INFORMAL, ORGANIC RESPONSES TO HIV/AIDS IN THE WORKPLACE: Cases from Nigeria[1]

1. Background

1.1. The epidemic

The scourge of HIV/AIDS is undoubtedly one of the most significant borderless realities of our time. The global estimate for the number of persons living with HIV is alarming. Sub-Saharan Africa has the world's highest HIV prevalence - 28.4 million people, out of which about 60% are women - and thus faces the greatest demographic impact[2]. In Nigeria, since the first documented case in 1986[3], it has been established that the nation has the highest number of people living with HIV in West Africa; HIV infections are higher in urban than rural areas[4]; and more than half of infected people are women[5]. Although the analysis of the status and trends indicate a downturn in the national prevalence rate from 5.8% in 2001 to 4.4% in 2005, figures on the number of children orphaned by AIDS reveal otherwise, with an increase from 1.8 million in 2004 to 1.97 million in 2005[6].

1.2. HIV/AIDS in the workplace

The incidence of HIV/AIDS spans various spheres of interaction and has implications for different constituencies. One of such is the workplace. According to ILO figures, as many as 36.5 million persons who are engaged in some form of productive activity were HIV positive as at 2003. Even more worrisome is the prediction that by year 2020, about 36 African countries will suffer losses between 10 and 30% or more in this sector[7]. Expectedly, the most populous country in Africa, Nigeria ranks high in this regard, with a report of 2.4 million cases of workers in different sectors who are HIV positive[8], out of the estimated 2.86 million infected persons[9] in the country.

1.3. Policy and non-policy responses

Over the years, especially in the last decade or so, there has been a huge focus on internal mainstreaming of HIV/AIDS all around the world by multinationals, governments, international organisations, donors, civil society organisations (CSOs, FBOs, CBOs, etc) and others, using a multi-prong approach. Some of the interrelated reasons for managing HIV/AIDS in the workplace include socially responsible employership; reducing direct, indirect and systemic costs incurred by organisations due to HIV/AIDS - related illnesses; demonstrating credible behaviour within communities of work; among others. A major motivation for developing strategic intervention programmes within the workplace is to mitigate the spread as well as the consequences of the phenomenon in the society. Thus organisations are responding by putting in place programmes and activities to tone down its effects such as employee sensitisation and education, care and support, provision of access to VCCT, ART, PMTCT etc.

1.4. Nigeria and workplace responses to HIV/AIDS

The Nigerian government launched the national response policy on HIV/AIDS in the workplace in 2005 as one of the intervention efforts to curb the menace of the disease. Despite this, the workplace which is a vital entry point for reversing the trend remains largely untapped in both the public and private. It is observed that within the non-government, apart from some of the organisations whose core business is HIV/AIDS programming, only a

handful of organisations respond to HIV/AIDS in the workplace. The majority of these organisations are undertaking internal and /or external mainstreaming at the request of donors. To ensure progress in the area of mainstreaming, some of these organisations have developed workplace policies to raise awareness and to protect the rights of their workers. Due to the high rate of spread, many organisations are either directly or indirectly programming externally around HIV/AIDS. Another category which constitutes a tiny minority is organisations that have developed some form of informal, undocumented intervention mechanisms to cope with the effect of HIV/AIDS in the work environment.

2. Aims and Objectives of the Study

2.1 Aims

2.1.1. To make visible non-HIV policy responses to HIV and AIDS in the workplace
2.1.2. To find out what motivated these responses and how they can be supported from outside
2.1.3. To explore the links between informal, organic responses and formal policy responses.

