

**SCHOOL OF PUBLIC HEALTH  
COLLEGE OF HEALTH SCIENCES  
UNIVERSITY OF GHANA, LEGON**

**EFFECTIVENESS OF THE IMPLEMENTATION OF THE WORK PLACE  
HIV/AIDS POLICY & TECHNICAL GUIDELINES FOR THE HEALTH SECTOR  
AT AN URBAN TERTIARY REFERRAL HOSPITAL, GREATER ACCRA REGION,  
GHANA**

**BY**



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## DECLARATION

I, Margaret Lartey, hereby declare that except for other people's work which have been duly acknowledged, this work is the result of my own original research done under supervision and that this dissertation has neither in part nor whole been presented elsewhere for another degree.

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**ACADEMIC SUPERVISOR:**

.....

DR. IRENE AGYEPONG

## **DEDICATION**

I dedicate this work to Jehovah God, the Almighty



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## ABSTRACT

HIV Infection continues to impact the world of work. This is especially more evident in the health sector where health workers are at risk of hospital acquired infections and attitudes and practices strongly influence the response to the provision of prevention, treatment, care and support interventions for infected patients. The ILO thus recommends the implementation of HIV Work place policies at Global, Regional, County and Local levels. In line with this the MOH, Ghana published its Work Place Policy in 2004, for implementation by all institutions under the Ministry of Health.

The policy has three major objectives: Protection from Stigma and Discrimination, Prevention of spread of HIV; and the Provision of care and support. The study sought to determine the effectiveness of the implementation at an urban tertiary referral hospital located in the Greater Accra Region of Ghana.

A qualitative cross sectional descriptive, mixed methods study was carried out using in depth and key informant interviews and open, non participant structured observations of managers, infected and non infected health workers at the hospital. Interviews were transcribed verbatim and coding was done by two investigators. Codes were compared and categorized into recurring and extreme themes. Data from interviews from the three groups was triangulated for validity. Data from the structured observations was also used to validate the interviews. Quotations representing themes were selected for inclusion. The level of attainment of each objective was summarized from data from the themes and described as fully achieved, partially achieved and not achieved. The three objective achievements were summarized to describe the policy implementation as highly effective, partially effective and not effective.

The knowledge and awareness of the policy document was poor. Provision of care and support to health workers was fully achieved prevention of HIV infection at the workplace partially achieved and protection from stigma and discrimination not achieved.

The policy was thus judged to have been partially effective in its implementation. Recommendations were made to the hospital management to help achieve full implementation of the policy objectives.

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## LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CHMI	Centre for Health Marketing Innovations
DFID	Department for International Development
FHI	Family Health International
GAC	Ghana AIDS Commission
GFATM	Global Fund for AIDS, TB & Malaria
GHI	Global Health Initiative
GHS	Ghana Health Service
GNP+	Global Network of Persons Living with HIV
GRI	Global Reporting Initiative
HCP	Health Care Provider
HCW	Health Care Worker
HIV	Human Immune Deficiency Virus
HNHW	HIV Negative Health Worker
HPHW	HIV Positive Health Worker
ICRW	International Centre for Research on Women
IEC	Information, Education and Communication
IFC	International Finance Cooperation
IHW	Infected Health Worker
ILO	International Labour Organisation
IPPF	International Planned Parenthood Federation
ISO	International Organization for Standardization
MDAs	Ministries, Departments and Agencies

MMT	Member of Management Team
MOE	Ministry of Education
MOH	Ministry of Health
MOL	Ministry of Labour
MOYES	Ministry of Youth, Education and Sports
MPH	Masters in Public Health
NACP	National AIDS Control Programme
NANGO	National Association of Non Governmental Organizations, Zimbabwe
NGO	Non-Governmental Organization
NIHW	Non Infected Health Worker
PEP	Post Exposure Prophylaxis
PLHIV	Persons Living with HIV
PPE	Personal Protective Equipment
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
TB	Tuberculosis
UNGASS	United Nations General Assembly Special Session
UNAIDS	United Nations Joint Programme against AIDS
VCT	Voluntary Counseling and Testing
WEF	World Economic Forum
WHO	World Health Organization
ZAN	Zimbabwe AIDS Network

## **DISCLAIMER**

All identifying information (places and names) have been removed from this study/dissertation to protect health workers from stigma and discrimination.

The photograph used (figure 2) was culled from the internet (open source) and persons and places in it bear no relation to the subject matter studied.

## CHAPTER ONE

### INTRODUCTION

#### 1:1 Background

Ghana like other countries in the world has been mitigating the effects of the Human Immune deficiency (HIV) pandemic since its first case was reported in 1986. Ghana has a generalized epidemic and the HIV prevalence for 2012 was 1.37% in the general population and 2.1% among pregnant women. (NACP, 2013)

The health ministry is the lead technical agency leading the health response to the epidemic. In addition, health workers by virtue of their work are at risk of acquiring HIV through occupational exposure. The health institutions employ many people and like any other workplace must protect against discrimination of workers based on HIV status and offer care and support. In response to the above and the general direction for ministries, departments and agencies (MDAs) to produce and implement policies and guidelines for HIV workplace programmes as stipulated in the National HIV/AIDS &STI Policy (GAC, 2004), the Ministry of Health(MOH) developed the workplace policy and technical guidelines for the health sector. Its main goal is to prevent new infections and protect the health worker.

The present workplace HIV/AIDS policy was developed in 2004 and has been in use for the past nine years. Its main policy objectives are to:

- Provide protection from discrimination in the workplace for people living with HIV/AIDS;
- Prevent HIV/AIDS spread amongst workers
- Provide care, support and counseling for those infected and affected and
- Promote the incorporation of educational programmes aimed at reducing the spread of HIV/AIDS at the workplace into health insurance schemes.

The legal context of the policy is under pinned by international laws, the 1992 constitution and local laws, the national HIV/AIDS and STI policy and the International Labour Organization (ILO) Code of practice. The provisions apply to both public and private health institutions. The scope of the policy and technical guidelines apply to:

- All employees within the health sector
- Prospective employees of the health sector
- Clients and patients of the health sector.

### **Policy Statement**

The policy statement notes among other things that the workers of the health sector institutions acknowledge HIV/AIDS as a serious medical and economic threat to themselves and their clients and therefore will take steps to prevent the spread among members and clients and protect worker rights and foster social responsibility on the part of workers, clients and institutions. The following policy statements are guiding principles (GAC 2004):

- That the ethical principles governing health conditions in employment should apply equally to HIV/AIDS
- That HIV/AIDS shall not be a basis for pre-employment testing or refusing to employ an applicant
- That no employee should be dismissed on the basis of his or her HIV status and it shall also not influence retrenchment procedures
- That effort will be made to maintain the care and confidentiality of the HIV status of a health worker in line with national policies existing practices and legal requirements.

The technical guidelines cover confidentiality, information, communication and education, general preventive measures, voluntary counseling and testing (VCT) and sexually

transmitted infection (STI) management, epidemiological surveillance and occupation related HIV/AIDS.

The policy makes provision for monitoring and evaluation as well as reviews through meetings, writing and submission of reports and recommendations and through periodic independent evaluative surveys.

## **1.2 Statement of the Problem**

Policies are formulated to respond to various challenges and are usually meticulously designed with stakeholder involvement. Policies however must be implemented to achieve the desired change. Interventions face challenges thus creating gaps between the policy as designed and the actual implementation. The purpose of the study was to assess whether or to what extent the implementation of the HIV Work place policy in an urban hospital in Ghana has been effective in attaining three of its objectives. The following objective questions were framed to guide the study:

- 1) What forms of protection and discrimination exist at the workplace for people living with HIV/AIDS (non-discrimination; confidentiality; continued employment)
- 2) What are the preventive measures available at the workplace to stop the spread of HIV/AIDS among workers (healthy working environment; prevention)
- 3) What forms of care, support and counselling exist at the work place for individuals affected with HIV/AIDS at the workplace (care, support and counselling services)

## **1.3 Conceptualization of the Research Problem**

The core problem investigated was whether the implementation of the policy was in tandem with what the designers of the policy envisaged and to what extent had the stated objectives of the policy been achieved. Conceptually, this represents an outcome and the assessment

was to study three major contributors which were the content, the processes that had been used in ensuring that the policy objectives were attained at the workplace and the context in which these had been carried out. Other contributors like the actors were explored during the course of the study.

### **Content**

Awareness of the policy and knowledge of its content by managers and health care workers (HCW) also contributes to its effective implementation. Some of these are confidentiality, prevention measures, provision of care and support and non discrimination. Thus, the policy will be examined in terms of the knowledge of the following:

- Recognition that HIV/AIDS is a workplace issue
- Knowledge of the policy
- Non discrimination
- Healthy work environment
- Screening for purposes of exclusion from employment or work processes
- Continuation of employment relationship
- Confidentiality
- Prevention
- Care and support

### **Process**

Some of the steps in the implementation process are appointing a focal person or task team, gathering of strategic information and drafting of standard operating procedures (SOPs) among others. With regard to the processes involved in the implementation the following were examined:

- Appointment of a focal person or oversight committee
- Reached consensus on key elements of policy to adopt

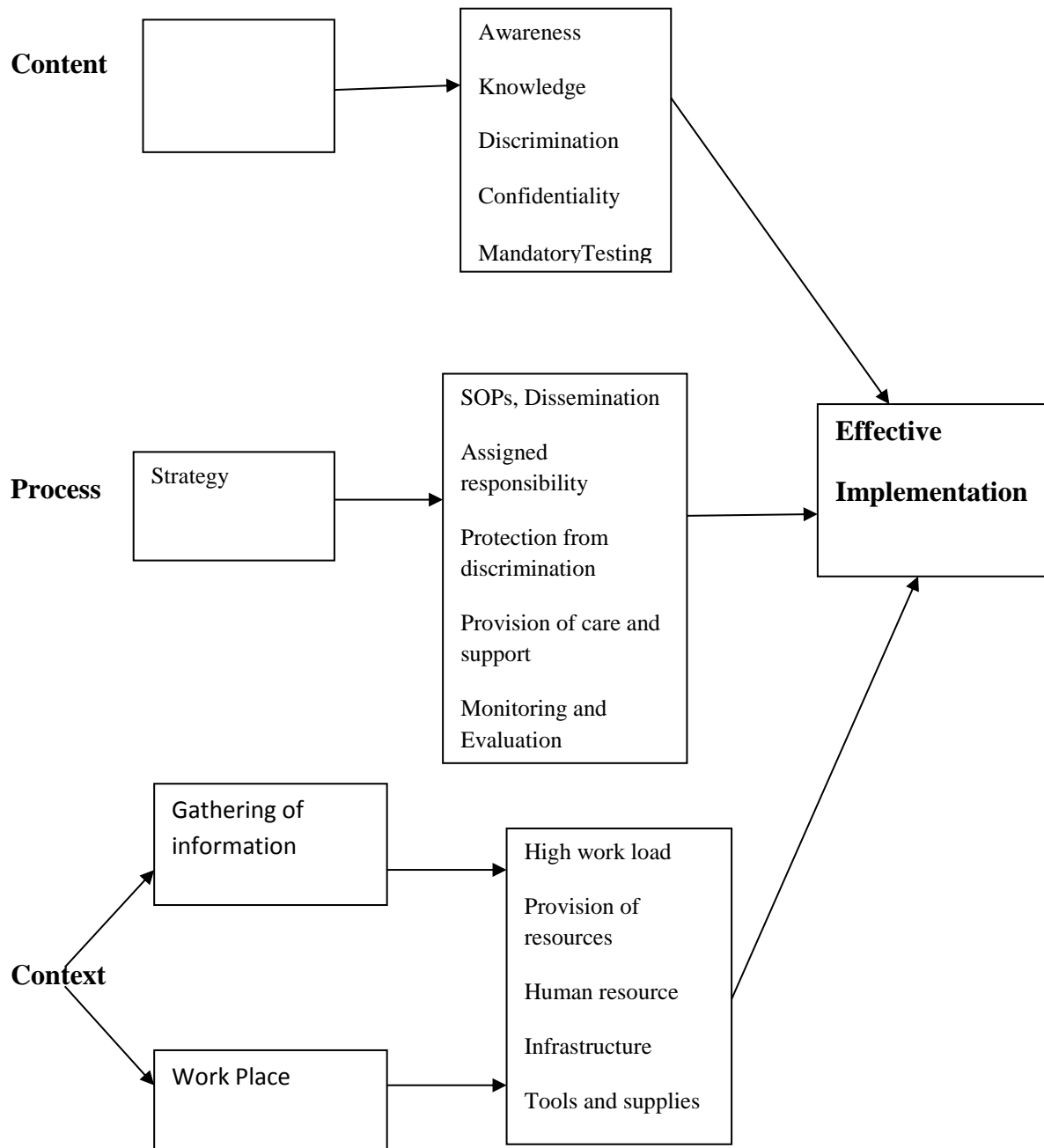
- Develop SOPs
- Popularize or disseminate policy
- Gathering of relevant information
- Provide education, information and commodities to aid prevention
- Monitor and evaluate policy

### **Context**

In assessing the effectiveness of the policy, the context within which the implementation occurred was also be explored. The availability of the following to implement the policy was explored under the context.

- Provide resources for implementation to include human, training, orientation
- Provide protective equipment and tools to HCW and training in its use
- Provision of essential supplies
- High work load of staff

All these have been depicted in figure 1.1.

**Figure 1.1 Conceptual framework**

## **1.4 Aim and Specific Objectives**

### **1.4.1 Aim**

To describe the extent to which the workplace HIV/AIDS policy has achieved its first three objectives and the reasons for achievement and gaps in achievement at an urban tertiary referral hospital, Accra.

### **1.4.2 Specific Objectives**

1. To describe the extent of awareness of the HIV Work Place Policy
2. To describe the extent of protection from discrimination in the workplace for health care workers living with HIV/AIDS
3. To describe the provision of care, support and counseling in the workplace for health care workers living with HIV/AIDS
4. To describe the measures instituted to prevent the spread of HIV/AIDS at the workplace
5. To describe the extent to which the policy has contributed to the attainment of protection from discrimination, provision of care and support, and prevention of spread of infection
6. To develop recommendations for improving the attainment of the HIV/AIDS workplace policy objectives

## **1.5 Outline of the Dissertation**

Chapter 1-This provides a background for the dissertation. It presents the statement of the problem and a justification for the study. It also explains how the research problem was conceptualized and the aims and objectives of the study.

