



Workplace HIV and AIDS policy and programme: Development and Implementation among employers organizations in Calabar metropolis of Cross River State, Nigeria

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Abstract

Introduction: The HIV and AIDS pandemic presents to the world one of the most challenging and serious public health issues. The burden of HIV and AIDS are felt at all levels of the human society, including individual, family, community, workplaces and nations manifesting in the forms of poverty, increased unemployment rates. Tackling the problem of workplace HIV and AIDS-based stigmatization, bias and refusal; and diminishing the effects of HIV and AIDS on labour and productivity depend tremendously on executing successful HIV and AIDS progressive policies and programmes for the workplace organization.

Objective: This study was carried out to assess the development and implementation of the workplace HIV and AIDS policy and programmes in Calabar Metropolis of Cross River State, Nigeria.

Methods: The study was a cross-sectional descriptive survey of 112 private and public organizational managers of formal employers' organizations. A semi-structured questionnaire was used to collect data from the respondents. The collated data was analysed using the Statistical Packaged for the Social Sciences (SPSS) software (version 16), expressed as frequencies and percentages, and presented in tables and charts.

Results: The major findings revealed that 84.7% of the respondents were from the public sector. Only 10.2% of the organizations had workplace HIV and AIDS policy documents. Majority of the organizations (86.7%) were not implementing any workplace HIV and AIDS programme. Majority of the respondents (96.4%) stated that developing and implementing organizational workplace HIV policy and programme will cost money, 78.6% of the respondents identified time, 88.1% pointed out personnel, 47.6% of the respondents identified output reduction, disruption of the organization's activities was identified by 75% of the respondents, and 82.1% identified materials as some of the costs in developing and implementing workplace policy and programmes on HIV/AIDS.

Conclusions: only a few organizations have developed and are implementing workplace place HIV/AIDS policies and programmes. Money, materials, disruption of organization's activities, and output reduction, were identified as barriers to the domestication of National workplace HIV/AIDS policy. The Nigerian government should provide employers' organizations with the necessary support needed to domesticate the HIV/AIDS workplace policy.

Keywords: workplace HIV/AIDS policy, workplace HIV/AIDS programme, development, implementation, costs

Introduction

The HIV and AIDS pandemic presents to the world one of the most challenging and serious public health issues. Several decades have passed since the HIV virus emerged, and there is no cure yet, no vaccine to prevent its infection and about 6.1 million people yet to know their HIV status and needing access to HIV testing services^[1]. Despite the global efforts and commitment to stopping new HIV infections and increasing access to HIV testing and treatment services, the challenge remains very formidable. Currently, in 2018, about 37.9 people were living with HIV worldwide, 1.7 million people became newly infected with AIDS virus, and about 770,000 people died from HIV/AIDS-related illnesses^[2].

The concomitant health, economic and social burdens of the HIV and AIDS epidemic are concentrated most in Sub-Saharan Africa – which accounts for 60 percent of the global HIV and AIDS prevalence rate^[3]. The burden of HIV and AIDS are felt at all levels of the human society, including individual, family, community, workplaces and nations, manifesting in the forms of poverty and increased unemployment rates^[4]. This threat is particularly present in Nigeria, a country that despite the progress being made in the global efforts to combat HIV and AIDS, still contributes huge figures to the global HIV and AIDS incidence and prevalence rates. In 2018, 1.9 million people were living with the AIDS virus in Nigeria, 130,000 people were newly infected with the virus, and 53,000 people were killed by HIV/AIDS-related illness^[1].

HIV and AIDS is a very serious and vitally important workplace organization-related issue with implications for workers' health, productivity and rights^[5]. The issues emerging from HIV and the workplace organizations are so serious that they are capable of unsettling organizations as entities and weakening their ability to attain their

specified goals and objectives. HIV and AIDS cuts down the supply of labour, diminish productivity, encourages absenteeism and bring about the loss of expert, trained and experienced workers owing to untimely retirement, illness and death of HIV and AIDS infected workers [6, 7]. The depletion in labour and loss of employment as a result of HIV and AIDS is a straightforward danger to the achievement of the Sustainable Development Goals of lessening poverty and enhancing sustainable development [8].

According the global labour body – International Labour Organization – (ILO) [9], Tackling the problem of workplace HIV and AIDS-based stigmatization, bias and refusal; and diminishing the effects of HIV and AIDS on labour and productivity depend tremendously on executing successful HIV and AIDS progressive policies and programmes for the workplace organization. The workplace provides a readily available opportunity as well as provides a portal of entry for providing HIV and AIDS education, care and support services, and measures that are aimed at combating discrimination and stigmatization [10].

