DEVELOPING WORKPLACE POLICIES ON HIV/AIDS: AN IMPETRATIVE IN NIGERIAN ORGANISATIONS

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ABSTRACT

Most organisations have successfully developed and are implementing health and safety policies and programmes that cover a wide range of health and safety issues. In recent times however, the HIV/AIDS pandemic has introduced a critical new dimension to occupational health and safety that is generally outside the purview of existing health and safety policies and programmes. The issues emerging from HIV / AIDS in the workplace possess a high potency for destabilizing organizations as entities and undermining their ability to achieve their stated goals and objectives. The threat is particularly present in Nigeria which has the third largest number of HIV/AIDS infections in the world, and the highest number of HIV/AIDS – infected adults in West Africa. Unfortunately, the subject of HIV/AIDS is a difficult, controversial and 'undiscussable subject' in the Nigerian workplace. Moreover, there appears to be no determined effort to provide formal policies on HIV/AIDS in the workplace in Nigerian organisations. These conditions expose Nigerian organisations to the negative but full impact of HIV / AIDS. Using the ILO Code of Practice on HIV / AIDS and other international experiences with workplace policies on HIV / AIDS, this paper argues that the existence of formal policies on HIV/AIDS is a prerequisite for stemming the problem of HIV/AIDS in the workplace in Nigeria. The paper also highlights what appropriate workplace policies on HIV / AIDS must provide for in Nigerian organizations.

INTRODUCTION

Most organizations have successfully developed and are implementing health and safety policies and programmes that cover a wide range of issues. In recent times however, the HIV/AIDS pandemic has introduced a critical new dimension to occupational health and safety. The human resource challenges that the pandemic pose to today's organizations and human resource managers are generally outside the purview of existing health and safety policies and programmes. The issues emerging from the pandemic possess a high potency for destabilizing organizations as entities and undermining their ability to achieve stated goals and objectives. Indeed, as the ILO (2001) has succinctly put it:

HIV/AIDS is a major threat to the world of work: it is affecting the most productive segment of the labour force and reducing earnings and it is imposing huge costs and loss of skills and experience. In addition, HIV/AIDS is affecting fundamental rights at work, particularly with respect to discrimination and stigmatisation aimed at worker and people living with and affected by HIV/AIDS (ILO, 2001: iii)

The threat to the world of work posed by HIV/AIDS is particularly present in Nigeria which has the third largest number of HIV/AIDS infections in the world, and the highest number of HIV/AIDS – infected adults in West Africa (UNAIDS, 2004). By implication, HIV/AIDS is already a major workplace challenge in Nigerian organizations. This demands that Nigerian organizations and human resource managers evolve novel approaches in managing human resources, particularly

with respect to occupational health and safety in order to ensure that the skills and competences of their employees are continuously and optimally utilized. This is especially the case in Nigerian organisations given the negative cultural taboos and beliefs that surround the disease and HIV/AIDS patients in Nigeria (Okonofua, 2006).

Indeed, not have employers been known to dismiss employees who have tested positive to HIV (Agence France-Press, 2001; AFRO-NETS, 2006); in certain cases, the courts in Nigeria have been known to refuse to conduct legal proceedings brought by HIV/AIDS patients against their employers for wrongful dismissal because of the attitudes of judges to HIV/AIDS. For example, in April, 2001 a judge of the High Court not only refused to allow an HIV positive plaintiff in a case of wrongful dismissal into the court but withdrew from hearing the case on the grounds that 'the plaintiff was a health hazard' (Agence France-Press, 2001:1).

In the workplace, the subject of HIV/AIDS is thus likely to prove a difficult, controversial and 'undiscussable subject' given the acknowledged beliefs about the illness among employers and workers alike. As the Journalists Against AIDS (JAAIDS) Nigeria (2003:7) observed in a detailed study of the situation, 'Nigerian society (is) still secretive about HIV/AIDS'. The situation is made even more difficult by the fact that, in Nigeria, there appears to be no determined effort to provide formal policies on HIV/AIDS in the workplace (Rosen, 2004). Yet, it would appear that the existence of such policies is a prerequisite not only for limiting the spread of HIV/AIDS but also for dealing with the associated human resource management problems in the workplace which include care and support for workers who have tested positive to HIV, elimination of

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stigma and discrimination against employees who are perceived to be or are actually HIV positive, respect for the rights of workers on the question of testing for HIV and with regards to the records of those who are actually infected, managing relationships between HIV positive and other employees, job placement or exit decisions for HIV positive employees and the gender dimension of the illness. Thus there is an urgent need for discussions not only on the need for organisations in Nigeria to evolve and implement workplace policies on HIV / AIDS but also on what should be the essence of such policies.