Chapter 2-This chapter describes how thematic content analysis was located within the theoretical context, what has been done by others and what their findings were.

Chapter 3-Chapter 3 provides information on the study design and methods, data collection techniques, data collection tools, informed consent, data analysis plan and plan to improve validity of the data.

Chapter 4-The result from the study are presented in this chapter as summaries and quotes and displayed in tables and bar charts.

Chapter 5-The findings are discussed, placing them within the theoretical context and compared with findings from other studies.

Chapter 6-This presents the conclusions of the study, recommendations and limitations

## CHAPTER TWO

### LITERATURE REVIEW

Human immune virus infection (HIV) epidemic continues to be one of the world's biggest challenges. Globally, 34.0 million [31.4 million–35.9 million] people were living with HIV at the end of 2011. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide. The number of persons acquiring new HIV infections in 2011 was estimated at 2.5 million, 20% less than the number in 2001 (UNAIDS, 2012)

In 2011, 1.7 million people still died from HIV representing a 24% decline in AIDS related mortality compared to 2005. An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV (UNAIDS, 2012). This population remains the most sexually active as well as the productive sector of any economy.

Ghana like other countries in the world has been mitigating the effects of the HIV pandemic since its first case was reported in 1986. Ghana has a generalized epidemic and the HIV prevalence for 2011 was 1.5% in the general population, declining from 2.7% in 2005 and 2% among pregnant women (NACP, 2012). In Ghana the incidence rate is believed to have decreased by more than 50%. By the end of 2011, the estimated number of persons living with HIV was 225,478 out of which 65,087 were on treatment. It is also estimated that 12,077 new infections occurred in 2011 out of which 1,707 were children (NACP, 2012). The prevalence of HIV for 2012 was 1.37% with an estimated 231,205 persons living with HIV infection. The need for antiretroviral therapy is estimated at 120,000 persons and these are expected to engage the health sector at one point or another (NACP, 2013).

In 2001 the ILO estimated that at least 25 million workers aged 15-49, the most productive segment of the labour force were infected with HIV (ILO, 2001). It therefore recommended that HIV/AIDS should be recognized as a workplace issue, and be treated like any other

serious illness/condition in the workplace. This was necessary not only because it affected the workforce, but also because the workplace, being part of the local community, had a role to play in the wider attempts to limit the spread and effects of the epidemic. HIV has continued to impact the world of work, reducing the supply of labour with attendant increase in labour costs while at the same time reducing personal incomes with greater dependency on public services.

In 2001, the ILO developed the Code of Practice on HIV/AIDS and the World of Work (ILO, 2001). The ILO Code approaches workplace HIV/AIDS issues from the perspective of human rights. Its basic premise is that a decent workplace and proper health care must be ensured for workers regardless of their HIV/AIDS status; therefore, workers who are infected by HIV/AIDS are entitled to appropriate medical care and support, employment opportunities and correct information and education (ILOAIDS, 2005).

This Code officially set forth guidelines for workplace policies and programmes on HIV/AIDS, covering the four key areas of action: prevention of HIV/AIDS, management and mitigation of the impact of HIV/AIDS on the workplace, care and support, and elimination of stigma and discrimination (ILO, 2001). The 10 policy principles of the Code include recognition of HIV/AIDS as a workplace issue, no screening for purposes of exclusion from employment, continuing the employment relationship, and gender equality in prevention, care and support, healthy work environment, social dialogue, confidentiality, HIV prevention, care and support. These principles are drawn from the ILO's Fundamental Principles on Rights at Work and the Tripartite Declaration of Principles concerning Multinational Enterprises and Social Policy (ILO, 1977, 1998).

The policy areas in the code are (ILO, 2001):

1. *Recognition of HIV/AIDS as a workplace issue:* HIV/AIDS is a workplace issue because it affects workers and enterprises – cutting the workforce and increasing labour costs and reducing productivity.
2. *Non-discrimination:* There should be no discrimination against workers on the basis of real or perceived HIV status. Non-discrimination is a fundamental principle of the ILO and is at the heart of the ILO's response to the epidemic. The principle of non-discrimination extends to employment status, recognized dependants, and access to health insurance, pension funds and other staff entitlements.
3. *Gender equality:* The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and economic reasons.
4. *Healthy work environment:* The work environment should be healthy and safe, as far as is practicable, for all concerned parties. This includes the responsibility for employers to provide information and education on HIV transmission, and appropriate first aid provisions in the event of an accident.
5. *Social dialogue:* The successful implementation of an HIV/AIDS policy and programme requires co-operation and trust between employers, workers and their representatives and government or management as it is more likely to be implemented effectively. Emphasis is also given to the leadership role of employers' and workers' organizations in breaking the silence around AIDS and promoting action.
6. *No screening for purposes of exclusion from employment or work processes:* HIV/AIDS screening should not be required of job applicants or persons in employment. Compulsory HIV testing not only violates the right to confidentiality but is also impractical and unnecessary.

7. *Confidentiality*: There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers.

8. *Continuation of employment relationship*: HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be encouraged to work for as long as medically fit in available, appropriate work. This principle is based on the fact that being HIV-positive is not the same as having AIDS and related infections.

9. *Prevention: HIV infection is preventable*. Prevention of all means of transmission can be achieved through a variety of strategies. A climate for prevention needs to be created, including an open discussion of relevant issues and respect for human rights. Measures for prevention include a combination of information, participatory education, practical support for behaviour change such as condom distribution, treatment for sexually transmitted infections (STIs), and the promotion of voluntary counseling and testing (VCT) where available.

10. *Care and support*: Solidarity, care and support should guide the response to HIV/AIDS in the world of work. Prevention, care and treatment should be seen as a continuum rather than separate elements of a workplace programme. The availability of treatment encourages confidential voluntary testing, making it easier to provide care and encouraging prevention. Care and support includes the provision of voluntary testing and counselling, treatment for opportunistic infections – especially TB - and antiretroviral therapy where affordable, workplace accommodation, employee and family assistance programmes, and access to benefits from health insurance and occupational schemes.

### **Health Related work place policies**

A workplace policy provides the framework for enterprise action to reduce the spread of HIV/AIDS and manage its impact. An increasing number of companies have workplace or company policies on HIV/AIDS. The policy:

- provides a clear statement about non-discrimination;
- ensures consistency with appropriate national laws;
- lays down a standard of behaviour for all employees (whether infected or not);
- gives guidance to supervisors and managers;
- helps employees living with HIV/AIDS to understand what support and care they will receive so they are more likely to come forward for voluntary testing;
- helps to stop the spread of the virus through prevention programmes;
- assist an enterprise in planning for HIV/AIDS and managing its impact, thus ultimately saving money.

In line with the ILO code various ministries of health developed work place policies. The government of Trinidad and Tobago launched a workplace policy for the health sector in 2010(MOH Trinidad and Tobago, 2010). It provided the framework for action to reduce the spread of HIV and to manage its impact on the health workforce, including the care and support of Health Care Workers Living with HIV. The royal Government of Cambodia's Ministry of Education, Youth and Sports also launched an HIV workplace policy on HIV and AIDs in 2008 ,the objective of which was to help protect staff from HIV infection, to help them care for themselves and to know what support was available from the ministry (MOE YS Royal Government of Cambodia, 2008).

The Ministry of Labour in Malawi also launched an HIV and AIDS workplace programme in 2010 with an aim 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 (MOL Malawi, 2010). In Ghana the Ministry of Health launched its Workplace HIV/AIDS policy and technical guidelines for the health sector in 2004 with policy objectives of protection from discrimination, prevention of HIV/AIDS and promotion of care support and counseling. The provisions apply to both public and private health institutions.

In South Africa the number of firms with HIV/AIDS policies increased from 27% in 2003 to 58% in 2005 (Mahajan, 2007), an increase of about 100%. Workplace policies were of different sophistication and had achieved a high prevalence of preventive programmes and an increase in VCT. Challenges included lack of monitoring and evaluation methodologies for work place programmes, persistent stigma at the work place resulting in a low uptake of testing and a low enrollment into workplace ART programmes.

### **Implementation of policy**

In South Africa, large firms with employees of more than 500 as well as firms from the financial services, mining, and transport sectors led the way in implementing workplace HIV/AIDS policies (Ellis, 2005). The health sector seemed to lag behind in launching and implementing workplace policies despite facing similar labour challenges and also having more workers at risk from occupational exposure. Health care workers are at increased risk of occupationally acquired HIV infection. Based on limited data, it has been estimated that approximately 500,000 percutaneous blood exposures may occur annually among hospital-based HCWs in the United States. Of these, approximately 5,000 may involve exposures to blood that is known to be HIV infected (Bell, 1997). The average risk of HIV transmission after percutaneous exposure to HIV-infected blood is approximately 0.3%; however, the risk is believed to be higher for exposures involving an increased volume of blood and/or high viral load.

In 2002 the WHO estimated that 700,000 health care workers worldwide received percutaneous exposures to HIV infection resulting in 500 infections. More than 90% of these occurred in developing countries. Worldwide about 2.5% of HIV in health workers was attributable to occupational sharp exposures (WHO Global Health, 2002).

Workplace prevention programmes generally refer to the following alone or in combination: HIV awareness and education activities, condom promotion and voluntary counseling and testing (Mahajan, 2007). Few monitoring and evaluation programmes of workplace prevention programmes have been identified (Mahajan, 2007).

### **HIV Education**

In one study HIV-related knowledge, attitude and practice among employees exposed to HIV/AIDS peer education was compared with employees at another company who were not exposed. Exposure did not have a significant impact on knowledge, attitude and practice. (Sloan, 2005).

Education programmes are an essential component of workplace HIV/AIDS programme (ILO, 2002). The Global Reporting Initiative (GRI) and Family Health International (FHI) guidelines identify a range of key issues to be covered in the HIV/AIDS education programme. Table 2.1 presents the proposed content of an HIV/AIDS work place education programme as proposed by GRI and contrasts it with that proposed by FHI. All these programmes contribute to reduction of stigma and discrimination at the work place.

**Table 2.1: Subjects to be included in Workplace HIV/AIDS Education Programmes**

<b>Subject</b>	<b>FHI Guidelines (FHI,2002)</b>	<b>GRI Guidelines (GRI,2003)</b>
<b>Company HIV/AIDS policy and position</b>	Details of company policy and position on HIV/AIDS	Communication of HIV/AIDS Policy
<b>Legal rights and grievance procedures</b>	Procedure for handling HIV/AIDS related grievances	
<b>Working alongside co-workers who are HIV positive</b>		Working alongside positive employees
<b>HIV modes of transmission</b>	Modes of transmission of HIV	Methods of HIV Transmission
<b>Methods of preventing HIV prevention</b>	Methods to prevent spread of HIV/AIDS	Condom Use (male and female)
<b>Prevention and treatment of STIs</b>	Prevention and treatment of STIs	HIV association with STIs
<b>Safe sexual behaviour</b>	Responsible sexual behavior	Behavioural change to safer sex
<b>Access to treatment</b>		Access to health care
<b>Additional Programme Information</b>	Access to additional information and available resources	Awareness

Modified from (Whelan, 2007)

### **HIV Stigma and Discrimination**

Goffman (as cited in Mahajan et al, 2008) described stigma as an attribute which is highly disturbing and which reduced the bearer from a whole or usual person to a tainted or discounted one.

HIV stigma comes in many forms, including gossip and verbal abuse, judgments, and morally-driven values about people living with HIV and populations that are more vulnerable

to infection. It can be manifested in discrimination, including violence and physical abuse as well as loss of jobs and lack of services.

The Global Network of Persons Living with HIV (GNP+), International Community of Women with HIV/AIDS (ICW), International Planned Parenthood Federation (IPPF) and UNAIDS, (2010) reported that, in the Asia Pacific Region, stigma and discrimination 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%). In a number of countries, employment was named as a key reason for undertaking HIV testing, particularly in the Philippines, Sri Lanka and Pakistan (45%, 27% and 15%, respectively).

In another study conducted on the global level, 43% of respondents globally reported loss of employment, 38% in Africa and 53% in East Africa. In addition to job losses, 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. The respondents (particularly in Kenya) indicated that this occurred, in whole or in part, primarily due to ill health. However, substantial numbers of the respondents in both countries reported that discrimination by an employer or co-worker was responsible (Sprague, Simon and Sprague, 2011). Except for East Africa, North Africa, South Africa and West and Central Africa reported similar percentages of HIV related work place discrimination. (Sprague et al., 2011)

### **Stigma and Discrimination in Health Care Settings**

Research has shown that three main causes of HIV stigma prevail in healthcare settings: (1) insufficient awareness by health providers about what stigma looks like and its consequences; (2) fear around HIV transmission in the workplace; and (3) attitudes that associate HIV with

perceived immoral behaviours. Over time, interventions targeting each of these drivers can effectively reduce HIV stigma and discrimination (USAID Futures Group, 2010).

HIV related stigma reduces access to healthcare since many people avoid clinics because of their positive status. In the Asia Pacific study reported by the GNP+ et al (2010), reduced access to health care occurred in 4-33% of respondents while of the countries reporting health-care avoidance despite needing care, 7-35% of PLHIVs avoided clinics while 7-25% avoided hospitals because of their positive status.

### **HIV Testing**

HIV testing still continues to be a source of stigma and discrimination and may involve testing of a patient on the ward or for pre-employment screening. In most of the countries participating in the Asia Pacific study, respondents (8-68%) had not received either pre or post test counseling (GNP+ et al, 2010).

### **Confidentiality**

Breach of confidentiality and reporting a person's status without consent is common. In one country, (4-41%) of the respondents said health workers were told of their status without consent. In all countries, some respondents, (3-26%) believed their medical and health records were not confidential. Far greater numbers of respondents (8-64%) were unsure of, or doubted the confidentiality of, their medical and health records (GNP+ et al, 2012).

