SOCIAL CONSEQUENCES OF HIV/AIDS: STIGMA AND DISCRIMINATION IN THE WORKPLACE IN NIGERIA

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Paper being presented at the XXV International Population Conference held at the Vinci Convention Centre, Tours, France, 18 – 23 July 2005.

Abstract

The paper assesses the level and manifestations of HIV-related stigma and discrimination in the workplace in Nigeria. A purposive and accidental sample of 150 people living with HIV/AIDS were interviewed in three states of Nigeria using a structured interview schedule from 11th March 2004 to 4th April 2004. This was complemented by focus group discussions. Out of the 150 PLWHA, 80 had worked. Of these 80, 16% were rejected, restricted from sharing toilets, canteens and sports facilities (36%) and (13%) respectively. 48% lost their jobs, threatened with dismissal (16%). Job duties were changed for 26%. About 10% lost prospects for promotion and 40% were excluded from insurance schemes. Mandatory HIV tests and testing without specific and informed consent affected 5%. More women than men experienced these stigmatizing and discriminating acts. *Massive HIV/AIDS education and enlightenment campaigns should be organized. ILO, anti-discriminatory laws and CEDAW should be enforced.*

1.0 Introduction

This paper presents a part of a national study[1] on human rights of people living with HIV/AIDS (PLWHA) and people affected by HIV/AIDS (PABA) conducted from 11th of March 2004 to 4th April 2004. Since the first AIDS case was diagnosed in 1986 in Nigeria the prevalence rate has increased unhindered from 1.8% in 1992 to 4.5% in 1996 and to 5.8% in 2001 (Nigerian Institute of Medical Research (NIMR), 2000; National AIDS & STD Control Programme (NASCP), 2002). The 2003 Sentinel Survey recorded a rate of 5.0% lower than that of 2001 (Federal Ministry of Health, 2004). This drop could be due to increased level of awareness of HIV/AIDS or increase in AIDS mortality. It is estimated that 800 people die every day from HIV infection (NASCP, 2002). In Nigeria, the cumulative number of deaths due to AIDS and number of AIDS orphans in 2002 were 1.4 million and 847 thousands respectively (NASCP, 2002). It has been established that PLWHA not only suffer the health consequences of being infected with the HIV virus, the fact of being infected introduces and accentuates their experience of discrimination and stigma. Nelson Mandela, in his speech at the closing ceremony of the International AIDS

[1] This is a UNIFEM funded national study on human rights of people living with HIV/AIDS (PLWHA) and people affected by HIV/AIDS (PABA). It has legal and social components. The author is the principal investigator of the social component.

Conference held in Barcelona in 2002, posited that "*people die not from the disease but because of the stigma*"

Reports have shown that PLWHA in Nigeria have experienced various forms of stigma and discrimination; mandatory HIV testing, barriers to employment and housing, access to medical treatment and care, to education, health insurance scheme, names reporting, partners notification and breach of confidentiality in various institutions particularly in the workplace (Anarfi, 1995; Iwuagwu et al 2001, 2003; Akparanta – Emenogu, 2002; Durojaiye, 2003; Adirieje, 2003; Udom, 2004). The questions are: what is the extent of HIV/AIDS-related stigma and discrimination in the workplace? In what forms do they manifest? This paper seeks to unravel these questions.

HIV/AIDS related stigma and discrimination are now widely acknowledged as key obstacles to successful care and prevention throughout the world particularly amongst more disadvantaged and marginalized groups such as women. Stigma and discrimination translate into human rights violation and are some of the main factors for high prevalence of silence blanketing HIV/AIDS in Nigeria. Some patients retaliate against communities that discount sick people (Carlisle, 2001). This in turn has fuelled the HIV epidemic. Fear of discrimination may cause individuals living with HIV/AIDS to be less inclined to live freely, declare and/or acknowledge their HIV status (NARHS, 2003). This can lead to denial, the continued adoption of a lifestyle that puts others at risk, continued under-reporting of the epidemic and a resistance to the use of voluntary confidential counseling and testing services.

Empirical studies necessary to develop an understanding of the ways in which stigma and discrimination are manifested in the workplace are non-existent only reports of personal experiences of PLWHA are available. Most of the studies have focused on perpetrators rather than targets. The complexity of the network of factors and reactions related to this issue makes it imperative to study the problem from the vulnerable groups' perspective. In view of the afore-stated this study assesses the level and manifestations of stigma and discrimination in the workplace.