2.2. Objectives

To achieve the aims of the study, the following objectives were so set to find out:

2.2.1. How organisations are responding to HIV/AIDS in the workplace in the absence of a formal policy; that is their 'organic' coping activities for responding to HIV
2.2.2. Organisational motivation and catalyse for responding to HIV
2.2.3. How HIV workplace response can be stimulated in informal, often pioneer-led organisations;
2.2.4. The extent to which some of the organic and informal responses of these organisations can be documented as well as costed and budgeted for; and
2.2.5. How the informal responses can be integrated into a formal policy

3. Methodology

The research project employed the qualitative case study method to gather contextual data. Data collection was through semi-structured interviews during face-to-face visits or telephonic interviews with two (2) or more staff members of six (6) non-governmental organisations from five (5) states, spread over three (3) of the six (6) geo-political zones in Nigeria. There was also a desk study of relevant literature. This process spanned five weeks

4. Participating Organisations[10]

The following organisations participated in the study: (i) Alliances for Africa (**AfA**), Ikoyi, Lagos State (South-West zone); Communal Care Centre (**CCC**), Oguta, Imo State (South-East zone); Family Health Initiative (**FAHEDI**), Ile-Ife, Osun State (South-West zone); International Women Conference Centre (**IWCC**), Ilorin, Kwara State (North Central zone); Prevent AIDS Society (**PAS**), Ado-Ekiti, Ekiti State (South-West zone); and Wellbeing Foundation (**WBF**), Ilorin, Kwara State (North-Central zone). The core businesses of the organisations include: governance and participation; leadership; economic empowerment; and HIV/AIDS prevention, care and support. Orphans and vulnerable children (OVC), women, youth, men and the community in general are the beneficiary constituencies of the organisations.

5. Findings

5.1. Motivation for Organisational Response

In the course of the interviews, it was revealed that in addition to the reasons highlighted in Section 1.3 organisations were motivated by:

5.1.1: Personal Experience/involvement /reality

The responses of Communal Care Centre **(CCC)** and Prevent AIDS Society **(PAS)** were stimulated because of personal encounters with HIV/AIDS as infected (PLWHA) and affected persons (PABA).

Three (3) of the staff at CCC are living with the virus. Two of these SLWHA are siblings. The reality of her status and the desire to help herself and other PLWHAs prompted the Executive Director of the organisation to the establish CCC. It was also anticipated that the intervention efforts will prevent the further spread of the virus within the community.

For PAS, the founder's interest arose from his personal loss. His best friend died of AIDS in his third year in the university. The victim, a first class student of Accountancy and the only child of his parents, was not aware that he had been infected with the virus until three days before his death. This was the founder's first confirmation that HIV/AIDS was a reality, and it was a lesson learnt the hard way. According to PAS' Executive Director, that was the only challenge he needed to take action. He then started a small group in 1995 which he labelled ANTI AIDS Club as a student. With time the group gained government recognition and donor support over the years. The organisation subsequently evolved into PAS in 2001. One of the staff members is living with HIV.

5.1.2: Awareness and information

A vital motivation for the responses to HIV/AIDS in the workplace is information about the spread of HIV/AIDS. At **FAHEDI**, there was a SLWH as at the time of this study. Prior to joining the organisation most of the staff members were already aware of the magnitude of HIV/AIDS. This made it easier for them to work with the staff living with HIV (SLWH). Therefore, what was needed was to enhance their capacity to respond more effectively to related issues in the area of programming. Having a colleague that is living with the virus has impacted the lives of other staff members for the better.

IWCC and **WBF** were prompted to respond to HIV/AIDS within the walls of the work environment because of the knowledge of the degree of the outbreak and consequences of the virus in the state. It was obvious from the prevalence rate that there should be concerted efforts to stem the tide from every angle possible. Additionally, **CCC** received so much information on the different aspects of HIV/AIDS prevention, care and support from other organisation that it became imperative to put all the information received to good use. This serves the organisation well in both internal and external responses to HIV/AIDS. Also in this category is **AfA.** In the course of its work at local, national, regional and international levels over the years, the organisation has gained so much knowledge and insights into the issue of HIV/AIDS. Consequently, it believes that it is well equipped to deal with the different aspects of HIV/AIDS, including the gender dimensions.

5.1.3: Walking the talk

As a development organisation dedicated to the promotion and protection of human rights, **AfA** deems it important to face the reality of HIV/AIDS from a rights perspective. The organisation believes that to be effective at the journey of restoring the dignity of women, it is necessary to lead by example. In 2005, it employed an SLWHA who never expected it.

