

A COMPARATIVE REVIEW OF
**CHILD AND
ADOLESCENT HIV
GUIDELINES AND
POLICIES**
IN 7 SUB-SAHARAN
COUNTRIES



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Abbreviations

AIDS	Acquired immunodeficiency syndrome
ALHIV	Adolescents living with HIV
ANECOA	African Network for the Care of Children Affected by HIV/AIDS
ART	Antiretroviral therapy
CLHIV	Children living with HIV
EID	Early infant diagnosis
GBV	Gender-based violence
HCW	Health care worker
HIV	Human Immunodeficiency Virus
HTS	HIV testing services
KII	Key informant interview
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NSP	National Strategic Plan for HIV and AIDS response
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-initiated testing and counselling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
UNAIDS	United Nations Joint Programme on HIV and AIDS
WHO	World Health Organization

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Executive Summary

Background

The global community has set the goal of ending the AIDS epidemic by 2030. Recent data from UNAIDS postulate that only half of treatment-eligible children living with HIV in sub-Saharan Africa are likely to receive antiretroviral therapy compared with HIV-positive adults. As compared to adults, adolescents are experiencing poorer outcomes, higher rates of mortality, loss to follow up and lower rates of virological suppression. Adolescents are the only age group in which AIDS-related deaths increased. The annual number of AIDS-related deaths among adolescents almost doubled between 2005 and 2012. Non-existent and inconsistent policies are some of the reasons that have prevented national and subnational governments in sub-Saharan Africa from explicitly programming for children and adolescents living with HIV.

ANECCA received a grant from the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund) to implement the “Catalysing access to quality services for children and adolescents living with HIV” regional project to address issues that impede optimal coverage and quality of care. The project aims to 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 seven countries.

This descriptive study was carried out in seven Sub-Saharan countries with the least coverage for antiretroviral treatment for children and adolescents living with HIV compared with adults. These are Burundi, Ethiopia, Malawi, Nigeria, South Sudan, Tanzania and Uganda. The objectives were to review and assess existing national paediatric and adolescent HIV policies and guidelines, 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 and to document best practices and success stories.

The WHO-defined standard of care for children and adolescents living with HIV in prevention, HIV testing and counselling, HIV care and treatment was used as the gold standard to assess the various documents. Consultants in each of the seven countries conducted the assessment in partnership with the national HIV and AIDS programmes while relevant ethical approvals were obtained from respective national institutional review boards.

Findings

The following strengths were noted in the country policies:

- The process of developing policies and guidelines is largely an inclusive process at the national level.
- Paediatric and adolescent HIV testing services, care and treatment policies exist but are mostly integrated with policies and guidelines addressing adults.
- Children and adolescents are recognized as a special group and so it is easy to target them with care and treatment.
- Current 2015 WHO guidelines have to a large extent been adapted.
- There is good linkage with maternal and child health, sexual reproductive health and tuberculosis disease.

Gaps:

- National policies lacked national, subnational and health facility action plans to operationalize these policies.
- Though country HIV policies recognize children and adolescents living with

HIV as a special group, there were no clear strategies on how to identify, link, initiate and retain them in HIV care and treatment programs.

- Country HIV M&E systems are unable to track uptake, coverage and quality of service for children and adolescents living with HIV. Indicators for paediatric and adolescent quality of care are lacking.
- Important child health issues such as nutrition, water and sanitation, gender-based violence and non-communicable diseases are not clearly addressed in the policies. For example, non-communicable diseases and gender-based violence among the children and adolescents are on the increase in some countries in the general population, but current HIV policies do not address these key issues among children and adolescents living with HIV.
- Health workers lack knowledge of the current national paediatric and adolescent guidelines in their countries and express a lack of confidence and skills to optimally provide psychosocial support to children and adolescents living with HIV.
- UNAIDS provides estimate data for only two age groups (<15 and >15 years). Adolescent age group estimates will help in better program planning.
- In some countries, country HIV testing services policies on age of consent are inconsistent with country legal frameworks for adolescents to independently seek medical treatment.

Recommendations

These strengths and weaknesses were presented to regional stakeholders' meeting that was held in November 2016 in Kampala, Uganda. The meeting recommended each country addresses the following action items:

- On data management, each country should:
- make efforts to move to electronic medical records
- ensure that data is disaggregated by age particularly for adolescents (10–14,

15–19 years)

- include paediatric and adolescent quality indicators in their national reporting system
- share country success stories to scale up best practices.
- Regional bodies and individual countries should lobby UNAIDS to provide ART estimates that encompass adolescent age cohorts (10–14 years, 15–19 years).
- Carry out multi-sectoral harmonization of policy and legal documents for consistency.
- Update sub-national paediatric and adolescents' action plans with explicit and measurable strategies for identification, linkage, initiation and testing.
- Promote paediatric and adolescent operational research through widening partnerships with professional associations, academia, and others.
- Promote a multi-sectoral engagement with ministries of health, social affairs (OVCs), agriculture (nutrition), education and justice (child protection) to manage children and adolescents living with HIV holistically.
- Mainstream and integrate services to prevent, detect and care for survivors of sexual gender-based violence in paediatric and adolescent HIV care.
- Deliberate efforts be made to establish effective, sustainable, structured pre-service and in-service training curricula/programs and national structured mentorship frameworks that address the capacity needs of health care workers for children and adolescent HIV services, including counselling and psychosocial support and care.
- Develop an adolescent HIV toolkit that includes adolescent HIV minimum package of care, country guidelines for teen clubs and other adolescent activities.
- Share intercountry success stories and best practices for scale-up purposes.
- Create awareness in the community of available care and support for children and adolescents living with HIV and AIDS.

1 Situational Review

1.1 Introduction

1.1.1 Global and Sub-Saharan Background

The number of persons newly infected with HIV has continued to decline from 3.4 million new HIV infections in 2001 to 2.1 million new infections in 2013 (1). There has been a 58% drop in new infections among children from 580,000 new infections in 2002 to 240,000 in 2013 (1). Even with these commendable gains, there are still gaps. Three of four children living with HIV, or 76%, are not receiving HIV treatment (1). Globally, 15% of all women living with HIV aged 15 years and older are young women 15–24 years old. Of these, 80% live in sub-Saharan Africa where it is estimated that adolescent girls and young women account for one in four new HIV infections in eastern and southern Africa (1). In this region, women acquire HIV infection at least 5–7 years earlier than men. Table 1 summarizes the HIV epidemic among adolescents in eastern and southern Africa. Of significance is the higher number of female adolescents with HIV compared with male adolescents.

Table 1: Summary of HIV epidemic among adolescents (10–19 years), Eastern and Southern Africa (ESAR), 2015

	Global		ESAR		% of global total
	Female	Male	Female	Male	
Estimated number of adolescents 10–19 years living with HIV	990,000	780,000	640,000	440,000	61
Estimated number of adolescents 15–19 years newly infected with HIV	160,000	87,000	100,000	32,000	53
Estimated number of adolescents 10–19 years dying of AIDS-related causes	20,000	21,000	12,000	12,000	58

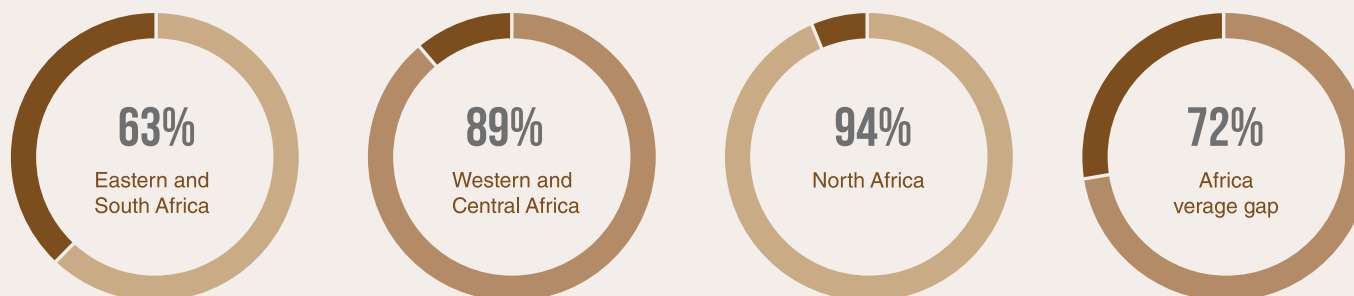
Source: UNAIDS 2016 estimates. (Available at: <https://data.unicef.org/topic/hivaids/adolescents-young-people/>)

The global community has set the goal of ending the AIDS epidemic by 2030 (2). The intermediate goal was by 2020 were; 90% of all people living with HIV would know their HIV status, 90% of all the people with diagnosed HIV infection would receive sustained antiretroviral therapy (ART) and 90% of all the people receiving ART will have viral suppression (3).