2.0 Earlier studies

This section deals with clarification of the key concepts and review of some relevant literature. Thus, HIV-related stigma refers to unfavorable attitudes, beliefs, and policies directed toward

people perceived to have HIV/AIDS, their families, friends, associates, social groups, and communities. Goffman (1963:3) described stigma as "an attribute that is deeply discrediting within a particular social interaction that reduces the bearer from a whole and usual person to a tainted, discounted one". His explanation of stigma focuses on society's attitude toward people who possess attributes that fall short of public expectations. Contrary to Goffman's description, Weiss and Ramakrishna, (2001) define stigma as a social process or related personal experience characterized by exclusion, rejection, blame, or devaluation that result from an adverse social judgment about a person or group. The judgment is based on an enduring feature of identity attributable to a health problem or health-related condition, and this judgment is in some essential way medically unwarranted. According to Herek (1990) HIV-related stigma is not necessarily a stigma of the diseased; but rather, is often related to perceived lifestyle "choices" of infected populations or to perceptions about racial and ethnic minorities. For instance, in 1990, he noted that gay men and injection drug users were disproportionately vulnerable to HIV-related stigma and discrimination; yet, people who acquired HIV through no action of their own were often referred to as "innocent" or "blameless".

On the other hand, discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of belonging, or being perceived to belong to a particular group (Aggleton and Parker, 2002). Giddens (1994) defines discrimination as activities which serve to disqualify the members of one grouping from opportunities open to others.

There is limited empirical evidence on the stigmatization and discrimination of PLWHA in the workplace in Nigeria. However, few of the available ones will be reviewed here. In Nigeria, stigma and discrimination in the workplace manifest mainly in the loss of employment and is pervasive. Akparanta – Emenogu (2002) and Durojaiye (2003) reported that Mr. Cliff Elisha Ishaku was denied admission into the Nigerian Naval Training College, Onne, Port Harcourt, on account of his HIV status despite being successful at the recruitment test. According to his narration, he was admitted into the navy as a squadron leader and was then sent to Calabar for assignments. During the period a medical test was conducted without his knowledge of the reason of the test. He was later informed that he was HIV+ and was subsequently denied employment.

In another instance, Adirieje (2003) and Iwuagwu et al (2001) reported that in 1995, a nurse, Georgiana Ahamefule filed a suit in court against her employer, a private hospital, for dismissing her on the grounds of her HIV status. She alleged that she was tested for HIV virus without her knowledge and consent. Following the suit, a high court judge also withdrew from it in 2001 because the judge feared the plaintiff was a health hazard. The Nigeria Police demoted a Nigeria policewoman living with HIV/AIDS when her HIV status was revealed to the public by a media house without her consent (Iwuagwu et al., 2003).

Iwuagwu et al (2001; 2003) conducted a national study to document the pattern of human rights abuse of PLWHA in Nigeria. Three states namely Lagos, Kano and Onitsha were studied using focus group discussions (FGDs) that involved 53 PLWHA. They found that an auxiliary nurse's appointment was terminated because of her HIV status. She had worked for five years in the hospital and became pregnant. She developed some boils that led to a laboratory test by the employer. The result of the test showed that she was HIV positive and she was instantly dismissed because the management felt they could not afford to put the staff and patients at risk. And when she lost the pregnancy, the hospital refused to evacuate her uterus of the product of conception because the hospital management reasoned that they could not afford to contaminate the theatre.

Udom (2004) reported that a receptionist in a hotel, Olamide was dismissed by her employer after she was diagnosed HIV+ so as not to "*spread the fruit of her waywardness to other members of staff and clients*". Not only did the employer call her names and terminate her appointment, she also called Olamide's aunt and informed her about the result of the HIV test. Olamide was subsequently evicted from her aunt's home. Why should people living with HIV/AIDS be stigmatized and discriminated against? A theory of symbolic interactionism, will attempt to explain that in the next section.

3.0 Theoretical framework

The paper is anchored on symbolic interactionism, particularly on the work of a well renowned scholar; Erving Goffman (1963) to explain the relationships between HIV/AIDS and stigma cum discrimination. In his book, ***Stigma: Notes on the Management of Spoiled Identity***, Goffman (1963:3) described stigma as "an attribute that is deeply discrediting within a particular social interaction." His explanation of stigma focuses on society's attitude toward people who possess

certain attributes. In the domain of HIV/AIDS these attributes refer to nuances like extreme wasting (excessive emaciation), skin rashes, diarrhoea, periodic fever, persistent cough and swelling of lymph nodes that are in fact signs and symptoms of AIDS. They fall short of public expectations and are collectively referred to as abominations of the body (Goffman, 1963). According to Goffman, a person who is stigmatized is "reduced in our minds from a whole and usual person to a tainted, discounted one." (Goffman, 1963:3).

Goffman (1963) used what he called "blemishes of individual character" to describe the perceived character of PLWHA. They are labelled promiscuous, immoral and careless people. They are therefore stigmatised. A stigmatised person, according to Goffman (1963), is someone who has a spoilt identity i.e. when there is a gap between what an individual ought to be, ***"virtual social identity"*** and what that individual actually is, ***"actual social identity".*** PLWHA are perceived to have spoilt their identities and have deviated from their normal and usual social identities. Shame, blame and moral judgment occur when the origin of HIV infection is perceived to be unsanctioned sex. HIV/AIDS is the first in human history in which the transmission of the causative agent is predominantly under voluntary control of the individual, where heterosexuality is concerned activity that facilitates extremely pleasurable experience and in which sexual enjoyment is frequently associated with a long history of reinforcement. Hence PLWHA are conceived to be responsible for contracting HIV and therefore deserve some form of punishment that can take various forms. Facts pertaining to the transmission, treatment and prevention of HIV/AIDS are limited. Several surveys in Nigeria have shown that there is a gap in the knowledge of HIV/AIDS (Nwanna, 2002:137; National Population Commission, (NPC); 2003). This gap in knowledge culminated in the spread of general misinformation, which contributed to the stigmatization of people living with the disease. This stigmatization has led to outright discrimination: PLWHA have lost their jobs or were not recruited at all on the grounds of their HIV screening (Akparanta-Emenogu, 2002; Udom, 2004) which in many parts of the world is illegal (ILO Code of Good Practice on HIV/AIDS). Others were forced to have HIV test (Iwuagwu et al, 2001; 2003).