### **Denial of Care**

Denial of care is another recognized form of discrimination. Some respondents in the Asia Pacific study (2-20%) were denied family planning and sexual and reproductive health

services. In others the provision of ART was conditional on the use of contraception (GNP+ et al 2010).

### **Challenges in the implementation of workplace policies**

Hadjipateras, Abwola and Akullu, (2006) recognized leadership, budgetary constraints and human resource costs as some of the challenges. Other challenges of implementing workplace prevention programmes are persistent fear of discrimination and stigma in the workplace resulting in poor uptake of HIV testing (Hadjipateras, Abwola and Akullu, 2006) and lack of monitoring and evaluation methodologies for workplace HIV prevention programmes (Mahajan, 2007). Knowledge of HIV is presumed to reduce stigma but distrust of employers and low uptake of VCT services at workplaces have contributed to persistent high levels of stigma. One of the challenges in South Africa was the implementation of the legal and policy frameworks of the workplace policy. There seemed to be few focal points in the ministries yet with no coordinator (Centre for Health Policy, 2001).

Leadership has already been recognized as key to the implementation of the policy and is essential for its success. Management commitment and lack of budgetary resources also contributed to poor implementation of workplace policies (Hadjipateras et al, 2006). In Zimbabwe, the implementation of HIV Workplace policy was reviewed. The authors found weak policy advocacy and poor dissemination and distribution strategies. Though the policy was considered an important document, little had been done by government to popularize and enhance its use (NANGO & ZAN, 2001).

Workplace treatment and care programmes involve management of opportunistic infections and antiretroviral therapy. This is supposed to present an alternative to public treatment services and also save organizations costs in terms of less time off work by employees among other things. Workplace treatment programmes also need to be evaluated. Some of the

challenges of workplace treatment programmes are low uptake of workplace ART programmes because of low uptake of VCT and concerns about confidentiality. (Stenson et al, 2005) evaluated counseling in a work place ART programme. Patients had found it very useful and the authors recommended inclusion of counseling in all ART programmes for workers.

### **The effectiveness of HIV workplace policies**

Monitoring and evaluation is necessary to determine the effectiveness of HIV workplace policies. Monitoring and evaluation can be of the content, process, context, output, impact and cost benefit analysis.

An independent evaluation of HIV workplace policies and programmes was carried out in two countries, Ethiopia and Uganda after the initial part of the project had been funded by the Italian Government and the ILO. The evaluation covered the second phase of HIV/AIDS prevention and mitigation in the world of work from 2007-2009 (ILO, 2009). The purpose of the evaluation was to assess if the project had achieved its stated objectives, assess any longer-term sustained improvements, provide recommendations on a possible way forward in terms of HIV/AIDS response in the world of work and assess the ILO comparative advantage in responding to HIV/AIDS in the project countries.

To answer these questions, the evaluation assessed the relevance of the project objectives, effectiveness of the project, efficiency in terms of use of resources, project's sustainability, and level of stakeholder commitment to project. The evaluation summaries showed that some of the objectives were achieved, others were not but overall more objectives were achieved in Uganda compared to Ethiopia due to various structural and implementation weaknesses like leadership engagement, resource availability, linkages to other services and ownership (ILO, 2009).

## CHAPTER THREE

### METHODS

The study was a descriptive, qualitative, mixed methods study. A qualitative mixed methods design was selected strategically as it is an interpretative, multi-method approach that investigates people in their natural environment (Christensen B, 2007:62).

Methods used for data collection were a combination of key informant interviews, structured observations and in depth interviews. The study was carried out between May and June 2013 at an urban tertiary referral in the Greater Accra Region.

**Figure 3.1: Health Workers in a discussion**



**This picture shows health workers in a discussion. It depicts health workers going about their usual duties. There is no way to tell by looking at the picture whether the HIV work place policy is being implemented. (Source-open source from internet)**

#### 3.1 Study Site- Urban Tertiary Referral Hospital

The referral hospital is located in the Greater Accra Region, the region that also hosts the city of Accra, the nation's capital. It is part of the Ghana Health Service (GHS) and serves as a referral centre for patients in the Greater Accra Region (GAR) of Ghana. Its other core functions are to provide specialist support services to health institutions in the GAR, provide emergency services and serves as a training site for staff and students.

The hospital is headed by a medical director and is managed by a team comprising the medical director, head of nursing, head of administration and support services, head of finance, head of clinical services and head of pharmaceutical services. The hospital has co-opted the in service training coordinator as part of the management team. The hospital management is the highest decision making body and supports the medical director to implement government policies (i.e. GHS Council, MOH/GHS/RHD policies) in the hospital and also formulates and implements internal/local policies.

The hospital provides in-patient, out-patient and emergency services. It provides specialist and general medical clinical services as well as public health, preventive, promotive and rehabilitative services. It has a total of 191 in-patient beds. In 2012, it had a total staff of 837 on nominal roll with 693 (83%) being permanent workers, 142 (16%) casuals and 85 new entrants. This is made up of 131 medical officers of various categories, 2 optometrists, 452 (64%) nurses and midwives and 252 other established staff. Some of its successes are increasing client satisfaction and reduced mortality while its main challenges are inadequate space, lack of infrastructure and overcrowding. (GHS, 2012)

The hospital has been providing antiretroviral services since 2006 and preventive services since 1994. It runs daily clinics with a day dedicated to counseling and another day dedicated to prevention of mother to child transmission (PMTCT). The paediatric clinic which initially started at the ART unit is now integrated into mainstream paediatrics. The unit is headed by a deputy director of nursing services and administratively is part of the medical department. The number of patients enrolled by the end of 2012 was 1,180. One of their biggest challenges is not having doctors to consult at the unit due to stigma and prioritization of other medical units over the ART unit such that doctors are only assigned if they are many (personal communication, May 31<sup>st</sup>, 2012).

### **3.2 .Study Context**

At the time of conducting the study the hospital was in the process of implementing the infection prevention and control policy and guidelines of the Ministry of Health and had just completed a peer review of health facilities in Ghana. The hospital like other hospitals in Ghana was facing challenges in mobilizing adequate financial resources as reimbursements from the National Health Insurance Scheme had stalled. At the time of the study, the national HIV prevalence had dropped to 1.37% (NACP, 2013), however the country was in the process of implementing treatment as prevention strategy and this required that more infected persons be identified and treated at health facilities of which this particular hospital was key. The hospitals case load was also on the increase due to population expansion in the region and also implementation of a policy not to turn any patients away.

### **3.3 Study population**

The study population included all health workers working in the clinical departments of the hospital. In these areas health workers are at risk of HIV infection, need to be protected from HIV infection, are exposed to HIV infected colleagues and contribute to provision of care, treatment and support and stigma and discrimination if any.

### **3.4 Sample Population and Sampling**

The sample comprised nineteen HIV positive and HIV negative frontline workers and members of the hospital management team selected purposively for the study. Purposive sampling is a method of sampling where participants are strategically selected so that their in depth information will give insight into a problem about which little is known. Purposive sampling was used for HIV positive health workers because their experiences were peculiar and also because there was perceived stigma and there was the need to protect the

confidentiality of these health workers. Purposive sampling was also used for management staff because of their in-depth knowledge on issues relating to policies and their implementation. After purposively selecting wards on which health workers may have been exposed to HIV infected patients, a simple random sampling was used to select HIV negative health workers for interviewing out of those on day duty and at post at the time of the interview.

### **Hospital Management**

Four members of management: the head of nursing, the head of clinical services, the head of pharmaceutical services and head of administration and support services were interviewed. The role of management in leading the implementation of the policy and the synergistic roles of the various team members required that they all be interviewed. A fifth manager, the in service training coordinator was interviewed as a key informant, her role and position having come up in all previous management interviews as the main person driving the implementation. In all five members of the management team were involved in the study.

### **HIV Negative Health Workers**

Eleven health workers were purposively selected from some clinical departments namely the paediatric, general medicine, surgical and labour wards. Others were from the hospital laboratory, the ART clinic, the antenatal clinic and the public health department. Health workers in these departments have some experience with working with HIV/AIDS patients, with implementing HIV/AIDS-related tasks and general caring tasks and are at a much greater risk of percutaneous injuries. They included nurses, midwives, ward orderlies, biomedical scientists, doctors and phlebotomists. At each department the day's duty roster was used to select those on day duty and at post and one randomly selected. The Public

Health unit was selected after the preventive role of the unit had come up in some interviews. The nurse in charge of the ART center was interviewed as a key informant.

### **HIV Positive Health Workers**

Three HIV positive health workers were also interviewed after identification by a key informant.

### **3.5 Data Collection Techniques**

**Key informant and in-depth interviews:** The key informant was a knowledgeable health worker who had adequate and professional knowledge on the issue under study ie HIV and all matters relating to HIV in the hospital. Face to face in depth interviews were conducted using an interview guide. There were three interview guides, one for management (appendix 3, one for HIV positive health workers (appendix 4) and a third for HIV negative health workers (appendix 5). These were administered to 5 members of management, 3 HIV positive and 11 HIV negative health workers.

The interview guide was structured along components of the work place policy identified earlier in the literature review and conceptual framework and used open ended questions. Interviews were conducted in empty consulting rooms or offices on the wards where it was quiet and without interruption. Interviews were conducted until saturation was achieved. However all scheduled interviews were completed and two more unscheduled interviews were conducted. Interviews lasted between 20 minutes to an hour. A portable Sony recorder was used for the audio recordings. The participants were made to feel at home and written informed consent obtained for both the interview and the recoding. At the start of the interview the record button was depressed. The record button was put off after the interview

had been completed, pleasantries exchanged and goodbyes or permission to come back if further clarification was needed had been obtained.

**Structured Observation:** Observation is a technique that involves systematically selecting, watching and recording behaviour and characteristics of living beings, objects or phenomena (Varkevisser, Pathmanathan and Brownlee, 2003). A non-participatory open structured observation was conducted to complement in depth interviews for describing infection prevention resources and practices. In this study, the researcher observed the situation but did not participate and was not concealed. An observational check list (appendix 4) was used to determine the presence and use of safety equipment by HCW to prevent transmission of HIV. There was one observation each of four health workers in the labour ward, hospital laboratory, paediatric, medicine, surgery, maternity and emergency wards as these were common areas where staff get exposed to HIV infection. On arrival at the ward, permission was sought and number of staff who were involved in specific procedures were collated. One was selected at random and observed using the observation check list. This process was repeated on subsequent visits until four observations had been made. Health workers previously observed were excluded from subsequent lists prior to randomization. Some of the procedures were giving of intravenous medications, carrying out a venepuncture, creating an intravenous access and performing deliveries.

A general (non department specific) observation was also undertaken of the hospital to determine presence of information, education and communication material on HIV and STI prevention, presence of condom dispensers in washrooms with condoms in them, SOPs on PEP pasted at various wards and whether antiretrovirals had been reserved for staff for PEP at the hospital pharmacy. A day and time during the first week in the field was selected for this observation and the investigator moved from site to site documenting observations. This

observation was done early on in the study to reduce the bias of interventions that may occur as a result of the interviews.

### **3.6 Ethical Considerations and Informed Consent**

Ethical clearance was obtained for the study from the Ghana Health Service Research and Ethics committee. A visit was paid to the medical superintendent and the study explained. He in turn informed members of management and then designated the in-service coordinator to inform all unit heads. Unit heads then informed staff members in turn. The interviewer was introduced to staff on duty on each ward prior to the interviews and participant observations. Interviews were conducted only after written informed consent was obtained for both interviews and audio recordings. All participants gave consent.

### **3.7 Data Analysis**

Data analysis was guided by the research question: How effective is the HIV work place policy in attaining its stated objectives in an urban hospital?

#### **Demographic/Participant Data**

This was summarized in a table along age, sex, professional groupings or rank. Electronic recordings of all interviews were transcribed verbatim (Welman et al, 2008: 211).

Data analysis of the interviews was done manually and conducted using principles of thematic analysis. This included multiple readings of the transcripts to capture context and meaning, followed by coding and categorization of recurring concepts and ideas. A master list of all categories were assembled and examined for common themes. Categories of codes were then organized into overarching themes. Data verification was done by a second person, a master's student in social sciences, who also coded all transcripts. Categories were

compared and added or removed based on the agreement between the two analysts. The results of the interviews were also compared with the literature and verified with participants. Following coding, a frequency distribution list was developed, and the number of responses for each category of participants was recorded and tallied. This allowed identification of the most frequently mentioned issues and the proportion of participants who identified an issue as a policy issue. Relative frequency of each thematic issue identified during analysis was calculated and expressed in such statements as “most of the health workers” or “all of the health workers” or “none of the health workers” as appropriate.

Data was analyzed along thematic areas for each specific objective. Patterns included recurring or extreme positions which were then triangulated to arrive at a common position. Triangulation is approaching the research problem from different angles (e.g., by selecting complementary study populations or using different research techniques at the same time). In this study, the second strategy of using different research techniques at the same time was used to improve on the validity of the findings.

Appropriate quotes were selected from the interviews to support the thematic content analysis and presented verbatim. Codes were used to identify respondents when quoted to ensure anonymity. For example, HPHW represented infected health worker and HPHW-1 represented infected health worker 1. In the same vein, HNHW represented non infected health worker and MMT represented member of management team.

Data from the structured observation checklist was entered into excel software and presented using frequency distributions and tables.

The thematic areas under each objective were summarized as not achieved, partially achieved and fully achieved. The summary of the themes resulted in objectives also being described as not achieved, partially achieved and fully achieved. Where all three objectives had been fully achieved, the policy implementation was described as highly effective, where all objectives

had not been achieved, the policy implementation was described as not effective, and all other permutations of achievement of policy objectives resulted in the implementation being described as partially effective.

### **3.8 Validity of Data**

The data was also coded by a second person and the codes compared and synchronized.

Validity of data was also assured by triangulation. Data was triangulated by interviewing managers and health workers on the same topics. Similar questions were asked during interviews and information from interviews compared and contrasted. The results of the structured observations were also compared to that of the interviews for validity.

