

**EXPLORING HIV/AIDS STIGMA IN THE WORKPLACE, VOICE OF THE
STIGMATISED**

by

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DEDICATION

This study is dedicated to my parents, Eric and Lalitha Ramroop, to my sisters, Resheen, Nereen and Shereen and to my loving husband Shivaan Jugdeo.

DECLARATION

I, Nesheen Jugdeo (Ramroop), declare that:

EXPLORING HIV/AIDS STIGMA IN THE WORKPLACE, VOICE OF THE STIGMATISED

- Is my own work and that all the resources that I have used or quoted have been indicated and acknowledged by means of complete references.
- This report has not been previously submitted in full or partial fulfilment of the requirements for an equivalent or higher, qualification at any other recognised educational institution.

NESHEEN JUGDEO (RAMROOP)

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**By: JUGDEO, N MA (INDUSTRIAL AND ORGANISATIONAL
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SUMMARY

The purpose of this research was to explore HIV/AIDS stigma in the workplace, with a special focus on the stigmatised. The sample consisted of 10 HIV/AIDS positive employees. A qualitative interview schedule was designed. The interview guide was used to facilitate one-on-one interviews with each participant. An analysis of the data revealed that the majority of the participants were shunned by family, friends and partners. Others were too ashamed or afraid to reveal their positive status. The majority of the participants did not feel comfortable revealing their positive status to their line managers and to their co-workers. All participants felt that others viewed people living with HIV/AIDS as dirty and unclean and many had been exposed to stigmatising behaviours towards them due to their HIV/AIDS positive status. As a coping mechanism, most participants noted that they would walk away if stigmatised against. Recommendations were made to address HIV/AIDS stigma in the workplace.

Key words: HIV/AIDS, Stigma, Workplace, Personal Experiences, Negative Feelings, Discrimination, Coping Mechanisms.

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CHAPTER ONE

INTRODUCTION, BACKGROUND AND MOTIVATION FOR THE RESEARCH

Chapter one is divided into two sections. The first section comprises of the introduction which gives the reader an overview of the aims, paradigm perspective, research design and research methods employed in this study. Section two consists of the background and motivation for the study which entails the problem statement, research questions and chapter summary.

1.1 SECTION ONE: INTRODUCTION

1.1.1 AIMS

The aims for this research are discussed in terms of general and specific objectives.

1.1.2 General aim

To explore HIV/AIDS stigma from the perspective of the stigmatised, with a special focus on the workplace, and to make recommendations that may assist in dealing with challenges that emanate from HIV/AIDS stigma.

The following specific aims are derived from the general aim of this study:

1.2.1 Specific aims

The more specific aims of the study are to explore the following:

- The participants' personal experiences of being HIV/AIDS positive
- The life experiences of living with HIV/AIDS in the workplace

- How the participants feel about opinions expressed by others towards them as a result of their condition
- The coping mechanisms or skills the participants use to cope with stigmatising situations
- Recommendations with the view to ameliorating the challenges emanating from HIV/AIDS stigma.

1.3 PARADIGM PERSPECTIVE

1.3.1 Paradigms, disciplines and concepts

The research paradigm explains the researcher's choice of a research method or preference for a research design and is influenced by the ontological and epistemological assumptions that a researcher embraces or makes (Burrell & Morgan, 1979). The epistemological assumptions reveal a researcher's view of knowledge, for instance, knowledge being hard, real and transmitted in tangible forms or knowledge being softer, subjective and based on personal experience. In the social sciences, these methods range from those that take knowledge as more objective to those that regard it as more subjective. To gravitate towards the view that knowledge is hard and objective has the implication that one will prefer the more positivistic and functionalist approaches to social science research. The functionalists' most preferred methods are quantitative because, as in the natural sciences, they take knowledge to be objective. In most instances, they have to measure or compare dependent and independent variables (Burrell & Morgan, 1979).

A decision to adopt the interpretive method in this study presupposes the researcher's view that knowledge is subjective and is based on personal experience. This study deals with individual employees' experiences of living with HIV/AIDS and their experiences of the HIV/AIDS stigma.

HIV/AIDS has become one of the daunting challenges facing business organisations. As a result, employers have initiated workplace programmes

That may help in circumventing some of the challenges those employees who are living with HIV/AIDS face. This places the study within the field of Industrial and Organisational Psychology. The deleterious consequences of the virus for business are discussed elsewhere in this dissertation. The relevant sub field in Industrial Psychology is Employee and Organisational Wellness.

According to Mulvihill (2003), employee and organisational wellness can be defined as a set of organised activities and systematic interventions that is implemented within organisations and whose primary purpose is to provide health education, care and treatment to its employees. The aim of wellness programmes is to assist employees by helping them focus on healthy positive behaviours, thus moving people from their current state of health to a higher state of well-being.

This study is descriptive and attempts to capture the subjective life experiences of employees living with HIV/AIDS in the workplace.

A qualitative approach is adopted because it enables the reader to understand individual subjective experiences. To this end, interviews were conducted with the individual participants on their experiences of living with HIV/AIDS and their experiences of the HIV/AIDS stigma.

Epistemologically, the involvement of the researcher is seen not as neutral but as contributing towards the research process. In this study, the researcher is also an employee of the same organisation as the respondents in the research. The ontological assumptions are that shared life experiences are subjective. It is the purpose of this research to explore these subjective experiences.

1.4 RESEARCH DESIGN

According to Bless and Higson-Smith (1995), research design has two meanings. Firstly, it is a programme used to guide the researcher in collecting, analysing and interpreting observed facts. Secondly, it is a specification of the most adequate operations to be performed in order to attain specific hypotheses under given conditions. The aim of research design, according to Mouton and Marais (1993), is to plan and structure a given research project in such a way that the eventual validity of the research findings is maximised.

1.4.1 Typology of the research

Mouton & Marais (1993), distinguish between three research goals, namely, exploratory, descriptive and explanatory. The presentation of this research can be categorised as descriptive. A descriptive research project is designed with the intention of extracting information relating to the present status of the phenomena (Ary *et al.*, 1990). Descriptive analysis entails the researcher analysing the frequency of responses from the interview schedule and pinpointing the number of times a particular category is mentioned by the participant.

1.5 RESEARCH METHOD

In an attempt to obtain scientific and objective findings, the research method assumes the following sequence:

- **Phase one: Literature review**

Step 1: Literature review of the impact of HIV/AIDS on the workplace

This involves an analysis and integration of the existing literature on HIV/AIDS, with a special focus on costs to the business and the business response to the epidemic.

Step 2: Literature review of stigma.

This involves the conceptualisation of stigma, with emphasis on discrimination, impact on people living with HIV/AIDS (PLWHA) with special focus on the workplace.

- **Phase two: Empirical study**

Step 1: Selection of the population

The population comprised of HIV/AIDS positive employees employed at a retail company in the Western Cape region. Ten participants were selected for this study. Owing to the sensitivity of this study, the company's nurse approached all respondents who had revealed their HIV/AIDS status to her. The nurse thereafter enquired on the researcher's behalf if they would be willing to participate in the study. The participants thereafter gave their verbal consent to participate in the study.

Step 2: Data gathering

Data for this research was collected using a semi-structured interview schedule that allows for probing. The schedule comprised of biographical items and open-ended questions. Due to the sensitive nature of the topic, the participants requested that the audio recording not be used as this could have compromised their identity. Only the interview guide was used to record the responses. However, generally speaking this can have the effect of prolonging the interviews as the researcher attempts to capture the verbatim statements.

Step 3: Data collection and analysis

The responses retrieved from the participants have been recorded using one-on-one interview guides. To ensure accuracy, the raw data was transcribed from the interview guides verbatim. Thematic analysis was then used by the researcher to retrieve the actual findings of the research (Sanders & Pinhey,

1979). The techniques that have been employed in the analysis of the information provided, is discussed in greater detail in chapter three.

Step 4: Reporting and interpretation of the results

The results retrieved from the processing of the information is presented in order to compile a conclusive picture of HIV/AIDS stigma from the perspective of the stigmatised, with a special focus on the workplace. The data is then interpreted in a manner that enables the researcher to answer the research questions as presented in 1.7.2.

Step 5: Conclusion

The conclusions are based on the results and are presented per specified aim.

Step 6: Discussion of the limitations of the research

The relevant limitations to the literature review and the empirical study are discussed.

Step 7: Recommendations

Recommendations are presented with reference to the literature review, the qualitative study as well as to the group concerned and to the field of industrial psychology.

1.6 SECTION TWO: BACKGROUND AND MOTIVATION

Daily, over 6800 people suffer from HIV/AIDS infection and over 5700 people die from AIDS (UNAIDS, 2007). Recent statistics reveal that on a global level, 30.8 million people are infected with HIV/AIDS and 1.7 million adults have died from AIDS related causes (UNAIDS, 2007).

Cases of HIV/AIDS have been reported in all regions of the world, but research shows that more than 95% of those living with the virus are from low and middle income countries, where most HIV infections and AIDS deaths are reported (Kaiser Family Foundation, 2007). Sub-Saharan Africa has been marked as the most seriously affected area, with more AIDS deaths reported than in any other region (Kaiser Family Foundation, 2007; UNAIDS, 2007). It is estimated that approximately 25.8 million people are living with the virus in this region.

HIV/AIDS is one of the serious challenges confronting South Africa at present. In South Africa, one out of nine adults or 5.5 million South Africans were living with HIV at the end of June 2006 (UNAIDS, 2006). Among the adult population there is a prevalence of HIV infection, affecting people in the productive prime of their lives (Dickinson, 2004; UNAIDS, 2000). For the South African economy, HIV/AIDS threatens to weaken an already weak skills base (Dickinson, 2004). The HIV/AIDS epidemic is a labour and workforce issue as it puts strain on productivity, economic growth and the livelihood of many working men and women.

According to a survey conducted by the South African Business Coalition on HIV/AIDS (2004), more than a third of the companies surveyed indicated that HIV/AIDS had impacted negatively on their labour costs, productivity and increased labour turnover. As productivity falls, businesses within both the public and private sectors will be faced with increased costs for overtime, recruitment and training. It is expected that these businesses will need to increase their contributions to pension, disability and medical benefits owing to the increasing costs associated with HIV/AIDS (Department of Labour (2003; UNAIDS, 2004).

According to Experts in Responsible Investment Solutions (2008), the South African business sector has been increasingly dedicated to humanitarian support and has contributed considerably to the HIV/AIDS field. Businesses are in a powerful position to effectively mobilise resources to respond to HIV/AIDS management in the workplace. Apart from finances, companies

have infrastructure, expertise, skills and experience that can be harnessed to reduce the impact of HIV/AIDS.

Businesses have been initiating workplace HIV/AIDS prevention and treatment programmes (UNAIDS, 2007). Some companies have expanded their support programmes to include voluntary counselling, testing, care and treatment. Yet, it has been identified through research that a major barrier to effective HIV/AIDS workplace support programmes is stigma (UNAIDS, 2007).

The HIV/AIDS pandemic has brought about a wide range of reactions from individuals, communities and even nations, in the form of sympathy, denial, fear, anger and even violence (Brown, Trujillo & Macintyre, 2001). Stigma has been identified as an important factor in how people react to the virus (Brown *et al.*, 2001).