This paper focuses on the need for Nigerian organizations to develop workplace policies on HIV/AIDS as a way of making discussion and management of the issue less difficult and controversial. As a background to indicating the importance of the need, the paper explores issues of health and safety in the workplace, the nature of the HIV/AIDS pandemic and the ILO code of practice on HIV/AIDS in the workplace. It also examines the nature of the actions being taken by firms in workplaces by presenting examples from South Africa, Brazil, the Philippines, and Nigeria as well as addresses the question of what should be the essence and contents of workplace policies on HIV/AIDS in Nigerian organisations. The paper concludes by highlighting the need for empirical studies on the experience of Nigerian organisations with the management of disease in the workplace so that existing policies can be improved and where such policies are non-existent, they could be developed and implemented.

Health and safety in the workplace

The health and safety of every employee in an organization is important if the organization is to continuously operate to meet its stated goals and objectives. A healthy worker is an able worker, and a safe worker is a focused worker. An unhealthy or unsafe environment affects an employee's ability and motivation to work. Thus, health and safety policies and programmes are directed at protecting employees from health and safety hazards that may arise in the course of performing their work. According to Armstrong (2001), managing health and safety at work is usually a matter of: developing health and safety policies; conducting risk assessment which identify hazards and assessing the risks attached to them; carrying out health and safety audits and inspections; implementing occupational health programmes; managing stress; preventing accidents; measuring health and safety performance; communicating the need for good health and safety practices; training in good health and safety practices, and organizing health and safety. Health hazards relate to those aspects of the work environment that slowly and cumulatively (often irreversibly) lead to deterioration of an employee's health. Examples are cancer, poisoning and respiratory diseases; as well as depression, loss of temper, and other psychological disorders (Ivancevich and Glueck, 1989) Occupational health programmes are thus primarily concerned with the prevention of ill-health arising from workplace conditions, while safety programmes deal with the prevention of accidents and with minimizing the resulting loss and damage to lives and properties (Armstrong, 2001).

Since ill-health and injuries inflicted by the system of work or working conditions jeopardize employees' ability to effectively discharge their duties, close and continuous attention to quality health and high standards of safety must be maintained at all times in the workplace. This places a moral as well as an economic responsibility on employers to take measures in ensuring the highest standards of health and safety in the workplace. However, since it is the government that takes the primary responsibility for ensuring the safety of its citizens, government of many nations have developed laws that prescribe the scope of workplace health and safety policies. In the United States of America for example, the law that governs health and safety in the workplace is the Occupational Safety and Health Act (OSHA) (1970). The Act was designed to remedy safety problems on the job. The law established safety and health standards that organizations are expected to comply with and when these standards are violated, the law prescribes penalties depending on the severity of the outcome of the violation (Ivancevich and Glueck, 1989). In Britain, the Health and Safety at Work Act (1974) and other related Acts provide the legal framework for the code of practice on matters relating to workplace health and safety.

In Nigeria, the government's attempt to protect its citizens in the workplace is contained in two Acts. These are the Factories Act (1987) and the Workmen's Compensation Act (1987). The object of the Factories Act (1987) was defined as:

> An Act to provide for the registration, etc, of factories; to provide for factory workers and a wider spectrum of workers and other professionals exposed to occupational hazards, but for whom no adequate provisions has been made; to make adequate provisions regarding the safety of workers to which the Act applies and to impose penalties for any breach of its provisions (Laws of the Federation of Nigeria, Vol. 6, Chapter F1: F1-4).