A workplace HIV and AIDS programme is an actionable blueprint that can be implemented by the organization with the aims of preventing new cases of HIV infection, providing care and support services to workers who are either infected with HIV or affected by the AIDS epidemic, and controlling the consequences of HIV and AIDS on the workplace or organization [11]. The Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) gave a prescription of the essential components of the workplace HIV and AIDS programme to include mobilization of employees for Sexually Transmitted Infections (STIs) and Tuberculosis (TB) treatment, awareness campaigns on HIV and AIDS, voluntary HIV testing and counseling services, provision of universal infection control, providing anti-retroviral or making referrals to appropriate service providers, adjustment requirements to accommodate infected workers, provision of social of social support to infected workers, distribution of condoms to all employees and ensuring a stigma- and discrimination-free environment, among others [12]. The objective of this study was to assess the development and implementation of workplace HIV and AIDS policy and programmes among employers' organizations in Calabar Metropolis of Cross River State, Nigeria.

Material and methods

Study setting

The setting for this study was Calabar Metropolis. Calabar Metropolis is the capital of Cross River State in Nigeria. It comprises of Calabar Municipality and Calabar South Local Government Areas. Calabar Metropolis lies between Longitudes 8°18'00"E to 8°24'00"E and Latitudes 4°54'00"N and 5°04'00"N. Calabar is the self-acclaimed tourist destination of West Africa with a total population of 371,022 based on the 2006 National Population census. Calabar is situated on the Atlantic seashore near the Cameroon border.

Study design and study population

The study was a cross-sectional descriptive survey that employed a quantitative method of data collection. The study population consisted of organizational managers (including directors, state coordinators, chief executive officers, chief operating officers, general managers, permanent secretaries) of formal employers' organizations or establishments that provided stable employment and regular income to at least five employees.

Sample size and sampling procedure

The sample size for this study was determined using the Taro Yamane's formula, with 95% confidence level, 0.05 level of precision, and a population size of 156 (number of formal employer's organizations in Calabar Metropolis). The determined sample size after substituting the numbers into the formula was 112.

Proportionate random sampling method was used to select the organizations from the various categories (Federal establishments, State and Local Government establishments, Banks, Private establishments). The number of establishments proportionately selected from the various categories included federal establishments (36); state and local establishments (57); banks (12); private establishments (7). Simple random sampling technique was then used to select these organizations. From each of the selected establishments, only one manager or executive officers was selected.

Instrument for data collection and data collection procedure

The instrument used for data collection was a questionnaire. The questionnaire was semi-structured i.e., it consisted of both open- and close- ended questions; it gathered information on the demographic characteristics, development and implementation of workplace HIV/AIDS policy and programme, and respondent's perceived costs of developing and implementing workplace HIV/AIDS policy and programme. The instrument for data collection was pretested on 15 (10% of the total sample size,) organizational managers in Ikom, Cross River State. The result of the pre-test gave a clue on the respondents' likelihood to understand the questions; and provided the basis for modification of the questionnaire where necessary, to ensure reliability. After the pre-test, the questionnaires were administered by the researcher with the help of trained research assistants.

Data analysis

The collected data was manually collated and analyzed with the help of Microsoft Excel and the statistical Package for Social Sciences (SPSS) software (version 16.0). The data was expressed in simple frequencies and percentages and presented in tables and figures.

Ethical considerations

A certificate of ethical approval for the study was obtained from the Cross River State Health Research Ethics Committee (CRS-HREC), granting full ethical approval. The informed consent of each of the respondents was sought and obtained before administration of questionnaire.

Results

Demographic characteristics of the respondents

A total of 108 respondents were surveyed using the questionnaire, but only 92 of the questionnaires were completely completed and retrieved, giving a response rate of 90.7%. The distribution of the respondents by sector of establishments showed that 15 (15.3%) were in the private sector while 83 (84.7%) were in public sector organizations. Results also showed that 44 (44.9%) had between 5 – 104 employees, 22 (22.4%) had between 105 – 204 employees, 9 (9.2%) had between 205 – 304 employees, 10 (10.2%) had between 305 – 504 employees, while 5 (5.1%) had 505 employees and above. The result also indicated that 6 (6.1) of the respondents were general managers, 28 (28.6%) were managers, 45 (45.9%) were directors, 3 (3.1%) were registrars, 2 (2.0%) were superintendents while 14 (14.3%) were state coordinators (Table 1).