Women receive harsher forms of stigma. They are seen as the "carriers" or "vectors" of HIV/AIDS and are assumed to have brought AIDS into the family because they are most often the first to be diagnosed HIV positive either through antenatal screening or the birth of a sick

child. They are often subject to emotional harassment, thrown out of their jobs[2]. These are illustrated in most of the women's cases reviewed earlier.

4.0 Methods

4.1 Study settings

This was an urban-based cross-sectional survey and conducted in three out of six geo-political zones of Nigeria: North Central, South East and South West zones. A state was chosen from each zone based on the HIV prevalence rates of the 1999 Sentinel Survey: Benue with 16.8%, Enugu – 4.7% and Lagos -6.7% (NIMR, 2000) from North Central, South East and South West zones respectively. However, 2003 prevalence rates of Benue and Lagos have declined to 9.3% and 4.7% respectively (Federal Ministry of Health, 2004) but they are still significantly high. That of Enugu, rather than dropping, increased to 4.9%. The survey was conducted in the state capitals namely Makurdi, Enugu and Lagos metropolis.

Benue State

Benue state lies in the Middle belt Region of the country, astride the Benue River. The state has a population of over 6 million people (National Population Commission, (NPC) 1998) who are popularly farmers and of different ethnic groups mainly Tiv, Idoma and Igede. It has an agrarian economy interspersed by a few industries. The larger population of the state can be found in the rural areas. The urban areas are populated mostly by civil servants, retired and serving army and police officers, a few "nouveau rich" politicians, and traders of southern (mainly of southern eastern origin). Due to its high prevalence rate, there are about 31 screening centres, and 6 anti-retro viral (ARV) centres.

Enugu State

Enugu State is one of the five states in the South – East zone of Nigeria. The other four States are Abia, Ebonyi, Anambra and Imo. The advent of colonial rule saw Enugu town as the seat of government as it became the capital of the former East Central State. Enugu State has a total population of 3,161,295, with males accounting for 1,482,245 of the population and females 1,679,050 (NPC, 1998). There are 48 Government owned hospitals and clinics, 3 ARV centres and 4 screening centres.

Lagos State

Lagos state is located on the south western part of Nigeria on the narrow coastal plain of the Bight of Benin. According to the 1991 census, the state has a population of 5,725,116 (NPC,

[2] Source: http//www.aidslaw.ca/maincontent/issues/discrimination

1998). Based on a UN study and the state regional master plan, the state is estimated to have above 12 million inhabitants presently. Until 1991, Lagos was the capital and the nerve centre of Federal Republic of Nigeria. As a cosmopolitan city, Lagos has a mix of people from all ethnic, religious, social and economic backgrounds. It has a good concentration of both public and private hospitals, 3 health facilities providing ARV, 15 voluntary counseling and testing (VCT) centres and 5 screening centres. Each of these states described above enjoys the presence of both the State Action Committee on AIDS and the Local Action Committee on AIDS.

4.2 Data collection

The study was guided by the principle of Greater Involvement of People Living with AIDS (GIPA). Therefore two PLWHA from each state were recruited as research assistants. A comprehensive capacity enhancement workshop for them took place between the 1st and 5th of March, 2004. The workshop aimed at equipping them with basic knowledge and skills in conducting research. The training covered a wide range of issues including the art of interview, research methods, human rights and basic issues in HIV/AIDS.

Due to the nature and categories of target population, purposive and accidental sampling techniques were adopted to collect data from 150 PLWHA in the three states using a structured interview schedule complemented with data from 4 focus group discussions involving 29 PLWHA. In Enugu and Benue states, two focus group discussions (FGDs) (one per state) were conducted comprising 9 persons, with a minimum of 4 women. In Lagos state, two FGDs were held separately for each gender. At the end of the fieldwork the data were cleaned, coded and transcribed into the computer for processing. Data were analyzed by the use of Statistical Package for Social Sciences (SPSS). The outputs were interpreted using qualitative, quantitative and comparative analyses. Five corporate and two government organizations were also selected for interview to assess the knowledge and attitudes of employers and colleagues towards PLWHA. This was futile because all the organizations declined. They also had no HIV policy at the time of the study although one of the organizations was in the verge of having one.

