Review and Assessment of Existing **National Policies and Guidelines** Related to **Paediatric and Adolescent HIV Care in Ethiopia**

ANECCA
Healthy Children and Adolescents In Africa

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Review and Assessment of Existing **National Policies and Guidelines** Related to **Paediatric and Adolescent HIV Care in Ethiopia**

Solomie Jebessa , Makeba Shiroya-Wandabwa Denis Tindyebwa , Robert Iriso

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Design/ Layout
tuchecommunication@gmail.com
+256 777 968 997, +256 706 135 361

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List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ANECCA	African Network for the Care of Children Affected by HIV/AIDS
ART	Anti-retroviral therapy
ARV	Anti Retroviral
BCC	Behavioral Change Communication
CDC	Centers for Disease Control
CS	Congenital Syphilis
CSW	Commercial Sex Workers
DBS	Dried Blood Spot
EID	Exposed Infant Diagnosis
e-MTCT	Elimination of Mother to Child Transmission
EPHI	Ethiopian Public Health Institute
EPS	Ethiopian Pediatrics Society
FBO	Faith-Based Organizations
FMHACA	Food, Medicine, Healthcare Administration and Control Authority
FMoH	Federal Ministry of Health
GTP	Growth and Transformation Plan
HAART	Highly Active Anti-Retroviral Therapy
HDA	Health Development Army
HEW	Health Extension Workers
HIV	Human Immune-deficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counseling
HSTP	Health Sector Transformation Plan
ICAP	International Centre for AIDS-care Treatment Programs
IPD	In-patient Department
IMNCI	Integrated Management of Newborn and Childhood Illness
IRIS	Immune Response Inflammatory syndrome
KII	Key Informant Interview
LB	Live Birth
MDG	Millennium Development Goals
M and E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonate and Child health
MOH	Ministry of Health
MOWCYA	Ministry of Women, Children, and Youth Affairs
NAT	Nucleic Acid Testing
NGO	Non Governmental Organization
OPD	Out Patient Department
OVC	Orphan and Vulnerable Children
PITC	Provider Initiated testing and Counseling
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PLHIV	People Living with HIV
QA	Quality Assessment
SNNPR	Southern Nations Nationalities and Peoples Region
STI	Sexually Transmitted Infection
UNAIDS	United Nations program on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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We would like to pass our appreciation and gratitude to all the selected facilities in the eleven regions involved in the key informant interviews for sacrificing their precious time. Our deepest gratitude also goes to all the study teams and study assistants involved in the accomplishment of this research.

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Executive Summary

Background: In Ethiopia there were an estimated 748,933 people living with HIV including 78,834 children in 2016 and the total estimated new HIV infections were 21,565 and children under 15 comprises 2,212. In 2015, of the total number that needs ART i.e. of 636,556 People, 391,844 (61.6%) accessed antiretroviral treatments however children under 15 were only 22,967 (27.3%). The pediatric HIV populations in Ethiopia are mostly older children who were vertically infected in earlier years when the coverage and effectiveness of PMTCT in the country was low with high rates of mother to child transmission (MTCT). 1 In addition Children 5-14 account ~60% of those enrolled in Care and treatment. New HIV infections among young adults (15-24 years) showed a sustained increase between 2008 and 2014 and there is significant gap in the provision of pediatrics and adolescent psychosocial support.2 The African Network for the Care of Children Affected by HIV/AIDS (ANECCA) received a grant from the Global Fund to fight AIDS, Tuberculosis and Malaria to implement a regional project on "Catalyzing Access to quality services for Children and Adolescents living with HIV" (CACA). The goal of the project is to identify gaps and improve the coverage and quality of HIV care, treatment and support for children and adolescents living with HIV in seven sub-Saharan African countries in which Ethiopia is among them. The goal of this analysis was to identify gaps in policies and guidelines in coverage and quality of HIV care, treatment and support for children and adolescents living with HIV in Ethiopia.

Methodology: The study employed descriptive study design with stratified purposive quota sampling to select 20 hospitals and 15 health centers from 9 regions and 2 city administrations which are providing comprehensive HIV care. In addition, qualitative data was collected through in-depth interviews with key stakeholders at national and facility levels. The policy review followed a process adapted from Wetland Gilson policy review methods. The WHO defined standard of care for children and adolescents living with HIV was used as gold standard to assess the above documents. The documents revised: were 1) National Guideline for comprehensive HIV prevention, care and treatment, 2014; 2)Health Sector Transformation plan (HSTP), FMOH, Aug 2015 ; 3) HIV and AIDS Strategic Plan 2015-2020 in an investment case approach, FMOH, Addis Ababa Ethiopia, 2014, 4) The national strategic plan (2013-2015) for Elimination of Mother to Child Transmission of HIV & Congenital syphilis Feb. 2013, 5) National HIV and nutrition guidelines, FMOH, 2006 ; 6) National Adolescent Sexual and Reproductive Health strategy, 2007-2015; 7) National Adolescent Sexual and Reproductive Health strategy, 2016-2020; 8) National guideline for HIV care /ART clinical mentoring in Ethiopia, June 2015.

Results: The study findings are presented in various subheadings as follows.

Policy strengths: pediatrics/adolescent HIV care and PMTCT

The following were found to be the strengths of the policy/guidelines: Community and health facility testing with 5 Cs (consent, confidentiality, counseling, correct test results and connections to care, treatment and prevention services) ; existence of national testing algorithm , provision of ART for all <15 years of age , patient readiness adherence counseling' , age specific preferred regimen and monitoring, 95% EMTCT targets, with ensuring of access, integration and decentralization and HIV Exposed infant diagnosis and follow up service.

Policy gaps identified

The following were policy gaps identified based in the desk review; 1) No clear strategy available to operationalize child and adolescent friendly care, 2) No specific strategy for orphan consent and testing , 3) No clear

1 Ethiopian Public Health Institution (EPHI) HIV related estimates and projections for Ethiopia , July 2015 p-6

2 Federal Ministry of Health (FMOH); Participants Manual for National Pediatrics Psychosocial Support Training, , 2016 p -3

strategy for pediatric and adolescent retention to HIV care, 4) No clear definition of adolescent age group, 5)No adolescent specific HTS or Care and Treatment indicators, 6) No clearly defined minimum adolescent care package, 7) Contradiction between age of consent for testing adolescents in the HIV guideline and Ethiopian law and regulation, 8) ART guidelines do not mention of third line ART regimen , 9) No specific PMTCT strategy to access mothers delivering at home and living in underserved areas and 10) Lack of Pediatrics and adolescent-specific HTS and treatment targets

Key gaps identified during national stakeholders interviews

There was Shared consensus among stakeholders that the national policy framework is not inhibitive. However the following gaps exist: 1) psychosocial care (adherence and disclosure) is not adequately addressed , 2) Challenges with implementation as reflected in low achievements; 3) No system in place to reach OVCs and street children for HIV testing and care, 4) Gaps in health worker skills and attitude, lack of confidence to manage pediatrics /adolescents with HIV; attrition of trained staffs , 5) Operational and logistic challenges in establishing adolescent friendly care, 6) Gap in collaboration between ministries of Health, Education, and Women and Children's Affairs, 7) Data management and reporting: gaps in age disaggregation, gaps in monitoring and tracking progress, 8) Community HIV testing at schools, universities is not well organized, not integrated no tracking or proper reporting mechanism

Key findings during facility key informant interviews

Most providers were aware of the consolidated HIV guideline which is also accessible in most facilities. Most mentioned at least very basic policy provisions, commonly "treat all <15 years regardless of CD4 or staging". However, the following gaps were mentioned: Orphans testing and follow up is forgotten, age for disclosure and how to disclose and counsel children is lacking, lack of psychosocial support activity, HIV data lack of age disaggregation for adolescents, awareness creation and continuous advocacy at all levels, HIV policy should prioritize adolescent cohorts and define minimum care package for ALHIV, focus on pediatrics and adolescent psychosocial support, integrating facility pediatrics and adolescent program and health extension program, continuous and aggressive demand creation, harmonize age of consent in the guidelines and national law and regulations, age of assent need to be clarified and Pediatrics and adolescent HCT and treatment targets need to be put in strategic documents.

Conclusions and Recommendations: Despite the policy guidance for the e-MTCT, all stake holders agreed that there is huge gap of implementation towards capturing the targeted mothers and more so the targeted HIV exposed infants for testing and linkage to follow-up and /or HIV care. The current initiative /work which is being done by the government involving HEW and HDAs is encouraging towards improving the rollout of mother –baby pairs in to the PMTCT program, and this has not been well mentioned in the policy and guidelines presented for desk review. The issue of capacity building of health care providers has been cited as the big gap in both document review and key informant interviews which needs to be tackled systematically by the government. The policy and strategy documents need to set clear targets for adolescents for tailored approaches in HTC, care and treatment for adolescents as has been one of the gap identified in the desk review and mentioned by the key stakeholders. Although adolescents are recognized as a special group in the HTS guidelines, the policy does not provide strategies for identification of adolescents at health facility and community level. The policy mentions youth friendly services but fall short of describing the standard package of care to be delivered at the youth clinic. Yet strategies for targeted, age-appropriate routine HIV testing to youth presenting

to outpatient clinics in epidemic settings is essential. The lack of adolescent friendly services have been mentioned as significant gaps both in the desk reviews and during interviews with the stake holders , hence there is a need to prepare operational guideline as to how to make this strategy a reality to address more adolescents . Defining adolescent HIV care package is another significant shared strategy which needs to be done so that the country can develop proper guidance towards tackling HIV in this age group; and this has been told by the key informants and as captured from the desk reviews. The other important area to be addressed is the issues of HIV testing approach in the schools and collages which are not as such organized and reported. These HIV testing activities are not also integrated with health care system hence even if some young people are tested positive they are not linked to HIV care, and system need to be established for these group of young people. Regarding data keeping , monitoring and evaluation the age specific data are important which are not present in the current HMIS system that the country is using hence this has been observed in the desk review and spelt out significantly by the facility as well as by the stakeholders key informants. All national stakeholders commented that there is good opportunity now as the pediatrics taskforce is being revitalized and the identified gaps can be raised and actions can be taken.

Introduction and Background

As of June 2015, 15.8 million adults and children were receiving lifesaving anti-retroviral therapy globally. Of these, 11 million are in sub-Saharan Africa

Pediatrics and Adolescent HIV

Globally, as of June 2015, 15.8 million adults and children were receiving lifesaving anti-retroviral therapy, out of which nearly 11 million are in sub-Saharan Africa3. However, compared to about 50% of adults in Africa with access to ART, only about 30% of children requiring ART were on ART as of December 20144. Moreover, increases in the number of adolescents (10–19 years old) dying from HIV-related causes indicate that preventive and ART services are inadequate and inefficient for this age group in the region.5 Adolescents are the only age group in which AIDS-related deaths increased for the period 2001 to 2012 and between 2005 and 2012; the annual number of AIDS related deaths among adolescents almost doubled6. The deaths are attributed to low ART initiation especially for perinatally infected adolescents and for those who had initiated ART; deaths are attributed to poor follow up and retention in care. WHO also postulates, the increase of AIDS related deaths amongst adolescents, is also partly due to governments' failure to prioritize adolescents in national HIV plans and create adolescent friendly testing and counseling services. Adolescence is a period of transition between childhood and adulthood and is characterized by major physical, emotional and cognitive changes. Early sexual debut (before 15 years) is commoner among adolescent girls leading to early marriage and early childbearing. Social and economic challenges also put adolescents at risk of injecting drugs, sexual experimentation and sexually exploitation. Hence, adolescents living with HIV are more vulnerable. Female adolescents living with HIV are disproportionately more affected. It is estimated that 2.1million adolescents are living with HIV; 82% are in sub Saharan Africa and about 58% are female7.

In order to reach the goal of ending AIDS epidemic by 2030, new targets have been set. By 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression8. To reach the 90-90-90 global target in HIV prevalent areas such as sub Saharan Africa, there needs to be concerted effort to address challenges towards adapting systems to deliver

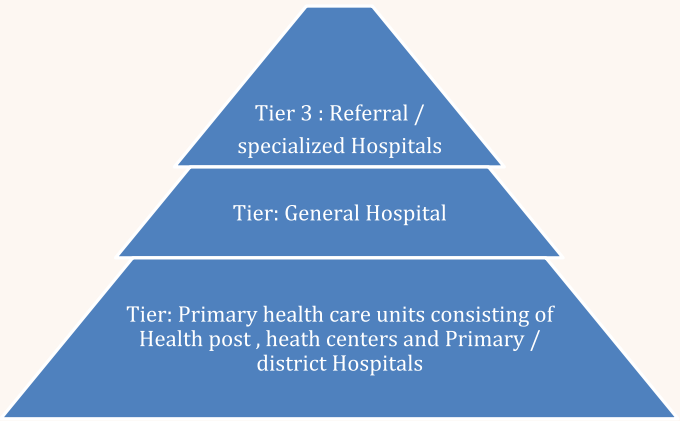
3 UNAIDS, "15 by 15" target achieved, 2015
4 UNAIDS, World AIDS Day Report, 2015
5 World Health Organization (Progress Report), Global Health Sector Response to HIV, Focus on Innovations in Africa, 2000-2015, p-9
6 Global update on HIV Treatment, UNAIDS 2013. http://www.unaids.org/sites/default/files/media_asset/20130630_treatment_report_en_0.pdf
7 Idele P, Luo C. Epidemiology of HIV and AIDS among Adolescents: Current Status? Inequities and Data Gaps (J Acquir Immune Defic Syndr 2014;66:S144–S153)
8 UNAIDS 90-90-90 An Ambitious Treatment Target to Help End the AIDS epidemic. Available at : http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

good quality, effective health care and social support for children and adolescents living with HIV. A lot has to be done at the national and regional level, towards improving the coverage and quality of care to children and adolescents living with HIV.

National HIV Healthcare Service Delivery System

Ethiopia is divided in to 9 regional states based on ethnicity and two city administrations. The regional states are: Afar, Amhara, Benishangul Gumuz , Gambella, Harari , Oromia , Somali, Southern national and nationalities and peoples'(SNNPR) and Tigray region and the two administrative cities are Addis Ababa and Dire Dawa . The country has a total of 68 zones and 834 districts called Woredas. Zones are the second level administrative divisions and Woredas are the third-level administrative divisions of Ethiopia. Woredas are composed of with a number of "***kebele"*** or farmer's associations, which are the smallest unit of local government in Ethiopia.

Figure1: The Ethiopian national health care delivery system



(Source: FHAPCO, HIV /AIDS Strategic Plan)

The lowest level of referral system in Ethiopia is the primary health care unit, which is composed of five satellite health posts, one health center and one primary hospital. Each health post is staffed by two health extension workers who provide preventive, promoting and basic curative services, including early recognition and follow-up during and after treatment for mental health problems. Health posts also provide training on selected parts of the Health Extension Program during household visits and outreach services. Each health post is expected to serve about 5000 populations. Health posts provide only counseling and testing and other preventive and promoting services like condom provision, linking HIV positive pregnant mother to HIV care, making mass campaigns etc.

Health centers are staffed by around 20 professionals and provide preventive, curative, inpatient and ambulatory services, treatment of common psychiatric disorders, and dental services. Some selected health centers at high HIV case load areas give comprehensive HIV care for both adults and children. Primary hospitals are staffed by around 53 persons and provide preventive, curative, inpatient and ambulatory services, and emergency surgical services, including caesarean section and blood transfusion. They also serve as referral centers for health centers and practical training centers for nurses and paramedical health professionals. Most district hospitals provide comprehensive HIV care except those who are recently opened / built.