Primarily, the Factory Act (1987) prescribes the aspect of the workplace for which employers are expected to develop health and safety policies in order to protect their workers. The general provisions for health in this Act cover such areas as; cleanliness; overcrowding; ventilation; lighting; drainage of floors; and sanitary conveniences. The general provisions for safety covers equipment and facilities such as prime movers; transmission machinery; powered machinery; construction and maintenance of fencing; vessels containing dangerous liquids; hoist and lifts; chains, ropes and lifting tackles; cranes and other lifting machines; self-acting machines etc.

The Workmen's Compensation Act is an "Act to make provisions for the payment of compensation to workmen for injuries suffered in the course of their employment" (Laws of the Federation of Nigeria, Vol. 16, Chapter W6 W6-12) This Act specifies the liability of the employers to the employee in the event of any personal injury or harm sustained in the course of his work. Section 32 of this Act, which relates to occupational diseases, specifies that compensation is to be made as if any disease so specified was a personal injury by accident arising out of and in the course of the

employment. Paragraph (a) of this section emphatically states that the disease must be due to the nature of the employment.

Though the Factory Act (1987) generally covers the 'hygiene' and safety requirements of work environment, it however focuses purely on factory workplaces, and only by extension could it be applied to non-factory workplaces. Also, the health issues addressed in the Act are merely factory hygiene issues that do not take cognisance of serious health issues that may arise in the workplace. In the Workmen's Compensation Act, where various degrees of accidents that could occur in the workplace and the compensation for them were identified, no mention or description of such was made concerning occupational diseases except that compensation would be made for them as if they were accidents arising from the course of work. Since the emphasis of these two Acts is on accidents or ill health arising out of the nature of the employment, it therefore may not provide adequate legal protection for workers who may be infected with diseases from outside the workplace. Nonetheless, most organizations have workplace health policies that provide for the treatment and care of sick workers including those who may be infected with debilitating diseases such as cancer, hepatitis diabetes and tuberculosis. However, unlike the diseases mentioned above, HIV/AIDS is a dreadful illness that is presenting organizations with new human resource challenges that traditional health policies may not have envisaged. It is in recognition of the inadequacy of existing health and safety laws in dealing with HIV/AIDS that some national governments have began enacting laws to protect the HIV/AIDS infected both in and outside the workplace (Tosali, 2005). However, it is the International Labour Organization (ILO), the United Nations organ that regulates workers and employers' relations that have taken the initiative to ensure the protection of the HIV/AIDS infected worker. The ILO has developed a code of practice on HIV/AIDS in the workplace that is expected to serve as a guideline and a standard for relating with, and taking action on HIV/AIDS in the workplace.

The HIV/AIDS pandemic and the workplace

The HIV/AIDS epidemic is now a global crisis, and constitutes one of the most formidable challenges to development and social progress (The ILO, 2001). Since 1981 when the first known cases of Acquired Immune Deficiency Syndrome (AIDS) were reported in the United States (Ivancevich and Glueck, 1989), an estimated 40.3 million people have been infected with the virus worldwide (UNAIDS, 2005).

The Human Immunodeficiency Virus (HIV), which causes AIDS, is a virus that breaks down the immune system of the infected person. The virus, once contracted by the human body, evades the immune system defences and attacks it, rendering the body defenceless. Following the weakening of the immune system, the body becomes vulnerable to opportunistic infections such as diarrhoea, encephalitis with dementia (HIV infection of the brain), toxoplasmosis of the brain (a protozoan infection), herpes simplex, pneumonia, and other lower respiratory infections such as tuberculosis or a persistent cough. Such symptoms as fever, muscle ache, exhaustion, fatigue, loss of appetite, night sweats, swollen lymph glands and weight loss accompany many of the illnesses. This condition is what is known as the Acquired Immune Deficiency Syndrome (AIDS) (Tembo, 2004). There is an incubation period between HIV infection and the on set of AIDS. This period may range from few months to as many as thirty years (Shenton, 1998). The infected person dies of complications from massive attacks from many opportunistic infections (Agadzi, 1989; Flanders and Flanders, 1991). HIV is transmitted through body fluids – in particular blood, semen, virginal secretions and breast milk.