Development of an HIV/AIDS policy

As shown in Table 2, the responses on this item showed that only 10 (10.2%) of the respondents indicated they have developed a workplace HIV/AIDS policy while most of the respondents, 88 (89.8%) indicated they have not developed an HIV/AIDS policy. The result also showed that 7(70%) of the respondents who said they had developed a workplace HIV/AIDS policy were in the public sector and 3(30%) were private sector respondents. When the participants who have not developed workplace HIV/AIDS policies were asked why they have not done so, as presented in Fig.1, 54 (61.4%) said they are yet to see HIV/AIDS as a workplace issue, 78 (88.6%) pointed out their establishments not having the knowledge and skill to develop a HIV/AIDS policy, 80 (90.9%) said their establishments do not have the capacity to develop HIV/AIDS policies, 21 (23.9%) revealed that they have not seen the need to develop; workplace HIV/AIDS policies, and 36 (40.9%) of the respondents indicated their establishments not having HIV/AIDS infected employees as one of the reasons for not developing workplace HIV/AIDS policies.

When the respondents who said they had developed workplace HIV/AIDS policies were asked what they used as a guide or reference for doing so, 2 (20%) said they were guided by the ILO code of practice on HIV/AIDS and the world of work, 4 (40%) indicated using the national workplace policy on HIV/AIDS as a reference while 4 (40%) claimed to have used the Cross River State workplace policy on HIV/AIDS as a guide to develop their workplace HIV/AIDS policies, as shown in Fig. 2.

Table 1: Demographic variables of the respondents

Variable	Frequency	Percentage
Sector of organization	Private	15
	Public	83
Number of employees	5-104	44
	105-204	22
	205-304	9
	305-404	205
	405-504	10
	505 and above	5
	Respondents' position	General manager
	Manager	28
	Director	45
	Registrar	3
	Superintendent	2
	State coordinator	14

Table 2: Respondents' development of workplace HIV/AIDS policy (n = 98)

Workplace HIV/AIDS policy development status	Establishments		Total No (%)
	Public No (%)	Private No (%)	
Have developed	7 (7.1)	3 (3.1)	10 (10.2)
Have not developed	76 (77.6)	12 (12.2)	88(89.8)
Total	83 (84.7)	15 (15.3)	98(100)