The reality is that this will be an uphill task. Data from UNAIDS postulate that only half of treatment-eligible children living with HIV in sub-Saharan Africa were likely to receive ART compared with HIV-positive adults (4). In 9 out of the 21 sub-Saharan African countries prioritized by Africa Global Plan towards the “Elimination of new

HIV infections among children and keeping their mothers alive”, 25% or fewer children eligible under the 2010 World Health Organization (WHO) guidelines received ART in 2012. The same analysis compared the number of children receiving antiretroviral therapy with the potential eligible under the WHO 2013 guidelines and found the gap in paediatric ART coverage was significant: the average continental child ART gap was 72% with the highest child ART gap being 94% in North Africa and the lowest (63%) in the eastern African region (Figure 1), although the burden of disease was higher in East and southern Africa, hence more children are affected (4).

Figure 1: Regional gaps in paediatric antiretroviral therapy, Africa, 2012–2013



Source: UNAIDS 2012 estimates

Note: Based on numbers receiving treatment as of December 2012 and estimated number of people eligible as of December 2013 under the 2013 WHO HIV treatment guidelines

The situation was not any better among adolescents (10–19 years) living with HIV (ALHIV). Studies had shown that adolescents who adhered to ART had lower rates of virological suppression and immunologic recovery as well as higher rates of virological rebound after initial suppression (5). Compared with adults, adolescents were experiencing poorer outcomes, higher rates of mortality, higher loss to follow up and lower rates of virological suppression. (6). Adolescents were the only age group in which AIDS-related deaths increased. From 2005 to 2012, the annual number of AIDS-related deaths among adolescents almost doubled (7). The deaths were attributed to late ART initiation especially for perinatally infected adolescents (8), and poor follow-up and retention in care (9). It was estimated that 2.1 million adolescents were living with HIV; 82% were in sub-Saharan Africa and about 58% were female (10), making females living with HIV disproportionately more affected. Early sexual debut, before 15 years of age, was more common among adolescent girls, leading to early marriage and early childbearing (11). Social and economic challenges also put ALHIV at risk of intravenous drugs use, and sexual experimentation and exploitation (2).

WHO postulated that the increase of AIDS-related deaths among adolescents was partly due to the failure of governments to prioritize adolescents in national HIV plans and to create adolescent friendly testing and counselling services (12). Evidence suggests that few national HIV/AIDS strategies and policies in HIV high-burden countries in sub-Saharan Africa have explicit programmes for adolescents to address their HIV prevention, control, treatment and care needs (13). A study assessing age-related barriers to HIV and AIDS in Rwanda found that the policy defining age of the majority as the cut-off point for accessing HIV services was a barrier to HIV prevention, control, testing and treatment services for adolescents living with HIV (14).. A review of Tanzania’s HIV testing and counselling policies showed that the ministry of health’s HTC guidelines provide for adolescents less than 18 years under the category of “mature minors”, but the statutory age of consent for independent consenting to HTC and HIV treatment is 18 years (15). This apparent conflict between the ministry of health’s HTC guidelines and the statutory age of consent as reflected in the Tanzania’s HIV and AIDS Act causes confusion and prevents health care providers from offering HTC to adolescents (15).

Church et al. (2013) carried out a comparative analysis of national HIV policies in influencing access to HIV testing and treatment services in six sub-Saharan countries and demonstrated the variation in national policies influencing access to service and attrition through the continuum of care (16). Although this study did not focus on children and adolescents living with HIV, it found that no country stood out as having a consistently enabling policy environment that would have meaningful impact on service access and attrition.

Regional, national and subnational HIV programmes in sub-Saharan African countries need to put in place policy and guidelines that would provide for

innovative strategies to deliver high-impact interventions for children and adolescents living with HIV (11). These include youth-friendly programmes for adolescents and young women to increase prevention, initiation and retention in care (11). Addressing issues around gender inequalities such as gender-based violence, will improve access and adherence to HIV services (11) particularly for adolescent females who were disproportionately affected. An AIDS-free generation by 2030 will remain unattainable if national programmes do not focus on children and more importantly adolescents by strengthening and monitoring policies that provide adolescents with access to tailored high-impact interventions in HIV prevention, control, testing, treatment as well as social support (13).

1.2 Country Background

Here, is a summary of the current HIV background in seven sub-Saharan countries with the lowest ART coverage for children and adolescents living with HIV compared with adults and this is where ANECCA will implement a regional project to improve coverage and quality of care.

However, there are still challenges in increasing coverage of paediatric HIV services. Only 2% of infants exposed to HIV received early infant diagnosis and 29% children living with HIV accessed ART (19). There is limited data for adolescents living with HIV although national programmatic assessments show that about 50% of all new infections occur in persons aged < 25 years, with 25% of these related to the transmission of HIV from mother to child (20, 21).

BURUNDI

With a total area of 27,830 km², Burundi is one of the smallest but most densely populated countries in East and Central Africa. The HIV national prevalence is estimated at 1.4% (17). There is a disproportionately higher HIV prevalence in the urban than in the rural population (4:1): the capital city, Bujumbura, is estimated to have HIV prevalence of 4.3% (18).

Over the last decade, there has been progress in the fight against HIV. In 2015, fewer than 300 new HIV infections were reported among children compared with more than 1600 in 2009 (19). In 2015, 89% of pregnant women living with HIV accessed antiretroviral medicines to prevent mother-to-child transmission while ART coverage for children (0–14 years) increased from 12% in 2009 to 30% in 2015 (19).

ETHIOPIA

Compared with other Horn of Africa countries, Ethiopia has a low generalized HIV epidemic with diversity among the regions and key populations. According to 2014 HIV estimates, the national HIV prevalence in Ethiopia is 1.14%, with urban populations being more affected than rural areas, and the ratio of HIV infection in females is twice that in the male population (22). Ethiopia has made commendable strides in the fight against HIV. Between 2000 and 2011, the annual rate of new HIV infections declined by 90% and AIDS-related deaths by 53% (23). HIV prevalence among 15–24-year-old pregnant women decreased from 12.4% in 2001 to 2.1% in 2012 (24, 25). According to 2014 estimates, access to HIV services also increased in the 1,047 health facilities in Ethiopia: 79% of the facilities are providing HCT

services, 57% PMTCT and 24% ART services (26). To address the human resource challenges and to create awareness and demand for HIV services, Ethiopia implemented an extensive community health strategy that included task shifting, deploying health extension workers (HEW) and a health development army (HAD). This led to increased uptake of HIV testing and counselling services (27).

Nevertheless, there are still challenges. In 2016, it was estimated that there were about 21,565 new HIV infections; of these 2,212 were children under 15 years (28). There has been a sustained increase in new HIV infections among young adults

(15–24 years) between 2008 and 2014 and currently, the highest HIV prevalence rates in the country are among young adults (29). Countrywide, ART coverage is still sub-optimal, and is worse among children. In 2014, about 339,043 adults (65% of ART coverage) received ART while paediatric coverage is 22,955 or 15% (30). The paediatric HIV population consists mostly of older children who were vertically infected in earlier years when coverage and effectiveness of PMTCT in the country was low with high rates of mother-to-child transmission (28).

MALAWI

Malawi has a population of about 17 million people. HIV prevalence steadily declined from 12% in 2004 to around 10.6% in 2014. It is estimated that 1 million people are currently living with HIV and of these, 100,000 are children less than 15 years (31). ART coverage is lower in children compared with adults. By September 2015, estimated ART coverage was 50% (50,533 / 101,000) among children (<15 years) in need of treatment and 68% for adults (31). Viral suppression rates in children are lower (70%) compared with adults (90%) suggesting challenges related to ART adherence and higher rates of loss to follow up (32). National data on ART coverage for adolescents (10–19 years) is limited. However, comparing the 2004 and 2010 Malawi Demographic and Health Surveys, HIV prevalence increased among adolescents age 15–19 years, from 0.4% to 2.7% in boys, and from 3.7% to 4.2% in girls (33). Malawi decentralized its delivery of HIV services since March 2016: 653 clinics provide comprehensive HIV services. Like other countries in the region, Malawi faces a significant shortage of staff and task shifting has been adopted to mitigate the shortage. HIV testing services are primarily provided by health surveillance assistants and more recently by a new cadre, the HIV diagnostics assistants, hence leaving ART initiation to medical assistants and

nurse technicians. The National Health Accounts and the National AIDS Spending Assessment show that approximately two-thirds of the health expenditure and three-quarters of the HIV expenditure are financed by development partners.

NIGERIA

Although HIV prevalence among adults is low (3.1%) compared with that in other sub-Saharan African countries, the total population living with HIV is about 3.5 million, making Nigeria the country with the second-highest HIV burden in the world (34). There are wide interstate differences—Benue State has HIV prevalence of 15.4% and Zamfara State 0.9% (35). In 2013, there were 51,000 new HIV infections among children that accounted for one-quarter of all new HIV infections among children in the 21 Global Fund priority countries (36, 37). In 2014, new infections from adolescents and youth age 15–24 years were estimated at 227,518 (25%), with females disproportionately more affected than their male counterparts (38).

Nigeria was one of the few countries with low coverage of PMTCT services and corresponding little improvement in reduction of new paediatric infections (39). As of 2012, PMTCT services were offered in 1,320 of the over 26,000 facilities

countrywide, reaching about 19% of pregnant mothers with HIV testing and counselling (HTC) and about 17% of HIV-positive mothers with antiretroviral for PMTCT (40–42). Thus, paediatric infections in Nigeria account for 29% of the global burden and 12% of HIV-associated maternal deaths (43). The Nigeria National Acceleration Plan for Paediatric ART reported that there were about 380,000 children living with HIV in Nigeria. HIV testing services identified only 9% of children living with HIV and of these, only 21% accessed ART compared with 48% of adults.