It has been established that transmission takes place in four ways: unprotected sexual intercourse with an infected partner (the most common); blood and blood product through, for example infected transfusions and organ or tissue transplants, or the use of contaminated injection or other skin-piecing equipment; transmission from infected mother to child in the womb or at birth and breastfeeding. It should be noted however, that HIV is not synonymous to AIDS. A person may contract the virus but may not develop AIDS for a long time. During this period, the person looks well like every other uninfected person without any compromise in ability or capability.

At the end of 2005, an estimated 40.3 million (range 36.7- 45.3 million) people around the world were living with HIV, including the 4.9 million (range 4.3- 6.6 million) people who acquired HIV in 2005. The epidemic claimed an estimated 3.1 million (range 2.8- 3.6 million) lives in 2005. Two- thirds of all people living with HIV are sub-Saharan Africa as are 77% of all women with HIV (UNAIDS, 2005). The emergence and spread of HIV/AIDS is having severe impact on virtually every facet of human life and the disease has become a household word (Flanders and Flanders, 1991). As Kofi Annan (2001) puts it, "AIDS is uniquely destructive to economies, because it kills people in the prime of their lives". UNAIDS (2005) aptly captures the growing threat of the HIV/AIDS pandemic as follows:

> At the economic, social, security and demographic levels the AIDS epidemic is having an impact more devastating than ever imagined. In addition to the untold grief and human misery caused by AIDS, the epidemic is wiping out development gains, decreasing life expectancy, increasing child mortality, orphaning millions, setting back the situation of women and children, and threatening to undermine national security in highly- affected societies. ...Because AIDS kills people in the prime of their working and parenting lives, it represents a great threat to development. By reducing growth, weakening governance, destroying human capital, discouraging investment, and eroding productivity, AIDS erodes the foundation on which countries seek to develop their societies and improve living standards. In the worst affected countries, the epidemic has already reversed many of the development achievement of the past generation. Now, AIDS threatens to thwart the hopes of the next (UNAIDS, 2005:4).

Sub- Saharan Africa, with the world's highest HIV prevalence, is said to face the greatest demographic impact. In the worst affected countries of Eastern and

Southern Africa, the probability of a 15-years old dying before reaching age 30 has risen dramatically. In some countries, up to 60% of today's 15- year- olds will not reach their 60th birthday (Timaeus and Jassen, 2003). In short, HIV/AIDS has become a global security issue. On 17 July 2000, the UN Security Council discussed a health issue for the first time – the AIDS epidemic – and adopted Resolution 1308, which identified the spread of AIDS as a threat to global peace and security, especially in the context of peacekeeping operations (UNAIDS, 2005).

With the kind of attention that HIV/AIDS is drawing across the globe, it would be unwise for organizations not to recognize it or adopt 'mark time' poise in relating to it at the workplace. HIV/AIDS is no longer just a social issue, it is a workplace reality, because the people in the prime of their lives, that happen to be the most susceptible to the virus are also most likely to comprise the workforce of any organization (Annan, 2001; UNAIDS, 2004). Thus, it would be a grave negligence of severe consequences for organizations or human resource managers not to consider HIV/AIDS as a workplace issue. There may be organizations that simply ignore AIDS since they do not want to be public about the disease. They fear tarnishing their image in the community. By not talking about AIDS, they hope that it will not become an issue. It is an issue (Ivancevich and Glueck, 1989).

The need for sound human resources management is hinged on the premise that the human resources of an organization are its most valuable assets, and that improved management of employees will lead to improved performance for organizations. The implication this has for organizations is that they cannot afford to turn a blind eye to anything that is likely to jeopardize employees' ability to perform their organizational duties. The HIV/AIDS pandemic presents itself as one of the gravest dangers to employees' health in today's workplace. The disease, when it begins to take its toll, reduces both the productivity of infected employees and those who have to put up with them in the workplace (Banas, 1992).

The responsibility thus falls on organizations to recognize and take steps in countervailing the effect of the disease in the workplace. The fight against HIV/AIDS cannot to be left to government alone because as Plumley et al (2002:1) has rightly observed,

> HIV/AIDS pose a challenge of such magnitude that no pillar of state or economic entity can deal with them alone. They can only be dealt with through collective efforts – actions from government, the private sector, civil society, faith-based organizations, trade unions and the global community. The private sector can make a unique contribution through its privileged access to people, its communications and implementation skills and the product and services it delivers.

