COLLEGE OF MEDICINE

Exploring Factors Affecting the HIV/AIDS Workplace Policy Development and Implementation in Selected Public Hospitals in Lilongwe, Malawi

By

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CERTIFICATION OF APPROVAL

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DECLARATION

I, Patricia Kapangama, hereby declare that this dissertation titled **"Exploring factors affecting HIV/AIDS workplace policy development and implementation in selected public hospitals in Lilongwe, Malawi**" represents my original work. It is submitted to the University of Malawi, College of Medicine for my Master's Degree in Public Health. No one has presented it for any purposes and due acknowledgements have been done where the work of other scholars has been used.

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Date: 31st December 2020

DEDICATION

I dedicate this work to my husband, Mr Rodrick Masinda. I will forever be grateful for your psychological and financial support from the very beginning of this thesis until the very end.

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The researcher is indebted to several individuals, whose contribution played a critical role in this study.

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ABSTRACT

Introduction: Malawi has a national workplace HIV/AIDS policy. Despite its existence, the adoption of the policy is low. Many organizations are yet to adopt the policy as a guiding document in recognizing and addressing HIV/AIDS as a workplace issue. There is a dearth of information on the factors that affect the policy's implementation in public institutions.

Objective: The study's main objective was to explore factors affecting the development and implementation of HIV/AIDS workplace policy in public hospitals in Lilongwe district.

Methods: An exploratory qualitative cross-sectional study was conducted from June to July 2020 at Bwaila hospital and area 25 health Centre in Lilongwe district, Malawi. Twenty-four in-depth interviews (IDI) with employees and 6 key informant interviews (KII) with hospital administrators were conducted. All IDIs and KIIs were digitally recorded, transcribed and translated verbatim into English. The data were analyzed using thematic analysis.

Results: The study found that major factors affecting the HIV/AIDS workplace policy's development and implementation included stigma and discrimination, lack of knowledge and inadequate resources. The main challenges facing policy implementation were lack of policy sensitization, stigma and discrimination, lack of employee involvement, lack of privacy and confidentiality and lack of management commitment. The potential optimizing factors were staff sensitization, adequate resources, establishing of a staff welfare committee, strengthening HIV prevention, provision of additional support to staff and HIV/AIDS workplace policy availability.

Conclusion: There is a low implementation of the HIV/AIDS workplace policy in the selected public hospitals due to poor enforcement of the policy, lack of hospital management support and commitment to developing and implementing the HIV/AIDS policy at the workplace. Close supervision by the Ministry of Health and regular monitoring and evaluation at all public

health institutions, provision of regular sensitization and staff involvement would ensure the development and implementation of HIV/AIDS workplace policy.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency syndrome
ART	Antiretroviral Therapy
A/25 HC	Area 25 Health Centre
BT	Blantyre
CD4	Cluster of differentiation 4
COMREC	College of Medicine Research and Ethics Committee
DHO	District Health Office
HIV	Human Immunodeficiency virus
HTC	HIV testing and counselling
IDI	In-depth interview
KII	Key informant interview
LL	Lilongwe
ORT	Other Recurrent transactions
PLHIV	People living with HIV
VCT	Voluntary counselling and testing

DEFINITION OF KEY OPERATIONAL TERMS

In this study, we adopted the following definitions:

Adoption of HIV/AIDs workplace policy: Having an existing policy that is either in the process of operationalization and implementing the components therein

AIDS: A cluster of medical conditions often referred to as opportunistic infections.

Confidentiality: The right of every person, employee or job applicant to have his or her medical or other information, including HIV status kept secret.

Discrimination: Refers to an individual's unfair and unjust treatment based on his or her actual or perceived HIV status.

Employer: A person or organization employing workers or contracting labor under a written or verbal contract of employment that establishes the rights and duties of both parties, per national law and practice.

HIV: A virus that weakens the body's immune system, ultimately causing AIDS.

HIV and AIDs workplace policy: Refers to a written document that sets out an organization's position and practices related to HIV and AIDs.

Policy: A statement setting out a department's or organization's position on a particular issue.

Stigma: Refers to a process of devaluation of people, either living with, affected by HIV/AIDs.

Workplace: Occupational settings, stations and places where workers spend time for employment gainful.

Workplace programme: An intervention to address a specific issue within the Programme

CHAPTER 1: INTRODUCTION AND OBJECTIVES OF THE STUDY

1.1 Background

HIV stands for Human Immunodeficiency Virus, the virus that causes HIV infection. AIDS stands for acquired immunodeficiency syndrome. HIV attacks and destroys the infection-fighting cells called cluster of differentiation 4 (CD4 cells) of the immune system. The loss of CD4 cells makes the body not able to fight against infection and certain cancers. Without treatment, HIV can gradually destroy the immune system and advance to AIDS.

HIV/ AIDS continues to be a major public health issue in the 21st century, which has affected 77.3 million people globally since the start of the epidemic and 1.8 million people become newly infected with HIV(1). It is the number one cause of deaths worldwide (2). 34.4 million people have died from AIDS-related illnesses since the start of the epidemic(3). Sub-Saharan Africa bears an inordinate share of the global HIV burden, Out of 77.3 million people living with HIV/AIDS, 22.9 million people (68 %) are from sub-Saharan Africa (4).

In Malawi, it is estimated that the HIV prevalence rate amongst people aged 15 and 49 stands at 10.6 (3). HIV prevalence according to socioeconomic characteristics shows that the HIV prevalence rate is higher among working women and men (9 %) than among their counterparts who are not working (7.9 %) (5). This indicates that HIV/AIDS affects them whilst in their productive ages, affecting their families, organizations and society's economy. HIV/AIDS undermine the growth of an organization (6). It aggravates labor shortages due to the loss of skilled labor (4). It also results in low productivity since it is associated with high morbidity and mortality rates. It leads to more absenteeism and lower morale at the workplace (7). Furthermore, it increases

organization's training and recruitment costs since employees retire or die untimely, and the organization have to replace them. To address these problems, the Malawi government introduced HIV policy at the workplace in 2010. The policy exists to reduce the prevalence of HIV amongst employees and attain improved productivity through effective and quality HIV and AIDS prevention, treatment, care and support interventions in the workplace (6).

In support of the Malawi government efforts to reduce HIV/AIDS and its impact in the work place, it is expected that every workplace should use the Malawi HIV/AIDS workplace policy to develop, implement and refine their HIV/AIDS policies and programmes to suit the needs of their workplace. The policy helps employees with HIV/AIDS to understand what support and care they will receive; it also outlines a standard behavior for all employees (whether infected or not). Furthermore, the policy helps stop the spread of HIV through prevention programs (8).

However, Malawi has low adoption of HIV/AIDS workplace policy. A study done in Malawi on adopting formal HIV and AIDS workplace policies has shown that 38 % of the sampled private sector companies had adopted formal HIV and AIDS workplace policies, in comparison, 62 % of the companies had not yet adopted such policies (9). In another study done on HIV and AIDS workplace intervention gaps between policy and practice at the College of Medicine, University of Malawi, related low policy adoption to lack of interest and lack of knowledge on the existence of the workplace programs. Whilst a study done on analysis of factors hindering the adoption of HIV/AIDS workplace policies of private sector companies in Malawi indicated that HIV/AIDS was not being regarded as a priority business issue, and there was no staff participation in the activities of HIV/AIDS institutions (10).Often public organisations develop policies but fail to

move to the implementation phase. A possible explanation for this can be the inability of organisations to operationalise HIV/AIDS policies into effective programmes, due to a lack of knowledge, skills and resources, especially in small and medium-sized organisations (11). This echoes with the findings of one of the studies done in public institutions of Malawi, which indicated that despite the availability of many number of HIV and AIDS activities, the majority of respondents did not know about the University of Malawi (UNIMA) HIV and AIDS policy or any HIV and AIDS activities that are guided by the policy (12). Therefore, investigating factors affecting development and implementation of the HIV/AIDS workplace policy is paramount to reducing HIV/AIDS negative impact on workplace.

1.2 Literature Review

1.2.1 Burden of HIV Infection

The Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV and AIDS) constitutes a significant challenge to development, worldwide. The HIV/AIDS epidemic has affected first-world and third-world countries, globally (13) .The majority of HIV/AIDS infections are found in adults at the prime of their economically active life (11). The emergence of HIV/AIDS as an epidemic has affected many aspects of life. The livelihoods of individuals, their families, friends, and their means of survival and betterment of life such as relationships, work, and wealth, has been affected (13). Furthermore, HIV/AIDS affects workplaces through increased absenteeism, accident rates, deaths, early retirement, disability retirements, industrial disputes and emigration. There will also be increased costs related to increased employee benefits of group life insurance, pensions, funeral benefits and medical aid increases. Employees who die or retire on an

early age will have to be replaced, which will have increased the recruitment and training costs (11).

Of the estimated 6000 new infections that occur globally each day, two out of three are in the Sub-Saharan Africa (14). Over the past several decades, the HIV/AIDS epidemic has dramatically altered Sub-Saharan Africa's morbidity and mortality patterns, potentially impacting human capital investment and economic growth (15). HIV/AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal (16). The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two significant economic effects are a reduction in the labor supply and increased costs. The decline in labor supply comes due to loss of young adults in their most productive years, affecting overall economic output. The increased costs result from expenditures for medical care, drugs, funeral expenses, recruitment and training costs to replace workers, and care of orphans (16).

Malawi is severely affected by HIV/AIDS. The HIV prevalence among men and women remains high, and there has been little change in Malawi's HIV prevalence since 2004 (from 11.8 to 10.6) (17). HIV/AIDS was a burden on households, communities, public institutions and private enterprises when margins were already small or non-existent (18). The impact of HIV/AIDS on the public sector and other economic sectors includes loss of experienced workers, increased absenteeism and attrition, high costs for the replacement of staff affected by HIV/AIDS and, in

general, lower productivity in the delivery of public services have accompanied the spread of the disease. The impact on the public sector has been disproportionately large (18)

1.2.2 Adoption of HIV/AIDS Workplace Policy

Supporting HIV-positive workers is an issue of social responsibility and an economic necessity for employers. HIV-positive workers can remain productive and healthy for many years if able to access appropriate HIV management support. To effectively support the employees concerning HIV/AIDS issues, organisations should have the HIV/AIDS workplace policy which is a living document that is not just filed (11). Having the HIV/AIDs policy in place shows that the organisation acknowledges the potential impact of HIV/AIDs and is committed to addressing the effects in a responsible way. The HIV/AIDS workplace policy is a written document that sets out the organisation's position and practices as they relate to HIV/AIDS (8). It provides the framework for action to reduce the spread of HIV/AIDS and manage its impact on the workplace. It guides managers and supervisors on addressing HIV/AIDS consistently and informs employees about their responsibilities, rights and expected behavior.

Although HIV/AIDS mainly affects young people in their years of economic productivity (3). These people spend eight or more hours every day in their workplace but some workplaces have not taken steps to respond to the scourge of HIV/AIDS despite this. The HIV/AIDS workplace policies have not been formulated, and in some cases, they are on paper, but no implementation is being done. Studies done indicated that there is low adoption of HIV/AIDS workplace policy despite global efforts to reduce the burden of HIV/AIDS among employees, through the implementation of the HIV/AIDS workplace policy. Only 1.8 % (PuS) and 6 % (PrS) reported that

their organisations had a workplace HIV and AIDS policy ($p<0.05$) (19). Similarly, a study done in 128 randomly selected member companies of the Zambia Federation of Employers in Lusaka reported that policies were found in 47/128 (36.72 %) workplaces and the private sector accounted for 34/47 (72.34 %) of all workplaces with a policy (20).

A study on adopting the formal HIV/AIDS workplace policies in Malawi revealed that there are sector variations in adopting the policies. The company sector showed that 55 % of the companies in the services sector had adopted the formal HIV and AIDS workplace policies, compared with 43 % of the companies in the transport, communication and distribution sectors; 31 % of the companies in the manufacturing and construction sector and 21 % of the companies in the trading sector. The Chi-square value for state of HIV and AIDS workplace policy by company sector was significant [$x2$ ($df=3$, $N=152$) = 12.021, $p<0.05$]. These results seem to suggest that there were significant variations in the adoption of formal HIV and AIDS workplace policies across sectors. Companies in the services sector were actively taking action to address HIV and AIDS through the adoption of formal HIV and AIDS workplace policies compared with companies in other sectors such as the trading sector (9).

Another study in Malawi on the evaluation of HIV and AIDS Workplace Policy at Nkhotakota District Council, revealed that Nkhotakota District Council employees were not well acquainted with the policy (12) This is a significant setback, as most respondents has been in the employment for more than 2 years and should have been exposed to the policy in some way or another. This means that Nkhotakota district council has not yet reached all of their personnel with information on HIV and AIDS. The study further revealed that the institution faced challenges in

implementation of its HIV/AIDS policy due to poor coordination and funding (12) In addition to the above difficulties, top management support emerged as the most significant factor facilitating the adoption of formal HIV/AIDS workplace policies. Overall, the results reveal that organizational rather than institutional factors appear to play a more substantial role in adopting formal HIV/AIDS workplace policies. This implies that the adoption of formal HIV/AIDS workplace policies by private sector companies in Malawi is not just a matter of conforming to institutionalized expectations of acceptable behavior but rather an assessment of the perceived organizational value of responding to HIV/AIDS (12).

