

**WORKPLACE HIV AND AIDS-RELATED  
DISCRIMINATION:**

**UNRAVELLING THE PHENOMENON'S PERSISTENCE**

by

JOEL WILBERFORCE SENANKYA MUKASA

submitted in accordance with the requirements

for the degree of

DOCTOR OF ADMINISTRATION

INDUSTRIAL AND ORGANISATIONAL PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF JPR JOUBERT

CO-SUPERVISOR SUPERVISOR: PROF C JVAN AARDT

JUNE 2012



# TABLE OF CONTENTS

WORKPLACE HIV AND AIDS-RELATED DISCRIMINATION: .....	i
TABLE OF CONTENTS.....	i
DECLARATION.....	xx
ACKNOWLEDGEMENTS .....	xxi
DEDICATION .....	xxiv
SOURCES OF INSPIRATION .....	xxv
ABSTRACT.....	xxix
KEY CONCEPTS.....	xxx
LIST OF TABLES .....	xxxii
LIST OF FIGURES.....	xxxiv
ABBREVIATIONS .....	xxxv
TERMS .....	xxxvii
<b>CHAPTER 1: SCIENTIFIC ORIENTATION TO THE STUDY.....</b>	<b>1</b>
1.1 INTRODUCTION .....	1
1.2 BACKGROUND AND MOTIVATION OF THE RESEARCH .....	1
1.3 RELEVANCE OF STUDYING WORKPLACE HIV AND AIDS-RELATED DISCRIMINATION .....	3
1.4 IMPACT OF HIV AND AIDS ON THE WORKPLACE.....	5
1.5 IMPORTANCE OF WORKPLACE HIV AND AIDS POLICY.....	6
1.6 HIV AND AIDS PREVALENCE IN SOME NEIGHBOURING COUNTRIES .....	7

1.7	<i>HIV AND AIDS EPIDEMIC IN SUB-SAHARAN AFRICA</i>	7
1.8	<i>HIV AND AIDS ISSUES IN THE PUBLIC AND PRIVATE SECTORS</i>	8
1.9	<i>CULTURAL AND TRADITIONAL BELIEFS ABOUT HIV AND AIDS</i>	15
1.10	<i>PROBLEM STATEMENT</i>	23
1.11	<i>THE PURPOSE OF THE STUDY</i>	26
1.12	<i>THE RATIONALE OF THE STUDY</i>	26
1.13	<i>RESEARCH QUESTIONS</i>	28
1.14	<i>AIMS/OBJECTIVES OF THE RESEARCH</i>	29
1.14.1	General aim	30
1.14.2	Specific aims	30
1.15	<i>THE PARADIGM PERSPECTIVE</i>	31
1.15.1	Applicable psychological paradigms	32
1.15.1.1	The humanistic paradigm	32
1.15.1.2	The positivism paradigm	35
a	Definition	35
b	Positivist view of the objective world	35
c	Positivism as it applies to the research purpose	36
d	Positivism as it applies to the research design	37
e	Positivism as it relates to research method	37
f	Positivism as it applies to reliability and validity	37
g	Positivism as regards to research data	38
h	Positivism as it relates to theory in research	38
i	Main features of the positivist paradigm	39
(i)	Determinism	39
(ii)	Objectivity	39
(iii)	Probability	40
(iv)	Reliability	40
(v)	Quantification	40
(vi)	Generalisability	41
1.16	<i>PARADIGM FOR QUALITATIVE PART OF THE STUDY</i>	41
1.16.1	Phenomenology	41

Phenomenology offers one to understand unique individuals and their meanings, interactions with others and the environment (Lopez & Willis, 2004).According to Cohen and Manion (1987:151) phenomenology is ‘a theoretical point of view that advocates the study of direct experience taken at face value and one which sees behaviour as determined by the phenomena of experience rather than the external, objective and physically described reality’ .....42

1.16.1.2 Philosophical basis relevant to the qualitative part of the study.....43

1.16.1.2 ‘Epistemologically’ Guba (1990:26) says: .....44

1.16.2 Social constructionism .....45

**1.17 ADDRESSING VALIDITY AND RELIABILITY OF QUALITATIVE RESEARCH .....45**

1.17.1 Trustworthiness .....45

1.17.2 Credibility .....46

1.17.3 Prolonged engagement and experience .....46

1.17.4 Peer debriefing.....46

1.17.5 Member checks.....47

1.17.6 Transferability .....47

1.17.7 Dependability .....48

1.17.8 Confirmability.....48

**1.18 PILOT STUDY .....48**

**1.19 RECRUITMENT OF STUDY PARTICIPANTS .....49**

**1.20 ETHICS AND HUMAN RIGHTS ISSUES.....49**

**1.21 RATIONALE FOR USING A TRIANGULATED RESEARCH DESIGN .....50**

1.21.1 Triangulation .....50

1.21.1.1 Data triangulation .....50

1.21.1.2 Investigator triangulation.....51

1.21.1.3 Theory triangulation.....51

1.21.1.4 Methodological triangulation.....51

**1.22 THEORY TO GUIDE THE STUDY .....54**

1.22.1 Applicable theoretical models .....55

In this research, three behavioural models, namely social cognitive theory (SCT) (Bandura, 1980, 1994, 1997), the theory of reason action (Ajzen & Fishbein, 1972) –and its improved form – and the theory of planned action of (Ajzen and Fishbein, 1980) are fundamental to this study and are detailed as follows: .55

1.22.1.1 The Theory of Planned Behaviour (TPB).....55

1.22.1.2	The Theory of Reasoned Action (TRA).....	57
1.22.1.3	Maslow's hierarchy of needs theory .....	61
a	Orientation.....	63
b	Humanistic psychology of Maslow.....	63
c	Maslow's hierarchy of needs structure.....	63
d	An analysis of Maslow's motivation theory .....	65
(i)	Needs as instincts.....	66
e	The problem of need satisfaction .....	67
f	Unclear definition of need levels .....	67
g	The concept of self-actualisation .....	67
1.22.1.4	Social Learning Theory (SLT).....	68
a	Affection.....	70
1.22.1.5	The Social Cognitive Theory (SCT) .....	70
a	Meta-theoretical statements .....	76
b	The market of intellectual resources .....	76
c	Research hypothesis .....	77
d	Operational definitions .....	78
1.22.1.6	Knowledge.....	80
1.22.1.7	Traditional beliefs.....	80
1.22.1.8	Perceptions.....	80
1.22.1.9	Discrimination .....	80
1.22.1.10	Person.....	81
a	Methodological convictions.....	81
b	Meta-theoretical concepts.....	82
1.22.1.11	Individual.....	82
1.22.1.12	Awareness .....	82
a	Meta-theoretical convictions.....	82
b	Intellectual climate.....	83
1.23	<i>RESEARCH DESIGN</i> .....	83
1.23.1	Research variables .....	86
1.23.2	Type of research.....	87
1.23.3	Unit of analysis.....	87
1.23.4	Research design component for quantitative part of the study.....	88
1.23.5	Research design component for qualitative part of the study .....	91

1.24	<i>RATIONALE FOR USING THE CORRELATIONAL METHOD</i> .....	93
1.25	<i>RESEARCH METHODOLOGY</i> .....	93
1.25.1	This study conducted in three phases, each with different steps.....	93
1.26	<i>ETHICAL CONSIDERATIONS: AN ELABORATION</i> .....	105
1.26.1	Ethical considerations relating to the respondents .....	105
1.26.2	Ethical considerations pertaining to institutions where the study was conducted .....	106
1.26.3	Scientific integrity of the researcher as an ethical consideration .....	106
1.27	<i>DISCIPLINARY RELATIONSHIPS</i> .....	108
1.27.1	Philosophical level.....	108
1.27.2	Inter-disciplinary level.....	109
1.27.3	Disciplinary level .....	110
1.27.4	Intra-disciplinary level .....	111
1.27.5	Psychology .....	112
1.27.5.1	Industrial Psychology.....	112
1.27.5.2	Personnel psychology.....	112
1.27.5.3	Organisational psychology .....	113
1.27.5.4	Psychometrics .....	113
1.27.6	Applicable behavioural models.....	113
1.27.7	Research approach.....	114
1.28	<i>THE BASIS OF TRIANGULATION</i> .....	115
1.28.1	Methods to ensure reliability and validity .....	115
1.28.2	Validity and reliability of the literature survey .....	116
1.28.3	Validity and reliability of the empirical study .....	116
1.29	<i>CHAPTER DIVISION</i> .....	120
1.30	<i>CHAPTER SUMMARY</i> .....	121
<b>CHAPTER 2: KNOWLEDGE OF HIV AND AIDS .....</b>		<b>122</b>
2.1	<i>INTRODUCTION</i> .....	122
2.1.1	Definition of knowledge .....	122
2.1.2	Components of knowledge.....	122
2.1.2.1	Concepts forming the framework of HIV and AIDS knowledge .....	123
a	Belief .....	123

b	Truth.....	123
c	Justification .....	123
2.1.2.2	Forms of knowledge .....	124
s	Conceptual knowledge.....	124
b	Procedural knowledge .....	124
c	Episodic knowledge.....	125
2.2	<i>KNOWLEDGE OF TRANSMISSION OF HIV AND AIDS</i> .....	126
2.2.1	Knowledge of the routes of HIV transmission .....	127
2.2.1.1	Sexual risk behaviours .....	127
2.2.1.2	HIV transmission through unprotected sex.....	128
2.2.1.3	Mother-to-Child Transmission of HIV (MTCT) .....	128
2.2.1.4	Transmission through blood and blood products .....	129
2.2.1.5	Transmission through sharing of sharp objects .....	129
2.2.1.6	Knowledge of misconceptions about HIV and AIDS .....	129
2.3	<i>KNOWLEDGE OF PREVENTION OF HIV</i> .....	130
2.3.1	Knowledge of methods of HIV prevention .....	131
2.3.1.1	Abstinence from sex.....	131
2.3.1.2	Promotion of safe sexual behaviours .....	131
2.3.1.3	Knowing signs and symptoms of HIV and AIDS .....	132
2.3.2	Condom use .....	132
2.3.3	Multiple sex partners.....	133
2.3.4	Willingness to discuss HIV and AIDS .....	133
2.4	<i>KNOWLEDGE OF CAUSE AND HISTORY OF HIV AND AIDS</i> .....	133
2.5	<i>KEY DEFINITIONS AND RELATED HIV AND AIDS KNOWLEDGE</i> .....	134
2.5.1	AIDS (Acquired Immuno Deficiency Syndrome) .....	134
2.5.2	Aetiology.....	134
2.6	<i>UNDERSTANDING HIV AND AIDS</i> .....	135
2.6.1	What HIV is .....	135
2.6.2	How HIV infects blood .....	136
2.6.3	How HIV differs from AIDS.....	136
2.7	<i>COURSE OF AIDS</i> .....	138
2.7.1	Initial phase: Preceding sero-conversion.....	138



2.7.2	Asymptomatic phase: Latent or ‘silent’ infection .....	139
2.7.3	The symptomatic phase: HIV-related disease .....	139
2.7.4	Severe symptomatic phase: Clinical AIDS .....	139
2.8	<i>TRANSMISSION OF HIV</i> .....	141
2.9	<i>THE ORIGIN OF HIV</i> .....	144
2.9.1	How HIV entered the human population .....	145
2.9.2	How HIV might have crossed the species barrier .....	147
2.10	<i>IMPORTANCE OF WORKPLACE HIV AND AIDS POLICY</i> .....	149
2.11	<i>HIV AND AIDS-RELATED FEAR AND SEX IN THE WAKE OF HIV AND AIDS</i> .....	150
2.11.1	Fear of HIV and AIDS .....	150
2.11.2	Sex in the wake of HIV and AIDS .....	151
2.11.3	Safe sex .....	152
2.11.4	The safety of using a condom .....	152
2.12	<i>MYTHS ABOUT HIV AND AIDS</i> .....	154
2.13	<i>HIV AND AIDS-RELATED LAWS IN SOUTH AFRICA AND UGANDA</i> .....	155
2.13.1	Knowledge of law relating to HIV and AIDS .....	155
2.13.2	HIV and AIDS discrimination and the law in South Africa .....	156
2.13.3	The South African Constitution and HIV and AIDS .....	157
2.13.4	Labour legislation and HIV and AIDS .....	158
2.13.5	Labour Relations Act No.66 of 1995 (LRA) .....	159
2.13.6	Occupational Health and Safety Act No. 85 of 1993 (OHSA) .....	160
2.13.7	Mines Health and Safety Act No.29 of 1996 .....	161
2.13.8	Compensation for Occupational Injuries and Diseases Act No.130 of 1993 (COIDA) .....	161
2.13.9	Basic Conditions of Employment Act No.75 of 1997 (BCEA) .....	162
2.13.10	Medical Schemes Act, No. 101 of 1998 .....	162
2.13.11	Common law protection .....	163
2.14	<i>HIV AND AIDS IN THE WORKPLACE: LEGAL ASPECTS IN UGANDA</i> .....	163
2.14.1	Non-discrimination law in the Ugandan education sector .....	163
2.14.2	Recruitment, deployment, etc in the education sector .....	164
2.14.3	HIV testing and confidentiality .....	164
2.14.4	HIV and AIDS prevention, information and support programmes for employees .....	165

2.14.5	Refusal to study or work with, teach or be taught by persons living with HIV and AIDS or other discriminatory and disruptive practices.....	166
2.14.6	Ill health and absenteeism .....	167
2.14.7	Exposure to HIV at the workplace.....	167
2.14.8	Defilement and sexual abuse .....	168
2.15	<i>HIV AND AIDS GUIDELINES FOR EDUCATORS IN SOUTH AFRICA</i> .....	168
2.15.1	School policy on HIV and AIDS in South Africa.....	168
2.16	<i>HIV AND AIDS KNOWLEDGE ISSUES FROM CHINA: A RECENT SURVEY FOR COMPARISON</i> .....	169
2.17	<i>SUMMARY</i> .....	170
<b>CHAPTER 3: ATTITUDES AND RELATED PSYCHOLOGICAL CONCEPTS .....</b>		<b>171</b>
3.1	<i>INTRODUCTION</i> .....	171
3.2	<i>DELINEATION OF ATTITUDES</i> .....	171
3.2.1	What is an attitude? .....	171
3.2.2	The nature of attitudes .....	176
3.3	<i>A CONSIDERATION OF BELIEFS AND THEIR ROLE IN ATTITUDE MEASUREMENT</i> .....	180
3.4	<i>COMMENT ON ATTITUDE'S DEFINITION</i> .....	183
3.4.1	Positive and negative attitudes .....	184
3.4.2	The nature of attitude: An alternative view .....	184
3.4.3	Two conceptions of attitude.....	185
3.5	<i>POINTS OF INCONSISTENCY IN DOOB'S DEFINITION</i> .....	188
3.6	<i>MEASUREMENT OF ATTITUDES</i> .....	192
3.6.1	Means of measuring attitudes.....	192
3.6.2	Some of the roles of attitudes .....	194
3.6.3	Reliability and validity of attitude measure .....	194
3.6.4	Relationship between attitudes and behaviour .....	194
3.6.5	The theory of planned behaviour in predicting behaviour .....	195
3.7	<i>ALTERNATIVE VIEWPOINT ON THE ATTITUDE-BEHAVIOUR RELATIONSHIP</i> .....	198
3.7.1	Attitude consistency .....	199
3.7.2	Self-efficacy.....	199
3.8	<i>LOCUS OF CONTROL</i> .....	200

3.8.1	Theoretical background .....	201
3.8.2	Social learning theory .....	201
3.8.3	Definition of locus of control .....	202
3.8.4	Dimensions of locus of control .....	202
3.9	<i>CHAPTER SUMMARY</i> .....	204
<b>CHAPTER 4: TRADITIONAL BELIEFS IN LIGHT OF HIV AND AIDS .....</b>		<b>205</b>
4.1	<i>INTRODUCTION</i> .....	205
4.2	<i>DEFINITION OF BELIEF</i> .....	205
4.3	<i>THE INFLUENCE OF THE AFRICAN WORLDVIEW ON MATTERS OF ILLNESS</i> .....	210
4.3.1	Perceived causes of illness.....	211
4.3.2	God as a causative agent .....	211
4.3.3	Pollution as a causative .....	212
4.3.4	Ancestors as a causative agent .....	212
4.3.5	Witchcraft and sorcery as causative agents .....	213
4.4	<i>TRADITIONAL BELIEFS</i> .....	213
4.4.1	Prevalence of traditional beliefs about HIV and AIDS.....	214
4.4.2	Prevalence of traditional beliefs in some other places.....	216
4.5	<i>ILLNESS REPRESENTATIONS</i> .....	217
4.5.1	Cultural meaning of HIV and AIDS .....	217
4.5.2	Sub-Saharan perspectives on illness identity .....	218
4.5.3	Causes of illness: Proximate and ultimate causes .....	219
	In this study, it was expected that the educators, particularly those of Black African origin, share some of the beliefs with regard to the causes of illness. Therefore, it was deemed necessary to investigate these beliefs in order to try to understand how they relate to workplace HIV and AIDS-related discrimination. .....	220
4.5.3.1	A witnessed case of discrimination .....	220
4.5.4	Lessons learned from this case .....	220
4.5.5	Giving meaning to AIDS .....	221
4.5.6	The language of HIV and AIDS .....	224
4.5.7	Traditional Xhosa culture, health, illness and dying .....	225
4.5.7.1	Attitude to health within the Xhosa culture.....	225
4.5.7.2	Illness within the Xhosa culture .....	226

4.5.7.3	The Xhosa traditional attitude to death and dying .....	227
4.5.7.4	The contamination or pollution discourse .....	227
4.5.8	HIV and AIDS and the death discourse .....	228
4.5.8.1	Ubuntu in the wake of HIV and AIDS.....	228
4.6	<i>FAITH AND CULTURAL ISSUES RELATING TO WORKPLACE HIV AND AIDS RELATED DISCRIMINATION</i> .....	231
4.7	<i>CHAPTER SUMMARY</i> .....	231
<b>CHAPTER 5:</b>	<b>DISCRIMINATION BASED ON HIV AND AIDS STATUS</b> .....	<b>233</b>
5.1	<i>INTRODUCTION</i> .....	233
5.2	<i>DELINEATION OF DISCRIMINATION</i> .....	233
5.2.1	Definition of discrimination .....	234
5.2.2	Stigma and discrimination based on HIV and AIDS.....	235
5.2.2.1	Cultural differences on workplace HIV and AIDS-related discrimination.....	236
5.3	<i>TYPES OF HIV AND AIDS DISCRIMINATORY CONDUCT</i> .....	237
5.3.1	Individual discrimination .....	237
5.3.2	Structural discrimination .....	238
5.3.3	Institutional discrimination.....	238
5.4	<i>THE LEGAL RESPONSE TO HIV AND AIDS IN THE WORKPLACE</i> .....	238
5.5	<i>PREVALENCE OF STIGMA AND DISCRIMINATION</i> .....	241
5.6	<i>THE IMPACT OF STIGMA AND DISCRIMINATION DUE TO HIV AND AIDS ON THE WORKPLACE</i> .....	242
5.7	<i>SUPPORTIVE SOCIAL RELATIONS</i> .....	243
5.8	<i>BENEFIT OF DISCLOSURE OF HIV STATUS TO THE ORGANISATION</i> .....	245
5.9	<i>SELF-ESTEEM AND WORKPLACE HIV AND AIDS-RELATED DISCRIMINATION</i> .....	245
5.10	<i>LINKING ATTITUDES WITH WORKPLACE HIV AND AIDS-BASED DISCRIMINATION</i> .....	246
5.11	<i>STAKEHOLDERS' IMPACT ON WORKPLACE HIV AND AIDS-RELATED DISCRIMINATION</i> .....	246
5.11.1	Contributions of faith communities TO HIV and AIDS impacting on the workplace.....	247
5.11.2	Opinion leaders' influence on workplace HIV and AIDS-related discrimination.....	251
5.12	<i>PRELENCE OF STIGMA AND DISCRIMINATION IN SOME OTHER COUNTRIES</i> .....	252
5.12.1	HIV and AIDS stigma in SADC countries .....	252
5.12.2	Discriminatory language in light of HIV and AIDS: A case of Uganda .....	255

5.12.2.1	Elaboration on the qualities of communication .....	256
5.13	<i>DECISION BASED ON MORAL ISSUES</i> .....	257
5.14	<i>GAPS IN THE LITERATURE REVIEWED</i> .....	259
5.14.1	Need for more information on workplace HIV and AIDS-related discrimination .....	260
5.14.2	Workplace HIV and AIDS-related discrimination: How much is due to traditional beliefs? .....	262
5.14.3	Comment on the reviewed literature .....	263
5.15	<i>CHAPTER SUMMARY</i> .....	263
<b>CHAPTER 6: RESEARCH DESIGN AND METHODOLOGY .....</b>		<b>265</b>
6.1	<i>INTRODUCTION</i> .....	265
6.2	<i>INSTRUMENTATION</i> .....	266
6.2.1	Cross-sectional quantitative survey.....	266
6.2.2	In-depth interviews.....	266
6.3	<i>SELECTING THE MEASURING INSTRUMENTS</i> .....	267
6.3.1	The HIV and AIDS-knowledge questionnaire .....	267
6.3.2	HIV and AIDS biomedical knowledge scale/ FHI-knowledge scale .....	267
6.3.2.1	Development .....	267
6.3.2.2	Rationale .....	268
6.3.2.3	Aim .....	268
6.3.2.4	Dimensions .....	268
6.3.2.5	Administration.....	268
6.3.2.6	Interpretation.....	268
6.3.2.7	Reliability.....	268
6.3.2.8	Validity.....	268
6.3.2.9	Justification .....	268
6.3.3	HIV and AIDS-legal knowledge scale (H/ALKS).....	269
6.3.3.1	Development.....	269
6.3.3.2	Rationale .....	269
6.3.3.3	Aim .....	269
6.3.3.4	Dimensions .....	269
6.3.3.5	Administration.....	269
6.3.3.6	Interpretation.....	269
6.3.3.7	Reliability.....	269

6.3.3.8 Validity.....	270
6.3.3.9 Justification for inclusion.....	270
6.3.4 Attitude Scale (AS) or the HIV and AIDS attitude scale (HAAS).....	270
6.3.4.1 Development.....	270
6.3.4.2 Rationale .....	270
6.3.4.3 Aim .....	270
6.3.4.4 Dimensions.....	270
6.3.4.5 Administration.....	270
6.3.4.6 Interpretation.....	271
6.3.4.7 Reliability.....	271
6.3.4.8 Validity.....	271
6.3.4.9 Justification for inclusion.....	271
6.3.5 HIV and AIDS Discrimination Scale (HADS) .....	271
6.3.5.1 Development.....	271
6.3.5.2 Rationale .....	271
6.3.5.3 Aim .....	271
6.3.5.4 Dimensions.....	272
6.3.5.5 Administration.....	272
6.3.5.6 Interpretation.....	272
6.3.5.7 Reliability.....	272
6.3.5.8 Validity.....	272
6.3.5.9 Justification for inclusion.....	272
6.3.6 Traditional Belief Scale (TBS) .....	272
6.3.6.1 Development.....	272
6.3.6.2 Rationale .....	272
6.3.6.3 Aim .....	273
6.3.6.4 Dimension .....	273
6.3.6.5 Administration.....	273
6.3.6.6 Interpretation.....	273
6.3.6.7 Reliability.....	273
6.3.6.8 Validity.....	273
6.3.6.9 Justification for inclusion in research.....	274
6.3.7 The Socio-Demographic Questionnaire (SDQ).....	274
6.3.7.1 Development.....	274

6.3.7.2 Rationale .....	274
6.3.7.3 Aim .....	274
6.3.7.4 Dimensions .....	274
6.3.7.5 Administration.....	275
6.3.7.6 Interpretation.....	276
6.3.7.7 Reliability.....	276
6.3.7.8 Validity.....	276
6.3.7.9 Justification for inclusion in this research .....	276
6.3.8 Locus of control scale .....	276
6.3.8.1 Development.....	276
6.3.8.2 Rationale .....	276
6.3.8.3 Aim .....	276
6.3.8.4 Dimensions.....	277
6.3.8.5 Administration.....	277
6.3.8.6 Interpretation.....	277
6.3.8.7 Reliability.....	278
6.3.8.8 Validity.....	278
6.3.8.9 Justification of inclusion of the instrument in the study.....	278
6.3.9 Self-Esteem Scale (SES).....	279
6.3.9.1 Development.....	279
6.3.9.2 Rationale .....	279
6.3.9.3 Aim .....	280
6.3.9.4 Dimension .....	280
6.3.9.5 Administration.....	280
6.3.9.6 Interpretation.....	280
6.3.9.7 Reliability.....	280
6.3.9.8 Validity.....	280
6.3.9.9 Justification for inclusion in research.....	280
6.3.10 Self-Efficacy Scale (GPSES) .....	280
6.3.10.1 Development.....	280
6.3.10.2 Rationale .....	281
6.3.10.3 Aim .....	281
6.3.10.4 Dimension .....	281
6.3.10.5 Administration.....	281

6.3.10.6 Interpretation.....	281
6.3.10.7 Reliability.....	281
6.3.10.8 Validity.....	282
6.3.10.9 Justification for inclusion in the research.....	282
6.3.11 Measuring instruments for the qualitative part of the study.....	283
6.3.11.1 Development.....	283
6.3.11.2 Rationale.....	283
6.3.11.3 Aim.....	283
6.3.11.4 Dimensions.....	284
6.3.11.5 Administration.....	284
6.3.11.6 Interpretation.....	285
6.3.11.7 Reliability.....	286
6.3.11.8 Validity.....	286
6.3.11.9 Justification for inclusion in the research.....	287
6.4 <i>THE PROTOCOL FOR THE IDENTIFICATION OF DISCRIMINATION</i> .....	287
6.4.1 Discrimination and the human rights framework.....	288
6.4.2 The employment part of the UNAIDS Protocol of HIV and AIDS-related discrimination.....	290
6.5 <i>CONCERNS ABOUT THE PROTOCOL ON HIV AND AIDS-DISCRIMINATION</i> .....	291
6.5.1 Outline of the protocol.....	291
6.5.2 General validity of the indicator.....	292
6.5.3 Conclusion.....	294
6.6 <i>DATA COLLECTION</i> .....	295
6.6.1 Quantitative data collection.....	295
6.6.2 Qualitative data collection.....	296
6.6.2.1 Preparation for the interview.....	296
6.6.2.2 Recording of data.....	297
6.6.2.3 On site data analysis.....	297
6.7 <i>HYPOTHESES</i> .....	297
6.8 <i>DATA PROCESSING AND ANALYSIS</i> .....	298
6.8.1 Quantitative data processing.....	298
6.8.1.1 Descriptive statistics.....	298
6.8.1.2 Reliability of instruments.....	298
6.8.1.3 Correlations.....	299



6.8.1.4	Regression analysis.....	300
6.8.1.5	t-Tests.....	301
6.8.2	Qualitative data processing .....	302
6.8.2.1	Managing data.....	302
6.8.2.2	Reading the transcripts .....	302
6.8.2.3	Describing, classifying and interpreting data .....	303
6.8.2.4	Representing and visualising .....	304
6.8.2.5	Analyses of socio-demographic characteristics of the sample.....	304
6.8.2.6	Analyses of the samples .....	304
6.8.3	Notes on standardised interviews versus in-depth interviews.....	307
6.9	<i>DATA ANALYSIS PROCEDURE FOR THE QUALITATIVE PART OF THE RESEARCH</i> .....	308
6.9.1	Data analysis .....	308
6.9.2	Reliability and validity.....	309
6.9.3	Note on validity.....	310
6.10	<i>CHAPTER SUMMARY</i> .....	310
<b>CHAPTER 7: RESEARCH RESULTS .....</b>		<b>312</b>
7.1	<i>INTRODUCTION</i> .....	312
7.2	<i>QUANTITATIVE RESEARCH RESULTS</i> .....	312
7.3	<i>RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF BIOMEDICAL KNOWLEDGE</i> .....	313
7.4	<i>RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF LEGAL KNOWLEDGE</i> .....	318
7.5	<i>RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF ATTITUDE</i> .....	321
7.6	<i>RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF EMOTIONS</i> .....	325
7.7	<i>RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF TRADITIONAL BELIEFS</i> .....	327
7.8	<i>RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF DISCRIMINATION</i> .....	330
7.9	<i>RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF PERCEPTIONS OF EDUCATORS ON MANAGEMENT</i> .....	335
7.10	<i>RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF SELF-ESTEEM, SELF-EFFICACY AND SUBJECTIVE NORMS</i> .....	338
7.11	<i>COMPARISON BETWEEN SOUTH AFRICA AND UGANDA ON MAIN CONCEPTS</i> .....	341

7.11.1	Knowledge .....	341
7.11.2	Attitude .....	342
7.11.3	Emotions .....	342
7.11.4	Traditional beliefs .....	343
7.11.5	Discrimination .....	343
7.11.6	Self-esteem and self-efficacy .....	344
7.12	<i>CORRELATION ANALYSIS BETWEEN KNOWLEDGE, ATTITUDE, EMOTION, TRADITIONAL BELIEF AND DISCRIMINATION</i> .....	345
7.13	<i>REGRESSION ANALYSIS TO PREDICT DISCRIMINATION</i> .....	348
7.13.1	Combined data.....	348
7.13.2	Regression for South Africa.....	350
7.13.3	Regression for Uganda .....	352
7.14	<i>INVESTIGATION OF THE EFFECT OF PERSONALITY CONCEPTS ON ATTITUDE, EMOTIONS AND DISCRIMINATION</i> .....	354
7.15	<i>EFFECT OF DEMOGRAPHIC/BIOGRAPHIC VARIABLES ON MAIN CONCEPTS</i> .....	356
7.15.1	Describing the Sample .....	356
7.15.2	Comparing the groups.....	358
7.16	<i>FINDINGS OF THE QUALITATIVE RESEARCH</i> .....	359
7.16.1	Incidents of discrimination and how they manifest themselves .....	359
7.16.2	Issues surrounding confidentiality with regard to a colleague’s HIV status .....	362
7.16.3	Perceptions of being conversant with HIV and AIDS knowledge: Legal and biomedical HIV and AIDS knowledge .....	364
7.16.4	The state of HIV and AIDS issues in schools.....	366
7.16.5	Perception and treatment of colleagues suspected or who are HIV-positive .....	368
7.16.6	Traditionally/culturally attributed causes of HIV and AIDS and how they seem to contribute to fostering workplace HIV and AIDS-related discrimination.....	370
7.16.7	Issues surrounding secrets - HIV and AIDS-related secrets.....	375
7.16.8	Summary on the issue of secrets relating to HIV and AIDS in the workplace .....	401
7.17	<i>THEME 1: IMPACT OF HIV AND AIDS ON YOUR INSTITUTION (SCHOOL)</i> .....	403
7.17.1	Summaries pertaining to qualitative data on workplace HIV and AIDS-related discrimination ..	409
7.17.1.1	Summary of the qualitative data regarding the issue of witnessing incidents of shunning a coworker due to HIV status:.....	409

7.17.1.2 Summary of the qualitative data on the issue of witnessing incidents of not eating with or refusing to eat with an HIV-positive coworker is as follows: .....	409
7.17.1.3 Summary of the qualitative data on witnessing incidents of discussion of HIV and AIDS in the workplace .....	409
7.17.1.4 Pertaining to shunning an HIV-positive worker by colleagues .....	410
7.17.1.5 Regarding the issue of refusing to eat with a coworker suspected to have HIV and living with AIDS, the following responses were recorded .....	411
7.17.1.6 Regarding individuals discussing HIV and AIDS in the workplace, the following responses were: .....	411
<b>7.18</b> <b><i>THEME 2: TRADITIONAL BELIEFS AND RELIGIOUS GROUPS' ACTIONS AND REACTIONS TOWARDS HIV AND AIDS INFECTED AND AFFECTED PERSONS</i></b> .....	<b>414</b>
<i>*The total adds up to 100.2% instead of 100% because of having computed the percentages to a single decimal point. It approximates to 100%.....</i>	<i>417</i>
7.18.1     Sub-theme 1: Traditional beliefs and the causes of HIV and AIDS.....	417
<i>Punishment from God ranked third in the rate of frequency as a cause of HIV and AIDS. ....</i>	<i>422</i>
7.18.2     Sub-theme2: Religion's action and reactions to HIV and AIDS and towards those infected with HIV and AIDS    423	
7.18.4     Moral support through prayers, acceptance of the sick, infected or affected and actual visits. .	424
7.18.5     Fair treatment of an HIV-infected person.....	425
<b>7.19</b> <b><i>THEME 3: SECRET KEEPING AND RELATED ISSUES</i></b> .....	<b>426</b>
7.19.1     Reasons for non-revelation of HIV status of colleagues .....	430
7.19.2     Noted limitations of using the quotation approach relevant to this study .....	433
<b>7.20</b> <b><i>CHAPTER SUMMARY</i></b> .....	<b>433</b>
<b>CHAPTER 8: DISCUSSION: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS.....</b>	<b>434</b>
8.1 <b><i>INTRODUCTION</i></b> .....	<b>434</b>
8.2 <b><i>GENERAL DISCUSSION OF RESULTS</i></b> .....	<b>434</b>
8.3 <b><i>LIMITATIONS TO THE RESEARCH</i></b> .....	<b>450</b>
8.4 <b><i>SOME STRENGTHS OF THIS STUDY</i></b> .....	<b>452</b>
8.5 <b><i>FUTURE DIRECTION/GENERAL RECOMMENDATIONS</i></b> .....	<b>453</b>
8.6 <b><i>DISCUSSIONS OF FINDINGS OF THE QUALITATIVE PART OF THE STUDY</i></b> .....	<b>456</b>

8.6.1	The issue secret telling .....	456
8.6.2	Limitations specific to the qualitative part of the study.....	457
8.7	<i>SPECIFIC RECOMMENDATIONS</i> .....	458
8.7.1	Recommendations for practice .....	458
8.7.2	Recommendations regarding the empirical study.....	462
8.7.2.1	Sample.....	462
8.7.2.2	Population group.....	462
8.7.3	Recommendations regarding the literature review .....	462
8.8	<i>CONCLUSION</i> .....	463
8.9	<i>PROFILE OF AN ORGANISATION MANAGING HIV AND AIDS STIGMA AND DISCRIMINATION</i> .....	466
8.9.1	CRITERION 1: HAVE A WORKPLACE POLICY ON HIV AND AIDS.....	466
8.9.1.1	The purposes of a workplace policy on HIV and AIDS, include the following: .....	466
8.10	<i>COMPONENTS OF A WORKPLACE HIV AND AIDS POLICY</i> .....	467
8.10.1	Implementation, Advocacy and mainstreaming .....	468
8.10.1.1	Mainstreaming .....	468
8.10.1.2	Advocacy and related issues .....	468
8.10.1.3	Implementation.....	469
8.11	<i>CRITERION 2: WORKPLACE PROGRAMME ON HIV AND AIDS</i> .....	469
8.12	<i>HUMAN RESOURCE PLANNING AND DEVELOPMENT</i> .....	476
8.12.1	Deployment recruitment, appointment and transfers .....	477
8.12.2	Human resource management – monitoring of absenteeism and ill-health.....	478
8.12.3	Analysis of job descriptions.....	479
8.13	<i>STRENGTHENING INFORMATION SYSTEMS AND INFORMATION EXCHANGE</i> .....	480
8.14	<i>THE CONTRIBUTION OF THE RESEARCH</i> .....	480
8.15	<i>PERSONAL REFLECTIONS</i> .....	481
8.16	<i>SUMMARY</i> .....	482
	<b>REFERENCES</b> .....	<b>483</b>
	<b>APPENDICES</b> .....	<b>566</b>
	<i>APPENDIX I: PERMISSION TO CONDUCT RESEARCH</i> .....	566

<i>APPENDIX II: INTRODUCTORY LETTER.....</i>	<i>567</i>
<i>APPENDIX III: LETTER TO RESPONDENT .....</i>	<i>568</i>
<i>APPENDIX IV: QUESTIONNAIRE (UGANDA VERSION).....</i>	<i>570</i>
SECTION A .....	570
SECTION B .....	573
SECTION C .....	577
SECTION D .....	578
LOCUS OF CONTROL (i.e. Scale) .....	583
<i>APPENDIX IV: REQUEST TO PARTICIPATE IN SURVEY (SOUTH AFRICA).....</i>	<i>589</i>
<i>APPENDIX VI: QUESTIONNAIRE (SOUTH AFRICA VERSION) .....</i>	<i>591</i>
SECTION A .....	591
SECTION B .....	594
SECTION C .....	598
SECTION D .....	599
LOCUS OF CONTROL (I.E. Scale) .....	604
<i>APPENDIX VII: INTERVIEW GUIDE QUESTIONS FOR A TARGET SAMPLE.....</i>	<i>610</i>
<i>APPENDIX VIII: CONSENT FORM .....</i>	<i>612</i>
<i>APPENDIX IX: DETERMINING SAMPLE SIZE .....</i>	<i>613</i>

## DECLARATION

I declare that “WORKPLACE HIV AND AIDS-RELATED DISCRIMINATION:

UNRAVELLING THE PHENOMENON’S PERSISTENCE” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

---

SIGNATURE

DATE

MUKASA S.J.W.

## **ACKNOWLEDGEMENTS**

I wish to express my deepest gratitude to my thesis supervisor, Prof Pierre Joubert whose consistent guidance, support, enthusiasm, expertise and assistance have contributed to the success. I am equally indebted to co-supervisor, Prof Carol van Aardt whose brilliant guidance, availability and faith in me have been very helpful.

Prof EJ Louw of the Department of Industrial Psychology of the University of North West, Mmabatho Campus who set me off, is greatly thanked. Prof Frans Cilliers is thanked for the work of reading and advice on the very first proposal.

I would like to thank all those who contributed to the success of my thesis. The list is formidable, but these deserve special mention:

Mrs Elbie Ströh and Fionna du Preez, your dedication in typing my work needs God's blessings.

Mrs P. Maseng and Ms Idah Mogogwelo are thanked for their assistance.

My diaspora long-standing friends Mr Wilson, M. Letsoalo and Mr F.G. Sewanywa Sekiswa are thanked for ferrying study materials on many occasions and getting me essential information.

Mr Fedinand Letanke's invaluable help is greatly appreciated. Also great thanks go to Mr Safari Zake, Ms Olivia Nambalilwa Kanyike, Mr Daniel Meyer and Mr Obed M. Moleele who assisted me in typesetting this research thesis. The late Mr James Kitching of UNISA Library is thanked for his assistance (R.I.P).

Colleagues at work and all those many teachers in many schools both in North West Province (RSA) and those in Kampala (Uganda) for their time and responsibility when they participated in the research. Principals and Departmental officials are all appreciated too.

Mrs Kabirizi of MoES Kampala – Uganda, is thanked for her assistance and understanding.

Mr Eric T. Lwanga for the bother he stood in the last days of my studies.

Ms Marianne Schmidt is thanked for her love and continued encouragement.

On a personal level, I am extremely grateful for the unwavering support and understanding from my beloved wife Juliet Senankya Mukasa, who stood my continued absence from home and divided attention, but never lost hope and kept on encouraging me. Again, special thanks to my valued daughter Joella Nakaye who missed me a lot in her earliest life. You are all my love. Jojo's keen observation surprised me when at two and a quarter years could identify a photo of our hero, Barak Obama, H!

Ms M. Coetzee who did the statistical work for me, your understanding is inspiring.

Astra Funerals staff, especially Mr Piet Swart, for photocopying my work.

Mr James Kishaija, my former headmaster and all staff of Kako Secondary School for the firm foundation they laid for me.



Lastly, and for strategic reason, I am very grateful to the Almighty God for giving me the ability, health and perseverance to complete this thesis.

## DEDICATION

This piece of work is dedicated to my late parents, Mr John Kiwanuka Nsubuga and Mrs Peruth Margaret Najjuka Kiwanuka. Although you are both long gone, with my siblings Namusisi Joyce, Eleanor Nkinzi, Frank Serwanja, Abraham Kizito, Godfrey Lule, Mabel Namusoke and Winnie Nakazzi, Andy Galiwango, niece Winnie Nalwoga and mum Namusoke (4-5-7) of tragedy, you meant a lot to me and showed me the fruit of good character which has enabled me to manage life in the diaspora. My dear aunt, the late Juliet Nalunkuuma Nakyagaba who guided me in my early days in formal education in Sala, Christ the King Primary School. May the souls of my beloved grandparents, parents, siblings, and relatives, especially those claimed by HIV and AIDS rest in peace.

My remaining grandparents Brenda Nakimuli Mulasa and Phoebe Nagaddya for their love and foresight even at advanced age.

Nothing great as this piece of work could have been accomplished without the critical love, responsibility and selflessness of my natural sister and mentor - a symbol of dedication, hard work and order - Mrs Christine Deborah Ssendendo.

My academic mentors, namely the late CBK Mukumbya, Prof PJM Sebuwufu and Associate Prof PK Baguma - all inspired me more than others in many ways.

## SOURCES OF INSPIRATION

Emerson: What lies within you is more important than what lies behind you or ahead of you.

Anonymous: Great is a man who plants a tree in whose shade he will never sit.

Apollo Kivebulaya: This 19<sup>th</sup> - 20<sup>th</sup> century evangelist is said to have loved Jesus and God to the extent that he wanted to evangelise as far as he could. He set his eyes on the then Boga-Zaire Province of the Anglican church. In his last days when he became frail, it is said, he left a will to be buried facing where he was going. In a way, he would one day accomplish what he had set himself.

Thomas Edison: After trying to make a light bulb about 6000 ways he was asked how he felt. He replied, "I have learned it wouldn't have been done that way".

Anonymous: It is said one time a young boy below the age of ten had a Shilling. (*Kisumuluzo Book Series*).As the boy was playing, moreover, in a four-way junction, the Shilling got lost. The boy started crying. The first person to come noticed the boy and asked him why he was crying. The boy told him that he had lost his Shilling and could not find it yet it was getting dark. The man gave him a Shilling but the boy continued crying. The man asked him why he was crying. The boy said that he would have had two Shillings. After failing to stop crying, the man gave him another Shilling. The money became two Shillings

but the boy continued crying. Why? He had lost his Shilling; and he would have had three Shillings. This desire for more without forgetting what the lost Shilling was insatiable.

(I wish all human beings would have the same insatiable desire to contribute to the good of the world during their life time.)

Anonymous: "If you lose money, you have lost nothing. If you lose time, you have lost something. If you lose hope, you have lost everything".

Anonymous: GRECO - METEOR AND SHADOW

Then you held out your hand, as though I was drowning and you wanted to save me.

I clutched at your hand eagerly, bespattered as it was with multi-coloured paints.

"My dearest grandfather", I said,

"give me a command".

"Reach where you can, my child".

"Grandfather", my voice was louder now,

"give me a more difficult, more certain command".

"Reach where you can't".

Abraham Lincoln: Abe, as he was fondly known, said in his sketchy autobiography, what he had in the way of education he had "picked up." He never became a learned man, but of his eagerness for books and learning there could be no

doubt. The tradition of his walking thirty or forty miles to borrow a book, of reading crouched before the fire, as in Eastman Johnson's painting of 1868, of improvising a slate from a blackened shovel - these stories made up the exemplary legend passed through generations of children. Indeed, Abraham's poverty of books was the wealth of his life. This last bit suggests the benefits of narrow but concentrated study of select texts.

#### BEGIN IT NOW

Until one is committed

there is hesitancy, the chance to draw back,  
always ineffectiveness.

Concerning all acts of initiative (and creation)

there is one elementary truth  
the ignorance of which kills countless ideas  
and splendid plans.

That the moment is definitely commits

oneself

then Providence moves too.

All sorts of things occur to help one

that would never otherwise have occurred.

A whole stream of events issues from the decision

raising in one's favour all manner of  
unforeseen incidents and meetings and material assistance  
which no man could have dreamt  
would have come his way.

Whatever you can do or dream you can  
begin it.

Boldness has genius, power and magic in it

begin it now

Goethe

There is nothing uninteresting, only uninterested persons Anonymous

“The main interest in life and work is to become someone else that you were not in the  
beginning.”

Foucault

## ABSTRACT

Despite HIV and AIDS knowledge and attitude change programmes, workplace HIV and AIDS-related discrimination persists in workplaces in many sectors, including the education sector. This study set out to investigate why the phenomenon of workplace HIV and AIDS-related discrimination persists; and to predict which factors were responsible and how they related to HIV and AIDS-related discrimination in the workplace. A stratified random sample of 205 teachers; 123 of whom were from 10 schools of varied backgrounds in Bojanala Region of North West Province of South Africa and 82 from schools around Kampala, Central Region of Uganda was drawn. Twenty-seven respondents of the South African sample participated in both the quantitative survey and in-depth interview while the rest responded to a self-administered questionnaire. Using a stepwise regression analysis, traditional beliefs predicted workplace HIV and AIDS-related discrimination, explained 11% of variance in the second model while the third model explained only 2% more – 13% (R square of 0.136) but each of the three models was significant ( $p$ -values of 0.000). Attitudes were the second strongest predictor; and only HIV and AIDS-legal knowledge could predict discrimination but not biomedical HIV and AIDS knowledge. In the in-depth interview, incidents of discrimination were reported, possible reasons for HIV and AIDS-related discrimination were reported; and it was found that workers varied in ways of keeping secrets regarding sensitive information such as colleagues' HIV-positive status, and cited reasons for revealing such information which included malice, jealousy, moral responsibility, anger and loose talks. There are implications for reducing workplace HIV and AIDS-related discrimination which include: Integrating HIV and AIDS-legal knowledge with biomedical HIV and AIDS knowledge, more efforts should be spent in designing and imparting information to reduce traditional beliefs, develop and evaluate instruments to measure traditional beliefs and HIV and AIDS-legal knowledge; and to study more about secret keeping, particularly in regard to workplace HIV and AIDS-related discrimination.

## **KEY CONCEPTS**

The following key words from the core of this study:

Discrimination

HIV and AIDS Knowledge – both biomedical and legal

Attitudes

Traditional beliefs

Ajzen's Theory of Planned Behaviour (TPB)

Ajzen and Fishbein's Theory of Reasoned Action (TRA)

Bandura's Social Cognitive Theory (SCT)

Workplace



# LIST OF TABLES

Table1.1: Summary of the advantages of the qualitative and quantitative methods .....	53
Table 6.1: Inter-correlations of the three subscales. ....	278
Table: 6.2 Range of effect size.....	300
Table 7.1: Reliability statistics for biomedical knowledge .....	313
Table 7.2: Seven factor solution from the principle factor analysis on biomedical knowledge – South Africa ....	314
Table 7.3: Descriptive information for South Africa and Uganda on biomedical knowledge .....	316
Table 7.4: Reliability statistics for legal knowledge .....	319
Table 7.5: Descriptive information for South Africa and Uganda on legal knowledge .....	319
Table7.6: Reliability statistics for attitude.....	322
Table 7.7: Descriptive information for South Africa and Uganda on attitude statements .....	322
Table 7.8: Reliability statistics for emotion .....	325
Table 7.9: Reliability Statistics for emotions for South Africa and Uganda .....	326
Table: 7.10: Descriptive information for South Africa and Uganda on emotions.....	327
Table 7.11: Reliability statistics for traditional beliefs.....	327
Table 7.12: Descriptive information for South Africa and Uganda on traditional beliefs .....	328
Table 7.13: Reliability statistics for discrimination .....	330
Table 7.14: Descriptive information for South Africa and Uganda on discrimination .....	331
Table 7.15: Reliability statistics for perception of educators of school management teams (SMTs).....	335
Table 7.16: Descriptive information for South Africa and Uganda on perceptions of educators .....	335

<b>Table 7.17: Descriptive information for South Africa and Uganda perceptions of school management team (i.e. SMT) .....</b>	<b>336</b>
<b>Table 7.18: Reliability statistics for perception of self-esteem .....</b>	<b>338</b>
<b>Table 7.19: Reliability statistics for perception of self-efficacy.....</b>	<b>338</b>
<b>Table 7.20: Reliability statistics for perception of subjective norms.....</b>	<b>339</b>
<b>Table 7.21: Descriptive information for South Africa and Uganda on self-esteem and self-efficacy .....</b>	<b>339</b>
<b>Table 7.22: Summary of direction of construct measurement .....</b>	<b>340</b>
<b>Table 7.23: Comparison between South Africa and Uganda on knowledge scales .....</b>	<b>341</b>
<b>Table 7.24: Comparison between SA and Uganda on attitude scales .....</b>	<b>342</b>
<b>Table 7.25: Comparison between South Africa and Uganda on emotions scale .....</b>	<b>342</b>
<b>Table 7.26: Comparison between South Africa and Uganda on traditional beliefs scale .....</b>	<b>343</b>
<b>Table 7.27: Comparison between South Africa and Uganda on discrimination scales .....</b>	<b>343</b>
<b>Table 7.28: Comparison between South Africa and Uganda on self-esteem and self-efficacy scales.....</b>	<b>344</b>
<b>Table 7.29: Correlations among factors on knowledge, attitudes etc.....</b>	<b>345</b>
<b>Table7.30: Regression analysis results: Predicting discrimination .....</b>	<b>349</b>
<b>Table 7.31: Coefficients of the regression with discrimination as the dependent variables .....</b>	<b>349</b>
<b>Table 7.32: Regression analysis results: Predicting discrimination for South Africa .....</b>	<b>350</b>
<b>Table 7.33a: Coefficients of the regression with discrimination as the dependent variables: South Africa .....</b>	<b>351</b>
<b>Table7.33b: Correlation matrix (Uganda).....</b>	<b>352</b>
<b>Table7.33c: Correlation matrix (South Africa) .....</b>	<b>352</b>
<b>Table 7.34: Regression analysis results: Predicting discrimination for Uganda.....</b>	<b>352</b>

<b>Table 7.35: Coefficients of the regression with discrimination as the dependent variables: Uganda .....</b>	<b>353</b>
<b>Table 7.36: Correlation between main constructs and personality constructs .....</b>	<b>354</b>
<b>Table 7.37: Scores of Males and Females on the Different Concepts .....</b>	<b>358</b>
<b>Table 7.38: Frequency of possible causes of HIV and AIDS based on traditional belief.....</b>	<b>415</b>
<b>Table 7.39: Frequency of religions’ reactions to HIV and AIDS and to those infected/ affected with HIV and AIDS* .....</b>	<b>415</b>
<b>Table7.40: Frequencies of witnessed selected discriminatory actions .....</b>	<b>423</b>
<b>Table7.41: Level of difficulty of keeping secrets.....</b>	<b>426</b>
<b>Table 7.42: Types and frequency of secrets revealed.....</b>	<b>426</b>
<b>Table 7.43: Factors prompting revealing secrets and their frequency .....</b>	<b>428</b>
<b>Table 7.44:Factors that would prevent one from keeping a colleague’s HIV status.....</b>	<b>429</b>
<b>Table 7.45: Reasons for why colleagues reveal coworkers HIV-positive status .....</b>	<b>430</b>
<b>Table 7.46: Self-ranking of keeping highly sensitive information like HIV and AIDS status of colleagues .....</b>	<b>432</b>

# LIST OF FIGURES

Figure 1.1: Deficit and being needs in terms of Maslow’s hierarchy of needs theory (Maslow, 1999: 33) .....	64
Figure 1.2 Schematisation of triadic reciprocal causation. ....	73
Figure 1.3: Research model (Mouton & Marais, 1996:22). ....	107
Figure 1.4: Disciplinary relationship of research .....	108
Figure 1.5: Theoretical model (envisioned by the researcher).....	114
Figure 2.1: The HIV family tree.....	145
Figure 3.1: The personality – values – attitudes – opinions ‘tree model’.....	179
Figure 3.2 Theory of planned behaviour .....	196
Figure 7.1: Descriptive information of definitions of HIV and AIDS .....	316
Figure 7.2: Summary of construct scores for South Africa and Uganda .....	345
Figure 7.3: Summary of emotions for South Africa and Uganda .....	345
Figure 7.4: Gender distribution of the sample.....	356
Figure 7.5: Age distribution of the sample .....	356
Figure 7.6: Marital status of the sample .....	357
Figure 7.7: Educational level distribution of the sample .....	357

## ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ALP	AIDS Law Project
APA	American Psychological Association
ARV	Antiretroviral
CD 4	A protein imbedded on the surface of a T lymphocyte to which HIV most often binds – a CD4+ or T4 cell
CHW	Community Health Worker
DoH	Department of Health
HIV	Human Immunodeficiency Virus
HIV+ve	Human Immune Deficiency Virus positive
HOD	Head of Department
HSRC	Human Sciences Research Council
KENWA	Kenya Network of Women with AIDS
KZN	KwaZulu-Natal, South Africa
MoE	Ministry of Education
MoH	Ministry of Health
NASA	National Aeronautics and Space Administration
OI	Opportunistic infection
PLWA	People living with AIDS
PLWHA	People Living with HIV and AIDS
SADC	Southern African Development Community
SDA	Seventh Day Adventist

SPSS	Statistical Package for Social Scientists
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific & Cultural Education
UNISA	University of South Africa
USA	United States of America
UK	United Kingdom
WHO	World Health Organisation
WLWA	Women Living with AIDS
www	World wide web
ZCC	Zion Christian Church

## TERMS

**Affected:** Refers to a person who experiences the impact of HIV and AIDS through loss or sickness of family members, friends or colleagues.

***Ceterisparibus:*** Other things being equal.

**Cultural factors:** Culture is a way of life characteristic of a particular group of people and may be symbolised by traditions and customs. Cultural beliefs and differences impact on the understanding of HIV and AIDS as a pandemic problem.

**Discrimination:** Treating a person or group differently (usually worse) than others, for example, because of their race, gender, sex-orientation or HIV status.

**Employee:** Any person engaged in the education (and sports) sector to perform a certain task for the purpose of earning a wage or salary or any other form of remuneration.

**Employer:** A person or body that engages others to perform certain tasks for payment of a wage or salary or any other form of remuneration.

**HIV:** The AIDS virus; a retrovirus of the lentivirus class that produces disease with a greatly delayed onset and protracted course (Kalichman, 1995: 363).

**HIV-positive:** A positive test result for HIV.

**HIV testing:** Taking a medical test to determine a person's HIV status. This may include written or verbal questions inquiring about previous HIV tests; questions related to the assessment of 'risk behaviour', (for example, questions regarding sexual practices, the number of sexual partners or sexual orientation); and any other indirect methods designed to ascertain an employee's or job applicant's HIV status.

**Immune deficiency:** A breakdown in or an inability of certain parts of the immune system to function; increases susceptibility to certain diseases especially TB (Kalichman, 1995: 362).

**Infected employee:** An employee who has tested positive for HIV or who has been diagnosed as having HIV and AIDS.

**Informed consent:** A process of obtaining consent from a patient which ensures that the person fully understands the nature and implications of the test before giving his or her agreement to it.

**Opportunistic infection:** An opportunistic infection is one where the infection occurs while the patient is undergoing some treatment and where that treatment predisposes the patient towards acquiring the infection.

**People Living with HIV and AIDS:** Individuals who are infected with the human immunodeficiency virus (Kalichman, 1995: 367).

**Perception:** The capacity to view and understand which serves as the basis for formulating opinions and judgment on phenomenon or any prevailing state of affairs.

**Pre- and post-test counseling:** A process of counseling which facilitates an understanding of the nature and purpose of the HIV test. It examines what advantages and disadvantages the test holds for the person and the influence the result positive or negative will have on them.

***Prima facie:*** At first glance.

**Reasonable accommodation:** Means any modification or adjustment to a job or to the workplace that is reasonably practicable and will enable a person living with HIV or AIDS to have access to or participate or advance in employment.

**Sex and gender:** There are both biological and social differences between men and women. The term 'sex' refers to biologically determined differences, while the term 'gender' refers to differences in social roles and relations between men and women. Gender roles are learned through socialisation and vary widely within and between cultures. Gender roles are affected by age, class, race, ethnicity and religion, and by the geographical, economic and political environment.

**Social support:** The resources provided by other persons (Cohen & Syme, 1985: 4).



**STDs:** Acronym for 'sexually transmitted diseases'. These are infections passed from one person to another during sexual intercourse, including syphilis, gonorrhoea and HIV.

**Termination of employment:** The dismissal of an employee at the initiative of the employer based on a valid and fair reason that the capacity and conduct of the employee are unsatisfactory. The meaning is attributed in the Termination of Employment Convention, 1982.

**Ubuntu:** An African concept for humanity and altruism.

**Workplace:** Refers to occupational settings, stations and places where workers spend time for employment.

NOTE: The terms 'participant' and 'respondent' will be used interchangeably in this report. However, because participant and respondent do not imply any power position where the researcher plays the role of 'boss' and the interviewee a 'subordinate' role, they will be used most frequently throughout the report.

# **CHAPTER 1: SCIENTIFIC ORIENTATION TO THE STUDY**

## **1.1 INTRODUCTION**

This chapter outlines the core scientific background of why workplace HIV and AIDS-related discrimination persists despite intervention with many HIV and AIDS knowledge programmes and attitude change programs.

The chapter begins with the background to the study and motivation for the research including discussions on HIV and AIDS in the workplace, the impact of HIV and AIDS in South Africa and Uganda; and cultural/traditional beliefs about HIV and AIDS. The problem statement is then given as well as the aims of the research. Next, it considers its paradigm perspectives meta-theoretical statements; applicable theories, operational definitions, research designs, research methodology; plan of literature review; empirical study and results analysis. The chapter concludes with the outline of the discussion chapter and a list of the chapters to be included in this thesis.

## **1.2 BACKGROUND AND MOTIVATION OF THE RESEARCH**

South Africa and Uganda are facing a catastrophic Acquired Immunodeficiency Syndrome (AIDS) epidemic. HIV prevalence in South Africa is measured by actuarial extrapolations of tests carried out in state antenatal clinics on an annual basis. Because of the necessary assumptions required to generate a model representing the entire population, there is room for uncertainty over the exact levels of HIV infection. The most recent release shows that 22% of South African adults are HIV-infected, that is more than 6.2 million people (Department of Health, June 2005). However, UNAIDS (2009) estimated that 5.6 million South Africans were infected with HIV at the end of 2009. In Uganda, there has been some positive change in terms of reduction in infection rate from about 15% in 1991 to about 6% in 2007 (UNAIDS 2008), but the impact of HIV and

AIDS is still great. The Human Sciences Research Council, a South African institution, estimates 10.9% of all South Africans are infected with HIV and AIDS.

The Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV and AIDS) epidemic has become a major challenge for many countries. A report by UNAIDS/WHO (2007:3) estimates that, worldwide, 33.2 million are infected and living with HIV and AIDS. This report claims that HIV and AIDS has been the cause of more than 2.9 million people dying. The report goes on to describe HIV and AIDS as the biggest social, health, developmental and security issue facing the world. Savaser (2003:71) notes that the problem of HIV and AIDS does not respect country, border, culture, race, language, sex or age. However, the degree of severity of the burden of HIV and AIDS is not uniform. Sub-Saharan Africa accounts for the highest numbers of HIV and AIDS infections in the world (UNAIDS 2007:8). According to the World Watch Institute, South Africa's HIV pandemic is perhaps the worst in the globe (cited in Stine 2010:290). Worldwide, ending 2010, heterosexuals made up about 87% of the estimated 36 million people living with HIV-infected people. About 65% of these infected people live in sub-Saharan Africa (see Stine 2010:290; *UNAIDS/WHO 2007updated*). Sub-Saharan Africa remains the most affected region with approximately 67% of people living with HIV (UNAIDS 2008:1). In South Africa, the country most affected by HIV and AIDS, the prevalence rates range from an estimated 16.9% in the Western Cape to 37.5% in KwaZulu-Natal Province (South African Department of Health study, 2009).

Southern Africa remains the world's most affected region, with epidemics that have grown rapidly. There is no single explanation for why the epidemic is so rampant in Southern Africa. A combination of factors, often working in concert, seem to be responsible, including: poverty and social instability that result in family disruption; high levels of other sexually transmitted infections; the low status of women; sexual violence; high mobility, which is largely linked to migratory labour systems; and ineffective

leadership during critical periods in the epidemic's spread (Crush, Frayne & Grant, 2006; Halperim & Epsein 2006).

Discrimination against those infected with HIV and AIDS is rife in the workplace. The general consensus is that teachers in Africa living with AIDS are seriously discriminated against by school principals/managers, teaching colleagues and students (Bennell, Hyde & Swainson, 2002:86). Researchers reveal that the level of denial and secrecy, that is, not wanting to be identified that one carries the virus that causes AIDS is high among teachers in schools. Given the stigma, educators are not prepared to reveal their HIV status.

### **1.3 RELEVANCE OF STUDYING WORKPLACE HIV AND AIDS-RELATED DISCRIMINATION**

With workplace HIV and AIDS-related discrimination rife in many sectors including the education sector, understanding factors which influence workplace HIV and AIDS-related discrimination may help in controlling it, thus helping organisations to cut down their costs, say, for replacement of workers who suffer from reduced morale and stress related to increased workloads originally meant to be shared with colleagues who fall sick frequently due to HIV and AIDS or out attending to others affected by HIV and AIDS. Also, those infected with HIV and AIDS may be more available (or turn up) for duty if workplace HIV and AIDS-related discrimination can be controlled.

Organisations may and will additionally benefit from retaining their trained and experienced employees who are infected or affected by HIV and AIDS, who may perform more competitively compared to those newly hired and who stand in for them.

To be able to control workplace HIV and AIDS-related discrimination one must understand its dynamics, which incidentally are rather complex because the phenomenon has social, economic, political, ethical, legal and psychological implications. Controlling workplace HIV and AIDS-related discrimination can also help to reduce incidences of violent conflict related to workplace discrimination based on HIV

and AIDS status. It's also likely that overt or covert discriminatory behaviour in the workplace may result in litigations which may be costly to organisations economically as in cases of legal settlements and loss of productive time, and in terms of public relations.

Employees experiencing negative psychosocial conditions can devote only a fraction of their mental energy to their work. Though physically present on the job, they succumb to “presenteeism” (Copper & Williams, 1994) as they struggle to cope with the work environment and manage their reactions to stressors. Successfully utilising leaner, higher-performing work forces requires employees who are able to focus on the job at hand with a clear mind and a willing spirit. A healthy psychosocial environment will be required to create and maintain a workforce such as this one. Unfortunately, the education fraternity, which is at the centre of this study, is a highly labour intensive one. Being a direct service, teaching requires highly motivated workers who are also well-trained and experienced. To be effective, there is a limit to the number of learners who can be handled by a teacher at any one time. However, with the historical past of the rather newly independent South Africa, teachers are not well-trained; and the teacher to learner ratio is still high compared to the situation in Western Europe and North America. This has now been worsened by the high prevalence of HIV and AIDS among teachers/ educators, standing at 12% (Shisana, *et al*; 2005). Institutional capacity is further eroded as the South African epidemic is claiming a large number of public educators and civil workers (Peltzer, 2008:103-4).

The situation is just slightly different in Uganda, but comparable. In this study, supervisors' direct influence on employees' well-being is examined by focusing on both parties' perceptions regarding their job status as pertains to a few issues about HIV and AIDS in the workplace. The focus is, however, more on the supervisors because they can be a major influence on employees' work life. Supervisors are an essential link in introducing change to work environment (Bunker & Wijnberg, 1985) and play an

important role in mediating the intersection between individual needs and organisational demands (Walker, Guest, & Turner, 1956). Although they must implement management directives, supervisors must also transmit employees' concerns upward, sometimes defending employees from management actions that would have negative effects on them (Hirszonicz, 1985).

Unfortunately, although supervisors' potential contribution to employees' well-being is substantial, it is often ignored. By being supportive, supervisors can build a psychologically healthy work environment (Jones, Flynn, & Kellsway, 1995). This is essential in the presence of HIV and AIDS.

#### **1.4 IMPACT OF HIV AND AIDS ON THE WORKPLACE**

HIV and AIDS can have a great impact on the workplace. HIV and AIDS increase personnel costs and/or reduce efficiency on the job through increased use of sick and reduced productivity on the job (Lule & Haacker, 2012:252). HIV and AIDS are reported to cause absenteeism as employees attend funerals (Haacker, 2004; Neema & Koster, 2007:37). Another element of the costs arising from the impact of HIV and AIDS on public servants including teachers is costs of increased turnover of government employees. The costs include the costs of administering the exit (due to death or retirement) of employees, advertising and filling a position (including financial costs as well as time of staff for selecting candidates and processing appointments), and productivity losses resulting from new employees (or people moving to a new assignment) who are learning on the job (Rosen *et al*, 2004 in Lule & Haacker (2012:252-253).

The psychological impacts and implications of HIV and AIDS include: loss of morale due to overwork, stress due to fear of contracting HIV and AIDS from infected or suspected HIV and AIDS colleagues (Stine, 2010:405); and strained relationships as workers may not want to associate freely (ibid).

## **1.5 IMPORTANCE OF WORKPLACE HIV AND AIDS POLICY**

A workplace policy provides a framework for action to reduce the spread of HIV and AIDS and manage its impact. It defines an institution's position on HIV and AIDS, and outlines activities for preventing the transmission of the virus and providing care and treatment for staff (and sometimes their dependants). It also ensures that the response is balanced, activities complements each other, and resources are used most effectively. As argued by the ILO (2005), effective policies:

- provide leadership and make an explicit commitment to corporate action;
- ensure consistency with appropriate national laws;
- lay down a standard of behaviour for employees;
- give guidance to supervisors and managers;
- help employees living with HIV and AIDS to understand what support and care they are entitled to receive, so that they are more likely to come forward for voluntary testing; and
- help to stop the spread of the virus through prevention programmes; and assist in planning for HIV and AIDS and managing its impact ultimately saving resources.

Policies also provide a basis for putting in place a comprehensive workplace programme that combines prevention, care and protection of rights (ILO, 2005). The creation and dissemination of workplace policy can, also by itself, begin to raise awareness about HIV and AIDS and, by enshrining the rights of both HIV-positive and HIV-negative employees, help to combat stigma and discrimination.

In June 2010, the ILO passed an international labour standard on HIV and AIDS, (the Standard) in an effort to strengthen implementation of the Code at country level. The Standard was designed to better protect the rights of workers with HIV and AIDS by

guiding member states to eliminate any remaining areas of discrimination against people with HIV. The Standard also updates the Code by:

- Including migrant labourers and sex workers;
- Calling for the provision of HIV treatment, care and support for workers; and
- Calling for the use of dispute resolution mechanisms to resolve cases of employment discrimination (ILO, 2010:10-21).

## **1.6 HIV AND AIDS PREVALENCE IN SOME NEIGHBOURING COUNTRIES**

According to UNAIDS (2010b), the prevalence of HIV among the population aged 15-49 was 24.8 percent, and 320,000 people were living with HIV in Botswana. Twenty-six percent of Swaziland's working-age population is estimated to be HIV positive (UNAIDS, 2010a, 2010b). In both countries, the impact of HIV and AIDS is great, affecting all spheres of life.

## **1.7 HIV AND AIDS EPIDEMIC IN SUB-SAHARAN AFRICA**

An estimated 33.6 million people worldwide were living with HIV and AIDS; and 67 percent (22.4 million) of all people living with HIV are in sub-Saharan Africa (UNAIDS, 2009:21). Three quarters of all women living with HIV (15 years and older) are in sub-Saharan Africa (UNAIDS, 2006:15). The statistics vary depending on the source; and there was an increase in the number of people infected with HIV in all regions, with sub-Saharan Africa's figures rising from 23.5 million people in 2003 to 24.5 million people in 2005 (UNAIDS, 2006:13); the world total for those infected with HIV and living AIDS were 36.2 million people for 2003 and 38.6 million people for 2005 (UNAIDS, 2006:13). By the end of 2010, about 62 million people worldwide were estimated to have been infected with HIV and about 26 million of them had died of AIDS (Stine, 2010:275). Many of them died of opportunistic infections (OIs) such as Tuberculosis (TB) in addition to AIDS (UNAIDS & WHO, 2007:3).



## **1.8 HIV AND AIDS ISSUES IN THE PUBLIC AND PRIVATE SECTORS**

The public sector as well as the private sector have been affected and continue to be affected by the scourge of HIV and AIDS. An Education Labour Relations Council (ELRC) commissioned the Human Sciences Research Council study (cited in Peltzer, 2008:106) measured the impact of HIV and AIDS via a nationally representative sample of 17 088 teachers who gave an oral fluid or blood specimen for testing. Nearly 13% (12.7 percent of the educators) tested positive. African educators were most likely to be HIV-positive (Tisane, 2005). They were also likely to be of low economic status, and more likely to be in rural areas without their families (ibid). HIV prevalence is highest (21%) among 25 to 34 year olds, followed by 35 to 44 year olds (13%). More than a fifth (22%) of HIV-positive group needs immediate anti-retroviral therapy — about 10,000 teachers. And, because of the highest lower prevalence of HIV and AIDS in the 25-29 age range group, there will not be sufficient teachers in the system to provide education for all the learners. This situation is exacerbated in rural areas, where the prevalence is much higher.

About 4,000 teachers died of AIDS in 2004 (ELRC reports in their study). Again, it was noted that the health of teachers is apparently poorer than that of the general population: 10, 6% had been hospitalised in the preceding 12 months, as opposed to the 7% observed generally in the Nelson Mandela/HSRC (Human and Social Research Council) study of HIV and AIDS. The South African Democratic Teachers' Union (SADTU) (cited in *Mail & Guardian*, 2005) says that HIV-related illness will lead to higher absenteeism, and is associated with low morale.

Socially, there will be an increase in female headed households (Bequele, 1999). Stigmatisation and discrimination against people living with HIV and AIDS prevail.

People living with HIV and AIDS (PLWHA) have been stigmatised and discriminated against worldwide since the epidemic began. In South Africa, instances of overt discrimination, including violence, remain common. Indeed, too common to warrant continued reporting in the mass media (Stein, 2003:4). However, while incidences of discrimination have been reported, the factors which drive it in the workplace have not been yet investigated in South Africa and Uganda; and hence, the need for this study.

The stigma associated with HIV has led to disturbing levels of AIDS-related discrimination, which affect the quality of people's lives and impact on people's ability to access care and support (Bharat *et al*; 1998; Castro *et al*; 1998; Herek, 1999; Mukasa Monico *et al*; 2001; Muyinda *et al*; 1997; Ravies *et al*; 1998; Songwathana & Manderson, 2001). However, it is worth noting, as suggested by Deacon, Stephaney and Prosalendis (2005:37) that it is important to avoid defining stigma in terms of discrimination or discrimination solely in terms of stigma because discrimination is not always caused by stigma and is not a good measure of the impact of stigma. They note that stigmatisation may have negative effects, for example increasing expected stigmatisation and discrimination without actually resulting in discrimination. Perceived discrimination may be greater than actual or enacted stigma (Green, 1995). Nonetheless, the stigma associated with HIV and the subsequent fear of abuse or rejection deter many people from testing for HIV and inhibit people diagnosed with HIV from disclosing their status to others (Alubo *et al*; 2002; Kilewo *et al*; 2001; Haman *et al*; 2001; Petrak *et al*; 2001, Pool *et al*; 2001). This ultimately threatens efforts to prevent HIV transmission.

HIV and AIDS impact on companies in a number of ways, and estimating the scale of these is complex (UNAIDS, 2002b). The primary impact is on employee's ability to work effectively as they become ill. This lowers productivity (of the individual and of coworkers) as absenteeism increases. Replacement of workers that die from AIDS involves recruitment and training costs, in addition to lower levels of productivity before

new employees' gain experience. Other considerations within the workplace are the impact of AIDS illness and death on medical, insurance, and pension provision (Nullins, 2002, Rosen *et al*; 2000).

Orr and Patient (2004) say that the stigmatisation of people living with HIV or AIDS (PLWHA) — by others and by the PLWA himself/herself — is an obstacle to dealing effectively with the epidemic. Primarily, it prevents people from accessing resources - getting tested, seeking support from family, friends, the community and colleagues, and medical services - even when such facilities exist.

Jaya and Colaco (1996) say that HIV and AIDS have detrimental effects on society because it brings fear, blame and stigma into families, neighbours and the workplace. It exacerbates longstanding prejudice against stigmatised groups such as prostitutes, homosexuals and intravenous drug users or mainliners. It threatens human rights such as medical confidentiality, rights to privacy and human dignity. HIV and AIDS-related discrimination can also lead to the greatest deprivation of human rights: a denial of the right to life. In 1998, a South African woman who publicly announced that she had HIV was killed by her neighbours in KwaZulu-Natal (McNeil, 1998). In other instances, fear of discrimination has led people diagnosed with HIV to consider, attempt or commit suicide (Demi *et al*; 1998; Heckman, *et al*; 2002; Kwalombota, 2002).

AIDS discrimination takes a wide variety of forms in South Africa. In a country with a past riddled with of institutionalised and brazen forms of discrimination (on the basis of race, gender and sexual orientation), another category can be added: discrimination against people living with HIV and AIDS (PLWHAs) (Richter, 2002).

Discrimination against people believed to be infected with HIV or those believed to be affected by HIV and AIDS is a clear violation of their human rights. The principle of non-

discrimination is central to human rights frameworks and practices. All international human rights instruments and the African Charter prohibit discrimination as is similarly stipulated in the Constitution of the Republic of South Africa of 1996 (UNAIDS, 2003; Constitution of the Republic of South Africa, 1996). The issue of violation of human rights is central to the workplace with regards to HIV and AIDS.

Laws governing the manner in which employers handle HIV and AIDS in the workplace have been enacted in both South Africa and Uganda. In South Africa, the Employment Equity Act (1998) No.55, expressly refers to HIV and AIDS. It prohibits unfair discrimination against an employee on the grounds of HIV status. It also bars medical testing except under special circumstances, and then, on one interpretation, only with the authorisation of the Labour Court. Those circumstances are: when it permitted or required by legislation or it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of the job.

In Uganda, the Education sector policy on HIV and AIDS was developed in 2001 and revised in 2004. This inertia and delay in the development and adoption of the education sector policy on HIV and AIDS was arguably to allow the widest possible consultation among all stakeholders in the country. However, it does also demonstrate a lack of political will on the part of the leadership of Ministry of Education and Sports (MoES) to respond to HIV and AIDS (Kamugisha, 2007:4). The Education and Sports sector policy and guidelines on HIV and AIDS (2004b), is another attempt to address HIV and AIDS in the workplace. Uganda was one of the first countries to experience the rapid spread of infections of HIV and AIDS. The first infections were diagnosed in the early 1980s, but AIDS-like symptoms and high mortality had been observed earlier (Allen & Heald, 2004). The development of HIV and AIDS in South Africa was rather late compared to Uganda. This is likely to influence the way people behave towards those infected with HIV and AIDS in the workplace.

There are laws in fields such as labour, health and safety which impinge on companies; and check for compliance. In the Constitution of South Africa of 1996, the Bill of Rights provides that every person has the right to equality and non-discrimination: Section 9; privacy: Section 14; fair labour practices: Section 23; and access to information: Section 32. As for Uganda, the Constitution of the Republic of Uganda of 1995, Chapter 4, fundamental and other human rights and freedoms: Section 20, equality and freedom from discrimination: Section 21(1),(2) and (3); and, protection of right to life: Section 23(1d). These rights are not absolute and may be limited provided such a limitation is reasonable and justifiable: Section 36 in case of the Constitution of South Africa; and Section 21 (4a), (4b) and (4c) in case of the Constitution of the Republic of Uganda of 1996. These rights should, in turn, be reflected in workplace policies, and they should guide the nature and form of all employment relationships. In particular, the right to privacy implies an employee's right to confidentiality regarding medical information, including information about HIV status.

Litigation is an essential strategy in reducing stigma and discrimination and in fostering the implementation of human rights at national level. The Universal Declaration on Human Rights (Article 8) states, "Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or law" (UNAIDS 2003). Litigation holds governments accountable for action or inaction. When private actors are sued or prosecuted, litigation provides the necessary testing and enforcement of law and public policy. Litigation can also empower the socially disadvantaged, including those groups most vulnerable to infection, and can also influence legal and policy reform.

Litigation has been used extensively to test and advance HIV and AIDS law policy in many countries, and in many different contexts (UNAIDS, 2004). The recent growth of HIV and AIDS litigation in Africa can be attributed to at least two factors: an increase in

the number of violations and an increase in protection. The law is increasingly being used to enforce positive action (UNAIDS2004). It is, therefore, worthwhile to investigate to a certain extent the knowledge of laws pertaining to HIV and AIDS among site managers, heads of departments and educators and how this knowledge interacts with attitudes and traditional beliefs and the relationship they have with workplace HIV and AIDS-related discrimination.

Discrimination is a highly subjective phenomenon and is determined by people's perceptions and preconceived notions — seldom by verifiable and objective facts. This means that a person suspected to be infected with HIV may run the same risk of becoming a target of discrimination or prejudice as someone who has openly declared his/her HIV status (Richter, 2002).

The prevalence of perceptions and preconceived notions which surround HIV and AIDS-related discrimination make it worth investigating why it persists even through attitude change programmes and knowledge related to HIV and AIDS have been provided.

Fear of contracting AIDS in the workplace can be very strong, and this fear can produce false perceptions, confidentiality leaks, workflow interruption and adverse public or employee relations (Oswald, 1996). The ethics of health screening and the issues surrounding confidentiality and stigmatisation make the issue of HIV and AIDS at work far more complicated than that of any other diseases (Welch, 1998).

There is little doubt that HIV and AIDS has generated a lot of anxiety in South Africa (Crewe, 1992). Crewe says that although HIV and AIDS is a new disease, it lays bare and exacerbates social prejudices, economic inequalities, discriminatory practices and political injustices that have been the cornerstones of apartheid. HIV and AIDS confront society with all of its prejudice, stereotypes and discrimination which tend to be ignored,

from homophobia, racism and Puritanism across to political participation and healthcare. In dealing with the epidemic, be it at the workplace, it is imperative to simultaneously address such issues. This is what makes tackling the AIDS epidemic so challenging.

HIV and AIDS concerns in the workplace are compounded by a significant amount of misinformation, fear and prejudice about people with HIV and AIDS. Because HIV is both deadly and transmittable, fear about catching HIV is common (Stodghill *et al*; 1993). They note that despite education and sophistication, AIDS can trigger irrational things in many people. Gatty (1992) observes that generally widespread misunderstandings of HIV and AIDS often lead to irrational attitudes and actions. Williams and Ray (1993) say that a number of people with HIV do not wish their coworkers and employers to know about their HIV status and with good reason. However, people living openly with HIV, as well as greater overall understanding of the virus, have lessened the barriers of stigma, discrimination, denial and shame that hindered action against AIDS during the early days of the epidemic. But as the epidemic reaches further and deeper into societies so does the fear that surrounds it. In many countries and communities, the shame and stigma associated with being HIV-positive have reinforced denial and hindered effective action (Chesney & Smith, 1999; Parker & Aggleton, 2003). Stigma and discrimination undermine prevention efforts and have powerful psychological consequences for people living with HIV (UNAIDS, 2003). These consequences extend to the workplace.

In the workplace, managers, in particular, must be prepared to deal effectively with workers who are infected with HIV or have AIDS (Kohl *et al*; 1997). The authors continue to say that managers need to know how HIV is transmitted, the stages of the disease, how to prevent discrimination against employees who have AIDS or infected with HIV, how to manage the psychological challenges of work groups that have employees infected with HIV or are living with AIDS to prevent workplace disruption,

and how to use employee assistance programmes to provide support and information to the organisation's workforce. Managers should be knowledgeable about discrimination laws in order to handle reactions of coworkers (Scheerhorn, 1995 & Slack, 1995). Eshleman (1994) maintains that managers should institute HIV and AIDS policies addressing discrimination, confidentiality, infection control, and education before the first cases of the disease emerge in the organisation.

How to deal effectively with employees affected by AIDS and HIV (the virus that causes AIDS) has been until recently, a topic discussed to a lesser extent compared to others in workplace management education programmes or by management educators in their classes (Miller, 2000). He continues to say that with the rapidly increasing number of affected workers, it is imperative that managers know how to deal with the challenges of HIV and AIDS in the workplace.

### **1.9 CULTURAL AND TRADITIONAL BELIEFS ABOUT HIV AND AIDS**

As the workplace forms part of society, what prevails in society tends to also prevail in the workplace. Hence, not understanding the role of traditional beliefs in the aetiology of HIV and AIDS may have an impact on how people react to either apparent or real HIV and AIDS in the workplace. Benedicte Ingstad (1990) speculates that HIV and AIDS might be in the category of diseases traditionally believed to be due to sexual transgression – known as *meila* (Setswana for a disease connected with sexual taboos). That is, she argues that it was possible that in Botswana, HIV and AIDS was likely not to be seen as a 'new' disease but an 'old' one. Indeed, it has been interpreted as a manifestation of old Setswana diseases acquiring new virulence because of increasing disrespect for the mores of traditional culture, or because these diseases have 'mixed together', they mutated (Ingstad, 1990). The possibility of alternative understanding of HIV and AIDS has been and continues to be ignored by those involved in HIV and AIDS intervention and education in Botswana.



South Africa and Botswana share common cultural attributes in that both countries share a border and the Setswana language spoken in the North West province of South Africa and Botswana. It is because of these cultural attributes that it becomes important to look at how common beliefs derived from the tradition may be helpful in understanding the prevalence of attitudes toward HIV and AIDS which, among other things, have a bearing on workplace HIV and AIDS-related discrimination. This will give a balanced view when contrasted with Western biomedical knowledge.

According to estimates provided by the World Health Organization (WHO) (2002) approximately 80% of the African population uses traditional medicines, while the Department of Health (2003b) believes that there are over 200000 traditional healers in South Africa. According to MacFarlane, traditional healers are often the first of call for people with HIV and AIDS's treatment. Their popularity may be seen in that 2006, 300000 traditional healers were operating in South Africa and claimed R250 million (ibid). It can be deduced from the above that traditional healing is important to many Africans including South Africans, yet it is rarely incorporated into companies' HIV and AIDS programmes (Dickinson, 2004). The public sector does not fare any better in terms of its awareness programmes on HIV and AIDS.

Despite the widespread use of traditional healing in South Africa, there is considerable skepticism over its value. This stems from a number of sources including Western or biomedical practitioners and some religious perspectives. Despite these tensions it should be noted that many users of traditional healing combine Western medicine with traditional medicine and also feel that there is no conflict between practicing traditional healing and Christianity (Dickinson, 2004). Challenging the scientific effectiveness of traditional healing misses an important point – many people believe in its value and regularly access this form of healing. This is a reality that will not disappear.

The Department of Health (DoH) (2003) estimates that 97% of people living with HIV and AIDS first use traditional or complementary medicine before seeking help from a biomedical doctor. The high percentage of those consulting traditional healers is indicative of a belief in traditional means of therapy. However, it is uncertain whether these people, the users of traditional healers, access alternative medicines of their own accord or on the advice and insistence of others. . It needs to be noted that not all treatments traditional healers offer are effective or without debilitating effects (Dickinson, 2004).

It is common in many traditional African cultures to attribute illness to spirits and supernatural factors (*AIDS - Weekly*, 2001), and these beliefs may be related to stigmatising afflicted persons. Abnormal psychology abounds with examples of projective reactions. Mqotsi (2002) deals with two variants only — namely, witchcraft and sorcery in Xhosa society. Although the Xhosa people do not make any verbal distinction between witchcraft and sorcery, they do differentiate between one who specialises in witchcraft, associated with such familiars as *tokoloshe* (a kind of spirit), baboons, *impundula* (a mystical bird used as a powerful carrier of witchcraft), and *ikhetshi* (the ability to fly at night by means of mysterious cage) on the one hand, and one who uses malevolent medicines and rituals which are socially disapproved, whether used for social or individual purposes, on the other. The former Mqotsi (2002) calls witchcraft and the latter sorcery.

Witchcraft seems to represent an extreme form of projection. The rationale behind witchcraft follows as: 'I hate Person X. I wish to harm him. I therefore harm him. I capture his soul and do the worst possible things with it.' Witchcraft is, therefore, *not actually* practiced. Sorcery is, however, *actually* practiced and consists in a material substance with the malevolent magic power it is supposed to have. As far as the Xhosa people are concerned, the distinction between witchcraft and sorcery is blurred. Mqotsi

(2002) concurs with Schapera (1952); and additionally views this as the case with all Southern Bantu-speaking groups.

On closer examination, it will be seen that witchcraft among the Xhosa nation is supposed to be used for destructive purposes. There is no suggestion that it is ever used for socially approved ends or in any productive way whatsoever. The position among the Juku-speaking people of Nigeria as reported by Meek (1931:301) cited in Mqotsi's (2002) work, is different. Here, witches are regarded as necessary, for they help increase crop yields and assist in the capture of game when they are tired of human flesh - despite these being temporal and antecedents, they are believed.

The Xhosa also believe that *impundulu* suck people's blood and 'kicks' them. Women are believed to be able to keep a snake around their waists and in other private parts. Men are able to keep a snake called *umamlambo* (in order to acquire riches), or baboons to ride on, while on witchcraft campaigns. Witches are able to kill people magically and then exhume them after they have been buried, in order to enslave them, body and soul. Sorcerers can make use of severed body parts, any bodily fluids such as spittle or excreta, hair, nail parings, and even footprints to harm adversaries and foes. Personal effects and belongings, such as clothes may also be objects of sorcery. This is what Frazer (1929) cited in Mqotsi (2002) calls contagious magic. It is believed that whatever is done to your cut hair or nails, which were once part of your body, will have a corresponding effect.

The nature of beliefs in witchcraft and sorcery has to be understood in the context of human situations and in interpersonal relationships fraught with stress, strain and conflict, such as the workplace. The mainsprings of human behaviour are to be found in conflict, and magic is one of the ways in which an attempt is made to resolve the conflict. This is done by means of a process of projection and, in all cases, it is the

individual's will, desire and fear that is being projected on to others. The worker, for example, accuses others of evil intentions, jealousy and hate (Mqotsi, 2002:167).

These beliefs have social and psychological functions. Firstly, they enforce morality in that they regulate human relationships for the good of society as it is constituted. People must not be too stingy; they must show kindness to others, although not too much; they must not go about boasting about their success (Mqotsi, 2002). What would be valuable in this study is to know whether the same functions are still served in the midst of HIV and AIDS, particularly in the workplace situation.

The accusations of witchcraft and sorcery work through a projective mechanism. The emotional stresses set up by conflictive interpersonal relationships in the social and economic fields are relieved by sublimating them so that they appear as a conflict between man and the forces of evil. Krige (1941) cited in Mqotsi (2002) observes: 'witchcraft provides an explanation of the worst evils, such as sickness and death, which befall man; it is the principle of evil, the Bantu Satan'. The psychological function of witchcraft and sorcery beliefs as anxiety-relieving mechanisms should not be underestimated (Mqotsi, 2002). To all magic there is counter magic.

Witchcraft beliefs are not peculiar to Africa. For approximately sixteen centuries, Europe was dominated by demonology, exorcism and expiation. Men of learning did not disclaim the practice of displaying their erudition in expounding theories in justification of prevailing beliefs about witchcraft and sorcery and brutalities related to such beliefs. Those who disclaimed the barbarism were ostracised and their works confiscated and destroyed (Holland, 2004; Mqotsi, 2002). However, beliefs in witchcraft and sorcery appear to have diminished amongst people of European extraction.

The conviction in witchcraft and sorcery among Africans continues to exist in its present form because the conditions that gave rise to it (and still influence it) such as illnesses/

sicknesses have not changed in any fundamental way and are not likely to change for a variety of reasons such as selective conservatism. Also traditions die hard and the dogmas of a culture tend to linger long after the social reality and objective conditions have changed. In some areas of Africa, such as South Africa, it is the expressed policy of those in power to resuscitate tribalism and primeval institutions - even in the midst of 21<sup>st</sup> century scientific and technological development (Mqotsi, 2002).

With respect to HIV and AIDS, 4% of South Africans believe that AIDS is caused by witchcraft and 14% are unsure whether witchcraft is to be blamed (Shisana & Simbayi, 2002) – traditional beliefs are likely more prevalent in rural areas (Bochene, 1996; Bond, 1993; Bond *et al.*; 2002; van Dyk, 2001). In a study conducted in Zambia, Yamba (1997) reported that 25% of the individuals interviewed believe that sexually transmitted infections (STIs) are caused by spirits and witchcraft. The misconception that HIV and AIDS originate from supernatural sources is believed to be the underlying source of AIDS-related stigma in South Africa (van Dyk, 2001). Nonetheless the existing information is inconclusive because of the paucity of the research on the prevalence of the belief in AIDS being caused by witchcraft.

Alternatively, traditional beliefs about HIV and AIDS may merely reflect a more general state of misinformation about the facts of HIV and AIDS and this misinformation may be the source of the stigmatising beliefs. Support for the hypothesis that associations between traditional beliefs about HIV and AIDS and stigmas related to HIV and AIDS are mediated by HIV and AIDS knowledge comes from observed correlations between HIV and AIDS stigmas and HIV and AIDS knowledge (Shisana & Simbayi, 2002). However, as Brown *et al.* (2003) note, even well-informed and well-educated professionals have been shown to harbour HIV and AIDS stigmas. Stine (2007:372) reported a case of one person's physician refusing to treat him because he was HIV-positive; this person's attorney also advised him to find another attorney.

With sputum, spittle and blood found in Xhosa beliefs connected with witchcraft and sorcery and to some of the elements found in Tswana beliefs, it is likely that other socio-cultural groups have similar or related beliefs. Hence, it is worthwhile to investigate how these beliefs relate to workplace HIV and AIDS-related discrimination.

Piot (2002) states that South Africans have to ensure that AIDS is not only being talked about by activists, but also enters the mindset of the health ministers, the rural development workers, the trade unions and employers — Piot (2002) was trying to get mining giant Anglo-American provide HIV treatment to all its employees — not just its managers. There are economic implications for such a move, for example many employees will remain able to work for a longer period and there will be less money spent on recruitment, selection and training.

On the other hand, association implications may include less work due to disruption resulting from coworkers not wanting to work with infected employees, stigmatisation and discrimination. Productivity suffers when employees lose confidence that their work environment is not safe. If they do not understand how HIV is transmitted, coworkers may refuse to use the same car pool, bathrooms, lunchroom, tools, drinking fountain or cubicle used by an HIV-infected coworker (Breuer, 1995). Fear erodes the carefully nurtured teams that managers work hard to build. Anger erupts when misinformed coworkers learn that they do not have the right to know anyone else's medical diagnosis — they feel compromised by a law they do not understand. Coworkers are less willing to perform first aid on an injured employee when they do not know how to manage a bleeding injury safely (Breuer, 1995). On the whole, productivity levels may not be greatly affected in adverse ways if the workforce is knowledgeable.

Several studies of social perception suggest that it is a very complex process (Greenberg & Baron, 1995). Greenberg and Baron reiterate that one thing that is for

certain is that a great deal of the way other people are perceived has to do not only with what those people are actually like, called subject characteristics, but also the characteristics and experiences of people perceiving them, called perceiver variables. With HIV and AIDS taking its toll in the workplace and the closeness of perceptions to attitudes, it is worthwhile to understand why the phenomenon persists in the workplace by investigating the above-mentioned concepts together with HIV and AIDS knowledge and traditional beliefs of site managers, heads of departments and educators.

In a research done in the United States of America, Slack (1998: 123) reports that personal characteristics of the Chief Administrative Officers (CAOs), attitudes toward those people infected with HIV and AIDS in the workplace, the CAOs' knowledge of law and; knowledge of HIV and AIDS have more effect HIV and AIDS plan adoptions than either the size of the workplace and/or the organisation's experience in dealing with HIV and AIDS in the workforce. Implementing HIV and AIDS-related activities also depends more on the beliefs of the manager about HIV and AIDS than on the presence of an HIV and AIDS plan (ibid). As conditions of the United States are very different from those in sub-Saharan Africa, it is worth investigating managers' attitudes those infected by HIV and AIDS, their beliefs and knowledge of the law about HIV and AIDS; and knowledge of HIV and AIDS effects and variations in order to clearly explain the persistence of workplace HIV and AIDS-related discrimination.

This literature review demonstrates that workplace HIV and AIDS-related must be tackled. As plausible factors have to a certain extent been identified, it is now imperative to try to explain how factors like traditional beliefs, attitudes and knowledge of HIV and AIDS interplay to account for the persistence of HIV and AIDS-related discrimination while HIV and AIDS knowledge and attitude change programmes have been in place for some time.

## 1.10 PROBLEM STATEMENT

Burns and Grove (2005:36, 70) define a research problem as an area of concern where there is a gap in knowledge. LoBiondo-Wood AND Haber (2002:520) concur that the problem statement of a study is the foundation of the research. This study was led by a problem statement which guided and directed the exploration of the subject area, especially where there is a gap in knowledge regarding the research topic (Burns & Grove, 2003:70). According to Polit and Beck (2004:85), the problem statement articulates the nature, context and significance of the study problem.

In South Africa, a country with a history of institutionalised and brazen forms of discrimination (on the basis of race, gender and sexual orientation), another category can be added – discrimination against people living with HIV and AIDS, referred to as PLWHAs or PLWAs (Richter, 2002). HIV and AIDS discrimination takes a wide variety of forms in every country where it exists. HIV and AIDS discrimination in South Africa (Richter, 2002) and in Uganda may not be different except in the degree to which it exists; and this has not yet been thoroughly investigated. According to the AIDS Law Project (ALP), a non-governmental organisation that specialises in HIV and AIDS and the law, there have been many different cases of discrimination pertaining to HIV and AIDS. Richter (2002) recorded the following cases of discrimination from 1993 to 2000:

- 77 cases of employer discrimination (rejection, dismissal or demotion of PLWAs)
- 79 testing cases (HIV testing without consent, pre- and post-test counseling or breach in confidentiality)
- 74 other cases (willful transmission, harassment, death certificates, adoption of children)
- 32 insurance cases (insurance policies for PLWAs due to HIV status)
- access to education cases (refusal of access to centres of learning for pupils with HIV and AIDS)



- 8 wills cases (drawing up wills for PLWAs)
- 18 prisons cases (AIDS-related discrimination in prisons)
- 12 medical aid (exclusion of PLWAs from medical aid policies or benefits)
- 11 privacy cases (disclosure of a person's HIV status in a non-medical setting)
- 14 not AIDS-related cases (advice sought without direct bearing on HIV and AIDS such as gay and lesbian issues) (Richter,2002:3).

These figures are for ALP only but it is plausible for the situation to be worse than this, noting that some cases are not reported. The prevalence of HIV and AIDS discrimination, especially workplace HIV and AIDS-related discrimination in Uganda may not be any different although it has not yet quantified or even investigated thoroughly. Alupo (2011:2) says that HIV and AIDS remains one of the major challenges threatening the attainment of international and national goals related to education globally, accounting for 77% of the teacher shortages in countries with high infection. In Uganda, the education sector is experiencing an increase in staff attrition, low morale and stigma and discrimination due to HIV and AIDS related factors (ibid).

The industrial psychological dimension of this problem has manifested itself along with an increase in

- absenteeism due to illness caused by HIV and AIDS or absenteeism due to attendance of funerals of colleagues and/or relatives resulting from HIV and AIDS;
- costly law suits resulting from cases related to HIV and AIDS issues;
- work disruptions where coworkers refuse to work with HIV and AIDS infected colleagues;

- the high replacement cost of workers who become absent due to reasons related to HIV and AIDS due to prolonged medical treatments like attending clinics;
- reduced morale due to added workload shared when colleagues are sick or absent for long periods; and
- the difficulty of getting trained, yet experienced workers who are fit for work.

Thus, understanding the relationship of the interplay of attitudes, knowledge and traditional beliefs about HIV and AIDS – the probable key factors which influence workplace behaviour and more specifically, discrimination relating to HIV and AIDS – will help to explain why the phenomenon persists. In the same vein, it will pave the way to understanding how to reduce the prevalence of workplace HIV and AIDS-related discrimination.

Since 1994, South Africa has enacted a number of laws which impact on the workplace, which include, among others, those about affirmative action and discrimination in the workplace. These have changed the reality in the workplace. The composition of many management teams now has more people from the formerly disadvantaged racial groups – “blacks”, a term referring to African blacks, Indians (people of Indian origin) and coloured (people of mixed race). However, the effects of apartheid (the of old socio-economic-political order), directly or indirectly, would not disappear just because apartheid has gone (Venter, 1997). Affirmative action came with the inherent pedagogical problems between blacks and whites which still prevails such as the evident knowledge gap between the races; and lack of conceptual skills mainly among many blacks. This may have an effect on the acquisition, appreciation and internalisation of HIV and AIDS knowledge with relevance to the workplace. Venter (1997) notes there are disparities the quality and resources within the South African education system which are the origin of the biggest division among the people. The blacks were among the most disadvantaged; they received poor formal education. It is

blacks who form the largest part of the workforce in the education sector. Many live far from their families, which may prompt them to have more than one sexual partner. The situation in Uganda may just vary in terms of degree but not in nature. However, there is a difference in the socio-politico-economic history between South Africa and Uganda.

### **1.11 THE PURPOSE OF THE STUDY**

According to Burns and Grove (2005:36, 71), and LoBiondo-Wood and Haber (2002:60), the research purpose is a concise, clear statement of a specific goal or aim of the study that is generated from the research problem. The purpose usually indicates the type of research (quantitative or qualitative) to be conducted and often includes the variables, population, and setting of the study. In relation to the problem statement, The purpose of this study is to explore how knowledge of HIV and AIDS, attitudes towards those infected and affected by HIV and AIDS; and traditional beliefs about HIV and AIDS influence workplace HIV and AIDS-related discrimination among teachers/educators in Bojanala District in the North West Province in South Africa and Kampala District in Central Uganda.

### **1.12 THE RATIONALE OF THE STUDY**

The rationale of this is underpinned by the persistence of workplace HIV and AIDS-related discrimination among educators/teachers in Bojanala District of North West province in South Africa and in Kampala District in Central Region of Uganda, despite the many HIV and AIDS knowledge campaigns, attitude towards those infected with HIV and affected by AIDS. It is, therefore, worthwhile to explore how factors, such as traditional beliefs about HIV and AIDS, in conjunction with HIV and AIDS knowledge and attitudes towards those infected and affected with HIV and AIDS in relation to workplace HIV and AIDS-related discrimination.

