

Case study 3: The Malawi Police Service

KEY FINDINGS

- Of the three institutions, the Malawi Police Service (MPS) comes closest to having in place a comprehensive institutional response to HIV/AIDS. The police service began tackling the problem of HIV/AIDS among its staff in 1999 and has among the most developed of Malawi's public sector responses to the epidemic.
- Both the age and gender profile of the police service and characteristics of the work environment suggest that personnel are susceptible to HIV infection.
- A number of existing institutional capacity constraints are likely to increase the vulnerability of the MPS to HIV/AIDS. The MPS is already understaffed, and a dependence on highly skilled and experienced staff, in particular, could see it negatively affected by the epidemic as personnel require specialised (often foreign) training and are hard to replace. A tendency towards hierarchy may leave it less able to cope with high levels of attrition, while the provision of generous funeral benefits and lenient sick and compassionate leave policies may prove financially costly in the context of the epidemic.
- Levels of illness are high and several officers have retired on medical grounds. Data on deaths for the period between 1990 and 2003 show that death rates have increased substantially over the last decade, with death becoming an increasingly important cause of attrition over this period. Similar death rates were recorded among senior and middle management and frontline staff.

- Again, managers and staff reported that AIDS-related attrition is aggravating existing staff shortages, resulting in work not being done or other, often already overburdened staff having to take on additional responsibilities. Attrition may also be absorbing an increasingly large proportion of the police's operating budget.
- The MPS is the only institution to have an HIV/AIDS policy in place. However, this policy has been poorly disseminated and is weakened by a failure to clearly define roles and responsibilities, overly generic and sometimes contradictory policy statements, and a limited range of activities.
- The MPS has created national, regional, and station-level structures to co-ordinate HIV/AIDS activities within the ranks. The participation of senior personnel in these structures shows crucial commitment to fighting the epidemic, but the co-ordination of activities by junior officers at the regional and station level is likely to make it difficult to target senior personnel, or obtain their crucial buy-in and support.
- The MPS is the only one of the three institutions to have a formalised HIV/AIDS programme in place. However, while efforts to raise awareness about HIV/AIDS have reached most personnel, the programme has yet to adequately address stigma and discrimination or tackle the complex issue of behaviour change.
- Care and support-oriented activities within the police services are limited. Police officers have established some self-help mechanisms.
- The MPS, with the assistance of DFID, is putting in place strategies to mitigate the effects of HIV/AIDS on its operational effectiveness. With the assistance of DFID and the NAC, the service is also developing a comprehensive funding proposal for expanding the institution's care and support activities.

INTRODUCTION

By far the largest of Malawi's security sector institutions, the MPS not only plays a key role in maintaining the security of Malawi's citizens, it is also a significant public sector employer. It is the only one of the three institutions studied to have begun putting in place a comprehensive response to HIV/AIDS among its staff. This case study examines the extent and nature of this response. As previously, this chapter begins by discussing the HIV/AIDS situation in Malawi, the national HIV/AIDS policy framework and the institutional context in which the MPS operates, before exploring the perceived impact of HIV/AIDS on the service and its efforts to combat the epidemic.

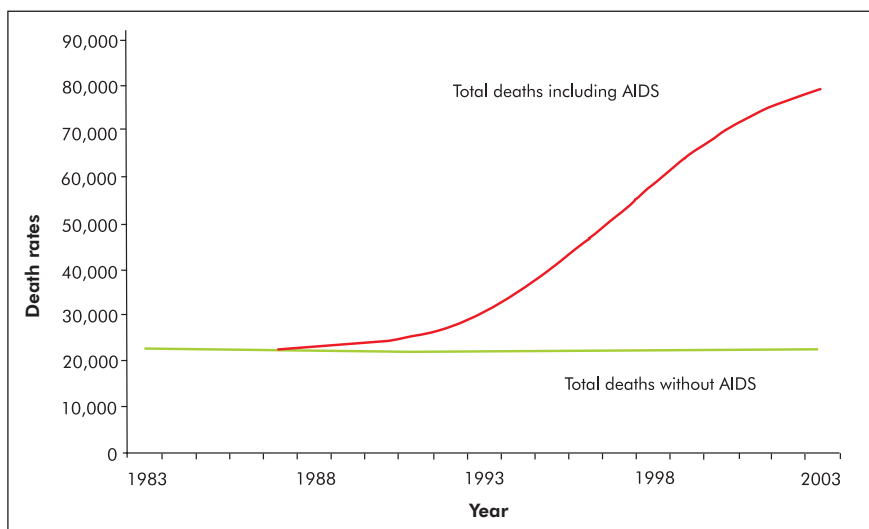
HIV/AIDS IN MALAWI

While still amongst the countries with the highest prevalence in the world, Malawi is less affected by HIV/AIDS than Botswana and Lesotho (see Figure 4). According to UNAIDS, approximately 900,000 Malawians are currently living with HIV/AIDS which, when calculated as percentage of total population, equates to a little under one tenth (roughly 8%) of the population. It is estimated that approximately 14% of adults between the age of 15 and 49 are HIV-positive.¹⁰⁷ Prevalence in this age group peaks in the 25-29 year age bracket, where it is estimated that one in four are HIV-positive. Analysis of reported AIDS cases by gender and age suggests that more women than men are infected in the 15-29 year age group, while levels of infection are higher among men over the age of 30.¹⁰⁸

Prevalence in Malawi increased rapidly between the late 80s and the early 90s, but stabilised by the mid-90s and has remained largely constant ever since.¹⁰⁹ HIV/AIDS rates are significantly higher in urban areas than in rural areas, with recent estimates by the NAC suggesting prevalence rates of between 19% and 29% and 10% and 15% for urban and rural areas respectively; analysis also suggests that prevalence in the Southern Region is about double that of the Central and Northern regions.¹¹⁰

