DESIGN AND METHODOLOGY

### Study Design

This is a nonexperimental, descriptive study using a case study design that looked at the Malawi HIV/AIDS Policy from 2003 to 2013. In-depth stakeholder interviews were used and supplemented by document review to give some background information and other perspectives that were not obvious from in-depth interviews. Methods are organized into literature review methods, interview procedures, and document review.

### Feasibility and Validity of the Study

This study is feasible because it used generic scientific methods for qualitative work in the enquiry and data analysis. Qualitative research is derived from understanding of diversity and intelligence of people in their thinking and interpretation of issues around them. Therefore research should be purposeful, dynamic, and effective, not only to quantify and verify problems but also to further explore and create understanding. A good study should have a mix of philosophical worldviews with a specific method of enquiry and sound research methods, which was the case here. Equally important is the fact that there should be an underlying theory or perspective within which the research is going to contribute (Creswell, 2009). The inception of this study followed through these principles.

**Document Review Importance and Methodology**

Document review is a way of collecting data by reviewing existing documents. It provided some important information that was not readily available from the data collected. It helps with general understanding of the history, philosophy, and operation of the program

being evaluated. The importance of this approach is that the researcher is provided with good

sources of background information and a "behind-the-scenes look" at a program that may not

be directly observable through the data collected (Evaluation briefs, 2009).

In this case, document review helped provide the general status quo of the

implementation of the specific policy components. Relevant documents were searched

through Google using terms such as Malawi HIV testing reports, Malawi sexually

transmitted reports, Malawi PMTCT reports, and Malawi Health Facility Survey reports.

Various program reports from the Ministry of Health were also used. Specific information

looked for in these documents were service uptake pertaining to the policy component,

operational challenges, lessons, and recommendations.

The principal investigator also provided personal insights to supplement the

document review because of his longtime experience working in the health sector,

particularly in HIV/AIDS programs, sexually transmitted infections programs, and other

reproductive health programs. Although this may be a source of bias, this approach is

acceptable and has been successfully applied before (Hobbs et al., 2004).

**Interview Procedures**

**Specific study procedures.**

To have a good understanding of the implementation issues of the Malawi 2003

HIV/AIDS Policy, three main levels of stakeholders were interviewed. These were: (1)

operational-level stakeholders, such as local healthcare workers or their leaders from the

Ministry of Health and CHAM health units; (2) high-level supervisory and policy leadership

(senior health workers/policy makers) at the Ministry of Health, National AIDS Commission,

and the Office of the President and Cabinet, including the Malawi National AIDS

Commission; and (3) health rights or lobbying groups that were basically members of

HIV/AIDS service organizations that also promote health equity issues.

Twenty in-depth interviews were conducted with healthcare workers, senior health

leaders/policy makers, and health rights groups. The healthcare worker interviews were

conducted in 2 of the 5 health zones. Senior health leaders/policy makers were selected from

among the current or previous officer holders. The principal investigator was privileged that

he knew most of them, having worked or officially collaborated with them in various

capacities within the health sector. This relationship made it easier to secure interviews.

Five people from the senior health official/policy maker category were interviewed, thirteen

participants were healthcare workers, three of which were local health workers leaders.

This is an important group because they are the local policy implementers. Two interviewees

were from the health rights groups. The interviews were conducted at convenient locations

for the participants so that they did not incur travel expenses.

Health workers with at least 3 months tenure in their respective roles were recruited.

A full description of study participants is presented in

Table 3.

Schedule and Description of Study Participants

| Name of Stakeholder | Level of Stakeholder | Number of Units | Description/Remarks |
| --- | --- | --- | --- |
| Official from Office of President and Cabinet | Senior health leader/Policy maker | 1 | The top ranking person in policy issues of HIV/AIDS such as Secretary for HIV/AIDS and Nutrition or his/her representative (current or previous) |
| National AIDS Commission or Ministry of | Senior health leader/Policy maker | 1 | The Executive Director/Secretary for Health or an official whose |

| Health | | | jurisdiction is in HIV/AIDS policy (current or previous) |
|---|---|---|---|
| HIV/AIDS Department | Senior health leaders/ Policy makers | 3 | These are the national focal persons who run the programs. 1 PMTCT, 1 STI and general general HTC coordinating person (this person will be very important to give insights on general PITC issues) (current or previous) |
| HIV/AIDS Coordinators | Health care workers (to be referred as Health Care Supervisor) | 3 | These are local health workers leaders supervising the people working on the ground. They coordinate implementation of HIV/AIDS issues. Two from districts and one from an AIDS Service Organization |
| Officials from Health rights/interest groups | Health rights/interest groups | 2 | Intervening stakeholders between policy makers and implementers |
| Health care workers who have worked long enough in their HIV/AIDS related services | Health care workers (facility level stakeholders) | 10 | (Purposefully chose 6 providers from outpatient clinics where STI or other general outpatients and 4 from PMTCT services) |

**Rationale for choosing study groups and methods.**

*Interview with healthcare workers (facility-level stakeholders).*

The backbone of implementation of HIV/AIDS or other health-related policies is the healthcare workers. It is therefore very important for them to be involved in the implementation process.

Healthcare workers were interviewed about their knowledge of the policy and the reasons that motivate them or discourage them from supporting the policy's implementation.

In a typical bottom-up approach, it would be expected that this group would have fully participated. With a top-down approach, we would expect to observe dominance of and dictations from the policy makers with little engagement of the healthcare workers who would be required to implement the policy.

### *Interview with senior health leaders/policy makers.*

In cases of the traditional top-down approach policy process, the central government is at the center of formulating policies and directing its implementation. It was therefore expected that the senior health workers/policy makers would understand the intention of the HIV/AIDS Policy, for whom it was intended, who was supposed to implement it, how it was implemented, and the outline of challenges. Because policy implementation is part of a chain that starts with other components such as problem identification and policy making, it is important to highlight if there were any issues of importance from policy makers regarding how these other processes were handled. Face-to-face interviews were the preferred method, however because some of the participants are very busy, an option of telephone call interview was used in such cases. Two participants were interviewed through telephone because one was in a very remote district and the other was in the United States.

### *Interview with health rights/interest groups.*

Issues dealing with implementation of government policies may sometimes be very sensitive. Some senior people may thus deliberately withhold important information or say something simply to impress their masters. The healthcare workers on the ground may also have different views.To come up with balanced perspectives, the principal investigator involved people at the leadership level who are outside the government system. Groups advocating people's rights to health access and equity, especially HIV/AIDS, were chosen

because of their perceived good understanding of implementation of HIV/AIDS programs through their local and international engagement.

## Data Collection and Management

Interview guides (Appendix 1) were developed under the guidance of Sandra Greene, DrPH, Professor and Interim Chair of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill. The guides were also peer reviewed by my doctoral classmates through formal class presentation. Finally they were reviewed by a five-member dissertation committee before being administered to participants. I conducted the in-depth interviews in English for all (except for healthcare workers who were not able to properly handle the interview in English, in which case I used the local language–Chichewa). A combination of handwritten notes and audio-recording were used to capture the information, depending on the preference of the participants and convenience. Audio recording enables details to be obtained with accuracy that cannot be obtained from field notes or memory alone; it also allows more eye contact and a more relaxed setting (Babirye et al., 2011). For those people were interviewed by telephone as a matter of their convenience, permission for recording was also sought from them.

The digital recordings were transferred into a password-protected computer, which was accessed only by the principal investigator. Afterward, in-depth interviews and, whenever appropriate the audio were translated from Chichewa to English and transcribed accordingly.

The guides addressed the following substantive question areas for policy components:

Involvement of stakeholders in policy formulation and implementation
How the policy was disseminated
Strategies that were put in place to implement policy
Facilitators for implementing policy

Barriers for implementing policy
Strategies for monitoring policy
Leadership support in implementing policy
Recommendations to address barriers
Stakeholder coordination

**Data Analysis**

Data analysis was done by CDC EZ Text, version 4.06, developed by Info SciSi Co.

Inc. A database was developed and data from transcripts were entered according to

corresponding questions. A code book was developed and re-created in the database. The

initial code book was populated with predetermined themes from the in-depth interview

guides, which were developed using insights from the literature review and the study's

conceptual framework of top-down and bottom-up. After reading and rereading the

transcripts, there were no additional codes worth adding. Respective data for participants

were retrieved through the database queries. I continuously wrote some analytical memos of

interesting text through comment tab from the transcripts, kept track of them and used them

during the analysis.

To achieve reliability and validity, coding should ideally done by two or more people

and assessed through intercoder agreement (Morgan & Oxtoby, 1996).

 To fulfill this requirement, I liaised with a trained qualitative interviewer /social scientist

from my organization on code selection and there was almost total agreement. Data from

interviews and literature were synthesized and summarized and recommendations were made

accordingly. Document review provided the important background updates and some

historical perspectives of the policy implementation and general understanding of the policy

coordinating structure.

The dissertation committee asked me to provide some reflections about my data after the first three interviews so as to take note of any possible amendments to the interview guides. The questionnaires looked consistent and did not warrant amendments. The only notable modification was that I removed some excess questions from some senior health workers/policy makers and left those pertaining to their areas of expertise. In this case, only those who were coordinating the overall policy were asked questions covering all the components. When asking participants about involvement in the 2003 HIV/AIDS policy-making process, participants mostly volunteered to talk about their involvement in the new 2003 HIV/AIDS Policy as well and this was noted accordingly.

**Personal Reflections about Data Collection and Analysis**

I approached this data collection with an open mind by "listening" to myself while conducting interviews. My understanding of the Malawian culture and the way people talk or respond to questions helped me easily pick up what the participant was trying to say. This led me to ask appropriate probing questions at the end of the participant's explanation. However this has the potential to negatively influence a participant's responses if the interviewer is too preemptive (i.e., the interviewer has a conscious or subconscious sense of knowing what the participant wants to say and therefore finishes sentences or phrases for the participants). I was on my guard against that tendency throughout data collection.

My experience and passion in this field worked to my advantage because I easily understood and appreciated technical terms used by participants and their emotional reaction to issues under discussion.

It was tempting in some situations for me to lead, conform to, and support the participant's reactions, but I actively refrained and maintained my position as a researcher.

As a researcher and a person who worked in the field of this policy area, I am an additional source of information for this research and wherever necessary in this dissertation, I declared my personal observations accordingly to avoid mixing them with my participants' data.

## Ethical Considerations

### Ethical Approval

Before the study was conducted, ethical approval was obtained from the Malawi National Health Sciences Research Committee and the UNC at Chapel Hill IRB. Written permission was also sought from gatekeepers such as heads of institutions to interview personnel.

### Informed Consent

An informed consent was obtained from all participants. Consenting agreement was discussed before conducting interviews.

For those undergoing face-to-face interviews, a signature was sought, but for participants who agreed but opted for telephone interview, their consent was only verbal and documented accordingly. Those who opted for telephone interview were asked if willing to have the conversation recorded.

### Confidentiality

The digital recordings were transferred into a password-protected computer that was accessed only by the principal investigator. Any other interview recordings such as notes and hard-copy scripts were kept in a lockable cabinet accessed only by the principal investigator and other authorized agents.

Electronic documents were backed up in a personalized institutional server space and an external hard drive, which was kept in a securely lockable place. Participants were not

identified by names but by type of participant and number, such as PITC/STI 3XW, PMTCT 3XX, Health rights activist 3XY, senior health worker/policy maker 3XZ.

I ensured no link of personal information to findings. However, there is a small risk that for people with very senior positions for their identity to be inferred based on what they might have said. This might put them in some conflict, especially if it is deemed that what they said was tantamount to criticizing their superiors (government authorities). To mitigate this, I included current and former office holders as my participants.

# CHAPTER 4: RESULTS

Data from the interviews were reviewed and analyzed according to study aims. The outputs of data are stakeholder perspectives, which are mostly narrative. These have been displayed according to major themes that emerged. I presented a descriptive summary table for both, barriers and facilitators of policy implementation according to stakeholders in appendix 7.

## Barriers for Policy Implementation

### Problems with the Process of Policy Making

#### Healthcare workers perspectives on policy-making process.

Most of the health care workers interviewed especially in the STI/PITC category were not involved in the policy-making process. Only one of the 6 participants interviewed reported having been involved partially in the policy-making process. At least 2 of 4 PMTCT participants were involved in the policy formulation of the overall HIV/AIDS Policy. One of the involved PMTCT healthcare worker participants emphasized the importance of the involvement of healthcare workers in the policy-making process:

> "In fact in those meetings, there are a lot of things being done at the implementation level 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, things that will benefit the people we are targeting, problems that the communities are facing, and how best can the policy address those issues." (PMTCT 300)

**Health rights activists' perspectives on policy-making process.**

The participants who have been categorized as senior health worker/policy makers are the representatives of government in various capacities. Apart from initiating policy, some of them form part of the very top leadership and are held responsible for the implementation of their respective HIV/AIDS-related programs while some oversee the entire HIV/AIDS response. It is not unusual to find biased responses of successful implementation from this level of stakeholders. It is also natural for healthcare workers not to speak well of their superiors. To mitigate this, I added health rights activists to act as tie breakers to ensure credibility to the findings.

The health rights activists interviewed expressed dissatisfaction with involvement in the policy-making process. They bemoaned lack of adequate involvement for them as health rights groups and they also complained of poor involvement of the health care workers on the ground.

One of the health rights activists hinted on this challenge,

> "As a structure we were involved but it was not meaningful . . . what I believe
> is that issues in the policy needed to come from us, people on the ground. That
> could have been the very first page of the policy, looking at the issues, what
> are the objectives?" (Health rights activist 319)

**Problems with Policy Awareness/Dissemination**

Knowledge of the entire policy is important because it broadens holistic understanding and the interface of various components, which will eventually help to inform how to more effectively implement a policy. There were very few instances where healthcare workers seemed conversant with the entire HIV policy. Some healthcare workers were only conversant with their specific clinical guidelines and implemented them.

They ignored the HIV testing component because most of them did not have good

awareness about its importance; there was no proper enforcement about it.

Only one of four PMTCT participants had actually seen and read the actual

HIV/AIDS Policy but all were implementing it. From the policy document, there was good

intention and a national plan for dissemination of the HIV/AIDS Policy from the top

leadership to the people on the ground. However there was lack of commitment from top

leadership to translate dissemination into practice.

**Healthcare worker perspectives on policy dissemination.**

Local health leaders also need to make sure they take proactive role in disseminating

the policy to the people they supervise. There was a lack of clear leadership by the local

healthcare leaders to pass on the policy to the implementing healthcare workers. In one

instance, a health worker team leader said he had the policy placed in his office and library

for providers to read but the providers from that facility denied having being informed about

where to get policy. The participant stated,

> "The policy generally is available in this office, so that when people want to
> see what is stipulated in the policy, they have a chance to do so, to access it."
> (Health Care Supervisor-305)

Healthcare workers in a busy setting like Malawi do not easily find time to read

guidelines. Ironically, the same health worker supervisor observed:

> "In this way, (training health care workers) people will be enlightened rather
> than asking people just to read because people may not necessarily read. You
> can not necessarily point fingers at them that they are lazy but it may be
> because they were busy implementing and they don't have the chance to go
> back and (read)…" (Health Worker Supervisor 305)

There was need for deliberate efforts by leadership to disseminate the policy to

healthcare workers but this was lacking. Sometimes healthcare workers learned about the

policy or amendments informally through their own personal initiatives and sometimes

through response from clients who may have heard elsewhere. It is difficult for such

healthcare workers to take the policy provisions seriously enough and implement. Moreover,

they may not have learned the actual details of the policy component. A healthcare worker

reiterated concern over this and advised the way forward:

> "Aah, basically just hearing from people without any particular initiative …
> they (leadership) should hold immediate briefing when people have just
> graduated or have just come from anywhere, we need to ask them if they have
> ever heard about the policy and then sensitize them. Someone like a
> coordinator should be responsible for that." (PITC/STI 304)

This participant works in an outpatient setting that attends to several thousands of patients

per month. As a result of lack of awareness of the HIV/AIDS policy by healthcare workers,

thousands of patients are denied the routine offer of HIV testing in this setting.

Another healthcare worker who participated in the policy-making process also stated

that dissemination to healthcare workers on the ground was problematic. The on-the-job

training or sensitization did not go well.

> "… as I said, the first sessions were for focal people/coordinators, and then
> those coordinators had these sessions. But for the rest it was on job training.
> So those on the job training had challenges." (PMTCT 300)

Considering the fact that it is not practical to train everybody on a new policy in the

shortest time possible, healthcare workers can be debriefed by their peers who went for

formal training and go on with the implementation. However, in practice, this arrangement

does not work well with most healthcare workers.

Those who have just been briefed become jealous and frustrated that their colleagues

benefited more in terms of incentives like certification, monetary allowances, and official

recognition by various authorities. One healthcare worker said that no matter how well a

person who has just been peer-debriefed performs on the job, when there are further job openings or on-the-job promotions they consider those who went for formal trainings first.

Most participants reiterated that the best way to sensitize the healthcare workers should be formal trainings. They argue that mere briefings miss some important issues the healthcare workers need to know. There is better acceptance of peer debriefing in institutions with good training programs because healthcare workers know that it is just a matter of time, those debriefed will also have their opportunity of training.

> "I think formal trainings are very important because when you come from trainings you just brief your friends only on the important information but you may miss some of the other information. So briefing may also just be for an hour or 30 minutes while someone may have been trained for one week. Formal trainings are very important for each and every person, because that's where you really have the full information and it's easy for you to implement when you have the full knowledge about that." (PITC/STI 307)

> "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 place where I am deployed is a government facility, people resent such an arrangement because they say, "iyeyo wadyapo, ndiye akufuna ife timugwirire ntchito yake" (GK: meaning he/she has been paid and yet want us 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)

This challenge is very important and it was also acknowledged by a senior health worker/policy maker. (316)

On a personal experience note, the Johns Hopkins Program for International Programs reproductive health (JHPIEGO) in collaboration with the Malawi Ministry of Health trained me in several reproductive health services so that I could train my colleagues on the job in the early 2000. There was a great deal of resistance from colleagues to learn from me and practice some skills because they felt I benefited from incentives as a trainer while they were not benefiting. I discussed this concern with the Ministry of Health and

JHPIEGO authorities and we came up with a plan where healthcare workers were awarded certificates upon completion of the on-the-job training sessions. Thereafter the compliance was better with the on-the-job training. However, that experience does not cover how to address the issue of monetary incentives which is also a problem in the case of this policy.

The policy enforcement approach in PMTCT services was very good in that PMTCT services had almost 100% coverage of HIV testing for all antenatal women. All healthcare workers were trained in HIV testing and there was deliberate deployment by the government of special HIV testing counselors in antenatal clinics. This was not the case with PITC/STI services.

There was no deliberate strategy of training all healthcare workers on HIV testing and the placement of HIV testing counselors was not consistent.

> "I would say resources were there as well as human resources. But I think if everybody, doctors, clinicians and nurses were trained they can provide the (HIV testing) services. The problem is that there are some specific people who are trained and when those people are not available others will not take initiative because they will say someone is already trained in this." (PITC/STI 304)

In addition to many health workers dissemination of this policy missed, the other important healthcare cadre missed was health surveillance assistants (HSAs). This is a junior multitasked healthcare cadre key in the provision of several public health services. It is important that they should be fully aware about the HIV/AIDS Policy because they are the people who do a lot of HIV testing in Malawi. One healthcare worker stated,

> "… HSAs don't have full knowledge about what the policy says. I wish that they could start (sensitizing) those that work at grassroots like the HSAs, community workers or volunteers so that they should be aware of the policy." (PMTCT 303)

Implementation of the HIV/AIDS policy requires an adequate number of healthcare workers. HIV testing for PITC/STI and PMTCT can be done by the trained healthcare workers but due to shortage of staff, a lesser cadre of healthcare workers/health surveillance assistants are deployed to help out with HIV testing. This cadre unfortunately is trained in several other public health tasks to the effect that they fail to meet HIV testing needs.