According to the Executive Director, “I felt if I did not employ her simply because of her HIV status, I should just pack up and leave the development sector. I believe it was God that put the situation on my table to see how I will deal with it. If I say that I am walking this walk with women, I have to make fairness and justice at the centre of all that we do at AfA”.

5.2. Coping Mechanisms

Whereas some of the responses of the participating organisations to issues around HIV/AIDS within the workplace and in the community of work were similar in nature, there are also some intervention mechanisms that are different. The common features include: (a) preventive activities such as training, counselling, education, information sharing, sensitisation; (b) eradication of stigma and discrimination; (c) treatment and care through facilitating access to ART, providing home-based care; facilitating regular medical checks (d) establishment/ identification of support group; e) greater involvement of persons living wit HIV/AIDS (GIPA); (f) direct financial assistance, among others.

5.2.1. Preventive Measures

CCC management shows its commitment to the prevention of HIV/AIDS amongst the work force in different ways. The organisation has a strong support group that is dedicated to helping other members in the areas of *counselling*. There is a well trained professional counsellor who is a SLWHA, and whose job description is to guide other staff in making choices and taking informed health-related decisions and other actions that have implications for their wellbeing. Staff also access VCCT from the Global Health Action Initiative (GHAIN) CENTRE at Awo Omama. In addition, **CCC** organises regular programmes to disseminate information on the most current trends and issues around HIV/AIDS to avoid risky behaviour. Similarly, **FAHEDI**’s dedication to slowing down the growing rate of the virus manifests in *information and education* activities among the workforce especially on knowing how to adopt best practices on prevention methods. As with the other organisations, **IWCC** and **WBF** also respond through counselling and the provision of information to their staff on the various issues associated to HIV/AIDS. Furthermore, **WBF** and **CCC** hold internal training workshops and seminars periodically. They also, attend external workshops on HIV/AIDS from time to time.

PAS has a slightly different perspective from the other participating organisations on prevention. As an organisation which programmes around all areas of HIV/AIDS, it is believed that there is adequate information and education among staff. Since they have been equipped as resource persons who have the responsibility to educate and empower other people, staff members are familiar with prevention methods. Therefore, PAS does not undertake special activities geared towards enhancing the capacity of the staff on protection within the workplace. However, in spite of this, the organisation makes provision for *condoms* for its staff. It is assumed that staff take advantage of this facility as required. It is pertinent to mention nevertheless that as at the time of this study, PAS did not have the condom for its female staff. In the same vein, staff at some of the participating organisations – **FAHEDI, IWCC, WBF,** and **CCC** - identified the ABC method for prevention, in addition to healthy eating habits and stress-free lifestyles. The issue here is that there have been discussions around the effectiveness of the ABC method of prevention from HIV because women do not have control over their sexuality. This is a manifestation of gender inequality and injustice that permeates societies around the world.

5.2.2. Treatment, Care and Support

a) Treatment

The SLWHA at **FAHEDI** was ill for a substantial length of time. When the organisation got her into the hospital, she was placed on anti retroviral therapy (ART). She has since got back on her feet and very strong except for occasional bout of malaria fever, a commonplace illness in Nigeria. **PAS** facilitated the SLWH to access drugs free of charge through PEPFAR, after the initial registration payment. After much advocacy, the state government got its own ART programme and presently provides the services at the Medical Centres. This has made the therapy more easily accessible. **AfA'**s response in this regard was to ensure that its SLWH is on the free treatment programme of Médecins sand Frontières at the Lagos General Hospital. Although her status is such that she does not require any medication yet, she goes for regular CD4 Count and other relevant tests. **WBF** and **IWCC** also provide ART for their SLWH.