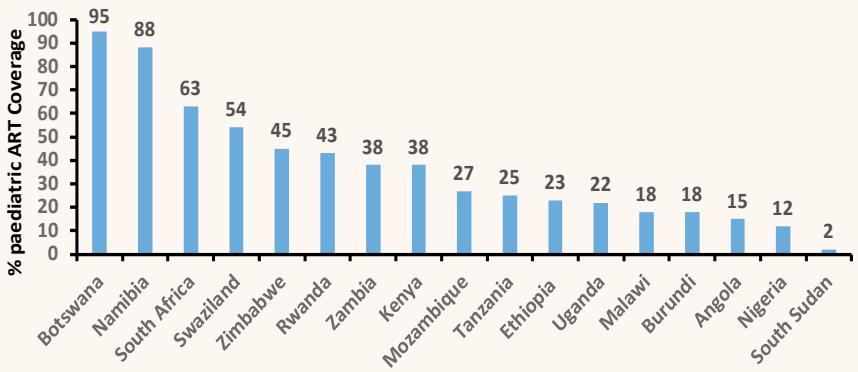
General hospitals are staffed by around 234 persons among which six or more specialists will be working and provide inpatient and ambulatory services. They are also referral centers for primary hospitals and training centers for health officers, nurses, emergency surgeons and other categories of health workers. Almost all general Hospi-

tals provide comprehensive HIV care. The specialized hospital is staffed by around 440 professionals and serves as a referral center for the general hospitals and provides inpatient services. All specialized hospitals provide comprehensive HIV care including some giving special adolescent HIV youth group activities.[9] The total number of HIV care clinics providing comprehensive care (counseling and testing, PMTCT and ART care) is 1047 according to the 2013 data. And these constitute the health services tire levels from one to three.[10]

In Ethiopia, in 2016, there were an estimated 748,933 people living with HIV including 78,834 children. The total estimated new HIV infections were 21,565 and children under 15 comprises 2,212.[11] In addition to being one of the most HIV burden countries in Africa, the country is also one of the countries with the lowest coverage of peadiatric and adolescent HIV treatment, care and support services in sub-Saharan Africa with only a quarter of children infected with HIV started on ART based on the 2010-2014 strategic plan for ART coverage (figure2)[12] [13]. The HIV testing counseling coverage among adult population in 2014 was only 27% and was much less for children which was ascribed to low parent HIV disclosure, low index case testing, attitudes and skill gap of professionals and inadequate service availability. In 2014, close to 20,000 (65%) of HIV positive pregnant women have received ARV/ART to prevent the vertical transmission of HIV to their babies.[14]

Similar to the global situation the issue of adolescents in Ethiopia is alarmingly worrisome, the estimated number of adolescents newly infected with HIV in 2013 were 1500 and in the same year the total number of adolescents estimated to be living with HIV were 140,000 and adolescent girls outnumber the boys by 1000. Significantly Ethiopia alone also has contributed to the highest estimated adolescent deaths accounting for 10% of 120,000 adolescent deaths estimated globally.[16]

Figure2: Pediatric ART coverage in targeted sub-Saharan African countries with high HIV burden, 2013[19]



(Source: FHAPCO, HIV /AIDS Strategic Plan)

In guiding the implementation of the HIV/AIDS program so far the country had key strategic interventions, included in the five years Growth and Transformation Plan (GTP, 2010-2015) and Health Sector Development Plan (HSDP IV, 2010-2015), and specifically, five years Intensifying Multi-sectoral HIV/AIDS Strategic Plan (SPM II, 2011-2015) which have been implemented. The Country has also developed a strategic planning document for the next five years named "Country Investment Case for HIV/AIDS strategic-planning (2015-2020)"17. Currently the country

9 WHO , African Observatory : Analytical summary service delivery , Ethiopia : available at : http://www.aho.afro.who.int/profiles_information/index.php/Ethiopia:Analytical_summary_-_Service_delivery, accessed 6/3/2016
10 Ibid FHAPCO, HIV /AIDS Strategic Plan, 2015-2020, page 19
11 HIV related estimates IBID
12 ANECCA, Regional Concept Note to the Global Fund for Tuberculosis, AIDS and Malaria, 2014.
13 Federal HIV/AIDS prevention and control office (FHAPCO) , HIV/AIDS strategic plan, 2015-2020 in an investment case approach, December 2014, p- 19
14 Ibid, FHAPCO, HIV/AIDS strategic plan, page 18
15 UNICEF (2013) and National HIV Strategic Plans of Burundi, Ethiopia, Malawi, Nigeria, South Sudan, Tanzania and Uganda – as cited in the ANECCA Regional Concept Note to the Global Fund for Tuberculosis, AIDS and Malaria)
16 UNAIDS, UNICEF, ALLIN End Adolescent AIDS, p-
17 World Health Organization HIV/AIDS progress in Ethiopia, March 2015, pp1-2

is using a comprehensive HIV guidelines adapted from the WHO 2013 consolidated HIV guideline to provide comprehensive ART/HIV care to peoples living with HIV. The Ethiopian government also has also been implementing the national strategy for the reproductive health of young people (2007-2015) and one of the objectives of this strategic document has been to improve access to quality reproductive health and STI HIV services18 however given the high burden of HIV disease and death in adolescents; this is the high time to look through deeply what were the bottlenecks on the implementation of this policy.

Problem Statement and Rationale

The African Network for the Care of Children Affected by HIV/AIDS (ANECCA) is a non-profit Pan African network of clinicians and social scientists with a mission to improve access to quality and comprehensive HIV prevention, care, treatment and support services for children, integrated within the broader maternal and child health framework. Through a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria, ANECCA has implemented a regional project on ''Improving coverage of quality services for Children and Adolescents living with HIV'' in seven African countries including Ethiopia.

This HIV policy review and analysis has tried to assess the current policies structured to bridge the aforementioned gaps in HIV testing, prevention, care and treatment for children and adolescents living with HIV. This assessment has also analyzed how the policies are being implemented with a view of identifying both enabling and limiting factors'. This study, also has tried to identify best practices for purpose of developing national and regional plans to improve coverage and quality of services for children and adolescents living with HIV in Ethiopia.

Objectives:

The objectives of this assessment were:

1. To review and assess existing National Paediatric and Adolescent HIV Policies and Guidelines in*, Ethiopia,* with a view to identify strengths and gaps for provision of quality services for children and adolescents living with HIV
2. To document best practices and opportunities within National Policy Frameworks, Strategies and Guidelines for provision of quality services for children and adolescents living with HIV in Ethiopia
3. To make recommendations that inform the development of national plans to promote the adoption and implementation of policies that increase coverage and quality of paediatric and adolescent HIV care, treatment and support
4. To facilitate national stakeholder's consultations to develop national action plans to bridge the gaps in the policies and guidelines in Ethiopia

Methodological Approaches

Study Design

This was a descriptive study; the primary research was through qualitative data collection through in depth interviews with key stakeholders at national and facility level. The secondary research was conducted through desk reviews to assess content of policy documents, guidelines, strategic document and action plans. The WHO defined standard of care for children and adolescents living with HIV was used as gold standard to assess the various documents. The desk review also helped to facilitate mapping of key country stakeholders.

Study setting and population

National Level

At National level, in collaboration with the Federal Ministry of Health of Ethiopia and ANECCA ministerial focal persons, the national consultant did a stakeholder analysis and identified key stakeholders based on their key contribution for the HIV /AIDS program and their involvement in the development of the national guidelines, strategic documents and HIV/AIDS policies. (Table 1)

Health Facility Level

This policy and guidelines review selected fifteen districts using stratified purposive quota sampling from the 11 regions. The selected health facilities were at tier 1 and 2; excluding tire 3 level specialized hospitals which are equivalent to tertiary Hospitals. The facilities were those rendering comprehensive HIV care i.e HIV testing /ART/

18 Federal Ministry of Healthy, National Adolescent and youth reproductive health strategy, 2007-2015, pp 18-19

PMTCT clinics from each of the selected districts using purposive sampling. A total of 35 facilities, 15 health centers and 15 public district /primary or general Hospitals and 5 private hospitals were included in the assessment as indicated in Table 2.In each of the selected health facilities, health workers were purposively sampled from service delivery points that provide Pediatrics and adolescent HIV care services and interview questionnaires' were administered.

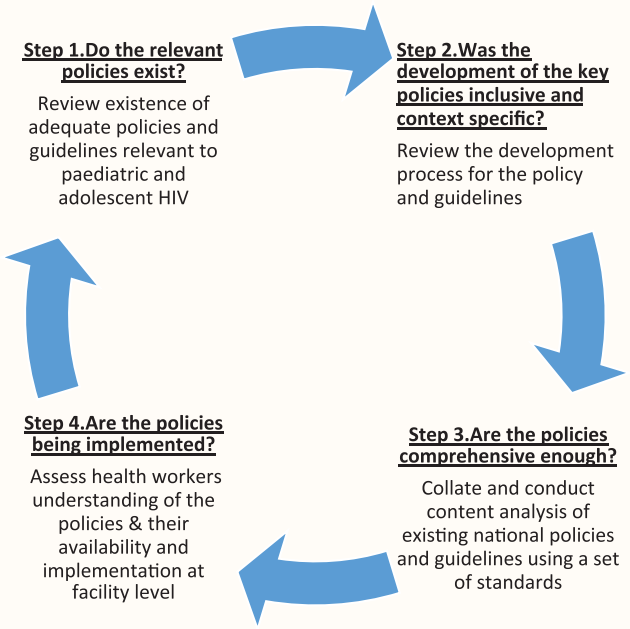
Table 1: List of Stakeholders involved in the national level key informant interview for Policy and guideline review on pediatrics and adolescent HIV services, 2016

List of key Stakeholders	Participation
Ministry of Health, Disease prevention control Directorate, HIV case team	
Ministry of Health; Federal HIV/AIDS Prevention and Control office	
World Health Organization (Ethiopia Office)	
CDC/ICAP Ethiopia office	
UNICEF Ethiopia office	

Table 2: Study sites selected in Ethiopia for Policy and guideline review on pediatrics and adolescent HIV services, Nov 2016

Regions	Name of selected district	Names of selected HIV testing /ART/PMTCT facilities	
		Primary/district / general Hospital	Health centers
Afar	Dubti	Dubeti	Semera HC
Addis Ababa	Akaki Kaliti	Tirunesh-Beging Hosp	Saris HC
Amhara	Efrata Gidem	Ataye Hosp.	Ataye HC
	Woldia	Dessie Hospital	Dessie HC
Benishangul Gumuz	Assosa	Assosa Hospital	Assosa HC
Diredewa	Sabian	Sabian district Hosp	Lagehare HC
Gambella	Gambela	Gambela Hospital	Gambela HC
Harari	Abadir	Jugula Hospital	Jenela HC
Oromia	Jimma	Shenen Gibe Hospital	Jimma HC
	Fitche	Fitche Hospital	Fitche No 1 HC
Somali	Jigjiga	Jigjiga Hospital	Jigjiga HC
SNNPR	Yirgalem	Yirgalem Hosp	Yirgalem HC
	Hawassa town	Adare Hospital	Loke HC
Tigray	Axum town	Kidist Mariam Hosp	Axum HC
	Semen	Mekele Hospital	Semen HC
Addis Ababa	Kirkos	Bethezatha Hospital	
Addis Ababa	Bole	Saint Yared Hospital	
Addis Ababa	Bole	Meungsang Hospital	
Addis Ababa	Kolfe Keranio	Bethel Hospital	
Addis Ababa	Asco	Girum Hospital	
Total		**20**	**15**

igure 3: Key Questions to answer in the Policy review and assessment during desk review and Key informant interviews



Data Collection Methods

Desk review

Policy documents, Guidelines and strategic planning documents have been collected from the Federal Ministry of health disease prevention and health promotion directorate HIV AIDS case team. The desk review was done based on the key steps on the desk review template adapted from Walt and Gilson policy review process.[19] (Figure 3) (Annex 1 Table 3 and 4). All of the thematic areas were investigated and compared with the WHO 2013 and 2015 consolidated guidelines. [20], [21]

Inclusion and exclusion criteria of literature: Most recent up to date policies, guidelines and strategic documents which are in current use / being implemented were included and old materials which have been replaced by the most recent ones and which are no more in use were excluded.

National level Key Informant Interviews

The Key informant Interview was conducted using pre-structured Key informant interview guide, adopted from Walt and Gilson policy review process , with several questions and probes classified in to five sections: 1)Existence of policy 2)Policy Development Process 3) Policy content gaps 4)Policy implementation 5) recommendations for addressing identified gaps (Annex 2). The selected organizations indicated in table 1 were officially requested to participate in this study.

Facility level Key informant interviews (KIIs)

The facility level key informant interviews were carried out by the trained data collectors using pretested pre- structured qualitative research tools (Annex 2 Table 6). The data collectors captured the responses using tape recorders and took detailed notes.

Data Management and Analysis

The desk review detail findings were summarized in the following thematic areas: Current policy provisions, gaps in the policy provisions and opportunities. The recordings from the national Key Informant Interviews were documented in detail and draft report was prepared.

19 Gill Walt G, Shiffman J et al. 'Doing' Health Policy Analysis: Methodological and Conceptual Reflections and Challenges. Health Policy Plan. (2008) 23 (5): 308-17 doi:10.1093/heapol/czn024

20 World Health Organization , Consolidated Guidelines on the use of antiretroviral drugs for treating and preventing HIV infection , Recommendations for public health approach , June 2013

21 World Health Organization ,Policy briefs , Consolidated Guidelines on the use of antiretroviral drugs for treating and preventing HIV infection , what is new November , 2015

The facility level key informant interview audio recorded data and notes were transcribed and entered in to Atlas ti software for management by a qualitative data analyst. Thematic content analysis was done based on predefined themes was done to generate the final report. Excel sheet was used to analyse some of the data such as background characteristics.

Discussion from the national stakeholder review forum held in Addis Ababa is also included in this report. The final consolidated document is prepared using a simple descriptive narrative, paying particular attention to emerging themes, content of the discussions and issues that generate consensus.

Quality Assurance

The lead consultant in conjunction with ANECCA secretariat continuously supported the study. The national consultant and ANECCA in country team provided supportive supervision throughout the study period to carry out this review and assessment.

The national consultant and the ANECCA project officer identified competent field assistant who have experience on pediatrics /adolescent HIV care and research. The study assistants received three days data collection training including practical sessions at Addis Ababa health facilities. The training had the following components:

a) Orientation on the overall project and study protocol
b) Introduction and practice on study tools
c) How to take qualitative data with proper techniques for conducting key informant interviews including practical session using tape recorders and feedback sessions
d) Ethical issues of maintaining confidentiality and obtaining informed consent
e) How to Secure data storage while in the field

Facility level Key informant interviews (KIIs) were carried out by the trained data collectors supervised by the national consultant and ANECCA project officer. All the tape recorded and note forms of the data were checked for completeness and clarity by the qualitative data analyst and stored securely for data entry.

Ethical Considerations

Permission to undertake the study

As this is an operational study, the study protocol was submitted to the Ministry of Health of Ethiopia Disease prevention control Directorate who actively revised and commented on the methodology and activities of the study. After getting the final revised and agreed upon protocol, support letter and letter of collaboration to the regions was provided by the ministry of health to undertake this study.