## CHAPTER FOUR

### RESULTS

#### 4.1 Participant Characteristics

A total of nineteen (19) health workers were interviewed. Five (5) were members of the hospital management team, 3 females and 2 males with an age range of (44 to 56 years, a mean age  $\pm$  SD of  $49.8 \pm 5.54$  years).

Eleven (11) were HIV negative health workers (10 females and 1 male, age range was 27 to 54 years, a mean age of  $39.6 \pm 9.6$  year). There were three (3) HIV positive females with (ages of 39, 41 and 51).

Their professional ranks are shown in Table 4.1 below.

**Table 4.1 Profession/Rank of HCWs interviewed**

Profession	Rank	Number Interviewed		Status
		Non- HIV	HIV	
<b>Doctors(2)</b>	Specialist Paediatrician Medical Officer	2		Clinician
<b>Nurses (5)</b>	Deputy Director Nursing Services	1		Nursing
	Nursing Officers	2		
	Senior Staff Nurse	1		
	Staff Midwife	1		
	Senior Midwifery Officer	1		
<b>Biomedical Scientists Support (4)</b>	Senior Biomedical Scientists	2		Laboratory Scientist Support
	Health AID/HCA Orderlies	1		
<b>Management(5 )</b>	Head of Nursing	1		Management
	Head of Clinical services	1		
	Head of Pharmacy	1		
	Head of Administration	1		
	In Service Coordinator	1		
<b>Total</b>		16	3	

## 4.2 Content Analysis

### 4.2.1 Extent of awareness of HIV Workplace policy

Majority of the managers had heard about the policy, few had seen a copy and only one owned a copy. Of the non infected health workers majority had heard of the policy, less than half had seen a copy and even fewer owned or had a copy in their possession. The exception was the nurse in charge of the ART clinic who had two copies, one from ILO and the other from MOH. The three infected health workers had heard about the policy, one had seen a copy and none owned or knew where copies were kept. Overall the health workers had heard about the policy but had neither seen nor owned copies. One health worker commented as follows:

“Yes I’ve heard about it. I’ve not seen a copy before but I’ve heard about it.” HNHW-4

This was echoed by a member of management:

“Ok I’ve heard of it but we don’t have a copy to implement at the workplace. The last time I saw it was in Kumasi when we had a workshop on occupational health and safety. And so I have a policy document on occupational health and safety but this was just mentioned in passing. It wasn’t dealt with.” MMT-4

The in service training coordinator however had a different position. She reiterated that copies of the policy had been disseminated to health workers and therefore they should own copies. On further probing this was done in 2007, about 6 years before the study.

“Normally when we have things, (policy documents) we disseminate it almost immediately. And that was around that time. Not at, not in 2004 so in 2007 during our first reduction of stigma and discrimination training.” MMT-5

An attempt was made to find out if health workers knew the contents of the policy. The assumption was that they might have been informed of various aspects in some HIV/AIDS training workshops or might have heard of it at a health workers forum or had been able to deduce some policy content from their general knowledge on HIV/AIDS. Probes on the contents included testing, discrimination, confidentiality, continuity of employment, healthy work environment, HIV prevention and provision of care and support.

Of the managers interviewed, there emerged a pattern of the in service coordinator knowing of all the requirements of the policy whereas the others knew little. The policy area that was common to all who knew of the contents was the provision of treatment, care and support for infected health workers followed closely by prevention and the provision of a healthy working environment.

Probes for the contents were also initiated in discussions with HIV negative health workers. In this population the nurse in charge of ART clinic and the paediatrician knew almost all the contents whereas others knew little. The majority of the workers had some clues even though these were diverse. The most common content staff were familiar with was HIV prevention, closely followed by the provision of a healthy working environment and the prevention of stigma.

The only HIV positive health worker who had seen a copy of the policy also knew a substantial amount of the policy contents. She had been at a workshop where the policy was discussed. Her comments on continuation of employment care and support and testing are transcribed below.

“I know a few of them.(policy content). That if someone is positive that doesn't mean he should be denied of his work, he shouldn't be sacked, whatever the person is due, he's supposed to be given. The status shouldn't be a barrier to whatever the person is entitled to.” HPHW-3

“When the person is sick he's supposed to be attended to. And also when he wants to take some days off when he's not feeling well he should be given that permission” HPHW-3

“I think you shouldn't force anybody to go and do testing although it is good for you to know it(your status) but that is a private affair.” HPHW-3

Knowledge of policy content was minimal amongst the health workers and management. The few who had seen or owned copies knew of the contents and vice versa.

#### **4.2.2: The extent of protection from discrimination in the workplace for people living with HIV/AIDS (Health Workers), the contribution (if any) of the HIV/AIDS workplace policy to the observed situation**

The HIV positive health workers experienced stigmatization and discrimination in the past and still continued to experience it. Two positive health workers shared their experiences thus:

“In this compound a lot of the staff talk about it (my HIV status). Even in the beginning, when I’m walking about then people are pointing (at me) but I didn’t dwell on it. In the beginning I had decided not to come (to work) again.” HPHW-2

“Yes, but after that I went to do stigma reduction and it reduced a little but (even) as at last year , people at the canteen and other places were still talking about it. If they say that I don’t hear it (I may not have heard others talking) but as for the canteen staff they said it and I heard it.” HPHW-1

There still continues to be discrimination in the provision of health care:

“Stigma is the biggest problem on this compound because if you fall sick and you even go to the out patients department (OPD) and it’s written in your folder that you are HIV, instead of looking after you they will refer you back to the clinic so I don’t take my folder from this place (ART clinic) to the OPD. I take my insurance folder and when I go I make sure I see the doctors that come here so that they can look after me. But if you take your folder there and they see that thing, it’s hardly that they will make a doctor see you, they will just refer you back to ART because some know and some don’t know.” HPHW-1

“The problem is the stigma. There is still a lot of stigma at the OPD. Sometimes we are not seen when we go there.” HPHW-2

A third HIV positive health worker was of the opinion that stigma could not be done away with but could only be reduced and narrated the ordeal a colleague had to go through in the past:

“Stigma and discrimination, Yeah. For that one, aah well, we are all trying our best because stigma per se is something that we cannot do away with. You are being stigmatized; you are being given names, certain times its like people do not even want you to come into their territory. Which is very bad but at the end of the day they are doing it. And I remember the first time I came, the first lady that we had from the ward she was sick on admission and the nurses got to know her status. To the extent that her results was placed on the notice board for everybody to know. The staff washroom was locked; a whole lot of things” HPHW-3

The HIV positive health workers had not been discriminated against by management. One of them expressed it as such:

“In my 7 yrs here I haven’t heard that anybody has fallen sick and they’ve told the person to stop working here.” HPHW-1

The HIV negative health workers were in two groups, those who had not experienced any stigma or discrimination of HIV positive health workers and those who had. The health workers, who had been at the hospital longer than 3 years belonged to the latter group, whilst those who had been there for shorter periods belonged to the former group. The commonest form of stigma described was gossip and talking behind ones back. Two HIV negative health workers commented on stigma as follows:

“Ok, they gossip about them a lot, they gossip about them paa (a lot).” HNHW-3

“A lot of gossip, a lot of gossip. And you know they hear when you hear gossips like that sometimes they actually maybe they want to....”.HNHW-4

And collaborated the canteen story

“Somebody went to the canteen for instance one person living with HIV went to the hospital’s canteen to go and buy food. Somebody, a staff, a health worker who knew about the status of that lady told one of the canteen staff that this person is so, so and so. And so the person was like ah and she’s been coming here and I’ve been talking to her. You know, earlier she didn’t know but since she was told she was so surprised that she’s actually talked to somebody living with HIV. It is so; she’s felt so bad that she actually talked to her [someone living with HIV]. HNHW-4

Another form of stigma arose from the perception that all health workers working in the ART clinic were infected and therefore any health worker seen going in that direction was presumed positive. An HIV negative health worker at the ART clinic put it like this:

“[Laughter], yes, because they assume that well, we have a lot of people living with HIV as our health staff, trained staff at the clinic so when they see you going there; they assume that you probably have it.” HNHW-2

Majority of the health workers had not observed or heard of discrimination against the positive health worker. Specifically of all, those who knew an HIV positive worker none had heard off or experienced a change of work schedule without reason, refusal of time off work and loss of employment because of positive status. One commented on the perception of being stigmatized by a positive health worker on admission but felt he had been treated well without discrimination.

“Ok, he didn’t complain as much but what he told me was that at times if some of the staffs come to visit him, he feels [as though it is] because of his illness, that is why they just come and have a look at him. And I told him that no, I don’t think. Because I didn’t hear of this diagnosis before I came to him.” HNHW-6

“No. For one he was in the side ward. Yeah, he was in the side ward so any time you go there, he’s alone or with some visitors. Eh heh. As for that I can [say for sure], and it’s not a rejected side ward that he was lying in...” HNHW-6 [who visited a positive health worker on admission]

An HIV negative health worker spoke about early discharge from wards.

“As for medical as soon as they find out, even when you are not well they discharge you, even when you cannot walk.” HNHW-2

Another HIV negative health worker at the ART centre however had a catalogue of stigmatizing incidents and discrimination. This was not only against patients but the staff of the unit as well.

“For that stigma thing, my people usually go to the kitchen to pick food. Then one day when they went, there was this lady who was turning the fufu there.[fufu is a local dish made from tubers that is pounded in a mortar, a second person turns the pulp in the mortar as the first pounds with a pestle] Then she said to a third person, they say that all those in that room are positive. So the third party was like, so the matron is also positive? Yes all of them, don’t you know that it’s only HIV people that have been put there?” HNHW-11

“The telephonist can pick a phone. I was chasing (following up on) a client in the market then she called, ah matron, why are you making the woman who sells watermelon at your place sell watermelon here also?” HNHW-11

The hospital management however, had a different view. They reckoned that stigma was present but had reduced quite drastically. Management was actively involved in protecting health workers from discrimination. Work schedules of positive workers had not been changed without reason, there had been no refusal of time off work and there had been no loss of employment:

“Ok fine, fine you see, in the past yes we witnessed such situations because I would say that it was because maybe there were few infections so people were very, you know, they didn’t know how to handle such issues so there was some kind of stigma but I think as time went on and many more people got infected, they then saw that it was something that could happen to anybody so now people don’t see things that way.” MMT-4

Another refuted one of the cases of stigmatization and said the worker had been misunderstood and had come to lodge a formal complaint against her being accused of stigmatization.

“I think there was some (mis)information; I don’t think she was even aware. She was asking about something and they misunderstood her and said she was stigmatizing so she came up to complain.” MMT-3

Management had actually discussed with HIV positive health workers an offer to be moved to less demanding jobs and had respected the wishes of those who had declined the offer. One member of management put it this way:

“And then if you take the staff themselves, you see, we approach (their) you know their problems quietly, do you see quietly, to discuss with them. And depending on what the person wants us to do for him or her, for instance, if let’s say an orderly is infected and the person is prepared to be relocated to a place closer to the ART, not necessarily the ART but the ART for instance is close to the eye clinic, the family planning clinic, so if the person is willing to move closer to such an area so that he or she can take his or her medication early in the morning whilst he or she works, then we do it that way. There was one; in fact, one has just died. The poster is even there (Obituary Notice). He didn’t want to go to anywhere, do you see, so we left him at where he was and the place was very demanding, the theatre, the theatre, but” MMT-3

A very important step taken by management was the offer of employment at the hospital to PLHIV who worked as volunteers at the ART clinic. This management believed had helped to reduce stigma and discrimination:

“And then the other thing that has also helped a lot was the engagement of I think about 5 models of hopes (PLHIV volunteers) on our payroll. Do you see, and because of the interaction with the people and all that...” MMT-4

Most of the respondents, management, HIV positive and negative health workers recommended continuing sensitization, training and education in stigma reduction as a means of solving the problem. One HIV positive health worker recommended that someone should be sued to serve as precedence and a deterrent.

#### **4.2.3: Provision of Care and Support**

Care and Support for HIV infected workers provided by management was explored. Management without explicit knowledge of the requirements of the policy still went ahead to support the health workers and this was captured succinctly by a member of management:

“So, fine we’ve been using our own discretion to do one thing or the other. Let’s say in terms of their placement, in terms of supporting them to have their medications or sometimes when it is difficult for them to come to work, we try to give them some days off and all that to be able to support them.” MMT-3

Management was also supporting the workers by providing them with refreshment at the work place and although this support was initially available to all patients; abuse of the facility had resulted in its provision only to clinic staff:

“We used to even provide refreshment at the ART clinic to encourage them to go in for their medication. In fact that worked but we noticed that other patients or clients were coming from all over. So now we have limited it to only the staff that are running the place. Aha, only the staff that are running the place including our staff who are also patients because they are staff.” MMT-4

“Because right now you would find out that the welfare issues relating to HIV/AIDS is absolved into the welfare committee that we have, the quality assurance program and all that. I mean if you look at the welfare policy, in fact we have, there is even an aspect relating to support of an HIV, a staff who is a victim.” MMT-4

The fact that management was open and supportive and would consider positive health workers request for transfer or otherwise, was echoed by majority of the management team.

Management support was also expressed by HIV positive health workers.

“Oh, over here, they look after us very well because when I get sick I collect excuse duty and go home. When I get better I come back to work but when I come back and I’m still not feeling too well then I go back.” HPHW-1

The HIV negative health workers were asked what their role was in supporting infected colleagues. There were few responses. Management supported the positive health workers with free meals during clinic days and staff at the ART clinic said HIV positive staff were well looked after.

From ART clinic:

“Here, I will say we are looking after them very well.” HNHW-2

“Hmm, the only support we get is the lunch that is given to us on every clinic day. On Wednesdays and Fridays they give as lunch.” HNHW-11

HIV negative health workers working outside the ART unit expressed the support for positive health workers this way:

“Yes, from the clinic, from the ART clinic they had the support but from the other staff it was the way they were treated was very bad.” HNHW-6

And

“We treated him as a colleague health worker so we gave him all the needed support that he needed. Feeding him, bathing him, all the nursing cares that he needed we did for him.” HNHW-7

#### 4.2.4: Measures instituted to prevent the spread of HIV at the workplace

Measures to prevent the spread of HIV were documented.