b) Management, Care and Support

FAHEDI believes strongly that it is the management's responsibility to care and provide support for its SLWH staff or their families. This commitment falls in line with the mandate of the organisation to the needs of vulnerable people. Thus, it copes with the vulnerability of the staff vis-a-vis HIV/AIDS. To guarantee the sustenance of its SLWHA and other beneficiaries, **FAHEDI** initiated the first support group in Ile-Ife. This became imperative because it was obvious that the SLWHA needed to be propped up by other people in similar situations. This ensures that she receives counselling and gets more updated knowledge on HIV/AIDS. **AfA** also started the Association for Positive Change (ASPOCA), the only support group in Imo state. The objectives of this intervention effort include building the capacity to take care of themselves and facilitating access to free treatment at the hospital, among others. The organisation also contacted Journalists against AIDS (JAAIDS) for counselling and other support facilities for the SLWH. **CCC** on its part links its SLWH to existing support groups for the immense benefits that abound within the groups. The organisation realises, from personal experiences, the significance of this strategy because they are aware of the difficulties encountered by PLWH at the initial stage of discovering their status. **WBF and IWCC** provide treated mosquito net, home - based care and counselling services to its SLWH. In addition, the management does not hesitate to render any assistance especially as it concerns their health.

5.2.3 Elimination of Stigma and Discrimination

Stigmatisation and discriminatory practices and attitudes against PLWHA continue to be widespread in the Nigerian society, as with many other developing nations. The implications of this are numerous, key among which is the reluctance to access VCCT services even when they are provided free of charge. In addition, the fear of stigmatisation ranks high on the list of reasons that many infected people do not declare their status or seek help. Thus, organisations which respond to HIV/AIDS in the workplace often put emphasis on the elimination of stigma and discrimination. For this reason, the organisations under investigation place a high premium on the issue.

One of the SLWH at **WBF** had suffered so much from stigmatisation prior to working with the organisation. He was discriminated against by his family members and friends. They all deserted him and no one seems to care. Then he became critically ill and was hospitalised for three months and diagnosed to suffer from malaria and depression. WBF organised counselling for him to overcome the effects of the psychological and emotional trauma. The SLWH is doing well as at the time of this report. It was established that none of the SLWH has ever suffered discrimination at WBF. The absence of stigma and discrimination in the organisation is attributed to the enhanced capacity of staff on HIV/AIDS which is ensured by

regular training and sharing. However, another reason given for this positive attitude is the non-disclosure of the status of SLWH to others, with the exception of the senior management staff. It is not clear whether the situation would have been different if the SLWH were living openly. This lack of information on the status of colleagues also predisposes others to the possibility of contracting the infection.

Similarly, stigma and discrimination is uncommon at **PAS**. This has been helped by the trainings which staff members benefit from regularly by virtue of the demands of their jobs as resource persons on HIV/AIDS. They have been empowered to recognise the warning signs of stigma and discrimination and they pass these on to other people. They are also knowledgeable about the modes of transmission. The interview also revealed an isolated case of discrimination against the SLWH by a newly recruited staff member who, on discovery of a SLWH at PAS, selected items in the kitchen decided to separate them for her personal use, for fear of being infected. This was a learning point for the organisation which then took some measures such as counselling and exposure of the staff to series of training programs which facilitated her education, information and empowerment in this regard.

All **FAHEDI** staff members have good interpersonal relationships and apart from official interactions, the SLWH visits the homes of other staff and vice-versa without any reticence. Talking about HIV/AIDS is as normal as discussing other issues bordering on development and health within the office environment. The knowledge has helped staff to engage friends, family members as well as beneficiaries of their programs in discussions around HIV/AIDS. FAHEDI believes that with the level of awareness and training in the organization, there is no manifestation of stigma and discrimination. **AfA** is regarded as one big family as a result of its openness. Consequently discrimination on the basis of any form of diversity is unacceptable, and staff members look out for each other. Like the other organisations, the increased level of awareness through information dissemination/staff trainings makes it easy to accept the SLWH. In addition, the organisation has worked in the area of women's right to health. At **IWCC,** non-discrimination is taken to another level which could be risky for other staff members who may be required to care for PLWHA from time to time to the extent that they may have to clean up a bleeding PLWHA without any form of protection. Within **CCC,** looking after SLWH is considered as normal as taking care of a person who has any other kind of ailment because of the information, knowledge and education that everyone has received. With the awareness that two of the management members and another staff are living with the virus, HIV/AIDS is a reality and this has helped put faces to the phenomenon. Like AfA, the staff regards CCC as one big strong happy family and feel secure in that knowledge.