According to Brown *et al.*, (2001, p. 4), “stigma is an important factor in the type and magnitude of the reactions to this epidemic”. Stigma is divided into felt or perceived stigma and enacted stigma. Felt or perceived stigma refers to real or imagined fear of negative attitudes or treatment by society arising from an undesirable attribute, for example HIV/AIDS. Enacted stigma on the other hand refers to an individual’s or a group’s actual experience of discrimination. Felt or perceived stigma is viewed as the survival strategy in avoiding or limiting the occurrence of enacted stigma (Brown *et al.*, 2001). Individuals who enact stigmatising behaviours are referred to as the perpetrators or stigmatising, whereas individuals living with HIV/AIDS are the targets of stigma, referred to as the stigmatised (Brown *et al.*, 2001).

Since the start of the epidemic, people living with HIV/AIDS have been stigmatised (Herek, Capitano & Widaman, 2002). Due to the stigma attached to HIV/AIDS, people are afraid of being discriminated against, preventing them from seeking treatment for HIV/AIDS or acknowledging their status publicly (International Centre for Research on Woman, 2006; UNAIDS, 2007). People are afraid of being rejected by their families, friends or co-workers, denied housing or employment, suffering physical violence or even being

divorced. With regard to employment, employees infected or rumoured to be infected with the virus have been shunned by colleagues. In certain cases, many employees are denied employment, promotions and are fired after their HIV positive status is revealed to employers (Herek, 1995; UNAIDS, 2007).

HIV/AIDS stigma stems from individuals who express negative attitudes or feelings towards people living with the virus. According to Herek and Mitnick (1996), the negative reactions to HIV/AIDS seem to be derived from two fundamental sources, namely, instrumental stigma and symbolic stigma.

Instrumental HIV/AIDS stigma relates to the fears individuals have with regards to certain outcomes directly related to the virus (Herek & Mitnick, 1996). For instance, HIV/AIDS shares common characteristics with many other diseases, for example, it is perceived as a permanent, degenerative and fatal disease. Also, the virus is considered to be contagious and people carrying the virus should be avoided. Lastly, others see the symptoms of HIV/AIDS at its last stage as repellent, ugly and upsetting. Magnifying these reactions to HIV/AIDS, there is a tendency to blame people who have contracted the virus. This blame is directly related to sexual intercourse and needle sharing, which are seen as immoral and voluntary (Herek & Mitnick, 1996).

Symbolic HIV/AIDS stigma relates to the social meaning that is attached to the virus (Herek & Mitnick, 1996). It entails the use of the disease to voice feelings and opinions towards the groups affected with HIV/AIDS and the behaviours they engage in. According to research, in America the public continues to associate HIV/AIDS infection with homosexuality (Herek & Capitano, 1999; Herek & Mitnick, 1996). As a result, gay men who have contracted the virus through male-male sex are more likely to be blamed and stigmatised than heterosexuals with HIV/AIDS.

Cultural prejudices, such as sexism and racism also interact with HIV/AIDS stigma, playing an important role in shaping people's responses to the epidemic (Herek & Mitnick, 1996). When women and members from other

ethnic groups and racial minorities become infected with the virus, their disadvantaged status subjects them to unsympathetic and sometimes unresponsive reactions by society (Herek & Mitnick, 1996).

HIV/AIDS related stigma has been recognised as a crucial barrier to the effective prevention, care and treatment of people living with HIV/AIDS (International Centre for Research on Woman, 2006). However, research investigating HIV/AIDS stigma from the perspective of the stigmatised is limited (Herek & Mitnick, 1996). A review of literature has highlighted that available data on stigma has been drawn from studies where stigma is not the main focus of the study. Therefore, there is a clear need for more in-depth research on exploring the social nature of the virus from the perspective of the stigmatised. Such information would be highly valuable in drawing up policies to protect the rights of people living with HIV/AIDS. Yet, more importantly the data can be utilised in creating programs to help reduce the persecution of people living with HIV/AIDS, especially in the workplace (Herek & Mitnick, 1996).

1.7 PROBLEM STATEMENT

1.7.1 The problem

As the number of people being infected or affected with HIV/AIDS in South Africa increases, the number of infected people in the working environment will increase. It cannot be denied that HIV/AIDS poses one of the greatest challenges ever faced by South African businesses (UNAIDS, 2007).

However, as mentioned above, a major barrier in the management of HIV/AIDS is stigma towards PLWHA (UNAIDS, 2007). While the HIV/AIDS epidemic has triggered responses that include compassion, solidarity and support from families, friends and co-workers, the virus has also triggered responses of rejection, blame, and exclusion (UNAIDS, 2004).

A review of literature has highlighted that stigma plays a crucial role in the effective prevention of HIV/AIDS, care and treatment of PLWHA (Herek & Mitnick, 1996). However, very little research is available that focuses primarily on stigma, from the perspective of the stigmatised within the workplace.

To address this problem, this study endeavours to explore HIV/AIDS stigma from the perspective of the stigmatised within the workplace. This will enable the reader to develop an understanding of life experiences of PLWHA including how they grapple with HIV/AIDS stigma. It is hoped that the data will reveal information essential for developing solid workplace programmes and policies that may assist in circumventing some of the challenges faced by PLWHA.

1.7.2 The research question

The following are the specific questions that this study endeavours to investigate:

- What are the personal experiences of being HIV/AIDS positive?
- What are the life experiences of living with HIV/AIDS in the workplace?
- Do the participants feel that others hold negative opinions towards them because of their condition?
- What coping mechanisms or skills do the participants use to cope with stigmatising situations?
- What recommendations can be made to address HIV/AIDS stigma in the workplace?

1.8 CHAPTER SUMMARY

Chapter one provides the reader with the background to this study as well as a discussion on the importance and relevance of the research. Thereafter, the details of the research question and empirical aims of this research are discussed. The description of the research design and research method

follows the paradigm perspective. The division of the chapters describing the research are presented below.

1.8.1 Chapter divisions

The chapters of this research will be presented as follows:

Chapter 2: Impact of HIV/AIDS on the workplace

Chapter 3: HIV/AIDS Stigma

Chapter 4: Empirical study

Chapter 5: Results

Chapter 6: Conclusion, recommendations and limitations

CHAPTER TWO

IMPACT OF HIV/AIDS IN THE WORKPLACE

Chapter two will highlight the impact of HIV/AIDS on the business environment by delving into the macro and micro economic impact of HIV/AIDS on the business arena. Thereafter, the chapter will look at the business response to HIV/AIDS, which can be categorised into defensive or constructive. Lastly, the reader will gain an understanding of what is HIV/AIDS stigma and its impact in the workplace.

2.1 MACRO-ECONOMIC IMPACT OF HIV/AIDS ON THE BUSINESS ARENA

According to statistics, it has been noted that the “pandemic is a powerful brake on economic growth” (UNAIDS, 2003a, p. 7). Owing to the steady increase in HIV/AIDS infection rates, there has been a growing need to model the economic impact of the virus within Sub-Saharan Africa and in South Africa.

According to the Department of Labour (2003), an annual macro-econometric forecasting model to investigate the impact that the virus could have on the South African economy was developed. The model revealed that the South African economy would be 5.7 percent smaller by the year 2015 than it would have been without HIV/AIDS. According to Whiteside and Sunter (2000), in the long term it cannot be disputed that the virus will have a marked impact on the country's economic growth.

As the pandemic robs countries of their most valuable assets, namely their human capital, this will have profound effects on the business sector. Not only will the size of the labour force shrink but also its quality (UNAIDS, 2003a). This will be evident in the large numbers who will be lost to the virus (UNAIDS, 2003a). The impact of HIV/AIDS on the business sector could

seriously hamper its ability to operate efficiently. A drastic decline in effective labour supply and intellectual ability could discourage foreign investment, which would adversely affect our countries economic growth (UNAIDS, 2000).

According to UNAIDS (2003a), apart from the devastating effects of HIV/AIDS on the business environment at an indirect level (macroeconomic), literature has forewarned that the virus will also impact businesses at a direct level (microeconomic level). This will be probed in greater depth in the following section.

2.2 MICRO-ECONOMIC IMPACT OF HIV/AIDS ON THE BUSINESS ARENA

In terms of a microeconomic impact, it has been predicted that two broad areas will be affected by the spread of the virus within the working arena, namely declining productivity and increased costs (UNAIDS, 2000). Only during the early 1990s did the human resource cost of the HIV/AIDS pandemic become apparent to businesses (UNAIDS, 2003a). Businesses worldwide are reporting a loss of productivity as the levels of morbidity (illness), mortality (death), absenteeism, replacement and training costs increase (UNAIDS, 2003a). Other reported costs include demoralised staff, funeral expenses, medical care, as well as insurance cover and retirement funds (Whiteside, 1995; UNAIDS, 2003a).

The impact of these elements on a company can cause a serious decline in productivity and profitability. The principal areas that will be most affected by HIV/AIDS are outlined below.

- **Morbidity**

Employees diagnosed with HIV/AIDS take time off work, including the maximum allowable sick leave. In some instance, employees might take unauthorised sick leave (Whiteside & Barnett, 1996).

- **Mortality**

Following the death of an employee, productivity suffers during the time it takes to replace workers, especially skilled and senior employees (UNAIDS, 1998; UNAIDS, 2003a).

- **Absenteeism**

Employees find themselves taking time off work to care for sick family members. This inevitably disrupts the production cycle and leads to the under utilisation of work equipment (UNAIDS, 2002).

- **Staff morale**

The loss of colleagues, increased workload, potential discrimination, general uncertainty about HIV/AIDS and the fear of infection might undermine staff morale. According to Whiteside and Barnett (1996), cases have been documented in literature where certain workers have refused to continue working with co-workers infected by the virus. In some countries, production line stoppages have occurred as a result of fear of HIV/AIDS infection from colleagues (UNAIDS, 2003a).

- **Increased recruitment and training costs**

Training and recruitment costs escalate as a result of staff turnover and the loss of skilled workers. Finding qualified managers and workers to replace staff that can no longer work can be difficult, especially in many developing regions (UNAIDS, 1998).

- **Increased labour turnover**

The efficiency and productivity of the company is seriously jeopardised during the time it takes to replace workers, especially the more skilled

and semi-skilled workers (UNAIDS, 1998). In addition, it often takes an extended period before replaced staff can work at the same productive capacity as those whom they have replaced.

- **Increased health care costs**

As a result of the onset of the virus, companies spend more on health care to ensure that their staff work at their maximum performance levels for as long as possible. It is important to note that companies also bear the brunt of increased medical and insurance costs, death benefits, disability and pension payouts (UNAIDS, 1998).

- **Insurance cover and pensions**

Life insurance premiums and pension fund commitments for businesses have the potential to increase substantially owing to early retirement and death as a result of HIV/AIDS. This will undoubtedly be less of a concern in countries with better economies and more advanced benefits (UNAIDS, 2003a).

The discussion above illustrates that since the onset of the virus, there has been a change in the age and sex distribution of the workforce, causing a loss of skilled workers (UNAIDS, 2003a). It cannot be disputed that the cost of HIV/AIDS for the business sector over time can be substantial. If not managed appropriately, these costs could easily cripple South African business enterprises and prevent them from being global competitors. To remedy this problem, it is imperative that businesses respond constructively and proactively in the fight against HIV/AIDS within the workplace.

2.3 BUSINESS RESPONSE TO THE VIRUS

In responding to the impact of HIV/AIDS within the business sector, enterprises can either take a defensive approach or a constructive approach. The advantages and disadvantages of each approach will be discussed further (Sections 2.3.1 and 2.3.2 below).