The country is already experiencing high numbers of AIDS-related deaths, particularly among working-age adults and children under the age of five. The NAC estimates that over half a million Malawians have died of AIDS since it was first diagnosed in Malawi in 1985,¹¹¹ while UNAIDS reports that approximately 84,000 Malawian men, women, and children died of AIDS in 2003.¹¹² As shown in Figure 12, they

Figure 12: Projected annual number of deaths amongst adults (15-49) in Malawi with and without HIV/AIDS



Source: National AIDS Commission, 2003

calculate that AIDS has nearly tripled the annual number of deaths among adults between the ages of 15 and 49, from an expected 22,000 in the absence of HIV/AIDS, to nearly 80,000 deaths per annum in 2003. They estimate that AIDS is now responsible for almost three out of every four deaths in this age group.¹¹³

THE NATIONAL RESPONSE TO HIV/AIDS

The government of Malawi has recognised HIV/AIDS “as by far greatest development threat”¹¹⁴ facing the nation and, although it has not taken the route of Botswana and Lesotho and declared HIV/AIDS a national emergency, it has undertaken to vigorously combat the epidemic at all levels of Malawian society. In this, it would seem to be performing relatively well compared with many other countries in sub-Saharan Africa. In a recent international assessment of HIV/AIDS programming in this region, the AIDS Programme Effort Index, Malawi achieved a total score of 77 out of a possible 100—behind only Botswana and Rwanda.¹¹⁵ Like Botswana and Lesotho, Malawi is a signatory to the UNGASS Declaration on HIV/AIDS, as well as a range of regional commitments.

The government was among the first in Southern Africa to begin responding to the epidemic. Like Botswana, its current response has evolved from seeing HIV/AIDS as an almost exclusively medical concern to regarding it as a far-reaching issue with wide-ranging health, economic, social, and developmental implications for individuals, communities, and the state. An extensive review of the country's initial response in the late 90s led to the formulation of a more progressive National HIV/AIDS Strategic Framework (2000–2004) in 1999. This document constituted the government's primary policy statement on HIV/AIDS, until it was recently augmented by the publication of a national HIV/AIDS policy.

NATIONAL POLICY FRAMEWORK

The National Policy on HIV/AIDS, which was publicly launched in February 2004, establishes the technical and administrative framework for an expanded, multi-sectoral response to HIV/AIDS and calls on all Malawians to play their part in responding to the epidemic. Its focus is on preventing new infections and mitigating the “impact of HIV/AIDS on the socio-economic status of individuals, families, communities and the nation”.¹¹⁶ With regard to HIV/AIDS in the workplace, the policy explicitly acknowledges that “HIV/AIDS is weakening institutions and destroying institutional memory in both the public and private sector” and “is destroying the capacity to formulate, analyse and manage the public policies, development programmes and strategies essential ... for sustainable development”.¹¹⁷ It tasks all public and private sector institutions with developing and implementing HIV/AIDS workplace policies, as well as HIV prevention, treatment, and care and support programmes.

IMPLEMENTATION

The NSF—which is being revised to address the priorities of the next three years (2005–2008)—provides the basis for government, NGOs, and the private sector to formulate a range of operational programmes, projects and activities in response to the epidemic. Its key objectives include reducing the incidence of HIV, improving the quality of life of those infected with and affected by the virus, and mitigating the impact of HIV/AIDS at all levels of Malawian society. It highlights HIV/AIDS among civil servants as a key concern and prioritises:

- the development of human resource strategies which take into account health-related sources of personnel loss;
- the development of an institutional framework for assessing the impact of HIV/AIDS and the benefits of prevention programmes;
- the formulation and dissemination of workplace policies designed to protect people living with HIV/AIDS against stigma, discrimination, and denial of work-related privileges and benefits;
- the establishment of workplace support and counselling groups for personnel at all levels; and
- the restructuring of workplace benefits schemes to ensure broader coverage, equity of distribution, and the incorporation of funeral policy guidelines and benefits for dependants.¹¹⁸

Despite its stated emphasis on mitigating the impacts of the epidemic, the NSF—like the other strategy documents reviewed in this book—focuses almost exclusively on prevention and care and support activities for the infected and affected. Little attention is given to strengthening the capacity of organisations to cope with the attrition-related impacts of the epidemic.

The national response is driven and co-ordinated at a number of levels. The government of Malawi has placed a Principal Secretary for HIV/AIDS and Nutrition in the MoH and has established both a cabinet and a parliamentary committee on HIV/AIDS.¹¹⁹ The cabinet committee provides policy direction on HIV/AIDS issues, while the parliamentary committee on HIV/AIDS provides parliamentary oversight, monitors policy implementation, and provides input into the deliberations of the cabinet committee. The NAC, formerly the National AIDS Control Programme (NACP), is responsible for co-ordinating the national response and mobilising the resources to implement the strategies outlined in the NSF.

EXTERNAL PARTNERS

A number of development partners are supporting Malawi in its fight against the epidemic. These include DFID, the United States Agency for International Development (USAID), the Canadian International

Development Agency (CIDA), the UNDP, UNAIDS, and the World Bank. Most relevant to the study at hand, DFID is directly supporting the mainstreaming of HIV/AIDS in the Malawi security and justice sector, and is helping to develop sectoral capacity to mitigate the organisational impacts of the epidemic.

The UNDP is similarly aiding the government in improving the capacity of the Malawi civil service to cope with the effects of HIV/AIDS through the development and implementation of:

- a specialist volunteer placement strategy as a short-term measure for capacity replenishment; and¹²⁰
- a mainstreaming strategy to address the impacts of the epidemic on productivity and service delivery.

