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

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Abstract

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

Methods

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

Results

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

Conclusion

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

Introduction

Sub-Saharan Africa bears a disproportionate share of the global HIV burden. An estimated 23.8 million people (66% of the global burden) reside in Sub-Saharan Africa in 2015. Malawi is one of the top ten countries in southern Africa most affected by HIV. The country’s adult HIV prevalence is high at 8.8%. HIV and AIDS negatively affects the health and well-being of productive people. In 2003, Malawi published its first ever HIV/AIDS policy—a Call to Renewed Action. The goal of the policy was to prevent further spread of HIV infection and to mitigate the impact of HIV/AIDS on the socioeconomic status of individuals, families, communities and the nation. This paper reviews the implementation of that policy by assessing provider initiated HIV testing and counseling (PITC) for sexually transmitted infections (STIs) for patients with sexually transmitted infections (STIs). It also looks at how PITC in antenatal care, for prevention of mother to child transmission of HIV (PMTCT), was implemented. This approach was not clarified in the initial design of the Policy but Malawi adopted it soon after World Health Organization (WHO) recommended it in 2007. The 2012 Malawi Global AIDS Response Report indicated an uptake of only 28% in the general outpatient PITC, but 71% among antenatal women (for PMTCT purposes). The universal uptake goal was 75%. The follow up analysis in 2015 showed higher HIV testing uptake of 79% among pregnant women and 49% for STI patients. The study’s findings explain some of the factors that affected the HIV testing and counseling component of the policy. There are several known barriers that affect implementation of health-related policies. Fear of stigma and discrimination may impede the implementation of certain policies, low motivation and commitment, conflicting policies, and challenges at multilevel coordination affected implementation in three United States Agency for International Development (USAID) supported countries. Other barriers are lack of awareness policies, limited familiarity, and a lack of agreement among related guidelines. Limited time and personnel resources, as well as work pressure have also been noted as contributing factors to poor policy implementation. Lack of political will was a barrier to implementation in South Africa, lack of clear government endorsement of these guidelines was another reason. In Uganda, lack of directives on exactly how HIV related policies were to be implemented negatively affected implementation. Top leadership’s low regard for HIV/AIDS, at odds with the recommendation of their own renowned technocrats and scientists, is also another barrier to implementation. Issues that enhanced good policy implementation include: health care workers’ training and mentorship in HIV-related services as well as their involvement in policy development.

Studies that evaluate policies require drawing lessons or concepts from existing policy analysis frameworks. Issues of interest that must be considered include: problem identification, policy formulation, policy implementation, and evaluation. Our work focused on the implementation phase of the policy process and is modeled under the “top-down” and “bottom-up” perspectives of policy decision-making. “Top-down” is defined as hierarchical execution of a centrally-defined or -formulated policy. Such a policy is handed down from the top leadership to those who are supposed to implement it. On the other hand, “bottom-up” is a process of policy formulation that is driven by grassroots stakeholders and their coalitions partners. The latter includes substantial involvement of local users in the process and it is very relevant as it stimulates individual motivation, will and internal commitment to influence good implementation. On the other hand, non-involvement of local users in the process brings resistance to acceptance. The adoption of Malawi HIV and AIDS services is well-structured in a hierarchical system. The policy keeper and leader for HIV/AIDS in Malawi is the Department of Nutrition and HIV/AIDS (DNHA) in the Office of President and Cabinet (OPC). They work in close cooperation with the National AIDS Commission (NAC), whose role is to provide leadership on the coordination of the national HIV/AIDS response and resource mobilization. There is also the leadership of HIV and AIDS (DHA) in the Ministry of Health whose role is to lead implementation of clinical response. We assessed the roles in policy implementation played by these key coordinating entities and other system players. We interviewed key policy makers, health leaders and right groups to implement the policy. Health leaders exhibited bias by prioritizing PITC for PMTCT operations over the general STI population.

Methods

This is a descriptive case study of the HIV testing and counseling component of the Malawi HIV/AIDS policy from 2003 to 2013. We looked at PITC in STI outpatient settings and PITC in antenatal settings to ensure a balanced understanding of the HIV testing component. Experts, policymakers and health care workers who worked in respective positions for more than a year were chosen to be part of the interviews. In some cases, former experienced health workers were also interviewed. We conducted twenty in-depth interviews (12 PITC) in January and February 2015. Two were with 3 senior healthcare workers (high level supervisor), 2 policy makers, 3 healthcare worker supervisors (middle level supervisor), 10 healthcare workers and 2 health rights activists. The interviews were conducted in 2 of the 5 health zones. We made audio recordings of the interviews and transcribed the records. Factors influencing the data collection were: presence of clear government endorsement of these guidelines, implementation of selective prioritization by the government. The interpretive inquiry helped to understand the knowledge and context of the issues. The data were analyzed using the constant comparative method. The codebook was populated with predetermined themes from existing policy analysis frameworks. Issues of interest that must be considered include: problem identification, policy formulation, policy implementation, and evaluation. Our work focused on the implementation phase of the policy process and is modeled under the “top-down” and “bottom-up” perspectives of policy decision-making.