2.3.1 Defensive response to HIV/AIDS

The assumption driving the defensive business response to HIV/AIDS is that workers infected with the virus are a liability and can generate problems that will inevitably impact negatively on a company's performance (Goss & Adam-Smith, 1995). As mentioned above, these problems are capable of emerging in the form of absenteeism due to sickness, replacement costs, spreading fear of infection throughout the workforce and decreased employee morale as discrimination and stigmatisation infiltrate the workplace.

A defensive workplace response is usually characterised as being negative, and is associated with negative metaphors such as attack, war and battle (Goss & Adam-Smith, 1995). In the early 1980s and 1990s it was documented that numerous businesses had adopted a defensive workplace response that included conducting HIV/AIDS tests in an attempt to isolate or exclude HIV/AIDS infected people (Goss & Adam-Smith, 1995). Thus, HIV/AIDS testing is seen as a business defence mechanism to protect the workplace from significant and unreasonable costs posed by infected workers. It follows from this that businesses adopting the defensive approach were under the impression that they could dismiss or demote employees according to their HIV/AIDS status. Furthermore, by conducting pre-employment testing, companies were in a position to either accept or reject a potential applicant (Richter, 1995).

However, with the emergence of South African legislation that aims at protecting the rights of infected employees, businesses are no longer in a position to reject, dismiss or demote employees on the basis of their HIV/AIDS

test results. The Employment Equity Act states that no employer has the right to force an employee to take an HIV/AIDS test, except if granted permission by the Labour Court (Richter, 1995). In addition, the Code of Good Practice on Key Aspects of HIV/AIDS has also been passed to protect infected employees from unfair labour practices and discrimination (Richter, 1995).

Taking a defensive response to HIV/AIDS within the workplace is based on secluding or excluding HIV/AIDS infected employees. In the long term, such an approach is destructive to the business environment on many levels, as resentment and distrust infiltrate the workplace and employees sense that their company is not taking an interest in their health and well being. As morale decreases among workers, productivity and efficiency decline as well, resulting in a loss of profits (Richter, 1995).

2.3.2 Constructive response to HIV/AIDS

A constructive response implies a different orientation to HIV/AIDS management in the workplace (Goss & Adam-Smith, 1995). The first responsibility that companies have is to create a well-defined and well-executed commitment to protect and support their workforce in the face of the rapidly growing epidemic. It has been noted in literature that the business sector can bring unique skills, capabilities and resources to the fight against HIV/AIDS (UNAIDS, 2003a). Some of the key strengths that businesses have to offer in relation to resource management are communication and marketing skills, to develop educational campaigns, distribution of information materials and improving the management of HIV/AIDS programmes (UNAIDS, 2003a). According to UNAIDS (2003a), the workplace is an ideal place to disseminate HIV/AIDS prevention messages.

The workplace wields a vast influence on workers' social attitudes, values and even sexual behaviour. Workers interact with each other within the working arena and socially, thus having the ability to influence each other's attitudes and behaviours. Therefore, educating workers to be HIV/AIDS peer educators can be a key factor in influencing workers' thinking and behaviour.

The workplace creates a sense of unity and shared identify among employees. Some workplaces incorporate medical assistance to employees by having onsite clinics, which not only provide employees with adequate information but also provide high–level care to all workers and their immediate families.

Businesses can respond constructively to the HIV/AIDS virus by using five main initiatives as identified by UNAIDS (2003a, p. 16), namely:

- Developing an HIV/AIDS policy for the company
- Providing HIV prevention education in the workplace
- Providing care and support in the workplace
- Implementing fair employment practices
- Community involvement

Early investments by businesses in the management of the pandemic within the working environment can dramatically help to reduce the spread of the virus to workers, their families and surrounding communities (UNAIDS, 2003a). From the argument outlined above it is evident that HIV/AIDS has become a “bottom line” issue for businesses worldwide. Therefore, by developing and implementing sound HIV/AIDS interventions, companies can reap the benefits of economic and human savings (UNAIDS, 2003a).

2.4 UNDERSTANDING HIV/AIDS STIGMA

2.4.1 HIV/AIDS stigma from a South African context

Globally, it has been documented that HIV/AIDS stigma has made itself evident in the form of anger, avoidance, ostracism and the belief that they deserve to be infected with the virus (Herek *et al.*, 2002; Stein, 2003). Since the early days of the epidemic, the American public has expressed negative attitudes towards people living with HIV/AIDS (PLWHA) in the form of

quarantine, mandatory testing and even the tattooing of infected people (Herek & Mitnick, 1996).

In South Africa there are a number of documented cases of HIV/AIDS stigma and acts of discrimination. For example, Nkosi Johnson was denied admission to schooling and Gugu Dlamini was attacked by a mob and murdered after she had publicly revealed her HIV/AIDS status (Skinner & Mfecane, 2004; Stein, 2003). In 2004, Lorna Mlofane was raped and thereafter murdered after her three rapists discovered she was HIV positive (Skinner & Mfecane, 2004).

In South Africa there are indigenous languages, in which there are many euphemisms for the disease. For example, in the Western Cape province of South Africa the Xhosa-speaking people refer to HIV/AIDS as 'ulwazi', which means "that thing" (Stein, 2003). This reveals that HIV/AIDS is viewed by the Xhosa speaking people of Western Cape not only as a disease that has no cure but also as a disease that is highly stigmatised because people are unable to refer to the disease by its correct name.

2.4.2 What is HIV/AIDS stigma?

The term 'stigma' originated from the Greeks and refers to a tattoo that has been marked on the skin of an individual to indicate guilt of an incriminating act (Stein, 2003). The tattoo served to publicly identify the individual as someone to be avoided. Therefore, stigma had nothing to do with illness or disease but rather focused on behaviour.

A review of literature has revealed various definitions of stigma. According to Naidoo (2001, p. 16), stigma is defined as "the holding of derogatory social attitudes or beliefs, the expression of negative affect or hostile or discriminatory behaviour towards members of a group on account of their membership in that group". Goffman (1963) defines stigma as the labelling by society of an individual or group as being deviant or different from the norm. He further argues that someone who is stigmatised is seen in the eyes of others as "spoiled identity", in that there is something about that person that is

discrediting and thus to be treated with less respect. Goffman (1963), grouped stigma into three categories, namely:

- Abominations of the body, for example various physical deformities.
- Blemishes in an individual's character, weak will, domineering or unnatural passions, treacherous, rigid beliefs or dishonesty. Blemishes of character are linked to mental disorders, imprisonment, suicidal attempts or radical political behaviour.
- Tribal stigma that stems from race, nation and religion that has the ability to be transmitted through lineages and thus contaminates all members of a family.

The different types of stigmas as cited above, can lead to the devaluation of the person who manifest them (Varas - Diaz, Serrano-Garcia & Toro-Alfonso, 2005). In the context of HIV/AIDS, stigmatisation is defined as a process that devalues people infected with the virus (Miller & Forehand, 2007; UNAIDS, 2003a). HIV/AIDS stigma embodies a set of shared values, attitudes and beliefs that can be placed at both a cultural and individual context. At the cultural level, HIV/AIDS stigma is evident in laws, policies, popular discourse and the social conditions of people living with HIV/AIDS. To protect the rights of people living with HIV/AIDS and to safeguard them from discrimination, legislation has been enacted to ensure that their rights to employment, education, confidentiality and privacy, as well as access to treatment, information and care are upheld.

At the individual level, HIV/AIDS stigma assumes the form of behaviours, thoughts and feelings that express stigmatisation towards those infected with the virus. The primary targets for HIV/AIDS stigma are individual's diagnosed HIV/AIDS positive and those that are suspected of being positive (Herek & Mitnick, 1996).

In chapter one, it was discussed that stigma can be divided into two areas, namely felt or perceived stigma and enacted stigma (Brown *et al.*, 2001). It is

important to re-iterate that due to the stigma and discrimination associated with being HIV/AIDS positive, PLWHA may experience real or imagined fear of negative treatment from families and the community at large. This is referred to as felt or perceived stigma. Sub-section 2.4.1 made reference to acts of actual cases of stigma and discrimination against PLWHA. This is labelled as enacted stigma. Individuals that exhibit acts of stigmatising behaviours are labelled as perpetrators. The individual who experiences the stigmatising behaviour due to being HIV/AIDS positive is referred to as the stigmatised.

2.4.3 Understanding the relationship between HIV/AIDS stigma and discrimination

Stigma can be harmful to an individual as it leads to feelings of shame, guilt and isolation, but it also has a larger societal impact (Aggleton, Parker, & Maluwa, 2003). Discrimination is defined as the “acts or omissions in which the content of the stigma is applied, either at an individual or social/community level” (Skinner & Mfecane, 2004, p. 158). Discrimination occurs when there is a difference in someone else that results in him/her being treated unfairly or unjustly based solely on his/her belonging or being perceived as belonging to a particular group (Aggleton *et al.*, 2003).

The association of stigma and discrimination with a disease is not a new phenomenon. History has documented stigma and discrimination attached to various epidemics and the social groups linked to them, which has often led to the hampering of treatment and prevention. Such illnesses include people with mental illnesses, physical disorders, cancer, TB and STD's. HIV/AIDS stigma therefore follows the footsteps of past epidemics (Herek & Mitnick, 1996; Skinner & Mfecane, 2004).

Since the early days of diagnosing the virus, people infected with HIV/AIDS have been subject to social ostracism, discrimination and even violence (Campbell, Nair, Maimane, & Subiya, 2005; Herek *et al.*, 2002; Herek & Mitnick, 1996;). HIV/AIDS stigma can manifest in the following forms, physical

and social isolation, verbal stigma (for example gossip and insult), loss of role (for example, loss of religious rites and loss of respect), loss of resources (for example, loss of job, customers, housing or being given poor quality or no medical assistance) (Cao, Sullivan, Wu & Xu, 2006; Miller & Forehand, 2007).

It is therefore understandable that PLWHA may be afraid or hesitant to disclose their HIV/AIDS status. This fear will undoubtedly have a profound impact on HIV/AIDS prevention, care and treatment programmes, as PLWHA may be afraid to access the services provided. According to International Centre for Research on Woman (2006), qualitative studies have revealed that people are afraid of being tested for HIV/AIDS due to the social repercussions that they will be faced with if found to be HIV/AIDS positive. In addition, people who do get tested fear going back for their test results because being seen at the clinic could create suspicions with regards to their health. Research has also highlighted that people are less willing to disclose their HIV/AIDS positive status to their spouses, for fear of physical violence (in the case of women) and abandonment (International Centre for Research on Woman, 2006).

As a result of HIV/AIDS discrimination, the rights of PLWHA are usually violated. This gross violation of an individual's right increases the negative impact of the virus at various levels. At the individual level, undue anxiety and distress is elevated and these factors can contribute to ill health. At the level of the community whole families and groups bear the shame. Families attempt to conceal their association with the epidemic in order to receive a positive social response (Cao *et al.*, 2006; Miller & Forehand, 2007).

HIV/AIDS stigma creates a significant amount of stress for many people living with the virus. PLWHA might fear disclosing their status with family, friends and co-workers as this might place undue strain on their relationships. Revealing their status might also make it difficult for them to maintain a normal life. In addition, HIV/AIDS stigma can undermine their livelihood and quality of life as PLWHA lose their jobs or are denied employment due to their HIV/AIDS

status. The above inaccurate beliefs make it acceptable to ostracise, blame and shame PLWHA (Cao *et al.*, 2006; Miller & Forehand, 2007).