Consent and confidentiality

The field data collectors carried consent forms written both in English and Amharic and explained to each participant, in their local language before obtaining consent. They explained the purpose of the study, procedures, risks, benefits, rights of the participant, and protecting data confidentiality. (Annex 3)

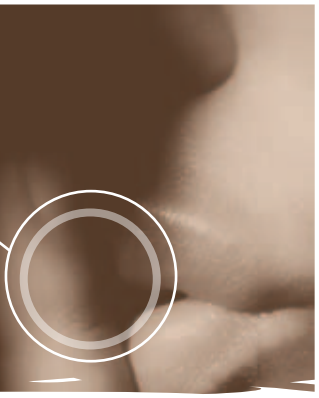
The study participants were asked if they have any questions; and the study assistants tried to answer to the satisfaction of the study participant before obtaining consent and proceeding with the interview. Some participants did not want their voice recorded so the data collectors deferred tape recording in those cases and took detailed notes during the interview.

Privacy and confidentiality were maintained during the interviews through ensuring records are kept in safe storage and interview rooms were selected to be convenient and private. All interviewees identification were kept anonymous and data were labeled with codes prepared based on the regions and facilities. Completed questionnaires were stored in a locked cabinet and were only accessible by the study team.

Study challenges and solutions

There was some unforeseen risk such as security problem to access one of the district and we were obliged to change to another district in the same region. One of the facility selected as ART health center was found to have not yet started the service , hence was replaced by another nearby health center with comprehensive HIV care.

Privacy and confidentiality were maintained during the interviews through ensuring records are kept in safe storage and interview rooms were selected in onvenient and private locations



RESULTS and DISCUSSION

Desk Review Results

I-Over view of the key documents revised

The main documents reviewed were 1) National Guideline for comprehensive HIV prevention, care and treatment (2014), Health Sector Transformation Plan, (FMOH, Aug 2015), HIV and AIDS Strategic Plan2015-2020 in an investment case approach, FMOH, Addis Ababa Ethiopia (2014) and 4) The national strategic plan (2013-2015) for Elimination of Mother to Child Transmission of HIV and Congenital syphilis (February 2013). The following were additional reference documents consulted 1) National HIV and nutrition guidelines (FMOH, 2006), 2) National Adolescent Sexual and Reproductive Health strategy, 2007-2015, 3) National Adolescent Sexual and Reproductive Health strategy, 2016-2020, and 4) National Guideline for HIV care /ART clinical Mentoring in Ethiopia (FMoH, June 2015). Below is a summary of analysis of each of the policy documents.

1. National Guideline for comprehensive HIV Prevention, Care and Treatment, FMOH, 2014

This guideline was adopted from the WHO guideline and it mainly provided guidance on the use of ARV drugs among adults, adolescents, children and pregnant mothers for PMTCT within the context of the continuum of HIV-related prevention, treatment and care. This guideline promotes the consistency of approaches and linkage between settings in which ARV drugs and related services may be provided, including specialized HIV care, primary care, community-based care, maternal and child health services, TB services and services for people who use drugs. It also addresses key clinical, operational and programmatic implications of new science and emerging practice in the use of ARV drugs with evidence-based clinical recommendations. It also provided guidance on key operational and service delivery issues that need to be addressed to increase access to HIV services strengthen the continuum of HIV care and further integrate the provision of ARV drugs into health systems; and serves as a reference material for health service providers and program managers

The guideline is intended to be used by health workers (physicians, health officers, nurses, pharmacy personnel, laboratory technicians and case managers) providing care to people infected and affected with HIV. It is also used by HIV/AIDS program managers, health planners and researchers, organizations involved in ARV drug procurement, supply management, and ART service delivery and community and faith based organizations working on HIV/AIDs programs.[22]

2. Health Sector Transformation Plan, 2015/16 - 2019/20

In the past two decades, the Government of Ethiopia has invested heavily on health system strengthening guided by its pro-poor policies and strategies resulting in significant gains in improving the health status of Ethiopians.

22 Federal Ministry of Health Ethiopia , National Guideline for comprehensive HIV prevention, care and treatment, 2014

As a result, Ethiopia has done remarkably well in meeting most of the MDG targets. Regarding HIV; new infection has dropped by 90% and mortality cut by more than 50% among adults. Besides, Ethiopia is one of the few sub-Saharan African countries with "rapid decline" of mother-to-child transmission of HIV, with a reduction by 50% of new HIV infections among children between 2009 and 2012. Similarly the country has achieved the targets set for tuberculosis prevention and control. Mortality and prevalence due to Tuberculosis has declined by more than 50% and incidence rate is falling significantly.

Building on the lessons learned in implementing the earlier plans and to be highly responsive to the current socioeconomic landscape, the Government of Ethiopia has developed Health Sector Transformation Plan (HSTP), which is part of the second Growth and Transformation Plan (GTP II). HSTP is also the first phase of the 20-year health sector strategy called 'Envisioning Ethiopia's Path to Universal Health Care through strengthening of Primary Health Care'.

The Health Sector Transformation Plan (HSTP) has three key features: quality and equity; universal health coverage and transformation. The HSTP sets out four pillars of excellence which are believed to help the sector to achieve its mission and vision. These are: 1.Excellence in health service delivery; 2.Excellence in quality improvement and assurance; 3.Excellence in leadership and governance; 4.Excellence in health system capacity. These four areas of excellence are further decomposed in to fifteen strategic objectives categorized under two driver perspectives (business process and learning and growth) and two results (community perspective and financial stewardship). The strategic objectives are linked each other with a cause-effect relationship and every strategic objective has set of performance measures and strategic objectives.

The impact-level targets of HSTP by 2020 is to reduce MMR to 199/100,000LB; reduce under five-year, infant and neonatal mortality rates 30, 20 and 10 per 1,000 live births respectively; reduce stunting, wasting and under-weight in under-5 year to 26%, 4.9% and 13%, respectively; reduce HIV incidence by at least 60% compared with 2010 and achieve zero new infections among children; reduction in number of TB deaths and incidence rate by 35% and 20% respectively compared with 2015 and reduce malaria case incidence and mortality by at least 40% each compared with 2015. It has also set target to stabilize and then reduce deaths and injuries from road traffic accidents.

The overall costing for HSTP implementation is prepared in two scenarios: base and high case scenario with a total cost of 15.6 billion USD and 22 billion USD, respectively. The targets of HSTP are related to the base case scenario and the resource gap under this scenario is estimated to be 21%. In general, the ultimate purpose of HSTP is to improve the health status of the peoples of Ethiopia in an equitable manner, being cascaded to all levels, translated into annual operational plans using the Woreda-based health sector annual plan. Its implementation will be consistently monitored using the agreed monitoring framework in a coordinated manner.23

3. HIV/AIDS Strategic Plan 2015-2020; FHAPCO, Addis Ababa, December 2014

The 2015-2020 Ethiopia HIV/AIDS Prevention care and treatment strategic plan was developed in an investment case approach using case tool which focuses on four core elements namely understand the problem , design the optimal program to solve the problem , deliver and sustain for impact and ending AIDS. The investment case targets are in line with the 90-90-90 targets set by UNAIDS to help end HIV/AIDS epidemics. The four strategic objectives are 1. Implement high impacted and targeted prevention program; 2. Intensify targeted HIV testing and counseling services; 3. Attain virtual elimination of MTCT and 4. Optimize and sustain quality care and treatment. The six year investment case was designed through a combination of model based activity based costing approach. The overall resources need for the 2015-2020 HIV investment is estimated to be US$ 1.65 billion. Scaling up the priority programs in the investment case to the set coverage targets with this cost will have a significant return through averting at least 70,000 new HIV infections and 162,000 deaths and saving about half a million lives by 2020.24

23 Federal Ministry of Health Ethiopia , Health Sector Transformation Plan, 2015/16 - 2019/20

24 Federal HIV/AIDS Prevention and Control Office, HIV/AIDS Strategic Plan 2015-2020;, Addis Ababa, December 2014, page v-vi

4. The National Strategic Plan (2013-2015) for Elimination of Mother to Child Transmission of HIV and Congenital syphilis (e-MTCT-HIV and CS), February 2013

Low PMTCT service utilization is among one of the key challenges to HIV prevention and control efforts. Although PMTCT services have been implemented in Ethiopia since 2001; by June 2012, only 25% of the pregnant women were reached with ARV prophylaxis in the 64% of all Antenatal Health facilities which were providing PMTCT services.

To respond to these challenges, Ethiopia launched and implemented a one-year PMTCT Acceleration Plan, in 2011 aiming at expanding PMTCT sites and improving quality of services. In a related move to sustain and increase the momentum achieved in the accelerated plan, the National Strategic plan for elimination of Mother to Child Transmission of HIV and Congenital Syphilis is developed and implemented for three years (2013 - 2015). This is in line with global plans to eliminate HIV and syphilis infections from MTCT by year 2015.

The plan outlined the community engagement through Health Extension Program; strengthen Health facilities - community linkage for HIV and syphilis testing so that women obtaining ANC services at health posts can receive the full battery of antenatal laboratory tests including for HIV; building capacity of Health Care workers (HCW) on administering PMTCT option B+; and supporting Health Extension Workers and Health Development Army through mentoring and supervision by government institutions. In addition there were actions towards strengthening the logistics and supply system; improving quality through integration of PMTCT/EID within maternal, new-born and child health platform; and expand PMTCT services in areas with highest numbers of women with unmet need for PMTCT interventions.

Ethiopia has adapted option B+ for PMTCT to dramatically increase PMTCT uptake in to its public health feasibility approach and simplification. Based on knowledge of high prevalence areas, the eMTCT Plan proposed to identify high prevalence areas and prioritize elimination activities in urban, peri-urban and hotspot areas. In urban settings, extended efforts to recruit pregnant mothers and their partners in both public and private facilities need to be emphasized. To achieve e-MTCT goal, national and regional indicators were regularly monitored to ensure quality and progress.25

II-Existence and comprehensiveness of Policies on e-MTCT /PMTCT

The policy documents on e-MTCT/ PMTCT program in Ethiopia that were reviewed were: 1) National Guideline for comprehensive HIV prevention, care and treatment, 2014; 2) Health Sector Transformation plan (HSTP), FMOH, August 2015; 3) HIV and AIDS Strategic Plan2015-2020 in an investment case approach, FMOH, Addis Ababa Ethiopia, 2014 and 4) The national strategic plan (2013-2015) for Elimination of Mother to Child Transmission of HIV and Congenital syphilis (e-MTCT-HIV and CS), February 2013. Below is summary of findings from the documents.

Policy provisions on e-MTCT/PMTCT:

With a vision of ending AIDS by 2030, eMTCT is one of the key objectives of the 2015-2020 strategic document that target to identify 95% of HIV+ pregnant women with 95% enrollment for Option B+ (both mother and newborn); reduce vertical transmission to less than 2% (building on the 2013-2015 eMTCT strategic goal of reducing vertical transmission to less than 5%).

All modalities of prevention of the transmission of HIV from Mother to child PMTCT (option B+) from health service expansion to the detailed facility interventions are mentioned in the guideline. To ensure access and enhance uptake of PMTCT services, the consolidated guideline pushes for integration with MNCH services; Integrating and linking services are likely to reduce missed opportunities for initiating ART, enhance long-term adherence support and optimize patient retention in care.

Decentralizing ART to primary care settings will ease the burden of routine management on other parts of the health system and will improve equity by promoting access to ART in rural areas; Key ethical principles of fairness, equity and urgency should also be observed in the process of reviewing and adapting guidelines.

Provider-initiated testing and counseling is recommended for women as a routine component of the package of care in all antenatal, childbirth, postpartum and pediatric care settings; Women shall be routinely offered HCT during pregnancy, labor, post natal and at Family Planning

25 FMOH, The national strategic plan (2013-2015) for Elimination of Mother to Child Transmission of HIV and Congenital syphilis (e-MTCT-HIV&CS), February 2013

service centers with the right to refuse testing. Re-testing is recommended in the third trimester, or during labor or shortly after delivery, because of the high risk of acquiring HIV infection during pregnancy. All HIV-exposed infants must have HIV virological testing at six weeks of age or at the earliest opportunity thereafter; See algorithm for testing HIV exposed infants <18 months in page 14 of the Consolidated guideline.

Provisions for data quality assurance at facility level (on a monthly basis) and administrative levels (quarterly basis) using LQAS before the data are sent to the next higher level reporting unit is in place. Regular Integrated Supportive Supervision with an overall aim of promoting continuous improvement in staff performance and additional Supportive Supervision on TB/HIV conducted whenever gaps are observed. Review meetings should be organized at various levels creating a very good opportunity to review the status of program implementation, achievements and challenges and come up with workable solutions for the problems and challenges encountered.

Key indicators to be tracked in 2015-2020 strategic plan period include: Number and percentage of Pregnant women who were tested for HIV and received results; Number and percentage of HIV positive pregnant who received ARV prophylaxis (ART or B+ option) to prevent MTCT of HIV; Number and percentage of infants born to HIV positive mothers who received the four to six weeks ARV prophylaxis; Number and percentage of infants born to HIV positive women receiving virological testing for HIV within two months of birth; Number and percentage of HIV exposed infants (initially negative by 4 to 6 weeks) tested for HIV by 9 to 18 months and /or by the time of cessation of breast feeding; Percentage of infants born to HIV positive women who are HIV infected; Estimated percentage of child HIV infections from HIV positive women delivering in the last 12 months

Policy gaps identified on e- MTCT/PMTCT

Even though integrated supportive supervision and integrated review meetings are wonderful opportunities for improving performance, quality, and management of programs, however, given the load of agenda on these events in-depth discussions may not be realistic enough to address important issues in a specific program. Hence better strategies to address the issues of technical capacity building should be sought in an organized and practical way to improve the quality and coverage of care for children and women. There need for some government-led mentorship programs framed well in the policies and guidelines

Despite the fact that the policy talks about integration of PMTCT and HIV care with MNCH services such as the Ante-natal care (ANC), facility delivery, Post natal Care (PNC) are not utilized very well by the community, hence the policy does not tell how to address the issue of women delivering at home, or not going to the facility for ANC or PNC care.

Even if the policy stresses on the need for equitable service provision, it falls short of providing specific policy guidance on how to ensure equity for the underserved and hard to reach population.

III- Existence and comprehensiveness policy, strategy and guidelines for Pediatric HIV care

The policy documents revised are: 1) National Guideline for comprehensive HIV prevention, care and treatment (2014); 2) Health Sector Transformation plan (HSTP), FMOH (Aug 2015); and 3) HIV and AIDS Strategic Plan 2015-2020 in an investment case approach, FMOH, Addis Ababa Ethiopia (2014).

Policy Provisions on Pediatrics HIV counseling and testing

All forms of HIV testing and counseling should be voluntary and adhere to the five C's: consent, confidentiality, counseling, correct test results and connections to care, treatment and prevention services. The national consolidated guideline has adopted the WHO recommendations (guiding principles) for testing as part of its policy base for testing.

The policy makes provisions for both the facility based and the community based testing models. The community based model of HIV testing and counseling is recommended at the following settings: 1) Home-based testing targeting specific sub-population group; and 2) Outreach HIV testing and counseling services targeting specific geographic areas with high HIV prevalence (hot-spots). While planning outreach HTC, effective linkage of the

identified HIV infected clients is very critical. The policy makes provision for both facility and community based HIV counseling and testing applicable for all age groups of the population including children and adolescents. All clients undergoing HIV testing should be provided with post-test counseling in person (as individual or couple).

Repositioning the HIV testing and linkage integrated with in MNCH in to the health development army (HDA) from the health extension program will intensify the community level BCC and this initiative will serve as one of the main strategies to raise knowledge about HIV/AIDS prevention methods, improve PMTCT uptake and overall to strengthen the community based HIV programs in rural and urban areas.

