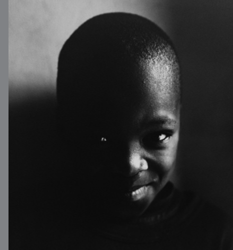

Implementation: guidelines, barriers and proposed solutions

Policies and strategic plans must be supported by broad goals and objectives, as well as by detailed guidelines for turning principles into practical operations. The guidelines are usually developed using evidence from scientific studies. National and international guidelines that tend to be generic should be localised through a process of consultation. The guidelines become useful if they can be implemented locally. That is, the resources must be available and personnel must have the necessary competence to implement them. This may necessitate training of staff.

The existence of guidelines implies that those in the front line of service delivery have an explicit and detailed set of instructions to use in delivering the service. Without these guidelines, the frontline workers may be unable to provide quality service.

A brief description of guidelines is provided, followed by the findings for each country.

Guidelines: voluntary counselling and testing (VCT)

VCT is 'the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV. The decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.' (UNAIDS Technical Update, May 2000)

VCT is necessary because:

- Research has shown that it is an effective strategy for HIV/AIDS prevention and care.
- People want to know their HIV status.
- It is a useful prevention measure for those who are HIV positive (i.e., it prevents further infections) and for those who are HIV negative.
- Knowing one's HIV status helps one to plan for the future.
- It is an entry point for care.

Guidelines: prevention of mother-to-child transmission of HIV (PMTCT)

There are best practice guidelines for PMTCT, developed by UNAIDS, WHO and UNICEF. The programme comprises VCT, short-course ARV therapy, and options for infant feeding. The guidelines aim to reduce transmission of HIV from mother-to-child, based on protocols that are nationally affordable to a country. The guidelines may be specific for women who receive antenatal care, as well as for those who do not. The guidelines may also have related interventions, such as good antenatal care services, information, education and communication, primary prevention of HIV to specific high-risk groups, family planning, prophylactic treatment, monitoring and evaluation and laboratory testing. (http://www.cdc.gov/nchstp/od/gap/text/strategies/2_2_preventing_mtct.ht)

Guidelines: treatment of opportunistic infections

A key component of the management of HIV/AIDS-related illness is prevention and treatment of opportunistic infections and associated malignancies. If these conditions are not adequately treated, they can lead to increased morbidity and mortality for PLWHAs. If they are treated, PLWHAs can have a better quality of life, contribute to society and prevent further spread of communicable diseases, such as TB.

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There are guidelines for prevention and treatment of HIV/AIDS related infections, which require steps to be taken at national, hospital or clinic and at community/home level. These include standard clinical guidelines used by clinicians to provide care in public health settings, training of medical staff, medicines in the essential drugs list, access to affordable medicines and ensuring adequate laboratory services. At community level, the guidelines may include basic education on the prevalence of HIV/AIDS-related infections, referral mechanisms and treatment for TB. As highly active ARV therapy reduces the occurrence of opportunistic infections, it is critical that the guidelines also include provision of this type of treatment. Such treatment must be coupled with palliative care and psychosocial support services.

Guidelines: infant feeding of HIV positive mothers

WHO, UNICEF and UNAIDS issued guidelines on infant feeding options for consideration by HIV-positive mothers. They include:

- Replacement feeding with commercial formula or home prepared formula.
- Traditional exclusive breastfeeding for at least the first six months.
- Breastfeeding exclusively at first but early cessation.
- Use of heat-treated expressed breast-milk.
- Wet-nursing.

Timely and adequate inclusion of complementary feeding is also emphasised. The guidelines do not require women to use one option over others, but simply to require that women take an informed decision based on the information provided. Such a decision would be influenced by availability of resources. (WHO/FRH/NUT/CHD; 1998)

Guidelines: nutrition for people living with HIV/AIDS

The World Health Organisation and the Food Agricultural Organisation recently (February 2003) published a new manual, which offered guidelines for balanced nutrition that can help the body fight back against the disease and maintain the level of body weight necessary to support drug treatment. (http://www.fao.org/DOCREP/005/Y4168E/y4168e02.htm)

Medical nutritional therapy includes both assessment and appropriate treatment, aimed at improving their nutritional status. The American Dietetic Association and Dieticians of Canada (2000) maintain that the diet for PLWAs may include diet therapy, counseling, or the use of supplemental nutrition (oral, enteral, and/or parenteral delivery of nutrients.

Existence of guiding documents

The summary in Table 4 indicates that only South Africa has all the protocols and guiding documents. Botswana has most of them, however, no mention is made in the report on VCT protocols and manuals, so it is not clear whether these are available. Similarly, in Zimbabwe and Mozambique, most of the documents are reported to be available. In Swaziland, some of the documents are available, many in draft form, and others are yet to be completed. In Lesotho, only STI case management guidelines are available. Most of the other documents were reported to be in the process of the development.

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Table 4: Summary of findings on the existence of guiding documents

Document/ Country	B	L	M	SA	Sz	Z
National VCT Protocol.	✓			✓	✓	✓
National VCT Curricula/ Manual.	✓		✓	✓	✓	✓
National VCT Facilitators and Participants manual.	✓		✓	✓	✓	✓
National HIV/AIDS Testing Manual.	✓		✓	✓	✓	
National Guidelines on PMTCT.	✓		✓	✓		✓
National Training manuals on prevention of opportunistic diseases and HIV related diseases in adults.	✓		✓	✓	✓	
National Guidelines on infant feeding of HIV positive mothers.	✓			✓	Draft	✓
Guidelines on nutrition for People living with HIV/AIDS.	✓		✓	✓	Draft	
Home-based care.	✓		✓	✓	Draft	✓
Orphan care.	✓			✓		
Case management guidelines for HIV illness and AIDS.	✓		✓	✓	Draft	✓
HIV/AIDS and Prisons.	✓			✓	Draft	
STI case management guidelines.	✓	✓	✓	✓	Draft	
Condoms	✓		✓	✓	Draft	
Youth manuals on HIV/AIDS.	✓			✓	Draft	
Dual manual on TB and HIV.	✓		✓	✓	✓	
Clinical management of HIV in children.	✓			✓		

✓ Indicates existence of a document
Botswana (B), Lesotho (L), Mozambique (M), South Africa (SA), Swaziland (Sz) and Zimbabwe (Z)

Existence of policies on orphans and rape

Of the six countries studied, only Botswana and Zimbabwe lack a national policy on rape. However, in Zimbabwe, as well as South Africa and Mozambique, there are systems and co-ordinated strategies for assisting rape victims.