The rationale of the proposed study was that although there was some research on various aspects of HIV and AIDS like increased labour costs resulting from HIV and AIDS-related illnesses and deaths, research on the costs resulting from absenteeism

and medical cost on business, and research on the impact of HIV and AIDS on the municipal authority in the United States of America (Slack, 1998), there is paucity of research pertaining to factors underlying HIV and AIDS in the workplace. Some studies indicate that stigma is linked to the social environment and not the result of people's misconceptions and misinformation about HIV and AIDS (Parker & Aggleton, 2003; UNAIDS, 2002b). Gresak (2001) notes that providing people with knowledge about HIV and AIDS and its transmission has not changed attitudes towards those who are infected and it has not resulted in condom-using behaviour amongst the population being educated. Hence, this study seeks to examine how knowledge, attitudes and traditional beliefs can explain the persistence of workplace HIV and AIDS-related discrimination in South Africa and Uganda's education sector. The study aims to shed some light on the issue of workplace HIV and AIDS-related discrimination in a sector of public service which is labour intensive.

Because of the nature of teaching particularly at primary and secondary school levels as well as the need for teamwork, it is worthwhile to engage in the proposed study because of the high percentage of the infected labour force, especially educators (or teachers), which is estimated at 13% (ELRC study, 2005), and the high mortality rate due to AIDS-related conditions, estimated to be 4000 teachers (ibid). Again, the cost of training teachers, the time it takes to gain experience and the remuneration costs are compelling reasons for engaging in this study. Indeed, teachers' salaries are a big part of the 18% of South Africa's national government expenditure (*The Budget*, 2005). The figures for Uganda were not readily available, but are likely to be comparable in terms of proportionality. This is an added need for engaging in this study.

As Whiteside and Sunter (2002) observe, some private sector firms particularly in KwaZulu-Natal (KZN) –incidentally the worst affected and infected province in South Africa – and Gauteng are beginning to feel the effects of HIV and AIDS manifesting in increased illness and deaths of the workforce. Even closely related studies done in

mines have either focused on HIV and AIDS attitudes or knowledge, separately or together or have been largely of a descriptive nature. Mitchell and Kaufman (2002) found knowledge and attitude to be only slightly correlated with each other — and neither was significantly correlated with behaviour. This disconnection has been reported by other researchers as well (Bryan *et al*, 2000; Canpana 1999). Stine (2007:316) observes that educational programmes in any media have achieved only limited success in changing people's behaviour.

The disjuncture between knowledge and/or attitudes and behaviour remains a puzzle and underscores the challenges both in theory testing and programme development. Young adults do not always act on what they know or feel about HIV and other STDs, suggesting that they perceive that no imminent danger exists or, alternatively, that they are unable to act on what they know or feel (Mitchell & Kaufman, 2002). Hence, there is a need to embark on an exploratory study of workplace HIV and AIDS-related discrimination to gain more confidence in our understanding of the phenomenon's persistence.

### **1.13 RESEARCH QUESTIONS**

To aid in the collection of data, research questions enabled the researcher to understand teachers' knowledge, attitudes, traditional beliefs regarding HIV and AIDS, and workplace-HIV and AIDS-related discrimination. Answer to some research questions were needed in this respect. Burns and Grove (2005:158) posit that a research question is a concise, interrogative statement that is worded in the present tense and includes one or more variables (or concepts). LoBiondo-Wood and Haber (2002:499) define a research question as "a key preliminary step wherein the foundation for a study is developed from the research problem, and results in the research hypothesis". Polit and Hungler (1999:91) state that in a quantitative study, the research questions identify the key variables, the relationships among them and the population under study. De Vos (2001:116) posits that research questions are more relevant if the researcher works qualitatively, and hypotheses when the researcher works

quantitatively. So the researcher working quantitatively will be compelled to transform his/her research questions into testable hypotheses.

Questions that were asked in order to investigate the knowledge, attitudes and traditional beliefs about HIV and AIDS and their relationships with workplace HIV and AIDS-related discrimination among educators were as follows:

Based on the above problem statement, the following research questions need to be addressed:

- How does workplace HIV and AIDS-related discrimination relate to attitudes, knowledge and traditional beliefs among site managers, heads of departments and educators?
- Do individuals engage more in workplace HIV and AIDS-related discriminatory behaviour when they hold more traditional beliefs than when they have more HIV and AIDS knowledge? If so, why?
- Do individuals engage more in workplace HIV and AIDS-related discriminatory behaviour when they hold more traditional beliefs than when they have more positive attitudes toward HIV and AIDS infected/affected individuals? If so, why?
- Do individuals engage more in workplace HIV and AIDS-related discriminatory behaviour when they have more HIV and AIDS knowledge than when they have more positive attitudes toward HIV and AIDS infected/affected individuals? If so, why?

#### **1.14 AIMS/OBJECTIVES OF THE RESEARCH**

According to Burns and Grove (2005:156), research objectives or aims are clear, concise, declarative statements that are expressed in the present tense. For clarity, the objective or aim usually focuses on one or more variables (concepts) and indicates whether the variables are to be identified or described. Objectives/aims can also focus

on identifying relationships or associations among variables, Polit and Hungler (1999:49-50) concur that there are specific accomplishments the researcher hopes to achieve by conducting the study. Objectives are developed from the research problem and purpose, and clarify the variables and population to be studied in quantitative research (Burns & Grove, 2005:156). The words aim(s) and objective(s) were used interchangeably in this study.

The research aims guiding this study were as follows:

#### **1.14.1 General aim**

The general aim of the proposed research was to explore the knowledge, attitudes and traditional beliefs regarding to HIV and AIDS, and workplace HIV and AIDS-related discrimination; and to determine the relationships, if any between knowledge, attitudes and traditional beliefs regarding HIV and AIDS and workplace HIV and AIDS-related discrimination; and to determine the predictive values of key variables.

#### **1.14.2 Specific aims**

With regard to the literature review, the specific aims were to:

- Conceptualise attitudes and to identify the constituents of workplace HIV and AIDS attitudes.
- Conceptualise knowledge and to identify the constituents of HIV and AIDS knowledge – legal and biomedical knowledge.
- Conceptualise traditional beliefs and to identify the constituents of traditional beliefs relating to HIV and AIDS.
- Conceptualise discrimination and to identify constituents of workplace HIV and AIDS-related discrimination.

The specific aims of the empirical study were to:

- Establish whether HIV and AIDS-traditional beliefs relate more to workplace HIV and AIDS-related discrimination than HIV and AIDS-knowledge does and provide explanations therefore.
- Establish whether HIV and AIDS-traditional beliefs relate more to workplace HIV and AIDS-related discrimination than having positive attitudes toward HIV and AIDS infected individuals does and provide explanations therefore.
- Establish whether HIV and AIDS knowledge relates more to workplace HIV and AIDS-related discrimination than having positive attitudes toward HIV and AIDS infected individuals does and provide explanations therefore.

### **1.15 THE PARADIGM PERSPECTIVE**

This research was conducted within the boundaries of industrial psychology as a discipline which is conceptually described as ‘the specific study of human behaviour and psychological conditions in the work-related aspects of life and the application of knowledge towards the minimisation of problems in the work context’ (McCormick & Ilgen, 1981 cited in Pheiffer, 1994).

According to Reber (1985:352), industrial psychology refers to a branch of applied psychology and is the umbrella term covering organisation, economic, and personnel psychology and includes such areas as tests and measurement, study of organisation and organisational behaviours, personnel practices, the effects of work, fatigue and pay on the individual. With reference to the proposed research, organisational behaviours and their effects on HIV and AIDS-related knowledge, attitudes and traditional beliefs of site managers, heads of departments and educators were investigated, and their relationships, individually and in combination, with workplace HIV and AIDS-related discrimination were established, with plausible explanations for the links provided.



The relevant sub-fields of industrial psychology included in the proposed research are organisational psychology and psychometrics.

### **1.15.1 Applicable psychological paradigms**

The literature survey on HIV and AIDS knowledge, attitudes and traditional beliefs of site managers, heads of departments and educators, and the literature on workplace HIV and AIDS-related to discrimination was presented from the humanistic paradigm because it is in consonance with the aims and methodology of the research. Also, the phenomenological approach was to be applied in the qualitative part of the study, as it gives a good ground of understanding the phenomenon by in-depth interview.

The three perspectives that were applied in the study are the humanistic paradigm, positivism and phenomenology. These paradigms were the ones in which the literature survey for discrimination and the survey of HIV and AIDS-related knowledge, attitudes and traditional beliefs was presented. Hence, they were in agreement with the way data were to be analysed and interpreted against.

#### *1.15.1.1 The humanistic paradigm*

This research has a strong bearing on individual behaviour and more specifically on the behaviour of employees (site managers, heads of departments and educators) within the organisational context. Knowledge, attitudes and traditional beliefs relating to HIV and AIDS – the independent variables in the empirical study – relate to human relations in the work environment and are to be investigated in the humanistic frame of reference. The basic assumption of the humanistic paradigm is the responsible human being who is able to choose freely from the possibilities available to him. It emphasises man in the making, that is, a person in the process of growing and striving to realise his/her potential' (Meyer, Moore & Viljoen, 1990:321-322). Maslow and Rogers exemplified the humanistic approach (Pettijohn, 1991). This approach is sometimes referred to as the 'third force' in psychology, because it is presented as an alternative to psychoanalytic and behaviouristic theories.

According to Quitman (1985: 16-17) the human paradigm relates to:

- Humans being more than the sum of their parts.
- Human beings are unique and have awareness of being.
- Humans have rights.

Underlying humanistic thinking is the need for actualisation of potential. Humans who have and make decisions based on choice can actively change their lives and situations. Motivation is conscious in humans; they search for meaning and are capable of taking responsibility (Quitman, 1985:16-17).

The humanistic paradigm features in this study because exploring and understanding effective being and relating behaviour pertaining to HIV and AIDS-related discrimination is necessary, particularly as it can assist in reducing problems emanating from the gap existing between the interaction of knowledge, attitudes and traditional beliefs, thus making the workplace more favourable to HIV and AIDS-infected employees in the public sector, particularly the education sector.

Humanism proposes that every individual is a free person, with a free will, conscious and creative and born with an inner motivation to fulfill his/her potential (Meyer, Moore & Viljoen, 1988). It is accepted that an individual has a natural tendency to take control of his/her life and to overcome environmental limitations preventing him/her from achieving his/her full potential (Meyer *et al*; 1988). According to Meyer *et al*; (1988), the basic suppositions of the humanistic approach include the tenets that:

- Every individual functions as an integrated whole and should be studied in his/her 'gestalt'.
- Recognition should be given to higher spiritual processes, for example, growth and actualisation.

- The nature of a person is basically good and positive.
- The conscious processes of individuals, specifically with regard to decision making, play an important role.
- The individual is regarded as an active being who participates in determining his/her own behaviour and who has an inherent disposition towards actualisation of potential and creative abilities.
- Psychological wellness serves as a criterion against which functioning is measured.

According to Gall (1996, p. 134) humanistic psychologists 'attempt to help people to develop to their fullest potential. They tend to focus on the "here and now" rather than looking for insights of the past. They seek to understand the individual whether exceptional or conventional. They generally reflect an influence of the Gestalt movement'.

Humanism as a paradigm asserts the overall dignity and worth of human beings and their capacity for self-actualisation. Humanistic theorists oppose what they see as pessimism and despair of the psychoanalytic perspective and the 'robot' conception of human beings offered by behaviourism. Such theorists believe that we contain within ourselves the potential for healthy and creative growth and that if we are willing to accept responsibility for our own lives, we will realise this potential, overcoming the sometimes constricting influences of parental training, education, and other social pressures.

In short, humanism stands for respect for the growth of persons, respect for differences of approach, open-mindedness to acceptable methods, and interest in exploration of new aspects of human behaviour. It is concerned with topics having little space in

existing theories and systems, for instance love, creativity, self, growth, organism, basic need-gratification, self-actualisation, higher values, being, becoming, spontaneity, play, humour, affection, naturalness, warmth, ego-transcendence, objectivity, autonomy, responsibility, meaning, fair play, transcendental experience, peak experiences, courage and related concepts (Maslow, 1964:70-71).

In this study, discrimination related to HIV and AIDS in the workplace is deemed to fall within the category of the aforementioned concepts. However, it should be borne in mind that Maslow (1966, 1971) observes that people (including notable scientists and theorists) do not exclusively rely on systematic, rational thinking. They also call upon more intuitive, empathic and emotional ways of knowing.

#### *1.15.1.2 The positivism paradigm*

##### *a Definition*

According to Birger and Jeppe (2007:1), positivism refers to a broad attitude about science and philosophy that in particular is ascribed to Auguste Comte (1798-1857) and to 20<sup>th</sup> century logical positivism (that dominated about 1920-1960). Comte's positivist claims were:

- That science is the highest form of knowledge and philosophy therefore must be scientific.
- That there is one scientific method common to all science.
- Metaphysical claims are pseudoscientific.

##### *b Positivist view of the objective world*

One of the fundamental questions in philosophy is about the nature of the world. That is known as ontology or the nature of reality (Polit & Hungler, 199:10). There are three areas of research, namely: the objective world, the socially constructed world and the individually constructed world (Mouton, 2006:140).

Realists take the view that there is a real objective “world”, which exists independently of human belief, perception, culture and language we use to describe it” (Hart, 1998:85). This world is observable; and research can be used to verify using measure, the existence of something. This thinking developed from the 19<sup>th</sup> century philosophical position known as positivism that later became known as logical positivism (Popper, 1959).

Quantitative research traditionally takes a positive approach. Positivism has its roots in research in the natural sciences – physics, chemistry and biology - and is seen to be objective. It takes the position that scientific knowledge is a direct reflection of a real world. One of the ways of researching the objective world through gathering quantitative data is through a survey, using a fixed response format to generate knowledge. This type of objective knowledge is seen to be applicable to the whole population.

That is why the participants in the quantitative part of this study were so carefully sampled. The sample has to be representative of the population under study. This type of positivist research is designed to find out truth a real world.

*c Positivism as it applies to the research purpose*

The purpose of research will be different depending on the philosophical perspective from which the researcher asks the questions. If the researcher comes from the positivistic tradition, he or she will adopt a descriptive, correlational (explanatory), explorative and predictive study; usually including variable, population and setting for the study (Burns & Grove, 2005:36; Polit & Hungler, 1999:17).

In positivist research, the researcher begins with a phenomenon that has been previously studied or defined (Polit & Hungler, 1999:16). Thus in positivist research, identification usually precedes the inquiry; and description involves the prevalence, size, incidence and measurable attributes of the phenomenon. In this research, purpose was

to explore how knowledge, attitudes and traditional beliefs about HIV and AIDS associate with workplace HIV and AIDS-related discrimination among educators in Bojanala District of North West Province in South Africa and in Kampala District of Central Region of Uganda. The goal of explanatory research is to understand the underpinnings of specific natural phenomena and to explain systematic relationships among phenomena (Polit & Hungler, 1998:18). In positivist research, theories are used deductively as the basis for generating explanations that are then tested empirically. That is, based on some previous developed theory or body of evidence, the researcher makes specific explanations. In this study, various correlational relationships were sought, using principally, TPB, SCT and Maslow's hierarchy of needs theory.

*d Positivism as it applies to the research design*

Shepard *et al* (1993:92), say that the selection of the research design follows naturally from the philosophical perspective and the stated purpose of the study. With positivistic traditions, the choice of design is likely to be experimental, quasi-experimental, descriptive or a survey; and these designs are built around a *priori* hypotheses that can be confirmed or rejected. The data are usually numerical (quantitative) or categorical; and data analysis is directed towards testing, verifying or predicting identifiable human behaviours or physical phenomena. The quantitative part of this study is built on a quantitative, positivist non-experimental design to investigate the HIV and AIDS-related knowledge, attitudes and traditional beliefs; and workplace HIV and AIDS-related discrimination among educators in Bojanala District in North West Province in South Africa and educators in Kampala District of Central Region in Uganda.

*e Positivism as it relates to research method*

Measurement is the process of assigning "numbers" to objects (or events or situations) in accord with some rules (Burns & Grove, 2005:41). In a positivist method, a component of measurement is instrumentation, which is application of specific rules to the development of a measurement instrument or device.

*f Positivism as it applies to reliability and validity*

The issue of reliability and validity – internal validity and external validity are very crucial the positivist approach (Shepard *et al*; 1993:93). Reliability is based on the assumption that there is a single reality and, if this reality is studied repeatedly, the same results will appear (Merriam, 1988:70). For example, to ensure reliability of the measurement, operational definitions (what to do and what to look for) are established by the researcher and used as prescribed guidelines for researcher and subject(s) behaviours (Merriam, 1988; Michels, 1982:832). Issues pertaining to reliability and internal validity were dealt with in chapter 6 for each instrument that was used in this study, refer to it for details.

#### *g Positivism as regards to research data*

The data gathered and analysed from positivistic perspective are typically quantitative. It can be numerical data or nominal data in the form of single words or phrases, which are then quantified (Shepard *et al*; 1993:94).

As there are many different types of analyses to choose from, the challenge for the researcher is to choose a form of analysis that is most appropriate for both the type of data collected (nominal, ordinal, interval, ratio) and the projected relationships among the data as determined by a priori hypotheses. The outcomes of this data analysis are reported as numerical significance or lack of significance (Shepard *et al*; 1993:94). If the hypotheses are stated, they are accepted as being true or they are not accepted. If the purpose of the research is descriptive, the findings are conveyed by descriptive and correlational statistics (Burns & Grove, 2005). In this study, data collection and analysis see data collection (section ..... ) and data processing (section.....) for qualitative part of the research.

#### *h Positivism as it relates to theory in research*

In positivism, theory appears at the entrance and exists of all quantitative processes. It is what guides all research endeavours. In the positivist tradition, theory is what guides the establishment of priori hypotheses and establishes the conditions under which the hypotheses will be tested (Tammivaara & Shepard, 1990:580).

*i Main features of the positivist paradigm*

According to Broom and Willis (2007:22), positivism has five main features:

*(i) Determinism*

Determinism is the belief that phenomena are not haphazard or random, but rather have antecedent causes; an assumption in the positivist paradigm (Burns & Grove, 2005:127; Polit & Hungler, 1999:10, 700). The roots of the notion of determinism surely lie in a very common philosophical idea, the idea that everything can, in principle, be explained, or that everything that is, has a sufficient reason for being and being as it is, and not otherwise (Polit & Hungler, 1999:10).

Thus, determinism opposes the doctrine of free will – that all man’s volitions are invariably determined by pre-existing circumstances. This has implications for this study in that educators’ HIV and AIDS-related discriminatory behaviours are determined by pre-existing natural laws and not their traditional beliefs, or attitudes about HIV and AIDS. This type of argument could lead in the humanities to fallacies such as that “knowledge” would automatically lead to appropriate actions and behaviours. Positivism, therefore, in the present day format, relates to probability rather than to determinism. The notion of determinism, however, still applies to quantitative research, especially in the natural sciences.

*(ii) Objectivity*

Objectivity refers to the degree to which two independent researchers can arrive at “score” or make similar observations regarding the concepts of interest, that is, make judgments regarding respondents’ attributes or behaviours that are not biased by personal feelings or beliefs (Babbie, 2005:40; Bless & Higson-Smith, 2000:4; De Vos, 2001:350). Objectivity also refers to the proper distance between the researcher and the



respondents that minimises bias and is achieved through such procedures as instrumentation and randomisation. Objectivity is considered a desirable attribute within the positivist paradigm (De Vos, 2001:350; Polit & Hungler, 1999:311). In this study, objectivity was maintained by the fact that the researcher maintained neutrality in the process of sampling and data collection.

*(iii) Probability*

In quantitative positivist research, the researcher can never prove scientific hypothesis but can show support for it by rejecting the null hypothesis, i.e. by showing that the null hypothesis has a high probability of being incorrect. The probability of an event is the event's long-run relative frequency in repeated trials under similar conditions (Burns & Grove, 2005:127; LoBiondo-Wood & Haber, 2002:350). LoBiondo-Wood and Haber (2002:127) stress that it is the notion of repeated trials that allows researchers to use probability to test hypotheses

*(iv) Reliability*

Reliability is the consistency, constancy, or dependability, accuracy and precision with which an instrument measures the target attributes (Burns & Grove, 2005:374; LoBiondo-Wood). This means that administering the same instrument by various researchers will provide the same results under comparable conditions (De Vos, Strydom, Fouche & Delport, 2005:163).

*(v) Quantification*

Data that will be subjected to statistical analysis must be gathered in such a way that they can be quantified. For statistical analysis in a positivist paradigm, all variables must be quantitatively measured (Polit & Hungler, 1999:311). For this research, quantitative data regarding educators' knowledge, attitudes, traditional beliefs regarding HIV and AIDS; and workplace HIV and AIDS-related discrimination were collected through the use of a self-designed questionnaire with some items drawn from existing

questionnaires; and data was analysed statistically, in order to test the hypotheses generated for the study.

*(vi) Generalisability*

Generalisability refers to the degree to which the research procedures justify the inference that the findings represent something beyond the specific observations on which they are based; in particular, the inference that the research findings can be generalised from the sample to the entire population (Burns & Grove:2005:342, 737; LoBiondo-Wood & Haber, 2002:372, 493; Polit & Hungler, 1999:13, 703). In this study, a random probability sampling technique was used to select the sample. This enabled the results of this study to be generalised to the target population of educators in Bojanala District in North West Province of South Africa and Kampala District of Central Region of Uganda.

## **1.16 PARADIGM FOR QUALITATIVE PART OF THE STUDY**

### **1.16.1 Phenomenology**

In order to meet the aims and answer the questions of part of this study, a qualitative research design using hermeneutical phenomenology which studies interpretive structure of experience was used. Qualitative research examines life experiences (i.e. lived experience in an effort to understand and give them meaning (Byre, 2001). This usually is done by systematically collecting and analysing narrative materials using methods that ensure credibility of both data and results. Phenomenology is one of the many types of qualitative research that examines and describes the lived experiences of humans.

Phenomenology offers one to understand unique individuals and their meanings, interactions with others and the environment (Lopez & Willis, 2004). According to Cohen and Manion (1987:151) phenomenology is 'a theoretical point of view that advocates the study of direct experience taken at face value and one which sees behaviour as determined by the phenomena of experience rather than the external, objective and physically described reality'.

The phenomenological school of thought is regarded to have been launched by Franz Brentano (1838 -1917) and developed by the German philosopher Edward Husserl at the beginning of the 20<sup>th</sup> century to investigate conscious as experienced by the subjects. According to him, the researcher is interested in how respondents give meaning to their experience, in other words, how they perceive their world. The phenomenologist investigates subjective phenomena in the belief that essential truths about reality are grounded in people's lived experiences (Burns & Grove, 2005:55; Polit & Hungler, 1999). A phenomenological study often involves four steps which are bracketing, intuiting, analysing and describing (Polit & Beck, 2004:253; Polit & Hungler, 1999).

Phenomenology affords a researcher a new way to interpret the nature of consciousness and of an individual's involvement in the world. Based on the research purposes, the approach also focused on individual's interpretation of their experiences and on the way in which they expressed them.

Phenomenological studies involve a small number of study participants (Burns & Grove, 2005:358). Although numbers have a less prominent place in qualitative research, they are integral to qualitative data. According to Sandelowski (2001), as in quantitative research, numbers e.g. in the form of demographic, epidemiologic and survey data are used in qualitative research to establish the significance of a research problem, to

document what is known about a problem, and to describe a sample. In this part of the study, therefore, a non-probability sample was used because it was appropriate for qualitative research since the purpose was to contribute to an understanding of and therefore this sample provided the best required data.

Unlike the positivist, the phenomenologist does not consider the world to be objective but instead focuses on the primacy of subjective consciousness. Each situation is seen as totally unique and its meaning is a function of the circumstances and individuals involved. To the phenomenologist, the researcher is not independent of what is being researched but is an intrinsic part of it. The world is not essentially deterministic, but rather stochastic and parsimony is not a central issue.

The phenomenologist believes the world can be modeled, but not necessarily in a mathematical sense. A verbal or diagrammatic or descriptive model could be acceptable (Remenyi, 1996). To use a phenomenological approach the researcher has to look beyond the details of the situation to understand the essences working behind them. The researcher constructs a meaning in terms of the situation being studied (Remenyi, 1996). Furthermore, the phenomenologist understands that the world is not composed of a single objective reality, but rather is composed of a series of multiple realities, all of which should be understood and taken into account. Each reality is an artifact in its own right. According to Remenyi (1996), it is generally of little interest to the phenomenologist that his or her work will not lead to law-like generalisations in the same sense as that of the positivist. Thus, for the phenomenologist the world is socially constructed.

#### *1.16.1.2 Philosophical basis relevant to the qualitative part of the study*

On embarking on the qualitative approach as the complementary approach in this study, the researcher borrowed from Guba's (1990) embraced views which have implication of the relativistic position. Guba (1990) is an individual who has espoused many positions

common to post-modernists, such as that reality exists only in the mind and objective methods are not available. According to Guba (1990:27), 'realities exist in the form of multiple mental constructions, socially and experientially based, local and specific, dependent for their form and content, on the person who hold them' (*emphasis on multiple realities is his*). Note that in this statement Guba is denying that there is a single reality that exists independently of the individual. According to Guba, the origin of these constructed multiple realities is in the social interactions that occur between and among people. Guba (1990:26) also says,

*'Ontologically, if there are always many interpretations that can be made in any inquiry, and if there is no foundational process by which the ultimate truth or falsity of these several constructions can be determined, there is no alternative but to take a position of relativism....Realities are multiple, and they exist in people's minds'*(Guba, 1990:26).

By denying that there is any foundational process for discovering what Guba calls ultimate truth, he is denying that there is, or can be any methodology that is any better than any other for addressing nature.

#### *1.16.1.2 'Epistemologically' Guba (1990:26) says:*

*'The constructivist chooses to take a subjectivist position. Subjectivity is not only forced on us by human condition...but because it is the only means of unlocking the constructions held by individuals. If realities exist only in respondents' minds, subjective interaction seems to be the only way to access them'*.

By a subjectivist position, Guba is denying that there is any hope for isolating objective procedures that are useful in making informed decisions about independent reality. If reality exists only in respondents' minds, as Guba asserts, then it follows that there is no external reality that can be known.

Guba (1990:25), much like Shife and Williams (1995), also says that no theory can ever be fully tested because of the problem of induction. Observing one million white swans does not provide indisputable evidence for the assertion: 'All swans are white'. There are always a large number of theories that can, in principle, 'explain' a given body of 'facts'. Thus no unequivocal explanation is ever possible.

#### **1.16.2 Social constructionism**

Within psychology, a prominent variety of post-modernism goes under the name of *social constructionism*. Kenneth Gergen (1985) characterises social constructionism as a view that is concerned with *realities* that are created as a result of social interactions among individuals. Similarly, Barnes and Bloor (1982) have stated that for the relativist there is no sense attached to the idea that some 'standards' and 'beliefs' are really rational or as distinct as such, in so far as truth is concerned, it is general agreement among people that counts, rather than the correspondence of a statement with reality

### **1.17 ADDRESSING VALIDITY AND RELIABILITY OF QUALITATIVE RESEARCH**

Validity in qualitative research is an important requirement as the case is in quantitative research. The key features of qualitative research are dealt with in the proceeding sections.

#### **1.17.1 Trustworthiness**

Trustworthiness refers to credibility and validity of qualitative research. In a qualitative study, the main goal is not to generalise the results but to accurately represent participants' experiences and perceptions coming from their rich descriptions in the truthful manner (Burns & Grove, 2005). According to Polit and Hungler (1999), many qualitative researchers ensure validity and reliability by evaluating the quality of their

data and findings. In this study, issues of validity and reliability in the individual in-depth interviews were considered important by the researcher. This is called trustworthiness and it was established using the four criteria, namely: credibility, transferability, dependability and conformability. The following section will explain detail how trustworthiness was ensured in this study.

### **1.17.2 Credibility**

Credibility ensures that research findings are in accordance with the reality of participants, i.e. how true the findings of a study are within the context in which it was done (Polit & Beck, 2004). In this research, steps have been taken to improve and evaluate the credibility of the data obtained, i.e. has been presented have been presented to gain confidence in the truth of the data. This was done through peer review where interpretations of the data were discussed with experts in the field of psychology at work and discussions were done with the research supervisor at UNISA. The data were reviewed and comments regarding the plausibility of emerging findings were sought. Credibility of qualitative data and the resulting findings is the aspect of data quality (Malata, 2004; Polit & Hungler, 1999).

### **1.17.3 Prolonged engagement and experience**

This refers to investment of sufficient time in data collection activities in order to have an in-depth understanding of the views or phenomenon of the individual or group under study. The researcher's training and experience were very important in establishing confidence in the data that was obtained. Adequate time was set aside to spend time with the participants during data collection to build a trusting relationship. Conversations which were in-depth were only those that were relevant to the phenomenon being studied. No research assistant was engaged in the study to ensure that there was no variation depending on difference of interviewers. This enhanced of data.

### **1.17.4 Peer debriefing**

In qualitative research, peer debriefing refers to discussion of the researcher's interpretation and conclusions with another person not directly involved (Burns & Grove,

2005). In his study, the interview guide was reviewed by experts who have experience of the phenomenon being studied, namely workplace HIV and AIDS-related discrimination. These experts reviewed and explored various aspects of the inquiry. The experts critically looked at the relevance of the questions and assessed the degree to which the study variables adequately represented the phenomenon being studied.

#### **1.17.5 Member checks**

Member checking is also one of the most important techniques for establishing the credibility of qualitative data. It entails providing feedback to the study participants regarding the data and the researcher's emerging findings and interpretations in order to secure participants' reaction (Polit & Hungler, 1999). In this research, in order to be sure that participants' reality had been presented, the researcher continually asked participants for clarification on what they had said. By doing this participants were provided with an opportunity to change information which was given by mistake and the same time assessed the researcher's understanding and interpretation of the data. At the end of the interview, the participants were given a summary of what they had said and an interpretation of the interview to check on the researcher's accuracy and understanding of the information.

#### **1.17.6 Transferability**

Transferability refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings (Burns & Grove, 2005). The researcher had a responsibility to provide adequate descriptive data in the research report in order for people to evaluate the applicability of the data to other settings or groups. When transferability is considered, participants should be representative (Polit & Beck, 2004). In this study, purposive sampling was used so that participants were suitable and representative of the group under study. The researcher has therefore made available thick description of data to people who might need it in order to permit judgments about contextual similarity.



### **1.17.7 Dependability**

The dependability of qualitative data will always tell the stability of data over time and over conditions. There can be no credibility in the absence of dependability (Morse, 2004; Polit & Hungler, 1999). Dependability determines whether findings would be consistent if the inquiry were to be replicated with the same participants in a similar context (Polit & Beck, 2004). In this study, the findings of the research were checked by external checks in order to be dependable.

### **1.17.8 Confirmability**

The confirmability refers to the degree to which the results could be confirmed or corroborated by others (Polit & Beck, 2004). In qualitative research, the issue of confirmability does not focus on characteristics of the researcher but rather on characteristics of the data. Inquiry audits can be used to establish both dependability and confirmability of the data. In this study, reflexivity assisted the researcher to be free of bias in processing the data. This was done by making sure that information was briefly handwritten in order not to distract the interviewee and sooner after the interview, the whole information was written down in full so that no details were lost. Data was transcribed and therefore minimised researcher bias and it ensured that data can be confirmed. In qualitative research, objectivity or neutrality of the data which brings an agreement between two or more people about the data's relevance or meaning is necessary (Polit & Hungler, 1999; Sandelowski, 2001).

## **1.18 PILOT STUDY**

Pre-testing of the interview guide was done prior to the actual study to determine if the instrument would bring out the desired information, how long the instrument would take to administer and to identify difficulties or ambiguous questions. Pre-testing also determined relevance and appropriateness of the tool.

According to Polit and Beck (2004:51), a pre-test of an instrument is a trial run to determine, insofar as possible, its clarity, research adequacy and freedom from bias.

This pilot therefore, assisted to clarify questions which would possibly be misinterpreted during the actual study. Questions which were not very clear were modified and rephrased.

### **1.19 RECRUITMENT OF STUDY PARTICIPANTS**

Recruitment of study participants was described in the part on quantitative study (see section 1.23.2 of this thesis).

### **1.20 ETHICS AND HUMAN RIGHTS ISSUES**

When humans are used as study participants, care must be exercised in ensuring that the rights of those humans are protected (Polit & Beck, 2004:141). Permission was sought from the Superintendent General of the Education Department in North West Province and it was granted). Consent was also obtained from the schools in which the participants worked.

Human beings need to be treated as autonomous agents who have freedom to conduct their lives as they choose without external control (Burns & Grove, 2005; Polit & Beck, 2004:147). Participants signed the individual consent forms after being given adequate information about the nature and purpose of study, methodology, possible benefits and risks associated with participation in the study (see section 1.26.2 of this thesis).

Virtually all research with humans involves intruding into personal lives (Polit & Beck, 2004:149). Researchers should ensure that their research is not more intrusive than it needs to be and that participants' privacy is maintained throughout the study. In this research therefore, all interviews were conducted in private; and no data were linked to any participant.

There were no known risks or harm to people who participated in this study. According to Polit and Beck (2002:144), psychological consequences of participating in a study are usually subtle and thus required no close attention and sensitivity.

At this point it would be worthwhile to briefly look at the rationale of using a combination of the qualitative methods and a quantitative one in this study. For brevity, a comparison of quantitative methods with qualitative methods will suffice to highlight the suitability of combining the two methods in this study. Overall, the two methods are viewed as being complementary rather than competitive.

## **1.21 RATIONALE FOR USING A TRIANGULATED RESEARCH DESIGN**

### **1.21.1 Triangulation**

The term 'triangulation' was originally used by land surveyors to describe a particular position in relation to two other positions (co-ordinates). But triangulation has come to refer more generally to the use of multiple perspectives against which to check one's own position. This process may be applied both to a single case or many across cases (Kelly, 2006:380).

Denzin (1970) cited in Kelly (2006:380) identifies four types of triangulation:

#### *1.21.1.1 Data triangulation*

This refers to the use of a variety of data sources in a study. It is important to be circumspect about particular kinds of data, such as the following: data that are vivid and have been given emphasis in an account because they are all that was remembered, but are not necessarily the whole story; personal experience which has filtered out important features of the context, and is presented in a compelling way purely because it is currently relevant in the person's life, 'data' which are presented in an already-reflected-on and thematised way, leading us to interpret the situations as more patterned than they really are, and data from particular informants whose accounts can seem more compelling, charming, or illuminating than the data gathered from others.

#### *1.21.1.2 Investigator triangulation*

This refers to the use of several different researchers or evaluators, which is useful in drawing attention to previously unnoticed researcher effects (i.e. the effects of the researcher on the research context).

#### *1.21.1.3 Theory triangulation*

This refers to the use of multiple perspectives to interpret a single set of data, and this also means finding that the research findings can be incorporated into a more macro-analytical level of inference.

#### *1.21.1.4 Methodological triangulation*

This refers to the use of multiple methods to study a single problem, looking for convergent evidence from different sources, such as interviewing, participant observation, surveying, and a review of documentary resources.

Following (Janesick, 1994), a fifth type of triangulation, the *interdisciplinary triangulation* is added. By using the findings of other disciplines, one can triangulate to check out the effects of the disciplinary perspective that one has adopted – for example, one might compare the findings of medical sociologists, epidemiologists, and health psychologists an socio-cultural factors affecting HIV transmission (Kelly, 2006:380).

Triangulation can be used to gain more confidence in the researcher's conclusions (2006a:287).

In this study, methodological triangulation, data triangulation and theory triangulation was used to determine the relationships between HIV and AIDS knowledge, attitudes towards those infected with HIV or affected by AIDS, traditional beliefs about HIV and AIDS; and workplace HIV and AIDS-related discrimination among educators in Bojanala

District of North West Province in South Africa and teachers in Kampala District in Central Region of Uganda.

Camic *et al* (2003a) provide their impression of psychology's attitudes towards qualitative methods and how their world view differs from that embodied in academic psychology and quantitative methods:

- 'As a profession, psychology has generally decided that numbers are more real than words and responses on paper-and-pencil are more real (and valid) than interviews' conversation and other complex forms of representation' (2003a: 4-5).
- 'Research that exist[s] outside of positivism and the experimental methods are looked on as inferior and are not taken as seriously by journal editors, funding sources, doctoral dissertation committees, or faculty in psychology departments'(2003a:5).

"Objectivity as taught in many psychology textbooks and classrooms, is a myth" (Camic *et al*; p. 6). Camic *et al* (2003a) also indicate that, in their view, qualitative methods have several advantages, which include:

- The ability to supply a "holistic analysis of complex, dynamic, and exceptional phenomena" (p. 9).
- Usefulness "as a tool for exploring a topic or problem that has not been previously researched" (p. 8).
- Seeking "to maximise economic validity of the data by gathering it in real-world contexts" (p.8).

According to Eisner (2003), qualitative research is differentiated from what is commonly referred [to] as quantitative research by its form of disclosure.

“Qualitative research uses language and image to capture, describe, and interpret what is studied. The language it uses operates on a continuum extending from literal to literary, from factual to evocative” (p. 24).

Following below is the summary of the advantages of the qualitative and quantitative methods.

**Table1.1: Summary of the advantages of the qualitative and quantitative methods**

<b>Qualitative methods</b>	<b>Quantitative methods</b>
Human science perspective	natural science perspective
Multiple realities, socially constructed and context dependent	one true measurable reality.
Inductive methods	deductive methods
Theory generating	theory driven
Phenomenology idealism and constructivism	positivism
Seeking meaning	understanding laws and causes.
Understanding	prediction.
Hypothesis generating	hypothesis testing.
Involved and interactive researcher	objective and detached researcher.
In-depth interviews and participant observation	experimental designs

Description	quantification.
-------------	-----------------

Source: McGrath& Johnson, 2003.

Eisner (2003) further notes “Whereas qualitative research has ecological validity (i.e. applies to real world contexts), quantitative research does not (cannot be generalised to the real world)”.

Furthermore, as Marecek (2003:49) notes, qualitative research has the following advantages: “Firstly, qualitative inquiry embeds the study of psychology in rich contexts of history, society, and culture. Secondly, it resituates the people whom we study in their life worlds, paying special attention to the social locations they occupy. Thirdly, it regards those whom we study as reflexive, meaning-making, and intentional actors”.

## **1.22 THEORY TO GUIDE THE STUDY**

After an intensive perusal of the existing theories in the field of psychology, the Social Cognitive Theory (SCT) of Bandura (1977), the Theory of Reasoned Action (TRA) of Ajzen and Fishbein (1972), the Theory of Planned Behaviour (TPB) of Ajzen and Fishbein (1980) and Maslow’s theory of hierarchical needs came to be the most appropriate in guiding this study of understanding why workplace HIV and AIDS-related discrimination persists despite the extensive work already done in providing HIV and AIDS-knowledge, enacting discrimination laws and intensive HIV and AIDS attitude change programmes.

### 1.22.1 Applicable theoretical models

In this research, three behavioural models, namely social cognitive theory (SCT) (Bandura, 1980, 1994, 1997), the theory of reason action (Ajzen & Fishbein, 1972) –and its improved form – and the theory of planned action of (Ajzen and Fishbein, 1980) are fundamental to this study and are detailed as follows:

#### 1.22.1.1 *The Theory of Planned Behaviour (TPB)*

According to this Theory of Planned Behaviour (Ajzen, 1985, 1991 & Fishbein, 1989), the central determinant of behaviour is the individual's *intention* to perform the behaviour in question. Intentions are assumed to capture the motivational factors that influence behaviour, they are indications of how hard people are willing to try, or how much of an effort they are planning to exert in order to perform the behaviour.

The theory postulates three conceptually independent determinants of intention. The first is the *attitude toward the behaviour* and refers to the degree to which the person has a favourable or unfavourable evaluation of the behaviour in question. The second predictor is a social factor termed *subjective norm*, it refers to *the perceived social pressure* to perform or not to perform the behaviour. The third determinant of intention is the degree of *perceived behavioural control*. This factor refers to the perceived ease or difficulty of performing the behaviour, and it is assumed to reflect past experience as well as anticipated impediments and obstacles. As a general rule, the more favourable the attitude and subjective norm with respect to a particular behaviour and the greater the perceived behavioural control; the stronger the individual's intention to perform the behaviour under consideration should be.

Intention, in turn, is viewed as an immediate antecedent of actual behaviour. The stronger people's intentions to engage in a particular behaviour or to achieve their behavioural goals are, the more successful they are predicted to be.



Because one of the main focuses in the present investigation is to determine how strong attitudes are, in predicting engaging in discriminatory behaviour, related to HIV and AIDS in the workplace as compared to traditional beliefs and/or knowledge of HIV and AIDS, concentrating on intentions in this regard will be a good indicator as far as attitudes are concerned.

Note that predictors in theory of planned behaviour are assumed to be sufficient to account for intentions, but that they are not all necessary in any given application. The relative importance of attitude, subjective norm and perceived behavioural control in the prediction of intention is expected to vary across behaviours and populations. Thus, in some applications it may be found that only attitudes have a significant impact on intentions, in others that attitudes and perceived behavioural control are sufficient to account for intentions and still, in others, that all three predictors make independent contributions. By the same token, the relative weights of the three predictors, even when significant, can vary from application to application.

The theory of planned behaviour and the theory of reasoned action will be used together in this study so that predictions of behaviour, namely engaging in workplace HIV and AIDS-related discrimination, can be fully accounted for as those actions under volitional control and not under volitional control will be brought in focus and explained.

The most important reasons for the use of Ajzen and Fishbien's theory of planned behaviour (1985) are as follows:

- The theory emphasises intentions as being very vital in driving behaviour.
- Recent literature indicates that the theory is frequently used.

In the discussion of the theory reference is made to the interaction between the components and thus has predictive value.

#### *1.22.1.2 The Theory of Reasoned Action (TRA)*

The Theory of Reasoned Action (TRA) was another theory applied to this study. The Theory of Reasoned Action was developed by Martin Fishbein and Ajzen in 1967 as a general theory of human behaviour that deals with the relationship of components such as beliefs, attitudes and intention to behaviour (Fishbein, Middlestadt & Hitchcock, 1994:62; Montana & Kasprzyk, 2002:67). TRA is used when one is attempting to develop an intervention that has an informational, educational and/or communication component (Fishbein *et al.*, 1994:62). The Theory of Reasoned Action has been used to predict and explain why people have or have not engaged in a wide variety of behaviours like smoking, drinking, using contraceptives, dieting, and wearing seatbelts (Fishbein *et al.*, 1994:62). This is a Behaviour Change Theory, which is based on the fact that “performance of a given behaviour is primarily determined by the strength of a person’s intention to perform that behaviour and that the intention to perform that behaviour is based on the person’s attitude towards performing that behaviour and secondly on the person’s subjective norm concerning the behaviour’ (Fishbein & Yzer, 2003:165).

The Theory of Reasoned Action also assumes that all individuals are ‘rational actors’; that individuals process information; and are motivated to act on it. This theory points out that there are underlying reasons that determine one’s motivation to perform that behaviour. If one has a positive attitude about an issue, there is likelihood that he/she will perform that behaviour. If one has a negative attitude, chances of performing that behaviour may be nil.

To apply the “Theory of Reasoned Action”, one needs to select and identify the behaviour(s) of interest, which is based on four elements, that is, the elements of action,

target, context and time. In other words, “every action occurs with respect to some target, in a given context, and at a given point in time.... Change in any one of the four elements, redefines the behaviour of interest” (Fishbein *et al.*, 1994:64). This theory posits that every action occurs with respect to some target, a given context and at a given time. This theory also suggests that each incidence of behaviour is based on its own unique set of determinants, and that each kind of behaviour may require a different strategy; and that the beliefs that underlie the decision to perform (or not to perform) the targeted behaviour may be varied (Fishbein *et al.*, 1994:64). The TRA does provide a “framework for deciphering individuals’ action by identifying, measuring, and combining beliefs that are relevant to individuals or groups, allowing us to understand their own reasons that motivate the behaviour of interest” (Montana & Kasprzyk, 2002:73). This is done by conducting open-ended elicitation interviews to identify the relevant behavioural outcomes and referents for each kind of particular behaviour; and the population under investigation. A sample of at least 15 to 20 people from the population of the group under study is identified and divided into two groups, one group have performed or have intentions of performing that behaviour. The individuals are then asked to describe any positive or negative benefits of performing the behaviour under investigation. The individuals are also asked to identify people or groups they listen to, in other words, who their opinion leaders are who support or are against the behaviour under investigation. The elicitation interviews are then content analysed to identify the relevant attributes and outcomes of their behaviour and the relevant social referents and they form the content of the questionnaire and TRA measures are developed (Montana & Kasprzyk, 2002:73) Once the behavioural and normative beliefs affecting the behaviour under study have been identified, interventions can then be designed to target and change these beliefs or the value placed on them, thereby affecting attitude and subjective norm and leading to change in intention and behaviour (*ibid*).

The TRA is criticised on account that it is an individual-based theory and it is not appropriate for teachers. Montana and Kasprzyk (2002:67) argue that this theory

focuses on the theoretical constructs that are concerned with individual motivational factors as determinants of the likelihood of performing a specific behaviour. This theory assumes that environmental, demographical factors do not directly influence the likelihood of a person performing behaviour. Fishbein has referred to these factors as peripheral factors yet it has been observed that these peripheral aspects are very important determinants as to whether an individual will change his or her behaviour.

Michal-Johnson and Brown (1992:153) describe the TRA as emphasising “a highly rational decision-making process, a presumption that may not be entirely relevant for HIV and AIDS-related behaviours that are heavily influenced by emotions”. Singhal and Rogers (2003:212) point out that the rational intentions to use condoms can be overcome by a passionate sexual encounter. They also point out that zeroing in on the individual leads to designing individual-based interventions whereby individuals become the units of analysis. But it has been observed that there are unique factors in the case of HIV and AIDS. The social situation in which the infection takes place is very important. The context of HIV and AIDS is thus very important (2003:208).

With the available treatment for HIV and AIDS through the use of anti-retrovirals (ARVs), many people infected with HIV are capable of continuing to work for a long time provided they take the treatment following testing at the appropriate time. As such, the number of PLWHAs in the workplace will continue to grow and their concerns need to be taken care of, especially not being discriminated against just because they are HIV-positive. In the same category are those who would otherwise be discriminated against and stigmatised because they are affected by HIV and AIDS. To determine predictors of why workplace HIV and AIDS-related discrimination continues to prevail, Maslow's hierarchy of needs theory was used together with Ajzen and Fishbein's (1972) theory of planned behaviour and Bandura's (1986) social cognitive theory.

The aim of Ajzen and Fishbein's (1984) reasoned action theory, which is fundamental to this study, is to understand and predict an individual's behaviour. The theory is based on the assumption that people are usually rational, that they make systematic use of accessible information and that they consider the results of their actions before they make a decision. Their assumption is that the majority of actions that are socially relevant are under volitional control and intentions to engage in certain behaviour should be regarded as a defining or determining action. This does not mean that intention and behaviour are always congruent. Given that the objective of the theory is to predict and understand behaviour, the variables of intentions should be identified.

According to Ajzen and Fishbein's theory (1973, 1977, 1980), the individual's intention is a function of three variables:

- the individual's personal attitudes to behaviour,
- the social influence and subjective norms, and
- the individual's understanding of their control over their behaviour.

Their model does not, however, relate to specific emotional and psychological factors.

The theory of reasoned action will be applied along with that one of planned behaviour (Ajzen, 1988, 1989, 1991) because the later model accommodates the fact that behaviours are often not under the volitional control as assumed by the theory of reasoned action as it incorporates another factor of perceived behavioural control.

The theory is based on the assumption that people are usually rational, that they make systematic use of accessible information, and that they consider the results of their actions before they make a decision. Ajzen and Fishbein's assumption is that the majority of actions that are socially relevant are under volitional control, and intentions to engage in certain behaviour should be regarded as a defining or determining action.

This does not mean that intention and behaviour are always congruent. Given that the objective of the theory is to predict and understand behaviour, the variables of intentions should be identified.

### *1.22.1.3 Maslow's hierarchy of needs theory*

What accounts for why people in the workplace engage in discriminatory behaviour is only partly explained by Ajzen and Fishbien's (1980) theory of planned behaviour together with Ajzen's (1972) theory of reasoned action. Much as Bandura's (1980) social learning theory was contributory in trying to explain the phenomenon at hand, the question of why people (workers) engage in discriminatory behaviour can better be explained more fully by combining the other mentioned theories with that of Maslow's theory of motivation, namely, Maslow's hierarchy needs theory.

Abraham Maslow, pointed out in the 1950s that there is a hierarchy of needs and that lower needs need to be satisfied first and that they dominate higher needs until they are satisfied (Maslow, 1999: 65; Zalenski & Raspa, 2006). If a worker's physiological needs, for example, food, water, air, shelter, sleep and sex have been satisfied, the worker then is no longer motivated by basic needs but needs in the next hierarchy. The second level of needs is comprised of safety and security needs; and this includes feeling safe both physically and emotionally. According to Richards (2004), if a person experiences feelings of safety, he/she will venture to the next level. The third level includes the need for love and belonging, human beings' need for warm interpersonal sharing, love, affection and affiliation. These needs involve the giving and receiving of affection. When they are unsatisfied, a person will feel keenly the absence of friends, a mate or children (Benson & Dundis, 2003). Having obtained relationship/belongingness and security, it is then possible to look for the fourth level. The fourth level emphasises the need for self-esteem or self-assured and esteem by others, the human need for a sense of confidence and competence, achievement, independence and freedom (Benson & Dundis, 2003). Lastly, at the top of the hierarchy are self-actualisation needs, the individual's need for growth, development, utilisation of potential, the need to become

more and more what he/she is capable of becoming/achieving (Hoffman, 1996:10; Maslow, 1999:33). Living at this level can lead to peak experiences and even transcendence – the experience of deep connection with others, nature, or God, and the perception of beauty, truth, goodness and sacred in the world (Zalenski & Raspa, 2006).

Understanding motivation is important in this study. For example, understanding why a worker is selected against or discriminated against a well-performing worker because he/she exhibits symptoms associated with HIV and AIDS would help us to recognise the discriminatory tendencies which result in frustrating those infected or affected by HIV and AIDS. As alluded to in the introductory part of the study, discrimination may be very hard to track down as it can be elusive in some circumstances such as in an interview situation.

Furthermore, since a person who does not discriminate in one situation may engage in discrimination in another situation in favour of or against an individual who is or suspected to be HIV-positive, Maslow's hierarchy of needs theory is well suited in explaining the phenomenon of discrimination as different needs may be operating at different times in the same person.

What motivates a worker to engage in discriminatory behaviour with regard to HIV and AIDS remains an unanswered question especially in a situation where people and workers in particular, in many work organisations have been exposed to HIV and AIDS knowledge and attitude change programmes. While the answer may be found partly in different behavioural theories like social learning theory, the theory of planned behaviour and the theory of reasoned action, Maslow's hierarchy of needs, in the context of workplace HIV and AIDS-related discrimination among members of the teaching fraternity in both South Africa and Uganda, serves as an appropriate choice to complement other theories discussed to explain why workplace HIV and AIDS-related

discrimination is and continues to be engaged in. Maslow's hierarchy of human needs applies to those who perpetuate workplace HIV and AIDS-related discrimination and those who are at the receiving end of the same phenomenon.

*a Orientation*

Maslow expressed his dissatisfaction with the highly esteemed First- and Second-force psychological theories of his time and refocused attention on the natural goodness of people. Maslow saw deficiency needs as essentially survival needs; even love and esteem are needed for the maintenance of health. All people have a need for self-respect and the esteem of others; gratification of self-esteem needs leads to feelings of confidence, worth, strengths, capabilities and a sense of being needed in this world.

*b Humanistic psychology of Maslow*

Maslow believed that human beings can be impressive in their human and biological nature (Maslow, 1996:84), but he still embraced the duality of human nature. Maslow's Third-force (Humanistic) psychology opposed almost every basic tenet of First-force (Freudianism) and Second-force (Behaviourism) psychology – that only self-interest, sexuality and aggression are innate motivators for survival and reproduction of the human species (Hoffman, 1996:6). The core of human nature is basic goodness and decency, asserts Maslow and when people appear to be something other than good it is because they are reacting to the deprivation of basic human needs. Aggressiveness is only a reaction to the circumstances of one's particular human situation. As a Third-force psychologist, Maslow's most distinct contribution was a compelling theory of human motivation. His vision of a hierarchical arrangement of human needs gave a tenable basis for explaining how a person's desire for kindness could be as basic as the need for water (Lowry, in Maslow, 1999: v - ix). In the context of this study, engaging in discriminatory behaviour towards those infected or affected by HIV and AIDS may be understood as a reaction to the fear of the dreadful nature of HIV and AIDS. Thus, one may seek safety and security, for example, due to his needs and his humanness, reflected in both concrete external and interpersonal activities and relationships.

*c Maslow's hierarchy of needs structure*



Maslow's theory of motivation is concerned with the process where a particular class of need operates as a motivator. Maslow proposes that the five classes of needs can be organised in a hierarchy of prepotency or priority, starting with physiological needs at the bottom of the hierarchy and working up to self-actualisation. This is illustrated in Figure 1.1.

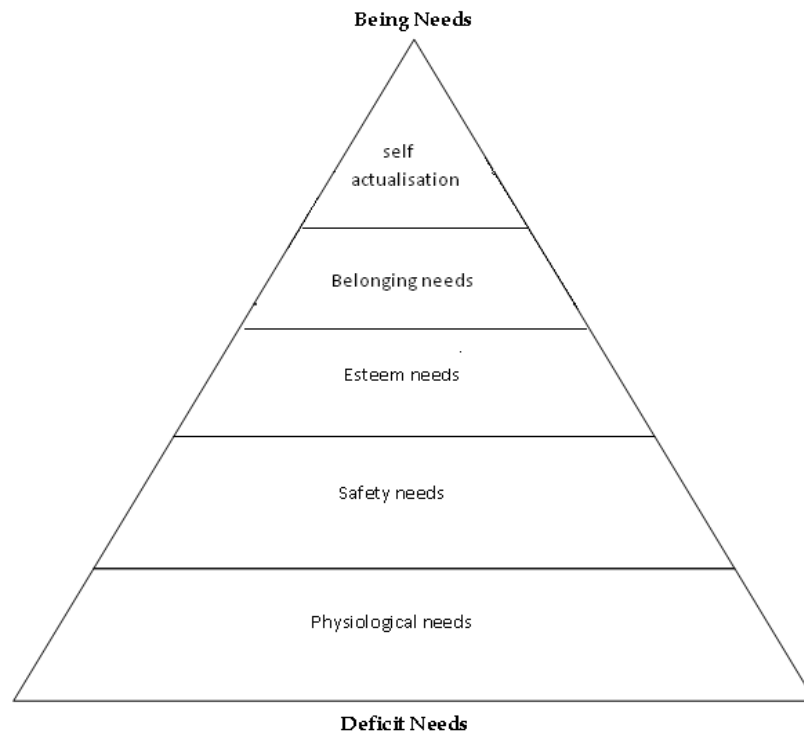


Figure 1.1: Deficit and being needs in terms of Maslow's hierarchy of needs theory (Maslow, 1999: 33)

The physiological needs are the rock-bottom survival needs for air, food, shelter, sleep and sex. The second level comprises of safety and security needs. The third level relates to love and belongingness needs: the human need for warm interpersonal sharing, love, affection and affiliation. The fourth level comprises of the need for self-esteem and esteem by others: the human need for a sense of confidence, competence, achievement, independence and freedom. Self-actualisation needs form the fifth level of needs: the individual's need for growth, development, fulfillment of potential, the need to

become more and more of what one is capable of becoming and achieving (Hoffman, 1996: 10; Maslow, 1999: 33).

Once a need has been satisfied, it loses its prepotency or importance and ceases to have any motivational impact. As it becomes less important, the next level of the hierarchy assumes greater importance until needs at this level are in turn satisfied. This process continues until we reach self-actualisation which is qualitatively different from the other levels of need in that increased satisfaction leads to increased importance. According to Maslow, people's behaviour is governed by attempts to satisfy the needs which are most important at a given point in time. The process is dynamic but predictable: satisfaction will lead to movement up the hierarchy; deprivation will lead to movement downwards. Although Maslow has elaborated these ideas, in the organisational literature the focus has almost always been on these central elements.

The first four levels of needs, termed *deficit needs* by Maslow, are said to occur when human beings experience deficiencies. For example, if the hunger caused by lack of food cannot be met, then the hunger need is dissipated. Once the need for food is met, it ceases to be a motivating force. If this need is not met, it is regarded as a deficiency in the organism. Maslow equated deficiency needs with 'empty holes that must be filled up for health's sake' (Maslow, 1999: 28). It must be remembered that these deficiency needs must be filled from *without*, by a human being other than the subject. In contrast, *being needs*, according to Maslow, are not informed by deficits. Being needs do not cease to be motivating once met, but are motivated by growth. They become stronger as the person 'feeds' them from *within*. Examples of being needs are the need for truth, uniqueness, justice and meaningfulness. Being needs drive people and involve the continuous desire to fulfill further potential (Maslow, 1999: 13). Maslow maintained that human beings are capable of knowing right from wrong and desire to behave in accordance with a belief in ultimate values such as truth and love (Maslow, 1987:249).

*d An analysis of Maslow's motivation theory*

Maslow's ideas can be analysed from a number of perspectives; however, for the purpose of this study we should restrict ourselves to conceptual problems. There are five main conceptual issues that need to be considered in forming an evaluation of Maslow's theory.

(i) *Needs as instincts*

Maslow was critical of the 'either/or' nature of much of the debate on instincts and as a way out of the impasse, argued for the existence of 'weak' instincts, which can be suppressed by experience and circumstances. Here, he seems to be thinking of what he termed the 'growth' needs of esteem and self-actualisation. Underpinning this view, nevertheless, resides a belief in the inherently instinctive nature of the needs in the classification implying that it is sensible in Maslow's terms to describe them as universal human needs.

This view presents some problems since it implies that 'normal' behaviour is to pursue need satisfaction in the way prescribed. Maslow explicitly accepts this, especially for the basic needs which he maintains: 'stand in a special psychological and biological status...They *must* be satisfied or else we get sick' (Maslow, 1970:92).

The problem with this view is that it is self-fulfilling in that anyone whose behaviour fits the theory is healthy while anyone who does not is, by definition, maladjusted.

*e The problem of need satisfaction*

Does a need have to be totally or only partly satisfied before an individual moves up the hierarchy? Maslow accepted some overlap and therefore, by implication, that behaviour could be multi-motivated, but he never specified how much.

In this study, an SMT member who represents the Department of Education on a selection panel of new staff may engage in discriminatory behaviour stemming from his/her needs for safety and security or because of his/her esteem needs.

Another issue which is at times raised concerns the time dimension of needs. It could be argued that every time someone was hungry they moved down the hierarchy. Maslow counters this by suggesting that temporary and non-threatening deprivation will not influence the hierarchy of prepotency.

*f Unclear definition of need levels*

Maslow listed five levels of needs. At one point he suggested that a division into deficiency and growth needs would be more sensible, implying at the same time that only self-actualisation would fit into the growth category (see, for example, Maslow, 1962).

Another source of confusion is that esteem needs are sometimes divided into two; separating external feedback and recognition from internal sense of achievement and growth.

*g The concept of self-actualisation*

The term self-actualisation was originally coined by Jung and has been adopted by a number of 'Third Force' or growth psychologists other than Maslow. Most of them and Maslow in particular, seem to have difficulties with the definition. Maslow describes it as the need to 'become more and more of what one idiosyncratically is, to become everything one is capable of becoming' (Maslow, 1970: 45), is really to avoid a

definition. Nor is it of much help to say that 'what man *can* be, he *must* be, he must be true to his own nature' (Maslow, 1970: 46).

Still questioning Maslow's theory, there are social scientists who argue that postmodern notions such as the politics of knowledge might suggest that there are more accurate representations of contemporary cultural force and dynamics of motivation. This discourse of how knowledge is legitimated, for whom, and for what purposes, might challenge Maslow's notion of a universally shared human nature. Social constructivism, as well, would argue that such knowledge of needs is local, context specific, and culturally configured rather than total, universal, and natural (Zalenski & Raspa, 2006:1122). A further criticism of the theory is that Maslow was Eurocentric in his thinking and created the theory from an individualistic stance. The needs and drives of those in an individualistic society are different from those in a collectivist culture (March, 2010:59).

#### *1.22.1.4 Social Learning Theory (SLT)*

Social learning theory provides a tentative set of principles to account for complex human social behaviour (Rotter, 1954). This theory proposes that behaviours are rooted in previous experiences or 'social learning' (Rotter, Chance & Phares, 1972).

According to Phares (1976), individuals make choices from a variety of potential behaviours available to them. Social learning theorists are of the opinion that neither the individual nor the situation exclusively determines behaviour. Behaviour is a result of the interaction between the characteristics of the individual and of the situation.

The social learning theory equally emphasises value, expectancy of reinforcement and situational specificity (Lefcourt, 1982). It stands alone in this respect among other learning theories. According to Rotter (1966), an individual's behaviour is predicted on

the basis of his/her values, expectations and the situations in which he/she finds himself/herself. Rotter's general formula reads as follows:

$$NP = f (F M \& N V)$$

Where:

NP = Potentiality of occurrence of a set of behaviours that lead to the satisfaction of some need (need potential);

FM = the expectancy that these behaviours will lead to these reinforcement (freedom of movement);

NV = the strength of value of these reinforcements (needs value).

In this theory, reinforcement acts to strengthen the expectancy that a particular behaviour or event will be followed by that reinforcement in the future. Reinforcement values are rewards, positive or negative, that are anticipated to follow specific behaviours. They vary with the specific situation and, as such, they are learned (Rotter, 1975).

Once the expectation of such a behaviour-reinforcement sequence is built up, the failure of the reinforcement to occur will reduce or extinguish the expectancy. It therefore seems likely that, depending upon an individual's history of reinforcement, individuals will differ in the degree to which they attribute reinforcements to their own actions (Rotter, 1966).

Expectancies generalise from a specific situation to a series of situations that are perceived as related or similar. A generalised attitude, belief or expectancy regarding the nature of the causal relationship between the individual's own behaviour and its consequences might affect a variety of behavioural choices in a broad band of life

situations. Such generalised expectancies act in combination with behaviour along with determining the value of potential reinforcements (Rotter, 1966).

*a Affection*

Affection refers to ‘the amount of overt affection and acceptance that the parents seemed to feel and reported expressing toward their child’ (Tubbs, 1994:519). According to Goldstein (1990) and Tubbs (1994), the more affectionate, supportive and protective the parents are, the more likely the child is to develop an internal locus of control. It is thought in this study that it continues to be part of that person’s personality to a certain extent. Locus of control has a bearing on how an individual behaves in certain situations.

*1.22.1.5 The Social Cognitive Theory (SCT)*

This theory was developed by Albert Bandura in 1962. He argues that in order to achieve self-directed change, people need to be given both a reason to alter risky habits and also behavioural means and the resources and social supports to do so (Bandura, 1994:25). To change behaviour one needs what Bandura calls “self-regulative skills and self-guidance” which should be used effectively and consistently under difficult circumstances. That one’s success is based in one’s self-belief in one’s capability or one’s efficacy to exercise personal control (Bandura, 1994:25). The Social Cognitive Theory (SCT) addresses both the psychosocial dynamics influencing health behaviour and methods for promoting behaviour change. Human behaviour is explained in terms of a triadic, dynamic and reciprocal model in which behaviour and personal factors interact. “Among the crucial personal factors are: the individual’s capacities to symbolise behaviour, to learn by observing others (also referred to as vicarious learning), to have confidence in performing a behaviour, to self-determine or self-regulate behaviour and to reflect on and analyse experience” (Baranowski, Perry & Parcel, 2002:165). This theory has been used to develop interventions, procedures, techniques that influence

these underlying cognitive variables, thereby increasing the likelihood of behaviour change (Baranowski *et al*; 2002:165). Important components of the SCT such as modelling, peer education or peer involvement have been singled out as important aspects in designing HIV and AIDS programmes (Peer Educators National Conference, 2006).

According to the Social Cognitive Theory, behaviour is dynamic and is determined by two aspects; the environment and the person involved; and the two factors influence each other simultaneously. This continued interaction of the two aspects leads to behaviour, which is referred to as reciprocal determinism, which is a major principle in SCT (Baranowski *et al*; 2002:168; Glanz & Rimer, 1997:23). A change in any one of these aspects implies a change in the other aspects. The term environmental in reciprocal determinism is used to refer to factors that can affect a person's behaviour that are physically external to that person. The social environment includes family members, friends, peers at work or in the classroom. The physical environment may include the size of the room, temperature or the availability of certain foods. Baranowski *et al* (2002:168) use the term 'situation' to refer to the cognitive or mental representation of the environment that may affect a person's perception of the environment such as time, place, physical features, activity, participants and their role in the situation (Bandura, 1994:25; Glanz & Rimer, 1997:23).

Bandura (1994:25) asserts that in the prevention of HIV and AIDS, people or individuals are required to exercise influence over their own behaviour and their social environment.

It is widely assumed that if people are adequately informed about the HIV and AIDS threat, they will take appropriate self-protective action but this is not the case although heightened awareness and knowledge of HIV and AIDS is an important precondition of self-directed change (Fishbein & Guinan, 1996:5; Bandura, 1994:25). Bandura points



out that there is a difference between possessing self-regulating skills and being able to use them effectively and consistently under difficult circumstances; and that to successfully change one's behaviour requires strong self-belief in one's efficacy to exercise personal control (Bandura, 1994:26). Perceived self-efficacy is concerned with people's beliefs that they can exert control over their own motivation, thought processes, emotional states and patterns of behaviour (Bandura, 1994:26). Bandura continues to say that people's beliefs about their capabilities affect what they choose to do, how much effort they mobilise, how long they will persevere in the face of difficulty (Bandura, 1994:26).

The Social Cognitive Theory also asserts that the major problem is not about safer sex guidelines which are easily achievable but equipping people with skills and self-belief that enable them to put the guidelines consistently into practice in the face of social, economic and cultural challenges. This theory suggests that translating health knowledge into effective self-protection action against HIV infection requires social and self-regulative skills and a sense of personal power to exercise control over sexual and drug activities, the two major avenues of HIV virus. Safer sex practices often do interfere with self-protection because this conflicts with interpersonal pressures and feelings and sentiments (Bandura, 1994:26)

In the Ugandan situation and South African situations, beliefs, attitudes, traditions and socio-economic status are determinants of whether a safe practice will be adopted or not. The Social Cognitive Theory states that people's beliefs can motivate and regulate their own behaviour. Belief in one's personal efficacy to exercise control over one's sexual behaviour emerged as the best predictor of sexual risk-taking behaviour (Bandura, 1994:29). This study seeks to determine whether beliefs, specifically traditional beliefs, are the best predictor of workplace HIV and AIDS-related discrimination.

The Social Cognitive Theory explains human functioning in terms of triadic reciprocal causation. The “human functioning is explained in terms of a model of triadic reciprocity in which behaviour, cognitive and other personal factors and environmental events all operate as interacting determinants of each other” (Bandura, 1994:30; Bandura, 1986:24). This is indicated in the diagram below:

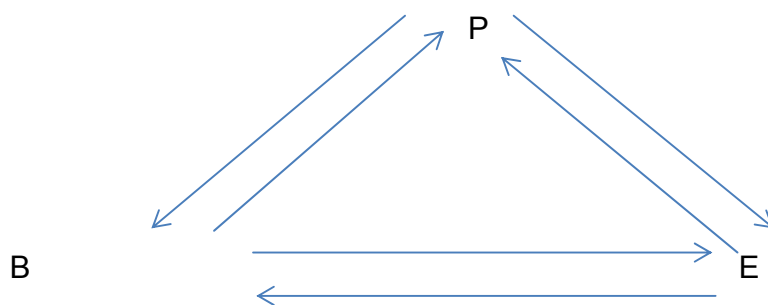


Figure 1.2 Schematisation of triadic reciprocal causation.

“B” signifies behaviour, P the cognitive, biological, and other internal events that affect perceptions and action; and E the external environment “.

*Source* Bandura, 1994: 32.

The Social Cognitive Theory asserts that the ability to learn by social modelling also referred to as observational learning, and provides a highly effective method of increasing human knowledge and skills. Social learning or observational learning takes place when a person watches the actions of other people and the consequent reinforcement that the person receives. The learner discovers rules that account for the behaviour of others by observing the behaviour and the reinforcements they receive for their behaviour. Many types of behaviour can be learnt through observational learning (Bandura, 1986:47; Baranowski *et al*; 2002:170; Glanz & Rimer, 1997:24; Melkote &

Steeves, 2002:133). This seems to affect the way educators behave towards HIV-positive colleagues by observing how others behave towards the HIV infected or AIDS affected co-workers.

Social modelling is also used as a way of increasing human knowledge and skills (Bandura, 1994:37). When people see other people who are similar to them assuming or adopting safer behaviour in HIV and AIDS prevention, this builds self-assurance and enhances self-efficacy of the person being communicated to. The model must be similar in age, sex, and status and in a similar type of situation. Modelling also advocates for role-playing and corrective feedback.

Regarding to workplace HIV and AIDS-related discrimination, it is likely that a similar process may occur and the individual observing others not engaging in discriminatory behaviour may probably not engage in it. This is yet to be found out.

Another important concept in SCT is *behavioural capability*; this means that if a person is to perform a particular behaviour he/she must know what the behaviour is and how to perform it (skill). This concept distinguishes between learning and performance in that a task can be learnt and not performed; and that performance presumes learning (Baranowski *et al*; 2002:171; Glanz & Rimer, 1997:24). There have been cases where people have lacked knowledge of some disease and therefore not changed their behaviour. But there are cases where people have knowledge of some disease but they do not change their behaviour.

Bandura (1994:44) says that acquiring knowledge alone about the mode of HIV transmission and effective self-protective methods is not enough as a preventive

measure because there are other major factors that do hinder behaviour change such as interpersonal relations, socio-cultural, religious and economic factors.

Most behaviour change interventions that have been developed are based on cognitive-behavioural theories, which emphasise the individual as a rational actor in altering behaviour, but recent theoretical contributions emphasise the importance of group norms and collective change and anticipation (Harrison, Smit & Myer, 2000:285; Campbell, 2003:8; Morris, 2003:226).

The Social Cognitive Theory advances the skill enhancement approach to HIV and AIDS, which focuses on individual-based strategies of behaviour change that are only acceptable in the western cultures. The social cognitive theory does not rhyme with non-western cultures whose values and social norms are different (Kalichman & Hospers, 1997: S197)

The Social Cognitive Theory(SCT) (Bandura, 1990, 1994, 1997) has been used in a number of HIV-related studies (Walters *et al*; 2000). SCT builds on the concept of reciprocal determinism, wherein behaviour, cognitive and other personal factors and environmental influences interact as determinants of each other. Most of the research to date has focused on behavioural and cognitive components to clarify the relationships among various knowledge, attitudes and behaviours (KABs). SCT purports that cognitions or attitudes mediate the relationship between knowledge and behaviour. Among the various types of attitudes, Bandura (1980) hypothesised that none is more influential in everyday life than expectations: an expectation about the likelihood of a particular consequence following a specific behaviour (outcome expectation) and a judgment of one's ability to produce a specific behaviour (self-efficacy, or efficacy expectation). According to Bandura (1997) efficacy expectations are determined primarily by three components:

- direct experience with a specific behaviour (enactive mastery),
- indirect experience involving people who are important to the individual (vicarious experience), and
- being convinced by someone important to the person (verbal persuasion).

In the proposed study, the framework of social cognitive theory (Bandura, 1994) will shed light on the cognitive decision-making process that precedes engaging in workplace HIV and AIDS-related discriminatory behaviour. The theory posits that people base their decision to engage in behaviour on a risk assessment by which they weigh the costs and benefits of the action.

*a Meta-theoretical statements*

The meta-theoretical statements represent an important category of assumptions underlying the theories, models and paradigms of this research. The meta-theoretical values and beliefs have become part of the intellectual climate of a particular discipline in the social science (Mouton & Marais, 1996:192). Meta-theoretical statements are presented on industrial psychology and organisational behaviour because these two disciplines very closely relate and the proposed study impacts on the workplace which is in their realm.

*b The market of intellectual resources*

According to Mouton and Marais (1996:21), the market of intellectual resource refers to the collection of beliefs which relate to the epistemic status of scientific statement, to their status as knowledge-claims. The beliefs fall into two categories, namely theoretical beliefs about the nature and structure of phenomena on the one hand, and methodological beliefs concerning the nature and structure of the research process, on the other hand. The theoretical beliefs are testable statements about social phenomena. They are the 'what (descriptive) and why (interpretive) aspects of human behaviour'. Statements applicable to this research are evident from relevant models, theories, hypotheses and conceptual descriptions (Mouton & Marais, 1996).

*c Research hypothesis*

Babbie (2005:42) describes a hypothesis as: “A specified testable expectation about empirical reality that follows a more general proposition; more generally an expectation about the nature of things derived from a theory. It is a statement of something that ought to be observed in the real world if the theory is correct.” Burns and Grove (2005:159) concur that a hypothesis is a formal statement of the expected relationship between two or more variables in a specified population. The hypothesis translates the research problem and purpose into a clear explanation or prediction of the expected results or outcomes of the study.

Brink and wood (1998:48) say that hypotheses are statements concerning predictable relationships between the variables under study that link a study’s theoretical framework to experimental realities. Babbie (2005:44) asserts that hypotheses are connected using rules of logic. The logic can be inductive or deductive. A deductive hypothesis suggests assertions which are related in a consistent way (Babbie, 2005:44). Inductive reasoning involves the observation of a particular set of instances that belong to and can be identified as part of a larger set. This reasoning moves from a particular to the general and underlies qualitative approach to research (LoBiondo-Wood & Haber, 2002:110). On the other hand, deductive reasoning uses two or more variables or related statements that, when combined, form the basis for a concluding assertion of a relationship between the variables called relational statements. This reasoning moves from the general to the particular; and it is typically applied to quantitative inquiry approaches (Lobiondo-Wood & Haber, 2002:110). Burns and Grove (2005:165) add that deductive thinkers examine more abstract statements from theories, models or previous research and then formulate hypotheses for the study; while the inductive thinkers have a tendency to focus on relationships that are observed in practice, and they synthesise these observations to formulate a general statement about the relationships observed. Initially, the general hypothesis was developed for this study:

Traditional beliefs of HIV and AIDS correlates more positively with engaging in or intention to engage in workplace HIV and AIDS-related discriminatory behaviour than either knowledge of HIV and AIDS or attitudes toward HIV and AIDS infected individuals.

Specific hypotheses derived from the general hypothesis were also formulated. For brevity and no need of duplication, they are found in Chapter 6 of this thesis.

#### *d Operational definitions*

A concept is a term that abstractly describes and names the object, thereby giving it a separate identity or meaning (Burns & Grove, 2005:122, 731; LoBiondo-Wood & Haber, 2002:113).

A conceptual definition differs from the denotive (or dictionary) definition of the word, though it is more like the dictionary definition. The conceptual definition goes beyond the general language meaning found in the dictionary by defining the concept as it is rooted in the theoretical literature (Burns & Grove, 2005:122; LoBiondo-Wood & Hager, 2002: 113). Burns and Grove (2005:122) add that defining concepts allows consistency in the way the terms are used in the discipline, in application to theory, and the field of study. Operationalising a variable or concept involves developing conceptual and operational definitions (Burns & Grove, 2005:171).

Operationalisation adds another dimension to the conceptual definition by delineating the procedures or operations required to measure the concept. It supplies the information needed to collect data on the problem being studied (Burns & Grove, 2005:

171-172; LoBiondo-Wood & Haber, 2002:113). The language of operational definition is closer to the ground than that of conceptual definition. Operational definitions are lower on the ladder of abstraction than conceptual definitions.

In this study, conceptual and operational definitions are given for key variables, while only conceptual definitions are given for some key words pertaining to the study. Therefore, in this study the following terms were used as defined in section (.....) in this thesis:

Attitude is an enduring response towards persons, objects and ideas. Attitudes are also defined as personal beliefs that impact on the way people treat others (Ajzen & Fishbein, 1972). Eagly and Chaiken (1993:155) refer to attitudes as tendencies to evaluate an entity with some degree of favour or behavioural responses. As indicated by this definition, attitudes have cognitive (beliefs, knowledge, expectations or perceived associations between attitude objects and attributes), affective (feelings, moods, motive and emotions and associated physiological changes), and performance (behavioural or action, either intended or actual) components (McGuire, 1985). Allport (in Sears, Peplau & Taylor, 1991:546) portrays an attitude as a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related. Attitude is "someone's opinion or feelings about something, especially as shown by their behaviour (Macmillan English Dictionary, 2006:76). Therefore, attitude refers to the way of thinking and behaving.

In this study, attitudes refer to educators' opinions or feelings about HIV and AIDS; towards people with HIV and AIDS infected persons (actual or presumed). A teacher may react positively or negatively to the concepts of HIV and AIDS. Attitude being enduring response can be assumed that it does not change over a period of time. Thus,



when teachers learn or have the right attitudes regarding HIV and AIDS and towards PLWHAs, such attitudes can be maintained over a long period of time.

#### *1.22.1.6 Knowledge*

Knowledge or cognition in psychological terms refers to basic biomedical knowledge of HIV and AIDS and awareness of the laws relating to HIV and AIDS-related discrimination (Slack, 1998).

#### *1.22.1.7 Traditional beliefs*

Traditional beliefs about HIV and AIDS refer to the beliefs in the spiritual, supernatural or witchcraft as the causes of HIV and AIDS (Kalichman & Simbayi, 2004).

#### *1.22.1.8 Perceptions*

According to the Concise Oxford Dictionary (1999:1049), perceptions refer to a way of regarding, understanding or interpreting something. Perception is also defined as an organised process in which an individual interprets situations from an environment and draws subjective and personal inferences and conclusions from these in order to take certain actions or behaviours (George, 2002:225; Quinn, 2000:73).

In this study, perceptions refer to the ways educators in Bojanala District in North West Province of South Africa and Kampala District in Central Region in Uganda regard, understand and interpret facts and situations regarding HIV and AIDS in workplace.

#### *1.22.1.9 Discrimination*

Discrimination refers to treating a person or group of individuals differently (usually worse) than others (Hornby, 1998). Also, discrimination refers to a behaviour by which an individual or a group of people are treated unfairly due to prejudice, sex orientation, HIV and AIDS-status, and so forth – actual or presumed (The Constitution of the Republic of South Africa, 1996).

Sexual orientation as a right is deliberately missing in the Ugandan Constitution of 2005 and thus it is not regarded as grounds for discrimination in Uganda.

### 1.22.1.10 Person

Person can be defined as ‘an individual human being who can act independently’, which implies that the individual leads a physical, psychological and spiritual existence (Meyer *et al*; 1989:7). Plug *et al*; (1986) support this definition by concluding that psychological and spiritual dimensions cannot be separated from the physical dimension of a person.

#### *a Methodological convictions*

Methodological convictions concern the nature of scientific research and social sciences (Mouton & Marais, 1996). In this research, the role of the first person is that of a researcher seeking new knowledge to apply to a scientific problem in a work setting, test administrator and interpreter of psychometric information. The role of the second person is that of the test subject and respondent contributing to research.

Standardisation requirements include statistical procedures to determine reliability, validity and freedom from bias. Reliability refers to the stability, dependability and predictability of the results (Kerlinger, 1973). Cronbach’s alpha is a calculation to establish the internal consistency of a scale. It establishes the correlation within a scale where it is assumed that items on the scale are positively correlated because they measure a common entity (Norusis, 1992).

Validity means that an instrument should measure what it purports to measure (Roscoe, 1975). Different types of validity include construct, content (Cole, 1981), differential (Lawshe, 1983), criterion-related (Cole, 1981) and concurrent (Barrett, Phillips & Alexander, 1981). Kerr’s (1990) view — that the distinction between types of validity has value only for indicating the various inferences that can be drawn from test scores — is relevant to this research.

Construct validity explains the variance or meaning of the test according to the factors or constructs that lie behind test performance. The empirical testing of the constructs (Kerlinger, 1973) will be assessed by stepwise regression analysis involving knowledge, attitudes and traditional beliefs relating to HIV and AIDS among site managers, heads of departments and educators as the independent variables, for establishing co-variance. Regression analysis will be done to determine the predictive power of the independent variables for the dependent variable, that is to see which independent variable predicts workplace HIV and AIDS-related discrimination most or least, or not at all. Content validity relevant to this research will determine whether the internal test structure of items or sub-scores is similar for different groups (Cole, 1981) as a second application of Cronbach's coefficient alpha to establish generalisability.

*b Meta-theoretical concepts*

The following concepts are accepted at the meta-theoretical level and form part of the research:

*1.22.1.11 Individual*

The term *individual* means a simple human being, in direct or indirect contrast with members of a larger group or with society at large (Babbie, 2005). Individual human beings are studied by social scientists in term of various characteristics. A number of individual descriptions may be aggregated to provide a description of the population that the individual comprise. In this research, individual human beings, in the occupational or industrial context, are regarded as holons.

*1.22.1.12 Awareness*

According to Edgerton (1994), having *awareness* means to have conscious knowledge of something. This implies an alertness in drawing inferences from what one experiences, such as being aware of phenomena or relationships between phenomena in the client system.

*a Meta-theoretical convictions*

Whilst the research is clearly directed at meeting the stated aims and answering the research questions, substantial use is made of different thinking methodologies. The reviews of literature and the analysis thereof are mostly the product of directed thinking (Pidd, 2003)

*b Intellectual climate*

The intellectual climate refers to the variety of meta-theoretical beliefs, values and assumptions that are not directly related to the epistemic objectives and aims of the research. Due to the nature of social science disciplines, these meta-theoretical concepts can pertain to social reality in general as well as to specific disciplines, such as sociology, society, labour, education and history (Mouton & Marais, 1996).

The meta-theoretical constructs applicable to this research pertain to *psychology* in general, and more specifically to *industrial psychology*. The object of this study focuses on the *person* and workplace HIV and AIDS-related discrimination. These concepts are accordingly defined (refer to paragraph 1.22.5.5).

### **1.23 RESEARCH DESIGN**

A research design is a blue print for conducting a study that maximizes control over factors that could interfere with the validity of the findings (Babbie & Mouton, 2002:72; Burns & Grove, 2005:211). The research design could therefore be equated to the end result of a series of decisions made by the researcher concerning how the study will be implemented. The design is closely associated with the framework of the study and guides planning for implementation of the study (Burns & Grove, 2005:211). Bless and Higson-Smith (2000:63); Burns and Grove (2003:195); LoBiondo-Wood and Haber (2002:188); and Polit and Hungler (1999:155) add that in quantitative research such as part of the this study, the design is the researcher's overall plan for obtaining answers to research questions or for testing research hypotheses.

In this study, a mixed method research design, partly quantitative and partly qualitative survey was used in order to explore the knowledge, attitudes and traditional beliefs regarding HIV and AIDS; and workplace HIV and AIDS-related discrimination educators in Bojanala District in North West District of South Africa and Kampala District in the Central Region of Uganda.

In this research approach, the content of the instruments will be examined to determine whether it assesses the construct in ways consistent with the definition of the variables. External validity is synonymous with the requirement to generalise results (Mouton & Marais, 1996). In this study, reliability will be controlled by applying sampling disciplines, involving experts in the research process and cross-checking data. Theoretical and inferential validity will be achieved through basing conceptualisations on the analysis and synthesis of established models, theories and literature. Measurement validity will be enhanced by applying accepted methodological convictions. Stratifying the sample to emphasise all possible differences will further enhance external validity. Most recent literature will be used except, where necessary, as in the case of classical theories, where old literature will be used

For this study, the research design sought to meet the maximum use of the available resources, practicalities, methodological choices, personal judgments and creativity.

Having decided on the research objectives and the sample, the different options and methods of data collection were considered. On the one hand, qualitative data from in-depth interviews gave the desired in-depth information about workplace discrimination pertaining to HIV and AIDS among site managers, heads of departments and educators. On the other hand, a questionnaire enabled quantitative data relating to HIV and AIDS knowledge, attitudes and traditional beliefs of site managers, heads of departments and educators and workplace HIV and AIDS-related discrimination to be collected. Consequently, the research objectives were best be met by using both methods of data collection. However, both qualitative and quantitative methods have

strengths and weaknesses which had to be considered prior to research design. These are briefly discussed below.

The major advantages of qualitative data are that they provide depth and detail through quotation about the situations, events, interactions and behaviours, and the data are not constrained by predetermined categories of analysis as in a questionnaire. However, qualitative responses are usually much longer and variable in content than questionnaire responses and because the replies are not systematic and standardised, analysis can be difficult and comparisons imprecise. By contrast, quantitative data fit diverse opinion and experiences into predetermined response categories. The advantage of quantitative approach is that it facilitates comparison and statistical aggregation of data and gives a broad set of findings, which can be standardised.

The disadvantage of this standardised approach is that respondents must fit their experiences into predetermined categories which can distort what they really mean or have experienced. However, even though the purposes and functions of these two methods of data collection are different, it is possible to use them in a complementary way by incorporating both methods into a research design (Henwood & Pidgeon, 1995; Patton, 1987). Thus, the statistics from quantitative data make summaries, comparisons and generalisations relatively easy and precise. Qualitative data provide a forum for elaborations, explanations and descriptions of events in context and frequently lead to meaningful and new ideas (Patton, 1987).

Denzin and Lincoln (2003) note that qualitative methods imply an emphasis on the qualities of entities and meanings that are not experimentally examined or measured in terms of quantity, amount intensity or frequency. As qualitative researchers seek answers to questions that stress how social experience is created and given meaning, a qualitative research is therefore *value-laden* because it highlights the *process* (Denzin &

Lincoln 2003). In contrast with quantitative studies which emphasise the measurement and analysis of causal relationships between variables.

One of the most common methods used in qualitative research is in-depth interviewing (Faircloth et al 2004; Van der Hoonard 2004; Wilson 2007). In this study, in-depth interviewing had the potential to yield rich data because it gave respondents the opportunity to tell their own life histories and reflect on their experiences. As stated by Guion (sa) in-depth interviewing is an important data gathering tool characterised by mainly open-ended questions, semi-structured format in the discussion (which almost resembles a natural conversation) seeking understanding and interpretation, and recording responses, observations and reflections.

Open-ended questions are questions that cannot be answered by a simple “yes’ or “no” and therefore encourage respondents to elaborate on their responses.

Guion (sa) further stresses that in-depth interviews involve not only asking questions but also recording and documenting systematically the respondents’ response, coupled with intense probing in order to obtain deeper meaning and understanding of the responses.

Kvale (in Guion) proposes several stages of conducting in-depth interviews which include thematising, designing, interviewing, transcribing, analysing, verifying and reporting.

### **1.23.1 Research variables**

The independent variables were HIV and AIDS knowledge, attitudes and traditional beliefs of site managers, heads of departments and educators. The dependent variable will be workplace HIV and AIDS-related discrimination. Moderator variables will include emotions, locus of control, self-efficacy, age, race, gender, religion, income (total carry home) and education level.

### **1.23.2 Type of research**

This study was partly qualitative and partly quantitative cross-sectional correlation survey. The sequential mixed type of research was chosen to best meet the objectives of the research while the correlation study was preferred because it allows the analysis of the relationships among a large number of variables in a simple study, which was the case in this study. Also, the correlation study provides information concerning the degree of relationship between variables being studied, thus allowing the researcher not to conclude with a list of frequencies or arithmetic means (univariate statistics) but to go further by postulating relationships among variables (Mouton & Marais, 1996).

In this study, the quantitative cross-sectional correlational survey was followed by a qualitative in-depth survey of individuals in the School Management Team and ordinary teachers in selected schools. This was to ensure validity and reliability as representatives of the SMT and ordinary teachers was interviewed. For pragmatic reasons, only participants from Uganda participated in the in-depth interview.

### **1.23.3 Unit of analysis**

Two units of analysis used in this study, namely individuals and groups. Babbie (1979) cited in Mouton & Marais (1996:38) makes it clear that where the individual is the unit of analysis, then the researcher focuses on the characteristics and the orientations of individual behaviour. The individual is addressed in the masculine, which includes the feminine, except where specific gender reference requires the use of she/her.

Mouton and Marais (1996:39) say that the reason for studying groups rather than individuals is that groups possess characteristics which are not applicable to the behaviour of individuals. While the group's characteristics are usually derived from the characteristics of its individuals, groups possess their own characteristics. It was, therefore, necessary to try to understand and explain the behaviour of groups based on their training (hence, belonging to one department) and the level they occupy in the



organisational hierarchy as this may be influenced by group think as is in case of decision-making which has a bearing on HIV and AIDS policy formation and implementation.

Since data was collected from individual group members, it was absolutely necessary to assess for the presence of group effects before proceeding to other statistical analysis. This assessment is required even if the study's hypothesis specify individual effects. In these instances, group membership may still be a significant source of variance that needs to be accounted for (Zaccaro & Marks cited in Leong and Austin, 1996:155-163). Alternatively, if a researcher is interested in group phenomena but does not uncover a group effect in this initial assessment, careful consideration must be given to the meaning of the data. If the individual's own group has a meaningless influence on his or her behaviour, the investigator has to wonder if the data has any relevance regarding group or collective behaviour (ibid). Hence, group researchers need to attend carefully to the presence or absence of group effects in their data and the meaning of such effects (or the lack thereof) for subsequent data analysis and interpretation.

The purpose of the research design is to structure the research so as to maximise the internal and external validity of the research results. Research design, therefore, is synonymous with rational decision making during the research process. Regardless of how structured or unstructured a research project is likely to be, it is the researcher's duty to ascertain which general nuisance variables may render results invalid, and hence, to take every possible step to ensure that these factors are either minimised or eliminated (Bless & Higson - Smith, 2000).

#### **1.23.4 Research design component for quantitative part of the study**

A quantitative survey design with a focus on correlational analysis was used to achieve the research objectives and to test the research hypotheses. In a survey research design the relationships that occur between two or more variables at one time are

examined (Wellman & Kruger, 2001). The information obtained from the sample can then be generalised to an entire population. Survey research is usually a quantitative method that requires standardised information in order to define or describe variables or to study the relationship between variables (Wellman & Kruger, 2001). According to Wellman and Kruger (2001) this research design is ideally suitable for descriptive and predictive functions associated with correlational research. There was no control group and all variables were measured at the same time.

To ensure the reliability of the measuring instruments, Cronbach Alpha coefficients and inter-item correlation coefficients were used. The validity of instrument was assessed through exploratory factor analysis.

The study sets out to establish why workplace HIV and AIDS-related discrimination continues to prevail among teachers in both South Africa and Uganda despite the intensive HIV and AIDS knowledge programmes and attitude change campaigns, and to establish the relationship of traditional beliefs with the prevalence of the phenomenon. Although the study combined quantitative and qualitative designs, which Howard (1983) describes as methodological pluralism, it was mainly quantitative. The quantitative approach was in the form of a questionnaire with both closed and open-ended questions. The qualitative approach examined the personal constructs of both managers and subordinates in the teaching fraternity. The respondents' personal constructs were later analysed.

Miles and Huberman (1994) describe data as words rather than numbers, yet Strauss and Corbin (1990) view qualitative research as comprising any study that produces findings by means other than statistical procedures or any other means of quantification. Thus, the adopted design for this study was suitable for a number of reasons. It permitted the collection of rich data from the informants relating to issues pertaining to

workplace HIV and AIDS-related discrimination. Palton (1987) advises that the chosen research design should be appropriate to the subject under investigation. The management and subordinates in this study narrated their subjectively constructed thought, perceptions and behaviours about the phenomenon of workplace HIV and AIDS-related discrimination which were later to contribute to the development of a workplace HIV and AIDS-related discrimination model.

The research design provided the necessary detail and depth of data analysis to make findings relevant to practice (Douglas & Moustakas, 1984). The data included the school management team members and subordinates' thoughts, perceptions and actions pertaining to workplace HIV and AIDS-related discrimination.

Gergen (1985) argues that research products are not facts or findings that reflect objective reality, but are rather versions of worldviews that are constructed by the researcher and the participants/respondents. A research report comes to conclusions that exceed what subjects understand about their own world (Kelly, 1997:413).

The qualitative approach had a strong discovery-orientation. This encouraged the informants to introduce important concepts from an experiential standpoint.

According to Bond, Keogh and Walker (1996), experiential learning is a constructivist view (regarding knowledge as a product of the way people's imaginations are organised). Kolb (1984) developed a theory that attempted to clarify exactly how people learn by integrating their concrete emotional experiences with reflection. In this study, all participants, that is, SMT and subordinate teachers combined (N=27) were given opportunities to discuss their perceptions of the variables under investigation. This created a holistic view of the complexity of respondents' experiences and provided new insights into their lived experiences.

### **1.23.5 Research design component for qualitative part of the study**

A post-modern, post-structural approach guided the way in which the qualitative part of the research was conducted. Post-modern thought, according to Anderson (1997:26) tends toward 'knowledge as a discursive practice, toward a plurality of narratives that are more local, contextual and fluid; it moves toward a multiplicity of approaches to the analysis of subjects such as knowledge, truth, language, history, self, and power'. This approach recognises that there is no one truth, which may be grasped and clung to by all. Each person develops their own particular truth as they journey through life, in interaction with others. In the same vein, there is, I imagine, no one best way of trying to understand why individuals who have been exposed to a fair battery of HIV and AIDS-related knowledge and attitude change programmes continue to engage in workplace HIV and AIDS-related discrimination.

Anderson (1997: 27) notes the emphasis in post-modern 'suppositions' on the 'social' or relational creation or embeddedness of reality. Bosch (1991: 354) points out that whilst modernists are concerned with facts, post-modernists look for meaning. In post-modern post-structural practice, language is seen to constitute our world and beliefs. Accordingly, it is in language that societies construct their views of reality.

Language is so fundamental that to the post-modernists the only words that people can know are the words we share in language. Freedman and Combs (1996: 28) describe language as an interactive process. Through language, people construct knowledge between them, arrive at meaning, and create a new reality. This gives people agency because they can change the way they speak and the way they do things. Having read this text, you will construct your reality; that is, the meaning you ascribe to the unwritten words, which may or may not be different from the reality in which I am writing, which is my understanding of the words I put on paper. If we were to meet and discuss with each other we might arrive at some shared third reality as well as gaining newly constructed additional relational realities. Through our interaction, new knowledge would have been

created for us both, using language, thoughts spoken as well as those unrecognised and unspoken and words and meanings questioned and deconstructed. That is how it can be in an in-depth interview or focus group.

As Derrida (1995: 350) suggested:

'It is always an opening, at once in the sense of an unclosed system, of the opening left to the other's freedom, but also in the sense of overture, advance or invitation made to someone else. The intervention of the other ... is an indispensable but always improbable counter-signature. It must remain something one cannot anticipate. The chance of the absolute event always has a bottomless fund of initiative which must always return to it.'

I visualised the possibilities and opportunity of constructing knowledge from the in-depth interviews of those teachers and school management teams who work in institutions which may have colleagues infected or suspected to be infected by HIV and AIDS. I intended to critically look at their perceptions, behaviour and intentions, among other things, in workplace-related discrimination issues pertaining to HIV and AIDS. Ngugi Wa Thiong'o (1986:15) refers to language as 'the collective memory bank of a peoples' experience in history'. Language carries the culture, and 'culture carries the entire body of values by which we come to perceive ourselves and our place in the world' (Wa Thiong'o, 1986: 16).

I was expecting to learn from the responding teachers and school management team members about their belief systems and how they prefer to make meaning from these traditions and beliefs as regards to HIV and AIDS, especially as far as these traditions and beliefs may filter through into discrimination in the workplace. I understood these belief systems and thoughts as 'discourse'. Lowe (1991:44) suggests that the term 'discourse' has become a central concept in post-modern thought. 'Discourse' refers both to the process of conversation (Lowe, 1991:44-45) and acts as a medium that

provides word and ideas for speech (Hace - Mustin, 1994: 19). Meanings are constituted through this process of conversation; our words shape our realities and the way we make meaning of our lives (Derrida, 1995).

### **1.24 RATIONALE FOR USING THE CORRELATIONAL METHOD**

Correlational method allows one to analyse the relationships among a large number of variables in a single study. In behavioural science we are frequently confronted with situations in which several variables are contributing causes of a particular pattern of behaviour. The correlational method allows us to analyse how several variables, either singly or in combination, might affect a particular pattern of behaviour. (Path analysis and structural equation modeling are particularly useful for this purpose). The experimental method, in contrast, is not well suited for studying the effects of more than a few variables at a time. The correlational method also provides information concerning the degree of relationship between the variables.

The correlational method is used for two major purposes:

- To explore relationships between variables.
- To predict scores on a variable from subjects' scores on other variables.

In relationship research, the variables may be measured at the same point in time (cross-sectional study) or at different points in time (longitudinal study).

### **1.25 RESEARCH METHODOLOGY**

#### **1.25.1 This study conducted in three phases, each with different steps.**

Phase 1: Literature review Step 1	In building a theoretical model for this research, knowledge, the first core variable, was explored first by looking at how it could be conceptualised and deciding on its most appropriate definition as regards to biomedical knowledge of HIV and AIDS and basic
--	---

	<p>knowledge of laws related to discrimination in regard to HIV and AIDS among individuals of different employee categories. Essentially, knowledge's historical development, definition and measurement were critically examined to establish one part of the theory to drive the research.</p>
Step 2	<p>Attitudes of site managers, heads of departments and educators (individuals or employee of different categories), another core variable, were explored first by looking at how they could be conceptualised and deciding on the most appropriate definition. In essence, attitude's historical development, definition and measurement were thoroughly examined in order to establish another part of the theory to drive the research.</p>
Step 3	<p>Traditional beliefs about HIV and AIDS, the third independent variable, as it relates to workplace, were explored by reviewing literature with the purpose of coming up with a testable construct. Hence, its measurement was thoroughly considered.</p>
Step 4	<p>Discrimination, the dependent variable, as it relates to workplace HIV and AIDS was explored with the aim of conceptualising it. This was done through reviewing literature from regulatory bodies, namely government. The purpose was to come up with a testable construct, hence its measurement was considered.</p>
Step 5	<p>In this research, a theoretical integration of the dependent and independent variables was attempted to establish the relationships between the variables. This was done through justification from the view point of HIV and AIDS attitudes of site managers, heads of departments and educators firstly. Secondly, this was done through justification of biomedical and legal knowledge of HIV and AIDS of</p>

	<p>site managers, heads of department educators and other teaching employees, especially teachers. Thirdly, through justification of traditional beliefs of HIV and AIDS of individuals in the three employee categories. Finally, this was done through justification of HIV and AIDS-related discrimination. It was then hypothesised the relationships between these variables.</p>
--	--

<p>Phase 2: Empirical study Step 1</p>	<p>In this study, the sample was drawn from site managers (and their deputy site managers), heads of departments and educators (post level 1) from a stratified random sample of urban and rural, private and government (public), day and boarding, and primary and secondary schools as categorised by the National/Provincial government. The site managers, formerly referred to as principals in South Africa or head teachers, (Headmasters or Headmistresses in Uganda) and their deputy site managers and heads of departments form the School Management Teams (SMT) which are charged with the management task per se), will form one category while educators, formerly referred to as teachers and currently referred to as post-level 1 educators in South Africa and teachers in Uganda, were the other category.</p> <p>The sample consisted of school-based educators (a general name for teachers and management teams in schools), from two private, rural primary schools (one boarding and the other a day school); two private, urban primary schools (one boarding and the other a day school); four rural, government secondary schools (two of which were boarding and two day schools); and four private, urban secondary schools (two of which were boarding and the other two</p>
--	--



day schools).