##### 4.2.4.1. Personal Protective Equipment, Tools, Supplies and Commodities

The HIV positive health care workers had access to personal protective equipment and tools for use in their work and thus were protected from further infection:

“I receive the things I need. Both the utility and disposable gloves. I receive all. We also have sharp boxes and if we need more we get them.” HPHW-1

##### *HIV Negative health workers*

Majority of this group of health workers had protective equipment to work with. They had been supplied gloves, masks, goggles, sharps boxes, aprons, laboratory coats and new disposable sharps:

“It cuts across all staff and effort had been made to provide the dustbins, now we have the colour coded bins. Those for infectious waste, non- infectious waste and the sharp boxes have been provided regularly. Talking about the lab for example we’ve been provided with lab coats. Now I’ll say supply of gloves compared to some years back had improved.” HNHW-4-

“We have the goggles. We have personal ones and we have the ones there. Like the face mask. The face mask is done in such a way that there is a goggle there. It is attached to it. And the apron we have everybody have his or her own apron that we use but we have one there so if yours is soaked you can use the clean one.” HNHW-9

The general consensus among the group was that the hospital management or the administrator should make personal protective equipment available through the hospital stores and subsequently to their ward in-charges for onward distribution. There were still some challenges with availability though:

“The administration should make it available with the stores so that the in-charges can go for it for us to us it.” HNHW-5

“It’s the administrator. Err... they provide but it’s not in large quantities. Yeah. So at times there are certain things you have to use it once and dispose it but because they are not available we have to use it twice.” HNHW-6

Only one person emphasized the role of the health worker in protecting him or herself from infection:

“I think that basically, basic, basic is that the health worker you are responsible for your own safety. Alright, yes, there are inputs that might help to protect you or keep you safe in your workplace but then if they bring everything and you yourself do not practicalize those things you will still put yourself at risk.” HNHW-4

### *Management*

Management was aware of its role in providing personal protective equipment for the staff.

Some of these responsibilities had been delegated to the in-service coordinator and the quality assurance team. One manager put it bluntly like this:

“There are minimum standards for protection which we have to implement. Personal protective measures and reducing the potential risk of infection of any patient. The hospital management and the heads of departments should make sure that the right logistics are available. The quality assurance team will address the infection prevention issues.” MMT-2

Overall, personal protective equipment was being provided by hospital management and health workers appeared satisfied. The actual use was collaborated using an open structured observational checklist (see Table 4.3).

#### **4.2.4.2. Training on use of personal protective equipment**

Majority of the non infected health workers had heard of training in the use of personal protective equipment not in relation to HIV per se but as part of infection prevention and control implementation or occupational health and safety measures. Some had had training at the hospital whereas others had their training as part of regional training for health workers. Some had their training in the past year and for others it had been more than three years. The laboratory staff had their training in preparation for ISO accreditation. There were two who had not received any form of training:

“Yes, infection they’ve done it. Erm to my best of knowledge, they did it last year but for this year I don’t really know about it.” HNHW-5

“Early last year I remember there was, we had one and it cut across all staff” HNHW-3

“Oh for last year they did it about 4 times. It was in batches.” HNHW-3

Management reiterated their involvement in training on the use of PPE as part of ongoing programmes:

“Ok we are doing a lot in areas of education. In fact they have been (staff) especially involved in the occupational health and safety programme and I can count about 4 of such workshops that have been organized for them and we have been very particular about segregation of hospital waste.”  
MMT-4

“In fact we’ve had several trainings on infection prevention and control but we haven’t had specific training on HIV. The HIV issues are embedded in the infection prevention and control training.”  
MMT-5

The two HIV positive health workers who used PPEs had not benefitted from any training on the use of PPEs.

#### **4.2.4.3. Post Exposure Prophylaxis**

Post exposure prophylaxis as a strategy for preventing hospital acquired HIV infection applies to non infected persons. Thus this was explored mainly with management and HIV negative health workers.

##### *Health workers*

Despite the importance of the PEP to the health workers, there was little documentation on non availability of the policy. It seemed to have become less significant or at best remain a verbal policy:

“We have had one. We can’t find it now. There is a protocol that you are supposed to follow which the senior nurses know, the nursing managers know. The only thing is that it’s unlikely that the new staff, the new people who come, have access to it or know what is to be done.” HNHW-1

“If you do set about to access it, the workplace policy, especially for post exposure prophylaxis it actually works. Somebody knows that you have to go and do this test, you have to get this person counseled, you have to go see the pharmacist and the drugs must be available within 30mins and all that. All that works, I’m talking from personal experience and I’ve also had to get it done for a nurse and a house officer. So it does work but somebody has to remember to initiate the process”  
HNHW-1

One health worker expressed his frustration at staff having little knowledge of the procedure for PEP:

“Because most of the time when the staff gets a needle prick, what they are interested in is, if it’s a needle that has been used, they are more interested in knowing the status of the patient and not their own status so it’s, it takes time, going back and forth, trying to let them understand that they also need to know their own status. That is the only way you can know whether if you get infected, it’s from the patient or if you are already infected. So the ignorance creates problems for us in the lab when we have to do the test because they are not prepared to do the test themselves but they want you to test the blood of the patient, even without the consent of the patient.” HNHW-3

Two of the health workers involved in the dissemination of the SOPs remembered the occasion vividly:

“I remember that we prepared PEP posters and distributed it to all the wards but when matron went to the OPD they had packed all kinds of things on it so you wouldn't even know that there is a PEP poster under it. The posters have telephone numbers for people you can call for treatment. That also includes people you can call at weekends in case you need treatment but they are not making use of it.”HNHW-2

“I laminated all. If I come to your facility and I ask you where do I paste it for you? Then they tell me, we put it there.... I remember I pasted it here. We went there and they've put a lot of newsletters on top of it so I had to pull it out for them that this is it”HNHW-20

Management recognized the role of PEP in HIV prevention and had facilitated the process:”In fact seriously, to the extent that when anybody gets the slightest you know prick, the person quickly reports and then we take the necessary steps to ensure that the person is ok and we have had nurses, doctors, orderlies, in fact it happens a lot to the orderlies and immediately it happens they come. And with the, even the senior officers like the nurses, the doctors, eii, why not. It does happen to them; sometimes they even threaten to withdraw services.” MMT-4

The pharmacy also provided the necessary counseling and drugs:

“When you even have it,(sharp injury) after the nurses doing the counseling, we also give you the counseling to let you know the side effects of the drug that you are supposed to take and the duration that you are supposed to take depending on the severity of the injury.” MMT-1b

#### **4.2.5 General Observation on Infection Prevention**

Structured Observation was performed on 29<sup>th</sup> May 2013 at 10.30 am and involved a tour of facilities at the hospital, to explore how infection prevention was carried out by the health facility.

##### **4.2.5.1 Waste disposal and cleanliness**

The hospital was generally clean. One striking observation was the presence of colour coded dustbins at waste disposal points in most wards. The dustbins or disposal bags observed were yellow for infectious waste, brown for pharmaceutical and chemical waste and black for general waste. At the beginning of the study there were not many SOPS for accessing PEP but by the end of the fourth week, laminated posters were seen on all the wards. Sharps

disposal containers were also seen in the wards. The results from the observations are shown in table 4.2 below.

**Table 4.2: General HIV infection prevention practices**

<b>Observation</b>	<b>Yes</b>	<b>No</b>
<b>IEC posters on HIV and STIs pasted at OPD</b>		x
<b>Condom dispensers at washroom at OPD</b>		x
<b>Condom dispensers at washroom contain condoms</b>		x
<b>Staff VCT centre available</b>	x	
<b>Guidelines for PEP pasted at medical ward</b>		x
<b>Guidelines for PEP pasted at paediatric ward</b>	x	
<b>Guidelines for PEP pasted at surgical ward</b>		x
<b>Guidelines for PEP pasted at maternity ward</b>		x
<b>Guidelines for PEP pasted at emergency wards</b>		x
<b>Guidelines for PEP pasted at resuscitation area at OPD</b>		x
<b>Guidelines for PEP pasted at venepuncture site of Laboratory</b>		
<b>Guidelines for PEP contain phone numbers of providers</b>	x	
<b>ART for PRP reserved at pharmacy</b>	Could not be observed	

#### **4.2.5.2 Health Worker Infection Prevention Practices**

One observation each of four health workers was carried out in seven units namely labour ward, hospital laboratory, paediatric, medicine, surgery and maternity and emergency wards making 28 encounters. One form got missing resulting in 27 valid observations. Some observations were ward specific e.g. use of goggles and aprons at the labour ward, hence the number of total valid observations were 4 whilst hand washing cut across all sites. To ensure

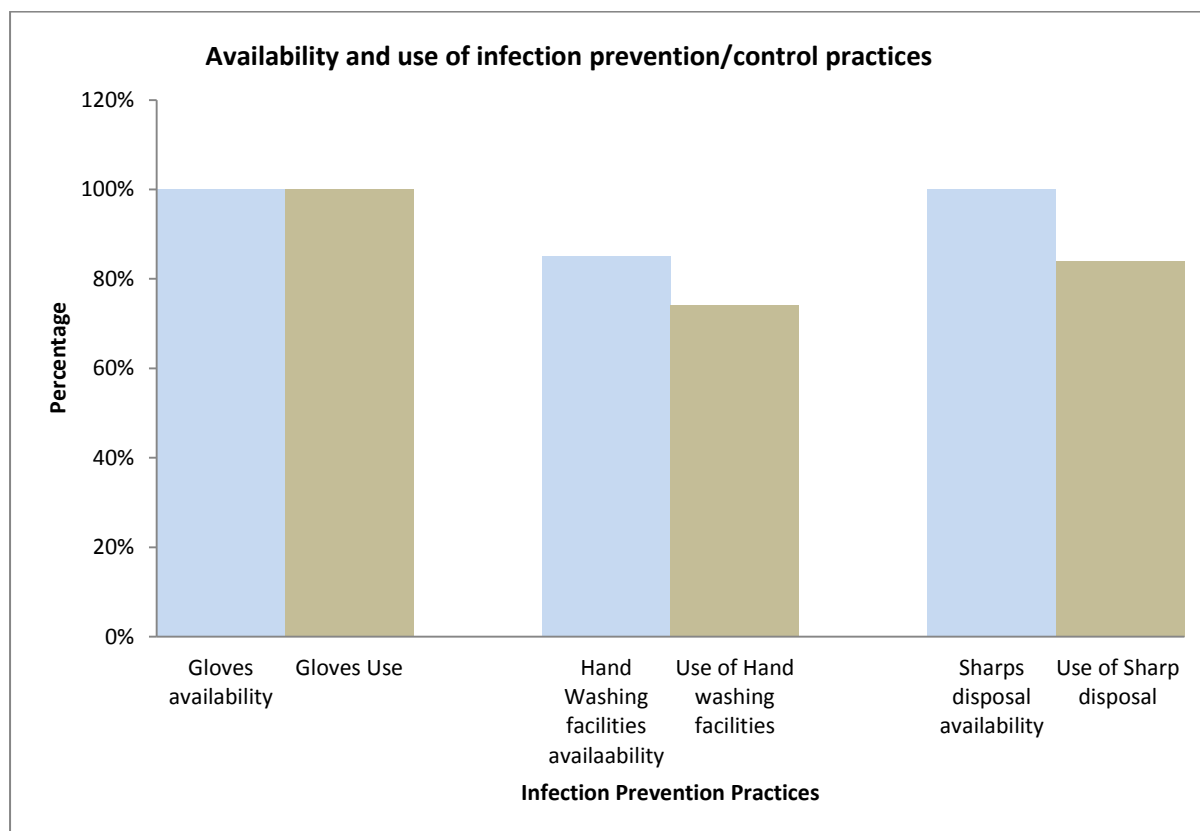
compliance and standardization a practice performed some of the time was captured as not performed.

Sex distribution-There were 27 observations that recorded sex resulting in 18 females and 9 males observed, giving a ratio of 2:1

These involved 8 doctors (29.6%), 4 biomedical scientists (14.8%), 1 healthcare assistant, 3 midwives and 11 nurses(40.7%) made up of 9 staff nurses, 1 nursing officer and 1 enrolled nurse.

**Table 2.3: Health Worker Infection Prevention Practices**

<b>Availability/Practice</b>	<b>Present/Yes No (% total)</b>	<b>Absent/No No (% total)</b>	<b>Total N (100%)</b>
<b><i>Personal Protective Equipment</i></b>			<b>27</b>
<b>Availability of disposable gloves</b>	27(100%)		
<b>Use of disposable gloves</b>	27(100)	<b>0</b>	
<b><i>Hand Washing</i></b>			<b>27</b>
<b>Availability of running water</b>	23(85.2)	4(14.8)	
<b>Availability of soap</b>	24 (88.9)	3(11.1)	
<b>Availability of hand drier/ paper towel/personal cotton towel</b>	17 (63.0)	10(37)	
<b>Hand washing in between procedures</b>	20 (74.1)	7(25.9)	
<b><i>Use and Disposal of Sharps</i></b>			
<b>Use of new sharps per patient</b>	24 (100)	0	24
<b>Recapping of needle after use</b>	8 (38.1)	13(61.9)	21
<b>Available sharps disposable containers</b>	25 (100)	0	25
<b>Use of sharp disposable containers</b>	21 (84)	4(16)	25
<b><i>Use of Aprons and Goggles (Labour ward)</i></b>			<b>4</b>
<b>Use of rubber aprons</b>	4 (100)	0	
<b>Use of goggles</b>	0 (0)	4(100)	

**Figure 4.1: Availability and usage of Infection Prevention/Control Practices**

#### 4.2.6 Focal person or HIV committee, effect of staff strength, monitoring e.t.c.

##### 4.2.6.1. HIV Focal Person or Committee

Majority of the non infected health workers interviewed did not know if there was a focal person or a standing committee. One knew of a committee in the past which was now defunct, one thought a local level (ward committee) was in existence and another said the hospital had a focal person.