Reducing stigma and discrimination is duly emphasized in all aspects of HIV programming in the consolidated policy document; has been stated as one of the guiding principles for program managers as well as "Promotion and Protection of Human Rights shall be based on the principles of fundamental human rights, social justice and equity guaranteed by the constitution of the country, including avoidance of stigma and discrimination and addressing criminalization of HIV-related behaviors;"

Guiding principle for program implementation stresses "The HIV/AIDS programs are designed and implemented in order to ensure equitable and universal access" for all "following the human rights principles of non-discrimination, accountability and participation." One of the main objectives in HIV testing and counseling is to identify and link HIV positive persons to care and treatment services and HIV negative people to prevention services. Referral and linkage of clients must get necessary attentions to maximize the number of identified HIV infected persons that are linked to available care and treatment services in the country.

The guideline states that Youth-friendly counseling and testing services shall be made widely available for youth population; however it does not stipulate how this can be done or achieved.

Main indicator to be tracked is "Number of individuals Tested and counseled for HIV and who received their test results:- is the Number of individuals who have been tested for HIV and who received their test results"; the targets set are :

- Offer targeted HIV testing and counseling to 8.5 M people and repeat test to 400,000 female sex workers, discordant couple and other needy annually.
- Offer voluntary counseling and testing to 5 million adult people annually.
- Identify 95% of HIV positive pregnant women and attain 95% enrolment for Option B+ (Both mother and newborn)
- Test 90% of infants born to HIV mothers by four to six weeks of age

Policy gaps identified in Pediatrics HIV counseling and testing

The following were major gaps identified regarding HIV counseling and testing. 1) Specific strategies as to how to organize or prepare child friendly services is lacking. 2) No children specific HIV Counseling and testing (HCT) T targets provided in the policy documents.

Policy Provisions on pediatrics care and treatment

The "90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; 90% of all people receiving antiretroviral therapy will have viral suppression" applies to pediatrics age group as well.

ART is recommended for all HIV infected children less than 15 years regardless of CD4 count and WHO clinical stage. Specific preferred ART regimens are present in the guideline based on their ages: for those < 3years/36 months of age and those 3 to 10 years and 10 to 19 years (adolescents) and their body weight. Preferred ART regimens in children with TB disease and anti TB treatment status depending on their age and the timing of ART initiation is as well outlined.

The guideline makes clear provisions for 85% enrollment of children to ART and it appears that the "Retain 90% of those who are put on treatment" does equally apply for children as well.

The OVC care and support will be treated as part of the social protection and broader child welfare and will be handled by Ministry of Women, children and Youth Affairs and its regional bureaus in collaboration with local NGOs, FBOs etc. The orphan support focuses on ensuring continuum of care and creating a sustainable mechanism

of support through strengthening the community based support approach.

The guideline mentions “Good practices for retention across the continuum of care” which requires interventions at multiple levels of the health care system:

1. Distance from health care facilities is a barrier to retention due to related transport costs and loss of income while seeking care hence bringing service closer to the community improves retention.
2. Waiting times at the facility during consultation are frequently high, especially in settings with a high burden of HIV infection. Reorganizing services, such as systems for appointment, triage, separating clinical consultation visits from visits to pick up medicine, integrating and linking services and family-focused care may reduce waiting times.
3. The fact that all children under 15 years of should be started on ART right away will avoid lost to follow up , however follow-up of adolescents’ who have not yet started on ART should be have regular important to ensure continual monitoring and timely initiation of ART.
4. Key populations generally experience more barriers to accessing health services. Interventions harnessing social support have emerged as a promising approach to counteract the structural, economic, service delivery and psychosocial constraints that affect retention in care.

Through this approach about 50% (400,000) of the AIDS orphan will be reached in the first two years of the investment period and since the third year it is assumed to decrease by 25% annually as many will be graduating from the support and also many households will able to support themselves. Before ART initiation and thereafter patient readiness and adherence to therapy are always assessed and necessary support provided. Opportunistic infections including TB, IRIS, and co morbidities are always looked for and managed.

Patients qualifying for antiretroviral therapy are thoroughly evaluated at baseline and for the rest of their lives to monitor toxicity, intolerance, response or failure to treatment. Monitoring individuals receiving ART is important to ensure successful treatment, identify adherence problems and determine whether and which ART regimens should

ART is recommended for all HIV infected children less than 15 years regardless of CD4 count and WHO clinical stage. Specific preferred ART regimens are present in the guideline based on their ages

be switched in case of treatment failure. The value of viral load testing as a more sensitive and early indicator of treatment failure is increasingly recognized. In settings with limited access to viral load testing, like our country, a targeted viral load determination to confirm failure suspected based on immunological or clinical criteria should be used if available. In areas where viral load testing is impossible treatment failure must be decided based on clinical and immunologic criteria. The guideline indicates key ARV drug interaction and the suggested management.

Policy gaps identified in pediatrics HIV care and treatment services

The following were some of the major gaps identified in relation to HIV care and treatment services. 1) The guideline discusses retention in detail but does not provide clear strategies/modalities to ensure retention of children on ART specifically. 2) The guidelines do not mention about third line ART regimen at all.

IV- Existence and comprehensiveness policy, strategy and guidelines for Adolescent HIV care

The documents revised are: 1) National Guideline for comprehensive HIV prevention, care and treatment, 2014; 2) Health Sector Transformation plan (HSTP), FMOH, Aug 2015; 3) HIV and AIDS Strategic Plan2015-2020 in an investment case approach, FMOH, Addis Ababa Ethiopia, 2014; and 4) National Adolescent Sexual and Reproductive Health strategic plan. Below is summary of review findings.

Policy Provisions for Adolescent HIV counseling and testing

Generally the policy document does not priorities adolescent HIV strongly however it identifies adolescents/young people age 10-24 as one of the priority population groups in two of the four strategic objectives - namely high impact targeted prevention programs and targeted HCT. Specifically mentions in school youth, out of school youth, and university students and the approaches suggested reaching them. However, most of those approaches address adolescents with the adults as age 15 years and above.

Adolescent girls and adolescents from key populations are also vulnerable to HIV infection and would benefit from access to acceptable and effective HIV services, including HIV testing and counseling.

HIV testing and counseling with other prevention services and linkage to treatment and care is recommended for all adolescents and youth age 15-24 years.

The guideline put the adolescents along with MARPS as eligible clients for routine HIV test. “Persons 15 years and above are considered mature enough to give informed consent for themselves.” HIV testing for children less than 15 years of age shall only be done with the knowledge and consent of parents or guardians, and the testing must be done for the benefit of the child. However, children aged 13-15 years, who are married, pregnant, commercial sex workers, street children, heads of families, or sexually active are regarded as “mature minors” who can consent to HIV testing. NB, WHO guidance on consent26.

The policy makes the following provisions for coupes as a whole, even if it does not specify adolescents: Pre-engagement, premarital, and preconception counseling and testing will be promoted. Couples shall be encouraged to be counseled, tested and receive results together. Partner notification shall be encouraged in cases where one partner receives the results alone. The policy document also provides detailed guidance on disclosure and partner notification. The privacy and autonomy of the couple and individual must be respected. Informed decisions shall be encouraged among discordant couples to protect negatives and support positives. HIV+ Adolescents be counseled about the potential benefits and risks of disclosure of their HIV status and empowered and supported to determine if, when, how and to whom to disclose.

As part of its Quality Management (QA) provisions, the document advises “enough physical space to provide HCT that ensures privacy of the clients and point of care testing”. Privacy is again emphasized in the Ethics in counseling section. In general, the document stresses “The privacy and autonomy of the couple and individual must be respected”

26 *WHO does not provide specific guidance on the age of self-consent but highlights on the need for countries to do so to improve access and uptake of HIV services by adolescents?*

The document emphasizes the five C's as per the WHO guideline stating that all HTCs should adhere to those guiding principles. These are stressed in the Ethics section as "All service providers shall observe the ethical requirements of confidentiality, informed consent, proper counseling, anonymity and privacy"; In addition, it encourages shared confidentiality in an attempt to avoid reinforcing secrecy, stigma, and shame.

The general care package for PLWHIV", "pre-ART care package", and "preparing people living with HIV for ART" sections on the consolidated guideline provide a detailed description of measures to take until they are ready for ART. These sections are dedicated to all adults and adolescents and makes a separate provision for children <15yrs of age. Youth-friendly counseling and testing services shall be made widely available for youth population

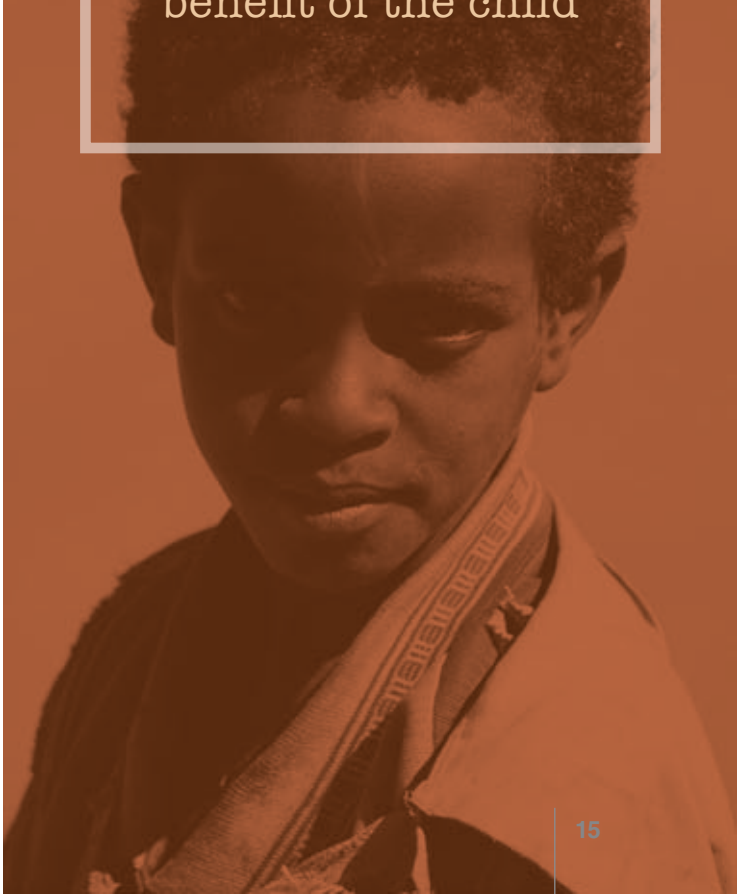
The policy has clear provisions for linking individuals testing positive to care and treatment through the following:

- Implement standardized service delivery system that will improve referral and linkage between HCT and HIV chronic care;
- Standardize documentation, reporting system and feedback practice;
- Ensure standardization of HCT guidelines and training materials on referral and linkages issues;
- Improve the involvement of Health Extension Workers (HEW), PLHIVs in awareness creation activities as to improve referral and linkages;
- Reduce stigma and discrimination through community involvement;
- Promote health seeking behavior and encourage HIV positive people for service utilization.

Policy gaps identified on Adolescent HIV counseling and testing

- It does not clearly define the adolescent age group and it does not highlight the unique needs of this group and technique approaches/policy and program provisions commensurate with those needs in both the prevention and HCT work.
- The strategic focus does not exist when it comes to the quality care and treatment strategic objective

Persons 15 years and above are considered mature enough to give informed consent for themselves. HIV testing for children less than 15 years shall only be done with the knowledge and consent of parents or guardians, and the testing must be done for the benefit of the child



where the only two population groups mentioned are adults (15+) and children (0-14).

- Where specific targeted programs exist such as in the schools; they are not properly tracked, supported and evaluated.
- Adolescent age group are not well mentioned and are not labels as standalone target group for priority HIV testing
- Although the document stresses privacy in general terms, it does not emphasize the need for privacy for adolescents making service provision more adolescent-friendly.
- The policy frame-work mentions youth-friendly services but falls short of describing what it entails.
- The policy does not make specific provisions for adolescents based on their unique needs for support and follow up.

Policy Provisions for Adolescent HIV Care and Treatment

The guideline states that HIV testing and counseling with other prevention services and linkage to treatment and care is recommended for all adolescents and youth age 15-24 years. The national guideline recommends the following for all adults and adolescents infected with HIV: (a). HIV infection with CD4 count ≤500 cells/mm3 should be started on HAART irrespective of WHO clinical stage. (b) HIV infection and WHO clinical stage 3 and 4 should be started on HAART irrespective of CD4 cell count. And (c) HIV infection and active TB disease should be started on HAART irrespective of CD4 cell count. The policy makes clear provisions for care and support services for OVCs and PLHIV along with clearly defined strategies on how to achieve.

Policy gaps on Adolescent HIV Care and Treatment

The major gaps identifies pertaining to adolescents HIV care; the fact that no specific guidance for adolescents disaggregated by age; the evised 2015 WHO guidance stipulates initiating ART irrespective of CD4 count and WHO clinical stage; clear strategies are not set how to improve specifically linkage to treatment; and as with the care and treatment provisions, no specific mention of adolescents age group. However, given OVCs include 0-18 years, there is no apparent policy gap on care and support for adolescents.

Qualitative research Results

National key stakeholders' interview Results

Key informants from the following institutions were interviewed on policies and guidelines on HIV care for pediatric and adolescent age groups. The findings are presented below.

1-Existence of the policy

Ethiopia endorsed a comprehensive HIV/AIDS policy in 1998 that formed the basis for an aggressive multi-sectoral response across the country. Under that policy framework, a number of separate guidelines and strategy documents on care, support and anti-retroviral treatment (ART) were developed along with the respective training manuals and operational guidance's. Cognizant of the fact that the scattered documents are causing operations difficult and at times confusing for the health workers and other front liners, Ethiopia has followed suite in developing a consolidated document on HIV care and treatment following the recommendations of the World Health Organization (WHO). In alignment with Growth Transformation Plan (GTPII) and the transformation agenda as set forth in the Health Sector Transformation Plan (HSTP), a strategic plan for the period 2015 – 2020 was also developed using an investment case approach.The National strategic plan for Elimination of Mother to Child Transmission of HIV and Congenital syphilis (e-MTCT HIV and CS) and the National Adolescent and Youth Reproductive Health Strategy; address the missing detail of the e MTCT and Family planning link in the consolidated guideline.

The other adjustment in the current documents is that, in the previous training materials, two weeks was allocated for adult HIV training and two weeks for pediatrics; and out of the two weeks allotted for pediatrics, one week was for Integrated Management of Newborn and Childhood illness (IMNCI) and one week was for pediatrics HIV to integrate the two components of pediatrics care. However in the most recent consolidated HIV guideline, the IMNCI is not included since it has its own standalone guideline. Pediatric nutrition, growth and development and nutritional palliative care would help provide a comprehensive care package for pediatric HIV along with the detailed guidance provided in the IMNCI Manual.

Ethiopia does not have a standalone document on adolescent HIV care, support and treatment; however most of the respondents believe that specifically the issue of treatment has been duly addressed within the consolidated guideline with the exception of psychosocial care and support. The latter has been raised unanimously by all a cause for concern. Psychosocial care for pediatric and adolescents needs an in-depth guideline and a separate training manual for health workers. Accordingly, a working document has been developed and two rounds of training sessions conducted to health workers (HWs) using the training material. Although already in use, this document is yet to be approved and rolled out officially.

2. Policy Development Process

There is a well-defined policy document development process including clearly defined roles and responsibilities outlined for all key stakeholders in the sector. Respondents believe that there is an accommodative and inclusive consultative process in place that engage all specialties, implementing partners; donors, UN agencies, universities, as well as entities like EPHI and FMHACA as key players in the expert panel, advisory committee and the task force. There is an advisory committee on HIV care and treatment where all key partners are represented. Out of this advisory group is a panel of experts, tasked with drafting and/or adopting the various policy documents. The drafts are presented and debated at the advisory group level before they are forwarded to the State Minister's Office for review and endorsement. The development process is informed by lessons from the in-country implementation of previous policies and guidelines as well as the international documents, particularly those of the WHO.

