RAPID ASSESSMENT OF POLICY GAPS FOR CHILDREN AND ADOLESCENT HIV SERVICES IN MALAWI

CONTENTS

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FIGURES

TABLES

LIST OF ACRONYMS

AIDS	:	Acquired Immuno-Deficiency Syndrome
ALHIV	:	Adolescent Living with HIV
ANECCA	:	African Network for the Care of Children Affected by HIV/AIDS
ART	:	Antiretroviral Therapy
COMREC	:	College of Medicine Research Ethics Committee
DHO	:	District Health Office
EGPAF	:	Elizabeth Glazer Paediatric AIDS Foundation
EHP	:	Essential Health Package
EID	:	Early Infant Diagnosis
FGD	:	Focus Group Discussion
FRS	:	Family Referral Slips
HIV	:	Human Immune-deficiency Virus
HTS	:	HIV Testing Services
KII	:	Key Informant Interviews
MOH	:	Ministry of Health
NAC	:	National AIDS Commission
NHA	:	National Health Accounts
NSP	:	National Strategic Plan for HIV and AIDS response
OVC	:	Orphans and Vulnerable Children
PEPFAR	:	Presidents Emergency Plan for AIDS Relief
PITC	:	Provider Initiated Testing and Counseling
PLHIV	:	People Living with HIV
PMTCT	:	Prevention of Mother To Child Transmission of HIV
SRHR	:	Sexual Reproductive Health and Rights
UNAIDS	:	United Nations Joint Programme on HIV and AIDS
WHO	:	World Health Organisation

ACKNOWLEDGEMENTS

This report is a culmination of worthwhile efforts from many players whose support was instrumental in making this assessment possible and hence deserve acknowledgement. First and foremost, the support rendered by the ANECCA through the Malawi project officer Mrs Treza Chunda and at regional office in Uganda, especially Dr Denis Tindyebwa and Dr Robert Iriso. The efforts, commitment and leadership of the lead consultant for this policy analysis Dr Makeba Shiroya Wandabwa is greatly appreciated. The Ministry of Health HIV and AIDS Department especially the guidance and willingness to support of the Director and Deputy Director of HIV and AIDS Department, Mrs Rose Nyirenda and Dr Thoko Kalua respectively.

The efforts of a wonderful team of data collectors, data transcribers and drivers who played the critical role in ensuring quality in the process of data collection and data transcription for analysis. Mr Bernie Zakeyo, for the great work of managing numerous and bulky transcripts to make sense of the qualitative data. The support of all five District Health Officers and their staff involved in this assessment (Rumphi, Dowa, Dedza, Mulanje and Nsanje) in providing institutional clearance sparing their time to grant us interviews is highly appreciated. A great measure of gratitude and appreciation also to the wonderful adolescent members of the teen clubs from various sampled health facilities who availed themselves and offered very important perspectives to this work that is targeting them.

EXECUTIVE SUMMARY

Background: Survival chances of people living with HIV have significantly improved world over and in Malawi, largely due to the use of potent anti-retroviral drugs with reduced toxicity. As of June 2015, 15.8 million people around the world were receiving Antiretroviral Therapy (ART), with sub-Saharan Africa contributing approximately 11 million. While there has been remarkable increase in coverage of ART for both adults and children, the coverage for children and adolescents has continued to lag behind that of adults. This is true for Malawi as well as evidenced by the phenomenon that as of September 2015, only half (50%) of the children under 15 years of age eligible for ART were on treatment relative to more than two thirds (68%) ART coverage for adults living with Human-immune Virus (HIV). The low coverage of ART among children and adolescents has been attributed to several factors, including limited knowledge and skills of health care workers to effectively initiate and support children on HIV treatment; lack of explicit policies and guidelines pertaining to children HIV response; inadequate care and support of children and ALHIV.

Considering the implications of low coverage of paediatric ART to the global target of ending Acquired Immune-deficiency Syndrome (AIDS) by 2030, and to the implementation of the 90-90-90 strategy for Malawi by 2020, improving the policy framework to support an effective and efficient HIV and AIDS response for paediatrics and adolescents, is urgently needed.

Methods: To provide data required for effective and efficient paediatrics and adolescents HIV programming, a rapid assessment of policy gaps was conducted to ensure evidence-based programming for children and ALHIV in Malawi. The study involved collecting various qualitative data among: policy makers and health managers; CLHIV (CLHIV); and health workers taking care of people living with HIV (LVHIC) in selected health care facilities offering comprehensive HIV services in five districts (one in each health zone). Data were collected using in-depth key informant interviews (KIIs), focus group discussions (FGDs), and a desk review guided by a policy analysis framework proposed by Walt and Gilson. Data were analysed using Nvivo software whilst descriptive statistics were used to describe quantitative data, where appropriate.

Findings: This study has revealed that except for the elimination of Mother To Child Transmission (eMTCT) of HIV and Youth Friendly Health Services (YFHS) strategies which are stand-alone pertaining to children and adolescents, other aspects of HIV and AIDS response for children and adolescents are embedded in generic policies. However, the HIV Testing Strategies have featured both children and adolescent age groups prominently in its content. Key informants at policy and service delivery level have diverse opinions on stand-alone policies for children and adolescents with some suggesting that it would be worthwhile to address the issues of adolescents and children along the HIV care cascade while others indicating that it may create verticalisation hence integration needs to be fostered.

In general, Malawi's policies and strategies are consistent with WHO recommendations along the cascade of care (i.e HTS guidelines, care and treatment guidelines, linkage to other support services). The majority of policy makers and health workers are largely aware of policy provisions including those relating to children and adolescents albeit most are more aware of treatment guidelines than

other generic policies. In some critical cases, significant policy-practice gaps exist in that while policies provide guidance on some aspects, there is limited policy adherence at implementation level. This is mostly the case with managing the HIV disclosure process for adolescents and children. In some cases, best practices exist in service provision for ALHIV but coverage of these promising interventions remains low. Specifically, there is evidence in Malawi that teen clubs promote treatment adherence, retention in care, positive living and overall psychosocial support but coverage remains low and in places where it is implemented there is heavy partner support rendering sustainability concerns. The Option B plus was lauded as critical in preventing mother to child transmission of HIV and strengthening care for HIV exposed children. Key informants also lauded the monitoring and evaluation system in other aspects of HIV and AIDS response, but observed that its lack of explicit age-disaggregation to capture the adolescent period and other groups of young children (especially after 2 years) limits understanding of the HIV epidemic and response in these important age groups thereby negatively affecting HIV programming for adolescents and children. The study has also confirmed that various health system challenges compromise HIV and AIDS response for children and adolescents. Some of the salient challenges include: inadequate health infrastructure, lack of confidence among health workers to handle children and ALHIV, inadequate finances and human resources to scale up some proven interventions for children and adolescents, lack of partner coordination at service delivery level, little emphasis on child and adolescent specific policies, limited data disaggregation and research on adolescents and children, unavailability of child and/or adolescent health expert at coordination level, lack of policy monitoring to ascertain that policy provisions pertaining to children and adolescents reflected in generic policies are adhered to or adequately supported.

Recommendations: In light of findings from this study,, the following recommendations are proposed:

- HIV and AIDS monitoring data to include age-disaggregation capturing adolescents response periodically
- Scale up provision of essential HIV services to ALHIV using the teen club platform
- Ministry of Health to provide guidance on establishment and comprehensive package of services delivered in teen clubs
- Comprehensive guidance on HIV disclosure process for adolescents and mentorship in undertaking HIV disclosure
- Clearer guidance is required on flexibility related to age of consent
- Institutionalise coordination entity for children and adolescent HIV and AIDS response
- Comprehensive guidance and establishment of inter-sectoral linkages to address needs of ALHIV in boarding schools
- External quality assurance is critical to quality improvement in HTS hence a robust EQA
- Advocacy for access to Sexual Reproductive Health Rights (SRHR) and HIV services in the school setting

Conclusion:

This study has implications for the role of policy makers, and health service providers at all levels in addressing the needs of children and ALHIV and general HIV and AIDS response. The current state, while promising in many aspects of HIV and AIDS response among children and adolescents, is suboptimal. A recent interest by Ministry of Health (MoH) and implementing partners to strengthen the children and adolescents support as evidenced by commissioning of children and adolescent specific studies using routine data, setting up of paediatric and adolescent working group, and establishing a children and adolescent implementation framework derived from generic strategies and policies, represent opportunities that need to be harnessed and sustained.

CHAPTER

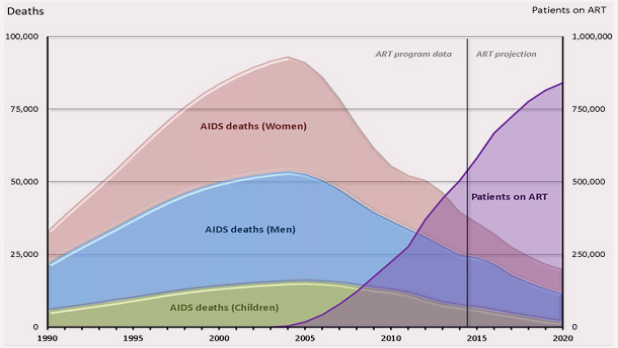
01

1. BACKGROUND

1.1 The HIV epidemic profile: global and Malawi status

Since its emergence about four decades ago, the HIV and AIDS epidemic has remained a significant global public health and social challenge. Sub-Sahara Africa has been the epicenter of HIV as it has infected millions and wreaking havoc to the social, economic and health care fabric of many countries. The UNAIDS estimates indicate that 36.7 million people were living with HIV globally at the end of 2015, of which 1.8 million were children under the age of 15. Of the estimated 5,700 new HIV infections in a day, 66% are in sub-Sahara Africa and 400 occurring among children below 15 years of age

Figure 1: Impact of ART on AIDS related deaths among children and adults in Malawi; with projections to 2020



At the beginning of the pandemic, HIV infection was an automatic death sentence. The discovery of potent anti-retroviral (ARV) drugs, coupled with improved expertise in the overall management and care of people living with HIV has led to a progressive improvement of the prognosis for HIV infection to the present situation where most people living with HIV can now live a relatively normal life. Malawi's HIV epidemiological profile reflects the significant effect of ARV drugs as part of the care and treatment programme revolution. Figure 1 below illustrates a decrease in AIDS related deaths as ART coverage increased following rolling out of the national ART programme from 2004 in Malawi

The use of potent ARV drugs is central to increased survival of PLHIV, and with recent evidence from the HPTN052 trial also conducted in Malawi, is crucial as Treatment as Prevention (TasP) and hence integral to epidemic control.

Indeed, the exponential progress in combating HIV within the last decade has been such that the global community now believes that it can end AIDS by 2030 – a technical expression that refers to suppressing HIV infection to the point that it is no longer a major public health problem. As a path to the goal of ending AIDS by 2030, the global community has identified a five-year window of opportunity to fast-track the HIV response and pursuing the 90:90:90 targets. These targets entail that 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 ART and 90% of all people receiving ART will attain viral suppression

Malawi is one of the first countries to adopt the 90:90:90 targets and explicitly reflecting them in the National Strategic Plan (NSP) for HIV and AIDS response (2015-2020). The success story of Malawi's HIV and AIDS response reflects the plausibility of achieving the targets. Within the decade: new HIV infections have declined from 68,000 per year in 2009 to 42,000 in 2014, more than 270,000 deaths have been averted due to improved access to lifelong Anti-retroviral Treatment programme; HIV prevalence has steadily declined from 12% in 2004 to around 10.6% in 2014 in the age group of 15 – 49 years with recent estimates suggesting national HIV prevalence of 9.1%

A recent progress report for the Global Plan to reduce new HIV infections among children and keeping their mothers alive indicates that in Malawi, mother to child transmission of HIV has reduced by 71% between 2009 and 2015 with slightly above 50,000 new HIV infections averted among children; and an ART coverage of 80% among pregnant and lactating women over the same period. In spite of the global and country level successes in HIV and AIDS response, certain challenges remain and some population groups are being left behind in the response. At present, treatment-eligible CLHIV in sub-Saharan Africa are only about half as likely to receive ART as HIV-positive adults
. Over the past few years, data from Malawi showed that it mirrored this regional picture of higher adult ART coverage relative to that of children. Evidently, by September 2015, estimated ART coverage was 50% (50,533 / 101,000) among children (<15 years) in need of treatment and 68% for adults. However, recent estimates following Spectrum upgrades indicate a slight difference in ART coverage at 64% and 62% for adults and children respectively. Nonetheless, it is recognised that HIV and AIDS response among children and adolescents is suboptimal owing to various health system challenges. Moreover, the increasing burden of HIV among young people and the disproportionate burden of HIV among adolescent girls and young women has been documented in Malawi. To illustrate, between the 2004 and 2010 Malawi Demographic and Health Surveys, HIV prevalence increased among adolescents aged 15–19, from 0.4% to 2.7% in boys, and from 3.7% to 4.2% in girls[5,]

The HIV response for children and adolescents in Malawi shows a mixed picture albeit the common age category of reference (below 15 years) in many indicators, as reflected in routine HIV data, excludes an important age of late adolescence (15-19years). The Malawi integrated HIV program report for the first quarter of 2016 (January to March) indicated that 38% of people tested were between 15-24 years, 16% were children below 15 years and less than 1% of rapid tests done were among infants.

Viral suppression rates for children and adolescents are low at 70% relative to 90% viral suppression rates for PLHIV who received viral load testing in first half of 2016. The above notwithstanding, age disaggregated data particularly capturing the adolescent period (10–19 years) is sparse and hardly covering many critical indicators. In particular, lack of routine information in programme reports on access to care and treatment services for ALHIV further compromises adolescent specific HIV programming in Malawi. Nonetheless, global evidence suggests that ALHIV are worse off with regard to treatment coverage and outcomes. Adolescents are the only age group in which AIDS-related deaths increased for the period 2001 to 2012, and in the period from 2005 to 2012, the annual number of AIDS related deaths among adolescents almost doubled.

Some children and adolescent specific service delivery initiatives in Malawi provide opportunities to effectively respond to the needs of children and ALHIV but coverage levels remain low. Specifically, there is evidence that teen clubs in Malawi promote treatment adherence, retention in care, appropriate linkage to other

support services and with potential to improve HIV treatment outcomes. However, only about 15% of Malawian health facilities are implementing teen clubs for ALHIV. In the broader health system context, various factors contribute to the limited access to HIV treatment, care and support and poor outcomes among children and adolescents in Malawi, and these include[2]:

- Limited early infant diagnosis (EID) services
- Insufficient number of service providers trained and practicing YFHS delivery
- Inadequate health system infrastructure and socio-cultural factors such as stigma
- Limited knowledge about PMTCT and ART for children
- Limited training on management of ALHIV

  Lack of confidence among different cadres of health care workers in managing ART among ALHIV

The strong community belief in traditional birth attendant system which encourages pregnant mothers to seek antenatal care, birth assistance and postnatal care outside the health system

1.2 Rationale for the study

In order to attain the 90:90:90 targets, there needs to be concerted efforts to address challenges towards adapting systems to deliver quality, effective health care and social support for children and adolescents along the HIV care cascade in the context of maternal and child health care frameworks. In this regard, global and country level policies and guidelines have a prominent role in providing strategic direction in various aspects of HIV and AIDS response, and in the case of the current study focus, among children and adolescents in Malawi.