PROGRAMMES

The response to date has focused on preventing HIV/AIDS, and treatment and care and support infrastructure remains relatively weak—although the situation is changing.¹²¹ Free antiretroviral therapy is provided through the public health system at a handful of sites, while pilot PMTCT projects have been established by a range of non-governmental and medical research organisations in eight of Malawi's 30 districts.¹²² Such facilities, however, are extremely limited and recent estimates suggest that only 2% of eligible Malawians have access to antiretroviral therapy.¹²³

Provision of treatment for opportunistic infections is also inadequate and has been hampered by a lack of clear treatment guidelines, inconsistent supplies of drugs, inadequate training of health personnel, and poor referral systems. VCT facilities are available at sites throughout the country, including 44 major hospitals.¹²⁴

INSTITUTIONAL CONTEXT

The MPS falls under the jurisdiction of the Ministry of Home Affairs and Internal Security, which also provides political oversight, policy guidance, and strategic direction to the prison services and the Department of Immigration. The police service is by far the largest of these institutions and in December 2003 employed 7,915 staff. As in Lesotho and, to a lesser extent Botswana, Malawi's civil service is

already characterised by low productivity and capacity, irrespective of HIV/AIDS. Staff turnover and vacancy rates are high—over 50% in some institutions.¹²⁵ Studies attribute the existing situation to similar factors as discussed in the previous chapter, including:

- poor and declining conditions of service, which make it difficult to attract optimally qualified people to the civil service and lower morale;
- a lack of retention strategies for rare skills, which are difficult to replace;
- lengthy recruitment processes;
- a shortage of personnel and skills at technical and professional levels;
- inadequate transformational leadership, as evidenced by a recent training needs assessment, which concluded that leadership is hampered by “blurred direction, an absence of strategic planning, eroded work ethics and commitment, low employee morale ... inertia and a failure to take decisions”;¹²⁶
- a weak human resource policy framework;
- poor human resource planning capacity; and
- inadequate resources and accountability, and weaknesses in control of expenditure.¹²⁷

The security and justice sector is no exception to these trends, with a recent study by the Institute for Security Studies and the Malawi Institute for Management highlighting similar constraints.¹²⁸

The government has established a framework for a public sector reform programme aimed at improving the efficiency, effectiveness, and responsiveness of the public sector, although implementation of this programme has been slow. The major objectives of the programme, which was initiated in the late 1990s, include institutional capacity development, improving accountability and transparency, and more effective resource management.¹²⁹ Interestingly, it is envisaged that one of the outputs of this

programme, particularly its capacity-building aspects, will be the successful mainstreaming of appropriate responses to HIV/AIDS in the public sector. Police-specific reforms were also introduced in 1995 in order to improve the image, efficiency, and effectiveness of the MPS. Many of these reforms are still under way, but are to be achieved by improving management capabilities, investigative and other policing skills, as well as the effective use of available resources.¹³⁰

THE IMPACT OF HIV/AIDS

SUSCEPTIBILITY OF STAFF TO INFECTION

It is widely argued that members of the uniformed services, including the police, are at particular risk of contracting HIV. A disproportionate number of personnel in these services are young men, who tend to be more sexually active; personnel often operate in a dangerous environment that encourages risk taking and machismo; staff are often posted away from home; and personnel enjoy status and relative wealth compared to the communities in which they live and work—all of which increase opportunities for sex with multiple partners.¹³¹ The information suggests that the MPS conforms to many of these trends.

A look at the demographic profile of the MPS shows that the majority of personnel (61%) are young—between the ages of 18 and 35—and that men outnumber women on a ratio of 5:1. The findings from the in-depth interviews also suggest that:

- Personnel frequently do work away from home—particularly those in the Police Mobile Force, the Criminal Investigations Department (CID) and constables involved in patrol work—and may be posted away from their families and communities for as long as three months at a time.
- Personnel do enjoy relative prosperity and status in relation to the communities they serve. It is also alleged that some senior personnel may use their power within the organisation to obtain sexual favours from more junior members of staff.
- Many do not see themselves as at personal risk of contracting HIV,¹³² although a recent climate study by the National Statistics Office (NSO) indicates that levels of perceived risk may be higher than implied by this study's respondents (Box 11).

Box 11: Attitudes and awareness of police personnel regarding HIV/AIDS

IN 2003, the Criminal Justice Division of the NSO conducted an internal climate study in the police force. This study, in which 2,355 employees were interviewed, was designed to assess the working environment and attitudes and awareness of employees with respect to a broad range of workplace issues. It also asked a series of questions aimed at examining people's awareness about HIV/AIDS. The research found that:

- a little over half (55%) of respondents felt that characteristics of their job made them susceptible to HIV/AIDS;
- a little under two thirds (61%) reported knowing someone in the service who had died of AIDS; and
- virtually all (90%) felt that HIV/AIDS was negatively affecting the performance of the police service.

Interestingly, when asked whether the MPS should screen new entrants for HIV, a little over two fifths (44%) felt that this would be a good idea—largely on the grounds that the police should only employ fit and healthy personnel.

The study did not speculate on the meaning of these findings. However, the results suggest that although most personnel are aware of HIV/AIDS at some level, a significant proportion have yet to personalise the risk of infection and the realities of AIDS-related death. The relatively high levels of support for mandatory pre-employment testing may be the product of exasperation with the perceived under-performance of the police as a result of HIV/AIDS, but could also be indicative of a certain level of denial; an 'us versus them' mentality which sees HIV/AIDS as something that can be kept out of the organisation given sufficient resources.

Source: Malawi Police Service internal climate study, unpublished report, Crime and Justice Statistical Division, NSO, October 2004

VULNERABILITY OF THE INSTITUTION TO EFFECTS OF AIDS-RELATED ATTRITION

The findings suggest that existing institutional capacity constraints are likely to leave the MPS more vulnerable to the effects of HIV/AIDS. An establishment review conducted in 2003 suggests that, in addition to the productivity and capacity constraints discussed, the police service is already understaffed. It shows that an additional 4,625 personnel need to be employed if the service is to reach its strategic goal of one police officer for every 1,000 Malawians (Table 4).¹³³ It is also evident that although the police have been authorised to recruit more staff, they do not currently have the infrastructure or resources to meet such targets—although DFID is in the process of helping the government expand existing training facilities.