SOUTH SUDAN

South Sudan is Africa's youngest republic having attained independence a little over 5 years ago. The decades-long civil war left over 2 million dead and led to the neglect of the health system, contributing to high rates of morbidity and mortality across the social strata (Table 2).

Table 2: Summary of South Sudan HIV epidemiological statistics (UNAIDS 2015)

Prevalence: Adults age 15–49: 2.5% [1.6–3.4%]

Living with HIV

Number of people living with HIV: 180,000 [110,000–240,000]

Adults age 15 years and over: 170,000 [110,000–220,000]

Women age 15 years and over: 97,000 [63,000–130,000]

Children age 0 to 14 years: 14,000 [9,200–19,000]

Deaths due to AIDS: 12,000 [7,300–16,000]

Orphans due to AIDS, age 0–17 years: 100,000 [68,000–140,000]

South Sudan has 1,147 functioning health facilities serving a population estimated at 12 million. Infrastructure is poor and health systems are weak. There is a big crisis in availability of health personnel, necessitating task shifting to community health workers and home health promoters. The estimated HIV prevalence for 2015 was 2.7% (44). In the same year, it was estimated that about 180,000 people including 14,000 children were living with HIV. Similar to other sub-Saharan countries, women, particularly in the age groups 20–24 and 25–29 years, are disproportionately affected due to sociocultural and economic risk factors. By June

2016, only 27 sites across the country were offering comprehensive HIV treatment, care and support to people living with HIV (45). Hence, the low coverage with less than 5% of all adults and 3% of all children living with HIV being on treatment.

UGANDA

Uganda's population is estimated at 34.9 million. It has one of the youngest and most rapidly growing populations in the world with 70% of the total population being less than 25 years old and children below 18 years constitute 56.7%. HIV prevalence is estimated at 7.3% (UAIS,2011) from 6.4%(UAIS,2004). The number of persons in the country living with HIV has continued to increase from 1.4 million in 2013 to 1.56 million in 2015. The rise is attributed to new HIV infections, high enrollment in HIV Care & Treatment, good retention and reduced HIV related morbidity.

Uganda has adopted key global strategies to end the HIV epidemic by 2030:

“Towards zero new infections, zero HIV/AIDS-related mortality and morbidity and zero discrimination”; the UNAIDS treatment targets of 90-90-90 by 2020 and efforts “Towards an AIDS-free Generation”. The Uganda Country Report (2015-2016) reported reduction of new infections amongst CLHIV from 12,000 in 2013 to 3,500 in 2015. In addition, there was an 86% reduction in new infections among exposed infants since 2011 which was the highest reduction in eastern and southern Africa. Adaptation of the test and treat for all HIV-positive children has led to increased CLHIV coverage from 54% in 2014 to 66% (60,124/92,370) by end of June 2016.

Even with these gains, there are still challenges to be overcome. Among children under 2 years initiated on ART in 2015, 23% were lost to follow up in the first year. For children under 5 years, the viral suppression rate was at 70% compared to 90% for adults. This is coupled with a higher sample rejection rate of 7% compared to 5% for adults. Only 39% of the health facilities had adolescent friendly services. This shows that despite scaling up the prevention of mother-to-child transmission (PMTCT) programme and roll-out of HIV services to lower-level health facilities, there are still gaps in paediatric and adolescent HIV testing, linkage care and treatment and retention on ART.

TANZANIA

The United Republic of Tanzania national HIV prevalence declined from 7% in 2004 to 5.3% in 2012 among adults aged 15–49 years. Despite this improvement, there is great regional variation: Njombe has HIV prevalence of 14.8% while Zanzibar has less than 1% (46). An estimated 1.4 million people are living with HIV and of these, approximately 28% are children (0–14 years) and 11.2% are young people age 15–24 years. Tanzania has the second-largest burden of HIV-positive children who have not been initiated on antiretroviral treatment, based on the 2010 WHO eligibility criteria. Young females aged 15–24 years are three times more likely to contract HIV than boys of the same age (47). In 2010, about 335,000 people living with HIV were reported to be on ART; of these only 25,000 were children under 15

years representing only a third of the estimated number of children in need of ART (*ref. www.unicef.org/tanzania/children_aids10624.html*)

Based on a UNAIDS estimate of 130,000 children and adolescents in need of treatment, Tanzania partnered with PEPFAR and the Global Fund and, enrolled 34,524 children on ART by the end of 2013, representing 26.5% coverage. This places Tanzania below the global coverage estimate for paediatric antiretroviral treatment of 34%. A wide disparity exists in ART coverage between adults and children, with an adult ART coverage estimate of 68%. Additionally, only 43% of infants had access to early infant diagnosis (DNA PCR).

1.2 Rationale for a policy and guidelines rapid assessment

The African Network for the Care of Children affected by HIV and AIDS (ANECCA) is a non-profit pan-African network of clinicians and social scientists with a mission to improve access to quality and comprehensive HIV prevention, care, treatment and support services for children, integrated within the broader maternal and child health framework. Through a grant from the Global Fund, ANECCA will implement a regional project “Improving coverage of quality services for children and adolescents living with HIV”. This project targeted seven countries: Burundi, Ethiopia, Malawi, Nigeria, South Sudan, Tanzania and Uganda—all in sub-Saharan Africa and with the lowest ART coverage for children and adolescents living with HIV compared with adults. The project aims to improve coverage of quality services for children and adolescents living with HIV 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. The rapid guidelines and policy assessment commissioned by ANECCA aimed at identifying the strengths and gaps in national policies, as well as best practices for

purposes of developing national and regional plans to improve coverage and quality of services for children and adolescents living with HIV.

1.3 Objectives

The three objectives of the child and adolescent policy and guideline rapid assessment in the seven African countries with the lowest ART coverage were:

- To review and assess existing national paediatric and adolescent HIV policies and guidelines in Burundi, Ethiopia, Malawi, Nigeria, South Sudan, Tanzania and Uganda with a view to identifying strengths and gaps for provision of quality services for children and adolescents living with HIV
- To document best practices and success stories within national policy frameworks, strategies and guidelines for provision of quality services for children and adolescents living with HIV 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.

2 Methodology

2.1 Study Design and Setting

This was a rapid assessment of children and adolescent HIV and AIDS policy and guidelines that employed a cross-sectional descriptive design across seven Sub-Saharan African countries: Burundi, Ethiopia, Malawi, Nigeria, South Sudan, Tanzania and Uganda. The qualitative assessment method was used to collect primary data and the secondary data were abstracted using a desk review of the relevant national HIV and AIDS policy documents. The Walt and Gilson policy analysis framework was used to guide the key informant interviews and the desk review. The assessment which was conducted over a period of 5 months from July to November 2016 was led by ANECCA in partnership with the relevant departments of the ministries of health (MOH) of the respective countries. The ethical and research committee approvals were obtained from the various accredited national institutional ethical and review boards for research.


2.2 Sampling Procedure

This was a nationwide study in 7 countries involving national and subnational stakeholders. The study population for this policy review and assessment constituted key informant interviews at two levels: health facility and national level.

2.2.1 Health facility sampling

At the health facility level, a simple random sampling technique was used to select one district per region or zone in each country. Within the selected district, all health facilities providing HIV care and treatment were listed and categorized into primary and secondary health facilities as per the WHO definition.

Subsequently, within each category, 10% of the primary health care facilities and 10% of secondary health care facilities were selected by simple random sampling. This method was employed in all the selected countries except Nigeria, which selected a higher proportion of secondary health facilities. Additionally, Malawi conducted focus group discussions with adults living with HIV to provide insights to the gaps and lessons learned at implementation stage. Table 3 shows the final selected primary and secondary health facilities.



The Walt and Gilson policy analysis framework was used to guide the key informant interviews and the desk review.