1.2.3 Personal/ Interpersonal Factors Affecting the Development and Implementation of HIV/AIDS Workplace Policy

Knowledge, attitudes and practices (KAPs) regarding HIV/AIDS are corner stones in the fight against the disease (21). Therefore, the management at the workplace should identify them to implement the workplace programmes and policies effectively. Personal factors such as knowledge, values, attitude and perception of employers and employees can influence the implementation of the HIV/AIDS workplace policies. These personal factors determine how an individual responds to the HIV/AIDS programs interventions at the workplace. If the staff has inadequate knowledge they end up having various myths and misconceptions about HIV infection. In addition, they will indulge in risky sexual behaviors. For example, a cross-sectional study on 464 participants in Fako, from April to June 2014, revealed misconceptions about transmission routes to evaluate their KAPs regarding HIV/AIDS. In this study 3.4 to 23.3 % had misconceived ideas about how HIV is spread, moreover risky sexual behaviors were found among participants

as about 60 % practice safe sex, and 40 % reported not engaging in safe sex practices. Almost half of the respondents had negative views about HIV infected people.

In addition, stigma also affects the development and implementation of HIV/AIDS workplace policy. People living with HIV/AIDS (PLWHA) face medical problems and also social problems associated with the disease. One barrier to reaching those at risk or infected with HIV/AIDS is stigma (22). Similarly, Zarnaq et al discovered that stigma of the HIV/AIDS pandemic was another barrier to HIV/AIDS policy-making process in Iran (23). In their study all participants, including PLHIV, agreed on the pervasive stigma of the disease within the country. They believed in the failure of the policies related to HIV/AIDS stigma reduction among Iranian communities. They explained the problem to be worse when there was still a high level of stigmatization in the attitudes of the clinical practitioners and health care providers toward patients. Additionally, general knowledge on HIV/AIDS among the Iranian population was still limited, and the attitudes were still negative (23).

1.2.4 Institutional Factors Affecting Development and Implementation of HIV/AIDS Workplace Policy

Most people with HIV and AIDS are in the productive group between 15 to 49 years. The age group is the age group of productive workers, working in various employment sectors (24). Therefore, workplaces should aim to mitigate HIV/AIDS by developing and implementing HIV/AIDS programmes and policies at the workplace. However, some studies revealed that some facility factors that affect the development and implementation of HIV/AIDS workplace policies (25).

In Asia Pacific Region, stigma and discrimination for PLWHA had played a part in respondent's loss of income or employment (16-50 %), being refused the opportunity to work (9-38 %), or being refused promotion or the nature of work changing (8-52 %) (25). In addition, approximately one in four respondents in Kenya and Zambia reported that they had been denied promotions or had their job responsibilities changed because of their HIV status (26). Despite these negative consequences, discrimination against PLHIV remains a challenge at workplaces. Workplace discrimination involves the applying different standards, requirements and treatment to the existing and prospective workers on grounds that are not informed or justified by the requirements of the work concerned. At the pre-employment stage, the discriminatory practices include prejudice in initial employment, where treatments or standards unrelated to work requirements are applied in determining access to employment (27). Stigma and discrimination play an important role in the lack of in-depth knowledge regarding HIV/AIDS. The associated stigma causes some to withhold information regarding their own, or family members status since they believe that there exists a risk of others finding out and thus discriminating against them (28).

In addition, lack of knowledge and skills also influence the HIV/AIDS workplace policy development and implementation. According to a study done in South Africa, 23.6 % of the respondents indicated that their workplace does not have a policy. The majority of these respondents (50.8 %) do not know why the organisation did not implement a policy. The respondents further explained that the reasons given for not having a policy were that the organisation does not have the knowledge or skills to develop a policy (35.6 %) and that the organisation cannot create a policy (11.9 %) (11).

Availability of financial and human resources also determines the implementation of the HIV/AIDS workplace policies. Resources are scarce but organisations should do proper budgeting of the limited resources available. Budgeting is how policymakers and technical personnel make plans of the funds they expect either from the government, donors, internally generated revenue for the implementation of government policy(29). The policy-making process involves planning which includes budgeting. Mc-Robie et al. conducted semi-structured interviews with key informants (policy-makers, implementers, researchers) to identify factors influencing implementation at health facilities serving two health and demographic surveillance sites in Kyamulibwa, in Rakai. They found that factors facilitating the implementation were the donor investment and support and effective planning. Limited human resources, infrastructure was perceived as significant barriers to effective implementation (30).

Furthermore, management involvement also influences the HIV/AIDS workplace policies implementation. The managers play an essential role in the implementation of the HIV/AIDS workplace programs. Apart from implementing procedures and initiatives, they also have to act appropriately to set an example, using leadership characteristics such as charisma (31). A study was done in Kenya which aimed at improving the health promotional workplace programs, pointed out that the lack of management involvement became a major obstacle for the progress of the HIV/AIDS programs. The participants indicated that they wanted to see higher participation from middle-level management such as the production manager and the quality manager, because they believe it would augment the employee motivation for participating. They thought that a greater management involvement would make it easier to justify the number of resources needed to have the program working, which had been difficult so far (31).

1.2.5 Challenges in Development and Implementation of HIV/AIDS Workplace Policy

All employees and employers perceive HIV/AIDS as a serious workplace issue. They should acknowledge that HIV/AIDS is an issue that affects the workplace and requires a response. It is better to be proactive and to develop a workplace policy rather than wait for a potential crisis. However, studies done indicate that there are challenges to developing and implementing HIV/AIDS policy. Some of them are lack of use of evidence in the HIV/AIDS policy-making process. In Iran, it was noted that there was a lack of evidence used in some specific areas. Lack of interest and competent management in applying evidence, lack of accountability among the managers, high workload of managers and lack of time to refer to evidence were other managerial factors affecting evidence non-use (23).

Cawley et al. in 2017 identified stock-out of resources as another challenge to the implementation of HIV/AIDS policy programmes (32). In their study, a more significant proportion of health facilities in Kisumu reported frequent stock-outs (defined as more than one stock-out in the past year, or a stock-out lasting >2 weeks) of HIV test kits, maternal or infant prophylaxis for infant PMTCT and first-line ARVs compared with facilities in Nairobi. However, stock-outs of HIV test kits were common across both sites, at both small and large health facilities (50 % of all facilities in Nairobi and 70 % of all facilities in Kisumu reporting frequent stock-outs) (32).

A study done in 56 HCT sites in South Africa by Matseke et al. in 2016, on clients' perceptions and satisfaction with HIV counselling and testing gives evidence for the challenge for implementing the HIV/AIDS workplace policies. It was reported that the most cited perceived

barrier to HIV testing was lack of awareness about the HCT service (98 %), while staff attitudes (37 %), confidentiality (29.6 %) and privacy (23.6 %) were perceived barriers (33).

1.2.6 Theoretical Framework

The study was guided by critical theory and Social Ecological Model (SEM).The frameworks helped in the formulation of the study's objectives, the tools that guided data collection as well as analysis. The various constructs of the frameworks aided in developing of the interview guide used to collect participant information. The frameworks also informed the analysis of the study. The frameworks are rich as they include relevant domains that are relevant for this study to explore the factors that affect the development and implementation of HIV/AIDS workplace policy. With the use of the frameworks, the researcher was able to assess individual and institutional factors that influence the workplace policy development and implementation

1.2.6.1 The Critical Theory

The critical theory focuses upon social science and humanities, with an emphasis on examining and criticizing society and culture issues such as exploitation, asymmetrical power relations and distorted communication (34). The critical framework has an element of the reflective assessment and society critique (34) which helped the researcher critique the public health institutions, specifically the management why they do not develop the policy and if the policy was developed, why it is not implemented. There is a culture of merely having the policy but not used as a road map for related activities. A possible explanation for this can be the inability of organizations to operationalize HIV/AIDS policy as an effective program, and the lack of knowledge, skills and resources. In addition, the problem is often that the policy is not understood or communicated to

employees (11). If employees were given enough support (power) then the policies would be implemented. An effective workplace policy implementation needs help from all sectors of the workplace, and HIV positive employees.

The first domain: exploitation is defined as employees' perceptions that they have been purposefully taken advantage of in their relationship with the organization, to the benefit of the organization itself (35). Such perceptions are associated with both outward-focused emotions of anger and hostility toward the organization and inward-focused ones of shame and guilt at remaining in an exploitative job (35). Labour exploitation is a violation of human dignity and hence unacceptable. Exploitation of HIV/AIDS employees may negatively affect HIV/AIDS workplace policy implementation because it creates dangerous or unhealthy work, long working hours, physical and psychological pressure.

The second domain: asymmetrical power relations can influence HIV/AIDS workplace policy implementation. Power is the ability of one actor to influence another to perform in a manner that he/she would not have otherwise done (36). If the employer abuses his power he/she widens relationship gap between employer and employees, and this may make it so hard for him/ her to communicate issues concerning HIV/AIDS workplace policy to employees. In turn, the employees may not be involved in HIV/AIDS related activities. The involvement of HIV positive employees is strongly recommended as they understand being HIV positive in the workplace and help develop strategies. The strategies could focus on addressing and managing the wellness of infected and affected employees to ensure the quality of health, life and productivity of all employees (11).

The final domain: distorted communication significantly influences development and implementation of the HIV/AIDS workplace policy because it leads to lack of information, stigma and discrimination against HIV infected employees. On the other hand, for HIV/AIDS workplace policy to be implemented effectively there is need for proper communication between management and employees regarding the HIV/AIDS policy issues. This may influence employees' response to HIV/AIDS.A comprehensive workplace response to HIV/AIDS is needed to strategically address this issue (11). The employees' knowledge of the policy will enable them to perceive significance of the policy's existence hence facilitating implementation of the HIV/AIDS- related programs.

1.2.6.2 The Socio Ecological Model

The choice of the Social Ecological Model (SEM) model was based on its ability to address multiple determinants of behavior and identify interventions at the population and individual-level. Hence, this provided an opportunity for the researcher to explore factors affecting the development and implementation of HIV/AIDS workplace policy. The SEM is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental determining behaviors, and identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations (37). The SEM takes into consideration the individual and their affiliations to people, organizations, and their community at large to be effective (38). This model has the following five socio-ecological layers that might act as barriers or facilitator of a service provision: Individual, Interpersonal, Organizational, Community, and Public Policy (38). Therefore, to understand factors that affect HIV/AIDS workplace policy development and implementation, it is essential to understand the factors at every level of the social system.

Figure 1: Social-Ecological Model (38)

The individual-level factors are concerned with an individual's knowledge and skills influencing behavior such as attitudes, beliefs, values and personality(37). Knowledge about a disease helps the individual understand more about it. It helps inform them about how susceptible they are to the disease, how serious the disease is, and the overall threat of the disease (37). On the one hand knowledge about HIV/AIDS helps in influencing key attitudes and decisions made at workplace. On the other hand low knowledge levels of HIV related issues at work place are the most common reasons for non-adoption of HIV/AIDS workplace policies.

The interpersonal level has to do with a person's relationships with other people (38). Interpersonal factors, such as interactions with other people, can provide social support especially to people living with HIV(37). At this level, the organization's management can have regular health talks

with their employees about safe sex and the need to go for HIV/AIDS screening from time to time. They can also make condoms available at the workplace as part of HIV prevention. But if relationships between employers and employees are not good, the result will be non-adoption and non-implementation of HIV/AIDS workplace programmes.

The organizational level factors such as rules, regulations, policies, and informal structures can influence decision making in regard to adoption and implementation of HIV/AIDS workplace policies. How the organization is structured and the networks within it will define how well the workplace policies will be implemented .If the organization has got supportive health care system, the end result will be effective implementation of HIV related programs[7,8]. In addition, confidentiality, privacy and adequate funding also influence how well the HIV/AIDS related services are delivered to reduce HIV transmission at workplace

Community-level factors such as formal or informal social norms among individuals, groups, or organizations, can limit or enhance healthy behaviors. In this model, a community refers to the culmination of the various organizations in an area(38). These organizations can pool resources and ideas together to improve community health. For example, a hospital can agree to have some nurses teach safe sex practices in nearby workplaces. In addition, organizations could coordinate health events designed to educate and equip affiliates with knowledge and materials to help prevent the spread of HIV/AIDS in the community.

Public policy level is the final level of Socio-ecological Model and its important because it affects a larger portion of the population than the other levels (38). The Public Policy are the governing

bodies in charge of the HIV prevention effort(37). They do can this by establishing agencies and laws at every level of government to do research on the spread of HIV/AIDS and figure out more effective ways of dealing with the problem. The government should set the laws and enforce those laws. For example, a law that provides funding to the adoption and implementation of HIV/AIDS workplace policies in all public institutions.