In an attempt to avoid HIV/AIDS stigma and discrimination, many PLWHA have opted to conceal their status (Cao *et al.*, 2006; Miller & Forehand, 2007). They have decided to deny their positive status to family, friends, employers and even physicians. However, by concealing their status they forfeit social support, as well as medical and social services that could assist in improving their health and longevity (Cao *et al.*, 2006).

2.4.3.1 Stigma and discrimination: the causes

It is important to understand the causes of HIV/AIDS stigma in order to reveal what stigma is.

PLWHA are perceived as a threat to those who are HIV/AIDS negative because of the threat they present of catching an incurable and terminal disease. The fear of contracting the virus and fear of the potentially terminal nature of HIV/AIDS is referred to as instrumental stigma (Herek & Capitano, 1999; Stein, 2003). This fear of contracting the virus often leads people to labelling PLWHA as being a threat to the community at large. This results in HIV/AIDS stigma and discrimination in the form of isolation of those infected or suspected of being infected with the virus (International Centre for Research on Woman, 2006).

HIV/AIDS stigma is closely linked to sexual stigma, mainly because the virus is most commonly spread through sexual interaction. As a result, HIV/AIDS stigma has reinforced pre-existing sexual stigma associated with sexually transmitted diseases, homosexuality, promiscuity and prostitution (Stein, 2003). For example, homosexuals are commonly stigmatised to be at blame for the spread of the virus or the only group at risk of infection. Infected women are commonly accused of promiscuous sexual behaviour and the cause of the spread of the virus among heterosexuals. HIV/AIDS stigma is strongly fuelled by beliefs of moral integrity and the immoral values of PLWHA

(International Centre for Research on Woman, 2006). There is a tendency for people to associate HIV/AIDS with moral impropriety. This moral component of HIV/AIDS stigma is referred to as symbolic stigma (Stein, 2003). Symbolic stigma is based on judgemental attitudes towards individuals who have put themselves at risk of infection through immoral or irresponsible behaviours.

Symbolic stigma serves the purpose of distancing the individual or group from the fear of contracting the virus. The individual or group distance themselves from infection by denying that they can also be at risk of contracting the virus. Therefore, symbolic stigma responds to the pending threat by controlling anxiety. However, this form of protection from HIV/AIDS infection is counter productive as it gives one a false sense of protection (Stein, 2003). Its goal is to protect one from fear and not infection.

According to Stein (2003, p. 9), literature highlights that “people always underestimate their own risk of misfortune in comparison to others”. This is referred to as optimistic bias. Yet, blame and stigma play a specific function, to make an individual feel safe or less vulnerable to misfortune because he/she has not done anything to deserve it. Thus, the individual reduces anxiety without the discomfort of altering his/her behaviour.

Another function of symbolic stigma is to maintain social order. According to Stein (2003, p. 9) a UNAIDS report reveals that, “stigma is a powerful means of social control applied by marginalising, excluding and exercising power over individuals who display certain traits”. The moral component associated with HIV/AIDS serves to strengthen and reinforce social norms around fidelity and family. Due to the sexual transmission of HIV/AIDS, the virus is identified as a symbol of promiscuity and deviant sexual practices that threaten to disrupt family life through decreased social cohesion, fatherless children and women in poverty.

HIV/AIDS stigma plays a role in all key axes of inequality, for example, class, gender, sexual orientation, age, race and ethnicity. PLWHA's are often thought to have deserved their illness because they have engaged in

wrongful behaviour (Aggleton *et al.*, 2003). More often these wrongful behaviours are linked to sexual activities or socially frowned-upon activities such as injecting drug use.

Men who are diagnosed HIV/AIDS positive may be suspected of being homosexuals, bisexual or as having sexual relations with sex workers. On the other hand, women who are HIV/AIDS positive are seen as being promiscuous despite clear evidence of infection from their husbands or regular male partners (Aggleton *et al.*, 2003). International Centre for Research on Woman (2006) notes that women generally experience more HIV/AIDS related stigma than men. This is because women are expected to uphold moral traditions but when they are infected communities tend to label them as not upholding traditional moral values. This indicates gross double standards as men are often expected to engage in reckless sexual practices and therefore more likely to be exposed to HIV/AIDS and sexually transmitted diseases while women are expected to be sexually faithful and chaste (International Centre for Research on Woman, 2006).

Racial and ethnic stigmatisation is closely linked to racist assumptions around “African sexuality” and the belief of developed Western society that “immoral behaviour” contributes to the spread of HIV/AIDS (Stein, 2003). Racial and ethnic stigmatisation results in the marginalisation of minority groups thus increasing their vulnerability to HIV/AIDS infection. This form of stigma can therefore be viewed as a psychological defence mechanism in the form of denial and is dependant on the operation of symbolic stigma.

The causes of HIV/AIDS stigma that have been described above reveal that stigmatisation persists across time and culture as it serves an important function. HIV/AIDS stigma is not merely the result of inadequate knowledge. People are not motivated to hear the true facts about the risks of contracting the virus alone, as this form of denial gives them a sense of protection (Parker & Aggleton, 2002).

2.4.4 Stigma in the workplace

Studies have revealed the presence of HIV/AIDS stigma and discrimination in the workplace against PLWHA (Dickinson, 2003; Herek & Mitnick, 1996; Lau & Wong, 2001). Employees who are known to be HIV/AIDS positive usually face the brunt of stigma and discrimination from co-workers, supervisors and managers in the form of being dismissed from work, being relocated to another position or having their job benefits limited (Dickinson, 2003; Herek & Mitnick, 1996). Yet, people suspected of being infected with the virus are also open to stigma and discrimination, as people look for signs such as weight loss or skin rashes. Stigma is so powerful that peer educators in various workplaces have noted that their co-workers suspected them to be HIV/AIDS positive because of their involvement in addressing HIV/AIDS in the workplace (Dickinson, 2003).

Known incidents of HIV/AIDS stigma in the workplace include gossiping about someone known to have taken an HIV/AIDS test, fear of having coffee breaks with or changing in front of the person suspected to be HIV/AIDS positive (Milan, 2004). It can therefore be ascertained that HIV/AIDS infected employees have the potential to make co-workers feel uncomfortable, thereby adding to their own feelings of rejection in the working environment (Lau & Wong, 2001).

According to Dickinson (2003), HIV/AIDS stigma impacts on the workplace in the following ways, namely:

- Lowering of workforce morale
- A workplace environment in which PLWHA are afraid of gossip or of being suspected of being HIV/AIDS positive is not a conducive working environment.
- The overall effectiveness of the company's workplace programme is undermined as PLWHA are afraid of having their status diagnosed and accessing the benefits, care and treatment that is readily available.

Taking into consideration the costs of HIV/AIDS stigma to individuals, relationships and businesses, it is vital that the HIV/AIDS stigma be addressed. Legislation, such as the Employment Equity Act and the South African Constitution are instrumental in prohibiting discrimination in the workplace.

In addition to this Dickinson (2003) highlights the following actions that can be taken to address stigma in the workplace:

- Create an HIV/AIDS policy that promotes a working environment that is not stigmatised.
- Ensure that senior management and the company's trade union openly show their support for the company's workplace programme and policy on HIV/AIDS.
- Have an all-inclusive HIV/AIDS workplace programme that aims to educate all staff on how the virus is transmitted and how one can contract the virus. This will assist in reducing individual fears by disseminating accurate knowledge.
- Address the consequences of stigmatised behaviours towards individuals, the workplace and the society at large.

HIV/AIDS stigma is one of the most serious issues facing people who are living with the virus. Many people with HIV/AIDS find themselves isolated and rejected as a result of their positive status. Therefore we need to understand what HIV/AIDS stigma is, where it comes from and how to manage and combat it.

2.5 SUMMARY

This chapter discussed the micro and macro economic impact of HIV/AIDS on various aspects of employment within the business sector. Thereafter, defensive and constructive approaches to HIV/AIDS management in the working environment were discussed. It was found that in order for

businesses to remain competitive it is vital that they adopt a constructive response to HIV/AIDS management. Then the challenges of HIV/AIDS stigma on an effective response to HIV/AIDS workplace programmes were discussed. Thereafter, HIV/AIDS in the South African context and the factors contributing towards HIV/AIDS stigma were considered.

CHAPTER THREE

RESEARCH DESIGN

This chapter provides an outline of the various techniques used in this study. It is a qualitative study that aims to explore HIV/AIDS stigma from the perspective of the stigmatised. The following aspects will receive attention in this chapter:

- Description of the pilot project
- Justification for employing a qualitative research methodology
- Population and sample procedure
- Tools for data collection
- Methods of analysis
- The validation process
- Reliability
- Ethical consideration

3.1 PILOT PROJECT

In the context of this study, the pilot project accomplished the following tasks, namely, enabling the researcher to become familiar with the research setting, determining the feasibility of conducting the study, assessing the appropriateness of the data assessment instrument and the adequacy of the research procedures (Ary, Jacobs, & Razavieh, 1990). By conducting a pilot study, the researcher was able to solve unanticipated problems.

According to Polit and Hungler (1995), a pilot study can be viewed as a trial run on a smaller scale of the main study being conducted. This serves as a validating procedure. The main principles governing the pilot study in this research are as follows:

- The population for the pilot project was selected from the same population as for the main study, i.e. individuals infected with HIV/AIDS.
- The participants in the pilot project had the same characteristics as those in the main study.

The population for the pilot project consisted of five participants from the same organisation in which the main study was conducted. It is important to note that the company's nurse had identified all five participants as being infected with HIV/AIDS. The pilot project was conducted two weeks prior to the main study.

3.1.1 Findings of the pilot project

A thorough analysis of the results revealed the following information:

- One respondent had a matric certificate whereas four participants had tertiary education. This might imply that the majority of respondents participating in this study had some form of educational background.
- All participants had been living with HIV/AIDS for over 1 year.
- All participants had indicated that their lives had changed negatively after they had been diagnosed HIV/AIDS positive.
- Three participants highlighted that they did not feel comfortable revealing their HIV/AIDS status to friends and family whereas two participants had decided to reveal their status.
- All participants did not feel comfortable in revealing their HIV/AIDS status to their co-workers. Two participants felt it was important to reveal their status to their immediate line managers.
- In order to qualify for company benefits, all participants revealed their positive status to the company's nurse and psychologist.
- Three participants noted that being HIV/AIDS positive had negatively affected their work performance in terms of absenteeism due to ill health. This in turn affected their productivity and efficiency.

- Three participants felt strongly that the company could do more to address HIV/AIDS in the workplace, in the form of workshops, showing videos, inviting guest speakers who are HIV/AIDS positive to speak to staff members and putting up more posters to promote HIV/AIDS awareness throughout the company.
- All participants felt that if they revealed their HIV/AIDS status to their work colleagues they would be subjected to discrimination and stigmatisation.
- All participants felt that most people were unreceptive to people living with HIV/AIDS due to the stigma that is attached to the virus.
- Two participants mentioned that they had been victims of direct stigmatisation due to being HIV/AIDS positive. Three participants revealed that they had witnessed acts of HIV/AIDS stigma and discrimination towards other people who were HIV/AIDS positive or suspected to being positive.
- All participants noted that if they were to be victims of HIV/AIDS stigma, they would walk away from the situation in order to avoid being physically assaulted or publicly ridiculed.

