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Institutional Support Mechanisms for Workplace HIV and AIDS IEC Programmes: A Case of Hospitality Facilities in Botswana

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Abstract: *Background:* The purpose of the study was to determine institutional support mechanisms of workplace HIV and AIDS Information, Education and Communication (IEC) programmes of hospitality facilities in Botswana. Effective implementation of the programme required that organisations support their programmes with HIV and AIDS IEC policy, develop internal and external support mechanisms as well as training support for the programmes. M*ethods:* This study adopted the explanatory sequential mixed methods research design. Data was captured using structured questionnaires and fact-to-face interview guide. Quantitative sample comprised 50 hospitality facilities represented by the heads of HIV and AIDS programmes while qualitative sample was 25, determined through saturation. A mixed data analysis method was used for this study. Descriptive statistics was used to capture the distribution of categories of hospitality facilities while informants' responses were captured in both the frequency and percentages. Inferential statistics was used to make meaningful conclusions based on the responses. Pie chart was used to capture the distribution of HIV/AIDS Coordinators by age whereas qualitative analysis adopted the deductive design approach. *Results:* Sixty two percent (62%, 31/50) of hospitality facilities supported their HIV and AIDS programmes, 64% (32/50) did not have annual budgetary allocations for their programmes, 94% (47/50) did not receive support from either the government or its agencies, and 92% (46/50) of facilities did not receive supports from NGOs, the private sector and other hospitality facilities. Most (57%, 29/50) hospitality facilities organised their HIV and AIDS IEC training at real-time, 62% (31/50) conducted training at full financial cost to their organisations while 52% (26/50) encouraged all levels of staff to attend trainings at least twice a year. *Conclusion:* Hospitality facilities need to re-engineer their institutional support mechanisms through the development of planned and systematic assistance mechanism with their internal and external environments as well as collaborate with research based institutions as part of the external support mechanism for their HIV and AIDS IEC programmes. The recommendations to the hospitality facilities are that the present practice of full-time and real-time cost IEC training should be sustained and enhanced, develop external support mechanisms for their programmes, and liaise with appropriate government organs to develop necessary workplace HIV and AIDS policies for the sector.

Keywords: Information, Education and Communication, HIV and AIDS, Workplace, Hospitality Facilities, Institutional Support Mechanisms, Botswana

1. Background

Botswana, a Sub-Sahara African country with a population of about 2.1 million, and is one of the HIV and AIDS highly endemic countries in the world [1]. Botswana HIV and AIDS indicator reveals that the number of people living with HIV is 340, 000 of which adults aged 15 years and above constitute 97%. The HIV incidence rate for the country stands at approximately 3%, while the prevalence rate is 18.5% [2]. Among the government's HIV/AIDS response strategies is the adoption of a national HIV and AIDS strategic framework (NSF), which is in its second version (2010 – 2016) [3]. The key provision of the NSF is the adoption of Information, Education and Communication (IEC) as a programme-strategy as part of HIV/AIDS risky behaviour change interventions [4].

The advent of sex tourism poses an HIV and AIDS challenge to the hospitality facilities and the tourism sector specifically worldwide. This is because they hire a large number of young single employees, who are highly sexually active, frequently mobile, and away from their families for prolonged periods of time. This scenario exposes the employees to frequent opportunities for sexual interactions between tourists [5]. Hence, the need for hospitality facilities to embark on workplace HIV and AIDS IEC programmes implementation.

The workplace therefore provides a suitable platform for implementing public health interventions aimed at making staff, guests and residents of its environment to be better informed. Workplace HIV and AIDS Information, Education and Communication (IEC) enable organisations, workers and their families, guests and residents of local communities to play active role in protecting and sustaining their businesses, individuals and family as well as community health [6]. The success of the workplace HIV and AIDS IEC programme implementation relies heavily on strong and effective institutional mechanisms. Without effective institutional mechanisms, implementation of programmes become subjective, and cannot produce the desired results [7, 8]. The extent to which the hospitality facilities in Botswana have developed institutional mechanism in support of their workplace HIV and AIDS IEC programme implementation informed this study.