Some NGOs have used non-medically trained counselors to solely do HIV testing (Kamanga & Gumbo, 2006). They are even deployed to help with HIV testing in public health facilities. It is sensible for the government to formally adopt this group to scale up HIV testing. One of these HIV testing counselors explained:

> "Another issue is that although we are doing our job well, we are not a recognized cadre (by the government)...As I earlier pleaded let the authorities think about us so that we do this work whole heartedly." (PMTCT 301)

Two senior health workers/policy makers corroborated and recommended this cadre.

The other strategies include training all STI health workers in HIV testing and counseling and/or recruiting more from among the healthcare workers. However, the latter is not an achievable option in a short time given the inadequate number of healthcare workers.

Sometimes policy dissemination information or updates were done to the general public through the media before sensitizing the healthcare workers. As a practicing healthcare practitioner and leader of a large HIV/AIDS and STI unit, I myself have encountered similar situations. At one point, we saw an increasing number of patients asking for emergency contraception once they had unprotected sex because they heard from the media that such a service is available at all hospitals.

We used to send them away until we took the initiative to find out what was happening and we were told it was new government policy to offer HIV emergency

contraception for all female clients who report unprotected sex. It was surprising, because we felt we were too big to be ignored about such an important update. In other words, demand had been created without the healthcare workers being ready to handle the issues.

This does not only frustrate the healthcare workers who feel embarrassed for failure to assist their clients because of lack of knowledge about the policy, it is also a bad experience for a client. A healthcare worker lamented this tendency:

> "We should be brought together and briefed. What is happening currently is that most of the staff are not briefed on some new things that have come up. Sometimes we first hear things through radios or TVs and yet we health care workers are not informed." (PMTCT 301)

Although many PITC/STI healthcare workers indicated that they were aware of the existence of the 2003 HIV/AIDS Policy, only three participants of seven had seen the actual policy document. Without proper sensitization on the HIV/AIDS policy, healthcare workers only focused on their clinical mandate rather than "additional" issues of HIV testing. The approach that will help move to effective implementation is to sensitize people on the actual policy, which will help HIV testing stand out as an important intervention.

**Health rights activists' perspectives on policy dissemination.**

Health rights activists indicated that policy dissemination among their members of staff and member organizations was through staff meetings, public awareness, and distribution of copies of policy documents. They complained that the policy dissemination generally lacked wide community consultation/participation. One health rights activists observed the need for policy holders to make use of existing community structures for effective dissemination of policies:

> "A policy is not law, people may refuse. I would recommend use of existing structures. The target audience should have a say and decide whether a

particular way is appropriate… These are critical because people will be able to identify what belongs to them." (Health rights activists 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 305) and a health worker supervisor for for (312). He emphasized the fact that government was supposed to lead the dissemination but relied on other stakeholders to roll out the entire process:

> There was a gap about awareness of the policy. (Knowledge) of what is really in the policy was a challenge because after the government launched it, they depended on other stakeholders to take (the policy) to the community…I did not see any other ways of publicizing it, the launch was the end. (Health rights activists 318)

Although government held the leadership role in the implementation of the policy, the expectation is that various stakeholders also take responsibility over supervision of the policy process in their respective constituencies. Ironically, one leading health rights group organization that was involved in the policy process faulted the government for poor policy awareness among fellow health rights groups that were actually under his jurisdiction to coordinate. The health rights activist said:

> "I don't think there has been a better time of awareness. It was just at a time when the new HIV Bill was developed that provoked activists to say why this, why that? That's when people started relating to the HIV/AIDS Policy. Before that, I don't think people were really in the know how." (Health rights activists 318)

Informing such groups could have been done by this leading health rights activist group (not necessarily by government) because these were members of their constituency. As part of the policy process the expectations, roles, and mandates of stakeholders and local supervisors need to be properly defined to ensure smooth implementation process.

**Health worker supervisor perspectives on policy dissemination.**

Health worker supervisors were the least satisfied about the policy-making process among those higher in the hierarchy. They felt sidelined by their top-ranking officials in the execution of the HIV/AIDS policy. The major reason for dissatisfaction was lack of involvement in policy formulation and major decisions about implementation. One health worker supervisor sounded very concerned about lack of involvement:

> "Largely I would think because we are not actually involved or give contribution to the policy and that we do not even know what is in the policy… But I have to be honest with you that there are a lot of things that we are not sure. We do not know them because we are not involved in giving contributions to the policy." (Health Worker Supervisor 312)

> "No, they (health care workers) were not informed of the policy and they don't actually know about this HIV Policy or what is contained in it." (Health Worker Supervisor 312)

This is worrying considering that policy implementation activities are implemented on the ground. One of the two healthcare workers working under the supervision of this health worker supervisor knew about the policy from top leadership, a sign that the supervisor was bypassed in the process. The other healthcare worker knew about it from other programs she was involved in. These participants also preferred formal sensitization as the best way forward.

**Problems with Leadership Support**

Lack of good leadership support at various levels of the processes of policy cycle negatively affected implementation. Several participants (health worker supervisor 305, health rights activist 319, and senior health worker/policy maker 316) expressed a concern that the three coordinating stakeholders—the Office of the President and Cabinet, Ministry of

Health, and National AIDS Commission—do not provide a clear line of authority of supervision. As a result, healthcare workers get some conflicting directives.

**Healthcare workers' perspectives about problems with leadership support.**

Many PITC/STI health worker participants indicated some problems with current supervision and leadership support. The main complaints were erratic supervision or no supervision at all. The lack of supervision was more prominent among the PITC/STI participants than PMTCT.

Two participants from PITC/STI lamented,

"Umm! Honestly speaking, there is no support but when people are trained in that area, they just do it for the first weeks and then just leave it like that. Umm! That's what happens in most cases." PITC/ STI 304)

"I can say supervision is not that good since I came here in the HIV Department, I haven't seen anyone coming here to supervise STI (services)." (PITC/ STI 310)

Another area where the government or the coordinating mechanism has not done well is lack of deployment of enough number of HIV testing counselors in testing sites.

A healthcare worker complained that the Ministry of Health and National AIDS Commission have double standards, setting minimum requirement and yet they do not comply with their own set standards. One Health care worker lamented:

"… Now at that level they know that there are supposed to be two counselors but they only fund one. So it's like there are contravening their own policy. So that's the challenge." (Health Worker Supervisor 305)

**Senior health worker/policy-makers' perspectives about leadership problems.**

Senior health worker/policy makers were responsible for coordinating operations with healthcare workers, but their coordinating structure did not provide for full responsibility and leadership in creating awareness and implementation. There was a lot of blame shifting within this level of stakeholders, especially among those directly overseeing the healthcare

workers' operations (from Ministry of Health). They blamed other senior health

workers/policy makers who were just in the decision-making group (those from the Office of

President and Cabinet). Health rights activists, too, expressed concerns about the poor

coordination.

Another challenge for failure of supervision was lack of funds to buy fuel for the

supervision trips. This made leaders miss scheduled supervisions. The fact that the

supervisors in most cases had to come from national headquarters made it more problematic.

If supervision was locally driven, there could have reduced financial logistical challenges

because less money could have been spent on the supervision. A more decentralized

supervision through health zones or districts could have eased that burden.

Another source of inadequate implementation was lack of training for the healthcare workers.

One senior health worker/policy narrated:

> "… Although the policy has been there, HTC uptake has not been adequate in
> most outpatient or STI settings. 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
> counseling and testing as well." (Senior health worker/policy maker 316)

The observation above was made by a very senior policy maker and the observation is in

contrast with that of another senior policy maker who said almost every healthcare worker

was trained about the 2003 HIV/AIDS Policy. The policy's intention was to train all health

worker staff and those stakeholders who wanted to see it as successful may have the

tendency to exaggerate the success, but the observations by other stakeholders will help

determine the actual position. Nevertheless, it is evident from almost all healthcare workers

and many fellow policy makers that there was a problem in healthcare sensitization. The

recommendation is to train all healthcare workers.

Local leadership of healthcare workers also fell short of their mandate by not effectively enforcing supervision to ensure that the policy is known to healthcare workers and that its implementation is going well.

A senior health worker/policy maker observed:

> "…When sometimes we do spot check supervision on the field you get shocked to see people say have not seen the policy document. They have not even displayed flow charts, but the good thing is that you will find that they do the right thing regardless 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 Health Worker/Policy Maker 316)

There was an opportunity for some senior health workers/policy makers who are focal program people to be involved in the policy making process and dissemination. These are very important in communicating the policy to the healthcare workers they work with. There were instances where top leaders did their job of sensitizing leaders of local health care workers who unfortunately did not do enough to brief the staff they were responsible for on the ground. This was confirmed by Health Worker Supervisor 305 who indicated that he had custody of the policy in his office and library but it was not actually taken to the people.

**Health rights activists' perspectives about leadership problems.**

There was dissatisfaction among health rights activists about the government's leadership and commitment toward policy implementation. The government did not do enough to make necessary follow-up mechanisms to see the policy implementation through. Not much was done beyond formulation of the policy and its distribution. One health rights activist observed:

> "…There has been little of that commitment even the methodology of how to get it out and usability of that policy. There has been very little commitment from the government in getting the policy out apart from distributing as any other IEC materials." (Health Rights Activist 319)

There was failure of government's leadership to coordinate HIV testing for STI patients who patronize healthcare services in private clinics/hospitals. HIV prevention efforts require collective responsibility.

On the other hand, government had successful coordination with private clinics regarding provision of antiretroviral therapy. Private clinics also handle a significant number of patients who need to benefit from HIV testing, hence the need to get them on board. A health rights activist recommends:

> "The advice is that there should enforcement of the HIV policy in private clinics so that the services (HIV testing for STIs) should be accessible to those who going to private hospitals. I would say government has all the machinery that can provide the necessary mechanisms to monitor how private hospitals carry out their activities. As long as there is commitment from the government, these things can happen." (Health rights activist 318)

**Lack of Community Awareness and Male Involvement with the Policy**

Implementation of a health policy such as the HIV policy depends on healthcare workers, but the ultimate goal is to have the people or communities benefit. This dissertation particularly looked at the issues from policy formulation, dissemination, and delivery or implementation to the beneficiaries/communities. There is need to have good communication between policy makers, healthcare workers, and the communities as ultimate beneficiaries of the HIV/AIDS policy. There were times when such collaboration was not good. One health worker supervisor recounted:

> "Suddenly without giving enough sensitization to the general public, you say every mother has to be tested. This was a problem because women somehow refrained from attending antenatal services and opted to go to private clinics or traditional birth attendants. This is because it was something that just came without preparing the minds of the women that if you are pregnant you will be tested. People, including health care workers did not receive it readily, including me." (Health worker Supervisor 311)

A health rights activist decried lack of people-centeredness in the policy due to inadequate input of people at the grassroots.There was no plan for feedback so that the beneficiaries hold the duty bearers responsible for its implementation; there was also poor government commitment to resource provision and unclear policy statements in the policy document, which led to inaction in the area concerned because implementers did not really know what to do.

Poor male involvement was cited by health care workers and health rights activist as problematic in the implementation of HIV testing for the 2003 HIV/AIDS Policy. Good male involvement in PMTCT will enhance HIV testing of partners/spouses and boost partner return for female index patients in PITC/STI set ups to benefit from HIV testing. The sentiments were that it was easy for women to accept HIV testing when their husbands asked them to do so, but it was not the case the other way round. Malawi is a male dominated society, therefore promotion of male involvement will greatly contribute to improvement in implementing HIV testing. It will also help reduce potential social harms some women may experience if they decide to go for HIV testing on their own. A health rights activist recommended this,

> "What is remaining now is the issue of male involvement, the time the woman decides to disclose (HIV results) to the man you find the man chasing the woman. These are the issues that need to be looked into." (Health rights activists 318)

A healthcare worker participant indicated that one of the reasons for poor male involvement is poor infrastructure to accommodate men in the facilities. My observation is that mere improvement of infrastructure to accommodate may not be adequate. Malawi culture is very sensitive on issues of male and female interaction. The nature of Malawian society customs is that males and females do not sit together in various forums. At churches, funerals, and

other social gatherings, women normally sit separate from men. In school, girls are not supposed to sit together with boys. In view of this, male involvement needs to be tackled from cultural perspective alongside the infrastructural improvements.

**Cultural and Attitudinal Reasons**

There are some healthcare workers'/patients' cultural and attitudinal reasons that affect the uptake of HIV testing.

Some barriers include patients refusing to be tested for HIV because their religions do not support HIV testing and failure to take an HIV test because of lack of a husband's consent.

A healthcare worker pointed to cultural and religious beliefs as an obstacle in that it deters people from accessing healthcare services, and this directly affects implementation of HIV testing, which is largely accessed from healthcare facilities.

> "… some people, cultures or religious groups forbid their members from attending health services. So it is difficult for such people to access HIV testing because it predominantly linked to health facilities." (PMTCT 301)

Healthcare workers who are not knowledgeable about issues of HIV/AIDS are a threat to the implementation of an HIV testing policy. Such healthcare workers can directly discourage people from accessing HIV testing. It is important here to make reference to a health worker supervisor (311) who indicated they initially did not appreciate the importance of routine HIV testing. (This was while the person was in charge of the HIV/AIDS services.) Leadership from the hospital also initially resisted implementation of the policy until a series of sensitizations were given to them.

Any person who is uninformed is vulnerable to some misconceptions merely based on personal beliefs or feelings. A senior health worker/policy maker expressed a typical scenario arising from lack of information.

> "At first…members of staff would ask, are you really sure you want to be tested for HIV? This is not true (You are not serious), go home, you are not sick…" (Senior health worker/policy maker 317)

This observation strengthens the argument for proper targeting of healthcare workers with correct information and proper sensitization about the HIV policy and its importance. Healthcare workers are the backbone of policy implementation and it is important to put all necessary strategies in place to get them on the side of active involvement in implementation. The HIV/AIDS policy cannot be implemented without the sensitization of healthcare workers.

Such inborn and cultural attitudes can be tackled through ongoing dialogue, professional commitment to change, and also by supervisors instilling the correct attitudes through supervision. In my example of healthcare workers and leaders resisting implementation, sensitization and consensus-building meetings made a difference.

Another aspect of cultural effects of policy implementation was evident through the expression of male dominance over decision making about HIV/AIDS issues. Women failed to access HIV testing because they wanted to consult their husbands before getting tested. Thus male involvement was one of the barriers for effective implementation of the policy. A senior health worker/policy maker observed:

> "Cultural issues vary from one are to area. ...you could see people's resistance for a woman to seek PMTCT may sometimes need to seek consent from the husband. Should woman do alone, it could even warrant being chased if found to be HIV positive..." (Senior health worker/policy maker 319)

Another aspect of male involvement comes in the sense that many healthcare facilities are not accommodative for male participants. In an environment where male partners play a very big role in decisions women (wives) make, it is important to have facilities that are supportive of male participation.

**Policy Design and Selective Prioritization by the Government**

The government needs to have control over delivery of health services and its policies. The design of the 2003 HIV/AIDS Policy did not properly provide for government control over HIV testing in private clinics other than those belonging to CHAM. As a result, some potential patients were not provided with HIV testing services.

Government and CHAM health facilities have good oversight of the implementation of HIV testing for PITC/STI and PMTCT. This is not the case with private clinics. There is very poor enforcement of the HIV testing policy in the private clinics.

A good number of people at high risk for HIV, particularly those who have money and buy sex, mostly patronize private clinics for services. Therefore, the failure of government to institute HIV testing arrangements with the private clinics is a lost opportunity for HIV prevention efforts.

The other problem was the tendency of government to over-prioritize some programs at the expense of others. For example, HIV testing for PMTCT was favored at the expense of HIV testing for STI services, and this also negatively affected service delivery.

> "Sometimes you could see that this government had put too much emphasis on one thing and sideline the other. For example they put too much emphasis on PMTCT but each and every service is very important." (PITC/STI 307)

The favoring of PMTCT Program is further explained in detailed document review in

Appendix 6, under "PMTCT Program Highlights with Respect to Implementation of the HIV

Testing Policy"

Policies need to present very clear guidance to the user. Unclear policy statements can

be a hindrance to implementation because some participants will be denied the intended

service. Two participants expressed concern over vagueness of some sections of the

policy.As an example, one participant referred to a section where the policy says a healthcare

worker provider can disclose a client's HIV status to sexual partners in the case that they are

not ready to disclose, but unfortunately there is no proper guidance on exactly how to do it.

**Resource constraints.**

Apart from health worker personnel, policy implementation requires some resources

and supplies such as HIV test kits, gloves, and other related supplies. The implementation of

the 2003 HIV/AIDS Policy has been characterized by shortage of some of these supplies.

Out-of-stock for test kits are a major problem. However as time goes on, there has been

steady improvement, with the year 2013 registering the least episodes of test kits stock-outs.

In the event that there was low supply, priority was given to PMTCT services at the expense

of STIs. A senior health worker/policy maker confessed:

> "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 services then the baby is also denied of such intervention."
> (Senior health worker/policy maker 314)

**Stakeholder coordination issues.**

There have been coordination problems among the stakeholders of the 2003

HIV/AIDS Policy. This challenge was stated by all the groups of stakeholders. Sometimes

healthcare workers received conflicting information from coordinating stakeholders, and they

had no way to determine whose guidance should be followed in the course of their

implementation.

One health 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/unity. You talk about the big three;
> HIV/AIDS Department which is Ministry of health, National AIDS
> Commission, and Office of President and Cabinet (OPC). At one point, I
> began to think that they work in isolation. I remember at one point there was
> information that came from there (OPC) but then the HIV/AIDS Department
> trashed it (GK: participant laughs) because it was not technically correct,
> technically sound. So you know at one point you think that the three needs to
> put their carts together if we have to effectively implement HIV/AIDS
> activities in this country." (Health Worker Supervisor 305)

Both health rights activists interviewed and a senior health worker/policy maker

decried the poor relationship among the three coordinating stakeholders—the Ministry of

Health, the Office of the President and Cabinet, and the National AIDS Commission. A

senior health worker/policy maker, who was rather hesitant to give me this information

opened up and said:

> "Honestly the coordination through that office was sort of political…at the
> beginning; the role of OPC was very difficult to understand, the reporting
> relationship and coordination roles between NAC and OPC are still unclear on
> some issues. At some point we started developing some TORs (GK: Terms of
> references) for the coordination." (Senior health worker/policy maker 316)

There was also poor coordination between top leadership from the Ministry of Health

and leaders who directly supervise the policy. Sometimes new policy updates or information

were not well communicated to their leaders. The people from the headquarters were

sometimes micromanaging the supervision and communication system, as evidenced by the

bypass of local supervisors.

One health workersupervisor narrated:

"Yea, coordination was not that simple, I am supposed to know what changes
are taking place and then when you go for supervision you will find somebody
doing something extraordinary and when you ask they will tell you we were
told by somebody from headquarters ... We were supposed to go together or I
was just supposed to know." (Health worker Supervisor 311)

Although it is important for people from the headquarters to do some spot-check

supervision on how the policy is being implemented on the ground, there is need for good

connection between top leadership and local supervisors.