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A senior healthcare worker observed: “Sometimes it affected services negatively, certain districts would run out of test kits for about two or three months and we know that if a woman is denied PMTCT at the baby’s birth it is at risk.” (Senior healthcare worker 314)

Process of Policy Making

Healthcare workers’ perspectives on policy-making process

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

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

Health rights activists’ perspectives on policy-making process

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

“As an institution, we were involved but it was not meaningful. What I believe is the most essential is to have the healthcare workers on the ground. That could have been the very first page of the policy process.” (Health rights activist 319)

Policy Awareness/Dissemination

Healthcare worker perspectives on policy dissemination

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

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

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

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

“A different health care worker echoed the need for formal training:

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

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

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

Health rights activists’ perspectives on policy dissemination

Health rights activists indicated that policy dissemination among staff and member organizations was through staff meetings, policy awareness, and distribution of copies of policy documents. However, they complained that policy dissemination generally lacked wide community consultation or participation. One health rights activist observed the need for policy holders to understand the relationship and coordination roles between NAC and OPC are still unclear on some issues.

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

Another health rights activist bemoaned lack of clear leadership to enforce the policy process, a view that was supported by two health care workers (PMTCT 300, PITC/STI 305) and a healthcare worker supervisor (312). The health rights activist said:

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

Although there has been generally poor coordination of policy implementation within the entire health care system, a view that was shared by most counterparts from OPC, that their structure did not provide any support or coordination. Health rights activists, too, expressed concerns about the poor coordination.

‐ Coordination was not that simple, I am supposed to know what changes are taking place in the implementation of services, but sometimes I get surprised when something is different, and when I ask they tell me, ‘we were told by somebody from headquarters (Ministry of Health)’…” I feel we were supposed to go together or I was supposed to be informed.” (Healthcare worker supervisor 305)

Coordination among Malawi Government units

The HIV testing component of the 2003 HIV/AIDS policy faced coordination problems among the Malawi Government HIV/AIDS leadership units of DNHA, NAC and DHA. This challenge was shared by all the stakeholders. Sometimes healthcare workers received conflicting information from coordinating stakeholders, and this was also the way to determine whose guidance should be followed during their implementation. One healthcare worker supervisor spoke strongly about the coordination problem among the stakeholders involved in the implementation of the HIV/AIDS policy:

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

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

“Honestly the coordination through that office (OPC) was sort of political. At the beginning the rule of OPC was very difficult to understand, although there is some improvement now, the reporting, the relationship and communication between NAC and OPC are still unclear on some issues.” (Policy maker 316)

Therefore, there was lack of support for the policy implementation even among the health care workers. There were problems with current supervision and leadership support. The main complaint was; erratic supervision or no supervision at all. PITC/STI healthcare workers were more prominent among the communities. Two participants from PITC/STI lamented:

“Honestly speaking, there is no support but when people are trained in that area, they just do it for the first weeks and then just leave it like that…” (PITC/STI 304)

“I can say supervision is not that good, since I came here I haven’t seen anyone coming to supervise services.” (PITC/STI 310)

The top leadership from the Ministry of Health (HIV/AIDS Department) was accused of micro-managing supervision. Complaints of lack of direction were also heard. PITC and STI healthcare workers were very critical of the lack of leadership support. Two healthcare worker supervisors noted this:

“…There has been little commitment of how to get the policy out and implementation. They felt government did not do enough to ensure the policy is known to healthcare workers and that its implementation was going well. A senior healthcare worker observed:

“We do not have clear direction on how to get the policy out and implementation.” (Senior healthcare worker 316)

Health rights activists’ perspectives about leadership

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

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

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

Specific facilitators of policy implementation were highlighted and included the following attributes:

1. Adoption of Option B+
2. The presence of a strong sense of leadership with clear change management attributes
3. A clear sense of purpose and a shared vision
4. Good articulation of tasks
5. Strong coordination and collaboration with stakeholders
6. Effective communication of policies and their importance
7. Sustained and consistent funding

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Summary of recommendations

The study identified several barriers and facilitators that may help effectively improve policy implementation. We made recommendations to facilitate positive change. These emanate from the study findings and are in concordance with the fact that change does not just happen but is derived from a situation that is clearly change-driven and that has change attributes. The recommendations are summarized as follows:

- **Enhance human capacity and resource mobilization for HIV/AIDS policy implementation**
- **Create a national policy harmonization and supervision committee.**

Conclusions and implications for practice

While good strides were made in Malawi's HIV/AIDS response between 2003 and 2013, some aspects of the Malawi HIV/AIDS policy were not well implemented. The oversight and implementation of HIV/AIDS programs with speed and zeal. Policies and programs that are not well implemented miss a very important step in accounting for the resources and time invested in public finding and reporting health and national statistics. When Malawi is in its early phase of implementing a new HIV/AIDS policy that was operational at the beginning of 2014. The recommendations presented in this study are therefore well timed and should contribute towards implementation of the new policy.

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Limitations of the study

Stakeholders interviewed included health care workers, governmental leaders and health rights activists. Other important stakeholders would have idealy been included, such as, donor community. These may have had an influence on certain implementation components. Community members were also not included; they could have provided useful insights into policy implementation. For good policy implementation, it is an area that has not been extensively studied, those selected were still important informants who provided useful information that could help improve policy implementation.

Discussion

This study was aimed at documenting barriers and facilitators in the implementation of the HIV testing components for the STI/PTC and PTC for PMTCT in the 2005 HIV/AIDS policy in Malawi and to provide lessons on how to move forward. The study aimed at documenting barriers and facilitators in the implementation of the HIV testing components for the STI/PTC and PTC for PMTCT in the 2005 HIV/AIDS policy in Malawi and to provide lessons on how to move step forward. The study aimed at documenting barriers and facilitators in the implementation of the HIV testing components for the STI/PTC and PTC for PMTCT in the 2005 HIV/AIDS policy in Malawi and to provide lessons on how to move forward.