3.1.2 Conclusion of the pilot project

Methodologically, the pilot study enabled the researcher to systematically test the following:

- If each participant was able to understand the interview questions that were asked by the researcher.
- If the researcher was able to extract the information needed to answer the research questions of the study.
- If any questions needed to be simplified in order for the participants to answer them accurately.

As the participants in the pilot project voiced no major concerns, the researcher decided to retain the same format of the interview in the main study.

3.2 RESEARCH DESIGN

A research design can be defined as the planning of the scientific study (Bless & Higson-Smith, 1995). In essence, it is the process that guides the researcher in the analysis and interpretation of the observed facts.

A research design can be used for either a qualitative or quantitative approach. For this study, a qualitative approach was adopted.

Qualitative research assumes that reality is based on the definition and meanings that people give to it rather than being something that is externally present. The theory is compatible with this research as it empowers the participants to reflect on their experiences (Ary *et al.*, 1990). This would give the researcher the opportunity to explore accurately the range of opinions and perspectives as reflected on by the participants.

According to Pernice (1996, p. 339), “qualitative research is committed to understanding the unique experiences of the individual from his or her perspective of the social world by seeking to develop shared meaning”. Miles and Huberman (1994) state, that qualitative research is relevant where the aim of the research is to study phenomena as they unfold in real world situations without manipulation. Therefore, qualitative research seeks to uncover the meaning of social events and processes, based on the lived experiences of human society from the actor’s point of view.

Furthermore, since qualitative data are collected for a sustained period, this allows the researcher to understand and study the process. Therefore, instead of getting a “snapshot” of a particular event or situation, the researcher can attain a holistic picture of the situation under investigation (Ary *et al.*, 1990).

The information retrieved from the literature review was used as the source guiding the formulation of the discussion guide. The literature review was compiled drawing credible information from a range of sources. By reviewing the chosen literature, the researcher was in a position to ask the right questions in the interview session to the participants in an attempt to explore HIV/AIDS stigma from the perspective of the stigmatised. The pilot study as explained in section 3.1 assisted the researcher in ensuring that she had asked the right questions to each participant.

The researcher conducted in-depth one-on-one interviews in order to examine employees' experiences in relation to HIV/AIDS stigma. The themes underlying the dimensions being investigated were put into categories (Pilot & Hungler, 1995). The qualitative features that define HIV/AIDS stigma from the perspective of the stigmatised within the workplace were noted.

It is important to note that the researcher used descriptive analysis in the analysis phase of the research. Descriptive analysis assisted in determining the frequency of responses for items displayed in the interview schedule. Therefore, in the interpretation of the results, the researcher was able to highlight the number of times a certain category was named by the respondents.

According to Sanders and Pinhey (1979), a descriptive study intends to accurately describe the social events, institutions, groups or behaviour patterns under observation. It is for this reason, that a descriptive research design was justified in the use of this investigation.

3.3 POPULATION AND SAMPLING PROCEDURE

For this study, the researcher targeted members of the population who had the attributes relevant to the research. The targeted population also had to be readily accessible. To achieve the outcomes of this study, the population consisted of employees who had been identified as HIV/AIDS positive by the company's nurse.

3.3.1 Population

According to Polit and Hungler (1995), population is defined as the total or collective number of cases that aims to meet a required or compulsory set of criteria. It is also stated that a population can be classified in terms of actions, words, organisations and groups. The population considered in this study consisted of HIV/AIDS infected employees who are currently employed at the same company. The participants that had participated in this study were readily available and easily accessible, as they all worked in the same organisation, therefore costs associated with time and travels were reduced. Participants wanted to retain their anonymity throughout the research and preferred not to sign consent forms.

3.3.2 Sample

Sampling involves making decisions about who will be participants in the study. According to Polit and Hungler (1995), sampling is defined as a process of selecting a section or segment of the population to represent the entire population. This statement is reiterated by Bailey (1987), who states that sampling entails the selection of a subset of some predetermined size from the population being studied, whereby those selected will become participants or respondents in the study.

In this study, a non-probability purposive sampling technique was used. The sampling method chosen allows for the selection of individuals from the spectrum that interests the researcher (Christensen, 1994; Sanders & Pinhey, 1979). Therefore, in accordance with this sampling method, the researcher with the assistance of the company's nurse handpicked the sample according to the nature of the problem and the phenomena being studied. The specific research questions this study endeavours to investigate are as follows:

- What are the personal experiences of being HIV/AIDS positive?
- What are the life experiences of living with HIV/AIDS in the workplace?
- What recommendations can be made to address HIV/AIDS stigma in the workplace?
- Did the participants feel that others hold negative opinions towards them because of their condition?
- What coping mechanisms or skills do the participants use to cope with stigmatising situations?

As a result of the sampling method used, ten employees that had been identified as being infected with HIV/AIDS were selected to participate in the study. Qualitative inquiry typically focuses on relatively small samples, selected purposefully to permit inquiry into and understanding of a phenomenon in depth (Pernice, 1996). For this reason, the researcher considers the small sample used in this investigation justifiable. Because HIV/AIDS is not limited to any gender, both male and female participated in this study. The participants in this study generally fall within the age range of sexually active people. Their ages ranged from 24 to 50 years.

3.4 DATA COLLECTION

As mentioned in chapter one, the researcher used a non-directive semi-structured one-on-one interview schedule. Interviews are at the heart of qualitative research because they seek the words of the people who are being studied so that the researcher can understand their situation with increased clarity. The interview schedule was of paramount importance to the study as it guided the interviewer in terms of the phrasing of the questions and the subsequent recording of the answers (Polit & Hungler, 1995). In the context of this study, the interview schedule enabled the researcher to gather data that would prove to be useful in examining participants' experiences with regards to HIV/AIDS stigma.

All interviews were conducted in the participants' place of work in a spacious office isolated from the other offices in the organisation. According to Huysamen (1994), in-depth interviews are appropriate when there are sensitive or emotional issues to be explored. Taking into consideration that the topic of HIV/AIDS is a sensitive issue, the choice of the venue was intended to make each participant feel comfortable about sharing his/her thoughts, feelings and opinions on the topic under investigation. Prior arrangements included making telephonic arrangements with management to secure the venue well in advance.

The interview schedule was designed to direct the researcher in extracting those issues that are pertinent to the specific aims of the study. The guide displays a list of topics which have a bearing on a specific theme, and which the interviewer would raise during the course of the interview (Huysamen, 1994). The advantage of having an interview schedule is that, although the researcher had a set of pre-determined questions, the process of the interview was spontaneous. For this reason, participants were encouraged to discuss their opinions and feelings on the relevant topic freely. The researcher had the responsibility of keeping the discussion focused on the participants' experiences of HIV/AIDS stigma but also allowed for deviations from the topic when other issues that are pertinent to the subject were discussed.

The major advantages of using an interview schedule include the following (Bailey, 1987; Huysamen, 1994; Sanders & Pinhey, 1979).

- Interviews have a high response rate, which can be as much as 85% if not higher.
- Interviews allow for some flexibility pertaining to the order in which questions may be asked, thus unanticipated factors can be fully probed and explored.
- The researcher's presence can help to reduce the confusion attached to ambiguous questions, thus allowing the researcher to attain more valid responses.

- The researcher can use probes in order to clarify vague responses.
- Interviews allow the interviewer to observe the non-verbal behaviour of the interviewees as they respond to questions.

The interview guide in this investigation consisted of open-ended and closed questions. The interview guide comprised of a series of questions that were answered by all participants. During each interview, the researcher observed and recorded participants' non-verbal behaviour. According to Polit and Hungler (1995), people also communicate through their facial expressions, gestures and changes in their tone during speech. By observing participants' non-verbal behaviour throughout the interview, the researcher was able to gather invaluable data. It is important to note that the interviews were carried out in a one-on-one interview session with each participant because of the sensitive nature of the topic under discussion.

3.5 DATA ANALYSIS

The transcripts were analysed using thematic analysis. The use of thematic analysis is important in terms of the factual findings on what is being researched. The aim of thematic analysis is to identify and analyse themes (or patterns) within collected qualitative data.

The first step is to collect the data (Aronson, 1992, Braun & Clarke, 2006). For this research, data was collected by transcribing interview scripts verbatim. The researcher then became familiar with the data by reading and re-reading the interview scripts. From the transcribed interview scripts, the researcher then identified patterns of experience. This is done by singling out direct quotes or paraphrasing certain ideas (Aronson, 1992). For example, this research aims to explore HIV/AIDS in the workplace, focusing on the experiences of those that are stigmatised. The first pattern of experience was the participants' personal experiences of being diagnosed HIV/AIDS positive. The second pattern of experience was how family members, friends, the

workplace and the community at large acted or treated the participants after they revealed their status.

The second step in thematic analysis is to group or classify all data that relate to the already classified patterns (Aronson, 1992). This is referred to as coding of the data in a systematic fashion across the entire data, collating data relevant to each classified pattern (Braun & Clarke, 2006). This is done through reading and re-reading the text, and attempting to make sense of patterns that emerge from the data. For example, each participant voiced their personal experiences of revealing their HIV/AIDS positive status to family members. One participant stated that he/she had a “fear of their entire family being ostracised by the community” and another participant noted “feelings of shame in revealing to family”.

The third step to a thematic analysis is to collate and combine certain patterns into potential themes (Aronson, 1992, Braun & Clarke, 2006). Themes are defined as “bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone” (Aronson, 1992 p.2). Themes become apparent from the participants’ stories as transcribed from the transcripts. The participants’ experiences of being HIV/AIDS positive are pieced together to form a comprehensive picture of their collative experiences of being HIV/AIDS positive.

The last step in thematic analysis is for the researcher to build a valid argument for choosing the themes and by making use of related literature (Aronson, 1992). In this research, the researcher made use of relevant and current literature on HIV/AIDS. It is important that there is on-going analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme. When the literature is interwoven in the themes, the researcher can present her study as a study that stand with merit.

By employing the techniques noted above, the researcher was able to generate some initial and tentative insights into the research material. As a

result, modifications to the final interpretation of the data were made and conclusions arrived at.

3.6 VALIDATION PROCESS

According to Mouton and Marais (1993), certain factors can influence the integrity of the data. This entails the researchers, the participants, the measuring instruments and the research context. The researcher took cognisance of the influence these factors may have had on the study and attempts were made to address them.

3.6.1 Researcher influence

Researcher influence can be minimised by the researcher abiding strictly with the ethical guidelines of research (Christensen, 1994). In relation to this, the purpose and benefits of the research were clearly communicated to all persons involved in the research. The researcher obtained permission from the organisation to conduct the study and this was openly communicated to all the participants. Confidentiality was maintained throughout the research, the integrity of the candidates and the data was respected and the research was conducted with the aim of achieving its intended purpose. Ethical considerations as employed by this research are discussed in greater depth in section 3.7.

3.6.2 Participant influence

The company has benefits in place for those employees who are HIV/AIDS positive and who require assistance, such as counselling, medical treatment and medication. The identities of those employees who do make use of the services offered by the company remain confidential. Therefore, the company's nurse approached ten participants and asked their permission to participate in this research. All participants agreed to take part in the study. To facilitate the audit process, every step of the research was documented. The researcher obtained consent from the organisation and the participants to

ensure validity (Christensen, 1994). This was done to minimise participant influence.