Health rights activists also expressed concerns regarding poor definition of roles of

the coordinating stakeholders.

One of the health rights activists stated,

"Aah, now it is becoming clearer but in the past there were conflicting roles
…But at first it was really difficult as to who is doing what? Others will tell
you do this and others will say no." (Health Rights Activist 318)

Another concern from the health rights activists was about lack of harmonization of

health policies, which one of them felt negatively affected implementation of the 2003

HIV/AIDS Policy. He reiterated that policies are supposed to be complementary with each

other for effective implementation but every related policy seemed to take its own vertical

path. He called for the setting up of a sexual reproductive health (SRH) policy coordination

unit with clear coordinating roles so that all related policies "talk to each other" for effective

implementation.

**Health Systems Challenges**

Inaccessibility to health facilities due to inaccessible roads and long distances to

health care facilities are reasons that negatively affected implementation of the policy.

Such developmental issues are beyond the Ministry of Health alone and require collaboration

with several sectors of the government. It is important that where necessary ministry of

health should negotiate with other government line ministries where collaborative efforts are required.

## Facilitators of Policy Implementation

### Involvement in the Policy-Making Process

Many of the healthcare worker participants, some senior health worker/policy makers, and both health rights activists indicated that there was poor policy-making involvement of the communities and stakeholders. One senior health worker/policy maker emphatically stated that there was very good involvement of people at the grassroots.

> "No, no, the beauty about this HIV/AIDS policy is that it has been driven from the grassroots; therefore people had issues which were taken into the policy and then there is an annual review report which is provided, so whoever has not been taken care of during the reviews comes up and present their issues which are taken into the actual implementation of the program." (Senior health worker/policy maker 317)

Such discrepancies of information were anticipated during the design of the study and that was why an intervening group, the health rights activists, was included so that we get a better reflection of the actual practice on the ground. Top-down and bottom-up policy-making approaches can both deliver the intended purposes as long as they lead to acceptance of the policy, however in the contemporary "democratic" world the preference is toward bottom-up because it is deemed very participatory.

One health rights activist observed that even top-down approach can effectively be made acceptable to the beneficiaries when he stated:

> "If at formulation level it was top down, you may wish to bring it to the people at the end of the day. We cannot run away, some of the things will have to start from the top to down. But what is crucial is how we are utilizing the bottom to bring to the top." (Health rights activist 319)

In the case of this policy, it is clear that there was very good intention and a plan for implementing the policy process, but there was need to have an effective and coordinated way of overseeing and monitoring the process and engagement among all stakeholders, especially the healthcare workers and the beneficiaries.

**Availability of Policy Guidelines and Services**

The availability of the policy document to the implementation level was cited as a facilitator by a health rights activist. This was corroborated by a health worker supervisor, who indicated that the availability of the policy relies on good leadership on the ground:

> "The national document has been passed on from that level to us as implementer, that's a plus for them… It is one thing to have a national document and another thing for people to know there is one… (GK: Name of the institution) is one of the institution which has been encouraged by local leadership in implementing the HIV Policy to make sure that HIV testing among STI patients and the general population is happening…we had support from within to make sure that we are implementing the services according to the policy." (Health Worker Supervisor 305)

The Malawi government recently adopted and Option B-plus treatment algorithm where all pregnant women who test HIV-positive are put on highly active antiretroviral treatment. The availability of this instant treatment for PMTCT improved HIV testing services for antenatal mothers.

A health worker supervisor lauded this:

> "For PMTCT, I think it's because of the new guidelines, we all know that if we test pregnant women and they are HIV positive, there is something that we offer. We offer them ARVs and we reduce the risk of transmission from the woman to the child. This acts as a great motivation for people to test." (Health Worker Supervisor 312)

**Sustained Counseling and Sensitizations**

People generally resist new initiatives. However sustained counseling and sensitization of the beneficiaries will make them appreciate the benefits and finally accept the

services. The author already presented a scenario at his workplace where there was resistance

among healthcare workers and their leaders to start implementing HIV testing.

A healthcare participant narrated how persistent counseling helped improve implementation.

> "Mostly it's counseling, because most patients do not expect that they will
> HIV testing when they come. So in the past we used to have problems but
> after several times of educating the people in the communities and when they
> come here they also go through the counseling. This has helped a lot."
> (PITC/STI 301)

**Good Stakeholder Coordination and Support from Implementing Partners**

Good support from donors and other international partners were a source of success

in the implementation of the policy. So far, there have been excellent resource and

supervision support for PMTCT services. A senior health worker/policy recounted:

> "I recall 2007 there was inflow of several donor agencies. They convened a
> meeting and said, were not comfortable with the progress of PMTCT and
> what can we do to accelerate PMTCT? That's where we saw development of
> the 18 months acceleration plan in 2009." (Senior health care worker/policy
> maker 314)

This intensive backing and support from government as a facilitator has been one-

sided, specifically supporting PMTCT and not PITC/STI.

 One healthcare worker complained,

> "…you could see that this government had put too much emphasis on one
> thing and sidelined the other. For example they put too much emphasis on
> PMTCT but each and every service is very important." (PITC/STI 307)

Partnership with other implementing organizations and support groups from

communities involving people who were infected with HIV as well as psychosocial support

to those who tested HIV-positive also helped enhance HIV testing among those of unknown

status. A health care worker expressed the importance of partnerships:

> "…we engage community workers employed by Baylor to visit the mothers,
> or (engage) mother to mother (support group). The mother to mother is a

group of infected women who share experiences they have gone through to their fellow mothers… These are the people who have helped Dowa clinic to have 100% who are tested during antenatal." (PMTCT 303)

The coordination on other specific program areas about HIV/AIDS-related services at the facility level and with top-level leadership was good especially on clinical delivery. This is an opportunity that can easily turn into good coordination of the overall policy issues because it is the same leaders and healthcare workers who are concerned with the HIV/AIDS policy.

> "We also coordinate with them (well) in terms of clinical mentorship. So they provide us with resources for clinical mentorship, training coordination for the sites in the district, also…" (Health Worker Supervisor 312)

**Availability of Resources and Training Opportunities**

Although erratic availability of HIV testing supplies such as test kits has been mentioned as a barrier, the good thing is that people access HIV testing free of charge. One senior health worker/policy maker reiterates the importance of that:

> "… Another facilitating aspect was that all HIV testing services were free, nobody paid for the services, and this attracted people who felt, ah! After all I will not pay." (Senior health care worker/policy maker 317)

At a certain STI clinic HIV testing was always provided because of leadership commitment to provision of HIV testing resources and STI treatment drugs. The participant brought in a very important insight that policy implementation requires steady provision of resources.

> "Yes, I think at (name of hospital) STI Clinic, you could see that the other clinics run out of drugs but here, there is a lot of back up STI drugs and patients were assured that they will be helped. So you can see that when you implement the policy, care should be there. Not having the policy without resources… So the appeal is that the resources should be there so that the government fulfills its mandate during implementation (of the policy)." (PITC/STI 307)

This clinic didn't run out of drugs because a donor (UNC Project) supplied them, making the clinic more attractive to the patients and supported the implementation of the policy.

Another very common concern from many participants was that healthcare worker providers did not implement the policy after being debriefed by their colleagues because they wanted to be formally trained as well. However, healthcare workers in institutions with guaranteed training opportunities were implementing the policy well because they knew for sure they would also be trained.

> "Everybody is comfortable to listen and implement based on the debriefing by others because our organization organizes many skill building or refresher trainings, so everybody knows that it is just a matter of time before his her turn comes." (PITC/STI 306)

**Good Leadership Support and Consistent Supervision**

Many participants highlighted the importance of supervision of healthcare workers as a motivator to implement the policy. Supportive leadership should be demonstrated in the course of supervision of the HIV policy components. The importance of this was highlighted by several participants. One participant emphasized that supervision is a great motivator for them when she asserted:

> "It is a very good thing for us, because it encourages that our leaders care about what we are doing and it is a great learning atmosphere for us." (PMTCT 301)

**Political Will**

Government commitment in varying degrees is very important in positively affecting implementation. There has been general high political will and adoption of deliberately aggressive strategies by government in collaboration with international collaborators in some areas such as PMTCT to ensure success for the implementation of the policy. One senior health worker/policy maker observed:

"(There is) highest political will and commitment. Remember, the office of president and cabinet has made all it can and Malawi is a shining example in that regard… Malawi is one of the very few countries that have put resources over that work and over 2% of each Ministry's funding is dedicated to the (HIV/AIDS) work." (Senior health care worker/policy maker 317)

There were a lot of similarities between findings of the study and those of the literature review, though there were also unique issues in the Malawi context. The major findings from this study and literature review are summarized side by side in Table 4.

Table 4.

Summary of Barriers and Facilitators from Interview Findings and Literature Review

| Barrier | Status (where it was prominent interview or literature review) |
|---|---|
| Noninvolvement in policy making | interview |
| Lack of health worker training/sensitization | both |
| Poor leadership support (including supervision) | both |
| Lack of stakeholder coordination | both |
| Lack of policy harmonization | interview |
| Health systems challenges | interview |
| Poor male involvement | interview |
| Staff deployment and development issues | interview |
| Resource constraints | both |
| Selective government prioritization | interview |
| Attitudinal/cultural reasons | both |
| Resistance to implement externally developed policies | literature review |
| Lack of political will | literature review |
| **Facilitator** | **Status** |
| Involvement in the policy making process | both |
| Availability of policy guidelines | interview |
| Sustained counseling/sensitizations | interview |
| Good stakeholder coordination | interview |
| Support from international partners/donors | both |
| Availability of resources | interview |
| Availability of trainings | both |
| Good leadership/supervision | interview |
| Good political will | interview |
| Incentives for staff | literature review |

**Summary of Results**

There were several barriers that affected the implementation of the policy, which included lack of healthcare workers and some senior health worker/policy maker involvement in policy making, lack of healthcare training/sensitization about the policy, lack of supervision, and unacceptability of debriefing by peers who have undergone formal training. There were also problems with leadership because they did not make the policy available to the intended people. Other reasons were; lack of systems coordination and policy harmonization; poor road access to some health facilities, poor infrastructure support to accommodate male participation, and shortage of healthcare workers; logistical challenges to take supplies and test kits to the intended facilities, lack of stakeholder coordination and government's selective prioritization of HIV-related services.

In general, facilitators were the opposite of barriers. Facilitators have been stated here for their uniqueness and as a matter of emphasis They were; were involvement in the policy-making process, availability of policy guidelines, sustained counseling and sensitizations, good stakeholder coordination, adequate support from implementing partners, availability of resources, availability of training opportunities, good leadership support, consistent supervision,good political will anddonor support.

**Implementation Strategies**

In leadership practice, things should not just happen by accident but should be out of design and consistent effort. Strategy formulation involves analyzing the environment in which the organization operates, before making strategic decisions for implementation (Mintzberg et al., 1996). The state of implementation of each of the components of the policy is generally affected by its methods of operations or strategies. In this study, I sought and

examined strategies that were put in place to advance the implementation of the specific policy components and understand their reasons of success and failure.

Use of appropriate strategy for a particular policy component will boost the uptake of HIV testing services in that area. This section looks at the strategies that were used both in HIV testing for PITC/STI and HIV testing for PMTCTMy view is that all strategies were captured because sources of such information were the senior health workers/policy makers who were at the center of driving these services.

The other guiding documents such as the policy document itself and the PMTCT, STI, and HIV testing guidelines stipulated the same strategies.

These implementation strategies included participants walking in to HIV testing sites, provision of HIV testing to patients in the wards including sensitizing guardians of patients from their waiting shelters, door-to-door HIV testing/home-based community HIV testing, HIV testing for general patients through outreach clinics, HIV testing for all patients seeking STI services, HIV testing for all antenatal mothers, HIV testing for women in labor, HIV testing for women during postnatal check-ups, and HIV testing for women with undocumented results when they come with their babies to the under-five clinics, and use of HIV testing weeks.

The most widely accessed and reliable strategy is the routine offer of HIV testing for all patients who come for health services, especially for PMTCT services. Outside the patient care setting, voluntary walk-in of patients to access HIV testing is the most important strategy. A senior health worker/policy maker hinted that the most promising strategy is door-to-door HIV testing approach.

> "Of course door to door is going on very well in districts where it is
> implemented. But unfortunately door to door is not in all the districts, in other

districts it is there and in other districts it is not there." (Senior Health worker/policy maker 313)

If a door-to-door testing strategy were effectively implemented, it would benefit a lot of people in the general population as well as the concerned policy components—HIV testing for PMTCT and HIV testing for STI and others. Although it is a potential strategy, the challenge is that this service is not available in all districts and abandoned in some areas.

Another senior health worker/policy maker indicated that the most important HIV testing strategy was HIV testing weeks. Since the release of the 2003 HIV/AIDS Policy to December, 2014, there have been three national HIV testing weeks.

The senior health worker participant emphatically stated,

"HIV testing week was number one because the services were taken to where people are, services were taken to community level that made people comfortable to get tested."(Senior Health worker/policy maker 317)

In practice the national trend is that about 96% of HIV testing is done in healthcare facilities (Malawi Integrated HIV Program Report, October to December 2013). There is need to maximize the opportunities available for capturing people through healthcare facilities such as HIV testing for PMTCT and HIV testing for PITC/STI. At the same time, some potential HIV testing strategies such as door-to-door approaches and HIV testing weeks should be enhanced to capture yet another group of people who do not access healthcare services.

**HIV Testing for STI/PITC Implementation Strategies**

Almost all participants had knowledge that every patient that comes for STI treatment needed to be offered HIV testing. Major challenges for failure of this strategy were limitations of space, personnel shortage, and lack of training in HIV testing for STI among

other outpatient healthcare workers. The decision to accept HIV testing may not be instant to some patients. The importance of training PITC/STI healthcare workers is to take an advantage of their clinical interaction or follow-up visits to remind the patient about HIV testing. Some people access HIV testing through this way.

A healthcare worker stated this advantage:

> "First of all our patients were going into the HTC counselors to be offered HTC but sometimes they could refuse. So when they come to the nurse after you counsel and exam them and upon seeing the good care (they received), they could say, oh! I have changed (my mind), I refused HIV testing but now I want to be tested. You could not send them back to the HTC again, so you can just do the HTC since the test kits are just right there in the room." (PITC/STI 307)

Most PITC/STI healthcare workers and some senior health workers/policy makers indicated that it is important to engage a special lay HIV testing and counseling cadre to assist where healthcare workers are very busy with other clinical engagements.

An additional strategy that helped with enhancement of uptake of HIV testing was general health sensitization conducted prior to the individual interaction about HIV testing and counseling. By the time a patient went to a healthcare worker, the call for HIV testing was just like a recap of the prior sensitization.

**HIV Testing for PMTCT Implementation Strategies**

Just like for PITC/STI, all PMTCT workers know about the policy of HIV testing for all antenatal women. The main strategies for implementing HIV testing for PMTCT are: when women present themselves at an antenatal clinic, which was rated as the main strategy; during labor and delivery if for some reason they were missed during antenatal care; at any opportunity when people come to a clinic as a couple; when mothers come to under-five clinics with their babies; during postnatal check-ups; and sometimes during family clinics. Of

these, the PMTCT during the antenatal care worked better because many people are generally

aware they will be tested when they come for the antenatal check-ups. A healthcare worker

stated,

> "I think the PMTCT at the antenatal worked better. I think by now everybody knows
> that when I go to antenatal, I will be tested for HIV." (PMTCT 302)

Some healthcare worker participants and senior health worker/policy makers

indicated that the immediate offer of antiretroviral treatment and the quest to prevent

infection to their unborn babies make women favorably respond to HIV testing.

Unlike PITC/STI, there were no notable challenges in the course of implementation

of PMTCT services apart from the general shortage of test kits, especially before 2013.

This is most likely due to the overwhelming support the program got from the government

and international collaborating partners.

Some of these strategies for HIV testing for PMTCT and HIV testing for STI were

controversial among the human rights activists, but after a lot of discussion and debate about

the advantages and disadvantages these policies were eventually adopted.

A health rights activist gave an example of how controversial routine offers of HIV testing to

antenatal mothers was—some health rights activists thought in a way this was tantamount to

forcing people, but this concern was overridden by an interest to prevent infection on the

unborn baby.

I also encountered a similar challenge to implement HIV testing regardless of the

availability of the policy from experience at his STI clinic. I met a great deal of resistance

from healthcare workers and hospital leadership because many felt it was not right to offer

HIV testing to all STI patients despite the policy document. They felt routine HIV testing

was tantamount to forcing patients to be tested. Showing them a clause in the national HIV

policy that allowed for this testing did not initially change things. A series of meetings and

sensitizations with all manner of staff helped the policy get accepted at Kamuzu Central

Hospital STI clinic.

One day, the then–hospital director said to the head of the clinic: "Ok. Since you have

shown me the policy, you can go ahead and start implementing HIV testing for the patients;

however I don't want to hear any complaints that people are being forced into HIV testing.

You know how sensitive running this hospital can be."

**Monitoring Strategies**

Monitoring of HIV testing for PITC/STI and PMTCT was largely done through

statistics from monthly, quarterly, and annual review reports.

Routine supervision done monthly at the site level and quarterly at the national level

was also part of the monitoring strategies for this policy. Knowledge or awareness of these

implementation strategies was common among all healthcare worker participants. The

importance of tracking routine statistics and supervision was highly cherished by many

participants.

A PITC/STI and PMTCT healthcare worker hinted on the importance of these:

> "You can start well but as time goes it stops but may be also people at the top
> do not pressurize. Take an example antenatal (HIV testing), leaders
> pressurize… They demand data, like, how many people you helped as a
> provider."(PITC/STI 304)

> "Ah! We strongly like to be supervised because we learn a lot from it. They
> assist you where you do things wrongly so that you should not repeat the same
> mistakes." (PMTCT 301)

Another monitoring strategy was annual review meetings where all stakeholders came

together and reviewed the progress of the policy. Despite the fact that annual review

meetings were mentioned only by one senior health worker/policy maker and most of the interviewed were not aware of it, it remains part of a very important strategy to enhance implementation assuming it is properly executed.

Just like healthcare worker participants, senior health workers/policy makers highlighted the same monitoring strategies. They emphasized the importance of a good monitoring plan for smooth policy implementation. One participant appreciated the availability of a coordinating mechanism comprising the NAC, Ministry of Health, and OPC because of its oversight and tracking the progress of the HIV/AIDS response.

> "The Department of HIV and nutrition in the office of president and cabinet is the policy holder. I also look at the Ministry of health being at the forefront of the biomedical intervention. Now, in terms of the monitoring component, most of it was through the National AIDS Commission and we as Ministry of health and other stake holders report the indicators and also submission of progress reports to them. This to me has been the strongest part of HIV monitoring the response. Secondly, NAC being the disburser of resources, they also track where resources have been disbursed. I also look at that as another strong component of monitoring of the plan." (Senior Health Worker/Policy Maker 314)

This is one of the two unique participants who spoke about good coordinating roles of these three main coordinating stakeholders that form the coordinating unit.

Many other participants from all stakeholders spoke of poor relationship and non-clarity of roles of these institutions.

## Summary of Issues from Document Review

This section provides background information that is important for understanding of the stakeholders and environment in which the 2003 Malawi HIV/AIDS Policy operated. The details of the document review are provided in appendix 6. It presents a brief historical perspective of HIV testing under this policy and the coordinating structure within which it operated.