Table 3: Health facilities sampled in 7 target countries

Country	Hospital	Health centre	Total
Burundi	Bubanza, Buvyuko, CCMK, Apecos, Rushubi, Gasanda, Bururi Buta, Rumonge, Kigwena, Cankuzo, Mabayi, Rubona, Ntita, Nyabiraba, Buhiga, Rugazi, Kayanza, Rubura, Kirundo, Ruhehe, Makamba, Kayagoro I, Kiganda (24)	Rama, Giteranyi, Rabiro, Kibumbu, Mbogora, Kinyinya, Gasanda, Gihofi, Giharo, Kiremba, Gakere, Muyaga (12)	36
Ethiopia	Dubeti, Tirunesh-Beging, Ataye, Dessie, Assosa, Sabian, Gambele, Jugula, Shenen Gibe, Fitch, Jigjiga, Yirgalem, Adare, Kidist Mariam, Makele (17)	Semera, Saris, Ataya, Dessie, Assosa, Lagehare, Gambela, Jenela, Jimma, Fitch no 1, Jigjijjga, Yirgalem, Loke, Axum, Semen (15)	35
Malawi	Rumph District H, Mhuju Rural H, Dedza District H, Nsanje District H, Dowa District H, Mponela rural H, Mulange District H (7)	Mayani, Lujeri, Nyamithuthu (3)	10
Nigeria	St. Francis Hospital, Yola Specialist Hospital, Adammawa Hospital (Yola), Fufore Cottage Hospital, Sokoto Specialist Hospital, Dongo-Daji General Hospital, Tambuwal General Hospital, Wuse General Hospital, Rainbow Hospital & Maternity (Apo), St. Mary's Catholic Hospital, Rhema Hospital, Bishop Shanahan Hospital, Adani Hospital (Nsukka), Royal Hospital (Aria), Ntasi Obi Hospital, Terrebor General Hospital, Our Lady of Apostle Hospital (Oluyoro), Alawaye Hospital, Saki State Hospital, Baptist Hospital (Ogbomoshu)	Pope John Paul Clinic, Maryam Abacha Maternal & Child Health Centre,	24
South Sudan	Juba, Nimule, Yambio, Bor, Mpuordit, Yirol, Yei, Aweil, Kuajok, Renk		10
Tanzania	Arumeru Infectious Dx Centre, Mirembe Geita, Tosa Maganga, Bukoba, Mpanda District, Matyazo, Kilema, Nyangao, Babati, Butiaa, Igawilo, Mazimbu, Ligula, Misungwi, Ilembula, Bagamoyo, Mtowisa, Peramiho, Kolandoto, Bariadi, Manyoni, Nzega, Korogwe	Dreams USA, Buguruni, Makole, Katoro, Migoli, Zamb Zam, Bitale, Umbwe, Milola, Bashnet, Kiagata, Ruanda, Mafiga, Mikindani, Lupembe, Msata, Mbarika, Matai, Madaba, Kambarage, Nuglyati, Itigi, Busondo, Mombe	50
Uganda	Murchison Bay Hospital (Prisons), Naguru Health Center (MoH), Kadic Hospital (Private), Family Care Clinic (Private), Makerere Sickbay Hospital (MoES), Paragon Hospital (Private), Bugolobi Nursing Home (Private), Andrews Medical Center (Private), Nkozi Hospital (PNFP), Mpigi HCIV (MoH), Bunjako (MoH), Buwama (MoH), Masindi Hospital (MoH), Bwijanga (MoH), Field Artillery (UPDF), Ikoba (MoH), Kimengo (MoH), Kambuga (MoH), Bwindi Community (PNFP), Kihiihi (MoH), Kanungu (MoH), Katete (MoH), Lira Hospital (MoH), Amach (MoH), Ogur (MoH), Pag Mission (PNFP), Ayago (MoH), Ober (MoH), Ongica (MoH)	Kyambogo University Clinic (MoES), Kisenyi Health Centre (MoH), Kiswa (MoH), St. Thereza Medical Clinic (MoH), AIDS Information Center (MoH)	55
Total no. of health facilities sampled across the 7 countries			220

2.2.2 Selecting Key Informant Sampling

Health facility level: Health facilities in each country were selected using systematic sampling (Table 1) and health workers were purposively sampled from service delivery points that provided child and adolescent HIV care services. To understand integration and provision of services such as provider initiated testing and counselling (PITC), the health facility officer in charge was also sampled for interview (KII).

National level: In collaboration with the selected countries' Ministries of Health and ANECCA, the ministerial focal persons and the national consultant carried out one stakeholder analysis for each country after mapping key stakeholders in child and adolescent HIV and AIDS care and support. These included United Nations agencies, professional associations, civil society organizations (CSOs) and the relevant government programmes, departments or units (Table 4).

Table 4: National level respondents

Stakeholder	Partner
Ministry of Health	AIDS Control Programme Reproductive and child health units
UN agencies	UNICEF, UNFPA, WHO, UNAIDS
Professional associations	Paediatric Association
CSOs	USAID/PEPFAR, GFATM

Thereafter, purposive targeted sampling was carried out to identify two or three respondents per organization who were directly involved in paediatric and adolescent HIV policy and guidelines for key informant interviews. Across all seven countries, 85 national stakeholders were interviewed at national level and 386 respondents at subnational or health facility level (Table 5).

Table 5: National level respondents from seven countries

Country	National	Subnational
Burundi	17	104
Ethiopia	5	35
Malawi	21	20
Nigeria	12	55
South Sudan	14	20
Tanzania	6	92
Uganda	10	30
Total	85	368

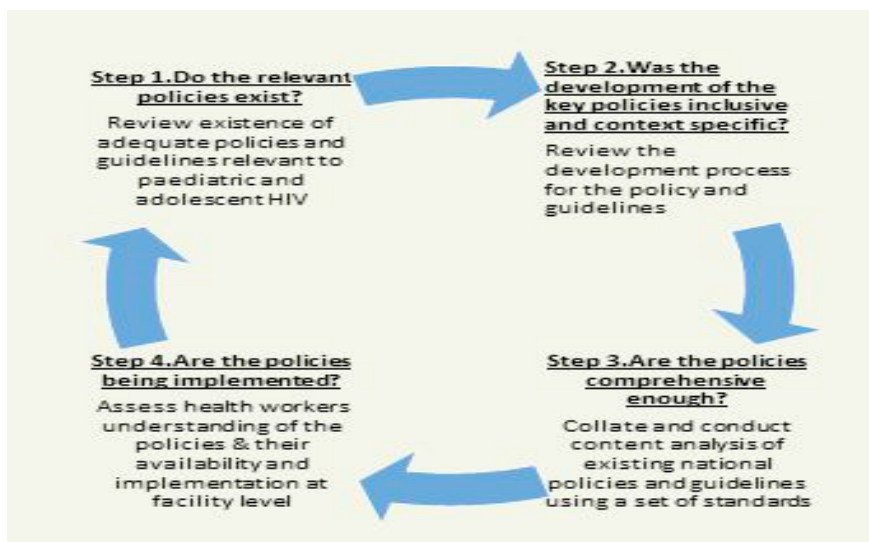
2.3 Data Collection

2.3.1 Policy review

Secondary data collection was carried out through desk reviews to assess content on HIV and AIDS policy documents, guidelines, strategic documents and action plans. The review and assessment of the existing national policies and guidelines related to child and adolescent HIV care was based on the Health Policy Conceptual Model by Walt & Gilson (49, 50) and was adapted to review four critical policy issues:

- i) existence of paediatric and adolescent HIV care policies
- ii) the processes of policy development including the role of various stakeholders (actors)
- iii) the content of the policies and guidelines including comprehensiveness of the policies
- iv) modes of implementation of the policies (Figure 2).

Figure 2: Key questions to answer in the policy review and assessment



A desk review was carried out on various HIV policies, guidelines, strategic documents and actions plans to assess content and comprehensiveness of the documents using the Walt & Gilson policy review process. All national policies that made reference to paediatric and adolescent HIV were included for review and analysis (Table 6). The desk review also facilitated the mapping out of key country stakeholders.

Table 6: Minimum listing of policy documents for review

National HIV strategic plan
National HTC strategy or guidelines where these exist
ART/Treatment policy/strategy/guidelines
Paediatric HIV care and treatment guidelines
Early infant diagnosis policy/guidelines where these exist
PMTCT/EMTCT guidelines/policy/strategy

All policies that were reviewed were also approved as the official policy documents by the various national ministries of health. For this review, policies included any documents that provided direction for official government position on the thematic areas under this assignment. These included policies, action plans, guidelines, curricula, legislation, and strategy documents.

Content analysis commenced with collating and cataloguing all relevant policy documents and guidelines to be reviewed. The WHO (2015)-defined standards of care for children and adolescents living with HIV and AIDS, that is, the *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* (51) and the *Adolescents: guidance for testing and counselling for adolescents and care for adolescents living with HIV* (52) were used as benchmarks to assess each country's policy and guidelines documents.

2.4 Data Management

All data generated from target countries were analysed separately and individually. Using the policy review guide template, findings of the policy assessment were documented. Existing policy provisions were summarized and gaps, opportunities lessons learned were highlighted using descriptive narratives and schematic diagrams.

The recordings from the key informant interviews were transcribed within 24 hours by the field assistant or by the ANECCA project officer who facilitated the interviews. The transcriptions were compared with the manual notes and gaps in the recordings filled.

The final consolidated documents were analysed by the national consultant using a simple descriptive narrative, paying particular attention to emerging themes, content of the discussions and issues that generated consensus. The major themes and issues identified were compared across categories of respondents, geographic location and, where applicable, by countries.

Discussions from the stakeholder review forum were also summarized in the form of a national position paper with an action plan.

2.5 Quality Assurance

To promote the rigor and quality of the assessment, the teams ensured that data were authentic and methods of data analysis were trustworthy. The lead consultant with the ANECCA secretariat supported the national consultants and the ANECCA in-country teams to carry out this review and assessment. At the national level, the national consultant trained the assessment team for three days on the objective, ethics, study tools, participant consent based on protection of their rights, maintaining confidentiality and security of all collected data. The training was also structured to cover the data collection tools, proper techniques for conducting KIIs, study protocols, secure data storage while in the field, and ethical issues of maintaining confidentiality, anonymity and obtaining informed consent.