The number of secondary schools was double that of primary schools because the former generally have more adolescents than the latter and, hence, are prone to more adolescent-related problems like indiscipline which requires more attention from teachers, thus draining them psychologically and physically.

Boarding schools were included because they generally tend to require much more of the teachers' time to maintain discipline for 24 hours. Rural and urban school teachers were included in the study because the locality of the school tends to have some influence on the general school environment, including the economic, social, political, psychological and cultural environment. These may influence the individual's behaviour in varying degrees.

Private and public (government) schools were included because, despite the common labour laws, educational laws and the National Constitution, there are some variations in how these laws are applied, thus offering slightly different working environments: for example, salary structures vary from one private school to another, yet in government schools of any one category, there may be variations in salary structure, but with a certain degree of consistence. This economic variable may have an influence on an individual at work.

Drawing the respondents from school samples of various socio-economic environments enabled analysis by selected socio-

economic variables which were deemed to influence workplace HIV and AIDS-related discrimination, by enhancing the psychological explanation to which they may be having a bearing. Being inclusive and random enhances external validity.

To recap, management (the school management team [SMT]) and educator (educator post-level 1) were the two categories by status and/or operations which were used in analysis as they might have some influence on the variables bearing on one's hierarchy and management thinking about HIV and AIDS in the workplace.

The sample size is dictated by the precision required or the maximum cost that can be expended. Such an aim involves a complex number of considerations:

- What is the cost structure for sampling in a given structure?
- How do we access the precision we require of our estimators?
- How do we balance needs in relation to different characteristics of the population which may be of interest?
- How do we deal with a lack of knowledge about the parameters such as the population variance, which may affect the precision of estimators?

It was the last consideration that concerns the proposed study mostly. In this study, the main population characteristics which were of interest were:

- The HIV and AIDS biomedical knowledge and basic HIV and AIDS legal knowledge of site managers, heads of

departments and educators.

- The HIV and AIDS attitudes of site managers, heads of departments and educators.
- The traditional beliefs of HIV and AIDS of site managers, heads of departments and educators.
- The workplace HIV and AIDS-related discriminatory behaviours and/or intentions.

While there were some studies on HIV and AIDS-related discrimination, there was no specific previous research which sought to identify these characteristics in the population of site managers, and heads of departments and educators, particularly the interplay between the variables in the education sector of the Republic of South Africa and that of the Republic of Uganda. Again, there are a range of different institutional settings in which site managers, heads of departments and educators interact with HIV and AIDS-infected employees of all categories, all of which are influenced by knowledge, attitudes and traditional beliefs. There was no adequate previous measurement of variability of knowledge, attitudes and traditional beliefs relating to workplace HIV and AIDS-related discrimination.

Hence, the need to estimate the required sample size by an alternative way which represented both the whole population and a valid sample from each of the types of provision. This was done without prior knowledge of any measurement of variability of this population.

	<p>There are four ways in which the minimum sample size may be estimated when the population variance <math>S</math> is unknown, namely from pilot studies, previous surveys, a preliminary sample and practical considerations of the structure of the population — all useful in varied circumstances when using random sampling. However, the proposed study is a correlation one, so using stratified random sampling, makes the process of estimating the number of cases needed much easier.</p> <p>The probable size of the correlation likely to be obtained was based on previous research and on the results of the pilot study. Then using Table 9B (see Appendix VII), one can go down the <math>R</math> column until one comes to the estimated correlation and then reads the number of cases one requires in the <math>N</math> column to be statistically significant. In this study, the sample size estimated was 120 lower rank employees at <math>r=.20</math>, statistically significant at <math>.01</math>, and 40 managers (site managers, deputy site managers and heads of departments as these formed the school management team [SMT] which manages the school) combined in the ratio of 1:3 to cater for proportional representation of the two categories at <math>r=.40</math> at the same level of significance. This sample size of site managers and heads of departments took into consideration pragmatic reasons such as the smaller percentage of workforce contributed to by site managers and heads of departments, their busy schedules of work, and not ignoring their possible reluctance to participate in the study.</p>
Step 2	<p>For this investigation, four major measuring instruments merged into one were used, namely:</p> <ul style="list-style-type: none"> <li>• the HIV and AIDS-attitude scale,</li> </ul>

	<ul style="list-style-type: none"> <li>• the HIV and AIDS knowledge scale,</li> <li>• the HIV and AIDS traditional beliefs scale; and</li> <li>• the workplace HIV and AIDS-related discrimination scale, and</li> </ul> <p>all were drawn from existing studies, based on the relevant issues, with incorporation from previous related scales, pre-tested and then piloted. Efforts were made not to include individuals who had participated in the pilot sample for the purposes of controlling the quality of the findings of the actual research. The scales' reliability and validity was determined. The validity of these survey instruments was strengthened by modifications made after a pre-test had been sent to a variety of practitioners, HIV and AIDS-experts and academics.</p> <p>The aim of these instruments was to measure the constructs, while the rationale of using them was their relevance. Justification for their use was because of their precision and brevity so as to tap the necessary information yet in minimum time. Regarding their administration, the instruments were paper-and-pencil fill-in type and interpretation was in accordance with established criteria. The questions were in English as all respondents are conversant with this language at a good level.</p>
Step 3	<p>Regarding data collection, the researcher present his introductory letter, written by the Industrial Psychology Department (or Supervisor) to the authorities in the selected schools requesting for permission to conduct a survey among their workforce. The letter clearly stipulated the purpose of the survey and assured confidentiality and anonymity of each individual participant who was requested to sign a consent form. It was indicated that they are free</p>

to stop participating in the research at any time and that nobody was forced to participate.

Data was collected by multi-method multi-source design from two categories of source material: interviews with one member of the schools management team (SMT) drawn randomly and one member from educators who are not members of the SMT from each participating school as well as questionnaire surveys of the site managers (and their deputies), heads of departments and educators (Post level 1) about knowledge, attitudes and traditional beliefs about HIV and AIDS together with HIV and AIDS-related discriminatory behaviours. The researcher himself conducted the in-depth interviews of one SMT member and one educator (post level 1) drawn randomly by picking a 'Yes' from the many 'No' answers equal to the total number of members in both categories, i.e. SMT and educators (post level 1) on and during the day the researcher visited the school in the survey sample.

Listed below were the chief purposes of these interviews:

- To determine the effect(s) of HIV and AIDS on these schools.
- To document the internal range of perceptions of HIV and AIDS-related matters, including discrimination relating to HIV and AIDS.
- To get the views of the executive about the role of the company – at present and historically – regarding serious epidemics like HIV and AIDS.
- To identify the dominant coalition that defines organisational

	<p>perceptions.</p> <ul style="list-style-type: none"> <li>• To formulate questions for the follow-up questions on knowledge attitudes and traditional beliefs pertaining to HIV and AIDS among site managers, heads of department and ordinary teachers/educators.</li> </ul> <p>The administration of the questionnaire to each individual in the sample was done by the contact person with the assistance of the researcher, who was available to clarify whatever needed clarification. While it is possible to hand over the completed questionnaire to the contact person or the researcher, a stamped self-addressed envelope was issued. However, participants were urged to mail the completed questionnaire immediately. To maximise the return of completed questionnaires, a reminder was sent to respective contact persons.</p>
Step 4	<p>Data processing included scoring of the HIV and AIDS-attitude scale, the HIV and AIDS-knowledge scale, the HIV and AIDS-traditional beliefs scale and the workplace HIV and AIDS-related discrimination scale. The scores were captured onto a data sheet formatted by means of the PC Tools package (Dyson, 1990) for that purpose. The analysis of that data was handled through the use of the Statistical Package for Social Sciences 11.0.1 (SPSS inc 2003) programme.</p> <p>The statistical procedures relevant to this research included:</p> <ul style="list-style-type: none"> <li>• Item-test reliability and Cronbach's alpha to test the reliability of the measuring instruments.</li> <li>• Factor analysis to determine the factor structures of the questionnaire.</li> </ul>

	<ul style="list-style-type: none"> <li>• Inter-correlations to determine the relationship between variables and constructs in the research model (Kerlinger, 1986:188).</li> <li>• Confirmatory factor analysis to refine the instruments developed for the proposed study.</li> </ul> <p>Specific statistics included descriptive multiple regression analysis, factor analysis, Cronbach’s alpha and correlation.</p>
Step 5	<p>Hypotheses were formulated around the aims of the research. In this study, the hypotheses included the following:</p> <ul style="list-style-type: none"> <li>• Individuals who score highly on traditional beliefs of HIV and AIDS scale are more likely to engage in workplace HIV and AIDS-related discrimination than those individuals with more HIV and AIDS knowledge i.e. those individuals who score highly on the knowledge scale.</li> <li>• Individuals who score highly on traditional beliefs of HIV and AIDS are more likely to engage in workplace HIV and AIDS-related discrimination than individuals who score highly on attitude scale i.e. those individuals with a positive attitude toward HIV and AIDS infected individuals.</li> <li>• Individuals who score highly on the HIV and AIDS knowledge scale, i.e. those with more HIV and AIDS knowledge, are more likely to engage less in workplace HIV and AIDS-related discrimination than individuals who score highly on the attitude scale, i.e. those with a positive attitude toward HIV and AIDS infected individuals.</li> </ul>



Step 6	Results were reported objectively, accurately, and conventionally, and interpreted according to standardised requirements relating to the statistical measures used. The descriptive statistics were presented first, followed by factor analysis, stepwise regression analysis, a Cronbach's alpha and lastly, interpretation followed.
--------	--

Phase 3: Conclusion, limitations and recom- mendations Step 1	Regarding the conclusion, it was expected that the aims of this study would be met, that is, to find the relationship between HIV and AIDS knowledge, attitudes and traditional beliefs of site managers, heads of departments and educators; find the relationship between HIV and AIDS knowledge, attitudes and traditional beliefs of workplace HIV and AIDS-related discrimination; and determine which factor predicts workplace HIV and AIDS-related discrimination.
Step 2	Limitations expected to play a role in the research included indifference among some participants, non-response, delay of response and false reporting. However, as the questionnaire was designed with almost half the attitude items in the negative, this minimised the bias. The face-to-face in-depth interviews were done by the researcher, using an interview guide and allowing for some flexibility to maximise response rates. To render generalisability to the findings, a sizeable representative sample was used. Where 70% of the questionnaire was unanswered, that questionnaire was eliminated; and if over 70% but less than 100% of the questionnaire was answered, the questionnaire was accepted for use in analysis and reporting. Thus, the sample varied for such items and this was indicated whenever it happened.

Step 3	Recommendations were made relating to the revelations from the relationships between HIV and AIDS knowledge, attitudes and traditional beliefs and workplace HIV and AIDS-related discrimination. Suggestions for future research efforts aimed at measurements and analysis of HIV and AIDS attitudes, knowledge and traditional beliefs as they relate to workplace HIV and AIDS-related discrimination were made. Also, recommendations for practice were made where appropriate.
--------	--

## **1.26 ETHICAL CONSIDERATIONS: AN ELABORATION**

The conduct of research requires not only expertise and diligence but also honesty and integrity (Burns & Grove, 2005:176). Babbie (2005:61); LoBiondo-Wood and Haber (2002:492); as well as Polit and Hungler (1999:701), define ethics as “a set of widely accepted moral principles that offers rules for, and behavioural expectations of the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and learners.” The following ethical issues were considered in this study: rights of respondents, rights of institutions and scientific honesty on the part of the researcher

### **1.26.1 Ethical considerations relating to the respondents**

The following ethical considerations ensured that the respondents’ rights were not violated (Burns & Grove, 2005:181; LoBiondo-Wood & Haber, 2002: 273):

- The respondents’ self-determination was ensured by providing verbal and written information regarding the study (Burns & Grove, 2005:181; LoBiondo-Wood & Haber, 2002:273).
- Ensuring anonymity and confidentiality of the information provided enhanced the respondents’ right to privacy. This means that the respondents remained

anonymous in the reports and publication of the study (Babbie, 2005:188; burns & Grove, 2005: 188).

- The respondents were free to withdraw from the study if and when they desired to do so (Babbie, 2005:62).
- The respondents were given opportunities to give voluntary written consent (Babbie, 2005:64; Burns & Grove, 2005:193)

### **1.26.2 Ethical considerations pertaining to institutions where the study was conducted**

Permission to conduct the study was sought from the principals of the participating schools following permission to conduct research in school was sought and granted by the Head of Department of Education in the North West Province of South Africa. The survey required educators to complete a questionnaire, and only two individuals in each participating school participated in the in-depth interview. No harm or discomfort was inflicted on any respondent or any non-respondent. The researcher's telephone numbers were provided in case any respondent wished to inquire about anything or discuss anything with the researcher during or after completing the questionnaire (Babbie, 2005:70; Burns & Grove, 2005:199).

### **1.26.3 Scientific integrity of the researcher as an ethical consideration**

The researcher generated knowledge through honest conduct, reporting and publication of research results. The researcher is aware that scientific misconduct had to be identified and reported in order to maintain the quality of results and report (Burns & Grove, 2005: 203-206; De Vos, 2001:30). Efforts were made to acknowledge all sources of literature used in this study in form of bibliography at the end of the report.

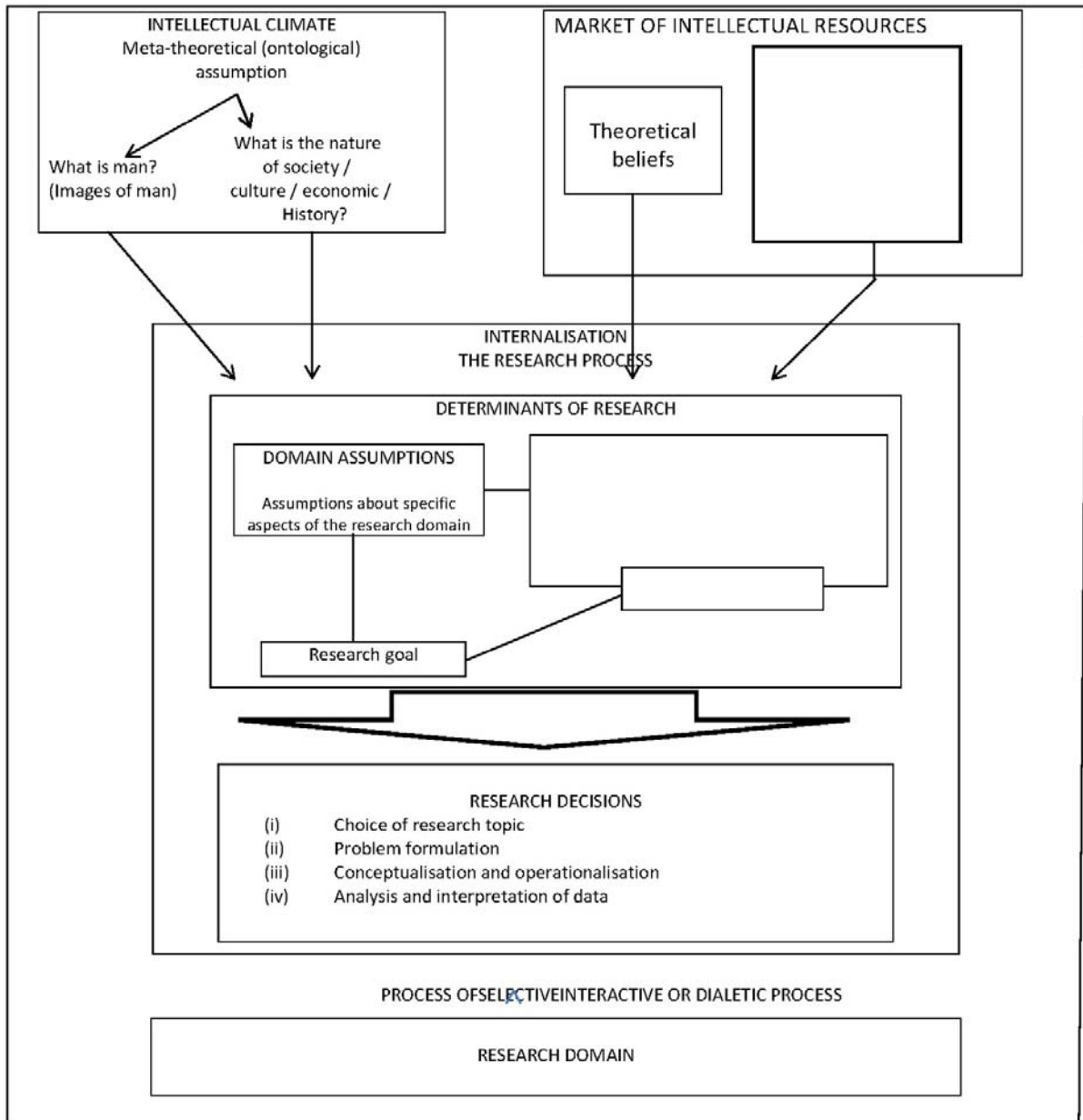
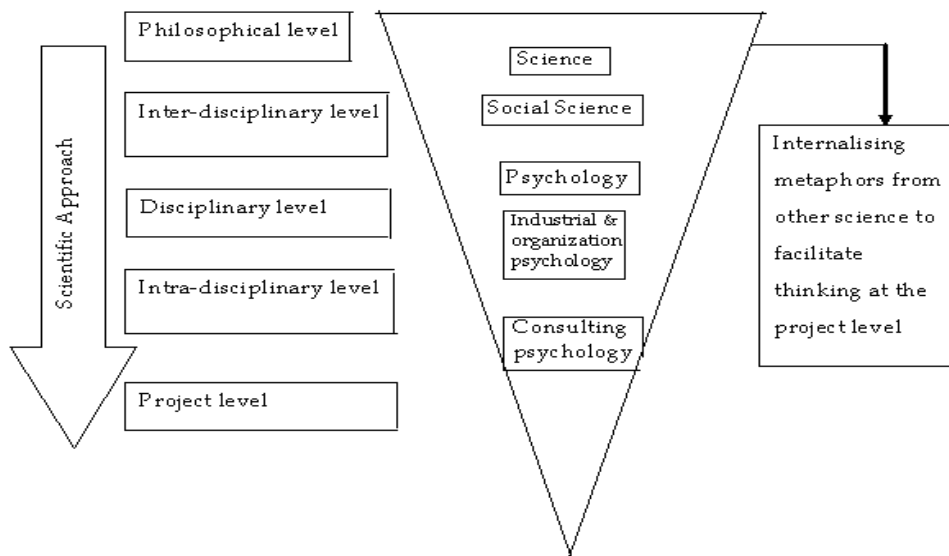


Figure 1.3: Research model (Mouton & Marais, 1996:22).

## 1.27 DISCIPLINARY RELATIONSHIPS

Figure 1.4: Disciplinary relationship of research

Constructed by the researcher (Freedman, G. 2006), illustrates the disciplinary relationship of this research in terms of meta-theoretical and theoretical levels and is described below:



Source Freedman, G. 2006

### 1.27.1 Philosophical level

At the philosophical level, the research adopts a scientific approach. Kerrod (1983) describes science as a 'broad field of human knowledge, acquired by systematic observation and experiment and explained by means of rules, laws, principles, theories, models and hypotheses'. The researcher views reality as what Bergson in Wulf (1996:126) terms, 'a process of becoming' and that life is 'becoming, acting and action (élan vital)'.

The research relies strongly on the phenomenological proposition that consciousness, which is seen as containing and comprising the entire horizon of the world and the

meaning of all known objects, must be understood *from the inside*, through the use of the intra-psycho processes (Wulf, 1996). It also draws on existentialist perspectives of individual human existence and issues related to the meaning of human existence, freedom and destiny (Wulf, 1996). There is a strong focus on understanding *what is* and on considering human beings in their real life situations, connected to the world and to other human beings.

### **1.27.2 Inter-disciplinary level**

Wulf (1996) describes the beginning of the 20<sup>th</sup> century as having been characterised by the explosive development of science. The scientific disciplines of physics, biology, chemistry and medicine were making rapid progress. According to Kaku (2004), a theoretical physicist, the three main challenges of the 21<sup>st</sup> century are the study of matter, biology and the mind. He views the task of science as being to cross-pollinate the advances in these three areas. This point of view is critical in terms of the interdisciplinary perspective of this research, which is open to the cross-pollination of ideas, concepts, analogies and metaphors from the study of matter (physics), living organisms (biology) and the mind (psychology).

The social sciences aim at describing, explaining, predicting or intervening in the development and behaviour of social systems (Kerrod, 1983). Bornstein and Lamb (1999) regard the social sciences (anthropology, economics, education, environmental disciplines, history, political science and sociology) as the closest allied disciplines to psychology. However, there is tension between these disciplines, such as the issue of resolving whether individual behaviour aggregates to social and cultural behaviour (for example, psychology) or whether aggregate level social and cultural behaviour help to explain individual conduct (for example, sociology).

This study does not challenge the various physical and biological science rules, laws, principles, theories and hypotheses but accepts them at the meta-level.

The reason for exploring what may be gained from these allied disciplines is an attempt to cross-pollinate the researcher's thinking at the object level with metaphors and analogies based on selected elements from these sciences.

### **1.27.3          Disciplinary level**

At the disciplinary level, the research is conducted from within the discipline of psychology. As a science, psychology evolved from primordial currents in philosophy and the natural science (Boeree, 2000a). Boeree (2002a) adds that psychology should not have any boundaries imposed on it by scientists or practitioners. Once again, this supports the notion of attempting to create new knowledge and insights using concepts from other sciences.

McCormick and Ilgen (1985) describe psychology as the scientific study of behaviour. This includes the behaviour of any organism, human and non-human. (Are trees or plants included in this definition?) Psychologists seek to do this through four basic goals: description, explanation, prediction and intervention.

Given the vastness of this field, the subject has evolved into many independent sub-disciplines with their own history and approaches. The discipline is described by Bornstein and Lamb (1999) as having a unique status among what they term *domains of knowledge*. These domains (or disciplines), the humanities, the social science and the physical science, are simultaneously autonomous and interrelated.

Psychology contributes to and benefits from a great variety of disciplines. The humanities (art, linguistics, literature, music, philosophy and religion) have yielded interfaces with psychology from the emotional, intuitive, aesthetic and idiographic perspectives, drawing on historical analyses, biographical accounts, experiential or self-reports and empirical study methods (Lundin, 1996). Many psychologists work at the interface of psychology with another discipline – or at least touch another discipline on a

regular basis. This is especially true in the world of work, where individual, group and organisational performance are almost always related to a particular business.

The research draws on streams of theories, concepts, models and constructs from the discipline of psychology, especially those of Gestalt psychology. The research also draws from narrative psychology, in terms of the thought experiment (Chapter 6), which deals with the research's phenomenological experience by creating a story that is analysed and explored for meaning and Gestalt. In the development of a methodological framework for the application of the thought experiment (Chapter 6), provision is also made for encouraging participants to tell their story of the individual, group or organisation so that they, other participants and the researcher may listen to it, reflect on it and develop heightened awareness of domain phenomena.

#### **1.27.4 Intra-disciplinary level**

At the intra-disciplinary level, this research is conducted within the sub-discipline of industrial and organisational psychology. Industrial and organisational psychology has both a scientific and a professional focus (McCormick & Ilgen, 1985). Its scientific aspect is founded in research that is a prerequisite for practical application. Many industrial psychologists are professionally active in the field of consulting to organisations, groups and individuals and are always seeking new ways of viewing business organisations so that they may assist these organisations to achieve their goals (APA, 1999).

This level serves as a lens to focus the research project on problems, issues, theories, concepts and constructs that are the study of individual, groups and organisational behaviour in the context of work. It is important that the definition of the interactive field of consulting psychology be understood to contain these three levels of behaviour in an integrated and holistic manner.



### **1.27.5 Psychology**

More than a hundred years ago, William James (1890, cited in Kuper, 1988:347) epitomised *psychology* as ‘the science of mental life’. More recent definitions support James’s original epitome. Consequently, psychology is defined as the science that studies behaviour and mental processes (Gall, 1996) and, in a similar vein, as ‘the systematic study of behaviour and the mind’ (Sutherland, 1995:372). Plug, Louw, Gouws and Meyer (1986) support these definitions of the construct, but emphasise that this science is aimed at utilising objective methods to study the individual as opposed to studying group and societal behaviour and mental processes.

#### *1.27.5.1 Industrial Psychology*

*Industrial psychology* is a sub-field of psychology (Gall, 1996) and can be defined as ‘the psychological study of all aspects of the working environment, and the application of psychological findings to improving efficiency and contentment at work’ (Sutherland, 1995:222).

The field of industrial psychology focuses on the behaviour of people working together and includes various aspects of the working environment; such as recruitment and selection, training and development, job evaluation, job analysis, job descriptions, job specifications, motivation of staff, performance management, the study of morale, stress management, ergonomics, organisational psychology, consumer psychology and industrial safety (Plug *et al*; 1986; Pond, 2004).

This research specifically pertains to three sub-disciplines of the industrial psychological field, namely personnel psychology, organisational psychology and psychometrics.

#### *1.27.5.2 Personnel psychology*

Personnel psychology is concerned with the psychological characteristics of individuals/employees, which impact on their work functioning and their relationships with fellow employees (Plug *et al*; 1986). According to McCormick and Ilgen (1989), this

field of psychology focuses on the study of a wide spectrum of human problems, which presents itself during the course of various processes in the workplace.

Psychological characteristics of individuals which can cause these human problems include ability and personality (Uhlener, 1970, cited in McCormick & Ilgen, 1989). The emphasis of this study was, thus, on the study of the psychological characteristic of personality.

#### *1.27.5.3 Organisational psychology*

Organisational psychology is defined as the scientific study of human behaviour in the workplace and involves interaction of individual and work processes to predict behaviour, mental health and productivity (Pond, 2004).

#### *1.22.5.4 Psychometrics*

Psychometrics, as a sub-discipline of industrial psychology, also plays a role in this research. Psychometrics can be defined as the study of aspects of psychological measurements that is aimed at the development and application of mathematical and statistical procedures in psychology (Plug *et al*; 1986). Psychometric instruments will be utilised appropriately.

### **1.27.6           Applicable behavioural models**

The term 'model' is one of the most ambiguous terms in the vocabulary of the social scientists (Mouton & Marais, 1996). Kerlinger (1986:167) describes a model as 'an abstract outline specifying hypothesised relations in a set of data'. Mouton and Marais (1994:140) support this definition by concluding that a model is an attempt 'to represent the dynamic aspects of the phenomenon by illustrating the relationships between the major elements of that phenomenon in a simplified form.

The psychometric variables that were utilised in the empirical study when measuring the individuals' knowledge, attitudes and traditional beliefs were by means of psychometric

scales. The theoretical model that was applied during the course of the quantitative survey is illustrated in Figure 1.5 below

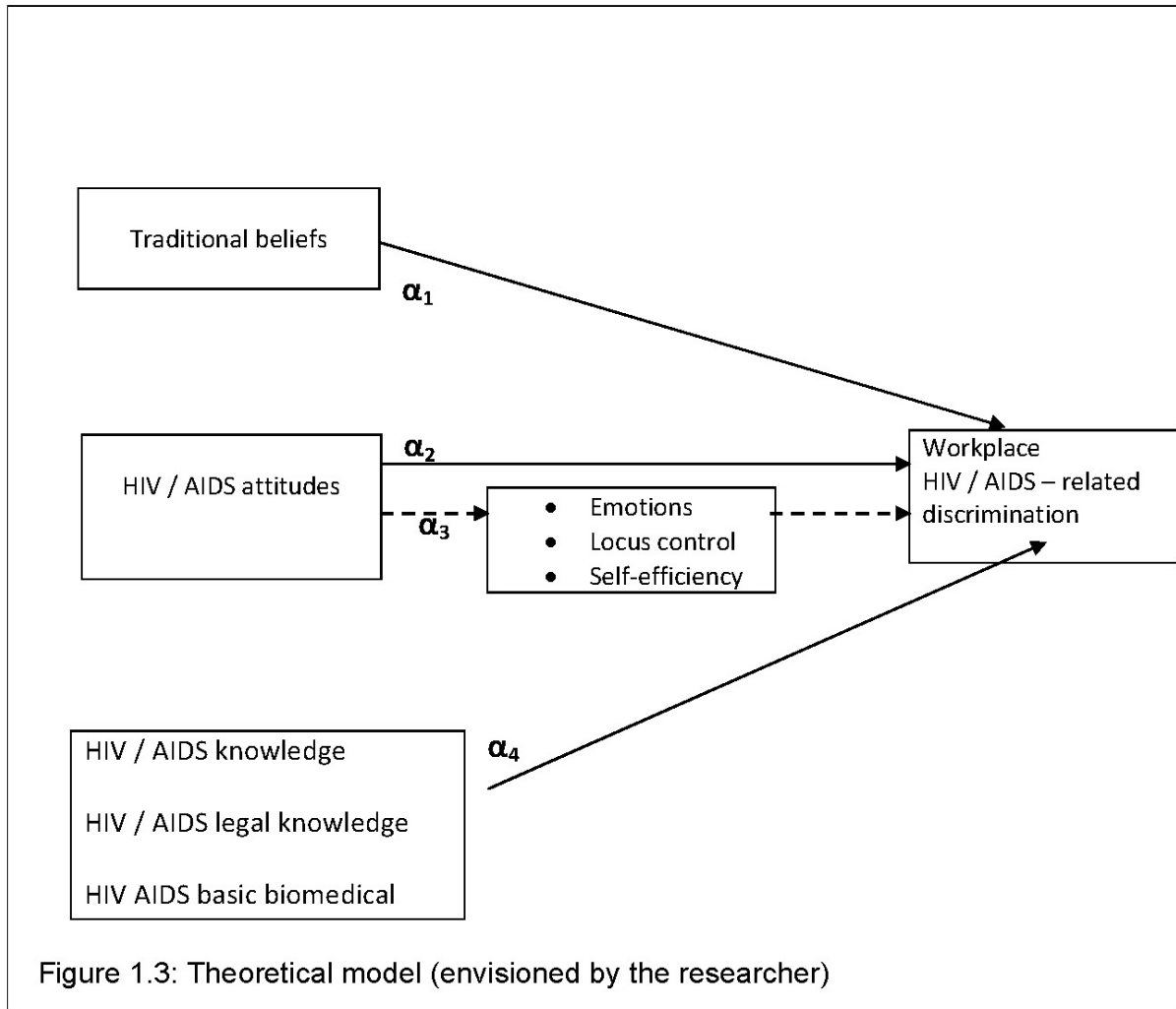


Figure 1.5: Theoretical model (envisioned by the researcher)

Where the correlational coefficients are as indicated:  $\alpha_1$   $\alpha_2$   $\alpha_4$ .  $\alpha_3$  is the correlational coefficient between attitudes and workplace, HIV and AIDS-related discrimination whereby the attitudes are moderated by emotions, locus of control and self-efficacy.

### 1.27.7 Research approach

For the purpose of this study, quantitative and qualitative approaches were utilised. Quantitative research is a systematic, controlled, empirical and critical investigation of

phenomena guided by theory and hypotheses about the presumed relations among such phenomena (Kerlinger, 1986). The quantitative approach was therefore applicable to this research in that statistical evidence of relationships were calculated and used to scientifically either confirm or reject the research hypothesis.

McCracken (1988:17) suggests that 'qualitative research does not survey the terrain, it mines it. It is, in other words, much more intensive than extensive in its objectives'. The qualitative approach does not assume an absolute understanding of psychological reality, but seeks to describe the life world of the respondent. Because this type of research is primarily concerned with behaviour motivation, the qualitative approach has been applicable to describe what respondents communicate as what sets them to engage in workplace HIV and AIDS-related discriminatory behaviours.

## **1.28 THE BASIS OF TRIANGULATION**

Surveys of social research methodologies generally divide analytical procedures into two categories: quantitative and qualitative. The former approach focuses on enumeration and statistical analysis, while the latter is more interested in the interpretation of meaning (Tulloch & Lipton, 1997: 19-20). There are, however, overlaps between these categories. For example, the content of a series of one-to-one interviews or focus groups that explore issues in-depth (usually described as a 'qualitative' method) may be quantified through the use of counting, while, on the other hand, self-administered questionnaires may include open-ended questions in which the respondents are asked to expand on their views in their own words.

### **1.28.1 Methods to ensure reliability and validity**

The aim of social sciences research is to study social reality objectively with the aim of not merely understanding the phenomena, but also providing a *valid* and *reliable* understanding of reality (Mouton & Marais, 1996). In this study methods to ensure reliability and validity of the research pertain to both the literature survey and the empirical studies have been adhered to.

### **1.28.2 Validity and reliability of the literature survey**

Validity of the literature study is firstly assured through the correct selection of the archival resources that are relevant to the aims and problem statement of the research. By means of comparing different literature resources, such as cross-referencing of topics involved, assumptions and conclusions drawn from the literature, which also ensured the internal validity of the literature review (Huysamen, 1994).

The literature review covered constructs pertinent to the ultimate aims and objectives of the study. In order to increase the theoretical validity, as evident in scope, clarity and systematisation, a detailed literature survey of discrimination, more specifically workplace HIV and AIDS-related discrimination, was presented together with the detailed survey of the key independent variables, namely HIV and AIDS knowledge, attitudes and traditional beliefs.

Throughout the literature survey, the researcher attempted to order and identify the essence of the key constructs in a logical and systematic manner, which ensured that the underlying dimensions and/or meaningful relationships between relevant constructs were explained in a logically correct manner (Mouton & Marais, 1996). Where possible, an attempt was made by the researcher to use the most recent archival resources. However, for some classical work, dated resources were used, but kept to a minimum. Reliability was furthermore generated through adherence to the research design and by references to similar existing research.

### **1.28.3 Validity and reliability of the empirical study**

Reliability and validity are assessed by different criteria in quantitative and qualitative research. The validity and reliability of the empirical study have to be considered in terms of quantitative and qualitative focus. Validity and reliability of the empirical study pertaining to quantitative research and qualitative research was established. Reliability

of an instrument refers to 'how consistently it measures what it purports to measure' (Huysamen, 1983:24). Kiplinger (1986) defines reliability as 'the accuracy or precision of a measuring instrument'.

Reliability is the consistency, constancy, or dependability, accuracy and precision with which an instrument measures the target attributes (Burns & Grove, 2005:374; Lobiondo-Wood & Haber, 2002: 319-327; Polit & Hungler, 1999:713). This means that administering the same instrument by various researchers will provide the same results under comparable conditions (De Vos, Strydom, Fouche & Delport, 2005:163). According to Van der Riet and Durrheim (2006:92), reliability refers to the extent to which the results are repeatable; and according to them, this applies to both the subjects' score on the measures (measurement reliability) and outcome of the study as a whole.

The Cronbach Alpha Correlation is utilised to calculate the reliability of the measuring instruments. This correlation coefficient reflects the extent of internal consistency of an instrument and indicates the degree to which all the items in the instrument measure the same attribute (Huysamen, 1983). An instrument's 'reliability' (true score) and its 'unreliability' (error score) are regarded as two proportions that add up to unity (1.00). The value of the Cronbach Alpha correlation coefficient of 0.5 is regarded as statistically significant (De Waal, 1997) and will be used in this research.

Pertaining to validity, researchers are often confronted by a typical question: '*Are we measuring what we think we are measuring?*'

Answering the question requires establishing validity of the measuring instrument. There are several types of validity, but in this study we need to consider three which are very relevant, namely content validity, criterion-related validity and construct validity. Construct validity is probably the most important form of validity from the scientific point

of view because it links psychometric notions and practices to theoretical notions – it is thus preoccupied with theory, theoretical constructs and scientific empirical inquiry involving the testing of hypothesised relations (Kerlinger, 1986; Singleton *et. al.*, 1988).

‘Construct validation is an analysis of the meaning of test scores in terms of psychological concepts or constructs’ (Cronbach & Meehl, 1955, cited in Cronbach, 1970). Construct validity is involved whenever a measuring instrument is to be interpreted as a measure of some attribute or quality that is not ‘operationally defined’. Construct validity therefore has to be investigated whenever no criterion or universe of content is accepted as entirely adequate to define the quality measured (Cronbach & Meehl, 1955).

The validity and reliability of the qualitative research will be done in accordance with the steps as described above.

Sandelowski (1986) supports the viewpoint that the focus of *qualitative research* is the rich description of human experiences, rather than the control and prediction of variables. Polkinghorne (1994) proposed two criteria against which the validity and reliability can be measured, that is, the soundness of the methodology utilised and the usefulness of the research findings. Accordingly, with regard to these two criteria, the role of the researcher and the transparency of the research results was critical (Segal, 1996; Sykes, 1991).

According to Van Kaam (1958, cited in Kruger, 1979), the role of the researcher can be defined as observing, comprehending and coming to an explication of the lived experience of the research subject with the intention of disclosing the world of the individual. Strasser (1963, cited in Brendell, 2004) emphasises that the researcher has to be objective during the course of the whole process and has to display an intellectual

attitude of someone who pursues his study in an unprejudiced fashion and allows his judgment to be determined by that, which really presents itself. Van den Berg (1972, cited in Kruger, 1979) says that the researcher has to remain true to the facts as they are happening and therefore cannot allow 'fore-understanding', meaning his/her personal values, expectations, preconceptions and feelings, cannot influence the research process. In order to fulfill the role of the researcher effectively, it was critical that the researcher scrutinise this fore-understanding through a process of self-awareness and openness, to ensure that the research subject discloses itself to the researcher 'in all its manifestations and complexity' (Kruger, 1979).

The transparency of the research results was determined by the soundness of methodology utilised and itself determines the usefulness of the research findings. Sykes (1999) emphasised this when he stated that the task of the qualitative researcher is to attempt to communicate the research process in a transparent manner. According to Segal (1996), the reader should be able to relate to and interact with the research process and follow the logic of how research conclusions are drawn. The foundation of transparency lies in descriptive adequacy, which refers to findings based on sound and explicit argumentation that forms the basis for reasonable extrapolations regarding the applicability of findings to similar situations (Segal, 1996).

The first criterion, which determined whether this empirical study was valid and reliable, was soundness of the methodology utilised. The methods enabled the researcher to get close to the data included participant observation and in-depth interviewing (Lofland, 1975, cited in Mouton & Marais, 1996). To ensure the reliability and validity of this phase, a framework was thus provided within which subjects could respond in terms of their own meanings. Interviewing was thus included to obtain first-hand knowledge from the respondents.

The second criterion for reliability and validity is the usefulness of the findings. This can be ensured by means of a high correlation between the data and the findings in the



research; accurate descriptions of the phenomena under investigation, the findings can be replicated and be confirmed by other researchers (Sykes, 1991). Therefore, to ensure the usefulness of the findings in this study, thereby increasing the reliability and validity, certain procedures were followed. Firstly, the correlation between the data and findings was monitored continuously as the researcher was flexible by constantly questioning and checking emerging data, without selecting or neglecting data just to fit a specific argument. Secondly, through self-awareness and openness, the researcher attempted to limit fore-understanding and described the phenomena as they were, before establishing any theories or hypotheses thereby demonstrating above all, respect for the phenomena (Kruger, 1979). Lastly, to ensure that the findings in this study can be replicated and confirmed, the methodology utilised, the content of the research and the approach followed during the entire course of this study was documented precisely (Kruger, 1979).

## **1.29 CHAPTER DIVISION**

The research is divided into the following chapters:

- Chapter 1 provides the introduction and statement of the problem, aims, theories, methods and the chapter division of this research.
- Chapter 2 presents a literature review on HIV and AIDS knowledge, starting with the definition of knowledge, HIV and AIDS biomedical knowledge and HIV and AIDS legal knowledge.
- Chapter 3 presents a literature review on attitudes, especially HIV and AIDS-related attitudes, starting with the definition of attitudes.
- Chapter 4 presents a literature review on HIV and AIDS-related traditional beliefs, starting with the definition of traditional beliefs, especially those about causation of illness.
- Chapter 5 provides a literature review on workplace HIV and AIDS-related discrimination, starting with the definition of discrimination.

- Chapter 6 discusses the design of the empirical study and research methodology with regards to the questionnaire and interview guide used in the study and their administration.
- Chapter 7 presents the results of the study, their analysis and interpretation.
- Chapter 8 presents the discussion of the findings of this study, incorporating significant literature; the limitations to this study; and proposed recommendations emanating from this study.

### **1.30 CHAPTER SUMMARY**

In this chapter, the background to the study and rationale were stated and the independent variables and dependent variable have been operationally defined. Also, the applicable paradigms and applicable theories have been laid out, as the research design and methodology have been detailed. All in all, the chapter lays the ground for the chapters which follow beginning with knowledge of HIV and AIDS attitudes toward HIV and AIDS infected and affected employees, traditional beliefs related to HIV and AIDS, workplace HIV and AIDS-related discrimination, the empirical study, results and finally the discussion which entails conclusions, limitations and recommendations.

## CHAPTER 2: KNOWLEDGE OF HIV AND AIDS

### 2.1 INTRODUCTION

In this chapter, a few key definitions, aetiology and understanding of HIV and AIDS are dealt with. The knowledge of HIV and AIDS in this study comprises of basic biomedical HIV and AIDS knowledge and HIV and AIDS-related legal knowledge. The chapter ends with a chapter summary.

#### 2.1.1 Definition of knowledge

According to Oxford Advanced Learners Dictionary (2000: 693), knowledge refers to an organised body of information on an issue. Knowledge might also be defined as belief which is in agreement with fact (Bertrand cited in the theory of knowledge [sa]). Knowledge differs from simple awareness and is highly differential and multifaceted (Du Plessis *et al*;1993). Even simply creating awareness and acquiring knowledge are influenced by different intermediate variables, such as “*selective perception, the interpretation of messages and selective access to sources of information*” (Du Plessis *et al*;1993:4).

Knowledge also refers to a recall of factual information, and is a pre-requisite to appropriate behaviour. It is the most important tool to effect behaviour change (Gwefwi, 2004:36). The Tripartite theory of knowledge [sa] defines knowledge as ‘justified true belief’.

#### 2.1.2 Components of knowledge

Knowledge is defined in the Wikipedia (online encyclopaedia) as (i) facts, information, and skills acquired by a person through experience or education towards the understanding of a subject; (ii) what is known in a particular field or (iii) awareness or familiarity gained by experience of a fact or situation. Knowledge is also used to mean confident understanding of a subject, potentially with the ability to use it (the knowledge)

for a specific purpose (Knowledge [sa]). The concepts making knowledge and their linkage with the different forms of knowledge are discussed below.

#### *2.1.2.1 Concepts forming the framework of HIV and AIDS knowledge*

Three concepts have been identified as conditions that must be satisfied in order for one to possess knowledge. These concepts include: beliefs, truths and justification. According to the tripartite theory of knowledge, if one believes something, with justification; and it is true, then one possesses the knowledge of it, otherwise, one does not possess the knowledge (Tripartite theory of knowledge [as]).

##### *a Belief*

According to the Webster dictionary (online [sa]), belief in philosophy refers to 'accept as true'. Most philosophers assume that in order to know that something is a case; you have to accept it or believe that it is the case (Pryor, 2004). According to the tripartite theory of knowledge [sa], belief is the first condition for knowledge. Naidoo and Wills (2000:220) argue that belief is based on the information a person has about an object or action; and it links the object to some attributes. In this study, the researcher will explore the sources of HIV and AIDS information among the research participants as the basis for their belief on the HIV and AIDS issues.

##### *b Truth*

Truth refers to the fact that have been verified (Webster dictionary online [sa]). Truth, therefore, is an epistemological criterion upon which scientific knowledge is based. Scientific knowledge such as the routes of transmission and methods of prevention of HIV are statements which are better or worse approximations of reality (TRUTH) (Babbie & Mouton, 2001:13). These facts on HIV and AIDS are explored in this study.

##### *c Justification*

Philosophers argue that in order to know a thing, it is not enough to merely believe it. One must have a good reason for doing so (justification) (Pryor, 2004; Tripartite Theory of knowledge [sa]). This concept links knowledge with learning or experience. In this

research the HIV and AIDS knowledge of respondents is defined by their personal contact with PLWHA or experience with HIV and AIDS issues.

#### *2.1.2.2 Forms of knowledge*

##### *s Conceptual knowledge*

Conceptual knowledge refers to a person's representation of the major concepts in a system. This form of knowledge is rich in relationships and understanding. It is a connected web of knowledge (a network) in which the linking relationships of the discrete bits of information about a phenomenon are made (Definitions [sa]). This implies that a teacher possessing this knowledge would be able to rationalise the cause and effect of the processes within that phenomenon. Therefore, conceptual knowledge on HIV and AIDS pertains to the pathogenesis of AIDS from HIV. This includes the actual process by which the virus destroys the white blood cells thereby weakening the immune system. It also includes the understanding that HIV causes AIDS; and that a weakened immune system is prone to a variety of opportunistic infections which constitute AIDS. Other conceptual knowledge an educator needs to possess about HIV and AIDS are the differences and relationships between HIV and AIDS; and the understanding of how HIV is transmitted and the methods of prevention.

##### *b Procedural knowledge*

Procedural knowledge is the knowledge exercised in the performance of some task (Procedural knowledge [sa]). The implication of this type of knowledge is that instructions on the specified task or situation lead to increased understanding of the phenomenon and adoption of the procedure (Definitions [sa]).

Thus, teachers possessing this form of knowledge will, for example, be able to discuss sexuality and HIV and AIDS issues with colleagues and family or community without fear or limitation. And, a teacher with procedural knowledge will be able to teach learners about HIV and AIDS.

The use of condom during unsafe sexual intercourse and seeking early treatment for sexually transmitted infections (STIs) are other tasks that indicate the possession of this type of knowledge.

*c Episodic knowledge*

Episodic knowledge refers to the memory of events, time, places, associated emotions, and other conception based knowledge in relation to an experience (Episodic memory [sa]). This type of knowledge is associated with the awareness of trends of HIV prevalence in a given period in South Africa or Uganda.

Teachers possessing episodic knowledge will be aware of someone infected with HIV or who has died of AIDS. The teacher will also be aware of the trends of the AIDS epidemic in either South Africa or Uganda, including the different age groups most affected. This form of knowledge is explored by the knowledge of, for instance, number of colleagues or learners with HIV or who have died of AIDS in a given period within the institution.

The linkage between knowledge and behaviour has been stated in the cognitive-behaviour theory, where behaviour was stated to be mediated through cognition; and that knowledge is necessary but not sufficient to produce behaviour change (Glanz & Rimer, 2001:16; National Cancer Institute, 2005:12). Hence, UNAIDS (2005b: 41) stated that sound knowledge is an essential pre-requisite – albeit, often an insufficient condition for adoption of behaviour that reduces the risk of HIV transmission.

According to Burns and Grove (2005:9-10), knowledge is an awareness or perception of reality acquired through insight, learning or investigation expressed in a form that can be shared. Knowledge is a “state of understanding” that exists only in the mind of the individual knower (King, 1994:16).

The purpose of this brief description is to illustrate the complexity surrounding these issues of knowledge and the fact that there is no precise, universal agreement about different kinds of knowledge.

In this study, knowledge refers specifically to issues relating to HIV and AIDS biomedical knowledge and legal-related HIV and AIDS knowledge. HIV and AIDS biomedical knowledge includes topics such as key definitions of relating to HIV and AIDS, modes of transmission, preventive measures, risk behaviours and implications. The HIV and AIDS legal-related knowledge includes HIV and AIDS-related laws in South Africa and Uganda.

In this study, knowledge of the mode of transmission of HIV and AIDS and knowledge of protection against HIV and AIDS were articulated through the practice of safer sex and true knowledge of the issues of transmission and prevention. In support of this, Campbell (2003:25) states that knowledge of HIV and AIDS is about more than just the regurgitating of facts. Garrick and Rhodes (2000:4,17), highlight the fact that knowledge is not only about reciting memorised facts concerning a phenomenon but the “authentic demonstration” of knowledge in relevant situations.

## **2.2 KNOWLEDGE OF TRANSMISSION OF HIV AND AIDS**

Odwori *et al;* (2002), notes that awareness about the HIV and AIDS epidemic is high but positive behaviour change is low. Noky (2002) in her study in Mbuya–Uganda, reports that there was still knowledge gaps, especially among women and men about HIV and AIDS transmission and discordance. Again, Musulo (2002) cited in Barongo and Happy (2004:15), in a study in Mbuya-Uganda found out that knowledge about different aspects of HIV and AIDS was high but not universal.

In South Africa, Peltzer (2003:354) reports that life skill teachers in secondary schools were well informed about HIV and AIDS. In Uganda, Neema and Koster (2007:8) report

that knowledge about HIV and AIDS transmission was high: 77.5% had good, 22.5% medium, and 0% poor knowledge. In Nigeria, the majority of teachers (97%) were aware of HIV and AIDS. Slightly more female teachers (97%) than male (95%) were aware of HIV and AIDS (FME, 2006:174). Among primary school teachers in Kano, Lagos and Nasarawa States in Nigeria, Ssengozi *et al;* (2004:4-29) report that more than 99% of the respondents have heard of HIV and AIDS. In this study, the extent of HIV and AIDS awareness among teachers in Bojanala District in North West Province in South Africa and Kampala District of Central Region in Uganda might help to understand why workplace HIV and AIDS-related discrimination persists.

## **2.2.1 Knowledge of the routes of HIV transmission**

### *2.2.1.1 Sexual risk behaviours*

Kraemer, Kazdin, Offord, Kessler, Jensen and Kupfer (1997:338) define a risk factor as “*a measurable characterisation of each subject in a specified population that precedes the outcome of interest and which can be used to divide the population into two groups (the high-risk and low-risk groups that comprise the total population).*” The subject in this case can refer to an individual or specific groups (for example school teachers), with “characterisation” also referring to the individual’s or subject’s context. Within this study, risk behaviours refer to activities that place an individual or group directly at risk of contracting HIV.

Cantebury, Clavet, McGarvey and Koopman (1998) as well as Hall, Holmqvist and Sherry (2004) see sexual risk behaviours as engaging in unprotected vaginal, oral or anal intercourse. Irwin, Igra, Eyre and Millstein (2005), as well as Rothspan and Read (1996:132) state that risky sexual behaviours also include engaging in sexual encounters at an early age, non or inconsistent use of condoms, and multiple sex partners.



These risky sexual practices are influenced by many factors including the lack of accurate information on the modes of transmission of HIV, ignorance of own or sex partner(s)' HIV status, economic conditions, mobility and gender inequalities (Mekonnen, Sanders, Messele, Wolday, Dorigo-Zestma, Schaap, Meless, Mekonnen, Mihret, Fontanet, Continho & Dukers, 2005:358; Nyindo, 2005:40; Volk, Prestage, Jin, Kaldor, Ellard, Kippax & Grulich, 2006:45).

#### *2.2.1.2 HIV transmission through unprotected sex*

Unprotected sexual intercourse is one of the risk factors for sexual transmissions of HIV and AIDS. In a study conducted among university students in the Republic of South Africa, respondents maintained that real men do not use condoms, and condoms cause vaginal injuries (Nicholas, 1998:893). In his closing remarks, the co-chairman of the 16<sup>th</sup> International AIDS Conference held in Toronto in 2006, Dr Mark Wainberg said: “indeed, we will have failed unless we dramatically and rapidly expand by millions the numbers of people around the world with access to anti-retroviral drugs and simultaneously scale up prevention” (AIDS, 2006:1). One of the ways of scaling up this prevention is by correct and consistent use of male condoms during sexual intercourse. It is an undisputed fact that unprotected vaginal intercourse accounts for the vast majority of HIV infection globally (2006:126).

#### *2.2.1.3 Mother-to-Child Transmission of HIV (MTCT)*

HIV can be passed on from an infected mother to her child before birth, during delivery or while breast feeding. It is estimated that 600,000 children are infected through mother to child transmission (MTCT) each year, accounting for 90% of HIV infection in children (WHO, 2002b:63). Without preventive treatment, up to 40% of children born to HIV-positive women will be infected (ibid). In this study, an educator would be expected to know this mode of HIV transmission.

#### *2.2.1.4 Transmission through blood and blood products*

Blood transfusion saves many lives each year worldwide but recipients of blood have an increased risk of acquiring HIV-infection. Although transmission from infected donor blood and blood products is now at a much lower risk, as all donated products are tested for HIV antibodies, there is a need to know whether educators know much about this matter. This is because of the existence of the window period. The window period is a period from the point of infection to the time one tests positive (MoH/CBoH, 2002:153). In the window period, the HIV antibody test may provide a false negative result. During this period, one may experience flu-like symptoms frequently after a few weeks to a few months from the point of infection.

#### *2.2.1.5 Transmission through sharing of sharp objects*

Other ways through which HIV infections could be transmitted is by sharing sharp instruments such as razor blades and needles. In this study, educators would be expected to know that this route of transmission is vital because of the use skin piercing needles or any sharp instruments such as razor blades contaminated with blood or other bodily fluids from an HIV-infected person should be discouraged.

#### *2.2.1.6 Knowledge of misconceptions about HIV and AIDS*

Addressing misconceptions related to HIV and AIDS is an important issue in the context of HIV-related knowledge; and has implications in promoting behaviour change among teachers' regarding workplace HIV and AIDS-related discrimination.

Misconceptions about HIV and AIDS are widespread among people. These vary from one culture to another; and are particularly rumourous in some populations both on how HIV is spread (by mosquito bites or witchcraft, for example) and on how it can be avoided or cured (for example, by eating a certain type of fish, or having sex with a virgin) (UNICEF/UNAIDS/WHO, 2002:13). HIV is not spread by sharing utensils, toilets seats, shaking hands, hugging, casual kissing or mosquito bites (CDC, 2007b). In South

Africa, 25% of secondary school teachers had a misconception that HIV can be contracted through mosquito bite (Peltzer, 2003:355).

In many parts of Africa ignorance about HIV and AIDS remains profound; and it is considered a crucial reason as to why the pandemic has run out of control. The review of literature in Peltzer (2003:351) shows that teachers often lack adequate knowledge of the disease HIV and AIDS. The epidemic is sometimes blamed on witchcraft. Poison and witchcraft are widely believed to be the main causes of ill health (AIDS) (Kinge, 2003:145-146). AIDS patients may suffer isolation and discrimination because their illness is erroneously believed to be a divine punishment for moral wrongs or transgressions. PLWHA are also regarded as “dangerous’ to the environment because transmission is believed to include some social aspects of life such as sharing household utensils. The ultimate end of such misconceptions may be a disintegrated society characterised by over caution and suspicion of one another (Kinge, 2003:146), while the spread of the disease is not realised and unwittingly advances.

With regard to this study, misconceptions may result in wrong knowledge, attitudes, and perceptions of educator regarding HIV and AIDS, which in turn could give rise to engaging in discriminatory behaviours towards those infected with HIV or living with AIDS in the workplace. So research into workplace HIV and AIDS-related discrimination must identify and take cognisance of myths, misconceptions and misinformation; and falsity and danger these have people. Peltzer (2002:51) cited in Tarkang (2009:170), says that such myths must be curbed before growing stronger and becoming the basis for attitudes, perceptions and risky practices.

### **2.3 KNOWLEDGE OF PREVENTION OF HIV**

There are several ways in which individuals can protect themselves against contracting HIV; and also prevent transmitting it to those they come in contact with, even in intimate

ways. Using condoms during sexual intercourse and putting on gloves when handling bodily fluids, for example, are very effective means.

### **2.3.1 Knowledge of methods of HIV prevention**

According to UNICEF (2005:76), the methods of prevention of HIV include prevention of mother to child transmission (pmtct); behaviour change strategies, such as abstinence, being faithful to a partner and consistent use of condom; transfusion of screened blood; use of sterilised sharp objects; and taking universal precautions by health workers.

Neema and Koster (2007:9), in a study covering four regions in Uganda, about the views of staff regarding HIV and AIDS in the workplace, found that 79.5% of respondents reported HIV prevention strategies by organisations. The main messages concerned being faithful (63.7%), HIV testing (53.4%), abstinence (49.2%) and condom use (44.2%). About one-fifth (20.5%) indicated that their organisation does not promote any HIV prevention strategy. Almost all respondents (96.7%) indicated it is necessary to talk about HIV and AIDS prevention. This shows the staff's awareness of AIDS as a problem and the willingness to talk about it.

#### *2.3.1.1 Abstinence from sex*

Abstinence is an important HIV prevention method that needs to be promoted among educators in school work environment. However, "abstain and delay sexual initiation" is an approach that is said to be of limited value (UNAIDS, 2004:68). Abstinence within marriage is not a viable option. Many women and girls are not in position to negotiate abstinence because they lack the social and economic power and live in fear of male violence (UNAIDS, 2004:68).

#### *2.3.1.2 Promotion of safe sexual behaviours*

Being faithful to a sexual partner and reduction in the number of sexual partners are essential as safe sexual behaviours in the wake of HIV and AIDS. However, being safe by being faithful or reducing the number of partners is easier said than done (Wanyoike, 2011:67). The basic reality regarding the plight of women as far as monogamy is

concerned is that it is women who are usually monogamous. Research has shown that 80 percent of cases of where women in long-term stable relationships are HIV-positive, they acquire the virus from their partners who become infected through their sexual activities outside the relationship or through drug use (Kenya National AIDS and STI control programme, 2005:2).

There are some encouraging reports regarding to being faithful to one partner. Neema and Koster (2007:9) in a study about the view of staff regarding HIV and AIDS in the workplace in organisations throughout Uganda found that 79.5% of the respondents reported HIV prevention strategies by organisation. The main messages concerned being faithful (63.7%),

#### *2.3.1.3 Knowing signs and symptoms of HIV and AIDS*

The knowledge that a healthy looking person can be infected with HIV is important in promoting positive behaviour associated with HIV and AIDS. Likewise, the knowledge of common health problems of people living with HIV and AIDS is important. Among student teachers in Zimbabwe, (Chifunyise *et al*; 2002:380 cited in Oyewale, 2008:28), reports that 60% of respondents in the baseline survey and 71% of those in the follow-up survey knew that a person with HIV could look completely normal.

#### **2.3.2 Condom use**

Many researchers have purported that male condoms are highly effective in preventing the spread of STIs and HIV and preventing unintended pregnancies (Cates, 2001:231; Trussell & Vaughan, 1999:72). Holmes *et al*; (2004:454), say that when used correctly and consistently, male condoms can provide as much as 94% reduction in the transmission of HIV. Condom usage to prevent HIV is most effective when it is part of a broader safer sexual behaviour change that includes sexual abstinence, non-penetrative sexual practices, and reduced numbers of sexual partners (MTV, 2008; South Africa, 2009).

### **2.3.3 Multiple sex partners**

Mohapeloa (2006:10) states that multiple concurrent sexual partnerships where condom use tends to be low are among the key drivers of HIV infection in Africa. HIV infection is more likely to occur within long term multiple concurrent sexual partnerships, as people are less likely to consistently use condoms within these more regular relationships (Mohapeloa, 2006:2). Ford, Sohn and Lepkowski (2002:17) say that having multiple sexual partners may promote rapid transmission of HIV within and across sexual networks. In this study, the issue of multiple partners is likely to prevail, as many teachers usual work far from their families. The Zulu culture in the Republic of South Africa encourages men to have more than one woman lover or sex partner (Mogotlane *et al*; 2007:40). The practice negatively impacts on the spread of HIV and AIDS.

### **2.3.4 Willingness to discuss HIV and AIDS**

Discussing HIV and AIDS issues in the public as well as disclosing results of HIV test is an important manifestation of HIV and AIDS knowledge and a major step in adopting appropriate HIV and AIDS-related attitude. According to Peltzer (2003:354) secondary school teachers felt moderately comfortable to teach HIV and AIDS. Specifically, about 29% of the teachers interviewed in the study had been teaching HIV and AIDS education for one year or less and about 48% for two years or less. In this study, willingness to discuss HIV and AIDS is an indication of knowledge of HIV and AIDS among educators; and were investigated.

## **2.4 KNOWLEDGE OF CAUSE AND HISTORY OF HIV AND AIDS**

People's health seeking behaviours to a large extent depend upon their understanding and interpretation of the causes of illness, in this regard, the causes of HIV and AIDS. Where people accept the germ theory of disease causation, their attitudes to the search for a cure to a disease will be different from the attitudes of those who attribute the disease to supernatural causes (Awasuko-Asare & Anarti, 1997:250). In this study, the traditional beliefs about the causes of HIV and AIDS among educators in Bojanala District of North West Province in South Africa and those in Kampala District in Central

region of Uganda were investigated; and correlation between it and workplace HIV and AIDS were also investigated.

## **2.5 KEY DEFINITIONS AND RELATED HIV AND AIDS KNOWLEDGE**

In this section, a few key definitions, aetiology and understanding HIV and AIDS are dealt with.

### **2.5.1 AIDS (Acquired Immuno Deficiency Syndrome)**

AIDS is a recently described viral disease occurring in humans. The human immunodeficiency virus (HIV) which causes AIDS is transmitted by sexual intercourse, blood and blood products and vertically from mother to child. In some people, infection by virus produces profound damage to the cell mediated immune system resulting in the occurrence of opportunistic diseases – infections and certain cancers – with a high mortality rate. Unlike any other disease in history, it has no constant, specific symptoms (Stine 2010:3).

### **2.5.2 Aetiology**

The causative agent is a retrovirus, human immunodeficiency virus (HIV) previously known as HILV-III or LAV-I. Recently another group of viruses, HIV-2 (HILV-IV, STLV-III, LAV-2, SBL-6669) which may cause a disease similar to AIDS has been isolated in a number of countries in West Africa.

HIV-I is a slow growing virus giving life-long infection and probably belonging to the group of lent viruses. These viruses are spherical, enveloped RNA viruses characterised by a unique morphology, a unique genome and a unique enzyme and life history. The virus has an affinity for lymphoid cells, which have the CD4 receptor on their plasma membrane. Cells with this receptor are predominantly comprised of a subgroup of T lymphocyte known as the helper T cell, or T4 cells. Cells of the macrophage lineage also have CD4 receptors, albeit a lesser number, but they may be important as a reservoir for the virus (Stine, 2010:34).

## 2.6 UNDERSTANDING HIV AND AIDS

### 2.6.1 What HIV is

The acronym HIV stands for Human Immunodeficiency Virus. Because HIV is a virus, understanding its nature starts with a basic understanding of viruses in general. All viruses share important features. A virus consists of a small strand of genetic material (Deoxyribonucleic acid and Ribonucleic acid – DNA and RNA respectively) enclosed within a protective covering or coat. A virus is not a cell and does not have any of the essential parts of living cells. It can be described as something between an inanimate object and a living organism. A virus invades a cell and takes control of its functions; it uses the cell's own resources to recreate itself and to make millions of new virus particles. Unlike living cells, a virus does not have a life of its own; a virus is able to survive and reproduce only when it is inside a living cell. Although symptoms caused by viruses can often be treated, viral infections are difficult to cure. HIV is a member of a group of viruses called retroviruses that are unique in the way that they infect cells and cause disease.

As the name suggests, the life cycle of a retrovirus is the reverse of other viruses, making it far more difficult to understand than common viruses. HIV belongs to a group of retroviruses called lentiviruses (*lenti* means 'slow' in Latin) because it progresses slowly; it usually takes years before symptoms appear. HIV is an infection of the immune system, the very system that the body uses to fend off infections. The outer envelope of HIV consists of lipids, or fats, and glycoproteins, such as gp120 and gp44. The glycoproteins play a critical role in determining how HIV attaches itself to immune cells. Inside the envelope is HIV's genetic core, which consists of a strand of RNA. The core also has three important enzymes: reverse transcriptase, protease and integrase. These enzymes are essential to the process by which HIV replicates itself and produces new virus inside of immune cells.



### **2.6.2 How HIV infects blood**

The target of HIV is a specific type of white blood cells called T-helper lymphocyte cells or just T-helper cells. T-helper cells control several branches of the immune system. T-helper cells are like the generals of the body's army, commanding other immune cells to destroy possible causes of infection and disease. By killing T-helper cells, HIV disables the entire immune system. HIV attaches itself to the lymphocyte cell surface at an area called the CD4 receptor site, the location on the T-helper cell that HIV uses to gain entry to the T-helper cell. Infected T-helper cells are rendered defenseless against HIV. Over time, T-helper cells are destroyed by HIV, greatly impairing the body's ability to fight off many diseases. Even before they are killed, infected T-helper cells, as well as other immune cells called monocytes and macrophages, lose their ability to fight infections and prevent disease. The immune system attempts to control HIV by producing antibodies against the virus. Unfortunately, these efforts are only partly effective, because HIV hides inside the T-helper cells, slowly infecting more and more cells until the entire immune system itself is rendered non-functional (Marks, 2002).

### **2.6.3 How HIV differs from AIDS**

HIV and AIDS have often been confused. HIV is the name of the virus that, when introduced into the human bloodstream, infects white blood cells that do much of the immune system's work to control disease. A person who is infected with HIV does not necessarily feel sick. In actual fact, people usually feel healthy for several years after they have become infected with HIV. As HIV infection progresses, the immune system slowly breaks down, leaving the person vulnerable to other diseases, normally referred to as opportunistic infections (OIs) that are normally fought off by a healthy immune system. AIDS is the later stage of HIV infection. An individual person is diagnosed with AIDS after the immune system has become disabled by HIV or when the person becomes seriously ill from diseases that take advantage of the broken-down immune system.

AIDS is the acronym for Acquired Immuno Deficiency Syndrome. Each word in the nomenclature bears a meaning of significance (Whiteside & Sunter, 2000: 1):

- 'Acquired' categorically means that the virus cannot be passed on through casual contact, like influenza or the recent SARS (Severely Acute Respiratory Syndrome) virus. It can only be acquired by the particular actions of people.
- 'Immunodeficiency' highlights the fact that the virus affects the immune system of the people making it increasingly less capable of warding off infections.
- 'Syndrome' is a very important statement of the fact that AIDS is not a disease in itself, but a syndrome that affects the immune system. The syndrome of the failing immune system makes the body vulnerable to secondary infections like pneumonia, Kaposi's sarcoma, Tuberculosis (TB) (Whiteside & Sunter, 2000: 1).

Discovered only in 1979/80 as an unusual and inexplicable phenomenon (the outbreak of a rare 'cluster of diseases' like pneumocystis caranii, which is normally spread by birds and a rare form of skin cancer called Kaposi's sarcoma), the virus was positively identified by scientists on either side of the Atlantic in 1983 (Whiteside & Sunter, 2000: 1).

There are broadly two strains of the virus, HIV-1 and HIV-2 with multiple sub-strains in each. The dominant strain globally and in South Africa is HIV-1, sub-strain HIV-2 is found mainly in West Africa and is less virulent, which means that it is less easily transmitted and 'slightly less harmful than HIV-1'. However, given the migration and mobility of populations, the HIV strains are not geographically isolated (Whiteside & Sunter, 2000:2; Barnett & Whiteside, 2002:280).

People are said to be HIV-positive or sero-positive, when HIV antibodies are detected in their blood. A person who is HIV-positive does not necessarily have the condition of AIDS. When a person living with HIV status starts to become ill with what we call AIDS-defining conditions such as severe thrush, brain conditions, severe pneumonia, we say

that the person has AIDS. In places such as Western Europe and North America where sophisticated testing facilities are available, AIDS is defined by the CD4 count in the body. Anybody with a CD4 count of 200 or less is in this AIDS stage. A person normally has about 1200 CD4 per micro-litre of blood. In a person diagnosed with AIDS, the CD4 count falls below 200 (Barnett & Whiteside, 2002:32-34).

The reduced CD4 count compromises the immune system of the body, rendering the person living with the virus vulnerable to infection from opportunistic infections (OIs) and cancers that the body would normally be able to ward off. In the next section, the four stages of HIV and the symptoms that go with them will be discussed.

## **2.7 COURSE OF AIDS**

The course of HIV infection is generally divided into four different stages: the initial phase (preceding sero-conversion), the asymptomatic phase, the symptomatic phase (during which less serious opportunistic diseases occur), and the severe symptomatic phase, during which the patient has full-blown or clinical AIDS. Understanding the course of AIDS may demonstrate conceptual knowledge. It can serve to make one to know that at certain stage, an individual who is HIV-positive may not show the symptoms yet he/she may pass on the virus. Below are the stages HIV and AIDS development briefly outlined:

### **2.7.1 Initial phase: Preceding sero-conversion**

The initial phase begins very shortly after a person has been infected with HIV. The symptoms are similar to those of influenza (fever, night sweats, headaches, muscular pain, skin rashes and swollen glands). This phase continues until sero-conversion occurs (when antibodies develop in the person's blood in an ineffective attempt to protect the body against HIV). Sero conversion takes place on average six to twelve weeks after exposure to the virus (in exceptional cases even later). The period between infection and sero-conversion is known as the window period. Blood tests that are generally used to determine whether a person has been infected with HIV cannot trace

HIV itself, but react to the presence of antibodies. The fact that antibodies are formed only after a lapse of time entails that blood tests conducted during the window period may deliver false negative (sero-negative) results. Where antibodies have not yet developed, the blood test for antibodies will be negative in spite of infection. During the window period an infected person can transmit HIV but will not test positive for the virus.

### **2.7.2 Asymptomatic phase: Latent or 'silent' infection**

The person is infected with HIV; antibodies have already developed and will be indicated by an antibody test from this stage onwards. Although he or she will show no symptoms of illness, the body's resistance and immune response are slowly being impaired. This second phase can continue for many years while the infected person remains otherwise healthy. In this phase, infected persons are often not aware that they have HIV; they can therefore unknowingly transmit the virus to others.

### **2.7.3 The symptomatic phase: HIV-related disease**

This phase can also continue for several years. As the immune system continues to deteriorate and the person with HIV becomes more immune-deficient, and symptoms of the opportunistic diseases that cause death in the next (severe symptomatic) phase now occur. These include swelling of the lymph glands in the neck, groin and armpits as well as a drastic loss of body weight, occurrence of skin rashes and bacterial skin infections, and persistent diarrhea.

### **2.7.4 Severe symptomatic phase: Clinical AIDS**

Only during the severe symptomatic phase can a person be said to have AIDS. As a result of the compromised immunological response because of the HIV infection, a person, during this stage, is prone to infections by organisms that are normally present but do not cause disease in otherwise healthy and uninfected persons. This type of infection is referred to as opportunistic infection. In this phase, such a person's body is no longer capable of withstanding opportunistic diseases, the symptoms of which were observed in the preceding phase. Unless effectively treated the person may no longer

be able to work productively. Without recourse to appropriate medication, he or she usually dies within two years as a result of these diseases.

Diseases that generally occur are pneumonia, tuberculosis and Kaposi's sarcoma (a rare type of skin cancer). Not infrequently, the nervous system is affected and there may be meningitis (inflammation of the covering of the brain) or encephalitis (inflammation of brain tissue itself) with a spectrum of neurological and psychiatric disorders (previously known as AIDS dementia). This can occur in the final phase (and in rare cases may also occur earlier). Symptomatic presentation differs from continent to continent. The most important opportunistic diseases in Africa are tuberculosis and chronic diarrhea, whilst a form of pneumonia (caused by *Pneumocystis Carinii* [PCP]) is responsible for the majority of deaths among persons with AIDS in Europe and North America. The disease conditions from which people with AIDS suffer are generally not transmissible. Persons with AIDS usually pose no threat of infecting others with opportunistic diseases (as opposed to the transmission of HIV itself).

The course of HIV infection varies from person to person. The period before sero-conversion can last on average from six to twelve weeks. The average duration in Africa of the asymptomatic phase is estimated to be seven years, and it is generally accepted that the average period of time from infection with HIV until full-blown AIDS develops is less than 10 years. The severe symptomatic phase (clinical AIDS) lasts on average of one to two years. However, the life expectancy of persons with HIV differs according to their general state of health, their living conditions, available health services and treatment, and the opportunistic disease in question. Although the course of the disease follows the same overall pattern in developed and developing countries, the period between becoming infected and death is much shorter in the latter. This can probably be ascribed to the prevalence of endemic diseases (such as tuberculosis) and to a lack of adequate medical treatment. In South Africa, severe poverty and malnutrition could probably be included as reasons why most patients with HIV have a shortened life

expectancy. It is likely to be the case in Uganda, also since Uganda is far less resourced than South Africa.

Not all persons with HIV go through all four phases. Some do not even show symptoms before they develop clinical AIDS. During periods of symptomatic infection, a person with HIV may be able to live and work actively, but may experience fatigue or brief periods of illness.

## **2.8 TRANSMISSION OF HIV**

As soon as a person is infected with HIV, he or she is able to transmit the infection to other people irrespective of whether he or she shows any symptoms of the disease. However, HIV is not easily transmitted (in contrast with many other serious diseases such as certain sexually transmitted diseases and certain other viral infections).

HIV has been identified in varying concentrations in blood, semen, vaginal and cervical discharge, breast milk, the brain, bone marrow, cerebrospinal fluid, urine, tears, fetal material and saliva. Current scientific knowledge indicates that only blood, semen, vaginal and cervical discharge and breast milk contain a sufficient concentration of the virus to be able to transmit HIV.

At present no scientific evidence exists that HIV can be transmitted in any other mode than the following:

- By hetero- or homosexual intercourse.
- By receipt of or exposure to blood, blood products, semen, tissues or organs of a person who is infected with HIV. This can occur *inter alia* by the use of dirty or used syringes and/or needles for intravenous drugs or by injecting infected blood in a victim.

- By a mother with HIV to her fetus before or during birth, or to her baby after birth by means of breastfeeding (also called perinatal transmission).

To infect a person, HIV must reach the blood stream or lymphatic system. HIV does not survive well outside the specific environment of the human body, making environmental transmission remote. Once outside the human body the virus rapidly weakens or dies. The longer it is outside the body the less the chance for transmission to occur. There are many variables that determine how long the virus will live outside the body, including whether the conditions surrounding the virus are wet or dry. The virus cannot survive in a dry environment (in dried blood or dried semen). How long it will survive in wet conditions (in body fluid spills) is uncertain and depends on the specific conditions. Generally speaking, under most circumstances, the virus can survive only for a few minutes outside the body. Blood spills (which would carry a large concentration of virus) should, however, always be handled with extreme care. The virus is destroyed by disinfectant.

The virus cannot be spread by other forms of personal contact than those described above. There is, thus, no risk of HIV transmission from casual contact. HIV cannot be transmitted by daily social contact such as breathing, coughing, shaking hands or hugging. Casual contact through closed-mouth or 'social' kissing is not a risk for transmission. Open-mouth kissing may, however, carry some risk because of the potential for contact with blood during such kissing. HIV cannot be transmitted through food preparation, by toilet seats, or by sharing food, water or utensils. Even if blood contact did take place in these circumstances the chances of being infected are small. (The incidence of infection, for instance, among health care workers who received injuries from needle-sticks and other sharp objects contaminated with blood known to be HIV-infected, is calculated to be approximately three to four in 1000. Where the status of the blood was not established, but surgical procedures were prone to expose a person to blood, the risk of infection was considered to be at most one in 42 000).

Not every person exposed to HIV becomes infected. Similarly, it is possible that not every person who is infected with HIV eventually develops AIDS. Scientists are as yet uncertain of the precise position. There is apparently reasonable consensus that 45%–50% of infected persons will develop AIDS after 10 years, but it has also been estimated that between 65%–100% of infected persons are likely to develop the disease within 16 years (UNAIDS, 2004).

The AIDS virus (HIV) has been found in all body fluids (precisely and otherwise): blood, urine, semen, saliva and even tear drops. This is at first sight alarming. And not surprisingly, the discovery of the virus in saliva prompted a good deal of public alarm. The US Fire Brigades Union, for example, instructed members not to offer mouth to mouth resuscitation to anyone they suspected of being homosexual (cited in Jonson, 1987).

There is no evidence that the virus is transmitted via saliva in casual contacts. Nor is it spread via swimming pools or toilet seats or by handshakes or hugs. There is no evidence that it is spread through food, water or air. On the contrary, the transmission of the HIV virus requires close personal contact. It is transmitted through sexual contacts involving exchanges of bodily fluids, and through contaminated blood, blood products and hypodermics.

Because of this mode of transmission, the AIDS virus is different from the various flu viruses which are frequently transmitted via aerosols of infected saliva. A virus (any virus) can infect a person only by first entering the cells of that person's body. This is because a virus is *entirely dependent* upon the enzymes in living cells for its own reproduction. A virus can enter the body by either infecting the cells on one of the surfaces, external or internal, or by infecting a non-surface cell after some trauma.



The surfaces of the respiratory and gastro-intestinal tracts are particularly vulnerable to viruses because they are designed to absorb oxygen, food and water from the environment. Measles, influenza and the common cold are all caused by viruses which leave the body in invisible droplets when an infected person sneezes. Another individual in the vicinity breathes in the same droplets, which attaches to and multiplies within the cells lining the respiratory tract. The Hepatitis B virus (serum Hepatitis), on the other hand, is unable to multiply within any epithelial cell. It requires a breach in the body surface to get it into the blood stream where it may then be carried to the liver.

Being retroviral, HIV changes the structure of the cells it attacks. When an HIV virus infects a cell, its genetic material becomes incorporated in the code of that cell. When the cell multiplies it then automatically produces more viruses. One consequence of HIV being a retrovirus is that there is no way of getting rid of the virus without getting rid of its host cell. In other words, people infected with HIV will remain infected with HIV for life.

## **2.9 THE ORIGIN OF HIV**

It is important to understand what is known about the origin of HIV because of its centrality in influencing both HIV knowledge and beliefs about the scourge of HIV and AIDS.

HIV derives from a virus that crossed the species barrier into humans. It is closely related to a number of Simian (monkey) Immunodeficiency Viruses (SIVs) found in Africa. The evolution of the virus over time is traced through a 'family tree' as shown in Figure 2.3.1. It is vital to note that this differs from the more familiar family tree because to read it you must start near the middle. In this case, the proximity of the different types of virus is an indication of how closely they are related. For instance, HIV-1 is clearly related to chimpanzee SIV and HIV-2 is closely related to SIV.

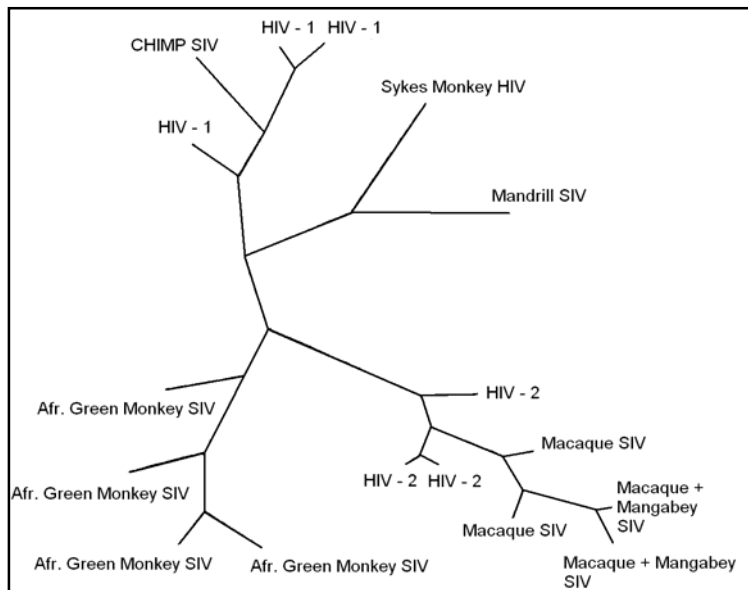


Figure 2.1: The HIV family tree

Source: Wills (1996).

### 2.9.1 How HIV entered the human population

It is important to note from the start that the spread of diseases from animals to humans is neither a new phenomenon nor a unique one. Indeed we know that human diseases also spread to animals – but unfortunately, animals have no access to either science or the media, thus this goes unrealised by most people. The influenza virus evolves in birds, particularly in waterfowl. Virologists describe these birds as ‘reservoirs’ of infection. They carry nearly all known types of influenza, with no ill effects, and spread them to the rest of the animal kingdom through their feces. Hence, many kinds of animals can get the flu – horses, pigs and human beings.

However, viruses can only infect and take over a cell if it has a proper ‘receptor’. Human cells do not have a receptor enabling them to contract avian flu directly. For human infection to occur another species must act as an intermediary; it can play this role by having a receptor for avian flu and humans in turn having a receptor for its flu. Pigs are one such species. The process can be as simple as a flu-contaminated duck dropping

its feces into the dirt in which a pig then rolls for either play or shaking of ecto-parasites such as lice. The pig is then infected and passes the virus on to man, a farmer in this case. Again, it can be more complex than what has so far been described. It is possible for a pig to be infected with one kind of flu, say human flu, only to contract another avian flu. The pig then has two types of flu simultaneously. When the pig re-infects the human, it passes on a pig-bird-human influenza. The Hong Kong flu, for example, held seven genes from a human virus and one gene from a duck virus, which met inside a pig, producing a new hybrid.

Viruses, and indeed all diseases, replicate themselves within the host. This gives rise to variants of the virus within one person. These may in turn recombine to create new variants, some of which may be more virulent or drug resistant.

The speed with which the HIV-1 replicates makes it a formidable enemy. There are two major strains of HIV-1. Group M causes 99% of the world's HIV and AIDS infections. Group O and the newly discovered N cause the remainder (Stine, 2007:33). Group M is divided into eleven sub-types or clades (A to K). The ability of the virus to mutate rapidly has significance in the quest for both a cure and vaccine.

As Barnett and Whiteside (2002) note, the question of when and how HIV entered human population has been a source of great debate. We know that at some point the virus entered the blood of humans and then spread through *sexual* contact from person to person. In West Africa, the less virulent HIV-2 spread from macaque monkeys. HIV-1 spread from chimpanzees into humans in Central Africa. Four lines of evidence have been used to substantiate the zoonotic (transmission of a disease from one species to another) origin of AIDS:

- similarities in the organisation of the viral genome;
- phylogenic relatedness of a particular HIV strain to that of SIV in the natural host;

- geographical coincidence between the SIV and particular HIV strains; and
- the plausible routes of transmission (Van Rensburg, 2000).

Molecular biologists have examined the genetic structure of HIV (actually HIV-1 and HIV-2) in great detail and compared it with retroviruses of the lentiviruses subclass. From these studies, it is clear that HIV has a common origin with other lentiviruses, and they evolved from a common ancestral retrovirus over a million years. In particular, HIV-1 and HIV-2 represent recent infections in humans of lentiviruses native of African primates (simian immuno deficiency virus or SIVs). HIV-1 came from infection in humans of an SIV from chimpanzees, and HIV-2 came from an SIV of sooty mangabeys. Epidemiological studies tell us 30 to 40 years ago, HIV-1 spread into high-density populations in Africa and the Western world, leading to the AIDS epidemic. Recent changes to human social behaviour, such as the sexual revolution, may have also contributed to the spread of HIV infection. Numerous apocryphal stories as to the origin of HIV have been circulated since the beginning of the AIDS epidemic: HIV was the result of germ warfare research by the CIA; HIV was a laboratory experiment involving recombinant DNA; HIV resulted from a plot between Israel and South Africa; HIV resulted from sexual relations between humans and sheep; and HIV resulted from sexual relations between humans and monkeys – none of these is true (Fan, Conner & Villareal, 2007).

### **2.9.2 How HIV might have crossed the species barrier**

Barnett and Whiteside (2002) say that HIV is not an easily transmittable disease. It is carried in body fluids, with the highest concentration in blood, semen and vaginal secretions. For transmission to occur it had to enter the human body and reach the infectible cells. It, thus, had to breach the skin or mucosal barriers. There are a number of hypotheses as to how this might have happened:

- *Bush meat.* It is not difficult to imagine that a hunter killing, or someone butchering, an infected monkey and in the process contaminating a cut on his hand with monkey's blood.
- *Contaminated vaccine.* This is the most elegantly (and lengthily) argued by Hooper (1999). He suggests that experimental polio vaccination campaigns in Central Africa in the 1950s, using vaccine cultivated in chimpanzee kidneys, may have provided the opportunity for the virus to cross the species barrier.
- *Contaminated needles.* The above two arguments may explain how the virus crossed into humankind but they do not explain the rapid spread. It has been suggested that vaccine campaigns and poorly equipped clinics in rural Africa may have contributed to this through the use of unsterilised needles on one patient after another.
- *Ritual behaviour.* Finally, it has been suggested that the use of monkey blood in certain rituals might have caused transmission. This hypothesis reflects a high degree of ethnographic ignorance and no little prejudice, as no one has described these rituals or given any examples as to where they take place.

Barnett and Whiteside (2002) say that the second and the third hypotheses place the beginning of the HIV and AIDS epidemic in the twentieth century. Hooper suggests that the polio campaigns of the late 1950s in Congo (now, the Democratic Republic of Congo) and Rwanda were the spark that ignited the fire. The cut hunter view has been used to suggest that the epidemic originated in infection across the species barrier in the 1930s. Interestingly, in this case the transfer of the virus from an animal into a human may have happened on a number of previous occasions. However, because on those occasions each infected person did not in turn infect more than one other person, the potential petered out. It is possible that there could have been a pool (or pools) of infection among isolated peoples in some parts of Africa for many years. What was different about the crossing of the species barriers in the 1930s (and the subsequent pattern of the HIV epidemic) was the environment into which the virus was introduced.

The upheavals of the colonial and post-colonial periods and development of modern transport infrastructure allowed HIV to spread quickly into the global community.

While the above explanations of how, where and when HIV might have originated are plausible, one thing that often complicates matters is the issue that many Africans, particularly the Blacks, are suspicious of the intentions of those who colonised them. In a way, this suspicion may make some people not to take the explanations without a pinch of salt. There are people who ascribe the origins of HIV to conspiracies by scientists in the western world. Wangari Maathai, a Kenyan ecologist and 2004 Nobel Prize winner said, in 2004, that HIV was created by scientists “for the purpose of mass extermination. We know that developed nations are using biological warfare, leaving guns to primitive people. AIDS is not a curse from God to Africans or black people. It is a tool to control them, designed by some evil-minded scientist” (cited in Stine 2007:30).

## **2.10 IMPORTANCE OF WORKPLACE HIV AND AIDS POLICY**

A workplace policy provides a framework for action to reduce the spread of HIV and AIDS and manage its impact. It defines an institution’s position on HIV and AIDS, and outlines activities for preventing the transmission of the virus and providing care and treatment for staff (and sometimes their dependents). It also ensures that the response is balanced, activities complement each other, and resources are used most effectively. As argued by the ILO (2005), effective policies:

- provide leadership and make an explicit commitment to corporate action;
- ensure consistency with appropriate national laws;
- lay down a standard of behaviour for employees;
- give guidance to supervisors and managers
- help employees living with HIV and AIDS to understand what support and care they are entitled to receive, so that they are more likely to come forward for voluntary testing;

- help to stop the spread of the virus through prevention programmes; and
- assist in planning for HIV and AIDS and managing its impact ultimately saving resources.

They also provide a basis for putting in place a comprehensive workplace programme that combines prevention, care and protection of rights (ILO, 2005). The creation and dissemination of workplace policy can, in itself, begin to raise awareness about HIV and AIDS and by enshrining the rights of both HIV-positive and HIV-negative employees, help to combat stigma and discrimination.

## **2.11 HIV AND AIDS-RELATED FEAR AND SEX IN THE WAKE OF HIV AND AIDS**

Some issues related to HIV and AIDS knowledge seem to influence HIV and AIDS-related fear. And, they also hinge on HIV and AIDS knowledge which is sex-related. These are briefly discussed in the following paragraphs.

### **2.11.1 Fear of HIV and AIDS**

AIDS leads to death, and it is not a pleasant death. The opportunistic infections associated with AIDS are serious and painful. Pneumocystis pneumonia leads to debilitation and dramatic weight loss. Kaposi's sarcoma brings about disfiguring cancerous lesions of the skin. Cytomegalovirus attacks the lungs and eyes, and can lead to blindness. Cryptococcus causes severe meningitis and Candida albicans (or thrush) can occur so thickly in the throat and mouth that swallowing becomes problematic. With AIDS, the patient's body will be simultaneously ravaged by a number of these serious diseases (Jonson, 1987).

Getting AIDS Related Conditions (ARC) is not pleasant either. There are swollen glands, diarrhea, night sweats and high temperatures. It affects your work and social life (Jonson 1987).

If one is fortunate enough to escape AIDS and ARC, the HIV virus can attack the brain directly. The result is gradual dementia with its concomitant mood swings, loss for physical coordination and linguistic abilities. Once in the brain, the HIV virus can also be responsible for symptoms which mimic conditions as varied as schizophrenia and multiple sclerosis (Jonson 1987).

Once one is infected with the HIV virus, AIDS, ARC and dementia become frighteningly real possibilities. According to the World Health Organisation, the probability of developing AIDS within five years of infection is between 10% and 30%, and the probability of developing ARC in that same five year period is between 20% and 50%. The probability of dementia or other neurological complications in the long run may well be 100% (Jonson, 1987).

### **2.11.2 Sex in the wake of HIV and AIDS**

There is no way of telling whether a person is infected with HIV just by looking at him or her. A person can be infected with HIV and be infectious to others, but feel and look perfectly well. If the person is infected then the HIV virus will be present in blood, semen and vaginal fluids, and be passed on in all these fluids. If you have sex with someone infected with HIV and this involves an exchange of body fluids, then you are at risk of being infected.

There are a number of ways of reducing the risk of catching HIV through sex. The most effective way to protect one is to abstain completely from sex. Another way to cut down the risk of sexual transmission of the virus is monogamy – that is, having sex with only one person. However, monogamy in itself is no assurance against becoming infected with the virus since you are only safe if your partner is not infected. You can get AIDS while being totally faithful to someone, if that person happens to be infected with HIV. The fact that he/she is being faithful to you is now irrelevant if he or she has been infected with HIV by some previous lover. On the other hand, while monogamy cannot ensure that you will not become infected, promiscuity will increase the chance that you may be exposed to HIV.



### **2.11.3 Safe sex**

Another way to reduce the risk of catching HIV is to always use condoms in situations where there is an exchange of body fluids. This means using a condom *every time* one has vaginal or anal sex. It means putting the condom on correctly and ensuring that there is no leakage from the condom after ejaculation. It means using a condom whenever there is penetrative sex and not just putting it on before orgasm (Jonson 1987).

### **2.11.4 The safety of using a condom**

Using a condom gives one a lot of safety from contracting HIV but it is still not 100% effective. Accidents are possible even if some of the fluid escapes from the condom and that fluid contains HIV, and then there is risk of infections.

Not all sexual activities carry with them the same risks of infection with HIV – activities like masturbation are generally very low risk. The following is a list of sexual behaviours and the relative risks of HIV infection associated with them. Some are virtually risk free (Jonson, 1987):

- Sex: Also known as fucking and screwing, usually means vaginal intercourse where the male inserts his penis into the female's vagina. The risk of HIV transmission is high for the female and moderate for the male.
- Kissing: Ordinary social kissing – the proverbial 'peck on the cheek' – is without risk. 'French', 'tongue' or 'deep' kissing carries an unknown but presumably very low risk of transmission unless either partner has cuts or ulcers in the mouth. In the latter case the risk is higher but still presumably quite low.
- Masturbation (male): Masturbation, otherwise known as jerking off, pulling yourself, wanking, whacking off, tossing off, is where a male or female partner uses his or her hand to stimulate his or her partner's penis.

Providing that any skin that comes into contact with the semen is intact there is no risk.

- Masturbation (female): This is where a male or female partner uses his or her hand to stimulate a partner's clitoris and genital area. Again, as long as any skin that comes into contact with vaginal secretions is intact, there is no risk.
- Fellatio: This is also known as going down on, giving head, sucking off, or a blow job. This is where a male or female partner uses his or her mouth to stimulate a male partner's penis. The risk for the receptive partner is moderate to high depending on that partner's state of oral hygiene and whether or not the ejaculate is swallowed. The risk for the insertive partner is unknown but presumed to be low.
- Cunnilingus: This is also known as going down, eating, licking out. This is where a male or female partner uses his or her mouth to stimulate a female partner's genital area. The risks for both partners' are unknown but presumed to be low.
- Anal intercourse: This is also known as fucking, Greek fucking, bugging, and 'exhause' (from exhaust pipe). This is where a male partner inserts his penis into a male or female partner's anus. If a condom is not used the risk is extremely high for the receptive partner, and moderate to high for the insertive partner. If a condom is used the risks for both partners are lower. However, there is still some risk for the condom may tear or there may be spillage of ejaculate from the condom.
- Sadomasochism: Otherwise known as S & M. This is where one partner inflicts pain upon the other as an aid to sexual arousal. Sadomasochistic practices are safe as long as there is no exchange of body fluids.

The use of a condom significantly lowers the risk of HIV transmission but it does not totally eliminate the risk. Because a condom provides a barrier between the sexual organs of the individuals engaged in intercourse, it is able to provide some protection with respect to the transmission of STDs. Using condoms to lower the risk of becoming infected with HIV is therefore a strategy, which also gives some protection against infection with other unpleasant diseases.

## **2.12 MYTHS ABOUT HIV AND AIDS**

A number of myths exist pertaining to HIV and AIDS. Bauni, Garimoi, Maharaj, Mushingeh, Neema, Ngirwamungu and Riwa (2010:2) point out that many myths and false beliefs regarding the transmission of HIV and treatment of AIDS remain. These myths have to a certain degree contributed to the way individuals in certain situations think and, possibly, react towards those infected or presumed to be infected with HIV and AIDS.

Before dealing with the myths associated with HIV and AIDS, it is important to know exactly what we mean by myths. In his essay *Debunking the Myths*, Ya Salaam (2006) defines myths as 'traditional beliefs that are accepted uncritically'. He argues that even though many people may believe that myths are inherently false, some may even be true or have a historical basis. However, the main characteristic of a myth is that it is generally accepted as the truth without being questioned. The main reason for accepting myths at face value is that they either confirm what we want to believe or they reinforce collective ideas about how we see the world. He notes that myths have a danger of encouraging people to conform to social illusions and to become self-fulfilling prophets of untested and unquestioned values. The main function of myths, according to Ya Salaam (2006), is to stabilise the status quo by causing or encouraging conformity rather than challenging reality (cited in Motsei, 2007).

## **2.13 HIV AND AIDS–RELATED LAWS IN SOUTH AFRICA AND UGANDA**

In this section, laws relating to HIV and AIDS in South Africa and Uganda are looked at in some detail to suit their purpose in this study

### **2.13.1 Knowledge of law relating to HIV and AIDS**

The Constitution of South Africa (1996) is the supreme law of the country and all other laws must comply therewith. Several provisions of the Bill of Rights within the Constitution protect the rights of employees. The government has amended certain laws and introduced a host of new pieces of legislation to ensure that labour laws are consistent with the Constitution. There are five key pieces of labour legislation in South Africa, plus one applying specifically to the mining industry:

- the Employment Equity Act, No. 55 of 1998 (EEA);
- the Labour Relations Act, No. 66 of 1995 (LRA);
- the Occupational Health and Safety Act, No. 85 of 1993 (OHSA);
- the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993 (COIDA);
- the Mines Health and Safety Act, No. 29 of 1996; and
- the Basic Conditions of Employment Act, No. 75 of 1997 (BCEA).

In the South African education sector, the National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions forms part of the National Education Policy Act No.27 of 1996.

HIV and AIDS are expressly referred to in the Employment Equity Act, Labour Relations Act and National Education Policy Act, but there are provisions in all other Acts which have relevance to HIV and AIDS in the workplace.

Smart and Strode (1999) note that there are also other pieces of legislation and common law, while not directly employment-related, which impact on the management of HIV and AIDS in the workplace and these include:

- the Medical Schemes Act, No.131 of 1998; and
- the protection of the right to privacy and dignity.

South Africa has become a signatory to a number of international agreements and codes such as the International Labour Organisation (ILO) Convention III on Discrimination (Employment and Occupation) 1958. The only one which relates specifically to HIV and AIDS in the workplace is the South African Development Community (SADC) Code on HIV and AIDS and Employment, which was approved by the Council of Ministers in September 1997

### **2.13.2 HIV and AIDS discrimination and the law in South Africa**

Since 1994, a number of policies have been enacted that protect the rights of PLWAs. Ten years ago, no explicit legal protection for PLWAs existed (Jennings *et al*; 2002). At present, special protection in South African law is afforded to PLWAs:

- Section 6 of the Employment Equity Act (Act 55 of 1998) specifically prohibits unfair discrimination on the grounds of HIV infection, while section 7(2) prohibits HIV testing of employees, unless permission has been obtained from the Labour Court.
- Section 34(1) of the promotion of Equality and Prohibition of Unfair Discrimination Act (Act 4 of 2000) requires the Minister of Justice and Constitutional Development to give special consideration to HIV AND AIDS as a prohibited ground of discrimination. A schedule attached to the Act names discrimination on the grounds of HIV AND AIDS in the provision of insurance as an example of unfair practices in the insurance sector.
- Section 3(4) of the National Education Policy Act (Act 27 of 1996) prohibits unfair discrimination against learners, students and educators living with

HIV and AIDS. Empowered by this Act, the Minister of Education promulgated the National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions in 1999.

- The National Policy for Health Act (Act 116 of 1990) includes a national policy of HIV testing that prohibits irrational testing. In terms of section 2 of this Act, the Minister promulgated the National Testing for HIV, which was published in August 2000.
- The Medical Schemes Act (Act 131 of 1993) prevents Medical Aid providers from discriminating on the grounds of 'state of health' and requires that the schemes comply with prescribed minimum benefits (PMBs) that are reviewed every two years.
- A Code of Good Practice on Key Aspects of HIV and AIDS and employment was promulgated in December 2000 by the Minister of Labour, and attached to both the Labour Relations Act and the Employment Equity Act.