Previous use of Social Ecological Model

Several studies have used the SEM to identify interventions aimed at improving access to health care. A review by Harper et al. in the United States of America in 2018 on the Social-Ecological Model to improve access to care for adolescents and adults described multiple factors that impact health care utilization and highlight opportunities interventions (12). In Nepal, Social-Ecological Model was used in a study to develop interventions aimed at improving dietary behavior for people living with diabetes or high blood glucose levels (39). The Social-Ecological Model incorporated multiple determinants into different levels of influence on behavior(intrapersonal, interpersonal, organizational, community and public policy) and considered the interaction of behaviors across these different levels of influence, which led to multi-level suggestions for interventions to effectively change behavior (39) Socio-Ecological Model was also used to explore HIV testing behaviors and attitudes among young Black women ages 18-24 years in southern North Carolina (N =17) using a semi-structured interview based on the Socio-Ecological Model. The findings showed that individual, interpersonal, social, and organizational factors contributed to participants' testing behaviors and attitudes. Understanding the factors that influence attitudes and intention for HIV testing among young Black women will inform the development of culturally congruent prevention interventions and programs (40).

1.3 Rationale/Justification of the Study

In response to HIV/AIDS epidemic, the Malawi government made a commitment to ensure that at least two percent of other recurrent transactions (ORT) funds should be allocated to implement HIV/AIDS workplace programs in all the public institutions (8). Therefore, all ministries are required to spend the stipulated. However, there is a lack of knowledge on the current situation regarding the policy development and implementation of HIV/AIDS workplace policy programs in public institutions, specifically the Ministry of Health. Therefore, this study intends to address this knowledge gap. The study will determine how many organizations have HIV/AIDS workplace policies in place, and if not, why not. This study will give insight into the reasons why organizations do not have HIV/AIDS policies and also shed light on what type and size of organizations don't have policies. This will provide a greater understanding of where the possible weaknesses are in policy development and implementation. This will in turn inform future policy development and it will help to strengthen support and compliance with the existing national HIV /AIDS work place policy. A similar study was done on the HIV/AIDS workplace policy development and implementation in selected South African organizations. However, the results from the study cannot be applicable in Malawi because South Africa and Malawi are two different countries socially and economically (South Africa is more developed than Malawi). Therefore, the implementation of HIV/AIDS workplace policy programs cannot be the same in the two countries, despite both being African. The methodology used in the study was weak because the researcher did not engage all stakeholders. The evaluation should engage stakeholders (41). In addition to this, the researcher just asked the respondents about the availability and the implementation of HIV/AIDS workplace policy programmes. He did not look into administrative data to check for

evidence (whether the policy was present and active). A policy evaluation should involve gathering of credible evidence on the policy development process and implementation (41).

1.4 Objectives of the Study

1.4.1 Broad Objectives

To determine factors affecting the policy development and implementation of HIV/AIDS workplace policy in selected public health facilities in Lilongwe.

1.4.2 Specific Objectives

- To determine availability of HIV workplace policy at area 25 health Centre and Bwaila hospital.
- To identify the personal/ interpersonal factors (knowledge, values, attitudes, perceptions) affecting the development and implementation of HIV workplace policy.
- To identify institutional factors that affect the development and implementation of HIV/AIDS workplace policy.
- To determine challenges of the implementation of HIV work place policy at area 25 health Centre and Bwaila hospital.

CHAPTER 2: METHODS

2.1 Introduction

This chapter explains the methods and process that the study used to explore factors affecting the development and implementation of the HIV/AIDS workplace policy in public hospitals in Lilongwe, Malawi. Research methodology refers to how the research was done and its logical sequence (42).

2.2 Study Design

This study employed an exploratory qualitative cross-sectional study design to explore factors affecting the policy development and implementation at the workplace. In a cross-sectional study design, either the entire population or a subset thereof is selected, and from these individuals, data is collected to help answer research questions of interest (43). The researcher chose an exploratory qualitative cross-sectional study design to gain new insights and discover how the HIV/AIDS workplace policy is developed, who is involved in the development and how the policy is implemented. The researcher also wanted to gather ideas and insights on the implementation of the policy.

2.3 Study Setting

The study setting refers to the place where the data is collected (44). The study setting's nature is an important component of a research study. The nature, context, environment, and logistics may influence how the research study is carried out (45). This study collected data at the two purposively selected public hospitals: A/25 HC and Bwaila hospital. The two public hospitals are

located in the central region in Lilongwe, Malawi. According to the 2018 Malawi population and housing census report, Lilongwe district has a total population of 2,626,901. The HIV prevalence for Lilongwe district was estimated at 10.3 % with 95 % CI [sic] (9.3 %, 11.3%) (46). A/25 HC provides health services at the primary care level and serves approximately 10, 000 populations. Bwaila hospital provides services at the secondary care level and provides referral services to surrounding health Centres. The researcher selected the above two sites because they are all public institutions and they operate at different health care system levels. Therefore, the researcher wanted to determine variations in developing and implementing of HIV/AIDS workplace policy. The researcher also wanted to find out if the size of these institutions affects the development and implementation of HIV/AIDS workplace policy. The study interviews were specifically conducted in the private rooms of the study sites.

2.4 Study Population

The study population is the study's target population that it intends to study or treat (45).This Study targeted hospital administrators and employees: Clinicians, nurses and support staff at A/25 health Centre and Bwaila hospital who have worked for at least three years.

2.5 Study Period

The study period was from April 2019 up to December 2020. The study period included the research concept development to final dissertation writing and submission.

2.6 Sample Size and Justification

Sampling is the process of selecting a statistically representative sample of individuals from the population of interest (47). Sampling is an essential tool for research studies because the people of interest usually consists of too many individuals for any research project to include as participants (45). The main function of the sample is to allow the researchers to conduct the study to individuals from the population so that the results of their study can be used to derive conclusions that will apply to the entire population (48). A purposive sampling method was used to recruit 30 participants in this study. The Purposive sampling was chosen to have a sample that is rich in information and experience with the phenomenon of interest. (48).The researcher selected a sample size of 30 participants because it is within the recommended sample size (32). Out of 30 recruited participants, 6 were administrators and 24 employees. Of the 24 employees, 14 were nurses, 3 were clinicians and the remaining 7 were support staff. The potential participants were purposively identified by getting a list of eligible employees from the administrator's office. Then the potential participants were approached by the researcher who sought informed consent from the selected participants. Then an appointment was scheduled at a time and place convenient to the participant The sample size had been reached based on Guest and Creswell who stated that to reach a saturation point in a qualitative study a total of twelve to thirty participants is sufficient (49). According to Dworkin, 25 -30 participants is a minimum sample size required to reach saturation in qualitative studies that use in-depth interviews. Saturation is defined as the point at which the data collection process no longer offers any new or relevant data (50). The researcher stopped data collection when saturation was reached.

2.6.1 Eligibility Criteria of Participants

2.6.1.1 Inclusion Criteria

The eligibility criteria determine whether an individual is qualified to participate in a research study. Eligibility criteria consist of inclusion criteria, which are the main characteristics of the population of interest. A potential research participant has to fulfil all criteria in order to participate in the study (45). In this study, the inclusion criteria were administrators and employees who have worked for at least three years at A/25 HC and Bwaila hospital. If the employee met the above criteria, she/he was contacted to determine willingness to participate in the study. Of all the potential participants, only 2 refused to participate due to their busy schedules

2.6.1.2 Exclusion Criteria

The exclusion criteria are characteristics that may interfere with data collection, follow-up, and safety of research participants (47). If a potential participant fulfills any one of the exclusion criteria (45), he/she is excluded from the study. The following were excluded from the study: all the employees and administrators who have worked less than three years.

Table 1: Summary of Methods

Method	Purpose	Sample characteristics	Sample size
In-depth interviews	To understand employees' insights on the factors affecting the development and implementation of HIV/AIDS workplace policy.	Hospital employees: clinicians, nurses and support staff, with at least three years of working experience at the study site	N=24 employees
Key informant interviews	To understand the hospital administrators views on the institutional challenges in the development and implementation of HIV/AIDS workplace policy	The hospital administrators with at least three years of working experience at the study site.	N=6 administrators

2.7 Data Collection Procedures

The principal investigator collected data through In-depth face to face interviews and key informant interviews using a semi-structured interview guide (Appendices 2 and 3). Participation in the study was voluntary and written informed consent was obtained from all study participants prior to the interview. Interviews were conducted in a private room, with a low voice to prevent others from hearing hence ensuring privacy. Anonymity and confidentiality were ensured by identifying the participants by codes and not their names. The participants were asked to describe the current situation regarding the HIV/AIDS policy at their workplace. They were also asked to

explain their understanding of the importance of the HIV/AIDS workplace policy and how it was developed. The participants were also asked to explain factors that affect the development and implementation of the HIV/AIDS workplace policy. Probing was done following the above questions to capture more depth on the subject according to interview guide and the interviews were audio recorded. The participants were asked to sign a consent form after reading the study information leaflet. The consent form and data collection tools were in English only because all the respondents understand the language.

2.7.1 Rigor in the Study

Evaluating the quality of research is essential if findings are in practice and incorporated into care delivery (51) .Qualitative data is assessed for its trustworthiness or its actual value. The researcher established the trustworthiness and true value of data using the philosophical and procedural criteria to ensure the quality of the research. A study is trustworthy if and only if the reader of the research report judges it to be so. Trustworthiness has been further divided into *credibility*, which corresponds roughly with the positivist concept of internal validity; *dependability,* which relates more to reliability; *transferability*, which is a form of external validity and reliability (52).

2.7.1.1 Reliability and Validity

Ensuring the validity and reliability of qualitative research is crucial to producing quality and acceptable results. Reliability refers to a research method's ability to yield the same results over repeated testing periods consistently. In other words, it requires that a researcher using the same or comparable methods obtained the same or comparable results every time he uses the procedure on the same or equivalent subjects (53). Assessing the reliability of study findings requires

researchers and health professionals to make judgments about the soundness of the research concerning the application and appropriateness of the methods undertaken and the integrity of the conclusions (51). The data collection tools were reviewed by the supervisor and COMREC to ensure that they captured the needed information to achieve reliability.

Validity refers to the extent to which an instrument accurately measures what it aims (54). To improve validity in this study, the researcher ensured that the study's goals and objectives are clearly defined and operationalized with corresponding and appropriate assessment measures. The researcher also achieved validity by providing that the data collection tools were checked by her supervisor, an expert in the research and health field. In addition, the interviews were audio-recorded in the language of the participant.

2.7.1.2 Credibility

Credibility refers to the authenticity of the data and its interpretations (55). In this study, credibility was ensured by prolonged engagement in data collection and interpretation. Sufficient time was dedicated to the participants for data collection activities to help the participants unfold naturally. The use of multiple methods for data collection was used. The researcher created rapport with participants at the beginning of the interview to allow participants' free expression. Confidentiality was maintained throughout the study and unintended disclosure was avoided.

2.7.1.3 Dependability

Dependability refers to the consistency and reliability of the research findings and the degree to which research procedures are documented, allowing someone outside the research to follow,

audit, and critique the research process (56). Detailed records of the research process are available to enable an audit trail (57) and replicability of the study.

2.7.1.4 Transferability

Transferability is the extension of research findings and conclusions from a study conducted on a sample population to the population at large (58). Transferability describes the process of applying the results of research in one situation to other similar cases. In other words, they transfer the results of a study to another context. The researcher provided thick descriptions, so that those who seek to transfer the findings to their site can judge transferability (59). The researcher also produced a detailed description of the participants and setting (57) and, a detailed description of the methods used in data collection and analysis to enable another researcher to apply findings to other locations. We also included appropriate participants in the study to increase transferability. Data collection and analysis were carried out simultaneously.

2.8 Data Management

All interviews were audio-recorded. The data was transcribed in English verbatim then written to avoid loss of information. The transcripts were checked thoroughly against the audio records for accuracy. The audio records were transcribed in the same audio recorded language. A unique identification number was assigned to each recorded interview. The recorded interviews and the written transcripts were kept in a laptop, secured by a password accessed only by the researcher and the supervisor.