5.2.3. Greater involvement of persons living with HIV/AIDS (GIPA)

To demonstrate their commitment to progress in the area of HIV/AIDS some of the organisations have specifically targeted and recruited PLWHA onto the workforce. These organisations are AfA, PAS and WBF. According to **PAS**, ignorance remains the key reason for not employing PLWHA. This is associated with another common factor – the fear of death. The SLWH was in a terrible state when she came in contact with PAS – she had been dismissed from her teaching job on account of her status and had lost a baby because she had no access to PMTCT. In the first place she had lost her means of livelihood, secondly she was divorced, thirdly she had other children to cater for, and fourthly she had just lost her baby to HIV/AIDS. And lastly she herself was infected and everything seemed so dark for her. So, she was depressed and psychologically down. What the PLWH needed at that point was a job and getting her health back. Then, PAS offered her a position. The direct implication of working with a SLWH does not affect the entire productivity of **FAHEDI** as an organisation. SLWH is usually invited to bring her experiences to bear on programmes directly related to PLWHA. There is always a provision for a colleague to stand in for her. **WBF** encouraged the SLWH to join the organisation when they came to seek assistance. The reason was that they looked very strong and agile. It was therefore necessary to engage

them and make them see the possibilities. Now they are part of the counselling team of the organisation. The SLWH at **AfA** performed well at the interview and was one of the top two recommended for the position. She came in with very good credentials and references. When her medical report showed the presence of the virus in her system, it was an opportunity to put theory into practice. It is the general belief that when an organisation employs PLWHA, it is surely likely to suffer a loss. This, from the experiences of these organisations, is baseless. If the organisations make allowance for SLWH to attend their clinics and encourage them to live positively, they will have meaningful lives.

5.2.4. Direct financial assistance

In addition to the responses described earlier, the interviews reveal that the organisations also provide financial support to SLWH. **WBF** claimed that the staff members have a fat take home pay. Also in this league is IWCC which also ensures that the SLWH are financially comfortable so they do not fall ill often. Same goes for **FAHEDI.** SLWH at **IWCC** can also access micro credit loans. **PAS** has funds set aside for staff welfare in emergency situations. It is from this pool that the organisation makes available whatever financial assistance required to the SLWH, such as her transportation costs and medical bills for other non-HIV/AIDS- related ailments. The funds are not tied to HIV/AIDS because the organisation believes that it is a form of discrimination to categorize it as such. The needs of all staff are considered without any form of bias. Although the SLWH at **AfA** has access to free medical and counselling services, the organisation is directly responsible for her health-related transportation costs. **CCC** collaborates with networks and development partners to source funds for internal and external HIV/IADS mainstreaming to ensure the wellbeing of SLWH and PLWHA.

5.2.5 Indirect Financial Assistance

PAS also exposes the SLWH to other sources of assistance because she has responsibilities as a single parent of three children. The organisation recommends the SLWH for participation at national and international HIV/AIDS conferences so that she could use the allowances for the maintenance of her family. Furthermore, it recommended the SLWH for participation in a media advocacy programme on HIV/AIDS where she receives a monthly salary. This she uses to supplement her salary as a staff of PAS. This strategy that has worked in helping the SLWH meet all her needs and thus reduced her stress level.

5.3 Financial Implications of Responses

The responses of these organisations to the effects and consequences of HIV/AIDS within their office spaces are not without implications for their budgets. However, the impact has not been the same for all the participating organisations. It was gathered that whereas some of the organisations are able to access funding from some networks and other development partners, funding is a major limitation to the intervention efforts of some others.