Each national consultant selected a competent study assistant with experience in qualitative data collection. The study team was trained in qualitative research techniques and ethical issues pertaining to confidentiality and informed consent. The research team was trained in the qualitative methods, specifically key informant interviews and data tools that ensured standardization of understanding. The research team used a standard research guide and data was triangulated to enhance understanding of the theme. Each national consultant carried out key informant interviews (KIIs) with the help of the national ANECCA project officer and study assistant.

2.6 Ethical Considerations

2.6.1 Ethical review

Ethical clearance was obtained from each national institutional review boards and the study was conducted in accordance with all the conditions of approval by the internal review board.

2.6.2 Informed consent

Each participant was requested to voluntarily consent to participate in the study and append their signature to the consent form. The study assistants explained to each participant in their country's local language the following aspects before obtaining oral consent from each participant: the purpose and objective of the assessment, procedures, risks, benefits, rights of the participant, and protecting data confidentiality. Subsequently, written informed consent was obtained from each study participant. Participants were also requested to consent to audio record an interview.

2.6.3 Privacy and confidentiality

Privacy and confidentiality were maintained by carrying out interviews in private rooms with only the participant and study assistant present. Data collection, process, administrative forms and other reports were coded to maintain anonymity. All study-related information was stored securely at the ANECCA office. All interviews were conducted anonymously and study identification numbers were used on documents to conceal the identities of the participants in the assessment. Completed questionnaires were stored in a locked cabinet that was accessible only by the study team.

2.6.3 Risks

This rapid needs assessment did not carry any known risks. The study participants in the assessment were worried that their performance gaps maybe exposed. However, study assistants reassured them adequately and guaranteed privacy and confidentiality.

2.6.4 Benefits

There was no direct benefit accrued to the individual participants in these

assessments. However, the information provided by the participants in these assessments would 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 the greater public good.

2.6.5 Harm

There was no direct physical, social or economic harm to the participants.

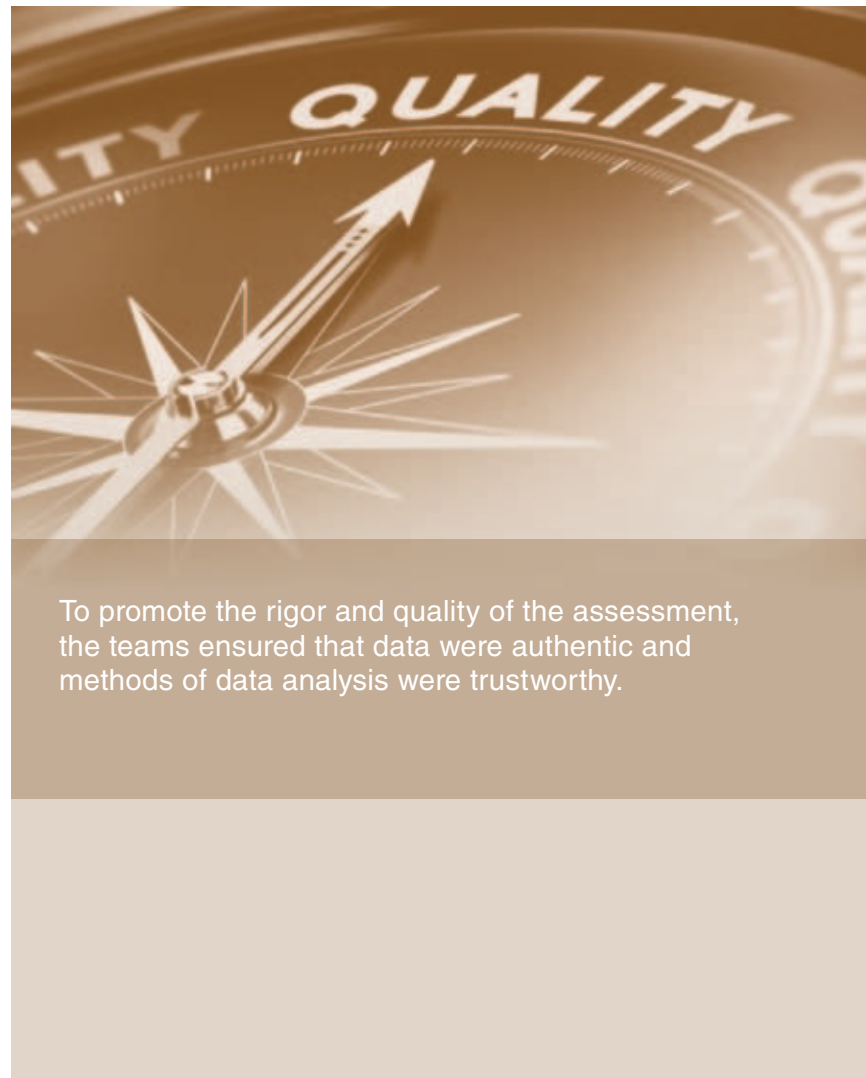
2.7 Stakeholder Validation Meeting

A stakeholder validation meeting were conducted in each of the seven countries and key findings from the rapid policy assessment were presented and approved. The meeting gave key stakeholders the opportunity to provide feedback. From the feedback some national teams had to revisit some of key stakeholders. For example, in Ethiopia private clinics had been inadvertently missed out in the selection; hence the team expanded the study population and interviewed health workers in private clinics to ensure representative sampling. Other feedback was given on country next steps and modifications were made while maintaining the independence and scientific rigor of the study.

2.8 Study Limitations

Differences in the time duration for institutional review board approval in the seven countries led to variations in the duration of the study. Categorization of HIV health services, for example, at the various primary and secondary health facilities varied across the seven countries. Similarly, the health system structures varied, which to some extent, limited comparability across the seven countries.

There was limited capture of best practices due to the limited time and resources of the rapid assessment.



To promote the rigor and quality of the assessment, the teams ensured that data were authentic and methods of data analysis were trustworthy.

3 Results of comparative review of paediatric and adolescent HIV policies and guidelines in 7 Sub-Saharan countries

The country policies were compared across the key thematic areas of the Walt & Gilson Model i.e. a simple quantitative score was used to empirically measure individual country score and an overall regional policy score



Malawi scored highest (71%) in the availability of policies and guidelines (5/7), followed by Uganda and Ethiopia, both at 57% among 4/7 policies and guidelines each

3.1 Existence of Key Paediatric and Adolescent HIV Policies / Guidelines / Action Plans

Comparison of the existence of various child and adolescent policy documents in the 7 study countries was carried out. All the 7 study countries had HTS as well as care and treatment in the child and adolescent policy and guideline documents. None of the countries had explicit action plans with defined targets to increase coverage and quality of care for children and adolescents living with HIV interventions at the sub national level specifically at the district or its equivalent and the health facility levels. Malawi had 70% of key child and adolescent policies and guidelines at the national level (Table 7).

Table 7: Summary of existing key child and adolescent policies and guidelines

Country	Prevention	HTS	Care & treatment	National child HIV action plan	National adolescent HIV action plans	Subnational child HIV action plans	Subnational adolescent HIV action plans	Country score	Country (%)
Burundi	Yes	Yes	Yes	No	No	No	No	3/7	43
Ethiopia	Yes	Yes	Yes	Yes	No	No	No	4/7	57
Malawi	Yes	Yes	Yes	Yes	Yes	No	No	5/7	71
Nigeria	No	Yes	Yes	Yes	No	No	No	3/7	43
S Sudan	Yes	Yes	Yes	No	No	No	No	3/7	43
Tanzania	Yes	Yes	Yes	No	No	No	No	4/7	43
Uganda	Yes	Yes	Yes	Yes	No	No	No	4/7	43
Policy existence	6/7	7/7	7/7	1/7	1/7	0/7	0/7		
Score (%)	86	100	100	14	14	0	0		

*C&A=Child & Adolescent

Malawi scored highest (71%) in the availability of policies and guidelines (5/7), followed by distantly by Uganda and Ethiopia, both at 57% among 4/7 policies and guidelines each. The remaining 5 countries scored below average (<50%) namely, Burundi Nigeria South Sudan and Tanzania, all at 3/7 of the policies and guidelines or 43%. The best performances among all the countries were in the availability of the HTS and care and treatment policies and guidelines at 100% followed by prevention at 6/7 (86%) except for Nigeria. It is only Malawi 1/7 (14%) which had both child and adolescent action plans at the national level and no other country in the selected sample in Sub Saharan Africa. None (0/7) of the sampled countries had child and adolescent action plans at the sub national level, implying marked inaction countrywide.

National key informants from the 7 study countries acknowledged that national guidelines were adapted from international documents specifically from WHO

guidelines. South Sudan specifically also adopted from regional documents for better contextualization.

“Yes, most definitely. I think most guidelines comes from WHO ... We also look at regional policies because our problem in South Sudan may not be different from our neighbors.... We are in the East Africa region our neighbors they must have some similarities; we are in sub-Saharan Africa our policies must have some particular areas of commonalities.” - County South Sudan AIDS Commission (SSAC), HIV/AIDS coordinator

Key informant in least two countries felt that there were no specific national policies and guideline to adequately address the care and management of children and adolescents with HIV:

“Strategic policies and guidelines are in place but not for children and adolescents exposed or affected by HIV. The current guidelines need to be updated to handle children and adolescents living with HIV.... No, there is none in the country. No stand-alone...” WHO Zonal Representative, S Sudan

“From what I know up to now we do not have specific national guidelines for management of children and adolescents infected by HIV” National level stakeholder, Burundi

In the other countries, there was a recognition that HIV policies and guidelines were integrated with provisions to address the needs of children and adolescents with HIV. The provisions could be a section or chapter of the policy or guideline.