Literature Review and Theoretical Framework

In the context of this study, institutional support mechanism (ISM) implies a series of actions or efforts put in place by hospitality facilities to reinforce the successful implementation of their workplace HIV and AIDS IEC programmes. ISM is pivotal for any workplace HIV and AIDS IEC programme delivery [9]. The key components of ISM are: management's backing for the workplace HIV and AIDS IEC programme; the existence of appropriate implementation structure; an HIV and AIDS policy; annual HIV and AIDS budget; government and NGOs material and financial support system for the programme; medical support for staff on ARV treatment; and requisite HIV and AIDS training and education [7, 8, 10].

Education and training is vital in health-related interventions. The success of workplace HIV and AIDS IEC programme rests with the management supporting the programme implementation through continuous training of all relevant stakeholders [11]. In the same vein, management must allocate necessary resources such as funding for HIV/Aids workplace IEC programme implementation [12]. Lack of material and financial support from government and other stakeholders might limit the ability of the organisations to effectively deliver its HIV and AIDS information education programmes. Other views hold that the ineffectiveness of HIV and AIDS IEC programmes delivery can be attributed to lack of HIV and AIDS policy in particular. It has also been suggested that lack of policy has contributed to failure by institutions to either provide support mechanisms for staff on ARV treatment or requisite HIV and AIDS training and education [6, 12, 13]. Although there has been a growing recognition for the important role played by institutional support mechanism in the implementation success of healthcare related programmes, empirical findings have revealed an apparent low level support for such programmes by management structures of organisation [12]. For example, in South Africa, management support for workplace HIV and AIDS IEC programme implementation was 36.4% [9]. While this level of support could be acceptable under an early adopters' environment, it cannot make for an effective HIV and AIDS mitigation at the workplace. There is need for maximum support. In another study in Botswana [14], it was found that the informant organisation did not have a budget for their workplace HIV and AIDS programme implementation and also did not keep any record of what they had spent in support of their HIV and AIDS IEC programmes. Furthermore, the informant organisation could not state how many HIV and AIDS training sessions they had conducted and how many people benefited from them. This state-of-affairs show the low level importance to which organisations could attach to the fight against HIV and AIDS pandemic at their workplaces. A study by Hirbod and Lindqvist (2011) [12] has also provided evidence of reluctance on the part of management to provide budgetary support. The situation is worse in small business enterprises. For instance, Kirby, et al (2006) found that the programme mounted by small business enterprises lacked strategy, had no objectives and did not have supporting HIV and AIDS policy [15]. The aggregation of the above findings confirms that many organisations do not accord premium support for their workplace HIV and AIDS IEC programme implementation.

This study therefore evaluated the institutional support mechanisms of the workplace HIV and AIDS IEC programmes of the hospitality facilities in the greater Gaborone area of Botswana with a view to establishing the support level of each of the mechanisms available for the programme and to proffer solutions where necessary.

The theoretical underpinning for this study was

Umunnakwe (2015) [7] HIVADIEF conceptual framework (Figure 1).