5.3.1 Financial Impact of Organisational Response to HIV/AIDS

FAHEDI is a growing NGO with limited funding, a major constraint to the actualisation of set goals and objectives. In addition, the organisation does not have a provision for the welfare of staff which could be used for HIV/AIDS prevention, care and support within the workplace. However, from the records, FAHEDI is quite clear about the cost implication of the informal responses from time to time based on the kind of the particular support they give. The committee responsible for HIV/AIDS takes note of expenses on provision of food supplement, and financial assistance, among other things. The intervention process has not only affected the organization's budgeting but the personal budgets of staff as well. What the organisation does is to devise ways of raising funds to meet these needs. This may involve personal contributions by other staff members when the need arises. Consequently this places a restriction on the level of support it can give at any given point.

Similarly, **AfA** has a small budget which though has coped with the needs of the only SLWH, will find it difficult, if not impossible to meet the medical and other associated costs of another SLWH should the case arise. As at the moment, the organisation does not have dedicated funds for staff welfare or provision for medical benefits apart from the allowance paid to staff with the monthly salary.

As for **WBF,** the responses have not in anyway affected the organisational budget because there is always funding set aside responsible for each separate project. Similarly, the intervention mechanism has not affected the budget of **CCC** in any way. The organisation has a separate account dedicated to HIV/AIDS prevention and support. As noted earlier in section 5.2.4, **PAS** has a small budget set aside for the welfare of the immediate needs of the staff. The organisation considers itself privileged that there has not been a situation of crisis for the SLWH on the basis of her status. As such, what is required is less than =N= 50,000 (US$500) annually, an amount that PAS considers very insignificant against the benefits. As for **IWCC,** staff members are on a 'fat' salary, in addition to the provision of loan facility to SLWH.

5.3.1 Funding for internal mainstreaming. Some of the organisations have identified organisations and networks that are favourably disposed to external and in some cases internal mainstreaming of HIV/AIDS. There are also internal initiatives towards generating funds for the welfare of staff. **IWCC** receives funding/financial support from Kwara state action committee on AIDS (KWASACA) and from the Centre for Women Virology. The **WBF** has sourced adequate funding for the organisation from which it programmes around HIV/AIDS. The funds received from ARFH are also used for the same purpose. **PAS** has an endowment fund. In addition, the excess from project funds is also diverted into the welfare pool. This is used for the wellbeing of all staff including SLWH. **CCC** receives financial support from the Centre for Development and population Activities (CEDPA), the Network of People Living with HIV/AIDS (NEPWAN) and the State Action Committee on AIDS (SACA), among others.

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5.4 Documentation of Response Mechanisms

Expectedly, the views of the organisations regarding the formalisation of the responses vary for different reasons. Though **CCC** is documenting the responses, the management understands the need to develop a legal and formal code. This is because it is essential to be specific on intervention strategies, for instance there is a section that deals with time off for a positive staff member who needs rest. That becomes standard operating procedure when the WPP is adopted. It is also anticipated that the policy will also help the workforce on preventive measures. To make the WPP a reality, there are currently activities aimed at bringing all the past records together to formally produce a policy document. The national workplace policy on HIV/AIDS is relevant as a framework in developing the CCC document.

AfA believes that it is essential to develop guidelines regarding the prevention of HIV, treatment, care and support of SLWH. This will guarantee that the needs of staff will be taken care of and their rights promoted and protected, regardless of who is directing the affairs of the organisation. The document will also serve to moderate the attitudes of staff to SLWH and to a large extent curb stigma and discrimination. AfA plans to adapt the WPP it developed for a government ministry in one of the states for internal use. However, the organisation does not see the policy as a stand alone document. It will be incorporated into the employee handbook of AfA, an easy to read document which helps understand the focus of the organisation and its modus operandi. As a UK-registered charity organisation, any form of discrimination on the basis of diversity is unacceptable. Thus, there are plans to

include specific reference to HIV/AIDS under the equal opportunities section of the handbook.