3.6.3 Measuring instrument

According to Polit and Hungler (1995, p.83), “the reliability of an instrument is the degree of consistency with which it measures the attributes it is supposed to be measuring”. This implies that the research instrument is meant to yield the same results when used repeatedly. Therefore, to test if the interview guide consistently measured the same attributes, the researcher first conducted a pilot study. The population for the pilot study consisted of fewer participants but they had the same characteristics as the participants in the main study, as they had been identified as being infected with HIV/AIDS. The results of the pilot study revealed that participants were able to understand the questions being asked of them and the researcher was able to extract the right information in order to answer the research questions for this study. Hence, the same format of the interview schedule was retained for the main study.

3.6.4 The research context

With regards to contextual influences, the researcher extracted comprehensive biographical data from each participant in an attempt to identify any factors that might influence the participants' results.

3.7 ETHICAL CONSIDERATIONS

When qualitative research is conducted to explore a sensitive area such as HIV/AIDS from the perspective of the stigmatised, ethical considerations predominate. It is essential that the researcher take into account the dignity and welfare of the participants. Therefore, it is vital for the researcher to abide by certain ethical principles to ensure that all participants are protected throughout the interviewing process. By definition, “ethics refers to the discipline dealing with what is good and bad, or right and wrong or with moral

duty and obligation" (Carrell, Norbert, Elbert, Robert, & Hatfield, 1995). In the context of this study, the researcher went to great lengths to ensure that an ethical stance was upheld throughout the study. What follows, are the ethical principles put into practice during the interviewing phase, analysis of results and finally the reporting of the results.

3.7.1 Confidentiality and informed consent

This ethical principle emphasises that every person has the right to privacy and that this right should not be violated without the individual's informed consent. A consent form is designed and handed to each participant prior to the commencement of the interview. The form stated that each participant voluntarily took part in the research and were adequately informed of the aims and purpose of the topic under examination. In addition, the consent form stated that all names and personal details that had the potential to identify the participant would be withheld during the reporting of the results. All participants had access to the final results. In addition, if there was a possibility that the results of this research would be published, all participants were assured that their anonymity would be upheld.

3.7.2 Fair treatment

According to Polit and Hungler (1995), participants have the right to be treated fairly and objectively before, after and during their participation in the research. The process of fair treatment includes the following factors:

- The fair and non-discriminatory selection of participants. In this study, all participants who had been diagnosed HIV/AIDS positive were given the opportunity to participate. All participants were employed at the same company.
- Participants who decline to participate or withdraw from the study should not be subject to any prejudicial treatment by the company. For

this study no participants declined to participate in the research and no participants withdrew from the research at a later stage.

- All participants agreed to be freely available to the researcher for the clarifying of information.

It is important to note that all of the above points were taken into consideration prior to commencing the study. In addition, the points were clarified to all participants before commencing with the interviews.

3.7.3 Trust

In this study, the researcher built trust by allowing the respondents to feel free to contact her with regards to any questions they may have around the study they will be participating in. Building trust between the researcher and the respondents is vital for the overall success of this study (Ary, 2007). The researcher is convinced that respondents would feel at ease to reveal personal information with regards to HIV/AIDS if trust is formed and maintained at all times.

3.7.4 Privacy

According to Polit and Hungler (1995, p. 88), "privacy means that a person can behave and think as he or she pleases without interruption and without the possibility that private conduct or thoughts may later be misused to embarrass the client."

The principle of privacy is maintained by informing participants that neither their names nor any other form/s of identification would be required for the completion of this study.

3.7.5 Freedom to decline

No participant is coerced to participate in this study. Therefore, participation is voluntary. This is because people have freedom of choice. If an individual chose not to be involved in the study, then that is accepted by the researcher. Similarly, if participants wished to terminate their presence midway through the research, they were permitted to do so. To fulfil this ethical principle, the researcher informed all participants of their right not to participate or to terminate their session if they so wished.

3.8 SUMMARY

This study is conducted from a qualitative stance, in which one-on-one interviews are held with employees that have been identified as being infected with HIV/AIDS. Prior to the commencement of the study, a pilot study was conducted. The benefits of such a pilot project have been explained above. This chapter also dealt with the way in which the participants were selected as well as the ethical issues that guided this study.

The next chapter deals with the analysis and discussion of the data.

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF THE DATA

Chapter four presents the findings of the research. The findings are divided into two parts. The first part consists of the demographics of the participants whom had participated in the research. The second part consists of the findings uncovered by the researcher by examining and analysing the information provided by the interview transcripts.

4.1 DEMOGRAPHIC DESCRIPTION OF PARTICIPANTS

4.1.1 Age

Table 1 displays the age distribution of the participants in this study. The highest number consisted of six young adults in the age category of 20 – 29 years old. Adults in the age category of 30 – 39 years followed with a number of three participants. There is one middle - aged adult in the age category of 40 – 49 years and no participants in the age category of 50 years and above.

Table 1 Age distributions of the respondents (N=10)

AGE	NUMBER
20- 29 YEARS	6
30 – 39 YEARS	3
40 – 49 YEARS	1
50 YEARS AND ABOVE	0
TOTAL	N = 10

The range of ages indicates that employees from different age categories participated in this study. This is beneficial as it enabled the researcher to extract an array of employee experiences from all working age levels regarding HIV/AIDS stigma from the perspective of the stigmatised.

4.1.2 Gender

Table 2 highlights the gender distribution of the participants in this research. It can be deduced from this table that a greater number of females participated in the research than males.

Table 2 Gender of respondents (N=10)

GENDER	NUMBER
MALE	4
FEMALE	6
TOTAL	N = 10

4.1.3 Marital status

Table 3 highlights the marital status of the participants. This table indicates that of the ten respondents interviewed, one is married, seven were single, one is separated and one is divorced.

Table 3 Marital status of respondents (N=10)

MARITAL STATUS	NUMBER
MARRIED	1
DIVORCED	1
SEPARATED	1
SINGLE	7
TOTAL	N = 10

4.1.4 Educational status

Table 4 looks at the educational status of the participants. It shows that eight respondents have a Grade 7-12 education, and two respondents have a tertiary qualification.

Table 4 Educational status of respondents (N=10)

EDUCATIONAL STATUS	NUMBER
GRADE 7 -12	8
TERTIARY	2
Total	N= 10

4.1.5 Ethnicity

Table 5 illustrates the ethnicity of the participants. Two race groups were represented. The Black and Coloured population groups were equally represented, with five respondents from each group.

Table 5 Ethnicity of respondents (N=10)

ETHNIC GROUP	NUMBER
WHITE	0
INDIAN	0
COLOURED	5
BLACK	5
TOTAL	N = 10

4.1.6 Language

Table 6 displays the primary languages that are spoken by the participants. Majority of participants speak Afrikaans as their primary language. Four respondents speak Xhosa as their primary language and one participant speaks Zulu as his/her primary language.

Table 6 Language of respondents (N=10)

LANGUAGE	NUMBER
ENGLISH	0
AFRIKAANS	5
XHOSA	4
ZULU	1
Total	N=10

4.2 QUALITATIVE ANALYSIS

This section deals with the respondents' perceptions of being HIV/AIDS positive and uses their verbatim statements to illuminate the stories behind their responses. Firstly, an account of the participants' personal experiences of being HIV/AIDS positive is provided. Secondly, the life experiences of living with HIV/AIDS in the workplace are reported. Thirdly, this will be followed by an exploration of participants' feelings that others held negative opinions towards them because of their condition. Fourthly, the coping mechanisms or skills the participants used in coping with stigmatising situations will be highlighted. Lastly, the participants' perceptions or views regarding what the organisation can do to address HIV/AIDS in the workplace will be explored.

4.3 FINDINGS

4.3.1 What are the personal experiences of being HIV/AIDS positive?

In trying to understand the respondents' personal experiences of being HIV/AIDS positive, the researcher asked each one how long they had known about their HIV/AIDS status. From the responses, it is found that two participants are HIV/AIDS positive for 1-3 years, four participants have been living with the virus for 4-6 years, two participants have been diagnosed HIV/AIDS positive 7-9 years ago and two participants have been living with the virus for ten years. All the participants voiced that finding out that they were HIV/AIDS positive was difficult and challenging to deal with at first.

The following statements illustrate the participants' reactions:

- "I have known [being HIV/AIDS positive] for 8 years now. It was a shock for me when I did find out. It was like everything stopped and I did not know where I was, what my name was or anything. It felt like I stood still for hours and hours. I just could not believe that it was happening to me".
- "I have known for almost ten years [being HIV/AIDS positive]. It's been so long now that it is definitely a part of me. I have accepted it and I have moved on from the shame and shock when I first found out. I think with years you become wiser in dealing with things. So I am okay with it, I carry on well".

As mentioned above, the participants noted that finding out they were HIV/AIDS positive was difficult and challenging to deal with.

Table 7 below illustrates how HIV/AIDS affected the participants' lives after being diagnosed with HIV/AIDS. Three participants received no support from their families or the community at large. Two participants opted not to get involved in a relationship due to their HIV/AIDS positive status. Four

participants revealed that they were now more prone to falling ill. Five participants voiced that they were doing their best to stay healthier. Lastly, four participants noted that they visited doctors and took medication more frequently than before being diagnosed HIV/AIDS positive.

Table 7 How HIV/AIDS had changed the participants' lives

CATEGORY	NUMBER
No support	3
Choosing not to be in a relationship	2
Falling sick more often	4
Trying to stay healthy	5
Frequent visits to the doctor and taking of medication	4

Participants' narratives were as follows:

- “My life has changed a lot once I found out that I was positive [HIV/AIDS]. My family threw me aside and I lived with my grandmother till I was able to find a job and support myself. My life has been very difficult and hard. Everyday is a struggle to live and be happy. My body is weaker and I feel sick, so sick sometimes that I cannot even come out of bed”.
- “My health takes certain turns for the worse. That’s when I can’t find the energy to come out of bed and you get scared because you never know how sick you are really going to get”.
- “I have joined a counselling centre for people living with HIV/AIDS. They have taught me about eating right and the need for me to continue with my medication”.
- “The food I eat, I monitor more closely. I follow a very healthy eating plan and avoid “take out foods”. I don’t even crave for it anymore. In fact this has been the healthiest I have been in a long time.”

- “I chose not to have a boyfriend because I am positive. I think it would be difficult to start a relationship with someone because I will be putting them at risk of infection. Plus it would be difficult being with someone because I will always wonder when I will get sick and I am a burden to that person”.

Table 8 explores how HIV/AIDS had affected the participants’ relationships with their families. It is interesting to note that four participants mentioned that they would be afraid of revealing their status to their family. Three participants opted not to reveal their positive status to their families due to feelings of shame. Two participants feared that their families would be ostracised by the community if they openly revealed their status. Lastly, one participant felt more comfortable in revealing his/her HIV/AIDS status to siblings who would be more understanding and accepting than his/her parents.

Table 8 Exploring participants’ relationships with their families after being diagnosed HIV/AIDS positive

CATEGORY	NUMBER
Fear of revealing to family	4
Feelings of shame in revealing to family	3
Fear of their entire family being ostracised by the community	2
Revealing only to siblings and not to parents	1

Participants’ responses are as follows:

- “I have not told my family about being positive [HIV/AIDS]. I think they will not understand me and how I got myself in this mess. I don’t want to be blamed and treated differently by my family”.