2.9 Data Analysis

Qualitative data were analyzed using thematic analysis described by Braun and Clarke (60). Thematic analysis is a method for identifying, analyzing and reporting patterns(themes) within data (60). The choice of thematic analysis over other forms of analyzing qualitative data was based on its goal or ability to identify patterns in the data that are important and interesting. In addition, thematic analysis is capable of interpreting and making sense of data (61). The researcher analyzed the data manually, immersing and familiarizing with the data started through conducting the interviews, reading, and re- reading the transcripts to understand the depth of the content. To become immersed in the data involves the repeated reading of the data actively This required that the researcher searched for meanings and patterns(59). Codes were isolated by writing down some notes. Codes identify a feature of a theme that appears interesting to the analyst and refer to the essential elements of segments of raw data that can be assessed in a meaningful way regarding the phenomenon (62). Inductive and deductive approaches were used in analyzing the data. Inductive codes were drawn from the data while deductive codes were created from the interview Guide and objectives of the study. Inductive analysis is a process of coding the data without trying to fit it into a preexisting coding frame or the researcher's analytic preconceptions. With an inductive approach, the themes identified are strongly linked to the data themselves and may be little relation to the participants' specific questions (59). A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (60). In this study searching for themes and subthemes followed the coding process in which the codes that form a similar coherent pattern were categorized and sorted into possible themes. Then the potential themes were reviewed and refined to see if they fit together with the rest of the data and code additional data within themes that were missed during the initial

coding stages. The identified themes and subthemes were named accordingly. Subthemes are themes within a theme and help give a structure to a huge and complex theme and demonstrate a hierarchy of meaning within the data (62).

2.10 Presentation and Dissemination of Results

The study was conducted to fulfill the academic requirement for the award of Master of Public health. Therefore, copies of the dissertation will be submitted for marking at the University of Malawi, College of Medicine. The final dissertation document will be submitted to the dean of postgraduate studies and research of the University of Malawi, the College of Medicine and the College of Medicine Research and Ethics Committee (COMREC). Furthermore, research findings will be disseminated at the institutions where the study was conducted (A/25 HC and Bwaila hospital). Besides, the research findings will be shared at local and international conferences and manuscripts will be submitted for publication in peer-reviewed journals.

2.11 Strengths and Limitations of the Study

2.11.1 Strengths

This study used both face-to-face in-depth and key informants' interviews. This helped to obtain rich data since the key informants were involved. Therefore, the findings from this study can be used to inform further research, policy and practice.

2.11.2 Limitations

The interviews were conducted within the hospital premises, which could have affected the responses by the participants, especially the junior employees, due to fear of being overheard by their seniors.

Data collection amidst the COVID19 pandemic was not accessible; the number of employees per day was reduced to prevent the pandemic. Therefore, finding the eligible participants was challenging.

The investigator had problems interviewing participants during working hours since health workers are busy people. This could have affected the participants' responses because they could respond while thinking of their busy schedules.

2.12 Ethical Considerations

Ethical approval to conduct the study was granted by the College of Medicine Research and Ethics Committee (COMREC) number P.02/20/2954, (appendix 8). The permission to conduct the study was obtained from Lilongwe DHO (Appendix 7). Participation in the study was voluntary and written informed consent (Appendix 1) was obtained from all study participants before interview. Interviews were conducted in a private room, with a low voice to prevent others from hearing ensuring privacy. Anonymity and confidentiality were guaranteed by assigning codes to the participants and not their names. Participants who declined to participate in the study were assured that their decision to withdraw would not affect learning and receipt of health care at the hospital.

CHAPTER 3: RESULTS

3.1 Introduction

The findings follow the study objectives. Therefore this section presents results from the first, second, third and fourth objectives. The first objective focused on determining the availability of HIV/AIDS policy at the study sites in contrast the second and third objectives focused on examining personal facility factors that affect the development and implementation of HIV/AIDS workplace policy.The fourth objective discussed challenges faced in the implementation of the policy. Various factors emerged as barriers to developing and implementing of HIV/AIDS workplace policy throughout the study, as presented below.

3.2 Demographic Characteristics of Study Participants

The demographic surveyed on the participant's age, gender, marital status, education background and occupation.

3.2.1 Age

The majority (13 participants) of the participants' age was above 36 years old (43 %). Another 13 participants (43%) were between 31-36 years, while 3 (10%) participants were between the ages of 26-30 years and the remaining participant (3 %) were between the ages of 21-25 years. The participants' age ranged from 21 to 54 with a median of 37.5. The above findings denote that most of the participants were middle-aged. See table 2 below.

3.2.2 Gender

Out of the 30 who participated in the face-to-face in-depth interviews and key informant's interviews, 25 were female and 5 were male.

3.2.3 Marital Status

The findings indicated that 23 participants were married (77 %), 5 of the participants were single, representing 17 % of the participants. Only 2 participants were single (6). The findings designate that majority of the participants were married.

3.2.4 Education Background

Twenty-two participants representing 73 %, had attended tertiary education, and 6 (20 %) of the participants attended school up to Malawi school of education (MSCE) 2 participants attended up to Junior certificate of education (7 %). The above findings signify that the majority of the participants went further with their education.

3.2.5 Position/Occupation

The majority of the participants (47 %) were nurses, 6 participants (20 %) were administrators, 3 participants were clinicians (10 %) by profession, and the remaining 7 were support staff (23 %). The period in which the participants had worked in the study sites ranges between 3-12 years with a median of 7.5. The above findings designate that the participants had an insight into the subject matter.

Table 2: Demographic Characteristics of Study Participants

Variable	Number of participants
Participants' age	
15 - 20	0
21 - 25	1
26 - 30	1
31 - 36	13
Above 36	15
Gender	
Male	5
Female	25
Marital status	
Single	5
Married	23
Divorced	0
Widow	2
Education level	
Never attended	0
PLSCE	0
JCE	2
MSCE	6
Tertially level	22
Occupation	
Nurses	14
Clinicians	3
Administrators	6
Supporting staff	7

Table 3: Identified Themes and Sub-themes

CATEGORY	SUB THEMES	THEMES
- Poor attitude - Denial - Organization politics	Stigma and discrimination	**Personal /interpersonal barriers/factors facing development and implementation of the HIV/AIDS workplace policy**
- Lack of training - Low level of education	Lack of knowledge	
- Lack of interest in HIV testing. - Lack of status disclosure	Denial	
Lack of awareness on the policy availability - Lack of policy - Unsure/no idea on the availability of policy	Lack of sensitization	**Institutional barriers/ factors facing development and implementation of the HIV/AIDS workplace policy**
- Inadequate funding	Lack of resources	
- Lack of participation in HIV related issues	Lack of employee involvement	
	Lack of privacy and confidentiality	
- No HIV/AIDS knowledge updates	Lack of management commitment	
- In-service training	Staff sensitization	

	Lack of privacy and confidentiality Lack of resources Stigma and discrimination	**challenges facing HIV/AIDS development and implementation**
- Employing more staff - Establishment of special consultation rooms. - PPE availability. - PEP accessibility	Adequate resources	**Institutional facilitators optimizing development and implementation of the HIV/AIDS workplace policy**
- In-service training	Staff sensitization	
	Establishment of staff welfare	
	Strengthening HIV prevention	
- Provision of extra money - Nutritional support - Care of carers	Provision of additional support to staff	
- Information package - Informative - Guiding principle	Availability of living HIV/AIDS policy	

3.3 Existence/Adoption of HIV/AIDS Workplace Policy

To determine HIV/AIDS workplace policy availability at the study sites, the participants were asked to describe if their workplace has got the policy, then they were asked to explain when it was adopted and the reason why it was adopted.

Despite participants' being in the workplace for a long time (at least three years), the results indicated that only a few participants responded that the HIV/AIDS policy was available at their workplace. However, the participants, who responded that the policy was available, admitted that they had no idea how the policy was developed. They also said that they had not seen the policy even though they knew that the policy was available at the workplace. One of the participants said:

> *"Yaa, I think the policy is there. I haven't seen it but the policy is there".* (A12, line number 17)

The majority of the participants had no idea of the availability of the policy at their workplace. Others were not sure whether their institution has the HIV/ AIDS policy or not, as expressed from these quotes:

> *"I don't know anything about that".* (A16, line number 17).
>
> *"Hmmm. I don't know. I have never heard of it".* (A18, line number 13).

However, in the interviews conducted, the presence of the HIV/AIDS workplace policy, which is active, was described as necessary in the employees' day to day activities. The policy was further

described as an information package that is both informative and guiding the employees' principles.

3.3.1 Information Package

3.3.1.1 Informative

The participants expressed that the HIV/AIDS policy informs them on the essential things which they should do regarding to HIV/AIDS at the workplace. They added that the policy protects both employees and their clients' health.

> *"It safeguards the health of health workers. It also safeguards the health of our clients (the clients we meet) and it helps you to know the dos and don'ts concerning HIV/AIDS … and also where to access treatment, access advise or whatever concerning HIV/AIDS"* (A4, line number 28 -30)

Other participants also highlighted that the policy might be used to orient new employees. One participant said:

> *"... Because everyone can follow the policy. If the health worker is new at the institution, after seeing the policy can follow according to the institution"* (A15, line number 22-23).

It was also stated that an active HIV/AIDS policy encourages the employees to undergo HIV testing and counselling, and makes them aware that they are infected with HIV. This helps to take necessary precautions to help prevent spreading the virus to others.

> *"Somehow it helps to; it helps the employees to know HIV status and if they know they will be helped accordingly. They reduce transmission to other, to others"* (NP1, line number 21-22).

They also added that the HIV/AIDS workplace policy's presence helps them start treatment as soon as they tested positive on top of knowing their status.

> *"I think it's important because we come in contact with different things which can make us be infected, so I think it's good because once you are in doubt, you can get tested to know your status, so it means if you are infected then, I think it can be one way of you to start getting the treatment"* (A5, line number 31-34).

3.3.1.2 Guiding Principle

The participants explained that HIV/AIDS workplace policy is crucial because it guides the provision of care to HIV infected employees. This means that without the policy, the employees can be mismanaged. This was expressed as follows:

> *"It guides in the way of management of those patients like health workers who are HIV positive" (NP2, line number 22-23).*

"It will guide us on what to do to ourselves or patient" (N1, line number 20).

"I think the policy is significant for the institution, as well as for the employees because, it works as a guide, yaa….it works as a guide on how we can offer services to patients...aha… with a common goal. Health workers as a team they should be able to know what is it they are supposed to do, so the policies will be guiding all the health as what to do, at what time" (A12, line number 27-31).

Also, for the affected one, the policy guides employees' compensation.

"It is important to have a policy because it guide ah…, the activities like HIV activities at the facility but also it helps to, maybe to track the people who have been exposed and if they have been assisted or not. And I would also think that it would also help cases that have been exposed on duty, and then they happen to acquire the infection, for the compensation and alike it would help them to access those benefits because there is a policy and it's being followed through" (M2, line number 38-42).

"*So for employees, it safeguards the rights of employees against being mmm, what's this word... against exploitation by the employer so the employer in this regard, we are talking of MOH. So they are some other rights which employee needs to have like access to ARVs. If there is exposure like in terms of a needle stick injury whilst*

at work. They should have proper measures to get compensated, in that regard so it is important" (P13, line number 37-41)

Participants stated that the HIV/AIDS workplace policy helps the management allocate tasks to their employees properly. The employees infected with HIV/AIDS need a reduced workload to maintain optimum health.

"It is important to have that policy because it can help you to know hmm, which area that person can work. For example, if you are HIV positive and you have got some problem, they can know how to locate you to work in the department, but if they don't know, they can give you a lot of work without knowing that, maybe you are not supposed to work like that so it's important to know" (A19, line number 31-35).

The participants highlighted that the policy stipulates protocol and guidelines.

"I think the policy would be able to stipulate ma standard protocols and guidelines for health workers and what is in the protocol for health workers as well" (HC, line number 25-26).

3.4 Personal/Interpersonal Barriers/Factors Affecting Development and Implementation of HIV/AIDS Workplace Policy

3.4.1 Stigma and Discrimination

Most participants reported that stigma and discrimination of employees infected with HIV/AIDS are some of the personal barriers that affect HIV/AIDS workplace policy implementation.

One possible reason for the stigma and discrimination might be poor attitude, leading to gossiping about the employees infected with HIV/AIDS. One of the participants said:

> "*We have poor attitude… ah… if we see our colleagues going for or if a colleague asks for testing, we just think that maybe she/ he is… what can we say… Maybe omebody who doesn't behave well. She is suspecting herself to be HIV positive. That's why she wants to test. Most of our staff doesn't go for testing at the facility. They go out because of the attitude we have, so it's also affecting our policy."* (A4, line number 49-54).

It was further narrated that employees refuse to take care of the infected employees because they didn't undergo HIV/AIDS training.

> *"I think for the personal factors, they could be something to do with for example HIV related training because if somebody was not trained, somebody would say, I wasn't trained in this thing. Therefore, I cannot handle any patients with HIV related illnesses, that's a personal approach to that subject, maybe sometimes,*

> *some people may feel that people with HIV, maybe they were just reckless, so aa… them having HIV is none of my business, let them die or let them go, am not handling those people it's none of my concern. Those factors could be available in some of the health workers…aa… especially the supporting staff because they do not have much information as far as HIV is concerned"* (A12, line number 49-56).