Consultation with the affected population such as the youth and other key population groups like commercial sex workers (CSWs), on the other hand, was limited for most of the national policy document development process. The psychosocial support guideline development, which was informed by experiences drawn from various African countries and documents such as those of ANECCA, has exceptionally engaged and consulted adolescents as appropriate, although it again falls short of engaging other affected population groups.

Although there is a consultative and engaging process involving partners in place, there is a shared concern among partners that the country is slow in adopting evidence based international recommendations such as those updates in pediatric ART and Option B+ that took long to endorse and roll out. The associated resource implications and the fear of the resulting breakdown in supply in the absence of a sustainable source of funding are cited as reasons for the delayed response.

Despite the strengths of the development processes, some believe that having a separate team dealing with pediatric and adolescent HIV would have further improved the policy documents dealing with Pediatric/adolescent issues. This has been reflected nationwide in the low HIV care and ART coverage for pediatric and adolescent age group.

3. Policy content and gaps

Ethiopia adopted a "treat all under 15years" approach two years ahead of the international guidance on the same basing its decision on the national experience and its commitment to increase enrollment of pediatric cases into ART and care as part of the accelerated plan. Despite delays in the roll out, this policy guidance has boosted the enrollment as planned.

In general, there is a shared consensus among key stakeholders that the national policy framework in Ethiopia is not inhibitive. However, all the key stakeholders do agree that pediatric and adolescent HIV is not adequately addressed in both the health and non-health responses. Cited particularly by the respondents is the level of depth adolescent HIV is addressed in the consolidated document. Of particular concern is the disclosure and adherence pieces in the consolidated guideline which appears to be a major gap as adolescents require a particular age friendly tailored approach. The psychosocial document has taken this into consideration and has incorporated a chapter as a "Disclosure Tool" to help provide the skills and an adolescent-friendly approach.

There are no standalone policy documents for adolescent HIV in Ethiopia and there is no consensus among stakeholders on the need for such a document. However, the government is open to consider with evidence on the

implications of not having an adolescent specific guideline and the value added. It would bring as opposed to keeping it within the consolidated document.

Other standalone documents such as the national Adolescent Sexual and Reproductive Health (ASRH) strategy, albeit strong in its emphasis on adolescent sexual and reproductive health issues and on the strategy to avail youth-friendly services, it falls short of adequately capturing HIV within the overall approach.

4. Policy implementation

All key stakeholders agree on the presence of a conducive policy environment. However they all said that there are a number of implementation related challenges which stand out as major stumbling blocks to realizing the goals and outcomes envisioned in the various documents. Below are some of the major ones brought up in the discussions with the key stakeholders:

4.1Testing and enrollment in to HIV care

All key informants indicated that there are challenges with implementation and achievements as the observed Pediatrics and adolescent HIV testing and enrollment are much lower than set targets according to the latest reports. Adolescent friendly care is the main obstacle to improve testing among adolescents despite the government's advice to referral Hospitals to establish youth friendly clinics.

Though the policy provides "test and treat" strategy which has simplified the linkage to ART care and the targeted testing for under 5 children; testing is still staggering at <10% low as an evidence of a weak implementation of pediatric PITC. As stated in the accelerated plan, the target was to enroll and treat 27,000 cases per year but implementation was not aggressive enough and coverage still remains at less than 13,000 cases per year.

There are no systems in place to reach OVCs and street children both for testing and enrolling them to care. With the foregoing, it is evident that policy provisions alone, in the absence of strong systems and structures in place, weak or no coordination among various Ministries, implementation can lag behind and results undermined. More recently the government with key stakeholders has drafted a small document which helps to support OVCS testing and linkage (2016-2020).

With the accelerated plan, the PMTCT coverage of only 28% has improved markedly to 78% using the collaborative actions between health extension workers (HEW)and women/health development army (HAD)programs; however it has not yet reached to a national target and there are still gaps in provisions of prophylaxis for the newborn testing and enrollment to care.

4.2 Health workers skill, capacity, and attitude

Health workers have been trained on treatment and care of pediatric HIV based on a standard training package followed by provision of all the essential tools and supplies needed to run the program. These efforts are negated with significant challenges such as attrition of trained staffs, lack of commitment, lack of confidence in managing pediatrics/adolescents and problem of accurate reporting. General observations by stakeholders spelt out that most health workers are still uncomfortable to deal with pediatric cases and with a tendency that it requires a specialty care. In some instances, there were follow up visits and on-the-job mentoring to help build their capacity and confidence in managing pediatric cases, however low case load in remote areas has limited the mentorship activity and their exposure to cases. As a result, implementation still lags behind despite the policy provisions and guidance.

This necessitates a discussion on whether there is a need to reposition pediatric/adolescent services and/or a need for further training based on a revised training curriculum that meets their specific gaps.

4.3 Operational and logistical challenges

Experience show that there is a high need of work among orphans and vulnerable children (OVCs) necessitating focused work on this segment of the population. Given the mandate for OVCs lies with the Ministry of Women, Children, and Youth Affairs (MOWCYA), discussions are currently going on between the Ministries on how to better reach and serve them. Result from these discussions is yet to be seen.

Psychosocial support: there is an initiative to establish youth centers in hospitals paving the way for adolescent friendly services. It has been rolled out in few hospitals but many more centers are yet to be established. It is

believed to improve the psychosocial support services provided to adolescents with HIV and to make coordination between ART treatment and care with psychosocial support easier. There is also a preliminary evidence that adherence improved with the roll out of the psychosocial support. However, there are two challenges to be addressed if this initiative is to successfully meet its objectives. First, a need for sustainable source of adequate funding to run the activities within the centers is a must to keep them open and functional. Secondly, since the centers are based in hospitals, adolescents from other districts are supposed to travel to those hospitals incurring transport and other expenses making it difficult to maintain attendance on a regular basis.

Ministry of Youth and Sport: with the recent restructuring and establishment of the Ministry of Youth and Sport, there is a need to reposition HIV within this Ministry so as to effectively reach the youth with the preventive services. This requires discussions with the Ministry on how to embed/mainstream HIV across the Ministerial objectives and functions.

Additionally in the past one year there was shortage of test kits nationally, which has been solved more recently.

4.4 Data management and Reporting

Data management and reporting appears to be one of the major implementation challenges raised by all key informants. There are still gaps in monitoring and tracking progress through quality data, analyzing and understanding the data locally and taking appropriate corrective measures, as well as gaps in generating quality reports. These weaknesses in Monitoring and Evaluation and the overall data management issues do hamper an evidence based response and affect the quality of services rendered at health facilities.

The age disaggregation (to capture clearly adolescent age groups) within the HMIS reporting system is lacking and WHO and UNICEF are working on joint advocacy for change

OVCs and street children: capturing accurate information on OVCs and street children has been another setback in pediatric/adolescent HIV programming. Information gathered through HMIS is usually incomplete falling short of providing the right data for decision making.

Furthermore, there are several co-curricular activities conducted in schools for in-school-youth that are not captured under the management information system or not shared between Ministry of health and Ministry of Education.

Facility key informant interviews results

1. Background characteristics of participants

The policy /guideline analysis key informant interviews were conducted in a total of 35 health facilities, 15 government hospitals and 15 health centers from 11 regions and five private hospitals from Addis Ababa. All of the facilities have HIV/ART clinic to provide comprehensive HIV care services to adults, adolescents and children. A total of 35 health care providers (29 health officers and nurses, six physicians) whose work experience ranging from 7 months to 32 years participated in this (Table 3).

Table 3: Background characteristics KIIs participants of policy gap analysis, for pediatrics and adolescents HIV services in Ethiopia, 2016

Policy gap analysis study	
Type of health intuition	
Government district/general Hospital	15
Private Hospitals (in Addis)	5
Health center	15
Type of health provider	
ART provider clinical nurse/health officer (government)	28
ART Provider Nurse (from private Hospital)	1
Physician	2
Pediatrician (from Private Hospitals)	4
Service year (min, median, max)	(0.6, 9, 32)

2. Participants response on Policies and guidelines in Ethiopia

The policy or guideline gaps related to pediatric and adolescent HIV/AIDS services analysis is presented using five thematic areas; these are a) awareness and availability of policies and guidelines, b) knowledge of the policy/guideline provisions, c) best practices in the policy guideline implementation, d) opinion on the policy/guideline gaps and e) how the policy/guidelines are implemented in to practice. The recommendations they mentioned are presented on recommendations section.

2.1 Awareness and availability of policies/guidelines

All the health care providers mentioned at least one or more guidelines or policy related to the pediatric and adolescents HIV/AIDS care/service and general guidelines. The most commonly mentioned guidelines were listed in Table 4 below.

Table 4: Available guidelines on pediatrics /adolescent HIV care enlisted by the facility key informant interview (KII) participants from 11 regions of Ethiopia, 2016 (n=35)

• Guideline for pediatric HIV/AIDS care and treatment in Ethiopia (2006/2007) • Pain management, Palliative and terminal care guideline(2007) • Standard operating procedure for comprehensive HIV/AIDS prevention, treatment, care and support (2015) • Comprehensive /consolidated ART guideline (2014) • Provider initiated counseling and testing manual, 2010 • HIV and Nutrition Guideline • WHO 2010 and 2013 guidelines	• VCT and disclosure manual • Pediatrics and adolescents HIV psychosocial care mentoring guideline, 2016 • Referral framework guideline (HIV) • guideline for HIV counseling and testing (HCT), 2007 • TB/HIV collaboration guideline • guideline for treatment of opportunistic infection • The cotrimoxazole provision guideline • INH provision guideline

There was an observed inconsistency among the health care providers related to their knowledge on what policy, guideline and manual mean. Guideline, policy and manual were used interchangeably by the respondents. They had also difficulty in mentioning the exact names of the policy or guidelines and as well did not exactly know the different versions of the guidelines. Some of them were not sure if there was a separate guideline/policy on pediatrics and adolescent HIV or not and difficulty to differentiate between the national guideline and the WHO guideline. For example, ART provider from one of the hospitals who has 3 years of work experience and who has been a mentor stated that;

> *"The consolidated WHO 2013 guideline is the one we are using despite the fact that we do not have detail training on pediatric and adolescent treatment. Personally I only know the consolidated WHO 2013 guideline but I do not know if other staffs have guidelines on counseling. Whenever a guideline is published, the hospital receives four to five copies and one copy of the guideline is usually made available at the ART clinic". [ART Provider, 3 years of service]*

Similarly, ART provider who has 8 years of work experience from a health center from another region said that;

> *"I know that few guidelines are available here at our health center; however I am not aware of them fully. The guidelines available are not located in easily accessible places. I did not take any training except the training I took on VCT long ago." [ART Provider, 8 years of service]*

Among the above listed guidelines, the frequently mentioned guideline by health center and both government and Private hospital staffs is "Consolidated /comprehensive ART guideline, 2014".

The guidelines were available and accessible in most health facilities. Few said that they were not accessible and hence failed to show during the time of the interviews. The Federal Ministry of Health of Ethiopia, the regional health bureaus and ICAP-Ethiopia where reported as the sources of the policy and the guidelines. Soft copies of the guidelines were also available as an alternative forms and additionally as well desktop references. Trainings were reported as the first means of exposure to the guidelines.

3. Knowledge on policy provisions

Most of the participants mentioned at least very basic provisions on the guidelines such as treatment procedures, disclosure, and follow-up and referral procedures. One of the concepts mentioned commonly when specifically probed about pediatrics and adolescents HIV care and treatment guideline provisions was the age(i.e <15 years of age) at which they have to start ART regardless of CD4 count and staging as stated below:

> *".....The previous pediatric ART guideline states initiation of ART for children and adolescents was based on CD4 count. Whereas the current guideline recommends all children under 15 years who are HIV positive should initiate ART regardless of CD4 count and staging....." [ART clinician, 5 years' service]*

Providers having less years of experience mentioned limited number of provisions of the guideline as evidenced by a general practitioner with only one year of experience who said that he does not know about the provision of the guidelines in detail and reported the age to disclose HIV status to adolescents should be 13 years old and the following was quoted from what he said:

> *"We know the existence of the guidelines but not say that I have been using them. We have to be trained on the guidelines. I cannot tell you exactly the contents or the provisions of the guidelines in detail but I think there are areas like treatment procedures". [ART Provider, 13 years of service]*

Generally, the following list of the different guideline provisions were presented by the participants as shown in Table 5.

Table 5: Different guideline/policy provisions on pediatric and adolescent HIV care and support listed by the KII participants in Ethiopia, 2016

- Means of transmission of HIV and how to diagnose
- WHO staging of HIV positive children
- Test all <5 years of age,
- Targeted PICT provision
- Start ART immediately regardless of CD4 count for <15 years children
- start ART for >15 years old children by using CD4 count (<500 and WHO stage 3 and 4)
- For HIV positive children less than 15 years old, CD4 count should be done at base line/initiation of ART to help on the follow up of toxicity and treatment response.
- Treatment follow-up of children on Chronic HIV care and acute conditions
- PMTCT Prophylaxis and follow up for HIV- exposed infants.
- How to give counseling for parents and how to link to HIV treatment
- Disclosure and follow-up.
- How to enable parents to teach about HIV to their children
- Different regimen for different ages of children
- Early identification of treatment failure
- If the first line medications do not work, CD4 and viral load should be done and second line medications should be started
- Integration of pediatric HIV services with adults
- Management of TB –HIV co infection
- Eligibility for CPT prophylaxis
- Treatment of opportunistic infections and STIs.
- Nutritional assessment of HIV infected children

Two professionals reported that they did not see policy provisions on viral load testing and disclosure on the consolidated guideline.

4. Success stories in policy/guideline implementations

The success stories mentioned among the key informants were generally categorized in the areas of testing, referral/linkage/communication, PMTCT and psycho-social care activities, and the details were:

Effective implementation on the area of pediatric HIV counseling and testing: such as testing all pregnant mothers, index family testing, risk group targeted testing, PICT at all departments of the health institution, this was

mentioned in the region with high prevalence of HIV. The health care provider indicated as directly quoted below :

> *"All targeted population are screened for HIV specially under-five children including all pregnant mothers and index cases family members. All children and adolescents who are coming to our hospital are counseled and tested. If clients tested positive, they are linked to ART clinic for chronic care….."(Clinical nurse)*

Effective referral linkage between government and private facilities: In one of the private hospital, a respondent reported that they have a good relationship/referral linkage with the government hospitals;

Strong PITC /HIV testing service at each service delivery point: This is another best practice mentioned by the private hospitals

Mother support group programs: In some, they reported that they have a group of HIV positive mother support groups where they share their experiences and promote PMTCT among HIV positive pregnant mothers as stated below in two health facilities from two regions:

> *"…… we have a group called "mother's support group". They are mothers living with HIV and grouped to support one another and also to support other pregnant mothers who are not in the group especially who are HIV positive. We have tea and coffee programs every month. During this event, they discuss about their illness, and plan to follow HIV positive pregnant mothers. They check if pregnant mothers are coming to follow-up at every month or not. They give advice for pregnant mothers on PMTCT and on adherence. As a result, MTCT is zero in our hospital… [HIV care provider, Hospital]*

> *"…Mother support groups prepare porridge for mother who deliver at the health facility to encourage health facility delivery and decrease the risk of HIV transmission. The group also celebrates birthdays for the HIV exposed infants whose result is negative" [A nurse with 5 years' experience]*

Escorting mechanism to strengthen referral and linkage: some respondents reported that they have very good communication / escorting system to link HIV positive mothers to PMTCT and ANC and HIV positive pediatrics patients identified at pediatrics outpatient and inpatient departments to ART care. For example a respondent from one of the regional hospital said that

> *"We have good internal referral linkage between the ART clinic and pediatrics OPD/IPD for HCT services. When a pregnant mother is found to be HIV positive, she will be linked to ART medication directly (option B+). The pregnant mother will be advised to have follow-up at the health institution. When the infant is born Neverapin syrup will be given. At 45 days, Dried Blood Spot sample will be sent for diagnosis and then cotrimoxazole syrup will be started for the infant. For under-five children who are found to be HIV positive, they will be linked to ART clinic. Then ART medication will be initiated. (ART clinic nurse/32 years old)*

Lost to follow up (LTFU) tracing through registering multiple family members' phone numbers

Psycho-social care –youth recreational activities were more common at hospitals than health centers. And most health centers requested to be supported to start psycho-social care activities. These institutions have psycho-social services for adolescents using different entertainment and establishing youth friendly activities. The following statements were from the participants report;

> *Best practice in our hospital regarding pediatric and adolescent ART is the establishment of youth friendly center. There is active involvement of case managers in the service. We get supervision from ICAP on youth friendly services and they provide us with indoor games like Table Tennis, chess, etc for youth entertainment. Currently, there are 40 adolescents who are actively participating and whenever they meet they discuss issues related to HIV (ART clinician)*

> *In our hospital adolescents and children get psycho-social support services. The children get education every day. They also learn from each*

other and have entertainment programs. These have helped the children to have better adherence (ART clinician).