It gives an overview of provider-initiated STI HIV testing and counseling as well the PMTCT program and the general impression about the attention the Malawi government placed to each of these components which eventually might have also influenced implementation.

**CHAPTER 5: DISCUSSION**

This study was aimed at determining barriers and facilitators in the implementation of the 2003 HIV/AIDS Policy in Malawi. It also sought to explain implementation strategies for HIV/AIDS policy components and draw recommendations. Through literature review, I determined the existing status and gaps regarding policy implementation for the HIV/AIDS policy, especially from the sub-Saharan African region prior to the study. The findings from both literature review and the study are very important in shaping the recommendations.

There were several barriers for implementation of the 2003 HIV/AIDS Policy including lack of healthcare worker and some senior health worker/policy maker involvement in policy making, lack of healthcare training/sensitization about the policy, lack of supervision, and unacceptability of debriefing by peers who have undergone formal training. There were also problems with leadership—they did not make the policy available to the intended people. There was a lack of systems coordination and policy harmonization, poor road access to some health facilities, poor infrastructure support to accommodate male participation, a shortage of healthcare workers, logistical challenges to take supplies and test kits to the intended facilities, and selective prioritization by the government of HIV-related services. All health related programs in Malawi depend on donor funds. The government should make tangible decisions about meeting its many needs within its wide range of prevention programs. For example prioritizing treatment and ignoring the primary prevention will ruin the gains for such programs. Likewise PMTCT needs should be addressed without

neglecting STI treatment and prevention efforts. Government should negotiate with donors to balance up or use their own resources to tackle areas not funded by donors.

Lack of involvement in policy making was cited by many healthcare workers and senior health workers/policy makers who were directly working with healthcare workers on the ground. Those at the national level also indicated partial involvement and sometimes no involvement at all.

Some of the officers who complained of noninvolvement were key participants in their respective areas of policy component and the legitimate expectation was that they needed to be fully involved. This was due to lack of deliberate strategies by leadership or due to the fact that the some of the participants were not available at the time the 2003 HIV policy process was initiated. However there was also a hint of very poor involvement of healthcare workers and other stakeholders in the formulation/review of a new HIV policy, which was launched in December 2013. This fact rules out the latter as a potential problem. If longevity in the system were the case in the 2003 HIV/AIDS Policy, there could have been a better involvement of these people with the new 2013 HIV/AIDS policy.

Lack of policy involvement erodes the sense of ownership of the policies and as a result, people will not be committed to implementing it. This finding is in agreement with that of the literature review, where implementation was also a problem when people felt they were not involved or the policies were formulated internationally and were just imposed on them. In the case of the literature review findings, resentment at higher policy-making levels potentially sabotaged implementation because senior people either refused or reluctantly took those policies to the people at ground level. The difference with the policy making in Malawi was that policy formulation was driven by local leadership in Malawi. It was up to the skill of

senior health workers/policy makers to take relevant people through the policy-making process, but that was problematic and this affected implementation. Being a locally driven policy, there was an opportunity to get necessary stakeholders properly involved in the process and instill ownership.

The other area that was problematic was awareness of the HIV/AIDS policy by healthcare workers. Healthcare workers are the actual implementers of the HIV testing policy either for PITC/STI or PMTCT, but there was lack of adequate information to them. In most cases, many healthcare workers had not even seen the actual policy document. In some instances knowledge of HIV testing was through related technical areas such as PMTCT or STI syndromic management, because such guidelines recently incorporated HIV testing as part of the service to be offered. Healthcare workers for the PMTCT were more likely to be informed than their counterparts in the PITC/STI. This finding was also true from the literature review findings, where it was found that there was lack of policy awareness both at the healthcare leadership level and among healthcare workers.

Lower-level leadership and health rights activists to some extent also did not demonstrate optimal support disseminating the policy to their respective constituents. For example, there was an instance where a lead healthcare worker acknowledged keeping the policy in his office and library but did not take active steps to actually train his colleagues on the policy. He ironically recommended training of healthcare workers as a best solution because healthcare workers will not easily find time to read. This healthcare worker missed an opportunity of active involvement in policy dissemination by expecting the dissemination from top leadership. Likewise, health rights activists also missed an opportunity to

disseminate to members of their constituency with the anticipation that top leadership from government needed to do it.

In a busy environment where healthcare workers are heavily loaded with tasks, it is difficult for them to take on "extra" burdens of work, especially if there is no commitment from leadership to enlighten or supervise them. We have learned from the findings that many healthcare workers did not accept and, in fact, resented debriefing by their colleagues because they felt that their colleagues had benefited from training incentives such as monetary allowances and certificates. This makes it difficult for those who have not been trained on service guidelines to comply with added components of HIV testing, and they just do their routine clinical care. Although the general problem of lack of training on the policy or guidelines also applied from the literature review findings, the refusal to implement after being debriefed comes in as unique problem for the Malawi setting. The reason for this distinction has not been ascertained. It is possible other countries are using different incentive arrangements or there is a guarantee that the debriefed healthcare workers will be trained more formally at a later time. When the latter was the case, in my study the attitude of healthcare workers was different. From the literature findings, there was also an element of reluctance of health workers to be debriefed by other people, but it was largely refusal of senior people like doctors to be trained by junior cadres who went for formal training (Nzinga et al., 2009). Although that did not come out in the Malawi context, it should not be ignored in the planning of trainings for staff where they are expected to come back and train others.

Supervision was another challenge in the implementation of the policy. It was rocked by logistical and financial challenges because supervisors were operating from a central

point. This could have been averted by decentralization of supervision to a zonal or district level. At the moment, the supervision at these levels is minimal and is mostly done from the central level. Supervision of the HIV testing policy at zonal level seemed not be well in place. This was evidenced from the fact that when I was collecting data for this research, I faced problems getting the actual zonal supervisor responsible HIV testing services from at least two zones responsible for the districts I targeted. It took a top Ministry of Health authority to advise me. The district-level supervisor is the most practical leader. Malawi's health system is structured in such a way that there is great opportunity for a well-coordinated supervision structure for the HIV/AIDS-related services.

The Ministry of Health has total command of the healthcare workers, which will make it relatively easy if all supervision is conducted through it. Unfortunately according to findings, what is happening currently is that even within the Ministry of Health PMTCT, HIV treatment, and HIV testing teams do not coordinate their supervision activities. Each team goes on its own. It has also been noted that NAC and OPC fell short of good coordination to enhance effective implementation oversight.

Inadequate resources such as HIV test kits and other supplies also caused erratic implementation of HIV testing—some people were denied the service when they needed it. Shortage of healthcare workers is another reason healthcare workers concentrate on their core service area rather than doing extra things like HIV testing. Malawi has a good opportunity in that it has an HIV testing cadre in the NGOs. Although these people are sometimes deployed to government health facilities to conduct HIV testing, ironically the government does not recognize it and cannot therefore employ them to do HIV testing. Healthcare workers and policy makers have strongly spoken in favor of government's recognition of the cadre. Such

an action will not only beef up staff to roll out HIV testing but will stabilize the existing HIV

testing teams because those on the ground will feel motivated and likely stay on their jobs.

One such healthcare provider echoed this:

> "Another issue is that although we are doing our job well, we are not a
> recognized cadre (by the government). They need to recognize HIV testing
> counselor as a cadre… As I earlier pleaded let the authorities think about us so
> that we do this work whole heartedly." (PMTCT 301)

There were challenges with coordination among stakeholders and lack of clear roles

within the HIV/AIDS policy coordinating stakeholders. This resulted in healthcare workers

receiving conflicting directives. Failure to update policy mandates to healthcare workers,

who are the main implementation players, caused frustration to local healthcare leadership

due to micromanaging or bypassing of supervision. Finally lack of clarity on reporting lines

among coordinating stakeholders makes it difficult to take responsibility over performance

among the coordinating stakeholders. From the literature review, poor stakeholder

coordination was one of the prominent problems that affected implementation.

Clear coordination roles are critical to the successful implementation of the policy.

Good coordination among the three coordinating stakeholders will instill confidence in other

stakeholders and properly direct healthcare workers to do the right things. The current

situation requires good linkage of the three coordinating stakeholders with input from other

stakeholders, particularly the health rights activists. There should be clear authority instituted

to guide stakeholders to avoid conflicting information.

One policy coordinating unit should be established so that other stakeholders or healthcare

workers know exactly where they will find what they need about implementation issues.

Apart from the barriers, the 2003 HIV/AIDS Policy had some notable facilitators that

helped its implementation. They included the following: involvement in the policy-making

process, availability of policy guidelines, sustained counseling and sensitizations, good stakeholder coordination, support from implementing partners, availability of resources, training opportunities, good leadership support, and consistent supervision.

Unlike lack of political will or unclear status of political will that was observed from the literature review as one of the prominent issues that hindered policy implementation, Malawi had very good political will and support for policy implementation. The government was at the forefront of leading an HIV/AIDS response and instituted policy formulation quite early in the HIV/AIDS response. This study presents a unique scenario of HIV/AIDS policy implementation response in a setting with high political support.

Despite the political will, the Malawi government does not put good effort in funding HIV/AIDS activities. More than 90% of funding comes from donors. The only significant contribution is at ministerial level where the government dedicates 2% of the every ministry's budget for HIV prevention activities. The government needs to take another step to give more funding commitment. This will help deal with some logistical issues like stock-outs of test kits—these sometimes happen due to delayed logistics with donor support and change of policies due to political governance. Clarification of coordination roles and supervision of implementation have been other main challenges with top-level leadership. With high-level political commitment, such problems can be easily ironed out. High-level technocrat commitment can iron out the supervision of policy implementation and create agreement on an appropriate leadership structure to implement the policy.

**Limitations of the Study**

My selection of stakeholders for interviews was; senior health workers/policy makers, healthcare workers, and health rights activists, and it left out patients or community members

as a very key component in policy implementation. However, in an area that has not been extensively studied, we can only start with so much.

The beneficiaries of policy implementation in this case are the healthcare workers instead of patients or community. Issues of patients and communities in the findings were simply inferred by the selected participants. Policies should aim at serving the interests of their ultimate beneficiaries. Further research should look at policy perspectives at that end level of beneficiaries.

I also acknowledge that out of five available health zones, my study area was restricted to two. This may have affected the generalizability of my results. For example, leadership from various sites might have handled logistical and supplies of HIV test kits problems better than other areas, some zones may have had easier access to road systems or better physical infrastructure to get supplies where they needed to go. Although they all procure through the same system, the two zones I worked in may have been impacted harder by some of these logistical problems.

To illustrate the importance of certain perspectives from findings, I included some personal experience in certain situations because of my familiarity with my area of study. The inclusion of these personal insights is some sort of "participant observer" and this is a potential source of bias. This is however often necessary in this kind of research.

# CHAPTER 6: PLAN FOR CHANGE

## General Overview of Barriers and Recommendations

This section presents recommendations to strengthen HIV/AIDS Policy implementation. The specific purpose of this dissertation was to understand barriers and facilitators to implementation of HIV/AIDS policies in Malawi in order to positively contribute towards improvement of HIV prevention and mitigation services. I was motivated to do this work because of the concern I have about the high burden of HIV/AIDS in this setting. This pandemic has negatively affected quality of life and retards many aspects of human social and economic development. I expect that effective implementation of the recommendations will reverse this.

This study identified barriers and facilitators that affected the implementation of the 2003 HIV/AIDS Policy. The findings in this dissertation likely resemble reality in other sexual reproductive health policies in Malawi as well. These policies are governed by the same leadership system and share the same resources as the HIV/AIDS Policy, particularly those governed by the Ministry of Health. The target age groups of these policies are also the same and finally, the implementers on the ground are largely the same healthcare workers. It follows that implementation of these related policies might also benefit from insights gained through these findings. The barriers and facilitators that hindered the implementation of the 2003 HIV/AIDS Policy are summarized below:

- Lack of involvement of implementers in the policy making.

- Lack of health worker sensitization or training about the policy.

- Poor leadership (especially supervision).

- Lack of stakeholder coordination.

- Lack of harmonization of policies.

- Broad health systems challenges.

- Insufficient male involvement.

- Staff deployment/development challenges.

- Resource constraints.

- Selective prioritization of policies by government.

- Attitudinal/cultural problems.

The facilitators cited are the opposite of the barriers cited, but I re-captured everything that was specifically mentioned by participants to reiterate their importance. They include: availability of policy guidelines, sustained counseling/sensitizations, good stakeholder coordination, support from international partners/donors, availability of resources, healthcare worker trainings, good leadership/supervision, and political will.

Typical of "top-down" and "bottom-up" perspectives, the findings showed that senior policy makers did not adequately involve health care workers and their supervisors in the policy making and dissemination process. While some leaders were defensive, believing that implementation was very good, others were happy to learn from mistakes and build on successes. A senior health worker/policy maker reiterated the importance of building successes of the 2003 HIV/AIDS Policy:

> "My own perception is that we need to build on the area of successes and continue implementing the policy with zeal. That's point number one. Point number two; is that we should use the challenges we had in the earlier

implementation of the policy as stepping stones for better progress and success of the new policy. That's the way I would look at it. Because most of the things we have done have been very successful." (Senior health worker/policy maker 317)

The findings of this study have come at a very good time, when the country has just approved a new policy but has not yet started disseminating it. My recommendations will therefore be important in contributing to dissemination and implementation of this new HIV/AIDS Policy.

The identification of weaknesses in the 2003 HIV/AIDS Policy is an opportunity for leadership to improve its implementation. We should consider barriers to implementation of the 2003 HIV/AIDS Policy as a crisis and take advantage of the window of opportunity to fix it. Robert Quinn suggested in his article "Moment of Greatness…" that great leaders can tap into their fundamental qualities during a crisis… (2005).

In the section that follows, I present the general leadership principles that form the basis of my specific recommendations. The notable leadership principles I employed are Kotter's steps to transformational change. (John P. Kotter, 2006). Where necessary, I also mingled these with other leadership principles.

### Adaptation of Kotter's Steps for Transformational Change

1. **Change requires a sense of urgency:** Kotter argues that transformation requires consciousness, great zeal and commitment from leadership to make a major change. The implication for the Malawi HIV/AIDS Policy is that there is great political will which is a good opportunity for this step.

2. **Creation of a powerful guiding coalition:** Kotter emphasizes great need for powerful coalition in a process of effecting change. Without good coalition the

momentum easily dies due to opposition. Poor stakeholders' coordination was one of the major concerns regarding implementation of the 2003 HIV/AIDS Policy faced.

3.  **Creating a vision:** Kotter challenges that without vision, transformation efforts easily dissipate. Although Malawi HIV/AIDS program has a guiding policy with vision, Malawi government has not fully utilized this opportunity to advance good implementation of the policy because there was poor participation in formulation of that "vision."

4.  **Communicating the vision:** Without communication, the vision will not be known to the intended beneficiaries. In the case of the 2003 HIV/AIDS policy dissemination of the policy was not well done. The fact that the new HIV/AIDS Policy has not yet been disseminated is an opportunity to have it well done this time and that it should be done better during the subsequent policies.

5.  **Need to overcome obstacles:** After successfully working through obvious major problem areas, leaders should look at other potential obstacles which can disturb the smooth implementation of the vision, even after dealing with what are seen as main problems. The examples of such issues in the 2003 HIV/AIDS Policy may include issues should may not concern main problems such as involvement in policy making or dissemination but; lack of personnel to implement the policy, stock out of resources such as HIV test kits, poor access to services due to long distances and impassable roads to certain areas during certain parts of the year.

6.  **Planning for and creating short term wins:** Leaders need to plan and review the progress of implementation in order to appreciate areas of success which is necessary to give positive momentum to the team. According to one of the senior health

worker/policy makers, there was a plan quarterly for stakeholder review meetings to discuss the progress of the policy implementation. This was a lost opportunity because this was not really taking place with all stakeholders but it was apparently happening within one of the coordinating stakeholders.

7. **Consolidating improvements and institutionalizing new approaches:** This entails making sure that adequate number of personnel are hired to carry out the work, finding ways of motivating staff to carry out the work and good leadership development. Shortage of health care workers and motivation were some of the pertinent issues that affected implementation. Some health care workers made some suggestions which they felt were important to motivate them such as trainings on new policies, and recognition of the HIV testing cadre by the government.

## Specific Recommendations

### Recommendation 1: Involvement of healthcare workers in policy-making process and dissemination through trainings (Kotter's step 4—Communicating the vision)

Findings have shown that many health care workers did not effectively implement the policy because they were not involved in the policy-making process and its dissemination. This was retrogressive to policy implementation because this created a situation of lack of ownership of the processes by health care workers. This is a very important group in implementing HIV/AIDS policies. Some health care workers mentioned instances when a policy document was just placed at a facility without formally training healthcare workers on it and therefore lacked impetus for implementation. Participatory leadership is important in getting people involved in bringing change. In accordance with the principles of community-based participatory research, involvement of stakeholders in programs execution is important as it can favorably influence successful implementation (Israel, 2005). Once you come up

with any new policy, it means you are asking people to deviate from their "comfortable" status quo so that they embrace something new, this may sometimes be quite a major change which requires acceptance and committment. Therefore people should be allowed to participate in decision making processes so that they are empowered for effective service delivery and quality improvement initiatives (Yukl G. Participative Leadership, Delegation, and Empowerment, 2010). Gostin also reiterates the fact of team playing in order to gain public health achievements. There is need for several entities or players to build onto each other's efforts (2010).

A PMTCT healthcare worker who was involved in the process strongly applauded her involvement because it helped policy makers to appreciate what exactly was happening on the ground and guided them in the process of policy making.

> "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, things that will benefit the people." (PMTCT 300)

In step 4, Kotter reiterated the importance of communicating the vision as one of the best ways to bring positive change. A policy spells out the components of organizational vision which can only be adequately acted upon if the people who will implement understand it. I recommend that health care workers be involved in the policy formulation process. To achieve this, policy makers should create policy interaction forums at the health facility level where health care workers give input towards to the formulation process (Yukl, 2010, Chapter 4- Participative Leadership, Delegation and Empowerment). Almost all health institutions conduct departmental meetings at least a day in a week or daily. These meetings should also be used for these policy discussions. Once such deliberate opportunity for health care worker involvement is created, relevant input will be collated by the lead healthcare

workers or HIV/AIDS coordinators, who will convey it to the relevant policy formulation team for incorporation of the ideas.

The other recommendation is to bring health workers from several institutions together for formal training about the policy and get their input and concerns. In leadership improvements do not just came out of the blue but should be guided by consistent planning of appropriate actions. If leaders want to introduce change, training should follow before a leader can hold change agents responsible (Yukl G. Leading change in organizations, 2010).