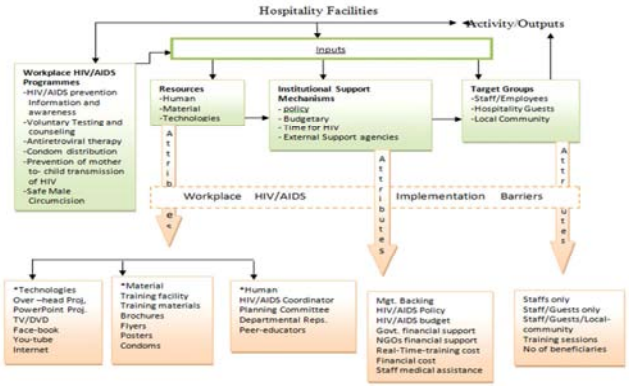

Figure 1. *Inputs Evaluation Theoretical Framework (HIVADIEF Model).*

This framework argues that institutional support mechanism for successful implementation of workplace HIV/AIDS IEC programmes is a multiple function of (a) the existence of HIV and AIDS policy (that determines and drives the programme implementation), (b) provision of annual HIV and AIDS budget (which ensure that the programmes are substantially financed), (c) external material and financial collaboration with government/s, private organisations and donors as well as NGOs, (d) IEC training at real time and costs, (e) medical assistance to staff living with HIV and AIDS. This is a preposition that seems to be largely in agreement with the International Labour Organisation's prescriptions [6] and the Botswana National Strategic Framework on HIV and AIDS (1 and 2) [16].

Evidence points to the fact that business organisations' support for their workplace HIV and AIDS IEC programmes-strategy implementation is very weak; with some as low as 18.0%, while many organisations that implement workplace HIV and AIDS IEC programmes do not have any annual budget for the programmes [14]. Most organisations have no mechanisms for financial and materials support and others do not have IEC training programmes whereas others that do have training programmes do not conduct them at real costs to their organisations [7]. Furthermore, many business organisations that implement workplace HIV and AIDS IEC programme-strategy rarely evaluate their programmes [17]. This scenario presented research gap which this study tried to fill.

The purpose of this study was to evaluate the institutional support mechanisms for implementing workplace HIV and AIDS IEC programmes by the hospitality facilities in Botswana. The specific objectives were to:

- establish the level of organisational support for workplace HIV and AIDS IEC programmes
- ascertain the extent of existence of HIV and AIDS IEC policy for workplace HIV and AIDS programmes
- determine the extent of external support mechanisms for workplace HIV and AIDS IEC programmes
- identify the training support mechanisms for workplace HIV and AIDS IEC programmes.

2. Methods

2.1. Study Site and Study Design

The study sites were Gaborone city, Tlokweng and Mogoditsane villages. It adopted the pragmatism paradigm and an explanatory sequential mixed methods research (ESMMR) design. Explanatory sequential mixed methods research implied that the researcher first conducted quantitative research, analysed the results and then followed up with qualitative research in order to expound on some findings from the quantitative data; and to explain them in more details [18, 19].

2.2. Study Population and Sampling, Sample Size Determination and Data Collection Instruments

The study sample, comprised 51 HIV and AIDS Coordinators representing their hospitality facilities. The respondents were purposively selected from guest-houses (24), lodges and camp sites (13), and hotels and motels (13), and a self-catering establishment group (1). Quantitative data was collected using structured questionnaire, which, was chosen because of its ease of administration especially among respondents with busy schedules [20]. Qualitative data was obtained using face-to-face interview which was adopted as a complementary data collection method to assist the study investigate some aspects of the study objectives which the questionnaire was not able to exhaustively elucidate.

2.3. Reliability and Validity, Data Collection and Analysis

The data collection instruments were tested for content-related validity as well as reliability. The instruments were face validated by three (3) experts from the Department of Library and Information Studies (DLIS) at University of Botswana, and one (1) HIV/AIDS expert from the monitoring and evaluation section of the Ministry of Health (Botswana). The construct validity of the questionnaire was established through pretesting of instruments. The result of the pilot test of quantitative instrument was validated by computing a content-related validity index (CVI), based on experts' rating of items. This was done by translating item-level CVIs into values which ranged from relevance (1), clarity (2), simplicity (3) and ambiguity (4) (where 1 = 25; 2 = 50; 3 = 75 and 4 = 100). CVI of 0.75 was adopted as inclusion criteria for content validity. Three respondents purposively selected were used for the face-validity of qualitative data; which was adjudged to be consistent with the aim of the interview as well as the research objectives. The trustworthiness of the qualitative data was established through a rigorous process of verbatim transcription of the audio-tape, reading the transcribed data by the researchers and comparing written documents with recorded data and agreeing as to their correctness and exact responses of key informant (in terms of interpretation).