While it is true that laws afford PLWAs some security against discrimination, it is important to note that laws cannot regulate or legislate against prejudice. Laws may be able to influence and change the superstructures of society, but they do not necessarily have an impact on the discrimination experienced by PLWAs in their daily encounters with others (Jennings, *et al*; 2002:8).

### **2.13.3 The South African Constitution and HIV and AIDS**

The Bill of Rights guarantees the right to equality and non-discrimination: Section 9; privacy: Section 14; fair labour practices: Section 23; and access to information: Section 32. These rights may be limited provided such a limitation is reasonable and justifiable: Section 36. All workplace policies should reflect the content of these rights and they should be used as principles to guide the nature and form of all employment

relationships. In particular, the right to privacy implies an employee's right to confidentiality regarding medical information, including HIV status.

#### **2.13.4 Labour legislation and HIV and AIDS**

The relevant sections of the Employment Equity Act are summarised, followed by an interpretation of the implications related to HIV and AIDS and any specific issues for workplaces which should be noted.

The Act aims at ensuring equality and non-discrimination in the workplace through anti-discrimination measures and affirmative action (equality provisions). It also provides two express provisions on HIV and AIDS.

Section 5 of the Act aims to promote equal opportunity by elimination of unfair discrimination, directly or indirectly, against an employee in any employment policy or practice on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.

Section 7 of the Act prohibits medical testing of an employee except in circumscribed circumstances. Testing of an employee to determine that employee's HIV status is prohibited unless it is determined justifiable by the Labour Court.

Section 59 of the Act states that any person who discloses any confidential information acquired in the performance of a function in terms of this Act, commits an offence.

The Act states that it is unfair discrimination to distinguish, exclude or prefer any person on the basis of an inherent requirement of a job. It is difficult to identify any such situations related to HIV; however, such situations may be identified in the future. Thus,

employers who believe that knowledge of an employee's HIV status is justified must approach the Labour Court for authorisation before embarking on such testing.

As seen, employees with HIV-related illnesses and AIDS should, therefore, be treated in the same way as employees with other life-threatening illnesses. While the Act does provide an absolute prohibition on HIV-testing within the employment relationship, it is likely that the Labour Court will rule that HIV-testing within the patient-healthcare worker relationship is justifiable.

Should HIV and AIDS be classified in the future as a disability, there will be other implications arising from the Act. For example, employees have responsibilities related to affirmative action in respect of people from 'designated groups'. These responsibilities include *reasonable accommodation* which is defined as 'any modification or adjustment to a job or working environment that will enable a person from a designated group to have access to or participate or advance in employment'. Designated groups are defined as black people, women and people with disabilities.

#### **2.13.5 Labour Relations Act No.66 of 1995 (LRA)**

Section 185 of the Act protects employees against arbitrary dismissal. A dismissal is only fair if it is related to an employee's conduct or capacity or is based on the employer's operational requirements (section 188). All dismissals must be effected with reference to the Code of Good Practice on Dismissals attached to the Act in schedule 8. This provides that where an employee no longer has the capacity to perform their functions the employer should

- investigate the extent of their incapacity;
- investigate alternatives short of dismissal, such as short-time, and extended sick leave without pay;
- investigate adapting the employee's duties; and
- investigate accommodating the employee's disability.



In this process, the employees should be given an opportunity to voice their opinion on possible alternatives or accommodations. They should be provided with an incapacity hearing before dismissal. A dismissal solely based on an employee's HIV-positive status is likely to be found to be either automatically unfair in accordance with section 187, because it is a dismissal based on discriminatory conduct by the employer, or simply unfair in terms of section 188 as it does not fall into one of the listed categories. However, if an employee with AIDS is dismissed for incapacity, it will, in all likelihood, be found to be fair, provided steps outlined in the Code of Good Practice on Dismissal have been followed to the letter.

#### **2.13.6 Occupational Health and Safety Act No. 85 of 1993 (OHSA)**

Section 8(1) of the Act requires employers, as far as it is reasonably practicable, to create a safe working environment. This places a duty on employers to ensure that

- the risk of occupational HIV infection is assessed;
- the risk of possible HIV infection is minimised;
- staff training is undertaken on safety steps to be taken following an accident; and
- infection control procedures are used in any situation of possible exposure to blood and blood products.

Employers are required to ensure that appropriate first aid equipment is readily available to deal with spilt blood and body fluids and that staff receive appropriate training on universal infection control procedures. Furthermore, the occupational transmission of HIV and AIDS should be placed on the agenda of the Health and Safety Committee to ensure that appropriate control measures are followed.

### **2.13.7 Mines Health and Safety Act No.29 of 1996**

Section (2) of the Act requires mine workers, as far as it is reasonably practicable, to create a safe working environment. Section 5(2) provides that, in terms of this duty, the mine manager must identify relevant health and safety risks, ensure that employees are not exposed to these risks and supply safety equipment and training. This places a duty on employees to ensure that

- the risk of occupational HIV infection is assessed;
- the risk of possible HIV infection is minimised;
- staff training is undertaken on safety steps to be taken following an accident;
- infection control procedures are used in any situation of a possible exposure to blood or blood products; and
- universal infection control equipment is available for employees at the site of any accident.

Employers have a duty to ensure that appropriate first-aid equipment is readily available for handling spilt blood and body fluids and that staff receive training on universal infection control procedures. Furthermore, the occupational transmission of HIV AND AIDS should be placed on the agenda of the Health and Safety Committee to ensure that appropriate control measures are followed.

### **2.13.8 Compensation for Occupational Injuries and Diseases Act No.130 of 1993 (COIDA)**

Section 22(1) of the Act provides for compensation to employees injured in the course and scope of their employment, provided such an injury causes disablement or death.

Compensation is thus possible in accordance with the Act where an employee becomes HIV-infected following an occupational exposure to infected blood or blood products

In accordance with information received from the compensation commission, within the Department of Labour (DoL), the success of a claim for compensation is likely to be

reliant on the procedures which were followed immediately after an accident. It will be necessary to show that the occupational accident was the direct cause of the person sero-converting (becoming HIV-positive). This requires consideration of the following issues:

- whether an accident protocol exists on occupational exposure to blood or bodily fluids;
- whether HIV-testing is offered to all persons after an occupational accident by the employer;
- whether procedures are in place to deal with situations where an employee refuses to undergo HIV-testing; and
- whether post-exposure prophylaxis (paid for by the employer) is provided to employees where a serious risk of HIV transmission exists.

#### **2.13.9 Basic Conditions of Employment Act No.75 of 1997 (BCEA)**

This Act sets out the minimum employment standards such as working hours, leave, among other work-related condition. Section 22 states that every employee is entitled to six weeks paid sick leave within every sick leave cycle. Furthermore, in accordance with section 22(6) provision is made to negotiate an extension of sick leave but at a reduced rate (provided it is not less than 75% of the ordinary rate of pay). Employers also need to establish policies regarding extended sick leave and leave for other reasons.

#### **2.13.10 Medical Schemes Act, No. 101 of 1998**

This Act provides that a medical scheme may not unfairly discriminate, directly or indirectly, against any person on the basis of his or her HIV status. Furthermore, such a scheme must offer a minimum level of benefits to employees with HIV and AIDS as prescribed by the Minister of Health in terms of section 67(g) of the Medical Schemes Act. Schemes will therefore no longer be able to discriminate against people with HIV or AIDS.

The Act came into operation on 1 September 1999, but medical aid schemes had a 12-month period to alter their rules to bring them in line therewith. The Medical Schemes Act regulates Medical Schemes, not employers, but the regulations have implications due to the fact that most employment contracts include some medical cover.

#### **2.13.11 Common law protection**

Every person has personal rights in terms of the Constitution and common law and these include the right to privacy and bodily integrity. This means that medical treatment (including HIV-testing) may only be carried out with the informed consent of the person concerned. The right to privacy also means that every person is entitled to keep certain personal information to themselves.

Medical practitioners are under a legal and ethical duty to ensure that patient information is not revealed to third parties without consent. This means that information on a person's HIV status may not, in the ordinary course of events, be revealed without consent.

### **2.14 HIV AND AIDS IN THE WORKPLACE: LEGAL ASPECTS IN UGANDA**

In this section, issues pertaining to workplace HIV and AIDS legal matter are presented to situate what is meant to be part of the legal knowledge in Uganda.

While the legal details in both Uganda and South Africa may differ a bit, the broad framework is generally the same. What follows below deals with non-discrimination, recruitment, deployment, HIV testing and confidentiality, among other important issues in the Republic of Uganda.

#### **2.14.1 Non-discrimination law in the Ugandan education sector**

All education sector employees and job applicants living with HIV and AIDS shall not be discriminated against in terms of access to or continued employment, training, promotion or employee benefits on the basis of their HIV status. They shall be protected

against stigmatisation by their employer, fellow employees, learners, parents, managers and communities. In this study, knowledge about non-discrimination law among educators would probably have some contribution to how colleagues treat those coworkers infected by HIV or affected by AIDS.

#### **2.14.2 Recruitment, deployment, etc in the education sector**

Education institutions and sports organisations shall review current policies, codes and practice for recruitment and deployment of staff. In particular, the Ministry (Ministry of Education and Sports) and the institutions falling under it shall:

- ensure that partners and spouses are not separated unnecessarily;
- promote effective succession and succession planning for managers and other staff;
- where possible, assist the redeployment of staff who need access to family or medical care; and
- improve the provisioning systems for teachers and other staff to avoid loss of teaching time (determination of staff ceilings).

#### **2.14.3 HIV testing and confidentiality**

There shall be no compulsory HIV testing in the workplace as a requirement for appointment or continued service. Voluntary testing for HIV at the request of an employee should be done:

- by a suitably qualified person in a suitable facility;
- with the employee's informed consent;
- in accordance with normal medical ethical rules including confidentiality; and
- with pre- and post-test counselling.

Voluntary disclosure by education and sports sector employees and job applicants of their HIV status shall be encouraged, within a supportive environment in which the

confidentiality of this information is protected and in which unfair discrimination on the basis of HIV and AIDS is not tolerated.

An employee is under no obligation to disclose his/her HIV status to their employer. However, where an employee voluntarily chooses to do so, he/she retains the right to confidentiality. Disciplinary steps, consistent with relevant legislation and regulations, shall be taken against any education and sport sector employee who discloses a fellow employee's status without consent.

#### **2.14.4 HIV and AIDS prevention, information and support programmes for employees**

Heads of all education and sports sector workplaces shall ensure that the contents of this policy are communicated to all employees and that they have access to copies of the policy. Heads of all education and sports sector workplaces shall ensure that all categories of employees are provided with appropriate HIV and AIDS education and prevention programmes without delay. These programmes shall be designed and implemented in consultation with all levels and categories of employees. Programmes should include:

- Basic information about HIV and AIDS, how it is spread and how it can be prevented.
- Promotion of positive living by people with HIV and AIDS.
- Promotion of non-discriminatory, supportive and sensitive attitudes towards people living with HIV and AIDS.
- Information on sexuality and safer sexual practices including abstinence, faithfulness and use of a condom correctly and consistently.

- Information on rights and services available in the workplace to employees living with HIV and AIDS, including employee benefits, counselling, condom distribution, peer education and any other support.
- Referral information and contacts with HIV and AIDS services, organisations and networks that can provide further support to employees that are infected or affected.
- Information on universal precautions to prevent accidental HIV infection as well as provision of materials to implement these precautions.

Heads of all education and sports sector workplace shall establish and maintain communication channels to enable employees to raise concerns and grievances and access support concerning HIV and AIDS.

All education and sports sector employees will be held responsible and accountable for complying with HIV and AIDS workplace policy and will be required to attend, lend support to and participate in HIV and AIDS prevention activities.

#### **2.14.5 Refusal to study or work with, teach or be taught by persons living with HIV and AIDS or other discriminatory and disruptive practices.**

Learners/sports persons shall not refuse to study, train with fellow learners, or to be taught or coached by an education and sport sector employee on the grounds that they are living with, or perceived to be living with HIV and AIDS. Similarly, educators, managers, administrators, support staff or other employees shall not refuse to teach or interact with learners, sports persons or colleagues on the grounds that they are living with, or perceived to be living with HIV or AIDS. All infections and contagious diseases associated with HIV and AIDS shall be managed according to national and international guidelines.

#### **2.14.6 III health and absenteeism**

All education and sports sector institutions will actively promote all feasible means to maintain the health and performance of employees living with HIV and AIDS.

All non-government (NGO) employers in the education and sports sectors shall be required to enlist their employees with social security schemes like the National Social Security Fund (NSSF).

Employees living with HIV and AIDS shall continue working as long as they have not been declared medically unfit by a competent medical authority. If employees are unable to continue their normal duties on medical grounds, employers and managers will act in accordance with the Ugandan government standing orders with respect to incapacity.

To reduce the negative effects of illness and incapacity of staff members and education delivery, the sector shall

- take steps to improve access to medical care for staff;
- develop efficient systems for relief staff such as the introduction of flexible staff ceilings providing additional posts from which relief staff can be drawn;
- take steps to improve efficient processing of retirement applications; and
- monitor and assess sick leave provisions and adapt them where necessary.

#### **2.14.7 Exposure to HIV at the workplace**

The heads of all education and sports sector workplaces have the responsibility of ensuring a safe working environment and to minimise the risk of accidental HIV infection in the workplace. An education and sports sector employee who accidentally contracts



HIV in the course and scope of his/her employment shall be entitled to immediate post-exposure prophylaxis (PEP) and follow-up in the form of compensation according to the prevailing law.

#### **2.14.8 Defilement and sexual abuse**

In the context of HIV and AIDS, employees of education and sports sector institutions have a responsibility to protect each other and particularly children in their care from all forms of sexual abuse, including defilement, harassment, sexual molestation, sexual exploitation and rape. Employees who exploit their authority over children for sexual reasons will be subject to disciplinary procedures of the Education Service Commission, instituting specific Codes of Conduct and other legal sanctions determined by a court of law.

Employers and managers of education and sports sector institutions shall have a responsibility to inform all employees of their rights, responsibilities and the sanctions applicable to sexually related misconduct (MoES Draft Pre-final, 2005).

### **2.15 HIV AND AIDS GUIDELINES FOR EDUCATORS IN SOUTH AFRICA**

As already alluded to in section 2.3 in Chapter 2, the legal aspects pertaining to HIV and AIDS in the workplace in Uganda do not differ too much from those in South Africa. To avoid duplication, I will only state what strikingly appears to be expressly stated in relation to HIV and AIDS laws in South Africa, which is either unique or not adequately dealt with in the Ugandan case.

#### **2.15.1 School policy on HIV and AIDS in South Africa**

Schools or institutions should develop their own policy on HIV and AIDS, in order to give operational effect to the national guidelines. Such a policy must be consistent with the Constitution and the law. A school policy must not contradict national policy or the guidelines provided in 'the HIV and AIDS Department of Education Guidelines for Educators based on the National Policy on HIV and AIDS for Learners and Educators in

Public Schools, Students and Educators in Further Education and Training Institutions of the Department of Education' (*Government Gazette* No. 20372, August, 1999).

The school has a responsibility to be a centre of information and support on HIV and AIDS in the community it serves. Major role players from the broader community, for example religious and traditional leaders, local health workers or traditional healers, should be invited to participate in developing the school's policy.

If the resources are available, a school may want to establish a Health Advisory Committee. This would be a Committee of the governing body. Its membership should include staff, parents, learners and health professionals. Someone with health knowledge should chair the Committee.

The Committee should advise the governing body on the implementation of these guidelines. It should help develop the school's HIV policy and monitor its implementation, especially HIV prevention.

The school policy should be reviewed as new scientific information becomes available, including advice from the national or provincial health or education authorities. In this study, teachers were expected to have some awareness of HIV and AIDS policy; and being involved in either its development or implementation would probably have some influence on how they behave towards those colleagues infected with HIV or affected by AIDS.

## **2.16 HIV AND AIDS KNOWLEDGE ISSUES FROM CHINA: A RECENT SURVEY FOR COMPARISON**

In a survey conducted in China by Lönn *et al*; (2007) almost half of the medical postgraduates (44%) believed that there was a medicine that can cure HIV and AIDS,

13% did not know and 4% did not answer the question. The knowledge was much better among the undergraduate students, where just 9.4% believed that such a medicine exists, 13.1% did not know and 2% did not answer. There were misconceptions especially concerning mosquitoes and kissing as modes of transmission. Similar findings have been obtained from several studies in different countries but the example of a Chinese study will suffice.

## **2.17 SUMMARY**

In this chapter, knowledge of HIV and AIDS was defined, which included legal HIV and AIDS knowledge and basic biomedical HIV and AIDS knowledge. The concept 'knowledge' was briefly delineated. Specifics of HIV and AIDS legal knowledge in South Africa and Uganda were dealt with in detail, indicating the basic differences in the two legal systems. Furthermore, basic HIV and AIDS biomedical knowledge was explored; including causes of HIV and AIDS, effects, modes of transmission and false means of HIV and AIDS transmission. In addition, HIV and AIDS prevention was discussed. The next variable of interest, HIV and AIDS attitudes is discussed in the chapter that follows.

# CHAPTER 3: ATTITUDES AND RELATED PSYCHOLOGICAL CONCEPTS

## 3.1 INTRODUCTION

In this chapter, the focus is on attitudes. Firstly, a brief historical background of the concept of attitudes is presented and then analysed for the purpose of coming up with the most appropriate definition for this study. Secondly, the measurement of attitudes and its attendant issues follows. Thirdly, concepts that relate to attitudes and are of relevance to this study are dealt with.

## 3.2 DELINEATION OF ATTITUDES

Attitude is an enduring response towards persons, objects and ideas. Allport (in Sears, Peplau & Taylor, 1991:546) portrays that attitude is a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related. Attitude is "someone's opinion or feeling about something, especially as shown by their behaviours" MacMillan English Dictionary, 2006:76). Attitudes are learned when observing how people behave in environments with different social and economic pressures. Attitudes once established, are much more resistant to change.

### 3.2.1 What is an attitude?

The term *attitude* commonly refers to our general evaluations of people, objects and issues. According to Ajzen (2001), the evaluative dimensions of attitude include good-bad, harmful-beneficial, pleasant-unpleasant and likeable-unlikeable. Although the study of attitudes has been central to the field of social psychology for a long time, the concept has evolved over time. In order to fully understand and appreciate its current usage, it is useful to know some of its history.

In the 1900s, sociologists and psychologists interested in individual differences began to adopt the concept of attitude. In part, this grew from increasing dissatisfaction with the term *instinct* (an instinct for craftsmanship), which fell from favour due to its connotations regarding biological or hereditary influence on behaviour, as cited in Fazio and Petty (2008). Allport (1935) views the desire for a term that placed more emphasis on the role of social and cultural forces as a reason for the emergence of the attitude construct within the social sciences. Sociologists Thomas and Znaniecki (1918) cited in Fazio and Petty (2008) are typically credited with this emergence. In a very influential book concerned with the Polish peasant, they used the term to refer to the plans, interests and sympathies of the average individual. Their enthusiasm for the attitude concept prompted Thomas and Znaniecki to define the field of social psychology as the study of attitudes (ibid).

Beginning with these early tracings of the attitude concept, Allport (1935) reviewed a large number of definitions that had been offered. His analysis of their common threads and the debates that had ensued regarding the meaning and utility of the construct led him to propose what is certainly the most commonly cited and widely known of the early definitions of attitude. 'An attitude is a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related' (Allport 1935).

Although Allport's definition is no longer widely accepted, its features provide useful points of departure that help to elucidate the evolution of the concept of attitude into its modern form. Following below is the consideration of some key elements of Allport's definition of attitudes:

*'An attitude is a... state of readiness...'* This idea obviously stems from the historical context noted earlier and, in particular, the connotations stemming from use of the term 'attitude' in the arts and in the early reaction time research.

The idea that attitudes *'prepare'* one to respond in some appropriate manner remains central to the concept of attitude as it is used even today; and indeed, it points to one of the ways in which attitudes prove functional for individuals in daily life. As we shall see later on, attitudes serve what is called a knowledge- or object-appraisal function, enabling the individual to make quick, easy, and efficient decisions about whether to approach or avoid an object. According to Oskamp (1991:8), the central feature of all definitions of "attitude" is the idea of readiness for response, which means that "attitude" is not behaviour or something one does but rather a preparation for behaviour, a predisposition to respond in a particular way to the attitude object. "Attitude object" is used to include things, people, places, ideas, actions or situations either singular or plural.

*'An attitude is...organised...'* The idea that an attitude is organised as a mental structure of one sort or another came to be embodied in what is known as the tripartite, three-component, or ABC model of attitudes (Katz & Stotland, 1959; Rosenberg & Hovland, 1960) cited in Fazio and Petty (2008). Rajecki (1990:347), Fazio and Olson (2003:259), Weiton (2007:649) and Lord (1997:223) also espouse the A-B-C model of attitude. According to this view, attitudes consist of three classes of information:

- affective – feeling or emotions that people have in response to the object,
- behavioural – actions that people have engaged in, or are inclined to engage in, with respect to the attitude object, and
- cognitive – beliefs that people have about the characteristics of the object.

This particular conception is no longer endorsed widely. The reasons for the shift away from the three-component view are detailed in the work of Zanna and Rempel (1988).

As these authors articulate, the tripartite model implies some degree of consistency among affective, cognitive and behavioural reactions to an object. Yet, what are we to make of a person who fails to behave consistently with his or her beliefs about some object? Does the person not have an attitude? If the answer were to be 'yes', then we are essentially 'defining away' what could be interesting questions for empirical research. These authors argue that there is no reason to ask about the consistency between attitudes and behaviour if consistent behaviour is a pre-condition for application of the attitude concept. The very definition calls for behavioural consistence. Instead of adopting a definition that prejudges the attitude – behaviour relation – Zanna and Rempel endorse a perspective in which attitudes are viewed simply as *evaluation*; evaluations that themselves can be based on beliefs, feelings, and/or past behaviour. As they note, this view encourages the pursuit of questions regarding how attitudes based differentially on affect, cognition, or behaviour might differ from one another in terms of the impact they have on behaviour and in terms of their persistence over time. The perspective also encourages empirical research regarding the consequences of having affective and cognitive reactions that are consistent with one another versus more contradictory or ambivalent in nature.

*'An attitude...[exerts] a directive...influence...'*. The assertion offered here is that attitudes guide subsequent behaviour toward the object. So an individual who thinks highly of a political candidate will vote for the candidate. An individual who regards donating to a charity as a noble gesture will make a monetary contribution. By the same token, an individual sympathetic to an HIV and AIDS-affected colleague will offer him/her the necessary support. The problem is that so far research has shown that such one-to-one correspondence between attitudes and behaviour does not necessarily occur (Zanna & Rempel, 1988). Other variables intervene. Many qualities of the person, the situation and the attitude itself can influence the extent to which attitudes guide behaviour. Although having a ready guide to behaviour is one important reason why people hold attitudes, it does not seem appropriate to assume attitude – behaviour consistence as part of one's very definition of attitude.

*'An attitude... [exerts] a dynamic... influence...'* The reference here is to the possibility that attitudes may actually motivate or energise behaviour, just as they drive states or needs such as hunger and thirst. This ascription of motivational power to the attitude concept never gained much acceptance (Fazio & Petty, 2008). Although the idea that one's evaluations of an object have the potential to direct one's actions regarding the object is unquestionably true, it seems far less plausible that evaluations would, in and of themselves, produce behaviour (ibid). Sometimes, individuals do actually seek out opportunities to promote their attitudes. Certainly that can be said of some evangelists and political activists. However, such actions seem more a property of the individual's intense personal attachment to the issue than to the favourability per se. Much more than a positive attitude is necessary for individuals to initiate advocacy.

The current perspective of attitudes or rather the most commonly accepted modern view of attitudes grew from the concerns that have been noted regarding Allport's definition and the tripartite model. In the interest of avoiding a definition that makes assumptions about the influence that attitudes may or may not exert, most attitude researchers, for example, Huffman, Verney and Verney (1994:627) and Weiton (2007:647), now adopt a fairly simple definition of attitudes. They refer to an attitude as a person's evaluation of an object – favourability or unfavourability toward the object. This definition actually can be traced back to the one-component perspective that various early theorists such as Thurstone (1928) espoused. However, as Zanna and Rempel (1988) argue, the modern conception explicitly acknowledges that the basis for any given evaluation can vary: the attitude may stem from beliefs, i.e., appraisals of the attributes that characterise the object; it can stem from emotional reactions that the attitude object evokes; it can be based on one's past behaviours and experiences with the object; or it can be based on some combination of these potential sources of evaluative information.



Fazio, Sanbonmatsu, Powell and Kardes (1986) take this perspective one step further. These authors view the attitude as an association that exists in memory between the attitude object and the summary evaluation of the object. Their model emphasises the strength of this association and, as a result, the accessibility of the attitude from memory can vary. In a series of experiments employing a priming paradigm, they demonstrate that attitudes sometimes involve sufficiently strong associations that the evaluation is automatically activated from memory upon mere observation of the attitude object (see Fazio, 2001, for a review of the research concerning the priming paradigm). Some people cannot help but experience a negative reaction when they observe a snake. Some have an inescapable positive reaction to the thought of chocolate, or an immediate 'yuck' response to the mention of ordering anchovies on a pizza. This view allows for the possibility that attitudes may exert some influence on perception, judgments and behaviour without an individual consciously reflecting upon how they evaluate the attitude object. An association in memory can get activated and begin to exert influence simply as a function of its heightened activation. The authors say, indeed, attitude accessibility has been found to play an important role with respect to both the power of attitudes and their functional value.

Most researchers seem to agree that an attitude is a state of readiness, a tendency to respond in a certain manner when confronted with a certain stimuli (Oppenheim, 1991:174). Most of an individual's attitudes are usually dormant and are expressed in speech or behaviour only when the object of attitude is perceived. Attitudes are reinforced by *beliefs* (the cognitive component) and often attract strong *feelings* (the emotional component) which may lead to particular behavioural *intents* (the action tendency component) (Oppenheim, 1991:175).

### **3.2.2 The nature of attitudes**

Oppenheim (1991) says that our thinking about the nature of attitudes has been rather primitive. Most of the times we tend to perceive them as straight lines, running from positive, through neutral, to negative feelings about the object or issue in question. Our

attempts at measurements then concentrate on trying to place a person's attitude on a straight line or a linear continuum in such a way that it can be described as mildly positive, strongly negative, and so on – preferably in terms of a numerical score or else by means of ranking. There is no proof, however, that a model of a linear continuum is necessarily correct, though it does make things easier for measurement purposes. Oppenheim (1991) continues to say that for all we know, attitudes may be shaped more like concentric circles, overlapping ellipses or three-dimensional cloud formations.

The model of a linear continuum or dimension is not always easy or appropriate. For instance, the positive part and the negative part may not be linear extensions of each other. According to a study of attitudes of mothers to their children by Oppenheim *et al.* (1991), they found that rejection is not the exact opposite of acceptance (as measured by two separate attitude scales). Apparently, a variety of other components enters into the attitude of a rejecting mother that is not present in a loving and accepting mother. Moreover, it is possible for some respondent to be ambivalent and to score highly both on acceptance and on rejection. It would, clearly, be a mistake to assess these attitudes by means of a single acceptance-rejection continuum. Again, the degree of differentiation at one end of an attitude continuum may be very different from that at the other end.

Attitudes have many attributes. While we have mainly talked about *content* – what the attitude is about – an attitude has *intensity* also. An attitude may be held with greater or lesser vehemence (Oppenheim, 1991). For arguments sake, to some people, the exploitation of animals may be but of passing interest or concern, whereas to others it may be of great importance and propels them to leading positions in animal liberation movement. We may accept the latter to agree or disagree more strongly with the former than with a series of statements dealing with the treatment of animals. By the same token, an individual with passing interest or concern about colleagues affected or infected with HIV and AIDS may agree or disagree more strongly than one who has more interest in colleagues affected or infected with HIV and AIDS would agree or

disagree to a series of statements dealing with workplace HIV and AIDS-related issues, including discrimination due to HIV and AIDS infection.

Some attitudes are more enduring than others. For instance, a man's belief in egalitarianism may be fairly stable throughout his lifetime, whereas his attitudes to alcohol drinking may undergo multiple changes. Similarly, some attitudes go much deeper than others and touch upon a person's fundamental philosophy of life, while others are relatively superficial. Again, some attitudes seem to be more embracing than others; they lie at the base of more limited or specific attitudes and beliefs, thus predisposing individuals in a certain way toward new attitudes and experiences that may come their way (Oppenheim, 1991). For ease of understanding, social psychologists make a rough distinction between these different levels, calling the most superficial one *opinion*, a moderately deeper level *value* or basic attitudes, and an inherently deeper level, *personality*. These rather vague distinctions between different levels of attitudes must be thought of as more versus less enduring, deeper versus more superficial, relatively stable versus relatively changeable, and more general versus more specific. Oppenheim (1991) goes on to say that these levels must not merely be thought of as the different layers of a cake; there are relationships and patterns of connection between these layers, rather like what is called the tree model.

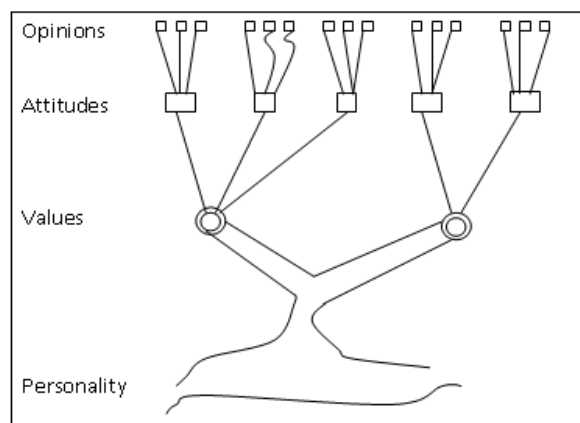


Figure 3.1: The personality – values – attitudes – opinions ‘tree model’.

Source: Oppenheim (1991)

This diagram’s chief function is to warn against treating opinions and attitudes too much as ‘isolated units’ and to illustrate the problems we face in trying to bring about a change in anyone’s attitudes. At the most specific level, that of opinions, change is relatively easy to bring about so long as the underlying attitude is not involved.

Typically, attitudes do not exist in isolation within the individual. They generally have links with components of other attitudes and with the deeper levels of value systems within the person. For instance, suppose we are having dinner with a friend in a restaurant and I suggest to him that he might like pork chops, which are on the menu. Our friend declines. At this point, we might say to ourselves that we are dealing with an opinion, with a relatively superficial and not immutable food preference at the moment. However, suppose we started questioning our friend. We might find that he is a vegetarian, a Jew or a Muslim, and that his refusal to eat pork chops has to do with a more general and deeper underlying attitude to pigs and other animals as food. This in turn may be linked to an underlying value system that has to do with the role of human beings *vis-à-vis* other creatures with religious proscriptions concerning ‘clean’ and ‘unclean’ animals or possibly with other taboos. An apparently simple matter of food preference may in fact be a key to the individual’s fundamental philosophy of life. A more pertinent example in light of this study would be a coworker who may refuse to put on a T-shirt with a picture of a condom and associated HIV and AIDS prevention message. On the peripheral, the coworker would say that he/she does not like to put on T-shirts. At a much deeper level, you might find that the coworker refuses to put on such a T-shirt because of his/her religious beliefs. This is very likely to be the case with some puritans and some very conservative Catholics.

Attitudes are also related to each other 'horizontally', at the same level. Some interesting research conditions in social psychology have been concerned with such interrelationships. For instance, research findings show that racial prejudice against one minority group is usually associated with prejudice against several other groups, and with the glorification of the individual's group (Oppenheim, 1991).

Interrelationships such as the above-mentioned ones follow no logic except the 'psychologic' – the logic of feelings and emotions. It is most important to realise that attitudes are only very rarely the product of a balanced conclusion after a careful assembly of evidence. As a rule, attitudes are acquired or modified by absorbing, or reacting to, the *attitudes* of *others*. We like to maintain the fiction of rationality and impartiality in reaching our conclusions, but, in fact, attitudes play a very considerable part. Attitudes can be highly emotional, both in the sense of irrational or illogical and in the sense of arousing powerful needs and ego defenses. When we ask a highland Peruvian woman to boil her drinking water to kill germs, we are, in her eyes, also asking her to adopt the white man's magic, to betray her ancestors and make a fool of or renegade of herself in her village. To us this may not seem very reasonable at first, but this is where research can help – by showing the underlying links with their strong emotional connections (Oppenheim, 1991:178). Pertaining to this study, issues relating to the way one views those infected or affected by HIV and AIDS may have underlying causes which are not so obvious; thus, they can be looked at in the same light.

### **3.3 A CONSIDERATION OF BELIEFS AND THEIR ROLE IN ATTITUDE MEASUREMENT**

Two persons who are equally opposed to workplace HIV and AIDS-related discrimination may have quite different conceptions of its nature, causes and consequences and may hold different views concerning the actions which should be taken to eliminate workplace HIV and AIDS-related discrimination. In the language of this study, these two persons are said to have the *same attitudes* toward workplace HIV and AIDS-related discrimination but to hold *different beliefs* about it. Attitudes are

learned predispositions to respond to an object or class of objects in a favourable way. Beliefs, on the other hand, are hypotheses concerning the nature of these objects and the types of actions that should be taken with respect to them.

Many writers do not maintain this distinction between attitudes and beliefs. Both notions are commonly subsumed under the single term 'attitude', which is said to have effective (evaluative), cognitive, and co-native (action) components. According to this view, an 'attitude' toward workplace HIV and AIDS-related discrimination would include not only a person's negative feelings toward workplace HIV and AIDS-related discrimination, but also his ideas about its causes and implications and his conviction that it should be fought through legislation and education, especially about cause, transmission and preventing HIV and AIDS. There is, of course, no overwhelming reason why the word 'attitude' should not mean all of these things. Words are created by man for his own convenience and they may be used in any manner that man finds appropriate. But certain considerations lead us to believe that 'attitude' is a more useful scientific word when it is given restricted meaning.

It is obvious that affect, cognition and action are not always highly correlated. Different people like the same thing for different reasons, and one individual may discriminate an HIV and AIDS infected/affected coworker because he/she got infected through a sexual orientation the individual abhors while another may not discriminate an HIV and AIDS infected/affected coworker for exactly the same reason. Consequently, a multi-component of attitude turns out to be a multi-dimensional conception and the 'attitude' of any one person toward an object or concept may fall at three very different positions on three different dimensions. But the operations by which attitudes are measured almost invariably yields a single score which is unlikely to reflect these three different components in any precise fashion. As a matter of fact, people who construct 'attitude scales' rarely maintain that their instruments are measuring three components; instead, they usually contend that their scales indicate people's evaluation (pro-con) of objects

or concepts. Thus, although 'attitudes' are often said to include all three components, it is usually only evaluation or 'the affective component' which is measured and treated by researchers as the essence of attitude.

It is the contention of this study that increased precision and understanding can be gained by bringing our definition of attitude into closer harmony with the techniques by which attitudes are measured. Multi-dimensional concepts are notoriously difficult to employ in rigorous theory and they create almost unmanageable problems when theory is translated into research. A conceptual system in which only the effective component is treated as attitudinal, and the other two components are linked to beliefs, should permit a more productive approach to the study of attitudes.

After reviewing many of the earlier definitions of attitude, Osgood and his associates (Osgood and Tannenbaum, 1955; Osgood, Suci and Tannenbaum, 1957) concluded:

It seems reasonable to identify attitude, as it is ordinarily conceived in both lay and scientific language, with the evaluative dimension of the total semantic space. The meaning of a concept is its location in a space defined by some number of factors or dimensions, and attitude toward a concept is its projection onto one of these dimensions defined as 'evaluative'.

Osgood's definition of attitude has many advantages. First, it has the virtue of treating attitude as a uni-dimensional concept. It equates attitude with the evaluative meaning of an object or concept, i.e. attitude refers only to the 'evaluation' of a concept – its 'favourableness' or 'unfavourableness', its 'goodness' or 'badness'. Other types of evaluative meanings which the object may have for a person (for example, its size, shape, speed) are excluded from the notion of attitude except insofar as they may influence the placement which the person gives the object on the evaluative dimension.

Second, as Osgood *et al.* (1957) point out, 'every point in semantic space has an evaluative component (even though the component may be of zero magnitude when the evaluative judgments are neutral)'. Thus, this definition makes it clear that with respect to any object or concept, an individual has a positive, negative or neutral attitude.

Third, it is consistent with the description of attitude as a learned predisposition to respond to a stimulus in a favourable or unfavourable way. According to Osgood, this definition characterises attitude as a mediating evaluative response – a learned, implicit response that varies in intensity and tends to 'mediate' or guide the individual's more overt evaluative responses to an object or concept.

Considerable evidence supporting the reliability and validity of Osgood's instrument for measuring attitudes (called the semantic differential) has been presented by Osgood *et al.*, (1957) and Fishbein and Raven (1962). Although the semantic differential is not the only technique by which uni-dimensional attitude scores may be obtained, it provides a clear operational definition of the term 'attitude' as it will be used in this study.

### **3.4 COMMENT ON ATTITUDE'S DEFINITION**

It is not difficult to trace a common thread running through these diverse definitions. In one way or the other each regards the essential feature of attitude as a *preparation* or *readiness for response*. The attitude is incipient and preparatory rather than overt and consummate. It is not behaviour, but the precondition of behaviour (Oskamp 1991). It may exist in all degrees of readiness from the latent, dormant traces of forgotten habits to the tension or motion which is actively determining a course of conduct that is under way.

It is difficult to construct a definition sufficiently broad enough to cover the many kinds of attitudinal determination which psychologists today recognise and at the same time, narrow enough to exclude those types of determination which are not ordinarily referred



to as attitudes. The definitions considered above contain helpful suggestions and yet none alone is entirely satisfactory. The chief weakness of most of them seems to be their failure to distinguish between attitudes, which are often very general, and habits, which are always limited in their scope.

Any attempt at a definition exaggerates the degree of agreement which psychologists have reached but is justified if it contributes toward securing greater agreement in the future. The following definition has the merit of including recognised types of attitudes: the *Aufgabe*, the quasi-need; the *bewusstseinslage*, interest and subjective value, prejudice, stereotype, and even the broadest conception of all, the philosophy of life. It excludes those types of readiness which are expressly innate, which are bound rigidly and invariably to the stimulus, which lack flexibility, and which lack directionality and reference to some external or conceptual object. Thus:

An 'attitude' is a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related (Frankfort-Nachmias & Nachmias 1992:241).

### **3.4.1 Positive and negative attitudes**

An attitude characteristically provokes behaviour that is *acquisitive* or *overtive*, *favourable* or *unfavourable*, *affirmative* or *negative* toward the object or class of objects with which it is related. This double polarity in the *direction* of attitudes is often regarded as their most distinctive feature. It has a central place in Bogardus' definition (1931:52): 'An attitude is a tendency to act toward or against some environmental factor which becomes thereby a positive or negative value'. Likewise, Thurstone (1932) defines an attitude as 'the affect for or against a psychological object'.

### **3.4.2 The nature of attitude: An alternative view**

Doob defines an attitude as an implicit response which is

- both anticipatory and mediating in reference to patterns of overt responses;

- evoked by a variety of stimulus patterns as a result of previous learning or of gradients of generalisation and discrimination;
- itself cue- and drive-producing; and
- considered socially significant in the individual's society.

### **3.4.3 Two conceptions of attitude**

An attitude, according to this conception, is a disposition to evaluate certain *objects*, *actions*, and *situations* in certain ways. For purposes of the present definition, evaluations require words; the *disposition* to evaluate need not, however, be verbalised. An attitude may be conscious (recognised and known by its 'possessor') or it may be unconscious.

It may be momentary or persistent. If it persists, it becomes salient in situations to which it is pertinent; otherwise, it may be relatively unobservable, except through its effects. It may pertain to matters socially significant or insignificant. The evaluations involved may correspond to, or differ from, the evaluations of most members of the culture or subculture or the 'coded' cultural and institutional values. They may or may not have strong personal persistence, self-reference or ego-involvement. They may or may not be associated with strong impelling motives. The disposition to evaluate in certain ways is generated by such factors as one's available knowledge concerning the object, action, or situation, one's comprehension of the interrelatedness and interrelations of phenomena and of the consequences of actions, one's time perspective, one's motives and motivational displacements or substitutions, one's conscious and unconscious patterns of phenomenal equivalences (symbolisms in the psychoanalytic sense), one's introjected moral values, and the interaction of these factors in relation to other attitudes. Various aspects of this conception will also be elaborated upon in the course of the following discussion.

From the viewpoint of this second conception of the nature of attitude, when Doob writes that 'the rat's aversion to a grid on which it has been shackled is doubtless implicit, it is anticipatory and meditative in avoiding the shock, it can be evoked by a gradient of stimuli, and it has drive value resulting in other responses which serve perhaps to allay its anxiety; but it is ordinarily not useful to call such a response an attitude', we may add that not only would it be not useful to call such a response (or response pattern) an attitude, but that it would be wrong. Rats may have aversions, but they do not have dispositions to evaluate which, in this case, would require a disposition to verbalise the aversion.

It should be noted that, although the two conceptions are assuredly different, there are many point of agreement or near agreement. Both would, for example, agree that

- a person is not born with his attitude,
- the learning process plays a major role in the development of attitudes,
- attitudes involve problems of perception and motivation,
- as a result of a particular attitude a person may be more likely to perceive certain objects than others,
- some attitudes affect perception after their arousal even though they may not have oriented the person originally in the direction of the perceived objects,
- specific behaviour cannot be safely predicted from a knowledge of attitude alone, and
- people may act contrary to their attitudes.

With the last two points, it becomes imperative that the interpretations from the survey should be taken with caution. By implication from sixth point, there is something more than attitudes to predicting behaviour. As for the last point, an individual may act to

appease those surrounding him/her yet the actual attitude he/she possesses is either for or against workplace HIV and AIDS-related discrimination.

This has implications for this study because once educators have negative attitudes regarding HIV and AIDS, and towards PLWHA, in this regard colleagues, it might be very difficult to change; and may behave in a discriminatory manner towards those infected and affected by HIV and AIDS. So this study explored educators' attitudes regarding HIV and AIDS and towards PLWHA, particularly co-workers; so as to make recommendations engendering more positive attitudes in the workplace in future.

People do not change their attitudes without putting a fight and being exposed to a considerable amount of pressure. The reasons for not changing attitudes or being resistant to change are that because once people are affectionate about something, it is difficult to automatically dislike it just because they are being told to do so. It takes a considerable amount of pressure to convince people to change their attitudes.

In some studies, attitudes towards HIV and AIDS; and towards PLWHA have been inconclusive. Several studies find levels of empathy, tolerance, acceptance and positive attitudes towards HIV and AIDS or PLWHA (Serovich & Greene, 1997: 440; Villarruel, Jommolt, Howard, Taylor & Bush, 1998:68). However, other findings show neutral, unfavourable or unsympathetic attitudes towards HIV and AIDS or PLWHA. For example, Owaish *et al*; (1999:170), report that 80 percent of Kuwaiti participants felt that PLWHA should not be left to live freely in the community. Lilia, Trummal and (2003:58) from their study on knowledge, attitudes and behaviours related to HIV and AIDS among Estonian youths that more than 50 percent of their respondents exhibited negative attitudes towards PLWHA. And, a study by the Centre for Social Group Development (CSGD) (2005:28-31) on knowledge, sexual behaviours and attitudes about HIV and AIDS in Kosovo, revealed that more than 90% of the respondents exhibited negative attitudes towards PLWHA but a very positive view regarding HIV and AIDS. A study of educators' view on the impact of HIV and AIDS in primary education in three states (Kano, Lagos and Nasarawa) of Nigeria reported that 56% of teachers in

Lagos State were of the view that HIV-positive teachers should not be allowed to teach. In the same study, 34% of teachers in Kano State lacked willingness to discuss HIV and AIDS in the workplace (Ssengonzi *et al*; 2004: 4-38).

In Uganda, Neema and Koster (2007:8) in a study of staff regarding HIV and AIDS in the workplace, reported that concerning attitude, 60% had a positive attitude while 8.1% had negative attitude; and attitude was best on non-discrimination of HIV-positive for further training (93.8%) and least on feeling comfortable working next to a HIV-positive person (73.2%). In this study, educators' attitudes regarding HIV and AIDS and towards PLWHA in the workplace were explored.

### **3.5 POINTS OF INCONSISTENCY IN DOOB'S DEFINITION**

The most important inconsistency has to do with the term in Doob's definition which asserts *that an attitude is a response*. Elsewhere, however, he writes that, 'the individual ... may not express his attitude in overt behaviour because its expression would be contrary to his general philosophy; *but his attitude persists*'. Now, by any ordinary usage of the word 'response', a response occurs and is gone; it does not persist. In other words, if an attitude can persist, it cannot be a response. Doob may, of course, have in mind a class of persistent responses, but such responses do not seem to belong in the stimulus –response formula and hence, in behaviour theory. In all S–R psychologies one looks for a stimulus which immediately precedes the response and to admit responses which keep going (perhaps for many years) is certainly to change the psychological significance of the stimulus term in the S–R formula.

Despite his definition of an attitude as a response, Doob often seems on the verge of thinking of attitude as a habit or an established stimulus – response 'bond'. Thus, he defines the strength of an attitude in terms of the strength of the stimulus – response bonds in which it is involved. This would give meaning to Doob's statement that an attitude may persist, for, while the response may be momentary, the bond presumably

persists. It may be more sensible, therefore, to think of an attitude as the *habit* rather than as the response.

But an attitude cannot be both a response and a habit; it must be *one* or the *other* or *neither*. It is our inclination to say *neither*. For customary usage it seems that there may be both persistent and momentary (possibly but not necessarily recurrent) attitudes. And it seems to us that both have more in common with each other than either does, respectively, with a habit or a response.

Closely related to the question of whether an attitude is a response is the question of the relation of attitude to set. In our own conception, attitudes are a species of set. Doob also concedes that 'attitude may be included among the sets determining both the orientation of the individual as well as the kind of perceptual response he makes'. Sets may also be momentary or persistent (and hence our previous question as to whether an attitude is best conceived of in relation to habits, responses, to neither and/or whether it applies to set as well), but even if we concede that all sets are responses, the important thing about a set is not that it is a response, but the selective function that it plays. In other words, in playing up the response aspect of attitude, Doob is missing the boat.

That Doob seems to have some kind of antipathy to 'sets' is suggested by the following passage: 'Writers on attitude are fond of recalling the tradition of set is somewhat hoary in academic psychology, in order to demonstrate their own respectability and their acquaintance with long German terms like *Bewnsstseinslage*'. Perhaps this antipathy accounts for Doob's insistence that an attitude is implicit, i.e. not 'overt behaviour that is observable to an outsider'. His sole justification for the criterion of implicitness in his opinion that 'the semantic connection of such sets [motor 'attitudes' like the physical set of the runners before the starter's gun is fired] with the concept of attitude employed by social scientists is ... largely fortuitous from an historical stand point'. But if attitudes are a species of set, then the connection is by no means a historical accident because,

apart from the question of whether any set which are manifestly motor and other sets have much in common, at least in a functional sense.

The matter is of some importance because, in making implicitness a defining attribute of attitude, Doob introduces a quite dispensable source of ambiguity. There is, of course, no sharp line of demarcation between *implicit* and *explicit* as Doob defines these terms; observability varies in degrees. This implies that it must in many instances be difficult to decide (by Doob's definition) whether or not one is dealing with an attitude. How unobservable must an attitude be before one ceases to refer to it as an attitude? Also, it must often be difficult to distinguish between an overt *manifestation* of an attitude and an overt *consequence* of it. For instance, is a *move* of distance a manifestation or a consequence? If it should be decided that it is a manifestation, then by Doob's definition, whatever it is a manifestation of *is not* an attitude; but if it is regarded as a consequence, then what it is a consequence of *is* an attitude. Insofar as we may arbitrarily regard it as either manifestation or consequence, then we may arbitrarily decide that we are or are not dealing with an attitude.

As the final item in this section we shall raise the question of whether an attitude is properly defined as anticipatory. Doob follows Hull in defining an anticipatory response as 'one which originally preceded another rewarded response' and which, as a result of being associated with or producing this reward, has been reinforced so that it occurs before its 'original time in the response series'. Doob's illustrations are singularly illuminating with regard to attitudes as anticipatory responses. Thus, in the case of an individual disliking another person, we are told: 'Originally the avoidance occurred only after actual contact had been established and after the contact had proven to be punishing and the withdrawal to be rewarding'. It is clear that the avoidance response may occur more quickly as a result of learning that it did originally, but it is not clear how it can be regarded as an anticipatory response since, being the goal response, it is always necessarily the last in the series. Doob, as a matter of fact, explicitly states that an attitude precedes (leads to) the goal response. Perhaps, of course, the attitude is the

dislike rather than the avoidance (the latter being regarded, perhaps, as a response to the former) and it is the dislike which moves up in the response series. The dislike presumably (at least by the definition) does not become an attitude until it moves up in the response series, but it is not at all clear why a dislike which arises more quickly should be called an attitude while one which arises less quickly (and is in fact the same dislike) should not be called an attitude. Moreover, Doob goes on to say that, 'when a thorough investigation reveals in actual prior contact, some process of generalisation or discrimination must have occurred since all behaviour has antecedents'. In other words, not only does an attitude occur before its original time in the response series, but it seems that it may occur in a response series in which it has never precisely occurred at all; if mere temporal placement may define anticipation, then this is anticipation with a vengeance.

Again, the matter is of some importance because making an attitude, by definition, anticipatory, leads to various difficulties. It precludes, for instance, the possibility of functional or dynamic contemporaneity between the attitude and the pertinent goal response. Even if an attitude may be said to persist, Doob's position implies that whatever effect an attitude may have has already taken place by the time the goal response occurs. Yet, to take one example, a young man may have an attitude about kissing girls even while acting in accordance with, or contrary to his attitude and his enjoyment of the process and later reactions to it may continue to be identified by his attitude. Another example, an HIV unaffected worker may have an attitude about helping an HIV-infected/affected colleague even while acting in accordance with, or contrary to his attitude and his satisfaction derived from the act of assisting and later reactions to it may continue to be identified by his attitude.

Doob's formulation raises the problem which confronts all attempts to deal with dynamics in historical as distinguished from historical (cf.1) terms, namely, how



something which no longer exists (and it no longer exists because it antedates its effects) can influence something which is now going on.

### **3.6 MEASUREMENT OF ATTITUDES**

In this section some pertinent issues relating to the measurement of attitudes are critically looked at.

#### **3.6.1 Means of measuring attitudes**

In this study, opinions were used as the means for measuring attitudes. There comes to mind the uncertainty of using an opinion as an index of attitude. The man may be a liar. If he is not intentionally misrepresenting his real attitude on a disputed question, he may nevertheless modify the expression of it for reasons of courtesy, especially in those situations in which frank expression of attitude may not be well received. This has led to the suggestion that a man's action is a safer index of his attitude than what he says. But his actions may also be distortions of his attitude. A politician extends friendship and hospitality in overt action while hiding an attitude that he expresses more truthfully to an intimate friend. Neither his opinions nor his overt acts constitute, in any sense, an infallible guide to the subjective inclinations and preferences that constitute his attitude. Therefore, we must remain content to use opinions, or other forms of action, merely as indices of attitude.

It must be recognised that there is a discrepancy, some error of measurement as it were, between the opinion or overt action that we use as an index and the attitude that we infer from such an index. But this discrepancy between the index and 'truth' is universal. Truth is inferred only from the relative consistency of the several indices, since it is never directly known. We are dealing with the same type of situation in attempting to measure attitude. We must postulate an attitude variable which is like practically all other measurable attributes in the nature of an abstract continuum, and we must find one or more indices which will satisfy us to the extent that they are internally consistent.

In this study we shall measure the subject's attitude as expressed by the acceptance or rejection of opinions. But we shall not thereby imply that he will necessarily *act* in accordance with the opinions that he has endorsed. Let this limitation be clear. The measurement of attitudes expressed by a man's opinions does not necessarily mean the prediction of what he will do. If his expressed opinions and his actions are inconsistent, that does not concern us now, because we are not setting to predict overt conduct. We shall assume that it is of interest to know what people say that they believe even if their conduct turns out to be inconsistent with their professed opinions. Even if they are intentionally distorting their attitudes, we are measuring at least the attitude which they are trying to make people believe that they have.

We take for granted that people's attitudes are subject to change. When we have measured a man's attitude on any issue such as workplace HIV and AIDS-related discrimination, we shall not declare such a measurement to be in any sense an enduring or constitutional constant. His attitude may change, of course, from one day to the next, and it is our task to measure such changes, whether they are due to unknown causes or to the presence of some known pervasive factor such as the reading of a discourse on the issue in question. However, such fluctuations may also be attributed in part to error in the measurements themselves. In order to isolate the errors of the measurement instrument from the actual frustration in attitude, one must calculate the standard error of the measurement of the scale itself, and this was accomplished by appropriate methods.

It is assumed that an attitude scale is used only in those situations in which one may reasonably expect people to tell the truth about their convictions or opinions. Again, it is assumed that attitude scales will be used only in those situations that offer a minimum of pressure on the attitude to be measured. Such situations are common enough. In this study, as indicated on the consent form, one was free to withdraw from the study if he/she felt he/she could not continue at any stage. Unfortunately, this had impacted on the response rate but it was counterbalanced by getting what one may assume to be

the most sincere responses; which then allowed to make some conclusions on what exists actually but with caution.

All that can be done with an attitude scale is to measure attitude actually expressed with the full realisation that the subject may be consciously hiding his/her true attitude or that the social pressure of the situation has made him really believe what he expresses. This is a matter of interpretation. It is something probably worthwhile to measure an attitude expressed by opinions. It is another problem to interpret in each case the extent to which the subjects have expressed what they really believe. All that can be done is to minimise as far as possible the conditions that prevent our subjects from telling the truth or else to adjust our interpretations accordingly.

### **3.6.2 Some of the roles of attitudes**

Attitudes influence the behaviour of man, be it in the workplace or otherwise. The prevalence of HIV and AIDS creates a pseudo minority which can be subjected to discrimination and prejudice emanating from factors like stereotyping, personality and culture.

### **3.6.3 Reliability and validity of attitude measure**

One cannot assume that attitudes remain the same over time; in fact attitudes may change as a result of being measured. Therefore, the reliability of an attitude measure is more difficult to establish.

### **3.6.4 Relationship between attitudes and behaviour**

The relationship between attitudes and behaviour is more complicated than one might expect. An attitude towards a PLWHA is just one factor among many that influences discrimination. Other factors have to be considered including demographic background, traditional beliefs, the actual interaction with a PLWHA, the stage at which a PLWHA is, and the prevailing policy regarding HIV and AIDS and knowledge of HIV and AIDS-related laws. So it is easy to envisage situations where, because of various constraints, people are prevented from behaving in a manner consistent with their attitudes.

Pratkanis and Turner (1994) put forward suggestions for establishing closer links between attitudes and behaviour. These include:

- the attitudes held are easily identifiable and retrieved from the memory;
- they are based on solid foundation of knowledge;
- they are protective of the self; and
- the object (for example of a PLWHA, actual or suspected) to which they relate are clearly defined and relevant.

The relationship between an intention to behave and actual behaviour has been the subject of rigorous investigation (Fishbein & Ajzen 1975). Intentions with regard to behaviour, such as intentions not to discriminate against a PLWHA, actual or suspected, are influenced by the individual's attitude toward an infected/affected or suspected HIV and AIDS coworker and by various organisational and social influences about the acceptability of this activity.

Let us now look at some pertinent theories of workplace HIV and AIDS-related discrimination.

### **3.6.5 The theory of planned behaviour in predicting behaviour**

In Ajzen and Fishbein's (1980) *Theory of Reasoned Action* (TRA), there is recognition that people's actions are best predicted by their intentions. In turn, intentions are determined by people's attitudes as well as by what they see as expectations held by others. The theory of reasoned action, now slightly amended by Ajzen and Maddlen (1986) and called the theory of planned behaviour (TPB) is shown in Figure 3.2 below.

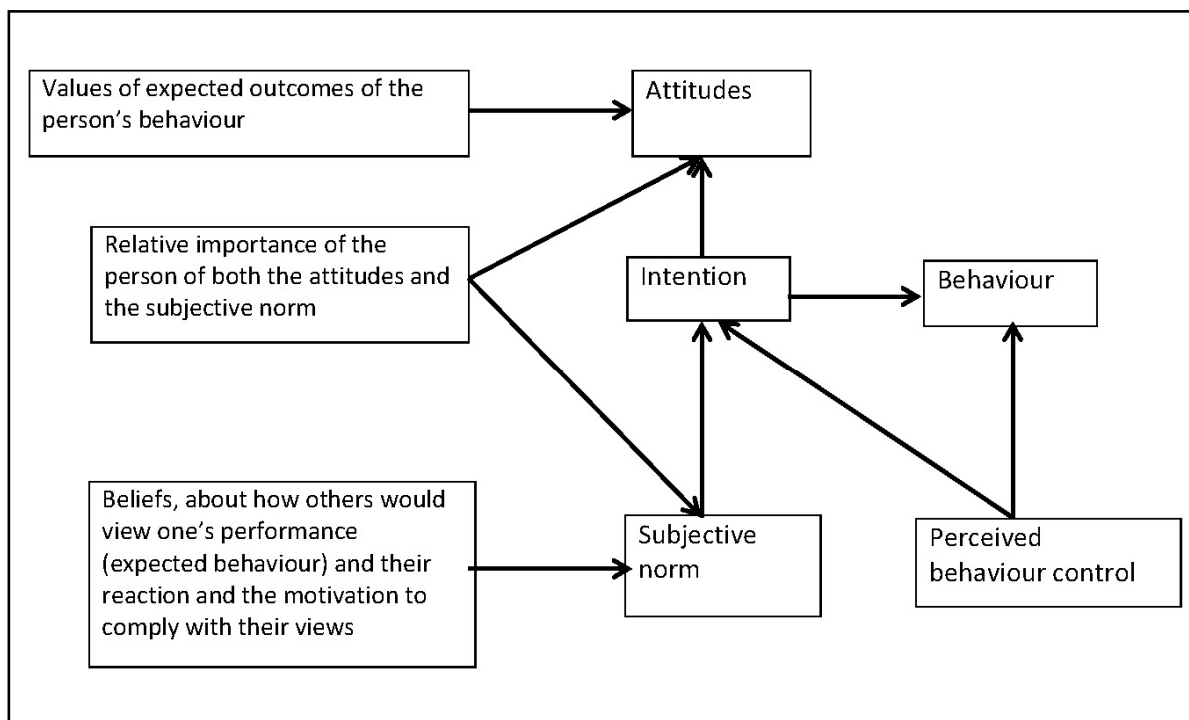


Figure 3.2 Theory of planned behaviour

Source: copied from *Journal of experimental social psychology*, 22, Ajzen and Madden, JT., Prediction of goal-directed behaviour: Attitudes, intentions and perceived behavioural control; pp. 453-74 Copyright (1986) with permission from Elsevier (cited in Arnold, J. & Randall, R., *eta*; 2010:257)

The theory of planned behaviour defines an attitude in a particular way. An attitude is expressed as a belief about the consequence of behaviour; it is not concerned about general beliefs or feelings related to the object or subject matter of the attitude. As such, it has something in common with expectancy theories of motivation. As a result, it is said that this is a good predictor of behaviour.

Along with 'attitude' we have to consider 'subjective norm' before arriving at 'intention'. Subjective norms embrace the beliefs of other people whose opinions we value with

regard to performing or not performing behaviours. It would also accommodate a person's desire or lack of desire to comply with the opinions of others. Before arriving at a final position on intentions, one should realise that people differ in the relative weighting they attach to 'attitude' and 'subjective norm'.

The theory of reasoned action has been successful in predicting behaviour in a range of areas such as smoking, alcohol abuse, contraception and consumer behaviour (Sheppard, Hartrick & Warshaw, 1988), but as Eiser and Van Der Pligt (1988) rightly point out, the theory has not escaped criticism at both theoretical and empirical levels. In the revised version of the theory by Ajzen and Madden (1986), the idea of perceived behavioural control is introduced. This is concerned with the extent to which people believe they can perform the required behaviour in particular situations. As a new variable, perceived behavioural control in Figure 3.2 has the potential to influence behaviour in a direct fashion or indirectly through intentions.

Ajzen (1991) reflects on the theory of planned behaviour (TPB) and suggests that the variables called the 'relative' importance to the person of both the attitude and the 'subjective norm' in Figure 3.2 should be recognised as situational in nature (that is, they vary with circumstances). He then goes on to say that we should closely examine the variables 'perceived behavioural control' and 'subjective norm' in case there are weaknesses in this part of the model, for example, if the individual mistakenly believes that they are in control of a situation, the delicate link between intention and behaviour can be damaged. Also, it should be recognised that the influence exerted by 'subjective norm' on intentions and behaviour in the model is rather weak because some people are guided by their own conscience rather than the opinions of others.

When Eiser and Van der Pligt (1988) closely examined the theory of reasoned action, the fore-runner of the theory of planned behaviour (TPB) – they felt it was better suited

where a person is deciding on a course of action for the first time. But many times in life the action we consider will be similar if not identical to actions performed many times before. Therefore, a model of the relationship between attitude and behaviour should have the capacity to explain 'habit' resting on previous behaviour which, unlike normal attitudes and beliefs, can be very resistant to change.

Reflecting on the above theoretical advances, Terry, Hogg and White (1999) state that:

'Two decades of research have revealed, across a range of behaviour, general support for the theory of reasoned action and the theory of planned behaviour. However, support for the role of the subjective norm in both theories has been relatively weak. Recent research has also examined whether the theory of planned behaviour incorporates all major predictions of intention and behaviour. One variable that has consistently been found to emerge as an additional distinctive predictor of intentions is self-identity that is the extent to which performing the behaviour is an important component of a person's self-concept.'

### **3.7 ALTERNATIVE VIEWPOINT ON THE ATTITUDE-BEHAVIOUR RELATIONSHIP**

An alternative view of the relationship between attitudes and behaviour was put forward by Fazio (1986). He maintains that an attitude influences behaviour by selectively activating various thought processes stored in the person's memory. The consequence of this development is that selective perception of the object to which the attitude relates is created. For example, a manager who holds a positive attitude towards a subordinate infected/affected by HIV and AIDS or suspected of HIV may exhibit a fair treatment of all workers. If so, it is likely that he or she will recall positive rather than negative thoughts or association (evaluative beliefs) with respect to HIV and AIDS infected/affected colleagues (and subordinates). These associations or thoughts will shape the person's selective perception of what fair treatment should be in a workplace, which in turn will influence a decision to treat HIV and AIDS infected/affected or suspected coworkers.

From Fazio's perspective, an attitude is dependent upon previous positive or negative experiences, but it influences (rather than being merely influenced by) the evaluative beliefs (for example, recall of positive thoughts and associations from memory) at the time the person decides on a course of action. This perspective underlines the view that people with different attitudes may see different aspects of an issue as important or salient

### **3.7.1 Attitude consistency**

There are occasions when people strive for consistency by bringing their attitudes in line with newly adopted behaviour. When workers were promoted to the job of Head of Department (HOD) they tended to acquire managerial attitudes consistent with their new organisational role. However, when some of them returned to their previous positions as workers (ordinary teachers) they experienced a significant dilution of their recently acquired managerial attitudes. In this study, the key issue was to find out why do SMT members and ordinary teachers look at HIV and AIDS-related discrimination slightly differently in line with their role in the particular schools.

### **3.7.2 Self-efficacy**

Bandura developed the construct self-efficacy, which refers to 'people's beliefs about their lives' (Bandura, 1989:1175) and their 'beliefs in their capabilities to mobilise the motivation, cognitive resources and courses of action needed to exercise control over task demands' (Bandura, 1990:316). Self-efficacy, therefore, refers to individuals' generative capability to organise cognitive, social and behavioural skills into integrated courses of action in dealing with their environment (Bandura, 1982).

Katz (1995) defines this construct as people's judgments about their ability. It is not concerned with the actual skills they possess, but with the opinions they hold of themselves regarding their mastery of and ability to use these skills.



As such, self-efficacy does not reflect a rational judgment about a person's real capacity but is based on thoughts and feelings of competence and mastery. These thoughts and feelings are derived from appraisals of cognitive, social, linguistic and/or physical skills and capabilities to execute those courses of action that are required to overcome problems in order to succeed in situations (Bandura, 1986; Grist, 1987). Schunk (1983) says that efficacy appraisal is an inferential process that involves the weighting of the relative contributions of many factors, including self-perception of ability, task difficulty, effort expended, amount of external aid received, situational circumstances under which the performances occurred and the temporal pattern of successes and failures.

Self-efficacy is, however, not similar to positive illusions or unrealistic optimism, since it is based on experience and does not lead to unreasonable risk taking, but rather leads to venturesome behaviour that is within the reach of an individual's capabilities (Schwarzer, 1993). According to Gist and Mitchell (1992), self-efficacy is an important motivational construct in that it influences the choices, goals, emotional reactions, effort, coping and persistence of an individual.

For the purpose of this study, the definition was compiled based on the above-mentioned literature. In essence, self-efficacy is regarded as thoughts and feelings of competence and mastery. In this research, educators' self-efficacy was determined to the relationship it had on workplace HIV and AIDS-related discrimination.

### **3.8 LOCUS OF CONTROL**

One of the most widely explored extensively studied and well-documented constructs across psychology including clinical, developmental, occupational, personality and social psychology is the locus of control concept (Furnham & Steele, 1993).

The construct of locus of control was first introduced by Rotter (1966) and is based on the principles of social learning theory. Locus of control is a stable personality trait and

refers to whatever an individual ascribes responsibility to in his/her life. Coetzee (1996:120) states, 'it is your decisions in life – and not your conditions – which are important'. An individual can attribute the cause or control of events either to factors within the self (one's decisions in life) or to factors outside the self (one's conditions).

This belief in personal control influences the cognitions and motivations of individuals, which in turn have an impact on the extent to which an individual can alter the environment or himself/herself to make events more pleasant and/or less aversive (Roselack & Hampson, 1991). Spector (1986) suggests that 'perceived control leads to greater satisfaction, commitment, involvement, motivation and performance, and lower physical and emotional distress, role stress and withdrawal'.

### **3.8.1 Theoretical background**

The construct locus of control was developed by Julian Rotter (1966) and originated from both the social learning theory (Rotter, 1954) and the attribution theory (Heider, 1958). Both these theories were developed from within the cognitive behaviouristic paradigm (Bandura, 1977).

### **3.8.2 Social learning theory**

Social learning theory provides a tentative set of principles to account for complex human social behaviour (Rotter, 1966). This theory proposes that behaviours are rooted in previous experiences or 'social learning' (Rotter, Chance & Phares, 1972).

According to Phares (1976), individuals make choices from a variety of potential behaviours available to them. Social learning theorists are of the opinion that neither the individual nor the situation exclusively determines behaviour. Behaviour is a result of the interaction between the characteristics of the individual and of the situation.

The social learning theory equally emphasises value, expectancy of reinforcement and situational specificity (Lefcourt, 1982). It stands alone in this respect among other learning theories. According to Rotter (1966), an individual's behaviour is predicted on the basis of his/her values, expectations and the situations in which he/she finds himself/herself. Rotter's general formula is applicable (refer to Chapter 1, p.117).

### **3.8.3 Definition of locus of control**

A variety of definitions of locus of control exist in literature. Daniels and Guppy (1992) define locus of control as an individual's perception, in a given social context and in light of past reinforcements, of the degree to which behavioural outcomes are due to personal (internal) or external control (forces outside oneself). Krampen, Galli and Nigro (1992) believe that this concept has been shown to be sensitive to past experience as well as present social context, and as such not to be an ending trait. Kren (1992) offers an alternative definition to locus of control, which is the extent to which individuals accept personal responsibility of what happens to them. However, for the purpose of this research, the definition of locus of control provided by Rotter (1966) is used:

Rotter (1966) defines locus of control as the belief individuals hold about the degree to which rewards follow from or are contingent upon their own behaviour or attributes versus the degree to which rewards are controlled by factors outside the individual such as powerful people, fate or chance.

### **3.8.4 Dimensions of locus of control**

Two dimensions of this construct can be identified – internal locus of control and external locus of control. Individuals who perceive their lives to be controlled by their own actions, skills and abilities are said to be internals or internalisers or to possess an internal locus of control. Individuals who perceive their lives to be controlled by external forces are referred to as externals or externalisers or as possessing an external locus of control (Hodgkinson, 1992; Rahim & Psenicha, 1996; Rotter, 1966).

Lefcourt (1982, cited in Bredell, 2004:75) defines internal locus of control from a social learning perspective as 'the perception of events, whether positive or negative, as being a consequence of one's own actions, and thereby potentially under personal control'. A key feature of internals is that they perceive themselves to be in control of life situations. People who possess an internal locus of control believe that they have control over the events, consequences, occurrences and circumstances in their life (Nwachukwu, 1995). Internals will, therefore, strongly believe that they get what they deserve and are responsible for their own fate (Tubbs, 1994). Furthermore, they believe that success results from hard work and that failure is an individual responsibility (Kren, 1992). Individuals with an internal locus of control see themselves as active agents; feel that they are masters of their fate and trust in their capacity to influence the environment (Boone *et al*; 1996). As a result, people who believe that they are in control of their own destiny have an internal locus of control (McCuddy & Peery, 1996).

On the other hand, external locus of control is defined as the perception of negative or positive events as being unrelated to an individual's own behaviour and therefore, beyond personal control (Lefcourt, 1982). A distinct feature of externals is that they perceive outside forces to determine and predict life situations. Individuals with an external locus of control will therefore interpret their daily experiences as being beyond their control, believing that positive reinforcements occur only by chance, fate, luck, powerful others or the unpredictable and that they are not masters of their own fate (Rotter, 1966). They 'see themselves as relatively passive agents and believe that the events in their lives are due to uncontrollable forces' (Boone, 1996). Externals lack a generalised expectancy that their own actions will lead to the attainment of rewards or the avoidance of punishment (Kren, 1992 cited in Bredell, 2004). Externals will therefore blame their environment for failures (Phares, Wilson & Klyver, 1971 cited in Bredell, 2004). As such, people who believe that what happens to them is the result of fate or the behaviour of other people are said to have an external locus of control (McCuddy & Peery, 1996).

From the above literature review, it can be deduced that locus of control is a personality trait that influences individual's attitudes and behaviours. In this study, an individual with an internal locus of control would be expected to have confidence to behave in a discriminatory way towards those infected with HIV or those affected by AIDS since he/she is attribute contraction of HIV is not because of external influences. On the other hand, an individual with external locus of control may probably not engage in discriminatory behaviour towards those infected with HIV or affected by AIDS in the workplace since he/she attributes the infected person's status as a result of influence beyond his/her control.

### **3.9 CHAPTER SUMMARY**

In this chapter, the definition of the concept 'attitude' was explained. The nature of attitudes, and the types and origins of attitudes were discussed in detail in order to understand the role attitude plays in HIV and AIDS-related discrimination. Reference to the ways in which attitude relates to behaviour was touched upon. Finally, self-efficacy and locus of control – two pertinent variables to the study – were discussed.

# CHAPTER 4: TRADITIONAL BELIEFS IN LIGHT OF HIV AND AIDS

## 4.1 INTRODUCTION

The chapter opens with a definition of beliefs and traditional beliefs. A detailed look at the intricacies of beliefs follows; beliefs about HIV and AIDS and how it can translate into workplace HIV and AIDS-related discrimination are the focus of the chapter.

## 4.2 DEFINITION OF BELIEF

*Beliefs* are propositions held to be true (OALD, 1995:97). The average person holds more beliefs than anyone can count; however, not all of these beliefs are equally valuable. Some beliefs – such as belief in God – are vigorously defended when called into question whereas others are not. Valuable beliefs are those that are personally meaningful, relevant and important to people in their daily lives.

Beliefs are valued for a variety of reasons: for emotional comfort (Lerner, 1980), self-expression (Prentice, 1987), ego defence (Katz, 1960), and behaviour regulation (Greenwald, 1989). Perhaps a belief's most basic instrumental function, however, is to serve as an explanation for one's observations. Belief in free will, for instance, explains one's own and other people's actions (Wegner, 2002).

Beliefs in right-wing conspiracies explain presidential impeachments. And religious beliefs explain the origin of the universe and life after death. Many of the beliefs people possess are in some sense causal explanations that organise their observations and reduce complexity (for instance, believing that life exists because of God), thereby providing expectations for the future (Berlyne, 1960; Gilbert, 1991; Heider, 1958) and reducing the anxiety associated with uncertainty (Ortony, Clore & Collins, 1988). If

beliefs serve as explanations for one's observations, then their value should be a function of their explanatory power.

The idea that beliefs serve as explanations is certainly not new (see Allport, 1935; Frazer, 1990/1923; Thagard, 1989). However, unlike previous functional accounts of belief, our account suggests that it is not simply the perceived truth of a belief that is influenced by its explanatory power, but its perceived value – its meaning, importance, and personal relevance. As people apply a belief to explain more observations, the value of that belief should increase. Applying a belief to other observations positions it as a first cause in a sequence of events, and unites different effects together through a mutual cause. The belief in love as a critical ingredient in romantic relationships, for example, can explain a spouse's steadfast monogamy, lifelong devotion and tender laughter at one's bad jokes. With each new application, belief in the importance, meaningfulness and personal relevance of love should increase. We therefore predict that applying a belief to explain one's observations should increase its perceived value.

Perhaps more important, the flip side of this argument is that explanatory power diminishes if the belief is itself explained by other beliefs. Love for one's spouse, for instance, can be explained by physical attraction, perceived similarity and the normal commitment that comes with marriage. Now all of the beliefs that could previously be explained by love can be explained by other, more basic, beliefs. Thus, explaining a belief also positions it in a causal sequence, but relegating the focal belief to a secondary or mediating status that may make it seem less important, meaningful, and relevant (Pennebaker, 1990, 1997; Wilson, Gilbert & Centerbar, 2003; Wortman, Silver & Kesster, 1993). We therefore predict that explaining a belief will cause it to lose some of its unique explanatory power, and therefore lose some of its meaning, importance, and relevance as well.

It may be concluded from this discussion of belief that it is plausible to suggest that the ultimately valuable belief (a) explains everything and (b) is explained by nothing. Few

beliefs can manage this feat, but those associated with science and religions are the most contentious.

Fishbein and Raven (1962:183-189) suggested a definition of belief that is analogous to the definition of attitude. According to these investigators, an individual may not only evaluate a concept (i.e. view it as 'good' or 'bad', 'clean' or 'dirty') but also he may believe or disbelieve in the existence of the concept (i.e. view it as 'existent' or 'non-existent', 'probable' or 'improbable'). As already seen, the first type of judgment has been viewed as a measure of the evaluative dimension of a concept, or more specifically, as an attitude. The latter type of judgment may be viewed as a measure of the *probability* dimension of a concept, or more specifically, as a 'belief'. Just as Osgood and his associates demonstrated that valid and reliable measures of attitude could be obtained by having the subject judge the concept on a series of bipolar evaluative scales, Fishbein and Raven demonstrated that valid and reliable measures of belief could be obtained by having the subject judge the concept on a series of bipolar *probabilistic* scales (such as probable – improbable, likely – unlikely, possible – impossible). It is this definition of belief – the position of the object or concept on the probability dimension – that will be used throughout this study.

At first glance, it may appear that this concept of belief, including traditional beliefs which are central to this study, is a highly specialised one. That is, this definition of belief appears to be concerned only with the probability of the existence of an object – it does not appear to deal with the type of beliefs that most psychologists have considered. Particularly in the area of attitude research, almost all psychologists have been concerned with beliefs about the object. As was pointed out earlier on, both the 'cognitive' and 'action' components of attitude can be viewed as beliefs about the object. The cognitive component refers to beliefs about the nature of the object and its relations to other 'objects', while the action component refers to beliefs about what should be done with respect to the object.



Fishbein and Raven (1962) recognised the problem and suggested a distinction between *belief in* an object and *belief about* an object. 'Thus far, we have defined belief in or more completely, belief in the existence of an object. One could also consider belief in the existence of a relationship between that object and some other object or same quality'. Thus, just as an individual may believe or disbelieve in the existence of 'God', so too might he believe or disbelieve in the existence of relationships involving 'God', such as 'God is omnipotent', 'God is omniscient', 'God is vengeful', 'God had a son'. With regard to this study, an individual educator may believe or disbelieve in the existence of 'HIV and AIDS', so too might he/she believe or disbelieve in the existence of relationships involving 'HIV and AIDS', such beliefs may include, 'HIV and AIDS can affect anybody', 'HIV and AIDS is a punishment from God', 'HIV and AIDS can be transmitted by mosquitoes'. Any of these statements could be placed above the probability scales and the belief in the existence of that particular relationship could be measured. 'The various *beliefs in the relationships* between an object and other objects or qualities would then be defined as *beliefs about* that object. While *belief in* refers to the existence of an object, *belief about* deals with the nature of that object, the manner in which it exists'.

Thus, like *belief in*, *belief about* an object is also equated with the probability dimension of a concept. However, in the latter case, the 'concept' is a relational statement – a statement associating the object of belief with some other object, concept, value or goal.

In general, then, a belief about an object may be defined as the probability or improbability that a particular relationship exists between the object of belief and some other object, concept, value or goal.

This definition of beliefs about an object is consistent with the descriptions of beliefs that most investigators have suggested. That is, most investigators have reached implicit or explicit agreement that a belief about an object may be described as a relationship between the object (of belief) and some other object, value, goal or 'concept'. Indeed, most investigators agree that any belief about an object may be diagrammed as X–Y, where X refers to the object of belief, Y refers to some other object or concept and the line represents the relationship or assertion linking X and Y. Thus, a belief about an object can, in part, be described as any statement that relates the object of belief to some other object, value, concept or goal. This description, however, is really a definition of a belief statement, the belief *per se* is the position that an individual ascribes to the statement on the probability dimension, and the probability or improbability that the particular relationship expressed the statement does exist.

This concept of beliefs about object appropriately represents the many different types of beliefs that an individual may hold. For example, consider the following different types of beliefs that have been referred to in the literature:

- Beliefs about the component parts of the object.
- Beliefs about the characteristics, qualities or attributes of the object.
- Beliefs about the object's relation with other objects or concepts.
- Beliefs about whether the object will lead to or block the attainment of various goals or 'valued states'.
- Beliefs about what should be done with respect to the object.
- Beliefs about what the object should or should not be allowed to do.

It should be noted that these six types of beliefs are the kind of beliefs that have been considered as comprising the 'cognitive' and 'action' components of attitude. That is, when most investigators are talking about an individual's 'cognitive structure' or the

'cognitive component', they are referring to beliefs of type 1, 2, 3, and 4. Similarly, when they are talking about the 'action component', they are usually referring to beliefs of type 5 or 6. In the current study, however, rather than viewing 'belief' as a part of 'attitude', these concepts have been described and defined independently and 'belief' more specifically is concerned with 'traditional beliefs'. 'Attitude' has been characterised as a learned, implicit response that mediates evaluative behaviour and has been operationally defined as a concept's position on the probability dimension and a distinction between *beliefs in* and *beliefs about* an object has been made. Specifically, *belief in* refers to the probability that a particular object or concept exists and *belief about* refers to the probability that a particular relationship involving the object or concept exists.

#### **4.3 THE INFLUENCE OF THE AFRICAN WORLDVIEW ON MATTERS OF ILLNESS**

The African Worldview influences beliefs about the causes of trauma, calamity and illness and how they are remedied (Wade, 2009:103,104). The emphasis on wholeness in the African Worldview means that the interrelatedness of all life forms is taken for granted. Little distinction is made between the mental and physical and spiritual or the individual and the group. According to Poland (2004:26), ancestors are believed to watch over the living with a benevolent eye. If, however, one fails to build up the household, the anger of the ancestors may be provoked. This anger is typically believed to be triggered by failure to provide hospitality to the wider community or by any display of disrespect to older members of the family by junior members. Behaviour that threatens the well-being and equilibrium of the social system such as selfishness, aggression, arrogance or envy are believed to precipitate mental problems (Beuster, 1997:6; Mokgatlhe, 2001:43). Illness or calamity can be sent as a warning or punishment. Thus the origin of illness, calamities and traumas are believed to be punishments from the gods, a curse, witchcraft, natural causes, a disruption in social relationships, angry ancestors, and possession by evil spirits or the breaking of customs or taboos (Mokgatlhe, 2001:43).

#### **4.3.1 Perceived causes of illness**

Beuster (1997:9) cited in Wade (2009:104) states that, traditionally, Africans do not believe in chance random causes. They believe that the cause of all problems can be uncovered. Little distinction is made between the mental and physical realms. The Zulu and Xhosa (Nguni people) group disorders into two broad categories based on the perceived cause of the difficulty. Some disorders are ascribed to natural causes and are categorised as “*umkhuhlane*”. The other category, “*ukafaa Kwabantu*” refers to disorders that are ascribed to supernatural factors such as God, ancestors, magic or pollution. Disorders that are ascribed to natural causes include colds, flu, venereal diseases and malaria. Traditional Black people are generally willing to consult Western doctors/practitioners about such problems. And, traditional healers are called upon to deal with all problems relating to ancestors, witchcraft, sorcery, possession or other spiritual forces. The task of the healer is to use divination to uncover the cause of the problem and prescribe a remedy.

#### **4.3.2 God as a causative agent**

In rare cases, disease or misfortune is ascribed to God, but only if no other cause can be identified by the traditional healer. Beuster (1997:9) notes that although God is acknowledged as the Creator, the role played by God in the individual’s life is perceived as distant and abstract. Christianity has influenced these ideas, particularly in the Zionist churches, where a fusion of traditional African and Christian beliefs are found. In this church, possession states are attributed to the Holy Spirit (ibid).

The idea of God as a causative agent is very important as this study included many educators who were/are referred to as blacks... Zulus, Pedis (Northern Sothos), Xhosa, Tswanas, Sothos (Southern Sothos) among other black groups in South Africa; any quite many belong to the ZCC.

### **4.3.3 Pollution as a causative**

Indigenous South Africans believe that certain situations or circumstances can cause contamination or pollution. It should be noted that this is not the sense as the two terms – contamination and pollution - are understood in physical or biological sciences. These conditions are associated with the reproductive system, sexual intercourse, and a woman's menstrual cycle. Situations relating to death, miscarriage and abortion are also believed to be the cause of contamination. Even going on a long journey is believed to place one at risk for possession by spirits in a strange area. Thus, illness, trauma or adversity may be the result of exposure to a polluted environment associated with major life events such as birth, death, miscarriage, abortion and menstruation (Beuster, 1997:12). States of pollution demand cleansing rituals involving washing, vomiting and purging. Contamination may be avoided by strengthening or immunised by using culturally prescribed rituals (ibid).

### **4.3.4 Ancestors as a causative agent**

Although explanations of misfortune or illness seldom refer to God, the ancestors are believed to be deeply involved in such situations. The living spirits of the dead are known as "*Badimo*" (Sotho) or "*Amadlozi*" (Zulu) in South Africa, or "*mizimu*" (Luganda) in Baganda of Uganda. The ancestors are the one's forebearers. The ancestors are generally believed to preserve the honour, traditions and good reputation of the tribe. They are believed to maintain intimate relationships, provide protection against evil and destructive forces (Beuster, 1997: 10; Mokgatlhe, 2001:44). However, transgressions can be punished by sending misfortune, calamity, trauma or illnesses as a warning to amend one's ways and follow the culturally prescribed code of conduct. To avoid punishment, many birth, initiation, marriage and death rites must be performed. If ignored, punishment in the form of ill-health, misfortune, lack of material resources or even death of a family member may ensue (Mokgatlhe, 2001:44).

The ancestors also require offerings in the form of animal sacrifices and sorghum beer. They need to be informed of developments in the family, such as marriage or births.

They may call individuals to serve them as a diviner or *sangoma* (Zulu) (Beuster, 1997:10). If these demands are ignored, calamity may follow. Favour can be gained by performing certain rituals (Beuster, 1997:10).

#### **4.3.5 Witchcraft and sorcery as causative agents**

The traditional African people believe that witches and sorcerers have the power to intervene in the affairs of humans. Witches are believed to have the power to change shape or become invisible, so they can cast spells without being detected. They are also believed to manipulate supernatural creatures, called familiars to inflict trauma on victims. Familiars can be mythical animals, snakes, rodents, owls or supernatural creatures such as "*Tokoloshe*". The *Tokoloshe* is a small man with one buttock and a giant penis that is carried over the shoulder (Beuster, 1997:11). A *Zombie* or "*Izitunzela*" is a familiar that is a living corpse with no tongue. Witches use these creatures to inflict trauma or mental illness in the lives of their victims (Beuster, 1997:11). Another agent who can affect the affairs of others is the sorcerer. Sorcerers do not have supernatural powers, according to the African beliefs, but use magic portions, medicines or poison to inflict harm or suffering on others. Sorcerers may poison their victims or may cast spells by blowing powder while using the victim's name (Beuster, 1997:11).

In Uganda, '*amayembe*' and '*amalogo*' which refer to traditional belief of diseases due to witchcraft. The phenomenon is abundant in Uganda; and very active as frequently reported on Wava Broadcasting Service (WBC), in program "*Agatalikonfufu*", literally meaning "*Freshnews*". Such news was broadcast on 10/07/2012 and 15/05/2012.

#### **4.4 TRADITIONAL BELIEFS**

Whether rightly or wrongly, often times, psychologists rely on Western models as a baseline for investigating behaviours in other cultures (Liddell, *et al*; 2004). Unlike many other social activities, sexual acts are private. The same applies to covert workplace HIV and AIDS-related discrimination, which is unlike overt workplace HIV and AIDS-related discrimination; and is strongly influenced by unconscious psychodynamics

processes and more frequently explored through thought than spoken or written language (Gold, 1993). Respondents often explain sexual behaviours in terms of what Harré (1995) calls IDKWIDI ('I don't know why I did it'), since sexual behaviours often circumvent the customary layers of control which people exert in other contexts. Similarly, workplace HIV and AIDS-related discrimination, particularly the insidious covert workplace HIV and AIDS-related discrimination does so. All of these factors make the insidious covert workplace HIV and AIDS-related discrimination much as sexual acts difficult to investigate using conventional psychological methods. Taken together, the problems encountered by anthropologists and psychologists have yielded a narrow instrumental perspective on either sexuality or insidious covert discrimination, especially workplace HIV and AIDS-related discrimination (Kelly & Levis, 2001).

Seldom investigated has been the extent to which *other* cultural beliefs, particularly those which are more specific to developing regions of the world, might influence workplace HIV and AIDS-related discrimination. In this study, an attempt is made to investigate and determine whether indigenous beliefs about the disease have any bearing on how Sub-Saharan African people make decisions about discriminatory behaviour. In social science, these beliefs about disease are collectively referred to as illness representations (Moodley, 2000).

#### **4.4.1 Prevalence of traditional beliefs about HIV and AIDS**

It is common in many traditional African cultures to attribute illness to spirits and supernatural forces (*AIDS-Weekly*, 2001; Mokgathle, 2001:43) and these beliefs may be related to stigmatising afflicted persons. In South Africa, the stereotypes and misconceptions about HIV and AIDS among Black people are likened to cultural beliefs and convictions. For example, for traditional Black people, illness is not a random event. Rather, every illness is a product of destiny and has a specific cause (Gracia-Morenos & Watts, 2000:225). For Black people, to eliminate the illness, it is necessary to identify, punish, eliminate and neutralise the cause and the agent of the cause of intention.

According to Black traditional beliefs, illness can be a result of disharmony between a person and the ancestors, caused by:

- God, spirits, witches and sorcerers;
- natural causes; and
- breakdown in relationships between people (Mlamoleli *et al*; 2000:268).

According to Kiragu (2001:4), traditional black African beliefs come from a tradition in which ancestor worship is the norm and for them evil spirits cause misfortunes and disease. Hence, there are only three reasons for something bad happening to traditional African people:

- someone has bewitched them and caused the disease and illness to happen;
- the ancestral spirits are angry with them and make them sick; and
- evil spirits are haunting them and making them sick.

A person who grows up with this belief system will not embrace such notions as 'human immunodeficiency virus (HIV)' (Mlamuleli *et al*; 2000:270). Instead he/she tends to believe that he has been bewitched and poisoned. His/her beliefs are based on a misconception such as that witchcraft medicine was mixed into his/her food and that is why he/she has contracted the virus (Mitchell & Smith, 2001:56).

With respect to HIV and AIDS, 4% of South Africans believe that AIDS is caused by witchcraft and 14% are unsure whether AIDS is caused by witchcraft (Shisana & Simbayi, 2002). Traditional beliefs are likely even to be more prevalent in rural areas (Boahene, 1996; Bond, 1993; Bond *et al*; 2002, van Dyk, 2001).

In a study conducted in Zambia Yamba (1997) reported that 25% of individuals believe that sexually transmitted infections (STIs) are caused by spirits and witchcraft. Viewing



HIV and AIDS as originating from the supernatural is commonly thought to be an underlying source of AIDS-related stigmas in South Africa as well (van Dyk, 2001). Alternatively, traditional beliefs about HIV and AIDS may merely reflect a more general state of misinformation about the facts of HIV and AIDS and misinformation may be the source of stigmatising beliefs. Support for the hypothesis that the association between traditional beliefs about HIV and AIDS-related stigmas are mediated by HIV and AIDS knowledge comes from observed correlations among HIV and AIDS stigmas and HIV and AIDS knowledge (Shisana & Simbayi, 2002). However, even well-informed and well-educated professionals have been shown to harbour HIV and AIDS stigmas (Brown *et al*; 2003).

The extent to which HIV and AIDS stigmatising beliefs and HIV and AIDS misinformation are related to traditional views about the origins of HIV and AIDS in South Africa and in Uganda is not known. Also, in reference to HIV and AIDS knowledge, it was not explicit as to what type of knowledge HIV and AIDS knowledge was limited to. In this study, both legal knowledge about HIV and AIDS and biomedical HIV and AIDS knowledge are variables seriously considered. It would be a worthwhile endeavour if we attempt to understand the extent of HIV and AIDS stigmatising beliefs, HIV and AIDS misinformation and how both legal HIV and AIDS knowledge and biomedical HIV and AIDS knowledge are related to traditional beliefs/views.

#### **4.4.2 Prevalence of traditional beliefs in some other places**

In Botswana, the north-western neighbour to South Africa, Christian beliefs are held by 50% of its nearly 1.7 million people, while 50% follow indigenous beliefs. Many local churches combine traditional beliefs with those of western Christianity (Tlou, 1996:27).

In Uganda, the majority of the people openly deny consulting spiritual and traditional health-care practitioners. Many urban residents and those affiliated with faith communities publicly denounce the efforts of traditional healers. Privately, however,

people avail themselves to multiple healing systems, especially when HIV is involved (Barz, 2006:5).

The mythology of African witchcraft is as vivid as the ancient legends of Greece and medieval Germany. Because witches inherit their supernatural powers, the Sotho witch-parent in South Africa is said to throw each of her new-born babies against the wall of the hut to test if it has inherited the role. The infant that clings to the wall like a bat is the one who will be carefully nurtured in the skills of witchcraft, beginning with charmed milk suckled from the possessed mother's breast.

Although African healers increasingly refer their clients to hospitals and clinics when their traditional remedies prove futile, patients sometimes resist hospitalisation. This is partly because witches are said to use bodily exuviae's, such as nail and hair clippings, urine or stool samples, to harm their victims. People who believe in witchcraft fear their excreta might get into dangerous hands while they are in hospital (Holland, 2001:19).

Modern doctors who decry traditional healers most vociferously are the ones who know that critically ill patients could have been saved had they not wasted valuable time consulting healers. Doctors treating a common form of septicemia, the result of enemas made from crushed beetles, accuse African healers of criminal activity because the highly acidic insects burn the lining of the intestine, often causing death.

## **4.5 ILLNESS REPRESENTATIONS**

In many cultures, illnesses have meanings. What follows next is the detailed illness meaning that deals with HIV and AIDS. It is basically afro-centric in orientation.

### **4.5.1 Cultural meaning of HIV and AIDS**

Judith Williamson (1989:69) once stated that nothing could be more meaningless than a virus. It has no point, no purpose, no plan, it is part of no scheme, carries no inherent

significance. It is through culture as well as via sensual embodied experience that a virus such as HIV and an illness such as AIDS take on meaning. Once this production of meaning has taken place, it continues to be redefined via the representation of HIV and AIDS in television texts, amongst other socio-cultural texts and practices (Tulloch & Lupton, 1997). That is not to say that HIV and AIDS does not exist outside society and culture – there is a biological entity that may cause serious illness and death which has been labelled HIV and AIDS – but it asserts that it is through society and culture that we make sense of this phenomenon, understand it and experience it (Tulloch & Lupton, 1997).

Beliefs about disease form part of a culture's indigenous knowledge system (IKS). An IKS represents a culture's collective body of accumulated knowledge and wisdom, evolved through successive generations of experience and trial-and-error (Slikkerveer, Warren & Brokensha, 1995). Unlike many aspects of the IKS, illness representations have been systematically investigated in both Western and non-Western cultures. Among other models of illness representation that appear to have universal validity are those deriving from Ajzen's (1988) theory of planned behaviour (TPB) for example the health beliefs model (Rosenstock, Strecher & Becker, 1988; see also Giles, Liddell & Bydawell, 2004). Also influential is Leventhal's self-regulatory model (Leventhal, Nerentz & Steele, 1984; see also Hagger & Orbell, 2003).

Core concepts in these and almost all other illness representation theories include *illness identity* (i.e. how symptoms are interpreted and the label given to a disease), *perceived cause of illness*, *treatment*, and *prevention* (Moodley, 2000).

#### **4.5.2 Sub-Saharan perspectives on illness identity**

Whilst illness representation theories in Sub-Saharan African cultures are each unique, they share a number of common elements. For example, illness is usually categorised into three types:

*Type 1:* Illnesses which have no discernible moral or social cause. These tend to be minor ailments such as rashes and colds. This is the only class of illness that occurs by chance and for which causes are not sought (Yamba, 1997).

*Type 2:* Modern diseases which can be contracted by people anywhere in the world, and which were first introduced into Africa by European settlers (Green, 1994).

*Type 3:* Diseases which only African people can contract and to which all African people regardless of tribal or geographical origin are all vulnerable (Ngubane, 1977).

#### **4.5.3 Causes of illness: Proximate and ultimate causes**

African cultures define two types of cause for Type 2 and Type 3 illness (Gluckman, 1956). First, there is a proximate cause which accounts for *how* a disease is contracted (Yamba, 1997). Infection and contagion from pollutants are examples of proximate causes (Ingstad, 1990), indicating that the understanding of infection and contagion predate contact with biomedical models (Ngubane, 1977). Second, there is an ultimate cause which accounts for *why* a disease is contracted by a particular person. Both proximate and ultimate causes are usually sought for Type 2 and Type 3 illness. As Green (1994) explains, a siSwati mother may accept her child has diarrhea because flies settled on its food (proximate cause) but she will also want to establish who sent the flies to harm her child (ultimate cause).

Three main types of ultimate causes are involved in containing illness:

- *Contact with pollutants:* Pollutants often originate in other people's bodies and include semen, menstrual discharge, vaginal secretions and blood (Ingstad, 1990). These are inherently polluting – discharges from healthy and sick people are equally dangerous. Death is also a pollutant (Ngubane, 1977). Since contact with pollutants cannot always be avoided, people fortify themselves from

contamination by maintaining strict moral codes and observing protective rituals (Green, 1994).

- *Witchcraft and sorcery*: Illness is inflicted by people who have been offended by a victim's behaviour. Failure to honour filial obligations, violence, or other forms of uncooperative behaviour risk creating a level of offence which leads kin or neighbours to seek redress through witchcraft (Douglas, 1997).
- *Ancestral vengeance or punishment*: The survival of ancestors in the spirit world depends on them being accorded regular attention from living offspring. This attention is manifest in rituals, sacrifices, avoidance of taboos and high standards of social behaviour. Where these requirements are not met, illnesses can be sent as a warning of punishment (Ngubane, 1977; Mokgathe, 2001:43).

In this study, it was expected that the educators, particularly those of Black African origin, share some of the beliefs with regard to the causes of illness. Therefore, it was deemed necessary to investigate these beliefs in order to try to understand how they relate to workplace HIV and AIDS-related discrimination.

#### *4.5.3.1 A witnessed case of discrimination*

On 11 December 2004, the researcher witnessed a case in which epilepsy was probably causing equal stigma and ensuing discrimination as HIV and AIDS. While epilepsy is an old disease, HIV and AIDS are very recent (about three decades since first noticed). A man could not be buried among his people or even get an heir in the Buganda culture, which is one of the established ethnic groups in Buganda.

#### **4.5.4 Lessons learned from this case**

This is an age-old practice. It has been done by many generations even following the 18th century when foreign religions like Christianity and Islam were introduced.

Western religion and ways of belief have done very little to change people's beliefs in some ways. Interestingly, even with the knowledge acquired about the nature and

causes of diseases like epilepsy, there has been no change in how my people treat people with diseases which they consider inexplicable.

As it has been the practice of past and present generations, this belief regarding the nature and cause of epilepsy is consciously fostered as a queer disease without being challenged even by some of those who have had the chance to know its real cause and nature. In a way, this typically discriminative practice is so engrained and it is likely to continue unless something is done. What has to be done must work on the beliefs about such a disease.

Strange as it may sound, this is an outright act/practice of discrimination which affects the person when he/she is alive as well as deceased. If one were to ask: Why do we not bury our diseased dead in the same graveyard when they die? The answers given will vary from one person to another. However, from a psychological perspective, it greatly hinges on fear and superstitious beliefs. There are, of course, some cultural beliefs which may be behind such a practice which defy common sense but not the way those people who practice it view it.

When epilepsy is associated with such stigmatising actions which follow even when one is dead, it may not surprise one to find HIV and AIDS – a new disease which is being linked to already stigmatised practices like sex and abhorred practices like intravenous drug use – is greatly stigmatised.

#### **4.5.5 Giving meaning to AIDS**

From the very first days of the epidemic, AIDS was imbued with meaning. Driven equally by delight and disgust, conservative moralists rushed to declare that the virus manifested sin in all sorts of ways. People living with HIV and AIDS (PLWHAs) –their partners and families included – were marked out as sinful recipients of their first deserts from God. The epidemic itself was heralded as a harbinger of the apocalypse, a

collective punishment from the Almighty, or a 'sin' against the cosmic order. De Waal (2006:14) states that 'social scientists tend to dissect (and deride) arguments from sickness to sin because we do not recognise moral agency in an epidemic. Yet we might be at fault for neglecting what AIDS means for the moral universe and the power relations embedded therein.'