A rapid policy assessment was therefore undertaken in order to 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 ALHIV. For purposes of this review, policies include any document that provide official government position on the thematic areas under study. These include policies, plans, guidelines, curriculla, legislation, and strategy documents among others.

The findings of this study will inform design and implementation of a regional project on "Improving coverage of quality services for Children and ALHIV" by the African Network for the Care of Children Affected by HIV/AIDS (ANECCA), a not-for-profit Pan African network of clinicians and social scientists, through a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The project will target 7 countries, ***Burundi, Ethiopia, Malawi, Nigeria, South Sudan, Tanzania and Uganda***, all in sub Saharan Africa and with low ART coverage for children and ALHIV compared to adults. The project aims to improve coverage of quality services for children and ALHIV by implementing interventions that remove policy bottlenecks, build capacity, and ensure access to appropriate information and services related to HIV testing, care and treatment for children and adolescents in the seven countries.

This report therefore provides key findings from a review of policies on HIV and AIDS response pertaining to children and adolescents in Malawi. It is part of a larger multi-country policy review targeting the seven countries in which ANECCA will implement the aforementioned project.

1.3 Study Objectives

- Objectives of this rapid policy review were:
- To identify all existing health sector and national HIV policies
- To review and assess existing health sector and national HIV policies, strategies and guidelines with a view to identify strengths and gaps for provision of quality services for children and ALHIV
- To document best practices and opportunities within National Policy Frameworks, Strategies and Guidelines for provision of quality services for children and ALHIV in the target countries
- 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.

1.4 The Malawi health system: a brief overview

To appreciate the context within which this policy review study was undertaken, this section provides an overview of the Malawi health system, specifically highlighting the service delivery context. The 2007 health workforce and facilities census shows that the MoH is the major provider of formal health services, contributing 55% of health facilities. Christian Health Association of Malawi (CHAM) – an umbrella organisation of health facilities owned by Christian churches operating on a not-for-profit basis contributes 14% of the health facilities. The private for profit sector operates 20% of the health facilities, NGOs provide 6% and the rest are run by statutory corporations which are autonomous public owned corporations

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The Health Sector Strategic Plan 2011-2016 aspires to ensure that all Malawians have access to the Essential Health Package (EHP) – a package of cost effective interventions targeting the commonest causes of morbidity and mortality in Malawi, including HIV for both adults and children. The EHP is delivered in a service delivery system which is organised in a pyramid structure (Figure 2) through which primary, secondary and tertiary levels of health care services are provided as outlined below:

- Primary level constitute basic health services offered at health centre and lower levels such as health post and community level through community outreach clinics and Village Health Committees (VHCs). Community and rural hospitals also fall under primary level albeit they have a wider scope of health service delivery (very minor operations can be done at this level) than a health centre
- Secondary level constitute health services offered at district hospital level, acting as a referral point for primary level care. Other CHAM hospitals are at this level of health care
- Tertiary level constitutes central hospitals which offer specialised services hence a referral point for secondary level care

Figure 2: Organisational structure of the Malawi Health System

It is noteworthy that Malawi actively decentralised its delivery of HIV services to the extent that health centres, which constitute the majority of health facilities, provide comprehensive services for HIV.

At the end of March, 2016, Malawi had 724 static ART sites and 653 sites with exposed child follow-up. For purposes of this review therefore, 653 facilities would be considered to provide comprehensive HIV services. Malawi faces a significant shortage of human resources. Consequently, task-shifting has been implemented as one of the strategies to reduce the negative effects of human resources for health. For example HIV Testing Services are predominantly provided by Health Surveillance Assistants and other lay cadres. More recently a new cadre dedicated to HIV Testing Services has been established and is termed HIV Diagnostic Assistants (HDAs). With significant task shifting, ART service provision can be initiated by medical assistants and nurse technicians in addition to professional cadres. With regard to availability of essential medicines and supplies, HIV commodities particularly ARVs have consistently been available and stock outs are hardly experienced, probably due to a robust parallel supply chain management system for HIV commodities.In Malawi, donors provide significant financing for general health and HIV. The most recent National Health Accounts (NHA) with HIV and AIDS sub-accounts covering financial years 2009/10 to 2011/12 and the 2012 National AIDS Spending Assessment (NASA) consistently shows that about two thirds of health and about three quarters of HIV expenditure is financed by development partners (see Figures 3 and 4 below)

Figure 3: Health financing sources for the Malawi health system

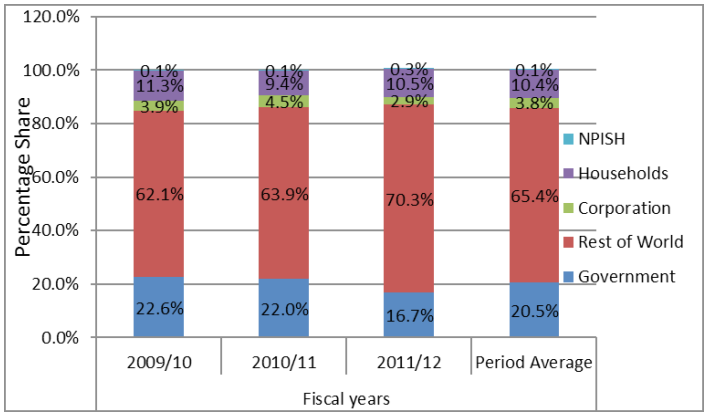
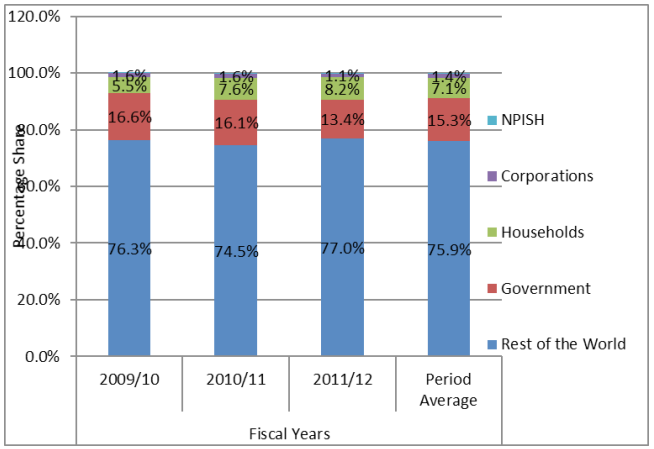


Figure 4: Sources of HIV financing



Note: Rest of the world refers to donors

CHAPTER

02

2. METHODOLOGY

2.1 Study design

The research was a descriptive study largely utilizing qualitative techniques and desk review of policies to appreciate the policy context for HIV and AIDS response among adolescents and children. Additionally, a framework guided policy analysis of existing policies, strategies and guidelines was utilized to guide both the desk review and interview with key informants.

2.2 Study setting and population

This was a nationwide study involving national, zonal, and district level stakeholders as participants. The study population for this policy review and assessment constituted two levels - national and health facility.

2.3 Sampling procedure

Health facility sampling

For purposes of obtaining a convenient national picture for the phenomenon under study, we randomly selected one district from each of the five zonal health support offices, as an initial step. The second stage involved selecting two health facilities, one secondary level health facility and another at primary level. In this regard, a district hospital in respective selected districts, was conveniently selected and the primary level facility providing comprehensive HIV services was randomly selected from a list of eligible facilities. We defined a facility providing comprehensive HIV services as any facility providing the following services: HIV Testing Services (HTS); Integrated Prevention of Mother to Child Transmission of HIV Services and ART (specifically an ART initiating site); and treatment of Sexually Transmitted Infections (STIs).

For steps involving random sampling, we arranged eligible units (districts at zonal level and primary facilities at district level) in ascending alphabetical order and attached numerical codes to each, and thereafter used computer generated random number(s) to choose a site for the study. Table 1 below shows the sampled facilities following the aforementioned procedure.

Table 1: Randomly selected health facilities for this study

Zonal Health Office	Sampled District	# facilities offering comprehensive HIV services (sampling frame)	Sampled Health Facility
Northern	Rumphi	**Secondary: 2** **Primary : 16**	Rumphi District Hospital Mhuju Rural Hospital
Central West	Dedza	**Secondary: 2** **Primary : 27**	Dedza District Hospital Mayani Health Centre
Central East	Dowa	**Secondary: 4** **Primary : 18**	Dowa District Hospital Mponela Rural Hospital
South West	Mulanje	**Secondary: 2** **Primary : 20**	Mulanje District Hospital Lujeri Health Centre
South East	Nsanje	**Secondary: 2** **Primary : 12**	Nsanje District Hospital Nyamithuthu Health Centre

Selecting individual participants

Selection of individual participants at health facility entailed the final step undertaken in the field. At this stage all health workers involved in provision of HIV services were requested to participate in the study at a health centre or rural hospital level whereas at a district hospital, up to 20 eligible health workers were randomly selected. Besides the selection process described above for health workers at facility level, this study used a snowballing approach to select study participants at national level. Using the snowballing approach entailed that; an initial list of stakeholders was selected and each of the interviewed participants from this list was requested to provide name(s) of relevant stakeholders that the study team could approach. An initial list of stakeholders included those listed in Box 1. A data saturation point determined the ultimate sample size for the study.

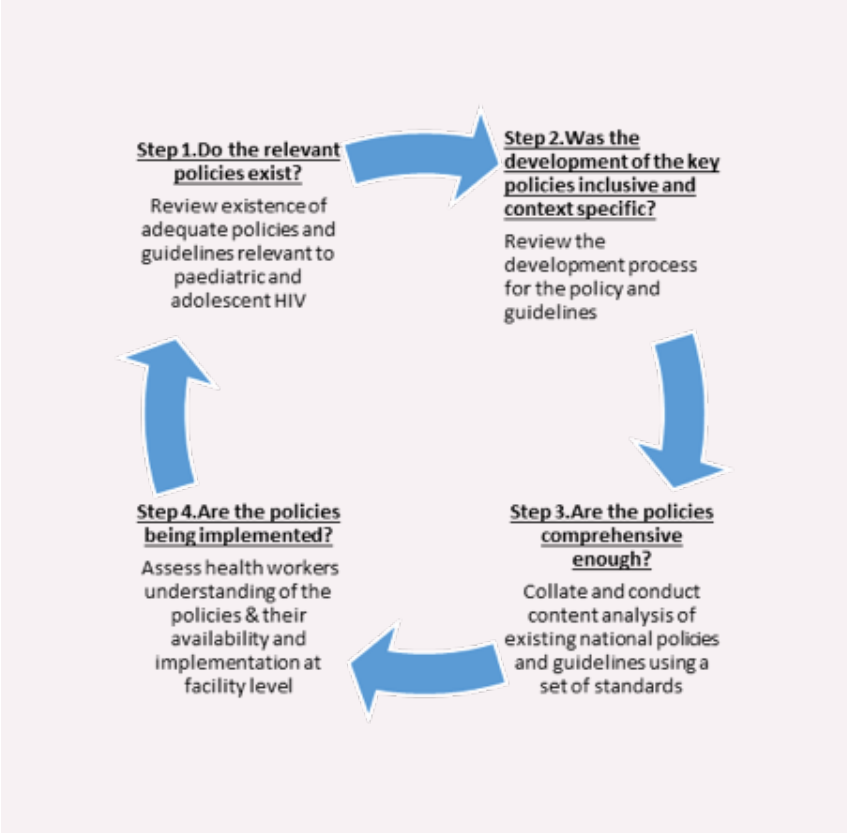
2.4 Data Collection Methods

Desk Review of policies - Content Analysis

The review and assessment of the existing national policies and guidelines related to paediatric and adolescent HIV care was based on the Health Policy Conceptual Model by Walt and Gilson and was adapted so that four critical policy issues are reviewed. These included ***existence*** *of Paediatric and adolescent HIV care policies*, ***process*** *of policy development including the role of various stakeholders (****actors****)*, **content** of the policy and guidelines including *comprehensiveness of the policy* and *the* ***implementation*** *of the policies.* (Figure 5)[15]

15. Walt, G and Gilson, L (1994). Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning 9 (4) 353-370

Figure 5: Policy analysis framework and key questions to answer in the Policy review



Desk review was conducted specifically to provide data for steps 1 and 3 of the policy analytical framework. A data abstraction form was used to enumerate all relevant existing policies, strategies and guidelines, as an initial step to the process. An abstraction form was used to undertake content analysis of the policies, strategies and guidelines identified in step 1. The policy content was reviewed against the WHO 2015 guideline documents as the gold standards which address, the prevention, care, and treatment of HIV for adolescents i.e. ***the consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*** and ***the Adolescents: guidance for testing and counseling for adolescents and care for ALHIV.*** The desk review also facilitated mapping of key country stakeholders.

Key Informant Interviews

The study utilized KIIs to collect data on aspects of policy development, policy implementation, HIV service delivery context for paediatric and adolescents; gaps in knowledge, and skills in delivery of HIV services to paediatrics and adolescents. Key informants provided information relating to all steps of the policy analysis framework.

Data from key informants was collected using face-to-face interviews aided by interview guides (see Annexes 3, 4, 8, and 9). Except for two key informants who did not provide consent for audio recording due to privacy concerns, the rest of the interviews were recorded using a digital voice recorder.

As described hitherto, national level participants were selected through an initial list and snowballing whereas those at district level using the sampled health facilities. Ultimately, organisations that provided key informants include: MoH(Reproductive and Child Health Departments; HIV and AIDS Department); UNFPA; WHO PEFPAR; Malawi Network of People Living with HIV (MANET+); National Association of Young People living with HIV; and NGOs working in Paediatric HIV (EGPAF; Baylor; CHAI); SAT Malawi; Lighthouse and National AIDS Commission. At health facility level, key informants included: health facility managers; clinicians and nurses working in HIV service delivery units.

Focus Group Discussions

FGD were conducted with ALHIV belonging to teen clubs, with intent of capturing the client perspectives on the care received. The FGDs were conducted with adolescents aged 13 to 18 years of age and only had one sex (either FGD with boys or girls). In all FGDs, participants ranged from 8 to 10.

A total of 10 FGDs were conducted (2 from each selected district and in each district one FGD was with adolescent girls and the other with adolescent boys). The FGDs were facilitated by a trained enumerator with an assistant who managed the recording. All FGDs were audio recorded.

2.5 Data Management and analysis

Qualitative data analysis followed three distinct but related steps. Firstly, recordings from the KIIs and FGDs were transcribed verbatim, where possible within 24 hours of data collection. The second step involved comparing the transcriptions of the audio recorded material and manual notes collected during the interview and gaps in the notes were filled. The output of this reconciliation process was a consolidated recording of the interview. The third step involved analyzing the consolidated transcripts aided by a qualitative data analysis software, NVivo.