5.0 Findings

5.1 Socio-demographic characteristics of respondents

Socio-demographic characteristics of PLWHA show that 83 (55%) respondents were women and 67 men (45%) (See table 1 below). The finding compares favorably with the 54% of women said

to be living with HIV/AIDS in Nigeria (UNIFEM, 2000), an indication that more women are infected than men except for Benue that had more men than women. This might be because Benue state had more retired and serving military and police men whose professions occasionally keep them outside their stations without their wives and thereby predisposing them to multiple sexual behaviours.

Table 1: Distribution of respondents' gender by states

	Lagos		**Benue**		**Enugu**		**Total**	
Sex	N	%	N	%	N	%	N	%
Male	22	44	26	52	19	38	67	44.7
Female	28	56	24	48	31	62	83	55.3
Total	**50**	**100**	**50**	**100**	**50**	**100**	**150**	**100**

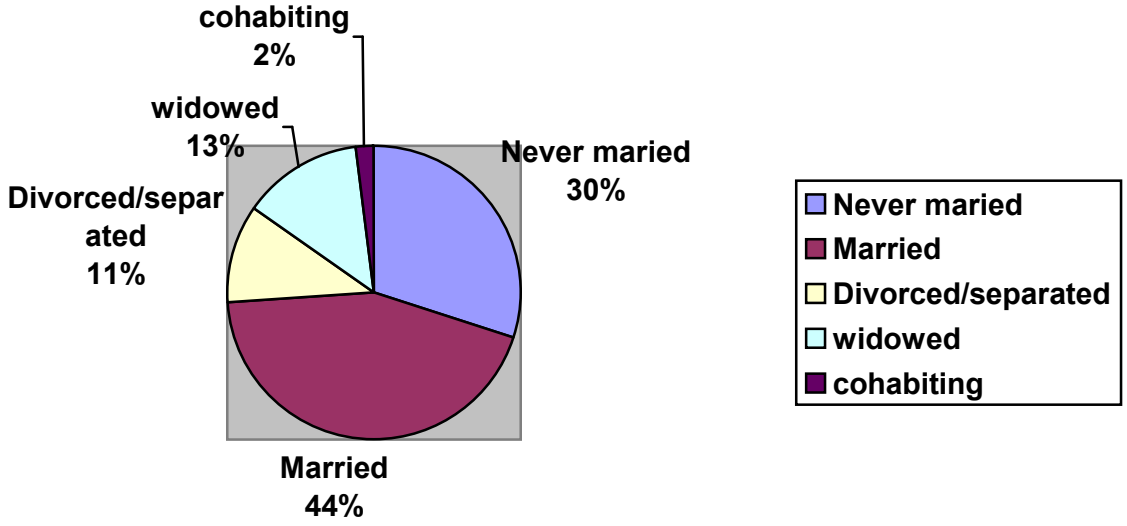
The mean age for the total respondents was 34.5 years. The findings corroborate the results of 1999 sentinel survey which discovered that HIV/AIDS infected most active productive age groups. More women PLWHA were found in younger age groups than men. For instance, the mean age for the women was 32 .9 years compared to 36.5 years for the men. These findings confirm the assertion that women tend to be infected at a younger age than men.

With regards to the respondents' marital status, almost One-third of the PLWHA in table 2 and figure 1 below were never married (30%). Gender analysis reveals no significant difference. About 44% of the respondents were married (40% women and 49% men). Twenty respondents (13%) were widowed. On the whole three respondents were co-habiting. The marital status of the surveyed PLWHA corresponds with that of national data where 48.7% were married, 35.5% single and others represented 15.7% (Nigerian Institute of Medical Research (NIMR), 2000:18).

Table 2: Distribution of respondents by marital status

Marital Status	**Male**		**Female**		**Total**	
Never Married	20	29.9	25	30.1	45	30.0
Married	33	49.3	33	39.8	66	44.0
Divorced/Separated	6	9.0	10	12.0	16	10.7
Widow	7	10.4	13	15.7	20	13.3
Cohabiting	1	1.5	2	2.4	3	2.0
Total	**67**	**100**	**83**	**100**	**150**	**100**

Figure 1: Distribution of respondents' marital status



The results further demonstrate in table 3 below that HIV/AIDS affects both educated and uneducated persons. Most of the respondents had secondary education (47%) and post secondary education (34%). While more men (40%) had senior secondary education, more women (31%) had post secondary education. Respondents' occupations reveal that civil servants formed 23% and professionals (12%). The findings confirm that HIV infection occurs in most skilled persons. Traders constituted 14% with more women than men. Similarly, among the unemployed, women (10%) out numbered the men (4.5%). Nine of the female respondents (10%) were housewives. Two out of three commercial sex workers were women. The occupations of women do not correspond with their levels of education. This indicates the lower employment status of women in the world, and, in Nigeria in particular even though, many of them had higher levels of education than the men. Supporting the findings above, income distribution shows that women (43%) earned an income less than N10, 000 per month (about 57 € per month @ N175.00 per €) compared to 25% of the men. More than one-third of the respondents received less than N10,000 per month,. An additional 19% were not receiving any income. This corroborates the view that poverty increases vulnerability to HIV infection and with what is known about the burden (in terms of financial costs) of living with HIV/AIDS, it demonstrates how HIV/AIDS increases poverty situation of the country and of individuals. The distribution of respondents' religion depicts that 93% belonged to the Christendom constituted as 94% women and 91% men. A few