The technical nature of police work also creates certain vulnerabilities. Like Lesotho's MoAFS, the police depend on staff with specialist skills, such as detectives, personnel involved in judicial processes and liaison, handwriting experts, and other technical staff, who require specialised (often foreign) training and are hard to replace. Whether involved in specialised or general activities, effective police work is also often about intuition, experience, and contacts—skills which are difficult to teach in the classroom and usually develop over time.

As noted in Chapter 1, all institutions depend on their staff having the requisite levels of skills, as well as many years of experience and extensive networks of personal contacts. The particular competencies involved in obtaining, interpreting and acting on information, however,

Table 4: Recommended staffing levels for the MPS

Position	2003 establishment	Proposed establishment	Remarks
Inspector General	1	1	No change
Deputy Inspector General	2	2	No change
Commissioner of Police	8	8	No change
Senior Deputy Commissioner of Police	0	10	10 new posts
Deputy Commissioner of Police	11	22	11 new posts
Senior Assistant Commissioner of Police	19	33	14 new posts
Assistant Commissioner of Police	68	75	7 new posts
Senior Superintendent	65	83	18 new posts
Superintendent	80	232	152 new posts
Assistant Superintendent	142	337	195 new posts
Inspector	218	839	621 new posts
Sub-inspector	410	1,481	1,071 new posts
Sergeant	889	2,626	1,737 new posts
Constable	3,558	6,791	3,233 new posts
Total	5,471*	12,540	7,069

* The actual number of personnel in-post currently exceeds the 2003 establishment by 3,444, as the MPS fast-tracked recruitment because of staff shortages.

Source: Establishment review by Malawi Police Service and the Department of Human Resource Management and Development, 2003

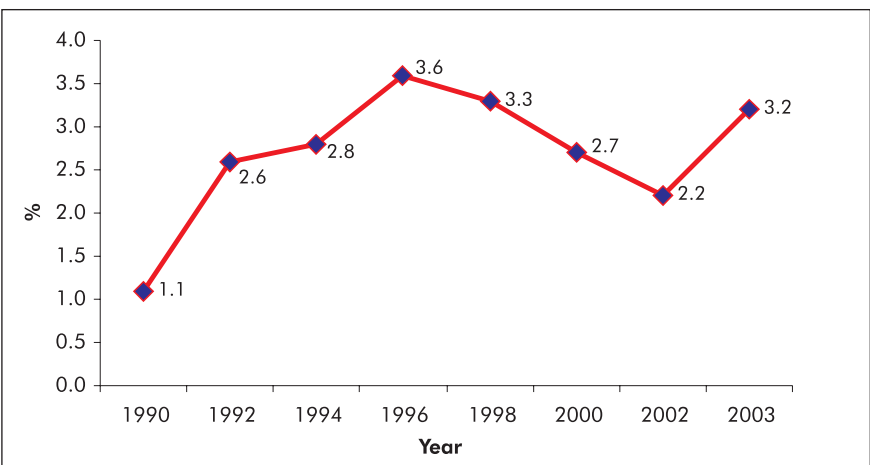
may make the police more reliant than most on the development of such resources—and thus vulnerable to their loss. Activities are also generally labour intensive. A number of organisational factors could similarly see the institution negatively impacted by the epidemic. These include a tendency towards hierarchy that prevents sharing of information and teamwork, the provision of generous funeral benefits, and lenient sick and compassionate leave policies that are financially costly and make it difficult to replace staff.¹³⁴

THE IMPACT OF HIV/AIDS ON ATTRITION

Although sick leave and absenteeism are supposed to be recorded, this information is not systematically collected, making it impossible to quantify levels of illness within the organisation. However, most respondents reported that levels of illness were high and that several officers had been retired on medical grounds. It is again impossible to attribute such illness directly to HIV/AIDS but, although managers were reticent about attributing illness and death to the virus, respondents noted that many of the sick suffered from chronic illness suggestive of AIDS.

Information on deaths is kept better and, despite the difficulties of retrieving and capturing primarily paper records, a number of studies have used human resource data to examine the impact of AIDS-related

Figure 13: Death rates in the MPS (1990–2003)



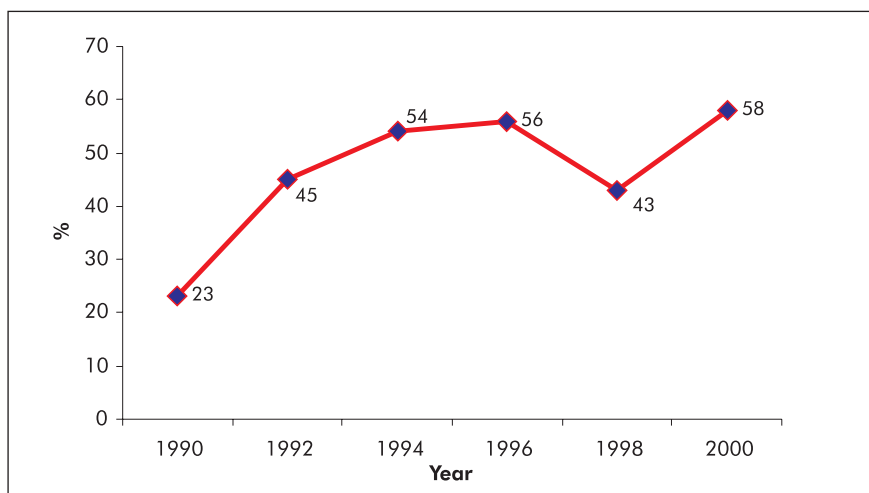
Source: Institute for Security Studies and United Nations Development Programme, 2002

deaths on human resources in various sectors of the Malawi public service. The largest and most comprehensive of these is a study funded by the UNDP in Malawi in 2001, which collected and analysed human resource data for a ten-year period between 1990 and 2000.¹³⁵ It is possible to combine this data with that collected in this study to create a picture of death and attrition trends over the last 13 years.