The process of data analysis used the following steps: development of a coding frame constituting main and supporting themes emerging from transcripts guided by the interview guide; the coding frame was then used to undertake analysis of the transcripts allowing for flexibility to accommodate any additional themes emerging from transcripts. Particular attention was paid to highlighting emerging themes and issues that generated consensus. The major themes identified were often compared across two categories of respondents – national level and service delivery level key informants.

2.6 Quality Assurance

To promote the rigour and quality of the research, the team made efforts to ensure authenticity of the data and that methods of analysis were trustworthy. In this regard, various steps were undertaken as follows:

The national consultant was in constant communication with the lead consultant to ensure that implementation of the research protocol was in tandem with the regional protocol and to solicit support when required.

Data collectors with experience in both qualitative and quantitative research methods were recruited. Despite their experience, the data collectors underwent a three-days training that covered: the study's protocol, qualitative and quantitative research techniques, ethical issues in research, and interviewing techniques. The training allowed for standardization in data collection and afforded opportunity for participants to understand the research protocol hence collect relevant data during field interviews. In the course of training data collectors, practice sessions of interviewing peers were undertaken under observation of investigators. A pilot study was conducted at three health facilities in Lilongwe and provided an opportunity to review and modify data tools with feedback provided to lead consultants.

A team of supervisors comprising national consultants, ANECCA project officer, qualitative data analyst and one person with significant experience in research fieldwork undertook supervision during data collection to ascertain that the data collection process was consistent with the study protocol. Where appropriate, on-site support was provided correcting divergent practice with regard to data collection.

To ensure coding reliability utilizing the coding frame for qualitative analysis, the qualitative data analyst and primary investigators discussed the findings to reach consensus on the emerging themes.

2.7 Ethical Considerations

Ethical review

Ethical clearance was obtained from the College of Medicine Research Ethics Committee (COMREC) under approval number P.05/16/1953 and the study was conducted in accordance with all the conditions of approval by the IRB.

Informed consent

Written informed consent was obtained from each study participant prior to the interview. Each participant was requested to voluntarily consent to participate in the study and append his/her signature to the consent form. Participants were also requested to consent to audio-record an interview.

Institutional clearance

The study team also obtained institutional clearance from managing authorities of all facilities selected in this study. For example, facility entry procedures were followed by informing the District Health Officer (DHO) and health facility in-charge of all selected sites prior to arriving at the facility and making courtesy calls to managers on the day of starting data collection. Similarly, permission was sought from selected organisations working with ALHIV to provide consent to undertake FGDs with adolescents under their care. Prior to institutional clearance, a briefing of the study was provided to respective institutional managers.

Privacy and Confidentiality

Every effort was made to protect participant's privacy and confidentiality. Interviews were conducted in private rooms with only participant and data collector present to ensure auditory and visual privacy. All research staff received training on confidentiality as part of the field workers' training. Study-related information is being stored securely at the offices of the ANECCA project officer. All participant information is being stored in lockable file cabinets in areas with access limited to study staff. Data collection, process, and administrative forms, and other reports have been coded to maintain anonymity. All records that contain names or other personal identifiers, such as locator forms and informed consent forms, are being stored separately from study records identified by code numbers. All databases have also been secured with password-protected access systems. Participant's study data, will not be released without the participant's written permission, except as necessary for review and monitoring by authorized study representatives, approving IRB or other authorized government representatives. In cases where a direct quote of a participant is being used in reporting (either in this report or subsequent presentations), attempts are/will be made to conceal participant identity by using pseudonyms or generic description.

Risks

This rapid needs assessment did not carry any known risks. The study participants may have experienced some psychological stress from being interviewed or required to answer some questions relating to their knowledge of management of HIV positive children and adolescents. They may have been worried that their performance challenges might become known to others. Consistent reassurance of confidentiality was being made by the interviewers in the course of the interview.

Benefits

There is no direct benefit accrued to the individual participants. However, the information provided by participants in this study can potentially contribute to major positive changes in policy and service delivery of HIV services along the care cascade. This may have provided participants a feeling/sense of satisfaction having contributed to greater public good.

2.8 Stakeholder validation meeting

A stakeholder validation meeting was conducted on 25th October, 2016 where key findings from this rapid policy assessment were presented. The meeting accorded key stakeholders the opportunity to provide feedback on the findings. Owing to the feedback from the validation meeting, modifications were made while maintaining the independence and scientific rigour of the study.

CHAPTER

03

3. FINDINGS OF THE POLICY REVIEW

This chapter provides the findings that emerged from desk review, KIIs with health workers and national level key informants and FGDs with ALHIV.

3.1 Relevant policies guiding children and adolescent HIV and AIDS response in Malawi

As part of the first step and question of the policy framework (figure 5) – *Do relevant policies exist?* - a listing of policies was undertaken to ascertain their existence. The listed policies were subsequently reviewed (desk review) with regard to content to determine their adequacy and relevance to paediatric and adolescent HIV response in Malawi. Our inclusion criteria included: active policies that were within their validity period; policies focussing on any component of the HIV care cascade (be it general or specific to children and adolescents); children and adolescent specific policies/strategies in areas with closer linkage to HIV such as SRH. Table 2 provides a listing of relevant policies and the thematic areas they respectively cover in this regard.

Table 2: HIV policies in Malawi

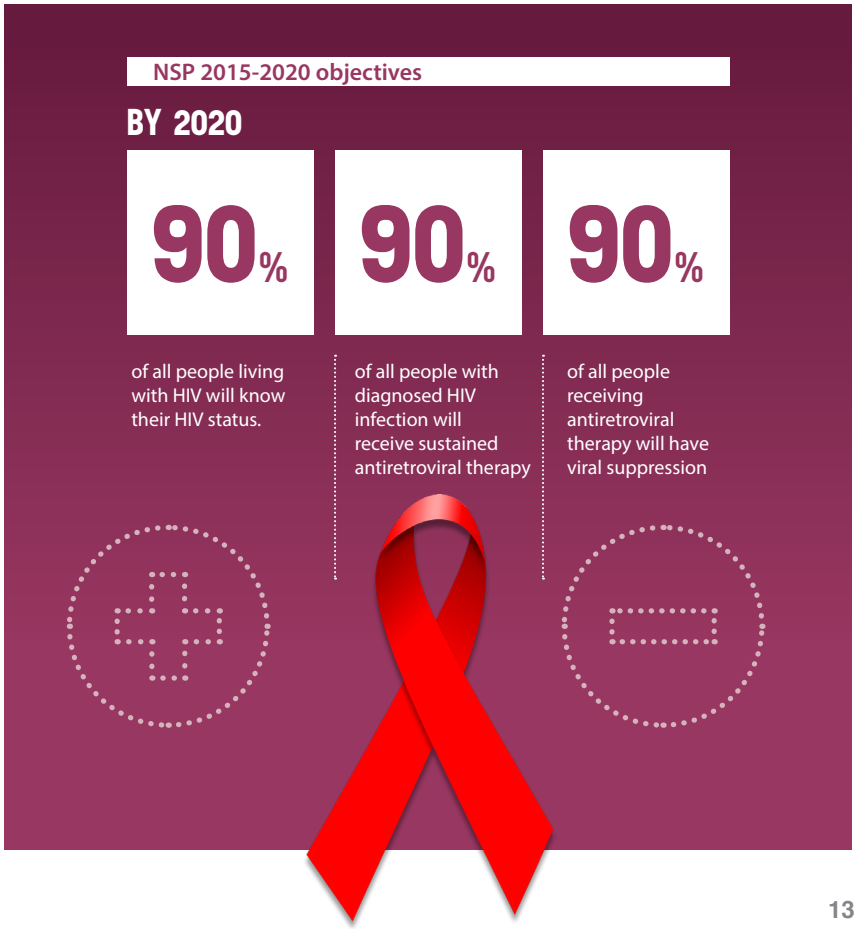
Thematic Areas	Policy/Guidelines
National coordination/overarching	Malawi National HIV/AIDS Policy, 2013 The National HIV Strategic Plan, 2015-2020 Sexual and Reproductive Health Strategy Youth Friendly Health Services Strategy
HIV Prevention and case HIV case identification	National HIV Prevention Strategy, 2015-2020 The National HIV Testing Service Guidelines, 2016 Handbook for HIV Testing Services Providers
Treatment, Care and support	Malawi Clinical guidelines for managing HIV in children and Adults, 2016 HIV Viral Load Scale Up; Strategic and Implementation Plan, 2015 to 2018

Thematic Areas	Policy/Guidelines
Impact mitigation	Malawi National Policy on Care and support of Orphans and other Vulnerable Children National Impact Mitigation Guidelines National Guidelines on School for Educational Support for Orphans and other Vulnerable children National Guidelines for Social Cash Transfer Program

Policy mandates: an overview of key policies along the cascade of care

The HIV and AIDS response in Malawi is guided by the HIV and AIDS Policy of 2013. The policy is operationalized through the National HIV and AIDS Strategic Plan (NSP) 2015-2020 objectives that, by the end of 2020, Malawi will have: diagnosed 90% of all PLHIV; started and retained 90% of those diagnosed on ART; and achieved viral suppression for 90% of PLHIV on ART. The HIV prevention component of the NSP is operationalized through the National HIV Prevention Strategy (NPS) 2015-2020. According to NPS, primary prevention activities will target, in particular, adolescent girls and young women where new HIV infections are noted to be increasing. The focus is on combination prevention (a mix of biomedical, behavioural and structural interventions).

HIV care and treatment is mainly guided by the Malawi Clinical Guidelines for managing HIV in children and Adults (2016), whose implementation is coordinated by the MoH through the HIV and AIDS Department. Other supporting Policies to the treatment component include the National HIV Testing Services Guidelines (2016) and the HIV Viral Load Scale Up, Strategic and Implementation Plan (2015 -2018). Impact mitigation, including psychosocial support as well as support of Orphans and other Vulnerable Children (OVCs) is guided by: The Malawi National Policy on Care and support of OVCs; National Impact Mitigation Guidelines; National Guidelines School for Educational Support for OVCs; and National Guidelines for Social Cash Transfer Program. The impact mitigation component falls under the jurisdiction of the Ministry of Gender, Children and Social Welfare through its district and community structures.



3.2 Policy content pertaining to HIV and AIDS response for children and adolescents: a desk review

As previously stated, a desk review was undertaken to understand policy content pertaining to HIV and AIDS response for children and adolescents. This was consistent with the third step of the policy analysis framework used in this study – ***Are the policies comprehensive enough: collate and conduct content analysis of existing national policies and guidelines using a set of standards.*** Findings for this desk review will be presented following the cascade of HIV care from HIV testing to linkages to care and treatment and other support services.

Key HIV Testing Services issues pertaining to adolescents and children

Prioritising adolescents and children in HIV testing and age of consent

WHO consolidated guidelines on HIV Testing Services (HTS) identify adolescents and infants and children among the priority populations for HTS focus. A rapid content review of the HTS guidelines and corresponding documents for Malawi shows that adolescents and young children are also prioritized as population groups of focus in the policy context for HTS in Malawi. In essence, the draft HTS implementation plan that is designed to operationalize Malawi HTS guidelines for 2016 spells out specific interventions targeting children and adolescents (separately) under each of the objectives and/or strategies of the plan. Age of consent is the most prominent area in policy content for HTS guidelines and corresponding HTS implementation plan that is specific to adolescents and children. WHO guidelines have not been prescriptive and explicit on an optimal age for children or adolescents to give consent for HIV testing. However, in the 2013 WHO HIV testing and counseling guidelines for adolescents and the subsequent WHO HTS guidelines for 2016, WHO recommends review of age of consent policies and practices so that they do not pose barriers to HIV testing for adolescents and children. The current HTS guidelines for Malawi have pegged age of consent for accessing HTS at 13 years and requiring parental or guardian consent or accompaniment for those younger than 13 years.

However, they provide flexibility to HTS providers to make judgment on the maturity of adolescents seeking HTS services and may offer to adolescents that may be younger than 13 years of age, if at the provider's discretion, those adolescents can understand and manage the HTS process. Evidently the HTS guidelines for Malawi stipulate; '***The counselor can determine what is in the best interests of the child and consider specific scenarios when a child younger than 13 should be allowed to consent for HTS***'. In spite of this flexibility, the guidelines fall short in providing some generic guidance on what may constitute maturity. The HTS age of consent is lower if placed in the context of other statutory provisions. For example, the recently enacted Marriage Divorce and Family Relations Act provides for 18 years as age of consent for marriage and 16 years with parental consent for marriage; the Penal Code considers 16 years as an age of consent for sexual activity. Nonetheless, according to the Demographic and Health Survey (DHS), age at sexual debut is earlier than 15 years for both men and women.

HIV status disclosure to adolescents and children

HIV disclosure to children and adolescents remains an integral part of HIV Testing Services. The WHO recommends that 'Children of school age (6–12) should be told their HIV positive status and their parent's or caregiver's status; younger children should be told their status incrementally to accommodate their cognitive skills and abilities' Malawi's provision in the HTS guidelines and its HTS implementation plan is consistent with this as evidenced by the following stipulation; 'Disclosure of HIV status to a child should be regarded as a process that is guided by the developmental age of the child and should not be a one-counseling-session event' . Detailed guidance for initiating HIV disclosure to children and adolescents is available and documented in an HTS providers handbook.

The Viral Load Scale up plan for Malawi also attaches particular importance of HIV disclosure to children and adolescents as a precursor to undertaking a viral load test. The following content in the Viral Load Scale up plan attests to prominence of HIV disclosure in delivery of viral load tests to children and adolescents in Malawi:

> *"….a simple message to be displayed in ART clinics reminding clinicians to check disclosure of children or adolescents, prior to discussing and referring for VL test. If not fully disclosed to, then an active disclosure process should begin. Recommended methodologies and guidance on disclosing HIV status to children and adolescents will be presented in detail in the appropriate module of the revised VL training curriculum"*

HIV testing and linkage to care as part of the PMTCT cascade focusing on children and adolescents

Prevention of Mother to Child Transmission (PMTCT) is central to the HIV epidemic control agenda especially to discourse pertaining to delivering an AIDS free generation. The Global Plan towards elimination of new HIV infections among children and keeping their mothers alive fostered prominence of the PMTCT agenda at global level and catalysed development of national level eMTCT strategies at country level . Malawi's eMTCT strategy 2011-2016 recently expired (in June, 2016) and preliminary efforts are underway to design a robust successor strategy. Nonetheless, the adoption of option B plus strategy for PMTCT in 2011 required integration of the PMTCT and ART programmes to an extent that key policy provisions addressing PMTCT are included in ART and HTS guidelines. The four prongs of PMTCT guide PMTCT cascade planning and implementation. Malawi's testing algorithm and frequency of HIV testing for HIV exposed children is consistent with WHO recommendations of: virological testing at four to six weeks of age; serological testing at about nine months of age and with virological tests for those with an HIV positive result from a serological test at this stage; and the use of a national validated adult testing algorithm for all children above 18 months of age. The critical time points for HIV testing for HIV exposed infants in Malawi are 6 weeks (virological test); 12 months (serological test but with a positive result to use virological test as confirmatory) and 24 months (serological test).