of them practised Islam. It may be recalled here that the lowest reported prevalence rate in Nigeria is found generally in the predominantly Muslim northern parts of the country (Federal Ministry of Health (FMOH), 1999). This raises the question, "Whether religion has any correlation with HIV infection?" It could also be explained that the demographic structure of two surveyed states (Benue and Enugu) reflects a preponderance of people of the Christian faith and that this, more likely than not, accounts for the high representation of Christians.

Table 3: Respondents' occupation, income and religion by gender

Occupation	**Male**		**Female**		**Total**	
	N=67	%	N=83	%	N=150	%
Unemployment	3	4.5	9	10.8	12	8.0
Student/ Pupil	6	8.9	9	10.8	15	10.0
Artisan	6	8.9	3	3.6	9	6.0
Trader	5	7.5	16	19.3	21	14.0
Business person	9	13.4	3	3.6	12	8.0
Civil Servant	21	31.3	13	15.7	34	22.7
Professional Person	7	10.4	11	13.2	18	12.0
Farmer	2	3.0	-	-	2	1.3
Apprentice	-	-	4	4.8	4	2,7
Housewife	-	-	9	10.8	9	6.0
Commercial Sex worker	1	1.5	2	2.4	3	2.0
Others	1	1.5	1	1.2	2	1.3
Missing	4	6.0	3	3.6	7	4.7
Monthly Income	**Male**		**Female**		**Total**	
Less than 10, 000	17	25.4	36	43.4	54	35.3
#10,001-#20,000	19	28.3	15	18.1	34	22.7
#20,001-30,000	10	14.3	3	3.6	13	8.7
#30,001-40,000	3	4.5	3	3.6	6	4.0
#40,001-50,000	4	6.0	5	6.0	9	6.0
#50,001and above	3	4.5	-	-	3	2.0
None	8	11.9	18	21.7	26	19.3
Missing	3	4.5	3	3.6	6	4.0
Religion	**Male**		**Female**		**Total**	
		%	N=83	%	N=150	%
Christianity	61	91.0	78	94.0	139	92.7
Islam	4	6.0	4	4.8	8	5.3
Traditional religion	2	3.0	1	1.2	3	2.0

5.2 Stigma and discrimination within the workplace

Table 4 displays the respondents' employers. Out of 150 respondents, 80 PLWHA consisting of 38 women and 42 men had worked or were still working as at the time of the study. Among these, 41.2% and 40% were working in organized private sector and public sector respectively.

About 8.8% were employed in government parastatals while 3.8% of them were employed in the informal sector. Five respondents, i.e. 6.8% worked with multinational organizations. A good proportion of women (44.7%) were civil servants as against 35.7% men. More men, 45.2% and 9.5% worked within the organized private sector and with multinational organization respectively where remunerations were usually higher than other public and informal sectors. These findings explain the lower income of the female PLWHA in the study. Many of the respondents (37.5%) had worked for less than 5 years while 25% had worked for their organizations for 10-14 years. About 7.5% had put in 20 years or more in their places of work.

Table 4: Organizations where respondents worked

Organizations respondents worked/work for	**MALE**		**FEMALE**		**TOTAL**	
	N	**%**	**N**	**%**	**N**	**%**
Civil Service	15	35.7	17	44.7	32	40.0
Parastatals	4	9.5	3	7.9	7	8.8
Organized PrivateSector	19	45.2	14	36.8	33	41.3
Informal Sector	-	-	3	7.9	3	3.8
Multi-National	4	9.5	1	2.6	5	6.8
Total	**42**	**100**	**38**	**100**	**80**	**100**

Among those who had worked, 31 acknowledged that their places of work knew about their sero-positive status. Out of these 31, majority pointed out that they did not inform their managements about their status. Even, 10% did not know who informed their employers and colleagues. Hospital (13%), other relations (10%), colleagues (7%) and friends (7%) notified PLWHA's organizations about the sero-positivity. As these sources of information were unauthorized, their gossips tantamount to a breach of privacy.

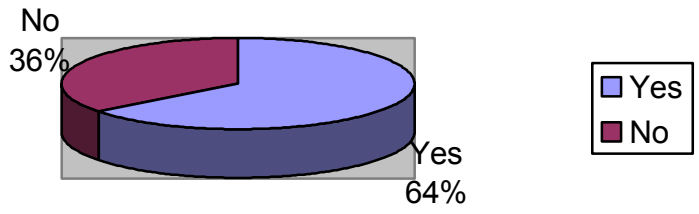
The respondents were asked to describe the reactions of their employers and colleagues when they learnt about the HIV status. Table 5 below highlights the reactions which ranged from rejection (16%), sympathy 16% to empathy 3.2%. Only 10% of the respondents were accepted without prejudice.