Perhaps the most famous American exponent of AIDS as sin and punishment was the Reverend Jerry Falwell, who in 1987 attributed the epidemic to divine retribution: God says...that homosexuality is a perverted and reprobate lifestyle. God also says those engaged in such homosexual acts will receive 'in their own persons, due penalty of their error.' God destroyed Sodom and Gomorrah primarily because of the sin of homosexuality. Today, He is again bringing judgment against this wicked practice through AIDS (cited in De Waal, 2006).

Fredrick Chiluba, President of Zambia (1991–2001), held similar views and even berated Peter Piot, Director of UNAIDS, on the subject. Similar views to Falwell's and Chiluba's are expressed from an Islamist viewpoint by Malik Badri, an Islamic civilisation professor in Malaysia. Badri (1997) writes:

The general [Muslim] belief about the AIDS pandemic is that of divine retribution for the immoral homosexual revolution of the West and its aping in other countries. This belief is firmly rooted in the Muslim mind because every child in his early school years must have been thrilled by the Qur'an story of the Prophet Lot (*pbuh* [peace be upon him]) and what God did to his homosexual people (in Sodom and Gomorrah). This is further ratified and explained in the most accurate and detailed exposition by a famous saying of Prophet Muhammad (*pbuh*) in which he speaks as though he miraculously describes the contemporary dilemma of the AIDS pandemic. The famous *hadith*... is translated as follows: "If *fahashah* or fornication and all kinds of sinful sexual intercourse becomes

rampant and openly practised without inhibition (emphasis in Badri 1997 [cited in De Waal, 2006]) in any group or nation, Allah will punish them with new epidemics (ta' un) and new diseases which were not known to their forefathers and earlier generations”.

De Waal (2006) says that there are two reasons why Badri (1997) emphasises sexual openness and lack of inhibition. Explicitly, he argues that an open community of practising homosexuals was essential for the emergence of a virulent strain of HIV. Implicitly, Badri wishes to contrast the US gay subculture with the covert and private homosexuality of the Islamic world, which he does not mention in his book but would not deny. Badri goes on to speculate that God in His mercy destroyed Sodom and Gomorrah because a worse fate might have befallen its sinful inhabitants – AIDS. In turn, Badri supposes that today's HIV pandemic may be a mercifully dissipated deterrent to an even more terrible fate – public homosexuality.

Interestingly, Badri, a practising psychiatrist personally, emphasises the need for compassion and empathy with the individual living with HIV and AIDS – and he is careful to assert that they are victims rather than individual sinners or deviants. But he faithfully delineates the moral cosmology of political Islam and the place that HIV and AIDS occupies within it. New-fundamentalist preachers across the Muslim world are rather little occupied with HIV and AIDS – they have more tangible and immediate enemies to rail against – but their views are close to Badri's.

Christian and Muslim ethics and the HIV and AIDS epidemic are far more subtle than the above examples might have indicated. Mbilinyi and Kaihula (2000) detail a vigorous local debate on the theology of HIV and AIDS in Rungwe, Tanzania. Mbilinyi and Kaihula state that some religious leaders cannot wait for the Day of Judgment and are issuing verdicts and sentences themselves. For instance in 1987 the Christian Council of Tanzania described HIV and AIDS as God's punishment for human beings' sins, and



others have promoted 'a better, mean-spirited and primitive ideology...linking HIV and AIDS with transgression' (Mbilinyi & Kaihula, 2000). Other Christians, however, have stressed forgiveness, repentance and faithfulness, while youth leaders have condemned the church for its hostility to condoms. As for the Jesuits, they have examined the HIV and AIDS pandemic with characteristic care and precision and conclude unequivocally that it is neither sin nor punishment, and that the doctrine of the lesser of the two evils indicates that condoms should not always be condemned and less harmful ways of drug use should be promoted (Kelly, 2004).

In their study of the cultural demographics of HIV and AIDS in the Rungwe area of neighbouring Tanzania, researchers Marjorie Mbilinyi and Naomi Kaihula introduce one of the principle issues with which religious institutions continue to struggle – that is, the mapping of morality directly onto sexuality:

Religion, namely Protestant Christianity, has formed the discourses within which morality and sexuality are debated and acted out in Rungwe, with often contradicting responses to the epidemic. Strong religious principles and doctrine govern people's overt moral, sexual and cultural behaviour (Kelly 2004: 77).

#### **4.5.6 The language of HIV and AIDS**

In her study, Nieuwmeyer (2002) reports that group members said that sometimes doctors and nurses spoke about 'dirty blood' and 'poison in the blood', when they were really talking about HIV and AIDS. The group did not see this kind of talk as helpful or informative. One respondent said that according to her there was only one word for HIV and AIDS in Xhosa and that was '*gawulayo*'. Another respondent said that the Zulu word was '*ingculaza*'.

A sangoma talking to Nieuwmeyer (2002) says that 'dirty blood' has sexual connotations. The words 'dirty behaviour' is used by men to describe women living with HIV and AIDS, and refer to promiscuity. Blood and the shedding of blood are important

in the Xhosa culture. When beasts are ritually slaughtered, the blood is shed for the ancestors. 'Strong blood' means health, whilst 'weak blood' means that a person's strength is gone, and the person may die soon.

Because blood is involved in the testing of HIV and AIDS antibodies, people understand HIV and AIDS as the illness of the blood. For the same reason, injections into the body are seen to be good treatment. Traditional healers scarify the person's skin, letting out a little blood, and then rub salve into the wound; in this way treatment is taken into the blood. The sangoma uses the word '*intsholongwane*', which means 'a disease which gets into the blood through sexual intercourse'. A Xhosa nursing sister says that blood is regarded as the 'most precious thing'. 'Weak blood' in men means that they 'cannot satisfy a woman', and in women it means that 'they cannot produce children'. 'Weak blood' means that a person is very sick, and in turn, can be associated with HIV and AIDS, tuberculosis or syphilis. People believed that if they took the sangoma's medicines their blood would become strong.

It is imperative to single out some traditional cultures and their related health, illness and dying beliefs and attitudes as we look at beliefs about diseases in Africa. For no special reason other than being well-documented and being recent, the Xhosa and Tswana cultures will be dealt with here.

#### **4.5.7 Traditional Xhosa culture, health, illness and dying**

Below I deal with the issues in more detail in the Xhosa culture.

##### *4.5.7.1 Attitude to health within the Xhosa culture*

Mndende (1997:794) explains that health in Xhosa-speaking people's culture does not only mean the absence of disease but involves the balance within an individual, the community and between the individual and the spiritual world. He continues to say that an imbalance between any of these aspects can affect the different systems of the individual and result in sickness. Frequently, the elderly in a community can look at the

symptoms of a disease and recognise whether its cause is 'just a normal dysfunction of cells requiring herbal treatments or the use of western medicine, or the disease has a deeper cause necessitating the performance of a ritual'. It can sometimes happen that causes of sickness overlap and require both traditional and western treatments. Mndende says: 'If the illness is unusual ... it is then attributed to evil causes (*ukungcola*) showing that some external agent has caused it' and will require the approach of a traditional healer. In this respect Tshabalala (1992:73) writes of the 'dualism African clients are likely to engage in'. He further explains that it is common practice for African clients to utilise, at the same time, western and traditional forms of seeking help. This practice is usual in the health, mental health and related fields.

#### *4.5.7.2 Illness within the Xhosa culture*

Louw (1994) writes that African people are constantly concerned with maintaining harmony and balance in their daily lives. When illness comes to a person, it is assumed that the cause is either that the ancestors are offended – that is, that the moral codes of society have been broken by the ill person – or that some agent such as a witch or sorcerer has brought the illness upon the person.

The mystery that surrounds HIV and AIDS as a disease has caused a crisis. Sontag (1978:5) says that a disease which is not curable is regarded as 'mysterious'. Any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious. The very names of such a disease are felt to have a 'magic power' (Sontag, 1978:6). If HIV and AIDS is seen as an illness with 'magic power' then people in the community will more than ever want to avoid the person living with HIV and AIDS and the power of the stigma associated with HIV and AIDS will increase. Sontag (1978:61) explains:

"The notion that a disease can be explained only by a variety of causes is precisely characteristic of thinking about diseases whose causation is not understood. And it is diseases thought to be multi-determined (that is,

mysterious) that have the widest possibilities as metaphors for what is felt to be socially or morally wrong”.

HIV and AIDS falls into this ‘mysterious’ category. In the early stages of infection, there are no signs of illness, and the person usually does not know that she/he is infected.

#### *4.5.7.3 The Xhosa traditional attitude to death and dying*

Gijana *et al*; (1989–90:247) write that death amongst Xhosa people is regarded as ‘extremely polluting and contaminating’, requiring the performance of the rituals of ‘washing of the hands’ by those who dug the grave and buried the person, and ‘washing of the spade’. Soga (1931:319) explains that the ‘fear of death is very real, not on the part of the dying person, but, because of its great mystery, on those watching beside the death-bed.

Mndende (1997: 796) writes: ‘If recovery from a particular illness is not achieved and it is recognised that ‘the day of departure’ is near, tradition teaches patients to accept the situation, examine what they are going to leave behind and consider the world they will be entering’. When a person dies, he joins the ancestral world to become ‘both guardian of the living and intermediary between the spiritual and physical worlds’. The job of the family or those present with the dying person is to ‘facilitate the transition’.

#### *4.5.7.4 The contamination or pollution discourse*

‘Contamination’ or ‘pollution’ is a discourse particularly directed at women. In traditional Xhosa culture, women are seen as contaminated and considered to be ‘dirty’ when menstruating. When writing of taboos as far as women are concerned, Soga (1931:354) notes: ‘All women are debarred entrance to the cattle-kraal as they will render it unclean, and the cattle will become weak at the knees and die’.

It is often believed by Xhosa men that it is women who spread HIV, Nieuwmeyer (2002) reports from the response of one of the respondents in her study who was accused by her boyfriend’s parents of ‘killing’ him when he died of AIDS. This contradicts evidence

that traditionally it is the men who are expected to have many sexual partners. In this way they prove themselves as men, but, in so doing, they spread infection such as sexually transmitted diseases and HIV. Matsau (2001:20) notes: 'Research reveals that men are more responsible' for passing on the HIV virus than women.

#### **4.5.8 HIV and AIDS and the death discourse**

HIV and AIDS and the discourse of death is looked at under the humanism philosophy of Ubuntu.

##### *4.5.8.1 Ubuntu in the wake of HIV and AIDS*

African writers, such as Kamwangamalu (1999:37), Mbiti (1998:145) and Masamba Ma Mpolo (1994:19) refer to the greater relevance in an African situation of the words: 'I am because we are and since I am therefore we are'. These words are in direct contrast with the individual self of modernistic western thinking; and it leads us to the acknowledgement that people exist in communities with others and realities are influenced by social interactions. *Ubuntu* is a word in the Nguni group of languages that has captured the imagination of westerners. *Ubuntu* (a Zulu word) serves as a spiritual foundation for African societies. It is a unifying vision or world-view enshrined in the Zulu maxim: *Umuntu ngumuntu ngabantu*, meaning: "a person through other persons" Shuttle (1993:46) concurs with Mbiti (1998:145). Essentially, this traditional African articulates a basic respect and compassion for others. It can be interpreted as both a factual description and a rule of conduct or social ethic. It both describes human beings as "being-with-others" and prescribes what "being-with-others" should all be about, As such, *Ubuntu* adds a distinctly African flavor and momentum to a decolonised assessment of the religious others. While Western humanism tends to underestimate or even deny the importance of religious beliefs, *Ubuntu* or African Humanism is resiliently religious (Prinsloo, 1995:4). In East Africa, the same or a very similar word exists for the whole 'Bantu' people, with '-muntu' meaning a person.

Tutu (1999:34) referred to *ubuntu* as ‘a central feature of the African Weltanschauung’ or world view. Tutu (1999:34) says that this word ‘speaks of the very essence of being human; with *ubuntu* a person is open and available to others, affirming of others, does not feel threatened that others are able and good for he or she has a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished ... or treated as if they were less than who they are’. Kotzé *et al;* (2002:60–61) note that *ubuntu* permeates every aspect of African life: ‘Where *ubuntu* flourishes, families know each other and help each other in times of crisis and need. *Ubuntu* determines that the dignity and self-respect of all must remain’. This should include all those people living with HIV and AIDS. ‘It’s time to practice *ubuntu*’ is the title of an article by Mapule Maelene (2001:30). Maelene writes of the need to love and care for others.

Motsei (2007:10) says that *ubuntu* is an ancient philosophy founded on the notion of communalism, *motho ke motho ka batho* (I am because we are). This is in agreement with Mbiti’s assertion (1990). She goes on to note that *ubuntu* is driven by attributes such as truth, justice and compassion. This philosophy does not discriminate on grounds of race, economic influence, social status or gender. It is a flow of life that is the same for every member of the human race. She continues to say that *ubuntu* is not tied to human life. It also concerns itself with respect for animals and the environment. The adoption of such a philosophy therefore seeks to create a balance between the self and others, as well as between the internal and external.

*Ubuntu* as an ancient philosophy or world-view has its roots deeply anchored in traditional African life. It is therefore defined as the “*the art of being human being*” (Bhengu, 1996:10). According to Broodryk (2002:56), a more comprehensive definition of *Ubuntu* is: *Ubuntu* is an ancient African world-view based on the primary values of intense humanness, caring, sharing, respect, compassion and associated values, ensuring a happy and quality human community life in the spirit of family. These primary

values of *Ubuntu* are not abstract, but form the foundations of *Ubuntu* life coping skills. These values will thus manifest in their particular applications during the exposition of *Ubuntu* personality.

The *Ubuntu* personality is thus a reference to the ideal human being as it is manifested in the living of the ancient *Ubuntu* values (Broodryk, 2006). The ideal man, according to the *Ubuntu* world-view possesses all the following virtues:

- A kind person
- Friendly
- Helpful
- Humble
- Living in harmony
- Modest; and
- Happy (Broodryk, 2006).

These values of *Ubuntu* are directly linked to the basic beliefs of the ideal *Ubuntu* person. In light of the *ubuntu*, workers, in this case, educators in Bojanala District of North West Province of South Africa and Kampala District in Central Region of Uganda would be expected to exhibit some sort of sympathy, kindness, respect and care for those infected or affected with HIV and AIDS. There is no substantial knowledge on this issue. It is reasonable to suggest that the philosophy of *ubuntu* may not be held in some situations such as when one has a coworker whom he suspects to be HIV-positive. Or, *ubuntu* philosophy is mediated by some other factors that its role becomes minimised. In this study, *ubuntu* will not be considered as a separate factor but embedded in attitudes.

According to Tarkang (2009:149), the traditional African practice of gender inequality, female genital mutilation and sexual risk behaviours such as coerced sex, multiple sexual partners, early sexual debut and non-use of condoms do not reflect the *Ubuntu* tradition. Further, in *Ubuntu* tradition, ancestral spirits are central to the different cultures and traditions in Africa. When an individual contracts a grave illness such as HIV and AIDS, it might be assumed that it is a result of unappeased ancestors. This assumption is severely damaging to HIV and AIDS intervention efforts, because it reduces the individuals' risk perception and vulnerability to HIV and AIDS. As a result of this assumption, HIV infection resulting from irresponsible sexual behaviours might be wrongly attributed to ancestral spirits. According to Goercke (2004:14), "those who believe that sexually transmitted diseases such as HIV results from unappeased ancestors rather than unsafe sexual practices also seem to be rejecting the fact that this disease is blood borne and primarily spread through sexual intercourse".

#### **4.6 FAITH AND CULTURAL ISSUES RELATING TO WORKPLACE HIV AND AIDS RELATED DISCRIMINATION**

In the Xhosa cosmology, beliefs about faith and culture are closely intertwined. As a lay person and a committed Christian, it seems to me that both belief systems work holistically together. The literature shows that people attending orthodox or mainline churches are often carrying out traditional practices at the same time (Mafeje, 1975: 172–173). In this study, it was deemed necessary to explore the way in which educators professing different Christian faith talk about the use traditional practices on several issues, including those concerning workplace HIV and AIDS-related discrimination.

#### **4.7 CHAPTER SUMMARY**

In this chapter, the concepts 'beliefs' and 'traditional beliefs' were delineated beginning with the nature of beliefs, the contents of traditional beliefs and the prevalence of traditional beliefs in South Africa, Uganda and in countries of SADC. Then, myths pertaining to HIV and AIDS were dealt with in detail along with related beliefs.



In the next chapter, the literature on HIV and AIDS-related discrimination will be reviewed.

# **CHAPTER 5: DISCRIMINATION BASED ON HIV AND AIDS STATUS**

## **5.1 INTRODUCTION**

This chapter opens with a definition of the concept of discrimination, and it then discusses HIV and AIDS-related discrimination in the workplace in varied countries, with emphasis on South Africa and Uganda. Instruments to measure HIV and AIDS-related discrimination are highlighted and some are discussed in detail to determine their suitability for the current study. The chapter ends with a chapter summary.

## **5.2 DELINEATION OF DISCRIMINATION**

The concept of 'discrimination' and disparate treatment is a broad one. Recently, a useful distinction emerged in the nature between the two types, or categories, of discrimination: overt and subtle (Gaertner & Davidio, 1986). Levine and Leonard (1984) termed overt workplace discrimination as 'formal' discrimination against gay and lesbian employees. This aspect corresponds to traditional notions of workplace disparity, including the inequitable allocation of work-related resources, such as pay and job responsibilities, and biased employment decisions, like hiring, termination, and promotion.

Subtle or 'informal' discrimination occurs during the course of interpersonal interactions between employees (Hebl, Bigazzi, Manmix & Davidio, 2002; Levine). The nature and, indeed, the full impact of these informal behaviours have not yet been fully explored in the sexual orientation literature, but they have received attention by race and gender researchers. Informal discrimination has been identified as one of the major contributors to the differential work experiences of workplace minorities. It is a natural tendency for people to affiliate with others like themselves (Ibarra, 1995). For members of the majority group (i.e. white, heterosexual males in most organisations), social networks

are often expansive because there are many individuals with similar backgrounds and life experiences with whom to interact (Kanter, 1977). Members of minority groups, however, have difficulty gaining access to these social networks and, thus, often find themselves cut-off from informal channels of communication and generally lacking the workplace social relationships that lead to career benefits (Ibarra, 1995; Kanter, 1977; Lyness & Thompson, 1997; Seibert, Kraimer, & Liden, 2001).

### **5.2.1 Definition of discrimination**

In the context of this research, 'discrimination' refers to the 'legal notion of arbitrary discrimination, which is [a]ny measure entailing an arbitrary distinction among person depending on their confirmed or suspected HIV-status or state of health' (UNAIDS, 2000:7–8) and it is with this that the protocol is centrally concerned. The following guides the determination about whether an action is arbitrarily discriminatory:

- the principle of non-discrimination requires that all persons in similar situations should be treated in an equal manner;
- arbitrary discrimination may be the result of an action or an omission. It may also be intentional or unintentional. It may also be direct or indirect; and
- rights to non-discrimination can be justifiably restricted in certain narrowly defined circumstances in the interests of a limited number of overriding goals.

But simply justifying a discriminatory measure as necessary for public health is not sufficient. Two important criteria must be met:

- The measure must be in the interest of a legitimate objective. Public health, the right of others, morality, public order, and national security are all examples of legitimate objectives; and
- In assessing a measure, its objective or purpose should be taken into account.

Even when a measure is for a legitimate objective, the means employed to achieve it must be proportionate to the aim pursued. They should constitute the least restrictive means available.

Since HIV and AIDS infected/affected or suspected individuals form a minority in the workplace, it is plausible that they may be suffering a similar fate to gays and lesbians. It is, therefore, important to establish whether this is the case; and this is part of this study.

### **5.2.2 Stigma and discrimination based on HIV and AIDS.**

Much of what has been written about stigma and discrimination in the context of HIV and AIDS has emphasised the complexity of these phenomena and has attributed our inability more effectively to both their complex nature and their high degree of diversity in different cultural settings (Parker & Aggleton, 2003). As a recent USAID concept paper put it: 'The problem is a difficult one, because underlying the apparent universality of the problem of HIV and AIDS- related [stigma, discrimination and denial] there appears to be a diversity and complexity that makes it difficult to grasp in a programmatically useful way' (USAID, 2000).

While it is important to recognise that stigma and discrimination are characterised by cross-cultural diversity and complexity, one of the major factors limiting our understanding of these phenomena may well be less their inherent complexity than the relative simplicity of existing conceptual frameworks (Parker & Aggleton, 2003). To make serious progress in analysing and responding to these phenomena, it may therefore not only be to attend to their cross-cultural complexity and specificity, but to rethink some of the frameworks taken for granted within which we are encouraged to understand the issue (ibid.).

Defining stigma has been problematic and limiting (Parker & Aggleton, 2003). Ranging from what appeared as dictionary definitions to no definition at all (ibid). According to Deacon (2005, p.ix0, 'stigma has come to mean almost anything people do or say that stands in the way of rational responses to public health campaigns of HIV/AIDS, restricts the access of people living with HIV/AIDS to employment, treatment and care, testing and a reasonable quality of life.' She further states that it is important to distinguish between stigma that is seen as 'negative things people believe about HIV and AIDS and PLWHA' and discrimination that is seen as things "people do to unfairly disadvantage PLWHA". Deacon defines stigma as an ideology that identifies and links the presence of a biological disease agent to negatively-defined behaviours or groups in society.

In addition to the problems involved in defining stigma, perhaps in part because of the strong social-cognitive focus adopted by most social psychologists, there has been individualistic emphasis in much of what has been published. The central thrust of most of the research has been on the perceptions of individuals and the consequences of these perceptions.

HIV-related stigma refers to "prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV and AIDS, as well as the individuals, groups, and communities with which they are associated (Herek & Capitano (1997) cited in Liu, Hu, Li, Stanton, Naar-King & Yang, 2006:133). In this study, stigma of work colleagues towards teachers who are HIV-positive in the workplace is the focus.

#### *5.2.2.1 Cultural differences on workplace HIV and AIDS-related discrimination.*

Bearing in mind that cultural difference may influence people's attitudes (Quah, 1998) towards having to work with an HIV-infected colleague, and that most workplaces have people of different cultures; a case can be made that this study investigates how

teachers of different cultures react towards those infected with HIV and those affected by AIDS.

### **5.3 TYPES OF HIV AND AIDS DISCRIMINATORY CONDUCT**

AIDS discrimination can be classified into three broad sectors: individual, institutional and structural.

#### **5.3.1 Individual discrimination**

This is the type of discrimination encountered on an intimate level in the personal relationships that the PLWHAs have with others. Discriminatory forms include harassment where people thought of as being trustworthy discloses a person's HIV status to others or spread rumours about others. Also, the break-up of romantic, platonic and familial relationships due to the fact that others are terrified by the PLWHA and reject him/her or that a PLWHA withdraws him/herself due to the fact that she/he might 'contaminate' his/her family, friends or community may result in discrimination (Jennings *et al*; 2002).

A refusal to invest in a relationship with a PLWHA or invest in the PLWHA as a person may also be responses to a person's HIV status. Promise Mthembu tells how her parents refused to pay for her university fees as they thought she was going to die anyway and that they should rather invest their money in other things, (interview with Promise Mthembu *op cit.*). Ms Mthembu openly lives with HIV. Community discrimination is such that infected individuals are ostracised and possibly punished for bringing a curse into the community or being perceived as a threat to the physical and psychological well-being of the community as a whole. In an interview with Thanduxolo Doro, a programme manager at NAPWA, he noted most cases handled by NAPWA involved discrimination at the community-level and that personal relationships constituted the sector that is hardest hit by AIDS discrimination. Interview conducted on 6 April 2001 (cited in Jennings *et al*; 2002).

### **5.3.2 Structural discrimination**

This type of discrimination is built into the structures of society and in the ways that societies function and are organised. An example is the position of women in many societies. Women have less power to negotiate safe sex than men do. They are also much more likely to be the target of violence and sexual assault within a society (Gupta, 2000).

### **5.3.3 Institutional discrimination**

This type of discrimination originates in specific institutions within societies. Certain people are given preference over others. Promise Mthembu told that one of her friends died in 1998 as she was told by the hospital that the government cannot treat people with HIV. Ms Mthembu also noted that PLWHAs would go to clinics seeking treatment and that healthcare workers would tell them opportunistic infections are supposed to happen to them and that they should just accept it. An interview with Ms Mthembu *op cit* (cited in Jennings *et al*; 2002) reveals that PLWHAs are typically excluded from certain forms of employment and certain positions within workplaces because they are seen as subjects not worthy of investment such as the building of their skills, capacity or knowledge. They are also excluded from insurance benefits and medical aid cover, as well the protection of law.

## **5.4 THE LEGAL RESPONSE TO HIV AND AIDS IN THE WORKPLACE**

Human rights activists in the southern African region have tried to ensure that laws do not discriminate against people who are HIV-positive. In order to do this, they work within existing legal frameworks, including national constitutions and, in the case of access to treatment, with reference to international treaties and protocols. There are advantages and limitations to the legal approach. On the one hand, it is important to protect against discrimination; while, on the other hand, the impact of the law is limited. Many HIV-positive people (real or suspected) face prejudice and stigma in spite of the law, which cannot protect them from finger-pointing, hostility and social ostracism (Figuera, 2001).

Namibia's legal framework for protection against discrimination is well developed, for example. The Namibian Constitution asserts the principle of equality for all persons before the law and includes an anti-discrimination clause (The Constitution of the Republic of Namibia, 1990). In addition, the Constitution upholds the fundamental right to privacy, supporting other common law legislation on privacy. This means that people have a right to informed consent before undergoing an HIV test, and the results may not be disclosed without authorisation. The Namibian government, both in terms of its own Constitution and by virtue of its status as a signatory to the International Covenant on Economic, Social and Cultural Rights, has committed itself to adequate healthcare for the population of the country (Figuera, 2001).

Labour legislation prevents employees from discriminating against anyone on the basis of HIV status. It also seeks to ensure that adequate information on AIDS is available at all places of work, confidentiality is protected and HIV-positive employees are protected from victimisation. However, 'despite the establishment of a fairly comprehensive policy and legislative framework that recognises the human rights of people living with HIV and AIDS, in practice people living with HIV and AIDS in Namibia suffer (from) widespread rights abuses. It is obvious that good policy does not automatically translate into good practice' (Figueira, 2001).

What has been described in regard to response to HIV and AIDS-related discrimination in Namibia also obtain in other countries including Uganda and South Africa. It would be naïve to say that to presume that the efforts put in drafting and applying anti-discriminatory laws and fostering related policies has had insignificant effect in combating discrimination related to HIV and AIDS in general, and in the workplace in particular. However, it is naïve to imagine that laws and policies, however good they may be, will stem out HIV and AIDS-related discrimination basing on the subtlety of some forms of discrimination.



Although South African law makes it illegal to discriminate against employees on the basis of their HIV status, few people have revealed their HIV-positive status at work. This is for a number of reasons:

- HIV and AIDS is a highly stigmatised disease – because of its association with sex and death – and many people are afraid that they will be injured or blamed by others if they are known to be HIV-positive.
- Despite legislation, discrimination against people who are HIV-positive (or who are thought to be HIV-positive) is widespread at work. This can range from open discrimination (such as being fired from work) to more disguised discrimination (such as not training or promoting an employee).
- People talk or gossip about something that is sensational, it is not possible for someone to be open about their HIV status in one environment and be sure that this information will not spread to other situations. This raises barriers to people being open about their HIV status – even if it might be safe to do so in some parts of their lives (Dickinson, 2004).

In contrast to this reality, best practice policy responses encourage the creation of an environment in which people can choose freely whether they want to be open about their status or not. Thus, the Code of Good Practice on key Aspects of HIV and AIDS and Employment agreed to in the National Economic Development and Labour Council (Nedlac) recommends that companies should ‘create an environment that is conducive to openness and acceptance among all staff’.

In Uganda, laws relating to workplace HIV and AIDS issues had been enacted. They include Ministry of Education and Sports Draft Policy of 2005 and the Constitution of the Republic of Uganda of 1996. The details of laws pertaining to HIV and AIDS and

discrimination have already been dealt with in Chapter 2 under HIV and AIDS legal knowledge. Reference can be made to that chapter when necessary.

As earlier on alluded to, this study endeavours to investigate the existence of workplace HIV and AIDS policy and their development based on the fact that, although having an HIV and AIDS policy is in itself not a sufficient indicator that a workplace response is underway, the information on what policies are based on, on who was involved in developing them and how it has been communicated to employees helps one to understand the extent to which a policy is a 'real' document rather than merely a 'piece of paper' (Stevens *et al*; 2005:290).

## **5.5 PREVALENCE OF STIGMA AND DISCRIMINATION**

Stigma and discrimination, the negative social responses to the HIV and AIDS epidemic, seem to be prevalent in almost every sphere of life wherever there is an individual or individuals infected or affected by HIV and AIDS. Stigma and discrimination have been increasingly recognised as major obstacles to HIV and AIDS prevention and care programs (Parker & Aggleton, 2003; UNAIDS, 2002; UNAIDS/WHO, 2003). Fear of stigma and discrimination often discourage people with HIV and AIDS from coming forward for HIV testing, counselling, and treatment, from informing their sexual partners, family, and friends about their sero-positive status, and from receiving guidance and support for HIV and AIDS-related behavioural changes and responses (Herek, 1999; Neema & Koster, 2007:24). It also leads to 'a lack of accurate information about levels of HIV prevalence, making informed preparation and responses impossible' (UNDP, 2003, p.80). Neema and Koster (2007:35) notes that despite the fact that staff, are knowledgeable about HIV and AIDS, stigma is still apparent as it became clear from answers to different questions: 1) a considerable proportion felt they would feel uncomfortable working with HIV-positive persons. 2) The reason why one-quarter of the respondents would not disclose HIV-positive test results was feared stigma. 3) The second main topic staff requested more information on how to fight stigma and

discrimination at the workplace. Even in the suggestions at the end of the questionnaire, participants expressed that something should be done about stigma and discrimination.

In this study, the issue of persistence of workplace HIV and AIDS-related discrimination was central that it motivated engaging in a comparative study of educators in South Africa and Uganda to determine any significant difference among the two samples to give a clue to what underlies workplace HIV and AIDS-related discrimination.

## **5.6 THE IMPACT OF STIGMA AND DISCRIMINATION DUE TO HIV AND AIDS ON THE WORKPLACE**

The stigma associated with HIV is insidious and has led to disturbing levels of AIDS-related discrimination, which affect the quality of people's lives and impact on people's ability to access care and support (Bharet *et al*; 1998; Castro *et al*; 1998; Herek, 1999; Mukasa Monico *et al*; 2001; Muyinda *et al*; 1997; Ravies *et al*; 1998; Songwathana & Manderson, 2001). Perceived discrimination may be greater than actual or enacted stigma (Green, 1995). Nonetheless, the stigma associated with HIV and the subsequent fear of abuse or rejection deter many people from testing for HIV and inhibit people diagnosed with HIV from disclosing their status to others (Alubo *et al*; 2002; Kilewo *et al*; 2001; Maman *et al*; 2001; Petrak *et al*; 2001; Pool *et al*; 2001). This ultimately thwarts efforts to prevent further HIV transmission.

The impact of AIDS-related discrimination can be subtle and can result in individuals hiding their secret and thus becoming withdrawn and isolated (Laryea & Gien, 1993; Lichtenstein *et al*; 2002; Nzioka, 2000). This can result in lowered self-esteem and deteriorating health. AIDS-related discrimination can also lead to the greatest deprivation of human rights: a denial of the right to life. In 1998, a South African woman who publicly announced that she was living with HIV was killed by her neighbours in the district hardest hit by HIV (McNeil, 1998). In 2006, an HIV-positive double orphan was killed with a garden fork in Kenya (*Mail & Guardian*, April 2006). In other instances, fear

of discrimination has led people diagnosed with HIV to consider or attempt suicide (Demi *et al*; 1998; Heckman *et al*; 2002; Kwalombota, 2002).

Findings from a qualitative in-depth study in India indicate that discrimination is all-pervasive: In the home, the workplace, the community and within health care setting (Bharat & Aggleton, 1999). Unfortunately, despite the study, the prevalence of HIV and AIDS infections in India is increasing (UNAIDS, 2006; and *Mail & Guardian*, August 2006).

## **5.7 SUPPORTIVE SOCIAL RELATIONS**

Widespread interest among researchers in the positive effects of social relationships on well-being dates from the mid-1970s when associations between social support and physical health were noted (Uchino, Cacioppo & Kiecott–Glaser, 1996). Since then, social support has been studied extensively. There are different types of social support, including *tangible support* (i.e. instrumental), *appraisal support*, and *informational support*, but what commonly comes to mind when the term ‘social support’ is mentioned is *emotional support*, which includes providing sympathy, listening, and showing that you care (Beehr, 1995).

Social support can promote both mental and physical health. Higher levels of social support are associated with better cardiovascular, endocrine and immune system function (Uchino *et al*; 1996); and higher levels of social support at work are related to lower levels of psychiatric disorder and sickness absence (Stansfeld, Real, Heed, Shipley & Marmot, 1997). Manning *et al*; (1996:745) found that for employees reporting high levels of psychological strain, doctors office costs were ‘considerably lower’ for those with high social support, and that social support may be especially important in terms of health outcomes when things are tough at work. It also indicates the potential for work-related psychosocial factors to affect health care expenses, which may be on the shoulders of either the employees or the employer.

A supportive style of supervision enhances employee well-being and helps protect employees from tension, depression, emotional exhaustion, and health complaints (Greller, Parsons & Mitchell, 1992; Landeweerd & Boumans, 1994). In the age of HIV and AIDS, it is very important for a supervisor to exhibit and offer any kind of support. Based on what the Social cognitive theory purports, an employee may become less discriminative towards colleagues infected with HIV or affected by HIV when he/she observes a colleague, be it a supervisor or one on the same rank assisting an HIV infected colleague. A supervisor assisting a colleague infected with HIV to climb steps in a workplace with multi-floored buildings but without lifts or non-functioning lifts would be a model of how to assist those needing such support. It is likely that by observing a colleague putting on a T-shirt with HIV and AIDS message will have his/her self-efficacy enhanced. He/she will then be more likely to do the same assuming very similar circumstances prevail.

In this study, statements such as “I would donate 1% of my salary to assist those colleagues with HIV and AIDS”, were meant to determine whether and how far can render support to colleagues in the workplace.

Perceptions can play a role in determining whether supervisors are doing what is necessary to assist HIV and AIDS infected and affected workers; and may determine how employees perceive discrimination in this regard. In this study, perceptions of the SMT and ordinary educators were investigated to determine how they influenced workplace HIV and AIDS-related discrimination.

Supervisors can provide emotional support by being empathic and caring. They can emotionally bolster employees who are having a difficult day by listening to and encouraging them. Employees who report that their supervisor provides support and

encouragement indicate that they have less job stress and psychiatric disturbance (Gilbreath, 2001). In this study, some emotions of relevance to workplace HIV and AIDS were investigated.

## **5.8 BENEFIT OF DISCLOSURE OF HIV STATUS TO THE ORGANISATION**

Open disclosure of an individual's HIV-positive status, which may result from an environment where workplace HIV and AIDS-related discrimination is in check, is of physiological benefit since the individual no longer lives with this secret. It can also be of great benefit for the HIV and AIDS programme of a company since PLWAs can help everybody in the organisation to acknowledge the reality of HIV and AIDS and get them – whether positive or negative – to take appropriate action (Dickinson, 2004). In this study, the issue of disclosure was not central. Educators who were respondents did not have had their HIV disclosed. However, the benefits that accrue from disclosure were assumed to be known by the educators.

## **5.9 SELF-ESTEEM AND WORKPLACE HIV AND AIDS-RELATED DISCRIMINATION**

Social identity theory (S.I.T) has spurred the search for self-esteem-based consequences of perceived discrimination (James, Lovats & Cropanzano, 1994). One benefit to forming social identities is the increased self-esteem that results from comparing one's social group positively to other groups. However, when individuals perceive that they have been treated negatively in the workplace on account of their membership in a group, social identification will have the opposite effect on self-esteem: it will be lower than the self-esteem of those who do not perceive discrimination. With HIV and AIDS affecting many individual of the working age group, determining self-esteem of educators is of importance. Self-esteem is about how confident one feels about oneself. It is reasonable to say that an individual with high self-esteem will engage less in workplace HIV and AIDS discrimination because he/she is likely to seek out correct information about many aspects of HIV and AIDS.

## **5.10 LINKING ATTITUDES WITH WORKPLACE HIV AND AIDS-BASED DISCRIMINATION**

It is important to note that while the empirical linkages between discrimination and attitudes have been made, the theoretical explanations are still largely unexplored. Similar relationships have been found in research that has examined race or gender discrimination (see Greenhaus *et al*; 1990; Shaffer, Joplin, Bell, Lan & Oguz, 2000) but the mediating mechanics have yet to be determined. This forms a major part of this study.

## **5.11 STAKEHOLDERS' IMPACT ON WORKPLACE HIV AND AIDS-RELATED DISCRIMINATION**

Stakeholders of workplace such as faith leaders and non-governmental organisations (NGOs) usually have a lot of influence on organisations with which they do business or offer services. Faith leaders are important in influencing the way individuals think and react toward issues, especially those which are complex such as HIV and AIDS. As for non-governmental organisations, they may also be able to influence individuals and organisations, in this case, workplaces for educators, i.e. schools, through the philosophy they pursue and the kind of service they render to a particular organisation.

Faith leaders pursue the philosophy of the denominations they belong to. In trying to curb the effects of the scourge of HIV and AIDS, different religious or faith leaders, a representatives of their particular organisations, have made statements which members of their faith follow to a certain extent. Here, the word 'extent' has been used to indicate that there are things which individuals follow which may not be in the realm of a particular denomination. An example of things pronounced on by the Catholic Church which impact on HIV and AIDS is the use of condoms which is not condoned. Yet it has been medically proven that a condom if consistently used, is a very effective means of preventing contracting sexually transmitted infections (STIs) including HIV. Instead, the Catholic Church insists on sex after marriage in a monogamous relationship. The

practicability of individuals sticking to what their faith leaders say is not usually possible. People then go on not using condoms, and may end up contracting HIV. With HIV, comes stigma and discrimination.

For the Moslems, according to the Koran, men are allowed to marry up to four wives so long as one can afford them and can love them equally. Such a practice can have a negative impact on prevention of HIV contraction and transmission. These are some of a variety of practices which different faiths do.

#### **5.11.1 Contributions of faith communities TO HIV and AIDS impacting on the workplace**

The reaction of faith communities to HIV and AIDS has been mixed. Some faith communities have acted in a way which gave hope, support and care to those infected and affected with HIV and AIDS while other faith communities have displayed a non-caring and unsupportive attitude.

Some faith communities have established programmes in prevention, care and support of those living with HIV and AIDS. The Fikelela AIDS programme of the church of the Province of South Africa encourages open dialogue about HIV and AIDS. It provides a platform to speakers to visit churches and to discuss issues of HIV and AIDS from the pulpit and encourages groups of church people to come together and talk about HIV and AIDS. Education and outreach programmes for marginalised people are encouraged throughout South Africa and care is provided for AIDS orphans by the Tuwelong Orphan Haven, north of Pretoria and by the Fikelela project. The Methodist church (Jacobs, 2001:1–13) also has a national programme; Dutch Reformed churches locally are addressing the epidemic at the circuit level by liaising with organisations already working within the field of HIV and AIDS and supporting them in their efforts. Catholic AIDS Action (Byamugisha, 2002:13–30) established programmes in Namibia in 1998. The Presbyterian J.L. Zwane Memorial Church in Gugulethu, Western Cape, has a programme for men, women and children. The Full Gospel and Moravian churches and other churches and organisations have established programmes too. In Uganda,



the Uganda Anglican Church, the Catholic Church and Uganda Moslem Supreme Councils are engaged in many programmes. These are the chief/main churches which have been in operation for over a century in Uganda. The Seventh Day Adventists have programmes too.

As earlier on alluded to, there are those faith communities which have displayed a non-caring and non-supportive attitude towards those living with HIV and AIDS. Strelbel (1997:109) describes those faith communities whose response has been one of 'moral panic'.

According to their view, people living with HIV and AIDS are judged as promiscuous and, therefore, deviant. 'Moral panic' leads to fear, blame and avoidance by others and feeds the stigma discourse and its attendant discrimination. More open talking about AIDS and a mutual, accepting attitude of those living with HIV and AIDS may help to overcome this unhelpful and judgmental moral attitude. What remains unclear is whether the stand of the church or faith community really translates into the stand of its individual members towards those infected or affected by HIV and AIDS.

This point was be elaborated upon in Chapter 7 which deals with results particularly regarding what was revealed by one respondent on the attitude of her former church leader now a retired but quite influential opinion leader. Byamugisha *et al*; (2002:99–100) write that faith communities can move 'the mountains of fear, stigma, indifference, ignorance and inaction that surround HIV and AIDS'. In light of the influence and role of religion, faith-based communities and other organisations can address judgmental attitudes and inhibitions about sexuality, in order to combat stigma and discrimination against those infected or affected by HIV and AIDS.

The AIDS epidemic is a relatively new biological and social phenomenon and, despite rigorous education drives initiated by governments, NGOs and the private sector, a great deal of ignorance regarding this epidemic still exists worldwide. Ignorance of basic HIV facts can lead people to project their fear of infection and contamination onto those infected by HIV (Jennings *et al*; 2002: 9). Ignorance of these basic HIV facts may give rise to popular myths about this condition, while at the same time contributing and strengthening people's beliefs in them (Jennings *et al*; 2002; Richter & Heywood, 2002).

An example of a fear popularly associated with the HIV and AIDS epidemic is that of not only becoming infected by HIV, but also assuming that it will inevitably entail a death sentence. Other fears include the fear of being confronted with the deaths of people that you care for and love, the fear of already being infected yourself but not knowing it for certain and also the fear of being responsible for infecting other people close to you if you are HIV-positive (Jennings *et al*; 2002). The destructive consequences of fear and ignorance are highlighted by the death of Gugu Dlamini following the disclosure of her HIV status in 1998. Gugu Dlamini was fatally attacked by members of her community!

Gugu being fatally attacked and many other sad events involving PLWAs not only highlight fear and ignorance but also serve as plausible explanations as to why so many people deny the scope and dangers of the HIV and AIDS epidemic, why they are reluctant to engage with it, as well as why many people support measures that will exclude PLWAs from society and make AIDS a notifiable disease.

'Deviance' from what is perceived as the 'norm' also plays a role in the development of feelings of prejudice. Rubert Brown (1995) notes how things that are 'less common than average or which happen only rarely seem to attract a disproportionate share of our attentions'. This partly explains why people are threatened by things that are irregular or different from them or what they perceive as 'the norm'. People may therefore harbour

prejudice against PLWAs because they are perceived to be sick and dying and are therefore set apart from the healthy and living 'norm'.

Brown (1995) defines prejudice as:

The holding of derogatory social attitudes or cognitive beliefs, the expression of negative effect, or display of hostile or discriminatory behaviour towards members of a group on account of their membership of that group.

Extrapolating from the first part of Brown's definition (1995), it is possible for someone to 'harmlessly' and perhaps secretly, harbour prejudice against another individual or group, which would translate into discrimination only once the person *acts* on that prejudice. Discrimination, therefore, entails the combination of an element of action, with a pre-existing sentiment of prejudice. Therefore, 'to discriminate against someone is to treat them unequally or differently to other people'. Yet, prejudice is typically enacted only when the object of discrimination is perceived as vulnerable and defenceless (Jennings *et al*; (2002), Richter & Heywood, 2002).

Discrimination has a powerful and insidious impact on the dignity and self-respect of the person being discriminated against. Mann (1994) wrote that dignity flowed from two sources: an internal one (the way an individual sees her/himself) and an external one (the way other people see them). Mann (1994) enumerated a number of elements, in what he termed a 'provisional taxonomy of dignity violations: not being seen; being subsumed into a group identity, invasion of personal space, and humiliation'.

Logically, any form of AIDS discrimination levelled against a PLWHA, regardless of scope or extent, would fall into one of the categories delineated by Mann and would impact on that person's dignity. When a person's dignity is repeatedly compromised by external sources, the chances are good that the person's internal source of dignity

would also be undermined. This will impact on that person's self-image, self-confidence and well-being and ultimately reduce their capacity to deal with his/her HIV and AIDS status and opportunistic infections associated with HIV (Jennings *et al*; 2002). This affects one's performance and relationships at work inevitably. In this study, workplace HIV and AIDS-related discrimination explored the reactions of faiths' teachings and practices which impact on the educators' workplace.

### **5.11.2 Opinion leaders' influence on workplace HIV and AIDS-related discrimination**

Museveni is famous for his openness in talking about AIDS. In the early days, Museveni spoke directly to the Ugandan people (de Waal, 2006:96). De Waal (2006) continues to say that at the end of the 1990s, Museveni began to trumpet his success and use it for political credit – perhaps because his military involvement in Congo (The Democratic Republic of Congo) was becoming politically costly and the country's long economic boom was coming to an end. At the African Development Forum, held at the United Nations Economic Commission for Africa in Addis Ababa in 2000, he recounted his triumphs and said, 'most important of all, the stigma attached to people living with HIV and AIDS has virtually evaporated'. But alongside this tolerant affability, from the outset he has also conveyed a different, tougher message that does not match up to the tonic of overcoming stigma. This message, consistently purveyed, is that his army and government cannot afford to invest in people with HIV. Museveni himself supported the policy of dismissing or not promoting members of the armed forces who tested HIV-positive Tumushabe (2006).

'The army is not a hospital', Museveni said, explaining why he did not promote soldiers who tested positive for HIV. Some Ugandan HIV and AIDS activists were outraged at his remarks at the passing-out ceremony for newly commissioned army cadets in April 2001, in which he said 'there is no reason why people living with HIV and AIDS should be offered opportunity in the army. Because training officers who later die not from bullets in combat but from AIDS is so frustrating. It is like fetching water in a basket with

holes' (Tslhamba, 2001). At a similar ceremony eighteen months later, the government paper reported how he cautioned the cadets against 'reckless and immoral sexual behaviour' (Jonathan Angura, 'Museveni Advises Cadets on AIDS', *New Vision* [Kampala], 11 November, 2002; As well as ' "ABC", his approach has an implicit "D": discipline').

## **5.12 PRELENCE OF STIGMA AND DISCRIMINATION IN SOME OTHER COUNTRIES**

### **5.12.1 HIV and AIDS stigma in SADC countries**

Whiteside *et al.*; (2004) point out that the social stigma around HIV and AIDS may prevent a full and candid appraisal of the extent and causes of illness and death. Such stigma and community taboos may disrupt the social flow of information about the disease. It is not clear, for instance, whether the ubiquitous reference to local elites and national leaders who 'died after a long illness' sends a coded signal that these were AIDS deaths or rather serves to confuse people.

Even where people are accurately aware of the increasing death rate, social and religious beliefs may lead them to conceive of or frame the epidemic as a consequence of personal morality or as fate, rather than as a 'public problem' that the government should address (Whiteside *et al.*; 2004:133–134).

An unfortunate but frequent consequence of stigma is the internalisation of the negative views by those who are stigmatised; the result is self-depreciation, making the decision whether to disclose and to whom a very complex one because of self-stigma (Bunting, 1996:64; Flynn *et al.* 2000:60). Stigma in Botswana is real. For example, in a recent report of the BMIS of 2000, 68% (N=6488) of women aged 15–49 expressed discriminatory attitudes towards HIV-positive people. The women in the study affirmed their beliefs that a teacher with HIV should not be allowed to work and that they would not buy food from a person with HIV and AIDS (GOB & CSO, 2000:10).

In 2002, a survey investigated the myths and misconceptions about HIV and AIDS among 367 field officers (75% women and 25% men) who were engaged in house-to-house community-based HIV and AIDS education in Botswana, encouraging people to go for an HIV test. Of the field officers, 37% did not know their HIV status and 22% thought that one could not become infected with HIV (GOB & CSO, 2000). Comparable rates have been found elsewhere in SADC countries at different times.

HIV and AIDS can evoke a strong stigma response because it is a communicable disease, fatal and has a mysterious origin, which when it was first discovered in the 1980s, was associated with homosexuals and commercial sex workers, both groups already stigmatised (Kalichman, 1995: 129). AIDS refers to prejudice, discounting, discrediting and discrimination directed at people perceived to have HIV and AIDS and at individuals, groups and communities with whom they are associated (Herek *et al*; 1998:36–47).

The underlying notion in most studies reporting stigma in sub-Saharan Africa includes the needs to address the cultural beliefs and attitudes that affect behaviour, as well as to convey accurate knowledge. A study of community educators in Botswana showed that as much as a fifth of this group of 'HIV-educated' persons conveyed the wrong information to the public and put them at risk, which is cause for concern. One out of every ten field officers was honest enough to report that they expressed discriminatory feelings towards HIV-positive persons; the actual numbers were presumably higher (Bara, 2002:4; Blecher *et al*; 1995:1281). One had unprotected sex with an HIV-positive person, 12% of those surveyed would take an HIV-positive result to mean that the person was promiscuous, and 10% felt that HIV-positive persons got what they deserved. The majority, 95%, would not, however, mind sharing a house or working next to an HIV-positive person and did not think it was a good idea to isolate an HIV-positive person (Bara, 2002:7). It is important that we note that not minding to share a house does not mean staying in the same room with an HIV-positive person. Similarly,

not minding to work next to an HIV-positive person does not mean that one is free from all other stigma and discrimination nuances.

Stigma is a complex phenomenon which, while often mentioned, resists simple definition. It is very close to discrimination, which is the enacted form of stigma, while stigma relates more to negative feelings towards a certain 'other' group. The 'otherness' is because of possessing an attribute regarded negatively. In 1963, Goffman described stigma theory and defined stigma as the expectation of a stereotypical and discrediting judgment of oneself by others in a particular context (Goffman, 1963:7). Barz (2006:30) writes that one's HIV status remains a serious matter in Uganda as stigmatisation, although fought aggressively, is still a very present reality for many in the society, especially children.

While the distinction the TASO Drama Group makes between 'positive living' and living as 'HIV-positive' relies heavily on societal abandonment of stigma, PLWAs living today still confront extreme levels of discrimination and face potential job losses, rejection by families and expulsion from homes when one's HIV status is made public for further documentation on 'living positively' with AIDS programme (see Hampton, 1998; Ruzindaza, 2001; and Barz, 2006:55). The issues of the HIV virus quickly move beyond the medical toward what UNAIDS refers to as the 'epidemic of stigma, discrimination, blame and collective denial' (*A Conceptual Framework and Basis for Action*, 2002:7). According to Rev. Gideon Byamugisha, the first Ugandan clergy member to openly disclose his HIV status, stigma is not only on par with presenting medical issues in Uganda, it sometimes surpasses physical condition:

It is not the condition itself that hurts most (because many other diseases and conditions lead to serious suffering and death) but the stigma and the possibility of rejection and discrimination that HIV-positive people have to deal with, (quoted in *Global AIDS: Facing*

*the Crisis*, 2002:5). Peter Piot, (2004) of UNAIDS suggests that stigma is rooted in shame and fear and must be actively addressed with regards to HIV and AIDS.

HIV and AIDS-related stigma comes from the powerful combination of shame and fear – shame because sex and intravenous drugs that transmit HIV are surrounded by taboo and moral judgment and fear because AIDS is relatively new and considered deadly. Responding to AIDS with blame or abuse towards people living with AIDS simply forces the epidemic underground, creating the ideal conditions for HIV to spread. The only way of making progress against the epidemic is to replace shame with solidarity and fear with hope (quoted in *A Conceptual Frame-work and Basis for Action*, 2002:7).

Former South African President Nelson Mandela addressed the issue of stigma in a typical emotional tone, 'AIDS is a war against humanity. We need to break the silence, banish stigma and discrimination and ensure total inclusiveness within the struggle against HIV and AIDS. If we discard the people living with HIV and AIDS, we can no longer call ourselves humans' (cited in *Fight Stigma!* 2002:15). The theme for the World AIDS 2002/3 Campaign on Stigma and Discrimination – 'Fight Stigma: Reach Out to Positive People' – represents a very necessary and very real, ongoing battle that must still be fought in many areas of the world, even for those living positively in Uganda.

#### **5.12.2 Discriminatory language in light of HIV and AIDS: A case of Uganda**

Communication is often reduced to the provision of messages, media and public health campaigns. More fundamentally, how Ugandans communicate about HIV and AIDS; and about those with AIDS reflects and influences the way the population responds. Low-Beer and Stoneburner (2004:176-178) say that there is something qualitative in the content of the communications and the channels through which they are communicated. Three aspects can be highlighted: trusted communications through personal sources, transparency in the consequences of the epidemic and attitudes of care. This was much more than a lack of stigma or 'live and let live' but reflected a quality of the population response in Uganda.



Despite the quality of the communication, it was a really difficult engagement with HIV and AIDS and people with AIDS in Uganda. The vast majority of Ugandans said they would care for people with AIDS: 86,2% of women and 77,4% of men. When men were asked in 1995 what the government should do for HIV and AIDS victims, many proposed treatment and helping relatives care. However, 29% also said that people with AIDS should be isolated, quarantined or jailed, and 3,5% said that they should be put to death. Opening up communications did not lead to clean, open conversations and stigma remained tied up if not opened out in the communication response (Low-Beer & Stoneburner, 2004).

This is reflected in the death of the famous Ugandan musician Philip Lutaaya (see the rest of story similar in detail in an interview between Barz and Muganga – quotation from Barz, 2006). When Lutaaya declared his HIV status, many people accused him of pretending to have AIDS to make money from his concerts (Kaleeba *et al*; 2000). There was an acrimonious national debate with all types of response to avoid his concerts and some of his concerts degenerated as sceptics shouted accusations of him.

#### *5.12.2.1 Elaboration on the qualities of communication*

Personal communications are important because they involve some form of knowledge. As Low-Beer and Stoneburner (2004) argue, this is against a background of widespread scepticism about sources of HIV and AIDS and other information, from the media and public sources (rarely acknowledged in policy), however healthy and bright the messages are. Also trusted communication about HIV and AIDS and people with AIDS are important qualitative elements: as a South African boy stated that the majority, especially the youth, do not take HIV and AIDS seriously... they just talk about it. 'I think people who make us[sic] clear about this are our parents when they tell us about somebody who died of Aids'(Brookes & Low-Beer, 2003).

Secondly, there was great transparency about the HIV and AIDS epidemic in Uganda and direct knowledge of people with AIDS through social networks. In other countries, even when there is AIDS mortality, it often does not lead to openness and secondary conversations.

The third important component of Uganda's communications is an attitude of care. The roles of the AIDS support organisation (TASO) and other NGOs were essential in creating these social networks and resources for care and have been described elsewhere (Kaleeba *et al*; 2000). Initially, due to stigma, people asked TASO workers/members not to park their vehicles with TASO label on them near their houses so as not to be associated with HIV and AIDS. However, their commitment to promote openness and 'living positively with AIDS' increasingly involved people with HIV and AIDS in their communities and mobilised social networks of support, counselling and care. They promoted 'shared confidentiality', openness about HIV status with a limited circle of trusted people, opening up channels of support and care. Considering this study, it would be very important if a similar kind of network and a sense of 'shared confidentiality' and openness would emerge in both the workplaces and the communities.

### **5.13 DECISION BASED ON MORAL ISSUES**

If one wants to comprehend people's commonplace and extraordinary actions, one must understand the values that inspire them. 'Extreme' actions (for instance, selfless heroism, suicide terrorism) show that strong values may motivate behaviour and some researchers suggest that 'all attitudinal and behavioural decisions should be traceable to personal value priorities' (Rohan, 2000:270).

Focusing on decisions involving protected values (PVs), Bartels and Medin (2006) say that there is evidence that when people have sacred or protected values (PVs), they reject trade-offs for secular values (i.e. 'You cannot put a price on a human life') and tend to employ deontological rather than consequential decision principles. People

motivated by PVs appear to show quantity insensitivity. That is, in trade-off situations, they are less sensitive to the consequences of their choices than people without PVs. In this study, the relevance of decision making which involves PVs is in the living promotion of those who are HIV-positive or suspected to be HIV and AIDS infected or affected.

It is hoped that in the qualitative part of the study it will be possible to critically look at verbal data to see whether there is a difference in those who tend to be high PVs than those low on PVs. According to Baron and his colleagues (Baron and Prance, 1997), people are more likely to use non-consequential, deontological choice strategies for problems entailing the exchange of a cherished resource (a PV) than for some less morally charged problems. Deontological reasoning is focused on means – some acts are wrong in themselves and there are morally unacceptable means to any end (Davis, 1993). In contrast, consequential reasoning is focused on outcomes and means are irrelevant; whatever values are adopted this perspective mandates bringing about the best outcomes (Pettit, 1993).

Contemporary ethics treats deontology and consequentialism as distinct modes of ethical reasoning. PVs are thought to be associated with deontological rules – rules that concern action, for example ‘do not harm’ (Baron, 1996). By extension such actions would be, ‘do not discriminate an HIV-positive person’, but not the overall consequences of those actions.

Properties of PVs include the following:

- PVs are associated with trade-off avoidance. For example, when offered a secular value (something that can be purchased or sold) in exchange for a PV

(for instance, auctioning body parts or selling futures that bet on the likelihood of acts of terrorism (Medin, Schwartz, Block & Birnbaum, 1999; Tetlock, 2002), people refuse trade-off on moral grounds (Tetlock, Kristel, Elson, Green & Leruer, 2000).

- Other properties of PVs are *omission bias*, and *quantity insensitivity* (Baron & Spranca, 1997). Omission bias is a preference for indirect harm caused by omissions (i.e. failures to act) over equal or lesser harm caused by acts (Spranca, Minsk, & Baron, 1991). Baron and his colleagues have amassed evidence that PVs are associated with a large omission bias (Baron & Greene, 1996; Rivot & Baron, 1990, 1999).

PVs are an important construct in the study of decision making because this field has adopted utility theory (Savage, 1954; von Neumann & Morgenstern, 1947) as a normative model and consequentialist theories as descriptive models (Kahneman & Tversky, 1979; Tversky & Kahneman, 1992). These theories assume quantity sensitivity: more of a good thing is preferable to less of a good thing, *ceteris paribus*. The relevance of these theories was anticipated from the responses of teachers and SMTs. In essence, in this study, core values among educators pertaining to how to behave towards those infected with HIV or affected by AIDS were assumed to have an impact on their behaviour. This was premised upon the fact that values permeate attitudes, knowledge and beliefs, the variable of concern in this study.

#### **5.14 GAPS IN THE LITERATURE REVIEWED**

One of the expected outcomes of research and indeed, the most central business of any academic discipline that wants to remain a legitimate professional discipline is knowledge creation. Industrial and organisational psychology is not different from many disciplines in the social sciences in that it usually borrows theories from other disciplines, particularly from social psychology. These borrowed theories from other but related disciplines may or may not be adequate to guide research or practice. It is, thus,

important to systematically evaluate whether their adoption should be considered. If there is congruence between the various concepts, an industrial/organisational psychology researcher can and should utilise innovations from other disciplines to their advantage (Villarruel *et al*; 2001:58).

Liehr and Smith (1999:81) say that through grafting the links between research and practice, new ideas are generated. To make this creative process easier to understand, one could compare it to a spinner who prepares wool by combing. The spinner discards debris and aligns the strands of a matted mass in much the same way as the researcher shifts through content to tease out central ideas from extraneous ones. Just as the spinner twirls strands to compose a single thread, the industrial/organisational psychologist for that matter spins central ideas into a synthesised thread for research and practice.

#### **5.14.1 Need for more information on workplace HIV and AIDS-related discrimination**

There are gaps in the literature reviewed in that most of the research on discrimination in HIV and AIDS has mostly been done in the developed world. With the difference in social, economic, cultural and political realms between the developed and developing world, there is a dire need for more information on workplace HIV and AIDS-related discrimination, more specifically, among those engaged in teaching activities in primary, secondary and/or high schools in both South Africa and Uganda.

In this study, focus is on basic HIV and AIDS biomedical and legal knowledge (hereto referred to as HIV and AIDS knowledge); attitudes and traditional beliefs (referred to as cultural beliefs); and how these individually or in combination relate to workplace HIV and AIDS-related discrimination. While there are studies which have dealt with HIV and AIDS knowledge and attitudes and their relationships with behaviour, these studies mostly paid little attention to traditional beliefs, which I think might have a strong

association with or influence the phenomenon of concern – that is, the persistence of workplace discrimination related to HIV and AIDS. Again, as regards HIV and AIDS knowledge, this was mostly restricted to biomedical knowledge. But since HIV and AIDS-related discrimination is purportedly a function of a number of variables, basic HIV and AIDS-legal knowledge was incorporated in HIV and AIDS knowledge to explore how it is linked to workplace HIV and AIDS-related discrimination.

With a dearth of up-to-date existing instruments, attempts were made to come up with relevant items for some instruments from relevant vital documents like the Constitution of South Africa (1996) and the Constitution of the Republic of Uganda (2000) together with other related documents like the Employment Equity Act (EEA) (1998). In all cases, the issue of reliability and validity was attended to and reported. This study endeavoured to explore the phenomenon using a double-pronged approach, using both quantitative and qualitative approach, with the former basing its interest in yielding conclusions that can be generalised while the latter sought to delineate why people in the workplace continue to engage in discriminatory behaviours against those suspected to be or are HIV-positive.

The research questions and the objectives of this study are unique to the two countries from which the participating samples were drawn, namely South Africa and Uganda. However, the literature reviewed is mainly from outside Africa, particularly the western world. A comparison of the findings of this study within themselves – that is, comparison of the findings from the South African and Ugandan samples – and also a comparison of the findings of this study with findings of studies done elsewhere will continue to discover the differences and the similarities in the adequacy of the driving theories. The insidious nature of workplace HIV and AIDS-related discrimination accompanied with its elusive nature, especially amongst people who are agents of change within their communities, expensive to train and not replaceable by machines, warrants an investigation of the relationships and interplay between variables.

#### **5.14.2 Workplace HIV and AIDS-related discrimination: How much is due to traditional beliefs?**

One other crucial question that was not answered in the literature review is: 'How do traditional beliefs influence workplace-related HIV and AIDS discrimination?'

The issue of conceptualising traditional beliefs was limited to the aetiology of the disease, treatment of and attitude towards bereaved member of a sexual couple and secret keeping. With the paucity of research on secret keeping, yet very central to confidentiality, particularly with sensitive information like the one concerning an employee's HIV status, a lot of attention was paid to investigating secret keeping in an in-depth interview to obtain reality through a discourse. I reasoned that if one could know why people cannot keep sensitive information, then one could be able to postulate how workplace HIV and AIDS-related discrimination may be effectively reduced by addressing, in appropriate ways, the purported causes of not keeping secrets.

In this study, concepts from Ajzen and Fishbein's theory of planned behaviour (TPB), Ajzen's theory of reasoned action (TRA), Bandura's social cognitive theory (SCT) and Maslow's hierarchy of needs theory were used and these theories were applied in practice. Building on these foundations which have been used in many studies, particularly those concerned with health behaviour change and combining them guided this study of workplace HIV and AIDS-related discrimination. This study went beyond the bounds of these theories since it even explored the motivation to reveal secrets which could lead one in the court of law. Another very important inclusion is that of focusing on traditional beliefs and how they may or may not influence workplace HIV and AIDS-related discrimination. The point to note is that a worker is a complete human being who impacts on and is impacted on by society.

In the workplace, particularly, in educational institutions, all actions of an individual worker towards a colleague who is HIV-positive or suspected to be infected with or affected by HIV and AIDS touch the lives of all those who one interacts with. Similarly, the actions of those interactions will influence his/her actions, and it is accepted that interaction can assist with personal growth and personal support.

### **5.14.3 Comment on the reviewed literature**

As noted from the various parts of the literature review, there is a discrepancy in the perception of stigma and discrimination. Firstly, it would be interesting to know why this is so.

Secondly, as seen in the literature review about HIV and AIDS knowledge, there are claims of knowledge having been passed on. However, failing to differentiate the terms knowledge and awareness, which I believe are not synonymous, may have led to these claims. If the two terms are fundamentally different but linked, may this be a cause for why people do not act on the information and knowledge they have on HIV and AIDS, particularly not to engage in workplace HIV and AIDS-related discrimination?

Thirdly, the literature review, especially from Botswana, has shown a disproportionate absence of HIV and AIDS knowledge even among those people who were meant to spread the knowledge of HIV and AIDS. It is upon this background that it is worthwhile to establish the HIV and AIDS knowledge among the teaching fraternity in both South Africa and Uganda. As indicated earlier on in Chapter 1, the concept of HIV and AIDS knowledge in this sample was broadened to include some basic HIV and AIDS legal knowledge as well as basic biomedical HIV and AIDS knowledge.

## **5.15 CHAPTER SUMMARY**

In this chapter, the concept 'discrimination' and its attendant related concept 'stigma' were dealt with, beginning with the definitions. The nature of discrimination and the prevalence of discrimination in South Africa, Uganda and the rest of the world were



dealt with. The chapter ended with the identification of knowledge gaps and an integration of all the concepts which drove the study.

# CHAPTER 6: RESEARCH DESIGN AND METHODOLOGY

## 6.1 INTRODUCTION

This chapter encompasses the empirical study undertaken to address the four specific aims of the research as identified in terms of an empirical approach, namely:

- to quantitatively evaluate HIV and AIDS knowledge, attitudes and traditional beliefs;
- to quantitatively evaluate workplace HIV and AIDS-related discrimination;
- to qualitatively evaluate HIV and AIDS knowledge, attitudes, traditional beliefs and workplace HIV and AIDS-related discrimination among South African teachers; and,
- to evaluate quantitatively the relationships between HIV and AIDS-related knowledge, attitudes, traditional beliefs and workplace HIV and AIDS-related discrimination among member actively working in the teaching fraternity in both South Africa and Uganda.

This chapter focuses on the selection of the measuring instruments. A differentiation is made between quantitative measuring instruments and qualitative measuring instruments. The quantitative measuring instruments are: a biographical questionnaire, an HIV and AIDS-knowledge questionnaire, an HIV and AIDS attitude scale, a traditional beliefs questionnaire and a workplace HIV and AIDS-related discrimination questionnaire. The qualitative measuring instrument is the interview guide.

The quantitative collection of data focuses on obtaining approval for conducting the empirical study of the research, and contact with teachers (subordinates and school

management teams) as well as the administration of the questionnaires. The statistical processing of the data involves the quantitative procedures and techniques. The qualitative collection of data and analysis are described. The chapter is concluded with a chapter summary.

## **6.2 INSTRUMENTATION**

Two methods were used to collect data. These were questionnaires and in-depth interviews. The tools were structured only for the quantitative part of the study while an interview guide was used for the qualitative part of the study. The tools were used in such a way that they did not interfere with the respondents' flow of discourse in their construction of reality. It was hoped that the respondents would perceive the researcher as trustworthy and thus be open to their own experience. Macleod (1995) observes that the authenticity of the respondents' responses depends on the trust between the respondent and the researcher.

### **6.2.1 Cross-sectional quantitative survey**

The cross-sectional quantitative survey was done with 205 respondents:123 educators from South Africa and 82 educators from Uganda.

### **6.2.2 In-depth interviews**

In the in-depth interviews, twenty-seven respondents (n=27) comprising of supervisors, heads of departments and subordinates were interviewed. On average, two participants were obtained from each participating schools, which were varied in location; thus, the diverse population of respondents provided rich information for this study.

Vygotsky (1986) emphasises the role of people's interactions with their socio-cultural environment in the process of constructing knowledge. This qualitative part of the study benefited from this design greatly in collecting reliable information from a smaller sample population. The approximate interview period for each respondent was between sixty minutes and ninety minutes.

An interview guide was used to collect the study data for the qualitative part of the study (see Appendix IV for the interview guide). The interview schedule was used as a guideline, which allowed additional questions to be asked to solicit relevant information. The researcher maintained an empathetic stance throughout and allowed for spontaneous contributions from the respondents. While no recording machine was used, jotting down of main points was not allowed to disrupt the interview process greatly. This was always followed by immediate writing up the details of the interview.

The interviews took place in separate rooms with a sitting arrangement of both the researcher and the respondent signifying no power bias.

### **6.3 SELECTING THE MEASURING INSTRUMENTS**

The process of the selecting of the quantitative and qualitative instruments will be presented next, starting with the instruments for the quantitative survey and then the instruments for the qualitative survey.

#### **6.3.1 The HIV and AIDS-knowledge questionnaire**

For the purpose of this study, the HIV and AIDS-knowledge questionnaire was made up of two combined scales, one from Family Health International (FHI) and another scale drawn from basic HIV and AIDS-related laws (see ALP – Wits) (Richter & Heywood, 2002).

#### **6.3.2 HIV and AIDS biomedical knowledge scale/ FHI-knowledge scale**

The development, rationale, aim, dimensions, administration, interpretation, reliability and validity of the FHI-knowledge scale are now discussed.

##### *6.3.2.1 Development*

The HIV and AIDS knowledge scale used was drawn from the FamilyHealth International(FHI) scaleof HIV and AIDS. This scale has been widely used in measuring HIV and AIDS knowledge. The original scale isan 18-items one, however, for this study

a 16-item scale was adopted and used. The original scale has a Cronbach alpha of 0.74.

#### *6.3.2.2 Rationale*

The rationale for using the FHI scale of HIV and AIDS is that the responses indicate respondents' biomedical facts about HIV and AIDS.

#### *6.3.2.3 Aim*

The aim of the instrument is to obtain the knowledge level of the biomedical facts about HIV and AIDS.

#### *6.3.2.4 Dimensions*

Dimensions included in this instrument are basic HIV and AIDS knowledge about the cause of HIV and AIDS, transmission of HIV and AIDS and prevention of HIV and AIDS.

#### *6.3.2.5 Administration*

The FHI-knowledge scale can be self-administered. All instructions are given on the front page of the questionnaire. No time limit is set. Individuals are asked to indicate appropriate responses on a number of statements which are HIV and AIDS-knowledge based. The response choices ranged from (1) definitely true to (5) definitely false.

#### *6.3.2.6 Interpretation*

A high score is interpreted as high HIV and AIDS knowledge.

#### *6.3.2.7 Reliability*

The biomedical scale has Cronbach alpha of 0.62.

#### *6.3.2.8 Validity*

The biomedical scale has content validity as it includes all the relevant dimensions.

#### *6.3.2.9 Justification*

The instrument is brief, easy to follow and taps the relevant basic HIV and AIDS knowledge.

### **6.3.3 HIV and AIDS-legal knowledge scale (H/ALKS)**

The development, rationale, aim, dimension, administration, interpretation, reliability and validity and reason for inclusion of H/ALKS are discussed.

#### *6.3.3.1 Development*

The HIV and AIDS-legal knowledge scale was drawn from the existing scales with minor modifications made from the literature review. The scale consists of 14 items which tap into legal knowledge pertaining to HIV and AIDS in the workplace.

#### *6.3.3.2 Rationale*

The rationale of the HIV and AIDS legal knowledge skill indicates the responses of the respondents of HIV and AIDS legal knowledge.

#### *6.3.3.3 Aim*

The aim of the HIV and AIDS legal knowledge scale is to obtain the HIV and AIDS legal knowledge level of the respondents.

#### *6.3.3.4 Dimensions*

The HIV and AIDS legal knowledge scale includes the basic human rights laws and HIV and AIDS workplace specific laws.

#### *6.3.3.5 Administration*

The instrument can be self-administered and responded to individually.

#### *6.3.3.6 Interpretation*

The high value of the respondents' responses is interpreted as indicating a high HIV and AIDS legal knowledge.

#### *6.3.3.7 Reliability*

The HIV and AIDS legal scale has a Cronbach alpha value of 0.52. This is rather lower than the recommended 0.6.

#### *6.3.3.8 Validity*

The instrument has sound content validity and covers the essential elements of HIV and AIDS legal knowledge.

#### *6.3.3.9 Justification for inclusion*

This instrument was included in the study to determine HIV and AIDS legal knowledge which is vital in issues pertaining workplace HIV and AIDS discrimination.

### **6.3.4 Attitude Scale (AS) or the HIV and AIDS attitude scale (HAAS)**

The development, rationale, aim, dimensions, administration, interpretation, reliability and validity and reason for inclusion of the Attitude Scale (AS) are dealt with in that order as outlined below.

#### *6.3.4.1 Development*

The attitude scale was drawn from already existing HIV and AIDS attitude scale. It contains 22 items all concerning the workplace.

#### *6.3.4.2 Rationale*

The rationale of the attitude scale (AS) is that the respondents' responses indicate their HIV and AIDS-related attitudes.

#### *6.3.4.3 Aim*

The aim of the attitude scale (AS) is to obtain the prevailing attitudes of the respondents with regard to HIV and AIDS in the workplace.

#### *6.3.4.4 Dimensions*

The dimensions of attitude scale (AS) include behavioural, cognitive and affective factors.

#### *6.3.4.5 Administration*

The attitude scale can be self-administered to individual and answered by choosing the appropriate response on a five-point Likert scale.

#### *6.3.4.6 Interpretation*

The high value obtained from the responses of the respondents on the attitude scale (AS) indicates a positive attitude and vice versa.

#### *6.3.4.7 Reliability*

The attitude scale has a Cronbach alpha of 0.75. This scale is fairly robust.

#### *6.3.4.8 Validity*

The instrument has sound content validity, hence appropriate for the study.

#### *6.3.4.9 Justification for inclusion*

The attitude scale (AS) was included in the study to determine the respondents' attitudes to HIV and AIDS in the workplace. The instrument is brief, simple to follow and covers all dimensions of attitudes.

### **6.3.5 HIV and AIDS Discrimination Scale (HADS)**

The development, rationale, aim, dimensions, administration, interpretation, reliability and validity plus reason for inclusion of HIV and AIDS Discrimination Scale (HADS) are presented below.

#### *6.3.5.1 Development*

The HIV and AIDS discrimination scale was drawn from existing literature and related scales. It is made 32 items.

#### *6.3.5.2 Rationale*

The HIV and AIDS discrimination scale (HADS) indicates the respondents' discriminatory tendencies and actions.

#### *6.3.5.3 Aim*

The aim of HIV and AIDS discrimination scale (HADS) is to obtain the level of discriminatory tendencies and actions of each respondent.



#### *6.3.5.4 Dimensions*

The dimensions covered by HIV and AIDS discrimination scale (HADS) include discriminatory tendencies and actions in the workplace which relate to HIV and AIDS.

#### *6.3.5.5 Administration*

The HIV and AIDS discrimination scale (HADS) was self-administered and responded to individually.

#### *6.3.5.6 Interpretation*

The high score on the HIV and AIDS discrimination scale (HADS) indicates high discriminatory tendencies and actions of the respondents.

#### *6.3.5.7 Reliability*

The HIV and AIDS discrimination scale has a Cronbach alpha of 0.85. This is robust measure.

#### *6.3.5.8 Validity*

The HIV and AIDS discrimination scale has sound content validity. It covers the essential elements of work discrimination pertaining to HIV and AIDS.

#### *6.3.5.9 Justification for inclusion*

The HIV and AIDS discrimination scale (HADS) was included in the study because it could tap effectively the discriminatory tendencies and actions in the workplace. Again, instrument is brief and easy to score.

### **6.3.6 Traditional Belief Scale (TBS)**

#### *6.3.6.1 Development*

The researcher designed an 18-item questionnaire drawn from earlier research work, particularly one done in sub-Saharan Africa.

#### *6.3.6.2 Rationale*

The rationale of the traditional beliefs scale (TBS) is that the respondents' responses indicate the traditional beliefs the respondent has pertaining to HIV and AIDS.

#### *6.3.6.3 Aim*

The aim of the instrument is to measure the level to which a particular respondent believes in traditional beliefs regarding to HIV and AIDS.

#### *6.3.6.4 Dimension*

The traditional belief scale consists off several dimensions, namely:

- Cure of HIV and AIDS traditionally (questions 1, 2&3).
- Cause of HIV and AIDS (questions 4, 5, 6, 12, 18 &13).
- Consulting traditional healers (questions 7, 9, 10, 11&14).
- Ancestors and control of life (questions 8, 15& 16).

#### *6.3.6.5 Administration*

The instrument can be self-administered and responded to individually.

#### *6.3.6.6 Interpretation*

The high value of the score of the respondents' response is interpreted as having a high belief in traditional beliefs while the low score will be interpreted to mean having a low belief in traditional beliefs about HIV and AIDS.

#### *6.3.6.7 Reliability*

The traditional belief scale has a reliability value of 0.87. This shows a very robust measuring tool.

#### *6.3.6.8 Validity*

The validity of the traditional beliefs scale is deemed to be quite reasonable based on the premises that it measures the three dimensions entailed in it adequately. It has sound content validity as its items were drawn from earlier researches in similar conditions to a good level.

#### *6.3.6.9 Justification for inclusion in research*

The traditional beliefs scale was included in the study to tap into the traditional beliefs individuals have about HIV and AIDS and it is briefs and easy to score.

### **6.3.7 The Socio-Demographic Questionnaire (SDQ)**

A socio-demographic questionnaire was compiled to obtain the following information: Age, gender, religious affiliation, annual income, educational level, race classification, place where one grew up, ethnic community, civil status/citizenship, job title and region of origin (in case of the Ugandan sample). The socio-demographic questionnaire will provide a general profile of the members of the teaching in terms of the dimensions mentioned above.

#### *6.3.7.1 Development*

The biographical questionnaire (refer to Appendix A) was developed by the researcher in order to obtain biographical information from the respondents to measure important factors that could possibly influence workplace HIV and AIDS-related discrimination among members of the teaching fraternity.

#### *6.3.7.2 Rationale*

The respondents' responses indicate their biographical characteristics and status.

#### *6.3.7.3 Aim*

The aim of the socio-demographic instrument is to obtain socio-demographic information from each respondent.

#### *6.3.7.4 Dimensions*

The socio-demographic information in this instrument covers the following dimensions: age, gender, marital status, population group, highest qualification, and religion, place of birth, income bracket, ethnic group, region of origin, and job title.

Each socio-demographic item has categories appropriate to its content. Agewas grouped into five categories: 25-30 years, 31-40 years, 41-50 years, 51-60 years and 61+ years. Gender consisted of two categories, only male and female. Marital status was divided into five categories: single, married, separated, divorce and widowed. There are four sub-groupings of population groups for South Africa: black, Coloured, Indian and white; and four sub-groups for Uganda: white, black, mulatto (half-cast) and Indian. One's highest qualification was divided into seven categories: Grade 0–6, Grade 7–12, 3-year University diploma, 4-year University degree, honours degree, masters/doctoral degree and other (for the South African sample); and eight categories for the Ugandan sample: O-level and Teaching Certificate, A-level and Teaching Certificate, 2-year Diploma in Education, 3-year University degree, 3-year degree and Teaching Certificate, masters/doctoral degrees, and other. Religion was categorised into six categories for South Africa: Christians, ZCC, Islam, Hindu, Jewish, and other; and five categories for the Ugandan sample: Protestants, Catholics, Moslems/Islam, Seventh Day Adventists (SDA) and other. Income brackets were categorised into six categories for South Africa: R10000–R15 000, R15 001–R20 000, R20001–R30000, R30 001–R70000, R70 001–R120000 and R 120000+. Income brackets for Uganda sample was categorised in five, namely: 1–2 million Uganda Shillings; 3–4 million Uganda Shillings; 5–6 million Uganda Shillings; 7–12 million Uganda Shillings; and 12 million Uganda Shillings plus.

Local nations or ethnic groups of respondents in South Africa fell in twelve categories: Tswana, Zulu, Sotho (Southern Sotho), Pedi (Northern Sotho), Tsonga, Xhosa, Venda, Swazi, Afrikaner, English, Ndebele, and other. In case of Uganda, region of origin was categorised into six: North East, Central, West, South West, East and other.

#### *6.3.7.5 Administration*

The socio-demographic questionnaire is administered individually. No time limit is applicable to the instrument. The respondent has to select the appropriate item by marking with an (X) in the block with the most appropriate description.

#### *6.3.7.6 Interpretation*

The item selected for each socio-demographic item would be an indication of the respondents' socio-demographic information. The information is recorded for statistical processing purposes.

#### *6.3.7.7 Reliability*

Not applicable for this instrument.

#### *6.3.7.8 Validity*

Not applicable for this instrument.

#### *6.3.7.9 Justification for inclusion in this research*

This instrument was included in the research to assist in drawing certain conclusions about possible effects of socio-demographic characteristics on workplace HIV AND AIDS-related discrimination.

### **6.3.8 Locus of control scale**

#### *6.3.8.1 Development*

The Locus of Control Inventory(LCI) of Schepers (1999) was used to measure locus of control. This instrument has been compiled within the Attribution Theory and Social Learning Theory contexts. The instrument was developed by Schepers in 1999 and was standardised on 2001 individuals in South Africa. This instrument was developed in an attempt to eliminate the weakness of the previous measuring instrument, developed by Schepers in 1995 (Schepers, 2001).

#### *6.3.8.2 Rationale*

The rationale of the locus of control scale is that it measures the locus of control of an individual – it measures an individual's attributory factor of what happens to him or her.

#### *6.3.8.3 Aim*

The aim of the instrument is to measure locus of control. Locus of control has been defined as the belief individuals hold about the degree to which rewards follow from, or

a contingent upon their own behaviour or attributes, versus the degree to which rewards are seen as controlled by factors outside the individual (Scheppers, 1995).

#### *6.3.8.4 Dimensions*

The instrument consists of three different dimensions namely external control, internal control and autonomy. The instrument consists of 88 items, of which 34 items were used to measure autonomy, 26 items were used to measure external locus of control and 28 items were used to measure internal locus of control. While the original scale had a seven-point scale (Scheppers, 2000), in this study only 2 alternative statements were used, moreover with only 3 items.

#### *6.3.8.5 Administration*

The instrument is completed individually or by people in groups. No time limit is set but the respondents were requested to reflect their initial thoughts and feelings. The point that no right or wrong responses existed but that feelings regarding a particular matter had to be indicated was emphasised. The instrument is scored accordingly. In this study, the instrument was completed individually.

#### *6.3.8.6 Interpretation*

High scores on the three items indicated an internal locus of control while a lower score on three items indicated an external locus of control. The high scores can therefore be interpreted as the perception of the individual that certain life outcomes are conditional on his/her own relatively permanent or stable characteristics (Van Wyk, Boshoff & Gilliers, 2003). On the other hand, low scores on the three items can be interpreted as the perception that outcome variables are the result of external conditions outside the control of the individual (Van Wyk *et al*; 2003). The scores on the three dimensions of locus of control were not used for purposes of this research, only the total score on the instrument, which indicated a particular individual's overall locus of control was used.

### 6.3.8.7 Reliability

The autonomy subscale has a Cronbach alpha of 0.884; the external control subscale has a Cronbach alpha of 0.871 and the internal control subscale has a Cronbach alpha of 0.822 (Schepers, 2001)

### 6.3.8.8 Validity

Schepers (2001) confirmed the constant validity. The following inter-correlations between the three subscales were found, as depicted in Table 6.3

**Table 6.1: Inter-correlations of the three subscales.**

Scales	Autonomy	External control	Internal control
Autonomy	1,000	-0,230	0,563
External control	-0,230	1,000	-0,160
Internal control	-0,563	-0,160	1,000

Source: Bredell, 2006.

### 6.3.8.9 Justification of inclusion of the instrument in the study

Various instruments have been developed by researchers to measure the construct locus control. In this discussion, only the most prominent measuring instrument is reviewed. One very prominent instrument to measure the construct of locus of control is the Rotter J.E scale (Lefcourt, 1981; Rotter, 1966). The Rotter J.E scale comprises 29 items, of which 23 items have been designed to assess respondents' locus of control beliefs while the other items are 'filler items'. Respondents are required to complete the instrument by choosing from a series of two alternatives those statements that best

reflect their beliefs. The respondents receive a point each time that they select a statement that reflects external locus of control beliefs. The scale is scored by totalling the number of externally worded items. The higher the score, the more the external locus of control the beliefs (Lefcourt, 1981; Rotter, 1966). This scale/instrument is an ipsative measure, which means that it is systematically affected by other measures and is referred to for interpretation to the same mean and standard deviation (Kerlinger, 1986). Schepers (1995) considers this scale as being of limited value as it cannot be used to determine inter-individual differences.

### **6.3.9 Self-Esteem Scale (SES)**

The development, rationale, aim, dimensions, administration, interpretation, reliability, validity and justification of the self-esteem scale are dealt with as in the below.

#### *6.3.9.1 Development*

The self-esteem scale used was developed by Rosenberg (1985) to determine self-perception of individuals using a sample of adolescents. It is a seven-item set of 5-point Likert scale statements. Respondents were asked whether they agreed or disagreed (1= strongly agree, 5= strongly disagree) with the statements such as the following: 'I feel I have a number of good qualities'; 'All in all, I am inclined to feel that I am a failure'; 'I take a positive attitude toward myself'; and 'On the whole, I am satisfied with myself'.

Negative items, such as 'I feel I do not have much to be proud of', were recorded to assign the highest point value (5) to strongly disagree, thus producing an additive scale in which higher scores reflect higher self-esteem; and the highest possible score is 35 (very high self-esteem).

#### *6.3.9.2 Rationale*

The rationale of the self-esteem scale is that it measures the self-perception of an individual.



#### *6.3.9.3 Aim*

The aim of the instrument is to measure the extent to which one perceives oneself as an individual.

#### *6.3.9.4 Dimension*

The self-esteem scale consists of two dimensions of self-perception, namely a positive self-perception and a negative self-perception.

#### *6.3.9.5 Administration*

The instrument is self-administered and can be answered by a pen or pencil.

#### *6.3.9.6 Interpretation*

On the self-esteem scale, a higher score is interpreted as having a positive self-perception while a lower score is interpreted as having a negative self-perception.

#### *6.3.9.7 Reliability*

The original self-esteem scale has a Cronbach's alpha coefficient of reliability 0.87

#### *6.3.9.8 Validity*

The self-esteem scale has a sound content validity and face validity as it can tap into all the positive and negative self-perception of an individual.

#### *6.3.9.9 Justification for inclusion in research*

The self-esteem scale is justified to be used in this research because it is robust, quite easy to respond to, can be answered by pen or pencil, and it is short and can be used along with other scales without biasing influencing the outcome.

### **6.3.10 Self-Efficacy Scale (GPSES)**

#### *6.3.10.1 Development*

The Generalised Perceived Self-Efficacy Scale (GPSES) was developed by Schwarzer in 1993. The instrument measures generalised self-efficacy (Schwarzer, 1993).

#### *6.3.10.2 Rationale*

High scores on the measuring instrument indicate a high occurrence of self-efficacy, whilst low scores indicate an absence of or lack of efficacy for a particular behaviour.

#### *6.3.10.3 Aim*

The aim of the instrument is to measure self-efficacy in general, defined as the thoughts and feelings of competence and mastery that the respondent has or does not have (Bandura, 1986).

#### *6.3.10.4 Dimension*

The GPSES measures one dimension, namely generalised self-efficacy. The original instrument consists of 10 items. A four-point scale is used to measure each of the items (Schwarzer, 1998). For the purpose of this study, only 2 items were used on a five-point scale; and in keeping with the general structure of the whole research instrument which was on a 5-point scale.

#### *6.3.10.5 Administration*

The instrument can be completed by people in groups. Although no time limit is set, the instruction pertaining to the completion of the instrument states 'Work quickly, and give your first impression'. The instrument is scored after completion thereof, and adding each of the items together to provide the total score achieved on the instrument.

#### *6.3.10.6 Interpretation*

A high score on the measuring instrument will be interpreted as a high occurrence of general self-efficacy whereas a low score will be interpreted as a low occurrence. Therefore, it can be concluded that the higher the score, the higher the prevalence of general self-efficacy.

#### *6.3.10.7 Reliability*

Schwarzer (1993) found alpha coefficient varying from 0.75 to 0.90 for the GPSES.

#### *6.3.10.8 Validity*

The scale has been proven to be valid in terms of convergent and discriminated validity. It was also found that the scale correlates positively with self-esteem and optimism and negatively either anxiety, depression or physical symptoms (Schwarzer, 1993).

#### *6.3.10.9 Justification for inclusion in the research*

Various measurements have been developed with the aim of measuring self-efficacy, validity and reliability. The most predominant measurement instruments include the following:

- Sherer devised a self-efficacy scale to assess individuals' beliefs and feelings about efficacy (Gardner & Pierce, 1998; Sherer, Maddux, Mercandante, Prentice-Dunn, Jacobs & Rogers, 1982; Wolfe, Nordstrom & Williams, 1998, Woodruff & Cashman, 1993).
- Shelton (1987, cited in Shelton, 1990) developed a 100-item general self-efficacy inventory, which differs from other self-efficacy measuring instruments in that specific situations that cover a broad spectrum of life's experiences were utilised, instead of general statements about oneself.
- Lee and Bobko (1994) utilised Wood and Locke's academic self-efficacy measure because the sample consisted predominantly of third-year undergraduate students and this scale was developed to measure self-efficacy in an academic setting.

The general perceived self-efficacy scale has shown better results in previous studies than any of the above-mentioned instruments. Rothmann (2002) strongly recommends the GPSES which has also been used in research studies done lately in South Africa (Rothmann & Malan, 2003; Rothman & Van Rensberg, 2002; Wissing & Van Eeded, 2002). This instrument possesses both high reliability and validity, coupled with the existing similarity between the conceptualisation in the literature review (in Ch.3) and the operationalisation made a good case for use of the GPSES for the purposes of self-efficacy in this study.

### **6.3.11 Measuring instruments for the qualitative part of the study**

The qualitative research was done by means of an in-depth interview, which took the format of a semi-structured face-to-face interview using an interview guide. In-depth interviewing is one of the most common methods used in qualitative research (for example, Faircloth et al 2004; Van den Hoonaard 2004; Wilson 2007).

#### *6.3.11.1 Development*

According to De Vos (2002), researchers make use of semi-structured face-to-face interviews to gain a detailed picture of a participant's beliefs about or perceptions of a particular topic. This method allows more flexibility for the participant and the interviewer/researcher.

According to De Vos (2002) and Kvale (1996), in this method the researcher has a set of predetermined open-ended neutral questions on an interview schedule, but the interview is merely guided by the schedule and not dictated by it. Guion (sa) adds that this method is seeking understanding and interpretation, recording and responses, observations and reflections.

#### *6.3.11.2 Rationale*

This interview method enables the researcher to follow up particularly interesting avenues that emerge during the interview and the participant is able to provide more in-depth explanations (De Vos, 2002).

#### *6.3.11.3 Aim*

The aim of this measuring instrument is to measure the respondents' detailed, in-depth personal experiences, thoughts and feelings pertaining to the areas highlighted by the researcher or to introduce new issues to the discussion. In this relationship, the respondent should be perceived as the expert on the topic/subject; and maximum time should be allowed to the respondent to tell his/her story (De Vos, 2002; Strauss & Corbin, 1990).

#### *6.3.11.4 Dimensions*

While the format and discussions pertaining to each interview were unique, four questions are covered in all the interviews; namely:

- According to you, how has HIV and AIDS impacted on your organisation?
- According to you, how do traditional beliefs in your culture influence workplace HIV and AIDS-related discrimination?
- In general, how does your religion influence HIV and AIDS-related issues?
- What are your views on secrets, particularly on confidentiality related to HIV and AIDS?

In this study, there was no invasion of privacy. The interview about secrets focused on how able individuals could keep secrets, what made them not to keep secrets sometimes; and the types of secrets they would not reveal under normal circumstances. In essence, exploring maintenance of confidentiality in the workplace was the issue.

Hereafter, the researcher only asks questions that seek to qualify matters such as 'Tell me more about ...' and 'What do you mean when you say ...' to facilitate a free exploration of the experience by the respondent (De Vos, 2002).

#### *6.3.11.5 Administration*

Apart from the permission sought to conduct research among the different organisations, specific permission was first obtained from every participant.

The interviews were conducted in meeting rooms that are removed from the immediate workplace, but on the premise, where it was quiet, well-ventilated and of favourable

condition of light and warmth, and no interruptions were allowed. The seating arrangement was of such a nature as to encourage free interaction and involvement.

Field notes were also made during each interview, but with minimum interruptions so as not to frustrate the interviewee/respondent. They keep track of respondents' thoughts, feelings, observations, statements, experiences, preconceptions and expectations in order to develop them in the final product.

Since the field notes were written in brief during the actual interview, they were later followed up with an elaborate write up soon after the interview so as not to miss out on any details. This was more important in a study like this where no tape – or video recording was used.

During this in-depth interview, the same questions, with flexibility, were asked to all respondents. After completion, a summary of the discussion was provided to the respondents for approval.

The interviews on the respective respondents were conducted only once for each respondent; and at least two respondents were interviewed in any one particular organisation on the same day for pragmatic reasons.

#### *6.3.11.6 Interpretation*

The coding and tabulation of answers to the interview are carried out. Thereafter, a pattern is sought which leads to the identification, exploration and development of qualitative themes which are common across the interviews (Camic, Rhodes & Yardley, 2003).

#### 6.3.11.7 Reliability

Lincoln and Guba (1985) refer to *dependability* as the alternative to reliability for a qualitative instrument. These needs to answer the question: 'How can we be reasonably sure that the findings would be replicated if the study were conducted with the same participants in the same context?' (Marshall & Rossman, 1995, cited in De Vos, 2002:351).

The in-depth interview questions were recorded. The instrument was therefore dependable, as repeating the questions as per the interview guide can replicate the findings. According to Kvale (1996), this method is widely used and accepted as a dependable instrument for qualitative purposes.

#### 6.3.11.8 Validity

*Credibility* (the alternative to internal validity) and *transferability* (the alternative to external validity) are applicable to the qualitative study (Lincoln & Guba, 1985). Henceforth, this study needs to answer two essential questions in this regard, namely, 'How credible are the particular findings of the study?' and 'How transferable and applicable are these findings to another setting or group of people?' (Marshall & Rossman, 1995, cited in De Vos, 2002:351).

With regard to credibility, the goal is to demonstrate that the inquiry was conducted in such a way as to ensure that the subject was accurately identified and described (De Vos, 2002; Kvale, 1996; cited in Bredell, 2004:196). Since this study was accompanied by an in-depth interview description showing the complexities of variables and interactions embedded into the data derived from the setting, De Vos (2002:352) states that 'it cannot help but be valid'.

With regards to transferability, the theoretical framework to show how concepts and models in this study have guided both data collection and analysis – was clearly

identified and stated. The triangulation of multiple sources of data is that more than one data gathering method was utilised, enhanced transferability. This strengthened the study's usefulness for other settings (Higgs & Smith, 2003). As Damar (2008), I used triangulation as part of my efforts to ensure trustworthiness and veracity of my findings.

#### *6.3.11.9 Justification for inclusion in the research*

The interview guide was selected on the grounds that the instrument allows for flexibility and interesting avenues to be followed up. While it was used to get data on a rather sensitive topic, it was simultaneously structured around certain central themes, which made comparability of the interviews possible. The instrument is both dependable and transferable and therefore suitable to be used for the purpose of this study.

## **6.4 THE PROTOCOL FOR THE IDENTIFICATION OF DISCRIMINATION**

This study used the Protocol for the Identification of Discrimination against people living with HIV (PLWHA, UNAIDS, 2000), selected in part because it is a UNAIDS endorsed 'best practice'. As much as possible, the translation of policy and legislation aimed to convey the sense and intent of the original and may not represent a strict legal translation guideline for documenting institutional forms of HIV-related discrimination in a cross-cultural setting. The Protocol was also written as an advocacy tool for reducing discrimination against PLWHA. It utilises a legal definition of discrimination, distinguishing *legitimate* (justifiable) from *arbitrary* forms (UNAIDS, 2000), and examines the occurrence of discrimination in ten key areas of social life, including healthcare, employment and social welfare (see Reidpath *et al*; 2005).

'Legislation' is broadly interpreted as any laws, national and ministerial documents and city ordinances.

'Institutional policy' is interpreted as any written documents produced by the organisations involved in the study that carried regulatory authority over the conduct of the employees.



#### **6.4.1 Discrimination and the human rights framework**

Assuming that overcoming HIV stigma, and perhaps more so discrimination, are fundamental to addressing the HIV epidemic, there needs to be an analytical framework within which the effects of stigma and discrimination can be understood and acted upon, on the level of the interpersonal and the structural (Parker & Aggleton, 2003). UNAIDS has argued that a human rights framework is an appropriate analytical framework within which to draw the structural and interpersonal aspects of HIV discrimination together (UNAIDS, 2000).

Within the framework, four interrelated levels of administration are targeted (Chan & Reidpath, 2004; Mann, 1999). At the highest level is the international commitment that binds all national governments to a list of common objectives, and holds each responsible for a set of actions (United Nations General Assembly, 2001). These actions include '[ensuring] the development and implementation of multi-sectoral national strategies and financing plans for combating HIV and AIDS, amongst other things, confront stigma, silence and denial' and eliminate discrimination and marginalisation (United Nations General Assembly, 2001 paragraph 37).

At the national level, the focus is on the comprehensive review and reform of government law and infrastructure, ensuring that all legislative and organisational mechanisms are human rights sensitive, including changes to public health law and criminal law, as well as the enactment of anti-discrimination law and changes to the correctional services and public health systems (United Nations General Assembly, 2001). The objective is the development of a national framework that not only prevents discrimination against PLWHA (and, where discrimination occurs, provides appropriate redress), but also uses legislation to regulate and provide an enabling environment for the provision of good HIV-related services.

The next level down, the institutional level, is focused upon the integration of human rights objectives (as specified in the documents written at the higher levels) within the government and the private sectors. The task of the state here is to ensure that: (1) the human rights responsibilities and obligations are known to each relevant sector through education and training programmes; (2) that appropriate institutional policies are drafted; and (3) that regulatory mechanisms are in place to monitor their implementation (United Nations General Assembly, 2001).

The final level targeted by the human rights framework involves the provision of an 'enabling environment' by the state at a community level. The task is to empower those who are affected by or vulnerable to being infected with HIV, to ensure they have correct information on HIV transmission and their rights. This will help them to self-advocate (plead and campaign for themselves), to be involved in the law-making process and to work effectively with the criminal justice system (United Nations General Assembly, 2001).