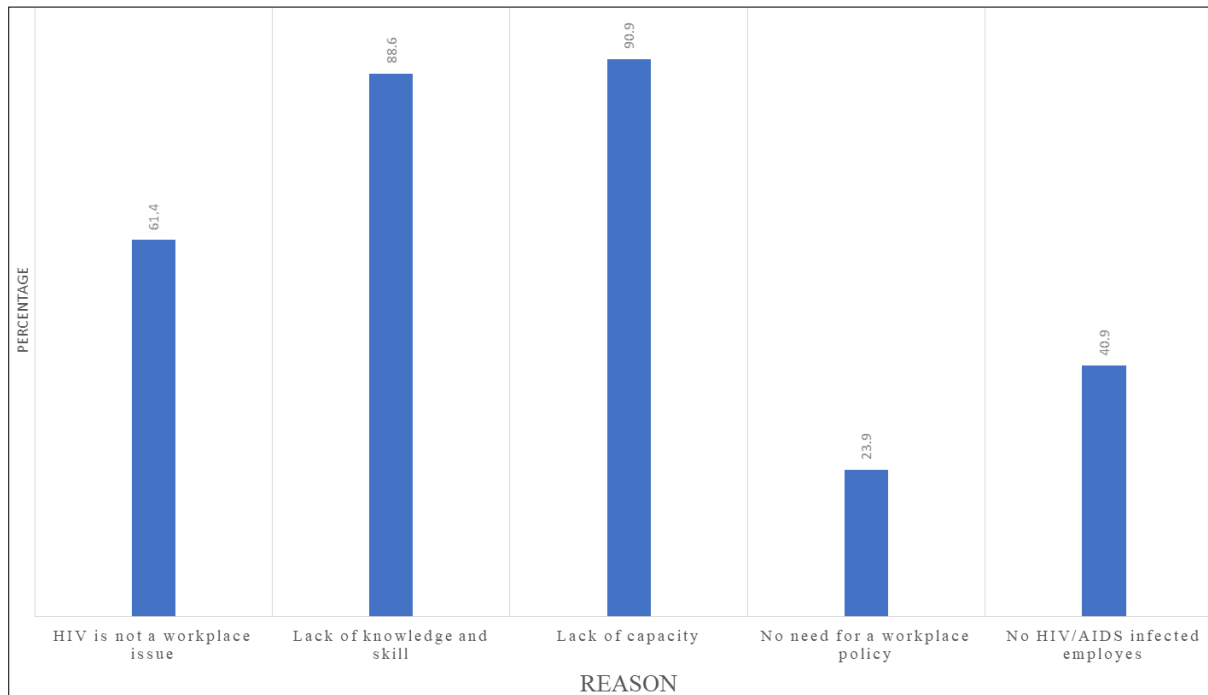


Fig 1: Reasons for not developing workplace HIV/AIDS policie

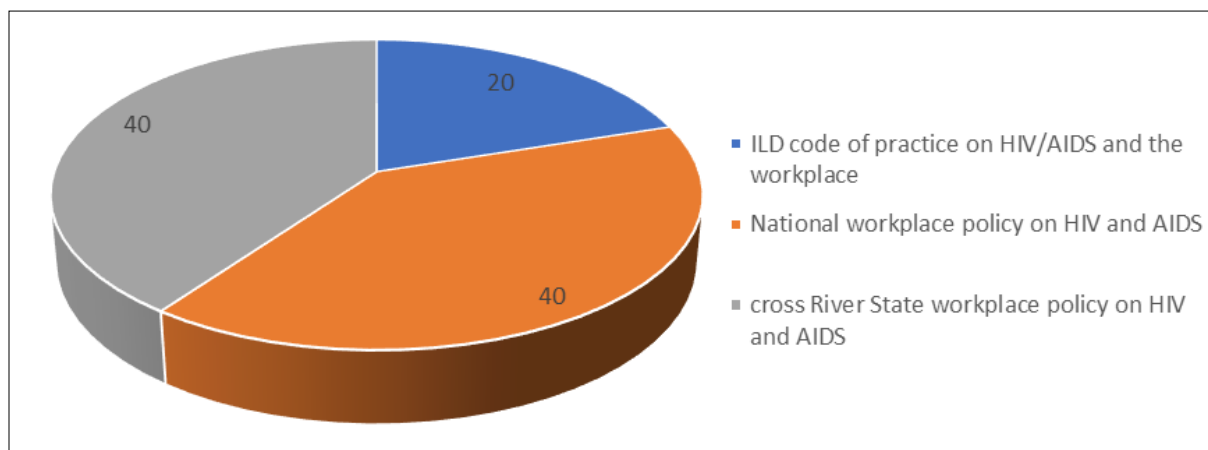


Fig 2: Reference/Guide used in developing workplace HIV and AIDS policy

Respondents’ implementation of HIV/AIDS programme

The response on this item of the questionnaire showed that 13 (13.3%) of the respondents indicated that their establishments are implementing HIV/AIDS programmes, while most of the participants, 85 (86.7%) said they were not implementing any HIV/AIDS programme as presented in Table 3. The result also showed that 10 (76.9%) of the respondents who said they were implementing workplace HIV/AIDS programmes were public sector respondents while 3 (23.1%) were private sector respondents.

As shown in Fig. 3, when the respondents who said they were implementing workplace HIV/AIDS policies were asked why they were doing so, all the respondents, 13 (100%) said they were doing so to prevent and manage HIV/AIDS, 8 (61.5%) of the respondents indicated protecting HIV/AIDS infected employees as one of the reasons, 10 (76.9%) said they were doing so to avoid stigma and discrimination, while 3 (23.1%) said they were motivated by the desire to provide counselling and support to HIV/AIDS infected and affected workers, to implement HIV/AIDS programmes in their establishments.

The results, as shown in Table 4 revealed that all the respondents, 13(100%) indicated HIV/AIDS awareness and education campaigns as part of their HIV/AIDS programme, 2(15.4%) indicated the training of peer educators, 3(23.1%) pointed out voluntary HIV testing and counselling as a component of their HIV/AIDS programmes, 4(30.8%) participants indicated condom distribution while 2(15.4%) pointed out universal infection control procedure as a component of their HIV/AIDS programmes. Also, 9(69.2%) of the respondents indicated encouraging health treatment of STIs and TB, 5(38.5%) pointed out referral to relevant service providers, 10(76.9%) of the respondents indicated education and awareness about antiretroviral and treatment literacy awareness as part of their HIV/AIDS programme, 11(84.6%) said their HIV/AIDS programmes included the provision of counselling and other forms of social support while 8(61.5%) indicated the provision of reasonable accommodation for affected and infected workers.