Fifty (50) questionnaires were finally administered to respondents which were successfully completed and

returned, representing a response rate of 100.0%; while twenty-five (25) HIV and AIDS coordinators were interviewed. SPSS 21 software was employed for processing the data. Descriptive statistics were used to capture the distribution of categories of hospitality facilities that were involved in the study. A pie chart was used to capture the distribution of HIV and AIDS Coordinators by age. Frequency and percentage were used to capture levels of respondents' responses to all the variables using the Likert's 5-point measuring scale (strongly agree, agree, neutral, disagree and strongly disagree).

2.4. Ethical Consideration and Informed Consent

A research consent form was read and discussed with key informants. The consent form covered items such as: introduction, name of the main researcher, purpose of study, issue of non-risk to informants, benefits of the study and assurance of confidentiality. It also covered the provisions that participation in the study was purely out of the informant's free will and how the results of the study would be disseminated. Each informant was requested to sign the consent form. In many facilities, however, verbal acceptance to participate was accepted in place of a signed consent form.

3. Results

With respect to the demographics of responding hospitality facilities, the findings revealed that they were made up of hotels and motels (42%), guesthouses (32%), lodges/camp sites (24%) and self-catering establishments 2%. The finding also revealed that 20 facilities (40%) had been in operation for over 10 years, 17 (34%) had operated for less than 5 years while 13 (26%) had operated for 6 to 10 years (Table 1).

Table 1. *Organisational Data (N = 50).*

Hospitality Facilities by Category and Years of Operation								
Facility Categories	**1-5 years**		**6 –10 years**		**Above 10 years**		**Total**	
	N	**%**	**N.**	**%**	**N**	**%**	**N**	**%**
Hotels and Motels	10	20	1	2	10	20	21	42
Guest House	3	6	7	14	6	12	16	32
Lodge/Camping	4	8	5	10	3	6	12	24
Self-Catering Establishment	0	0	0	0	1	2	1	2
Total	17	34	13	26	20	40	50	100

The gender of HIV and AIDS coordinators (who responded on behalf of their facilities) revealed that 31 out of 50 (62%) were female and 19 (38%) male. Out of the 21 respondents employed in the hotels/motels category 12 (24%) were female while 9 (18%) male. Sixteen (16) respondents were from the guesthouses, consisting of 10 females (20%) and 6 males (12%). Out of 12 respondents from the lodges/camp-sites, 8 (16%) were female while 4 (8%) were male. One respondent from the self-catering establishment was female (Table 2).

The educational attainment of respondents revealed that 25 out of 50 (50%) respondents had bachelors' degrees, 17 out of 50 (34%) had diploma certificates; 5 out of 50 (10%) had postgraduate degrees while 3 out of 50 (6%) had Cambridge school leaving certificates (Table 2).

Table 2. *Personal Data (N=50).*

Respondents by Hospitality Facility Category and Gender						
Hospitality category	Female		Male		Total	
	N	%	N	%	N	%
Hotel/ Motel	12	24	9	18	21	42
Guest House	10	20	6	12	16	32
Lodge/Camping Site	8	16	4	8	12	24
Self-Catering Establishment	1	2	0	0	1	2
Total	31	62	19	38	50	100
Respondents by Highest Educational Attainment and Gender						
Highest Educational Attainments	Female		Male		Total	
	N	%	N	%	N	%
Post graduate degree	2	4	3	6	5	10
First degree	17	34	8	16	25	50
Diploma certificate	9	18	8	16	17	34
Cambridge certificate	3	6	0	0	3	6
Total	31	62	19	38	50	100

The age range of respondents (Figure 2) showed that 37 out of 50 (74%) were between 21 and 40 years; 11 out of 50 (22%) were between 41 and 60 years while 2 out of 50 (4%) were above 60 years.