As shown in Figure 13, this data shows that death rates have increased quite substantially over the last decade. A seeming dip between 1996 and 2002 notwithstanding, death rates have more than doubled from approximately 1% in 1990 to a little over 3% in 2003—a rate well above the average national adult death rate of 1.1% observed by the most recent Malawi Demographic and Health Survey.¹³⁶

It is also clear that death has become an increasingly important cause of attrition over time. Analysis of the UNDP data shows that while death accounted for only a little over one fifth of attrition in 1990, it constituted just under three fifths of attrition by the close of the decade (Figure 14). Time constraints prevented the collection of representative data for the period between 2001 and 2003, but analysis of a sample of files of officers who exited the service in 2002 and 2003 seems to confirm this trend, with death accounting for 65% and 61% of attrition in the 55 and 57 files reviewed in 2002 and 2003 respectively.¹³⁷

Figure 14: Death in the MPS as a percentage of other attrition (1990–2000)



Source: Institute for Security Studies and United Nations Development Programme, 2002

As in the other case studies, it is difficult to say how many of these deaths can be attributed to HIV/AIDS, although the evidence makes a strong case for AIDS as a significant contributor. For instance, both the senior and more junior staff surveyed felt that HIV/AIDS was a concern for the police, with almost 90% of those who responded to the self-administered questionnaire highlighting it as a problem in the institution. As already mentioned, most managers agreed that many of those who had died in recent years suffered from repeated bouts of prolonged illness prior to their deaths. The quantitative data also suggests that death rates were highest among staff in their late twenties and early to mid-thirties—an age group that would not normally be expected to suffer high levels of death in the absence of HIV/AIDS. Analysis of a little under 900 files of deceased personnel on behalf of the UNDP in 2001 further indicates that approximately 16% died of infections and symptoms associated with HIV/AIDS, such as tuberculosis, diarrhoea, chronic fever, and pneumonia. Two fifths (40%) died after a “long illness”, a category which could incorporate a range of illnesses, including HIV/AIDS.¹³⁸

Whatever the cause, it seems that all staff categories are affected. Analysis of death rates by cadre in 2003 shows that, although frontline staff such as police constables and sergeants died in the greatest absolute numbers, there is relatively little variation in death rates across the breadth of the institution. Thus, while no deaths were experienced among executive management, death rates of 3.2%, 2.9% and 3.3% were recorded among senior and middle management and frontline staff respectively.¹³⁹ This highlights that all personnel are at risk of contracting HIV, and it is vital that interventions aimed at reducing the spread of HIV target all staff.

THE IMPACT OF HIV/AIDS ON SUPPLY AND DEMAND

Few respondents established a direct link between HIV/AIDS and demand for police services, but most felt that the virus was impacting on the capacity of the police service to combat crime. As many as three quarters (75%) of the those who returned a self-administered questionnaire felt that HIV/AIDS was having a moderate to large impact on the ability of the police to fulfil their duties (59% and 16% a moderate and large impact respectively).

As in Lesotho, managers noted that illness and death have resulted not only in the loss of staff, but also in productivity losses on the part of their

Table 5: Cost of recruit constable training in the MPS

	Cost (MWK)	Cost (US\$)
Food	46,000	435
Uniforms	24,000	227
Salary	14,580	138
Stationary	9,300	88
Housing allowance	4,500	43
Professional allowance	2,376	22
Interviews per candidate	655	6
Medicals	650	6
Total	102,061	966

Source: Establishment review by Malawi Police Service and the Department of Human Resource Management and Development, 2003

colleagues as workmates take time off to visit the sick at home or attend funerals. This, they argue, has aggravated staff shortages and resulted in work not being done or in other, often overburdened staff having to take on additional responsibilities. This finding is supported by the self-administered questionnaires, in which over three quarters (76%) of respondents reported having to do additional work owing to the illness or absence of colleagues.

It is also possible that AIDS and non-AIDS-related attrition are absorbing an increasingly large proportion of the police's operating budget. It is estimated, for example, that it costs approximately MWK102,000 (roughly US\$974) to put a new recruit through the police's compulsory six-month basic training course (Table 5). Taking only the 130 constables that died in 2003, the financial loss to the police services amounts to a little under MWK14 million (roughly US\$132,000)—a sum that would multiply substantially if deaths in other cadres and additional training costs were factored into the equation. Worked differently, the average annual intake ranges between 1,000 and 1,500; assuming that 200 of these recruits do not complete their training and that this cadre experiences a conservative death rate of only 1%, the MPS stands to lose between eight and 16 million Malawian kwacha (between US\$75,402 and US\$151,000) annually in forfeited basic training costs.

Funeral costs may also be diverting funds. Although the treasury is responsible for paying out death benefits to the families of deceased civil servants, most public sector institutions provide additional money towards

the funeral costs of staff and their families. These costs are usually not officially budgeted for and are drawn from other budget lines such as consumables and transport. It is estimated that funerals in the crime and justice sector may cost upwards of MWK50,000 (US\$473), depending on the position of the person in the organisational hierarchy.¹⁴⁰ Taking only deaths in the last five years, it is thus possible that the police service may have skimmed as much as MWK46 million (US\$434,000) or more from their official budget lines to pay for funeral costs.

POLICE SERVICE RESPONSES TO HIV/AIDS

As discussed in Box 12, over the last five years the government of Malawi has placed increasing emphasis on preventing and managing the effects of HIV/AIDS on the public service. Public institutions have been tasked with mainstreaming HIV/AIDS and developing and implementing appropriate responses to the epidemic. These institutions have made varying degrees of progress, but the police service, which began tackling HIV/AIDS among its staff as far back as 1999, has among the most developed responses.

POLICY FRAMEWORK FOR DEALING WITH HIV/AIDS

The MPS was the only institution studied to have an HIV/AIDS policy in place. This policy, developed by the Ministry of Home Affairs and Security in 2002, is an umbrella policy encompassing the ministry's own staff, the police and prison services, and the department of immigration. The focus of this policy is on preventing HIV infection and providing care and support to the infected and affected by the virus. Core strategies include:

- encouraging and protecting human rights and confidentiality;
- promoting sexual responsibility;
- providing condoms;
- providing information about breastfeeding and its alternatives;
- promoting VCT;
- treating opportunistic infections and promoting healthy living; and
- providing psychosocial support.