“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 can provide the service” National Level key informant, Malawi

In some of the countries health workers, specifically Malawi, Uganda and Nigeria it was challenging for health workers quote specific policy provisions in their entity but when given relevant case scenarios they were able, in most cases, to articulate management procedures that were in keeping with the prevailing guidelines. This was noted particularly for PMTCT and ART treatment. For South Sudan and Burundi there was perception that the child and adolescent guidelines were not being implemented

No, the pediatric and adolescent HIV/AIDS policy is not being implemented ... as per the desired standard. Ministry of Health State HIV coordinator, South Sudan

National key informants felt that that the policy regarding age of consent was challenging. As shown in table 9 above Nigeria, South Sudan, Tanzania and Uganda have age of consent for HIV testing set at the statutory age of consent for medical services, 18 years, and yet age for sexual debut in these countries is between 12 – 13 years. In addition, most countries had policies related to age-appropriate disclosure but health workers did not feel competent to carry out

disclosure and offer psychosocial support. In Uganda national and health facility informants proposed the incorporation of professional counselors to address the challenge.

The importance of research to inform local policy and practice was brought out by several national informants at national level informants in Burundi and Malawi:

“No deep analysis is done before planning, most of the time the planning is based on the WHO or UNAIDS recommendation which follow studies that have been done somewhere else, and there isn’t sufficient country specific researches to inform programs” MOH National level informant, Burundi

“..... 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, Malawi



In Malawi, Uganda and Nigeria health workers quote specific policy provisions in their entities but when given relevant case scenarios they were able, in most cases, to articulate management procedures that were in keeping with the prevailing guidelines, particularly for PMTCT and ART treatment.

3.2 Participation in the Policy Development Process

Stakeholder participation was full (100%) in all countries (7/7) at the national levels, National AIDS Control Councils (NACCs), implementing partners and CSOs. There were no participatory approaches at health facilities (0%), low at state or zonal levels (29%) and poor among community or opinion leader, care givers and adolescents (14%). This implied that bottom up approach did not exist and the top down approach failed in the prevention, control of HIV infections in Sub

Saharan Africa. Once again, Malawi had the best performance by fulfilling all the activities except one (86%) at the health facility level. It was distantly followed by South Sudan, Tanzania and Uganda, all of which achieved 71% of their activities by implementing 5/7 activities. Burundi, Ethiopia and Nigeria achieved 57% performance through implementation of 5/7 activities. All in all, the countries achieved above average performance in participatory approaches (Table 8).

Table 8: Summary of Inclusivity of Paediatric & Adolescent HIV Policy/Guideline/Action Plans Development

Stakeholder	Burundi	Ethiopia	Malawi	Nigeria	S Sudan	Tanzania	Uganda	Inclusivity policy score	Inclusivity policy %
Ministry of Health									
National level	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7	100
State/zonal /county	No	No	Yes	No	No	Yes	No	2/7	29
Health facility	No	No	No	No	No	No	No	0/7	0
National AIDS Control Council	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7	100
Implementing partners	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7	100
Civil society	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7	100
Community, opinion leaders, caregivers, adolescents	No	No	Yes	No	No	No	No	1/7	14
Country score	4/7	4/7	6/7	4/7	5/7	5/7	5/7		
Country %	57	57	86	57	71	71	71		

In all 7 countries stakeholders involved consultation with major stakeholders such ministries of health, national aids councils, academia, implementing partners and UN agencies primarily through the relevant technical working group, which was an important platform for reviewing evidence and country contextualization.

However, participants had contrary views regarding the level of participation from subnational stakeholders such as the county, district or facility health staff, so that the county context is given due consideration when developing guidelines and implementation plans:

The involvement of stakeholders was not enough because the representation at the counties level was not there in problem identification or in the development of these paediatric and adolescent policies *Ministry of Health, State HIV coordinator, South Sudan*

Lack of adequate participation in HIV policy and guideline development process by other key ministries such as education, justice and gender social services was cited as reason for conflict in policies at implementation in all 7 countries.

An important stakeholder that is missed out in the development and dissemination of child and adolescent HIV policies is the ministry of gender. There is a need to mainstream gender and rights in the implementation design ... because adolescent girls have different problems from adolescent boys, but each one of them needs to be addressed from their respective gender perspective. Key informant Development partner, Uganda

Most countries cited the lack of participation of the recipients of the community stakeholders such as adolescents, caregivers, opinion leader, etc., as a challenge and lack of inclusivity meant that the process was not fully participatory.

Of significance especially for HIV is the lack of involvement of parents/ guardians of children or adolescents living with HIV, involvement of teachers, multisectoral involvement, e.g. local leaders, religious leaders, opinion people, youths themselves . Ministry of Health national level key informant, Tanzania

3.3 Comprehensiveness of Paediatric and Adolescent HIV Testing Service

Comparing the Key WHO child and adolescent HTS provisions across the 7 target countries, all the 7 sampled countries recognized children and adolescents living with HIV as a special group and the country policies had provision for facility and community based testing as well as age appropriate disclosure. None of the countries had concrete provisions and practical measures for identifying and linking the ALHIV to prevention, care and treatment services. Ethiopia had the most comprehensive HTS policies 7/9 (78%) while Burundi had a below average 4/9 (44%) HTS policy framework. Nigeria and Ethiopia were the only countries that provided for the use of use of trained lay provider and they linked all HIV infected persons to health facilities (Table 9).

Table 9: Paediatric and adolescent HIV testing and services policies and guidelines against WHO recommendations

WHO recommendations	Burundi	Ethiopia	Nigeria	Malawi	S Sudan	Tanzania	Uganda	HTS thematic score (%)
Recognize special groups such as children and adolescents	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 (100)
Defined age of consent for HTC for adolescents which should be lower than the majority	No	Yes	No	Yes	No	No	No	2/7 (29)
Mature minors who independently consent to HTC should be allowed to consent to HIV treatment	No	No	No	No	No	No	No	0/7 (0)
Test for Triage—use of trained lay provider and link all HIV positive to health facility	No	Yes	Yes	No	No	No	No	2/7 (29)
WHO Essential 5Cs	No	Yes	Yes	Yes	Yes	Yes	Yes	6/7 (86)
Concrete provisions & practical measures for identifying & linking ALHIV to prevention care & treatment services	No	No	No	No	No	No	No	0/7 (0)
Age appropriate disclosure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 (100)
Facility-based testing for paediatrics and adolescents	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 (100)
Community-based testing for children & adolescents by HCWs through outreaches	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 (100)
Country score (%)	4/9 (44)	7/9 (78)	6/9 (67)	6/9 (67)	5/9 (56)	5/9 (56)	5/9 (56)	

*5 Cs: **C**onsent, **C**onfidentiality, **C**ounseling, **C**orrect test results, and **C**onnection/linkage to prevention, care and treatment.

3.4 Comprehensiveness of Paediatric and Adolescent HIV Care and Treatment Policies and Guidelines

Comparison was made of the treatment policies across the 7 sampled Sub Saharan African countries against the 2015 WHO HIV treatment guidelines which recommend testing and treating all HIV all persons living with HIV regardless of their immune status.

All (7/7) of the sampled countries in this assessment provided full services (100%) in the HIV treatment for children and adolescents in the strategies for retaining

CLHIV and routine monitoring of toxicity and ART side effects. But no country (0/7) had clear and explicit strategies for initiating ALHIV on ART. Slightly over half 4/7 (57%) of the countries had test and start strategy with the exception of Burundi, Nigeria and South Sudan. Ethiopia, Tanzania and Uganda had monitoring framework to strengthen adherence to ART using viral load, constituting 3/7 (43%) of compliance with the WHO guidelines and standards of practice.

Table 10: Summary of comprehensiveness of paediatric and adolescent HIV care and treatment policies and guidelines

WHO recommendations	Burundi	Ethiopia	Nigeria	Malawi	S Sudan	Tanzania	Uganda	Thematic policy score (%)
Test and Start strategy	No	Yes	No	Yes	No	Yes	Yes	4/7 (0)
Clear & explicit strategies for initiating ALHIV on ART	No	No	No	No	No	No	No	0/7 (0)
Strategies for retaining CLHIV on ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 (100)
Strategies for retaining ALHIV on ART	No	No	No	No	No	No	No	0/7 (0)
Routine monitoring of toxicity and ART side effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 (100)
Monitoring and adherence using viral load	No	Yes	No	No	No	Yes	Yes	3/7 (43)
Country score (%)	2/6 (33)	4/6 (67)	2/6(33)	3/6(50)	2/6 (33)	4/6 (67)	4/6 (67)	

The HIV treatment for children and adolescents was scored highest by Ethiopia, Tanzania and Uganda at 67% but all of them failed in the development of clear and explicit strategies for initiating ALHIV on ART (0%) followed by Malawi (50%). Malawi on the other hand, did not have a monitoring framework for adherence using

viral load, an important aspect of quality assurance. Burundi, Nigeria and South Sudan, all performed below par, succeeding in only two (2/7) of the six treatment activities namely strategies for retaining CLHIV on ART and routine monitoring of toxicity and ART side effects (Table 10).