HIV/AIDS is not only a threat to the economic prosperity of nations (Plumley et al, 2002), but also to organizations because organizations constitute the economic units of nations.

The ILO Code of Practice on HIV/AIDS in the workplace

The International Labour Organization (ILO) recognizes HIV/AIDS as a major threat to the world of work. That is why it is committed to making a strong statement through a code of practice on HIV/AIDS and the world of work. The code is expected to be instrumental in helping to prevent the spread of the epidemic, mitigate its impact on workers and their families and provide social protection to help cope with the disease. It covers key principles, such as the recognition of HIV/AIDS as a workplace issue, non-discrimination in employment, gender equality, screening and confidentiality, social dialogue, prevention and care and support, as the basis for addressing the epidemic in the workplace (Somavia, 2001). The document is a pioneering and groundbreaking effort to stir up organizations to take action on HIV/AIDS in the workplace. It addresses present problems and anticipates future consequences of the epidemic and its impact on the world of work (Somavia, 2001). We hereunder present the salient provisions of the code as embodied in the document.

Objectives, Use and Scope

The objective of the ILO code is to provide a set of guidelines to address the HIV/AIDS epidemic in the world of work and within the framework of the promotion of decent work. The guideline covers the following key areas of action: prevention of HIV/AIDS; management and mitigation of the impact of HIV/AIDS on the world of work; care and support of workers infected and affected by HIV/AIDS; and elimination of stigma and discrimination on the basis of real or perceived HIV status. This code is to be used to develop concrete responses at enterprise, community, regional, sectional, national and international levels. It applies to all employers and workers (including applicants for work) in the public and private sectors and all aspects of work, formal and informal.

KEY PRINCIPLES

1.   Recognition of HIV/AIDS as a workplace issue

HIV/AIDS is a workplace issue, and should be treated like any other serious illness/ condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggles to limit the spread and effect of the epidemic.

2.   Non-discrimination

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatisation of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.

3.   Gender equality

The gender dimension of HIV/AIDS should be recognized. Women are more likely to be infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and

economic reasons. Therefore, more equal gender relations and empowerment of women are vital to successfully prevent the spread of the infection and enable women cope with HIV/AIDS.

4.   Healthy work environment

The work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981(No. 155). A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.

5.   Social Dialogue

The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected or affected by HIV/AIDS.

6.   Screening for purposes of exclusion from employment or work processes

HIV/AIDS screening should not be required of job applicants or persons in employment. Any routine medical testing, such as testing for fitness carried out prior to the commencement of employment or as a regular basis for workers should not include mandatory HIV testing.

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. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data (1997).

8.   Continuation of employment relationship

HIV infection is not a cause for termination of employment. As with many other conditions, person with HIV-related illness should be able to work for as long as medically fit in available, appropriate work.

9.   Prevention

HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive. Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment. The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socio-economic factors.

10.   Care and Support

Solidarity, care and support should guide the responses to HIV/AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependents in access to and receipt of benefits from statutory social security programmes and occupational schemes.

Action on HIV/AIDS in the workplace: International Comparisons

Reporting on corporate HIV/AIDS policies and programmes is a new phenomenon, as are such policies and programmes themselves (Bendell, 2003). However, in response to the request by the United Nations General Assembly on HIV/AIDS (UNGASS) that data on the response of different sectors of society be generated and analysed, the United Nations Research Institute for Social Development (UNRISD) in partnership with the Joint United Nations Programmes on HIV/AIDS (UNAIDS) conducted a global survey of Transnational Corporations' (TNCs) response to the pandemic. They also conducted three surveys of large corporations in Brazil, the Philippines and South Africa, as well as case studies of selected corporations in these countries. These studies provide some baseline information on the nature of workplace responses to the HIV/AIDS pandemic that Nigerian organisations could certainly learn from. We shall start with the example of workplace responses in South Africa which is acknowledged to have one of the highest HIV/AIDS infection rates in Africa.