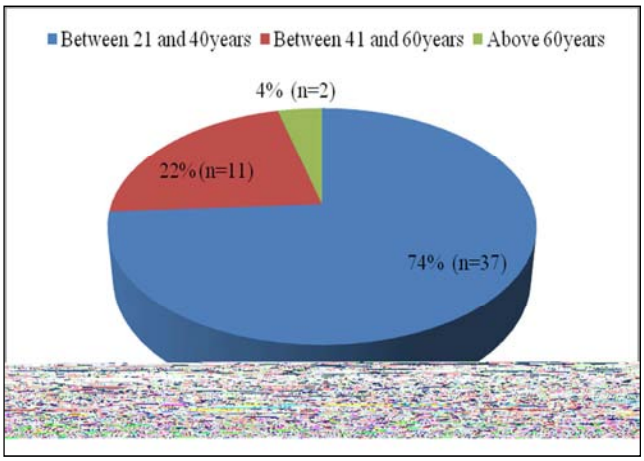

Figure 2. *Distribution of Respondents by Age Ranges (N = 50).*

With respect to organisational support and budgetary allocation for programmes, the findings showed that 31 out of 50 (62%) hospitality facilities supported their workplace HIV and AIDS programmes while 19 out 50 (38%) did not. With respect to annual budgetary allocation for the workplace HIV and AIDS IEC programme implementation, the finding revealed that 32 out of 50 (64%) the hospitality facilities did not have any budget provisions while 18 out of 50 (36%) facilities had budgetary allocation for the programme (Table 3).

Table 3. *Findings on Organisational Support, Budgetary Allocation and Financial Support and Training (N = 50).*

Organisational Support and Budgetary Allocation												
Measurement items	**Strongly agree 5**		**Agree 4**		**Neutral 3**		**Disagree 2**		**Strongly disagree 1**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N.**	**%**
The management of your organization backs the workplace HIV/AIDS programme	18	36	13	26	0	0	14	28	5	10	50	100
Your hospitality facility workplace HIV/AIDS IEC programme has an annual budgetary allocation	7	14	11	22	0	0	20	40	12	24	50	100
Financial Support and Training												
The organization's workplace HIV/AIDS programme receives financial/material support from government and government agencies	2	4	1	2	0	0	19	38	28	56	50	100
The organization's workplace HIV/AIDS programme receives financial/other support from non-government and private AIDS agencies	4	8	0	0	0	0	19	38	27	54	50	100
The organization's workplace HIV/AIDS programme receives support from other hospitality organizations	3	6	0	0	0	0	18	36	29	58	50	100
Training and Medical Support for Staff on ARV Treatment												
Training is organized at real-time cost to the organization? (Using working hours)	19	38	9	18	0	0	11	22	10	20	50	100
All trainings are at full cost to the organization? (Staff are not expected to contribute for their training)	23	46	8	16	0	0	10	20	9	18	50	100
Every member of staff is encouraged to attend HIV/AIDS training programme at least 2 times a year	15	30	11	22	0	0	15	30	9	18	50	100
Staff members on ARV treatment are assisted with medical costs	2	4	2	4	14	28	11	22	21	42	50	100

Regarding the measures on financial assistance from government and its agencies, 47 out of 50 (94%) hospitality facilities disagreed that they received such support while 3 out of 50 (6%) agreed that they did. Forty-six (92%) hospitality facilities disagreed that they received support from the NGOs and private sector while 4 out of 50 (8%) agreed. Forty-seven (94%) of the respondents disagreed that their organization's IEC programme received any support from other hospitality facilities (Table 3).