Weekend working HIV/ART clinics to avoid missing school days by children and adolescents were implemented in some health facilities.

Keeping experienced ART provider in the clinic : One of the participants from health center mentioned a best practice of not rotating ART providers to other departments unlike the other practitioners has helped to retain trained and experienced ART provider in the HIV unit.

Integration of HIV/ART program with in other departments: a participant from one private hospital mentioned integration of testing, treatment, PMTCT and other services helped to reduce missing link and stigma within the facility as reported by the following respondents :

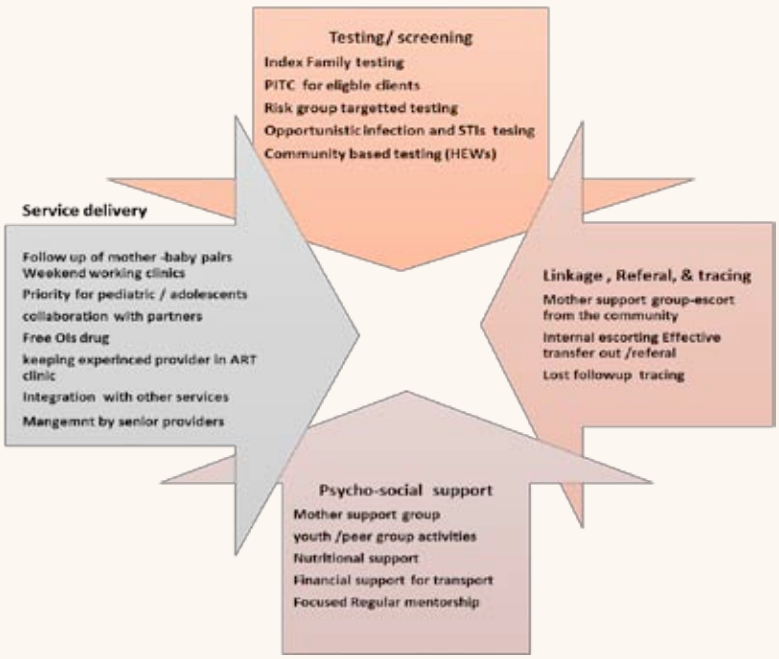
"The integration of the service makes the linkage very good because if pediatric service and HIV service was done in different places there may be missing link".

"Over all the HIV service is fully performed; pregnant mothers are tested during ANC follow-up if there is missed opportunity, they will be tested during labor and delivery. .....In addition, newborns also will be started on prophylaxis Nevirapine. We have been following a number of HIV exposed infants the good thing is that up to now ten are discharged from follow up being HIV negative. They were tested with DNA- PCR and thus the PMCTC service contributing to the elimination of pediatric HIV." [ART provider, private facility]

"Some of the patients come to us (Private Hospitals) from public hospital for fear of being labeled /identify as HIV + since the HIV/ART services are given in a separate room, however in our facility all services for pediatrics and adolescents are provided in the same room and as a result patients feel not identified (less stigma)".[ART provider at private facility]

Manageable patient flow in some private hospitals was additional factor for successful pediatric and adolescent HIV care. Treatment and follow-up are done **by highly qualified and trained Pediatrician and Gynecologists** makes the care as well more acceptable by clients attending at private hospitals

Figure 4: summary of success stories mentioned by the facility Key Informant Interview participants on the pediatric and adolescent HIV care services in Ethiopia, 2016



5. Policy gaps mentioned by facility key interview participant

Majority of the participants said that they saw several gaps in the guidelines. The most prominent gaps mentioned by most included gaps on disclosure related issues which is not well elaborated on how to do it. The other gap mentioned was age classification/disaggregation of adolescents for initiation of ART; ours still disaggregate < 15 years and > 15 years, however the WHO guideline uses the categories <10 years, 10-19 years, and >19 years of age. They also mentioned that there is mismatch between the national and WHO guidelines in the age classification of adolescents for post exposure prophylaxis medication. (Ours says < 15 years and the WHO, 2015 guideline mentions even those below 10 years of age.

Two health care providers suggested that if the guideline is more detailed it will be easier to understand and use it. ART clinician from one of the health centers reported as follows:

> *"We have always debate on whether exposed children should take cotrimoxazole for 18 or 12 months. Some say that we should give for 12 and others for 18 months…… I think sometimes the guidelines needs to be detailed. In hospitals, the setup is better and exposed infants are followed at pediatric clinic. But at the health center, we provide the service based on the guidelines…. and we encounter some vague issues"*

Another interviewee from another region health center mentioned that the guideline overlooked orphan children,

> *"The limitation of the guideline is that it does not mention anything about the orphans testing and follow-up, no testing rights of orphans. Orphans are one of the high risk groups for HIV. But they are missed because of lack of attention to them."*

A respondent from private facility suggested modifying the follow-up care mechanism for orphans as stated below:

> *"Orphans are more likely to have treatment failure as a result there is a need to improve the definition of orphan care since an orphan has lost either his/her mother or both parents ; most of the time the relatives/ caretakers fail to bring him/her for follow up visits"*

Another respondent mentioned that the guideline lacks exact age of disclosure for adolescents and has not given emphasis to psycho-social care as he stated below:

> *"There is no clear guideline on exact age of disclosure……this has resulted in, low identification and enrolment rate and low adherence of adolescents"*

A respondent from private hospital also mentioned that there issue of disclosure and mental health is not well addressed for children and adolescents as stated below:

> *"On the guideline the issue of disclosure is not included well and there is a lot of deficiency on mental health."*

Some Participants from health centers and private hospitals mentioned that the guideline lacks policy/law for enforcing family/parent/care giver if they refuse disclosure and /or medication for their children. Hence health care providers are troubled what action to take whenever they are faced by difficult parent / care taker. Another respondent from a private facility said the following:

> *The guideline lacks detail discussion regarding on how to disclose and who should disclose. This has affected the level of trust the adolescents should have on their physicians. This is because most of them know about their status before their physicians discuss it with them. Parents are most of the time the main reason for such events because they do not support early disclosure.*

One health center staff also presented language as a barrier since the guidelines are prepared in English. On the other hand, one physician from private hospital said that there is no problem on the guideline, but the way the professionals practice is the problem, he is concerned that some professionals do no implement according to the guideline. Almost half of the participants reported that the comprehensive guideline is barrier to give focused ART

service for pediatrics and adolescents and requested to have separate guideline; as stated below;

> *"One of the gaps in the guideline is the incorporation of pediatric guideline and services with adults ART care. I think children care need longer time and special attention than adults. The fact that the guideline is combined makes us to lose our focus to children and adolescents hence leads to poor assessment and evaluation of children. Separate guideline is needed. We do not have any policy documents, adolescent HIV care, psycho-social support and nutrition for pediatric and adolescents" [HIV care provider, from regional hospital]*

6. Policy practice

Several challenges were presented in putting the guideline in to practice. These include lack of separate room for care and guideline for pediatrics and adolescents with HIV; lack of laboratory services especially for DBS, CD4 and viral load tests; lack/shortage of trained man power at service delivery points like at ANC, OPDs etc; shortage/interruption in the supply of HIV test kits, drugs; low economic status/lack of transportation money of patients which affects their follow up to care. In addition there were gaps related to orphans in their HIV care follow-up, adherence and disclosure. There were prolonged laboratory results turnaround time was repeatedly mentioned specially at the health center level. Case identification is reported to be low, due to limited intervention at community level. Regarding disclosure major gaps mentioned were; lack of providers' technical skill on disclosure, lack of information about exact age of disclosure; lack of willingness by family for disclosure due to stigma and low awareness. The preference to visiting traditional healing places which affects adherence to treatment are also mentioned as challenge to implement the guideline successfully.

The following statement is quoted from ART provider from one regional hospital:

> *"There is no separate room (clinic) or special clinic for testing managing children and adolescents. We do not also have pediatrician and there are limited number of trained staff at ART clinic. All HIV testing are done at OPD level. There is also shortage of HIV testing kits… Parents and care providers do not want to tell their children and adolescents about their HIV status. There is shortage of INH (IPT)….There is also lack of support for psycho-social programs, staff shortage at ART clinic".*

- The following statements were quoted from participants from private hospitals:

> *"……..The relatives of the children are challenge to the follow up unless the mother is alive…."*

> *"…… the guidelines states that the INH prophylaxis should be given for pediatrics. Normally, INH is given for 6 months and prevents TB for three years. Here, due to pill burden is difficult to prescribe for them and families are mostly are not accepting, for the last four years, most children didn't start INH and we have a problem on implementing it.*

> *"The other controversy is that even if we didn't give IPT; no child developed TB. However it needs research, but as individual observation, perhaps IPT should be revised and should be seen depending on risk of TB disease".*

The most prominent gaps mentioned included gaps on disclosure related issues which are not well elaborated on how to do be carried out

Table 6: list of challenges by KII participants to implement guideline/policy on the pediatric and adolescent HIV care in to practice in Ethiopia, 2016

Human resource related	Infrastructure, service and technology related	Guideline and policy	Clients/patients related
• Training on pediatrics and adolescent health and HIV • Training on disclosure • trained Staff turnover • low motivation	• Absence of separate clinic/room • Delayed CD4 and viral load test result from regional labs • Lack of drugs • Pill burden • Low PICT • Low case identification • High patient overload	• Awareness/ Training on guidelines • Absence of separate guideline • Late distribution of guidelines • Preparation of drug dosing charts • The issue of IPT • The issue of disclosure	• Fear of stigma • Refusal of testing • Fear of side effects • Fear of suicidal thought if status disclosed to adolescents • Low adherence and follow-up • Low awareness and knowledge • Preference of syrup than tablets • Going to traditional healing places • Financial challenges for transport and food

The following quote very well summarizes the major contemporary gap in adolescent HIV care.

> *"….with the introduction of the HIV treatment services the chance of children dying of HIV/ AIDS has been minimized markedly and now the children are growing. For these growing children and adolescents, additional services are important ……. Generally it can be said that the adolescents' service is not in place; and in the future, it needs to be strengthened. This may require additional costs, needs adolescents involvement and support to arrange peer support program, needs additional guidelines focusing on adolescents. This should be given high level attention nationwide.".* **Respondent from a Private Hospital**

Key comments and suggestions from stakeholders meeting

A stakeholders meeting to share the Policy and guideline analysis was conducted in Ethiopia on October 6, 2016. Twenty four participants from various institutions attended this meeting. Most of the regional representative invited could not come due to security issues.

Comments given by the participants include the following. The Ethiopian Ministry of health should be the one catalyzing this pediatrics and adolescent policy and guideline agenda. Stakeholders suggested that they need to device a special focus to effectively the pediatric and adolescent agenda. In addition to the low pediatrics and adolescent HIV care service coverage, the quality of care at the facility level is compromised. Though government led mentorship have been started in some facilities, there is still gap in the coverage. Even though youth and adolescents are emphasized for HIV testing coverage, clear target is not set for them. The national level target of 90% works for all age groups including children and adolescents; at sub national level there are target set for HIV testing. However these may not have been mentioned in the policy and strategic documents.

The new HMIS has now age disaggregation for HIV testing and ART coverage ; for HIV testing report the age disaggregation is < 1 yr, 1-4 yrs , 5-9 yrs, 10-14 yrs, 15-19 yrs, 20-24 yrs and for ART coverage the age disaggregation is < 1 yr, 1-4 yrs, 5-14 yrs ,and those > 15 years are included along with adults.

The issue of Orphan testing has been a complex issue for the ministry as well since from the legal point of view it is the ministry of women and children affair that is mandated to take responsibility for orphans. There is clear direction / guidance on the SPM that there has to be a collaborative activity between several stakeholders to deal with Orphan testing issues but has not been achieved as it should be.

The national nutrition guideline has been included within the non-communicable disease guidelines and some of the issues of pediatrics HIV and nutritional support is updated. The policy guideline and Training need assessment are operational studies and we don't need to mention about an Ethical clearance. Stake holders agreed that there is now a prepared psychosocial training material, it still lack visual modality of training.

Assent /consent issue for HIV testing has been found to have some gaps like clashing with the legal codes as well as assent has never been mentioned in the policies or guidelines hence need to be seen critically and inclusion /modification has to be made. Community testing for adolescents: though the principle is there, has not been well worked on and operationalized. Stakeholders have requested that they want to see and compare this assessment with other African country assessments

Conclusion

This rapid policy assessment used the Walt and Gilson policy analysis model i.e. determining existence of current pediatric and adolescent HIV policies; process of development of these policies and guidelines; comprehensiveness of the guidelines and implementation of policy and guideline by primary healthcare workers to assess the strengths and gaps in pediatric and adolescent HIV policies and guidelines in Ethiopia.

The gaps identified in the Key informant interview align well with the desk review reports done as follows. Despite the policy guidance for the e-MTCT all stake holders agreed that there is huge gap of implementation towards capturing the targeted mothers and more so the targeted HIV exposed infants for testing and linkage to follow-up and /or HIV care. The current initiative /work which is being done by the government involving HEW and HDAs is encouraging towards improving the rollout of mother –baby pairs in to the PMTCT program, and this has not been well mentioned in the policy and guidelines presented for desk review.

The issue of capacity building of health care providers has been cited as the big gap in both document review and key informant interviews which needs to be tackled systematically by the government. The policy and strategy documents need to set clear targets for adolescents for tailored approaches in HTC, care and treatment for adolescents as has been one of the gap identified in the desk review and mentioned by the key stakeholders. Although adolescents are recognized as a special group in the HTS guidelines, the policy does not provide strategies for identification of adolescents at health facility and community level. The policy mentions youth friendly services but fall short of describing the standard package of care to be delivered at the youth clinic. Yet strategies for targeted, age-appropriate routine HIV testing to youth presenting to outpatient clinics in epidemic settings is essential. The lack of adolescent friendly services have been mentioned as significant gaps both in the desk reviews and during interviews with the stake holders , hence there is a need to prepare operational guideline as to how to make this strategy a reality to address more adolescents . Defining adolescent HIV care package is another significant shared strategy which needs to be done so that the country can develop proper guidance towards tackling HIV in this age group; and this has been told by the key informants and as captured from the desk reviews. The other important area to be addressed is the issues of HIV testing approach in the schools and collages which are not as such organized and reported. These HIV testing activities are not also integrated with health care system hence even if some young people are tested positive they are not linked to HIV care, and system need to be established for these group of young people .