**Recommendation 2: Improve stakeholder coordination (Kotter's step 2—Creation of powerful guiding coalitions)**

Formation of powerful guiding coalitions is necessary for meaningful advancement of public health change (John P. Kotter, 2006). Successful building of coalitions is like a "social skill" where HIV/AIDS policy makers offer their "good health product for people to buy." Although the barriers in this study were very diverse, one major broad concept to summarize these barriers is "lack of effective coordination." The specific recommendations under this section are presented as follows:

**Recommendation 2a: Formulation of clear terms of reference or clarification of stakeholder roles (Kotter's step 2, 5—Creation of powerful guiding coalitions and removing obstacles respectively)**

Following successful building of coalitions of stakeholders, successful implementation will depend on good execution of coordination. The Malawi 2003 HIV/AIDS Policy faced some coordination challenges albeit constitution of guiding coalition of stakeholders. All stakeholder groups interviewed lamented poor coordination among the coordinating stakeholders (the Office of President and Cabinet, Ministry of Health and National AIDS Commission). There is currently competition for supremacy or ownership of the policy leadership among these coordinating stakeholders. As it is Office of the President

and Cabinet is said to be policy holder, this "displeases" Ministry of Health as the main

implementer. The National AIDS Commission too feels they are better placed to be the

policy leaders and view leadership of Office of President and Cabinet as mere political and

very sensitive matter. This leads to state of neglect, uncoordinated supervision and poor

chain communication of roles to health care workers implementing the services. The gap in

this situation is lack of clear guidance about specific roles and chain of command among the

key stakeholders which was highlighted by one of the senior health workers/policy makers

and a health rights activist. I recommend that formulation of clear terms of references for

clarification of roles among the coordinating stakeholders be formed as quickly as possible

because this is very necessary to guide effective coordination and leadership.

**Recommendation 2 b: Link up organizational efforts and resources to maximize implementation (Kotter's step 2, 5-Creation of Powerful guiding coalitions and removing obstacles respectively)**

Through proper coalitions or coordination leaders can persuade or appeal to other

stakeholders to contribute and participate in health improvement efforts (Daniel Goleman,

2004). A PMTCT health care applauded partnership with another organization which brought

successful implementation in her district.

> I commend Baylor (GK: A university of Baylor Project) who focuses more on the
> infants. They recruit community workers who really assist us. These are the people
> who have helped (GK: name of district) to have 100% HIV testing during antenatal.
> (PMTCT 303)

Currently all organizations working in districts are supposed to submit their plans of

operations to the district health officer to inform district implementation plan. However, there

is no mechanism to enforce compliance to this. Proper collating of resources and plans from

various health stakeholders will help facilitate implementation of the policy. I propose formal

and legally binding agreements to enforce this. This should come as legislation which should

empower district health officers to institute defined punitive measure to those that do not

comply.

### Recommendation 2c: Creation of a national policy harmonization and Supervision committee (Kotter Step 2, 3—Creation of powerful guiding coalitions and vision respectively)

Another problem that contributed to poor implementation was poor harmonization of

related sexual and reproductive health policies. In keeping with Kotter's step 2 - creation of a

powerful guiding coalition; policies such as HIV/AIDS policy, Youth Policy, and

reproductive Health Policy need to work in harmony or merge as necessary to ensure joint

efforts in implementation of HIV testing. The basis of such an undertaking is the vision

leadership aims to attain. This will make things easy because these policies are targeting

almost the same age population. A health rights activist empasised the importance of policies

to "talk to each other." He reiterated the importance of integration of various reproductive

health services and recommended an inter stakeholder dialogue as one way of contributing

towards good implementation:

> "Another issue is that we need to initiate dialogue sessions. This is critical because people will be able to identify what belongs to them…This is very important especially for sticky areas which you need to bring to the attention of the people. At the end of the day people should know that this belongs to us and you will be held accountable. So you see that this is not coming from government but people should be empowered to hold the government accountable to give information and other related services… There should be a framework as to how we will be receiving feedback. The enforcement is where we need to spend more time. We may have good policies but may just be gathering dust. Have we instituted a task force to critically look at the enforcement mechanism?" (Health rights activist 319)

In line with this observation by the health rights activist, I propose the creation of a

national policy harmonization and supervision committee. This will be a policy team charged

with overseeing and coordinating how well the HIV/AIDS and other related sexual and

reproductive health policies are implemented and see what policies or components can be

merged so as to enhance good implementation and supervision This committee will also be

responsible for steering policy formulation/revision, dissemination, and implementation. It

will comprise senior technical officers from various sexual/reproductive health and HIV-

related policies. This committee will be reporting to the government of Malawi through

Office of President and Cabinet which is currently leading the HIV/AIDS Policy.

**Recommendation 3: Strengthen policy leadership through decentralization of supervision (Kotter Step 7—Consolidating improvements and institutionalizing new approaches)**

One of the important reasons the 2003 HIV/AIDS Policy was not well implemented

was lack of adequate supervision. Some of the reasons included; lack of empowerment of

health care worker leaders at local level to meaningfully participate in supervision of the

HIV/AIDS policy implementation and limited resources for supervisors to travel to health

facilities. This problem was complicated by the fact that supervision of HIV testing for

PITC/STI is done from central level by senior technocrats at the Ministry of Health

Headquarters. Travel to distant places creates logistical problems and demands a lot of

resources such as money for fuel and allowances. I recommend that supervision should be

decentralized so that it is done local level through health zones and districts.

At the moment, the Malawi Ministry of Health has relatively more senior technocrats

based at its national headquarters than at zonal officers. This group will be more beneficial to

provide leadership at implementation level.

The current supervision system does not encourage participatory leadership as it is

top driven. Lead health care provider in various health facilities should be given specific

leadership tasks to supervise the local staff without waiting for supervision team from

"headquarters" as it is mostly the case now. Margaret Wheatley's "New Science"

discourages imposition of strategies or models but leaders should work with the subordinates

and empower them (Wheatley, Margaret Leadership and the New Science, 2006). Strengthening local leadership in substantive supervision of the policy will create sense of responsibility and ownership to local health care workers and their supervisors.

An example of such leadership empowerment is seen in Donald Berwick's transformation story. This clever medical doctor and president of the Institute for Healthcare Improvement in the United States, turned implementation of health care services to a success story. He noted with concern that there was poorer quality of health services and many lives were lost despite hospitals spending more. In 2006, he launched two subsequent campaigns; "Save 100,000 Lives and Save 5 Million Lives." He demanded that participating hospitals depart from "business as usual attitude" but embrace real change through focused attention on achieving measurable goals through adequate participation of all key players. He convinced all participating hospitals to adopt simple self-checking quality assessment tools. Individual healthcare workers worked passionately because of good guidance and senior doctors from participating hospitals also committed to talking to each other and sharing strategies to improve productivity (Stanford Graduate School of Business, May 2010). Within few months, the quality of health service delivery improved, health expenditure was greatly reduced and a lot of lives were saved through simple empowerment efforts.

I recommend leaving very lean headquarters-based senior health technocrats and that the majority should be deployed to zonal and district levels, where they will be very useful in executing leadership in implementing. This change should be done without removing their remuneration benefits, otherwise they will lose motivation. At the top level, only a lean structure should be left. The technocrats at zonal and district levels will have a core supervision team with other stakeholders to monitor and supervise implementation.

My recommendation is in support of sentiments from a senior health officer colleague as I presented in the document review. During our informal chat, he said; "The Malawi Ministry of Health structure has the right number of technical expertise to deliver on its agenda to the people, but the problem is that these experts are delinked from their rightful mandate, they are soaked in too many tasks. They are used to make policies when their main duty is to manage the implementation of programs." This sentiment is vindicated by the failure of these leaders to ensure their policy implementation mandate is well done.

Strengthening district-level and zonal supervision will be cost effective and practical. The responsible officers will be physically closer to their areas of jurisdiction and the supervision logistics will not be as expensive. The empowering of many people on the ground will also increase the efficiency. Supervision of policy implementation is an enormous but important task which requires involvement of several entities. The importance of supervision is highlighted by a healthcare worker:

> "My comment is just to encourage national level policy makers that after making the policy they should have time to go to the implementation site and see how best the people are implementing. Are they implementing to the policy or are there diversions, or do they have gaps or knowledge so that they can fill in during their mentorship visits." (PMTCT 300)

### Recommendation 4: Intensification of community mobilization and improve male involvement in issues of HIV prevention (Kotter's steps 5, 1—Need to overcome obstacles and sense of urgency, respectively)

Many health worker participants recommended that dissemination of the policy should also be made to the communities because they are the ultimate beneficiaries. A health rights activist (319) echoed this sentiment when he stated that in a top-down approach system it might be difficult to make communities own the policy process. However, they can still be part of it after its formulation through proper dissemination mechanisms.

It is beneficial for people to be given information before they report to health facilities through other community based avenues. This is in line with Kotter's step number 4 which emphasizes the importance of communicating the vision to the intended participants.

Community sensitization has a flip side if health care workers were left during the sensitization. Some healthcare worker participants bemoaned lack of community sensitization, which made clients come unprepared for HIV testing services when they report to healthcare facilities. One healthcare worker recommended that healthcare workers should be informed first before creating demand through public sensitizations.

Communities are very important avenues of change for better lives. Without the input of people and taking their social and cultural perspectives into consideration, there will be no meaningful health improvement and interventions will be shunned. Another health rights activist observed that the 2003 HIV/AIDS Policy also lacked a mechanism to empower the communities or beneficiaries of the policy to hold the duty bearers responsible for commitments made in the policy

Community sensitizations and interractions should be made from various locales such as schools, village health committees and other community village meetings summoned by traditional leaders so that people move away from conservative philosophies regarding interaction of males and females in public. This may help shift the societal paradigm about the gender norms of men and women in groups so that there will be no qualms for men and women, girls and boys mixing freely in society. This approach might potentially influence attitudes of the future generation of men as regards to male involvement in health care issues. There is a problem of timeliness in disseminating policies to appropriate people who will implement. Some health care workers complained that sometimes they do not know about

policies until they are asked by patients. However, for immediate results, I recommend

intensification of peer education among men using culturally accepted interaction avenues as

soon as policies are in place. Peer education has shown to increase male participation in

HIV/AIDS related activities (Steve M. Mphonda et.al 2014).

**Recommendation 5: Enhance human capacity and resource mobilization for HIV/AIDS policy implementation (Kotter Step 6, 7—Creating short-term wins and consolidating improvements/institutionalizing new approaches)**

Kotter's step 5 reiterates the need to overcome additional obstacles as an important

step when one wants to effect positive change. In this case even effective policy making

process, and dissemination were achieved, there would still need to pay attention to other

obstacles which can hinder implementation. True to this, the 2003 HIV/AIDS Policy was

faced with many obstacles such as; lack of keenness by health care workers to implement

after debriefing by their peers, lack of personnel to implement the policy, stock out of

resources such as HIV test kits, poor access to services due to long distances and impassable

roads to certain areas during certain parts of the year.Government recognition of non

medically trained HIV testing cadre, training of regular health care workers and meaningful

partnerships for resource mobilization are some of the solutions that have already alluded to

as part of solutions to such problems. I have also outlined recommendations and relevant

leadership principles in Table 5.

I would like to single out lack of keenness by health care workers to implement after

debriefing by their peers because it has great potential to maximize policy dissemination.

Healthcare workers are many and it is a daunting task to reach out to each of them. In a

situation whereby it is difficult to train as many people to implement activities, it is a

reasonable solution for those who have been formally trained to debrief others on the job.

However, the majority of healthcare workers do not implement the services, because they

want to undergo a formal training as well because those who receive formal training get

incentives such as allowances and certificates. A health care worker emphatically expressed

this concern:

> "All health workers should be trained, not just few and then brief others, no!
> But if you want the policy to be implemented well, each and every person
> should go for formal training." (PITC/STI 307)

It is possible to sort out this resistance and get health care workers accept the peer

debriefing. I successfully implemented the peer debriefing to colleagues when I trained

people to use manual vacuum aspiration as a treatment of people reporting to hospital with

incomplete abortions at Kamuzu Central Hospital between 2001 and 2003. Healthcare

workers who were reluctant to be trained initially, accepted when we liaised with the

Ministry of Health and JHPIEGO to issue certificates after demonstrating competence and

after performing an agreed number of procedures.

I therefore recommend that the government or ministry of health should institute an

incentive package of giving certificates to people who have undergone a debriefing for a

policy or major amendment by their colleagues, provided they fulfill the prescribed number

of hours and competence.

The barriers were many and so the recommendations. Some recommendations will

take some time to be operational because the processes required will to do it will be longer. I

have therefore categorized some urgent recommendations which will be manageable within a

short time in Appendix 8, as a policy brief.

Table 5.

Outline of Major Barriers and Recommendations with Relevant Leadership Principles

| Barrier | Specific Recommendation | Leadership Principle supporting the recommendation | Who is Responsible to Act |
|---------|------------------------|--------------------------------------------------|--------------------------|
| Poor involvement in policy making | Organize institutional health care worker policy interaction forums/meetings | Participatory leadership-(Yukl, 2010,Chapter 4- Participative Leadership, Delegation and Empowerment). Also, John P. Kotter, 2006- Communicating vision | Principal Secretary, Office of President Cabinet and Ministry of health |
| Lack of training/sensitization | Train all health care workers on new policies or updates | Change management-(Yukl, 2010 Chapter 10- Leading change in organizations). Also, John P. Kotter, 2006- Communicating the vision | Principal Secretary, Ministry of Health |
| Lack of keenness by health care workers to implement after debriefing by their peers | Reinforcement of the debriefing by incentives such as certificates and good supervision | Creation of a vision and institutionalization of new approaches (John P. Kotter, 2006) | Zonal and District health officers |
| Poor leadership/supervision | Empower and decentralize policy supervision to districts and zonal levels. Deploy central level based technocrats to district and zonal level to help with implementation | Non imposition of strategies or models but should work with the subordinates and empower them. (Wheatley, Margaret (2006) and (John P. Kotter, 2006)- | Principal Secretary, Ministry of Health |

| | | Consolidating improvements and institutionalizing new approaches | |
|---|---|---|---|
| | leadership | | |
| Poor stakeholder coordination | Formation clear roles/terms of reference for coordinating stakeholders. Linkage of organizational efforts and resources | Formation of powerful guiding coalition/Stakeholder coordination (John P. Kotter, 2006) | Principal Secretary, Office of President and Cabinet and Ministry of Health |
| Poor policy harmonization | Creation of a national policy harmonization committee to oversee the HIV/AIDS and related sexual and reproductive health policies. | Formation of powerful guiding coalition/Stakeholder coordination (John P. Kotter, 2006) | Principal Secretary, Office of President and Cabinet and Ministry of Health |
| Health systems challenges such as lack of access to health facilities due to long distances and poor roads especially in rainy season | Coordination with ministry of health, other government line ministries and all other necessary stakeholders who can help in different areas | Building Social Skill. Daniel Goleman, 2004. Also, John P. Kotter, 2006-removing obstacles | Principal Secretary, Office of President and Cabinet and Ministry of Health |
| Poor male involvement | Conduct community sensitizations through village health committees, peer education and improvement of infrastructure to make them male friendly | Building Social Skill. (Daniel Goleman, 2004) and John P. Kotter, 2006- removing obstacles | Principal Secretary, Ministry of Health. The Director of Health Education Unit will be accountable for community mobilization part. Director of planning will handle the male friendly infrastructure |

| | | | |
|---|---|---|---|
| Shortage of staff/Staff development | Government to approve use of non-medically trained HIV testing counselors | Building Social Skill. (Daniel Goleman, 2004). and John P. Kotter, 2006- removing obstacles | Principal Secretary, Ministry of Health in conjunction with Office of President and Cabinet-Department of Human Resources |
| Resource constraints | Government to allocate more local resources rather depending on donors, should also mobilize resources from other NGO partners | Building Social Skill. (Daniel Goleman, 2004). John P. Kotter, 2006-removing obstacles | Chief Secretary, Office of President and Cabinet and Principal Secretary for Treasury |
| Selective prioritization by government | Government should be fully committed to the entire policy and mobilize support for all the components | Creation of a vision and institutionalization of new approaches (John P. Kotter, 2006) | Principal Secretary, Ministry of Health |
| Lack of community sensitization about the policy | Efficient community sensitization of communities through village health committees and other formal village structures. | Building Social Skill. (Daniel Goleman. 2004). Also John P. Kotter, 2006- overcome obstacles and sense of urgency | Principal Secretary, Ministry of Health. The Director of Health Education Unit will be accountable |
| Attitudinal/cultural problems | Organize trainings for health care workers and community sensitizations on pros and cons of certain beliefs and customs | Non imposition of strategies or models but should work with the subordinates and empower them. (Wheatley, Margaret (2006). Also John P. Kotter, 2006- overcome obstacles and sense of urgency | Principal Secretary, Ministry of Health. The Director of Health Education Unit will be accountable |

**Summary of Recommendations**

I identified a lot of barriers and facilitators regarding the implementation of the 2003 HIV/AIDS Policy. It is my hope that the recommendations will help contribute towards maximizing implementation of HIV/AIDS policies, enhance HIV prevention and ultimately improve public health and other aspects of human social economic development. The barriers and facilitators raised in this study undoubtedly mirror those of sexual reproductive health and other health-related policies. As a result, the recommendations are very important in influencing the problem solving approach to towards other related health policies. These recommendations are based on key public health leadership principle aimed at influencing public health change. All the recommendations are based on John Kotter's key steps for influencing change alongside other leadership concepts. The specific recommendations include;

- Involvement of health care workers in policy making process and dissemination through trainings
- Improve stakeholder coordination through formulation of clear terms of reference or clarification of stakeholder roles, linkages of organizational efforts and creation of national policy harmonization committee to coordinate implementation
- Strengthen policy leadership through decentralization of supervision
- Intensification of community mobilization and Improve male involvement in issues of HIV prevention
- Enhance human capacity and resource mobilization for HIV/AIDS policy implementation

- Creation of a national policy harmonization and Supervision committee

**Target Audience for the Dissemination of the Recommendations**

These findings and solutions will be presented to the policy holders; the Office of the

President and Cabinet, the Ministry of Health, National AIDS Commission, health rights

activists, representative organizations for HIV/AIDS related services such as Southern Africa

AIDS Trust and International Non Governmental Organization forum.

The specific dissemination strategies for the recommendations are described below.

**Dissemination Plan for Findings and Recommendations**

In this plan for change I will employ core public health leadership competences of

advocacy (the ability to influence decision-making regarding policies and practices),

communication (the ability to assess and use communication strategies across diverse

audiences), and leadership (the ability to create and communicate a shared vision for a

positive future) in delivering recommendations generated from the barriers and facilitators

identified in the study. I will undertake the following specific strategies for delivering the

recommendations;

**General Stakeholder Sensitization Meeting**

I will arrange a general stakeholder sensitization meeting through support from my

office. I also hope the National AIDS Commission can also be in a position to help with

logistics of such a meeting. The aim is to get all the respective stakeholders about HIV/AIDS

Policy implementation together and share the findings.

**Presentations at Health Sector Working Group Meetings**

I am a member of some influential health working groups that are patronized by

people who can influence polices such as Health Sector Working Group. This is a highest

level health technical working group which acts like a Board of governance body on health issues. Naional health issues of importance including health bugdets are discussed and forwarded to top management of Ministry of Health for final decision or referred to to the Cabinet of the Republic of Malawi if need be. I also participate in the International Non Organizational Forum which acts as national advocacy group for organizations working HIV/AIDS. There are also other consortiums of HIV/AIDS service organizations which my organization collaborates with such as Southern Africa AIDS Trust and Malawi Network of AIDS Service Organizations, both have very wide membership.  I therefore will use scheduled meetings of the groups to present the study findings and recommendations.

**Targeted Advocacy Meetings with Key Policy Makers**

I cannot assume that policy makers are paying enough attention to issues brought to them through general meetings or disseminations; hence I will arrange special advocacy meetings at least with key policy/decision makers and also the Parliamentary Committee on Health. Apart from mere presentation of research findings, such stakeholders will require good persuasive skills to go along with the science presented. This approach recognizes that change agents require respect, establish good rapport with them, consensus building, and good communication as well as scientifically sound evidence in order to move forward.