With respect to training, the findings showed that 28 out of 50 (57%) hospitality facilities agreed that their workplace HIV and AIDS IEC training is organised at real-time cost to the organisations, but 21 out of 50 (43%) disagreed. Thirty one (62%) respondents agreed that all training is at full financial cost to the organisations while 19 out of 50 (38%) disagreed. Regarding categories of staff who benefited from HIV and AIDS training, the finding showed that 26 out 50 (52%) of the facilities agreed that all levels of staff are encouraged to attend training at least twice every year. However, 24 out of 50 (48%) of the respondents disagreed that staff members are encouraged to attend training at least twice per year (Table 3).

The findings with respect to medical assistance to staff members on ARV treatment (Table 3) revealed that 32 out of 50 (64%) respondents disagreed that their hospitality facilities extended medical assistance. Fourteen (28%) respondents chose to be neutral on this measuring item while 4 out of 50 (8%) agreed that their staff members received medical assistance. Due to the high percentage of respondents who gave a neutral answer, this finding formed one of the issues taken up for investigation through the interviews. In seeking explanations on why facilities were not extending medical support to staff on ARV treatment, a typical response was as follows:

> No staff member has volunteered his/her HIV status, and you know that the issue of HIV/AIDS is not something you go about asking individuals. If no staff has reported being HIV positive, how do you assist? So the answer is "No", we are not yet extending medical assistance to staff on ARV treatment.

The practical implication of this response for the hospitality sector is how the management should budget for ARV IEC program. Whereas the workplace HIV and AIDS policy require that facilities support staff members' with ARV treatment, the ethical principle of workplace HIV and AIDS prohibits staff from disclosing their status. Nevertheless, there should be a means for the management to ascertain the number and category of support to plan for. Out of curiosity as to how the facilities might be coping with this predicament the respondent was asked "Does your response imply that there is no staff member that is infected who is on ARV treatment?" The response was:

> Based on my personal experience as a HIV/AIDS expert, I do see all the signs that point or suggest that an individual could be HIV^+ or on ARV treatment, but since HIV/AIDS and work ethics treats individuals' HIV/AIDS status as a private and confidential issue, you do not ask; unless a person freely communicates his or her status

These findings present the predicament for both staff members on ARV treatment who would expect their hospitality facility management to extend support while the management of facilities do not have an official means of establishing who among the staff required the assistance.

4. Discussions

According to the ILO (2001) [21], workplace HIV/AIDS IEC programmes must be mainstreamed if they are to achieve their desired impact. This is crucial not only because HIV/ and AIDS affects the workforce, but also the workplace has a role to play in the wider struggles to limit the spread and effects of the epidemic [22]. The level of support for the programme among hospitality facilities in Gaborone was found to be 62%. This level of institutional support is much higher when compared with another finding from an earlier study in South Africa wherein the level of institutional support for the informant organisation's HIV and AIDS IEC programme was 19% [9]. Notwithstanding the level of support in Gaborone, the findings of this study behoves every hospitality facility not only to adopt and implement workplace HIV and AIDS IEC programmes, but to effectively support the programme to succeed.

The Revised Botswana National Policy on HIV and AIDS [4] and ILO recommendation [6] require that regular HIV and AIDS IEC training be conducted for stakeholders. As far as the place of work is concerned, these stakeholders include managers, supervisors; shop-floor workers, peer educators as well as health and safety officers and local residents of an enterprises' operating communities. The study found that 52% of hospitality facilities encouraged all cadres of staff to attend HIV and AIDS training sessions twice annually. This shows that hospitality facilities in Botswana are doing well to comply with the national HIV and AIDS workplace policy as well as ILO recommendations [6, 21, 22].