Regarding data keeping , monitoring and evaluation the age specific data are important which are not present in the current HMIS system that the country is using hence this has been observed in the desk review and spelt out significantly by the facility as well as by the stakeholders key informants. All national stakeholders commented that there is good opportunity now as the pediatrics taskforce is being revitalized and the identified gaps can be raised and actions can be taken.

Recommendations

Based on the findings of policy and guideline assessment, specific and cross-cutting recommendations are provided which are believed to improve pediatric and adolescent HIV care in Ethiopia.

To improve PMTCT

- A new policy should systematically device how to address mothers who are not using ANC, delivery and PNC services and mothers in the underserved population which also constitutes nomadic /mobile population.
- The government should strengthen the existing efforts of improving the health seeking behavior / facility delivery of the community using different interventions in the context of MNCH services. However when we think of increasing coverage of facility delivery for HIV positive mothers we also need to see critically the quality and safety of facility delivery
- Male involvement in general and father's involvement in particular should be advocated and further strengthened
- Addition of nucleic acid testing (NAT) at birth to existing early infant diagnosis (EID) testing approaches can be considered to identify HIV infection in HIV-exposed infants as per the 2015 revised WHO guideline.

To Improve pediatrics HIV testing, treatment and care

- Testing for Orphans and vulnerable kids should be addressed clearly in the policies and guidelines and the concerned stakeholders need to device collaborative /synergistic guides which will be easy and operational at the facility levels
- The targeted testing of under-five years of age is still below 10% and missing out on a vast majority of the child population hence revising the targeted testing cut-off to under 15 years would improve the low enrollment rate compared to the estimates.
- Revised regional targets for pediatric and adolescent HIV testing need to be incorporated in to strategic documents
- A standard of child friendly care need to be set along its operability with sustainable government led logistics and budget supply
- The issue of child friendly care need to be contextualized among health centers and hospitals as hospitals may have the capacity and space to create such service , however health centers may not have the space , hence each health center can make it operational based on their infrastructure capacity
- The rights of children should be respected whenever parents / care givers refute and there should be well written legal guidance on this

To Improve adolescent HIV testing, treatment and care

- Adolescent care package: Developing a comprehensive adolescent care package including adolescent friendly HCT, a tailored approach for adolescents' HIV care and treatment, and the psychosocial support, along with a training manual and standalone defined care package document needs to be done to ensure improvement in enrollment and adherence to HIV chronic care.

- It will be good to allocate in country budget to establish adolescent HIV care and should be well streamed within the government system to keep its sustainability.
- Revised national and regional targets for adolescent HIV testing need to be incorporated in to strategic documents
- Retention to care : the FMOH should finalize and operationalize its effort towards separate strategy to improve retention to care for adolescent patients
- The other countries' experience of setting up transition clinics from childhood to adolescence and from adolescence to adulthood need to be focused and experience sharing should be thought.
- Age disaggregation: one of the major challenges with data management and reporting in regard to adolescent HIV programming in Ethiopia is the age disaggregation in the health management information system. Having a standardized age disaggregation of 10-19 years is recommended in order to get a clear and complete picture of adolescent HIV in the country, to understand and address implementation challenges associated with service provision, to be able to effectively track and report on progress and achievements.
- Adolescent age group specific guidance for ART initiation either through revision or supplementation of the existing guideline should be done as per the latest evidence and WHO recommendations.
- *Age of consent*/assent*:* Legal provisions under the current law stipulate that service providers cannot provide testing without consent from the parent or guardian for adolescents below the age of 18 which actually contradicts with the guideline provision, hence addressing the legality gap of the age of consent would pave the way for getting more adolescents into HCT and enrolling into treatment and care. Hence these issues need to be clarified and put in the HIV guidelines and as well in the legal documents.

Cross cutting recommendations

- The WHO guideline states that national programs should develop policies for third line ART regimen which will include new drugs with minimal risk of cross resistance to previously used regimens. The Ministry of health has already started quantitative study to ascertain adult patients who failed on second line treatment so that the country can strategize to avail third line ART drugs as WHO suggested
- Continuous quality improvement in the areas of capacity building of health care providers should be done through an organized and practical way to improve the quality and coverage of care for children and women. i.e. government led mentorship programs
- Pediatricians should make active involvement in the care of pediatrics and adolescents living with HIV
- Dissemination of guidelines should be done so that new staffs will not be challenged by lacking these documents
- Preparation of pocket size guidelines will also helpful to the health care providers
- Continuous updates should be done regularly/periodically at facility level to refresh the providers on new evidences
- Improving commitment of all level health care providers along with maximal retention of trained staffs should be done at facility level
- Adequate number of staffs should be assigned in the HIV clinics to ensure the delivery of continuum of care
- Pre-service trainings should be strengthened focusing on PMTCT, pediatrics and adolescent HIV care
- Awareness creation and continuous advocacy among different level of leaderships is vital to improve pediatrics and adolescent HIV care
- Psychosocial support: there is a strong consensus among all stakeholders that the psychosocial support

is not given the due emphasis it deserves both within the policy documents and at the implementation levels. Providing a clear and sound policy guidance, allocating a sustainable funding source for implementation, rolling that out along with a skills based training for the health workers would be of paramount importance to address the current gaps in adolescent HIV response. Logistical and transport issues for the adolescents that have to travel to the youth centers established with in the hospital premises need a serious revisit in terms of its design and feasibility for consistently engaging them throughout the care. Such a revisit should also consider a clear coordination and linkage with the treatment and care component of the program.

- *Demand creation:* a continuous and aggressive demand creation work is needed to reach those that are currently not identified and enrolled into the treatment and care services.
- Continuous and stringent performance monitoring on quality improvement of pediatrics and adolescent services is vital and it will be good if health facilities have separate pediatric and adolescent care records.
- Integration of pediatrics and adolescent programs with health extension programs including pre-service training among health care providers and health extension workers
- Review meetings: currently the government conducts joint review meetings for both the health and non-health responses together. Because of time constraints and the number of issues to be covered during these meetings, critical issues in the health response are usually left uncovered resulting in delays in guidance for various implementation challenges and pending decisions for addressing bottlenecks. Having a separate review meeting for the health response would create enough room for an in-depth discussion of critical issues to make timely decisions, to take timely corrective measures, and to provide appropriate guidance for the health workers.
- Using of family matrix to increase testing should be advocated in order to capture all children and adolescents from index family
- Continuous and uninterrupted drug, test kits and related equipment supply should be practiced all the time in all facilities
- New international recommendations on Pediatric and adolescent anti-retroviral treatment based on strong evidences need to be adopted fast enough as they contribute to improved survival and treatment outcomes.

ANNEXES

ANNEX 1: Desk review templates

Pediatrics HIV Care Policy Analysis desk review template

Country:					
Title of the Policy:	**Year:**	**Person completing the template:**			
Policy issue for review	**Response (Yes, No, NA)**	**Policy provisions**	**Policy gaps**	**Recommendations to address the gaps**	**Notes**
PMTCT a. Does the policy express renewed commitment and leadership to achieving full coverage of PMTCT services? b. Have clear targets been set? c. Are there systems for technical guidance at the national and subnational level to provide technical guidance to improve coverage and quality of care to optimize HIV prevention, care and treatment of women and children d. Does the policy give provision for the integration of HIV prevention, care and treatment services with maternal, newborn and child health and reproductive health programs. e. Does the policy give provision for equitable access for all women particularly those in hard-to-reach places or situations? f. Does the policy promote and support health systems interventions to improve the delivery of HIV prevention, care and treatment services for women and children. g. Does the policy track programs performance and impact on MTCT rates on maternal and child health outcomes. h. Does policy promote regional and in country partnerships for providing HIV prevention, care and treatment for women, infants and young children, and advocate					
i. Does the policy make provisions for identification of perinatal exposure?					

j. Does the policy make provisions for an optout strategy for testing of pregnant women?					
k. Does the policy make provisions for repeat HIV test for pregnant women in the third trimester?					
l. Does the policy provide for HIV testing during labour for pregnant women with unknown HIV status?					
m. Does the policy make provisions for diagnosis of HIV infection in infants and children?					
n. Does the policy provide provisions for use of assays to diagnose HIV in infants younger than 18 months with perinatal HIV exposure?					
o. Does the policy make provisions for timing of diagnostic testing in infants with perinatal HIV exposure?					
HIV COUNSELLING and TESTING i. Has the country HTS adopted the WHO's essential 5Cs: Confidentiality, Counseling, Correct results and Connection (linkage to prevention, care & treatment) i.e. test for triage? ii. Has the country adopted WHO recommended testing strategy? iii. Is there a nationally validated testing algorithm? iv. Does the country have provision for lay providers to carry out testing and counseling for adolescents and children? v. Has the country adopted the ''test for triage'' approach? Has the country HTS adopted the WHO's essential 5Cs : Confidentiality, Counseling, Correct results and Connection (linkage to prevention, care and treatment) i.e. test for triage? vi. Does the policy make provision for facility – based and community based HIV testing services for children and adolescents? vii. What innovative or creative approaches have been adopted to increase coverage of HIV testing for children and adolescents?					

viii.	Do the national guidelines emphasis the important of HIV testing that is respectful, nondiscriminatory and ethical in manner?					
ix.	Does the HIV policy or guideline make specific provision for special groups such as adolescents?					
x.	Does the HIV testing policy recognize the importance of disclosure to family members and sexual partners? Are there specific strategies that have been adopted to encourage disclosure to adolescent couples?					
xi.	Does the national HTC policy recognize the overarching goal is early identification of persons with HIV with early successful linkage to prevention, care and treatment					
xii.	services and for those who test negative link to prevention services? Are there specific guidelines / strategies for early identification of children and adolescents?					
xiii.	Do the Adolescent and Pediatric HIV guidelines outline specific service delivery models that target children and adolescents living with HIV?					
xiv.	Have the policy documents adopted to achieve universal and equitable access to HIV testing and counseling for children and adolescents					
xv.	Does the HIV testing and counseling policy build strong linkages to prevention, care and treatment services after testing					
xvi.	Does the country at national or sub national HIV strategic plans set targets for HTC for children and adolescents?					
xvii.	Are there monitoring systems to measure uptake and coverage of HIV testing?					

xviii. Does the adolescent HIV policy give emphasis to adolescent posttest counseling? xix. Are there concrete provisions and practical measures outlined for appropriate and successful linkage to prevention, treatment and care services? xx. Does the policy give provision for adolescent privacy and confidentiality? Is there a defined age for consent for HTC? xxi. Do the national adolescent HIV guidelines outline measures to retain adolescents testing positive for HIV, who do not yet require treatment? xxii. Do the Adolescent HTC guidelines stipulate adolescents should be counseled about potential benefits and risks of disclosure of their HIV status, empowered to determine when, how and to whom to disclose. xxiii. Does the guideline make provision for community based testing and counselling?					
HIV CARE and TREATMENT a) Are national policies and guidelines cognizant of the international 90-90-90 targets? b) Does the policy make provisions on when to initiate treatment in ART naïve children? c) Does the policy make provisions for regimens for in initial therapy in ART naïve children? d) Does the policy make provisions for regimens not recommended for ART naïve children? e) Does the policy provide clear strategies for ensuring retention of children to care? f) Does the policy make clear policy provisions on targets for ensuring for retention of children in care?					

g) Does the policy make clear policy provisions on linking children to other care and support services?					
h) Does the Policy provide clear strategies for linking children to care and support services?					
i) Does the policy provide clear targets for linking children to care and support services?					
j) Other paediatric HIV care policy issues- State the issues					
k) Does the policy give clear guidelines on monitoring response to treatment and diagnosis of treatment failure?					
l) Are there guidelines on monitoring and substitutions for ARV drug toxicities?					
m) Are there guidelines on key ARV drug interactions?					
n) Are there guidelines on Third-line ART?					
o) Policy on nutritional support					

Adolescent HIV Care Policy Analysis desk review template

Country:	**Type of Policy document:**				
Title of the Policy:	**Year:**	**Person completing the template:**			
Policy issue for review	**Response (Yes, No, NA)**	**Policy provisions**	**Policy gaps**	**Recommendations to address the gaps**	**Notes**
GENERAL Does the policy document prioritise adolescent HIV? **HIV TESTINGand COUNSELLING**					
a. Does the policy document define age of consent for HTC?					
b. If yes, does the policy defines age for consent for HTC for adolescent, state the age?					

c.	Does the policy have exceptions for adolescents HTC below defined age of consent?					
d.	If yes, provide the exceptions, under what clauses are the adolescents allowed to have a test					
e.	Does the policy provide clear provisions for privacy in provision of HTC services?					
f.	Does the policy provide clear provisions for confidentiality in provision of HTC services to adolescents?					
g.	Does the policy provide clear provision for adolescent friendly HTC services- such as flexible opening hours, adolescent service provider etc?					
h.	Policy has clear provisions for linking adolescents testing HIV positive to care					
ADOLECENT HIV CARE and TREATMENT						
i.	What are the current ART guidelines for adolescents living with HIV?					
j.	Does the policy document provide clear strategies for linking adolescents to HIV treatment?					
k.	Does the policy provide for clear targets on linking adolescents to HIV treatment?					
l.	Does the policy provide for clear provisions for adolescent retention to care					
m.	Does the policy provide clear strategies for ensuring adolescent retention to care?					
n.	Does the policy make clear policy provisions on targets for ensuring for retention of adolescents in care?					
o.	Does the policy make clear policy provisions on linking adolescents to other care and support services?					
p.	Does the Policy provide clear strategies for linking adolescents to care and support services?					
q.	Other Policy adolescent HIV care issues- State the issues					

ANNEX 2 – Key Informant Interview Guide

Key Informant Interview Guide for National Level Policy Makers

Thematic are	Key Questions	Probes
Existence of the policy	a. Please tell me about existing national HIV and AIDS strategic policies, guidelines and documents and whether these documents prioritize Paediatric and adolescent HIV? b. Does the country have stand-alone Paediatric and adolescent HIV and AIDS policies and documents? c. What are other Paediatric and adolescent HIV and AIDS relevant documents in the country? d. Do you think the country has all the necessary policy documents/guidelines to address Paediatric and adolescent HIV policy issues?	- Probe and get a listing of general HIV and AIDS documents in the country including strategic plans, policies, guidelines - Probe and get specific HIV and AIDS documents such as HTC guidelines and policy, HIV prevention policies, ART policies, PMTCT/EMTCT policy documents, HIV treatment and care guidelines - Probe for specific Paediatric and adolescent HIV documents for example EMTCT policy documents, Paediatric ART documents, Adolescent ART documents, early infant diagnosis guidelines - Probe for other policies such as child health policies, adolescent policies and see whether these include Paediatric and adolescent HIV issues - Using the policies reported; whether the respondent feels the country has adequate policies/guidelines for Paediatric and adolescent HIV response - Probe what the respondents thinks may be additional guidelines/policies etc that are required
Policy development process	e. How were the stakeholders involved at the various stages in the development of Paediatric and adolescent focused HIV and AIDS policies and guidelines? f. What do you think are the gaps in the engagement / involvement process and how do you think this can be addressed in future?	- Probe on adequacy of the involvement at the various stages including problem identification and prioritization, contextualization of the issues - Probe on the involvement of critical groups such as involvement of adolescents in the development of adolescent HIV policies, involvement of professional associations like Paediatric associations

Thematic are	Key Questions	Probes
	g. What informed the development of the various policies? - were these adopted from international documents/Policies h. What were the gaps in the process of identification of the policy problem?, what about in the contextualization of the policies?	- - Probe on process of policy problem identification - If policy was adopted, probe on the process of contextualizing the policy to the country, were there any gaps and challenges
Policy content and Gaps	i. Do the general HIV and AIDS policies discussed earlier priorities Paediatric and adolescent HIV? if yes what are the issues prioritized (both for Paediatric and for adolescent)? j. Are there areas where you think the HIV and AIDS general policies/ strategic documents could be strengthened to ensure better prioritization of Paediatric and adolescent HIV? k. For the specific Paediatric and adolescent HIV and AIDS documents reported, what do you think are the key strengths, opportunities and weaknesses? l. How do you think this could be addressed?	- Using the mentioned general documents probe on respondents' opinions on whether they priorities Paediatric and adolescent HIV, probe on the respondents' response to get the reasons for their response (Will be good if possible to read the documents in advance) - Probe on what respondents think should be done to the general documents to ensure they prioritize Paediatric and adolescent HIV - Some possible areas for probe include: consent to HIV testing, age criteria for self-consent, and exceptions for HIV testing below the age of consent for the general population or a stipulated subpopulation. Other themes will include initiation to ART for those testing HIV positive, targets, retention in care and treatment, approaches to care and treatment. See also a separate WHO guidelines on some standards - Probe whether for adolescents and children testing HIV positive there are policy provisions for : linkage, initiation to treatment and retention, and clear strategies and targets for each

Thematic are	Key Questions	Probes
Policy implementation	m. Are the policy provisions on Paediatric and adolescent HIV being implemented? n. What are the barriers to the implementation of the various policy provisions? o. How can the barriers be addressed?	- Use information on policy provisions to probe whether the policies are being implemented at the various levels - Probe for evidence of the implementation of the policy provisions - Probe for the challenges/ barriers to the implementation including: Lack of knowledge on the policy provisions among implementers, lack of availability of the policy documents at the implementation points eg health facilities etc - Probe on ways of addressing the various barriers to policy implementation identified
Recommendations for addressing identified gaps and concluding remarks	p. As we close, what would be your general recommendations for addressing policy related gaps on pediatric and adolescent HIV response in this Country? q. Are there any other pediatric and adolescent HIV and AIDS issues that you may wish to share with me?	