- “It will bring shame on my family because people with this disease like me are not accepted in the community. We are looked at as being dirty and unclean. Instead of just kicking me out, the community may even kick out my entire family and I can’t let that happen”.
- “When someone in my culture has HIV, people think that someone has cursed you or that your ancestors are angry with you. They [community members] can hurt you by targeting your house and your family”. It is for this reason that this participant has only shared his HIV/AIDS status with his immediate family and not extended family for fear of himself and his family being victimised and discriminated against.

Table 9 shows participants’ feelings when revealing their HIV/AIDS status to friends. When investigating participants’ feelings in revealing their HIV/AIDS status to friends, it was found that five participants expressed the opinion that they would rather not reveal their positive status to friends due to fear of being excluded or shunned. Two participants mentioned that they opted to isolate themselves from friends and family due to being HIV/AIDS positive. Three participants felt comfortable in revealing their positive status to friends and lastly, one participant stated that his/her friends shunned him/her after revealing his/her status to them.

Table 9 Revealing HIV/AIDS status to friends

CATEGORY	NUMBER
Not revealing to friends for fear of exclusion	5
Isolating oneself from others	2
Revealing to close friends and being accepted	3
Being shunned after revealing HIV/AIDS positive status to friends	1

Participants' responses were as follows:

- “I don't really have friends. I live a very lonely life. It is still hard telling people what I have gone through and what I have to live with”.
- “I have not felt ready to let people know that I am living with HIV/AIDS. I am scared that people will not want to accept me in their lives”.
- “I did reveal my status to my friends once, people I thought were my friends but that turned out badly. They just stopped being my friends, isolated me”.
- “I hear how they openly speak about people who are positive. They laugh at them and say they are irresponsible. Like don't they know how to use a condom or that they are prostitutes sleeping with everyone, so they deserve it. I listen to them and know that they will not be able to accept me being [HIV/AIDS] positive.
- “I have five very good friends. We grew up together. I told them and they were cool about it. They will stand with me and support me”.

From the above, it can be argued that the participants faced difficulties in revealing their HIV/AIDS positive status to family and friends due to the fear or shame of being stigmatised by their loved ones and the community at large.

Table 10 examines how open others were in accepting the participants after they revealed their HIV/AIDS status. One participant experienced rejection from his/her partner. Five participants revealed that their families had accepted them. One participant noted rejection from his/her immediate family after revealing his/her HIV/AIDS positive status.

Table 10 Acceptance or rejection of the participants by other people after the revelation of their HIV/AIDS status

CATEGORY	NUMBER
Rejection from partners	1
Acceptance from family	5
Rejection from immediate family	1
Not revealing to extended family	3

The responses from the participants were as follows:

- “My family threw me aside. No support, no one to lean on when I can’t go on anymore. If you have someone to support you, no matter what you are living with, you will find the will power to carry on”.
- One participant stated that after revealing his/her HIV/AIDS status to his/her partner, he/she ended the relationship. “He/She said that he/she could not live with someone that is HIV/AIDS positive.” The participant reported that this had hurt him/her more than when he/she found out he/she was HIV/AIDS positive, as his/her support structure had abandoned him/her.

Table 11 uncovers the negative and positive reactions from others after participants revealed their HIV/AIDS status. An analysis of the results revealed that two participants had not revealed their HIV/AIDS positive status. One participant was positively received once revealing her/his status to her/his family whereas seven participants noted that they had received negative responses from others after revealing their status.

Table 11 Positive or negative reactions from others after revealing their HIV/AIDS status.

CATEGORY	NUMBER
Have not revealed their status	2
Positive effect on others after revealing HIV/AIDS status	1
Negative effect after revealing HIV/AIDS status	7

Participants' responses were as follows:

- "Telling my family had positive effects on me. They have helped me a great deal. I am just not ready telling other people".
- "I trusted a very close friend and a very close family member. They have supported me. But not everyone is like that or has the same attitude. I feel that generally, people will be scared of you and will want to stay away. They can get angry at you and say it was my fault I am HIV and I deserve it".
- One participant was raped and as a result of the rape she was HIV/AIDS infected. She stated, "When I was raped and everyone knew about it in the neighbourhood, people treated me differently. They used to say shame that poor girl or she must have deserved it because she should not have let him the house wearing that mini skirt. If they [neighbourhood] knew I was HIV positive as well, I can only imagine the things people would gossip about".

4.3.2 Did the participants feel that others hold negative opinions towards them because of their condition?

Table 12 looks into how the participants feel others view PLWHA. Two participants felt that others viewed PLWHA as dirty. Two participants also voiced that others viewed PLWHA as unclean and one participant stated people had feelings of anger towards those living with HIV/AIDS. Seven participants stated that people were scared of HIV/AIDS positive people and two participants highlighted that people thought PLWHA were irresponsible, thus exposing themselves to HIV/AIDS infection. All participants noted that these sentiments were false.

Table 12 How the participants felt others viewed PLWHA

CATEGORY	NUMBER
Dirty	2
Unclean	2
Anger toward PLWHA	1
People are scared	7
Difficult to accept PLWHA	2
People think that PLWHA are irresponsible	2

Participants' narratives are as follows:

- “I think they feel we are dirty people because if you are clean, like a virgin or only have one partner your whole life, than you will not get it.”
- He/She also noted that people would think PLWHA are angry, as they will die soon.
- “I think people fear us and rather stay away and pretend that we don't exist. I think that most people don't want to associate with us or form relationships because they are afraid that we will infect them”.

- “People believe that if you have HIV/AIDS then you deserve it because maybe you slept with more than one person. They think you were irresponsible and immature”.
- “I think people are just scared to know more about this [HIV/AIDS]. People rather not hear about it, because then they don’t have to deal with it”.

Table 13 below explores participants’ feelings with regards to revealing their HIV/AIDS status within their work environment. It was interesting to find that there were only two participants who felt comfortable revealing their HIV/AIDS status to their immediate line managers. Ten participants felt comfortable in revealing their positive status to the company’s nurse and psychologist. Lastly, eight participants strongly felt that they would not reveal their status to co-workers.

Table 13 Participants’ feelings with regards to revealing their HIV/AIDS status at work

CATEGORY	NUMBER
Comfortable to disclose to immediate Line Manager	2
Comfortable to disclose to the Company’s Nurse	10
Comfortable to disclose to the Company’s Psychologist	10
Not comfortable revealing status to co-workers	8

Participants’ responses were as follows:

- “My supervisor must know if I am sick and why I am not coming to work or not meeting targets”.
- “Managers can do something like say we are not promoting you because you still need development in that area. But the real reason they are not giving you the job is because I have HIV/AIDS. In this way, they work around the policy”.
- “I had told my line manager that I was living with HIV/AIDS and I wanted him to know in case I get sick. But soon all the managers knew”. He/She noted that managers started giving him/her less work and certain staff members began avoiding him/her.

4.3.3 What coping mechanisms or skills do the participants use to cope with stigmatising situations?

Table 14 displays participants’ responses with regards to their experience/s of stigmatisation and discrimination as a result of being HIV/AIDS positive. An analysis of the results revealed that two participants experienced direct discrimination due to their HIV/AIDS status. Six participants witnessed acts of discrimination and stigmatisation on others. Lastly, two participants reported that they had only read about cases or articles that highlighted acts of HIV/AIDS stigmatisation and discrimination.

Table 14 Participants’ experiences of stigmatisation and discrimination as a result of being HIV/AIDS positive

CATEGORY	NUMBER
Directly discriminated against	2
Witnessing acts of discrimination and stigmatisation on others	6
Reading cases or articles of HIV/AIDS discrimination	2

Participants’ responses were as follows:

- “There was this one guy, older guy like 30’s and he was open and told people he had AIDS”. She mentioned that a gang had assaulted him openly in the township. She further stated, “My father told me that they beat him and kicked him, until you could not see his face anymore”.
- “Where I lived, there was a boy that committed suicide. We all knew he had AIDS. He was open about it and people did not accept it. They were cruel and hurtful. The old people would say he was filthy and unclean. Younger boys would beat him. His family was ashamed of him. He thought killing himself would be easier than living with the shame”.

Table 15 looks into participants’ coping mechanisms in dealing with HIV/AIDS stigmatisation and discrimination. Following from the participants’ responses above, with regards to coping mechanisms that they employed when dealing with stigmatising situations, four participants noted that they would withdraw from the situation; two said that they would confront the person that was stigmatising them, while four mentioned that they would get angry and upset at those stigmatising them.

Table 15 Participants’ coping mechanisms in dealing with HIV/AIDS stigmatisation and discrimination

CATEGORY	NUMBER
Withdraw from the situation	4
Confront the person	2
Get angry and upset at those discriminating	4

Participants' responses were as follows:

- “I guess if someone did discriminate against me because of being HIV, I would get very angry. I may just give them a piece of my mind and set them straight”.
- “I would stand my ground and tell them that what they are saying or doing is wrong and they are going against my human rights”.
- “I think walking away from the situation will help it from going out of control”.

4.3.4 What recommendations can be made to address HIV/AIDS stigma in the workplace?

Table 16 investigated what participants thought the company could do to help address the negative feelings people have towards those living with HIV/AIDS at work. Two participants voiced opinions that the company should put in place more awareness posters on HIV/AIDS throughout the company. Two participants stated that the company should invest in more HIV/AIDS awareness training for staff members and one participant noted that HIV/AIDS educational videos would be an effective way to help educate staff on HIV/AIDS and to reduce stigmatisation. Six participants said that there was a need for regular workshops on HIV/AIDS stigma and one participant suggested that people in management positions should play a more crucial role in the company's HIV/AIDS workplace programme.

Table 16 Participants' recommendations to address negative feelings people have towards PLWHA in the workplace

CATEGORY	NUMBER
HIV/AIDS awareness posters	2
HIV/AIDS training	2
HIV/AIDS Video's	1
Workshops on HIV/AIDS stigma	6
Management Involvement	2

Participants' responses were as follows:

- “They can have posters in different departments educating staff on HIV/AIDS. The company should make sure that all staff goes for training. They can even show us a video, like at church. It was about a lady and how she got infected and how she lives with it each day. Walk in her shoes to understand what she is going through”.
- “The problem is that our Head Office in Johannesburg has these great HIV awareness campaigns. But this does not happen here in Cape Town. We get a few posters and that is it. No workshops on HIV stigma”.
- “They can do more workshops with the people and have someone who is well educated and knows the facts to come and speak to us”.
- “I want the CEO to come down to Cape Town and speak to us about HIV and how we must respect one another if you have HIV or not. People will respect what he has to say”.

4.4 SUMMARY

In this chapter, all participants noted that being HIV/AIDS positive has been difficult and challenging to live with. Participants had to adjust their lifestyles in order to live long productive lives, through frequent doctor visits and consistent medication. Yet, majority of the participants voiced that the virus

had affected their lives negatively, as it affected their relationships with their families, friends and partners. Some participants had opted not to reveal their status due to feelings of fear and shame. All participants felt that others viewed PLWHA as dirty and unclean and they strongly felt that people are scared to associate with PLWHA. In the workplace, majority of the participants felt uncomfortable revealing their status to immediate line managers and colleagues for fear of being discriminated against. They felt that the company could do more to address HIV/AIDS in the workplace. Lastly, majority of the participants had experienced or witnessed acts of discrimination and if ever faced such a situation, most of the participants noted that, they would walk away from the situation.