The fact that HIV and AIDS IEC training sessions of the hospitality facilities are conducted at real-time and real-cost is the bipod for possible successful programme implementation. This is because conducting the training at real-time and cost has the propensity to encourage greater participation of target audience to training sessions; thus aiding achievement of programme goals. In the same vein, the conduct of training at least twice a year will help to keep the issue of HIV and AIDS at the front burner within the organisation. Each facility's HIV and AIDS IEC training programme was found to have benefited not less than 100 members of the target audience within the past 12 months. The implication for practice of this finding is the need for the hospitality sector to re-emphasise training. It highlights the positive impact sustained HIV and AIDS education and training could have if the local communities and staff families are also incorporated in the scheme; especially if those who have received these education and training translate them into behaviour change which is the core of IEC. If this is done, it is envisaged that HIV and AIDS incidence rate at the workplace will be minimised.

The finding that only 36% of hospitality facilities had HIV and AIDS annual budget shows that the implementation of the programme lacks strong organisational commitment. A key component of Institutional Support Mechanism provides for allocation of dedicated budget, which is critical to workplace HIV and AIDS successful implementation. Without a specific budgetary allocation, the implementation of the programme may be constrained as HIV/AIDS Coordinators may not be able to plan effectively or acquire the right materials and technologies for the programmes as designed [23]. In the same vein, the provision of annual budget for HIV and AIDS by a facility shows the importance the facility attached to the fight against the pandemic as well as help in the calculation of cost of fighting HIV and AIDS at facility, sectoral and national levels.

According to ILO [21, 22], innovative approaches should be sought to defray the cost of implementing workplace HIV and AIDS programmes. For instance, enterprises can seek external support from national AIDS agencies and or other relevant stakeholders. However, most hospitality facilities in Botswana were found not to have received materials, financial as well as training support from the government and its agencies, private AIDS donors, and the NGOs and other hospitality facilities. This finding has both practice and policy implications. The implication for practice for hospitality facilities require that they build cooperative support mechanisms across the broad societal spectrum as well as between themselves, the government and other private HIV and AIDS agencies as a means of attracting the requisite materials, financial and training supports for their programmes. The policy implication of the finding requires that appropriate government HIV and AIDS organs should initiate necessary policy on institutional support mechanisms for all workplace HIV and AIDS IEC programmes.

The ILO and Botswana National workplace HIV and AIDS policy provides that staff members be supported in accessing ARV treatment. According to ILO recommendation "*...these services could include the provision of antiretroviral drugs, treatment for the relief of HIV-related symptoms, nutritional counselling and supplements, stress reduction and treatment for the more common opportunistic infections"* [21]. The study found that hospitality facilities are not extending medical assistance support to their staff on ARV treatment. A possible explanation for this state of affairs could be due to the fact that Botswana Government provides free antiretroviral treatment for citizens. However, with the world becoming a global village, the possibility is that all workers in hospitality facilities in Gaborone area might not be from Botswana. The consequence of not implementing the ARV programme on such a premise could be counterproductive. Failure to extend medical support for a staff on ARV treatment (who is not a citizens) may actually exacerbate new HIV virus infections as a result of un-moderated sexual behaviour of the one individual in the community which can come back to haunt the hospitality facilities. Assuming that HIV and AIDS is someone else's problem, and or ignoring the affected staff while hoping that the disease will simply go away, are but grave assumptions at the peril of business enterprises that assumes this posture [24].

The above situation has both practice and policy implications for the hospitality sector. The implication for practice requires that hospitality facilities re-engineer their institutional support mechanism through the development of planned and systematic

assistance mechanism with their external environment. There is also need for the hospitality facilities to develop a working relationship with the research fraternity as part of the external support system for their workplace HIV and AIDS IEC programmes. The policy implication calls for the government of Botswana, in conjunction with the hospitality sector and other business enterprises to develop new workplace HIV and AIDS IEC policy that emphasises provision of ARV treatment assistance for all staff, and explicitly support disclosure of HIV status; which hitherto, ethical position on workplace HIV and AIDS policy prohibits. There is need for policy moderation that could assist the management of hospitality facilities establish number of staff to plan and budget for ARV treatment support. The policy should also specify extent of linkages between the hospitality sector businesses, the government and its organs, and NGOs as well as other external HIV and AIDS stakeholders. However, the policy should be specific with regards to the extent of external cooperation between hospitality facilities, business organisations and external HIV and AIDS donors to avoid abuse, external influence and or manipulation.