The South African Case

In South Africa, where 11.4 percent of the country's population of two years and older are living with HIV/AIDS, it was discovered that a majority of companies have policies or programmes on HIV/AIDS in the workplace (Bendell, 2003). For example, 81 percent of responding companies in the TNCs survey had policies and programmes at both group and subsidiary levels. This commitment is thought to be attributable to the fact that most of the responding companies in a national study considered HIV/AIDS threat to their companies as either extremely serious or serious. No organisation believed that HIV/AIDS is not a problem. The study also revealed that policies on HIV/AIDS in the workplace cover areas specified by the ILO code with the exception of one, which is, "screening to exclude from work processes."

At the level of preventive measures, a vast majority of the respondents comply with the internal or workplace – oriented AIDS policy requirements of condom promotion and provision, voluntary counselling and testing (VCT), diagnosis and treatment of Sexually Transmitted Illnesses (STIs), education and work-related safety. Also, the policies are generally very strong in prohibiting discrimination against employees who may be HIV positive, as well as in the provision of free counselling and treatment of STIs. Helping people stay in work if ill is required and guaranteed by law. However, respondents' policies are not as encouraging when it comes to the provision of more complex and perhaps

more costly treatment for employees. In general, it appears that a good number of South African companies are taking action on HIV/AIDS in the workplace.

The example of Brazil

In Brazil, where the impacts of HIV/AIDS are less than South Africa, the situation is that fewer companies are taking action. In spite of the fact that Brazil has the highest number of HIV/AIDS cases in Latin America only 5.9 percent of the Brazilian respondents in the national studies (Bendell, 2003) consider HIV/AIDS as an extremely serious problem now. Another 35 percent consider it a serious problem now. A little above half (52 percent) of the 25 companies reported having a workplace policy on HIV/AIDS at both group level and in subsidiaries. Some companies (11.8 percent) said they do not believe they currently have reasons to establish any specific HIV/AIDS policy or program. The study also revealed that each provision of the ILO code is covered by over 70 percent of the companies that have HIV / AIDS workplace policies and programmes except in the case of the code on screening to exclude from work or work processes.
At the level of preventive measures, less than half of those companies with policies and programmes were found to promote or provide condoms, or target high-risk groups. Education was also found to feature strongly as it does in South Africa, as well as prohibition of discrimination against workers living with HIV/AIDS. The first reason most respondents gave for taking action on HIV/AIDS was to act as responsible corporate citizens. The second reason was the recognition of the immediate and long-term danger to economic growth posed by HIV/AIDS.

Philippines and HIV/AIDS workplace policies

In the Philippines, HIV/AIDS prevalence is much lower than in South Africa and Brazil (Bendell, 2003). Thus, the study found that the majority of respondents did not consider that HIV/AIDS was a current problem for their company, or that it would be in 10 years. Only 19 percent of the 25 largest corporations had a workplace policy or programme on HIV/AIDS. The few companies that were acting on the issue said they were doing so in order to be responsible corporate citizens and that their actions were part of their strategic plan rather than representing the need to deal with pressing concerns.

On areas covered by policies, the study revealed that most aspects of the ILO code except those relating to social dialogue and screening to exclude from work or work processes were covered. Also, although most of the companies that had policies provided education on HIV/AIDS issues, the other prevention measures were not well covered. Similarly, not all the companies that had policies prevented discrimination. They also did not have a number of other key mitigation measures, indicating that, at present, the response to the problem was limited in the country.