Key Informant Interview guide for Health Workers for Policy gap analysis

Name of the facility _____ facility code _____

Position of respondent _____Participant ID _____

Service year_____

Thematic Area	Key Questions	Probes
I-Knowledge of policy provisions for Paediatric and adolescent HIV care and treatment	1-Please tell me about national guide promoting Paediatric and adolescent HIV care in this county? 2-What are some of the provisions in these documents? 3 Are these documents accessible to the health workers? 4-If no; Do you think this could be improved?	-Probe to get a listing of all the Paediatric and adolescent HIV care policy documents mentioned - Using the policy/guideline documents mentioned probe to see whether the health workers understand the policy provisions - Probe to see whether the reported documents have been disseminated/made available
II-Best practices in policy /guideline implementation	5 what are the best practice on PMTCT, pediatrics and adolescent HIV care in your facility?	Anything particular your HC/ Hospital has done on this area
III-Opinions on policy gaps for pediatric and adolescent HIV care and treatment	6-What would you say are the guideline gaps on **Paediatric** HIV care? 7-How has this affected HIV care to children in this facility? 8- What would you say or give examples of guideline gaps for **adolescent** HIV care? 9-How has this affected HIV care by adolescents?	- Use the various standard guideline provisions for **Paediatric** HIV care to make probes on the gaps under each - Use the various standard **adolescent** HIV care policy provisions to probe for gaps under each - Probe on how each of the identified gap impacts HIV care to children and adolescents

IV -Availability of policies/ guidelines on Paediatric and adolescent HIV at facility level	10- Are there some policy/guidelines/tools that are not available at this facility level? 11- if yes to Q 10 which ones? 12- How has that affected provision of services to children and adolescents? 13- What would be your suggestions for improving this situation?	- Using knowledge on the various national level Paediatric and adolescent HIV policies and guidelines, probe on their availability at facility level - Probe on whether the facilities have the most up-to-date guidelines - Probe on unavailability of the guidelines have impacted service delivery
V -PMTCT Pediatrics , adolescent HIV care guideline practice	14- How is the pediatrics and adolescent HIV **testing** services in your facility? 15- How is the **linkage to ART care** ? 16-How is the **ART care** implemented? 17-What are some guideline's provisions that have been implemented **successfully and why**? 18-What **challenges (gaps) do you face** in implementing those guideline provisions 19-What are your suggestions for addressing those practice barriers?	Probe on the practices of HIV testing , ART linkage , ART care and ask on the practice in the facility whether it has been based on the guidelines or not
VI Recommendations on policy gaps and practice	20-As we conclude what would be your advice for ensuring implementation of : a. Paediatric HIV care guideline provisions at facility level? b. Adolescent HIV care guideline provisions? c. what about PMTCT(Option B+)	Probe what will be the health workers recommendation to improve the implementation of available guidelines for PMTCT care , Pediatrics and adolescent HIV care

ANNEX 3: Information sheet and Consent forms

Rapid Assessment of Policy Gaps and Training Needs and Mentorship Approaches for Children and Adolescent HIV Services in Ethiopia

In Collaboration with The African Network for the Care of Children Affected by HIV/AIDS Funded by The Global Fund to Fight AIDS, Tuberculosis and Malaria

Information sheet

This study is designed by the African Network for the Care of Children Affected by HIV/AIDS (ANECCA) to do the policy gap analysis and Rapid training need assessment on the areas of pediatrics and adolescent HIV care in Ethiopia. The data generated will form part of the information needed to design regional training and mentorship materials and will assist identify strengths and gaps in national policies, as well as identify best practices for purpose of developing national and regional plans to improve coverage and quality of services for children and adolescents living with HIV in Ethiopia.

The study will be conducted at selected health centers and hospitals of the all regions and the two city administrations of Ethiopia. As a result, you are identified among the key personnel who can give us relevant information to the study. Participation in this study is completely based on voluntary bases. There is no risk associated with participating or not participating in this study to you or others who are associated with you. You have full right not to answer the whole or any part of the questions or you can withdraw from the interview at any time. But the information that you will give us will be very essential input for identifying challenges related with care of children and adolescents affected by HIV/AIDS. There is no wrong or write answer in our discussion. Therefore, please give be honest in giving us the information that you know. All the information you will give us will be maintained confidential and will be used for the study purpose. You will not be identified as an individual in the study as the finding will be presented as an aggregate with other interviews.

The interview may last from 30 to 45 minutes which will be conducted using face to face interview. The interview will be tape recorded if you fully agree and notes will be taken by the interviewer during the interview process.

If you have any problem regarding to the study you can also contact Dr.Solomie Deribessa (Phone Number: 0911407063)

Policy gap analysis , Rapid Assessment of Training Needs for Children and Adolescent HIV Services and Mentorship Approaches for Children and Adolescent HIV Services in Ethiopia

Informed Consent Form

I, ……., a staff of ……. have read and understood the information contained in the accompanying information sheet of the above study. I have been allowed to ask questions regarding the study, and I am satisfied all with the answers provided.

I hereby willingly consent to participate in this study.

Signed: _____ _____

Name and signature of the participant **Name and signature of consenter**

_____

Name and signature of witness

Consent to have interview audio taped

The need to have my interview audio taped has been explained to me. I, ……., a staff of ……. hereby willingly give the interviewers the permission/refuse the interviewers the permission (delete as appropriate) to record the interview using an audio recorder.

Signed: _____ _____

Name and signature of the participant **Name and signature of consenter**

_____

Name and signature of witness

ANNEX -4: National action Plan

Action Plan drawn for Ethiopia to improve Pediatrics and adolescent HIV Care as presented by the representatives from FMOH on the regional dialog / meeting Nov 30, 2016 Kampala Uganda

List of the problems /gap identified	Action plan	Responsible body	Time Frame
1. No clear strategy to operationalize child and adolescent friendly care	Develop national strategy to operationalization child friendly care and adolescent friendly care	**FMOH**	TBD
2. Operational and logistic challenges in establishing adolescent friendly care	Identify and address the logistics and supply problems in relation to the establishment of adolescent friendly care including allocation of government led budget	**FMOH;PFSA**	TBD
3. No clearly defined minimum care package for adolescent	Define adolescent care package	**FMOH;FHAPCO**	TBD
4. No specific strategy for orphan consent to testing and linkage to HIV care	Revise the OVC care and support guideline including consent for testing and linkage to HIV care	**FMOH; Women's and Children Affairs Ministry**	TBD
5. No clear strategy for pediatric and adolescent retention to HIV care	Revise the national strategic frame work for adherence and retention to care to refocus pediatrics and adolescents age groups	**FMOH**	TBD
6. No age disaggregated data for adolescent age group	Revise the national HMIS to disaggregate the child and adolescent age groups and indicators (0-4;5-9;10-14;15-19;20-24;24+)	**FMOH esp. Policy Plan Directorate;**	TBD
	Revise the national MRIS to disaggregate the adolescents age groups	**FHAPCO**	
7. No adolescent specific HTC or Care and Treatment target	Include adolescent specific HTC and HIV care targets	**FMOH(HIV team, and Policy plan directorate)**	TBD
8. Contradiction between age of consent for testing adolescents in the HIV guideline and Ethiopian law and regulation	Advocate to legislation body for harmonization of adolescent specific age for consent to testing and HIV care linkage	**FMOH; Women, Children Affair's ;Parliament**	TBD
9. ART guidelines do not mention of third line ART regimen	Finalize the assessment for third line ART regimen demand and revise the guideline accordingly	**FMOH;EPHI; PFSA; Partners**	TBD

List of the problems /gap identified	Action plan	Responsible body	Time Frame
10. PMTCT strategy gap to access mothers delivering at home and living in underserved areas	Strengthen the strategy of linking home delivering mothers to PMTCT service through the health post outreach program	**FMOH(Health extension program)**	TBD
11. Psychosocial care (adherence and disclosure) is not adequately addressed	Revise the national care and support guideline to include all aspects of psychosocial support to children and adolescents	**FHAPCO;FMOH**	TBD
12. Gap in collaboration between ministries of Health, Education, and Women and	Strengthen the collaboration across relevant sectors in terms of addressing the issues of child and adolescent HIV care	**FMOH; FHAPO; FMOE; Relevant Ministries; higher education forum**	TBD
13. No system in place to reach OVCs and street children for testing and HIV care	Advocate and develop joint strategic framework with social and Women and Children as well as education sectors	**FMOH; FHAPCO; RELEVANT MINISTRIES; partners**	TBD
14. Gaps in health worker skills and attitude, lack of confidence to manage pediatrics /adolescents with HIV; attrition of trained staffs	Provide training to Health care providers based on the revised curriculum on care, treatment and psychosocial support to children and adolescents	**FMOH**	TBD

*MRIS : Multi sectoral response Information system

References

1. Ethiopian Health and Nutrition Research Institute, Federal Ministry of health, HIV Related Estimates and Projections for Ethiopia, 2012, p- 6

2. UNAIDS, “15 by 15” target achieved, 2015

3. UNAIDS, World AIDS Day Report 2015

4. World Health Organization, Progress Report, Global Health Sector Response to HIV, Focus on Innovations in Africa 2000-2015.p-9

5. Global update on HIV Treatment, UNAIDS 2013. http://www.unaids.org/sites/default/files/media_asset/20130630_treatment_report_en_0.pdf

6. Idele P, Luo C. Epidemiology of HIV and AIDS among Adolescents: Current Status? Inequities, and Data Gaps. (J Acquired Immune Deficiency Syndrome 2014;66:S144–S153)

7. UNAIDS 90-90-90 An Ambitious Treatment Target to Help End the AIDS epidemic. Available at : http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

8. Ethiopian Health and Nutrition Research Institute, Federal Ministry of health, HIV Related Estimates and Projections for Ethiopia, 2012, p- 6

9. ANECCA, Regional Concept Note to the Global Fund for Tuberculosis, AIDS and Malaria, 2014.

10. Federal HIV/AIDS prevention and control office (FHAPCO) , HIV/AIDS strategic plan, 2015-2020 in an investment case approach, December 2014, p- 19

11. UNICEF (2013) and National HIV Strategic Plans of Burundi, Ethiopia, Malawi, Nigeria, South Sudan, Tanzania and Uganda – as cited in the ANECCA Regional Concept Note to the Global Fund for Tuberculosis, AIDS and Malaria)

12. Ibid, FHAPCO, HIV/AIDS strategic plan, page 18

13. UNAIDS, UNICEF, ALLIN End Adolescent AIDS, p-

14. World Health Organization HIV/AIDS progress in Ethiopia, March 2015, pp1-2

15. Federal Ministry of Healthy, National Adolescent and youth reproductive health strategy

16. WHO , African Observatory : Analytical summary service delivery , Ethiopia : available at : http://www.aho.afro.who.int/profiles_information/index.php/Ethiopia:Analytical_summary_-_Service_delivery, accessed 6/3/2016

17. Ibid FHAPCO, HIV /AIDS Strategic Plan, 2015-2020, page 19

18. Gill Walt G, Shiffman J et al. ‘Doing’ Health Policy Analysis: Methodological and Conceptual Reflections and Challenges. Health Policy Plan. (2008) 23 (5): 308-17 doi:10.1093/heapol/czn024

19. Federal Ministry of Health Ethiopia , National Guideline for comprehensive HIV prevention, care and treatment, 2014

20. Federal Ministry of Health Ethiopia , Health Sector Transformation Plan, 2015/16 - 2019/20

21. Federal HIV/AIDS Prevention and Control Office, HIV/AIDS Strategic Plan 2015-2020;, Addis Ababa, December 2014, page v-vi

22. FMOH, The national strategic plan (2013-2015) for Elimination of Mother to Child Transmission of HIV and Congenital syphilis (e-MTCT-HIVandCS), February 2013

List of Investigators and collaborators

Principal Investigator
Solomie Jebessa , MD, MPH, Pediatrician
Address: Addis Ababa Ethiopia
Tel : +251911407063,
Addis Ababa, Ethiopia
E mail: solomejebessa@gmail.com

Co-Investigators

Dr Makeba Shiroya-Wandabwa MBChB, MMED, MPH
African Network for the Care of Children Affected by HIV/ AIDS (ANECCA)
c/o P O Box 14971, 00800, Nairobi Kenya
Tel: +254 722 727743
Email: mswandabwa@hotmail.com

Dr Denis Tindyebwa MBCHB; MMED (Paed)
Executive Director
African Network for the Care of Children Affected by HIV/ AIDS (ANECCA)
Plot 4 B Kololo Hill Drive
P.O.Box 7484
Kampala, Uganda

Dr Robert Iriso
African Network for the Care of Children Affected by HIV/ AIDS (ANECCA)
Plot 4 B Kololo Hill Drive
P.O.Box 7484
Kampala, Uganda

ANECCA Project Officer in Ethiopia
Dr Berhanu Gudeta
Addis Ababa, Ethiopia
Tel: +251929338544
E mail: gberhanu@hotmail.com, gberhanu@anecca.org

Chairperson, Ethical Oversight
Member of the Technical advisory committee (TAC)
Dr Frehiwot Nigatu , Disease Prevention Control Director-ate, Deputy Director
HIV case team leader, Federal Ministry of Health,
Addis Ababa, Ethiopia
Tel: +251911380933
E-mail: ermias20002000@gmail.com

African Network for Care of Children Affected
by HIV and AIDS [ANECCA]

Plot 1 Kololo Hill Drive,
P.O Box 7484, Kampala Uganda
Tel: +256 039 3516266
Website:www.anecca.org