5. Limitations

The major factor that limited this study was the fact that it was limited to greater Gaborone area only.

6. Conclusion

Although many hospitality facilities in Botswana implement workplace HIV and AIDS IEC the institutional support mechanism for the programmes falls below expectation. Most of them do not have HIV and AIDS policies, annual budgetary allocation for their programmes and lacked external support mechanisms for their workplace HIV and AIDS IEC programmes. A greater percentage of the hospitality facilities in Botswana appeared not to be extending treatment support to staff. HIV and AIDS IEC training programmes of hospitality facilities in Botswana are being conducted at "real-time" and "real-cost" to the hospitality facilities; which resulted in active target audience participation.

Recommendations

On the basis of the findings of this study, recommendations are hereby proffered for the hospitality sector, government and its agencies and international HIV and AIDS organisations as well as for future research as follows:

Hospitality Sector

- Hospitality facilities HIV and AIDS IEC training programmes appeared to be supported as they are being conducted at real time and cost to the organisations. The study recommends that the present practice should be sustained and enhanced.
- Majority of hospitality facilities lacked external support mechanisms to run their HIV and AIDS IEC programmes. It is recommended that hospitality facilities should develop external support mechanisms for their programmes.
- Workplace HIV and AIDS IEC mainstreaming hospitality facilities were found to implement their IEC programmes without policies. It is recommended that hospitality facilities managements' liaise with responsible government organs to develop proper workplace HIV and AIDS policy that is suitable to the sector.
- Many hospitality facilities did not have HIV and AIDS budget for their workplace programmes. It is recommended that hospitality facilities provide annual budget for the implementation of their programme.
- Workplace HIV and AIDS IEC training programmes benefited many staff members. It is recommended that hospitality facilities incorporate staff members' families and local residents in their programmes to maximise the benefits.

Government and Its Agencies

- Most hospitality facilities are implementing their workplace HIV and AIDS IEC programmes without sector specific HIV and AIDS policy. It is recommended that the Ministry of Environment Wildlife and Tourism (MEW&T), the Hospitality and Tourism Association of Botswana (HATAB) and Botswana Business Coalition on HIV and AIDS (BBCA) to synergise with hospitality sector to draw up workplace HIV and AIDS policy for the sector in Botswana.
- High level of unawareness and misconception was found to exist with respect to the role of hospitality facilities in the implementation of workplace HIV and AIDS IEC programmes. The study recommends to Ministry of Environment Wildlife and Tourism (MEW&T), Botswana Business Coalition on HIV and AIDS (BBCA), Hospitality and Tourism Association of Botswana (HATAB) and National AIDS Coordinating Agency (NACA) to organise and conduct regular workplace HIV and AIDS awareness and re-education training programmes for the hospitality sector in Botswana.

International HIV/AIDS Organisations

- Hospitality facilities in Botswana do not extend medical support to staff members on ARV treatment due mainly to the non-disclosure clause of the HIV and AIDS principle. The ILO, regional and national HIV and AIDS Coordinating Agencies should come up with approaches that could resolve this situation, thereby ease the implementation of ARV IEC programme at the workplace.

Future Research

- The respondents in this study was restricted to HIV and AIDS coordinators of hospitality facilities. The study recommends that further study be carried out that will incorporate both HIV and AIDS coordinators and staff members, so as to understand the issues from both the top and shop-floor perspectives.
- The HIVADIEF theoretical framework adopted for this study is a novel model newly developed. The study recommends the theoretical model to other researchers in other to further develop and improve the HIVADIEF model.

Competing Interests

The authors received no external financial and other subvention/assistances from any individual or parties that could be considered to amount to conflict of interest.

Author' Contributions

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