The Nigerian experience

The first case of AIDS was identified in Nigeria in 1986. Between 1988 and 2001, the HIV/AIDS prevalence rate rose from 1.8% to 5.8%. Since 1991, the Federal Ministry of Health has carried out a National HIV/Syphilis sentinel seroprevalence survey every two years. The most recent survey was in 2003 and it established that there were 3,300,000 adults living with HIV/AIDS in Nigeria; 1,900,000 (57%) of these were women (Pennington, 2005). In spite of the fact that HIV/AIDS prevalence rates are much lower in Nigeria than in other African countries such as South Africa and Zambia, this low prevalence rate nonetheless translates to a large number given that Nigeria has a large population- the highest in Africa. The 2003 survey revealed while the HIV / AIDS prevalence rate had dropped from 5.8% in 2001 to 5%. However, there was a wide variation in the prevalence rates between the different states of the country. For example, while Osun State had a prevalence rate as low as 1.2%, Cross River State had a prevalence rate as high as 12%. Overall, 13 of the 36 states in Nigeria had prevalence rates of over 5%. These figures lend support to the claim that there are explosive, localized epidemics in some states. In 2004 it was estimated that there were 300,000 deaths from AIDS and 2 million AIDS orphans in Nigeria (Pennington, 2005). The fight against HIV/AIDS is being fronted at the national level by the National Action Committee of HIV/AIDS (NACA) based within the office of the President, who is the chair of the NACA board. NACA is coordinating the various HIV/AIDS prevention and treatment activities in Nigeria. NACA is entrusted with the responsibility of executing and implementing activities under the HIV/AIDS Emergency Action Plan (HEAP), introduced in 1996 as a bridge to long-term strategic plan. HEAP comprised two main components. First to break down barriers to HIV prevention and support community responses, and second, provide prevention, care and support interventions directly. HEAP has now been replaced with the National AIDS Strategic Framework, which will run until 2009 (Pennington, 2005).

Generally, NACA represents a strong political commitment to tackle HIV/AIDS in Nigeria. However, this commitment cannot be said to be a reflection of the commitment in the Nigerian workplace. Much is yet to be known about how Nigerians are relating with the HIV/AIDS pandemic in the workplace. Available evidence indicates that less than one-third of companies in Nigeria are taking any action to prevent HIV/AIDS in the workplace. This evidence emanates from a survey of manufacturing firms in Nigeria conducted by Rosen et al in 2004 on why firms took action on HIV/AIDS. The study focused on why Nigerian companies' responded the way they did to HIV/AIDS in their workplaces at the level of prevention of new HIV infections among the company's workforce. The overall finding of this study was that actions by Nigerian firms on HIV/AIDS were determined primarily by what managers knew about the epidemic: their exposure to external information about it and their knowledge of workers who were HIV-positive or had left the workforce because of AIDS. In spite of the fact that this study provides some illumination on workplace responses to HIV/AIDS in Nigeria, its primary focus was on the reasons why firms were taking action, and not necessarily on the scope of the actions being taken. Unlike the examples from South Africa, Brazil and the Philippines, this study did not evaluate the degree of workplace responses to HIV/AIDS especially vis-à-vis the ILO code of practice, which provides the most comprehensive guideline on workplace response to HIV/AIDS. There is therefore the need for a study that will provide baseline information on how Nigerian

organizations are relating with the HIV/AIDS issue in the workplace vis-à-vis the ILO code of practice on HIV/AIDS and the world of work. Such a study must, however, be prefigured by an understanding of the components of workplace policies on HIV/AIDS.

Implications for developing HIV/AIDS policies in the workplace in Nigeria

If the consequences of HIV / AIDS for nations and organisations and international experience with policy on the problem indicate the urgency for developing workplace policies on HIV / AIDS in Nigerian organisations, the ILO Code of Practice shows what must be the essentials of such a policy. The ILO Code of Practice shows that formal action must be taken to provide information and education to employees about the disease. Besides this, organizations must facilitate preventive measures and there must be a formalized way of managing those who may contract the virus as well as those that work with them. HIV/AIDS management must focus on treatment, care and support activities. Since HIV status is not a criterion that prescribes performance, organisations must evolve means of managing their HIV infected employees in order to continue to utilise their physical and mental strength until such a time that they are no longer able to discharge their duties due to complications arising from opportunistic infections associated with AIDS.