They were all unanimous that the hospital needed either a focal person or committee. As to who should be the focal person or form the committee, the answers were diverse with no pattern emerging. Some suggested the in service coordinator, others suggested the nursing administration, the hospital administrator or the DDNS in charge of ART. One person specifically wanted the committee to be revamped.

Management responses were more confusing. One insisted there was a committee which was not adhoc but somewhat functional and operating and went ahead to describe the members of the committee.

“A committee, HIV/AIDS committee which is one of the ...but it is not just an adhoc committee but an operational committee.” MMT-4

“Ok, I will say that it is not as functional as it used to be. So now we meet as and when necessary, sometimes about 3 times within the whole year. But in the past it was monthly; in the past it was monthly” MMT-4 Another said there was a committee which was the quality assurance committee. A third said there was neither focal person nor committee and suggested staff could be appointed as focal persons whilst a third agreed there was a committee which was the quality assurance committee and that the previous committee was defunct.

“Oh, about how many years now, [pause], it was there in 2007. I think by 2009 then it became defunct.” MMT-5

#### **4.2.6.2. Policy Dissemination**

On whose role it was to disseminate the policy, the responses from the non-infected health workers were diverse without a clear pattern. Some felt it was the role of management or the hospital administration whilst others suggested the HOD's, ward-in charges or the in service coordinator. One person each mentioned the public health unit and the Ghana AIDS Commission (GAC).

#### **4.2.6.3. Monitoring of Policy Implementation**

Majority of the health workers (both positive and negative) were of the opinion that monitoring should be done at the local level and should be carried out by heads of departments and ward in charges. A few felt it should involve the administration, quality assurance team or in service coordinator. One person wanted the hospital to replicate the laboratory model and employ safety managers for each ward whose responsibility will also

include monitoring. Others said the monitoring was inadequate and not effective due to lack of resources and commitment. The exclusion of the DDNS in charge of ART clinic from the QA team was also alluded to as one of the reasons for ineffective monitoring.

The hospital management was unanimous that monitoring should be done by the quality assurance team.

#### **4.2.6.4. Adequacy of human resources and risk of HIV infection**

Majority of HIV negative health workers were of the opinion that fewer staff resulted in increased work pressure making them prone to mistakes and therefore increasing their risk of HIV infection. Management's view was dichotomous with half agreeing with the workers and the other insisting that no matter the numbers, there was no excuse to deviate from standards at work.

#### **4.2.7. Improving Response to HIV Infection at the Workplace**

Health workers in all three categories were asked how they could improve on the response to HIV at the workplace considering the policy objectives.

The general consensus was that education of health workers on various aspects of the policy should be continuous. One respondent was passionate about the document being made available whereas another felt staff should be forced to read the document. A few mentioned the provision of personal protective equipment. Management was concerned about lack of adequate resources and inability to access funds from the Ghana AIDS Commission as well as being forced to procure poor quality personal protective equipment due to lack of adequate financial resources.

Two HIV positive health workers summed it up like this:

“The problem is the stigma. People need lots of education on stigma reduction. We have to continue the education” HPHW-1

“We should enforce. Some of the policies should be enforced... More, erm training, we’ve done so much. But we should keep on educating people. Yeah. With the education, it should be an ongoing thing” HPHW-3

#### The HIV negative health workers had similar opinions

“The only thing we can do is educate them. I think if they distribute the books people will not be able to read them on the wards, because when they come they are very busy. They have to conduct workshops, yes they have to conduct workshops and speak about the contents so that everybody will know.” HNHW-2

“First and foremost, the policy must be that available. Not just given as a policy that is sitting down. It should be something that should be available; it should be exposed over and over and over. For many workers they rarely stay here, if they are going to stay, if they are going to change its going to be three months so at least every quarter we should review or should come out, somebody should see that there is something that exists like a workplace policy. If it should be done at departmental level, at whatever departmental clinical meetings it should come out. And then if it is from administration, the in service coordinator must include it in her regular schedules also for the hospitals so that in addition to what the department is doing in clinical work that should also come from the in service coordinators side. So everybody and at every level must understand it, in whatever language it should be translated for them to understand because we have a lot of casuals who don’t speak any English but they must know that this exists and so this is how to protect themselves and to help themselves also. That’s the first thing in the policy dissemination.” HNHW-1

“I think, [stammering], we have only practically one option apart from continuous sensitization. So I think that well, its continuous education. We, you cannot relent. We cannot do anything else but to educate and to make people aware” HNHW-4

### 4.3 Summary of Results

The findings relating to each policy objective enabled the objective to be summarized as having been achieved or not as shown in table 4.4 below.

**Table 4.4: Summary for attainment of policy objectives**

<b>Objective and Sub themes</b>	<b>Fully Achieved</b>	<b>Partially Achieved</b>	<b>Not Achieved</b>
<i>Protection from Discrimination</i>			
<b>Stigma</b>			x
<b>Breach of Confidentiality</b>			x
<b>Work and Employment</b>	x		
<b>Sup optimal / Denial of Care</b>			x
<i>Prevent HIV/AIDS Spread</i>			
<b>PEP</b>		x	
<b>PPE</b>	x		
<b>Training/Information/Education</b>		x	
<b>VCT and Condom Promotion</b>		x	
<i>Provide Care and Support</i>			
<b>Provision of CT</b>	x		
<b>Provision of OI treatment/ART</b>	x		
<b>Other support-nutrition</b>	x		

Majority of the sub themes of protection from stigma and discrimination were not achieved so the policy objective was described as not achieved. Most of the subthemes on protection from HIV infection were partially achieved and thus the policy objective was described as partially achieved. All the sub themes on provision of care and support were fully achieved hence the policy objective was described as fully achieved.

With one policy objective fully achieved, a second partially achieved and the third not achieved, the implementation of the work place policy could best be described as being partially effective.

## CHAPTER FIVE

### DISCUSSION

The data from the interviews of the health workers and management at the tertiary referral hospital was used to determine the effectiveness of the Ministry of Health HIV & AIDS Workplace policy in achieving its three major policy objectives. The policy objectives are intended to:

- Provide protection from discrimination in the workplace for people living with HIV/AIDS
- Prevent HIV/AIDS spread amongst workers
- Provide care, support and counseling for those infected and affected ( MOH, 2004).

The study focused on the objectives as they pertained to health workers in a regional level referral hospital in Greater Accra and not the general population. The conceptual framework underpinning the study required that to be able to determine the effectiveness of implementation of the policy, one must first establish the awareness and knowledge of the policy by health workers and managers.

#### **5.1 Extent of Awareness of HIV Policy**

The policy was published in 2004, however the data suggest that the policy was probably first made publically available to the hospital in 2007 and was then disseminated. However at the time of this study in 2013 most of the health workers interviewed, both infected and non infected as well as the management of the hospital had never seen or owned a copy.

This lack of awareness was attributed by some to non prioritization of HIV and AIDS by management, lack of new documents or resources to photocopy policy documents for newly employed staff. It could also be attributed to the classical top down approach of policy development, where the policy is developed at the Ministry of Health and given to

institutions to implement. There are usually no resources allocated as well as no monitoring and evaluation plan. A similar situation was found in Zimbabwe where there was weak advocacy for the policy as well as poor distribution and implementation strategies (NANGO & ZAN 2001).

This lack of awareness of the policy is in direct contrast to the advocacy recommended by the ILO, which states that all workers be informed about existing HIV related policies and programmes in the workplace at the international, country or local community level. Awareness-raising measures should be emphasized among members of the community (ILO, 2010). Non dissemination of policies is not peculiar to the health sector and occurs in other sectors. In a study of 302 union shop stewards from firms representing 10 different sectors, 15% reported that their union discussed HIV/AIDS issues with the employer, 52% reported an existing HIV/AIDS workplace policy, and only 15% reported that they had received a copy of the policy (Mapolisa, Schneider and Stevens, 2004).

Despite the general lack of awareness of the formal policy, the hospital could be said to be implementing an unwritten policy as was evident by the interviews. Various actors in the hospital, management and health workers knew bits and pieces and could be said to be contributing to the implementation in their own way.

## **5.2 The extent of protection from discrimination in the workplace for people living with HIV/AIDS (Health Workers), the contribution (if any) of the HIV/AIDS workplace policy to the observed situation**

One of the major policy objectives is the protection of the health worker from discrimination. However, discrimination usually stems from stigma. All the infected health workers interviewed had experienced stigma and discrimination. The stigma was similar to published literature on stigma in health care settings, and included testing without consent, breach of confidentiality, gossip and denial of care (GNP+ et al 2010; ICRW, 2007; Nyblade, Stangl, Weiss and Ashburn, 2009). In a qualitative study on stigma and discrimination against people living with HIV in Ho Chi Minh City in Vietnam, the authors found that in the health setting, discriminating attitudes and practices included non verbal and verbal abuse, being ignored and being refused routine services like change of bedding or assistance at deliveries (Thi et al, 2008). A study conducted in Tanzania documented a wide range of discriminatory and stigmatizing practices, and categorized them broadly into neglect, differential treatment, denial of care, testing and disclosing without consent and verbal abuse/gossip (Synergy, 2005). In a study on experiences of stigma in health care settings among adults living with HIV in Iran, the four major forms of stigma experienced were refusal of care, sub-optimal care, excessive precautions and physical distancing and humiliation and blaming (Rajmahti-Najarkolaei, Niknami, Aminshrokavi and Bazargan, 2010). In a study conducted by Kingsler, Wong, Sayles, Davies and Cunningham (2007) on perceived stigma in health care settings, 20% of the respondents said the health care worker had been uncomfortable with them, 20% said they had been treated as inferior and 19% each said the health care worker preferred to avoid them or had refused them service. In other places health workers admitted to giving HIV infected patients differential care. (Andrewin & Chien, 2008). More often than not, it is the HIV infected patients who complain of being given differential care by the health workers (Zukoski & Thorburn, 2009).

Despite ongoing interventions at the hospital, including stigma workshops for staff, infected health care workers continued to be stigmatized and discriminated against by some of their peers. One of the most striking was the denial of care and early discharges by the medical team. The practice had also been documented in Uganda where early discharges and onward referrals were rife (Kafuko, 2009). This was similar to other countries where persons living with HIV were denied family planning and sexual and reproductive health services (GNP+ et al, 2010; (Rintamaki, Scott, Kosenko and Jensen, 2007; Rajmahti-Najarkolaei et al, 2010; (Thi et al, 2008). In another study on stigma in developing countries, nurses burned linen of HIV infected persons and also labeled beds and charts as high risk (Mahendra et al, 2007). In a study of attitudes of health workers to PLHIV in Lagos in 2003, only 42.5 % of respondents would encourage the admission of patients to wards and 34.7% felt they should be isolated while 87.4% advocated pre screening prior to surgery (Adebajo, Bamgbala and Oyediram, 2003). In the study by Adebajo et al, (2003) 39.4% of respondents had very good knowledge of HIV whilst 57.1% had fair knowledge so their attitudes and behaviour could not be attributed to lack of knowledge. Fear of acquiring the disease influenced the health workers more than knowledge of the facts relating to the disease. Writing a perspective on the discriminatory attitude of health workers, Letamo, (2005) reported that two-thirds of health workers in a study refused to care for HIV patients and 43% had observed HIV patients being refused admission. Li et al (2007) found that health workers in China generally had prejudicial attitudes towards HIV infected patients which was not affected by level of education. However, Cole & Abel (2000) documented positive attitudes of nurses to AIDS patients in the emergency room. The attitude was observed in the following descending order: the highest to acquisition through blood transfusion, then heterosexual transmission followed by homosexual transmission. The most negative attitude was to acquisition through injection

drug use. The negative attitude of health workers was still being exhibited in denial of care and provision of sub-optimal care at the hospital.

HIV infected health workers also had to deal with gossip and breach of confidentiality. This was not only from professionals like nurses but also by non professionals like catering staff.

Gossip in the health institutions was found to be similar to what happened in the community (Ahsan Ullah, 2011).

Some of the non infected health workers had not heard or seen any discriminatory practices in the hospital. The hospital management on the other hand was of the opinion that stigma and discrimination had reduced remarkably due to interventions that had been put in place. There had however been no formal evaluation of this perception.

Another form of discrimination is in pre employment testing, loss of employment or income and change of employment (GNP+ et al, 2010; Sprague et al, 2011). At the hospital, the infected health workers had maintained their jobs and there was no loss of employment. There was also no evidence of pre employment testing of health workers. The hospital management had gone a step further to employ persons living with HIV infection (Models of Hope) to work in the ART clinic so they could earn an income and also help to reduce stigma and discrimination. Another well intended act was transferring infected health workers to work at the ART unit so they could receive adequate support and also be close to care givers. Management could therefore be said to be working actively to reduce stigma and discrimination against infected health workers. Unfortunately, an unintended consequence of these two positive actions has been stigmatization of the ART centre and all staff working there as the general perception in the hospital is that only infected health workers are assigned to the center. Discrimination of HIV care providers has been documented and the hospitals well intended action had only gone on to fuel this form of stigma.

### **5.3 Provision of Care and Support for workers living with HIV**

A third objective was the provision of care and support to infected workers. Most work place care and support programmes include health and non- health programmes. There are three principal components of and HIV workplace healthcare programme (FHI, 2002; IFC, 2002; ILO, 2003). These include: a wellness programme which provides advice on healthy living, including nutritional counselling and stress reduction; a treatment programme which provides treatment for the relief of HIV/AIDS-related symptoms, treatment of opportunistic infections, and provision of ART drugs and a support programme which provides reasonable accommodation and care of terminally-ill HIV/AIDS employees.

In the ILO Brief on Workplace Policy (ILO, 2003) two alternatives exist, based on company size and available resources for the provision of healthcare: It recommends either an occupational health service that offers the broadest range of services to manage HIV/AIDS or a programme that assists employees living with HIV/AIDS to find appropriate services, support and self help groups in the community.