The participants further explained that the stigma and discrimination towards employees infected with HIV lead to excluding the infected employees from other workplace activities. The following quote illustrates that:

> *"People are afraid to be known if their status is positive just because sometimes when there is something to be done, they say this one should not take that because they are HIV positive, so to avoid stigma, some people don't want you to know their status. So that stigma is still on though we are saying nowadays stigma and discrimination is not there, but discrimination is still there"* (A19, line number 56-60).

The participants stated that stigma act as a barrier to disclosing one's HIV/AIDS status leading to further spread of HIV/AIDS at the workplace. Also, because the workplace management would not know the magnitude of HIV in the workplace. Often the infected employees opt to seek medical treatment outside their workplace. One of the participants said:

> *"Some people those who are HIV negative they stigmatize those who are HIV positive as such most of them who are shy they don't come normally to area 25 to get ARVS. They prefer to go to other facilities rather than area 25*". (NP2, line number 42-44).

Also, denial could lead to stigma and discrimination. Some participants indicated that denial acts as barriers to HIV testing, counselling and disclosure of HIV status, as expressed in the quotes below:

> "*Sometimes, before getting tested, you can be ok, but after being told that you are having malaria, though you were not feeling sick, you can get sick. That's what happens even with HIV, maybe just because you just want to know your status and your moods were just fine, you were not sick, and then you go for HIV testing. They said you are positive then to receive that thing it's not easy, so because of that people are just reluctant to go for the test, unless there is something maybe you are pregnant, you can undergo it just because it's a protocol to the hospital"* (A6, line number 54- 60).

3.4.2 Lack of Knowledge

Lack of knowledge on HIV/AIDS workplace policy was stated to affect the HIV/AIDS policy implementation. Some employees do not know the elements of the policy such as HIV testing and counselling. The lack of knowledge on HIV testing can hurt the implementation of the policy.

"Normally a lot of people here as the staff they don't have knowledge about HIV testing" (P4, line number 44- 45).

The lack of knowledge on the HIV/AIDS policy was attributed to a lack of sensitization on HIV issues at the workplace and a lack of HIV training. The participants further explained that HIV is dynamic, so if they are not regularly updated they can't keep up with the HIV/AIDS policy implementation. One of the participants said:

"*You know the guidelines for HIV they are being reviewed and implemented after two to three years so if you don't have or if you are not updated in the new knowledge that can affect implementation*" (N1, line number 39- 41).

The majority of the participants affirmed that they had not received any health education since joining their workplace.

"Health education? No, since I came here" (A14, line number 41-43).

"I have never received." (NP1, line number 30).

"*Never. I have never received any health education."* (P6, line number 26).

"(*silences)... Yhey don't give us any health education about HIV"* (P7, line number 34).

> *"I have never received any HIV thing that I can do, but what I know from our knowledge just because we are working in the health sector"* (A6. Line number 37-38).

The participants further stated that the employees lack knowledge because management does not advocate for implementing the policy, hence employees having no knowledge about the policy.

> "…. *I mean the management not advocating for the HIV workplace policy*". (A16, Line Number 52)

Lack of on-going training on HIV/AIDS was stated to contribute to employees' lack of knowledge. And this, in turn, leads to reluctance to provide care to HIV/AIDS infected employees. Lack of training also leads to poor attitude against the HIV/AIDS infected employees, as illustrated in the following quote:

> *"…For personal factors, they could be something to do with, for example, HIV related training because if somebody was not trained, somebody would say, I wasn't trained in this thing. Therefore, I cannot handle any patients with HIV related illnesses, that's a personal approach to that subject, maybe sometimes, some people may feel that people with HIV, maybe they were just reckless, so ah… them having HIV is none of my business, let them die or let them go, am not handling those people it's none of my concern".* (A12, line number 49 -54).

The participants highly linked the lack of knowledge to the educational level of the employees. The more educated (tertiary level) an employee was, the more knowledge he/she had on the HIV/AIDS related issues. Despite the non-availability of the HIV policy at the workplace, some participants responded to some questions on the policy because of previous knowledge from their tertiary training schools. One participant said:

> *"... May be most of the staff, they don't know what they can do, especially the junior staff because I know what I can do, because I have been told before and because, I am exposed to some information. But for the junior staff who cannot go about reading books, reading manuals. Suppose there could be a policy well-elaborated policy where people can know what to do"* (A4, line number 57 -60).

They further pointed out that lack of policy document dramatically contributes to the lack of knowledge because what one does not know, does not exist. Therefore, employees are not involved in implementing the policy because they don't know what they are supposed to do regarding HIV/AIDS.

> "*Hmm… the other thing is we don't have a policy that can guide on how we can conduct ourselves concerning HIV/AIDS so, maybe most of the staff don't know what they can do"* (A4, line number 55 -57).

3.5 Institutional Barriers Factors Affecting Development and Implementation of HIV/AIDS Workplace Policy

3.4.1 Inadequate Resources

The participants complained that the government's lack of resources due to inadequate supplies is one of the challenges they face during policy implementation. They further explained that insufficient resources hinder them from undergoing HIV testing and counselling because the supplies and equipment used for HIV testing are sometimes out of stock. One of the participants said,

> *"... Ah, for example, there was a time I went to the VCT and I wanted to get the determents for myself and my partner but they said, no we can't give you this, we will provide you with the oral quick, yet some people don't believe in that. They say so if you have flu and it turns you are positive then what next so because of limited resources you can't get the determents" (P9, line number 64-67).*

The participants further explained that lack of adequate financial support from the government also negatively affects the HIV/AIDS workplace policy implementation. They stated that the institution lacks the essential equipment and supplies necessary to implement the policy due to financial problems. Therefore, they depend on their partners to conduct HIV related activities; however, their partners do not also have enough supplies sometimes.

> *"Challenges like finances, financial support. Maybe the government should initiate supporting the Area 25 hospital, the health Centre because sometimes we are short*

of a lot of equipment here. So we rely on Baylor Project, if Baylor doesn't have those things, if Baylor can't supply those things we always have problems" (P11, line number 78-82).

3.5.2 Lack of Policy Sensitization

The participants pointed out that there is no employees' sensitization on the HIV/AIDS workplace programmes and policy. One of the participants said:

"Since I came here I have never seen one". (m2, line number 20).

Another participant pointed out that he doesn't have any knowledge of HIV/AIDS workplace policy document. He only knows from a lecture at his previous school.

What I know is that maybe I have been pricked, then I go and get tested then I also make sure the patient gets tested, and that is just knowledge from school like Post-Exposure Prophylaxis but not in such a way that this organization provides that maybe it does only that I don't know. I'm not sure. I would have known" (N1 50-51).

3.5.3 Lack of Management Commitment

The participants explained a lack of seriousness in implementing the HIV/AIDS policy at their workplace.

> *"Lack of serious commitment to implement those policies"* (A16, line number 65).

> *"Maybe the management here they are not serious with their fellow workers"* (P7, line number 61).

One of the participants further stated that the lack of management commitment comes about because there is no one to lead in the effective implementation of the HIV/AIDS workplace policy.

> *"I think there is no one (there are no people) who can advocate it*" (A16, line number 67).

It was pointed out that may be the management might not earnestly implement the policy. They are afraid that the employees could live reckless life because they would know that once they contract the HIV/AIDS, they will be well taken care of by their employers. One of the participants said:

> "*Ah maybe other people can take an advantage… ah... (Silences) I think people maybe carelessly when they are contracting HIV thinking that there is an institution that will help them to source all things that will be needed"* (A20, line number 59-60).

3.6 Challenges Faced During Development and Implementation of HIV/AIDS Policy

The researcher wanted to determine if the participants face challenges during the development and implementation of the HIV/AIDS workplace policy. The majority of the participants face challenges during the execution of the HIV/AIDS policy. However, other participants had no idea of the challenges faced during the implementation of the policy, as expressed in the following quotes:

> *"I don't know anything*" (A2, line number 49).

> *"I don't know"* (line number 65)

> *"... It's hard for me*" (A18, line number 46)

They added that they had no idea on the challenges faced during the implementation of the policy, because they have never observed the implementation of the policy at their workplace.

> *"Hmm, aa! I haven't witnessed the actual implementation of HIV related policies so I am not sure of the challenges which are faced the time they are implementing the policies"* (A12, line number 79-80).

3.6.1 Denial

Other participants said that the most significant challenge they face is denial. Most of the employees fail to go for HIV testing and counselling because of fear of positive HIV status. Therefore, they opt not to undergo HIV testing as long as they are not sick.

> *"Sometimes you can just say it's better to stay as I am because I don't have any problem, I am not sick. You know when you know that you are sick, you can go to the hospital and say that I want to go for malaria parasites testing* (mps*), and sometimes before getting tested, you can be ok, but after being told that you are having malaria, though you were not feeling sick, you can get sick. That's what happens even with HIV, maybe just because you just want to know your status and your moods were just fine, you were not sick and then you go for HIV testing. They said you are positive, then to receive that news it's not easy. So because of that people are just reluctant to go for test. Unless there is something maybe you are pregnant, you can undergo it just because it's a protocol to the hospital because if there is any client, any pregnant woman can undergo an HIV test. So in that, you find yourself in the system than like now, just go…am going for testing*" (A6, line number 53- 62).

> *"I think most of the health workers they are not interested in. They don't show interest in HIV testing"* (NP1, line number 51- 52)

The participants supplemented that most health workers who are HIV positive are in denial hence they find it harder to disclose their HIV status than other employees. They added that the HIV/AIDS infected don't want their status disclosed to the public.

> *"... Denial because the health workers are the most people who give problems. They don't accept, ... so they might be initiated on ART and they default... Or denying that they are on ART, so I can say that maybe, the major problem is denial"* (A5, line number 71- 74).

> *"As I have already said, people wouldn't want to be known to the public that they are HIV positive, so in that case, it means even to have staff to come out openly to say am HIV positive it will be very difficult"* (HC, line number 68- 70)

The participants stated that the failure of employees to disclose their status might lead to management failure to implement HIV/AIDS workplace policy because the management would not know the magnitude of HIV/AIDS infected employees.

> *"Hmmm, I think they will be unable to find those people who are HIV positive because everyone didn't come out to that am HIV positive or am not."* (P4, line number 61- 62).

3.6.2 Lack of Resources

When queried to describe the resources allocated to the implementation of HIV related interventions at the workplace, most participants stated that there are no specific resources earmarked allocated for HIV/AIDS activities at their workplace. Other participants had no idea regarding resources earmarked to HIV/AIDS-related interventions.

> *"I know nothing!"* (A7, line number 30).

> *"No knowledge about that"* (A15, line number 49)

> *"I have never heard about it"* (A16, line number 62)
>
> *"Hmmm, we don't have, I don't know, if we had, I would know because I could be oriented on that. We don't have"* (N1, line number 50-51).

Other participants stated that the HIV/AIDS infected employees receive no special attention because they are no specific resources allocated for their HIV/AIDS interventions. Some participants said:

> *"Ah, no, no special resources, no special resources for employees"* (P13, line number 85).

> *"Mm, there is none for like special treatment for staff yaa. If there are some they are just regarded as one of those patients in the ART department"* (HC, line number 64-65).

However, only a few participants stated that the resources allocated for HIV/AIDS interventions are condoms, personal protective equipment, money and drugs, especially PEP.

> *"What I know is that every month they have to receive some amount of money, I don't know how much but I just heard that they receive money every month and I don't know about other resources, I don't know if there is some flour or what, I don't know. What I know it's about money, about other resources hmm…. am not sure"* (A19, line number 72-75).

3.5.3 Lack of Employee Involvement

Lack of employee involvement in the HIV/AIDS workplace issues was also identified as one of the challenges faced during the policy implementation. They complained that they are not aware of the HIV/AIDS policy because they were not part of the policy development team. The participants suggested that the management should brief them on the policy.

> *"Yes, the challenge is that when developing the policy, they would have involved each member of staff because even if the policy is there, some of us don't know the policy. We can know part of things, but we don't know the policy. We just hear there is a policy… eh... If you are HIV positive, you have to be included in the care of*

carers, still we don't know what is there so it's difficult for us to explain unless you are HIV positive maybe. You can know more about it, but if you are tested you are negative. You don't know more about the policy. So it's good if it can be briefed to every staff member or health care worker so that we should know what is in the policy and also when they are writing their policy they have to involve the health care workers because they are the ones to have the concerns and they can know more about it. Without the concerns of health workers, it's difficult for them to develop a policy. Otherwise the policy and the need of people will be different" (A19, line number 78-88).

Some participants pointed out that they are not involved in HIV/AIDS activities because they are carried out by their partners (other non-governmental organisations).

"Hmmm, I feel like the challenge could be most of these HIV related issues are done by our partners…ah…so difficult for us as staff for government to participate in HIV related issues. I think that one is a challenge" (A13, line number 73-75).

Other participants complained that they have no recent updates on HIV/AIDS issues. Therefore, they fail to assist HIV/AIDS clients effectively.