Perceived costs for developing and implementing workplace HIV/AIDS policy and programmes

As presented in figure 4, the result of the study revealed that the respondents perceived various costs in the development and implementation of workplace HIV/AIDS policy and programmes. Majority of the respondents (96.4%) stated that developing and implementing organizational workplace HIV policy and programme will cost money, 78.6% of the respondents identified time as a cost, 88.1% pointed out personnel as a cost, 47.6% of the respondents claimed that developing and implementing workplace policy and programmes will lead to output reduction, 40.5% of the respondents said it will prevent the organization from attaining its goals, disruption of the organization's activities was identified by 75% of the respondents as a cost, and 82.1% identified materials as a cost in developing and implementing workplace policy and programmes on HIV and AIDS.

Table 3: Workplace HIV/AIDS programme implementation (n = 98)

Implementation of HIV/AIDS programme	Establishments		Total No (%)
	Public No (%)	Private No (%)	
Yes	10 (10.2)	3 (3.1)	13(13.3)
No	73 (74.5)	12(12.2)	85(86.7)
Total	83 (84.7)	15(15.3)	98(100)

Table 4: Respondents' components of workplace HIV/AIDS programmes (n = 44)

Component	Number of respondents	Percentage (%)	Rating
HIV/AIDS awareness and education programme	13	100	1
Training of peer educators	2	15.4	9
Voluntary HIV testing and counselling	3	23.1	8
Condom distribution	4	30.8	7
Universal infection control procedures	2	15.4	9
Encouraging treatment of STIs and TB	9	69.2	4
Referral to relevant service providers	5	38.5	6
Education and awareness about anti-retrovirals and treatment literacy	10	76.9	3
Counselling and other forms of social supports	11	84.6	2
Reasonable accommodation for infected workers	8	61.5	5