Anglo Gold is on record as being the first company in sub Saharan Africa to provide ART to its workers (WEF GHI, 2002). Anglo Gold Ashanti launched its programme in 2005 (CHMI 2013). Other companies moved quickly to provide anti retroviral therapy to their workers using various models successfully. The key components of provision of treatment had further been categorized to include treatment, observation and monitoring (Brink, 2005; IFC, 2002), Viral load testing (FHI, 2002) and CD4 count testing (FHI, 2002).

The hospital had been providing treatment services since 2006 and prevention services since 1994. Prior to the implementation of the National Health Insurance Scheme (NHIS), it had supported medical costs for its workers but has now transferred this to the NHIS.

Nationally, provision of antiretroviral therapy, laboratory tests including CD4 and Viral loads, some treatment for opportunistic infections are being borne by the Global Fund for

AIDS, TB and Malaria (GFATM), the government of Ghana and other donors at a subsidized cost of five dollars per month for all persons living with HIV and the health workers were also observed to be accessing these services.

As part of provision of comprehensive HIV programme for its workers, a mining company implemented ART for its employees (Churchyard et al., 2004). A survey carried eight months after the initiation of the programme to evaluate whether patients understood key information concerning ART and also to explore the perceptions of patients and health care professionals (HCP) regarding ART counselling showed that 95% thought counselling sessions were good, specifying knowledge gained, increased hope and ability to make choices (Stenson et al. 2005).

Despite not being a health facility, the mining company had offered counselling for ARVs successfully for its staff at its health facility and the health sector is expected to do same or more for its staff.

The hospital had however, gone a step further to provide nutritional support for the workers by providing two hot meals a week to support their nutrition and antiretroviral treatment. One infected health worker had been admitted to a side ward, a ward of higher status and privacy than an open ward. In a study conducted in HIV infected health workers in two districts in Zambia, support from the facility such as offering private wards, providing counselling and professional advice, offering free medication or financial support was non-existent in both districts (Dieleman et al, 2007). In one district the Zambian Nursing Association had organized income generation activities for infected nurses whilst another hospital had a peer support group for positive workers (Dieleman et al, 2007).

#### **5.4 Measures instituted to prevent the spread of HIV at the workplace**

One of the key objectives centered on the protection of staff from HIV infection. Protection of staff from HIV infection occurs in a number of policies with overlapping objectives. In Ghana these are the HIV Workplace Policy, Policy and Guidelines for Infection Prevention and Control in Health Care Facilities as well as the Occupational Health Safety and Policy Guidelines for the Health Sector (MOH/GHS, 2010). It was with this background that protection of staff from HIV was explored. In the health sector like any other workplace, HIV prevention programmes involve combinations of VCT, provision of condoms and education on sexually transmitted diseases [STIs] (Mahajan A et al, 2007).

##### **5.4.1 VCT and Condom Distribution**

In this study a VCT centre was available. However it was located within the ART center leading to stigmatization of people who accessed it. The study did not evaluate its use, however other studies have documented non use of available VCT centres due to fear of stigma from colleagues (Hadjipateras et al, 2006). There were no condom dispensers or condoms for staff. Despite the fact that most employees' sex life occurs outside the workplace, private sex life has an impact on business (GHI Coca Cola Africa, 2013) hence the decision by Coca Cola to be involved in condom distribution, education, use and tracking at its workplaces. Five components of a condom distribution programme have been found to be crucial for HIV prevention. These are condom promotion, education on condom usage, widespread discrete access, condom stock management and condom quality assurance (GRI, 2003). On the contrary, the health sector knowing the value of condoms in preventing HIV infection did not implement condom distribution as part of its workplace programme.

#### **5.4.2 Prevention Education, Information and Communication**

The results of the structured observations showed that there were no information, education or communication (IEC) posters on HIV and sexually transmitted infections on the notice boards at the out-patient department where most notices are pasted. Provision of education is a basic requirement of any prevention or treatment programme (MOH Work Place Policy, 2004). The work place policy stipulates that all health institutions shall have a work place prevention education programme which provides both managers and employees with opportunities to discuss and learn about HIV/AIDS (MOH Work Place Policy, 2004). Granted the hospital did not produce its own IEC materials but these could still have been procured from the health promotion division of the GHS or the National AIDS Control Programme. Of note is the fact that the hospital was a neighbour to the Ghana AIDS Commission which produces a lot of IEC materials. Education had however been offered in the form of workshops. The data suggested a lack of consistency on the frequency of educational workshops and a concrete plan to educate all the health workers. It appeared that emphasis was placed on new staff with few refreshers for old staff. The data also suggested that the hospital supported training and education but sometimes the initial capital outlay had to be put forward by a non Governmental organization (NGO). In the recent times of economic crises involving the Global Fund for AIDS, Tuberculosis and Malaria and other NGOs, funds for training had dwindled making it more difficult to organize workshops.

### **5.4.3 Post Exposure Prophylaxis**

Provision of post exposure prophylaxis is another strategy to prevent hospital acquired HIV infection. Health workers continue to be at risk of blood borne infections like HIV and Hepatitis B and C infections and this occupational risk is primarily due to percutaneous exposure to infected blood. The frequency of blood exposure among HCWs varies according to occupation, procedures performed, and use of preventive measures (Bell, 1997). In a study conducted in Zambia injuries with contaminated sharps was high. Nurses reported the highest number of injuries. The average annual sharps injury was 1.3 injuries per worker. Housekeepers, laundry workers and ward assistants had the highest rate of injuries at 1.9 injuries per worker (Phillips et al, 2012). In a study in Uganda, Newsom and Kiwanuka (2002) reported an incidence of 1.86 needle stick injuries per health care worker year. Interns suffered more than any other occupational group. In another study conducted in Uganda by Dieleman et al, (2007), 36% of respondents reported having had an injury from sharps in the past year. In this study, health workers had also been exposed to injuries, and had been able to access post exposure prophylaxis. The pharmacy had enough stocks of ART for health workers who may have occupational injuries. However, most of the SOPs for PEP which had originally been placed on notice boards could no longer be found. Staff needing PEP depended on verbal directions. This state of affairs was unacceptable as it could prolong the time to access PEP.

### **5.4.5 Infection prevention: Provision of equipment and practices**

The hospital had introduced differential waste disposal bins and sharps disposal boxes as part of implementing occupational and health safety policies. Bins were colour coded and instructions on their use pasted over the bins. Some training on the occupational health and safety policy had been carried out for the health workers. This had contributed to the correct

usage of the waste disposal bins. The provision of personal protective equipment for workers remains one of the strategies for preventing the spread of HIV infection. The hospital had provided personal protective equipment (PPE) although sometimes the quality was in doubt. The supply of personal protective equipment had increased over the years and except for goggles, the availability of the PPE was observed in the various wards. The PPE was however, not used all the time. In the study, availability and usage of latex gloves were both observed to be 100%. Hand washing facilities were present in 90% of wards visited but the usage after procedures was observed to be at 70%. Sharps disposal boxes were present in all wards visited, here also the usage fell below the desired at 90%. The non use of protective equipment was alluded to by one of the respondents as being one of the outcomes of a recent peer review the hospital had participated in. Health care workers had been observed not to use PPEs all the time and the same situation was observed in this study. The discrepancy between availability and use of PPE had also been observed many years earlier in health facilities in the Cape Coast Municipality in the Central Region of Ghana (Awusabo-Asare & Marfo, 1997).

#### **5.4.6 Barriers to prevention of HIV infection at the workplace**

The hospital however had its fair share of challenges. Majority of the non infected health workers were of the opinion that increased work load due to inadequate staffing put them at risk of HIV infection. This view had also been expressed by health workers in two districts in Zambia where over 80% said they worked overtime and this put them at risk. (Dieleman et al, 2007). A similar concern had been expressed by nurses in South Africa and Uganda (Dieleman et al, 2007; Smit, 2005). Health workers both infected and non infected felt management had not prioritized HIV hence the gaps seen in the policy implementation. This frustration was also shared by some nurses in South Africa who felt they received little or no

support from nursing administration and management (Smit, 2005). Management on its part also had their share of challenges, key amongst which was the lack of adequate financial and other resources. The issue of poor quality personal protective equipment was a concern at the hospital as in other places in Africa (Dieleman et al 2007).

### **5.5 Extent to which policy had contributed to the attainment of protection from discrimination, provision of care and support and prevention of spread of HIV infection at the workplace.**

The implementation of the HIV workplace policy was summarized as having been partially achieved since provision of care and support was fully achieved, prevention of spread of HIV partially achieved and protection from discrimination not achieved. However it was difficult to know to what extent the policy had contributed to this as most of the health workers were implementing parts of the policy that had been handed down in a non formal way. Awareness and knowledge of the policy document was poor across all categories of staff.

## **CHAPTER SIX**

### **CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS**

#### **6.1: Conclusion**

The effectiveness of the implementation of the MOH Workplace HIV/AIDS Policy for the Health Sector at the urban, tertiary, referral hospital was evaluated at the level of three policy objectives and a summary generated to determine overall effectiveness.

##### **6.1.1 Extent of Awareness of HIV Policy**

The level of awareness of the formal policy amongst management and health workers could at best be described as poor. However both management and health workers were implementing aspects of the policy they had picked up from one source or the other.

##### **6.1.2 The extent of protection from discrimination in the workplace for people living with HIV/AIDS (Health Workers)**

The policy objective on providing protection from discrimination in the workplace for persons (health workers) living with HIV/AIDS was not achieved. As shown by the data, levels of stigma and discrimination remained high despite attempts by management to mitigate these. Stigma and discrimination was perpetuated by peers and inadvertently also by management.

##### **6.1.3 Provision of Care and Support for workers living with HIV**

The policy objective on preventing HIV spread amongst workers was partially achieved. Management had provided post exposure prophylaxis, personal protective equipment, voluntary counseling and testing centre and some education to the health workers but made

no provision for the promotion and distribution of condoms. Usage of personal protective equipment amongst health workers was sub optimal.

Provision of care, support and counseling was evaluated as having been fully achieved. The hospital provided a full range of care and support services to health workers living with HIV.

#### **6.1.4 Overall achievement of implementation of policy objectives**

Overall, with one objective fully achieved, one partially achieved and one not achieved the workplace policy could at best be described as having been partially effective in its implementation at the hospital.

#### **6.1.5 Generalisabilty of study:**

The study was a case study at a large hospital. Despite the non generalisability of case studies, the study provides an insight into some aspects of policy implementation within the health sector. It documents some of the challenges in the implementation of the HIV Workplace Policy and some recommendations from the health workers on how these can be improved. Considering that the hospital was a better resourced large hospital, one can only speculate on the effectiveness of the policy implementation in smaller, less resourced hospitals. It is hoped that this and other studies will guide better policy formulation and implementation within the sector in the future.

#### **6.2: Recommendations**

The following recommendations are made to improve the effectiveness of the implementation of the MOH HIV work place policy at the hospital.

The recommendations are made in reference to the policy content, process and context and how these can lead to effective policy implementation as explored in the conceptual framework.

### **6.2.1: Policy Content**

1. The hospital management should pay more attention to HIV/AIDS as a workplace issue.
2. They should procure copies of the policy and distribute to all staff.
3. There should be orientation of all new staff and re orientation and continuous education of continuing employees on the HIV Workplace Policy.
4. Management should increase awareness of stigma amongst health workers, its consequences and the benefits of reducing it.
5. Health workers' fears and misconceptions about HIV transmission should be addressed.
6. Management should do more to maintain confidentiality of HIV status of staff.
7. Prevention of HIV infection at the workplace should be intensified.

### **6.2.2: Policy Process**

1. Focal persons should be appointed for departments and given specific roles of quarterly training, monitoring, enforcement and reporting back to committee. They may be part of the quality assurance committee.
2. There should be integration of policies with similar objectives so as to save on resources and staff time.

3. The policy should be disseminated systematically to all staff at various levels using available opportunities like departmental meetings, morning meetings, departmental educational meetings, updates and staff durbars.
4. Vernacular can be used for educating health workers who are not fluent in English.
5. IEC materials and SOPs should be pasted on the notice boards to serve as continuous reminders to health workers.
6. The hospital should carry out a survey with the health research unit of the GHS to establish the presence of stigma at baseline and post intervention research on stigma and discrimination using tools like “People Living with Stigma Index”.
7. There should be a participatory drafting of a hospital policy on a stigma free environment with enforceable sanctions.
8. The hospital should institute a comprehensive structured stigma reduction programme for all the workers (professional and non professional).
9. The focal person should be equipped to monitor implementation of the policy in general and stigma using standard indicators.

### **6.2.3 Context**

1. The hospital should collaborate with academia, research centers and the private sector to mobilize funds to implement the policy whilst broadening its own sources of income
2. The hospital should provide all equipment and facilities needed to prevent HIV spread and monitor and enforce its use.
3. Total compliance to use of PPE may be part of reward schemes for best performing departments.
4. PEP availability must be maintained.

### **6.3 Limitations**

The study had the following limitations:

The negative HIV status of health workers and managers was based on their declaration and was therefore not verified. Two key informants, the labour representative and the quality assurance manager were out of station and thus could not be interviewed for their inputs. The context of the study, where three policies with overlapping objectives were being implemented made it difficult to rule out the confounding roles of the others on study objective two i.e. prevention of spread of HIV at the workplace. It became obvious that stigma and discrimination was being perpetuated by all workers, not only health professionals working in departments where the risk of acquisition was high. Thus interviews should have included non professional health workers like health information, kitchen, administration and other staff. The qualitative nature of the study makes it difficult to quantify effectiveness.

### **6.4: Future Research**

In future both qualitative and quantitative methods should be used so that the policy objectives and effectiveness can be quantified. This will allow comparison of aspects of the policy like stigma and discrimination at different points in time.

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## APPENDICES

### Appendix 1:

#### CONSENT FORM 1

#### EFFECTIVENESS OF THE IMPLEMENTATION OF THE MOH WORKPLACE HIV/AIDS POLICY AND TECHNICAL GUIDELINES

Principal Investigator: Margaret Lartey

Address: Department of HPPM, School of Public Health, College of Health Sciences, UG

#### **General Information about Research**

You are being asked to take part in a research study. I will first explain the study and then ask you to participate. I will also explain the possible risks and benefits of being in the study. You can ask me any question you have about the study before you decide to participate. You will then be asked to sign this agreement which states that the study has been explained to you, that your questions have been answered, and that you agree to participate. This process is called informed consent.