"The main challenge I see is that most of the providers like myself are not very familiar with the recent updates, recent guidelines. So even a mother who is accessing HIV services comes to me, I always refer, so you know the mother has

developed some confidence in you, you refer to somebody, it seems, you are not sure of what you are doing and building that trust to somebody else for a mother it is difficult, so it is a matter of updating ourselves for getting to know the recent updates and developments" (A4, line number 78-83)

3.6.4 Lack of Privacy and Confidentiality

Some participants mentioned lack of privacy and confidentiality as a challenge faced during the HIV/AIDS workplace policy implementation. According to them, the lack of privacy and confidentiality causes HIV/AIDS employees to shun their workplace medical services because they fear that everyone will know their HIV status.

*"There should also be confidentiality when doing all these things so that people should open up" (*M, line number 64-65).

"*Those HIV positive health workers wouldn't want to be getting ART at the facility; they would rather go somewhere and get it because they wouldn't want to be known. So at the end of the day, it would be difficult to implement because people wouldn't want to be known at the facility*" (HC, line number 47- 50).

One of the participants added that lack of privacy and confidentiality leads to stigma and discrimination. This makes HIV/AIDS infected employees not disclose their status.

"*People are afraid to be known if their status is positive just because sometimes when there is something to be done, they say this one should not take that because they are HIV positive, so to avoid stigma, some people don't want you to know their status. So that stigma is still on though we are saying nowadays stigma and discrimination is not there, but discrimination is still there"* (A19, line number 56 -59).

3.7 Institutional Facilitators Optimizing the Development and Implementation of HIV/AIDS Workplace Policy

After describing the challenges that they face implementing HIV/AIDS workplace policy, the participants were also asked to suggest ways that they thought could help address the identified challenges.

3.7.1 Staff Sensitization on HIV/AIDS Policy

The majority of the participants suggested that the management should sensitize employees on HIV/AIDS workplace policy. They proposed that the sensitization should be on-going because employees' HIV status may change from negative to positive.

"*There is need for continued awareness to staff because today Iam negative, tomorrow positive. So we have to treat each other as one because those who are positive maybe got it from work, so that thing can also happen to me, so there is need to understand each other"* (A5, line number 77- 79).

On top of staff meetings where the policy can be introduced to employees to become well conversant with it, the participants suggested that the policy be distributed to every department where it's easily accessible by employees.

> *"Hmmm, I think that if they can be, if we can have a meeting with all health workers and introduce about this policy and explain a little bit about that policy so that every health worker should know the policy, should know what is in the policy and should follow the policy. Sometimes it's difficult for somebody to follow it because he/she lacks knowledge about it so if there can be a meeting once a month or once a year, sometimes you recruit new members they don't know, maybe the past members have gone somewhere. The departments don't know about the policy. So it's difficult to know that policy and if also the policy can be distributed to every department so that whenever somebody placed in that department should have a policy on board or should have policy somewhere so that each member should read it. Otherwise, we don't even see any policy" (*A19, line number 90- 100).

It was pointed out that sensitizing employees on HIV/AIDS would help to eliminate stigma and discrimination against HIV/AIDS infected employees.

> *"People should be educated; they should know that having HIV, is not like someone is a sinner because people relate it to sex or maybe you are having multiple sex but they have to know that you can take it in different ways. So I think the perception*

of us, we have to change the perception that when someone is HIV, we should not relate it to her having multiple sex partners" *(*A13, line number 25-28)

One of the participants further suggested that the management should be the first to be sensitized regarding the importance of the HIV/AIDS workplace policy.

"I think it's better to talk with the manager on the importance, the benefits" (A16, line number 69-70).

3.7.2 Provision of Adequate Resources

On top of staff sensitization, the participants also suggested that the supply of resources should be adequate. The resources should be made accessible to everyone at the workplace.

"*... Making resources available everywhere at the hospital, especially on Post Prophylaxis Exposure understanding. As a hospital, we access it from the high-risk postnatal ward. So for some people to know where they can access it, it is difficult unless they are briefed on (or they are made aware of what is available) even on the availability of protective wear"* (A4, line number 90-93).

Other participants suggested that special staff consultation rooms should be established, promoting employees to receive HIV/AIDS services at the workplace. In addition, health workers should be allocated solely for employees.

> *"I think we can find the best solution but some, maybe some of the solutions that can still work are like having a separate room for staff, having a separate office just indicated for staff and special clinician or nurse just solely for I think that approach can work"* (P13, line number 99-101)

Some of the participants proposed that the program which gives the extra package to HIV/AIDS employees should be restarted.

> *"I would wish ah if they can restart the program of giving the extra package to the staff because I understand in the past, we had that program they were receiving around 5000 Kwacha each month. Ya, for the staff who are HIV positive and now they are no longer receiving anything" (*A13, line number 85-88).

3.7.3 Establishment of a Staff Welfare Committee

Furthermore, some participants said that the other way of addressing the challenges is to establish the staff welfare committee. The establishment of the committee will be of much help to the employees.

> *"They should have executive or committee for welfare for health workers so that we can be helped"* (A15, line number 59-60).

The staff welfare committee would look into issues of employees with HIV/AIDS. The majority of the participants admitted that HIV/AIDS has dramatically affected their workplace in various ways.

> *"But I can see that that the hospital is affected greatly, greatly affected by HIV. You can see others are taking drugs not only that, others their children are given Niverapine."* (A6, line number 74-76).

> *"Ah… it is affected very much, starting from the health workers, we have lost some health workers with HIV positive suffering HIV related diseases, they passed away, so we have lost their services, diversion of financial resources, maybe resources which could have been used to implement some projects, maybe maintenance of infrastructures or purchasing some of the other drugs, the resources have been diverted to HIV care. So I feel the institution is affected by HIV in that manner"* (A12, line number 58-63)

> *"If you know that your colleague is HIV positive and get sick, I feel and see there is some discrimination in terms of caring for each other (care of carers). There is some discrimination, despite that, we are professionals, despite that we don't encourage discrimination. Still, we discriminate ourselves. We discriminate against our colleagues. We don't care for each other, that's what I noted"* (A4, line number 64-68).

3.7.4 Staff Welfare Strengthening

The participants stated that the welfare of employees should be strengthened through HIV testing/prevention, provision of additional support to staff through the provision of top-up allowance, nutritional support and enhancing the care of carers.

3.7.4.1 HIV Testing/ Prevention

The majority of the participants affirmed that HIV prevention through HIV testing is one of the HIV/AIDS workplace policy elements. Therefore, strengthening HIV testing would help employees know their status and start treatment if they have been diagnosed with HIV/AIDS, preventing HIV transmission to others.

> *"... It states that as health workers, we should also know our status so that we should be able to access and benefit from the HIV management which is maybe there, as a policy".* (A4, line number 19 -21).

Others stated that the HIV/AIDS policy equips employees with necessary measures to prevent HIV transmission.

> *"When working, we have to make sure that all the measures that can prevent the staff from contracting HIV are there"* (A6, line number 20-21).

The participants further suggested that the HIV testing should be extended to their spouses, and they also made suggestions on the specific intervals for regular HIV testing. There were varied views on the issue of HIV testing intervals, as expressed in the following quote:

> *"... If the policy can allow us to be tested every year together with our spouses"* (P2, line number 17-18).

Others suggested that HIV testing should be done monthly.

> *"Maybe testing every month because we are always exposed by working here to people with HIV. Sometimes you get needle pricks. You get blood splashes, body fluids accidentally, not deliberate. Yes, we take PEP after the exposure, but we should have a policy like a mandatory for everyone. Yaa"* (P9, line number 17-20).

Yet others added that apart from HIV testing, there should also be treatment through the provision of antiretroviral therapy.

> *"Ah, the things of HIV treat and treat could be included in the policy, the provision of the antiretroviral drugs could be there…yaa"* (A12, line number 22-24).

Most participants stated that post-exposure prophylaxis (PEP) is part and parcel of HIV/AIDS workplace policy. The employees are at high risk of contracting HIV because of the nature of their

job; therefore, they are supposed to have full knowledge of PEP, so that they know what to do whenever they have been exposed.

> *"Hmm, I feel ah, issues like for the staff they need to know about like PEP. Because a lot of risks that are involved here when you are working in a hospital starting from support staff, nurses, clinicians, in case they have pricked themselves or they have been exposed ah, to someone positive (HIV positive), they need to know like for the steps to go through. As of now what I can say it's like, it's not like there is a policy that people follow ah, what I know of, is of PEP that we give to people when they happen to have a needle prick then"* (M2, line number 26-31).

3.7.4.2 Provision of Additional Support to Staff

Additional support to staff was divided into the provision of extra money/allowance, nutritional support and care of carers.

3.7.4.3 Provision of Extra Money/ Top-Up Allowance

Provision of extra money or top-up allowance was identified as one of the core activities in implementing HIV/AIDS workplace policy. The participants stated that the government should give HIV infected employees financial support.

> *"… If the government can take part in helping the staff, the one who is the victim. Maybe supporting him with finances"* (P11, line number 31-32).

"Hmm, maybe an extra package for the people who are HIV positive, top-up, food supplements for the employees" (A13, line number 18- 19).

However, there were varied views on whether the employees are currently getting the top-up money or not. Some participants denied that the HIV infected employees at their workplace have never received the top-up money.

"I just heard somewhere that our friends who are HIV positive are receiving something as a package to be like their upkeep. I don't know why here in the Ministry of Health. I don't know because we are the ones implementing the testing, but we are not receiving anything". (P4, line number 67-70)

3.7.4.4 Nutritional Support

Some participants suggested that nutritional support of HIV infected employees is vital in an institution. They added that the food would help them in their day to day activities.

"I mean by giving them extra feeds so that they can be using them on a daily basis" (A16, line number 22).

"… *Food supplementation for those who are HIV positive"* (NP2, line number 28).

The participants added specifics on nutritional support. They said that the HIV infected employees get porridge and Chiponde.

"Some are getting like ah, nutritious food like porridge, aah, some they get chiponde" (P12, line number 20-21).

Some participants pointed out that the package which they are currently getting should be increased. One of the participants said:

"Hmm, ah, will go towards the package that the these are having, those who are positive are getting it has to be increased, and it has to timely" (M, line 63-64).

3.7.4.5 Care for Carers

Care for the carers was stated as a core element in implementing HIV/AIDS workplace place policy. The health workers have got the responsibility for the care for others (patients and clients). Therefore, when the health workers are sick, they should be given special medical and psychological attention. The participants added that separate consultation rooms should be spared for the employees. Still, to avoid stigma and discrimination, the rooms should not be identified to treat HIV/AIDS-related issues, as illustrated in the quote below.

"... By making care for the carers strong, by putting aside the rooms for carers, health workers go there to receive their treatment and HIV program as inclusive because if it to be put as if it's HIV only maybe people can know that those are going because they are HIV positive. But any problem should be put there, should be treated there, so that people can remove there, the thing that those who are going there are HIV positive" (A6, line number 120-124).

They added that care for the carers also involves giving handouts/packages to HIV infected employees, promoting their welfare. Participants disclosed that in the past HIV infected employees used to receive K5000 on top of their salary, but now they no longer receive it.

> *"Hmm, for employees specific. I know of care of carers, but it hasn't been as vibrant in the past. We didn't have a coordinator, but as of now, 2017/18, there was a formalization of some kind where the coordinator was placed. Still, I don't see it being vibrant as it's supposed to be, and at first, I heard that those people who are already positive, might not have been infected right here, but they had a package that they were receiving K5000 on top of their package, but as of now, I don't know how it's going. As I already said, it wasn't vibrant. It's not as vibrant as supposed to be, so it's difficult to follow through the issues that are happening at the program"* (M2, line number 44-55).

CHAPTER 4: DISCUSSION

4.1 Barriers and Enablers

Lack of sensitization emerged in this study as a barrier that affects HIV/AIDS workplace implementation. This concurs with the finding from a study done by Chatora et al., 2018, which highlighted that implementing the HIV/AIDS workplace policy was hindered by a lack of sensitization (20). The majority of the participants in this study were not sure whether their institution had an HIV/AIDS workplace policy or not. A study done in South Africa found that a quarter of the respondents were not sure whether their workplace had a policy or not. Concurring with the above study findings, Larger organisations (> 500 employees) were more inclined to have policies for the smaller organization (11). However, the results are no different from the policy availability and the implementation between the larger hospital (Bwaila hospital) and smaller hospital (A/25 health centre) in the current study. Contrary to the above finding, another study on overview of HIV/AIDS workplace policies and programmes in Southern Africa found that Workplace policies and programmes of varying sophistication are increasing in large companies (63). The fact that most of the participants in this study were not sure of the policy's existence doesn't justify an assumption that there is no policy in place. There might be a policy that they do not know of. The probable reason for being unsure whether their work has the policy in existence could be that the policy was not well communicated to employees. This study finding concurs with a study done in South Africa on the HIV/AIDS workplace policy development and implementation, which reported that Almost a quarter of the respondents (24.5 %) were not sure whether their organization has a policy or not. A possible reason for this high percentage of respondents unsure if they have a policy might be that the policy was not effectively communicated

to everyone in the organization (11). In support of the above, a study done in Malawi by Soko et al. (2012) revealed that despite the availability of HIV and AIDS activities, most respondents did not know about the UNIMA HIV and AIDS policy or any HIV/AIDS activities guided by the policy. This was due to a lack of knowledge on the existence of workplace programmes (64).