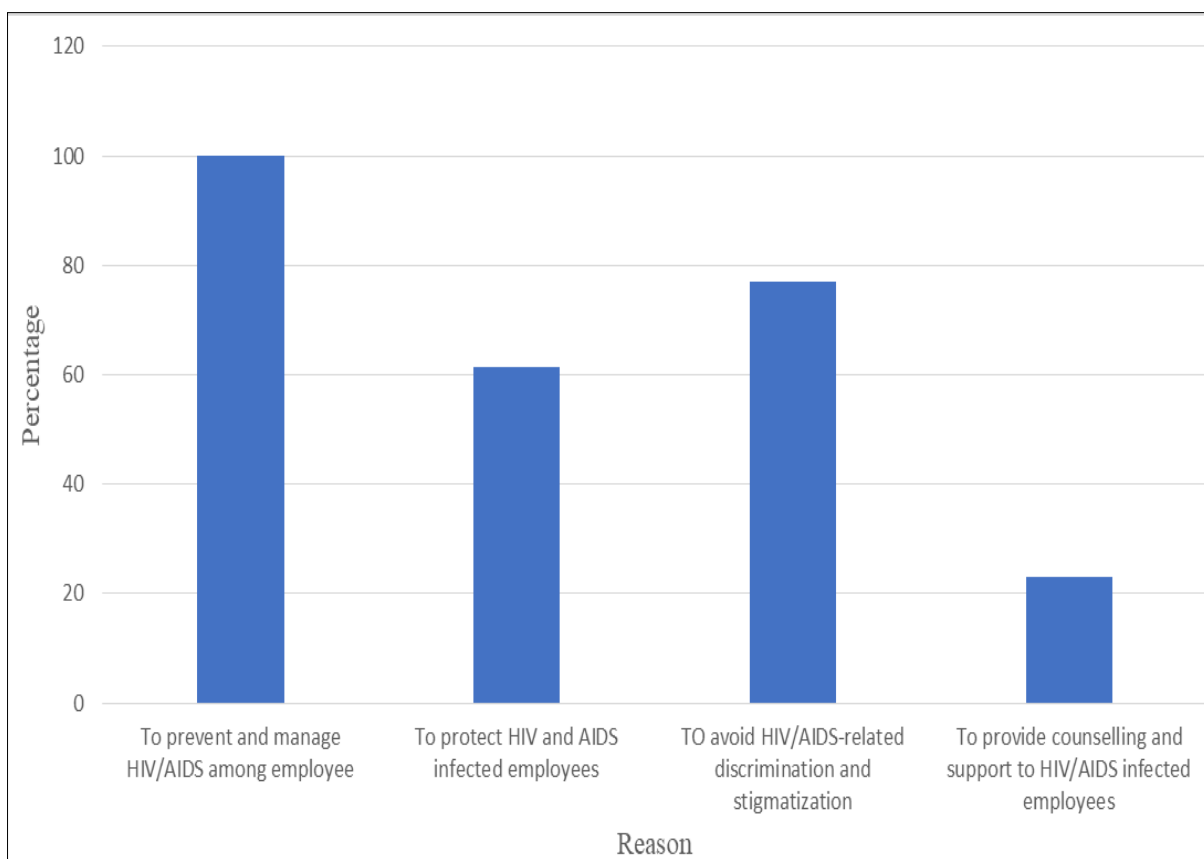


Fig 3: Reasons for implementing HIV and AIDS programmes

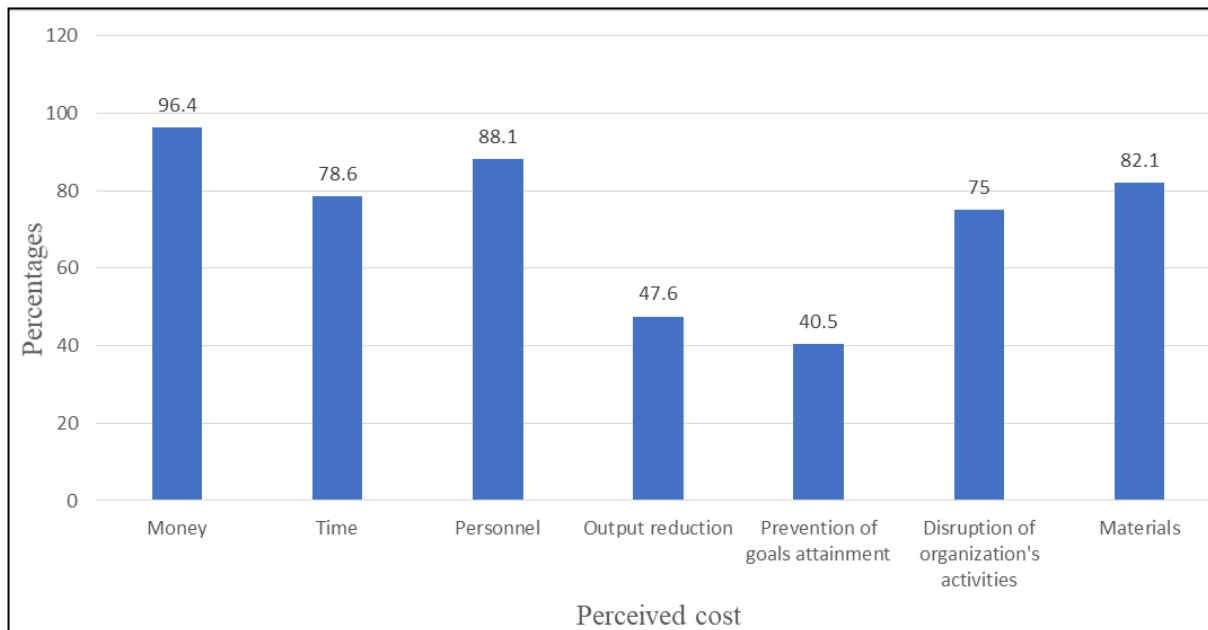


Fig 4: Perceived cost of developing and implementing workplace policies and programme on HIV/AIDS

Discussion

According to the National Workplace Policy on HIV/AIDS, the role of employers' organizations shall be: "to consult with workers and their representatives to develop and implement appropriate individual policies for their workplaces, consistent with the national workplace policy"^[13]. This study has revealed that the development and implementation of workplace HIV and AIDS policy and programmes by employers' organizations was remarkably low, indicating a low level of compliance with the requirements of the national workplace policy on HIV/AIDS. The finding agreed with^[14], who stated that there appeared to be no determined effort to provide formal policies on HIV/AIDS in the workplace by employers' organizations in Nigeria. It also agreed with^[15], who reported that only a very few companies in developing countries appeared to have developed strategies to combat fear, stigma and discrimination in the workplace, and with^[16] that only a small number of organizations have begun to define the responsibilities of employers towards employees with HIV/AIDS; and^[3], who reported a low level of existence of HIV and AIDS policies especially in private sector organizations. Also, unlike^[3], who established a low existence of workplace HIV and AIDS policies in the private sector, this study established a low existence of workplace HIV and AIDS policies in both the private and public sectors. One of the reasons for the low level of compliance with the development and implementation of workplace HIV and AIDS policy and programmes is the lack of understanding by the organizational managers of the essential role organizations can play in protecting human and organizational capacity as well as a failure of these employers and producers to understand the issues HIV and AIDS raises for them^[17]. On the other hand, this finding remarkably disagrees with Adkins^[18] who reported that from the late 1980s onwards, many workplace organizations put in place HIV/AIDS policies and programmes. The reasons for not developing workplace HIV and AIDS policy and programmes by most of the organizations corroborate the findings of^[3], in their study on the determinants of the implementation of HIV/AIDS workplace programmes.