It is clear, however, that the policy document has been poorly disseminated. Indeed, although the majority of managers knew about the

Box 12: Public sector responses to HIV/AIDS in Malawi

THE NSF identifies HIV/AIDS mainstreaming as one of the key strategies for addressing and scaling-up the national response to the epidemic. With this in mind, the NAC conducted a study in 2002 to assess the extent to which public sector institutions have mainstreamed HIV/AIDS. According to the NAC study few institutions have HIV/AIDS focal points or HIV/AIDS workplace policies, strategies, and programmes and none are focusing on impact mitigation. This gap was attributed to:

- limited commitment from senior managers;
- insufficient budgets for implementation;
- a lack of clear responsibility for monitoring the impacts of HIV/AIDS; and
- a lack of focus and consensus on the relative importance of impact mitigation.

Similar findings emerged from a rapid appraisal for mainstreaming HIV/AIDS in the public sector conducted by the World Bank (Malawi) in 2003, which highlighted a lack of policy guidelines and inadequate financial resources as key constraints to the successful mainstreaming of HIV/AIDS in the public sector. In response to this situation, the NAC has developed guidelines to help public sector institutions mainstream HIV/AIDS.

In 2001, the UNDP funded a study on the impact of HIV/AIDS on human resources in the public sector. This study showed that death was a major cause of attrition, accounting for as much as half (50%) of the attrition in the public sector institutions studied. The research also showed that almost all the institutions examined experienced excess mortality, particularly among younger employees—suggesting that AIDS may have been responsible for a significant number of deaths. The report's major recommendations included the establishment of information management systems, capacity-building, and the mainstreaming of HIV/AIDS in all public sector institutions.

On the basis of these recommendations, in 2003 the cabinet committee on HIV/AIDS instructed the department of human resource management and development to spearhead a co-ordinated public sector response to the epidemic. Under this initiative, each public sector institution is expected to develop its own action plan based on a public sector-wide strategy and is made responsible for establishing a working committee on HIV/AIDS.

A public sector steering committee on HIV/AIDS (comprising ministerial principal secretaries and the chief executives of key parastatal organisations) and a public sector technical committee on HIV/AIDS have been established to drive this response. There are also plans to review the Malawi public sector regulations in view of HIV/AIDS.

policy, few had ever seen a copy of the document. Similarly, less than half (45%) of the respondents to the self-administered questionnaire knew that a policy existed, while less than one fifth (19%) had ever seen the document.

Furthermore, although the policy represents a laudable effort to highlight and concretise the responsibility of the cluster to respond to the epidemic, a number of weaknesses reduce its usefulness as a framework for action. These include:

- lack of clarity on who is to drive activities or how they are to implemented or funded, which, in the absence of either a detailed strategy document or implementation plan, is likely to make it difficult to translate policy into action;
- largely generic policy statements that are insufficiently tailored to the specific needs and realities of the cluster, such as the small but real risk of occupational exposure to HIV among police personnel;¹⁴¹
- a limited range of prevention activities, such as condom distribution, promoting the sanctity of marriage, and providing HIV-positive female employees with alternatives to breastfeeding, that do not address the important broader, and more complex, issues of how to promote and sustain awareness of the virus, combat stigma and discrimination, and encourage behavioural change.
- contradictory policy statements that are likely encourage not only ambiguity but also potential discrimination. For example, in its section on human rights the document states that “privacy over health matters is a basic human right” and that “confidentiality regarding a person’s HIV status should be respected”, but only a few lines later makes it mandatory that spouses be informed of their partner’s status “for the purposes of care and prevention [and] discourag[ing] stigma and discrimination”.¹⁴²

Such factors, combined with silence on how the cluster should manage the day-to-day implications of the epidemic on institutional performance, seem a source of frustration for many senior personnel. As explained by one officer, “We would like more tangible things in the policy; we have had enough of condoms.” There are, however, plans to review the document in light of the new National Policy on HIV/AIDS.

It is to be hoped that with increasing awareness of the capacity implications of HIV/AIDS in the Malawian public service, it can be reformulated to provide greater guidance on the management of HIV/AIDS in the workplace.

HIV/AIDS CO-ORDINATING STRUCTURES

The police have a number of structures in place to co-ordinate HIV/AIDS activities within the ranks. The Police AIDS Control Unit (PACU) was established in 2002 to lead the service's response to the epidemic. Housed at the national police headquarters, the PACU consists of three officers and is headed by a high-ranking officer—an Assistant Commissioner of Police—who reports to the Deputy Inspector General of Police and has direct access to the highest levels of police leadership. The involvement of such senior personnel shows crucial commitment to fighting the epidemic and is likely to help to raise the profile of HIV/AIDS activities, improve access to funding, and encourage implementation. The PACU's responsibilities include:

- organising HIV/AIDS-related training;
- liaising with the NAC;
- training peer educators from amongst officers and their spouses;
- distributing condoms; and
- planning, co-ordinating, and implementing HIV/AIDS activities for the MPS.

In the last three years each of the service's four regional offices and 41 stations and sub-stations have put in place HIV/AIDS committees or, in the smaller sub-stations, focal points. These liaise with the PACU and are broadly responsible for raising awareness about HIV/AIDS, training peer educators, distributing condoms, and arranging recreational activities for younger officers.

Each station is responsible for introducing focal points at the unit and post level, but given the newness of station-level structures, most stations are waiting to consolidate their existing structures before taking on this responsibility.

Regional and station level committees are generally chaired by senior personnel, but it was observed that the individuals responsible for the day-to-day co-ordination of activities are usually junior officers with little influence. Such a situation would be undesirable in any

organisation, but is particularly problematic in a protocol-oriented institution like the police, where it may make it difficult to work with or target senior personnel or obtain their crucial buy-in and support. In this respect, it is clear that many senior personnel have little or no working knowledge of HIV/AIDS activities in their institutions, and almost without fail referred researchers to the more junior officers for information on this issue—suggesting that managers at the regional and station level are only nominally, if at all, involved in such activities and have yet to see combating the virus as a management responsibility. Thus, while the co-ordination of the central response conforms to the key principals of current good practice, there is a need to raise the profile and authority of AIDS co-ordinators at the regional and station level and make HIV/AIDS a management issue.