In the context of this research, 'discrimination' refers to the legal notion of arbitrary discrimination, which is '[a]ny measure entailing an arbitrary distinction among persons depending on their confirmed or suspected HIV sero-status or state of health' (UNAIDS 2000:7–8), and it is with this that the UNAIDS Protocol is centrally concerned. The following guides the determination about whether an action is arbitrarily discriminatory:

- The principle of non-discrimination requires that all persons in similar situations should be treated in an equal manner;
- Arbitrary discrimination may be the result of either an action or an omission. It may also be intentional or unintentional. It may also be direct or indirect; and
- Rights to non-discrimination can be justifiably restricted in certain narrowly defined circumstances in the interests of a limited number of overriding goals.

But simply justifying a discriminatory measure as necessary for public health is not sufficient. Two important criteria must be met.

The measure must be in the interest of a legitimate objective. Public health, the rights of others, morality, public order, and national security are all examples of legitimate objectives; and, in assessing a particular measure, its objective or purpose should be taken into account. Even when a measure is for a legitimate objective, the means employed to achieve it must be proportionate to the aim pursued. They should constitute the least restrictive means available. In this study, 'arbitrary discrimination' is generally referred to simply as discrimination.

#### **6.4.2 The employment part of the UNAIDS Protocol of HIV and AIDS-related discrimination**

In this study, the *employment* part of the UNAIDS Protocol of HIV and AIDS-related discrimination is discussed as it is the one most relevant to industrial/organisational psychology.

These are the situations in which discrimination related to HIV and AIDS status may occur in the *workplace/employment* with the UNAIDS Protocol:

- Mandatory testing at recruitment
- Mandatory testing during employment
- Questions on recruitment forms and/or during interview related to mandatory HIV and AIDS status and/or 'lifestyle'
- Lack of confidentiality regarding HIV and AIDS status
- Dismissal or change(s) in conditions of employment on the grounds of HIV status
- Restrictions (in terms of promotion, job location, training and/or employment benefits) due to HIV and AIDS status

- Denial of employment on the grounds of HIV status

Adapted from the UNAIDS Protocol (UNAIDS, 2000:23–285).

## **6.5 CONCERNS ABOUT THE PROTOCOL ON HIV AND AIDS-DISCRIMINATION**

Though the Protocol has not been widely tested, it was selected for this study because it encompasses a rights-based framework and has both a qualitative and quantitative research design.

### **6.5.1 Outline of the protocol**

The central concern of the UNAIDS Protocol is the identification of instances of ‘arbitrary’ discrimination against people living with HIV AND AIDS (PLWHA). In this context, arbitrary discrimination is ‘[a]ny measure entailing an arbitrary distinction among persons depending on their confirmed or suspected HIV sero-status or state of health’ (UNAIDS, 2000b:7). The arbitrary nature of the distinction is defined by reference to its obverse concepts, ‘legitimate discrimination’ - discrimination that is justified by legitimate objectives such as protecting the public - where the means employed are proportionate to the aim (UNAIDS, 2000b:8). Any form of discrimination that is not legitimate in nature is, axiomatically, arbitrary (see UNAIDS, 2000b:7–8; and Reidpath *et al*; 2005). To make it less cumbersome, hereafter, a reference to ‘discrimination’ should generally be read as a reference to ‘arbitrary discrimination’.

By design, the principal output of the Protocol is a quantitative indicator of discrimination. The manner in which the indicator is constructed effectively prescribes the procedural aspects of sampling, data collection and aggregation. The indicator is constructed on the basis of data from 37 items; each item is associated with a situation in everyday life in which discrimination is identified and represents the overall discrimination score for a study site. A high score indicates a more discriminatory environment. A process of deliberation is employed in the scoring of each situation, whereby instances of potential discrimination are debated amongst the team of investigators who conducted the research until consensus is reached.

The 37 situations are (unequally) divided between ten key areas of everyday life, such as health care, employment and education (UNAIDS 2000b). The area of health care, for instance, encompasses seven of the 37 situations. An example of one of these situations is HIV testing an employee without his/her knowledge or consent. In contrast, the area of social welfare contains only one of the 37 situations, which covers the denial of, or restrictions on, access to (social welfare) benefits.

The Protocol requires an independent analysis of the 37 situations to identify potential cases of discrimination across the domains of law, written policy and practice. The sources of data within the domains of law and policy are documentary. Within the domain of practice the data come from interviews with experts (key informants) within the key areas of life and from PLWHAs (direct witnesses).

#### **6.5.2 General validity of the indicator**

By definition, the validity of an indicator is the extent to which it actually points to or measures the concept under investigation (Clifford & Rexford, 1998; Spicker, 2004). To some degree, UNAIDS has sought to limit any scientific critique of the indicator with disclaimers that ‘the indicator, and the Protocol more specifically, are not scientific devices’ and that ‘the measurement of arbitrary discriminatory measures can only be approximate’ (UNAIDS, 2000b:13).

Notwithstanding the caveats, if the Protocol is to fulfil its purposes as a ‘best practice’ tool for the identification of HIV discrimination and for informing National AIDS Programmes, then it must fulfil the very basic requirement of validity.

‘Indicators’ are, generally, quantitative proxies or metaphors for complex social phenomena (Clifford & Rixford, 1998; Spicker, 2004). They are designed to allow the target of the indicator to be discussed, monitored and acted upon (Alston, 2000; Ferris,

2001; UNAIDS, 2000b) and their value lies in their relative simplicity compared with more thorough and direct measures of those complex phenomena (Clifford & Rixford, 1998; Spicker, 2004). Thus, an indicator of HIV discrimination might point to, but not necessarily directly measure, the discrimination itself.

The validity of an indicator may be judged, to a large degree, in the correlation between the increases and decreases in the indicator and the concomitant rise and fall in the object 'pointed to' by the indicator. The infant mortality rate (IMR), for instance, is generally regarded as a good indicator for a whole population's health. It directly measures only one component of the population's health, specifically the mortality of children under one year of age (Blaxter, 1981). It does not try to compare the morbidity of infants, nor does it capture the mortality and morbidity of older humans. Nonetheless, the rises and falls in the IMR have tended to reflect the health outcomes of whole populations (Reidpath & Allotey, 2003).

One of the dangers with indicators is that they can fall out of step with the object of interest. This is of particular concern if the nature of the indicator (as a proxy measure) is forgotten and it begins to drive the policy agenda (Dijkstra, 2002; Spicker, 2004). One criticism of IMR as an indicator of population health, for instance, has been that it focuses health policy on reducing infant mortality while failing to address broader issues related to the health of the whole population (Murray, 1996). In these circumstances, IMR may have dropped, indicating that population's health was improving while in reality no such improvement would be observed in a direct measure of the whole population's health (Murray, 1996).

A good indicator of HIV discrimination need not measure HIV discrimination itself, although it could capture components of HIV discrimination. It should, however, at least stand as a proxy (highly correlated with HIV discrimination). However, as an indicator,

its policy influence is necessarily limited and should be used to inform policy directions, but not direct them.

In this regard, the Protocol is somewhat confused. On the one hand, it describes a process for deriving an indicator of HIV discrimination by simply approximating the true level and form of the discrimination. On the other hand, by construction, it bears a greater likeness to a direct measure of discrimination, with each of the 37 items designed to capture verified occurrences of discrimination (UNAIDS, 2000b:10–14). As an advocacy tool, however, UNAIDS clearly intended the Protocol's policy impact to be greater than simply that of an indicator, that is, as a more direct measure that could actually influence policy direction. Unfortunately, as a direct measure, it is compromised by the intentional disregard for the relative frequency of discriminatory acts in the 37 situations or the intensity of the suffering caused by different forms of discrimination (UNAIDS, 2000b:11).

The absence of a standardised scoring system leaves significant room for inconsistent interpretations between research teams, not only in terms of whether a given law, policy or act constitutes discrimination but also how many instances of discrimination have to exist in one of the domains of law, policy or practice for it to be counted towards the combined discrimination score for any one situation. These inconsistencies in turn affect the comparability of the indicator score between studies.

### **6.5.3 Conclusion**

As it currently stands, the Protocol is inadequate for the direct or indirect measurement of HIV discrimination. Manifold problems exist. These include the confusion over the nature of the instrument, that is, whether it is an indicator or direct measure of discrimination and whether it is supposed to identify the magnitude or severity of discrimination. One may speculate that many of the problems have occurred because the Protocol is intended as both a tool of research and a tool of advocacy.

Despite its failure and without in any sense attempting to mitigate its problems as both a measure and an indicator of discrimination, the Protocol remains the only known attempt to develop a systematic means for examining institutional HIV discrimination. A well-developed instrument of this nature is important because of the effect discrimination has on PLWHA and the potential effect that discrimination has on the trajectory of the epidemic.

The critique of the Protocol offered here is intended to point to development that could improve its utility as a measure of HIV discrimination. Many of the improvements are very typical in the development process for any measure of complex social phenomena. It should still have enormous potential to generate a useful snapshot of the occurrences of institutional discrimination

## **6.6 DATA COLLECTION**

The data was collected using a combination of a quantitative survey and a qualitative survey by means of in-depth interviews. The details for the procedure for the quantitative survey are presented first, and the in-depth interviews followed.

### **6.6.1 Quantitative data collection**

The following procedure was used in gathering data:

A letter requesting voluntary participation, containing the rationale for the research as well as confidentiality in undertaking was taken to teachers (N=310), in randomly selected public and private schools in Bojanala West, Bojanala East and Central Regions of the Department of Education (North West Province) in South Africa; and (N=120) in Central Region in Uganda under the Ministry of Education (MoE).



The instruments were provided to respondents in a booklet form. Respondents in South Africa participated in the study from July 2006 to October 2006, and each one was requested to complete the questionnaire while following the instruction provided in each section of the questionnaire within a 3-week time frame. In Uganda the study was done from January 2007 to April, 2007. The contact person in each school received reminder phone calls after 2-, 4- and 6-week intervals in the case of each sample.

## **6.6.2 Qualitative data collection**

The data for the qualitative analysis was obtained by means of the procedure that is details in the following paragraphs.

In each school that participated in South Africa, one subordinate and one teacher in management was randomly selected by a yes/no draw to determine who participates in the in-depth interview. In all cases, the interview lasted between 60 minutes and 90 minutes in a separate, relatively comfortable room.

### *6.6.2.1 Preparation for the interview*

According to Leedy (1993), certain steps need to be followed to ensure the success of a semi-structured, qualitative interview. All these preparations were done prior to conducting the semi-structured, qualitative interview for the purposes of this study.

The interview was scheduled well in advance. Permission was obtained from the respondent to record the interview. The arrangements were confirmed telephonically. A reminder call was made a day prior to the interview date. On the day and time of the interview, the interviewer (researcher) arrived promptly and was prepared with a copy of the questions in the interview guide.

Following the interview, the interview notes were submitted to the respondents and acknowledgement of their accuracy as well as permission to use the notes in the report was obtained. The interview was administered as discussed in 6.4.2.

#### 6.6.2.2 Recording of data

The interviews were conducted in quiet rooms which were removed from the immediate place of work. Notes were taken at each interview and the details were filled in soon after the interview in order not to forget any important details.

#### 6.6.2.3 On site data analysis

The first aspect of data analysis took place at the research site during data collection. This resulted in revisions of data collection procedures and strategies. These revisions, in turn, yielded new data that was then subjected to new analysis. The result of this procedure has been the effective collection of rich data that generates alternative hypotheses and provides the basis for shared constructions of reality (Erlandson, Harris, Skipper & Allen, 1993, cited in De Vos, 2002). As described by Strauss and Corbin (1998:42), *“analysis begins with the first interview and observation, which leads to the next interview or observation, followed by more analysis, more interviews or fieldwork, and so on. It is the analysis that drives the data collection.”* According to these authors, alternating data collection with analysis enables validation of concepts and hypotheses as these are being developed.

## 6.7 HYPOTHESES

Several hypotheses were tested in the study:

- Hypothesis 1: Individuals who score highly on the traditional beliefs scale are more likely to engage in workplace HIV and AIDS-related discrimination than those individuals who score highly on the HIV and AIDS knowledge scale.
- Hypothesis 2: Individuals who score highly on the traditional beliefs scale are more likely to engage in workplace HIV and AIDS-related discrimination than

those individuals who score highly on the attitude scale towards those infected or affected by HIV and AIDS.

- Hypothesis 3: Individuals who score highly on HIV and AIDS knowledge scale are less likely to engage in workplace HIV and AIDS-related discrimination than those individuals who score highly on the attitude scale towards those infected or affected by HIV and AIDS.

## **6.8 DATA PROCESSING AND ANALYSIS**

### **6.8.1 Quantitative data processing**

The Statistical Package for the Social Sciences 11.0.1 (SPSS inc., 2003) programme was used for the statistical analysis. The specific techniques used in this research are discussed below for the quantitative data and the specific details for the qualitative data analysis procedures are described. The section is concluded with a summary.

#### *6.8.1.1 Descriptive statistics*

Descriptive statistics portray the characteristics of the sample in terms of the major chosen constructs as well as socio-demographic characteristics. The descriptive statistics used were frequencies, means and standard deviations (Salkind, 2001).

#### *6.8.1.2 Reliability of instruments*

The reliability of an instrument can be defined in terms of when a test measures the same thing more than once and results in the same outcome (Salkind, 2001). This study calculated the Cronbach's alpha (Lemke & Wireman, 1976) as a measure of the internal consistency of each of these scales. Cronbach's alpha indicates how well a set of items (or variables) measures a single uni-dimensional latent construct. When data exhibits a multidimensional structure, Cronbach's alpha will usually be low.

The alpha coefficient ranges in value from 0 to 1 and may be used to describe the reliability of factors extracted from dichotomous and/or multi-point formatted questionnaires or scales (Lemke & Wiersma, 1976). The higher the Cronbach's alpha,

the more reliable the test is. There is no generally agreed cut-off figure. Usually 0.7 and above is accepted (Nunnally & Bernstein, 1997). It is a common misconception that if the alpha is low, the test concerned must be unreliable. In actual fact the test may measure several attributes/dimensions rather than one and thus the Cronbach alpha is deflated.

The means of the inter-item correlation coefficients are also reported and are symbolised by  $r$ .

The procedure of item analysis involves the following:

Extracting a *single factor* on the items of a particular sub-scale, is as suggested by the theory. The factor loading is then inspected to ascertain whether the items should be reverse scored, as indicated by the theory, and to identify items with a very low factor loading (less than 0.1) which should be omitted from the final sub-scale. Factor analysis is only used to aid item analysis and not to indicate factorial validity.

Computing Cronbach's alpha for the sub-scale as well as the alpha, each item should be excluded from the scale (Lemke & Wiersma 1976). If it is found that the exclusion of any particular item in the sub-scale were to improve the alpha significantly, it is decided to omit this item from the calculation of the final sub-scale scores.

Once all the items in a sub-scale have been examined, those that are considered adequately reliable are used to calculate the final sub-scale score. The sub-scale scores are calculated by obtaining the mean over these items.

#### 6.8.1.3 Correlations

Pearson Product-moment Correlation Coefficients were used to indicate relationships between the constructs (Lemke & Wiersma 1976):

A negative value reflects an inverse relationship; and the strength of the linear relationship is determined by the absolute value of  $r$ . A strong correlation does not imply a cause-effect relationship (Steyn 2002).

Effect sizes can be used to establish whether relationships between two variables are practically significant or important (Steyn 2002). However, because a probability sample was used in this study, inferential statistics (rather than effect sizes) were used to decide on the significance of the findings.

#### 6.8.1.4 Regression analysis

A stepwise multiple regression analysis was conducted to determine the percentage of variance in the dependent variable (Workplace HIV and AIDS-related discrimination) that was predicted by the independent variable (knowledge, attitudes and traditional beliefs) (Lemke & Wiersma 1976).

It was decided to conduct a separate regression analysis for each of the three Workplace HIV and AIDS-related discrimination subscales owing to the diverse nature of these subscales. A stepwise regression procedure was used on all the data, with the three subscales of the *knowledge*, *attitudes* and *traditional beliefs* as independent variables and the Workplace HIV and AIDS-related scale (WHARS) as dependent variables.

The effect size (which indicates practical significance) in the case of multiple regressions is given by the following table (Steyn, 1999):

**Table: 6.2 Range of effect size**

Effectsize	Range
Small effect	small than 0.15
Medium effect	0.15 – 0.35
Large effect	larger than 0.35

Source: Steyn, 1999.

A cut off point of 0.35 (Steyn 1999) was set for the practical significance of the explained variance.

#### 6.8.1.5 *t*-Tests.

The appropriate inferential test when comparing two means obtained from different groups of subjects is a *t*-test for independent groups. The *t* value for independent groups is defined as the difference between the samples means divided by the standard error of the mean difference.

According to Shaughnessy, Zechmeister and Zechmeister (2003) the *p*-level reported with a *t*-test represents the probability of error involved in accepting our research hypothesis concerning the existence of a difference. The null hypothesis is that of no difference between the two categories of observations (corresponding to the groups). Shaughnessy et al; (2003) suggest that if the difference is in the predicted direction, one can consider only one half (one 'tail') of the probability distributions; and thus divide the standard *p*-level reported with a *t*-test (a 'two-tailed' probability) by two. Others, however, suggest that one should always report the standard, two tailed *t*-test probability.

In this study, it was considered unnecessary to divide the two-tailed *p* values even though the differences are in the expected direction because they are all highly significant (below 0.001).

## **6.8.2 Qualitative data processing**

The social phenomenological approach was used. This approach requires that the researcher will not be intimidated by social power or status, but will be concerned with the relevant values and ethics. The researcher asks the question, 'What is actually happening?', whilst exploring, re-looking and reflecting in ruthless honesty (Higgs & Smith, 2003). The authors continue to say that the researcher aims to 'penetrate the illusion in order to get to the reality underlying the illusion' (Higgs & Smith, 2003).

### *6.8.2.1 Managing data*

This is the first step in the data processing cycle; and it took place off site after the interviews had been conducted. The methodology for data management as recommended by De Vos (2002) was followed. The analysis started with data being organised into file folders. Thereafter, the data was converted into appropriate text units. This was transcribed whilst trying to preserve the meaning as captured in the interview notes and reading the respondent's mind during the interview. The transcription was done with the literature review, previous data and earlier analytic memos in mind.

### *6.8.2.2 Reading the transcripts*

The second step in the data processing cycle is to read the transcripts carefully to gain a sense of the whole database. Marshall and Rossman (1995, cited in De Vos 2002:343) state: 'Reading, reading and reading once more through the data forces the researcher to become familiar with these data in intimate ways. People, events and quotes sift constantly through the researcher's mind'.

For the purposes of the study, the transcripts were read through very carefully and comprehensively to familiarise one with the details of the data. Memos were written in the margins of the field notes and transcripts were used to help with the initial exploration of the data.

### 6.8.2.3 *Describing, classifying and interpreting data*

During this step in the data processing cycle category formation is the key. As Marshall and Rossman (1995, cited in De Vos 2002) note, this step is the most difficult, complex, ambiguous, creative and enjoyable phase of the processing. As these categories emerge, the researcher searches for those which have internal convergence and external divergence, that is, categories which are internally consistent but distinct from one another. These categories do not have to be mutually exclusive, but should also be salient, grounded categories held by participants in the setting.

According to Camic *et al.* (2003) and Higgs and Smith (2003), these themes are accordingly classified into categories, themes or dimensions of information. Classification normally involves the identification of five or six themes, with sub-themes where applicable, through a process of winnowing the data, thereby reducing them to a small, manageable set of themes to write into the final narrative (Camic *et al.* (2003); Higgs & Smith 2003).

The interpretation of data involves 'making sense of the data' through the formulation of larger opinions about what is happening in situations or at sites (De Vos 2002:344). These opinions can be based on personal views, insights, hunches and intuition or on an interpretation with a social science construct. As Marshall and Rossman (1995, cited in De Vos 2002) state, the researcher must search for identity and describe other plausible explanations for the data, the linkages among them and then demonstrate how and why the particular explanation is offered and is indeed the most plausible of all.

For the purposes of processing the data applicable to this study, the above-mentioned three procedures of description, classification and interpretation were followed.



#### *6.8.2.4 Representing and visualising*

For the purposes of this study, hypotheses specifying the relationship among categories of information were used to represent and visualise the data. The data was collected and categorised together according to common themes that emerged. The themes emerged as all possible explanations and views were sought, before the final hypotheses relating to each of the themes were formulated.

#### *6.8.2.5 Analyses of socio-demographic characteristics of the sample*

The presentation, analysis and details regarding the socio-demographic characteristics of the sample are presented in percentages in comparative tables. Chi-square is another statistical measure used in analysing socio-demographic characteristics.

#### *6.8.2.6 Analyses of the samples*

The samples consisted of a total of 204 teachers/educators with 123 teachers (subordinate teachers and school management teams) in South Africa and 81 teachers (subordinates and SMTs) in Uganda. The respondents were recruited randomly in a stratified way from those who were willing to participate in the study from randomly selected institutions.

The details of the samples were dealt with separately because the details in each sample differed significantly. For easy reading, details of the South African sample are given first followed by those for the Ugandan sample. Of those who indicated their age, 82.6% were aged between 31 and 50 years, only 2.6% were below 30 years of age while 14.8% were above 51 years.

54.8% of those who indicated their marital status were married, 31.3% were single and 13.9% were in a category comprising of those divorced, separated and widowed. No category for those co-habiting was catered for in the questionnaire for this study. 89.95% of all those who indicated their religious affiliation were Christians, 7.6% were in

the Zion Christian Church and 2, 5% belonged to other religious groups including Rastafarian.

The majority of educators were qualified to teach; and only less than 1% had qualifications between Grade 0 and Grade 12. 35.8% of the educators had a 3-year-diploma, 39.0% had a 4-year degree, and 17.9% had an honours degree. The remainder of those sampled, 3.2% had a Masters qualification or M+2 and only 3.3% did not state their qualifications. 86.8% of those who indicated their job title were teachers not in management positions while 13.2% were members of the school management team.

Of those who indicated their income brackets: 45.5% of the respondents fell in the income bracket R70001–R120000; 28.1% received between R10000 and R70000. 14.9% were paid over R120000 annually. 11.6% did not indicate their income bracket. Over 94.0% of respondents were citizens and the 5.7% that remained comprised of permanent residents, naturalised citizens and citizen by decent. 91.9 % were classified as Black, 0.8% Indians, 1.6% Coloured and 5.7% White.

Again of those who indicated place of growing up, 65.3% grew up in traditional village, 28.9% grew up in location/township, and 0.8% grew up in suburb while 5.0% grew up in city. According to community or ethnic group membership, 72.4% of the respondents were Tswana, 6.5% Northern Sotho (Pedi), 4.1% Afrikaner, 3.3% Zulu, 3.3% Sotho (Southern Sotho), 1.6% Xhosa, 0.8% Shangani, 0.8% English, 4.9% any other including Indian and permanent residents; and 2.4% did not indicate their ethnic group. 62.0% were females while 38.0% were males.

As for the Ugandan sample, 29.6% were married, 60.5% were single; and 10.05 were in the category comprised of divorced, separated or widowed; and no category for co-

habiting was in the questionnaire. 85.0% of all those who indicated their religious affiliation were Christians, 10.0% Muslims, 3.8% Seventh Day Adventist and 1.3% Hindu. 28.2% of the respondents had either 'O' level or 'A' level plus a teaching certificate, 24.45% had a 2-year Diploma in Education, 29.5% had a 3-year degree while 19.0% had any one of the following qualifications: 3-year degree plus teaching certificate, Masters, Doctorate or any other. Regarding job title, 88.5% of the sample was ordinary classroom teachers and 11.5% belonged to the school management team.

57.1% of all those who indicated their income brackets earned between 1 and 2 Uganda Shillings, 41.3% earned between 3 and 12 Uganda Shillings while only less than 2.0% earned over 12 Uganda Shillings. 70.4% of the respondents were citizens by birth, 19.8% were citizens by descent, 3.75% were citizens by naturalisation and 6.2% were permanent residents. An overwhelming 96.2% were Blacks and 3.8% were half-casts (Mulatto). 50.6% grew up in traditional village, 29.6% grew up in town, and 12.3% grew up in suburbs while 7.4% grew up in city. Regarding community membership/region of origin, 68.8% were from Central, 10.0% were from the West, 10.0% were from the East, 5.0% were from the North East, 3.8% were from the South West and 1.2% from the North West and another 1.2% from any other unspecified region.

Overall, on the key characteristics, the sample populations closely resembled those of the study populations, but certain differences were noted. The majority of participants' religious affiliation resembled that of the general population, that is, the majority of respondents were Christians in South Africa and Uganda. Again, there was a predominance of blacks in both samples; and this approximates to the current demographic representation of this dominant class of people. Although the South African sample had more females than males (62% females versus 38% males), the Ugandan sample was more equally distributed (52% females versus 48% males) which resembles the gender distribution in the population. No over-sampling was experienced generally.

With regard to educational status in either South African or Ugandan, the sample profiles closely resembled the respective national profiles in the core categories of teaching diplomas and degrees.

### **6.8.3 Notes on standardised interviews versus in-depth interviews**

The purpose of the exploratory interview is essentially heuristic: to develop ideas and research hypotheses rather than to gather facts and statistics. It is concerned with trying to understand how ordinary people think and feel about the topics of research.

The job of the in-depth interviews is thus not that of data collection but ideas collection. The primary objective is to maintain spontaneity; the ideal free style interview would consist of a continuous monologue by the respondent on the topic of research, punctuated now and again by an 'uhuh, uhuh' from the interviewer! The interviewers will seek to reduce their own role to an absolute minimum, to avoid leading the respondent. If something is not clear a 'non-directive' prompt will be used such as 'yes, yes' or 'I see, yes, do go on', or summarising what the respondent has just said, or maintaining a pleasantly expectant silence. In-depth interviewers must, as the saying goes, 'listen with the third ear.' They must note not only what is being said but also what is being omitted; must pick up gaps and hesitations and explore what lies behind them; and must create an atmosphere which is sufficiently uncritical for the respondent to come out with seemingly irrational ideas, hatreds or misconceptions.

It is essential for the exploratory interviews to be recorded on tape. In this way they can be analysed in detail afterwards, for there is much that will have escaped the busy interviewer in the stress of actual interview (Kvale in Guion sa). The tapes can also be examined by more than one person. A useful set of exploratory interviews can greatly broaden and deepen the original plan of the research, throw up new dimensions to be studied, suggest many new ideas and hypotheses highlight important differences

between groups of respondents and so on. As an added benefit, the interview tapes will produce a rich store of attitudinal and perceptual expressions on which questions and attitude items can be based. Thus, the in-depth interviews help in the formation of the research problem in the articulation of dimension and hypotheses and in the details of instrument building. Only in the eventual full-scale study will it be possible to test the validity of the hypotheses thrown up in the exploratory interviews.

## **6.9 DATA ANALYSIS PROCEDURE FOR THE QUALITATIVE PART OF THE RESEARCH**

### **6.9.1 Data analysis**

The following methods of qualitative data analysis were used:

- Familiarisation with the data:

This was done through reviewing and reading interview notes and the question guide.

- Coding/indexing of data.

Attride-Stirling (2001), suggests that this be done on the basis of the theoretical issues guiding the research, or on the basis of issues that arise during the research. In this study, both were used. The data from the interview was coded accordingly.

- Identification of themes.

Respective themes were identified procedurally, that is, the identified material was read and themes were abstracted from the coded segments.

- Refinement of themes and categories and exploration of relationships between categories. The reasons under each theme were not identical; rather they fell into categories and sub-categories. Part of the analysis involved exploring the relationship between themes, categories and sub-categories. Occasionally, themes were redefined and items that had been classified in one category were

moved to another category where they were considered, on second thoughts, to be more appropriate.

- Development of theory and incorporation of pre-existing knowledge.

The reasons for why people do not keep secrets, including very sensitive information like a colleague's HIV and AIDS status, as analysed by the themes, categories and sub-categories were then consolidated into a theoretical construct that partly attempted to explain the phenomenon of workplace HIV and AIDS-related discrimination among teachers and SMTs in schools. This construct was then compared with pre-existing theory on secret revelation, particularly as regards to discrimination in the workplace due to HIV and AIDS.

- Report writing included excerpts from the original data

For the qualitative part of the study, the thesis was written based on the analysis of the data, theoretical constructs, and a comparison of the findings with existing theory. Excerpts from the original data in the form of verbatim quotes of what respondents actually said have been included.

### **6.9.2 Reliability and validity**

The findings of this part of the study are expected to be valid and reliable in relation to teachers and SMTs in South Africa and Uganda where the in-depth interviews were done. The rigour of the findings of this part of the study was achieved through the following strategies:

- Asking the same questions to all 26 respondents and exercising flexibility<sup>1</sup>.
- Confirming whatever each respondent said by seeking clarification or re-stating it.

---

<sup>1</sup>Kvale (in Guion [sa]). Flexibility implies slight deviations from the topic should be allowed, which may require rearranging the questions or coming up with new questions.

- Allowing for free and open discussion of issues and minimising interruption of the respondents.
- Listening attentively and writing basic notes which were immediately rewritten in order not to lose detail.

For uniformity of conducting the research interviews, this was done by the same person. It was intended that this would not greatly bias responses even though no video or tape-recording was done due to ensuring anonymity and confidentiality.

The findings, however, may not be generalised for employees in every kind of employment because of the various living circumstances such as socio-economic standards, psychological bearings and legalities which are different, and moreover, compounded by several nuances.

### **6.9.3 Note on validity**

Face validity and logical validity are regarded as indications of content validity. Face validity does not refer to what the questionnaire actually measures, but to what the items apparently measure (Raftery, Tanner & Wells 2002). Since the items were developed according to a theoretical model and evaluated by a panel of experts, the questionnaire is assumed to have face validity. Logical validity firstly requires a careful definition in behavioural terms of the aspects of behaviour or traits dealt with in the questionnaire (Raftery et al; 2002). Secondly, it requires the analysis of that behavioural aspect in the parts which it represents, and, thirdly, an evaluation of the question whether the items have adequate discrimination value. In the course of its development, the questionnaire was subjected to the above-mentioned steps and it can be assumed that the questionnaire has logical validity.

## **6.10 CHAPTER SUMMARY**

This chapter has dealt with the details of the field study, outlining the instruments used in the study, the instruments' reliability, validity, relevance, justification and related

factors. Then, the description of the sample and population was dealt with. The description of the procedures for both the qualitative and quantitative parts of the study was also dealt with.



# **CHAPTER 7: RESEARCH RESULTS**

## **7.1 INTRODUCTION**

The purpose of the study is to determine the relative predictive value of attitude, knowledge and traditional beliefs of workplace HIV and AIDS-related discrimination among site managers, heads of departments and educators in order to explain why such factors play themselves out here that in order to understand how workplace HIV and AIDS-related discrimination can be reduced or even probably stemmed out.

As a starting point to the investigation, the reliability of the different constructs is examined and the basic descriptive information is provided on each question and construct. A comparison is made between the scores of South African and Ugandan respondents on the main scores. Thereafter, a correlation and regression analysis is performed between all the main scales/constructs. In the last section any differences between demographic groups are investigated relative to the main concepts.

## **7.2 QUANTITATIVE RESEARCH RESULTS**

This chapter contains the results of the empirical study. The quantitative results, first followed by the qualitative results were analysed, reported, interpreted and integrated accordingly.

The quantitative results were reported for the biographical characteristics, descriptive statistics, significance of statistical differences and the recommended statistical treatments according to the statistical model.

### 7.3 RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF BIOMEDICAL KNOWLEDGE

The first section of the research questionnaire measured biomedical knowledge with regards to HIV and AIDS matters. The Cronbach alpha value was computed to determine how interrelated these items were and therefore, if the scale was reliable. Initially, items were scaled so that a low score indicated a right/high level of knowledge (Items 3, 5, 7, 13, 14, 15, 16 were rescaled), yet it was decided to rescale all items so that a high score indicated a high degree of knowledge. Reliability statistics of the biomedical knowledge questions are presented in Table 7.1.

**Table 7.1: Reliability statistics for biomedical knowledge**

	<i>Cronbach's Alpha</i>	<i>N of Items</i>
South Africa	0.441	16
Uganda	0.301	16

The alpha values of the South African (0.42) and Ugandan (0.30) samples were relatively low considering the generally suggested cut offs of 0.7 or 0.6 in some cases (see Chapter 6). Field (2005:667) explains that a low alpha might indicate the fact that there are different underlying factors and he mentions that Cronbach, he suggests that it is a good measure to provide reliability per underlying construct.

The underlying structure of the Biomedical Knowledge Scale was tested by means of a principle factor analysis technique. Seven factors had eigenvalues over 1 (the set criteria for extraction of a factor, see Chapter 6). The 7-factor solution is given below in Table 7.2.

**Table 7.2: Seven factor solution from the principle factor analysis on biomedical knowledge – South Africa**

	Factor						
	1	2	3	4	5	6	7
V1 To have HIV means you have AIDS.					0.201	0.729	
V2 There is no known cure for HIV and AIDS to date.	0.299			0.620			
V3 HIV and AIDS can be cured by traditional medicines.	0.512						
V4 HIV causes AIDS.	0.690		0.540				-0.336
V5 Mosquitoes can transmit HIV.				0.533			0.238
V6 HIV does not spread through casual contact with an HIV-positive coworker.	0.469					-0.114	-0.280
V7 HIV can be transmitted through sneezing.					0.722		
V8 Effective and regular condom use is hundred % (100%) perfect in preventing HIV transmission.			0.450				
V9 It takes several years for those infected with HIV to show symptoms of the disease (AIDS).			0.333				

V10 HIV and AIDS is a preventable infectious disease.	0.584		0.497			-0.278	
V11 A man can get HIV by having sex with a woman who has the virus.	0.452					-0.375	
V12 You can reduce the risks of getting HIV from sharing needles by cleaning the needles with bleach.			0.300			-0.244	
V13 A pregnant woman with HIV cannot infect her baby if she does not have a full-blown case of AIDS.		0.642					
V14 A person can get HIV from giving blood or plasma.							0.676
V15 You can tell if a person has HIV just by looking at him or her.		0.624					
V16 A person can get HIV by using public toilet seats.		0.458		0.274			

It appears that there is a strong first factor that indicates ‘basic knowledge’ – that which is most integral to HIV (HIV causes AIDS). This type of information would also be most commonly published and discussed in everyday life. This factor has a good reliability value of 0.625.

Some of the other factors seem to relate to different types of methods of infection and prevention. The fact that these seemingly similar issues all fall into separate factors as

opposed to one single factor indicates that while one respondent might know or be right in terms of one factor, he/she might be wrong in terms of another. These other questions combined have a very low reliability of 0.227. Therefore, there is no consistent measurement of knowledge – no single score that can be computed to reflect the degree of knowledge.

As part of biomedical knowledge testing, respondents were also asked to provide a definition for HIV and AIDS. The answers were scored as either correct or incorrect.

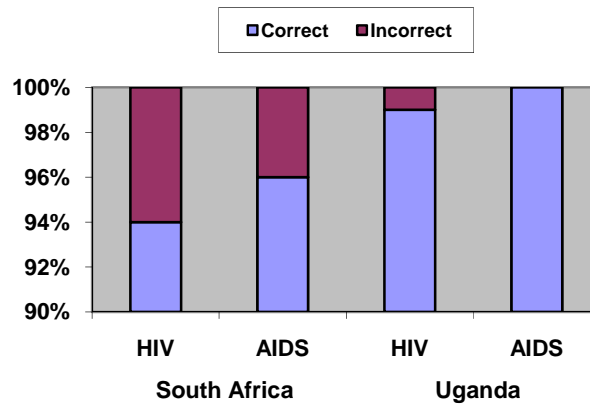


Figure 7.1: Descriptive information of definitions of HIV and AIDS

For the purpose of any hypothesis testing relating to knowledge only the biomedical knowledge was used as its reliability was sufficient. There was very little variation in the question on definitions and this was not be used in calculation of knowledge.

**Table 7.3: Descriptive information for South Africa and Uganda on biomedical knowledge**

	South Africa	
Variable and Label	(n = 112 <n>122)	Uganda (79 >n<81)

	Mean	Std. Deviation	Mean	Std. Deviation
V1 To have HIV means you have AIDS.	2.27	1.65	3.34	1.68
V2 There is no known cure for HIV and AIDS to date.	4.40	1.30	4.41	1.26
V3 HIV and AIDS can be cured by traditional medicines.*	4.15	1.30	4.56	1.65
V4 HIV causes AIDS.	4.47	1.14	4.56	0.98
V5 Mosquitoes can transmit HIV.*	4.09	1.47	4.25	1.13
V6 HIV does not spread through casual contact with an HIV-positive coworker.	4.04	1.66	3.79	1.52
V7 HIV can be transmitted through sneezing.*	1.30	1.00	1.60	1.12
V8 Effective and regular condom use is hundred % (100%) perfect in preventing HIV transmission.	2.67	1.53	3.38	1.41
V9 It takes several years for those infected with HIV to show symptoms of the disease (AIDS).	4.27	1.16	3.94	1.20
V10 HIV and AIDS is a preventable infectious disease.	3.71	1.73	4.38	1.21
V11 A man can get HIV by having sex with a woman who has the virus.	4.80	0.57	4.72	0.66
V12 You can reduce the risks of getting HIV from sharing needles by cleaning the needles with bleach.	2.35	1.59	3.18	1.64

Variable and Label	South Africa (n = 112<n>122)		Uganda (79 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V13 A pregnant woman with HIV cannot infect her baby if she does not have a full-blown case of AIDS.	3.36	1.74	2.89	1.27
V14 A person can get HIV from giving blood or plasma.*	3.02	1.88	2.62	1.56
V15 You can tell if a person has HIV just by looking at him or her.*	4.61	1.04	4.46	1.13
V16 A person can get HIV by using public toilet seats.*	4.69	0.93	1.99	1.39

Note: Scaled so that a high score indicated high level of knowledge (low score = disagree, high score = agree).

Take care in interpreting variables 3, 5, 7, 13, 14, 15, 16. A high score indicates disagreement and therefore a good level of knowledge.

#### **7.4 RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF LEGAL KNOWLEDGE**

In terms of legal knowledge, Uganda showed a low, yet almost acceptable reliability of 0.525 but the reliability value for South Africa was very low 0.435.

**Table 7.4: Reliability statistics for legal knowledge**

	<i>Cronbach's alpha</i>	<i>N of Items</i>
South Africa	0.432	14
Uganda	0.525	14

The underlying structure was examined as with biomedical knowledge yet no progress was made to identify any meaningful factors. This factor was used as it was, although the low reliability was noted as a limitation.

Initially items were scaled so that a low score indicated a right/high level of knowledge (Items 22, 23 were rescaled), yet it was again decided to rescale all items again so that a high score indicated a high degree of knowledge.

**Table 7.5: Descriptive information for South Africa and Uganda on legal knowledge**

Variable and Label	South Africa (n = 117<n>122)		Uganda (77 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V19 It's illegal to test employees for HIV against their will.	4.55	1.17	4.20	1.35
V20 An HIV-positive person (employee) is	4.28	1.18	4.59	0.63



Variable and Label	South Africa (n = 117<n>122)		Uganda (77 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
considered to be able to work if he/she can do the essential part(s) of the job.				
V21 HIV testing for job-applicants is illegal.	4.33	1.28	3.56	1.44
V22 HIV-positive employees must not mix/associate with uninfected colleagues.*	4.86	0.61	4.72	0.83
V23 Employing organisations are obliged to provide reasonable accommodation (eg, Longer work breaks for medication and flexible working time) to HIV-infected employees in AIDS state.*	2.79	1.47	2.29	1.29
V24 It's illegal to refuse to work with an HIV-infected colleague.	4.32	1.31	3.48	1.61
V25 It's illegal for an employee to seek to know a colleague's HIV status.	4.48	1.20	3.45	1.58
V26 Some legal provision is made for some jobs to demand an HIV test with consent before employment.	3.15	1.55	3.88	1.14
V27 Every employee has a right to fair treatment at work.	4.94	0.33	4.69	0.89
V28 Every employee has a right to be provided with medical treatment.	4.60	0.81	4.16	1.16

Variable and Label	South Africa (n = 117<n>122)		Uganda (77 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V29 Every individual has a right to some but NOT all information.	2.73	1.71	3.68	1.32
V30 Not revealing one's HIV status is a basic right.	4.55	1.01	4.18	1.20
V31 It is illegal to test and employee for HIV without first counselling him/her.	4.56	1.05	4.21	1.28
V32 It is against the law to leak information regarding a colleague's HIV and AIDS-status to any person.	4.78	0.75	4.32	1.30

Note: Scaled so that a high score indicated high level of knowledge (low score = disagree, high score = agree).

Take care in interpreting variables 22 and 23. A high score indicates disagreement and therefore a good level of knowledge.

## 7.5 RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF ATTITUDE

The attitude questions were scaled so that a high score results in a good/positive or progressive attitude. Items from the original questionnaire that were rescaled include: V33, V34, V37, V38, V41, V42, V44, V45, V47, and V49.

The reliability of attitude was high in both the South African and Ugandan samples (0.754 for South Africa and 0.667 for Uganda).

**Table 7.6: Reliability statistics for attitude**

	<i>Cronbach's alpha</i>	<i>N of Items</i>
South Africa	0.754	22
Uganda	0.667	22

The scores on each individual item are presented below in Table 7.7 for South Africa and Uganda. Note the items that were rescaled imply that the meaning of the question/statement phrasing was in reverse (marked with an \*) to aid quick interpretation). As the same formula was applied to both sets of data, they were comparable.

**Table 7.7: Descriptive information for South Africa and Uganda on attitude statements**

Variable and Label	South Africa (n = 112<n>122)		Uganda (79 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V33 Training an HIV-infected employee is a	4.02	1.42	4.04	1.34

Variable and Label	South Africa (n = 112<n>122)		Uganda (79 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
mere waste of scare resources (money, in particular). *				
V34 Promotion to a higher position of an HIV-infected worker is a discouragement to non-infected employees. *	4.02	1.27	4.00	1.23
V35 HIV-positive employees and their immediate family should get financial support for medication from the employing organisation.	3.24	1.35	3.74	1.19
V36 HIV-positive employees should be given social support by the employees in the workplace.	3.66	1.51	4.00	1.23
V37 Every employee should be tested for HIV every six (6) months.	3.46	1.50	3.34	1.33
V38 Every employee should declare his/her HIV status. *	3.48	1.41	3.65	1.33
V39 My workplace is up-to-date with HIV and AIDS knowledge (especially information) provision.	3.08	1.33	3.01	1.33
V40 There is no need to declare one's HIV status.	3.19	1.48	3.04	1.46

Variable and Label	South Africa (n = 112<n>122)		Uganda (79 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V41 There is not much an individual employee can do to stop getting infected with HIV.	4.01	1.34	4.19	1.25
V42 There is not much the employing organisation I work for can do to stop employees' from getting infected with HIV. *	3.55	1.36	3.75	1.35
V43 I believe individuals are to blame for the spread of HIV.	3.29	1.50	3.54	1.36
V44 I believe employing organisations are to blame for the spread of HIV. *	3.76	1.42	4.02	1.24
V45 I am bothered by working for a colleague who is absent from work because he/she is HIV-positive. *	3.75	1.26	3.10	1.30
V46 I prefer my religious leader (eg. a priest) to my supervisor in matters relating to HIV and AIDS.	3.09	1.36	3.45	1.30
V47 Employees who are HIV-positive should be given alternative jobs in the employing organisation. *	3.27	1.49	2.88	1.41
V48 My employing organisation is doing enough for HIV-infected employees.	3.11	1.23	2.96	1.24

Variable and Label	South Africa (n = 112<n>122)		Uganda (79 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V49 The HIV and AIDS policy in my workplace is hard to understand. *	3.38	1.32	3.12	1.21
V50 I have never lost a close relative because of HIV and AIDS.	2.69	1.65	1.58	1.21
V51 HIV and AIDS is a disease like any other chronic disease (eg diabetes or asthma).	3.10	1.61	3.12	1.61
V52 I feel comfortable wearing a T-shirt with the message such as 'TREAT AN HIV AND AIDS INFECTED PERSON WITH DIGNITY'.	4.00	1.36	4.28	1.11
V53 It would be okay for me to donate a fraction of less than one % (1 %) of my salary monthly for HIV and AIDS activities.	3.43	1.31	3.85	0.90
V54 It would be nice in our department/ section to have short breaks enjoying snacks with HIV-infected coworkers.	3.38	1.27	3.93	1.09

## 7.6 RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF EMOTIONS

In terms of emotions, three statements were asked: fear, irritation and pity.

**Table 7.8: Reliability statistics for emotion**

	<i>Cronbach's Alpha</i>	<i>N of Items</i>
South Africa	0.578	3
Uganda	0.491	3

Although a Cronbach Alpha of 0.578 was not altogether that low for South Africa (0.491 was low for Uganda), an investigation into the items showed 'pity' did not belong in precisely the same category with 'fear' and 'irritation'. Table 7.9 indicates that by excluding 'pity', the alpha value went up to a very high 0.837.

Therefore, emotions consist of two separate 'factors' (fear/irritation and pity) as opposed to only a single score.

**Table 7.9: Reliability Statistics for emotions for South Africa and Uganda**

<i>Variable and Label</i>	<i>South Africa</i>		<i>Uganda</i>	
	Corrected Item-Total Correlation	Cronbach's Alpha if item deleted	Corrected Item-Total Correlation	Cronbach's Alpha if item deleted
V55 Whenever I think of working with an HIV-positive coworker, I become fearful.	0.553	0.248	0.424	0.177
V56 Whenever I imagine sharing work with an HIV-positive coworker, I get irritated.	0.509	0.311	0.325	0.373
V57 Whenever I see an HIV-positive colleague, I feel pity.	0.182	0.837	0.200	0.590

A high score on this variable indicated a high score on fear/irritation and pity.

**Table: 7.10: Descriptive information for South Africa and Uganda on emotions**

Variable and Label	South Africa (n = 118<n>120)		Uganda (80 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V55 Whenever I think of working with an HIV-positive coworker, I become fearful.	2.57	1.81	3.16	2.18
V56 Whenever I imagine sharing work with an HIV-positive coworker, I get irritated.	2.26	1.83	2.38	1.93
V57 Whenever I see an HIV-positive colleague, I feel pity.	4.27	2.38	5.28	2.30

## 7.7 RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF TRADITIONAL BELIEFS.

The traditional beliefs scale had a very high reliability of 0.870 for South Africa and 0.858 for Uganda. A high score on this scale indicated a strong hold on traditional beliefs while a low score indicated disagreement with traditional beliefs.

**Table 7.11: Reliability statistics for traditional beliefs**

	<i>Cronbach's Alpha</i>	<i>N of Items</i>
--	-------------------------	-------------------



South Africa	0.870	18
Uganda	0.858	18

The individual item scores on the traditional belief questions are given below in Table 7.12.

**Table 7.12: Descriptive information for South Africa and Uganda on traditional beliefs**

Variable and Label	South Africa (n = 112<n>122)		Uganda (n=81) (79)	
	Mean	Std. Deviation	Mean	Std. Deviation
V69 Traditional healers can treat HIV.	2.24	1.26	2.11	1.37
V70 Traditional medicine can cure HIV.	1.78	0.98	1.73	1.14
V71 Vitamins can cure HIV.	1.91	1.12	1.62	0.92
V72 It is basically fate to contract HIV.	2.23	1.14	2.56	1.26
V73 Deviating from God's prescribed ways of living brought the curse of HIV and AIDS to humans.	2.55	1.45	3.28	1.41
V74 According to me, most diseases including HIV are due to witchcraft.	1.43	0.90	1.35	0.95
V75 While I use medicine from modern doctors, I have to consult an inyanga/ sangoma/traditional	1.90	1.23	1.47	0.94

Variable and Label	South Africa (n = 112<n>122)		Uganda (79 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
healer to be sure of the actual cause of the disease.				
V76 Without appeasing ancestors through sacrifice of a beast, one will have many problems and diseases.	1.69	1.03	1.60	1.08
V77 I consult my sangoma/inyanganga whenever I have a disease/sickness that does not cure easily.	1.73	1.07	1.56	1.05
V78 I would direct a coworker to a traditional healer in case of his/her having an inexplicable health problem.	1.88	1.09	1.65	1.04
V79 I trust a traditional healer more than a medical doctor in treating HIV and AIDS.	1.50	0.90	1.49	0.96
V80 HIV and AIDS is an African disease.	1.40	0.92	1.32	0.89
V81 Having sex with foreigners (Makwerekwere) caused HIV and AIDS in our country.	1.79	1.24	2.35	1.42
V82 I would do anything and everything a traditional healer told me to get cured (eg. Sleeping with a virgin, sleeping with a much older person).	1.37	0.85	1.38	0.94
V83 One's ancestors control one's life pattern, including health.	1.59	1.01	1.69	1.04
V84 I would sacrifice a person if that is what it takes	1.63	1.03	1.54	1.17

Variable and Label	South Africa (n = 112<n>122)		Uganda (79 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
to get cured of HIV.				
V85 Having sexual intercourse helps in purifying blood to reduce chances of developing high blood pressure.	1.46	1.00	1.51	1.00
V86 Breaking some sexual taboos can result in diseases like TB (tuberculosis) and HIV.	1.97	1.27	1.89	1.27

## 7.8 RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF DISCRIMINATION

The discrimination items showed a high reliability value of 0.901. Questions were initially scaled so that a high value indicated a low level of discrimination (therefore a good thing) and therefore the following items were rescaled to fit in with this direction: 98, 99, 100, 101, 102, 103, 104, 108, 111, 112, and 114.

**Table 7.13: Reliability statistics for discrimination**

	<i>Cronbach's Alpha</i>	<i>N of Items</i>
South Africa	0.857	30
Uganda	0.762	30

The descriptive information on each of the individual items of discrimination is presented in Table 7.14.

**Table 7.14: Descriptive information for South Africa and Uganda on discrimination**

Variable and Label	South Africa (77<n>122)		Uganda (74 >n<81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V87 HIV-positive employees should not be given extra sick leave with pay.	4.02	1.20	4.17	1.08
V88 HIV-positive employees should have their separate common room.	4.45	1.06	4.51	0.76
V89 No HIV-positive worker should be sent for further training.	4.20	1.23	4.01	1.26
V90 No HIV-positive employee should be promoted.	4.37	1.15	4.22	1.19
V91 No HIV-positive employment seeker should be interviewed for any job.	4.46	1.04	4.44	0.90
V92 HIV-positive employees should declare their status to the employer.	3.71	1.41	3.47	1.38
V93 Employees who contract HIV should be demoted.	4.41	1.10	4.56	0.88
V94 Employees who test HIV-positive should be dismissed.	4.43	1.13	4.65	0.85

Variable and Label	South Africa (77<n>122)		Uganda (74<n>81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V95 Job applicants should be tested for HIV.	4.20	1.28	3.57	1.35
V96 There is no need to cater for special needs of an HIV-infected employee.	4.09	1.13	4.34	1.01
V97 HIV-infected individuals should not have the same rights to health, information, housing, as individuals who are not HIV-infected.	4.27	1.22	4.52	1.05
V98 In the last 6 (six) months I have shared a work station with a colleague suspected of being HIV-positive	3.16	1.34	2.96	1.48
V99 I can share a teaspoon with an HIV-infected coworker.	3.70	1.30	2.67	1.28
V100 I can share a toilet with an HIV- infected coworker.	4.03	1.13	2.41	1.27
V101 I can shake hands with a coworker who is HIV-positive.	4.09	1.29	4.09	1.30
V102 I can kiss a coworker regardless of his/her HIV-status.	3.64	1.34	3.67	1.30
V103 In the last 3–12 months, I have shared a workplace table with an HIV-infected or HIV-suspected colleague.	3.17	1.31	2.73	1.33

Variable and Label	South Africa (77<n>122)		Uganda (74<n>81)	
	Mean	Std. Deviation	Mean	Std. Deviation
V104 In the last 3–12 months, I have dined with a coworker suspected to be HIV-positive.	3.05	1.38	2.65	1.41
V105 In the last 3–12 months, I have used the same facilities (eg. Toilet, lounge) with a coworker suspected of having HIV and AIDS.	2.94	1.34	2.70	1.32
V106 In the last 3–12 months, I have shunned (avoided) company of a coworker with AIDS symptoms.	3.71	1.30	3.78	1.35
V107 In the last 3–12 months, I have kissed a coworker suspected of having HIV and AIDS.	3.31	1.35	4.05	1.23
V108 In the last 3–12 months, I have donated money to assist an HIV and AIDS-infected colleague.	2.55	1.40	3.19	1.41
V109 In the last 3–12 months, I have leaked information regarding the HIV status of a coworker to someone else in my workplace.	4.04	1.28	3.81	1.38
V110 In the last 3–12 months, I have leaked information about the sexual orientation (homosexual or bisexual) of a coworker to another colleague.	4.16	1.21	3.71	1.35
V111 In the last 3–12 months, I have done my	2.30	1.26	3.33	1.44

Variable and Label	South Africa (77<n>122)		Uganda (74<n>81)	
	Mean	Std. Deviation	Mean	Std. Deviation
coworker's job when she was away due to HIV and AIDS-related illness.				
V112 In the last 3–12 months, I have participated in HIV and AIDS activities like campaign to reduce HIV and AIDS-related discrimination (eg. A drama or a song).	3.00	1.45	2.69	1.47
V113 In the last 3–12 months, I have parted ways (got detached) from someone due to fear of contracting HIV from his/her looks (physical appearance).	3.97	1.26	3.48	1.32
V114 In the last 3–12 months, I have offered transport to a colleague who is suspected to be HIV-positive.	2.78	1.28	3.10	1.39
V115 In the past 3–12 months, I have avoided using the same phone with a colleague who is suspected to be HIV-positive.	4.09	1.16	4.22	1.22
V116 In the past 3–12 months, I have not had a handshake with a colleague suspected to be infected with HIV and AIDS.	3.97	1.27	3.88	1.34

## 7.9 RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF PERCEPTIONS OF EDUCATORS ON MANAGEMENT

This section was answered only by educators and focused on their involvement in HIV policy making and decision making. A high score indicated a high degree of participation in decision making and an open and progressive attitude from the side of management. A high score indicated a climate where openness exists to discuss HIV matters.

**Table 7.15: Reliability statistics for perception of educators of school management teams (SMTs)**

	Cronbach's Alpha	N of Items
South Africa	0.758	5
Uganda	0.430	5

The descriptive information on the various items asked of educators only is given below in Table 7.16.

**Table 7.16: Descriptive information for South Africa and Uganda on perceptions of educators**

Variable and Label	South Africa (n = 95<n>97)		Uganda (62 >n<63)	
	Mean	Std. Deviation	Mean	Std. Deviation
V58 I was consulted in the development of our organisation's HIV and AIDS policy.	2.89	1.49	2.68	1.45



Variable and Label	South Africa (n = 95<n>97)		Uganda (n = 62<n>63)	
	Mean	Std. Deviation	Mean	Std. Deviation
V59 My HOD/supervisor(s) seems to be free to discuss HIV and AIDS with subordinates.	3.32	1.30	3.38	1.34
V60 My HOD/supervisor(s) seems to be free to discuss HIV and AIDS with people of his/her rank only.	2.26	1.19	2.50	1.20
V61 My HOD/supervisor(s) sexual organisation seems to be in agreement with the message he/she delivers to subordinates.	3.19	1.28	3.03	1.26
V62 My HOD/supervisor(s) seems to be co-operative and understanding when dealing with HIV and AIDS infected colleagues' matters (including confidentiality).	3.49	1.24	3.21	1.26
V63 My HOD/supervisor(s) and manager(s) seems to appreciate what the educators are doing in the area of HIV and AIDS.	3.53	1.19	4.16	2.52

Questions were asked of respondents who are SMT educators, yet only a small portion of each sample qualified for this section and the data will only be used for descriptive purposes only. Therefore, no reliability analysis was performed for this scale and only the descriptive information is presented in Table 7.17.

**Table 7.17: Descriptive information for South Africa and Uganda perceptions of school management team (i.e. SMT)**

Variable and Label	South Africa (n = 14<n>23)		Uganda (n =6)	
	Mean	Std. Deviation	Mean	Std. Deviation
V64 My subordinates seem to be co-operative in the way they handle HIV and AIDS issues relating to other coworkers.	4.22	1.00	3.67	0.82
V65 My subordinates seem to appreciate what management is doing with regards to HIV and AIDS in our organisation.	3.70	0.93	2.67	1.03
V66 My subordinates seem to appreciate what management is doing with regards to HIV and AIDS in our organisation.	3.41	1.28		
V67 My subordinates seem to be free to discuss HIV and AIDS with their supervisors.	3.36	1.50	3.50	1.22

## 7.10 RELIABILITY ANALYSIS AND CONSTRUCTS INVESTIGATION OF SELF-ESTEEM, SELF-EFFICACY AND SUBJECTIVE NORMS

Three personality concepts were tested towards the end of the questionnaire: self-esteem, self-efficacy and subjective norms.

The Cronbach's Alpha for the self-esteem scale is 0.623 for South Africa and 0.538 for Uganda. A value of above 0.6 is acceptably high, and although the Ugandan reliability is slightly lower than the cut off, the scale will be used while noting the lower reliability as a possible limitation.

**Table 7.18: Reliability statistics for perception of self-esteem**

	Cronbach's Alpha	N of Items
South Africa	0.632	7
Uganda	0.538	7

The self-efficacy scale shows lower reliabilities than self-esteem. Yet it should be remembered that the number of items also have an effect on the reliability (Field 2005:668). As this concept is only measured by two questions, the reliability would likely have been higher had more questions been included and therefore this scale will be used in the analysis.

**Table 7.19: Reliability statistics for perception of self-efficacy**

	Cronbach's Alpha	N of Items
South Africa	0.485	2

Uganda	0.542	2
--------	-------	---

The subjective norm scale shows a very low reliability in the South African sample (Alpha of 0.237). While the Ugandan sample has a slightly higher reliability, it is decided that this scale cannot be deemed reliable and will not be used in the analysis.

**Table 7.20: Reliability statistics for perception of subjective norms**

	Cronbach's Alpha	N of Items
South Africa	0.237	3
Uganda	0.474	2

**Table 7.21: Descriptive information for South Africa and Uganda on self-esteem and self-efficacy**

Variable and Label	South Africa (n = 119<n>121)		Uganda (n = 79)	
	Mean	Std. Deviation	Mean	Std. Deviation
V117 I feel I have a number of good qualities	4.47	0.67	4.28	0.75
V118 All in all, I am inclined to feel that I am a failure.	4.37	0.91	4.32	1.04
V119 I am able to do things as well as most other people.	4.28	0.99	4.35	0.83

Variable and Label	South Africa (n = 119<n>121)		Uganda (n = 79)	
	Mean	Std. Deviation	Mean	Std. Deviation
V120 I feel I do not have much to be proud of.	3.71	1.43	3.30	1.57
V121 On the whole, I am satisfied with myself.	4.31	0.89	3.67	1.15
V122 I take a positive attitude toward myself.	4.55	0.79	4.45	0.62
V123 I certainly feel useless at times.	4.09	1.01	3.97	1.26
V124 How certain are you that you could not shun an HIV and AIDS-infected colleague in any way?	3.26	1.42	2.69	1.47
V127 How confident are you that you can eat from the same plate with a colleague suspected to be HIV-positive?	3.32	1.43	2.55	1.41

To assist in the interpretation of any statistics, a summary table is provided with all directions that each of the constructs/scales measure.

**Table 7.22: Summary of direction of construct measurement**

	<i>Low score</i>	<i>High score</i>
Knowledge	Not knowledgeable	Knowledgeable
Legal knowledge	Not knowledgeable	Knowledgeable

Attitude	Negative	Positive/ progressive
Emotions	Low irritation/fear/ pity	High irritation/fear/ Pity
Traditional beliefs	More progressive beliefs	Strong traditional beliefs
Discrimination	High discrimination	Low discrimination
Perception for educators and management	Negative environment	Open/sharing

## 7.11 COMPARISON BETWEEN SOUTH AFRICA AND UGANDA ON MAIN CONCEPTS

In this section, the scores on the main concepts are compared for South Africa and Uganda. The scores per concept were created by obtaining mean scores across all the items in that comprise the concept as discussed in the above section on reliability.

### 7.11.1 Knowledge

The score on biomedical and legal knowledge was compared between South Africa and Uganda using a t-test for independent means.

**Table 7.53: Comparison between South Africa and Uganda on knowledge scales**

	<i>South Africa</i>	<i>Uganda</i>	<i>t-value</i>	<i>p-value</i>
--	-------------------------	---------------	----------------	----------------

Biomedical Knowledge	4.29	4.40	-1.12	0.262
Legal Knowledge	4.21	3.96	4.07	0.000

The two countries did not differ significantly on biomedical knowledge ( $p=0.262 > 0.05$ ). They did, however, differ with regards to legal knowledge where Uganda showed a lower level of knowledge than SA ( $p = 0.000$ )

### 7.11.2 Attitude

**Table 7.24: Comparison between SA and Uganda on attitude scales**

	South Africa	Uganda	t-value	p-value
Attitude	3.45	3.49	-0.520	0.604

There were no differences between the attitudes of Ugandans or South Africans ( $p=0.604$  was greater than the cutoff of 0.05).

### 7.11.3 Emotions

**Table 7.25: Comparison between South Africa and Uganda on emotions scale**

	South Africa	Uganda	t-value	p-value
Fear/irritation	2.41	2.77	-1.46	0.146
Pity	4.27	5.28	-2.95	0.004

In terms of the fear and irritation, there were no significant differences between Uganda and South Africa ( $p = 0.146$ ) but Uganda was more likely to show greater levels of pity ( $p=0.004$ ).

#### 7.11.4 Traditional beliefs

In general the degree to which traditional beliefs were adopted is low in both countries – 1.78 out of 5. The scores per country were virtually identical; and, there were no significant differences between the scores.

**Table 7.26: Comparison between South Africa and Uganda on traditional beliefs scale**

	South Africa	Uganda	t-value	p-value
Traditional belief	1.78	1.79	-0.06	0.952

#### 7.11.5 Discrimination

There was a significant difference in the degree to which South African and Ugandan educators discriminate in the workplace ( $p=0.046$ ). The score for South Africa was higher than that of Uganda, indicating that discrimination was lower.

**Table 7.27: Comparison between South Africa and Uganda on discrimination scales**

	South Africa	Uganda	t-value	p-value
Discrimination	3.84	3.68	2.0	0.46



### 7.11.6 Self-esteem and self-efficacy

A comparison between South Africa and Uganda on the personality concepts of self-esteem and self-efficacy indicated that South African respondents were higher on the self-esteem and lower on self-efficacy.

**Table 7.28: Comparison between South Africa and Uganda on self-esteem and self-efficacy scales**

	South Africa	Uganda	t-value	p-value
Self-esteem	4.26	4.05	2.64	0.009
Self-efficacy	3.27	2.64	3.68	0.000

As a summary of the results in this section, all the mean scores on the constructs were presented graphically in Figure 7.2 with an asterisk (\*) indicating the significant differences. Emotions were not included in the graph below as it was measured on a seven-point scale. Emotions were presented in Figure 7.2.

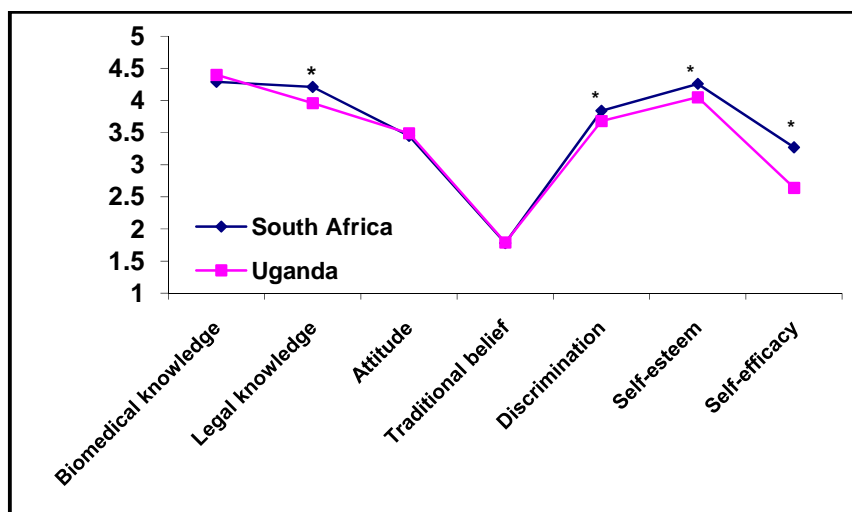


Figure 7.2: Summary of construct scores for South Africa and Uganda

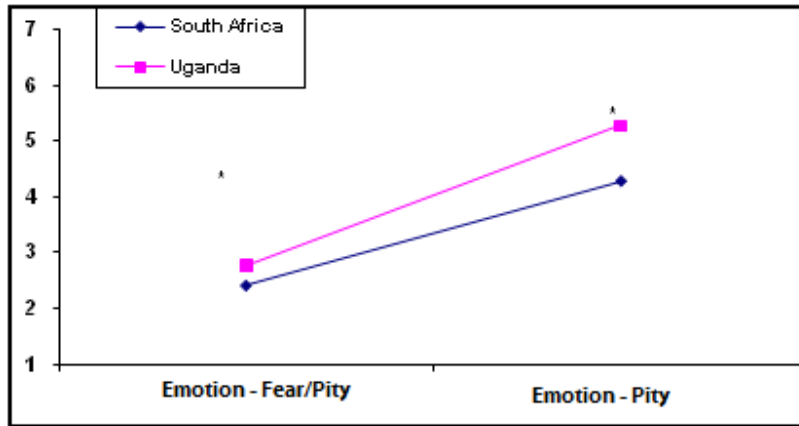


Figure 7.3: Summary of emotions for South Africa and Uganda

From figure 7.3 it could be seen that teachers in the Ugandan and South African sample a significant difference on the fear/pity emotion

### 7.12 CORRELATION ANALYSIS BETWEEN KNOWLEDGE, ATTITUDE, EMOTION, TRADITIONAL BELIEF AND DISCRIMINATION

A correlation analysis was performed between all the different components of the study and the results are given in Table 7.29.

**Table 7.29: Correlations among factors on knowledge, attitudes etc.**

	Bio-medical knowledge	Legal knowledge	Attitude	Fear/Irritation	Pity	Traditional belief	Discrimination
--	-----------------------	-----------------	----------	-----------------	------	--------------------	----------------

		Bio- medical knowledg e	Legal knowl edge	Attitude	Fear/ Irritation	Pity	Traditi onal belief	Discri minati on
Biomedical knowledge	Pearson Correlatio n  Sig. (2- tailed)  N	1   204						
Legal knowledge	Pearson Correlatio n  Sig. (2- tailed)  N	.194(**)  .006  203	1   203					
Attitude	Pearson Correlatio n  Sig. (2- tailed)  N	0.170(*)  0.016  203	0.207(**)  0.003  202	1   203				
Fear/Irritatio n	Pearson Correlatio n	-0.067	- 0.203(**)	- 0.170(*)	1			

		Bio- medical knowledg e	Legal knowl edge	Attitude	Fear/ Irritation	Pity	Traditi onal belief	Discri minati on
	Sig. (2- tailed)	0.348	0.004	0.016				
	N	201	200	201	201			
Pity	Pearson Correlatio n	0.002	-0.118	0.038	0.203(** )	1		
	Sig. (2- tailed)	0.974	0.098	0.597	0.004			
	N	198	197	198	198	198		
Traditional belief	Pearson Correlatio n	-0.148(*)	-0.051	- 0.225(** )	0.267(** )	- 0.00 5	1	
	Sig. (2- tailed)	0.035	0.471	0.001	0.000	0.94 4		
	N	204	203	203	201	198	204	
Discriminati on	Pearson Correlatio n	0.185(**)	0.188(**)	0.259(** )	- 0.168(*)	- 0.02 3	- 0.287(**)	1
	Sig. (2- tailed)	0.008	0.007	0.000	0.017	0.75 1	0.000	
	N	204	203	203	201	198	204	204

\* Correlation is significant at the 0.05 level (2-tailed).

\*\* Correlation is significant at the 0.01 level (2-tailed).

There were significant correlations between all of the main concepts and discrimination with the exception of pity. A positive correlation with biomedical knowledge and legal knowledge indicated that the higher the knowledge levels the higher the score of discrimination (low discrimination/good):  $p=0.008$  and  $p=0.007$ . The higher the attitude scores the higher the discrimination score (lower discrimination levels/good):  $p=0.000$ .

There was a negative correlation with fear/irritation which indicated that the higher the fear/irritation levels in individuals the more they were to discriminate. A large negative correlation existed with traditional beliefs which meant that the higher the traditional beliefs score (strong traditional beliefs) the lower the discrimination score (more discrimination). Therefore, the stronger a person's traditional beliefs the more they discriminate. The correlation value of 0.287 was much larger than that of knowledge (0.18) which indicated that the relationship was stronger.

Self-esteem correlated with discrimination. The higher your self-esteem the less you were likely to discriminate:  $p=0.014$ .

## **7.13 REGRESSION ANALYSIS TO PREDICT DISCRIMINATION**

### **7.13.1 Combined data**

A regression analysis was performed to determine how well traditional beliefs, attitudes, knowledge, emotions and personality concepts could predict discrimination. A stepwise regression was performed and the three possible models were extracted. From Table 7.30 one can see that the second model explains 11% of variance in the discrimination while the third model explains only 2% more – 13% (R Square of 0.136). Each of the three models are however significant (p-values of 0.000).

**Table 7.30: Regression analysis results: Predicting discrimination**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F-value	P-value
1	0.286(a)	0.082	0.077	0.54234	17.29	0.000
2	0.344(b)	0.118	0.109	0.53291	12.91	0.000
3	0.369(c)	0.136	0.122	0.52884	10.07	0.000

(a) Predictors: (Constant), traditional belief.

(b) Predictors: (Constant), traditional belief, attitude.

(c) Predictors: (Constant), traditional belief, attitude, legal knowledge.

The first predictor that the stepwise regression chose (model 1) was traditional belief, indicating that this was the strongest predictor of discrimination. In the second model, it included attitudes; and, only in the third model, did it include legal knowledge. Basic knowledge did not feature in the regression analysis at all.

**Table 7.31: Coefficients of the regression with discrimination as the dependent variables**

Model	Unstandardised Coefficients		Standardised Coefficients	t	Sig.
	B	Std. Error	Beta		
1 (Constant)	4.240	0.120		35.477	0.000

	Traditional belief	-0.266	0.064	-0.286	-4.158	0.000
2	(Constant)	3.366	0.332		10.140	0.000
	Traditional belief	-0.232	0.064	-0.250	-3.630	0.000
	Attitude	0.235	0.083	0.194	2.815	0.005
3	(Constant)	2.763	0.447		6.180	0.000
	Traditional belief	-0.230	0.064	-0.247	-3.613	0.000
	Attitude	0.202	0.084	0.166	2.387	0.018
	Legal knowledge	0.174	0.087	0.137	1.996	0.047

(a) Dependent Variable: Discrimination.

### 7.13.2 Regression for South Africa

A regression analysis of only the South African data showed that traditional beliefs were still the first and most important factor to predict discrimination. However, a slight difference came into the third model where biomedical knowledge, rather than legal knowledge came into play.

**Table 7.32: Regression analysis results: Predicting discrimination for South Africa**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F-value	P-value
1	0.287(a)	0.082	0.074	0.60415	10.34	0.002

2	0.377(b)	0.142	0.127	0.58686	9.42	0.000
3	0.426(c)	0.182	0.160	0.57562	8.36	0.000

(a) Predictors: (Constant), traditional belief.

(b) Predictors: (Constant), traditional belief, attitude.

(c) Predictors: (Constant), traditional belief, attitude, biomedical knowledge.

**Table 7.33a: Coefficients of the regression with discrimination as the dependent variables: South Africa**

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.362	0.175		24.985	0.000
	Traditional belief	-0.299	0.093	-0.287	-3.215	0.002
2	(Constant)	3.303	0.414		7.983	0.000
	Traditional belief	-0.273	0.091	-0.262	-3.008	0.003
	Attitude	0.294	0.105	0.245	2.806	0.006
3	(Constant)	2.659	0.490		5.427	0.000
	Traditional belief	-0.244	0.090	-0.234	-2.713	0.008
	Attitude	0.247	0.105	0.206	2.364	0.020
	Biomedical knowledge	0.175	0.074	0.206	2.344	0.021

(a) Dependent Variable: Discrimination.



**Table 7.33b: Correlation matrix (Uganda)**

	<i>Discrimination</i>	<i>Traditional Belief</i>	<i>Legal Knowledge</i>
Discrimination	1		
Traditional Belief	0.134	1	
Legal Knowledge	0.368	0.242	1

**Table 7.33c: Correlation matrix (South Africa)**

	<i>Discrimination</i>	<i>Traditional Belief</i>	<i>Attitude</i>	<i>Biomedical Knowledge</i>
Discrimination	1			
Traditional Belief	-0.109	1		
Attitude	0.184	-0.052	1	
Biomedical Knowledge	-0.118	-0.389	-0.104	1

### 7.13.3 Regression for Uganda

A regression analysis of only the Ugandan data showed that traditional beliefs were still the first and the most important factors to predict discrimination. This was followed by legal knowledge.

**Table 7.34: Regression analysis results: Predicting discrimination for Uganda**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F-value	P-value
1	0.316(a)	0.100	0.088	0.42381	8.53	0.005
2	0.393(b)	0.154	0.132	0.41348	6.93	0.002

(a) Predictors: (Constant), traditional belief.

(b) Predictors: (Constant), traditional belief, legal knowledge.

**Table 7.35: Coefficients of the regression with discrimination as the dependent variables: Uganda**

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.080	0.144		28.243	0.000
	Traditional belief	-0.228	0.078	-0.316	-2.921	0.005
2	(Constant)	3.189	0.427		7.472	0.000
	Traditional belief	-0.226	0.076	-0.313	-2.965	0.004
	Legal knowledge	0.224	0.101	0.233	2.212	0.030

(a) Dependent Variable: Discrimination.

## 7.14 INVESTIGATION OF THE EFFECT OF PERSONALITY CONCEPTS ON ATTITUDE, EMOTIONS AND DISCRIMINATION

**Table 7.366: Correlation between main constructs and personality constructs**

		<i>Self-esteem</i>	<i>Self-efficacy</i>
Biomedical knowledge	Pearson Correlation	0.18*	0.06
	Sig. (2-tailed)	0.012	0.423
	N	200	201
Legal knowledge	Pearson Correlation	0.21*	0.10
	Sig. (2-tailed)	0.004	0.152
	N	199	200
Attitude	Pearson Correlation	0.16*	0.14
	Sig. (2-tailed)	0.023	0.056
	N	199	200
Emotions – Fear/irritation	Pearson Correlation	-0.20**	-0.33**
	Sig. (2-tailed)	0.005	0.000
	N	197	198
Emotions – Pity	Pearson Correlation	-0.05	-0.03

		<i>Self-esteem</i>	<i>Self-efficacy</i>
	Sig. (2-tailed)	0.518	0.644
	N	195	196
Traditional belief	Pearson Correlation	-0.36**	-0.03
	Sig. (2-tailed)	0.000	0.666
	N	200	201
Discrimination	Pearson Correlation	0.17*	0.10
	Sig. (2-tailed)	0.014	0.138
	N	200	201

\* Correlation is significant at the 0.05 level (2-tailed).

\*\* Correlation is significant at the 0.01 level (2-tailed).

Self-esteem correlated significantly with knowledge, attitude and traditional beliefs. The higher the self-esteem the less likely respondents were to have strong traditional beliefs ( $r=-0.36$ ;  $p=0.000$ ). A higher self-esteem showed higher knowledge levels. Self-efficacy only correlated significantly with the emotions of fear/irritation ( $r=0.33$ ;  $p=0.000$ ). The correlation was negative; therefore, the higher self-efficacy scores, the lower the pity scores.

## 7.15 EFFECT OF DEMOGRAPHIC/BIOGRAPHIC VARIABLES ON MAIN CONCEPTS

### 7.15.1 Describing the Sample

As a start to describing the effect of demographic variables on the scores of the main concepts, the sample was firstly described in terms of these variables.

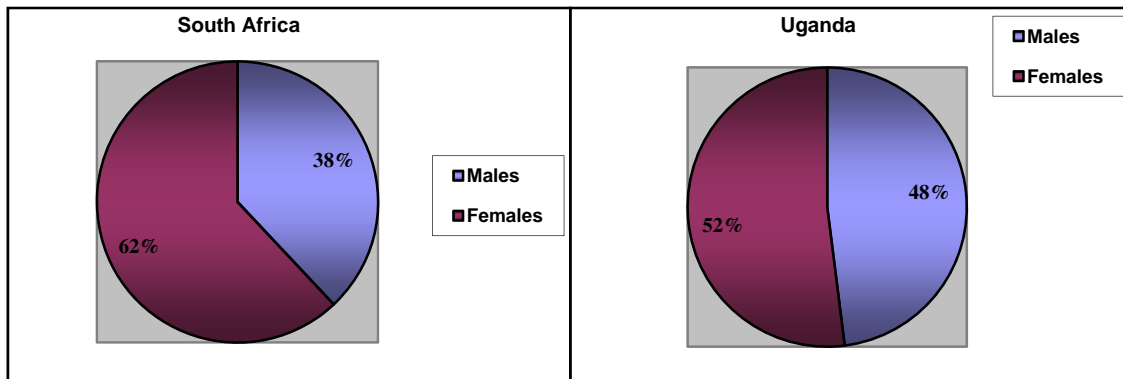
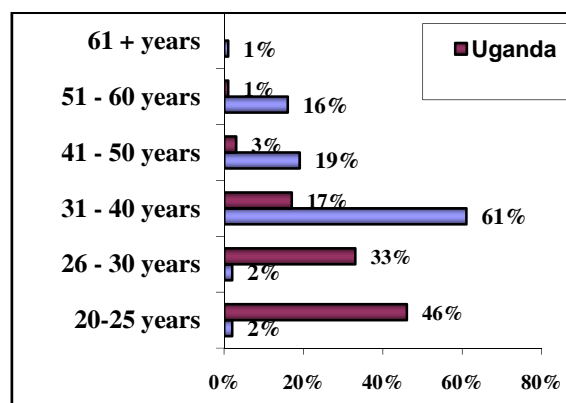


Figure 7.4: Gender distribution of the sample

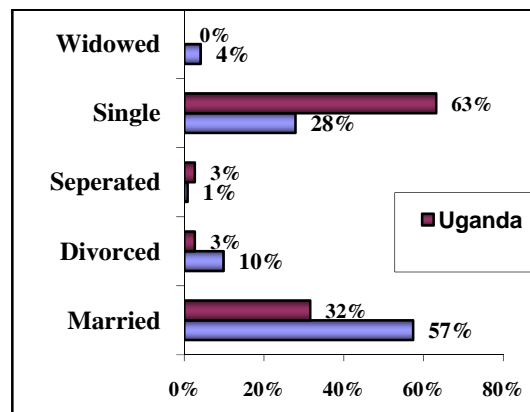
In the South African sample, there were more women than men (62% versus 38%). Although the Ugandan sample was more equally distributed (52% females and 48% males), this was not significant (chi-square=2.0.36; p=0.101).

Figure 7.5: Age distribution of the sample



The Ugandan sample appeared to be younger than South Africa's. Most of the South Africans were between the ages of 31-40 while Ugandan educators were mostly below 30. This difference is significant (chi-square=121.96;  $p=0.000$ ). In terms of marital status, more South Africans reported to be married (chi-square=28.213;  $p=0.000$ ). This was consistent with the age of respondents.

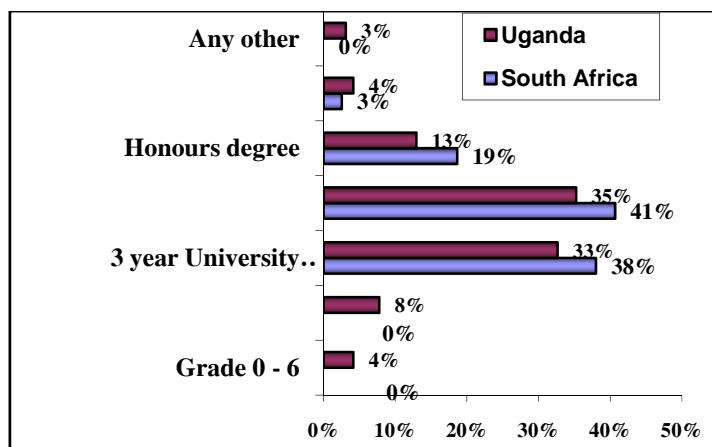
Figure 7.6: Marital status of the sample



In terms of religious orientation, both samples were predominately Christian (90% for South Africa and 85% for Uganda), with 10% Muslims in Uganda and 6% ZCC in South Africa. The percentage of Muslims in the Ugandan sample was consistent with the national Muslim population. However, the ZCC percentage in the South African sample seemed to be lower than the national ZCC population.

In terms of education qualifications, the most respondents had a 4-year university degree or 3-year university diploma. There were some Ugandan respondents who indicated that they have lower qualifications.

Figure 7.7: Educational level distribution of the sample



### 7.15.2 Comparing the groups

A comparison of the gender groups showed that the only difference between males and females was in terms of one of the concept: attitude ( $p=0.017$ ). Females had a more positive attitude than males (3.55 versus 3.39).

**Table 7.37: Scores of Males and Females on the Different Concepts**

	<i>Gender</i>	<i>N</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>t-test</i>	<i>P-value</i>
Biomedical knowledge	Males	81	4.38	0.60	0.10	0.545
	Females	110	4.32	0.77		
Legal knowledge	Males	81	4.17	0.43	0.91	0.218
	Females	109	4.09	0.43		
Attitude	Males	81	3.39	0.43	0.47	0.017
	Females	110	3.55	0.47		

Emotions: fear/irritation	Males	81	2.57	1.65	0.33	0.927
	Females	108	2.55	1.77		
Emotion: pity	Males	80	4.64	2.40	0.90	0.912
	Females	107	4.60	2.41		
Traditional belief	Males	81	1.83	0.65	0.92	0.247
	Females	110	1.72	0.58		
Discrimination	Males	81	3.72	0.56	0.80	0.182
	Females	110	3.83	0.57		
Self-esteem	Males	81	4.16	0.56	0.68	0.695
	Females	107	4.19	0.55		
Self-efficacy	Males	81	2.93	1.23	0.63	0.376
	Females	108	3.08	1.19		

## 7.16 FINDINGS OF THE QUALITATIVE RESEARCH

### 7.16.1 Incidents of discrimination and how they manifest themselves

With many laws in place and a relatively high level of biomedical knowledge, among other things, discrimination is not easy to expose but can be inferred from various subtle activities and tendencies towards those infected or affected with HIV and AIDS or those suspected to be HIV-positive in the workplace. I have to make it clear that some of these activities may be exhibited in overlapping situations and circumstances, which, however, are somehow connected to work or can translate into and even transcend work situations.



Discriminatory tendencies emerge during the exercise of interviewing people for various posts/positions which fall vacant or for promotion. This is illustrated by the response of one respondent to the question of whether she could recommend the appointment of an individual who outperformed others but was suspected to be HIV-positive.

The respondent's response was thus:

'I wouldn't appoint somebody whom I suspect to be HIV-positive even if he/she qualifies. I would fiddle with marks to make sure that that person does not get appointed. In case of a dispute, I would request him/her to clarify and substantiate his/her claims because the decision for appointment is made by the interview panel,' (40-50 years, female HOD).

The same question was posed to a male respondent aged 40-50 years and an HOD respondent in a rural primary school:

'In a situation when I'm on the interview panel, I would reconsider giving one employment if the best performer was with HIV and AIDS symptoms. In this regard, I would put the organisational interests, for example, teaching for learners, first. However, I know it is against the law but it does not make sense to me to appoint somebody who is soon going to the other world'.

'One could manipulate the marks obtained during the interview. However, it is a tricky situation since you may not be certain of the feelings and reactions of other panelists who may even have relationships with the interviewees for the post'.

'In labour intensive jobs, it should be plausible to give somebody a lighter job as his/her health deteriorates. This is mainly for manual work. However, even in teaching, somebody may have work description changed. Maybe, one should get conditions of

service changed instead of absolute dismissal which is illegal and discriminatory. If on an interview panel for employing teachers, I wouldn't in any way deny a successful person a chance to take up a job just because he/she looked to be sick or even just suspected him/her to be HIV-positive because I have no proof. Furthermore, while at work, I am "the government on the spot", that is, I represent the government; and hence I fulfil its policies. I cannot support the government and then go around sabotaging it.'

The intricacy of human behaviour regarding HIV and AIDS-related discrimination is illustrated by the responses of the respondents but in different circumstances:

'However, at home, I cannot at any one time hire somebody who looked sick or was sick as this would be a waste of time; and it would disorganise my work, assuming that the person was meant to look after my child'.

Pertaining to the issue of promoting a person who is HIV-positive or is suspected to be infected with the virus, responses were mixed as illustrated in the responses that follow:

'I'm not likely to promote a person who has obvious signs of being HIV and AIDS infected. However, the law must be observed'.

A black, widowed, female respondent, aged between 45-50 years had this to say:

'At work, I have not witnessed discrimination of an HIV-infected or suspected person. Outside (meaning away from the workplace), I have witnessed it. People fear using their cups and other utensils - referring to utensils used by HIV-infected individuals'.

'For me, I would not use the same toilet as an HIV-infected person. Faced with reality, I might shun a person who is HIV-positive. This is because, I'm not certain. However, I can hug a person but not use the same utensils and toilet/loo. I wouldn't disinfect it in an

infected person's presence because if seen doing that, one may imagine I'm discriminating.

Four years back, I was visited by a person who I suspected to be HIV-positive. It was me as the mother who cleaned the plates thoroughly. We're not yet certain of how HIV can be contracted'.

The respondent emphasised:

'I cannot allow a person who is HIV-positive to use my toilet/loo. I would clean it with a disinfectant fifty (50) times. I imagine if faced with such a situation, I would seek counselling first'.

#### **7.16.2 Issues surrounding confidentiality with regard to a colleague's HIV status**

There are many ways in which the confidentiality of an HIV-infected or suspected individual is violated. However, many of them may be subtle and varied. This is illustrated from the testimony of one respondent, a male, aged between 30-40 years:

'Once somebody has declared his/her status, you will hear people talking even if they are not directing it to you, but the affected person will know that they are talking about him or her'.

By the same token, another respondent, a female, aged between 40-50 years and an HOD had this to say:

'No confidentiality about HIV and AIDS prevails. This is evidenced from a teacher who revealed the status of an infected individual, incidentally a learner, who had confided in her. Much as she was buying her multi-vitamins, she could not keep the secret'.

Sometimes the lack of confidentiality prevails because of what might have happened in the past. In one instance, a respondent said that after a colleague had fallen sick for

long - and this caused persistent absence from work - that colleague was suspected to be HIV-positive.

Sometimes, information leaks easily from those who offer medical assistance. This is illustrated by one respondent's response:

'Information leaks easily. However, the information leaks from government hospitals, hence, it is better to go to a private doctor'.

'Since symptoms have become known, people can diagnose you correctly. However, information leakage is mostly not from work, except in cases of persistent absenteeism'.

There is, however, awareness of legal implications pertaining to divulging information about an individual's HIV status. This is illustrated by the response of a former HOD/principal of a farm school:

'Confidentiality prevails because of fear of legal implications. One can't even ask for one's HIV status as one may not be tested for HIV. In the policy, we encourage people to test so that once you know your status, then you may know how to look after yourself. Divulging HIV status is discouraged.'

Sometimes, there is ambivalence about issues of confidentiality pertaining to one's HIV status. As one female respondent indicated in the following illustration:

'Confidentiality is maintained. It is one's right and responsibility to disclose once infected. However, if a friend is involved, I could probably warn somebody to be careful about one's HIV and AIDS status of a man or woman proposing'.

As people in places of work form some informal social groups, there is a chance of HIV and AIDS information leakage mainly through gossip. 'Such a leakage then spreads the information like bush fire', said one respondent.

A reasonable number of respondents said that confidentiality regarding a colleague's HIV status prevailed. This is illustrated by a female HOD, aged between 50-55 years: 'Confidentiality prevails that is why we do not know who is HIV-positive'. However, since the respondent's comment was contrary to that of other two HODs in the same institution, this might have been a guarded response.

### **7.16.3 Perceptions of being conversant with HIV and AIDS knowledge: Legal and biomedical HIV and AIDS knowledge**

Generally, there was a higher perception of biomedical knowledge than legal knowledge of HIV and AIDS judged from the responses to the question on how one rated oneself on a scale of 1 to 10, where 1 (i.e. one) was the least and 10 (ten) the highest. Admittedly, this was a rather crude way of gauging the way individuals' rate their biomedical or legal knowledge. However, I argue that it could give an indication as to what people feel about their perception of their understanding of the two types of knowledge. The mean value for legal knowledge of HIV and AIDS is 5.1 compared to 7.1 of biomedical knowledge of HIV and AIDS.

It should be noted that even biomedical knowledge was acquired with a lot of reluctance or indifference as evidenced from what was a response of a 45-50 year old female as:

'I just read it (the HIV and AIDS information) for the sake of it. However, I also get it from the Pastor colleague of mine. I learnt about the CD4 counts from her'.

Again, the very same respondent who rated herself at level 5 on the HIV and AIDS legal knowledge lacked, to a certain extent, legal HIV and AIDS knowledge but stated with insight the truth as illustrated in the following quotation:

'Orphans should receive grants. However, employees should be pre-tested for HIV and AIDS if they work in profit generating companies'.

*(The former statement is true in South Africa and the latter is not true).*

Pertaining to legal knowledge, one of the respondents admitted that he was not inclined to legal issues and, hence, his knowledge is insufficient. In his own words:

'I'm not inclined to legal issues; hence, I know just a little'.

A 50+ year-old, male respondent, a naturalised citizen had this to say about legal HIV and AIDS knowledge:

'There is not a lot of emphasis on the legal part of HIV and AIDS knowledge compared to biomedical HIV and AIDS knowledge'.

There was a desire to know more about HIV and AIDS legal knowledge. This is illustrated by one black female teacher, aged 30-40 years:

'I have low HIV and AIDS legal knowledge. Hence, I want to study more about HIV and AIDS legal knowledge'.

However, respondents were not totally blank on the legal rights of HIV and AIDS affected and infected individuals as illustrated by the response of one respondent (31-40 years):

'An HIV-positive person has rights'.

Another respondent, a former principal/head of a farm school, nearing the retirement age of 60 years, was typical of a few legally knowledgeable educators as indicated by what he said:

'I rate myself at the level of 8 out of 10 on the scale of legal HIV and AIDS knowledge because I listen to the South African Broadcasting Corporation's (SABC 1) 'BEAT IT' OVERCOME HIV AND AIDS programme at 13:30 on Sunday.'

On this programme, they talk about infections, preventions, treatments, difficulty of not divulging HIV and AIDS information. And, the HIV-infected, HIV and AIDS specialists, doctors, researchers and victims in different disciplines have a chance to talk about HIV and AIDS and its implication'.

The respondent had this to say:

'As I have relatives who are infected, some do not want to talk; and others talk and I listen (*my emphasis*) to them. This has affected me because those who are infected are or, in some cases, were the young (15-35 years of age) who should carry our country forward'.

There was some expression of reality by respondents about what can be legally achievable. This is illustrated by the comment of one female respondent which is as follows:

'I know that there is legally no discrimination allowed; and those infected and affected by HIV and AIDS have to be supported - socially, economically and so forth. However, there is no expectation of adhering to the laws or even the full recovery for an HIV and AIDS-infected person because it is impossible'.

#### **7.16.4 The state of HIV and AIDS issues in schools**

Many schools have an HIV and AIDS policy. While most of them extracted the HIV and AIDS policy from the National Department of Education, very few participants were involved at the organisational level in drafting the policy on HIV and AIDS. There were

incidents where some organisations did not have any existing policy. In many instances, it was the School Management Team (SMT) and maybe with one or two other junior colleagues who drafted the HIV and AIDS policy. In some few instances, all stakeholders – learners, SMT, SGB and teachers were involved in policy drafting. Essentially, this drafting may indicate the meagre attention paid to HIV and AIDS in many schools - it appears to be just any one of those other extra responsibilities. Even where the policy may be present, this might be due to its being a Department of Education requirement.

From the above observation, one can infer that policy drafting and application still need further emphasis in order to help improve the awareness levels of HIV and AIDS issues in particular institutions. Hence, there is a need to call upon stakeholders to move from policy development to policy implementation.

Many organisations have been affected by HIV and AIDS to different extents. However, it is imperative to state that in the majority of cases, it is not stated that HIV is the cause of death. This, up to now, is still avoided under the guise of opportunistic infections (OIs), especially tuberculosis (TB) and pneumonia. However, people often conclude that a person has passed away because of HIV and AIDS, particularly when one dies after quite a long illness usually accompanied with the loss of weight. Once a person is observed to cough persistently, TB is inferred, and then HIV.

In some institutions, several teachers died after long illness accompanied with a lot of absenteeism which impacted on the productivity of the schools. The absence of teachers resulted in overloading of the remaining teachers; and this reduced the morale of both teachers and learners and resulted in ensuing inefficiency.



In many of the institutions surveyed, participants reported having many orphans whose parents were thought to have died of HIV and AIDS. This presumption is illustrated by one respondent's response (a female HOD, aged 50+ years):

'In the community we do not shun them – the HIV and AIDS affected and infected. People do not disclose their status. They say tuberculosis (TB) is the problem e.g., bone TB and other false stories, for example, somebody was working in a fridge'.

This has had an impact on the learners' performance as some often fall sick and, have more than normal levels of absence.

#### **7.16.5 Perception and treatment of colleagues suspected or who are HIV-positive**

The treatment of those colleagues suspected to be HIV-positive or those who were HIV-infected or affected, although not declared as thus, was varied. Some respondents like one Tswana 'born again' or 'saved' female educator aged between 30–40 years indicated that colleagues who were HIV-positive or suspected to be so based on symptoms, were accommodated. They could talk to them and eat with them. This is illustrated by her response:

'I had a colleague who was HIV-positive when I was working as a teacher in Taung (a rural place in the North West Province). She was not accommodated by her family and other relatives but me (the respondent) and my husband talked and prayed with her. Currently, I have a relative who is HIV-positive. I eat with this relative'.

Note that the issue of eating with someone is a vague one. It might mean different things to different people. For instance, eating together might mean sharing utensils at the same time, or sitting at the same place, and so on.

There is certain indifference toward HIV-positive individuals as illustrated by a divorced 45–50 year old white, male Afrikaner HOD respondent.

'I wouldn't like to know somebody's HIV status in the first place; and, I wouldn't tell anyone of anybody's HIV status. However, in sports situation one can get blood contaminations. So, I try to avoid such a person. A special position can be created for him or her, for example in rugby'.

A reasonably large number of respondents reported that stigma is abundant. This is illustrated by the response of one female respondent, aged between 31-40 years:

'People have not yet accepted the disease. Anyone in a relationship may get infected. Many pity and sympathise instead of empathising'.

A Sotho male HOD responded thus:

'Once symptoms are noticed, people are gossiped about, isolated and stigmatised - for example, they let everybody know that you are HIV-positive and look at you differently, wanting to scrutinise the person'.

Another female respondent (45-50 years) says that she noticed that relationships were strained between those affected and infected as in the illustration that follows:

'The relationship is not good. Those who are not infected do not want to mix with those who are infected. The non-infected do not want to eat the food brought by those infected or suspected to have HIV; and they gossip about the infected or those suspected to be HIV-positive since you will see the symptoms'.

Another HOD respondent aged 40+ claimed that women engaged in gossip more than men in this regard of HIV infection.

One respondent, a Tswana female aged 50+ years had this to say:

'Before we were taught how to treat people living with HIV and AIDS, we were a bit discriminative. We thought that eating with them would get infected. However, now with the knowledge of how to live with HIV and AIDS-infected persons or suspected individuals, we understand.

In case of a child bleeding, we have to put on gloves to handle him or her. We also teach children to treat one another with respect bearing in mind that they should also care for themselves'.

There has been some relative improvement in the way HIV-infected people are perceived. This is illustrated by the response of a Pedi (Northern Sotho) female (45-50 years).

'Positive attitudes are perceived unlike in the past when we were not enlightened. However, we still gossip a bit but show sympathy to those affected and infected or have lost parents. One colleague, a female pastor, shows very keen interest in helping and comforting affected persons, including learners. She shows empathy. She is a counselor in her church'.

#### **7.16.6 Traditionally/culturally attributed causes of HIV and AIDS and how they seem to contribute to fostering workplace HIV and AIDS-related discrimination**

Among the Tswana, Sotho and Pedi people (South African blacks) who participated in the in-depth interview, there was a common misconception attributing HIV and AIDS to breaking taboos following the death of a sexual partner. Also, some believe that the disease may be caused by not taking traditional medicines after a miscarriage. Some respondents said that HIV is a curse while some viewed it as a punishment from God - by God meaning the Almighty as understood in the Western context close to or related to the Biblical or Quranic/Koranic teaching. This goes further than that, that some

people do not see HIV as a disease, yet others attribute it to witchcraft. There is also a prevalent belief that HIV and AIDS is a result of ancestors turning their backs on you.

The myriad of what HIV and AIDS causes are attributed to included beliefs that HIV and AIDS is a white-man's conspiracy against the black people. Yet, there are also those who still believe that HIV and AIDS is caused by poverty, taking a leaf from Thabo Mbeki's views regarding HIV and AIDS.

With traditional beliefs being very central to the study, it is worthwhile to illustrate in a more detailed way the manner in which these traditional beliefs are ascribed as the cause of HIV and AIDS. The story is not meandering but purposeful as it is eminent in the way people hold on to these traditional beliefs.

One Tswana female respondent had the following to say regarding what her people attributed the cause of HIV and AIDS to be:

'Tswanas believe that HIV and AIDS is caused by breaking taboos (sexual taboos) and the disease is locally referred to as '*boswagadi*'. One gets this kind of disease once when a partner has died and you sleep around with another partner without undergoing the cleansing ceremony which lasts between six (6) months and one year. To prevent falling sick, one has to drink traditional herbs – '*Dipitsa*' or '*muti*' for about six months'.

But what is the reason behind taking such herbs? Immediately after the death of a spouse or a sexual partner, a herbal concoction is prepared for the widowed person to drink immediately. An elderly person, knowledgeable in these matters, prescribes a long term programme of drinking concoction of herbs for cleansing purposes.