3.5 Comprehensiveness of Paediatric and Adolescent HIV Monitoring and Evaluation Policies and Guidelines

Comparison of key monitoring and evaluation (M&E) components in child and adolescent HIV programs to track coverage and quality of care was assessed. All the 7 selected countries had indicators to track uptake of child HIV services but lacked

M&E policies to track intermittently assess coverage and quality of care amongst ALHIV. Except for Malawi (1/4), the rest of the countries' child and adolescent HIV monitoring and evaluation policies were not in existence (Table 11).

Table 11: Summary of paediatric and adolescent HIV monitoring and evaluation policies and guidelines

M&E provisions	Burundi	Ethiopia	Nigeria	Malawi	S Sudan	Tanzania	Uganda	Thematic policy score (%)
Subnational and health facility action plans with set targets for HTC, ART, retention for adolescents	No	No	No	No	No	No	No	0/7 (0)
Monitor systems to measure uptake, coverage and retention of CLHIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 (100)
Monitor systems to measure uptake, coverage and retention of ALHIV	No	No	No	No	No	No	No	0/7 (0)
Monitor viral load suppression rates in CLHIV and ALHIV	No	No	No	No	No	No	No	1/7 (14)
Country score (%)	1/4 (25)	1/4 (25)	2/4(25)	1/4(25)	1/4 (25)	1/4 (25)	1/4 (25)	

3.6 Stakeholder Perception of Child and Adolescent Policy to Practice at Service Delivery Level

Country key informants had varying observations of whether policies were adequately translated into practice. Below are some of the perceived reasons for the policy implementation gaps:

- A lack of critical commodity, supplies and infrastructure. For example, for Early Infant Diagnosis (EID) there are clear guidelines on the scheduling of HIV tests; however, due to the poor laboratory capacity and weak transport network system, EID samples are collected late, thus turnaround time for results is long.

• *Our infrastructure is not good. For example, to get DBS from Tambura to Juba, it takes time. I was thinking if we had hubs for EID in different regions in South Sudan that can facilitate things. Collecting all DBS from all over and then try to get it to*

a reference laboratory in Juba, it takes time. National NGO HIV/AIDS programme advisor, South Sudan

- Strongly centralized system of policy and guideline development that did not involve implementers:
HIV interventions flow from the central level and there is no initiative raised from the peripheral level (district level). The district health management team (DHMT) seems not to follow the settled interventions to reduce HIV infection. National level key informant, Burundi
- Lack of core competencies in child and adolescent HIV management that could be attained through mentorship by frontline health workers were cited in several countries.

Only some medical doctors have participated in one week or two weeks' training on paediatric HIV, the rest (medical doctors and nurses) are practicing what they learned at school or during a workshop on HIV in general Mentorship is something not known in practice in the Burundian health system. Health facility key informant, Burundi

Competency in age-specific HIV disclosure was consistently quoted as an area of weakness for health providers even where there was clear policy provision for age-specific HIV disclosure for children and adolescents.

- Poor dissemination and interpretation of the policies from national level policy makers to implementers at health facilities and in the communities. For example, providers in Uganda noted the policy documents were bulky and not user friendly.

We need key messages for each policy and guidelines to enable the target audiences internalize them. Key informant Development partner Uganda


- Low demand and utilization of paediatric and adolescent HIV services, limited community awareness

Government is good at producing those policies but they don't reach the public so if someone can come and disseminate them through workshops and go on radio creating awareness so that people can understand what is taking place'.(Key informant district education officer

- Lack of comprehensive monitoring and evaluation systems for ALHIV. 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

.... 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 now 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, Malawi



All the 7 selected countries had indicators to track uptake of child HIV services but lacked M&E policies to track intermittently assess coverage and quality of care amongst ALHIV.

4 National Stakeholder Meetings

National consultants from each of the seven countries presented findings of the rapid policy assessment to stakeholders drawn from the ministries of Health and Education, civil society, implementing partners, professional bodies and health care workers at the sub national level. The results of the findings were endorsed in all the countries. Participants had the opportunity to discuss and share the view on the finds as well as share perspectives on the way forward. Major discussion points are summarized in Table 12.

Table 12: National Validation Meeting Summary Discussion Points

Country	Concurrences	Concerns	Recommendations
Burundi	<ul style="list-style-type: none"> - Poor dissemination of guidelines - Age of consent not defined - Few youth friendly centers - Poor dissemination of guidelines to health facilities - Lack of age-disaggregated data for adolescents 	<ul style="list-style-type: none"> - Gender-based violence missing in current child and adolescent HIV policies - Age-disaggregated data for adolescents and specific adolescent indicators 	<ul style="list-style-type: none"> - Develop regional adolescent package of care that covers teen clubs, transition clinics, etc., for country adaptation - HMIS expand to capture adolescent-specific indicators along the continuum of care
Ethiopia	<ul style="list-style-type: none"> - Age disaggregation presently being used for data collection by the Federal Ministry of Health does not have separate data for adolescents. - Need to scale up strategies to identify, initiate and retain CLHIV and ALHIV - Inter-ministerial collaboration between MoH and more and woman & youth affairs viewed as critical to improve coverage - HCWs not well trained in psychosocial support of child and adolescents living with HIV 	<ul style="list-style-type: none"> - Challenge in care of orphans- testing and care/treatment data. HMIS does not capture this data - Regional health bureaus funded for mentorship so it is not the lack of mentorship that is a challenge, rather perhaps the quality of mentorship - Consent for counselling below age of 15 years is challenging - Age-disaggregated data for adolescents and specific adolescent indicators 	<ul style="list-style-type: none"> - Health management information system (HMIS) should expand and include adolescent indicators for HIV care and treatment for the country - FMOH should prioritize scale-up of interventions that increase coverage and quality of care for children and adolescents living with HIV - Expansion of youth friendly services would increase uptake of HIV services among youth

Malawi	<ul style="list-style-type: none"> - No specific targets for child and adolescents other than the 90-90-90 - Teen clubs play an important role in support of ALHIV - Implementation of age-specific disclosure a challenge - Assessment did not consider faith-based hospitals 	<ul style="list-style-type: none"> - Most teen clubs run by partners raising the issue of sustainability - Scale-up of teen clubs to all ART sites not advisable because of different adolescent cohort sizes - MOH supports sexual and reproductive health and rights in schools while MoE not supporting provision 	<ul style="list-style-type: none"> - Strengthen advocacy for inter-ministerial collaboration between MoH and MoE - Carry out a feasibility and operational assessment of the teen clubs, develop standard operating procedures - Strengthen child and adolescent monitoring and evaluation systems
Nigeria	<ul style="list-style-type: none"> - No national or sub national adolescent indicators to track coverage and quality of care 	<ul style="list-style-type: none"> - Need to be culturally sensitive when changing policy regarding age of consent - Lack of sufficient funding for HIV programmes - Poor advocacy to ALHIV & child caregivers affects uptake of services 	<ul style="list-style-type: none"> - Results of policy assessment should be shared and considered in current ongoing child and adolescent HIV policy revisions - Liaise with State HIV coordinators to establish if they developed State child HIV action plans after launch of accelerated plan
Tanzania	<ul style="list-style-type: none"> - Need to improve the adolescent HIV programme. At the time HMIS adapting adolescent HTC indicators 	<ul style="list-style-type: none"> - Conflict between age of consent for HIV testing, statutory age to seek medical treatment and legal age to marry - Poor dissemination of HIV guidelines to frontline HCWs - Weak policies for orphans and vulnerable children 	<ul style="list-style-type: none"> - Policy provision for HIV testing in schools - Adolescent HIV package of care - Strengthen Adolescent Teen clubs providing SOPs and scale up to public health facilities - Improve HCW mentorship - Collaboration with legal fraternity to sort out the areas of conflict - Explicit policy provisions to address the gap covering orphans and vulnerable children
Uganda	<ul style="list-style-type: none"> - Lack of provision for community-based testing - Lack of adolescent-specific indicators to track coverage and quality of care - Need for transition support for CLHIV transition to adolescent clinic and ALHIV to adult clinic 	<ul style="list-style-type: none"> - Policy gap on issues related to GBV and child protection - Limited community awareness and demand for child and adolescent HIV services - Limited role of private facilities in offering HIV services 	<ul style="list-style-type: none"> - Results of the rapid policy assessment should be considered in revision of various draft HIV policy documents such as HTS and ART guidelines - Advocacy for multi-sectoral collaboration between the ministry of health and the department of social services, ministry of education, justice department

5 Discussion

In this comparative review of child and adolescent HIV policy documents we demonstrated that all the 7 study countries have child and adolescent HIV policies in prevention, care and treatment. These policies are largely based on global WHO documents adopted to the regional and country contexts. However, these policies were not fully operationalized at subnational level due to lack of district and health facility implementation and action plans.