BUDGETING FOR HIV/AIDS ACTIVITIES

In 2002, the government of Malawi directed that each public sector institution should assign 2% of its monthly budget allocation to HIV/AIDS activities. In addition to this money, the police service has applied for and received funding from the NAC for a range of activities, including HIV/AIDS awareness training.¹⁴³ It also receives limited *ad hoc* donor funding for specific projects, such as the development of the HIV/AIDS policy and the training of peer educators.

Senior personnel, however, reported that the absence of an HIV/AIDS strategy and action plan has made it difficult for the police to mobilise resources and, even where money is available, it is often available irregularly. They noted, for example, that the police service's monthly budgetary provision varies and is not always disbursed when it is supposed to be, making it difficult for AIDS co-ordinators to plan their activities. It was also argued that delays in processing of proposals by the NAC has resulted in the slow implementation of programmes and activities, and a failure to expand programmes to other police stations, posts, and units.

The research suggests that in the absence of clear implementation guidelines, funding proposals have been written on an *ad hoc* basis, and monies have not been spent as strategically as they could have been. With the assistance of the NAC, the MPS is in the process of developing a comprehensive HIV/AIDS strategic plan, which should enable the police to mobilise resources more effectively and make better use of such funds.

WORKPLACE HIV/AIDS PREVENTION PROGRAMMES

The MPS was the only one of the three institutions studied to have a formalised HIV/AIDS programme in place. The focus of this programme has to date been on preventing the spread of HIV/AIDS and since 1999 the police service have undertaken a range of prevention-oriented activities, including:

- *Distribution of condoms:* An effort is made to ensure that condoms are always available to officers, particularly those deployed outside their duty stations. Condoms are placed in the toilets, and station-level HIV/AIDS co-ordinators are expected to liaise with the national HIV/AIDS co-ordinator to ensure a consistent supply.
- *Training of peer educators:* Peer educators have been trained to help raise awareness among police officers and their families. At the inception of the peer education programme, it was hoped that 400 educators would be trained over the course of three years, but professed shortages of funding have resulted in only 110 educators being trained. The National Co-ordinator hopes to continue training new educators if and when new funding is secured.
- *Capacity-building among HIV/AIDS committees:* Training has been conducted among personnel involved in three of the four regional-level HIV/AIDS committees, but has also been constrained by a lack of funds. Respondents hoped that money would be found to complete the training by the end of 2004. It is envisaged that the personnel on these committees will be provided with annual refresher courses to ensure that they are kept abreast of new information and issues in the sector.
- *HIV/AIDS awareness drama:* The police service has a theatre group which tours the various police institutions throughout Malawi performing plays on, among others, HIV/AIDS issues. These plays are supposed to be performed each quarter, but given the number of offices, stations, posts, and units the troop has to cover (224 altogether), it tends to visit institutions only once a year.

In implementing these activities, some HIV/AIDS co-ordinators have worked closely with district level HIV/AIDS co-ordinating structures and NGOs. These organisations have assisted in providing information

on HIV/AIDS and condom use and helped to develop the skills and capacity of the co-ordinators themselves.

Overall, they would seem to have reached most personnel. Of those who responded to the self-administered questionnaire, for example, virtually all (98%) recalled some kind of workshop or presentation on HIV/AIDS, while almost 70% recalled condoms being distributed. Only three respondents could not recall any activities being undertaken.

However, it seems that the activities to date have not yet adequately tackled the complex issue of encouraging behaviour change. Vehicles such as peer education and drama obviously include behavioural change messaging, but have yet to become widely and consistently available to all officers. In addition, managers identified a need for activities aimed at helping personnel to assess their own values and behaviour and empowering them with the skills to protect themselves and others. They noted that despite awareness-raising activities, many people are still unable to talk freely about HIV/AIDS, suggesting that more needs to be done around issues of stigma and denial within the organisation.

These issues notwithstanding, there is tentative evidence of a relatively supportive workplace environment. Anecdotal reports suggest that, despite the fear of stigma and discrimination, a small number of HIV-positive personnel have made their status known, and while they have received little or no formal support, have generally been treated well by their supervisors and peers (see Box 13). In the absence of a baseline attitudinal survey or monitoring, it is unclear whether this reflects success on the part of the police in raising awareness and discouraging discrimination, wider attitudes, or individual choices.

As discussed earlier, the MPS began tackling HIV/AIDS in the late 1990s, although a co-ordinated, more coherent response was established only in 2002. Given the relative immaturity of this programme, it would still be useful to conduct a KAP survey to establish prevailing knowledge, attitudes and behaviour, against which the success of the PACU's activities could be measured in the future.

WORKPLACE HIV/AIDS CARE AND SUPPORT PROGRAMMES

As noted above, care and support-oriented activities within the police services are limited. The police chaplaincy, which counsels personnel on a range of primarily spiritual and personal issues, provides some largely informal support, but their services are only available at the national and regional police headquarters and are not specifically tailored towards

Box 13: Lonnie's story

LONNIE is 30 years old and is based at Limbe police station, near Blantyre. Lonnie was diagnosed as HIV-positive in 1997 after becoming very ill with tuberculosis and failing to respond to treatment. Her husband died of tuberculosis in 1998. In 2001 she became very ill again and had to take a year off work. In line with public sector conditions of service, she remained in the employ of the MPS during this time, on paid sick leave.¹⁴⁴ Her CD4 count fell to 12 and her weight plummeted. In February 2002 she was chosen to enrol in an antiretroviral programme sponsored by *Médecins Sans Frontières*. Her CD4 count is now 300 and she weighs 90 kg. The only time she takes off work is when she travels to the hospital once a month to collect her medication.