Some of the limitations which are part of the cleansing ritual of a widowed partner include one removing oneself from society and the general public for sometime. Casual contacts are prohibited - these may include no shaking of hands or holding hands between a widowed and the un-widowed. Kissing, eating together, hugging and sharing of utensils are not allowed in some traditional communities to which the widowed belongs.

Some individuals who believe in traditional healers and/or witch doctors may take medicines from traditional healers. They endorse the idea that traditional healers and medical doctors should work together to treat HIV and AIDS. This is illustrated by one respondent's comment:

'Traditional medicines are helpful except for the problem of measurement. Wanting to heal fast, one may overdose which then becomes dangerous. It weakens the patient, but the probability of serious damage or even death may not be ruled out in some instances. Some traditional healers' intentions are not genuine – they may be liars or charlatans who want to swindle money out of the patient'.

Some people believe that HIV is a curse. They say that HIV is a punishment from God and it is not a disease. Also, there are those who blame witchcraft for HIV and AIDS. Because of these beliefs about HIV and AIDS, a person who has HIV or who is suspected of being infected by it may be treated badly, both at work and home.

The overall manner in which a widowed person is handled and treated in the traditions alluded to by the black South African respondents is rife with discriminatory innuendos. For instance, a bereaved woman usually puts on veiled black attire while a man puts on a hat or a black strip on the upper arm throughout the whole mourning period, which has already indicated varies from six (6) months to a year. In this whole period, one is

traditionally not supposed to indulge in any sexual activity unless they take the traditional medicine – the '*muti*' together.

Some people tend to avoid those who don the 'attire for mourning'. This may happen at work or in a taxi. This is illustrated by what one respondent had observed:

'Many teachers who have lost their spouses do not put on the mourning attire because some parents of the learners are opposed to their children being taught by people dressed in such an attire. In such instances, they only wear the attire at home'.

During the mourning period while one still wears the attire, one is traditionally not supposed to use the same cutlery used by the household - the same applies at work if one were to be fully observing one's tradition. Also, you should not directly hand over anything, be it a pen, a plate, a cup to a bereaved person. Normally, it would require one to put any article down and then the bereaved partner would pick it him/herself.

There are some differences in perception regarding the treatment of widowed people. Some do not view it as discriminatory but just as their tradition. This is illustrated by the remark of a female HOD over 50 years of age:

'For us blacks of the Tswana and Sotho nations believe in '*boswagadi*'. The widowed persons have to drink herbs so that they can be cleansed or cured. The herbs do not help but some insist their herbs work. They make money'.

'If you sleep with a widowed person who hasn't taken the herbal concoction, you will die. The legs get swollen, belly enlarges, and you become lean and will die. Your colour changes. However, you don't get pimples as in the case of HIV and AIDS.

This is a firm belief - a traditional belief. If the widowed person does not take the herbs (drugs), he/she will soon die. For example, one may die within two years. So, you need cleansing; that is, you need to 'drink the pots'.

Note the caution taken: It is believed that the same stove or fire place used for preparing food to be eaten by others is not to be used when preparing the 'herbs'/'pots'.

'By the way, we do not feel discriminated by respecting our customs. The widowed have to use separate utensils at home and at work. That is not discrimination. It's our culture. We do this until one is cleansed. Food has to be put down but not handed directly to the widowed. One has to eat the food with the last born or else he/she will contract an incurable "*sleeping sickness*"<sup>2</sup>. Traditionally, the person who serves the food must be a widowed person himself/herself'.

Her final remark was as follows:

'I cannot share food with coworkers'.

One respondent observed some 'reverse discrimination'. In this instance, those who believe or suspect themselves to be bewitched or perhaps HIV-positive tend to shun other people who are infected with HIV and AIDS as well as the uninfected whether in the workplace or at home. This may be because they do not want to associate, for example, with those persons they suspect to be bewitching them. They neither eat with them, nor sit with them.

---

<sup>2</sup>"Sleeping sickness" in this case does not refer to the one caused by the tsetse fly, i.e., trypanomiasis

Another notion that featured and seemed to be strongly adhered to was that of the power of ancestors on living persons with regard to HIV and AIDS, among other ailments. This is illustrated by the response of one Xhosa respondent:

'It's believed that HIV and AIDS is a result of the ancestors turning their back on you or you have been bewitched. A large majority of my people believe that this is the cause of HIV and AIDS.'

Unfortunately, once infected or affected, you are sidelined (shunned) because the unaffected/uninfected individuals are afraid of whatever might have caused the infection. This translates into a treatment which is discriminatory in all social situations, including the workplace.

Overall, many traditional beliefs still prevail as to what causes HIV and AIDS among black populations. Whites and Indians ascribe HIV and AIDS to a biomedical cause resulting from a lack of respect for oneself in most cases.

#### **7.16.7 Issues surrounding secrets - HIV and AIDS-related secrets**

To explore the issue of secrets in general and HIV and AIDS-related secrets in particular, I have reasoned that HIV and AIDS is a very sensitive issue, which to some people, almost spells death. I have reasoned that the dynamics driving revelation and keeping of secrets may have a profound contribution to understanding discrimination in relation to HIV and AIDS particularly in as far as violating the right to confidentiality of an HIV and AIDS infected or suspected person is concerned. The issue investigated was a very sensitive one, required something very close to soul searching and candid opinions about issues surrounding HIV and AIDS secrets.

The responses of the respondents were weaved into a narrative. However, the following questions are what informed the quest:



- (i) How difficult is it for you to keep a secret?
- (ii) Why is it difficult to keep secrets?
- (iii) What kinds of secrets can't you keep?
- (iv) What motivates you to leak secrets?
- (v) What do you think triggers other individuals to leak very sensitive information such as HIV and AIDS status of a colleague/coworker?

The respondents were allocated names/tags using the alphabet while disclosing their gender to personify the whole revelations. However, the names bear no relation to the actual names of the informants since it was not necessary to know their names in the first place for ethical reasons of anonymity and confidentiality. However, sometimes, some of their allocated tags corresponded with the initials of their real names.

### **Respondents 1: Abigail (A)**

*Q1: How difficult is it for you to keep a secret?*

I do not keep secrets for long but look for where to pour out my heart.

*Q2: Why is it difficult to keep secrets?*

It is hard to keep a secret because it will eat you inside like cancer! Very sensitive things may be poured out to a person I trust, not necessarily parents or relatives. To me, the more I confess, the more a secret will not bother me.

*Q3: What kind of secrets can't you keep?*

I have no category of secrets I can keep.

*Q4: What motivates you to leak secrets?*

I believe that a confession makes me free. The more you confess to people, the more you get people to sympathise with you and the support they accord to you – morally and socially. I would not reveal a colleague's HIV status without his or her permission. No leakages from me unless permission is first granted (*She stressed*).

*Q5: What do you think prompts others to leak sensitive information like HIV and AIDS status of a colleague?*

Colleagues are thought to reveal other people's HIV-positive status for the following reasons:

- To make us aware.
- To make us aware so that we may sympathise or become negative towards that person(s).
- Some lack room to accommodate other people's secrets.
- To prevent colleagues from falling in the trap of acquiring HIV and AIDS.

**Respondent 2: Bert (B)**

*Q1: How difficult is it for you to keep a secret?*

For me, secrets are kept but they have their own way of getting out. Say, you talk to the wife and the wife talks to another in confidence and so on.

*Q3: What kind of secrets can't you keep?*

I can keep any secret which may not endanger somebody else's life. Anything that may produce a fight I keep as a secret. It's a complex issue, not reveal or to reveal.

*Q4: What motivates you to leak secrets?*

Usually, I reveal secret information because of excitement or malice or saving one's skin even though I might be party to a certain bad act. Say, I can turn into a state witness. Generally, moral obligation would not force me to reveal a secret. However, anger may make me reveal a secret regardless of its sensitivity. *(He illustrates this with a local saying): Dikgang (ditaba) di tswa go omanwa.* That is, secrets come out when there is a conflict or quarrel about something; and also because of 'bedroom politics.

*Q5: What do you think triggers other individuals to leak sensitive information...?*

Malice and jealousy trigger others to reveal people's secrets including HIV status.

### **Respondent 3: David (D)**

*Q1: How difficult is it for you to keep a secret?*

Confidentiality is very essential for my job and I keep secrets absolutely. However, if I know that I can help somebody, then after getting permission to tell a third party, I can reveal the secret. According to me, it is not difficult to keep a secret. As an HOD and Guidance teacher, I have to keep secrets so that my trust with any other person involved or affected is not broken.

*Q3: What kinds of secrets would you reveal?*

I would reveal a life threatening secret. However, I must seek permission from the concerned person.

*Q4: What motivates you to leak a secret?*

Nothing would make me leak secrets! I wouldn't even like to know any one's HIV status in the first place.

**Respondent 4: Emely**

*Q1: How difficult is it for you to keep a secret? And, why?*

It is hard to keep a secret honestly, but it depends on what type of secret I have to keep. A secret haunts you, hence you may seek to confide in somebody neutral; that is, somebody who does not know the person concerned or affected. However, I can try to keep a secret around – (*referring to the workplace*).

*Q2: Why is it difficult to keep secrets?*

When it sometimes becomes very heavy you reveal a secret thinking that you may get help from an individual to help a victim of HIV and AIDS. However, nothing would force me to reveal a colleague's HIV and AIDS status. I can only do so with an infected person's permission. Without opening up, you die of stress among other things because of not having anybody to talk to.

*Q3: What kinds of secrets can't you keep? And, why?*

I cannot keep secrets which become available and secrets which are too heavy for me. Hence, I need to offload to a person who does not know the third party.

*Q4: What triggers other people to reveal sensitive information?*

Some people reveal sensitive information, say, a colleague's HIV and AIDS status because it becomes difficult when an infected colleague is very sick and will need help. Hence, you would reveal the secret after seeking permission of infected person. You will have convinced the person who is sick that he/she needs help. Some people reveal

sensitive information because it becomes too heavy for them or lack empathy and want to shame the infected person.

*Q5: What motivates you to leak secrets?*

While I keep secrets to a very large extent, for HIV and AIDS I may not go to that extent. HIV needs to be open and honest. For example, Emily said that when her sister became victim to HIV and AIDS, she (Emily) revealed the sister's status after the sister had accepted her HIV and AIDS status situation.

#### **Respondent 5: Frank (F)**

*Q1: How difficult is it for you to keep a secret? And why wouldn't you keep some secrets?*

It is not hard for me to keep secrets. However, I would not keep anything that would be dangerous to a person, for example, a plot of killing a person by somebody. I would warn somebody. In actual fact, I would reveal anything life-threatening. I feel a moral obligation in case of somebody would be killed without me informing him/her. I would reveal such a secret even if it puts me in danger. However, I would not tell anybody when a neighbour's partner is fooling around.

*Q4: What motivates you to leak secrets?*

Nothing may sometimes compel me to reveal certain secrets. I know that this is also in accordance with the law. However, when I do not reveal it, it is not for fear of persecution.

*Q5: What do you think triggers other people to leak sensitive information including HIV and AIDS status of a colleague/coworker?*

As for other people, they reveal a colleague's HIV status when they seek to know the reason for persistent sick leave. Some begin to speculate about somebody's HIV and AIDS status. Presence of symptoms may also prompt colleagues to reveal one's HIV and AIDS status.

**Respondent 6: Gabriel (G)**

*Q1: How difficult is it for you to keep secrets? And why?*

It is very hard for me to keep secrets. Sometimes a secret may just slip out and you talk about something but then state that it is confidential. I was taught by Catholics in grade 1–2 never to keep a secret. I will, hence, reveal a secret to do away with gossip for the better performance of the organisation. To me, a secret is a burden. Hence, once something is a secret, you rather not tell me because I can't live with it.

*Q3: What kind of secrets can't you keep?*

I cannot keep secrets which can badly affect the organisation's performance. However, I wouldn't leak someone's HIV and AIDS status, but can talk about a loafing individual.

*Q4: Why wouldn't you reveal a colleague's HIV status?*

I wouldn't divulge a colleague's HIV and AIDS status because of legal implications. I would not even talk with my wife about it for fear that she may divulge it. Some people usually reveal HIV and AIDS status of others, including colleagues, probably because they think that such an individual who is infected or suspected to be HIV-positive should be supported since one will be in the knowing. There is, generally, a need for social or moral support for infected individuals. Recently, my wife went to pray for a colleague along with her friends and later the individual became better when he saw the colleague's support.

*Q5: What do you think triggers other people to reveal HIV and AIDS status of colleagues?*

Others reveal HIV and AIDS status of others for discrediting such individuals.

**Respondent 7: Harriet (H)**

*Q1: How difficult for you to keep secrets?*

I am bad at keeping secrets. I would reveal secrets about relationships. For this matter, I wouldn't even cheat on my partner at all because I will end up revealing the whole thing.

*Q2: What kind of secrets can't you keep?*

I would reveal most illegal activities. However, I would not reveal some for fear of being killed. I would gossip about somebody to a friend if somebody is losing weight. I will always have a friend to tell. For me, I believe that a secret is between you and your conscience.

*Q4: What motivates you to reveal/leak secrets? Under what circumstances would you reveal secrets?*

Situations in which I am very likely to reveal a secret include: when I'm drunk, when no longer on good terms with a person. This is because of anger and sometimes when one is too happy (overexcited). Sometimes, I may reveal something unconsciously when talking about something related. Say, when one wants to borrow money, I may mention a person's name I may have learnt won *Lotto* – a kind of lottery. However, I would keep an HIV and AIDS status of a colleague secret, except if I get annoyed or angry.

*Q5: What do you think makes other people reveal colleagues' HIV and AIDS status?*

Some other people reveal other people's HIV status just because they do not mind whether they hurt them/you or not.

**Respondent 8: Isabella (I)**

*Q1: How difficult is it for you to keep a secret?*

'It is not easy to keep a secret being a human being.

*Q3: What kinds of secrets can't you keep? And why?*

I cannot keep secrets about relationships. I mean sexual relationships and love affairs. Again, I cannot keep secrets about shoddy deals and damaged property of any person. In the case of damaged property, if I do not reveal the information then I feel that I am unfair or cruel. Pertaining to relationships, in case I have a problem in a relationship, if I do not talk about it, I will be depressed. So I talk to get relieved.

In case of a friend who would want to fall in love with an infected person/or colleague, I feel obliged to tell him/her about the colleague's HIV status so that she/he can be safe from HIV and AIDS infection'.

*Q5: What do you think makes other people reveal their colleagues' HIV status?*

Other people reveal other people's HIV status because the disease is very dangerous. It kills people, so they cannot keep secrets about it. People fear HIV and AIDS. Others reveal colleague's HIV status because of jealousy, especially because most infected people are beautiful or handsome.

**Respondent 9: Janet (J)**

*Q1: How difficult is it for you to keep a secret?*



It is not hard for me to keep secrets. I keep them with confidence.

*Q2: What kind of secret can't you keep? And why?*

There is no kind of secret I can reveal generally. However, I cannot keep a secret pertaining to a friend and something criminal.

*Q3: What motivates you to leak secrets?*

In life-threatening situations, I would reveal the secret to save the life of one or both individuals - *this was in reference to HIV and AIDS status of a colleague*. I feel I have moral obligation to do so.

I may reveal a secret even when I don't have permission to disclose one's HIV status when I see that it will not embarrass the HIV-infected colleague. In this case, if people have some information they may not discriminate. In essence, I would reveal one's HIV status in presence of no adverse effect to the affected/infected individual. Some other people disclose colleagues' HIV and AIDS status because of suspicion. For example, a third party talks to one person who has a secret about another. The person holding the secret confirms it. In this case, it is a secret revealed.

*Q5: What do you think makes other individuals to leak colleagues' HIV and AIDS status?*

Others reveal people's HIV status because of anger. This happens when friendships end. People tend to talk bad about lost friends, i.e. the ones they have parted ways with.

**Respondent 10: Kitty (K)**

*Q1: How difficult is it for you to keep a secret and why?*

It's really hard for me to keep a secret because it will haunt me.

*Q: What kind of secret can't you keep?*

I cannot keep secrets of being ill (i.e. illness), but cannot reveal the HIV status. But people will see - meaning they will see the symptoms of an infected person. I will keep my HIV status a secret.

*Q: What motivates you to reveal a secret, say a colleague's HIV status?*

Sometimes I'll feel sorry and pity for a person infected or suspected to be HIV-positive and then talk about it. However, I can also tip a person about somebody's HIV status if I am sure, otherwise, I would fear being sued.

*Q5: What makes other people reveal colleagues HIV status?*

Some people reveal other people's secrets maybe because they want me to know that somebody is HIV-positive. However, even me, I would tell somebody's secret so that he or she can be treated nicely.

Other people divulge people's secret information maybe because they are having stress. However, often time, they tell the person they trust'.

### **Respondent 11: Loretta (L)**

*Q1: How difficult is it to keep a secret?*

It is hard to keep secrets.

*Q2: What kinds of secrets can you keep? And why not keep others?*

For me, I can only keep harmless secrets. Any harmful ('dangerous') secrets I cannot keep. I do not want to spend sleepless nights. Burdensome secrets should be shared with someone.

If a secret is burdensome, I release it. I want somebody to bear the burden with me (*She stressed*).

*Q4: What would motivate you to leak a secret, say, a colleague's HIV status?*

If a person trusted me, I would be loyal to that person. However, my sympathy may lead me to tell others to help him/her. It's really empathy versus sympathy when it comes to secrets about HIV status.

*Q5: What do you think makes other people leak colleagues' HIV and AIDS status?*

For other people reveal their colleagues' HIV status because of pity while others do it because of evil hearts.

#### **Respondent 12: Monica (M)**

*Q1: How difficult is it for you to keep secrets?*

It is not hard for me to keep secrets, but it also depends. If it is a family secret or my personal secret or that will hurt somebody, I cannot reveal it. However, I may disclose what one has told me not to reveal.

*Q2: What kind of secret can't you keep?*

Personally, I cannot keep any secret regarding useful information which can develop people. I cannot disclose secrets that would hurt a person, for example, a secret regarding denying a person a job.

*Q3: What motivates you to reveal a secret?*

The value of a secret may prompt me to reveal it. If it is a secret of a valuable kind of information, I will reveal it to those who will benefit from it. The delicate nature of the secret, the situation where we are and the emotion of the people I am working with, for example, the perceived prevailing atmosphere, emotions and stigma - all or any one of them may influence my revealing secrets which are very sensitive.

If people are open and free, then I can tell them to support the HIV-infected/affected or HIV-positive suspected individual. If people are not open and free, then I will not reveal the HIV and AIDS status of a colleague.

*Q5: What do you think makes other people reveal their colleagues' HIV and AIDS status?*

Other people reveal secrets pertaining to colleagues' HIV status because of fear. Sometimes, people reveal one's HIV status to help a person, presumably, uninfected of HIV and AIDS in case he/she may not be aware. Note: The infected person should reveal his/her status himself/herself. It is her/his right.

**Respondent 13: Noel (N)**

*Q1: How difficult for you to keep a secret?*

It is hard for me to keep secrets.

*Q2: What kind of secrets would you not keep?*

Generally, I would not keep minor secrets. Secrets such as when somebody is involved with another person's spouse, or a teacher/educator who is involved with a learner, or if somebody has stolen something from a person.

*Q3: What motivates you to reveal a secret?*

Several things can prompt me to tell secrets and these include the following: To relieve myself. In this case, I can tell a secret to another person. In some instances, by revealing the secret, one may be seeking information or advice to help someone. Also, I will reveal a secret so that I don't become incriminated alone. This would be the case of classified information, that is, top secret information pertaining to the State. I may tell a few people because I don't want to be found as the only one who has that particular information. By knowing that if the word comes out that I will go to jail, I will be relieved that I'm not alone in this case/thing.

As for the colleagues and people infected with HIV or those suspected, I sympathise, and I do not want to tell anybody until the infected or affected person discloses his or her HIV status.

*Q5: What do you think makes other people reveal colleagues' HIV AND AIDS status?*

Some people would reveal a colleague's HIV and AIDS status because they want to make a laughing-stock of the affected or infected person. There is friendship at face value and genuine friendship. In the latter case, one may not reveal a colleague's HIV and AIDS status.

Sometimes, a colleague talks about an HIV-infected or a HIV-suspected colleague's status because he/she wants to seek assistance to help a colleague. To date, HIV

status is a kind of information which is a secret. Once many people know, some of them may influence you to go and test. Then you may treat yourself better rather than believing in miracles for treatment.

**Respondent 14: Oliver (O)**

*Q1: How difficult is it for you to keep secrets?*

It is not very hard for me to keep secrets.

*Q2: What kind of secret would you not keep?*

I wouldn't keep secrets regarding financial status. This is generally about my financial status. However, I would not engage in discussions which border on gossiping. As for disclosing sensitive information regarding others, for example, one's HIV status, you expose yourself as a person who lacks trust.

*Q5: What do you think triggers other people to reveal colleagues' HIV and AIDS status?*

Other people engage in revealing colleagues' HIV status because of fear of HIV and AIDS. Fear of getting infected once you get in contact with an infected coworker. Others reveal such secret information because of the stigma attached to HIV and AIDS. In addition, there are those who reveal secrets just because of malice. This may be in the case where a colleague may be excelling in their work to the dismay of others. The motive behind this kind of revelation is to destroy that particular individual.

**Respondent 15: Paula (P)**

*Q1: How difficult is it for you to keep secrets?*

I generally do not have difficulty in keeping secrets. However, I would not keep a secret that can lead someone into problem. For example, if I knew of corruption incidents which can lead somebody to jail, I would be compelled naturally to reveal such information. As a matter of fact, this arises out of concern, sympathy and care for the person affected. In other circumstances which lead to a different result, I wouldn't reveal a secret.

For the person who does not understand what a secret is - it is like telling more than one person. So I keep what I regard to be a secret to myself only.

*Q4: What would motivate you to reveal a colleague's HIV status?*

With regard to revealing an HIV status of a colleague, this may be motivated by sympathy, care and concern for somebody infected or for those who can get infected.

*Q5: What do you think triggers people to reveal colleagues' HIV and AIDS status?*

Other people reveal the HIV status of infected or affected or those suspected to be infected with HIV because HIV and AIDS are closely related to death. It is a threat. When one is sick or suffering from HIV and AIDS, he/she might die, or might spread it to other people. All these are threats and they drive you to reveal the HIV status of colleagues. Some people reveal secrets of a colleague's HIV status to make other people aware so that they can take due precaution. However, this borders on discrimination much as it was done for safety reasons, especially before we were educated about HIV and AIDS.

I remember a colleague who once told me to assist a colleague by sending to me another colleague who was suspected to be HIV-positive much as I had not requested

the colleague for this information. Incidentally, I had earlier on invited that supposedly HIV-infected colleague twice to advise him on where to get some medical assistance'.

**Respondent 16: Queen (Q)**

*Q1: How hard is it for you to keep secrets?*

It is very hard for me to keep a secret. In situations where somebody who told me a secret annoys me, I will let the secret out.

*Q2: What kinds of secrets would you not keep?*

I would not keep a secret which can destroy somebody. I may not keep such secret! (*She stressed*). In situations whereby I keep a secret, I would be part of a conspiracy. I would not be able to keep such secrets at all for sure.

*Q4: What would motivate you to leak a secret?*

Anger is the prime factor which may prompt me to tell a secret. When I'm angry I'm not good; I'm not safe (*she stressed*).

If someone is careless about his/her HIV status, for example, being a risk to others, I will tell his/her HIV and AIDS status. I would risk being sued if somebody is very careless, for example, if one who is infected with HIV and AIDS does not use condoms; and he/she boasts of it. Or, in situations where one spills blood carelessly. I am confident I can prove my case and argue it successfully and win.

*Q5: What do you think triggers people to reveal colleagues' HIV status?*



Other people reveal their colleagues' HIV status because they like mocking others. Others do so because they naturally cannot keep secrets, yet others have a desire to share sensitive information with other people.

**Respondent 17: Robert (R)**

*Q1: How difficult for you to keep secrets?*

It is not hard for me to keep secrets. I can keep many secrets, especially very serious ones. I do not entertain grapevines and rumours.

*Q: What kind of secrets would you not keep? And why?*

I can keep secrets like those about domestic affairs and health-related issues. However, I cannot keep secrets which can lead me to jail, for example, those related with dealing in drugs (narcotic drugs).

While so far I have never revealed an affected colleague's HIV status, I can reveal a secret if the affected/infected colleague will be disadvantaged. Anything with detrimental results, I would not reveal such a secret at all. For example, I do not think of telling government one's health history. I respect the law.

*Q5: What do you think triggers other people to reveal colleagues' HIV and AIDS status?*

Other people reveal secrets just because they do not have backbones - that is, they cannot stand their ground. Others reveal secrets for financial gains. Often, promising a financial reward makes some people give essential and secret information. Some other people reveal colleagues' HIV status as a way of forging friendship with those who they give the information.

Also, some people reveal secrets like those of a colleague's HIV status because of bullying, especially in a workplace where a boss can extract something from you if he/she threatens you that you will not get your benefits unless you give the information.

Misunderstandings and anger between people, even in a workplace may result in one revealing the status of an HIV-infected colleague. Lastly, some individuals do reveal their colleagues' HIV status because of wanting to do harm to them. This could be done as an off-the-record remark, say in an interview or a verbal recommendation.

**Respondent 18: Simon (S)**

*Q1: How difficult is it for you to keep secrets?*

As for me, it is not hard to keep secrets.

*Q2: What kind of questions would you not keep?*

I would not reveal secrets that would not endanger my life, for example, those secrets which do not require testifying in the Court of Law. I would basically reveal minor secrets. When defending myself, say in a Court of Law, I would try to avoid going down the drain, hence, I would reveal the relevant secret.

Generally, I reveal secrets not really meaning to, but just as gossip and loose talk.

*Q5: What do you think triggers people to reveal colleagues' HIV status?*

'Other people usually reveal colleagues' HIV status through the gossip they engage in. Other people may reveal infected people's HIV status because of hatred, that is, if people do not like you and look forward to your down fall. In the workplace there is the

Pull Down Syndrome (PDS). In this case they like to know your mistakes and misfortunes and build on them.

**Respondent 19: Teresa (T)**

*Q1: How difficult is it for you to keep secrets?*

For me, I don't want to keep secrets. It is hard to keep secrets. I don't want to keep a secret for even two days.

*Q2: What kind of secrets would you not keep? And why?*

I would reveal a secret which could cause danger to another person, for example, a plot to kill a person. I do not want to put anyone in danger. If the information can help to save a person's life, then I will reveal it. However, even if my life would be in danger, I would dare to reveal a secret that can save life.

*Q3: What would motivate you to reveal a colleague's HIV status?*

Concern and care for the HIV and AIDS infected or suspected person, for example, in case of making him/her get convinced to go for medication would compel me to reveal the status of such a person. Otherwise, if the person infected is not in a dangerous state, i.e. not in an acute condition, I may keep the secret.

*Q5: What do you think triggers other people to reveal colleagues' HIV status?*

Other people usually reveal a colleague's HIV status as they gossip. Gossiping about negative things like sleeping around being the cause of one's HIV status may trigger me to reveal a colleague's HIV status.

**Respondent 20: Ursula (U)**

*Q1: How difficult for you to keep secrets?*

It's so hard to keep secrets, but I'm trying. However, it's hard to keep a secret about one who might spread a disease as dreadful as HIV.

*Q2: What kinds of secrets would you not keep?*

Secrets which I cannot keep include those involving loss of life. For example, HIV status of an ex-boyfriend/ex-girlfriend proposed by a friend of mine may not be kept.

*Q4: What would motivate you to reveal a colleague's HIV status?*

Factors which make me reveal one's HIV status may include the danger in which people may be in. This may be a matter of do or die but I would save a person even if I'm to go to jail.

I reveal secrets to save somebody's life. Also, the behaviour of a person may make you reveal a colleague's HIV and AIDS-status; or out of anger, I may reveal a colleague's HIV status. However, sometimes I may just ignore you.

*Q5: What do you think makes other people reveal colleagues' HIV status?*

Pertaining to why colleagues reveal their coworkers' HIV and AIDS status, this may be because of no respect for the dignity of other people. Others just talk carelessly without

minding the sensitivity of the issue. Hatred is another reason for revealing the HIV status of a colleague. In this case, anything harming your 'enemy' is your joy.

Lack of knowledge, especially legal knowledge and policy is yet another reason why some colleagues reveal their coworkers' HIV status.

**Respondent 21: Victor (V)**

*Q1: How difficult for you to keep secrets?*

It is so hard to keep secrets, but I try my best. However, it is hard to keep a secret about one who might spread a disease as dreadful as HIV. For me, no money could force me not to do it at all.

*Q2: What kinds of secrets would you not keep?*

I cannot keep secrets involving loss of life. I cannot keep this in anyway. I cannot keep the HIV status of an ex-boyfriend or ex-girlfriend who is proposed by a friend of mine.

*Q3: What motivates you to reveal a secret, including one's HIV status?*

Sometimes, the danger in which people may be in may force me to reveal a secret. This may be a matter of do or die, but I would save a person by revealing a secret even if I am to go to jail.

Essentially, saving somebody compels me to tell a secret. Sometimes, the behaviour of a person may make you reveal a colleague's HIV and AIDS status. This is usually out of anger. However, sometimes I may just ignore one.

*Q5: What do you think triggers other people to reveal colleagues' HIV status?*

Other people reveal the HIV status of colleagues just because they have no respect for the dignity of other people. Others do so because they just talk carelessly without minding the sensitivity of the issue. Some other colleagues reveal secrets regarding their coworkers' HIV status because of hatred. Therefore anything harming your 'enemy' is your joy. Also, there are those who leak secrets of infected colleagues because they lack knowledge, especially HIV and AIDS legal knowledge and HIV and AIDS policy.

**Respondent 22: Winnie (W)**

*Q1: How difficult is it for you to keep a secret?*

It is not hard for me to keep secrets.

*Q2: What kind of secrets would you keep? And, why not reveal other secrets?*

I can keep any secret, particularly all sensitive issues. However, I can reveal personal secrets so that I get relieved or 'healed'. For others, I can keep their secrets.

When something is 'eating' or bothering me because I know it alone, then I reveal it.

*Q4: What would motivate you to reveal a secret?*

Nothing would prevent me from keeping a secret of an HIV-positive colleague. However, moral obligation may force me to tell others to prevent them from falling into danger.

*Q5: What do you think triggers other people to reveal other colleagues' HIV status?*

Other people reveal coworkers' HIV status so that the infected person can get support. Actually, this is done out of care.

Other people reveal their colleagues' HIV status for several reasons, such as, care for the infected person, so that one can be supported. Some reveal colleagues' HIV status to 'down load' or lighten their problem onto someone so that they – the HIV-infected or affected person - becomes free or feels relieved to mix with others by making time to create a platform for the HIV-infected coworker. Others also reveal a colleague's HIV status because of anger and malice.

**Respondent 23: Yvonne (Y)**

*Q1: How difficult is it for you to keep secrets?*

It's very hard for me to keep secrets. So, I reveal secrets to get help to help the one who is sick or infected.

*Q2: What kinds of secrets would you not keep?*

I wouldn't keep a secret of the kind like when one has done something wrong. One must be counseled not to do even a worse crime. Again, if I have a relationship with somebody, and he/she gets involved with somebody else, I can boldly reveal such a secret.

*Q3: What would motivate you to reveal a colleague's HIV status?*

Some reasons why HIV status of a colleague may be revealed include care for the individual suffering. Sometimes, it is just because of concern for the sick. The conditions under which an infected person lives may cause you to reveal. If I don't reveal, he/she will be isolated. However, by not wanting him/her to be isolated, you may incidentally isolate him/her. It is a dilemma! *Ke kgomo ya Mosate o a e gapa o molato, o a e tlogelao molato*. Translation: 'A chief's cow, if you take it to the kraal, you have defaulted; if you leave it behind, you have defaulted – it is a real dilemma!

*Q5: What do you think triggers others to reveal their colleagues' HIV status?*

Other colleagues reveal colleagues' HIV-positive status to alert others about one's HIV status so that those uninfected may take care of the infected. Also, to help the one you have told and the one person whose HIV status is revealed to guard against HIV and AIDS.

**Respondent 24: Zeddy (Z1)**

*Q1: How difficult is it for you to keep secrets?*

It is not difficult for me to keep a secret. It is a question of maturity. As the head of the organisation, I'm trusted; I have confidence and do not seek popularity. Hence, I keep secrets. I work on trust and I'm trustworthy.

*Q2: What kind of secrets would you not keep?*

There are secrets I wouldn't keep including life-threatening secrets. For example, if one wants to commit suicide or when one who raped a person is known to me. I wouldn't keep such secrets! I would seek help from others who are capable. If an HIV-infected person who is so ashamed is known to me, I would look for a counselor to help prevent the person dying lonely. I feel guilty for a person dying without me offering assistance. I detest criminal activities and I would reveal such information.

There are reasons why I may reveal a secret I'm meant to keep. These include: compassion for the person and concern for the person. Surely, I do not reveal such information to humiliate the person, say in case of one's HIV status - we are all going to die. There is no need to embarrass a person to lose his/her pride.



*Q4: What would motivate you to reveal a colleague's HIV status?*

Regarding what would prevent me from keeping a secret of one's HIV and AIDS-status, this could be regulations regarding a status of a person, lack of evidence of one's HIV status and fear of incrimination - you can be sued since one may lose his/her job through being fired.

*Q5: What do you think triggers others to reveal a colleagues' HIV status?*

Other people in the workplace reveal their colleagues' HIV status to humiliate the infected. So they do it, that is, reveal the HIV status of someone to ostracise the infected. Hence, they do not want to associate with him. They can give you an emotional death as you are mentally ruined.

**Respondent 25: Zhubairi (Z2)**

*Q1: How difficult is it for you to keep secrets?*

I do not have difficulty in keeping secrets. It's a management requirement. We're not to divulge. You may be sued.

*Q2: What kinds of secrets would you not keep?*

There are secrets I wouldn't keep. I would not keep any illegal activity secret, for example, claiming that one is HIV-positive. Other secrets I may reveal include anything that is illegal and can badly affect the organisation. Anything which can put me in trouble at a later date would be revealed.

*Q3: What would motivate you to reveal secrets?*

What prompts me to reveal secrets may be, say, when participating in a survey or annual statistics. Also, on a humanitarian ground, to keep the sick and the family aware of what is going on, for example, in getting proper treatment. This may be to counter denial. It is to help the person positively. Again, on legal ground, I would reveal information if required legally.

It's only legal requirement which would make me reveal a colleague's HIV status once I'm compelled to do so.

*Q5: What do you think triggers other people to reveal colleagues' HIV status?*

Other people reveal colleagues' HIV status because of a number of reasons. Looking at the person's symptoms, people start talking based on observations reconciled with the knowledge gained from workshops.

Sometimes, the behaviour of those infected may cause others to reveal their HIV status. Behaviour in this regard includes recklessness and being promiscuous. Sometimes people may be forced to talk without any apparent obvious motivation. Also, some leakages of information from other people may make others to reveal a colleague' HIV status.

#### **7.16.8 Summary on the issue of secrets relating to HIV and AIDS in the workplace**

On analysis, it is generally hard for the individuals interviewed in this study to keep secrets. It is not clear whether this is cultural or relates to any other factor which is not yet established and not investigated in the study.

In a nutshell, secrets pertaining to HIV status are very likely to be leaked when counselors interact with colleagues they suspect of being HIV-positive.

The issue of moral obligation, in a disguised manner, breaches the rights of those individuals infected with HIV or affected with HIV and AIDS to a certain extent. Those who claim revealing people's HIV and AIDS status as moral obligation may do so with other intentions but these intentions may not be good but they are real. . They present the easily acceptable reasons in lieu of the real reasons behind not keeping secrets in order to 'protect' the infected and affected individual. The respondents seem not to want to reveal their real feelings about controversial issues which they deem to be personal. This is clear from the respondents' private and public perceptions and opinions of HIV colleagues.

This is an issue concerned with social desirability. I argue that this social desirability is not surprising especially regarding the issue of revealing the status of a colleague given the sensitivity of the issue. This may not come to the fore of moral obligation because moral obligation like morals themselves is not standardised. Morality is only what the majority at any given time agrees upon. In this regard, one may look at issues like polygamy. While in western society monogamy is the accepted norm perhaps because of strong and long standing Christian values, in many African societies, polygamy is embraced. This appears to be the case in some South African cultural groups -- Zulu men can have multiple wives irrespective of their religious affiliations. Similarly in Uganda, many Christians are also in polygamous relationships. Morality is also dependent on the current status quo of what is accepted or not.

Mention should be made here that while there were those who initially stated that it was easy for them to keep secrets, the overall in-depth interview revealed that in real life, people are likely to reveal secrets, including colleagues' HIV and AIDS status at one time or the other, for varied reasons.

### **7.17 THEME 1: IMPACT OF HIV AND AIDS ON YOUR INSTITUTION (SCHOOL)**

Researcher: How has HIV and AIDS affected your organisation on the past?

Respondent A (teacher): No teacher has been affected so far.

Respondent B (HOD): No effect on teachers; and no reported cases of learners.

Respondent C (Teacher): HIV and AIDS has made many learners to lose parents. Many learners are now acting as parents and are taking care of younger siblings at an early age. Poverty is predominant. I feel sorry for not being able to provide support effectively.

Respondent D (HOD): I don't know how much HIV and AIDS have affected this school. I joined this organisation only recently.

Respondent E: We lost one educator (male teacher) in 2001. And, many learners are affected. So far, one learner has disclosed to a teacher.

Respondent F (Teacher): HIV and AIDS have had a negative impact on our institution. HIV and AIDS-infected teachers are absent most of the time and hence, less work is being done. There is loss of human resource, i.e. there is waste of skills.

Respondent G (HOD): Absenteeism of one educator was rampant. It affected her performance, especially when she couldn't perform her duties of teaching about HIV and AIDS. She was in denial at first but later she accepted her HIV-positive status. She still performs her duties and has a constant body weight. No problems emerged from the community and learners because of the teacher's HIV status. Keeping secrets about HIV and AIDS led some people to die.

Respondent H (Teacher): No individual affected in this school, but in other schools, HIV and AIDS has had serious effects.

Respondent I (Teacher): HIV and AIDS have had an effect on my organisation. So far, five (5) teachers have been infected, and all have died in a period of 2 years. Learners do not have enough money for school fees so they end up sleeping around with different guys, especially with guys working in the mines. Girls get pregnant and infected since they sleep with whomever who can give them money; these girls usually have multiple sexual partners, an indication of more chances of getting HIV and AIDS. She referred to chances as 'possibilities'.

For teachers, even when they know that they have knowledge which one also referred to as 'light', through workshops they continue to have sex without condoms. They end up being infected with HIV and AIDS. They then perform poorly since they are no longer 'free' with their learners and coworkers. 'Not free' meaning that learners gossip about them since they look or seem sick; and hence, they become impatient with learners and become aggressive towards colleagues. They attack those colleagues who may be talking with each other, thinking that they are discussing them and talking about their health.

Respondent J (Teacher): HIV and AIDS is a very sensitive issue in our organisation. One learner had tuberculosis (TB) and was taken to clinic by the respondent herself. Teachers contributed to the welfare of this sick boy by buying vegetables for him. While no colleague has been affected with HIV and AIDS to my knowledge, there is still a lot of denial.

Respondent K (HOD): HIV and AIDS have affected our organisation badly. There are a lot of orphans who depend on their grannies. However, so far, no teacher has been infected. Ten (10) learners have been affected by losing parents.

Researcher: Have you witnessed any job restrictions due to one's HIV and AIDS status?

The responses to this question varied as illustrated in the quotations that follow:

Respondent L (HOD): No restrictions due to HIV and AIDS status. However, I wouldn't appoint somebody whom I suspect to be HIV-positive even if he or she qualifies. In case of a dispute pertaining to non-appointment, I would request him/her to clarify and substantiate his/her complaint, because according to me, the decision of appointment is for the interview panel and is not vested in any one individual. I may fiddle with marks to make sure that this person does not get appointed (HOD).

Respondent M: Yes, I have witnessed restrictions due to one's HIV and AIDS status. It took the form of reducing workload for an infected colleague who was frequently absent from duty. Reducing workload brings conflicts among colleagues since the affected person may be doing less work but earning the same salary. In case one is unable to carry out all his/her workload, such a person should be advised to opt for a medically unfit certificate and thus formerly retire from the job.

Researcher: Would you appoint somebody suspected to be HIV-positive?

Respondent N: This is a serious issue. At work you are required to be productive. This implies one must be able to do the job otherwise one should be off the job. However, on an interview panel, I would give somebody the benefit of doubt and appoint him/her

despite the symptoms which may be showing. It is not true that being HIV-positive you are going to die very soon, you may in fact live for another 20 (twenty) years if you look after yourself by changing your lifestyle to manage the disease.

Again, training should not be denied because of one's HIV status and employment benefits shouldn't be denied since there are no specific conditions of employment for HIV-positive workers.

Respondent P: I wouldn't refuse to appoint anybody because of HIV and AIDS status suspicion.

Respondent F: No witnessed case of restrictions due to HIV and AIDS status. All employees are treated the same. Those infected or affected by HIV and AIDS are treated as normal human beings until they close their eyes. HIV and AIDS are like any other disease; it's like a heart attack except that a heart attack kills you faster. Chronic diseases are equally serious. TB, much as it is infectious, is not as stigmatised except for the drug-resistant TB strain which kills fast.

Researcher: Have you witnessed any denial of employment on the grounds of HIV status?

Responses to this question yielded no affirmation to witnessing any denial of employment on the grounds of one's HIV status. However, that is just part of the answer. A number of respondents qualified their response; this is illustrated with the quotations that follow:

Respondents B, D, F and L: No discrimination witnessed as far as any denial of employment on the grounds of HIV status. This was in observance of the Constitutional requirement in the Republic of South Africa.

Respondent M: Those infected with HIV and AIDS must earn money to cater for themselves. It is against the Constitution. They have a right to be employed.

Respondent Q: No discrimination witnessed regarding to any denial of employment on the grounds of HIV status. However, if it is to be done, it has to be very indirect.

Respondent S: No denial of employment due to HIV status witnessed. According to me, I can employ that kind of a person who is HIV-positive because it could be me who is infected or affected. Even at home, I can employ an HIV-infected person depending on his or her stage of sickness.

Respondents T, V, W and X: While no denial of employment due to HIV and AIDS status was experienced, I would give a job to the person who succeeds at the interview even if he/she looks to have the symptoms.

Respondent Y: No incidence of denial of employment based on one's HIV and AIDS status was experienced, but in the case of somebody who is weak due to HIV and AIDS but passes the interview, I would not recommend him/her as he/she will be making me do his/her work in the long run and pulling the organisation down. However, if one is just HIV-positive but able to work, I would recommend him/her for the appointment. In essence, it is a dilemma to take him/her on or not.



Respondent Z: No denial of employment on the grounds of HIV status witnessed. As long as HIV-positive individuals are 'healthy', i.e. not weak and can manage to work and can cope with workplace stress, then they can work.

If one passed an interview, much as he/she looked to be infected, he/she would be given the job. He/she has the will to live and the will to work. He/she wants to contribute, and then one should be allowed to live with dignity. Therefore there is no denial of employment on the grounds of HIV status. The interview panel members don't ask for the interviewees' status during the interview for employment.

Respondent Z2: I would appoint someone who appears sick from HIV and AIDS but performs well at interview. I would support him/her in any way. Those infected with HIV and AIDS should be able to come out, especially with the members of the institution's management team supporting them. You can see a perfectly healthy person who eventually breaks down within three (3) weeks. It comes down to the same story.

Researcher: Have you witnessed such incidents as:

- Individuals shunning a coworker because he/she was suspected to be HIV-positive?
- Individuals refusing to eat with a colleague due to suspicion or effective HIV and AIDS status issues? and
- Individuals discussing HIV and AIDS in the workplace?

Responses were tabulated to give a quantitative picture of the issue while, wherever and whenever possible, qualitative analysis is done.

## **7.17.1 Summaries pertaining to qualitative data on workplace HIV and AIDS-related discrimination**

*7.17.1.1 Summary of the qualitative data regarding the issue of witnessing incidents of shunning a coworker due to HIV status:*

Slightly below one in five of respondents (18.5%) had witnessed an incident or incidents of colleagues infected with HIV and AIDS being discriminated against in the workplace. Close to four percent (3.7%) had not witnessed incidents of shunning employees in the workplace but had witnessed incident of shunning HIV and AIDS infected people in the community. Approximately four out five respondents (78%) had not witnessed any incident of shunning a coworker because of his/her HIV-positive status.

*7.17.1.2 Summary of the qualitative data on the issue of witnessing incidents of not eating with or refusing to eat with an HIV-positive coworker is as follows:*

About one in five (18.5%) of all respondents interviewed confirmed having witnessed a worker refusing to eat with an HIV-positive coworker or a coworker suspected to be HIV-positive. Close to four-fifth (74.1%) of the respondents reported not having witnessed an employee refusing to eat with an HIV-positive coworker or a coworker suspected to be HIV-positive. Seven percent of all interviewees claimed the issue was not applicable to their organisations.

*7.17.1.3 Summary of the qualitative data on witnessing incidents of discussion of HIV and AIDS in the workplace*

Of all respondents interviewed, just one in seven (14.8%) had not witnessed HIV and AIDS being discussed in the workplace. Various reasons were given for not discussing HIV and AIDS much as those given for discussing them. Close to eight out of ten (78%) respondents reported having witnessed HIV and AIDS being discussed in the workplace.

What follows is a series of responses given to qualify as a summary of the above in

7. 17.1.1, 7.17.1.2 and 7.17.1.3 above:

#### *7.17.1.4 Pertaining to shunning an HIV-positive worker by colleagues*

Respondent E: Individuals who are suspected of being HIV-positive tend to be withdrawn. It is reverse shunning, which happens when symptoms begin to show. Yet, this is when they need to be closer to people. Other coworkers not infected with HIV and AIDS, shun away because they do not want to show pity. Hence, the issue of shunning HIV-positive coworkers is a matter of 'yes' and 'no'.

Respondent L: Nobody likes to touch the infected people because of traditional beliefs and myths about what causes illness. They then isolate you and distance themselves from the infected. They do not want to touch. This results in social barriers.

No shunning HIV-positive employees witnessed. However, outside I have witnessed shunning of HIV-positive individuals. People fear using the same cups and other utensils.

For me, I would not use the same loo with an HIV-infected person. Faced with reality, I might shun a person who is HIV-positive. This is because I'm not certain. However, I can hug a person but not use the same utensils and toilet/loo. I wouldn't disinfect the toilet, because if seen doing that one may think that I'm discriminating.

Respondent P: They were whispering about her health, and they suspected she was HIV-positive. They avoided her a little bit.

Respondent S: Once you lose weight, they say you are HIV-positive. People who die of TB have the same symptoms and similar effects. People shun you once you are in this state.

Respondent L: Four years back I was visited by a person who I suspected to be HIV-positive. It was me as the mother who cleaned (washed) the plates thoroughly after use. We were not yet certain.

Respondent Z1: Seeing a very 'thin' lady, the physique of even one who eats a lot without getting any bigger, they show the attitude that you are infected by keeping away from such a person.

*7.17.1.5 Regarding the issue of refusing to eat with a coworker suspected to have HIV and living with AIDS, the following responses were recorded*

Respondent P: People refuse eat to with a coworker suspected to have HIV and AIDS. But ever since we were taught about HIV and AIDS, some people eat together even with those suspected to be HIV-positive.

Respondent S: People believe they can get HIV when they share the same plate with an infected person and they also prefer to drink directly from a bottle instead of sharing a glass. They go on to buy small bottles which are not convenient for sharing.

Respondent L: I have not witnessed a coworker refusing to eat with an HIV-positive colleague. For me, I cannot allow a person who is HIV-positive to use my toilet/loo. I would clean it fifty (50) times with disinfectant. If faced with such a situation, I would seek counselling first

*7.17.1.6 Regarding individuals discussing HIV and AIDS in the workplace, the following responses were:*

Respondent C: We discuss HIV and AIDS in the workplace because we have relatives who are affected. We discuss food, medication and lifestyles.

Respondent D: We always discuss HIV and AIDS in the workplace. Key topics which feature are the cause and transmission of HIV and how it can change the lifestyle and

economy of those infected and affected. We discuss how it influences life beyond the workplace; for instance farm owners, cost to government through campaigns and medicine. In effect, HIV and AIDS is affecting the whole country.

Respondent E: On going to weekends, people remind each other that HIV and AIDS kills; please take care. At work we are like a family.

Respondent F: We discuss topics like the treatment of HIV and AIDS, advantages and disadvantages of getting into the ARV programme and chances of a condom bursting (condom efficacy during sex).

Respondent G: Yes, we discuss HIV and AIDS in the workplace. Key issues discussed include the benefits of testing and the challenges faced when trying to enlighten people. However, people often shy away from such discussions. They want to shun the topic probably because they do not want to be associated with HIV and AIDS. People are not afraid of how people perceive them. That is, people fear discrimination rather than HIV and AIDS; otherwise they would be taking precautions to prevent infection or contracting HIV.

Respondent H: Yes, discussions about HIV and AIDS take place. The issues generally discussed include the following:

- How would you react if you find you are HIV-positive?
- How would you react towards those family members who are found to be infected with HIV?
- Would you tell us if you were HIV-positive?

She noted that people say that they would be able to disclose their HIV status but they do not know what would happen in reality. It is more of an issue of 'wait and see' until reality is amidst us.

Respondent I: The discussions centre on HIV and AIDS prevention and abstinence.

Respondent L (*She teaches in a middle school, usually with old and young adolescents who are not so much versed with personal hygiene*): We do discuss HIV and AIDS in the workplace. Topics discussed include impact of HIV and AIDS on learners' studies, for example, learners' parents who are HIV-positive, which then leads to learners' withdrawal from school.

We discuss with HIV-positive parents and TB-infected parents when they visit us. Sometimes, we discuss newspaper cutting like that one of a traditional healer who contracted HIV by cleaning her patient's wounds.

In our school, learners have been taught to clean their mess after menstruation because we don't know their HIV status.

Respondent M: We discuss issues relating to HIV and AIDS in the workplace and HIV and AIDS as a dangerous thing - a killer disease! Other topics discussed include:

- Abstinence
- Drugs and their impact on HIV and AIDS.
- People who are drugged before they are raped by HIV and AIDS infected people. They eventually contract HIV.

Respondents N, P and W: During HIV and AIDS discussions, topics include testing for HIV to know one's status before we can help anybody else and teaching them about the use of condoms. By the way, one needs to check his/her status every six months. We also advise one another about eating health foods.

When comrades are suspected to be HIV-positive, we advise them to condomise when having sex in order to avoid spreading the disease. Re-infecting one another or being re-infected is what we would want to avoid.

Respondent X: Yes, we discuss HIV and AIDS in the workplace because we are concerned. Topics discussed include:

- Where did the disease come from?
- Why is there no cure?
- Why do educators appear to be the most affected? This is stressful.

We have hope that after a time, a cure will be found as the case was with TB - another disease which took some time to get a cure.

Respondent Y: We discuss HIV and AIDS, but we just do it in passing. However, in the past four (4) months I started to go deep into HIV and AIDS-related issues.

Respondent Z1: Yes people are very concerned about HIV and AIDS. We discuss safe sex and the impact of HIV and AIDS to the community.

## **7.18 THEME 2: TRADITIONAL BELIEFS AND RELIGIOUS GROUPS' ACTIONS AND REACTIONS TOWARDS HIV AND AIDS INFECTED AND AFFECTED PERSONS.**

The data will be presented as follows:

- Quantitatively - present features coming out of the respondents' responses. This is not meant to subject the data to statistical analysis but to add clarity and to ease the making of justifiable claims of analysis and conclusions of the quantitative data.
- Qualitatively - present the respondents' responses which are illustrative of the traditional beliefs held by respondents (and the beliefs of those they represent) as well as the respondents' religious groups' reactions and actions towards those infected or affected by HIV and AIDS.

**Table 7.38: Frequency of possible causes of HIV and AIDS based on traditional belief.**

Cause	Frequency	percentage
<i>Boswagadi</i>	17	56.7
Witchcraft	5	16.7
Promiscuity	2	6.7
Punishment from God	3	10.0
Whiteman's conspiracy against blacks	1	3.3
Ancestors turning back on you	1	3.3
No actual cause known	1	3.3

**Table 7.39: Frequency of religions' reactions to HIV and AIDS and to those infected/ affected with HIV and AIDS\***

Reaction	Frequency	percentage
----------	-----------	------------



Reaction	Frequency	percentage
Encourage Western medicine/treatment	11	21.6
Moral support (e.g. prayers and actual visit and accept the sick)	11	21.6
Fair treatment even of the infected	5	9.8
Advocate abstinence	4	7.8
Use 'holy water' (including 'holy tea')	3	5.9
Render social support	3	5.9
Encouraging the use of condoms	3	5.9
Encourage both traditional and Western medicine/treatment	3	5.9
Shun the infected person(s)	2	3.9
Educate people (offer HIV and AIDS awareness)	2	3.9
Emphasise good morals	1	2.0
Holy communion still done with one cup for all congregation	1	2.0
Holy communion done with separate cups due to fear of contracting HIV	1	2.0
Provide food parcels, help in home and clean	1	2.0
Encourage traditional medicine/treatment	0	0.0

\*The total adds up to 100.2% instead of 100% because of having computed the percentages to a single decimal point. It approximates to 100%.

### **7.18.1 Sub-theme 1: Traditional beliefs and the causes of HIV and AIDS**

Researcher: What is the cause of HIV and AIDS according to the beliefs of the people in your culture and how does it influence workplace HIV and AIDS-related discrimination?

This question formed the first sub-theme of the second theme. Results showed that respondents' cultural groupings attributed the cause of HIV and AIDS to a variety of causes. The treatment of people who were infected with HIV and AIDS or those who had lost sexual partners, to a certain extent, influenced workplace HIV and AIDS-related discrimination, particularly amongst the black communities. The following responses illustrate the key issues pertaining to what is believed to be the cause of HIV and AIDS and how it translated into workplace HIV and AIDS-related discrimination.

Respondents A and Y: The Tswana people believe that HIV and AIDS is caused by breaking sexual taboos. The disease is called *boswagadi*. It is commonly believed among the Tswana people that when a sexual partner has died and you sleep with another sexual partner you fall sick. To prevent one from falling sick, the surviving partner has to drink traditional herbs locally or in vernacular referred to as *dipitsa* for a period of about six (6) months.

Respondent A: I had an aunt who lost a husband, she took both *dipitsa* and that aggravated her situation according to her belief. Somebody with such belief will not necessarily be discriminated against.

Respondent B: Discrimination of the surviving sexual partner may occur since he/she is "out of circulation", i.e. out of public for some time. Again, casual contacts are prohibited. For example, the bereaved sexual partner is prohibited from shaking hands

and sharing utensils. I am not certain about prohibition from kissing, eating together, hugging and using the same toilet facilities.

Respondent F: People do not open up in our culture (Tswana culture). However, we have to live with it. The secret we live with kills us. This contributes to HIV and AIDS discrimination as some families do not allow some people to visit those infected by HIV and AIDS. We want to hide it, maybe because of stigma. As such, family members influence discrimination in a way.

Respondent M: The drinking of traditional herbal drugs, also referred to as *muti* locally, is meant to cleanse the surviving sexual partner. While drinking the *dipitsa* in the cleansing process, we do not feel discriminated but respect our customs. He stresses that when still being cleansed, a process which may last up to a year in some instances, you have to use separate utensils at home and at work. Food has to be put down and not directly handled to the one mourning for a lost sexual partner. Similarly, work equipment and materials may not be handed to the mourning person directly according to our customs. Incidentally, the food is prepared and served by another person who is widowed himself or herself.

Respondent Q: After the funeral, they cleanse you. This goes on for a month. You are allowed to work but you are not allowed to attend functions, for example, burial ceremonies and weddings. Amongst us Xhosa, you are not supposed to cook and touch utensils used by others but you can share the food with others. However, while still donning mourning clothes, you are traditionally supposed to be in the house before sunset. However, you may negotiate the issue of what you can wear since you may not be comfortable to work with a full black robe. For men, while still in the mourning period, a strip of black cloth is put on the shirt or coat.

For me, I would mind to hear learners sympathise with my loss perpetually if I were to put on the mourning cloth for a year.

Respondent Q: Some people still believe HIV and AIDS is a myth. There are some who also still believe they can cure HIV and AIDS in my tradition. This is in line with former Minister of Health Manto Tshabalala (South Africa) who emphasises nutrition.

Respondent R: Some people believe HIV is due to *boswagadi*. However, I don't believe in *boswagadi* causing HIV and AIDS. On marriage, Tswana people are given medicine in their food during the wedding ceremony. So, when one partner dies, it has to be washed away. This lasts for three to twelve months. While undergoing treatment (which takes about six months) movement, especially among ladies, is restricted. Culturally, they are not allowed to work for six months. This brings down productivity. It's also discriminatory as one is restricted to move. However, for people who are working the leave structure does not allow this, maybe because it brings down productivity.

Respondent T: People believe HIV is caused by sleeping with widowed person during the period of cleansing or who has not been cleansed. The widowed person uses specific utensils alone, wears mourning clothes, and the food is cooked separately with some herbs added for cleansing. Widowed men put on a strip of cloth on the arm and a hat.

No random movement is allowed. But one can visit particular people who have to allow you to visit them by giving you sorghum seeds to spread in all directions of a particular place. There is no direct handing over of anything to a widowed person, eg, money, plates.

When the mourning period is over, cleansing is done; the person mourning (especially females) must throw herbs from home to workplace. It is alleged that once a widowed person passes nearby a baby, the baby may fall sick; and cows may have miscarriage and premature birth leading to death of the fetus. Whatever might have caused the sickness of the dead person, the widowed person must not be handed anything directly.

Respondent W: During the mourning period, the mourner is treated differently. This borders on discrimination. I remember an incident in which a lady dressed in mourning clothes was ordered to sit at the back seat of a taxi but not at the front seat as she could cause bad luck. However, in our school when one colleague lost a partner in a car accident, she was not discriminated against in anyway. This gave her courage. Everything was done as if she had not lost a partner.

HIV is caused by *makgome*, that is, sleeping around before the mourning period is over.

Respondent Y: While still in the mourning period, the widowed person is not supposed to talk a lot in meetings. Your freedom is curtailed until you take off the mourning clothes.

Respondent Z: People believe HIV is due to a traditional cause. Hence, traditional medication is preferred to Western medicine. The infected, I mean black Africans, prefer going back to their roots. When one is about to die, one goes to hospital, only to gain a death certificate!

People believe that once you have sex or you rape a virgin you get healed. Some believe that you can be prayed for so that the evil in you can come out. Some people believe that HIV is the evil brought by a white man.

Indians believe that promiscuity leads to HIV. Sex before marriage is a taboo, i.e. sex comes after marriage. There is no myth about HIV causation, he emphasised. We believe that HIV is caused by a virus, and affects irresponsible people. We believe in a single partner relationship.

Respondent Z2: The Indian community does not want to open up so much. Promiscuity may be the cause of HIV, but they don't attribute the cause of HIV to bewitching.

Witchcraft ranked number two as the cause of HIV (refer to Table 7.37). Several quotations illustrating the belief in witchcraft as being the cause of HIV are highlighted below:

Respondent E: Those people who believe in traditional healers and/or witch doctors would take medicines from them. By implication, those people believe that HIV is caused by witches.

Traditional medicines are helpful except for the problem of measurement. Wanting to heal fast, one may take an overdose and it may become dangerous as it causes the weakening of the patient. Some traditional healers are not genuine. They are liars; and, just want to make money out of people/patients, she remarked.

Respondent H: HIV and AIDS are caused by witchcraft.

Respondent J: People believe in witchcraft, and they believe that HIV is due to witchcraft. People do not want to name the disease HIV and AIDS even when the doctor names the disease! They do not want to associate with HIV instead they shift it to witchcraft.

Respondent L: At the beginning people thought that HIV was due to bewitching.

Respondent N: It is believed that HIV and AIDS is a result of ancestors turning their back on you or you have been bewitched.

Punishment from God ranked third in the rate of frequency as a cause of HIV and AIDS.

Below are some responses which illustrate people's beliefs in HIV being a punishment from God (refer to Table 7.37).

Respondent Z: Some people believe that you can be prayed for so that the evil in you can come out.

Promiscuity as a believed cause of HIV and AIDS:

Several respondents said that some people believed that HIV is caused by promiscuity. Interestingly, and by coincidence, the respondents were both of Indian origin, one a priest in his church and the other an ardent Moslem.

Other causes of HIV include:

Respondent D: My people believe HIV has a biological cause.

Respondent O, N and Q:

- Whiteman's conspiracy against black people;

- Ancestors turning their back on you; and
- No actual cause known respectively

**7.18.2 Sub-theme2: Religion’s action and reactions to HIV and AIDS and towards those infected with HIV and AIDS**

**Table7.40: Frequencies of witnessed selected discriminatory actions**

Issues witnessed	Frequency of responses		
	Yes	No	Not applicable
Shunning coworkers due to HIV status	5(18.5%)	21(78%)	1(3.7%)
Refusal to eat with HIV-positive colleague (suspected)	5(18.5%)	20(74.1%)	2(7.4%)
Discussing HIV and AIDS in the workplace	21(78%)	4(14.8%)	1(3.7%)

The analysis that follows is in line with Table 7.39. As indicated, the reactions of those belong to particular categories which were varied reactions to both HIV and AIDS and those infected or affected by HIV. Based on the tabulation on Table 7.39 religious groups featured moral support for those infected with HIV as the most important, followed by fair treatment of the infected and advocacy for abstinence. Other features included the encouragement of condom use, rendering social support, using ‘holy water’ (including ‘holy tea’), increasing awareness of HIV and AIDS, emphasising good morals, providing food parcels and helping with house cleaning, holy communion done with separate cups due to fear of contracting HIV in some churches; and holy communion still done with one cup for all congregation in some other churches. However, the last three practices in the list occur at the same but the lowest frequency.



Below are some responses from the respondents regarding specific reactions of religions (or religious groups) towards HIV and AIDS and those infected and affected by HIV and AIDS. The responses are presented in their specific categories.

**7.18.4 Moral support through prayers, acceptance of the sick, infected or affected and actual visits.**

Respondent A: For those infected with HIV, they are encouraged to take treatment. In case one gets infected, we accept you.

Respondent B: My brother with HIV is still my brother.

Respondent C: Your friend is your friend regardless of HIV and AIDS status.

Respondent G: Moral support and no discrimination is recommended. They even have a programme whereby if a family member is infected with HIV and AIDS, the church members provide food parcels and help in house cleaning.

Respondent H, I, J, K,L, N, O, and P: Our religion encourages people to go for treatment and to pray often.

Respondent Q: We, Methodists, advocate for medical attention, but if you want to visit traditional healers you may. You may mix the two for better results. We pay visits to sick people regardless of their HIV status. However, I do not know what the aged people do or think about this matter.

Respondent R: As Christians, we believe that HIV and AIDS does exist, and there must be treatment. We are in partnership with the government. We pray for the sick and

support those who are infected with HIV and AIDS. We advocate for modern medicine. However, all medicines come from herbs. They only lack measurements which are constant (referring to traditional medicine from herbs). Hence, I advocate for partnership between modern and traditional healers.

Respondent S: Our church emphasises trusting in God and we go to the extent of praying for you (the HIV-infected person) at hospital; but you cannot be visited at traditional healers. People feel healed after prayers.

Respondent V: My religion advocates modern medicine in the treatment of HIV and AIDS. They preach that my friend is my friend even if he/she is HIV-positive, but they somehow discriminate somewhere in practice. For example, once one discloses that he/she is HIV-positive, he/she gets fewer visitors and friends decrease. People do not practice what they preach!

Respondent Z: Western medicine is advocated but sometimes we go to a priest for prayers and 'holy water'. When you're losing life you try anything.

#### **7.18.5 Fair treatment of an HIV-infected person.**

Illustrative remarks/quotations for the above are cited below:

Respondent B: HIV-infected persons must not be shunned, however, I hesitate to drink from the same cup with one suspected to be HIV-positive.

Respondent N: While church and government advocate no shunning of HIV-infected people, once one is infected, you are avoided (shunned) because the uninfected individuals are afraid of whatever might have caused the HIV infection. This translates into discriminatory treatment which is in all social situations, including the workplace.

Respondent S: At work, colleagues may create excuses to avoid you once they suspect you are infected or affected by HIV and AIDS.

### 7.19 THEME 3: SECRET KEEPING AND RELATED ISSUES.

**Table 7.41: Level of difficulty of keeping secrets**

Gender	Very hard		Moderately hard		Easy	
	Frequency	%	Frequency	%	Frequency	%
Male	4	29	1	20	6	86
Female	10	71	4	80	1	14

Overall, 14 respondents out of 26 (54%) responded that it was very hard for them to keep secrets; 5 respondents out of 26 (19%) said it was moderately hard, while 7 (27%) of respondents said it was easy for them to keep secrets.

In terms of gender, it was found that 10 out of 14 (71%) females found it very hard to keep secrets, 4 out of 5 (80%) found it moderately hard to keep secrets compared to 6 out of 7 respondents (86%) males found it easy to keep a secret. Overall, male respondents found it easier to keep a secret compared to females. Overall, 5 female HODs found it very hard to keep a secret compared to 4 male HODs.

**Table 7.42: Types and frequency of secrets revealed**

Type of secret	Frequency	Percentage(%)
Life threatening (killing a person)	7	20.6
Heavy/burdensome secrets (personal problems)	5	14.7
Relationships (sexual relationship)	5	14.7
Performance-related (those affecting organisational effectiveness/performance)	4	11.7
All inclusive (shoddy deals)	3	8.8
Gossip	3	8.8
Destructive (jeopardising one's career)	2	5.9
Not endangering one's life and/or health	2	5.9
Helping a person (to seek medication, give useful information)	2	5.9
Financial (personal financial secrets)	1	2.9

Life-threatening secrets would be leaked most frequently, followed by secrets regarding relationships (sexual relationships which are extra-marital or burdened on infidelity). The burdensome secrets, organisational performance-related secrets, gossip, all inclusive secrets (for instance shoddy deals), not life-endangering secrets, helping secrets, destructive secrets and financial (personal financial secrets) follow in decreasing frequency.

**Table 7.43: Factors prompting revealing secrets and their frequency**

Factor	Frequency	Percentage (%)
Helping (giving helpful information, say, for treatment or promotion)	9	20.9
Relief (to relieve one of one's psychological burden)	8	18.6
Moral obligation (saving a life)	6	14.0
Excitement (and happiness)	4	9.3
Saving one's skin (turning into a state witness)	3	6.9
Gossiping	2	4.6
Anger	2	4.6
Seeking sympathy (looking for moral and social support)	2	4.6
Fear (worry its life threatening)	2	4.6
Survey/research reason	1	2.3
Drunkenness/intoxication	1	2.3
Unconscious (revealing by inference)	1	2.3
Malice	1	2.3
Legal reason (testifying)	1	2.3

A variety of factors prompting revealing secrets were given by respondents. The most frequent factor for revealing secrets was helping, relief, moral obligation, excitement

(and happiness), saving one's skin, seeking sympathy, fear (plus worry), anger, gossiping, malice, unconscious revelation, drunkenness, intoxication, survey/research and legal (revelation in Court of Law) under oath.

**Table 7.44: Factors that would prevent one from keeping a colleague's HIV status**

Factor	Frequency	Percentage (%)
Sympathy (psycho/socio-support environment seeking care concern for the HIV person)	9	34.6
Permission granted by concerned/affected person	3	11.5
Moral obligation	2	7.6
Pity	2	7.6
Anger	2	7.6
Carelessness (recklessness of colleague infected with HIV)	2	7.6
Distrust	2	7.6
Empathy	2	7.6
Performance concern of organisation (decline in performance of concern of an HIV-infected person)	1	3.8
Lack of knowledge	1	3.8
Participating in body contact sports/games in which blood spillage is a possibility	1	3.8

Factor	Frequency	Percentage (%)
Hatred	1	3.8

### 7.19.1 Reasons for non-revelation of HIV status of colleagues

The most frequent factor that the respondents gave which made people reveal coworkers' HIV status was, incidentally, being sympathetic to the infected or affected person. Permission granted by the infected colleague was the second most frequent while anger, distrust, carelessness/recklessness behaviour of the infected, gossiping, pity, empathy and moral obligation followed. Concern for organisational performance, participation in contact games/sport, hatred and lack of knowledge were less frequency. However, one should note that the high frequency response for non-revelation of a colleague's HIV status was respect of the law or fear of litigation.

**Table 7.45: Reasons for why colleagues reveal coworkers HIV-positive status**

Reason	Frequency	Percentage (%)
Malice	5	9.4
Instill negative attitudes (including stigma and ostracism)	5	9.4
Gossip (including compulsive gossiping)	5	9.4
Make others become sympathetic	5	9.4
Fear of the dreadful disease	4	7.5
Make others aware so as to take precautions to assist (care and concern)	4	7.5
Insensitivity	4	7.5
Suspicion (speculation following persistent	4	7.5

Reason	Frequency	Percentage (%)
absenteeism)		
Egoism ( plus mockery, humiliate)	3	5.6
Anger	3	5.6
Jealousy	2	3.7
Hatred	2	3.7
Pity	2	3.7
Financial reward	1	1.8
Relief	1	1.8
Recklessness of the HIV-positive person	1	1.8
Bullying	1	1.8
Lack of knowledge	1	1.8

Malice, gossiping, instilling negative attitudes and making others sympathetic to HIV-positive employees were the most mentioned as reasons why a colleague would reveal a coworkers' HIV-positive status. Making others aware, taking precautions, care/concern, insensitivity, suspicion (following persistent observation) and fear of the dreadful disease came next in equal frequency of being mentioned.

Anger and egoism followed with equal frequency in third place. Hatred, jealousy and pity were all in fourth place while bullying, lack of knowledge, relief, recklessness of the HIV-positive person and financial reward took the lowest level of frequency.



**Table 7.46: Self-ranking of keeping highly sensitive information like HIV and AIDS status of colleagues**

Level	Frequency	Percentage (%)
10	2	7.7
9	4	15.4
8	6	23.1
7	4	15.4
6	6	23.1
5	3	11.5
4	1	3.8
3	0	0.0
2	0	0.0
1	0	0.0

This self-ranking showed that 53.8% (14 respondents) rated themselves moderately high while 46.2% (12 respondents) rated themselves highly and none rated themselves lowest on keeping highly sensitive information. It would be wise to treat this rating with caution since the frequency rates may have been influenced by wanting to show social desirability. The percentages may be indicative of the job requirements or responsibility given the fact that the sample was highly populated with HODs (SMT members).

### **7.19.2 Noted limitations of using the quotation approach relevant to this study**

Qualitative methods as they are used by qualitative researchers deal with only a highly restricted portion of psychology, primarily the inner experience of mentally capable adult humans. Even to the most optimistic researcher it would be considered to be extremely impoverished. Under a less optimistic set of assumptions, it may be considered to be impoverished to the point of irrelevance. For example, there are many who believe that conscious processing of information, even for functioning human adults, plays only a small role in affecting human behaviour. *The New Unconscious* (Harsin, Ulman & Bargh, 2004), states that 'a new picture of the cognitive unconscious has emerged from a variety of disciplines' and 'according to this picture, unconscious processes seem to be capable of doing many things that were thought to require intention, deliberation and conscious awareness'.

### **7.20 CHAPTER SUMMARY**

This chapter presented the results of quantitative data first and then qualitative data. In both cases, results were presented in tables which were appropriately labeled. Summaries were also presented for the data in this research. The relevant descriptive and inferential statistics appropriate for the requirements of this study have been dealt with in this chapter.

# **CHAPTER 8: DISCUSSION: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS**

## **8.1 INTRODUCTION**

This chapter deals with the general discussion of results first, followed by interpretation and methodological certainty. A discussion of the findings regarding traditional beliefs, knowledge of HIV and AID; and attitudes towards those infected with HIV and AIDS or affected by HIV and AIDS, in integration with existing literature, and implications follow. .

Limitations to the study are discussed later in the chapter along with the strengths of this study. Then future directions, specifically future research and practical applications follow as recommendations.

## **8.2 GENERAL DISCUSSION OF RESULTS**

This research set out to determine the relationship between traditional beliefs about HIV and AIDS, knowledge of HIV and AIDS and attitudes towards those infected (real or suspected) with HIV and AIDS or affected with HIV and AIDS as well as workplace HIV and AIDS-related discrimination. The research also aimed to predict which factor drives discrimination, mostly in order to explain why the phenomenon of workplace HIV and AIDS discrimination continues to persist despite the provision of HIV and AIDS knowledge and attitude change programmes.

The findings of this study confirmed the hypotheses:

- Individuals who scored highly on the HIV and AIDS traditional beliefs scale were more likely to engage in workplace HIV and AIDS-related discrimination than those individuals who scored highly on the HIV and AIDS knowledge scale.

- Individuals who scored highly on the traditional beliefs scale were more likely to engage in workplace HIV and AIDS-related discrimination than those individuals who scored highly on the HIV and AIDS attitude scale.
- Individuals who scored highly on the HIV and AIDS attitude scale were less likely to engage in workplace HIV and AIDS-related discrimination than those individuals who scored more highly on the HIV and AIDS knowledge scale.

Further analysis of the results showed that traditional beliefs, regarded as a single concept, were the greatest predictor of workplace HIV and AIDS-related discrimination. Traditional beliefs were followed by attitudes toward those infected with or affected by HIV and AIDS. HIV and AIDS knowledge, as a general concept, did not predict workplace HIV and AIDS-related discrimination. However, when HIV and AIDS-legal knowledge was separated from HIV and AIDS biomedical knowledge, HIV and AIDS-legal knowledge predicted workplace HIV and AIDS-related discrimination in the Ugandan sample, but not in the South African sample.

Witchcraft (as a reason for causing HIV and AIDS) may be, to a certain extent, the reason why traditional beliefs are more likely to be associated with workplace HIV and AIDS-related discrimination than HIV and AIDS knowledge. Ashforth (2005a) has stressed the idea that witchcraft is the explanation put forward by traditional healers for people contracting HIV and AIDS. Inferring from the percentage of people who consult traditional healers in Africa, which is about 80% (see WHO, 2002), there is a very strong likelihood that belief in witchcraft as the cause of HIV and AIDS is predominant among those who believe in witchcraft.

The significant contribution of traditional beliefs over attitudes in predicting workplace HIV and AIDS-related discrimination is in agreement with Furnham *et al.*; (1999) from a study that looked at three cultures of Britain, Uganda and South Africa, which found that

the African participants were more likely to attribute illness to 'evil others' but all of the groups in that study rated interpersonal stress as a potential source of illness. Another theory, the personalistic disease theory attributes illness to intervention by an agent such as another human, witch, sorcerer, non-human, or supernatural force. Emotionalistic disease theories explain illness as caused by strong emotional states (e.g. intense anger, jealousy, shame, grief or fright). The personalistic and emotionalistic disease theories are easily applied to patients of non-Western cultural backgrounds who are familiar with and have faith in the medical beliefs and practices often in their own cultures (Foster, 1976:773-82; Foster & Anderson, 1978).

This provides another explanation within the dual form of diagnosis of illnesses. Dickinson (2008) says that belief in witchcraft is widespread within African societies and clearly forms part of the range of problems traditionally dealt with. He warns, however, that this is not always immediately visible because witchcraft is an issue that Africans are frequently reluctant to talk about, and belief in witchcraft is often implicit rather than explicit.

In this study, attitudes toward people infected or affected by HIV and AIDS had a more predictive value than HIV and AIDS knowledge; however, both biomedical HIV and AIDS knowledge combined with HIV and AIDS legal knowledge indicated otherwise. For example, Peltzer (2003) found that participants reported a weak positive attitude towards people with HIV and AIDS. In the same study, HIV and AIDS knowledge was associated with a more supportive attitude towards people with HIV and AIDS. Peltzer's (2003) finding was in line with the findings of other studies (Kaplan & Van den Worm, 1993; Royse, Dhooper & Hatch, 1987), which found that knowledge about HIV and AIDS fosters a more positive attitude toward people who have AIDS. It is worth noting that this result was missing in this study. The focus was on finding predictors of workplace HIV and AIDS-related discrimination rather than associations between HIV and AIDS knowledge and attitudes towards PLWHA.

What people do is motivated by what they believe, as surely as what people believe stems from their experiences. Put the other way round, what we experience influences what we believe, and what we believe motivates us to do what we do. Therefore, it is plausible to suggest that what people experience in their individual lives influences their beliefs about HIV and AIDS. And hence, these beliefs, if they promote discrimination toward those suffering from or affected by HIV and AIDS, their work situations HIV and AIDS-related discrimination will ensue.

What Holland (2004) notes corroborate with the findings of this study. A number of respondents stated that ancestors have a bearing on misfortune and the life of an individual in general. For example, ancestral spirits which normally protect the family can withdraw this protection if upset by a living member of the clan. Sickness can result from the wrath of formerly benign forebears, who are ever present and absorbed in the lives of their descendants. They must be appeased continually, especially in troubled times, lest they are angered through neglect and jealousy or slighted by broken religious tenets. So, given the centrality of traditional beliefs to Africans, here referring mainly to black Africans, it is plausible that those who believe or hold on to traditional beliefs tend to engage more in workplace HIV and AIDS-related discrimination, because behaviour motivated by traditional beliefs is more predominant than behaviour through one's attitudes toward HIV and AIDS infected or affected persons or HIV and AIDS knowledge.

This study confirmed that a number of constructs relevant to Social Cognitive Theory, the Theory of Planned Behaviour, and the closely related Theory of Reasoned Action were associated with workplace HIV and AIDS-related discrimination. Traditional beliefs, followed by attitudes towards people affected with HIV and AIDS and then knowledge, particularly HIV and AIDS legal knowledge, predicted workplace HIV and AIDS-related discrimination in decreasing order. In a nutshell, traditional beliefs about

the causes of HIV and AIDS predicted engaging in workplace HIV and AIDS-related discrimination more than attitudes towards HIV and AIDS infected/affected individuals, which was also more predictive of workplace HIV and AIDS-related discrimination than HIV and AIDS legal knowledge.

This argument, increasingly embraced by development agency benefactors, has lent support to this study of why workplace HIV and AIDS-related discrimination persists despite the provision of HIV and AIDS knowledge and attitude change programmes. The issue is that traditional beliefs rather than attitudes towards those people infected with or affected by HIV and AIDS or HIV and AIDS knowledge is the best predictor of workplace HIV and AIDS-related discrimination. As indicated above, traditional beliefs linger on in disproportionate manner though not easily expressed.

The findings from this study showed that despite the high knowledge, particularly, biomedical knowledge of HIV and AIDS and yet still discriminate, teachers may still be having some inappropriate knowledge. Linking this to that argument, Dixon (1999) argues that individual actions are mediated by meaning structures. This means that stigmatisation and discriminatory behaviour is seen to be a function of the individual's current meaning structures. It can therefore be speculated that those who stigmatise do not understand the condition, lack a relevant frame of reference/meaning structure and that this is supported by inappropriate knowledge of the condition. Furthermore, according to Chiliaoutakis *et al*; (1999), the initial characterisation of HIV and AIDS as being the result of clandestine, immoral and antisocial behaviour as well as the stereotyping of 'high risk' groups on this basis, paves way to a 'fullblown' AIDS social epidemic of stigmatisation and discriminatory practices. It can therefore be argued that HIV and AIDS-related (stigmatisation) and discrimination build upon and reinforce prejudices that already exist and strengthen existing social inequalities.

From the correlation matrix of Uganda, traditional beliefs correlated positively with discrimination,  $r = 0.134$ . This meant that individuals who scored highly on the traditional beliefs scale were more likely to discriminate more on grounds of HIV and AIDS. Legal HIV and AIDS-knowledge correlated positively with workplace HIV and AIDS-related discrimination,  $r = 0.368$ .

The findings of the South African sample, traditional beliefs correlated negatively with discrimination,  $r = -0.109$ ; attitudes correlated positively with discrimination,  $r = 0.184$  and biomedical knowledge correlated negatively with discrimination,  $r = 0.118$ .

Workplace HIV and AIDS-related discrimination was statistically dependent on traditional beliefs, attitudes and biomedical knowledge for South African educators, i.e.  $p < 0.05$ .

Workplace HIV and AIDS-related discrimination was statistically dependent on traditional beliefs and HIV and AIDS legal knowledge, i.e.  $p < 0.05$ .

The results about HIV and AIDS attitude's relevance in predicting workplace HIV and AIDS-related discrimination showed that more still needs to be done to continue HIV and AIDS campaigning so that more positive attitudes towards HIV and AIDS-infected persons can be instilled.

Pertaining to HIV and AIDS knowledge and its relationship with workplace HIV and AIDS-related discrimination, this study showed that only legal knowledge had a predictive value of workplace HIV and AIDS-related discrimination. Why this is the case, is not yet known. One would have assumed that since HIV and AIDS-knowledge would have had some predictive value since it has been in the public domain much longer



than HIV and AIDS-legal knowledge. One may argue that there is a need to emphasise HIV and AIDS-legal knowledge to enhance HIV and AIDS-biomedical knowledge which has so far had some impact in reducing the spread of HIV and AIDS among some people. Caution needs to be sounded here that HIV and AIDS-legal knowledge and HIV and AIDS-biomedical knowledge will probably work best in reducing workplace HIV and AIDS-related discrimination among educators if they adopt the right attitudes towards those infected with HIV and those affected by AIDS. Furthermore, HIV and AIDS-legal knowledge and HIV and AIDS-biomedical knowledge would be enhanced by reducing traditional beliefs.

This study, despite limitations already alluded to, has some important implications. The findings suggest that there is a need to focus much on traditional beliefs as we plan programmes intended to reduce workplace HIV and AIDS-related discrimination. The emphasis which has always been put on biomedical knowledge, especially basic knowledge about the cause, means of transmission and prevention of HIV, seems to yield little as far as not engaging in workplace HIV and AIDS-related discrimination is concerned, if it is not done in combination with other areas of knowledge and beliefs, particularly traditional beliefs.

As the multiple regression analysis showed, it was HIV and AIDS legal knowledge and not biomedical HIV and AIDS knowledge which had a significant predictive value of workplace HIV and AIDS-related discrimination. What this implies is that while biomedical HIV and AIDS knowledge should not be ignored or neglected there is a dire need to enhance the biomedical HIV and AIDS knowledge construct with HIV and AIDS legal knowledge. The study revealed that HIV and AIDS legal knowledge is lacking. Therefore, there is an urgent need to develop the content of the HIV and AIDS legal knowledge for various categories of workers.

This study corroborated with some other studies done in South Africa in which HIV and AIDS knowledge was found to be moderately adequate. However, the results showed that some misconceptions and myths about HIV and AIDS are still held by a sizable minority. In the South African Demographic and Health Survey (SADHS) of adults above 15 years of age, it was found that general HIV knowledge was high but misconceptions also existed (Medical Research Council, 1999). Abdool-Karim *et al.* (1991 and 2001) also found among urban black women aged 14 to 44 in Durban and women aged 14 and 44 years in peri-urban areas and a rural community in KwaZulu-Natal that the level of their HIV and AIDS knowledge was high.

The results of this study suggested that HIV and AIDS prevention campaigns that solely aim to promote understanding of the correct modes of HIV transmission are not likely to be sufficient in lowering discrimination of HIV and AIDS infected individuals in the workplace. AIDS educational efforts need to communicate more effectively how HIV is not transmitted or even caused, since we know that stigma is more likely to thrive in an environment of ignorance and half-truths. Emphasis should still be put on accurate beliefs about HIV transmission. This recommendation corroborates a recommendation by Holland (2004), who concurs with Dickinson (2008), that it is not witchcraft that is considered the sole cause of dangerous phenomena, such as lightning or fire. According to this theory, everyone knows that fire is meant to burn, but it is not supposed to burn you. In the same vein, lightning strikes are a common occurrence, resulting in death only when caused by witchcraft (Schiff et al; 2003).

The results of this study showed that traditional beliefs are a better predictor of engaging in workplace HIV and AIDS-related discrimination. In a way, this is in agreement with findings from other studies. For example, WHO (2002) reported that it estimates that at least 80% of Africa's population makes use of traditional healers and for many people, it is the only health system available to them. This corroboration is

premised on the assumption that those individuals who make use of traditional healers hold traditional beliefs about disease causation.

Regarding the issue of situations in which a coworker justified why she could discriminate against an HIV-positive colleague who acts in a sexually reckless manner, this same finding was implied in Jonson's (1988) work on justified discrimination. According to Jonson (1988), a strong advocate of non-discrimination on basis of HIV status, discrimination may be warranted in a situation where an individual chooses to behave in a sexual manner that increases the spread of sexually transmitted diseases, including HIV. Here, the crux of the matter is on the pretext that one consciously, without any mental inadequacy, chooses to behave in a sexually irresponsible way. It should be noted that this case differs from those involving psychotics, IV drug users and children in that all of the latter (for one reason or another) may be incapable of behaving in a morally responsible manner in situations likely to lead to transmission of HIV. The sexually irresponsible individual, on the other hand, is a danger to the health of others because he or she chooses to behave irresponsibly. In psychological terms, a sexually irresponsible person is behaving under his/her volition.

The other finding which corroborated with this study's findings about the prominence of traditional beliefs over knowledge and attitudes is that of Holland (1994) who notes that whereas technology-driven Western societies prefer to rely largely on logical explanations, many Africans continue to obey their intuition, trusting in images, dreams and divination to rationalise misfortune and illness. In a nutshell, so many Africans understand relationship between people and unfortunate events not through the western concept of chance in the case of accidents, or germ theory in the case of illness, but through beliefs in witchcraft.

The concept of duality of causation of illness which is advocated by traditional healers. According to Holland (1994), the most commonly understood duality is that of separating the illness itself (as biological disturbance) and the underlying cause of the illness – the explanation of ‘why me’ rather than ‘what’. The traditional healers’ diagnosis and treatments, generally and mostly, attends to the underlying spiritual and/or social imbalance at the root of the problem, unlike Western or modern healers, whose emphasis is based on biological causes mostly. In addition to this spiritual/biological duality of illness, there are observations of the dual nature of the disease; that is, one disease can emanate from two different sources (Wreford, 2005b). This takes variations, but while one variation may be treatable by Western doctors, the other can only be dealt with by traditional healers. Cumes (2004) ascribes to the same idea.

It was evident from this study that the existence of misconceptions and gaps in knowledge regarding HIV transmission has an impact on teachers’ attitudes towards those infected with HIV or living with AIDS. Significantly, more of the respondents who were misinformed about HIV transmission gave discriminatory responses, suggesting that increased understanding about behaviour related to HIV transmission may result in lower levels of discrimination of HIV and AIDS infected persons. This result is in agreement with Herek *et al*; (2002) finding that increasing understanding about behaviours related to HIV transmission may result in lower levels of stigmatising beliefs about HIV-infected persons.

The focus on traditional healers and witchcraft is informed by the assumption that those who visit traditional healers hold traditional beliefs. The high percentage of those who go to traditional healers, suggests prevalence of traditional beliefs. As Beuster (1997:9) states, traditionally, Africans do not believe in chance (random causes). They believe that the causes of all problems can be uncovered. A traditional healer, according to

Bodibe (1992:152), plays a prominent role in traditional African society in dealing with trauma, calamity, personal relationships and illness.

Since many respondents prefer traditional medicine to modern medicine (Holland, 1994) and traditional beliefs were implicated in the cause of HIV and AIDS discrimination in the workplace, it is important for those involved in designing attitude change programmes and HIV and AIDS knowledge programmes to pay particular attention to theory pertaining to causation of disease. This will highlight contradictions that prevail in the choices people make regarding treatment which, logically, are linked to the purported cause(s) of the illness. In all this, the element of how traditional beliefs distort our thinking remains very prominent. As indicated earlier on, it is close to impossible to eradicate the indoctrination acquired from childhood. Similarly, it can be reasonable to argue that we can only try to reduce workplace HIV and AIDS-related discrimination because of the manner in which the underlying causes for it are so ingrained in traditional beliefs, particularly among the blacks.

In the in-depth interviews, teachers' opinions related to HIV-infected persons (coworkers) were mostly positive and tolerant. However, some participants showed an ambivalent attitude towards HIV-infected individuals in some possible situations where they may come into contact with such persons. They recognised that, in imaginary situations, they would discriminate individuals who were infected with HIV. The possibility of acting negatively towards HIV-positive individuals might well translate into actual avoidance or any other form of discrimination in some real world interactions.

There concept of duality of sickness appeared to be implied in the in-depth study responses that attribute diseases to have a biological cause while others have a non-biological cause - referred to as having a spiritual cause or resulting out of breach of taboos. This finding is in consonance with findings from some other studies (Dickinson

2008). Mokgathe (2001:43) concurs with the idea that for many Africans the origin of illness, calamities and traumas are believed to be punishment from gods, a curse, witchcraft, natural causes, disruption in social relations, angry ancestors, and possession by evil spirits or breaking of customs or taboos.

In support of the centrality of traditional beliefs, Holland (2004) observed that once indoctrinated into a belief system from early childhood, the faith often runs too deep for critical analysis, especially in the absence of scientific education. African nurses often choose traditional rather than modern medicine for treatment of their own illnesses, even though they are medically trained and continually watch patients recover through scientific drug therapy. So, in this case it is not the lack of scientific education which fosters traditional belief but maybe earlier experience before one begins to get exposed to scientific education. In case of nurses who often opt for traditional medicine instead of modern medicine, it is argued that they do not perceive the contradiction because they have no theoretical interest in the subject; traditional remedies are integral to their view of illness and misfortune. They also know that the recovered African patient will in most cases have consulted a traditional healer somewhere along the line, so that his recovery may be a combination of science and traditional remedies.

As Holland (2004) notes, even in this study, it is important to state that believing in traditional beliefs and practicing them is almost one and the same thing. It is not unreasonable to say that adhering to traditional beliefs and practicing them at one's whim goes hand in hand.

The findings of this study were in line with those of Ashforth (2005a) who notes that it is clear that bewitchment is being put forward as an explanation for HIV and AIDS, though this may serve a range of purposes. One of the traditional healer roles is that of 'witch finder'. Hammond-Tooke (1989) supports the idea that traditional healers explain AIDS

by means of witchcraft. However, this is not a general explanation offered by all traditional healers for the cause of HIV and AIDS. According to Dickinson's (2008) findings the reasons given for not suggesting witchcraft may have bordered on security rather than revelation from thrown bones.

Belief in witchcraft contends that evil forces in society can be manipulated by specially endowed individuals to the detriment of ordinary people. It holds that every community has people with malevolent intentions, who cause havoc during their lives and whose spirits after death select suitable individuals – witches – to possess and endow wickedness.

Because traditional Africa trusts in the inherent good of worldly existence, destiny is linked to actions. Misfortune is not a matter of chance but is associated with the ire of the ancestral spirits or the evils of witchcraft, notes Holland (2004).

At present, there is a paucity of research investigating why workplace HIV and AIDS-related discrimination persists despite the many HIV and AIDS knowledge and attitude change programmes. This is due, in part, to the difficulty inherent in rendering what is typically a deeply personal experience amenable to codification in manual format in a way that is acceptable to workers in organisations with HIV and AIDS infected or affected colleagues. This study attempted to begin to fill this gap and to make a contribution to a growing movement that is acknowledging that discrimination is preventing people from disclosure, testing, obtaining treatment for AIDS, and enjoying life while positively contributing to the productivity of their workplaces despite their HIV status. This, in part, is in line with what earlier research recommended (cf. Parker & Aggleton, 2002; Maman, Mbwambo, Hogan, Kilonzo, 2001; Spielberg, Kurth, Gorbach, & Goldbaum, 2001).

As Holland (1994) says, the question of how far traditional Africa coexists with modern Africa remains a difficult one. Is the traditional belief system today a feature of the rural areas but not of cities of Africa? To date there are no statistics to prove the influence of traditional beliefs on the contemporary cosmology. However, it is not hard to find evidence of traditional beliefs in the cities of Africa. Maybe future research would be able to get the statistics from various countries and communities to prove the influence of traditional beliefs on the contemporary cosmology, especially on the issues pertaining to HIV and AIDS and more specifically workplace HIV and AIDS-related discrimination. Suggestion of such future research is on the basis that studies of the prevalence of traditional belief systems are, ultimately, studies of people in all the intricacies of traditional as well as modern life. Hence, traditional belief systems ought to be factored into economics and education as ignorance regarding African beliefs, particularly traditional beliefs, perpetuates misunderstanding of many African problems and responses.

As Evans-Pritchard (1977) demonstrated among the Azande of the Sudan/Congo, witchcraft beliefs attempt to explain the inexplicable and control the uncontrollable, in respect of misfortune and illness. It is plausible for me to argue that the findings of this study should come as no surprise, that is, showing rather a likelihood of individuals who hold strong traditional beliefs to engage more in workplace HIV and AIDS-related discrimination than either those with more positive attitudes towards those infected or affected by HIV and AIDS or those with more HIV and AIDS knowledge, since HIV and AIDS to many Africans is still inexplicable and rather uncontrollable.

As alluded to in Chapter 5, one of the underlying or traditional variant causes of an illness is identified as the neglect of ancestors and/or social behaviour that offend the ancestors who are constantly concerned with the behaviour of the living. This belief featured even in the responses of some of the respondents in this study. This is in line with what Dickinson (2004) notes that while few traditional healers go as far as to



suggest that the ancestors send disease, physical symptoms may be interpreted as their demand for attention. Again, it is believed that continued neglect of ancestors may forfeit their normal protective role, making the individual more vulnerable to infections and sickness.

Appreciating how traditional beliefs operate requires us to understand how traditional healers (referred to here as practitioners) and patients understand healthcare within a traditional African cosmology which uses a very different logic than that of scientific inquiry (Dickinson, 2008). Dickinson (2008) says that we should note that very few, if any, people anywhere in the world rely purely on scientific understanding in regard to their own health, but also draw on a range of non-scientific practices, such as prayer or 'positive attitude'. In the same vein, Beuster (1997) note that traditional healers form part of the traditional African 'world view' that includes a belief in ancestors, witches, and the polluting nature of certain objects and practices. These elements of the traditional world view constitute – as do all other world views – an attempt to make intellectual sense of the world and of life, so that in the broadest sense it involves theories of explanation (Hammond-Tooke, 1989). In context of this study, a traditional healer differs from a "modern healer" hereto meaning a western medical practitioner.

Again, as a further elaboration on the corroboration of this study with work done by other authors/researchers, Dickinson (2008) reports that traditional healing is now rooted within modern settings. Thus, workers use *muti* or 'traditional medicine' (usually a mixture of plant, animal and manufactured substances) to gain favour with superiors so as to be promoted or to doctor their machines so that others cannot operate them with the same proficiency. In response, other workers acquire their own *muti* from traditional healers or spiritual healers which will counter any negative impact on themselves.

The concept of '*muti*' relate to workplace HIV and AIDS-related discrimination against people living with HIV and AIDS in that coworkers associate *muti* diseases, more often, those which they believe cannot be treated using modern treatment. It is probable that if a coworker is seen using *muti*, he/she is likely to be shunned.

According to Holland (2004), witchcraft is a theory of causation to which traditional Africans attribute the misfortune that prove harmful to them. This is part of the African worldview which influences beliefs about the causes of trauma, calamity and illness and how such is matters should be remedied. The emphasis on wholeness in the African Worldview means that the interrelatedness of all life forms is taken for granted. Little distinction is made between the mental and physical and spiritual or the individual and group. Ancestors are believed to watch over the living with a benevolent eye (Poland 7 Hammond-Tooke 2004:26). Illness or calamity can be sent as a warning or punishment, Thus the origin of illness, calamities and traumas are believed to be punished from the gods, a curse, witchcraft, natural causes, a disruption in social relationships, angry ancestors, possession of evil spirits or the breaking of customs or taboos (Mokgatlhe, 2001:43).

Work HIV and AIDS-related discrimination is an issue of serious concern as it has effects on the individuals in the workplace and the organisations in which people living with HIV and AIDS happen to work. HIV and AIDS-related discrimination has implications for human resource. With discrimination based on HIV and AIDS, are likely to have a lot of labour relations issues, and if individuals prefer to go the legal way, companies will lose both time and money. In case of teachers in government employment, the government will have to pay for any kind of workplace HIV and AIDS-related discrimination cases. Furthermore, with workplace HIV and AIDS-related discrimination, apart from further increasing the number of people who do not disclose due to fear of stigma and discrimination, it will increase costs for recruitment, selection, development, as well as other human resource functions. Without people, in this case

educators going for testing, the scourge of HIV and AIDS will more likely increase. Educators will die in case they do not take ARVs or don't start on the regimen at the most appropriate time. It will be hard to get the right people in good numbers to meet the global millennium goals. According to Alupo (2011:2), HIV and AIDS remains one of the major challenges threatening the attainment of international and national goals related to education globally, accounting for 77% of the teacher shortages in countries with high infection rates.

As this study has shown, the factors underpinning it include traditional beliefs, attitudes and knowledge regarding HIV and AIDS.

According to Holland (2004), witchcraft is a theory of causation to which traditional Africans attribute the misfortune that prove harmful to them.

It is plausible to suggest that the issue of workplace HIV and AIDS-related discrimination is going to be here for some time. This is in line with other social problems man has been faced with in the past.

### **8.3 LIMITATIONS TO THE RESEARCH**

There were several limitations associated with this study.

First, this study focused on one province, the North West Province of South Africa, and one public sector, the education sector, particularly school-based teachers (educators). In Uganda, the sample was drawn from school-based teachers in the Central Region, the Kampala district which comprises of the capital city of the Republic of Uganda. Although the city is cosmopolitan, there was no way to guarantee the proportional representation of all ethnic groups of educators. Consequently, caution should be exercised when generalising the results to different settings.

Second, there was the limitation of possible systematic bias as data was not collected about refusals to participate in the survey in either the Ugandan or South African sample.

Third, the relationships described in this study are not necessarily causal and, therefore, more research is needed to clarify the mechanism underlying workplace HIV and AIDS-related discrimination. For example, in terms of the relationship between workplace HIV and AIDS-related discrimination and traditional beliefs, showing the exact relationship between traditional beliefs and HIV and AIDS-related discrimination needs to be made more explicit than implicit as in this study it was merely correlation.

Another limitation to this study was the relatively low response rate 39.75% for South Africa and 69.2% for Uganda. The previous studies in South Africa had indicated that most South African teachers often respond to directives, yet in this case, the study required voluntary participation. The lower in comparison response rates in other studies done in Uganda may be explained by the timing of the research since it took place when teachers were winding up the year or starting a new term and hence, overburdened by school responsibilities. In either case, no data was available on the demographic differences between those who responded and those who chose not to respond to the questionnaire. However, this limitation is largely outweighed by the knowledge that educators felt free to refuse participation in the study and exercise their right to informed consent.