Stigma and discrimination towards people living with HIV have been widely documented and have extended their impact into the workplace. Stigmatizing attitudes towards people living with HIV (PLHIV) in the workplace significantly hinder HIV prevention efforts and indirectly affect national development (65). The findings from this study indicate that stigma and discrimination is a barrier to the implementation of HIV/AIDS workplace policy. Stigma and discrimination compromise employee welfare, a safe and healthy work environment. They also undermine HIV prevention efforts, which depend on an atmosphere of openness, trust and respect for fundamental rights (66). Several studies have positively demonstrated that stigma cause panic or depression and shame, precipitating denial, isolation, and refusal to accept an HIV positive diagnosis [42,43]. In this study, stigma and discrimination coupled with a poor attitude, denial and organization politics were identified as hindrances to utilising the HIV/AIDS workplace policy. Workplace programmes refer to a range of company-based interventions, including the institution of an HIV/AIDS policy, voluntary counselling and testing (VCT), and antiretroviral therapy (ART) provision (63).

Similarly, a study done by Mahajan et al. found that persistent stigma in the workplace resulted in poor uptake of HIV testing and low enrollment into the workplace ART programmes (63). Furthermore, study findings from Kenya also reported that some employees do not go for HIV testing at the workplace. Instead, they attend other clinics outside of Raffia bags because of the

fear of stigma and exclusion (31). The fear of being stigmatized and excluded was evident when discussing VCT testing and the willingness and confidence to get tested. Some of the employees indicated that part of their co-workers feared that the results, if positive, would be passed on to the managers, whereby actions would be implemented against the employee. A few also stressed that the other employees would discriminate against them if knowing their status. Apart from stigma and exclusion, some worry that being diagnosed with HIV/AIDS will change their life for the worse. Choosing not to get tested thus becomes a way of avoiding reality (31). Stigma and discrimination result in a poor relationship between the provider and clients. In the same vein, a study done in metropolis reported that relationship with health workers was one of the most cited barriers to HTC. Some of the participants disclosed that the nurses did not treat them well at the facility, discouraging them from participating in HTC (69). Therefore, organizations should eliminate stigma and discrimination to implement their HIV/AIDS workplace policy effectively. The global plan towards eliminating HIV infection asserts that stigma and discrimination are among the key concepts that need to be addressed for a successful HIV and AIDS program (70).

The current study reported that lack of knowledge affects the implementation of HIV/AIDS workplace policy. The lack of on-going training /education on HIV/AIDS was a contributing factor to employees' lack of knowledge. This, in turn, leads to reluctance in the provision of care due to poor attitude towards the HIV/AIDS infected employees. These findings are supported by a study conducted in the United States of America (USA), which reported lack of education as one of the major causes of fear and negative attitudes and reluctance to care for people with HIV/AIDS among nursing students in the United States of America (71). Lack of information on the HIV/AIDS programs at the workplace would make employees underutilize programs such as HTC.

This is consistent with a study done in Metropolis, which revealed that lack of information was the most significant barrier to HTC, as indicated by the participants disclosing that they had never heard of HIV testing and counselling since they started attending ANC, and that was the reason why they had not taken the test (69). Therefore, improving employees' knowledge of HIV/AIDS through training or health education may maximize effective implementation of the HIV programs at the workplace and help reduce stigma and discrimination against HIV/AIDS infected people.

The study findings disclosed that most employees fail to go for HIV testing and counselling because of denial of acknowledging their HIV status, primarily due to fear of positive HIV status. Therefore, they opt not to undergo HIV testing as long as they are not sick. These findings are consistent with a study done by LEE et al., which reported low HIV testing practices indicated by only 6.2 % of participants said an average of two tests per year since the age of 18, as per Ministry of Health (MoH) guidelines. Ever-testers had a median of three (IQR 2–6) lifetime tests, and less than half (42.3%) had tested within the past year. The most common testing barrier among never-testers was a low self-perceived risk for HIV infection (46.9%), and 42 % had a fear of a positive result (72). Our findings are contrary to findings reported by Kadowa et al., in Uganda revealed that the independent factors that favour disclosure are not fearing adverse outcomes of disclosure and having communication skills to disclose (73). Our study also found out that most HIV positive health workers are in denial; hence they don't want their HIV status to be disclosed by the public because of fear of stigma and discrimination. The findings are consistent with results of a study done in Uganda who cited the following reasons for their non-disclosure: fear of discrimination and stigma 40/139 (29%), fear of rumour-mongering 29/139 (21%), and 11/139 (8%) said that they saw no reason to disclose (73).

This study revealed that lack of resources acts as a barrier to implementing HIV/AIDS workplace policy. The findings pointed out that one of the reasons for the current lack of resources is inadequate funding from the government. The budget allocated to health has been consistently below the 15% recommended in the Abuja declaration (74). The study findings concur with results from a study done on government stakeholders at central and district levels in Malawi, which revealed some issues with domestic and external funds. Respondents highlighted some challenges with the receipt of government funds. Firstly, government funds were universally perceived as insufficient relative to needs, with the budget reportedly remaining constant despite inflation. Secondly, the amounts received were generally lower than the amounts budgeted, with the shortfall varying between5–10 and 90%, especially during the second half of the financial year (74). The current study findings further indicated that the lack of resources hinders employees access to HIV testing and counselling because the supplies and equipment used for HIV testing are inadequate and sometimes out of stock. In the same vein, a study done by Lee et al. reported a lack of access to testing services (35.7 %) as one of the most frequently reported barriers to HIV testing (72).

This current study shows that lack of employee involvement is a barrier to implementing HIV/AIDS policy. Similarly, a study done in Malawi on analysis of factors hindering the adoption of HIV/AIDS workplace policies found that no staff participation in the activities of HIV/AIDS institutions impeded the adoption of HIV/AIDS policies (10).

Confidentiality is central in the communication between health workers and clients in counselling, testing and treatment services. Information gathered from patients must be managed in such a way as to keep it from other people. Confidentiality thus establishes trust between the two parties

because it enables clients to conceal their status from relatives and others and avoid the social costs associated with the disease (75). This study revealed that lack of privacy and confidentiality causes HIV/AIDS employees to shun their workplace medical services because they fear that everyone will know their HIV status. This concurs with a study done by Dyk et al., which reported fear about the lack of confidentiality as a critical service-related barrier affecting participation in VCT services in Kenya and the following problems were identified: Fear in case others learnt their results and fear of stigma both of being tested and of being HIV positive (76).

Similarly, a study done in Ghana found that many clients and potential users of services were uncomfortable with the quality of care given by some health workers, especially as they overtly and covertly breached confidentiality about their client's health status. This compelled many patients and potential users to adopt a modus vivendi that provides them access to care services while protecting their identity (75). It is often found that clients are, in principle, not against HCT, but that they have serious problems and anxiety about the breach of confidentiality. Firstly, they fear the reactions of their sex partners (violence, break-up of marriages) should health care professionals disclose their serostatus without their permission. Secondly, they fear the reactions of health care professionals themselves (76). This is similar to a study done by Kwapong et al., which revealed that HTC in some health facilities is done in the open with no privacy. They explained how the test is done, and the results disclosed is what is deterring clients from taking the test. They further revealed anxiety about the likelihood of another patient getting to know your status due to how and how the process is handled (69).

This study revealed that lack of management commitment also affects the development and implementation of HIV/AIDS workplace policy. The finding is consistent with results reported by Bakuwa in 2011, where he highlighted that HIV/AIDS is not being regarded as a priority business issue because there was no visible impact of HIV/AIDS on the company's operations (10). In contrast with the above finding, this study found that HIV/AIDS was perceived as having a significant impact, regardless of the management not taking it as a priority workplace issue.

Staff sensitization was suggested to reduce challenges faced during the implementation of the HIV/AIDS workplace policy. Knowledge is a critical behavioural antecedent [11] within the context of HIV and AIDS. The employers of labour, including crucial policymakers, should be very knowledgeable about HIV and AIDS. This will enhance their capacity to design, implement and institutionalize HIV and AIDS prevention and control programmes in workplaces in line with the recommended guidelines (77). This study revealed that most employees do not know what to do if HIV positive or how they can effectively help their HIV/AIDS infected colleague following HIV/AIDS policy.

Similarly, a study carried out in 29 districts in Malawi reported that in most health facilities, services providers were not aware of the policy that governs their work and did not have standards and guidelines for cervical cancer screening and treatment (78). Therefore, staff sensitization will ensure that every employee is aware of the existing policies, including HIV/AIDS workplace policy. On the one hand, this will impart them with adequate knowledge of HIV and AIDS, facilitating the prevention and control of the pandemic. On the other hand, inadequate or faulty

understanding of the disease may work against prevention and control efforts and promote stigmatization and discrimination against people living with HIV.

The current study reported allocating adequate resources to HIV related interventions to reduce challenges faced during the implementation of HIV/AIDS workplace policy. Sufficient funding to the policy would enable the workplace to establish a sound infrastructure that will ensure privacy and confidentiality hence, motivating access to HIV/AIDS care at the institution. On top of that, adequate funds will confirm the availability and accessibility of extra packages to HIV/AIDS infected employees. To achieve this, the institutions should employ an evidence-based allocation strategy, whereby resources are spent in a way that is likely to achieve the most significant result based on the best currently available evidence. In HIV and AIDS, outcomes are defined to prevent new infections, provide care and treatment, and mitigate impact (79).

This study revealed that strengthening HIV/AIDS prevention at the workplace would facilitate the effective implementation of HIV/AIDS policy. The current study findings further revealed that HIV testing and counselling reduces the further spread of HIV/AIDS at the workplace. This is consistent with study findings reported by Dyk et al. Most of the participants (87.3%) believed that every person should know his or her HIV status. 79.1% were prepared to go for VCT 51.4% had already been tested for HIV. Only 12.8% of the participants said they would not go for VCT, while 8. % was unsure. The participants gave the reasons as to why people should know their HIV status was mainly to prevent the transmission of the virus to others (49.5%), to access treatment (3.4%), to enhance surveillance and awareness programmes (76). However, stigma and discrimination hinder employees from undergoing HIV/AIDS testing and counselling. This is in

line with findings reported by Leta et al. in a study conducted in Ethiopia. They found that having no stigmatizing attitudes toward people living with HIV/AIDS was strongly and positively associated with voluntary counselling and testing (VCT) utilization in urban and rural strata (80). Provision of special support to staff such as the provision of extra money/allowance, nutritional support and care of carers was identified as facilitating factor to implementation of HIV/AIDS workplace policy. The provision of extra money helps them to buy nutritious food and other needs. This makes the employees motivated by the support rendered; hence, they feel free to disclose their HIV positive status and comply with the ART regimen. In addition, nutritious food is essential for HIV/AIDS infected people. These findings are supported by Yakob et al. in 2016, who found that the ability to buy food was associated with the acceptability of HIV care as participants believed that HIV care should be comprehensive and should include food. Both the community and people living with HIV (PLHIV) thought HIV positive people should eat "good foods" such as meat, eggs, butter, milk, etc. Unemployment resulted in low income, hindering access to such foods and increasing worries about health and the future. The inability to provide food, clothing and school materials for their children and pay rent caused some PLHIV to abandon HIV treatment. Some PLHIV who stopped ART said that they were depressed and not sure if they would restart ART. They couldn't take drugs without food (81).

This study found that the availability of an HIV/AIDS policy at the workplace is vital, and it would help facilitate the implementation of the policy. This is because the policy helps prevent the further spread of HIV infection, promote access to treatment for PLHIV and mitigate the health, social-economic and psychosocial impact of HIV and AIDS on individuals, families, communities and

the nation (82). Furthermore, HIV/AIDS workplace policy provides the framework for reducing the spread of HIV/AIDS and managing its impact (8).

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Developing and implementing HIV/AIDS workplace policy is one way of managing the HIV/AIDS pandemic. This is because the policy provides the framework for action to reduce the spread of HIV/AIDS and manage the impact in the workplace. Therefore, the HIV/AIDS workplace policy should be effectively implemented. However, the findings of this study identified the following barriers to the effective implementation of the HIV/AIDS policy: lack of policy sensitization, stigma and discrimination, lack of knowledge, denial, lack of resources, lack of employee involvement, lack of privacy and confidentiality and lack of management commitment. On the other hand, this study found that the following factors can facilitate the development and implementation at the workplace: staff sensitization, adequate resources, and establishment of staff welfare committee strengthening HIV prevention, providing additional support to staff and availability of HIV/AIDS policy.