Table 5: Initial Reaction of Organizations To PLWHA

Initial Reaction Of Organizations To PLWHA						
Sympathy	2	13.3	3	18.8	5	16.1
Disbelief	1	6.7	-	-	1	3.2
Sadness	3	20.0	2	12.5	5	16.1
Indifferent	3	20.0	5	31.3	8	25.8
Shocked	1	6.7	1	6.3	2	6.5
Empathy	1	6.7	-	-	1	3.2
Rejection	2	13.3	3	18.8	5	16.1
Acceptance	2	13.3	1	6.3	3	9.7
Missing	-	-	1	6.3	1	3.2
Total	**15**	**100**	**16**	**100**	**31**	**100**

Among the 80 PLWHA who had worked or were working at the time of the study, 5% were demanded to have mandatory HIV tests. Gender analysis does not show any significant difference. About 5% of the respondents (8% women and 2% men) had their blood tested for HIV infection without their informed or specific consent and knowledge. More women were victims of the breach of privacy.

Figure 2 : Sharing organizational facilities such as toilets, canteens etc



In figure 2 above, 36% of the 31respondents whose status has been made public in the workplace could not share workplace facilities such as toilet and canteens with other workers. Gender analysis indicates that more women (38%) than men (33%) experienced discrimination in the workplace. One male PLWHA was isolated in a separate office on the grounds of his HIV status while 7% of the respondents were restricted to certain areas within their premises of the organizations.

Figure 3: Ever threatened with dismissal by employer on grounds of HIV

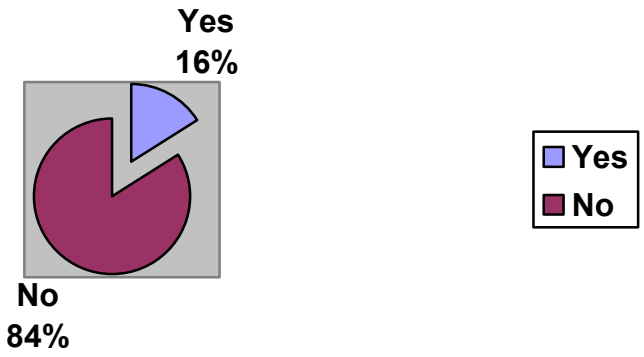


Figure 3 above shows that PLWHA (16%) reported that they had received threats of termination of appointments because of their status while 21 out of the 80 PLWHA who had worked were found to have actually stopped work (see figure 4 below). One male PLWHA in the Benue FGD recounted thus: "*I had a lot of problems with my Head of Department. He almost threw me out*" and escaped termination of his appointment only because of the intervention of some people. Most of the respondents (48%) lost their jobs as indicated in figure 4 below: by termination (19%) which constituted only women, discrimination (10%), self-stigma and ill-health (10%) each, 33% retired from their jobs i.e. men (57%) and women (21%). Other respondents mentioned reasons like relocation of residence. Their decisions must have been informed by discrimination in the workplace and neighbourhoods. One female PLWHA stopped work because of pregnancy. When one considers the percentage that stopped work it then becomes obvious that there is a high level of stigmatization and discrimination in the workplace.