The policy development process was noted to be largely participatory at national level in all the study countries and included stakeholders from the ministry of health, UN agencies, civil society and implementing partners. There is good linkage with maternal, child health, TB and sexual reproductive health but minimal involvement of other key line ministries such as education, gender, social affairs and justice. Pertinent issues related to gender-based violence and child protection were not sufficiently integrated into current child and adolescent HIV policies in all seven study countries. There were also policy gaps relating to identification and initiation into care of vulnerable children such as street children who are under the care of the ministry of social affairs. This was acknowledged during the national and regional stakeholder meetings. Implementation of prevention and testing strategies in primary and secondary schools was noted to be difficult due to the poor policy collaboration between ministries of health and education in the seven target countries. In Malawi, some implementing partners had initiated obtaining consent for child testing through the parent teacher association, raising the question of whether HIV testing standards were being compromised and highlighting the need for stronger inter-ministerial policy development collaboration and the need to enforce minimum standard operating procedures within the set standards.

HIV testing services are important for timely identification and linkage of children and adolescents living with HIV. All seven study countries had facility-based HTS policy but, in contrast, there was a policy gap in the lack of clearly defined age of consent for HTS for adolescents that is lower than the statutory age of consent, for more than half of the study countries. Therefore, although there is provision to carry out health facility testing, adolescents involved in sex on average at 12–13 years in these countries, cannot independently seek services, putting them at risk of new infections or late diagnosis. This highlights the need for multisectoral engagement and discussion to address this issue (53). Across all seven countries, there was a gap in translating age-appropriate disclosure from policy to practice since key informant health workers at primary health facilities expressed they lacked skills to carry out child and adolescent disclosure process and to provide psychosocial support during this process. Disclosure is associated with improved adherence, hence higher CD4 count (54). Adolescents living with HIV who have undergone disclosure were found to have improved coping skills and practised safer sexual practices to prevent secondary transmission (55). Ethiopia had the most robust HTS policies, primarily because they had defined age of consent for HTC lower than the majority and had adopted the test for triage using trained lay providers in the community to test and link all HIV positives to the health facilities.

In their HIV policy documents, all the 7 countries recognized children and adolescents as a special group but did not provide *explicit and clear strategies for identification and linkage particularly of adolescents living with HIV* and meeting their special health needs with regard to *disclosure of HIV status, adherence support, stigma and discrimination, mental health care, chronic care support, legal and social support*. In addition, the current monitoring and evaluation frameworks across the seven countries do not have adolescent (10–19 years)-specific indicators to track uptake, coverage and quality of service.

Lastly, although we did not assess the degree of adaptation to country context, key informants in Burundi, Malawi and Nigeria were of the opinion that there is need to carry out more country-specific child and adolescent HIV implementation research to inform policy, guidelines and implementation. For example, in addition to implementing age-appropriate disclosure it is of added value to develop standardized, culturally appropriate guidelines (56).

6 Recommendations

Considering the findings of this child and adolescent comparative policy review, countries should:

- develop national and subnational paediatric and adolescents action plans with explicit and measurable strategies for identification, linkage and retention in care for children and adolescents living with HIV to increase coverage of HIV services to children and adolescents living with HIV;
- update national policies to explicitly link HIV strategies with strategies to mitigate and address gender-based violence, child protection and other emerging non-communicable diseases;
- expand national HIV monitoring and evaluation frameworks to track adolescent-specific data disaggregated by age (10–14, 15–19) for optimal programme planning in HIV prevention, HTS and ART;
- should increase HCW capacity in paediatric and adolescent HIV management, particularly disclosure and teen clubs support;
- share best practices in country and regionally so as to contextually and innovatively address the various challenges facing children and adolescents living with HIV.

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8 Annexes

ANNEX I Summary of Consultancy Terms of Reference

ANECCA sought the services of a consultant to conduct a review and assessment of the existing national policies and guidelines related to paediatric and adolescent HIV care in the seven African countries to identify gaps that lead to low coverage and quality of services for children and adolescents living with HIV. The targeted countries have put in place and/or adopted some policy guidelines that facilitate HIV care and treatment among adults and children living with HIV. These include the national strategic plans for HIV/AIDS and PMTCT, as well as specific guidelines on HIV counselling and testing, provider-initiated testing and counselling, and care and treatment of adults.

However, several gaps exist in the policy environment for care of HIV infected children and adolescents. Apart from the fact that all these countries do not have national specific plans and policy documents in paediatric and adolescent ART, the guidelines being used are not comprehensive particularly in the areas of HIV testing as well as linkage, initiation and retention of infected children and adolescents on ART. There is also lack of clear targets and strategies on identifying and linking, initiating and retaining HIV-infected children and adolescents on ART.

It is also evident that whereas majority of the targeted seven countries have put in place the policy of provider-initiated testing and counselling (PITC), the guidelines and training curricula they have are mainly for adults with minimal content on children and adolescents. Therefore, implementation of PITC for children and adolescents is minimal in the majority of health facilities.

There are also several unresolved questions regarding policy on testing and

counselling of children and adolescents. Besides the variation in the age of consent for testing young adolescent across the countries, there is disharmony and uncertainty on how to deal with children/adolescents who seek HIV services on their own, due to various circumstances across the seven countries. Policy mix-up is hampering some adolescents from seeking and getting SRH/HIV services since they tend to visit health facilities without the knowledge and company of their parents/guardians.

Therefore, this project will:

- Leverage the experience from the countries that have national and programme-specific strategic plans to facilitate development of detailed national plans with clear strategies and targets for identifying, treating and retaining HIV infected children and adolescents in the countries where they do not exist;
- Support these countries to harmonise policy guidelines on HIV counselling and testing as well as the consent and assent ages; and
- Engage in-country stakeholders and advocate for development and adoption of policies on task shifting for use of lay counsellors in provider initiated testing and counselling of children where they do not exist; and
- Develop standardized operating procedures and mentorship resource materials on provider-initiated testing and counselling in children, task shifting and other practices that facilitate increased coverage and quality of care and treatment of HIV-infected children and adolescents.

This has necessitated seeking the services of a consultant to conduct the review and an assessment of the national policies and guidelines in the seven countries to identify gaps that lead to low coverage and quality of care and treatment of HIV-infected children and adolescents.

Objectives of the assignment

The main purpose of the assignment was to identify strengths and gaps in national policies and guidelines so as to develop country-specific action plans to improve coverage and quality of services for children and adolescents living with HIV in each of the 7 countries.

Specific objectives

To achieve this main purpose, the consultancy focused on the following specific objectives:

1. Review and assess existing national policies and guidelines in the seven countries to identify strengths and gaps in the provision of quality services for children and adolescents living with HIV.
2. Identify and document policy practices and emerging policy opportunities for provision of quality services for children and adolescents living with HIV in the targeted countries.
3. Make recommendations that inform the development of regional and national plans to promote the adoption and implementation of policies that increase coverage and quality of paediatric and adolescent HIV care, treatment and support.

ANNEX II Summary of Key Country Documents

Thematic area	Policy/Guideline	Comments
MALAWI		
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	Principle documents to ensure by end of Malawi would you have reached the 90–90–90 Goal
HIV Prevention and 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, 2015–2018	Implementation is coordinated by the Ministry of Health through the HIV and AIDS Department
Impact mitigation	Malawi National policy on care and support of orphans and other vulnerable children National impact mitigation guidelines National guidelines school for educational support for orphans and other vulnerable children National guidelines for social cash transfer programme	These documents guide support for OVCs and their implementation falls under the jurisdiction of the Ministry of Gender, Children and Social Welfare
BURUNDI		
National coordination	National policy for HIV control programme, 2002 (MOH, Plan d'Action National de Lutte contre le Sida au Burundi (2002–2007)	
HIV prevention	National guidelines for HIV testing and counselling, 2011 (MISPLS, 2014)	
HIV care & treatment	National guidelines for ART, 2010 and 2014 (MISPLS, 2014) EMTCT Plan and Road map 2014	

SOUTH SUDAN

National coordination	South Sudan national HIV and AIDS strategic plan, 2013–2017 South Sudan national HIV policy, 2015 HIV/AIDS monitoring and evaluation (M&E) framework, 2008
HIV prevention	South Sudan draft HTS guidelines, 2016 South Sudan national HIV prevention strategy, 2015–2017 HIV/AIDS behaviour change and communication strategy, 2008 Guidelines for voluntary counselling and testing, 2008
HIV care & treatment	Consolidated clinical guidelines on use of antiretroviral drugs for HIV treatment and prevention, 2014 Guidelines for ART use in adults and children, revised 2010

SOUTH SUDAN

National coordination	South Sudan national HIV and AIDS strategic plan, 2013–2017 South Sudan national HIV policy, 2015 HIV/AIDS monitoring and evaluation (M&E) framework, 2008
HIV prevention	South Sudan draft HTS guidelines, 2016 South Sudan national HIV prevention strategy, 2015–2017 HIV/AIDS behaviour change and communication strategy, 2008 Guidelines for voluntary counselling and testing, 2008
HIV care & treatment	Consolidated clinical guidelines on use of antiretroviral drugs for HIV treatment and prevention, 2014 Guidelines for ART use in adults and children, revised 2010



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