In summary, effective implementation of HIV/AIDS workplace policy involves removing the identified barriers and strengthening the facilitating factors.

5.2 Recommendations

This study recommends the following strategies to improve the HIV/AIDS workplace policy development and implementation.

5.2.1 Institutional Management/Leadership

- The management should take responsible efforts to implement the HIV/AIDS workplace policy effectively. The more management shows efforts, the more the employees will be willing to participate in the policy implementation.
- The management of the institution should prioritize the allocation of necessary supplies to HIV/AIDS-related interventions. This will reduce unnecessary stock-outs of resources.
- They should also ensure that all their employees have undergone formal training and in service training on HIV/AIDS. This will help to prevent stigma and discrimination.
- Management should involve employees during the process of the HIV/AIDS policy development and implementation. This will motivate employees to take ownership of the policy, and hence effective implementation.
- Management should make the HIV/AIDS workplace policy available and accessible to all employees.

5.2.2 Ministry of Health

- **Strengthening mainstreaming of HIV and AIDS in the Education sector**
  - Through the Ministry of Health, the Malawi government should liaise with the education sector to incorporate a module on HIV/AIDS at the workplace in all undergraduate curriculums. The module should focus on the importance of an HIV/AIDS policy and develop, implement and evaluate this policy. After completing that module, more students will understand the importance of such a policy and have the skills and knowledge to develop and implement a policy in their workplace.

- The Ministry of Health should conduct regular monitoring and evaluation at all public health institutions. The monitoring and assessment will give them an insight into the progress of HIV/AIDS workplace policy implementation.

5.2.3 Research

- We recommend implementation research on the feasibility of the HIV/AIDS workplace policy in public institutions.
- Government to increase the allocation of funds to its health institutions. This will facilitate the implementation of HIV/AIDS-related programmes.

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APPENDICES

Appendix 1: Information Leaflet and Informed Consent

TITLE OF STUDY: Exploring factors affecting HIV/AIDS policy development and implementation in public hospitals in Lilongwe, Malawi.

PRINCIPAL INVESTIGATOR: Patricia Kapangama, MPH student, BSc.Nsg Ed,

What you should know about this study

You are being invited to participate in the above titled research study. The information leaflet and consent form explains the research study and your part in this study. Please read carefully and take much time as you need. Before you decide whether to participate in this study, you need to know the purpose, procedure, benefits and risks of participation, compensation and what will be expected of you during the study.

Purpose of the Study

This study aims to enhance the development and implementation of HIV/AIDS workplace policy in public hospitals in Lilongwe, Malawi. The researcher would like to explore factors affecting HIV/AIDS workplace development and implementation. The qualitative data will be obtained through face to face in-depth interviews and key informant's interviews using a semi-structured interview guide.

Participants

You are being asked to participate in the study because you meet the inclusion criterion for this study: employees with at least three years of work experience in wards/departments at A/25 health and Bwaila Hospital. You will be excluded from this study if you do not meet all of these criteria.

Procedures

If you volunteer to participate in this study, you will be required to sign a consent form. The study participants will participate in in-depth and key informants' interviews, respectively. The in-depth and key informants' interviews will be audiotaped. You will also be required to give consent to be audiotaped.

Benefits of Participation

There are no direct benefits to you, like the financial or material benefits. However, your participation in the study will be of great importance because the information you will give will improve the implementation of HIV/AIDS workplace programs.

Risks of Participation

There are no foreseeable risks if you take part in this study. However, some questions during interviews may bring some discomfort, as you will be disclosing personal experience. You are free to decline to answer questions you deem uncomfortable.

Cost/Compensation

There is no financial cost to you to participate in this study. The in-depth interview and key informants interview will take approximately 60 to 120 minutes. You will not be compensated for taking part in this research.

Confidentiality

All information gathered in this study will be kept confidential; no one will have access to information except the researcher and her supervisor. The data collected will not be published or presented in a way that would expose your identity. Number code will be used instead of your name, and a record of your data will be kept in a researcher's locked cabinet. The computer information will be secured by a password only known to the researcher.

Voluntary Participation

Whether to participate in this research study is voluntary, and failure to participate in the study will not attract any penalty against you. If you decide to take part in this study, you may withdraw from the study at any time without fear of any kind of penalty.

Questions/Problems

You have the right to ask questions about this study before you sign this form and at any time during the study. If you have questions/concerns, you may contact the principal investigator on 0888661070, email: kapangamapatricia@yahoo.com. You may also contact the Chairperson, College of Medicine Research and Ethics Committee (COMREC), P/Bag 360, Chichiri, Blantyre 3.

CONSENT STATEMENT

I have read and understood the above information about this study, and I agree to participate in this study. I have been able to ask questions about this research study. I am at least above 20 years of age. A copy of this form has been given to me. My signature below indicates that I agree to participate in this study.

Name of Participant…… Date…….

Signature …….

Audio/Video Taping: (if participating in an in-depth interview and Focus Group Discussion)

I agree to be audiotaped for this research study.

Name of Participant……. Date…….

Signature……

I have explained the research study to the above participant using language understandable and appropriate.

Name of Investigator…… Date……

Signature…….

Appendix 2: Demographic Information Sheet

Instructions: Please respond to each of the following questions

1. What is your age category?

Age in years

A. 15-20 [ ]

B. 21-25 [ ]

C. 26-30 [ ]

D. 31-36 [ ]

E. Above 36 [ ]

2. Gender

A. Male [ ]

B. Female [ ]

3. What is your marital status?

A. Single [ ]

B. Married [ ]

C. Divorced [ ]

D. Widowed [ ]

E. Engaged [ ]

4. What is your level of education?

A. Never attended [ ]

B. PSLC [ ]

C. JCE [ ]

D. MSCE [ ]

E. Tertiary level [ ]

5. What is your position or occupation?

A. Nurse. [ ]

B. Clinician. [ ]

C. Medical doctor. [ ]

D. Administrator. [ ]

E. Others. [ ]

6. When did you join the organization?

A. 15-20 [ ]

B. 21-25 [ ]

C. 26-30 [ ]

D. 31-36 [ ]

E. Above 36 [ ]

Appendix 3: Interview Guide

I am Patricia Kapangama, a master degree in public health student. Currently, I am conducting a study exploring factors affecting HIV/AIDS workplace policy development and implementation in public hospitals in Lilongwe, Malawi. Completing these questions is voluntary, and you are not required to give any personal information to identify yourself. Your completion of these questions will be highly appreciated.

Code No: ---------- Date: ----------

Start time: ---------- finishing time: ----------

SECTION A: AVAILABILITY OF HIV/AIDS WORKPLACE POLICY

1. Can you tell me if your workplace has HIV/AIDS workplace policy, when it was adopted, why it was adopted?
2. Can you describe key elements of the HIV/AIDS workplace policy? (**Probe**: would you give examples).

SECTION B: KNOWLEDGE, VALUES, ATTITUDE AND PERCEPTION (PERSONAL FACTORS) TOWARDS HIV/AIDS WORKPLACE POLICY

3. What is the importance of HIV/AIDS workplace policy?
4. How was the policy developed?
5. Can you tell me about HIV/AIDS programmes at your workplace? How do they address the needs and concerns of employees?)
6. Can you tell me the health education on HIV/AIDS which you received at your workplace? What was the source of information?

7. Can you describe any personal factors that affect the development and implementation of HIV/AIDS workplace policy?

SECTION C: INSTITUTIONAL BARRIERS/ FACTORS AFFECTING DEVELOPMENT AND IMPLEMENTATION OF HIV/AIDS WORKPLACE POLICY

8. In your opinion, how is your organization affected by HIV/AIDS?
9. What resources have been allocated to HIV/AIDS-related interventions?
10. Can you describe how the policy was communicated to employees?

SECTION D: CHALLENGES IN THE IMPLEMENTATION OF HIV/AIDS WORKPLACE

11. Would you explain the challenges faced during the implementation of the HIV/AIDS workplace policy?
12. In your opinion, what can be done to reduce HIV/AIDS workplace policy implementation challenges at this organization?
13. What is your wrap up message?

This is the end of the interview, and I would like to thank you very much for participating in this study. Your views were valuable.

Appendix 4: Study Plan

Time period / Activity	A	M	J	J	A -S	O -N	D	F -A	M -J	J-A	S	O	N	D	J
	2019							2020							
Two paged proposal															
Research proposal development															
Proposal submission and approval															
Data collection and analysis															
Report writing															
Submission of research dissertation															
Dissemination of results															

Appendix 5: Study Budget

ITEM	QUANTITY	UNIT COST (MK)	TOTAL COST (MK)
STATIONARY			
A4 white papers	3 reams	K2500.00each	K7500.00
Writing materials - Pencil - Pen	 2 2	 K100.00 each K150.00 each	 K200.00 K300.00
Eraser	1	K300.00 each	K300.00
A4 envelopes	3	K100.00 each	K300.00
A5 envelopes	3	K50.00 each	K150.00
Punching machine	1	K4000.00	K4000.00
Flash disk	1	K4500.00	K4500.00
Lever arch file	1	K2500.00	K2500.00
Airtel dongle	1	K17000.00	K17000.00
SUBTOTAL			**K36,750.00**
SECRETARIAL SERVICES			
Proposal printing 35 pages	4 copies	K100/ page	K14000.00
Proposal binding	4 copies	K1000/copy	K4000.00
Dissertation printing approx. 50 pages.	4 copies	K100/copy	K20,000.00
Dissertation binding	4 copies	K5000/copy	K20,000.00
Photocopying questionnaire 5 pages	40 copies	K30/page	K6000.00

SUBTOTAL			**K64,000.00**
COMMUNICATION, TRANSPORT AND LODGING			
Transport to and from data collection centres.		K20,000.00	K20,000.00
Transport to meet supervisor (LL - BT)		K30,000.00	K30,000.00
Lodging (BT)		K20,000.00	K30,000.00
Airtel data/internet bundle		K10,000.00	K10,000.00
Phone calls		K5,000.00	K5,000.00
Meal expenses		K6,000.00	K6,000.00
SUBTOTAL			**K101,000.00**
CONTINGENCY 10 %			**K20,175.00**
GRAND TOTAL			**K221,925.00**

Appendix 6: Supporting Letter from Public Health Department

COLLEGE OF MEDICINE

Principal

M. H. C. Mipando, MSc, PhD.

Our Ref.:

Your Ref.:

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 01 871911
01 874107
Fax: 01 874 700

To whom It May Concern,

04th September 2019

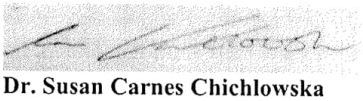
Dear Sir/Madam,

RE: PATRICIA KAPANGAMA RESEARCH DISSERTATION

This letter is written to confirm that Patricia Kapangama is a student studying for her Master of Public Health degree at the University of Malawi's College of Medicine. As part of her requirement to fulfill her Master degree she needs to complete a Masters dissertation entitled **"HIV/AIDS workplace policy development and implementation in public hospitals in Lilongwe, Malawi"**.

I believe she has approached your organisation in the hope that she may collect data for her research study, to be used solely for academic purposes. If you need any more information regarding her academic work please contact the undersigned.

Yours Sincerely,



Dr. Susan Carnes Chichlowska

MPH Course Director
School of Public Health and Family Medicine
College of Medicine, University of Malawi
P/Bag 360, Chichiri, Blantyre 3
Telephone: +265 888300905
Email: mphcoursedirector@medcol.mw

Appendix 7: Authorisation Letter from Lilongwe DHO

Ref. No.:
Telephone No.: 265 726 466/464
Telefax No.: 265 727817
Telex No.:
E-Mail. lilongwedho@malawi.
COMMUNICATIONS TO BE ADDRESSED TO:

In reply please quote NO DZH/MALAWI,
Lilongwe District Health Office
P.O. Box 1274
Lilongwe
Malawi

16th October, 2019

The In-charge, Bwaila Hospital

The In-charge, Area 25 Health Centre

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH STUDY IN LILONGWE DISTRICT

Permission has been granted to the bearer of this letter: Patricia Kapangama, **Masters in Public Health student** from College of Medicine to conduct research study at your facility.

Research Title:-
"HIV/AIDS Workplace policy development and implementation in public hospitals in Lilongwe, Malawi"

Any assistance rendered would be appreciated.

MINISTRY OF HEALTH & POPULATION
DMO/MO
14 OCT 2019
DISTRICT HEALTH OFFICER

Dr. Thokozani Nyasulu Liwewe
For: ACTING DIRECTOR OF HEALTH AND SOCIAL SERVICES

Appendix 8: Certificate of Ethics Approval

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.02/20/2954 - HIV/Aids Workplace Policy Development and Implementation in Public Hospitals in Lilongwe, Malawi by Patricia Kapangama

On 21-Apr-20

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC some of which are indicated on the next page for your study

21-Apr-20

Prof. E. Umar -Chairperson (COMREC)

Date

Approved by College of Medicine 21-Apr-2020 (COMREC) Research and Ethics Committee