According to the result of the study, the workplace HIV/AIDS policies and programmes of employers' organizations who already have HIV/AIDS policies and programmes in place seemed to be progressive in nature and compliant with standards as the respondents do not only cite the ILO code of practice on HIV/AIDS and the world of work, national workplace policy on HIV/AIDS, and the Cross River State workplace policy on HIV/AIDS as references and guides used to develop their individual HIV/AIDS policies, they also stated the prevention and management of HIV/AIDS, protection of HIV/AIDS infected employees, avoidance of stigma and discrimination, and the provision of counselling and support to HIV/AIDS infected and affected employees as reasons for their implementation of HIV/AIDS programmes. These findings are consistent with the findings of^[3].

From the study, HIV/AIDS awareness and education programmes, training of peer education, voluntary HIV testing and counselling, condom distribution, universal infection control procedures, encouraging health treatment of STIs and TB, referral to relevant service providers, etc., were stated as the components of the HIV/AIDS programmes being implemented by some of the workplace organizations. This complies with the basic elements or requirements of the standard workplace HIV/AIDS programme^[19].

The study revealed the lack of capacity (fund), lack of knowledge and skills, having no business with HIV/AIDS, not yet seen the need for developing workplace HIV/AIDS policies, and not having HIV/AIDS infected employees as reasons for employers' organizations not developing HIV/AIDS policies and not implementing HIV/AIDS programmes in their organizations. As stated by Gaube *et al.*^[20], people's perception of risk influences their safety behaviour and a heightened level of risk perception leads to more protective

behaviours. This implies that what the employers' organizations know and feel about HIV/AIDS and the world of work will determine their attitudes towards HIV/AIDS – whether to develop workplace HIV/AIDS policies and implement HIV/AIDS programmes or not.

The results of the study revealed that 85.7% of the respondents pointed out money, time, personnel, output reduction, prevention of organizational' goals attainment, disruption of organization's activities, and materials as costs of putting in place the workplace HIV and AIDS policy and programmes. The identification of costs by the organizational managers could undermine or serve as a barrier to the development and implementation of workplace HIV and AIDS policy and programmes by these organizations. According to the Protection Motivation Theory (PMT), the adoption of any preventive measures must be preceded by the extent of confidence in one's capacity to put into practice the prescribed interventions ^[21]. Consequently, the perception of costs by the organizational managers could undermine the believes in their capacities to develop and implement workplace HIV and AIDS policies and programmes for their organizations ^[22]. Similarly, according to the fourth construct of the Health Belief Model (HBM), for a person to adopt any preventive measures, the person must not perceive any cost or barrier to taking such action ^[23]. If these postulates are in any way correct, then such organizational managers who identified or perceived various costs in the development and implementation of workplace HIV and AIDS policies and programmes, are unlikely going to domesticate the workplace HIV and AIDS policy and programmes.

Conclusion

This study had revealed a lack of awareness of the international, national, state governments policies and recommendations on HIV and AIDS and the world of work and the failure of both private and public employers' organizations to develop and implement workplace HIV and AIDS policies and programmes as recommended. It is clear that, therefore, that employers' organizations need adequate sensitization and education on the consequences of HIV/AIDS at every level of the society - families, communities, workplaces and economies, and the need to formulate and implement individual workplace HIV and AIDS policies and programmes. More, so, employers' organizations should be provided with the needed support to come up with successful workplace HIV and AIDS policies and programmes.