CHAPTER FIVE

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

Chapter four discussed in-depth the analysis and interpretation of the data as received from the one-on-one interviews. This chapter contains the conclusion, limitations and recommendations of the study. Suggestions for future research are also put forward in this chapter.

5.1 OVERVIEW OF FINDINGS AND INTEGRATION WITH LITERATURE

According to Avert (2007), which is a charity organisation that stands for Advertising HIV and AIDS, they state that from the onset of the HIV/AIDS virus, social responses of fear and denial have been triggered, fuelling anxiety and unfair behaviour toward those infected and affected with the virus. HIV/AIDS stigma poses the greatest barrier to preventing further infection, and for providing adequate care and support to those infected with the virus as people are too afraid to find out what their status was, thus preventing them from adopting safe sex behaviour. Their families, loved ones and communities have rejected PLWHA. HIV/AIDS stigma can be so intense that people are afraid of making use of counselling services, testing services and treatment for fear of being victimised (UNAIDS, 2003b).

In this study, all participants that took part in the research were living with HIV/AIDS. Analysing the data revealed that the majority of the participants experienced negative responses, either from family members, friends, co-workers or community members after revealing their HIV/AIDS status. The fear of being victims to stigmatising and discriminating acts, had led to certain participants concealing their HIV/AIDS status or isolating themselves from forming close relationships with others.

Literature has highlighted that the negative reactions that the participants had experienced from others after revealing their HIV/AIDS status, could have stemmed from various factors, such as:

- HIV/AIDS being viewed as a life-threatening disease
 - People being afraid of getting the virus by associating with the person infected
 - Behaviours associated with the virus being stigmatised by society, for example, taking drugs by means of injection, sexual relationships between men and being involved in more than one sexual relationship.
- (Avert, 2007)

The participants' fear of being victims to stigmatising and discriminatory behaviour from others is not unfounded, as literature has documented numerous cases in which HIV/AIDS stigma has made itself evident in the form of anger, avoidance, ostracism and the belief that PLWHA deserve to be infected with the virus (Stein, 2003).

With regards to the participants' personal experiences in revealing their HIV/AIDS status to their family members, it was found that participants voiced feelings of shame, fear and guilt. The family is viewed as the main source of care and support to PLWHA, yet research has highlighted that negative family response is a common phenomena (Parker & Aggleton, 2002). In this research, participants voiced reluctance to reveal their HIV/AIDS positive status to their families, for fear that they would not be accepted and supported by them. It was also highlighted in the findings that participants feared that the community would victimise their families due to being HIV/AIDS positive and therefore opted to keep their status a secret.

Research has revealed that HIV/AIDS stigma is evident even among family members (Varas-Diaz *et al.*, 2005). The stigmatisation can lead to PLWHA feeling rejected or drive them to practice isolation in order to avoid tense interactions. Being HIV/AIDS positive can also become a family secret or a

rumour that everyone is aware of but would not discuss openly. This was evident in the findings of this research, as one participant was shunned by his/her family after revealing his/her HIV/AIDS status. The participant experienced feelings of rejection, shame and guilt and subsequently isolated himself/herself from his/her family.

Research shows that people experience stigmatisation by their friends after revealing their HIV/AIDS status (Varas-Diaz *et al.*, 2005). This stigmatisation manifested itself in the form of open rejection and abrupt endings to relationships. At times, some friends opted to end the relationship silently by steering clear of future social interactions.

In this study, the majority of the participants decided not to reveal their HIV/AIDS status to friends. They expressed similar concerns of being judged and excluded from their circle of friends. Some participants highlighted that they preferred to isolate themselves from others in order to avoid being judged and ridiculed. Because of the shame and guilt of being diagnosed HIV/AIDS positive, one participant stated that he/she had opted not to become involved in social relationships with others.

Goffman (1963) defines stigma as a, “profoundly discreditable attribute that could lead a person to be deemed almost inhuman.” This definition illustrates the social exclusion of those who carry the virus, because they are viewed by society as a risk or threat to others, and are ultimately seen as a burden to society. Literature has widely documented the social implications of HIV/AIDS stigma on PLWHA (UNAIDS, 2007). These include anxiety, depression, guilt, isolation, disruption of family dynamics, physical and emotional violence, intense grief, loss of social support and deterioration of service from health professionals.

Analysing the results further, the researcher was able to ascertain that the majority of the participants strongly believed that other people held negative opinions towards PLWHA. In general, the participants felt that others viewed PLWHA as dirty, unclean and engaging in irresponsible practices. In addition,

the participants felt that people had feelings of anger towards them for putting themselves at risk of infection but were mostly scared of associating with PLWHA.

Therefore, people living with HIV/AIDS bear feelings of shame, guilt and isolation. They fear people getting to know their status (Aggleton *et al.*, 2003). All these feelings were reported by the participants in their responses.

The workplace is no different with regards to acts of stigmatisation and discrimination towards PLWHA. According to Firmansyah and Kleiner (1999), HIV/AIDS infection, or rumours of infection has the potential to cause havoc in the workplace. The fear of working with someone who has the virus can decrease work productivity and cause stress. The majority of the participants felt uncomfortable in revealing their HIV/AIDS status to co-workers and line managers. They feared acts of stigmatisation and discrimination from the workplace in the form of demotions, not being considered for job promotions, being the subject of office gossip, being treated differently by co-workers or being shunned and isolated by other staff members.

Stigmatisation in the workplace is a common and frequent occurrence in developing and developed countries (Aggleton *et al.*, 2003). There have been reports of discriminatory practices in the workplace that have taken the form of pre-employment screening, denying employment to people that test HIV/AIDS positive and terminating the employment of employees who have revealed their HIV/AIDS status (Aggleton *et al.*, 2003). Research has also reported incidents of employees refusing to work with employees who are HIV/AIDS positive or assumed to be infected with the virus (UNAIDS, 2003b).

In this study, one participant noted that once the workplace has suspected he/she was HIV/AIDS positive, he/she noticed distinct changes in behaviour towards himself/herself, such as staff not wanting to sit next to him/her for lunch or management delegating fewer tasks or duties to him/her.

An analysis of the results revealed that the majority of the participants did not experience direct stigmatisation and discrimination from others. Rather, participants witnessed others being stigmatised or discriminated against. In terms of how they would cope with being stigmatised against, the majority of the participants noted that they would get upset but they would withdraw from the situation in order to avoid conflict.

To assist in addressing the HIV/AIDS epidemic, many South African companies have actively implemented HIV/AIDS workplace programmes (Dickinson, 2006). A workplace HIV/AIDS programme can include various components, such as counselling groups, peer educators, HIV/AIDS policies and procedures, workshops, training and the distribution of anti – retroviral drugs. Yet research has highlighted that reducing and managing HIV/AIDS stigma is a critical component to any workplace HIV/AIDS programme. According to Dickinson (2006, p. 333), “stigma drives the disease underground rendering all responses ineffective”.

All the participants thought that their company could do more to address HIV/AIDS stigma in the workplace than their company was doing. The majority of the participants voiced a need for HIV/AIDS workshops focusing on stigma towards PLWHA. They also highlighted a need for more HIV/AIDS awareness posters, videos, training, and workshops that involved members of the management team.

In conclusion, it can be noted that HIV/AIDS stigma is a powerful weapon that can isolate people from their families, friends, communities and co-workers. It can also result in people losing their homes, jobs or businesses. The fear of being victims to HIV/AIDS stigma can impact on the well-being of people and their ability to live productive lives in society. It can also cause a major stumbling block to HIV/AIDS interventions, as people are too afraid to seek treatment for fear of being labelled HIV/AIDS positive.

5.2 RECOMMENDATIONS

The following is recommended to assist in reducing HIV/AIDS stigma, with a special focus on the workplace.

- At present the company's workplace HIV/AIDS programme does not provide consistent HIV/AIDS education and training in the form of workshops for all employees. HIV/AIDS education and training help to teach employees how to stay HIV/AIDS negative and also how to accept and work productively with employees who are living with the virus (UNAIDS, 2003). The head office of the company is situated in Johannesburg and from the participants' responses, it is perceived that employees in that region are exposed more widely and frequently to the company's HIV/AIDS training programme. It is recommended that the company should implement widespread and frequent HIV/AIDS training interventions at a national level, as they have sister companies throughout South Africa and Namibia. In this way, all employees will equally benefit from the training initiatives.
- Apart from the workplace, HIV/AIDS stigma was evident among family members, friends and community members. It is therefore recommended that in order to address HIV/AIDS stigma holistically, the company's HIV/AIDS workplace programme must move beyond the company boarder to work in partnership with the community. This can take the form of providing HIV/AIDS education to employees' families, becoming actively involved in community interventions to help combat HIV/AIDS stigma and discrimination. Business resources and experience in aiding the community with education and care initiatives to those living with HIV/AIDS should be donated (UNAIDS, 2003).
- The company currently has a comprehensive HIV/AIDS policy that defines the position and procedure of the workplace in relation to HIV/AIDS. It is recommended that the company take steps to

communicate this policy to all staff. A workplace policy can assist in reducing personal anxieties and the level of discrimination exhibited towards co-workers living with HIV/AIDS.

- It is recommended that the company should carry out surveys throughout the year on their employees to determine what impact the workplace HIV/AIDS programme/s has had on addressing stigma and discrimination in the workplace. In this way, the company can establish the training needs of its employees with regards to HIV/AIDS education and also assess the effectiveness of the awareness programmes and workshops instituted by the company.
- There are no peer educator programmes evident in the company at present. It is recommended that the company should train employees to become peer educators who are equipped to disseminate factual information on HIV/AIDS and help reduce HIV/AIDS stigma and discrimination within the workplace and the community at large.
- It is also recommended that the company should form partnerships with other businesses, in order to share best practices and brainstorm programmes and initiatives that can assist in managing HIV/AIDS stigma within the workplace.
- Lastly, it is recommended that senior management demonstrate more commitment to the HIV/AIDS workplace programmes by attending HIV/AIDS workshops and training with the employees.

5.3 LIMITATIONS OF THE STUDY

The limitations attempt to guide future researchers in improving on this research in order to attain more conclusive findings.

- A qualitative research approach was adopted for this study and limited to only one organisation in the retail industry. This makes it difficult to generalise the findings to other organisations.
- The sample size was limited due to the sensitivity of the topic.
- Because of the sensitivity of the topic, some participants felt uneasy discussing the topic at hand. Taking into account that the interviewer for this study was female, male participants may have felt uneasy or uncomfortable discussing issues related to HIV/AIDS. In addition, some participants gave brief responses, as they were afraid that their identities might be revealed to top management.
- All race groups were not equally represented as participants had to volunteer to participate in the study and only those who were HIV/AIDS positive were selected as participants. The researcher therefore did not have control in the selection of equally represented race groups.

5.4 FUTURE RESEARCH

In view of the above, it is recommended that future research should consider the following:

- It would be beneficial to do this study on more than one South African company in order to compare the results and strengthen the validity and reliability of the results.
- The extent of the influence of HIV/AIDS workplace programmes in reducing stigma among employees needs to be explored further.
- It is suggested that the case organisation repeat this study to compare changes in participants' sentiments with regards to HIV/AIDS stigma, especially after some recommended interventions have been put into place.

5.5 SUMMARY

This chapter contained the conclusions the researcher has drawn regarding HIV/AIDS in the workplace by exploring the viewpoints and feelings of employees living with the virus. Limits of the research were identified and recommendations were made for future research.

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