Likewise, consistent with WHO recommendations, Malawi's policy provisions stipulate: HIV testing services to be offered as part of routine antenental care (ANC) and in child birth settings; re-testing of HIV pregnant women to be performed in third trimester or during labour and childbirth; and periodic HIV testing for lactating mothers. Indeed, HIV ascertainment rate has been consistently high (more than 90%) at ANC, in Malawi, largely through PITC as a consequence of these policy provisions. This indicates effective coherence between policy and practice and represents a particular strength based on conformity with WHO standards and high coverage levels.

Key HIV Testing Services strategies to reach adolescents

HIV Testing Services are important for both HIV prevention and entry into care and treatment. Studies indicate that whilst most adolescents know a place offering HIV testing services, uptake remains low. According to a review of national surveys data between 2008 and 2012 less than a third of adolescents aged 15 to 19 years reported to ever having been tested . In the context of low HTS coverage, it is logical to speculate that the majority of ALHIV do not know their HIV status. In Malawi's policy context, adoption of the 90:90:90 targets as reflected in the National Strategic Plan 2015-2020, provides policy impetus to reach undiagnosed people living with HIV including adolescents. To achieve the first 90 of the 90:90:90 targets specific strategies are spelled out. Consistent with WHO recommendations, Malawi's policy provisions have adopted key elements of HTS strategies and provisions including:

Intensifying Provider Initiated Testing and Counselling (PITC) as a key strategy in high yield clinical settings including Adult and pediatric inpatient wards; Nutritional rehabilitation units; ANC/labor wards; TB wards, STI clinics, and Out Patient Departments. Task-shifting for HIV testing service provision to the extent that a special lay cadre termedHDAs has been established to intensify HTS delivery especially utilizing PITC

Undertake targeted community based testing as a strategy to achieve high HIV yield among children, adolescents and adults using community based service delivery platforms. Notably, among the areas targeted to intensify PITC include those that provide platform to test children and adolescents ***viz*** NRU, Paediatric in-patient, STI clinics and OPD.

Two key strategies recommended by WHO have not been adopted by Malawi. Specifically, Malawi has not adopted test for triage and HIV Self Testing (HIVST) albeit the HTS guidelines for Malawi indicated that HIVST may be considered in national policy as new contextual evidence on its use and acceptability becomes available. Indeed, the Population Services International (PSI) in collaboration with WHO, UNITAID, Liverpool and London Schools of Hygiene and Tropical Medicine are implementing HIVST studies among key populations and the general population. Evidence from these studies may only be available in 2017 and may inform subsequent HTS guidelines or necessitate addendum.

Key care and treatment services issues pertaining to adolescents and children

The low HIV treatment coverage for adolescents is acknowledged (UNAIDS, 2015). Furthermore adolescents have unique behavioral characteristics which may negatively impact on ART adherence (Nachenga et al, 2013) and increase their risk of both morbidity and drug resistance. This context warrants the need for policy provisions and guidelines that pursue quality HIV care and treatment including fostering treatment adherence for children and adolescents.

When to start ART

The best time to initiate ARVs among PLHIV has been a subject of discussion that has evolved in the recent past in HIV and AIDS response. The recent WHO's Treat All guidance which entails that every person diagnosed with HIV can be initiated on treatment regardless of immunological status, and which effectively removes eligibility criteria with CD4 cell count test has settled discourse around when to start ART for all populations including adolescents and children.

Malawi's NSP has adopted the Test and Start approach consistent with recent WHO guidelines and as an important strategy to achieve the second 90 of the 90:90:90 targets. The 2016 Treatment guidelines for Malawi are operationalizing Test and Start and aim to strengthen integrated service delivery particularly with TB and Non-Communicable Diseases . Despite policy stipulation that ART would be initiated at the time of HIV diagnosis, the guidelines allow for reflection time if the client is unsure and/or wants to discuss with family but recommend scheduling a follow-up appointment for clients decision and to initiate treatment.

Linkage to other services and retention in care

Without linkage to care and treatment, HIV disclosure or knowing ones status is of little value for adolescents and children. With regard to HIV prophylaxis for HIV exposed infants, Malawi's guidelines are consistent with WHO recommendations, stipulating initiation on Nevirapine prophylaxis for 6 weeks duration and initiation

on ART in the event of an HIV positive result. There is paucity of information regarding uptake of ART and adherence for adolescents and children of different age groups in Malawi as the national HIV programme reports age categorization only entails below 15 years (as children) and 15 years and above as adults.

Apart from specific paediatric ART regimens, other aspects of guidelines pertaining to care and treatment of children and adolescents are largely similar to adults. However there are specific areas of guidance that are prominent for adolescents and children, such as:

- specific guidance on managing the disclosure process with specific recommended messaging appropriate for different age categories. For example guidelines stipulate that from age 5 – 7 years may entail telling the child that he/she has the germ that requires taking drugs everyday to keep the germ asleep whilst in adolescence the recommendation is to allow open dialogue on teenage challenges that may compromise treatment adherence e.g low self esteem, conflicts at home or school, alcohol or drug abuse etc
- use of teen clubs to promote access to essential HIV services, psychosocial support, retention on treatment including other support services along the cascade of care;
- special considerations to promote treatment adherence including: checking at every visit who supervises taking of ARVs and how it is done; select a teacher or fellow student as treatment supporter for ALHIV on treatment and at school, offer to transfer adolescents to most convenient ART site while at school
- specific guidance along the cascade of care for children especially as part of PMTCT

The use of the teen club model as recommended by the guidelines has yielded positive impact on HIV response among adolescents as will be demonstrated in the subsequent section (see discussion chapter). This notwithstanding, there are no specific standard operating procedures formally adopted for wider use by MoH. Moreover implementation of teen clubs is largely undertaken by NGO partners, principally Baylor and Dignitas International, and at present, coverage is low at national level.

Treatment adherence and monitoring

In order to achieve the third 90 of the 90:90:90 targets and ultimately epidemic control, promoting adherence to ART and institutionalizing robust treatment monitoring by ascertaining viral suppression, remain integral for adult, children and ALHIV. A study conducted in nine countries in Southern Africa found that adolescents had significantly lower ART adherence rate than adults; were less likely than adults, to achieve viral suppression at 12, 18, and 24 months after ART initiation. Even for ALHIV on treatment who had attained initial virologic suppression, they were more likely than adults to have viral rebound

.

In this regard, WHO recommends viral load testing as an essential part of HIV management for PLHIV of all age groups. WHO recommends a viral load testing algorithm that entails that every PLHIV and on ARV drugs should undergo viral load test at 6 months following ART initiation and every 12 months thereafter. However, the Malawi viral load testing algorithm requires viral load testing 6 months after ART initiation, 24 months from date of ART initiation and every 24 months thereafter. This divergence from the WHO recommendation is in consideration of limited laboratory capacity and that 24 months was still efficient despite limiting the frequency of viral load tests.

Viral load testing remains suboptimal in Malawi. Only about 55% of PLHIV on treatment that were due for viral load testing accessed the service
. Current published pr ogramme reports have not been disaggregated by age with the intention of denoting access to viral load testing by children, adolescents, and adults living with HIV.

Policies addressing quality of care along the HIV care cascade

Improving quality of care at all service delivery levels and throughout the HIV continuum of care is essential to improving outcomes in HIV and AIDS response. For example, in the context of test and treat, quality HTS is integral to linkage with appropriate services so that people are initiated on ART because of a correct HIV positive diagnosis and conversely are not denied ART due to a false HIV negative diagnosis resulting from lapses in quality during the HIV testing process. From early stages of scaling up country treatment programmes in 2004, the WHO

developed standards for quality in HIV care that could be used for improving quality and accreditation of facilities. It was, therefore, in the study's interest to ascertain existence of quality of care policies and strategies. The desk review noted that whilst there was no policy and strategy on quality of HIV care, specific policies addressing various aspects of the HIV care cascade included generic quality of care provisions for children and adults. Evidently, the HTS guidelines make explicit mention that ensuring quality HTS is integral to HTS and subsequent linkages hence make provision for quality control and assurance measures. The establishment of External Quality Assurance initiative, and provisions for: Proficiency Testing, recertification of HTS providers are cases in point.

Furthermore, as part of the quarterly integrated supervision of the HIV programme, HIV services quality improvement reports are produced focusing on areas requiring improvement at district level. Though not explicit to children and adolescents, these reports provide explicit direction on areas that require improvement albeit the focus has been on data recording and reporting and little on compliance to standards of care.

The Ministry of Health has recently established a Quality Management Unit (QMU) under the Directorate of Planning and Policy but it is envisaged that it (QMU) will progressively be established as a stand-alone Department to coordinate issues of quality health care across all programme areas including HIV and AIDS. Detailed policy frameworks are expected with this establishment.

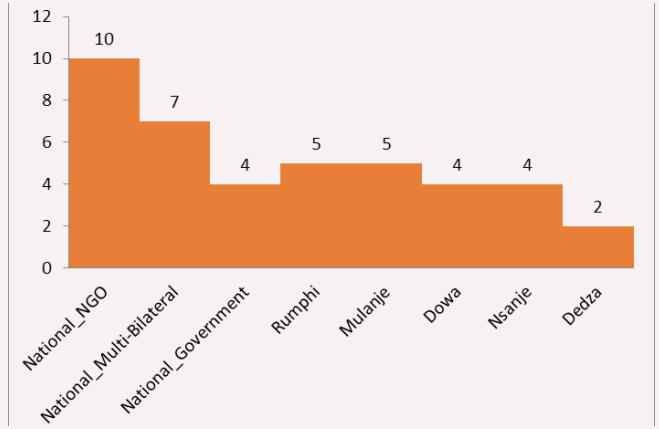
Existence of monitoring, evaluation and research policy framework for children and adolescent HIV

Similar to other areas of HIV and AIDS response, this review noted that there was no children and adolescent specific monitoring, evaluation and research policy framework. The monitoring, evaluation and research documents identified were a range of registers some of which are specific to children such as HIV Exposed Infants registers, monitoring reports, checklists and not necessarily policy framework guiding monitoring and evaluation. However, in each policy/guideline as aforementioned, there is a provision for monitoring, evaluation and research. It is worth mentioning that there is a National Health Research agenda that cites priorities for health research in Malawi. HIV and AIDS is featured as a priority research area in fields such as epidemiology, economic evaluations of HIV services, health systems analysis impacting on HIV service delivery etc albeit the children and adolescent age groups are not explicitly cited.

3.3 Key informants perspectives on policy provisions and implementation pertaining to children and adolescents HIV and AIDS response

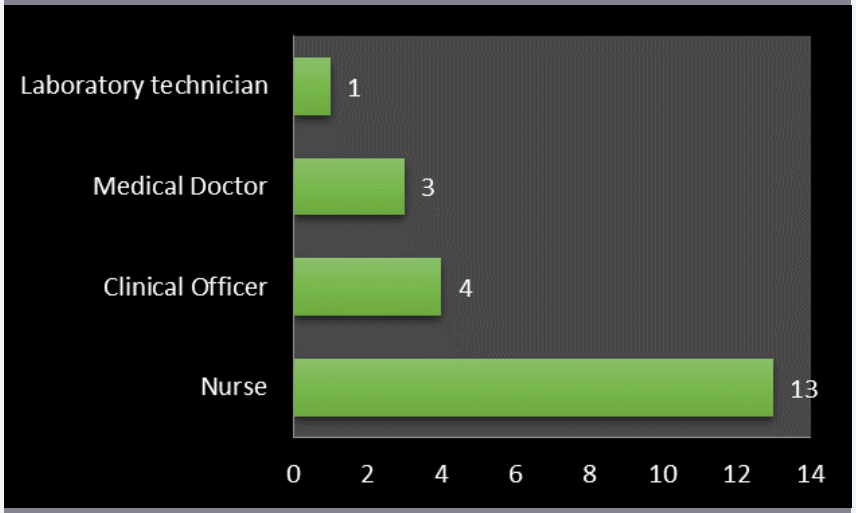
Characteristics of respondents for the rapid policy analysis

Figure 6: Number of key informants by central and district level



Background characteristics for key informants to the rapid policy review are presented in Figures 6 and 7. A total of 41 key informants, constituting 21 at central level and 20 at district level, participated in this policy assessment. As illustrated in figure 6, NGO partners at national level provided the majority 24% (10) of all key informants and about half of key informants at central policy level. At district level, Rumphi and Mulanje contributed the most number, each contributing a quarter (25%) of key informants at district level. With only 2 key informants interviewed, Dedza District Health Office contributed the least key informants.

Figure 7: Designation of key informants at national level



The mean age of key informants was 38 years (SD 9.7; Range 25 - 60). The majority (71%) of key informants were within 45 years of age. Key informants at central level were relatively older than those at service delivery level (mean age of 42 and 36 years respectively). With regard to sex, of all key informants, 54% (22) were men and 46% (19) were females. The sex distribution pattern was similar for key informants at policy and service delivery levels and reflect the aggregate pattern presented above. At service delivery level, nurses, 13 (65%) constituted the majority of key informants for this rapid policy assessment (see figure 7). The laboratory technician cadre was least represented with only 1 key informant across the 10 health facilities. The high representation of nurses was expected as they are present at every level of health care in the Malawi health system hence most likely to be encountered in an assessment that considered primary and secondary health facilities.