**Presentation at National HIV/AIDS Best Practices Dissemination Meeting**

Malawi conducts annual national HIV/AIDS best practices disseminations annually. I will also present my findings and recommendations to this forum. This is a very important forum because it attracts a much wider audience and will capture relevant stakeholders I may have missed through other dissemination forums.

To ensure timely delivery of these recommendations to relevant stakeholders, I have developed a timeline for dissemination of the plan and this is presented in Appendix 4. Dissemination of the recommendations to stakeholders will give them an opportunity to understand the findings and give them their critical analysis. It will also help leaders approach the execution of the new or subsequent policies with evidence based information.

## Conclusion

Malawi produced a very good HIV/AIDS Policy document but did not necessarily translate to implementation due to several reasons. This dissertation has given recommendations of how best best to move HIV/AIDS Policy to successful implementation. I have targeted specific stakeholders with my recommendations; the Office of the President and Cabinet, the Ministry of Health, National AIDS Commission, health rights activists, Christian Health Association of Malawi and other key non-governmental organizations implementing HIV/AIDS services. I made a delivery strategy for these recommendations based on Core Public Health competencies of;

1. Advocacy—targeted advocacy meetings
2. Communication—presentations at various meetings to share new plans/strategies
3. Leadership—presentations at various meetings as a forum to share new vision

Targeting specific stakeholders using strategies based on the key public health competencies will make it practical to disseminate and follow through the plan for change.

## APPENDIX 1: STUDY QUESTIONNAIRES

**Interview guide:       Health care workers (local level implementers)-STI/PITC**

Hello……My name is Gift Kamanga. I am a public health leadership doctoral student in the Department of Health Policy and Management from the University of North Carolina at Chapel. I would like to thank you for accepting to participate in this interview. This interview will be confidential and all the records will be kept as such. I will not directly link your name to the findings that I will document about this exercise.

As you know, our country faces many challenges related to HIV/AIDS. There is great need to move forward in finding ways of HIV/AIDS prevention and impact mitigation. The government and stakeholders have instituted HIV/AIDS policies and guidelines in 2003. Enabling policies are very important in driving programs in the right direction. Knowledge about barriers and facilitators of policy implementation will effectively inform the best direction to take in order to contribute to the goal of HIV prevention.

The purpose of the interview is to learn about what you think and what you have experienced as barriers and facilitators that affect the implementation of HIV/AIDS Policy in Malawi. I will also ask for your recommendations on what can lead to successful implementation. Since I will get such helpful information from many other people I will interview, this will help me develop a good summary and analysis that will improve HIV/AIDS related services in the country and other related settings.

The interview is expected to last about 45-60 minutes. In addition to senior health leaders/policy makers, I will be talking with health care worker providers and health interest/lobby groups.

I would like to seek your permission to record the interview so that I don't miss important points. Should you not be comfortable with the interview, then I will use hand written notes.

Do you have any questions about the study or the interview? Do I have your permission to proceed with the interview? (At this stage a brief consent agreement is signed)

**General perspectives**

**A policy is a rule, guide or protocol to guide decisions or operations in order to achieve desirable outcomes. Malawi developed HIV/AIDS Policy and it became operational in 2003. The policy has many components but I will start by asking you on general issues.**

1. How long have you worked in HIV/AIDS services?

2. Have you heard about HIV/AIDS Policy in Malawi? (Probe1. Have you ever seen the actual policy 2003 policy document? Probe 2. Have you been formally briefed or sensitized on this policy?) Probe 3. The policy has components such as HIV testing for STIs and PMTCT. Which policy component have you been involved with, i.e. HTC for STI, PMTCT, Tuberculosis or general PITC?

3. How were you as one of the health care workers informed of the 2003 HIV/AIDS Policy? (Probe 1. Were there formal meetings or trainings, Probe 2. Please state any other awareness mechanisms that were employed. Probe 3. Do you have suggestions on how best the awareness could have been done in order to positively affect implementation?)

**Earlier on I asked you about your experience on general components of 2003 HIV/AIDS Policy, now, I would like us to talk about HIV testing for STI and general PITC to patients you came across.**

4. How long have you worked in STI and other PITC service delivery?

5. Is there any (written) source or reference you know and use (a) for your routine guidance in STI service provision? (Probe, what is that source, if knows and does not use state the reason?) or (b) for general PITC (probe as above)

6. What support has been available from leadership regarding implementing this policy component?

7. What strategies were put in place to implement HIV testing for STI patients and general PITC? (Probe 1.List the strategies, if possible differentiate them from STI specific or general PITC Probe 2. What worked and why? Probe 3. What did not work and why?) (Note to interviewer: Ask the same question and probes for monitoring)

**One of the most important aspects of this review is to identify issues that helped with implementation or those that hindered it. Please feel free to share with me the issues experienced or those that you think contributed to implementation in either way.**

**Facilitators of policy implementation**

8. What were the facilitators for implementing this policy component? By facilitators, I mean those issues or situations which helped with smooth implementation of the policy. (Probe. What specific help from leadership was given to you, e.g. training, routine supportive supervision. How can those things be upheld for the good of policy implementation?)

**Barriers of policy implementation**

9.  What were the barriers in the implementation of this policy? (Probe 1. Did cultural
    and people's belief issues play any role, please explain? Probe 2.
    Were there any material resource challenges, what were they? Probe 3. Were there
    any human resource challenges, how did they affect implementation?
    Probe 4. Was there awareness of policies and guidelines? Probe 5. Did health care
    leadership provide necessary guidance in terms of supervision towards
    implementing the policy, how well was this done? Probe 6. Did people receive the
    skills needed to implement the policy? Probe 7. How were you involved in the
    policy making process, is that important to you, why?

10. What recommendations would you give to address the barriers for refinement of the
    current and to inform implementation of subsequent ones?

**Concluding remarks**

I am so glad that I was able to interview you. Thank you for your insights and experience
with the 2003 HIV/AIDS Policy – it has been very helpful.

30. Do you have additional insights and thoughts regarding implementation of any of
    these components or the overall HIV/AIDS Policy?

I would like to thank you for taking your precious time to participate in this interview. Let
me know if you have any questions otherwise this is the end of the interview.

**Interview guide:       Health care workers (local level implementers)-PMTCT**

Hello……My name is Gift Kamanga. I am a public health leadership doctoral student in the

Department of Health Policy and Management from the University of North Carolina at

Chapel. I would like to thank you for accepting to participate in this interview. This interview

will be confidential and all the records will be kept as such. I will not directly link your name

to the findings that I will document about this exercise.

As you know, our country faces many challenges related to HIV/AIDS. There is great need

to move forward in finding ways of HIV/AIDS prevention and impact mitigation. The

government and stakeholders have instituted HIV/AIDS policies and guidelines in 2003.

Enabling policies are very important in driving programs in the right direction. Knowledge

about barriers and facilitators of policy implementation will effectively inform the best

direction to take in order to contribute to the goal of HIV prevention.

The purpose of the interview is to learn about what you think and what you have experienced

as barriers and facilitators that affect the implementation of HIV/AIDS Policy in Malawi. I

will also ask for your recommendations on what can lead to successful implementation. Since

I will get such helpful information from many other people I will interview, this will help me

develop a good summary and analysis that will improve HIV/AIDS related services in the

country and other related settings.

The interview is expected to last about 45-60 minutes. In addition to senior health

leaders/policy makers, I will be talking with health care worker providers and health

interest/lobby groups.

I would like to seek your permission to record the interview so that I don't miss important

points. Should you not be comfortable with the interview, then I will use hand written notes.

Do you have any questions about the study or the interview? Do I have your permission to proceed with the interview? (At this stage a brief consent agreement is signed)

**General perspectives**

**A policy is a rule, guide or protocol to guide decisions or operations in order to achieve desirable outcomes. Malawi developed HIV/AIDS Policy and it became operational in 2003. The policy has many components but I will start by asking you on general issues.**

11. How long have you worked in HIV/AIDS services?

12. Have you heard about HIV/AIDS Policy in Malawi? (Probe1. Have you ever seen the actual policy 2003 policy document? Probe 2. Have you been formally briefed or sensitized on this policy?) Probe 3. The policy has components such as HIV testing for STIs and PMTCT. Which policy component have you been involved with, i.e. HTC for STI, PMTCT, Tuberculosis or general PITC?

13. How were you as one of the health care workers informed of the 2003 HIV/AIDS Policy? (Probe 1. Were there formal meetings or trainings, Probe 2. Please state any other awareness mechanisms that were employed. Probe 3. Do you have suggestions on how best the awareness could have been done in order to positively affect implementation?)

**The HIV/AIDS Policy encompasses prevention of mother to child transmission of HIV (PMTCT)**

23. How long have you worked in PMTCT service delivery?

24. Is there any source or reference you know and use for your routine guidance in PMTCT service provision? (Probe. What is that source, if knows and does not use state the reason?)

25. What support do you receive from leadership regarding implementing PMTCT policy component?

26. What strategies were put in place to implement PMTCT component of the HIV/AIDS policy? (Probe 1. List the strategies. Probe 2. What worked and why? Probe 3. What did not work and why?) (Note to interviewer: Ask the same question and probes for monitoring)

**One of the most important aspects of this review is to identify issues that helped with implementation or those that hindered it. Please feel free to share with me the issues experienced or those that you think contributed to implementation in either way.**

**Facilitators of policy implementation**

27. What were the facilitators for implementing this policy component? By facilitators, I mean those issues or situations which helped with smooth implementation of the policy. (Probe. What specific help from leadership was given to you, e.g. training, routine supportive supervision. How can those things be upheld for the good of policy implementation?)

**Barriers of policy implementation**

28. What were the barriers in the implementation of this policy? (Probe 1. Did cultural and people's belief issues play any role, please explain? Probe 2. Were there any material resource challenges, what were they? Probe 3. Were there any human resource challenges, how did they affect implementation? Probe 4. Was there awareness of policies and guidelines? Probe 5. Did health care leadership provide necessary guidance in terms of supervision towards implementing the policy, how well was this done?

Probe 6. Did people receive the skills needed to implement the policy? Probe 7. How were you involved in the policy making process, is that important to you, why?

29. What recommendations would you give to address the barriers for refinement of the current and to inform implementation of subsequent ones?

**Concluding remarks**

I am so glad that I was able to interview you. Thank you for your insights and experience with the 2003 HIV/AIDS Policy – it has been very helpful.

30. Do you have additional insights and thoughts regarding implementation of any of these components or the overall HIV/AIDS Policy?

I would like to thank you for taking your precious time to participate in this interview. Let me know if you have any questions otherwise this is the end of the interview.

**Interview guide: Senior health leaders/Policy makers-PMTCT**

Hello……My name is Gift Kamanga. I am a public health leadership doctoral student in the Department of Health Policy and Management from the University of North Carolina at Chapel Hill. I would like to thank you for accepting to participate in this interview. This interview will be confidential and all the records will be kept as such. I will not directly link your name to the findings that I will document about this exercise. I am mindful that high level officials like yourself may have concerns that people may deduce that certain statements might have been said by you. To minimize this risk, I will simply generalize that the information was said by "a high level leader or policy maker". I will also lessen this by interviewing previous leaders or policy makers.

As you know, our country faces many challenges related to HIV/AIDS. There is great need to move forward in finding ways of HIV/AIDS prevention and impact mitigation. The government and stakeholders have instituted HIV/AIDS policies and guidelines in 2003. Enabling policies are very important in driving programs in the right direction.

Knowledge about barriers and facilitators of policy implementation will effectively inform the best direction to take in order to contribute to the goal of HIV prevention.

The purpose of the interview is to learn about what you think and what you have experienced as barriers and facilitators that affect the implementation of HIV/AIDS Policy in Malawi. I will also ask for your recommendations on what can lead to successful implementation. Since I will get such helpful information from many other people I will interview, this will help me develop a good summary and analysis that will improve HIV/AIDS related services in the country and other related settings.

The interview is expected to last about 45-60 minutes. In addition to senior health leaders/policy makers, I will be talking with health care worker providers and health interest/lobby groups.

I would like to seek your permission to record the interview so that I don't miss important points. Should you not be comfortable with the interview, then I will use hand written notes.

Do you have any questions about the study or the interview? Do I have your permission to proceed with the interview?

**General perspectives**

The 2003 HIV/AIDS Policy is very broad, but before we go to issues pertaining to specific components, I will ask you about crosscutting issues for the entire policy.

14. Why was the formulation of HIV/AIDS Policy important?

15. As a senior person in the health field, you may have been involved in policy process at different levels. Of the three aspects of this policy process, problem identification, policy formulation and implementation, which one(s) were you involved in? Probe. What was your specific role?

**Effects of policy making process on implementation**

**Let us now talk about policy making process and implementation in general.**

16. Can you describe the policy making process for this policy? (Probe. Who initiated the process? Probe 2.Which stakeholders were actually involved? Probe 3. How do you think the policy making process affected the implementation?)

17. How were health care workers informed of the 2003 HIV/AIDS Policy?

(Probe 1. Were there formal meetings or trainings, please state any other mechanisms that were employed? Probe 2. Do you have suggestions on how best it could have been done in order to positively affect implementation?)

**Stakeholders involved**

18. Who were the intended stakeholders to implement the 2003 HIV/AIDS Policy? (Probe1. Which stakeholders were actually involved in the implementation? Probe 2. Which other stakeholders do you think were left in the implementation of the policy?)

**Let us now discuss another component of the 2003 HIV/AIDS Policy-Prevention of mother to child transmission of HIV (PMTCT)**

**Strategies for implementing and monitoring the policy**

9. What strategies were put in place to implement HIV testing for PMTCT (Probe 1.List the strategies. Probe 2. What worked and why? Probe 3. What did not work and why? Probe 4. What do you think could have been done to support the implementation better?) (Note to interviewer: Ask the same question and probes for monitoring)

**Facilitators of policy implementation**

10. What were the facilitators for implementing this policy component? By facilitators, I mean those issues or situations which helped with smooth implementation of the policy. (Probe 1. What can you say about training of health care workers on the policy? Probe 2. How was coordination of stakeholders like? Probe 3.

How was the involvement of health care workers in the process of policy formulation? How can those things be upheld for the good of policy implementation?)

**Barriers of policy implementation**

11. What were the barriers in the implementation of this policy? (Probe 1. Did cultural and people's belief issues play any role, please explain? Probe 2. Were there any material resource challenges, what were they? Probe 3. Were there any human resource challenges, how did they affect implementation? Probe 4. What was the political environment in the implementation of the policy? Probe 5. How user friendly was the policy? What recommendations would you give to address the barriers for refinement of the current and to inform implementation of subsequent ones?

**Concluding remarks**

**I am so glad that I was able to interview you. Thank you for your insights and experience with the 2003 HIV/AIDS Policy – it has been very helpful.**

12. Do you have additional insights and thoughts regarding implementation of any of these components or the overall HIV/AIDS Policy?

**I would like to thank you for taking your precious time to participate in this interview. Let me know if you have any questions otherwise this is the end of the interview.**

**Interview guide: Senior health leaders/Policy makers-HTC**

Hello……My name is Gift Kamanga. I am a public health leadership doctoral student in the Department of Health Policy and Management from the University of North Carolina at Chapel Hill. I would like to thank you for accepting to participate in this interview. This interview will be confidential and all the records will be kept as such. I will not directly link your name to the findings that I will document about this exercise. I am mindful that high level officials like yourself may have concerns that people may deduce that certain statements might have been said by you. To minimize this risk, I will simply generalize that the information was said by "a high level leader or policy maker". I will also lessen this by interviewing previous leaders or policy makers.

As you know, our country faces many challenges related to HIV/AIDS. There is great need to move forward in finding ways of HIV/AIDS prevention and impact mitigation. The government and stakeholders have instituted HIV/AIDS policies and guidelines in 2003. Enabling policies are very important in driving programs in the right direction. Knowledge about barriers and facilitators of policy implementation will effectively inform the best direction to take in order to contribute to the goal of HIV prevention.

The purpose of the interview is to learn about what you think and what you have experienced as barriers and facilitators that affect the implementation of HIV/AIDS Policy in Malawi. I will also ask for your recommendations on what can lead to successful implementation. Since I will get such helpful information from many other people I will interview, this will help me develop a good summary and analysis that will improve HIV/AIDS related services in the country and other related settings.

The interview is expected to last about 45-60 minutes. In addition to senior health leaders/policy makers, I will be talking with health care worker providers and health interest/lobby groups.

I would like to seek your permission to record the interview so that I don't miss important points. Should you not be comfortable with the interview, then I will use hand written notes.

Do you have any questions about the study or the interview? Do I have your permission to proceed with the interview?

**General perspectives**

The 2003 HIV/AIDS Policy is very broad, but before we go to issues pertaining to specific components, I will ask you about crosscutting issues for the entire policy.

19. Why was the formulation of HIV/AIDS Policy important?

20. As a senior person in the health field, you may have been involved in policy process at different levels. Of the three aspects of this policy process, problem identification, policy formulation and implementation, which one(s) were you involved in? Probe. What was your specific role?

**Effects of policy making process on implementation**

**Let us now talk about policy making process and implementation in general.**

21. Can you describe the policy making process for this policy? (Probe. Who initiated the process? Probe 2.Which stakeholders were actually involved? Probe 3. How do you think the policy making process affected the implementation?)

22. How were health care workers informed of the 2003 HIV/AIDS Policy?

   (Probe 1.

Were there formal meetings or trainings, please state any other mechanisms that were employed? Probe 2. Do you have suggestions on how best it could have been done in order to positively affect implementation?)

**Stakeholders involved**

23. Who were the intended stakeholders to implement the 2003 HIV/AIDS Policy? (Probe1. Which stakeholders were actually involved in the implementation? Probe 2. Which other stakeholders do you think were left in the implementation of the policy?)

**The 2003 HIV/AIDS Policy encompasses routine HIV testing for STI patients and general PITC. Let us now reflect on this component of the policy.**

**Strategies for implementing and monitoring the policy**

24. What strategies were put in place to implement routine HIV testing for STI patients and general provider initiated HIV testing and counseling (PITC)? (if possible make the strategies for STI and general PITC separate (Probe 1.List the strategies. Probe 2. What worked and why? Probe 3. What did not work and why?) (Note to interviewer: Ask the same question and probes for monitoring)

**One of the most important aspects of my work is to identify issues that helped with implementation or those that hindered it. Please feel free to share with me the issues experienced or those that you think contributed to implementation in either way.**

**Facilitators of policy implementation**

25. What were the facilitators for implementing this policy component? By facilitators, I mean those issues or situations which helped with smooth implementation of the policy. (Probe 1. What can you say about training of health care workers on the policy?

    Probe 2. How was coordination of stakeholders like? Probe 3. How was the involvement of health care workers in the process of policy formulation? How can those things be upheld for the good of policy implementation?)

**Barriers of policy implementation**

26. What were the barriers in the implementation of this policy? (Probe 1. What role did culture and people's beliefs play in the implementation of the policy? Probe 2. Were there any material resource challenges, what were they? Probe 3. Explain if there were any human resource challenges? Probe 4. What was the political environment in the implementation of the policy? Probe 5. How user friendly was the policy? What recommendations would you give to address the barriers for refinement of the current policy and to inform implementation of subsequent ones?

**Concluding remarks**

**I am so glad that I was able to interview you. Thank you for your insights and experience with the 2003 HIV/AIDS Policy – it has been very helpful.**

12. Do you have additional insights and thoughts regarding implementation of any of these components or the overall HIV/AIDS Policy?