Managing HIV/AIDS also means managing workplace relationships because discrimination and stigmatisation remain the worst threat to the HIV/AIDS infected employee in the workplace. The gender dimension of the illness must be appropriately acknowledged and addressed (Mbugua, 2000; Foreman, 2003; Kiragu, 2003; Iwere, 2003). Also, human resource planning must begin to take into cognisance the debilitating effect of the pandemic and make provisions for loss of employees that may be a direct or indirect consequence of it. Nigerian work organisations must also build measures on HIV/AIDS into their social responsibility plans so that action at the organisational level can be supported by change in beliefs about HIV/AIDS at the community level. Programmes of enlightenment that are focused on changing negative traditional beliefs and the negative attitudes of specific sectors of society such as the judiciary to HIV / AIDS should be incorporated into corporate social responsibility plans. In 2006, for example, a Nigerian Judge granted an application brought by an HIV positive woman that she be allowed to use a pseudonym in court so that her real identity would not be known. While undertaking to 'do everything within its power to ensure that the identity and privacy of the applicant is protected in this case', the Judge however, refused to grant another application by the same woman that 'the case be heard in camera' (AFRO-NETS, 2006: 2). The woman had instituted the court action against a government – owned hospital which refused her access to treatment on account of her HIV status. This case, illustrates, as the other case already cited, the degree of discrimination against HIV positive persons and people living with AIDS based upon negative beliefs and taboos about the illness in Nigerian society.

All the measures adopted by an organisation must, however, be set out in a set of workplace policies that are communicated and explained to employees at all levels. Such a set of policies must not only cover all the areas provided under the ILO codes; it must also deal with the specific problems and conditions that seem to make the disease an undiscussable and difficult subject in the Nigerian work context. It is in this regard that informal organisational action will need to complement formal action. As a highly masculine (Hofstede, 1986) and patriarchal society efforts that formally target the gender dimension of the illness in the workplace may be complemented by informal actions that encourage women to form groups within the organisation for the purpose of providing greater support to individual women to resist behaviours that expose them more than men to the disease. Indeed, workplace management can facilitate at an informal level, the emergence of communities of practice, especially among women, on HIV/AIDS in the workplace.

There is no doubt that there will be huge costs associated with managing HIV/AIDS related issues in the workplace in Nigerian organisations. But Nigerian organisations must consider it as part of their overhead costs, and especially so, because HIV/AIDS is not restricted to any particular firm, industry or environment. Denying HIV infected persons employment or terminating the employment of persons found to have contracted the virus with the aim of eliminating the likely cost of managing them is unethical and contrary to the ILO Code of Practice on HIV/AIDS and the World of Work (2001). Even if such unacceptable measures are taken without any immediate punitive consequences, organisations will suffer from the impact of their own actions in the long run, because the society where the HIV infected is left in or pushed back to, is the only source of human resource for organisations.

CONCLUSIONS

HIV/AIDS is a debilitating disease for which no cure has yet been found. Besides being a critical social and economic issue, HIV/AIDS has become a workplace reality. It is one of the gravest health hazards in today's workplace because of its high potency for undermining the performance of employees through sustained ill health and hence, the ability of organizations to achieve their objectives. Managing HIV/AIDS in the workplace is crucial because the 21st century organisation is a knowledge-based organisation. The implication of this for organisations is that some of the skills, capabilities and competences required for organisational performance may reside only in HIV/AIDS infected workers. For a country with 3,300,000 people living with HIV/AIDS, Nigerian organizations cannot afford to treat the pandemic with levity. Unfortunately, evidence does not yet exist as to the degree to which Nigerian organizations consider HIV/AIDS a workplace issue. Policies have not yet been formulated and designed to respond to it.

The peculiar nature of the disease presents a whole new dimension to occupational health and safety. The emerging issues are those that traditional health and safety policies and programmes do not adequately cover and therefore, there is the need to develop policies that will enable organizations to relate to this disease in the workplace. The International Labour Organization (ILO) recognizes this need and has thus

developed a code of practice on HIV/AIDS in the workplace. This code should serve not only as a basis, but also as a measure of workplace responses to the pandemic in Nigeria. Nigerian organisations need to adopt the code and expand it to include features that will enable the resulting policy set deal with the peculiarities of the conditions that foster the disease in Nigerian society in general and in the workplace in particular. Finally, beyond having policies in place, there is the need for a study on the experience of Nigerian organisations with the policies and how they are relating to the disease in the workplace. If anything, current experience strongly indicates that tomorrow's surviving and better performing organisations would be those that have developed effective policies and methods for managing the disease today.

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