Availability of paediatric and adolescent specific policies and strategies and implementation

Key informants at all levels (national, district level management and health workers) rightly observed that there are no stand-alone policies on care and treatment for children and/or adolescents. However, participants had differing opinions pertaining to the utility of stand-alone child and adolescent policies. Proponents of children and adolescents specific HIV policies cited advantages such as likelihood to be more specific and provide detailed guidance that would inform delivery of quality HIV services. Opponents of the approach posited that it has potential to create vertical arrangements and counters the spirit of policy and service integration, further arguing that the current arrangement of generic policies capturing all age groups already has some adolescent and children specific provisions where service delivery or interventions are deemed specific or unique. The two excerpts below, from key informants, illustrate this divergence in opinion:

"Children are not young adults, they are a special group with unique and specific needs hence the need for specific policies, guidelines and implementation modalities. In many ways it would be useful to have specific policy guidelines and provisions for children and adolescents." ***District Level Key informant***

"It is better when the policies and guidelines are integrated as they are now not to have children and adolescents on their own. Once we have the silos on their own you may have some challenges whereby people say I am not trained in adolescent HIV management so I will not do adolescent management. But when you have integrated it means whoever is trained and available is able to provide the service." ***National Level key informant***

In spite of divergent opinions pertaining to paediatric and adolescent specific HIV policies, key informants noted that even with current policy provisions for adolescents and children embedded in existing general HIV policies there is a policy-implementation gap on some aspects of HIV care rendering suboptimal service delivery especially for adolescents. Some of the policy and service delivery challenges noted include:

- Long waiting times at HIV clinics
- Health workers lacking confidence and skills to provide adolescent friendly health services
- Limited health infrastructure to provide for other activities such as play for children and adolescents
- Lack of adolescent specific monitoring and strategic indicators to afford evidence based planning
- Limited human resources to support care and treatment for in-school adolescents
- Limited mentorship on some critical aspects of children and adolescent HIV care such as HIV status disclosure

A convergence of findings is noted from key informants at national level, health worker key informants and adolescents themselves in FGDs pertaining to challenges faced at point of health care use by children and adolescents. Evidently, in one FGD with the ALHIV in Rumphi, one commented:

> *"We still collect our ARVs at a clinic mixed with adults and the waiting times are very long. This makes us uncomfortable as some of us have faced stigma even from adults that also take ARVs who wonder how we got HIV at our age. And even when we meet health workers in the clinic, sometimes you do not feel like they give you attention, I must say some are seemingly judgmental"*

The HIV and AIDS policy development process

Consistent with the second component (was the development of the key policies inclusive and context specific?) of the Walt and Gilson policy analysis framework, interviews with key informants sought to explore the policy development process. Main areas of focus included: extent of stakeholder consultations and inclusiveness, contextualization of global guidance and evidence, existence of governance structures to support policy development and implementation pertaining to children and adolescents HIV and AIDS response. Key informant interviews and desk review of policies provided information for this component.

The process of HIV and AIDS policy development in Malawi involves consultations with various key stakeholders including the following constituents: development partners, communities, opinion leaders, and implementers. At technical level, the Technical Working Groups (TWGs) are an important governance structure that provide platform for evidence synthesis, technical and policy deliberations, and crafting details of various policies (policy content). The National HIV and AIDS response has different TWGs based on programmatic thematic areas of Prevention; Treatment and Care; and Impact Mitigation. Under these broader TWGs, there are technical subgroups such as Voluntary Medical Male Circumcision (VMMC), Social Behavioral Change and Communication (SBCC); HTS, Condom programing, and recently Paediatric and Adolescents. The TWGs and sub groups comprise technical experts from various key stakeholders including: Ministry Departments, National AIDS Commission (NAC), UN agencies, PEPFAR, NGOs, network organisations of PLHIV, Civil Society Organisations (CSOs), Health Training Institutions etc.

When validity period of a policy document is coming to an end or when there is an emerging issue warranting policy change, the relevant TWG provides technical guidance to the policy review and development process which may involve using a consultant or relevant Government Departments. The Senior Management of Ministry of Health or Board of NAC (depending on policy jurisdiction – MoH if biomedical and NAC if overarching) represents the next step in the approval process prior to dissemination and policy implementation. Most key informants, particularly those at central level understood the aforementioned process and commended it for its inclusiveness, accommodating the diversity that often

enriches technical content of policies, as one key informant at national level remarked:

> *"Policy reviews and development in HIV and AIDS emanate from technical working groups …and this is good because many stakeholders are members including institutions like ours involved in implementation and research. So guidelines at global level such as WHO and practices of implementing partners and local evidence are deliberated through this channel to guide policies…"*

The aforementioned policy development process is followed by specific as well as generic policies. However, few key informants at central and service delivery level indicated that there is limited involvement of ALHIV themselves in policy review and development. This, they argued, is an omission of a crucial constituent, as one remarked:

> *"….even young people feel the same, nothing for them until they are involved. I think they should be involved more, not just speculating on their behalf that, I think they need this or that. They need to sit on the table and speak for themselves what their needs are, because I do believe that who feels it, knows better."*

In the same vein, some key informants indicated that in some cases the consultative process omits relevant stakeholders leading to limited buy in and consequently affecting policy implementation. For example, some key informants felt that the Ministry of Education does not fully support access to SRHR and HIV prevention interventions to adolescents in schools because it was not part of the HIV policy development process. At present the two ministries have conflicting policies targeting the same age group (the case of access to condoms and contraceptives by school-going adolescents).

With regard to contextualizing global guidance on issues of HIV and AIDS response for children and adolescents, most key informants cited that technical platforms such as TWGs have been critical in customizing global guidelines to the Malawi setting. Malawi's pioneering of Option B+ when WHO recommended Options A and B; modification of the Viral Load testing schedules; not adopting test for triage in HTS guidelines and not adopting PrEP in treatment guidelines, were cited by some key informants to illustrate consideration of context in adopting global guidance in HIV testing, care and treatment for children and adolescents. Evidently, a service delivery level informant indicated as follows:

> *"I think they have a Malawian touch, they were not adopted wholesome, yah but then they were fine-tuned to suit our environment."*

Knowledge of policy provisions for children and adolescents

There was a clear difference in knowledge of existence of policy and to some extent specific policy provisions between national level and health workers key informants. The majority of national level key informants cited most HIV policies and were more knowledgeable of specific provisions relating to children and adolescents in new guidelines, relative to their key informant counterparts at service delivery level.

The commonly mentioned policies include: National HIV and AIDS Strategic Plan 2015-2020, The Malawi HIV clinical management guidelines and the National HIV Testing Services (HTS) Guidelines. However, most of the respondents especially health service providers were not aware of the latest versions of the documents. This could be attributed to limited dissemination of revised strategic documents to date. Health facility level key informants seemed to be more aware of the existence of treatment guidelines, Standard Operating Procedures for HTS and other care and treatment aspects than they were about generic policies. This is probably due to the fact that they use this level of policies more and hence are considered more relevant to remember/retain than generic policies and strategic plans which are rarely used at implementation level.

The following National HIV Policies and Guidelines were mentioned by few respondents both at National and Health facility level: Malawi National HIV/AIDS Policy (2013),National HIV Prevention Strategy (2015-20120), National Youth Friendly Health Services Strategy (2015–2020), and National Sexual and Reproductive Health and Rights Strategy (2011-2016). This reflects inadequate dissemination and/or lack of consistent use which compromises retention of information.

None of the respondents at national and health facility level mentioned any policy or guidelines on psychosocial support or impact mitigation for children, adolescents or adults living with HIV. This could be attributed to the seemingly overemphasis on biomedical interventions which fall under the jurisdiction of MoH structures, especially at district level, while impact mitigation is championed by the Ministry of Gender, Children and Social Welfare where respondents were hardly selected from.

The study also unearthed knowledge gaps among health workers in terms of understanding of National HIV Policies and Guidelines. Some national level respondents could not link their projects to specific policies. Very few respondents were able to outline latest updates in the national policies and guidelines. The few who demonstrated understanding were either due to the fact that they participated in the development process or they belong to a National Technical Working group for that particular program area. This was expected at the time of data collection granted that dissemination processes for key policies such as HTS guidelines, and HIV treatment guidelines were still ongoing.

On the part of service providers, much as they could not explicitly cite policy names, it was apparent that they comply with some critical policy provisions and standard operating procedures during their day to day work. This could be due to in-service training or work experience. For example, one nurse in the ART clinic failed to list examples of national policies and/guidelines but demonstrated considerable knowledge in articulating the PMTCT protocols for mother and child and rightly cited as below when asked a question on PMTCT:

> *"….during antenatal when a woman is HIV positive, she is told to start ART treatment (5A), the whole essence is to prevent the vertical transmission of the virus to this baby, when the child is born, it is given Niverapine soon after birth up to a certain age, and we also encourage women that they must do exclusive breast feeding, and during that time, the child is given ART for six weeks until DBS is checked, and from there you still put the child under follow up care up to 24 months, to see how the child's status is, and when the child is being found that is HIV positive after that period, then the child starts the medication, and the care continues."*

Key informant perspectives on HIV Testing Services for children and adolescents

HIV Testing services are the gateway to prevention, care and treatment services for PLHIV including children and adolescents. Participants' perspectives strongly emerged on three main issues in the HTS thematic area with regard to policy and implementation of HTS, namely: age of consent; HIV status disclosure; HTS strategies targeting children and adolescents.

Age of consent for HIV Testing Services

Key informants at both levels demonstrated knowledge on the policy provision of age of consent for HTS being 13 years and did not perceive the age of consent as deterring access to HTS for children and adolescents. Many viewed this as a necessity considering that an HIV diagnosis maybe a complex psychosocial issue that requires maturity and understanding. The flexibility accorded to providers to use their discretion in offering HTS below the age of consent was considered useful and was reportedly applied in some situations such as when an adolescent girl below 13 years of age is pregnant:

"…there is a policy that says that we can only provide HTC from age 13 onwards but we waiver this at times depending on situations. For example, at ANC if a 13 year old girl …it happens you know these days…if she comes and is pregnant, we do not ask her parents to implement the HTC protocol, we test her"

Additionally, some health worker key informants noted that certain mechanisms are implemented to obtain blanket consent for adolescents below the age of consent so that they can still access HTS. This was cited in specific reference to school based HTS programme where implementing partners obtain consent from parents-teacher associations and through community meetings and if this is accepted every adolescent below age of consent who grants consent for HTS is regarded to have been covered irrespective of his/her age, thereby circumventing the potential barrier the requirement of parental/guardian consent at the time of test poses. It is important to note that in this situation the parental consent is the key and the secondary consent is sought from the adolescent himself/herself out of necessity in avoiding coercion.

"….age of consent may not be a barrier. For example, we have an NGO called Life concern which is implementing primary school based HTS programme. …..they obtained parent-teacher consent on the project earlier and now test the young ones if they give consent since parental consent is already covered…..but if that child's results come out positive then for the child to start ARV's they call for a parent"

A blanket consent from parents and guardians in school based HTS appears to be a good practice albeit one which is largely dependent on the level of understanding of parents and guardians in a particular society and also existence of such structures. It is potentially scalable in the Malawi context.

Disclosure of HIV status to children and adolescents

Some key informants at national and implementation levels expressed that guidelines pertaining to HIV status disclosure to children and adolescents represent one of the most explicit aspects of care for children and adolescents. The explicit gradual and age specific guidelines on disclosure process (part of section on guidance on HIV status disclosure for children and adolescents shown in Box 2) was hailed by some as a policy strength. This notwithstanding, some key informants cited a policy-implementation gap in that while guidelines exist and are explicit, effective disclosure to children is sometimes affected by parents unwillingness (probably due to lack of adequate counseling to prepare them as well); work overload on the part of health workers hence do not create ample time to initiate the disclosure process; lack of confidence among health workers to effectively undertake the disclosure process. In efforts to instill confidence in health workers on implementing the HIV disclosure process to children, adolescents and family members, one key informant at national level proposed the need for job aides and IEC materials

.".…I don't know if I would call it policy but yeah, I guess so, like there is a lot of work to do with the health education unit on IEC material on behavioural change and communication at community level around issues of disclosure... And discrimination because it's only if we tackle these things that we can make sure we have adherence to treatment for children and adolescents."

"…at the moment at facility level it's more passive in that you give them a family referral slip and you ask them to bring the children but we have to look into a policy of active index testing of going and testing in their homes, children of HIV positive parents. It is a bit more challenging because if you want to do so you have to address the issue of disclosure; you can only go to test family members of someone HIV positive if they formally give you consent for it, if they have not disclosed to the partner then obviously they will not give you consent."

HIV Testing Strategies targeting children and adolescents

Provider Initiated Testing and Counseling (PITC), school based HIV testing, and use of Family Referral Slips were the frequently cited strategies to increase access to HTS among children and adolescents. Of the three, PITC was the most frequently mentioned by national level and service delivery level key informants. Service delivery points such as OPD, Nutritional Rehabilitation Units (NRU), Immunization clinics and paediatric wards are targeted for implementation of the PITC strategy to ensure that no child is left behind. The use of HDAs was hailed in promoting PITC albeit some key informants suggested the need to enforce PITC among health workers.

Participants further indicated that index testing is very powerful in identifying children with HIV but also observed that the return rate for Family Referral Slips (FRS) is low in many health facilities. A best practice implemented by EGPAF was highlighted in one district where an index client is asked for consent so that providers can undertake home based testing of children and other family members. A similar approach uses what is termed a "Know Your Child Status Campaign" where index clients (women or couples diagnosed with HIV at ANC) and clients at ART clinics are requested to bring their children to a health facility on a particular day where HIV testing is undertaken, and they are provided with transport refunds. This however is implemented at a small scale and by an NGO, prompting some key informants to call for more active index testing (that involves following the client as opposed to passively waiting for them to return with the referral slip) at a wider level.

Key informant perspectives on HIV care and treatment for children and adolescents: strengths and gaps in policy provisions and implementation

Most key informants were aware of the existence of National guidelines for the clinical management of HIV, reported to have been trained in implementation of the guidelines (albeit some were yet to be trained in the 2016 guidelines) and were comfortable to discuss policy provisions pertaining to care and treatment for children and adults. Policy discourse around when to start ART for children represent a recurrent theme among participants at national level and health workers at implementation level and were often used as an example that the general policies still contain children-specific provisions. Specifically, key informants at both levels rightly indicated the country provision for universal eligibility for starting ART for children under the age of five diagnosed with HIV – a test and start approach that begun with the 2011 guidelines.

Key informants at both levels consented on the fact that adolescents are usually treated as adults with the exception of few elements for which guidelines seem to attach prominence in care and treatment, namely HIV disclosure and supporting treatment adherence for adolescents. However, in discussions regarding best practices in policy content and implementation for adolescent HIV and AIDS response, the significance of 'Teen Clubs' was mentioned by both national level key informants and key informants at health facilities across all districts. Other aspects of children and adolescent for which key informants perceived positively included: emphasis on family centred care; and implementation of Option B plus.

Implementation of Teen Clubs for ALHIV

Majority of key informants especially health workers valued teen clubs in supporting ALHIV with positive living particularly in promoting treatment literacy and psychosocial support from peers and health workers which lead to treatment adherence, retention in care and linkage to other support services.
Structure and implementation of the teen clubs as described by health worker informants is as illustrated in Box 3. Entry into a teen club follows a step by step process aimed at facilitating gradual disclosure and managing the associated psychological process.