FAHEDI has been taking records of all its activities both within and outside of the organization. However, it is not making specification/being particular as to whether it is responding to the PLWHAs or PABAs or to the community it is serving. Furthermore, it does not intend to develop a formal policy because it considers that having one would imply that there will always be special policies for different issues within the organization. For FAHEDI it does not look healthy to keep splitting things up for different reasons. It argues that since there is now a high level of awareness of HIV/AIDS and that stigma and discrimination have reduced to a great extent, there is no need for a formal policy.

IWCC does not have a formal policy on HIV/AIDS and has no intention of producing one now or in the future. The organisation considers it absolutely unnecessary because it is equivalent to stigmatization of those it is protecting. Furthermore, since everyone has the right to privacy a declaration of status will cause people to discriminate and stigmatize. Though the organisation keeps a list of its beneficiaries, it has not documented its responses and does not intend to do so because these are usually spontaneous responses. In the opinion of the management of IWCC, it is in government and other large establishments that a workplace policy document is necessary. This is useful so that staff could seek redress whenever their rights are violated. IWCC believes that organisations should strive to advocate for prevention, care and support for PLWHAs in their workplaces, rather than producing a formal policy document on HIV/AIDS. Furthermore, in the opinion of IWCC, documenting the responses is another form of discrimination against SLWH, and since HIV is just like any other disease, making a special case for it is unnecessary.

There is a clause in the contract document of **PAS** stating that because the mandate of the organisation revolves around HIV/AIDS, staff will work with PLWHA in the organisation and the community of work. For this reason, PAS does not see any need for developing a policy to guide its efforts or documenting its intervention strategies. The organisation believes that to a very large extent information is the key whether at the workplace or other spaces. If an organization is adequately informed on HIV/AIDS, then there will not be any need for a work place policy to reduce stigma and discrimination. It is argued that there is a difference between what provisions are made on paper in form of a policy document and the reality of the staff that one sees on a daily basis. The organisation has a personnel policy that addresses general welfare.

WBF does not see any reason whatsoever to document the informal responses to HIV/AIDS within the organisation because it will involve setting it aside as a project. The organisation is not prepared to go into that at the moment.

6. Conclusion

This report has shown that the organisations studied are not only conscious of the crisis of HIV/AIDS, they are also aware of the possible negative impacts on the workplace environment. Thus they are responding to it in a variety of ways.

First, it is observed that their responses have been motivated by such factors as personal experience or involvement of organizational heads, the reality of the spread of the infection, awareness and information and the need to promote and promote the human rights of SLWHA.

Secondly, they try to deploy such mechanisms as training, counselling, education, information sharing and sensitisation to cope with its incidence in the workplace. Other coping mechanisms include elimination of stigma and discrimination, treatment, care and

support facilitation of access to ART and medical checks, as well as direct and indirect financial support.

Thirdly, these organisations' finances have been impacted differently by their responses. While a few of them are able to access external funding, some others rely on internal resources, including personal financial contributions from staff members. It is also demonstrated in this study that most of these organisations do not do any formal budgeting or costing of their responses.

Fourthly, although most of them seem to have records of their regular activities/programmes, only CCC and AfA are of the opinion that there be some documentation of their informal workplace policies on HIV/AIDS because of some identified benefits.

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[1] I acknowledge the assistance from Ms. Cynthia Enem, Programme Assistant, LaRen Consulting NIGERIA.

[2] Joint United Nations Programme on HIV/AIDS, *2004 Report on the Global Epidemic* (Geneva: UNAIDS, 2004a)

[3] National Action Committee on AIDS, *Nigeria HIV/AIDS Country Report 2005: Preview (*Abuja,: NACA, 2005)

[4] UNAIDS 2004a

[5] National Planning Commission & UNICEF, *Children's and Women's Rights in Nigeria: A Wake-Up Call – Situation Assessment and Analysis 2001 (Abuja:, 2001)*

[6] Federal Republic of Nigeria (2007): Nigeria 2006 Millennium Development Goals Report

[7] ILO (2004) HIV/AIDS and work: global estimates, impact and response - 2004

[8] Ibid.

[9] Federal Republic of Nigeria (2007): Nigeria 2006 Millennium Development Goals Report

[10] See Appendix I for organisational information