After returning to work following her enrolment in the antiretroviral programme, she told her supervisor about her HIV status because she needed to take time off to go to the hospital to obtain her medication. Her supervisor was very supportive and assured her that she would not lose her job. She has also told her colleagues and often gives talks on HIV and AIDS at work. Her colleagues have all supported her and she has never felt discriminated against in any way.

Apart from a meeting with an HIV/AIDS co-ordinator, she has not received any specific support from her employer, the police. She would like to learn more about positive living, especially nutritious food. She has heard that about 21 officers at the police headquarters in Lilongwe are open about their status, but has not met them. She has not joined a local support group because her boyfriend doesn't want people outside her work knowing about her status, as he is afraid of how they will react.

Source: T Wilson, personal communication

HIV/AIDS issues. VCT facilities are also available but are confined to the police hospital in Zomba because of the limited number of trained counsellors. Most of those seeking testing are referred to governmental and non-governmental facilities—although funds are being sought to establish VCT infrastructure at the police service's other six medical facilities. Antiretroviral therapy is available only at the hospital in Zomba, but other hospitals and clinics provide treatment for opportunistic infections and are able to refer patients to facilities where the drugs are available.

Police officers themselves have established some self-help mechanisms. For instance, staff and their families make small monthly contributions to a welfare fund that is used to cover minor funeral expenses not covered by the institution. Welfare committees, consisting

primarily of officers' wives, run a home-based care programme under which volunteers visit and assist families in the event of death or illness. Most of the wives who volunteer for these activities have no specific expertise in home-based care, but a small number have received training in the provision of such care, and there are plans to train more.

MANDATORY TESTING

On the grounds of national security, the national HIV/AIDS policy provides for mandatory testing of personnel in the security sector. It states that "it is important that the army, police, prisons and immigration be permitted to carry out HIV testing as part of their pre-recruitment and periodic general medical assessment of staff for purposes of establishing fitness", and permits such institutions to test personnel "as part of a broader assessment of fitness to work".¹⁴⁵ Such testing has not yet been introduced in the police and, given the relatively scarcity of testing facilities, may not be introduced any time soon. The idea of mandatory testing, particularly of new recruits, is nevertheless widely supported by managers as a way of reducing and managing HIV/AIDS in the ranks.

Internationally, the idea of such testing has its supporters but at present it flies in the face of all international guidelines on managing HIV/AIDS in the workplace, which advocate informed, voluntary testing or—where information is needed for planning and management purposes—anonymous, consensual prevalence testing.¹⁴⁶

It is not the intention to enter this complex and emotive debate here—suffice it to say that it raises difficult ethical questions concerning the responsibilities of institutions in the context of the epidemic—but the findings of the study highlight areas of concern. For example, a great deal of fear and stigma still surround the virus in Malawi, and pre-employment testing could potentially reduce the number of people wanting to enter security-sector institutions—a possible cause for alarm given the difficulty of attracting skilled and committed staff to the public sector.

As already discussed, many characteristics of police life may increase the risk of police personnel contracting HIV. Mandatory pre-employment testing may reduce the number of HIV-positive personnel entering the service, but it will not—in the absence of effective prevention programmes—prevent in-service personnel from contracting HIV. Given prevailing attitudes, however, there is a danger that it could become seen as a definitive solution to the problem, a mechanism for keeping 'us' safe

and ‘them’ out, which would not only work against efforts to mainstream the virus but could also create a false sense of security that could encourage complacency and denial. In this way, mandatory testing could serve to further stigmatise HIV/AIDS and undermine efforts to create an environment conducive to developing and implementing policies to educate, provide support, and mitigate the epidemic’s impacts. In terms of in-service testing, it is clear that the current care and support infrastructure is too weak to adequately support and treat large numbers of personnel and would need to be greatly strengthened if the consequences of such testing are to be competently managed.

ADOPTION OF STRATEGIES TO MANAGE THE INSTITUTIONAL IMPACTS OF HIV/AIDS

The MPS has tended to respond to attrition by replacing and retraining staff.¹⁴⁷ It is evident from this and previous studies that both managers and staff have had a hard time seeing HIV/AIDS as an organisational issue and, although personnel recognise that their colleagues are increasingly falling ill and dying, many still find it difficult to accept that HIV/AIDS could be claiming a large proportion of these lives. Where the impacts of the virus are recognised, they tend to be viewed at an individual rather than organisational level, which has resulted in managers often adopting strategies—such as the flexible application of conditions of service (sick leave, compassionate leave, medical retirement, and funeral benefits)—that may exacerbate rather than ease the negative implications of HIV/AIDS on institutions.¹⁴⁸

This is, however, in the process of changing. In response to the findings of a 2003 study on the impacts of HIV/AIDS on the security and justice sector DFID, in collaboration with the government of Malawi, is supporting the implementation of a number of impact mitigation strategies within the sector, including:

- raising awareness on the impact of HIV/AIDS attrition on the organisation;
- conducting institutional audits to assess the impact of HIV/AIDS on organisations;
- developing a management information system for gathering and analysing attrition-related information;

- building capacity to manage all forms of attrition, including HIV/AIDS-related attrition;
- implementing appropriate non-replacement responses to manage attrition; and
- developing comprehensive HIV/AIDS workplace programmes.

In early 2004, DFID contracted a consultant to begin this process and held a series of high-level workshops to sensitise senior personnel and managers to the impacts of the epidemic on service delivery. Four workshops have been held with senior police personnel, including station commissioners and section heads. DFID has also begun work on a series of institutional audits, as well as the provision of training on monitoring, evaluating, and managing workplace policies and attrition in all of the sector's 14 institutions. Efforts are also underway to better integrate HIV/AIDS issues into the police's new recruit training curriculum.

In collaboration with DFID, the NAC is helping the MPS to develop a comprehensive funding proposal that includes plans for the creation of four VCT facilities and the provision of PEP to rape victims through the police's Victim Support Units.