Whilst the concept of teen club is universally understood, the scope of services delivered was noted to vary depending on the implementing partner and probably how long a teen club has been operational. For example, other teen clubs are linked to ART clinics and provide ART refills, screening for opportunistic infections and respond to sexual and reproductive health needs of adolescents while others only provide a platform for other activities as cited in the Box below Two excerpts below from key informant interviews from national level and district implementation level portray the value of teen clubs in promoting care and treatment for ALHIV:

"…teen clubs implementation is one of the best practices for delivering essential HIV care….it is a good program for the youth as they chat, share ideas, and support each other with the help of a health worker…sometimes in teen sessions we let adolescents write the problems they face on a piece of paper and secretly place in a box, we review these and then call parents in groups and have general discussions based on issues raised by adolescents so you can see teen clubs also help us strengthen support at family level and address those problems." ***District ART Coordinator"***

…then we have what we call enhanced adolescent programs which are essentially teen clubs. These are very beneficial as they also offer a platform for health workers to provide other services including family planning, screening for opportunistic infections and educate them prevention with positives so that they understand. ***"National level key informant"***

Teen club implementation process

Teen clubs bring together ALHIV together and conduct various activities aimed at supporting ALHIV live positively. Activities in teen clubs include: adherence sessions; life skills; HIV education tackling various topics such as viral load testing, treatment literacy, nutrition etc; drama; career talk and sports. Teen club events are facilitated by healthcare workers with support from teen club leaders and coordinators (often community volunteers). In most cases teen club sessions are conducted during out-of-school hours typically over the weekend. Teen clubs also offer a platform for service delivery the scope of which depends on the implementing partner and maturity of the club.

The impact of teen clubs on adolescents was also evident in various positive expressions by ALHIV during FGDs across all districts. Adolescents reported that Teen club interventions have helped HIV infected teens:

- accept their status – an important psychological state to promote access to HIV services,
- acknowledge they are not to blame for their condition effectively eliminating sense of shame and guilt that may characterize this age, reducing stigma and discrimination,
- increased HIV treatment literacy,created friendships and teen club members sometimes offer treatment reminders to each other hence promote treatment adherence offered platform for delivery of integrated services including contraceptives, life skills education etc
- While lauding teen clubs, ALHIV in FGDs, particularly those participating in

teen clubs not linked to ART clinic, indicated that there was potential for greater benefits if certain clinical services such as treatment of minor ailments and ART refills were offered during teen club sessions. Evidently, a participant from Mhuju health facility in Rumphi remarked:

> *"…some of us come from far…..and it is not easy to get here, we have to walk and it's difficult, that's why we want to be getting our medication the same day we come for teen clubs because we have fixed days for teen clubs and everyone knows that we all have to attend, sometimes we come for teen club but then have to come again to collect medicines, it would be better if such services were integrated."*

In spite of the benefits of a teen club and apparent popularity among ALHIV, key informants especially at implementation level expressed that low coverage of teen clubs in many districts represents a challenge as the benefits do not reach the intended majority. For example, in Rumphi only three of the 18 health facilities that provide comprehensive HIV services offer teen club services for ALHIV. In this vein, participants at national level have posited that limited funding to Ministry of Health may be a factor for not rolling out teen clubs albeit the benefits are recognized.

Some key informants at national level expressed concern that implementation of teen club services is predominantly led by NGOs and that while policies mention teen clubs as an important platform for delivering HIV services for adolescents, there is little in terms of policy direction from MoH with regard to set up, execution, scope of services, and standards for teen clubs.

Emphasis on family-centred care, use of treatment buddies and treatment supporters

Key informants at health facility level cited that the explicit focus of guidelines on presence of a family member as treatment supporter or treatment buddy during counseling when starting ART and in the course of care and treatment represents a good practice. Key informants expressed that this peer support and family centred support has led to treatment adherence among many PLHIV.

With regard to adolescents, this approach was noted to be particularly helpful to ALHIV in school albeit few key informants at service delivery level raised it. Where ALHIV are comfortable with HIV status disclosure to some school authorities, boarding masters or selected teachers are tasked with the responsibility to remind ALHIV on next appointment and provide constant reminders on need to take their ARVs and other medicines. This is considered important to facilitate treatment adherence which is a challenge for adolescents in boarding schools in the context of stigma and discrimination. An excerpt from an interview with an HTS programme coordinator below illustrates this practice and its benefit:-

"….they are taught that when they go to a boarding secondary school they should leave their treatment with the headteacher, so they disclose, they take the headteacher as a parent, so when it's time for drugs even if this child forgets the headteacher reminds the child……and this has assisted because in the past….. like I remember we had one child who passed away because of not adhering to treatment. When he was at primary school it was ok but then he went to, was it Phwezi secondary school he couldn't reveal, he couldn't give drugs to the head, therefore it was difficult for him to find time and take those drugs so it was so tough for him. Drug adherence was so poor, and he passed away in form 2. This initiative is a really good idea and it prevents avoidable deaths like these."

Nonetheless, some key informants observed this practice, despite its benefits, has not been widely institutionalized hence not many health providers have discussed with ALHIV in boarding schools on implementing this approach and few health facilities have engaged boarding schools to create a conducive environment for ALHIV to take their medicines.In lauding family-centred approaches such as using treatment supporters, some key informants indicated that where HIV status disclosure has been effectively undertaken, all PLHIV members of the family remind each other on taking medications and in other cases take ARVs together. Consequently this promotes treatment adherence and retention in care for children and adolescent members of the family as family support exists and parents and/or adult members are exemplary.

Policy guidance and implementation of Option B plus and its benefits for children

Most key informants at national level and health workers at facility level cited the explicit focus of policy on Option B plus, which Malawi pioneered, as a particular strength with regard to HIV and AIDS response among children. In particular, they cited the clear guidance from promoting HIV testing among pregnant women, initiating those diagnosed with HIV on ARVs, exposed child follow up including Early Infant Diagnosis and linkage to care and treatment for children diagnosed with HIV, as one health worker key informant indicated:

"……the good example is the one that am talking about, on PMCT/ART, whereby we are emphasizing on option B plus, we know that there is this policy whereby each and every woman that is coming for antenatal services has to be tested, if she is HIV positive has to be initiated on ART, people are able to do it and implement it, and it has been successful, and for your own information at Nsanje, our ANC attendance is at 98%, so, if it's at 98% we are sure that every woman who goes at antenatal care is tested, if she's HIV positive, starts ART, if she is in labour, the child gets the treatment if positive as well but we have seen significant reduction in mother to child transmission"

Key informants at service delivery level indicated that many pregnant and lactating women undergo HIV testing without coercion and with Option B plus many HIV exposed children are born free of HIV. In the same vein the majority of HIV exposed children who contract HIV are immediately initiated on treatment and have improved treatment outcomes as evidenced by high survival rates. The simplistic (easy to use) manner in which guidelines have been written was also lauded by some health workers at health facility level. This was considered particularly useful in the context of a highly decentralized HIV service delivery and significant task shifting to low level cadres.

Some key informants at national level also hailed policy integration for various components of HIV and health service delivery. These assertions were in specific reference to the HIV treatment guidelines, which in 2011 integrated ART and PMTCT programmes in order to implement Option B plus and effectively resulted in significant increase in ART coverage and the ultimate benefit of reduced mother to child transmission rates. In the same regard, other informants cited the policy integration in the third edition developed and disseminated in the 2015/16 fiscal year, which fosters integration of HIV, TB, and Non Communicable Diseases service provision. In this regard, one key informant remarked:

"……but when you have integrated guidelines and means of service delivery, whoever is available is able to provide the service without multiple horizontal referrals or asking the client to come again for a related service, it becomes a one-stop centre." ***National level key informant***

Monitoring and evaluating progress in children and adolescent HIV and AIDS response

WHO posits that due to the rapid physical, psychological, emotional and cognitive changes of adolescence, it is essential that data be stratified in ways that facilitate the design and implementation of interventions and services that are appropriate for adolescents aged 10–14 and 15–19 years in particular. In this regard, the study solicited key informants perspectives on the adequacy of strategic information (routine monitoring and evaluation frameworks and commissioned studies) to inform HIV programming for children and adolescents. Key informants from both policy and service delivery levels indicated that strategic information is limited especially for adolescents HIV and AIDS response. Key informants especially at central level indicated that the age categorization of 0 to 14 years and 15 years and above in routine HIV programme entails that adolescents are split into children and adult-age categories, as a policy level key informant remarked:

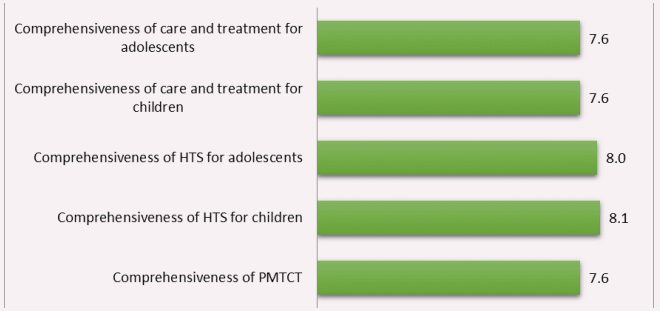
"In the current M&E adolescent and paediatric data is reported as one group. I think it is essential for targeted planning of adolescents and pediatrics that the monitoring tools should be revised to address reporting of specific age groups of adolescent and paediatric. In this way we can track the performance of these respective groups better and plan on mode of response."

Some key informants argued that it would be worthwhile if some critical indicators reflected age disaggregation that captures the adolescent period (early 10 to 14 and late 15 to 19). In spite of these positions, other key informants at central level observed that existing monitoring registers at facility level including ANC, ART, HTS and STI among others contain client individual age (as a continuous variable) in addition to pre-existing age categorization column. This, they argued provide an opportunity for secondary analysis to capture the adolescent period and other relevant age groups for children.

Key informants perspectives on comprehensiveness of policies pertaining to children and adolescents HIV and AIDS response

To gauge perspectives on comprehensiveness of policy and strategic provisions for HTS, Care and Treatment for children and adolescents and PMTCT, a likert scale with values from 0 to 10 was used. Key informants provided ratings on the likert scale and an average score for each programmatic area (i.e HTS, care and treatment and PMTCT) is presented in figure 8

Figure 8: Key informants' rating comprehensiveness of policy provisions for HTS, care and treatment for children and adolescents and PMTCT



As illustrated by figure 8, there is a general positive impression from key informants on comprehensiveness of policy provisions in HTS, care and treatment for both children and adolescents and for PMTCT. A higher mean score in HTS provisions for both children and adolescents probably reflects the prominence of children and adolescent sections in HTS guidelines, HTS providers handbook and HTS implementation plan.

Policy gaps and challenges in policy implementation for children and adolescents HIV and AIDS response

Participants' perspectives on policy gaps and service delivery challenges for effective provision of essential HIV services for children and adolescents reflected the need for explicit focus on children and adolescents across the HIV care cascade, health systems strengthening, policy monitoring and enforcement, and strategic information pertaining to care and support for children and ALHIV.

Policy level gaps and systems challenges

While all national level key informants were able to indicate some policy gaps and systems challenges, participants at service delivery level had divergent opinions on policy gaps in that some indicated that policies are comprehensive and yet others were able to cite some gaps at this level.

The lack of explicit focus on children and adolescents in some components of HIV care was highlighted by some participants at national level and health service delivery. In particular, some participants mentioned that whereas guidelines are explicit on children under the age of 2 years being part of PMTCT, there is little emphasis on explicit guidance targeting children from age 3 to 10 years and thereafter the adolescence period of 10 to 19 years. In this regard, participants acknowledged the special attention attached to the age-specific HIV status disclosure but argued that policy provisions and guidance around HIV diagnosis, care and treatment support for children and guardians, linkage to other support services could be more explicit:

"…..a bit of information about the children and adolescents is there but still more we could need something that will be at least stressing about the children, that will be exhausting enough information about the children and adolescents. I think the policies do not emphasise much particularly for adolescents."

The majority of participants observed that there are gaps between policy content and policy implementation largely due to inadequate policy monitoring and enforcement. Reasons cited as being attributable to this scenario include: limited policy dissemination, service delivery challenges especially those related to inadequacy of resources, limited commitment from health workers, among others:

"..so the tools and policies are clear. I think it's a matter of implementation to make sure that we are implementing them properly. The policy-practice gap is the one that we should be addressing as well. Its one thing to stipulate health infrastructure need and its another to effect that development at a health facility". National level key informant

Two examples often cited by key informants at service delivery level illustrating the policy-practice gaps include: that of EID where the guidelines and policies are clear on the scheduling of HIV tests and linkage to treatment but implementation challenges entail that samples for EID are collected late, laboratory capacity is inadequate, sample transportation is weak hence turnaround time of results is too long; and the fact that there is policy provision pertaining to age specific HIV status disclosure but many providers do not effectively implement this provision.

Monitoring and Evaluation for the HIV programme, while seen to be generally strong in many aspects of HIV and AIDS response, was noted to have some shortcomings insofar as providing comprehensive strategic information for HIV and AIDS response for adolescents was concerned. This observation related to both institutionalized monitoring systems and conducting HIV research to inform children and adolescent programming. Majority of key informants noted

that the age categorization of 0-14 years and 15+ years limits understanding of the HIV epidemic and response among adolescents as they are lumped in the children and adult category. Similarly, few participants at national level cited the so called 'overprotection' of children in HIV research has limited the much needed evidence generation that can inform HIV programming for this age group:

"…..we don't have age disaggregated information to inform progress in our commitments. For example, we should be able to say this is how many children were identified positive and this is how many children were initiated on treatment….. and in the same way we should be able to say this is how many children, this is how many adolescents and this is how many adults but at the moment we are just able to say this is how many people are identified HIV positive and this is how many are on treatment categorising less than 15 and 15 and above years of age. So when we talk about the 90/90/90 we don't have a specific children and adolescents component we are just talking 90/90/90 for the HIV population overall." ***National level key informant***

"……if we want to do research for children under 18 they say let's be careful with women who are pregnant, let's be careful with children because of that not a lot is known in children because everyone is too cautious. We are saying we are protecting them but then we are not learning much on what experience would be because they miss out on that…….. so I think it's just a matter of making sure that all our bioethics team can be able look at how best to represent this group to make sure that we understand a little bit more of what they need" ***National level key informant***

Some few participants at national level cited the lack of a dedicated child health and/or adolescent health expert at central level within the HIV Department as a barrier to effective coordination of issues pertaining to children and adolescents. They argue that existence of such an expert would be crucial to enhance implementation of existing children and adolescent specific provisions in policies and guidelines and would foster greater visibility of children and adolescent HIV aspects in policies. In backing this assertion, one key informant remarked:

"……..so it's either you should have a very strong partner that can support the Ministry with paediatric specific activities or even better the Ministry should have a paediatrician. At the moment, the Ministry of Health in the Department of HIV and AIDS there's not a paediatric specific person, there are PMTCT officers of course but that's only for the 0-2 years old on the child side. Other countries have a child health expert for HIV I think…..you need to have a paediatric HIV person who becomes the focal point who can liaise with the different units within the Department because at the moment you have HIV testing people you have the treatment and care people but then children fall somewhere there in HIV testing somewhere in treatment and care. Someone dedicated to paediatric will really communicate with the HIV testing for children specific things with treatment and care for children specific things, I think that's what the ministry needs, they need a paediatric person." ***National level key informant***

From all participants at national and health facility levels, limited funding available to Department of HIV of the Ministry of Health was seen as a significant challenge to effective policy implementation. There was consensus that some models of implementing children and adolescent care have proven to be effective or shown great promise but the inadequate funding to MoH due to limited fiscal space render it almost impossible to scale up effective interventions. Implementation of a robust sample transportation system, health infrastructure that allows for recreation for children or special rooms for adolescents, and scale up of teen clubs were cited as examples of shortcomings resulting from limited funding.