References

1. UNAIDS. Global HIV & AIDS statistics-Fact sheet, 2022. Available at: <https://www.unaids.org/en/resources/fact-sheet>
2. UNAIDS. Global HIV & AIDS statistics-2019 fact sheet, 2019. Available at: <https://www.unaids.org/en/resources/fact-sheet>
3. Chatora B, Chibanda H, Kampata L, Wilbroad M. HIV/AIDS workplace policy addressing epidemic drivers through workplace programmes. *BMC Public Health*, 2018, 18(180). <https://doi.org/10.1186/s12889-018-5072-y>. pubmed
4. Ismail S, Kari F, Kamarulzaman A. The socioeconomic implications among people living with HIV/AIDS in Sudan: Challenges and coping strategies. *Journal of the International Association of Providers of AIDS Care*,2017;16(5):446-454.
5. Dipeolu IO. HIV and AIDS in workplace: The role of behaviour antecedents on behavioural intentions. *African Journal of Medical Science*,2014;43(1):131-140.
6. Simtowe F, Kinkinginhoun-Medagbe FM. The impact of HIV/AIDS on labour markets, productivity and welfare in Southern Africa: A critical review and analysis. *African Journal of Agricultural Research*,2011;6(10):2118-2131
7. Mills CA, Govender I. Knowledge, attitude and practices of employers should they discover that their domestic worker is HIV positive: Cashan, Rustenburg. *Occupational Health Southern Africa*,2016;22(1):10-17.
8. All Answers Ltd. Impact of HIV on Society, 2018. Available at: <https://nursinganswers.net/essays/hiv-aids-effects-on-community-health-and-social-care-essay.php?vref=1>
9. International Labour Organization (ILO/AIDS). Facts on HIV/AIDS and the world of work, 2011. Available at: https://www.ilo.org/employment/units/rural-development/WCMS_159098/lang--en/index.htm
10. Van Laar C, Meeussen L, Veldman J, Van Grootel S, Sterk N, Jacobs C. Coping with stigma in the workplace: Understanding the role of threat regulation, supportive factors, and potential hidden costs. *Frontiers in Psychology*,2019;10:1879. <https://doi.org/10.3389/fpsyg.2019.01879>
11. Centers for Disease Control and Prevention (CDC). Understanding policy. HIV in the Workplace. HIV/AIDS, 2020. Available at: <https://www.cdc.gov/hiv/workplace/policy.html>
12. Global Business Coalition [GBC]. Elements of HIV/AIDS workplace policies, 2008. Available at: https://archive.gbchealth.org/files/reports/workplace%20Issue%20Briefs_Combined.pdf
13. Federal Ministry of Labour & Productivity (FML&P). The National Workplace Policy on HIV/AIDS, 2005. Abuja. Government Press.
14. Iyayi O, Igbinomwanhia OR. Developing workplace policies on HIV/AIDS: An imperative in Nigerian organizations. *Global Journal of Social Sciences*,2008;7(2):59-67.
15. Hughes H. Ze Cabra-Macho does it safely, building an AIDS awareness campaign among Brazil's construction workers. *AIDS Action*,1998;4:2-3.

16. Bezmalinovic B. The private sector, how are the corporations responding to HIV/AIDS? In Mann, J. & Tarantola, D. J. M. (Eds). AIDS in the World 11, 2006. New York: Oxford University Press.
17. International Labour Organization. Workplace action on HIV/AIDS: Identifying and sharing best practice, 2003. Available at: https://www.ilo.org/global/topics/hiv-aids/publications/WCMS_121308/lang--en/index.htm
18. Adkins L. Revisions: Towards a sociology of gender and sexuality in the late modertinity, 2002. Buckingham: Open University Press.
19. CAPE GATEWAY. Information on setting up workplace HIV/AIDS policy and programmes. Available at: <https://www.capegateway.gov.za/eng/directories/services>
20. Gaube S, Lemer E, Fischer P. The concept of risk perception in health-related behaviour theory and behaviour change. In M. Raue, B. Streicher, & E. Lema (Eds.) Perceived safety, 2019, 101-118. Switzerland. Springer Nature.
21. Rad RE, Mohseni S, Takhti HK, Azad MH, Shahabi N, Aghamolaei T, *et al.* Application of the protection motivation theory for predicting COVID-19 preventive behaviours in Hormozgan, Iran: a cross-sectional study. BMC Public Health,2021:21:466. <https://doi.org/10.1186/s12889-021-10500-w>
22. Boer H, Seydel ER. Protection motivation theory. In: Connor, M. & Norman, P. (Eds). Predicting health behaviours, 1996. Buckingham: Open University Press.
23. Rosenstoch I. Historical origin of Health Belief Model. Health Education Monograph,1974:2:334.