**I would like to thank you for taking your precious time to participate in this interview. Let me know if you have any questions otherwise this is the end of the interview.**

**Interview guide: Senior health leaders/Policy makers-(STI)**

Hello……My name is Gift Kamanga. I am a public health leadership doctoral student in the Department of Health Policy and Management from the University of North Carolina at Chapel Hill. I would like to thank you for accepting to participate in this interview. This interview will be confidential and all the records will be kept as such. I will not directly link your name to the findings that I will document about this exercise. I am mindful that high level officials like yourself may have concerns that people may deduce that certain statements might have been said by you. To minimize this risk, I will simply generalize that the information was said by "a high level leader or policy maker". I will also lessen this by interviewing previous leaders or policy makers.

As you know, our country faces many challenges related to HIV/AIDS. There is great need to move forward in finding ways of HIV/AIDS prevention and impact mitigation. The government and stakeholders have instituted HIV/AIDS policies and guidelines in 2003. Enabling policies are very important in driving programs in the right direction. Knowledge about barriers and facilitators of policy implementation will effectively inform the best direction to take in order to contribute to the goal of HIV prevention.

The purpose of the interview is to learn about what you think and what you have experienced as barriers and facilitators that affect the implementation of HIV/AIDS Policy in Malawi. I will also ask for your recommendations on what can lead to successful implementation. Since I will get such helpful information from many other people I will interview, this will help me

develop a good summary and analysis that will improve HIV/AIDS related services in the country and other related settings.

The interview is expected to last about 45-60 minutes. In addition to senior health leaders/policy makers, I will be talking with health care worker providers and health interest/lobby groups.

I would like to seek your permission to record the interview so that I don't miss important points. Should you not be comfortable with the interview, then I will use hand written notes.

Do you have any questions about the study or the interview? Do I have your permission to proceed with the interview?

**General perspectives**

The 2003 HIV/AIDS Policy is very broad, but before we go to issues pertaining to specific components, I will ask you about crosscutting issues for the entire policy.

27. Why was the formulation of HIV/AIDS Policy important?

28. As a senior person in the health field, you may have been involved in policy process at different levels. Of the three aspects of this policy process, problem identification, policy formulation and implementation, which one(s) were you involved in? Probe. What was your specific role?

**Effects of policy making process on implementation**

**Let us now talk about policy making process and implementation in general.**

29. Can you describe the policy making process for this policy? (Probe. Who initiated the process? Probe 2.Which stakeholders were actually involved? Probe 3. How do you think the policy making process affected the implementation?)

30. How were health care workers informed of the 2003 HIV/AIDS Policy? (Probe 1. Were there formal meetings or trainings, please state any other mechanisms that were employed? Probe 2. Do you have suggestions on how best it could have been done in order to positively affect implementation?)

**Stakeholders involved**

31. Who were the intended stakeholders to implement the 2003 HIV/AIDS Policy? (Probe1. Which stakeholders were actually involved in the implementation? Probe 2. Which other stakeholders do you think were left in the implementation of the policy?)

**The 2003 HIV/AIDS Policy encompasses routine HIV testing for STI patients and general PITC. Let us now reflect on this component of the policy.**

**Strategies for implementing and monitoring the policy**

32. What strategies were put in place to implement routine HIV testing for STI patients and general provider initiated HIV testing and counseling (PITC)? (if possible make the strategies for STI and general PITC separate (Probe 1.List the strategies. Probe 2. What worked and why? Probe 3. What did not work and why?) (Note to interviewer: Ask the same question and probes for monitoring)

**One of the most important aspects of my work is to identify issues that helped with implementation or those that hindered it. Please feel free to share with me the issues experienced or those that you think contributed to implementation in either way.**

**Facilitators of policy implementation**

33. What were the facilitators for implementing this policy component? By facilitators, I mean those issues or situations which helped with smooth implementation of the policy. (Probe 1. What can you say about training of health care workers on the policy? Probe 2. How was coordination of stakeholders like? Probe 3. How was the involvement of health care workers in the process of policy formulation? How can those things be upheld for the good of policy implementation?)

**Barriers of policy implementation**

34. What were the barriers in the implementation of this policy? (Probe 1. What role did culture and people's beliefs play in the implementation of the policy? Probe 2. Were there any material resource challenges, what were they? Probe 3. Explain if there were any human resource challenges? Probe 4. What was the political environment in the implementation of the policy? Probe 5. How user friendly was the policy? What recommendations would you give to address the barriers for refinement of the current policy and to inform implementation of subsequent ones?

**I am so glad that I was able to interview you. Thank you for your insights and experience with the 2003 HIV/AIDS Policy – it has been very helpful.**

12. Do you have additional insights and thoughts regarding implementation of any of these components or the overall HIV/AIDS Policy?

**I would like to thank you for taking your precious time to participate in this interview. Let me know if you have any questions otherwise this is the end of the interview.**

**Health Rights/interest groups**

Hello……My name is Gift Kamanga. I am a public health leadership doctoral student in the

Department of Health Policy and Management from the University of North Carolina at

Chapel. I would like to thank you for accepting to participate in this interview. This interview

will be confidential and all the records will be kept as such. I will not directly link your name

to the findings that I will document about this exercise.

I am mindful that high level officials like yourself may have concerns that people may

deduce that certain statements might have been said by you.

To minimize this risk, I will simply generalize that the information was said by "a high level

leader or policy maker." I will also lessen this by interviewing previous leaders or policy.

As you know, our country faces many challenges related to HIV/AIDS. There is great need

to move forward in finding ways of HIV/AIDS prevention and impact mitigation. The

government and stakeholders have instituted HIV/AIDS policies and guidelines in 2003.

Enabling policies are very important in driving programs in the right direction. Knowledge

about barriers and facilitators of policy implementation will effectively inform the best

direction to take in order to contribute to the goal of HIV prevention.

The purpose of the interview is to learn about what you think and what you have experienced

as barriers and facilitators that affect the implementation of HIV/AIDS Policy in Malawi. I

will also ask for your recommendations on what can lead to successful implementation. Since

I will get such helpful information from many other people I will interview, this will help me

develop a good summary and analysis that will improve HIV/AIDS related services in the

country and other related settings.

The interview is expected to last about 45-60 minutes. In addition to senior health leaders/policy makers, I will be talking with health care worker providers and health interest/lobby groups.

I would like to seek your permission to record the interview so that I don't miss important points. Should you not be comfortable with the interview, then I will use hand written notes.

Do you have any questions about the study or the interview? Do I have your permission to proceed with the interview?

**General perspectives**

1. Please describe your position.

2. How long have you been working as a health activist in your organization?

3. What aspect of 2003 HIV/AIDS Policy has your organization been involved in, formulation, and or implementation? (Probe. what was your role?)

**Effects of policy making process on implementation**

4. Can you describe the process how the HIV/AIDS policy made? (Probe 1. Which stakeholders were involved in making of this policy? Probe 2. How do you think the policy making process affected the implementation?)

5. How were health care workers informed of the 2003 HIV/AIDS Policy? (Probe 1. Were there formal meetings or trainings, please state any other mechanisms that were employed Probe 2. Do you have suggestions on how best it could have been done in order to positively affect implementation?)

**We have discussed the formulation and dissemination the policy; now let us talk about its implementation.**

6. Who were the stakeholders to implement the 2003 HIV/AIDS Policy? (Probe 1. Which other stakeholders do you think were left out in the implementation of the policy? Probe 2. What has been your impression about the coordination of different stakeholders in implementing any of the said policy components?

**Policy implementation strategies**

7. What were the strategies that were put in place to implement specific policy components?

Part 1. (Routine HIV testing for STI patients/PITC) (Probe 1.List the strategies. Probe 2. What worked and why? Probe 3. What did not work and why? Probe 4. What do you think could have been done to support the implementation better?)

Part 2. (HIV testing for PMTCT among antenatal mothers) (Probe 1.List the strategies. Probe 2. What worked and why? Probe 3. What did not work and why? Probe 4. What do you think could have been done to support the implementation better?)

Part 3 Apart for STI and PMTCT purposes, I would like to enquire about what you think about general PITC. (Probe 1.List the strategies. Probe 2. What worked and why? Probe 3. What did not work and why? Probe 4. What do you think could have been done to support the implementation better?)

(Note to interviewer: Ask the same question and probes for monitoring)

**Facilitators of policy implementation**

8. What were the facilitators for implementing this policy? By facilitators, I mean those issues or situations which helped with smooth implementation of the policy.

Probe. What specific help from leadership was given to you, e.g. training, routine supportive supervision. How can those things be upheld for the good of policy implementation?

**Barriers of policy implementation**

9. What were the barriers in the implementation of this policy? (Probe 1. Did cultural and people's belief issues play any role, please explain? Probe 2. Were there any material resource challenges, what were they? Probe 3. Were there any human resource challenges, how did they affect implementation? Probe 4. Was there awareness of policies and guidelines to the implementers? Probe 5. Did health care leadership provide necessary guidance in terms of supervision towards implementing the policy, how well was this done? Probe 6. Did people receive the skills needed to implement the policy? Probe 7. How were you involved in the policy making process, is that important to you, why? Probe 8. What was the political environment in the implementation of the policy? Probe 9. How user friendly was the policy?

10. What recommendations would you give to address the barriers for refinement of the current and to inform implementation of subsequent ones?

**Concluding remarks**

11. Do you have additional insights and thoughts regarding implementation of any of these components or the overall HIV/AIDS Policy?

**I would like to thank you for taking your precious time to participate in this interview. Let me know if you have any questions otherwise this is the end of the interview.**

**Consent to Participate in a Research Study**

**Title of Study: How Best Can HIV/AIDS Policy be Moved to Successful**

**Implementation? Lessons from Routine HIV Testing of Patients with Sexually**

**Transmitted Infections in Malawi**

**Protocol number 1189**

Version 2.0_28[th] September 2013

**Principal Investigator:** Gift Kamanga, MSc, DLSHTM

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Phone: 265 88 8 870 623

**General information**

You are asked to participate in this study because you are an important stakeholder in the field of HIV/AIDS, especially in your capacity as (any of the following) senior health leaders/Policy makers, health care workers (local level implementers) and health rights/interest groups.

**Purpose of this study**

This research is done with an intention of contributing towards HIV prevention in Malawi. I am going to examine barriers and facilitators that affect implementation of HIV/AIDS policy, which drive the realization of this important goal. This policy has been implemented since 2003 to date (2013). It is very important to examine it and learn from its successes and areas that need improvement for the benefit of HIV/AIDS prevention services. This study is expected to help with improvement of implementation of HIV related programs through subsequent policies.

**What is going to happen in this study?**

I am going to ask you some questions about 2003 HIV/AIDS Policy in Malawi. I would like to seek your permission to record the interview so that I don't miss important points. This recording is solely for my use for this study purpose. As soon as I am done with final analysis of my research study, I will destroy all the recordings and other notes I captured. If you are not comfortable with recording then I will collect the information using hand written notes.

**Duration of the study**

This research a one time off interview and there is no formal follow up except if there is need for further clarification from each other.

**Foreseeable risks**

In this study participants will provide information about how the HIV/AIDS Policy was implemented and give their recommendations. It is not anticipated that providing such information would get any participant into any problems with their employers. Participants will not be identified by names in the final report but pseudonyms such as health care 1, 2 etc. Policy maker 1, 2, health rights stakeholder. However, there is a small risk that it rare circumstances it may be inferred as to who might have said what, especially if it is deemed criticizing their superiors (government authorities). To mitigate this, the investigator has decided to include both, current or former office holders in the interview plan. In this case it will not be easy for one to guess who might have said what.

**Benefits to participation**

There is no direct benefit you will get from participating in this research. However, the knowledge to be obtained through your study participation might be of significant help in the fight against HIV in general and that might be satisfying to some people.

**Confidentiality**

All study-related information will be stored securely. The recordings from participants will be transferred into a password protected computer to prevent unauthorized access. Any written notes or scripts will be kept in a lockable cabinet which can only accessed by the principal investigator or authorized agents.

Electronic data will be properly stored and backed up in a secure personalized password protected institutional server space. In the study write up, there will be no link of your personal information to findings.

**Who to contact with questions**

Should you have questions or clarifications about your study participation, please contact me through phone 088 8 870 623. If you have concerns about your rights as a research participant, then you need to contact Malawi National Health Sciences Research Committee through Dr Kathyola, phone 088 8 344 443.

**Statement of costs**

The principal investigator for this research will find you at your convenient place; as such you will neither pay or be paid anything for participating in this research.

**Right to discontinue participation**

Your participation in this research voluntary and you may decide not to participate or withdraw from participation.

**Signature**

If you have read this informed consent, or have had it read and explained to you, and understand the information, and you voluntarily agree to participate in this research study, please sign your name in the signature area at the bottom of this page.

_____         _____    _____
Participant Name (print)               Participant Signature    Date

_____         _____    _____
Investigator Conducting                Study Staff Signature    Date
Consent Discussion (print)


If participant gave consent but refused to sign, check in the box        ☐

## APPENDIX 3: DISSERTATION TIMELINE

| Activity | Nov 2013 | Dec 2014 | Jan 2014 | Feb 2014 | Mar 2014 | Apr 2014 | May 2014 | Jun 2014 | Jul 2014 | Aug 2014 |
|---|---|---|---|---|---|---|---|---|---|---|
| Submit proposal to NHSRC | •———→ | | | | | | | | | |
| Data collection | | •————————→ | | | | | | | | |
| Data Analysis and writing | | | | •————————————→ | | | | | | |
| Submit draft to committee | | | | | | | •————————→ | | | |
| Responding to Committees comments | | | | | | | | •————————→ | | |
| Defense | | | | | | | | | | •———→ |

# APPENDIX 4: RECOMMENDATIONS FOR IMPLEMENTATION OF DISSEMINATION TIMELINE

| Activity | Nov 2014 | Dec 2014 | Jan 2015 | Feb 2015 | Mar 2015 | Apr | May |
|---|---|---|---|---|---|---|---|
| General Stakeholder Dissemination Meeting | →→ | | | | | | |
| Advocacy meeting with health rights groups and OPC | | •—→ | → | | | | |
| Presentation at National HIV/AIDS Dissemination Meeting | →→ | | | | | | |
| Presentation at Health Sector Working Group Meeting | | | | •—→ | | | |
| Advocacy meeting with NAC and MOH | | | | | •—→ | | |
| Advocacy meeting with Health Sector Working Group Meeting | | | | | | •—→ | |
| Advocacy meeting with parliamentary committee on health | | | | | | | •—→ |

| Brief Definition | Full Definition | When to use | When not to use | Account for changes |
|---|---|---|---|---|
| **TOPIC AREA: SENIOR HEALTH LEADERS/POLICY MAKERS PERSPECTIVES** | | | | |
| **General Issues** | | | | |
| **HIV/AIDS Policy making process** | | | | |
| Description of policy making process

(Polimake) | Any mention of policy initiation, involvement in HIV/AIDS Policy making and its effects. Some policies are made from top without the knowledge or involvement of people on the ground who implement while other are participatory, so any expressed satisfaction or dissatisfaction stated will be important. | Apply to discussions of process of HIV/AIDS and related health Policies | Discussions rather than process of HIV/AIDS and related health Policies | |
| **HIV/AIDS Policy awareness (emanated from questions about effect of process above)** | | | | |
| Stakeholders knowledge about the HIV/AIDS policy

(Poldisse) | Any mention dissemination, awareness, distribution of HIV/AIDS policy documents, meetings, workshops, trainings aimed at disseminating the policy, including the concerns and recommendations | When issues are discussed pertaining to HIV/AIDS Policy implementation | Discussion of issues not related to dissemination of HIV/AIDS Policy | |
| **Stakeholders for HIV Policy implementation** | | | | |
| Analysis stakeholders for HIV/AIDS | Discussion, description about stakeholders | When stakeholder coordination | Discussion of non HIV/AIDS stakeholders | |

| Policy (Stkcord) | coordination in the HIV/AIDS Policy making process and implementation | issues about HIV/AIDS are discussed | | |
|---|---|---|---|---|
| **Topic: STI/PITC** | | | | |
| **Strategies for implementing routine HIV testing for STI patients and general PITC** | | | | |
| Strategies for HTC for STIs and general PITC (Impsti) | Any mention of strategies, ways of implementing HIV testing and counseling (HTC) for STIs and general PITC. | When strategies mentioned are specific to STIs or general PITC | Non STI/PITC strategies such as PMTCT, HIV testing in tuberculosis patients | |
| **Strategies for monitoring routine HIV testing for STI patients and general PITC** | | | | |
| Strategies for HTC for STIs and general PITC (Monsti) | Any mention of strategies, ways of monitoring HIV testing and counseling (HTC) for STIs and general PITC. | When monitoring strategies mentioned are specific to STIs or general PITC | Non STI/PITC monitoring strategies such as PMTCT, HIV testing in tuberculosis patients | |
| **Facilitators for implementing routine HIV testing for STI patients and general PITC** | | | | |
| Positive attributes for uptake of HTC for STI/PITC (Facisti) | All issues or situations which helped with smooth implementation of the policy such as; health care worker trainings, good stakeholder coordination, motivation due to involvement in policy formulation | When the facilitators are related HTC for STIs or general PITC | Non STI/PITC facilitators | |
| **Barriers for implementing routine HIV testing for STI patients and general PITC** | | | | |
| Negative attributes for uptake of HTC for STI/PITC (Barsti) | All issues or situations which hindered implementation of the policy such as; lack of health care worker trainings, material and human resource constraints. Poor stakeholder coordination, | When the barriers are related HTC for STIs or general PITC | With non STI/PITC barriers | |

| | demotivation due to lack policy formulation involvement and non-conducive political environment including relevant recommendations | | | |
|---|---|---|---|---|
| **PMTCT** | | | | |
| **Strategies for implementing HIV testing for PMTCT** | | | | |
| Strategies for HTC for PMTCT (Imptct) | Any mention of strategies, ways of implementing HIV testing and counseling (HTC) for PMTCT. Description of what worked, what did not work and the reasons. | When implementation strategies mentioned are specific to PMTCT | Non PMTCT implementation strategies such as, HIV testing in tuberculosis patients and STI/PITC | |
| **Strategies for monitoring HIV testing for PMTCT** | | | | |
| Monitoring strategies for HTC for PMTCT (Monpmtc) | Any mention of strategies, ways of monitoring HIV testing and counseling (HTC) for PMTCT. Description of what worked, what did not work and the reasons | When monitoring strategies mentioned are specific to PMTCT | Non PMTCT monitoring strategies such as, HIV testing in tuberculosis patients and STI/PITC | |
| **Facilitators for implementing HIV testing for PMTCT** | | | | |
| Positive attributes for uptake of HTC for PMTCT (Facpmtc) | All issues or situations which helped with smooth implementation of the policy such as; health care worker trainings, good stakeholder coordination, motivation due to involvement in policy formulation | When the facilitators are related HTC for PMTCT | Non PMTCT facilitators | |
| **Barriers for implementing HIV testing for PMTCT** | | | | |

| Negative attributes for uptake of HTC for PMTCT (Bapmtc) | All issues or situations which hindered implementation of the policy such as; lack of health care worker trainings, material and human resource constraints. Poor stakeholder coordination, demotivation due to lack of involvement in policy formulation and non-conducive political environment | When the barriers are related HTC to PMTCT | Non PMTCT barriers | |
|---|---|---|---|---|
| Conflicting roles about policy implementation Stksonf | Any mention conflicting roles about policy implementation, supervision and coordination of any component of HIV/AIDS Policy | Any discussion or about conflicting roles or confusion about implementation and coordination of 2003 HIV Policy or other health policies | Confusion or conflicting roles other than those of health related policies | |
| General facilitators Facgen | Facilitators pertaining the whole policy implementation | All facilitators mentioned in general | Facilitators for specific policy component such as STI or PMTCT | |
| General barriers Bargen | Barriers for the general HIV/AIDS Policy | Barriers mentioned in general | Barriers for specific policy component such as STI or PMTCT | |
| General recommendations Recgen | Recommendations pertaining to the general policy | When general recommendations about HIV Policy are made | When recommendations are for specific policy area such as STI or PMTCT | |

# APPENDIX 6: DETAILED DOCUMENT REVIEW

## Historical Perspectives of the Policy

The 2003 HIV/AIDS Policy was introduced at a time when the general voluntary counseling and testing (VCT) concept was advocated. Healthcare workers were encouraged by the policy to offer HIV testing to vulnerable groups such as patients with STI and for women attending antenatal clinics for PMTCT. STIs are very important in facilitating HIV acquisition (Galvin & Cohen, 2004). Also, PMTCT is very important in the reduction of future HIV/AIDS burden (World Health Organization, 2010). The other dimension of HIV testing under this policy guidance was diagnostic testing, which encouraged medical personnel to perform HIV testing on patients as part of their diagnostic work-up if they suspected HIV infection.