Existence of ministerial policies

In Botswana, 80 per cent of Government Ministries have HIV/AIDS policies; while in South Africa, a majority of departments are reported to have draft policies. In Swaziland, only the Ministry of Defence has a policy, in draft. In Mozambique, most ministries are

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reported to have draft policies, while many have operational plans. In Lesotho, few ministries have HIV/AIDS polices in draft, while the Zimbabwe report makes no reference to ministerial HIV/AIDS policies.

Barriers to implementation of HIV/AIDS policies and strategic plans

Botswana

There were several factors that were identified as barriers to effective implementation of the policy. These included: lack of proper monitoring and evaluation, absence of trained professionals in the area of HIV/AIDS and poor access to financial resources. The inadequate commitment of some service providers was another serious impediment. Ignorance of policies among communities, as well as excessive governmental bureaucracy has also been observed. There is also low utilisation of existing services, such as PMTCT, VCT, HBC and orphan care programmes. This is compounded by heavy workloads among people in service areas other than HIV/AIDS and contributes negatively to the implementation process.

Lesotho

Apart from the lack of financial and skilled human resources, stakeholders and key informants have identified a number of barriers to the implementation of the National Policy and Strategic Plan. Government bureaucracy is one of these. Lack of human resources, poor organisation of agencies and lack of support at decision-making levels of government for the multisectoral approach were also deemed to be seriously undermining policy implementation. Lastly, institutional rivalry and duplication of efforts, among the various NGOs and other implementing agencies, were just some of the other issues of concern.

Mozambique and Swaziland

These two countries had essentially similar constraints that were identified as barriers to implementation of HIV/AIDS Policy and Strategic Plans. A lack of participation in policy development at local level was cited. Inadequate awareness of the national AIDS policy, limited funds for implementing programmes, together with inadequate human resources management skills, were identified as barriers to implementation. Finally, negative cultural and traditional norms, and objectives that were perceived as too ambitious were seen as contributing to the problem of implementation.

South Africa

The barriers to the implementation of HIV/AIDS policy were identified as inadequate human resources, poor infrastructure and lack of awareness. All these factors impacted on the quality of VCT. It was noted that there was a problem of lack of confidentiality because of present infrastructure that does not allow for privacy. Most hospitals and clinics could not provide special rooms for VCT. Stigma was another problem impacting implementation. This manifests itself in low numbers of people requesting testing. The stigma also impacted on PMTCT with relation to infant feeding, because culturally, a woman is expected to breast-feed the child, and family members were forcing mothers to breast-feed, to comply with the culturally expected maternal role.

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There was generally a lack of awareness of HIV/AIDS Policy and Strategic Plan. For example, key informants, representing the various organisations, were not aware of the existence of either the policy document on HIV/AIDS or the HIV/AIDS Strategic Plan.

Zimbabwe

There was a belief among NGOs that the agenda was determined by donors, rather than by the strategic AIDS plan. Although NGOs are represented in the various structures, it is accepted that the agendas of donors tend to have a major influence on which aspects of HIV/AIDS programmes the NGOs end up focusing on, eg., in the areas of prevention, control, care and or impact mitigation.

It was also reported that awareness is very low at the grass roots level. Many people are not aware of, let alone familiar with, the national policy on HIV/AIDS. Several reasons have been cited, including the inaccessibility of the document and the fact that it is not user-friendly. It was also believed that commitment was lacking, among the various sectors and players, to the full implementation of the National Policy on HIV/AIDS.

One particular obstacle to the full implementation of the HIV/AIDS policy that has been identified by the NAC, is the absence of a legal framework, constituted by an Act of Parliament, which would make the policies binding. Although the NAC was constituted by an Act of Parliament, its mandate is the co-ordination of a multisectoral response to the epidemic. It does not have policing powers. Legal provisions, such as the Statutory Instrument 202 of 1998 and the Labour Relations (HIV and AIDS) Regulations 1998, are examples of what is needed to enforce full implementation of the national HIV/AIDS policy. Another obstacle that was identified is the constant staff turnover and brain drain of those who had represented the various organisations during the policy development process, resulting in loss of institutional memory.

Recommendations for addressing barriers to implementation of HIV/AIDS policy and plans

Only Botswana and Mozambique made separate recommendations to address barriers, although many of these are relevant to the other countries, as well. In other countries, solutions are discussed in relation to specific HIV/AIDS programme areas and activities.

Botswana is considering the decentralisation of decision-making, including budget decisions, to be one of the key ways of improving the implementation processes. The country foresees a need to create units within Ministries and departments, which deal primarily with HIV/AIDS. The National AIDS Co-ordinating Agency (NACA) has to move from operations and implementation to co-ordination monitoring and evaluation. In Mozambique, key issues that need to be addressed include dissemination of the policy and developing appropriate mechanisms of funding for HIV/AIDS activities. Greater involvement of communities in all HIV/AIDS initiatives would help accelerate programme implementation.

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