Figure 4 : Reasons for stopping work

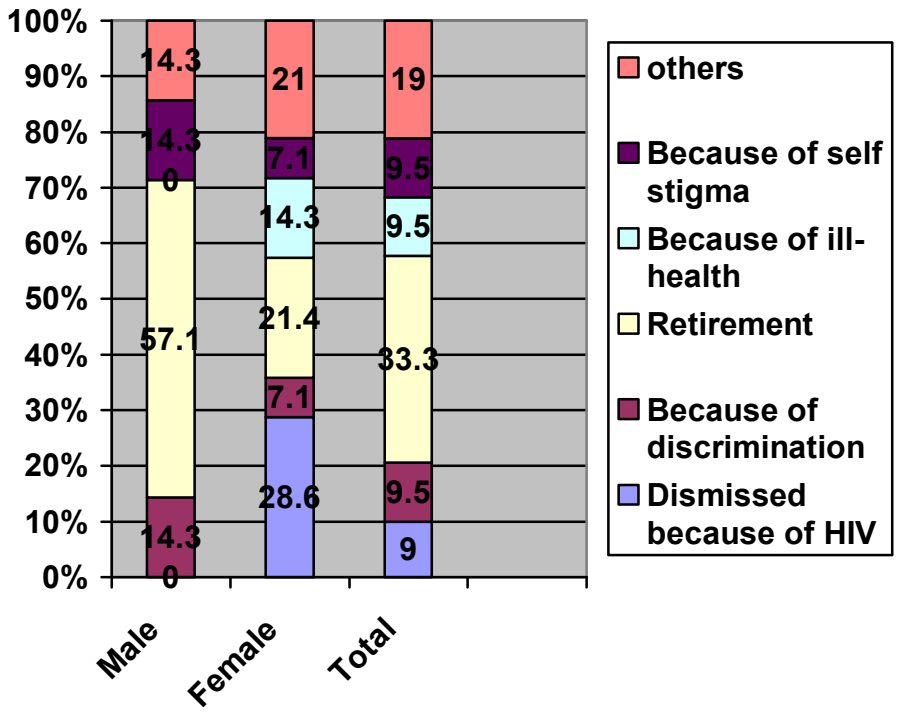
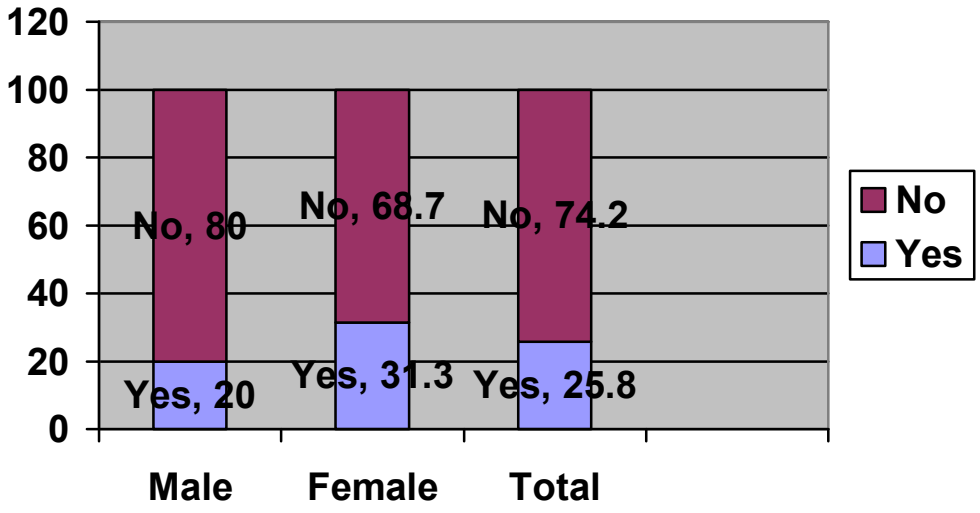


Figure 5 : Duties ever changed by Employer



In figure 5 above, more than one–quarter (26%) reported that their job duties were changed. About 10% of the respondents were deployed to other departments or units. One of them acknowledged that the change was to relieve him/her from stressful tasks. The respondent might

have become sick with either opportunistic infections or AIDS. Ten percent of the respondents were denied prospects for promotions on account of their HIV status as demonstrated in figure 6 below.

Figure 6: Ever been denied promotion on account of HIV status

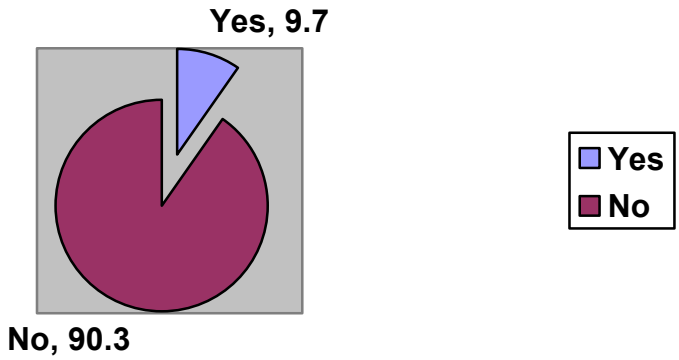
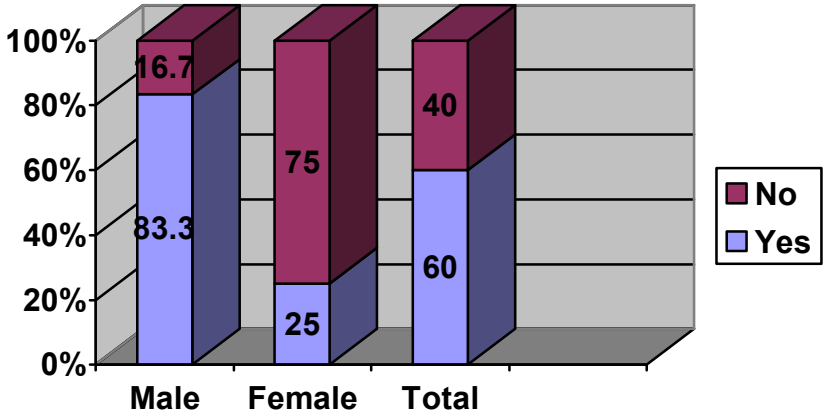


Figure 7: Allowed to participate in insurance scheme



Almost 40% of respondents in organizations with insurance schemes were excluded from policy cover (see figure 7 above). One probable reason for this is that insurance companies generally regard PLWHA as high risk insured for them because it is deemed that the HIV-infection significantly increases the risk of early liability which does not augur well for their business which can only be mediated by increased premium payment to be borne by the prospective insured. Majority of those affected were women (75%) (see figure 7 above). It is not clear how gender and designation in the organizations intersected with HIV/AIDS status to increase

women's vulnerability in this respect. The implication of these findings is that many organizations have not yet formulated HIV/AIDS policies to protect the PLWHA employees from stigma and discrimination.