> *"…well, I think sometimes Government fails to implement some promising activities to scale because of limited resources as they require finances. They rely on partners"* ***Service delivery level key informant***

Service delivery challenges to effective implementation of children and adolescent HIV services

At service delivery level, it was reported that HIV services for children and adolescents are challenged by various factors mostly relating to weaknesses of the health system, albeit it was recognized that children and adolescents constitute important groups if epidemic control is to be achieved. The information, mostly emerging from key informants at health facilities and FGDs with ALHIV, specifically cited health workforce issues, inadequate health infrastructure, and inadequate finances.

Health workforce issues that emerged related to shortage of health workers. Evidently, some programme coordinators in two districts indicated scheduling challenges particularly to support teen clubs sessions which normally take place during weekends. Lack of skills and confidence among health workers to effectively provide services to children and adolescents also emerged as a critical and commonly cited issue among health workers. Key informants especially at national and district management level (and programme coordinators) acknowledged that adolescents have specific needs and expectations and may require patience and special skills that most providers have not harnessed:

> *"….some of the staff do not have appropriate skills and attitude to manage the adolescents… because you need to really be patient and come down to adolescents level …you need to position yourself at 18 years or younger so that you acknowledge the language they use and the things they lack. They may want to have fun at the same time being seen for their clinical reviews."*

Similarly, the negative expression of some providers emerged in some few FGDs with ALHIV, as a significant barrier for effective access to essential HIV services. While some adolescents indicated that health workers treat them warmly others reported that some providers do not treat them with respect:

> *"…..the hospital should have good health workers who are caring and also dedicated…….sometimes you just miss your next appointment (for good reasons), the day you come for your medication, the doctors vent their anger on you, maybe they have family issues, they shout at you "this is not your appointment date, where were you on your day of appointment, you are the ones who are positive so why are you missing your appointments" so it's very worrisome to us. So if the health worker is dedicated to his or her job he or she cannot do that to clients, because they have to be professional, so a hospital needs dedicated, caring and hardworking staff. "*

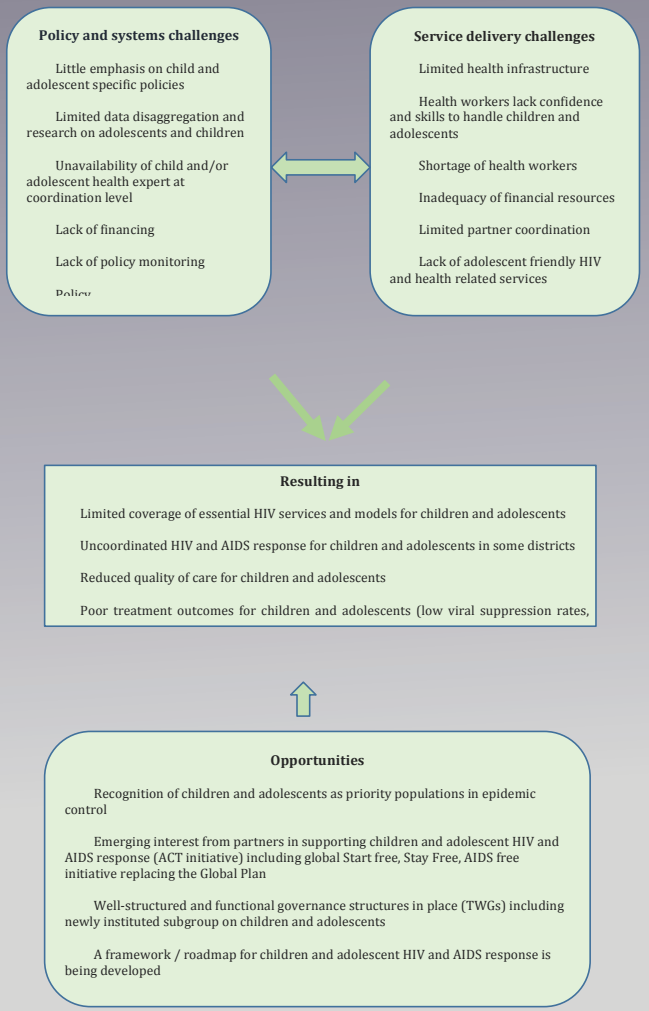
FGD with adolescent girls in Rumphi

Inadequate resources also emerged as a service delivery challenge compromising effective policy implementation at service delivery level. Key informants cited that the Department of HIV and AIDS in MoH and NAC budgetary allocations are usually grossly inadequate to meet the needs of HIV service delivery. Expressions of limited laboratory capacity to undertake EID including sample transportation, limited financial resources to fund volunteers to coordinate teen clubs or undertake community follow up of exposed children were common especially among health workers.

Even in the context of limited resources, some key informants suggested that better coordination of partners and more effective leadership would alleviate some of the problems emanating from resource constraints in some districts. Partner coordination in this case entailed the need to correct the maldistribution of partners so that they do not duplicate efforts and service delivery in one geographical area or district rather should be spread to other underserved parts.

The policy gaps and systems challenges on the one hand and service delivery challenges on the other hand are closely intertwined and for some, boundaries are blurred insofar as their effect on children and adolescents HIV and AIDS response is concerned. The schematic below (Figure 9) illustrates the interconnectedness and summarises the aforementioned gaps and challenges.

Figure 9: Policy and service delivery impacting children and adolescent HIV response in Malawi



Summary of Key Points

a. Except for few guidelines and strategies such as the YFHS and eMTCT strategies, there are no children and adolescent specific policies hence content on children and adolescents was largely part of generic policies and guidelines.

b. HTS policy content in Malawi considers adolescents and children among the priority populations consistent with WHO recommendations.

c. Age of consent is pegged at 13 years with flexibility on allowing access to children younger than 13 years albeit guidance on this flexibility is elusive.

d. HIV disclosure is important in HIV management but it is not widely undertaken and may be complex to do so to children and adolescents. Policy content addresses this issue but operationalization remains weak. The need to include this in skills building for ART providers and to be part of clinical mentorship can be considered. Additionally, parents/guardians of HIV infected children and adolescents need to collaborate in managing the disclosure process in practice.

e. Current policy for ARVs initiation in Malawi is consistent with WHO's Treat All recommendation which entails offering ARVs immediately one is diagnosed with HIV, albeit allowing time (a two weeks window) for decision making if client requires it.

f. While the generic policies and guidelines have some explicit provisions for children and adolescents, some participants felt greater emphasis or stand-alone policies would prioritise these age groups better.

g. Teen clubs represent a best practice in implementation of adolescent care and treatment but coverage remains low, is heavily dependent on non-government partners and may lack explicit policy provisions, hence need for scale up and more effective organization.

h. Policy-practice gaps exist for some components especially those related to managing HIV status disclosure for children hence the need for enforcement.

i. There is limited knowledge for high level policy provisions among health workers albeit good knowledge of guidelines – a reflection of limited dissemination for some policies

j. The routine monitoring and evaluation system is robust in other aspects of HIV and AIDS response but routine reports do not capture HIV and AIDS response among adolescents and some age groups for children (e,g 3 to 5, 5-9 years).

CHAPTER

04

4. DISCUSSION AND CONCLUSION

4.1 Discussion

his study focused on four interrelated areas namely: determining existence of current paediatric and adolescent HIV policies in Malawi; process of development of these policies and guidelines; comprehensiveness of the guidelines and policies for the target groups of CLHIV and ALHIV; determining whether policies are known and guidelines being utilized at service delivery level. For each of these thematic areas, strengths and gaps were identified.

With regard to policy content, in many aspects along the HIV care cascade, Malawi has been consistent with WHO recommendations albeit there are aspects that are applied differently mostly due to consideration of local context (adaptability to context or policy not supported). For example, test for triage, HIV Self Testing, Pre-Exposure Prophylaxis (PrEP), viral load testing schedule of every year have not been implemented for various reasons from considerations of cost, health infrastructure and equipment capacities and service provision dynamics. Except for few guidelines and strategies such as the YFHS and eMTCT strategies, Malawi does not have children and adolescent specific policies pertaining to HIV care cascade. Instead, policy content on children and adolescents is largely part of generic HIV and related policies and guidelines with prominence of sections on children and adolescents varying from one policy to another.

Despite diverse views on the utility of specific policies and strategic documents targeting adolescents, it was apparent that stakeholders felt that some areas were explicit and comprehensive whereas others were inadequately covered hence did not provide effective direction on the care of children and adolescents. Many stakeholders also noted that various policy and service delivery challenges resulted in policy-implementation gaps. For example, whereas teen clubs are cited in policy documents and guidelines as essential to promote adherence and retention among adolescents, there is paucity of information on guidance for health facilities in setting them up, package of services to be delivered through this platform and the entire coordination structure.

Additionally, coverage for teen clubs, despite all its benefits also alluded to in this study, remains low, at only 15% in Malawian health facilities with ART, and largely driven by NGOs. Indeed, a review of the teen club programme run by Dignitas International in Southern Malawi showed 97.3% retention on treatment and care for adolescents on ART and pre-ART care; more than 95% adherence in about 97% of ALHIV in teen clubs; and that adolescents in teen clubs were three times less likely to default on treatment than their non teen club member counterparts. As ART is a life-long treatment, critical consideration should equally be placed on effective

transition from the adolescent care, treatment and support as offered through teen clubs to adult care and treatment programme which may lack the psychosocial support to the level of that offered in teen clubs. Anecdotal reports abound that some adolescents on ART used to the teen club model find transition difficult to adapt and often want to return to teen clubs. Arguably, the policy guidance on teen clubs may include planning and executing an effective transition to adult care and treatment

HIV status disclosure among adolescents emerged as an important cross-cutting theme that relates to access of various essential HIV services for children and adolescents. The success of PMTCT programmes in recent decades has meant that an increasing number of children born with HIV in Malawi and elsewhere, are still alive and on treatment but some of them do not know their HIV status. A systematic review on prevalence of HIV disclosure among children and adolescents, in low- and middle-income countries, found that HIV disclosure only ranged from 1.7% to 41%. In the same study, up to 49.5% children living with HIV were provided non-HIV-related reasons for explaining illness and health care visits. Facilitators of disclosure included antiretroviral treatment initiation and caregivers' felt need for maintaining optimal adherence whereas barriers to disclosure included fear of negative psychological reactions and inadvertent disclosure to others. Consistent with these findings, key informants in this study suggested that HIV status disclosure among children and adolescents may be suboptimal. Whilst policy provisions exist guiding age-specific HIV disclosure process, many providers rarely initiate this process citing lack of confidence on the 'how to do it'. This reflects the need to transcend policy content to building skills and modalities to operationalize all the critical aspects of care. Various studies have demonstrated that effective HIV disclosure is critical to treatment adherence and retention in care for adolescents and adults[29]. The significance of imparting skills to health providers to effectively manage the disclosure process for children and adolescents is therefore evidently critical.

More importantly, effective disclosure of sero-status for adolescents needs to be supported for adolescents outside the home environment such as in boarding schools. Though not quantified, narratives from this study and elsewhere[30] have revealed that ALHIV in boarding schools face particular challenges pertaining to treatment adherence especially if not disclosed to school authorities who would support. The ***2011 WHO's HIV Disclosure Counseling for children up to 12 years of age*** provides a comprehensive guide and Malawi has adopted these in the HTS providers handbook which provides psychosocial developmental stages for children and how age appropriate disclosure can be offered. Additionally, granted the essence of HIV disclosure among children and adolescents for treatment adherence and retention in care, a deliberate policy could be in place that the basics of managing HIV sero-status disclosure should be part of training and/or refresher for ART providers. This is imperative considering that horizontal referral of adolescents and children from ART providers to HTS providers who are trained to undertake HIV disclosure appears to be limited or nonexistent.

Key informants at both policy and service delivery levels in this study cited paucity of critical HIV information for children and adolescents among challenges in HIV programming for these age groups. Indeed, routine integrated HIV programme reports produced by MoH on quarterly basis in Malawi use main age categorizations of: children (from birth to 14 years) and adults (classified as 15 years and above). Similarly, in modeling HIV estimates using Spectrum, the UNAIDS uses the same age categorization as the main ones albeit estimates also exist for under 24 months of age and age range of 1 to 4 years. This means that strategic information for the adolescent period (10-19 years) and other age bands for children (e.g 5 to 9 years) which have distinct characteristics, is unavailable routinely, for decision making. In essence, our understanding of the state of the epidemic and response among adolescents in Malawi is limited due to paucity of information. It is important however that as the country pursues the 90:90:90 targets, child and adolescent lens need to be applied so that 90:90:90 targets are attained within these target groups as well. Strategic information along the HIV care cascade for children and adolescents therefore remains crucial in tracking progress towards 90:90:90 for these age groups.

Generating individual client age during quarterly supervisory visits (which are source of HIV programme reports) to afford age disaggregated data capturing children and adolescents would be logistically complex especially in large cohorts of ART clients. However, considerations can be made such as the following: institutionalize a periodic (e.g once a year) more robust review of client level data that would allow to capture information for adolescents and children; use electronic medical records in high volume ART sites to allow efficient age disaggregation for essential HIV indicators for children and adolescents. To institutionalize this, it would be worthwhile to include in the Monitoring and Evaluation framework (indicator matrix for HIV and AIDS response), indicators focusing on relevant age disaggregation capturing children and adolescents. This would express a commitment to track performance of these indicators at feasible intervals e.g annually or bi-annually.

In the course of this study, some partners have embarked on initiatives that provide opportunities for children and adolescent HIV and AIDS response in Malawi. Notably, (a) UNICEF and MoH have commissioned a study aimed at reviewing service provision and status of HIV and Sexual and Reproductive Health related indicators for children and adolescents, (b) with support from CHAI, WHO and UNICEF, MoH is in the process of producing a roadmap for paediatric and adolescent HIV and AIDS response drawing from provisions in existing national policies and strategies and evidence from elsewhere (c) MoH has established a sub-group of stakeholders implementing HIV interventions targeting paediatric and adolescents aimed at sharing best practices and coordinating service delivery, and(d) with support from WHO and UNICEF, MoH has planned to review the eMTCT strategy (2011-2015) to inform development of the successor eMTCT strategy offering an opportunity for HIV programming for children. Sustaining these initiatives is crucial to HIV and AIDS response for children and adolescents.

At a global level WHO, UNAIDS, UNICEF, PEPFAR and EGPAF have spearheaded development of a framework succeeding the Global Plan termed Start Free, Stay Free, AIDS Free aimed at fast-tracking ending AIDS among children, adolescents and young women by 2020. The framework has specific targets from reducing new HIV infections through the cascade of care for its target groups

. Translating this global pursuit to Malawi taking advantage of the opportunities presented at local level as mentioned hitherto (e.g road map for paediatric and adolescent HIV response, new eMTCT strategy) is imperative.