In 2007, the World Health Organization/UNAIDS issued new guidance that all patients attending health facilities be offered HIV testing through the provider-initiated HIV testing and counseling (PITC) model (WHO, 2007). Malawi adopted this approach immediately. This means that all healthcare outpatient or inpatient settings, including STI and PMTCT sites, were mandated to start offering HIV testing to all patients. My personal experience is that although some components of this policy were well implemented, others were not.

Driven by my passion for good implementation of health policies, before my dissertation proposal process, I one day asked a senior health official whether he felt implementation of healthy policies were going on well. He said,

> "The Malawi Ministry of Health structure has the right number of technical expertise to deliver on its agenda to the people, but the problem is that these experts are delinked from their rightful mandate, they are soaked in too many tasks. They are used to make policies when their main duty is to manage the

implementation of programs. This puts them in conflict and program side will lack the needed leadership to move it."

I keenly followed through on the results to see the role of top-level officials to effective policy implementation.

**Coordinating Structure and Players in the Malawi HIV/AIDS Policy**

The HIV coordination in Malawi is well structured and clearly documented in the Malawi National HIV testing guidelines of 2009. The coordinating unit for the HIV/AIDS Policy is comprised of: the Office of the President and Cabinet (responsible for policy leadership), the HIV/AIDS Department in the MOH and the National AIDS Commission responsible for implementation and overall coordination respectively.

The policy holder for HIV/AIDS in Malawi is the Department of HIV/AIDS and Nutrition in the Office of the President and Cabinet. HIV prevention is the largest part of HIV/AIDS implementation and is done by the Malawi Ministry of Health. One of its main partners is the Christian Health Association of Malawi (CHAM). The Ministry of Health and CHAM also implement impact mitigation along with other stakeholders.

The policy was initiated at the level of the senior management committee in the Department of HIV/AIDS and Nutrition in the Office of the President and Cabinet. The Office of the President and Cabinet and the Ministry of Health are separate government ministries that have independent administrative hierarchies and policy-making processes. There is no reporting relationship between the two on operational issues relating to HIV/AIDS. The Ministry of Health's implementation coordinating unit is the HIV/AIDS Department. It is in a "default" reporting relationship with the Department of HIV/AIDS and Nutrition. It is not clear how strong this relationship is in as far as facilitation of implementation is concerned. It is also not known to the author how senior and top

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management of both sides relate over the management of the policy. The reporting and

coordination relationship for HIV/AIDS among stakeholders is presented in Figure 1.

Figure 1. HIV/AIDS policy reporting and coordination relationship for Malawi.
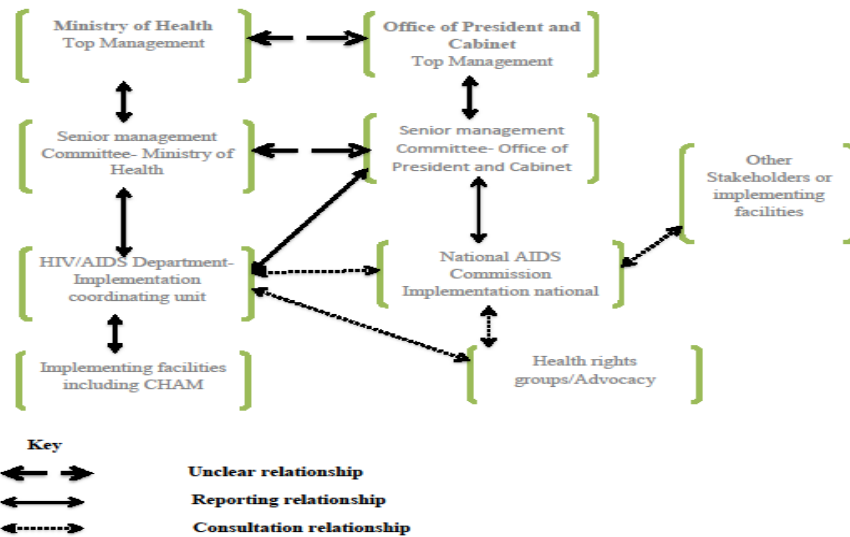


Malawi's health system is managed by the Ministry of Health headquarters through

five administrative health zones and 27 districts. The health zones are responsible for district

health facilities. The supervision by the zones is a way of decentralizing the authority from

central level but the mainstay of supervision of health services for a long time has been

district health offices. Within the district there are two main health service providers who

operate these health centers: the government (operated by the Ministry of Health) and others

owned by the Christian Association of Malawi (CHAM), which provides almost 37% of the

health care services (SHOPS Project, 2012). Malawi's health zones and districts are

presented in Figure 2.

Figure 2. Malawi administrative health zones and districts. (Sourced from the Ministry of Health Sector Wide Approach on 22 Feb 2013)
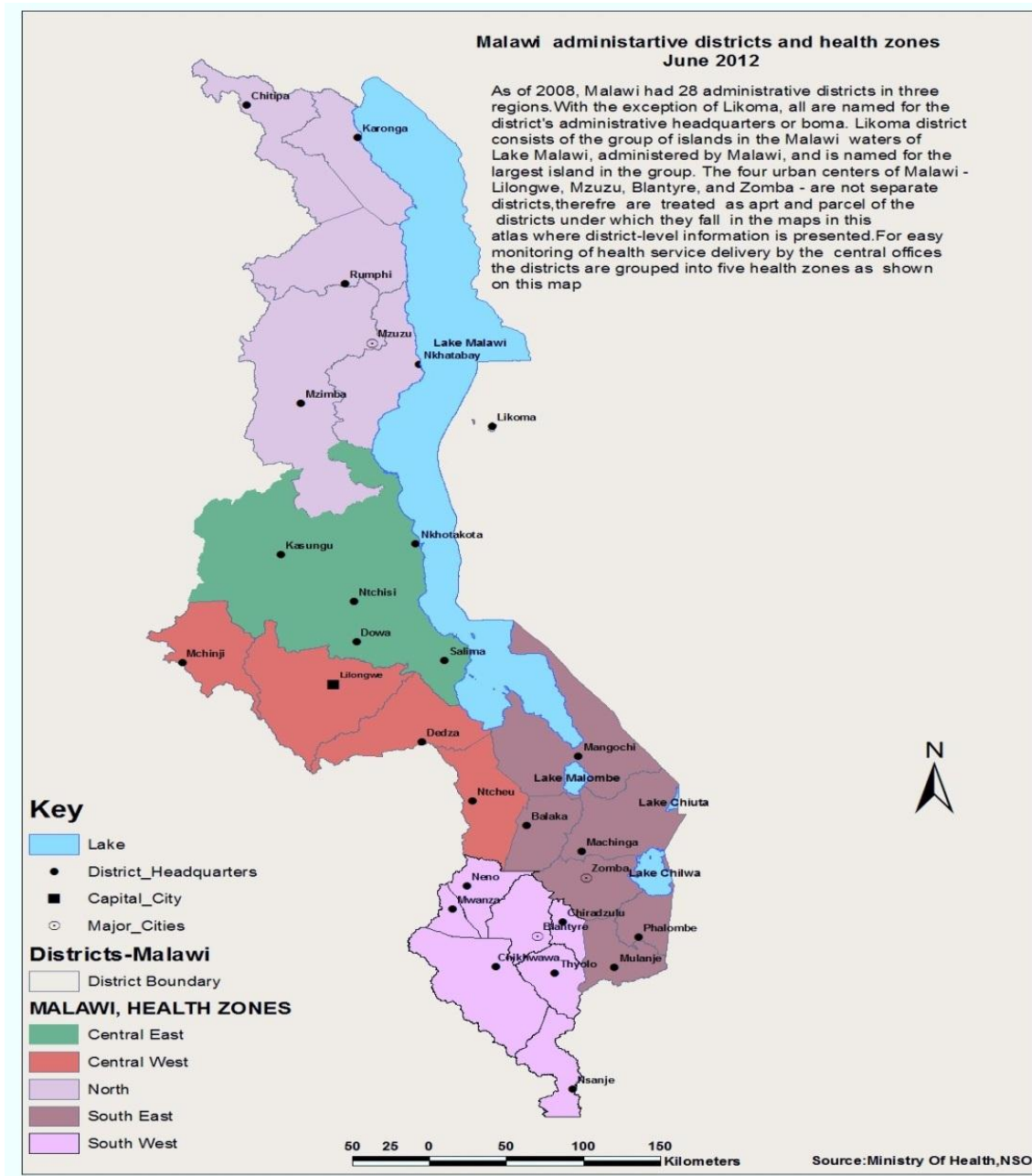
**PMTCT Program Highlights with Respect to Implementation of the HIV Testing Policy**

The interviews indicate that there is need for strong leadership to persuade people on the ground to implement policies. In Malawi, PMTCT activities are well structured and the entry point is antenatal clinics. This makes it easier for barriers and facilitators of implementation to be tracked. PMTCT had more recognition on global initiatives that Malawi subscribed to on HIV prevention than PITC/STI. This may have contributed to concentrated government support on the ground. This fact is acknowledged in Malawi's PMTCT blueprint, the "Malawi National Plan for the Elimination of Mother to Child Transmission; 2012." The government of Malawi's maternal and child health initiatives have been underpinned by a range of global commitments and interventions for scaling up PMTCT. In 2012, about 92% of antenatal women received a new HIV test. The following are the recent global HIV prevention initiatives, which clearly favor PMTCT:

- The 2001 UNGASS declaration on HIV/AIDS-committed countries to reduce new HIV infections in children by 20% by 2005 and 50% by 2010 by ensuring that 80% of women in need of services have access to HIV prevention services;
- The 2005 G8 Gleneagles Summit, where member countries called for the development and implementation of a package of HIV prevention, treatment, and care with the goal of reaching universal access to treatment by 2010;
- The 2005 PMTCT High Level Global Partners Forum, which called for governments to commit themselves to working together to achieve an HIV- and AIDS-free generation by 2015;
- The 2007 MTCT High Level Global Partners Forum from 8 African countries, which agreed on a number of actions required at the political level to address the identified challenges, including actions needed at the technical and implementation level;
- The 2007 UN Interagency Task Team (IATT) on the Prevention of HIV Infection in Pregnant Women, Mothers and their Children published their Guidance on Global Scale-Up of the Prevention of Mother-to-Child Transmission of HIV;
- The 2010 UNAIDS Getting to Zero Strategy 2010–2015—zero new infections, zero AIDS-related deaths, and zero discrimination against HIV-infected person strategy;
- The 2010 WHO-provided Rapid Advice on the use of antiretroviral drugs for treating pregnant women and preventing HIV infections in infants; and
- The 2010 WHO technical consultation, which advocates the elimination of new pediatric infections by 2015.

**PITC/STI Program Highlights with Respect to Implementation of the HIV Testing Policy**

Although HIV testing for PMTCT was relatively easily accepted (at least by 2004), this was not the case with PITC/STI HIV testing. The implementation was very slow. In 2007, implementation of HIV testing at Kamuzu Central Hospital-UNC Project STI Clinic was only achieved after relentless efforts to implement it (Kamanga et al., 2007). It took a great effort to gain consensus from senior health leaders, healthcare workers, and HIV/testing counselors to start implementation, although it was a policy that was already officially in place since 2003. There was unexplained reluctance from leadership and healthcare workers to implement it. As a member of the national STI advisory committee, the author observed the slow uptake of nationwide implementation of routine HIV testing among STI patients under the 2003 HIV/AIDS Policy.

**APPENDIX 7: DESCRIPTIVE SUMMARY OF BARRIERS AND FACILITATORS ACCORDING TO STAKEHOLDERS**

| Findings | Status of findings as mentioned by Stakeholders | | |
|---|---|---|---|
| **Barriers** | **Health Care workers** | **Senior Health Workers/Policy Makers** | **Health Rights Activists** |
| Lack of involvement in policy making | Yes | Yes | Yes |
| Lack of healthcare training/sensitization about the policy | Yes | Yes | Yes |
| Lack of supervision | Yes | Yes | Not captured |
| Unacceptability of debriefing by peers | Yes | Yes | Not captured |
| Lack of systems coordination and policy harmonization | Yes | Yes | Yes |
| Poor road access to some health facilities | No | Yes | Yes |
| Poor infrastructure support to accommodate male participation | Yes | Yes | Not captured |
| Shortage of healthcare workers who can implement | Yes | Yes | Yes |
| Logistical challenges with test kits and supplies | Yes | Yes | Yes |
| Government's selective prioritization of HIV-related services | Yes | Yes | Not captured |

| | | | |
|---|---|---|---|
| Cultural/attitudinal reasons | Yes | Yes | Yes |
| Lack of community awareness | Yes | Not captured | Yes |
| Lack of stakeholder coordination | Yes | Yes | Yes |

**Facilitators**

| | | | |
|---|---|---|---|
| Involvement in policy making process | Yes | Yes | Yes |
| Availability of policy guidelines | Yes | Yes | Yes |
| Sustained counseling and sensitizations | Yes | Not captured | Not captured |
| Good stakeholder coordination | Yes | Yes | Yes |
| Adequate support from implementing partners | Yes | Yes | Not captured |
| Availability of resources | Yes | Yes | Yes |
| Availability of training opportunities | Yes | Yes | Yes |
| Good leadership support | Yes | Yes | Yes |
| Consistent supervision | Yes | Yes | Yes |
| Good political will | Yes | Yes | Yes |

**APPENDIX 8: POLICY BRIEF, RECOMMENDATIONS TO POLICY MAKERS**

**Key Policy Recommendations to improve Implementation of HIV/AIDS Policy in Malawi**

**What is the problem?**

Policies are a basis for implementation of procedures to achieve a set vision (NCDDR, 2001). The 2003 Malawi HIV/AIDS Policy was not well implemented because of several barriers including lack of involvement of implementers in the policy making, lack of health worker sensitization or training about the policy, poor supervision, lack of stakeholder coordination, lack of harmonization of policies, insufficient male involvement, staff deployment/development challenges, resource constraints, selective prioritization of policies by government, and attitudinal/cultural problems. This policy brief presents recommendations to the overarching barriers whose solutions may also influence change for other related challenges.

**Why does the problem matter?**

Given the huge and detrimental effect of HIV/AIDS for peoples' general health and social economic development globally, in Sub-Saharan Africa and Malawi, it is imperative to effectively implement HIV policies and programs with speed and zeal. Malawi has a new HIV/AIDS Policy that has not yet been disseminated ten months after its launch in December 2013. Therefore recommendations presented in this policy brief are based on the 2003 HIV/AIDS Policy. They are well timed and will help address some of the barriers.

**The rationale for action**

Policies and programs that are not well implemented miss a very important step in accounting for the resources and time invested for public health. Consequently poor

implementation of the HIV policy is a threat to the efforts in the fight against HIV/AIDS. There is great dissatisfaction among healthcare workers, health rights activists, and some policy makers regarding poor implementation of the 2003 HIV/AIDS Policy. Fortunately, there is high political commitment from the Malawi government to combat HIV/AIDS. This creates hope that the recommendations for better implementation of the policy will be heeded.

**Appraisal of solutions and recommendations**

Because the policy implementation barriers are many, it will be difficult for proper and focused action. Therefore, a few more pertinent have been selected for urgent action in order of priority. These are lack of dissemination of the policy, decentralized supervision, poor stakeholder coordination, and lack of policy harmonization.

**Priority 1:    Improve dissemination of policy to healthcare workers through locally driven trainings and decentralized supervision**

Lack of awareness about the policy by healthcare workers was a big problem from the 2003 HIV/AIDS Policy. To overcome this, trainings/sensitizations should be done and reinforced at departmental meetings, institution-wide meetings, and district and zonal coordination meetings. This is more cost effective as compared to the current central level of supervision. This will also instill a sense of ownership in health workers and their local health leaders. In the top-driven supervision, local healthcare supervisors are frustrated over being bypassed by the top supervisory team, who micromanage the supervision of local health care workers.

**Priority 2:    Improve coordination for stakeholders and develop clear terms of reference for guidance**

In Malawi HIV/AIDS response is driven by three government departments: Office of President and Cabinet, Ministry of Health, and National AIDS Commission. There is lack of clear guidance about roles and reporting authority among them. To overcome this, clear terms of reference and clear line delegation and reporting should be developed to guide their operations. Currently the reporting roles are not clear for senior technical officers. This will lead to poor or a lack of action because of lack of knowledge about an appropriate function or frustration due to non-acceptance of imposed or non-accepted leader. Correcting this will reduce duplication of efforts and spend the energies where they are needed most. Health rights activists/civil society organizations dealing with HIV/AIDS issues should be involved in drawing up these terms of reference and roles to ensure objectivity of this process so that the outcomes should be acceptable to all the coordinating stakeholders.

**Priority 3: Creation of policy harmonization and supervision committee**

In Malawi, one HIV/AIDS or related policy is usually dealt with in more than one government department. This brings conflicting policy directives and confusion for implementers on the ground (Chinkonde et al., 2010). For effective policy implementation, there is need to harmonize some of the policies. A national Policy Harmonization and Supervision Committee for HIV/AIDS and Related Policies should be created. This will be a policy team charged with the responsibility of overseeing and coordinating how well the HIV/AIDS and other related sexual and reproductive health policies are implemented. This committee will also be responsible for steering policy formulation/revision, dissemination, and implementation. It will be comprised of senior technical officers from various sexual/reproductive health and HIV-related policies.

**Conclusion**

The Malawi 2003 HIV/AIDS Policy was not well implemented due to several barriers. This is retrogressive to the fight against HIV/AIDS, which has devastating effects on the health of the people as well as causing negative social economic development. Policy implementation is the springboard for public health action and should be given high priority. This policy brief presents recommendations on key barriers. These are dissemination of the policy to healthcare workers through departmental trainings, enforcement and decentralization of local supervision, improvement of stakeholder coordination, and creation of a policy harmonization and supervision committee. These recommendations have been carefully selected as potential leverage points that might induce commitment and ability to resolve other problems.

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