This form also explains the research and how it will be done. Please read the form and talk to me about any questions you may have. If you decide to be in the study, please sign and date this form in front of the person who explained the study to you. You will be given a copy of this form to keep.

#### 1. Nature and Purpose of the Study

You are being asked to participate in this research because you are a health care worker. The purpose of the study is to measure how effective the implementation of the MOH HIV workplace policy has been in this hospital. The policy was developed by the MOH in 2004 and various agencies have been implementing it. To date we have not evaluated it to determine whether we should continue implementing it as is or there is room for changes. The study will also help us to identify factors that enable or hinder the implementation. This research is part of the preparation of a dissertation for an MPH at the school of Public Health, Legon. The findings will also be shared with hospital management to share with the staff.

## 2. Explanation of Procedures

If you choose to participate in the research study, you will be asked some questions. Notes will be taken and you will also be recorded. The whole interview may take an hour or more. I may come back to you for more information when I start analyzing the study.

### **Possible Risks and Discomforts and Benefits**

There are not many risks as all we will be doing is talking however I will be pausing so you do not feel pressurized. There are no immediate benefits to you but some of my findings may result in changes in the future which will benefit all HCWS, both infected and uninfected.

### **Confidentiality**

All of the information you will give me will be confidential. The notes and tapes will be only available to me, will be kept under lock and key and will be transcribed by me. They will be kept under lock and key and destroyed three years after the study. There will be no linkage to anyone in the analysis of the data and no information will be traced to you.

### **Conflict of Interest**

The PI declares no conflict of interest in carrying out this study.

### **Voluntary Participation and Right to Leave the Research**

You decide whether or not you want to be in the study. Participation is voluntary. If you decide now to participate, you can change your mind later and quit the study.

### **Contacts for Additional Information**

If you have any more questions about this study you may contact Dr. Margaret Lartey on 0244-165851.

### **Your rights as a Participant**

This research has been reviewed and approved by the Ethical Review Committee of the Ghana Health Service. If you have any questions about your rights as a research participant you can contact me. You may also contact the chairman, Prof Fred Binka through mobile number 0244712919 at the Health Research Unit, Adabraka.

## **VOLUNTEER AGREEMENT**

I have read the above document describing the benefits, risks and procedures for the research titled (*Effectiveness of the implementation of the MOH workplace HIV/AIDS policy and technical guidelines*) and it has been explained to me. I have been given an opportunity to ask any questions about the research and they have been answered to my satisfaction. I consent voluntarily to participate in this study and understand that I have the right to withdraw from the study at any time.

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Date

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Signature or mark of volunteer

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

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Date

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Signature of Person Who Obtained Consent

## **Appendix 2**

### **CONSENT FORM II (HIV POSITIVE)** **EFFECTIVENESS OF THE IMPLEMENTATION OF THE MOH WORKPLACE** **HIV/AIDS POLICY AND TECHNICAL GUIDELINES**

Principal Investigator: Margaret Lartey

Address: Department of HPPM, School of Public Health, College of Health Sciences, UG

#### **General Information about Research**

You are being asked to take part in a research study. I will first explain the study and then ask you to participate. I will also explain the possible risks and benefits of being in the study. You can ask me any question you have about the study before you decide to participate. You will then be asked to sign this agreement which states that the study has been explained to you, that your questions have been answered, and that you agree to participate. This process is called informed consent.

This form also explains the research and how it will be done. Please read the form and talk to me about any questions you may have. If you decide to be in the study, please sign and date this form in front of the person who explained the study to you. You will be given a copy of this form to keep.

#### **1. Nature and Purpose of the Study**

You are being asked to participate in this research because you are a health care worker. The purpose of the study is to measure how effective the implementation of the MOH HIV work place policy has been in this hospital. The policy was developed by the MOH in 2004 and various agencies have been implementing it. To date we have not evaluated it to determine whether we should continue implementing it as is or there is room for changes. The study will also help us to identify factors that enable or hinder the implementation. This research is part of the preparation of a dissertation for an MPH at the school of Public Health, Legon. The findings will also be shared with hospital management to share with the staff.

## 2. Explanation of Procedures

If you choose to participate in the research study, you will be asked some questions. Notes will be taken and you may also be recorded. The whole interview may take an hour or more. I may come back to you for more information when I start analyzing the study.

### **Possible Risks and Discomforts and Benefits**

There are not many risks involved except that someone may identify you as HIV infected and because of this the interview is taking place far away from where anyone in the hospital may identify you. All of the time we will be talking however I will be pausing so you do not feel pressurized. There are no immediate benefits to you but some of my findings may result in changes in the future which will benefit all HCWS, both infected and uninfected.

### **Confidentiality**

All of the information you will give me will be confidential. The notes and tapes will be only available to me, will be kept under lock and key and will be transcribed by me. They will be kept under lock and key and destroyed three years after the study. There will be no linkage to anyone in the analysis of the data and no information will be traced to you.

### **Compensation**

The cost of your transportation to this place as well as that of a snack will be paid to you. Apart from this there is no other compensation for your time. All this should come close to GHC20.00.

### **Conflict of Interest**

The PI declares no conflict of interest in carrying out this study.

### **Voluntary Participation and Right to Leave the Research**

You decide whether or not you want to be in the study. Participation is voluntary. If you decide now to participate, you can change your mind later and quit the study.

### **Contacts for Additional Information**

If you have any more questions about this study you may contact Dr. Margaret Lartey on 0244-165851.

### **Your rights as a Participant**

This research has been reviewed and approved by the Ethical Review Committee of the Ghana Health Service. If you have any questions about your rights as a research participant you can contact me. You may also contact the chairman, Prof Fred Binka through mobile number 0244712919 at the Health Research Unit, Adabraka.

### **VOLUNTEER AGREEMENT**

I have read the above document describing the benefits, risks and procedures for the research titled (*Effectiveness of the implementation of the MOH workplace HIV/AIDS policy and technical guidelines*) and it has been explained to me. I have been given an opportunity to ask any questions about the research and they have been answered to my satisfaction. I consent voluntarily to participate in this study and understand that I have the right to withdraw from the study at any time.

---

Date

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Signature or mark of volunteer

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

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Date

---

Signature of Person Who Obtained Consent

### Appendix 3

#### HIV Work Place Policy and Technical Guidelines Study In depth Interview Guide for Administrators

Organisation

Name of respondent

Position of respondent

Date of Interview

Place of interview

Name of interviewers

File Name/ID

Is the recorder working?

Consent given?

#### Introductory Remarks

I am \_\_\_\_\_ from \_\_\_\_\_

General purpose of the study

Aims of the interview

How long it will last

Any questions?

#### Warm up

Name:

Age:

Sex

1. Can you briefly describe what you do? How long have you been in this position?

Does this hospital have an HIV policy? If yes-tell me about it

If no, how do you handle HIV?

Probes: What policy states on

- Testing
- Discrimination

- Confidentiality
- Continuity of employment
- Healthy work environment
- Prevention
- Care and support

## 2. Can you describe your role in the process (or what you've just described)

Who are the key actors/staff who ensure that staffs are protected from HIV?

Probe

- What is your role?
- What about the others?
- Committee or focal person appointed
- Dissemination-Describe method
- SOPs
- Training of health workers/orientation
- Maintenance of confidentiality
- Non discrimination-change of schedule without reason, loss of employment, refusal of time off work,
- Provision of protective equipment, other commodities
- Provision of education, information to staff
- Care and support-counseling services, OI Management including TB, ART, Nutrition Assistance, Staff Accommodation
- Staff strength, work load
- Monitoring
- So the health workers with HIV infection, how did you find out? How have you handled them?
- Do you think they are satisfied with the support you give them as management?

3. How safe is your hospital in preventing hospital acquired HIV infection among the workers? How much of this existed before the introduction of the policy and what new things have happened with the policy. Do you think implementing the policy changed anything?

Probe-

PPE, new sharps for each patient, use of gloves and availability, availability and use of sharps disposal containers

4. What are the key constraints and barriers that you face in implementing this policy? How can they be overcome?

What are the key facilitators?

## Probe

- Human resources available to implement the policy?
- What about infrastructure?
- Equipment and supplies to implement the policy?
- Do the HCW have specific tools? What are these?
- Is there anything else you'll like to share with me?

Re cap and Summary, Conclusion and thanks, need for follow up discussed. Departure.

**Appendix 4****HIV Work Place Policy and Technical Guidelines Study****In depth Interview Guide II(HIV Positive health Workers)**

Organization

Position of respondent

Date of Interview

Place of interview

Name of interviewers

File Name/ID

Is the recorder working?

Consent given?

**Introductory Remarks**

I am \_\_\_\_\_ from \_\_\_\_\_

General purpose of the study

Aims of the interview

How long it will last

Any questions?

**Warm Up****Study ID****sex****age****position**

Tell me about yourself, what you do, how long you've had the illness, whether you are on treatment etc

How long have you been working at this institution?

HIV Policy

1. Are you aware of any rules and regulations as to how positive health workers should be treated? If yes did you see, hear of one and have you read it? Tell me more about

what you know. If no, how do you think positive workers should be handled at the workplace?

Probes:-

- Testing
- Discrimination
- Confidentiality
- Continuity of employment
- Healthy work environment
- Prevention
- Care and support

2. Share with me your experiences in the work place as a positive HCW? Does anyone else know your status at the work place? I want you to tell me both the good things and the bad things.

Probes:

- Maintenance of confidentiality
- Non discrimination- change of schedule without reason, loss of employment, refusal of time off work
- Care and support- counseling services, OI Management including TB, ART, Nutrition Assistance, Staff Accommodation
- Protective equipment and commodities for prevention
- Education
- Continuity of employment

3. Tell me how we can improve on life at the work place for the positive HCW? Are there any things that we should stop doing or continue to do?

Summary, recap wrap up and conclusion, departures

**Appendix 5****HIV Work Place Policy and Technical Guidelines Study****In depth Interview Guide III (HIV Negative health worker)**

Organisation

Name of respondent

Position of respondent

Date of Interview

Place of interview

Name of interviewers

File Name/ID

Is the recorder working?

Consent given?

**Introductory Remarks**

I am \_\_\_\_\_ from \_\_\_\_\_

General purpose of the study

Aims of the interview

How long it will last

Any questions?

**Warm Up****Study ID****sex****age****position**

Thank you for speaking with me.

1. Can you describe briefly what you do at this institution? Mention any policies that guide your work in this hospital. Have you heard about the HIV work place policy? If yes, tell me what you know? If no, tell me what things should guide the way we work so as to prevent us from getting HIV at the workplace?

(Have you heard or seen a document, or rules and regulations that tell us how to manage HIV (as far as health workers are concerned) in our health institutions? These things have been put in a book called the HIV workplace policy.)

Probe:

- Testing
- Discrimination
- Confidentiality
- Continuity of employment
- Healthy work environment
- Prevention
- Care and support

Do you think you should have a copy? Whose responsibility is it to distribute this?

2. Can you tell me who is responsible for taking action for each of the things you have described? You can also add more to what you have already said.

- Committee or focal person appointed
- Dissemination-Describe method
- SOPs
- Training of health workers/orientation
- Maintenance of confidentiality
- Non discrimination
- Provision of protective equipment, other commodities
- Provision of education, information to staff
- Care and support
- Staff strength, work load
- Monitoring

Do you think whoever is responsible is doing the job effectively? Why or why not?

What is your role? Assuming that you were given a role or bigger role in HIV work place activities, would you accept it? Why or why not?

Are there any challenges to having a good work place policy? How in your opinion can these be solved?

Are there any good things being done as far as the policy is concerned?

Probe for resources for implementing the policy?

Human, infrastructure, equipment, supplies and tools.

3. How much has education and knowledge of HIV influenced the way you use PPE and others? Was this provided by the hospital? Has there been any HIV education organized by the hospital for you? Have there been any training sessions in the use of PPE specific to HIV carried out by the hospital for you?.
4. Do you know of any HCW who is HIV positive? If yes, Describe how the person has been handled” by colleague health workers and management. Are you satisfied with how this colleague has been treated? What can we do better? If not in this hospital do you know of any HCW elsewhere with HIV? Same questions  
If not at all, assuming one of the HCW had HIV, how should we treat him or her?
5. Please tell me how we can improve on our response to HIV in the workplace

Re cap, summary and departure. Thank you and see you later.

**Direct Observation Form (General)**

Health Facility

Date and Time

**General****Observation****yes****no**

IEC posters on HIV and STIs pasted at OPD

Condom dispensers at washroom at OPD

Condom dispensers at washroom contain condoms

Staff VCT centre available

Guidelines for PEP pasted at medical ward

Guidelines for PEP pasted at paediatric ward

Guidelines for PEP pasted at surgical ward

Guidelines for PEP pasted at maternity ward

Guidelines for PEP pasted at emergency ward

Guidelines for PEP pasted at resuscitation area at OPD

Guidelines for PEP pasted at venepuncture site of laboratory

Guidelines for PEP contain phone numbers of providers

ART for PRP reserved at pharmacy

**Direct Observation Form (Department specific)**

Health Facility Ward:

Date and Time:

Sex:

Professional Grade:

To be administered at the Labour wards, laboratory, medical ward, paediatric ward, surgery, female wards and emergency room. There will be five (4 encounters at each ward) following a different HCW at each encounter

**General(All wards)****yes****no****Infection Control****Personal Protective Equipment**

Availability of gloves/utility gloves

Use of gloves/utility gloves

**Hand Washing**

Availability of running water

Availability of soap

Hand washing in between patients

Availability of hand drier/paper towels/personal cotton towel

**Handling of Sharps**

Use of new sharp per patient

Recapping of needles after use

Available sharps disposal container

Use of sharps disposable container

**PPE(Labour ward only)**

Use of goggles/face shield

Use of rubber aprons