6.0 Discussion and conclusion

1. The results of the study show that PLWHA experienced discrimination at work in form of segregation and isolation in separate offices and many reported that they were not allowed to share toilets, canteens and sports facilities with other workers. The findings are not different from those of focus group discussions (FGDs). In fact the major problems expressed by the discussants were dismissal and mandatory pre-employment HIV tests. One of the PLWHA in Lagos state reported during the FGDs that she was denied employment because of her HIV status after passing all qualifying tests and the final interview. This does not augur well for the pandemic, for the PLWHA need their jobs and money to be able to cope with life. HIV/AIDS by its very nature impoverishes the PLWHA due to its protracted nature, its high management cost and the fact that it particularly affects the economically active groups in the society. Therefore adequate measures should be put in place to check these stigmatizing and discriminatory acts. Government should undertake the reform of labour laws to make them responsive to the challenges of HIV/AIDS and effectively guarantee to PLWHA the right to work, protection against unfair dismissal and other employment-related rights.

2. HIV/AIDS interventions at the workplace are minimal, particularly among indigenous companies, therefore there is need for organizational/institutional employers to adopt and implement appropriate workplace policies. Some national and multinational companies and international organisations have done this and now provide care and support services for their employees e.g. Unilever Plc., STATOIL and Coca-Cola Nigeria Plc. These policies as well as the HIV/AIDS Workplace Policy developed by the Ministry of Labour and Productivity offer some model.

3. All the findings suggest that there is a high level of stigmatization and discrimination in the workplace. Stigmatization and discrimination are manifestations of fear of contacting HIV and total ignorance about the modes of transmission and prevention of HIV/AIDS. Therefore, massive HIV/AIDS education and enlightenment campaigns should be organized for the workplace in particular and general population. International Labour Organization (ILO) has a

guideline on workplace practice for PLWHA. It needs to be turned into proper legislation for Nigeria and applied as a policy in the workplace.

4. Stigmatization and discrimination translate to violation of human rights of PLWHA to work. The right to work ensures that individuals have access to work without any discrimination. There are international instruments and some provisions of the Nigerian Constitution which guarantee the rights of people to work but they are not fully enforced. With regards to this right, the Universal Declaration of Human Rights (UDHR) in Article 23, section 1 provides that ***"everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment".*** Art. 15 of African Charter on Human and Peoples Rights (ACHPR) *inter-alia* states that ***'every individual shall have the right to work under equitable and satisfactory condition".***

Article 7 of International Covenant on Economic, Social and Cultural Rights (ICESCR) also guarantees safe and healthy working conditions and equal opportunity to be promoted without discrimination. With respect to discrimination, Article 2 of African Charter on Human and Peoples Rights (ACHPR), Article 7 of Universal Declaration of Human Rights (UDHR) and section 42 of 1999 Constitution of Nigeria guarantee the right to freedom from discrimination. The findings also run contrary to the following provisions: Art.20 (1) of UDHR, Art.9 (1) and Art.22 (1) of International Covenant on Civil and Political Rights (ICCPR), Art.10 (1) of ACHPR and Sec. 40 of 1999 constitution which state that *every one has the right to free association,* therefore isolating PLWHA in separate offices violates their rights to freedom of association. According to Articles 13 (1) of UDHR, 12 (1) of ICCPR, 12 (1) of ACHPR and Section 41 (1) of 1999 Constitution, everybody has the right to freedom of movement.

5. The findings also suggest that women are more vulnerable to HIV-related stigma and discrimination than men. Apart from provisions of CEDAW, Art.18 (3) of ACHPR also enjoins the State to ensure the elimination of all forms of discrimination against women. Therefore provisions of CEDAW and Art.18 (3) of ACHPR should be fully enforced.

6. The 2003 National Policy on HIV/AIDS ensures that the rights of PLWHA are protected by prohibiting stigma and discrimination against people living with HIV/AIDS on the basis of their health status with respect to employment, education, training etc. The policy also enjoins people

to respect the rights to privacy and confidentiality of PLWHA and avoid disseminating information on the HIV status of individuals without their consent. Furthermore, the policy states that mandatory HIV testing without consent is illegal. This policy is yet to be fully enforced and many people including employers are unaware of it. Therefore, government should expedite action in educating the populace especially in the workplace. Employers should be encouraged to have policies on HIV/AIDS for their employees.

7. Finally, capacity building workshop should be organized for the people living with HIV/AIDS to sensitize and empower them to litigate and seek redress when they experience any form of stigma or discrimination from their employers and colleagues.

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Human Rights Legislations

African Charter on Human and Peoples Rights (ACHPR)

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

ILO Code of Good Practice on HIV/AIDS

International Covenant on Civil and Political Rights (ICCPR)

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Universal Declaration of Human Rights (UDHR)

1999 Constitution of the Federal Republic of Nigeria

2003 National Policy on HIV/AIDS