4.2 Strengths and limitations of the study

The findings of this study should be interpreted in light of some strengths and limitations. A random selection of health facilities including representation from all zones; health facility selection at primary and secondary levels of health care; capturing of both policy level and service delivery perspectives represent the strengths for this study.

Potential respondent reporting bias represents a limitation as each key informant's opinion is arguably shaped by his/her experience which may not reflect the broader context. However, this limitation is common to all qualitative studies. Selecting only ALHIV in teen clubs for FGDs may present a systematic selection bias as some ALHIV not in clubs probably have experiences that are critical to HIV programming for children and adolescents. However, practical challenges in identifying ALHIV not in teen clubs while respecting ethics related to disclosure and confidentiality rendered it difficult to involve this important group. Conversely, ALHIV in teen clubs have disclosed their status, are often free to interact with third parties, and have a platform on which initial consent can be sought (teen club coordinators getting consent prior to members interacting with third party).

4.3 Conclusion

This study has implications for the role of policy makers, health service providers at all levels in addressing the needs of children and ALHIV and general HIV and AIDS response. This study has revealed that whilst at policy level Malawi has largely adopted the majority of WHO recommendations along the HIV cascade of care for children and adolescents, implementation of some policy provisions remains suboptimal. It is evident that implementation of some policy provisions such as managing the HIV disclosure process requires greater mentorship to build confidence of providers.

The paucity of age specific HIV epidemic and response data on groups of children and adolescents has emerged as a barrier to comprehensive HIV programming for children and adolescents. The children and adult categorization, while useful in some respects, limits understanding of the progress (or lack of it) in an important age group (older children above two years and adolescents) in the HIV and AIDS response. In the context of global pursuits for an AIDS free generation, monitoring performance in various HIV and AIDS response indicators in these age groups remains critical.

This study has confirmed some of the documented health system challenges in delivering health services which impact on delivering effective and quality services for children and ALHIV. These include: limited health infrastructure; health workers lack of confidence and skills to handle children and adolescents; shortage of health workers; inadequacy of financial resources; lack of partner coordination; little emphasis on child and adolescent specific policies; limited data disaggregation and research on adolescents and children; unavailability of child and/or adolescent health expert at coordination and inadequate financing for children and adolescent specific interventions. These challenges have led to inability to expand coverage for some best practices in responding to the needs of ALHIV such as teen clubs.

This study has also revealed that opportunities exist to increase the prominence of children and adolescent HIV programming through emerging initiatives. In particular, establishment of a Paediatric HIV subgroup; interest from partners such as UNICEF to generate data to understand the HIV situation for children and adolescents, and the current study to inform ANECCA support for Malawi are cases in point. The leadership of MoH is critical in this regard. It remains imperative that robust policies should be in place and effectively implemented, monitored and evaluated in order to improve HIV and AIDS response for children and adolescents in Malawi and achieve an AIDS-free generation.

Potential respondent reporting bias represents a limitation as each key informant's opinion is arguably shaped by his/her experience which may not reflect the broader context

CHAPTER

05

5. RECOMMENDATIONS

In light of the findings of this rapid policy review pertaining to children and adolescents HIV and AIDS response in Malawi, the following recommendations are warranted:

i. **HIV and AIDS monitoring data to include age disaggregation capturing adolescents response periodically**: MoH should consider explicit indication of monitoring frameworks to denote progress in HIV response for adolescents. With an increasing number of new infections and HIV prevalence in this age group, this should be considered a policy imperative.

ii. **Scale up provision of essential HIV services to ALHIV using the teen club platform**. There is evidence on the effectiveness of teen clubs, including in Malawi, but with only 15% coverage, its optimal benefits to adolescents may not be reaped. Strategies should, therefore, explicitly indicate the need to scale up teen clubs.

iii. **Ministry of Health to provide guidance on establishment and comprehensive package of services delivered in teen clubs**. In order to standardize service delivery and ensure comprehensiveness and quality of services for ALHIV, it is essential that MoH offers guidelines for establishment of teen clubs and a service delivery package including transition programme from adolescent care and treatment to adult care and treatment. This stewardship function will allow for an acceptable minimum package for teen clubs established by any implementing partner.

iv. **Include management of HIV sero-status disclosure in training curriculum and clinical mentorship for ART providers**. Training curriculum for HTS and ART/PMTCT/TB service providers should include sessions on managing HIV disclosure in children and adolescents to effectively prepare them to handle the disclosure process. Existing clinical mentorship could also include managing HIV disclosure to help build confidence of health service providers following the training.

v. **Clearer guidance is required on flexibility related to age of consent for accessing HTS**. While the flexibility in adhering to age of consent is meant to address the potential barrier of age of consent to accessing HTS, it is presently so open that other providers may opt for a safer position of sticking to the consent age of 13 and not exercising the flexibility provided for in policy. MoH should consider coming up with explicit situations where age of consent application in HTS can be waivered.

vi. **Institutionalise coordination entity for children and adolescent HIV and AIDS response by placing a desk officer and establishing a thematic sub-group as governance structure for children and adolescent HIV and AIDS response.** Granted the unique service needs for children and adolescents, MoH should consider allocating a Technical Advisor or senior government officer (e.g at the grade of Chief officer) to champion issues of children and adolescents HIV and AIDS response. This position will provide appropriate linkages with other sections within the HIV and AIDS Department such as HTS, Care and Treatment; and other MoH sections such as Integrated Management of Childhood Illnesses; Reproductive Health Department (responsible for YFHS) to ensure that appropriate child and adolescent lens are applied in policy development and implementation. A governance structure such as a subgroup of the ART/PMTCT TWG should be formally instituted and sustained.

vii. **Comprehensive guidance and establish inter-sectoral linkages to address needs of ALHIV in boarding schools.** Granted that adolescence is the secondary school-going age group, it is important to explicitly provide policy guidance on addressing the needs of ALHIV in boarding schools including collaboration with school authorities at service delivery level. In particular, supporting treatment adherence and retention in care is critical.

viii. **External quality assurance is critical to quality improvement in HTS hence a robust EQA** is warranted with explicit plans and timelines for policy and strategy implementation. Additionally, with the emerging Quality Management Unit in the Ministry of Health, Department of HIV should lobby for inclusion of key indicators of quality HIV care for children and adolescents.

ix. **Advocacy for access to SRHR and HIV services in the school setting:** In view of some policy inconsistencies between Ministries of Health and Education in promoting and affording access to SRHR and HIV services in the school setting, it is imperative that advocacy is sustained to achieve access to services for adolescents. The principle of Health In all Policies is relevant in this regard. CSOs in HIV, general health and youth work stand in good position to galvanize this advocacy initiative.

While the flexibility in adhering to age of consent is meant to address the potential barrier of age of consent to accessing HTS, it is presently so open that other providers may opt for a safer position of sticking to the consent age of 13

APPENDIX

APPENDIX I: KEY INFORMANT INTERVIEW GUIDE FOR POLICY DEVELOPMENT TARGETING NATIONAL LEVEL POLICY MAKERS

Thematic area	Key Questions	Probes
Existence of the policy	Please tell me about existing national HIV and AIDS strategic policies, guidelines and documents and whether these documents prioritise Paediatric and adolescent HIV? Does the country have standalone Paediatric and adolescent HIV and AIDS policies and documents?	Probe and get a listing of HIV and AIDS documents in the country including strategic plans, policies, guidelines e.g HTC guidelines and policy, HIV prevention policies, ART policies etc Probe on whether children and adolescents are priorities and seek justification for the response Probe for specific Paediatric and adolescent HIV documents for example EMTCT policy documents, Paediatric ART documents, Adolescent ART documents, early infant diagnosis guidelines Probe whether the non recognition of adolescent as a distinct cohort (rather than being lumped in the children's group of 0 -14) in the policies impede development of implementation models specifically catered for adolescents and children

Thematic area	Key Questions	Probes
	What are other Paediatric and adolescent HIV and AIDS relevant documents in the country? Do you think the country has all the necessary policy documents/ guidelines to address Paediatric and adolescent HIV policy issues?	Probe for other policies such as child health policies, adolescent policies and see whether these include Paediatric and adolescent HIV issues. This could be Child Health Strategy, Youth Friend Health Service Strategy Using the policies reported earlier; whether the respondent feels the country has adequate policies/guidelines for Paediatric and adolescent HIV response Probe what the respondents think may be additional guidelines/policies etc that are required to address specific issues of interest in children and adolescent response
Policy development process	How were the stakeholders involved at the various stages in the development of Paediatric and adolescent focused HIV and AIDS policies and guidelines? What do you consider as strengths of existing policies pertaining to adolescents and paediatrics What do you think are the gaps in the engagement /involvement process and how do you think this can be addressed in future? What were the gaps in the process of identification of the policy problem?. What informed the development of the various policies?- were these adopted from international documents/Policies What about in the contextualization of the policies?	Probe on adequacy of the involvement at the various stages including problem identification and prioritization, contextualization of the issues Probe on what platforms/structures were used for stakeholder involvement e.g Technical Working Groups Probe on what respondents consider as strengths of the policy e.g test and treat, specific guidance on HIV disclosure among adolescents, ease of understanding etc 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 Probe on process of policy problem identification warranting policy If policy was adopted, probe on the process of contextualizing the policy to the country, were there any gaps and challenges

Thematic area	Key Questions	Probes
Policy content & Gaps	Do the general HIV and AIDS policies discussed earlier prioritise Paediatric and adolescent HIV?, if yes what are the issues prioritized (both for Paediatric and for adolescents)? 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? For the specific Paediatric and adolescent HIV and AIDS documents reported, what do you think are the key **strengths, opportunities** and **weaknesses**? How do you think the weaknesses could be addressed?	Using the mentioned general documents probe on respondents opinions on whether they prioritise 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 prioritise 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 particularly on provision for assessment of adolescent maturity to guide consent for testing if below age Probe on best practices in implementation of adolescent related policies Probe on specific key strengths and weaknesses adolescent strategies after testing to remain negative or link to care if positive 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 area	Key Questions	Probes
Policy implementation	Are the policy provisions on Paediatric and adolescent HIV being implemented? What are the barriers to the implementation of the various policy provisions? How can the barriers be addressed?	Use information on policy provisions to probe whether the policies are being implemented at the various levels. You may include the following aspects: how targeted community testing is operationalized, strategies that are in place to increase coverage of teen clubs (to capture more adolescents) or in general to improve HIV treatment coverage 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 e Probe on ways of addressing the various barriers to policy implementation identified
Recommendations for addressing identified gaps and concluding remarks	As we close, what would be your general recommendations for addressing policy related gaps on pediatric and adolescent HIV response in Malawi ? Are there any other pediatric and adolescent HIV and AIDS issues that you may wish to share with me?	

Note to interviewer: In this study, policy is used as a general term to include any document that provides official government position on the thematic areas under study. These can include policies, plans, guidelines, curriculla, legislation, and strategy documents among others. Provide this operational definition to the respondent at the beginning of the interview and refer to it whenever necessary to ensure comprehensiveness of the discussion.

APPENDIX II: KEY INFORMANT INTERVIEW GUIDE FOR POLICY IMPLEMENTATION TARGETING HEALTH WORKERS

Thematic Area	Key Questions	Probes
Knowledge of policy provisions for Paediatric and adolescent HIV care and treatment	Please tell me about national policies pertaining to HIV and AIDS response and whether these prioritise Paediatric and adolescent HIV care in this county?	Probe to get a listing of all the care policy documents mentioned (please consider the entire cascade of HIV care from HIV testing to care and support e.g HIV Testing guidelines)
	Does the country have standalone Paediatric and adolescent HIV and AIDS policies and documents?	
	What are some policy provisions in these policy documents pertaining to adolescents?	Probe and list specific provision focusing on Paediatric and adolescent HIV
	Have these documents been disseminated to the health workers?,	Does the country have standalone Paediatric and adolescent HIV and AIDS policies and documents?
		Using the policy documents mentioned probe to see whether the health workers understand the policy provisions
	How was the dissemination done?	Probe to see whether the reported policy documents have been disseminated at implementation level
	Do you this think the dissemination process could be improved	Probe on modes of dissemination including documents sharing, workshops etc

Thematic Area	Key Questions	Probes
Best practices in policy implementation		
Opinions on policy strengths and gaps for pediatric and adolescent HIV care and treatment	In your opinion, what are the key strengths of policies (be it general or standalone) in guiding HIV and AIDS response for children and adolescents What would you say are the policy gaps on Paediatric HIV care? Would you give examples of policy gaps for adolescent HIV care? How has this affected access to HIV care by children in this facility? How has this affected access to HIV care by adolescents? What would be your recommendation (any additions) in policy content so it adequately informs policy implementation?	Probe on potential strengths of policies cited earlier in relation to (HIV testing, care and treatment e.g test and treat, guidance for disclosure, support for adolescents in boarding school etc) Use the various standard policy provisions for Paediatric HIV care to make probes on the gaps under each e.g age of consent could be restrictive to access HIV testing, low coverage of teen clubs Probe on how each of the identified policy gap impacts HIV care by children For each policy gap mentioned probe on how it impacts on access to HIV care by Ask for examples of how the effect is felt at implementation level for children and adolescents Specifically probe along the continuum of care (from HIV prevention, HIV testing, linkage to care and treatment and support, viral load monitoring) areas that need improvement at implementation to be guided by policy
Availability of policies/guidelines on Paediatric and adolescent HIV at facility level	How accessible are various adolescent and Paediatric HIV care policies/guidelines by health workers in this facility? Are there some policy/guidelines/tools that are not available at this facility level?, if yes, which ones? How has that affected provision of services to children and adolescents? 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 policies and guidelines Probe on unavailability of the guidelines/policies have impacted service delivery

Thematic Area	Key Questions	Probes
Policy practice	In general how is the implementation of the various Paediatric HIV policy provisions in this facility? What are some policy provisions that have been implemented successfully and why? What challenges do you face in implementing those policy provisions What are your suggestions for addressing those policy practice barriers?	Probe whether implementation of policies adheres to policy content/provision or Probe for each policy in terms of best practices in implementation e.g targeted HIV testing for adolescents? Teen clubs? Probe on issues of coverage for policy provisions and what strategies can be put in place to increase coverage of essential adolescent services e.g teen clubs (if available) Based on challenges cited, probe on nature of challenges Probe on potential policy related solutions to the problem and other health system solutions
Recommendations on policy gaps and practice	As we conclude what would be your advice for ensuring implementation of Paediatric HIV care policy provisions at facility level? What about implementation of adolescent HIV care policy provisions?	

Note to interviewer: In this study, policy is used as a general term to include any document that provides official government position on the thematic areas under study. These can include policies, plans, guidelines, curriculla, legislation, and strategy documents among others. Provide this operational definition to the respondent at the beginning of the interview and refer to it whenever necessary to ensure comprehensiveness of the discussion