Another issue is the positioning of the *protocol* (the UN Protocol on discrimination, 2000) as a research tool. It is most effective where legal and internal regulations are firmly entrenched. Where there exists a gap or ambiguity (an opportunity for personal discretion) within the legislation or written policies, educators are likely to selectively interpret it.

Another limitation was that the survey was based on self-reporting without objective verification except for the question regarding why other people engaged in telling of secrets, including the HIV and AIDS status of a colleague. However, in rather private venues, this procedure may not have greatly suppressed honest responses by those individuals who harbour the extreme stigmatising and discriminatory beliefs/tendencies.

It may also be plausible to suggest that a lower level of discrimination could mean that people know they should not discriminate and, therefore, report a more accepting attitude toward those living with HIV and AIDS in the workplace. By extension, it is also likely that a low level of stigma and enacted discrimination *per se* may be the result of no personal experience with people who have HIV and AIDS.

As alluded to already, attitudes cannot be measured, they are inferred and subjectivity is embedded in this inference. As such, this is also a limitation of this study.

The cross-sectional nature of the survey prevented any causal conclusions from being drawn in this study.

Another limitation to this study was that due to financial and time constraints there were no in-depth interviews with the Ugandan teachers. This then prevented a comparison of South African educators with Ugandan educators in regard to issues addressed in the in-depth interviews.

#### **8.4 SOME STRENGTHS OF THIS STUDY**

To counteract some of the study's limitation, the triangulation of the method of research combined quantitative information gathering with qualitative investigation was used. In this way, there was a maximisation of obtaining the best data in terms of the both quantity and quality in the given circumstances.

Traditional beliefs about the modes of transmission and manifestations of sexually transmitted diseases, and how those perceptions affect beliefs about the transmission of HIV, are particularly worthy of further study. This may have significant implications for the design and implementation of workplace HIV and AIDS-related discrimination reduction activities.

This study's other strength is that it was conducted mostly rural areas in North West province of South Africa and urban places of the Central Region comprising of Kampala district of Uganda. This catered to the presumption that traditional beliefs about illness are more prevalent and probably more socially reinforced in rural areas than in urban areas. However, while caution should be exercised before generalising the study findings to other geographic regions and demographic groups, the combination of a more rural and an urban setting offers a good comparison.

Furthermore, despite the limitations stated earlier on, this study provided a comparative view of the prevalence and underlying factors' relative contribution to workplace HIV and AIDS-related discrimination in two countries with quite different socio-economic and socio-political history. There are many similarities between the two countries' people. For instance, the majority of their populations are blacks (over 85% in South Africa and over 99% in Uganda). The two countries are multi-religious with the majority of the populations are Christians. Traditional beliefs seem to remain strongly held to, although not publicly acknowledged by some individuals.

## **8.5 FUTURE DIRECTION/GENERAL RECOMMENDATIONS**

Although, the Social Cognitive Theory and Theory of Planned Behaviour models have proved to be useful theoretical frameworks in this study, this does not preclude the possibility that other models derived from other theories might be equally capable of explaining why individuals continue to engage in workplace HIV and AIDS-related discrimination or identify differences we were unable to detect because they were not

addressed in our model. Therefore, future research would go a long way in trying to explain the phenomenon of workplace HIV and AIDS-related discrimination using attribution theories.

While TPB and SCT were applied in this study and to a good extent the key concepts were used to explore the relationships between attitudes, traditional beliefs and knowledge of HIV and AIDS, future research may consider to use theories like Herzberg's two-factor theory of hygiene/motivators. Also, future research may consider to use reinforcement theory, and equity theory.

Future research would be necessary to look specifically at the treatment/behaviour of those managers and subordinates who are infected with HIV and AIDS towards those who are not infected by HIV and AIDS in the workplace. This would help to know whether there is corresponding discrimination towards those not infected or affected by HIV and AIDS by those infected in the workplace.

While it may be easier to reduce deficiency in legal HIV and AIDS and biomedical HIV and AIDS knowledge than to reduce prejudiced attitudes, to reduce overt acts of discrimination such as not sharing toilets, working tables or eating from the same table, than to change subtle behaviours, such as gossiping, loose talk and engaging in malicious activities towards HIV and AIDS infected or affected colleagues, change traditional beliefs, research is still needed to improve our understanding of why traditional beliefs take so long to be abandoned.

Research is needed to explore and to determine how best traditional beliefs can be reduced in favour of adopting more biomedical/legal HIV and AIDS-knowledge and positive attitudes towards HIV and AIDS infected and affected colleagues in the workplace.

Future research should try to look at ways in which to increase secret keeping amongst workers of all ranks in light of not promoting workplace HIV and AIDS-related discrimination which can loosely be referred to as a domino effect in as far as preventing HIV and AIDS discrimination and mistreatment are concerned.

Additionally, future research should focus more on improving the scale for discrimination since to date the UNAIDS 2005 Protocol is the only available tool and is only an indicator and rather imprecise.

Future studies should focus on comparing employees in public service and those in the commercial sector, or even community-based organisations (CBOs), not-for-profit organisations, and non-governmental organisations (NGOs) as this may yield different findings bearing in mind respective goals.

While it should also be noted that the tool used to measure workplace HIV and AIDS discrimination had very good reliability in the samples, it is suggested that future research could try to come up with a shorter version of it so that it becomes more user-friendly, without compromising its reliability.

There is a dire need to examine what is referred to as 'traditional beliefs' pertaining to the cause of HIV and AIDS in various societies across Africa in order to come up with a cross-cultural measure for HIV and AIDS-related traditional beliefs, bearing in mind that Africa is not homogeneous, culturally and ethnically. Therefore, future research should conceptualise the concept 'traditional beliefs' better. And, in future it will be necessary to develop a shorter version of the HIV and AIDS traditional belief scale with the same or comparable content validity and reliability.



Researchers should think of how best to get more genuine responses even if using self-report pertaining to research in sensitive, but crucial issues, such as HIV and AIDS-related discrimination in the workplace in particular, but also in other situations. This will help in drawing right conclusions which will help in tackling workplace HIV and AIDS-related discrimination.

Researchers should conceptualise HIV and AIDS legal knowledge better since it has been shown to play a role in workplace HIV and AIDS-related discrimination. This should be accompanied with the development of a more reliable yet shorter version of HIV and AIDS-legal knowledge scale. Caution needs to be sounded here: the language used in such a scale should be appropriate for a lay person bearing in mind that there are many workers in different workplaces who have no basic legal training but would be of some use in obtaining relevant data.

## **8.6 DISCUSSIONS OF FINDINGS OF THE QUALITATIVE PART OF THE STUDY**

### **8.6.1 The issue secret telling**

The issue of lack of awareness of HIV and AIDS or having little knowledge together with misconceptions may result in discriminating a person. Once this is combined with malice, a person may be discredited. Similar incidents in a study done in India attest to this:

A man from Uttar Pradesh (UP) study group, diagnosed with juvenile diabetes, died at the age of 26 with his family and neighbours believing that he had died of AIDS. The symptoms of untreated juvenile diabetes are very similar to that of AIDS: weakness, loss of weight and emaciation. His uncle, with the idea of appropriating his wealth, spread misinformation that he had AIDS and prevented him from being treated by

arguing that it would be useless as he had HIV. Also, the Tamil Nadu (TN) came to the researchers' notice when reported in the lay press, where a wealthy businessman tried to discredit the husband of a woman he was infatuated with, by getting doctors to suggest that he (the husband) had HIV (Latha, 2005 and cited in Priya and Sathyamala 2007).

Siegel *et al*; (1995) reported the persistence of misconception regarding HIV-risky behaviours, misconceptions about contracting HIV through donating blood, mosquitoes, or toilets, and the 'deserving nature' of HIV infection among homosexuals. This study came to agree with Siegel *et al*; (1995). The question remains, 'Why?' It can be postulated that traditional beliefs have a strong influence. This is consonant with the findings by Charalambous *et al*; (2004) finding that Southern African traditional beliefs do not attribute health and disease to biological processes and infectious agents. In their study, Charalambous *et al* found that traditional beliefs of gold miners contributed to reluctance to give blood samples and difficulties with education about the HIV disease. As traditional healers use blood for medicinal purposes it is believed by some that blood is sold or that it may be used for malevolent purposes.

### **8.6.2 Limitations specific to the qualitative part of the study**

The analysis has several limitations. First, collapsing multiple categories into dichotomised variables may have obscured some important variations in workplace HIV and AIDS-related discrimination. For example, about 20% of the persons with stigmatising or discriminating attitudes in our sample also had some positive attitudes towards people with HIV and AIDS, and our analysis does not take this into account.

Second, for some individuals, self-reported attitude may not reflect their real attitude. A lower level of stigma/discrimination could mean that people know they should not discriminate and therefore report a more accepting attitude towards those coworkers/colleagues living with HIV and AIDS. It is also likely that a low level of stigma/discrimination may simply be the result of no personal experience with people who have HIV and AIDS (UNAIDS, 2000a).

## **8.7 SPECIFICRECOMMENDATIONS**

Recommendations were made according to the findings of this research. They are presented in the paragraphs that follow as regard to practice, future research and literature.

### **8.7.1 Recommendations for practice**

There is a need to train and equip management staff with HIV and AIDS-knowledge (biomedical knowledge and legal knowledge) if there is to be any lessening of workplace HIV and AIDS-related discrimination during recruitment and interviews.

Based on the findings from this study pertaining to the prevalence of misconceptions about HIV and AIDS transmission, there is a need to focus educational efforts on identifying and correcting misconceptions related to HIV and its transmission, rather than increasing general knowledge about the problem. It is hoped that with reduced misconceptions, there could be a possibility of reduction in workplace HIV and AIDS-related discrimination which emanates from misconceptions about HIV and AIDS and its transmission. However, it would be naïve to suggest that elimination of HIV transmission misconceptions or those about the HIV and AIDS itself will wipe out workplace HIV and AIDS-related discrimination. This is because it has so far emerged that workplace HIV and AIDS-related discrimination is a multi-factorial problem/phenomenon.

Following from the frequency of misconceptions about HIV and AIDS, particularly the three myths items: (1) that one may become infected with HIV by donating blood, (2) that HIV infection is the same as having HIV symptoms, and (3) that mosquitoes can transmit the HIV virus, there is a dire need for addressing these misconceptions through provision of appropriate information. This should be done with a view that misconceptions may have negative implications for the elimination of workplace HIV and AIDS-related discrimination.

Theoretically, there is need to develop more reliable and valid instruments for measuring workplace HIV and AIDS-related discrimination. As seen in the result section (see chapter 6), the reliability of measures of discrimination is rather low. There is a need to improve upon the item combinations so that more reliable and valid instruments are obtained.

All workers in the education sector, but more specifically managers and supervisors (HODs), need to realise that they should work hard to reduce workplace HIV and AIDS-related discrimination. Essentially, managers and supervisors should play a major role in demystifying the scourge of HIV and AIDS by providing good leadership and serving their subordinates in ways that can reduce the phenomenon of discrimination in the workplace.

Managers and supervisors need to help in educating employees about HIV and AIDS, assuming that they themselves know enough about HIV and AIDS. They need to try to reduce the adherence to traditional beliefs. This may be done by interacting with their subordinates and engaging them intellectually on the issue of traditional beliefs. Thus, they should try to educate their subordinates and persuade them from believing in the myths and other archaic ideas about the aetiology, transmission and cure of HIV and AIDS. It is presumed that they will have the appropriate knowledge and attitude to impart to subordinates.

Trying to make people not believe in traditional beliefs is a long term programme. It is not easy to change age-old beliefs and traditions. Without beginning in a small but consistent way, there will not be any change in such beliefs and traditions. If this work is done genuinely, the change will proceed progressively. I speculate that if such demystifying information emanates from their own people, that is, people with whom

they share the same socio-economic and political background, there may be a positive change. In this case, a change from believing in unproven and not provable traditional beliefs will possibly result in a reduction in workplace HIV and AIDS-related discrimination contribution. Traditional beliefs had the greatest explanatory power of workplace HIV and AIDS-related discrimination persistence.

It should be emphasised that correct information to erode traditional beliefs needs to be provided continuously, knowing that traditional beliefs, like all other beliefs, are not easily abandoned despite the evidence that there is a continued increase in scientific knowledge and facts permeating many societies in the world.

It is plausible that understanding why traditional beliefs persist, even among those who are knowledgeable about HIV and AIDS, is the way to go in understanding why workplace HIV and AIDS-related discrimination persists. As observed, even from this study, workplace HIV and AIDS-related discrimination prevails in many forms. This happens despite the many HIV and AIDS attitudes change campaigns and the provision of HIV and AIDS knowledge, which, so far, has been mostly biomedical HIV and AIDS knowledge.

Managers, supervisors and other workers in the education sector need to be adroit in the way they handle HIV and AIDS-related issues. They need to be perceived to be sympathetic, supportive and mindful of those who are infected with or affected by HIV and AIDS.

Managers, supervisors and other workers need to open up channels of communication to minimise the breeding of rumours and opportunities of secret leakages. Again, all those people entrusted with sensitive and confidential information need to show restraint. This seems to be more of a moral requirement than a legal one. Divulging

such information unnecessarily, prematurely and irresponsibly, may be detrimental to workers psychologically, socially and economically. By implication, telling of secrets has a profound effect at a personal level or at group level. And, as individuals and groups are affected, the organisations may be adversely affected in the short-term and long-term.

This study found out that traditional beliefs contributed to/ or associated more with workplace HIV and AIDS-related discrimination. This is, by implication, in agreement with Ingstad (1990) and with Corrigan and Penn (1999). It is, therefore, recommended that specific cognitive and emotional representation of the disease be targeted and changed in order to reduce workplace HIV and AIDS-related discrimination towards those infected or affected by the disease.

Future research would use causal modelling instead of multiple regression analysis. This will allow the researcher to assess an entire theoretical model rather than the prediction of each single variable.

In any study using causal modelling, there are things to look for, before and after model testing has taken place. The first question to ask before model testing is: 'How were the causal models developed?' Results of studies which employ causal modelling techniques to test well-developed theoretical models are much stronger than those which test more 'intuitive' models. When a model fits the data this means that the model is a plausible one, given the pattern of co-variation in the data (Brecker, 1990). If models have a strong theoretical basis, it is more difficult to argue for the plausibility of alternative models.

Compared with the separate influence of knowledge around transmission, nature and myths on discrimination, it appears that increasing overall knowledge on HIV and AIDS

would be more effective in countering high levels of workplace HIV and AIDS-related discrimination. Therefore, while any efforts to counter discrimination should place considerable emphasis on dispelling the myths surrounding HIV and AIDS, raising knowledge levels on the transmission and nature of the virus would strengthen these efforts.

### **8.7.2 Recommendations regarding the empirical study**

Recommendations stemming from the empirical study are discussed accordingly.

#### *8.7.2.1 Sample*

It is recommended that a larger sample should be used for purposes of quantitative research, in order to enable statistical findings to be derived from this sample.

Also, it is recommended that the research be repeated with a sample of managers in other public sector service providers which are labour intensive.

#### *8.7.2.2 Population group*

For future studies, it is recommended that a larger number of people of Asian and European origin sample be used to enable more convincing conclusions to be reached regarding these particular population groups.

### **8.7.3 Recommendations regarding the literature review**

It is recommended that the recent literature on humanistic psychology and its numerous new constructs be used in future research work.

Furthermore, there is a need to do more research relating to traditional beliefs so as to get more up-to-date literature. Alternatively, multi-disciplinary studies might go a long way in producing new literature on traditional beliefs, including precise definitions and instruments to measure it in specific cultural environments.

## **8.8 CONCLUSION**

There was widespread belief in traditional beliefs amongst the blacks in South Africa and Uganda. Again, traditional beliefs tend to be the greatest predictor of workplace HIV and AIDS-related discrimination. As evidenced from the persistent thread through many respondents' responses in South Africa, these beliefs, to a certain extent, translate into discrimination in the workplace, though indirectly, in relation to workplace HIV and AIDS-related discrimination. Thus, there is a need to address traditional beliefs pertaining to the cause of diseases, especially sexually transmitted diseases if any efforts to reduce stigma and discrimination are to go a long way. Although this is a long term project, it can be started slowly and take effect. In essence, it will be geared towards reducing superstitious beliefs which surround disease and death amongst blacks.

The fact that attitudes were having the second predictor value followed by HIV and AIDS-knowledge warrants more emphasis to be placed on equipping educators with HIV and AIDS-legal knowledge in combination with up to date HIV and AIDS-biomedical knowledge in order to make them aware of the basic biology of the disease along with pertinent laws which will enhance human rights issues pertaining to HIV infected and AIDS affected individuals in the workplace.

Regarding secrets and how they relate to confidentiality, reasons cited for why individuals, including workers, reveal confidential information, including colleagues' HIV status once known, were many. These, in order of their frequency, included: anger, malice, jealousy, and loose talk, amongst others. Since the causes have been identified, we should make sure that we reduce situations which can prompt anger, malice, jealousy and gossiping. It is deemed plausible to suggest that by observing confidentiality and applying one's conscience, HIV and AIDS-related discrimination in the workplace may be reduced. Furthermore, it can be suggested that those infected or



affected by HIV and AIDS should behave responsibly so as to reduce revelation of their HIV status as a cause their irresponsibility.

There is a dire need to educate workers, especially those supervising others, and those who are often involved in the recruitment, selection, appointment and promotion of employees, that even HIV-infected and affected persons have rights. These include the right not to be denied employment or/and promotion based on their HIV status. As long as anyone is qualified and he/she is still capable of performing the essential tasks involved in a job, he/she should be given a chance to perform. This staying in employment is further enhanced by the increased use of ARVs which are becoming more available and affordable with the passage of time. The ARVs enable those infected with HIV to living a productive life in which they can contribute to organisations. Work plays a crucial role in people's well-being, for example, work is a source of prestige, economic security, social security and motivational, among others.

The self-reported lack of legal HIV and AIDS knowledge, reported in the qualitative study is indicative of the need to do more to equip members in the educational sector with more HIV and AIDS-legal knowledge in conjunction with HIV and AIDS-biomedical knowledge. Basic HIV and AIDS-biomedical and HIV and AIDS-legal knowledge and, where appropriate, more advanced HIV and AIDS-knowledge, should be given to members of the educational fraternity.

It is anticipated that although equipping the workers within the educational sector with HIV and AIDS legal knowledge coupled with basic HIV and AIDS biomedical knowledge may not outright reduce workplace HIV and AIDS-related discrimination, it will form a springboard for taking informed decisions. Thus, it is hoped to help reduce workplace HIV and AIDS-related discrimination when it is combined with positive HIV and AIDS-related attitudes and reduced adherence to traditional beliefs about HIV and AIDS.

In summary, while many people in the educational sector had traditional information-based HIV and AIDS education, and while their knowledge of the basic facts about HIV and AIDS appeared to be fairly accurate, this factual knowledge was embedded within a range of potentially contradictory beliefs, which are weighed up against the incoming health – educational information within a range of normative and social constraints. As Michelle and Campbell (1998) observed, health education interventions seek not only to transmit facts about HIV and AIDS, but to do so in a way that takes account of the beliefs, norms and contexts within which these facts will be embedded. This is in agreement with what this study would recommend if workplace HIV and AIDS-related discrimination is to be worked on.

This study's analysis has extended the range of variables to include those not normally considered, most notably, variable traditional beliefs and HIV and AIDS legal knowledge. The results confirm an association between these variables and many others considered in this study. For once, there has been a study regarding the extent to which traditional beliefs, attitudes and HIV and AIDS-legal knowledge predicted workplace HIV and AIDS-related discrimination and highlighted that even HIV and AIDS biomedical knowledge is not *per se* a clearly defined concept.

The implications of workplace HIV and AIDS-related discrimination are many. As a sector employing very many people, the human resource of education sector has challenges in many of its core functions recruitment, selection, placement, development, promotion as well as other functions.

Regarding to recruitment, the express purpose of which is to ensure that a sufficient number of applicants apply for the various jobs in the business as and when required, the Human Resource in education sector will find it hard to set sufficient numbers as a

result of HIV and AIDS. This may imply spending more money on advertisements or take longer to fill the vacant positions.

Pertaining to training, hard decisions will have to be made as there will be chances of training some individuals who may be able to do their jobs because of their health status. Training and development are very expensive yet very necessary if the sector is to provide the necessary service to the clients they service.

## **8.9 PROFILE OF AN ORGANISATION MANAGING HIV AND AIDS STIGMA AND DISCRIMINATION**

Because of the effects of stigma and discrimination based on HIV and AIDS, such as not going for testing and voluntary counseling, it is important that any functional organisation, including those in the education sector, the largest sector in many countries (Chetty, 2006:74), should meet the following criteria:

### **8.9.1 CRITERION 1: HAVE A WORKPLACE POLICY ON HIV AND AIDS.**

This should be the guiding statement of the principles and intent taking into account all staff and personnel of an organisation. It should derive from the national policy on HIV and AIDS.

*8.9.1.1 The purposes of a workplace policy on HIV and AIDS, include the following:*

- To send a clear message that HIV and AIDS are a serious workplace issue and that there is a high level commitment to deal with it.
- To provide guidance to managers and all stakeholders.
- To protect rights and to specify the responsibilities of employees, employers, dependants and social partners, such as NGOs, in the workplace.
- To set standards of ethical and social behaviour for everyone in the organisation.
- To inform both the infected and affected people of the resources and services available to them.

- To provide a set of standards for practice and guidelines for all interventions in the workplace.
- To allocate responsibilities within the organisation for the management of the epidemic and accountability for decision-making and resource allocation.
- To set out the organisation's commitments in terms of financial and human resources.
- To provide a framework within which all interventions can be monitored.
- To provide a framework within which external partners (FBOs, NGOs and donors) can operate effectively.
- To provide linkages to and consistency with other national policies and international conventions (Chetty, 2006:78-79).

#### **8.10 COMPONENTS OF A WORKPLACE HIV AND AIDS POLICY**

**Introduction:** This is the rationale for the policy and context in which the policy is being developed.

**Scope:** That is the persons and institutions covered.

**Goals and objectives:** Statement on the organisation's goals in its response to HIV and AIDS. For example, reducing infections, reducing discrimination and stigma of those infected or affected by HIV and AIDS; support, accommodation and care.

**Principles:** These are statements on the rights that are inherent in the policy, such as, confidentiality, non-discrimination in all its forms, and access to care.

**Roles and responsibilities:** Statements on the organisation's or workplace's expectations of the employer, employees, managers (SMTs in case of schools), trade unions and external partners, e.g. CBOs NPOs and NGOs.

**Coordination and management structure:** Outlines of the institutional arrangements that will govern, plan, manage and report on the institution's/organisation's response to HIV and AIDS.

**Human resource management and HIV and AIDS:** The organisation's position of how it will address issues pertaining to HIV and AIDS in the workplace, which include: recruitment, selection, appointment, job security, voluntary HIV testing and counselling (VCT), confidentiality and disclosure, protection against discrimination, employee benefits e.g. housing allowance, medical insurance, pensions, sick leave and compassionate leave entitlements; access to training, incapacity and reasonable accommodation, grievance procedures and retirement (Chetty, 2006:84).

There are other pertinent issues concerning workplace HIV and AIDS policy worth considering:

### **8.10.1 Implementation, Advocacy and mainstreaming**

#### *8.10.1.1 Mainstreaming*

Regarding workplace HIV and AIDS policy, mainstreaming HIV and AIDS issues in sectors should follow from the strategies used in the development and implementation of the sector policy.

#### *8.10.1.2 Advocacy and related issues*

HIV and AIDS have differential impacts on men and women, boys and girls in social, economic and physiological terms. In light of these differences, workplace HIV and AIDS policy development must take careful account of the gender dynamics and socio-economic status in the education context. For instance, as primary caregivers in most families, women have to deal with various pressures that are time and energy consuming. The involvement of PLWHA in the development process and implementation should be encouraged as early as possible. Chetty (2009:86) adds that organisations specifically representing teachers living with HIV are beginning to take root, and the perspectives they bring to the development process are critically

important. Advocacy is the act of supporting or pleading cause. Advocacy is very important as much as leadership is in HIV and AIDS policy development.

#### *8.10.1.3 Implementation*

Implementation is the real test of the policy in terms of the commitment that employees the employer and social partners are willing to make. Implementation has many challenges. For instance, in education, the challenge will be reaching every workplace in communities that have widely differing social and cultural strengths and barriers.

The issue of costs in terms of human, material and finance is very central to workplace HIV and AIDS policy. It requires commitment from all stakeholders.

### **8.11 CRITERION 2: WORKPLACE PROGRAMME ON HIV AND AIDS**

Workplace programme, refers to a set of practical plans and systems for implementation. These plans follow from the workplace policy development.

Broadly, there are two objectives served by the HIV and AIDS-in-the workplace programmes:

- (1). Creation of a supportive environment that promotes the well-being and rights of infected and affected employees, so that they are healthy and productive as possible.
- (2). Managing and reducing the effects of HIV and AIDS on sector or workplace function.

Success of objective number 2 depends much on the success of objective number one. For example, if employees fear discrimination or do not expect support, they will most times not disclose their HIV-related problems, and this makes it more difficult to manage and reduce the effects of the problems.

There are two requirements for a comprehensive workplace HIV and AIDS programme. These are prevention needs and treatment, care and support needs; and cover the topics outlined below:

### **Prevention**

This covers:

- HIV and AIDS education ( awareness raising, peer education and advocacy),
- Voluntary (and confidential)counselling and testing (VCCT),
- Sexually transmitted infection (STI) management,
- Prevention services (condom distribution, prevention of mother–to-child transmission (PMTCT),
- Opportunistic infection management (Tuberculosis, etc); and
- Workplace safety.

### **Treatment, care and support**

This includes the following:

- Treatment awareness and education,
- Access to treatment,
- Home-based care (HBC)'
- Antiretroviral therapy (ART),
- Post-exposure prophylaxis (PEP),
- Referral mechanisms,
- Wellness management,
- Counselling,
- Basic support; and
- Social support.

Of great importance, in the education sector, all employees, including non-educators should be covered by the HIV and AIDS-in-the-workplace programmes.

Chetty (2006:90-91), states that several general issues that should be considered in HIV and AIDS-in-the-workplace programme. They include:

- Scope and coverage of workplace HIV and AIDS programme.
- Target interventions.
- Strong and visible leadership.
- Buy-in from all key stakeholders in all programme processes for successful implementation.
- Prioritise interventions.
- Structures and capacity.
- Building of partnerships and referral networks.
- Involving PLWHA in the whole process of the programme.
- Community and family outreach to allow a more holistic approach to prevention, care and support.
- An integrated approach to interventions to ensure effectiveness, efficiency and sustainability.

Workplace HIV and AIDS prevention programmes should ideally include the following



Components:

(1) Awareness/information education communication/behaviour change communication (BCC).

Behaviour change communication (BCC) seeks to promote and sustain behaviour change in specific groups and population as a whole, using targeted messages and a variety of channels and media. It aims to promote safer sexual behaviour, treatment services; promote positive living among PLWHA, and reduce stigma and discrimination through activities such as training and social events, seminars, group discussions, theatre, videos, posters and pamphlets. However, among other things, before implementing BCC interventions, the following points need to be considered as they will influence the success of the programme:

- Identify target groups and target situations clearly.
- Adapt approaches to the cultures, beliefs, languages and educational levels of target groups to ensure that they are appropriate and acceptable.
- Deliver positive messages. BCC should aim to be optimistic and highlight the benefits of HIV awareness and safety as well as living positively with HIV.
- Avoid moral lessons and scare tactics. For BCC to work, people must feel empowered to take positive actions to protect themselves, and not feel embarrassed, ashamed or singled out by certain actions they have engaged in.
- Avoid fuelling stigma and discrimination by citing high-risk groups or pointing out negative behaviours of people or groups.
- Design attractive user-friendly materials to capture the target groups' attention.
- Require participation of all members of staff. BCC activities should be made compulsory (during work hours) for all staff, to ensure engagement with the materials.

NB: In the Department of Education in South Africa, in particular, there is what they call “non-negotiable” which include not compromising learners’ contact time and a teacher being in time for work, at school with well-prepared lesson in class teaching. Since BCC needs to be implemented during working hours to make it seem important rather than tokenism, there is need to rethink some of the non-negotiable issues, particularly compromising learners’ contact time. Teachers/educator should not just be seen as service providers but as individuals who, if they can be involved successfully in BCC, they can change the course of HIV and AIDS since they work on minds and behaviour of children.

- Sustain BCC programmes throughout the year to increase buy-in from staff members.

## (2) Peer education

Dickinson (2012) is an advocate of peer education in workplace HIV and AIDS programmes. In peer education, selected members of a group are trained to become Peer educators, and it becomes their task to facilitate change in the group by promoting awareness and information/education on safe sexual behaviour.

Peer education works on the premise of trust and understanding between peers. The notion of the experiences of peers can be used as examples to encourage more responsible attitudes and reduce high-risk behaviour.

There are several factors vital for the success of peer educator programmes. These include:

- Selection of peer educators. They need appropriate communication skills, and must be able to motivate colleagues, win their trust, and act as role models.
- Support ongoing skills development for peer educators. This is important to maintain credibility, motivation and effectiveness.
- Numbers of peer educators. Adequate numbers need to be trained and maintained for ongoing effectiveness.
- Integrated with other programmes, peer education interventions should ideally combine prevention with care and support, such as VCCT, home-based care and ART, to maintain motivation, credibility and effectiveness of the educators.

### (3) Condom use, promotion and distribution

This involves the following:

1. Educating people about condoms, their use and purpose;
2. Promoting awareness and acceptance of their role in safer sexual activities
3. Ensuring reliable and sustainable access to condoms.

NB: In many communities, misinformation and beliefs about condom use persist. These can hamper the acceptance of condom promotion as a prevention intervention. Condom demonstrations could diminish this.

### (4) Treatment of sexually transmitted diseases (STIs)

Effective diagnosis and treatment of STIs other than HIV not only reduces STIs illnesses and complications, but also substantially lowers the risk of HIV transmission. STI intervention involves:

- Providing information and training on general reproductive health and the types of STIs that are prevalent in societies;
- Promoting the treatment and prevention of such infections.

#### (5) Voluntary (and confidential) counselling and testing (VCCT)

VCCT is confidential HIV testing of a person who has undergone pre-testing counselling, consents to the test, and will have post-testing counselling. VCCT programmes need to promote voluntary testing and then make provision for pre- and post-test counselling and reliable testing.

VCCT has a major role to play in HIV by helping to modify the behaviour of employees to avoid infection among other things.

#### (6) Universal Precautions and post exposure prophylaxis

Universal precautions (UP) are a standard set of infection control practices to be used to prevent infection (with HIV, Hepatitis B, etc.) through accidental exposure to blood/bodily fluid. They constitute one way of working towards the establishment of a safe working environment for education sector employees.

Though instances of exposure to HIV through blood or bodily fluid occurs less frequently in schools than in hospitals, workplace programmes provide an opportunity for staff and personnel to learn about UP to better protect themselves and others should an accident happen.

UP includes the following but not limited to the below mentioned (as taken from the World Health Organization) manual:

- Using new, disposable injection equipment is highly recommended.
- Washing hands with soap and water before and after procedures; use of protective clothing, e.g. gloves, masks, etc..

(7) Prevention of mother-to-child transmission and reproductive health services.

(8) Reducing structural risks

(9) Potential care and support interventions.

## **8.12 HUMAN RESOURCE PLANNING AND DEVELOPMENT**

HIV and AIDS put the need to ensure that sufficient numbers of skilled teachers, managers and other staff in the education sector in spotlight. To achieve its goals of accessibility and quality, a lot of education workers of all cadres are needed. Planning may need to consider a range of reasons for skills shortages, and different options for filling skills gaps most efficiently. Chetty (2006:106) says that, in this regard, HIV and AIDS may often present an opportunity to increase the efficiency of education HR planning and sector skills development strategies.

Several options may need to be considered:

- (1) **Recruitment and retention strategies.** In a number of education systems, skills shortages, and attrition may in large part be due to difficulties in retaining trainees and experienced teachers, rather than teacher deaths. Retained staff can be better at maintaining “institutional memory” and experience and can play important roles in keeping systems working efficiently.

- (2) Staffing norms and skills mixes.** These may also require consideration, especially in services that face high demand. The extra stress of HIV and AIDS on service delivery often gives organisation an opportunity to review whether existing procedures make sense.
- (3) Succession planning and career development.** These can be important tools to ensure that if employees leave, there is sufficiently experienced staff to take over from them.
- (4) Trainee prevention-and-impact-management skills.** Integration of prevention activities and impact management skills into the curriculum of pre-and in-service trainees should be considered as a way of avoiding future losses of skills and build skills in HR impact management that trainees can use within the teaching service.

#### **8.12.1 Deployment recruitment, appointment and transfers**

Inefficiencies in deployment, recruitment, appointment and transfer systems often cause substantial delays, costs and disruption in educational services. In case of South Africa, but not in Uganda, posts were blocked and frozen without consideration of the HIV and AIDS epidemic be a further problem. As more educators become ill and/or are lost to the HIV and AIDS epidemic, weaknesses in staffing become increasingly urgent to address. Traditionally under-served areas and communities warrant specific consideration as they can be further disadvantaged by shortages of trained and experienced professionals due to HIV and AIDS. To address such problems, it may require to consider issues of incentives for staff to work in under-served areas, and appropriate balances between centralised and decentralised decision-making in relation to recruitment and appointment (Rau, 2004 cited in Chetty, 2006:107).

### **8.12.2 Human resource management – monitoring of absenteeism and ill-health**

Ill-health and absenteeism can cause disruption and stress in education workplaces (Rau, 2002 cited in Chetty, 2006:107). It is important for employers to systematically manage and monitor absenteeism and ill-health of employees.

To be able to effectively manage absenteeism and ill-health, and possibly to understand the effects of HIV and AIDS on absenteeism, it is desirable for employees to disclose their HIV or health status as early as possible. However, in order to encourage employees to be tested and know their sero status, it is imperative to ensure that they have supportive environments for disclosure. Provision of access to treatment and support services should therefore be promoted.

Another issue is that sick leave and compassionate leave entitlements will often need review. The aim of such review will be flag absenteeism problems early so that they can be actively managed for the benefit of the employees and the overall functioning of the workplace.

Systems should also encourage ill employees to retire at the 'right' time for them and the employer. They will often require a review of care and support systems, including pension benefits and leave-related systems. If these are not well managed, employees often work for as long as possible, even if they cannot perform effectively. On the other hand, infected staff may retire too soon, leading to premature loss of education capacity. I imagine it can work well if there is trust between the employee and the employer.

Performance management systems can be a useful mechanism to allow objective judgement of when it is fair and appropriate to retire or re-deploy employees.

### **8.12.3 Analysis of job descriptions**

Job and process design can be shaped or modified in various ways that may help moderate HIV and AIDS impacts on service delivery and management. Several strategies may be used; and the strategies include:

- Simplifying tasks and their required sets of skills. This can facilitate easier cover for employees that are absent or lost to the system. For example, teaching aids or assistants may be able to perform certain functions when a qualified teacher is not available.
- Team work and multi-skilling can result in a better understanding of other people's functions and make it easier for other staff to cover key responsibilities for short or long periods. Teamwork and multi-skilling appear to be natural strategies that many schools adopt to cover for absent teachers and managers. The assumption here may be that teachers' morale remains high otherwise, they may perform poorly due to work overload.
- Systematic review of qualifications frameworks and requirements. Recruitments for unnecessarily high qualifications or specialisation to perform tasks that less skilled personnel could do make it difficult to cope with absences.
- Relief staff systems. This has worked well with maternity leave in education. With HIV and AIDS, there is need to implement it with care to make sure that such systems are affordable, efficient and of adequate quality to respond to larger numbers of absent staff or vacancies.
- Redeployment and reasonable accommodation. Law may require the reassigning of staff with disability or special needs to more manageable duties.



### **8.13 STRENGTHENING INFORMATION SYSTEMS AND INFORMATION EXCHANGE**

There are some benefits which can be derived from strengthening mechanisms for generating and sharing information in the workplaces and the education sector.

- Information and knowledge transfer systems seek to ensure that more employees have an understanding of the education sector, its jobs and functions, and recent developments in the workplace. This enables them to step in and take over from colleagues more easily, and perhaps remain in the system longer. These systems can often be useful as a part of general skills development strategy in a workplace or sector.
- Strengthening management information systems is another mechanism for managing the impacts of HIV and AIDS on the education staff. Well-managed information systems allow for identification, management and monitoring of HIV and AIDS impacts and interventions that are targeted at education staff. Effective workplace management will usually need central and decentralised information systems to facilitate design, monitoring and refinement of the management response.

### **8.14 THE CONTRIBUTION OF THE RESEARCH**

The research has made a contribution to the Profession of Industrial and organisational Psychology and body of knowledge within the discipline.

The research has achieved its goal of providing information about the nature and extent of workplace HIV and AIDS-related discrimination as influenced by knowledge, attitudes and traditional beliefs. A comprehensive report on the matter has been compiled

together with an account of the research methodology adopted. The use of a mixed method design enhanced the quality of the findings. While the research was conducted among teachers in Bojanala District of North West Province of South Africa and Kampala District of Central Region of Uganda, there are prospects that a similar research can be done in other public sectors to get more knowledge on the topic which is still not so much researched.

O'Leary (2005:60) suggests that research can produce data that can be a catalyst for change on a number of levels. She conceptualises these levels as a pyramid. The base of the pyramid is professional development. The next tier is practice, followed by programmes. The next level is policy. Change at all these levels may influence the culture of the organisation. At the level of professional development, she suggests that the research has an impact on the researcher and that personal growth is inherent to conducting research. It may provide data that allows individuals, organisations or communities to reflect on what they do. At this level, the research may take the form of a needs assessment, evaluate new practices or try out new ideas. At the level of programmes, the emphasis of the research is to change the projects, procedures and strategies in a systematic way. Finally, research may influence policy, that is, the guiding principles and directions of the organisation or community. Outlines of suggestions on some of the above-mentioned areas can be found in this chapter.

### **8.15 PERSONAL REFLECTIONS**

This research involved the researcher in a topic that holds deep personal relevance. I have been in the education sector for quite some time. I have witnessed teachers working in difficult and different conditions. In the four countries I have so far worked in, including Uganda, Lesotho, Botswana and South Africa, teachers have been infected affected by HIV and AIDS. I saw dear friends and colleagues dying of a disease which has many dimensions, was reason enough to embark on this program. I hope the efforts put in this thesis will one day make life more promising to those many workers who are witnessing the impact of the disease.

## **8.16 SUMMARY**

In this chapter, limitations to the study have been dealt with pertaining to the research methods, literature review and theories used along with the findings in general. Secondly, recommendations pertaining to the study have been dealt with in light of the findings of the study. Finally, conclusions have been drawn from the findings of the study. It is assumed that the objectives and aims of the study have been achieved as stipulated in project proposal which formed chapter 1 of this thesis.

## REFERENCES

Abdool, Q & Karim, S. 2001. Barriers to Preventing Human Immunodeficiency Virus in Women: Experiences from KwaZulu-Natal, South Africa. *Journal of the American Medical Women's Association* 56 (40):193-196.

AIDS-Weekly. 2001. In Africa, Stigma Blocks Treatment – even talk of. [Online]. Available: <http://www.newsrx.com>. [Accessed 20 April 2006].

Ajzen, I. 1985. 'From Intention to Actions: A Theory of Planned Behaviour' In J. Kohl & J. Beckamn (eds), *Action Control: From Cognition to Behaviour*. Heidelberg: Springer.

Ajzen, I. 1988. *Attitudes, Personality and Behaviour*. Milton Keynes, UK: Open University Press.

Ajzen, I. 1991. The Theory of Planned Behaviour. *Organisational behaviour and decision processes*, 50:179-211.

Ajzen, I. 2001. Nature and Operation of Attitudes. *Annual Review of Psychology*, 24:1251-1253.

Ajzen, I & Fishbein, M. 1973. Attitudes and Normative Beliefs as Factors Influencing Behavioural Intentions. *Journal of Personality and Social Psychology*, 27:41-57.

Ajzen, I & Fishbein, M. 1977. Attitude-behaviour Relations: A Theoretical Analysis and Review of Empirical Research. *Psychological Bulletin* 84:889-918.

Ajzen, I & Fishbein, M. 1980. *Understanding Attitudes and Predicting Social Behaviour*. Eaglewood Cliffs, NJ: Prentice-Hall.

Ajzen, I. & Madden, T.J. 1986. Prediction of Goal-directed Behaviour: Attitudes, Intentions, and Perceived Behavioural Control. *Journal of Experimental Social Psychology*. 22:453-474.

AIDS. 2006. XVI International AIDS Conference, 13-18 August 2006 – Toronto, Canada: Official press release: day 6. From:

<http://www.aids2006.org/admin/images/upload/1242.pdf>[Accessed: 14/07/2009].

Aggleton, P. 2000. HIV and AIDS-related Stigmatization, Discrimination and Denial: Forms, Contexts and Determinants. Research Studies from Uganda and India. *UNAIDS Best Practice Collection*. Geneva, Switzerland, UNAIDS.

Allport, G.W. 1935. Attitudes. In C.A. Murchinson (ed.). *A Handbook of Social Psychology*. 2:798-844. Worcester, MA: Clark University Press.

Allport, G.W. 1961. *Pattern and Growth in Personality*. New York: Holt, Rinehart & Winston.

Alubo, O., Zwandor. A., Jolayemi, T & Omudu. E. 2002. Acceptance and Stigmatisation of PLWA in Nigeria. *AIDS CARE* 14:117-126.

Alupo, J. 2001. Teachers and AIDS Group: Inter-sectoral Platform Activities. A report on the revised strategy, titled: 'The Education and Sports HIV and AIDS Prevention Strategic Plan, 2011/12-2015/16'.

Americans with Disability Act of 1990, Pub. L. No. 101 – 336, 104 Stat. 327. 1990, codified 4.2 U.S.C & 12101 et seq.

Amuyunzu-Nyamongo, M., Okeng' O.L., Wagua, A & Mwenzwa Wagure, E. 2007. Putting on a Brave Face: The Experience of Women Living with HIV and AIDS in Informal Settlements of Nairobi, Kenya. *AIDS Care*:19 (supplement 1): S25-S34.

Anderson, H. 1997. 'Conversation, Language, and Possibilities: A Post-modern Approach to Therapy', In McNamee, S & Gergen, K.J. (eds), *Therapy as Social Construction*. London: Sage.

Angura, J. 2002. 'Museveni Advises Cadets on AIDS'. *New Vision* (Kampala), 11 November.

Arnold, A., Randall, R., Patterson, F., Silvester, J., Robertson, I., Cooper, C., Burnes, B., Swailes, S., Harris, D., Axtell, C & Hartog, D.D. 2010. *Work Psychology: Understanding Human Behaviour in the Workplace*. 5<sup>th</sup> ed. Harlow: Pearson Education.

Ashforth, A. 2000. *Madumo: A Man Bewitched*. Cape Town, David Phillip.

Babbie, E. 1992. *Survey Research Method*, (2<sup>nd</sup> ed.), Belmont: Wadsworth.

Babbie, E. 2005. *The basics of social research*. Belmont, California. Thomson/Wadsworth.

Badri, M. 1997. *The AIDS Crisis: An Islamic Socio-Cultural Perspective*. Kuala Lumpur: International Institute of Islamic Thought and Civilization.

Balabanova, Y., Coker, R., Atun, R. A& Dronbiewski, F. 2006. Stigma and HIV infection in Russia. *AIDS Care*. October, 18 (7):846-852.

Bandura, A. 1977. Self-efficacy: Toward a Unifying Theory of Behavioural Change. *Psychological Review*. 84(2): 191-215.

Bandura, A. 1982. Self-efficacy Mechanism in Human Agency. *American Psychologist* .37:122-147.

Bandura, A. 1986. *Social Foundations of Thought and Action: A Social Cognitive Theory*. Eaglewood Cliffs, N J: Prentice-Hall.

Bandura, A. 1987. 'Human Agency in Social Cognitive Theory'. *American Psychologist*. 44:1175-1184.

Bandura, A. 1989. Perceived Self-efficacy in the Exercise of Control. In *Primary Prevention of AIDS: Psychological Approaches*, V.M. Mays, G.W. Albee, S.F. Schneider (eds). Newbury Park: Sage.

Bandura, A. 1990. Perceived self-efficacy in the exercise of control over AIDS infection. *Evaluation and Programme Planning*. 13: 9-17.

Bandura, A. 1994. 'Social Cognitive Theory and Exercise of Control over HIV Infection', In R. J. DiClemente & J. L. Peterson (eds). *Preventing AIDS: Theories and Methods of Behavioural Interventions*. New York: Plenum Press.

Bandura, A. 1997. *Self-efficacy: The Exercise of Control*. New York: W. H. Freeman.

Bandura, A. 1999. Social Cognitive Theory: An agent perspective. *Asian Journal of Social Psychology*. 2:21-41.

Bara, H. 2002. *Myths 1a-P50: Total Community Mobilization Survey 2002: Myths and Misconceptions on HIV and AIDS among Field Officers*. Gaborone: Total Community Mobilization.

Barnett, T & Whiteside, A. 2003. *AIDS in the Twenty-first Century: Disease and Globalization*. New York, Palgrave Macmillan.

Baron, J. 1996. 'Do No Harm', In D.M. Messick & A.E. Tenbrunsel (eds.), *Codes of Conduct: Behavioural Research into Business Ethics*. New York: Russell Sage Foundation.

Baron, J. 2006. *Protected Values for Acts and Omissions*. [Online] Available from [http://www.psych.edu/a\\_baron/crrb.pdf](http://www.psych.edu/a_baron/crrb.pdf). [Accessed 15 December 2006]

Baron, J & Greene, J. 1996. 'Determinants of Insensitivity to Quantity in Valuation of Public Goods: Contribution, Warm Glow, Budget Constraints, Availability, and Prominence'. *Journal of Experimental Psychology: Applied*, 2:107-125.



Baron, J& Spranca, M. 1997. 'Protected Values'. *Organisational Behaviour and Human Decision Processes*. 70:1-16.

Barongo, F& Happy, M. 2004. Women's access to and utilization of VCT services in HIV/AIDS prevention and care: A case study of Kawempe Division. An unpublished research report submitted to the network of Ugandan researchers and research users (NURRU)

Barrett, G. V., Phillips, J. S& Alexander, R. A. (1981). Concurrent and predictive validity designs: A critical reanalysis. *Journal of Applied Psychology*. 66(1), 1- 6.

Barz, G. 2006. *Singing for Life: HIV and AIDS and Music in Uganda*. New York: Routledge, Taylor & Francis.

*Basic Conditions of Employment Act, No. 75 of 1997*

Bauni, E. E., Garimoi, C. O., Maharaj, P., Mushingeh, A. C.S., Neema, S., Ngirwamungu, E & Riwa, P. 2010. People's perception of HIV/STD risk and unwanted pregnancy. <http://www.reproline.jhu.edu/english/6read/6issues/6progress/prog48d.htm> [Accessed: 17 June 2012].

Beehr, T. A. 1995. *Psychological Stress in the Workplace*. London: Routledge.

Bhengu, M. J. 1996. *Ubuntu: the essence of democracy*. Cape Town: Novalis Press.

Bektas, H. A& Kulakac, O. 2007. Knowledge and Attitudes of Nursing Students towards Patients Living with HIV/AIDS (PLHIV): A Turkish Perspective. *AIDS Care*, 19 (7): 888-894.

Bennell, P., Hyde, K & Swainson, N. 2002. The Impact of the HIV/AIDS Epidemic on the Education Sector in Sub-Saharan Africa: A Synthesis of the Findings and Recommendations of Three Country Studies. Sussex: Centre for International Education.

Benson, S. & Dundis, 2003. 'Understanding and motivating health care employees: Integrating Maslow's hierarchy of needs, training and technology'. *Journal of Nursing Management*. 11:315-320.

Bequele, A. 1999. *ILO Action Against HIV/AIDS – November*. Geneva, Switzerland.

Berger, B. E., Ferrans, C. E& Lashley, F. R. 2001. Measuring HIV Stigma in People with HIV: Psychometric Assessment of the HIV Stigma Scale. *Research in Nursing and Health*, 24 (6):518-529.

Berlyne, D. E. 1960. *Conflict, Arousal, and Curiosity*. New York: McGraw-Hill.

Beuster, J. 1997. Psychopathology from a traditional African perspective. *Unisa Psychologia*, 24(2):1-11.

Bharat, S& Aggleton, P. 1999. 'Facing the Challenge: Household Responses to HIV/AIDS in Mumbai, India'. *AIDS Care*. 11(1):31-44.

Bharat. S., Singhanatra-Renard. A & Aggleton. P. 1998. Household and Community Response to HIV/AIDS in Asia: The Case of Thailand and India'. *AIDS Care*. 12:117-122.

Biocca, L. J. 1985. The Relationship among Locus of Control, Perceived Parenting, and Sex-role Attributes in Adolescence. *Dissertation Abstracts International*. 47:2193B.

Blau, G. 1984. Brief Note Comparing the Rotter and Levenson Measures of Locus of Control. *Perceptual and Motor Skills*. 58 (1):173-174.

Blaxter, M. 1981. *The Health of Children: A Review of Research on the Place of Health in Cycles of Disadvantage*. London: Heinemann Educational.

Blecher, M.S., Seinberg, M., Pick, W & Hennick, M. 1995. AIDS Knowledge, Attitudes and Practices among STD Clinic attendees in the Cape Peninsula. *SouthAfrica Medical Journal*. 85 (12):1281-1286.

Bless, C& Higson-Smith, C 2000. *Fundamentals of Social Research Methods: An African Perspective*. Lance Downe: Juta Education.

Boehene, K. 1996. The IXth International Conference on AIDS and STDs in Africa. *AIDS Care*, 8:609-615.

Boeree, G. C. 1999. Abraham Maslow: 1908–1970. [Online] Available:  
<http://www.ship.edu/~cgboeree/maslow.html>. [Accessed 6 January 2008].

Bogardus, E.S. 1925. Measuring Social Distance. *Journal of Applied Sociology*. 9:299-308.

Bond, G. 1993. *Death, Dysentery, and Drought: Coping Capacities of Household in Chiawa*. Lusaka, Zambia: Paper presented at the Institute of African Studies.

Bond, V.2002. 'The Dimensions and Wider Context of HIV/AIDS Stigma and Resulting Discrimination in Southern Africa', In A. Sisask (ed.). *One Step Further-Responses to HIV/AIDS*. SIDA Studies No. 7, Elanders Novum AB. Gothenburg, Sweden: SIDA/UNRISD.

Bond, V., Chase, E& Aggleton, P. 2002. Stigma, HIV/AIDS Prevention, and Mother-to-child Transmission in Zambia. *Evaluation and Programme Planning*. 25:247 -256.

Bond, D., Keogh, R & Walker, D. 1996. Promoting Reflection in Learning: A Model in Boundaries of Adult Learning. New York: Routledge.

Boone, C., De Brabander, B & Van Witteloostuijn, A. 1996. 'CEO Locus of Control and Small Firm Performance: An Integrative Framework and Empirical Test'. *Journal of Management Studies*. 33(5):667-699

Bornstein, M. H& Lamb, M. E. (eds.). 1999. *Development Psychology: An Advanced Textbook* (4<sup>th</sup> ed.). Mahwah, NJ: Erlbaum.

Bosch, D. 1991. *Transforming Mission: Paradigm Shifts in Theology of Mission*. Minneapolis: Fortress.

Botswana Ministry of Health AIDS/STD Unit. 2003. *Botswana national policy on HIV/AIDS*. Gaborone: Ministry of Health.

Bredell, D. 2004. *A Developmental Programme in Salutogenic Functioning*. Unpublished Doctoral Thesis in the Department of Industrial and Organisational Psychology. Pretoria: UNISA.

Breuer, N. L. 1995. Emerging Trends for Managing AIDS in the Workplace. *Personnel Journal* 74.

Brink, P. J & Wood, M. J. 1998. *Advanced design in nursing research*. 2<sup>nd</sup> edition. Thousand Oaks: Sage

Brink, P. J & Wood, M. J. 2001. *Basic steps in planning nursing research: From question to proposal*. 5<sup>th</sup> edition. Sunbury: Jones and Barlett publishers.

Broodryk, J. 2006. *Ubuntu: African life coping skills: theory and practice*. Ubuntu School of Philosophy.

Brosschot, J. F., Gebhardt, W. A & Godaert, G. L. R. 1994. Internal, Powerful Others and Chance Locus of Control: Relationships with Personality, Coping, Stress and Health. *Personality and Individual Differences*. 16(6):839-852.

Brown, L., Macintyre, K & Trujillo, L. 2003. Interventions to Reduce HIV/AIDS Stigma: What Have we Learned? *AIDS Education and Prevention*, 15:49-69.

Brown, R. 1995. *Prejudice: Its Social Psychology*. Oxford: Blackwell

Bryan, A. D., Fisher, J. D., Fisher, W. A & Murry, D. M. 2000. Understanding Condom use among Heroin Addicts in the Methadone Maintenance using the Information -Motivation-Behavioural Skills Model. *Substance Use and Misuse*, 35:451-471.

Bunker, D.R & Wijnber, M. 1985. The Supervisor as a Mediator of Organisational Climate in Public Service Organisations. *Administration in Social Work*, 9(2):59 - 72.

Bunting, S.M. 1996. Sources of Stigma Associated with Women with HIV. *Advances in Nursing Science*. 19(2):64-73.

Burns, N & Grove, S. K. 2001. *The practice of nursing research: conduct, critique and utilization*. Philadelphia: W.B.Saunders.

Burns, N & Grove, S. K. 2003. *The practice of nursing research: conduct, critique and utilization*. 3<sup>rd</sup> edition. Philadelphia: W.B.Saunders.

Burns, N & Grove, S. K. 2005. *The practice of nursing research: conduct, critique and utilization*. 5<sup>th</sup> edition. St Louis: Elsevier.

*Business & Human Rights*. 2009.

Byamugisha, G. 2000. *Breaking the Silence on HIV/AIDS in Africa: How can Religious Institutions Talk about Sexual Matters in their Communities?* Kampala: Tricolour.

Byamugisha, G. 2002. 'Empowering Faith Communities', In Byamugisha, G. et al; (eds), *Journeys of faith: Church-based Responses to HIV and AIDS in Three Southern African Countries*. St Albans: TALC.

Cameron, E. 2005. *Witness to AIDS*. London. I.D. Tawis.

Camic, P. M., Rhodes, J. E & Yardley, L. 2003. *Qualitative Research in Psychology*. Washington, DC: American Psychological Association.

*Care*, 14, 431-433.

Carey, M.P. 1997. HIV Knowledge Questionnaire. Syracuse, NY: Syracuse University.

Carton, J. S & Nowicki, S. Jr. 1994. Antecedents of Individuals Differences in Locus of Control of Reinforcement: A Critical Review. *Genetic, Social and General Psychology Monograph*. 120(1):31-81.

Castro. R., Orozco., E. Aggleton., P. Eroza., E& Hernandez. J.J. 1998. AIDS-related Illness Trajectory in Mexico: Findings from a Qualitative Study in Two Marginalised Communities. *AIDS Care*, 10:583-598.

Castro, R., Orozco, E., Aggleton, P., Eroza, E & Hernandez, J.J. 1998. Family Responses to HIV/AIDS in Mexico. *Social Science and Medicine*, 47:1473-1484.

Catania, J., McDermott, L & Wood, J. 1984. 'Assessment of Locus of Control: Situational Specificity in the Sexual Context'. *Journal of Sex Research*, 20:310-324.

Cates, W. Jr. 2001. The NIH condom report: the glass is 90% full. *Family Planning Perspectives*, 33(5):321-233.

Centre for Disease Control. 2007a. *Basic information*.

<http://www.cdc.gov/hiv/resources/factsheets/print/transmission.htm> [Accessed on 12/07/2012].

Chan, K.Y & Reidpath, D.D. 2004. HIV Vulnerabilities, Stigma, Discrimination and the Human Rights Framework: Evidence and Action. [Online] Available: [http://www. Un.or. th/ohchr/issues/hiv aids/evdtoact.pdf](http://www.Un.or.th/ohchr/issues/hiv aids/evdtoact.pdf). [Accessed on 06/06/2011].

Charalambous, S., Grant, A. D., Day, J. H., Rothwell., Chaissou, R. E., Haye, R. J & Churchyard, G. J. 2004. ,Feasibility and Acceptability of a Specialist Clinical Aervice for HIV-infected Mineworkers in South Africa', *AIDS Care*. 16(1):47-56.

Chen, J., Choe, M. K., Chen, S & Zhang, S. 2005. 'Community, Environment and HIV/AIDS-related Stigma in China'. *AIDS Education and Prevention*. 17(1):1-11.



Chen, W. T., Han, M & Holzemer, W. L. 2004. 'Nurses' Knowledge, Attitudes and Practice Related to HIV Transmission in Northern China. *AIDS Patient Care & STDs*, 18:417-422.

Chesney, M & Smith, A. 1999. Critical Delays in Testing and Care: The Potential Role of Stigma. *American Behavioural Scientist*, 42:1162-1174.

Chetty, D. 2006. HIV/AIDS in the educational workplace  
.http://www.skillsportal.co.za/trai/training-providers/course/160-imsimbi -  
trainig/559-hiv.[Accessed on 26/06/2012].

Clark, D. A., Beck, A. T & Brown, G. K. 1992. 'Sociotropy, Autonomy and Life Event Perceptions in Dysphoric and Non-dysphoric Individuals'. *Cognitive Therapy and Research*. 16:635-652.

Clark, M. C & Dirks, J. M. 2000. *Moving beyond a unitary set: A reflective dialogue*. San Francisco: Jossey Bars.

Clifford, W. C & Rixford, C. 1998. *Lessons Learned from History of Social Indicators*. San Francisco: Redefining Progress.

Clive Evian. 2002. *PrimaryAIDSCare*. (3<sup>rd</sup> ed). Johannesburg: Jacana Education.

Coetzee, S. C. 2004. Dispositional Characteristics and the Quality of Work Life of Members of a Self-managing Work Team. Paper presented at the 2<sup>nd</sup> South African Work Wellness Conference. Potchefstroom, South Africa.

Coetzee, P. 2006. 'The Responsibility of the Internal Auditor in Managing the Risk of HIV/AIDS'. *South African Journal of Economics and Management Science*, 9(1):72-87.

Coetzer, E. L & Schepers, J. M. 1997. Verband tussen van beeher en die werksprestasie van swart bemarkers. *Journal of Industrial Psychology*, 23(1): 34-41.

Cohen, L. H., Pane, N & Smith, H. S. 1997. 'Complexity of the Interpersonal Self and Effective Reactions to Interpersonal Stressors in Life and in the Laboratory'. *Cognitive Therapy and Research*. 21:387-407.

Cohen, S & Syme, L. S. 1985. *Social Support and Health*. New York: Academic Press.

Cohen, S. 2001. *States of Denial: Knowing about Atrocities and Suffering*. London: Polity.

Cohen, J. 1999. *Statistical Power and Analysis for Behavioural Sciences*. (Revised edition). New York: Academic Press.

Cole, N. S. 1981. 'Bias in Testing'. *American Psychologist*. 36(10):1067-1077.

Cronbach, L. J. 1970. *Essentials of Psychological Testing* 3<sup>rd</sup> ed. New York: Harper & Row.

Cronbach, L. J & Meehl, P. E. 1995. Construct Validity in Psychological Tests. *Psychological Bulletin*, 52(4):281-302.

Cronbach, L. J. 1990. *Essentials of Psychological Testing*. New York: Harper and Row.

*Constitution of the Republic of Namibia*, 1990.

*Constitution of the Republic of South Africa* 1996.

*Constitution of the Republic of Uganda* 1996.

*Constitution of the Republic of Uganda* 2006.

Cooper, C. L & Marshall, J. 1976. Occupational Source of Stress: A Review of the Literature Relating to Coronary Heart Disease and Mental Health. *Journal of Occupational Psychology*. 49:11-28.

Copper, C. L & Williams, S. 1994. *Creating Healthy Work Organisations*. Chichester, UK. John Wiley & Sons.

Corrigan, P.W & Penn, D.I. 1999. 'Lessons from Social Psychology on Discrediting Psychiatric Stigma'. *American Psychologist*. 54:765-776.

- Craffert, P. F. 1999. *Illness and Healing in the Biblical World: Perspectives on Healthcare*. Pretoria: Biblia Publishers.
- Craig, A. R. Franklin, J. A & Andrews, G. 1984. 'A Scale to Measure Locus of Control of Behaviours'. *British Journal of Medical Psychology*, 57(2):173-180.
- Crabtree, B. F & Miller, W. L. 1993. Public Reactions to AIDS in the United States: A Second Decade of Stigma. *American Journal of Public Health*, 83:574-577.
- Crewe, M. 1992. *AIDS in South Africa: The Myths and the Reality*. Penguin Forum Series.
- Crush, J., Frayne, B., Grant, M. 2006. Linking Migration, HIV/AIDS and Urban Food Security in Southern and Eastern Africa. RENEWAL. IFPRI, SAMP. [Online] Available: [www.queensa.za/samp](http://www.queensa.za/samp). [Accessed 10 May 2011].
- Cumes, D.M. 2004. *Africa in my Bones: A Surgeon's Odyssey into the Spirit World of African Healing*. Claremont: New Africa.
- Deacon, H. 2005. *Understanding HIV/AIDS Stigma: A Theoretical and Methodological Analysis*. Cape Town: HSRC Press.
- De Vos, A. S. (ed.) 2002. *Research at Grass Roots*. (2<sup>nd</sup> ed.). Pretoria: Van Schaech.

De Waal, A. 2006. *AIDS and Power: Why there is no Political Crisis-yet*. Zed Books Co. UK.

De Waal, A& Tumushabe, J. 2003. *HIV/AIDS and Food Security in Africa*. London: DFID

De Waal, J. J. P. 1997. *Gereedheid van Toesighouers binne die Goudmynbedryf vir die Implementering van Selfgerigte Werkspanne*. Unpublished Master's Thesis. Vanderbijlpark: PU for CHE.

Demi, A., Bakeman, R., Moneyham, L& Seals, B. 1998. Thoughts of Women with HIV Infection: Effect of Stressors and Moderating Effects of Family Cohesion. *Journal of Family Psychology*.12:344-353.

Department of Education 1998. Draft National Policy for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions. *Notice 3005 of 1998*. Pretoria: Government Printer.

Department of Education 1999. *The HIV/AIDS Guidelines for Educators*. Pretoria: Department of Education.

Department of Health 2003. National HIV and Syphilis Sero-prevalence Survey in South Africa 2002. Summary Report. Pretoria: Government Printer.

Department of Health 2005. National HIV and Syphilis Sero-prevalence Survey in South Africa 2004. Summary Report. Pretoria: Government Printers.

Department of Labour HIV/AIDS Technical Assistance Guidelines. 1999. Published by the Department of Labour, Chief Directorate of Communication ASBN, No. 0621-336566-4:58. Pretoria: South Africa

Derrida, J. 1995. *Points: Interviews, 1974-1994*, edited by E. Weber and translated by P. Kamuf *et al.* Standford: Stanford University Press.

Dickinson, D. 2004. People Living Openly with HIV/AIDS in the Workplace. *Labour Bulletin*. 28(2):59-62.

Dickinson, D. 2004. Traditional Healers and HIV/AIDS. *Labour Bulletin*. 28(4).

Dickinson, D. 2004. Corporate South Africa's Response to HIV/AIDS: Why so Slow? *Labour bulletin*. 28(6).

Dickinson, D. 2008. Traditional Healers, HIV/AIDS and Companies Programmes. Paper presented at Wits HIV and AIDS in the Workplace Research Symposium, Wits Business School, Johannesburg. University of the Witwatersrand, 29-30 May 2008.

Dijkstra, A. G. 2002. Revisiting UNDP's GDI and GEM: Towards an Alternative. *Social Indicators Research*. 57:301-338.

Dixon, N. M. 1999. *The organizational learning cycle*, USA: Gower.

Doob, L.W. 1947. The Behaviour of Attitudes: *Psychological Review*. 54:135-156.

Dozois, D. J. A& Backs–Dermott, B. J. 2000. Sociotropic Personality and Information Processing following Imaginal Priming: A Test of the Congruency Hypothesis. *Canadian Journal of Behavioural Science*. 32(2):117-126.

Du, M., Wu, Z., Jiang, H & Bedi, R. 2002. HIV and AIDS in China: Attitudes of Dentists towards Provision of Care and Infection Control – A Pilot Study. *International Journal of Health Promotion & Education*, 10:559-576.

Dyson, P. J. 1990. *Mastering PC Tools Deluxe Six*. San Francisco, CA: SYBEX.

Eagly, A. H& Chaiken, S. L. (eds). 1993. *The Psychology of Attitudes*. Fort Worth, TX: Harcourt Brace Jovonovich.

Eagly, A. H & Chaicken, S. 1998. Attitude Structure and Function, in D. T. Gilbert, S. T. Fiske, & G. Lindzey (eds). *The Handbook of Social Psychology*. (4<sup>th</sup> ed.). New York: McGraw-Hill.

Edgerton, J. E. 1994. *American Psychiatric Glossary*. (7<sup>th</sup> ed.), Washington, DC: American Psychiatric Press.

Eiser, J. R& Van der Pligt, J. 1988. *Attitudes and Decisions*. London: Routledge.

Eisner, E. W. 2003. On the Art and Science of Qualitative Research in Psychology, in P. M. Camic., J. E. Rhodes & L. Yardley (eds). *Handbook of Qualitative Research in Psychology*. Washington, DC: APA.

Employment Equity Act. No. 55. *Government Gazette*. 19 October 1998. Pretoria: Government Printer. (No. 19370).

Eshleman, J. M. 1994. AIDS in the Workplace: Implementing an AIDS Policy. *Health Care Supervisor (HCS)*, 13(20):51-57.

Evans-Pritchard, E. 1977. *Witchcraft, Oracles and Magic among the Azande*. Oxford, Clarendon Press.

Faircloth, C.A., Boylstein, C., Rittman, M., Young, M.E& Guibriu, J. 2004. Sudden Illness and Biographical Flow Narratives of Stroke Recovery. *Sociology of Health and Illness*. 26 (2): 242-261.

Family Health International 2000. Behavioural Surveillance Surveys: Guidelines for Repeated Behavioural Surveys in Populations at Risk of HIV. [www.fhi.org](http://www.fhi.org). [Accessed on 5 December 2000].

Fazio, R. H. 1995. Attitudes as Object-evaluation Associations: Determinants, Consequences and Correlates of Attitude accessibility, in R. E. Petty & J. A. Krosnik (eds). *Attitude Strength: Antecedents and Consequences*. Mahwah, NJ: Erlbaum.



Fazio, R.H., Olson, M.A. 2003. Attitudes: Foundations , Functions and Consequences, in M.A. Hogg & J. Cooper (eds). *The Sage Handbook of Social Psychology*. Thousand Oaks, CA: Sage.

Federal Ministry of Education. 2006. School-based baseline survey on HIV/AIDS knowledge., attitude, practice and skills (KAPS) and school health in Nigeria. Abuja: UNICEF.

Ferris, A. L. (2001). The Use of Social Indicators. *Social Forces*,66(3):601-617.

Field, A. (2005). *Discovering Statistical Using SPSS (and Sex, Drugs and Rock 'n Roll)*. 2nd ed. London:Sage.

Field, J. (2003). *Social Capital*. London: Routledge.

Fight Stigma! Reach Out to Positive People. (2002). *2002/3 World AIDS Day Campaign/ World/AIDS Day*. Kampala, Uganda AIDS Commision Secretariat.

Figueira, M. (2001). HIV/AIDS: Human Rights Developments in Namibia since Independence. Paper presented at the AIDS in Context Conference, 4-7 April, University of the Witwatersrand, Johannesburg.

Fishbein, M& Ajzen. I. (1975). *Belief, Attitude, Intention and Behaviour: An Introduction to Theory and Research*. Reading, MA: Addison-Wesley.

Fishbein, M & Raven B.H. (1962). The AB Scales: An Operational Definition of Belief and Attitude. *Human Relations* 15:35-44.

Flynn, M. B., McKeever, J. L., Spada, T & Gordon-Garofalo, V. (2000). Active Client Participation: An Examination of Self-empowerment in HIV/AIDS Case Management with Women. *Journal of the Association of Nurses in AIDS Care*, 11(3):59-68.

Ford, N., Sohn, W & Lepkowski, J. 2002. American adolescents: sexualmixing patterns, bridge partners and concurrency. *Sex Trasm Dis*,29:13-19.

Foster, G. M. 1976. Disease etiologies in non-Western medical systems. *American Anthropology*, 78(4):350-64.

Foster, G. M & Anderson, B. G. 1978. *Medical Anthropology*. New York: McGraw-Hill.

Frazer, J. 1923 [1890]. *The Golden Bough: A study in Magic and Religion* (abridged ed.). Oxford, England: Macmillan.

Freedman, S. M & Phillips, J. S. 1985. The Effects of Situational Performance Constraints on Intrinsic Motivation and Satisfaction: The Role of Perceived Competence and Self-determination. *Organisational Behaviour and Human DecisionProcesses*, 35(3):397-416.

Furnaham, A. 1986. Economic Locus of Control. *Human Relations*, 39(1):29-43.

Furnham, A., Akande, D & Baguma, P. 1999. Beliefs about health and illness in three countries: Britain, South Africa and Uganda. *Psychological Health Medicine* . 4(2): 189-201.

Furnham, A & Steele, H. 1993. Measuring Locus of Control: A Critique of General Children's Health - and work – Related Locus of Control Questionnaires. *British Journal of Psychology*,84:443-479.

Furnham, A., Sake, V & Borwin, C. 1991. The Development of an Occupational Attribution Style Questionnaire. *Journal of Organisational Behaviour*, 13:27-39.

Gadzella, B. M., Williamson, J. D & Ginther, P. J. 1985. Correlations of Self-concepts with Locus of Control and Academic Performance. *Perceptual and Motor Skills* 61(2):639-645.

Gall, S. (ed.). 1996. *The Gale Encyclopedia of Psychology*. Detroit: Gale Research.

Garcia-Moremo, C& Watts. 2000. Violence against Women: Its Importance for HIV AND AIDS'. *AIDSCare*,14(3):S253-S265, 1-7.

Gardner, D. G& Pierce, J. L. 1998. Self-esteem and Self-efficacy within the Organisational Context. *Group and Organisation Management*, 23(1): 48-70.

Garrick, J & Rhodes, C. 2000. *Research and knowledge at work: perspectives, case studies and innovative strategies*. London: Routledge.

- Gaertner, S. L & Davidio, J. F. 1986. The Aversive Form of Racism. In J. F. Davidio & S. L. Gaertner (eds), *Prejudice, Discrimination, and Racism*. Orlando, FL: Academic Press.
- Gatty, B. 1992. ADA Will Project AIDS-Infected Workforce. *Hotel and Motel Management*, 207(9):14.
- Georgion, A& Bradley, 1992. The Development of a Smoking Specific Locus of Control Scale. *Psychology and Health*,6:227-240.
- Gergen, K. 1985. The Social Constructionist Movement in Modern Psychology. *American Psychologist*, 4:226-275.
- Gijans, E.W.M.,Louw, J& Manganyi, N. C. 1989-90. Thoughts about Death and Dying in an African Sample. *Omega*, 20(3): 245-258.
- Gilbert, D. T. 1991. How Metal Systems Believe. *American Psychologist*, 46:107-119.
- Gilbreath, B. 2001. Supervisor Behaviour and Employee Physiological Well-being. Unpublished doctoral dissertation. Las Cruces, NM: New Mexico State University.
- Giles, M., Liddell, C& Bydawell, M. 2004. Attitudes to Condom Use among Rural South African Adolescents: The Role of the Individual and Community Factors. *AIDS Care*.

- Gilmore, N & Somerville, M. A. 1994. Stigmatization, Scapegoating and Discrimination in Sexually Transmitted Diseases: Overcoming 'them' and 'us'. *Social Science and Medicine*,39(9):1339-1358.
- Gist, M. E & Mitchell, T. R. 1992. Self-efficacy: A Theoretical Analysis of Determinants and Malleability. *Academy of Management Review*,17:183- 211.
- Global AIDS: Facing the Crises 2002*. Pamphlet. Elkhart, In: Church World.
- Gmelch, W. H & Chan, W. 1994. *Thriving on Stress for Success*. California: Corwin Press.
- Goercke, B. 2004. *The impact of traditional Shona belief on HIV/AIDS intervention in Zimbabwe*. Pittsburg: Duquesne University.
- Goffman, E. 1963. *Stigma: Notes on Management of Spoiled Identity*. Harmondsworth: Penguin.
- GOB – see Government of Botswana. (2000).
- Gold, R. S. 1993. On the Need to Mind the Gap: On-line versus Off-line Cognitions Underlying Sexual Risk-taking. In D. J. Terry, C. Gallois & M. McCamish (eds). *The Theory of Reasoned Action: Its Application to AIDS-Preventive Behaviours*. Oxford: Pergamon Press.

Government of South Africa (2007). Traditional Health Practitioners Act, 2007. Act No. 22 of 2007. Proclaimed in the Government Gazette of 10<sup>th</sup> January 2008, 511(30660).

Goldin, C. S. 1994. Stigmatization and AIDS: Critical Issues in Public Health. *Social Science & Medicine*, 39:1359-1366.

Goldstein, A. E. 1990. The Relationship among Adolescent Perceptions of Control, Perceptions of Maternal Caretaking and Identity Development. *Dissertation Abstracts International*, 51:2167 A.

Goodman, S. H & Waters, L. K. 1987. Convergent Validity of Five Locus of control Scales. *Educational and Psychological Measurement*, 47(3):743-747.

Green, E.C. 1994. *AIDS and STDs in Africa*. Glencoe, IL: Free Press.

Green. G. 1995. Attitudes towards People with HIV: Are they as Stigmatising as People Perceive them to be? *Social Science and Medicine*, 41:557-568.

Greenberg, A & Baron, R. A. 1995. *Behaviour in Organisations: Understanding and Managing the Human Side of Work*. (5<sup>th</sup> ed.). Prentice-Hall International

Greenwald, A. G. 1989. Why Attitudes are Important: Defining Attitudes and Attitude Theory 20 years Later. In A. Paratkarnis, S. Breckler, & A. Greenwald (eds.), *Attitude Structure and Function*. Hillsdale, NJ: Erlbaum.

Greller, M. M., Parsons, C. K & Mitchell, D. R. D. 1992. Additive Effects and Beyond: Occupational Stressors and Social Buffers in a - Police Organisation. In J. C. Quick, L. R. Murphy & Hurrell, Jr. (eds.), *Stress and Well-being: Assessments and Interventions for Occupational Mental Health*. Washington, D.C: American Physiological Association.

Gresack, G. 2001. From Ostriches to Proteas: Looking into the Future. *AIDS Analysis Africa*, 12 (3) Oct/Nov:10. 1`

Guba, E. G & Lincoln, Y. S. 1981. What Have We Learned about Naturalistic Evaluation? *Evaluation Practice*, 8:23-43.

Guba, E. G & Lincoln, Y. S. 1989. *Fourth Generation Evaluation*. Newbury Park, CA: Sage.

Guba, E. G & Lincoln, Y. 1994. Competing Paradigm in Qualitative Research. In N . Denzin & Y. Lincoln. (eds), *Handbook of Qualitative Research*. Newbury Park, CA: Sage.

Gumede, M. V. 1990. *Traditional Healers*. Johannesburg: Stokaville.

Gupta, G. R. 2000. Gender, Sexuality and HIV AND AIDS: The What, the Why, and the How *Women's Health Report Newsletter*, 36(Nov).

Hace-Mustin, R. 1994. Discourses in the Minored Room: A Post-modern Analysis of Therapy. *Family Process*, 33:19-35.

- Hagger, M. S & Orbell, S. 2003. A Meta-analytic Review of the Common-sense Model of Illness Representations. *Psychology and Health*, 18:141-184.
- Hammond-Tooke, W. D. 1974. *The Bantu-speaking Peoples of Southern Africa*. London:Routledge & Paul.
- Hammond-Tooke, W. D. 1981. *Boundaries and Beliefs*. Johannesburg: Witwatersrand University Press.
- Hammond-Tooke, W. D. 1993. *The Roots of Black South Africa*. Johannesburg: Jonathan Ball Publishers.
- Harre', R. 1995. Agentive Discourse. In R. Harre' & R. Stearns (eds), *Discursive Psychology in Practice*. London: Sage.
- Harvey, J. H., Barues, R. D., Sperry, D. L. & Harris, B. 1974. Perceived Choice as a Function of Internal-External Locus of Control. *Journal of Personality*, 42:437 - 425.
- Heider, F. 1985. *Psychology of Interpersonal Relations*. Hillsdale, NJ: Lawrence Erlbaum Associate.
- Henorood, K & Pidgeon, N. 1992. Qualitative Research and Psychological Theorizing. *British Journal of Psychology*, 83:97-111.



Herek, G. M. 1999. AIDS and Stigma. *American Behavioural Scientist*, 42 (7):1106 - 1116.

Herek, G. M & Capitanio, J. P. 1994. Conspiracies, Contagion & Compassion: Trust and Public Reactions to AIDS. *AIDS Education & Prevention*, 6 (4):365-375.

Herek, G. M & Capitanio, J. P. 1999. AIDS, Stigma and Sexual Prejudice. *American Behavioural Scientist*, 42:1130-1147.

Herek, G. M., Capitanio, J. P & Widaman, K. F. 2002. HIV-related Stigma and Knowledge in the United States: Prevalence and Trends, 1991-1999. *American Journal of Public Health*, 92 (3):371-377.

Herek, G. M & Capitanio, J. P. 1993. Public Reactions to AIDS in the United States: A Second Decade of Stigma. *American Journal of Public Health*, 83:574-577.

Herek, G. M., Mitnick, L., Burris, S., Chesney, M., *et al.* 1998. AIDS and Stigma: A Conceptual Framework and Research Agenda. *AIDS and Public Policy Journal*, 13 (1):36-47.

Heywood, M. 2000. HIV Testing in the Workplace: Clarifying the Meaning of South Africa's Employment Equity Act. *AIDS Analysis Africa*, 10 (6) April/May.

Heywood, M. 2004. *HIV/AIDS: From the Perspective of Human Rights and Legal Protection*. Johannesburg: Witwatersrand University Press.

Heywood, M. 2004. The Price of Denial. *Development Update: From Disaster to Development. HIV/AIDS in Southern Africa*, 5 (93):93-122.

Higgs, P& Smith, J. 2003. *Rethinking Truth*. Landsdown: Juta.

Hill .D& Bale, R. 1981. Measuring Beliefs about where Psychological Pain Originates and Who is Responsible for Alleviation. *Research with Locus of Control Construct* vol. 1. London: Academic Press.

Hodgkinson, G. P. 1992. Research Notes and Communications and Validation of the Strategic Locus of Control Scale. *Strategic Management Journal*, 13 (4):311 - 317.

Hoffmann, M.A. 1997. Counselling the HIV-infected client: A Psychosocial Model for Assessment and Intervention. *The Counselling Psychologist*, 19:467-542.

Hoffman, M. 2000. *Empathy and Moral Development: Implications for Caring and Justice*. Cambridge: Cambridge University Press.

Hoffman, M. A. 1997. Counseling the HIV-Infected Client: A Psychosocial Model for Assessment and Intervention. *The Counseling Psychologist*, 19:467-542.

Holl, H. 1990. *African Magic: Traditional Ideas that Heal a Continent*. New York, NY: Viking Press.

- Holmes, K. K., Levine, R & Weaver, M. 2004. Effectiveness of condoms in preventing sexually transmitted infections. *Bulletin of the World Health Organisation*, 82:454-461.
- Hooper, E. 1999. *The River: A Journey to the Source of HIV/AIDS*. New York, NY: Little Brown.
- Hornby, A. S. 2000. *Oxford Advanced Learner's Dictionary of Current English*. (5<sup>th</sup> ed.). Cambridge: Oxford University Press.
- House, R. J & Howell, J. M. 1992. Personality & Charismatic Leadership. *Leadership Quarterly*, 3 (2):81-108.
- Howard, G. S. 1983. Toward Methodology and Real Pluralism. *Journal of Counseling Psychology*, 30:19-21.
- Human Rights Watch. 2003. Locked doors: The Human Rights of People Living with HIV/AIDS in China: III 7 IV.  
[http://www.hrw.org/reports/2003/China\\_0803/](http://www.hrw.org/reports/2003/China_0803/) [Accessed 20 April 2004]
- Human Sciences Research Council. 2002. Nelson Mandela/HSRC Study of HIV/AIDS: Executive Summary. Pretoria: HSRC Press.
- Hunter, S. S. 2003. *AIDS in Africa: Who Cares*: Basingstoke: Palgrave Macmillan.

Husserl, E. 1970. *Logical Investigation* (J.N Findlay, Trans.). New York: Humanities Press. (Original work published in 1900).

Huysamen, G. K. 1997. Parallels between Qualitative Research and Sequentially Performed Quantitative Research. *South African Journal of Psychology*, 27 (1).

Ibarra, H. 1995. Race, Opportunity and Diversity of Social Circles in Management Networks. *Academy of Management Journal*, 38:673-703.

International Labour Organization (ILO). 1999. *Regional Tripartite Workshop on Strategies to Tackle Social and Labour Implications of HIV/AIDS*, 11-13 October. Windhoek, Namibia.

International Labour Office (ILO) Report. 2001. *An ILO Code Of Practice On HIV/AIDS & the World of Work*. ILO: Geneva.

International Labour Organization (ILO). 2008. *ILO Sees a Significant Improvement in Workplace Attitudes to HIV/AIDS*. (Press release, April 2008).

Ingstad, B. 1990. The Cultural Construction of AIDS and its Consequences for Prevention in Botswana. *Medical Anthropology Quarterly*, 4: 28-40.

Irwin, C. E., Igra, V., Eyre, S & Millstein, S. 2005. *Risk-taking behaviour in adolescents: the paradigm*. From: <http://www.stanford.edu/~kcobb/femstudies/LectureOne.htm> [Accessed: 19/09/2010].

Jacobs, S. 2000. *Connexional Task Force on HIV/AIDS: Strategy and Implementation Plan*. Methodist Church of Southern Africa Mission, Justice and Service Unit.

Jacoby, A. 1994. Felt Versus Enacted Stigma: A Concept Revisited. Evidence from a Study of People with Epilepsy in Remission. *Social Science & Medicine*, 38 (2): 269-274.

James, W. 1890. *Principles of Psychology*. New York: Henry Holt.

James, L. R., Lovats, C & Cropanzano, R. 1994. Correlational and Known-Group Comparison Validation of a Workplace Prejudice/Discrimination Inventory. *Journal of Applied Psychology*, 67:219-229.

Jaya, S & Colaco, A. 1996. *Broadening the Front: NGO Responses to HIV & AIDS in India*. London: Action Aid.

Jennings, R., Mulaudzi, J., Everatt, D., Richter, M & Heywood, M. 2002. *Discrimination & HIV/AIDS. Strategy and Tactics for AIDS Law Project of the Centre for Applied Legal Studies*. Johannesburg: University of the Witwatersrand.

Jones, E. E., Faring, A., Hosterf, A. H., Markus, H., Miller, D. T & Scott, R. A. 1984. *Social Stigma: The Psychology of Marked Relationships*. New York, NY: Freeman.

Jones, B., Flynn, D & Kelloway, E. K. 1995. Perception of Support from the Organization in Relation to Work Stress, Satisfaction, and Commitment. In S. L.

Santer & L. R. Murphy (eds.), *Organizational Risk Factors for Job Stress*.  
Washington, DC: American Psychological Association.

Jones, J& Wuebker, L. 1985. Development and Validation of the Safety Locus of  
Scale. *Perceptual and Motor Skills*, 61: 151-161.

Jonson, E. P. 1987. *AIDS: Myths, Facts and Ethics*. New York, NY: Pergamon Press.

Kahnemann, D& Tversky, A. 1979. Prospect Theory: Analysis of Decision under  
Risk. *Econometrica*, 47: 263-291.

Kaku, M. 2004. *Einstein's Cosmos: How Albert Einstein's Vision Transformed our  
Understanding of Space & Time*. New York, NY: W. W. Norton.

Kaleeba, N., Kadowe, J., Kalinaki, D & Williams, G. 2000. Open Secret: People  
Facing Up to HIV and AIDS in Uganda, *Strategies for Hope Series 15*, London:  
Action Aid

Kalichman, S. C. 1995. *Understanding AIDS: A Guide for Mental Health Professionals*.  
Washington, DC: American Psychology Association.

Kalichman, S. C. 2002. *The Inside Story on AIDS: Experts Answer your Questions*.  
Washington, D.C: American Psychology Association.

Kalichman, S. C& Simbanyi, L. 2004. Traditional Beliefs about the Cause of AIDS &  
AIDS-related Stigma in South Africa. *AIDS Care*, 16 (5): 572-580.

Kanter, A. M. 1977. *Men and Women of the Corporation*. New York, NY: Basic Books.

Kaplan, M. E & Van Den Worm, Y. 1993. The Relationship between South African Adolescents' Knowledge and Fear of AIDS and their Attitudes toward People who have AIDS. *Journal of Social Psychology*, 133(4) Aug.:581-583.

Katz, A. 1996. Gaining a New Perspective on Life as a Consequence of Uncertainty in HIV Infection. *Journal of the Association of Nurses in AIDS Care*, 7: 51-60.

Katz, D. 1960. The Functional Approach to the Study of Attitudes. *Public Opinion Quarterly*, 24: 163-204.

Katz, I. 1981. *Stigma: A social Psychological Analysis*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Kelly, K. 1997. The hermeneutical function of distancing. *Knowledge Methods and the Public Good*. Pretoria: Human Sciences Research Council.

Kelly, K. 2006a. Lived experience and interpretation: the balancing act in the qualitative analysis in *Research in Practice Applied Methods for the Social Sciences*. 2<sup>nd</sup> edition. Edited by Terre Blanche, M; Durrheim, K. & Painter, D. Cape Town: UCT Press.

Kelly, M. J. 2004. The Case for the Condom. *Index on Censorship*, 104: 80-103.

Kelly, R. 1999. Isolation and Stigma: The Experience of Patients with Active Tuberculosis. *Journal of Community Health Nursing*, 16: 233-241.

- Kelly, K& Lewis, G. 2001. Reconceptualizing Behaviour Change in the HIV/AIDS Context. In C. Stones (ed.). *Socio-political and Psychological Perspectives of South Africa*. London: Nova Science.
- Kerlinger, F. N. 1973. *Foundations of Behavioural Research*. London; Holt, Rinehart 7 Winston.
- Kerlinger, F. N. 1986. *Foundations of Behavioural Research*. New York, NY: CBS.
- Kerr, M. R. 1990. The Impact of Canadian Validation Research. *Canadian Psychology*, 31(4): 334-344.
- King, R. 1999. *Sexual behaviour change for HIV: where have theories taken us?* Geneva: UNAIDS Best Practice Collection.  
<http://data.unaids.org/Publications/IRC-pub04/JC59-BehavChangeen.pdf>  
[Accessed: 20/06/2012].
- Kinge, T. N. 2001. *Know and conquer AIDS*.
- Kiragu, K. 2001. Youth and HIV/AIDS: Can We Avoid Catastrophe? Population Reports, Series L, 12. Baltimore, MD: The John Hopkins University Bloomberg School of Public Health. Population Information Program.
- Kilewo, C., Massawe. A., Lyamuya, E., Semali, I., Kalokola, F., *et al*, 2001. HIV Counseling and Testing of Pregnant Women in sub-Saharan Africa: Experiences



from a Study on Prevention of Mother-to-child HIV-1 Transmission in Dar es Salaam, Tanzania. *Journal of Acquired Deficiency Syndrome*, 28: 428-433.

Kohl, J. P., Miller, A. N & Pohl, N. F. 1997. AIDS in the Workplace: The Response of American Business Schools. *Journal of Education for Business*. 73 (20): 98-101.

Kolb, D. 1984. *Experiential Learning*. New Jersey, NJ: Prentice Hall.

Kotzé, D., Myburg, J., Roux, J & Associates. 2002. *Ethical Ways of Being*. Pretoria: Ethics Alive.

Kotzé, E & Kotzé, D. 2001. Telling Narratives, Doing Spirituality. In Kotzé, E & Kotzé, D. (eds). *Telling Narratives*. Pretoria: Ethics Alive.

Kotzé, E & Kotzé, D. 2002. Ubuntu: Caring for People and Community in South Africa. *International Journal of Narrative Therapy & Community Work*, 1: 60-64.

Mekonnen, Y., Sanders, E., Messele, T., Woldy, D., Dorigo-Zestma, W., Schaap, A., Mekonnen, W., Meless, H., Mihret, W., Fontanet, A., Coutinho, R. A & Dukers, N. H. 2005. Prevalence and incidence of and risk factors for, HIV-1 infection among factory workers in Ethiopia, 1997-2001. *Journal of Health Population and Nutrition*. 23:163-177.

Krampen, G. 1989. Perceived Childrearing Practices and the Development of Locus of Control in Early Adolescence. *International Journal of Behavioural Development*, 12: 177-193.

Krampen, G., Galli, I & Nigro, G. 1992. Sex-role Orientations and Control Orientations of Southern Italian and West German University Students. *Journal of Cross-Cultural Psychology*, 2: 240-250.

Kreitner, R & Kinicki, A. 1995. *Organizational Behaviour*. (3<sup>rd</sup> ed.). Chicago: Irwin.

Krejcie, R. V & Moran, D. W. 1970. Determining Sample Size for Research Activities. *Educational and Psychological Measurement*, 30: 607-610.

Kren, L. 1992. The Moderating Effects of Locus of Control on Performance Incentives & Participation. *Human Relations*, 45 (9): 991-1012.

Kruger, D. 1979. *An Introduction to Phenomenological Psychology*. Cape Town: Juta.

Kuper, J. (ed.). 1988. *A Lexicon of Psychology, Psychiatry and Psychoanalysis*. London: Routledge.

Kvale, S. 1996. *Interviews: An Introduction to Qualitative Research Interviewing*. London: Sage.

Kwalombota, M. 2002. The Effect of Pregnancy in HIV-infected Women. *AIDS Care*, 14(3) June: 431-433.

Labour Relations Act 1995. No. 66. *Government Gazette*. (No.16861).

Labs, S& Wurtale, S. 1989. Fetal Health Locus of Control Scale: Development & Validation. *Journal of Consulting & Clinical Psychology*, 54: 814-819.

Landeweerd, J. A & Boumans, N. P. G. 1994. The Effect of Work Dimensions and Need for Autonomy on Nurses' Work Satisfaction and Health. *Journal of Occupational and Organizational Psychology*, 67:207-217.

Laryea, M& Gien, L. 1993. The Impact of HIV-positive Diagnosis on the Individual, Part 1: Stigma, Rejection and Loneliness. *Clinical Nursing Research*. 2: 245-263.

Lawshe, C. H. 1983. A Simplified Approach to the Evaluation of Fairness in Employee Selection Procedures. *Personnel Psychology*. 36: 601-608.

Lee, C& Bobko, P. 1994. Self-efficacy Beliefs: Comparison of Five Measures. *Journal of Applied Psychology*, 79 (3): 364-369.

Lee, S., Chan, L. Y. Y., Chau, A. M. Y., Kwok, K. P. S & Kleinman, A.2005. The Experience of SARS-related Stigma at Amoy Gardens. *Social Science and Medicine*, 61: 2038-2046.

Leedy, P. D. 1993. *Practical Research Planning and Design*. (5<sup>th</sup> ed.). New York: Macmillan.

Lefcourt, H. M. 1982. *Locus of Control: Current Trends in Theory & Research*. (2<sup>nd</sup> ed.). Hillsdale, NJ:Lawrence Erlbaum Associates Publishers.

Lemke, E& Wiersma, W. 1976. *Principles of Psychological Measurements*. Chicago: Rand McNally College.

Lerner, M. J. 1980. *The Belief in a Just World: A Fundamental Delusion*. New York, NY: Plenum.

Levenson, H. 1981. Differentiating among Internality, Powerful Others, and Chance. In H.M. Lefcourt (ed.), *Research with the Locus of Control, Construct* vol. 1. New York, NY: Academic Press.

Leventhal, H., Nerentz, D. R & Steele, D. F. 1984. Illness Representations and Coping with Health Threats. In A. Baum & J. Singer (eds.), *A Handbook of Psychology and Health*. Hillsdale, NJ: Erlbaum.

Levine, M. P& Leonard, R. 1984. Discrimination against Lesbians in the Workforce. *Journal of Women in Culture and Society*, 9:700-710.

Lichtenstein, B., Laska, M. K & Clair, J. M. 2002. Chronic Sorrow in the HIV-positive Patient: Issues of Race, Gender, and Social Support. *AIDS Patient Care and STDs*, 16: 27-38.

Lincoln, Y. S& Guba, E. G. 1985. Naturalistic Inquiry. In Denzin, N.K. & Lincoln, Y.S. (eds), *Handbook of Qualitative Research*. Thousand Oaks, Sage.

Lindell et al;2005. Indigenous representations of illness and AIDS in Sub-Saharan Africa. *Social Sciences and Medicine*, pp. 691-700.

Likert, R. 1967. *The Human Organization: Its Management and Value*. New York: McGraw-Hill.

LoBiondo-Wood, G & Haber, J. 1990. *Nursing research: methods, critical appraisal and utilization*. St Louis: C.V.Mosby.

LoBiondo-Wood, G & Haber, J. 1994. *Nursing research: methods, critical appraisal and utilization*. 3<sup>rd</sup> edition. St Louis: C.V.Mosby.

LoBiondo-Wood, G & Haber, J. 2002. *Nursing research: methods, critical appraisal and utilization*. 5<sup>th</sup> edition. St Louis: C.V.Mosby.

Lock, R. D. 1992. *Taking charge of your career direction*. (2<sup>nd</sup> ed.). Monterey, California: Brooks/Cole Publishing.

Lönn, E., Sahlholm, K., Marmati, R., Abdulkarim, K& Anderson, R. 2006. A traditional Society in Change Encounters HIV/AIDS: Knowledge, Attitudes, and Risk Behaviour among Students in North Western China. *AIDS Patient Care and STDs*vol. 21 (1).

- Lopez, K& Willis, D. 2004. Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Quality Health Research*, 14(5): 726.
- Low-Ber, D & Stoneburner, R. L. 2001. 'In Search of the Magic Bullet: Evaluating and Replicating Prevention Program', Leadership Forum on HIV Prevention, Kaiser Family Health Foundation, Gates Foundation, New York (accessible from kff.org).
- Low-Ber, D & Stoneburner, R. 2004. Uganda and the Challenge of HIV/AIDS, in Poku, K.N. & Whiteside (eds.). *The Political Economy of AIDS in Africa*. Aldershot: Ashgate Publishing Limited.
- Lowe, R. 1991. Post-modern Themes and Therapeutic Practices: Notes Towards the Definition of 'Family Therapy'. Part 2. *Dulwich Centre News letter* 3: 41-52.
- Lundin, R. W. 1996. *Theories and Systems of Psychology*. (5<sup>th</sup> ed.). Lexington, MA: D.C. Health.
- Lyness, K. S & Thompson, D. E. 1997. Above the Glass Ceiling: A Comparison of Matched Samples of Female and Male Executives. *Journal of Applied Psychology*,82:359-375.
- Mackie, D. M & Hamilton, D. L. (eds.). 1993. *Affect, Cognition and Stereotyping: Interactive Processes in Group Perception*. San Diego: Academic Press.
- Maelane, M. 2001. It's Time to Practice Ubuntu. *Nursing Update*, 25 (8):30.

Mafeje, A. 1975. Religion, Class and Ideology in South Africa, in M. G. Whisson & M. E. West (eds.), *Religion and Social Change in Southern Africa: Anthropological Essays in Honour of Monica Wilson*. Phillip: University of Michigan.

*Mail & Guardian*, July 27-August 4 2001.

*Mail & Guardian*, November 26-December 2 (2004).

*Mail & Guardian*, March (2005).

*Mail & Guardian*, April 28-May 5 2006.

*Mail & Guardian*, May 2-May 8 2008.

Mak, W. W. S., Mo, P. K. H., Cheung, R. Y. M., Woo, J., Cheung, F. M & Lee, D. 2006. Comparative Stigma of HIV/AIDS, SARS, and Tuberculosis in Hong Kong. *Social Science & Medicine*, 63:1912-1922.

Malcolm, A., Aggleton, P., Bronfman, M., Galvao, J., Mane, P & Verrall, J. 1998. HIV - related Stigmatization and Discrimination: Its Forms and Contexts. *Critical Public Health*, 8:347-370.

Malinowski, B. 1945. *The Dynamics of Culture Change*. Yale University Press.

Maman, S., Mbwambo, J., Hoogan, N. M., Kilonzo, G. P & Sweat, M. 2001. Woman's Barriers to HIV-1 Testing and Disclosure: Challenges for HIV-1 Voluntary Counseling and Testing. *AIDS Care*, 13(5):595-603.

Mann, J. M. 1999. Human Rights and AIDS: The Future of the Epidemic. In J. M. Mann., S. Gruskin, M. A. Grodin & G. J. Annas (eds.), *Health and Human Rights*. New York: Routledge.

Manning, M. R., Jackson, C. N & Fusilier, M. R. 1996. Occupational Stress, Social Support and the Cost of Health Care. *Academy of Management Journal*, 39:738-750.

Marks, S. 2002. An Epidemic Waiting to Happen. *African Studies* 61 (1).

Masamba Ma Mpolo, J. 1985. African Symbols and Stories in Pastoral Care. *Journal of Pastoral Care*, 39(4): 314-326.

Masamba Ma Mpolo, J. 1994. Spirituality and Counseling for Healing and Liberation: The Context and Praxis of African Pastoral Activity and Psychotherapy, in Y. Larkey, D. Nwachuku & Kasonga wa Kasonga (eds.). *The Church and Healing : Echoes from Africa*. New York: Peter Lang.

Masindi, N. 2003. *Measuring HIV/AIDS-related Stigma: A Literature Review*. Centre for the study of HIV/AIDS: University of Pretoria.

Maslow, A. H. 1954. *Motivation and Personality*. New York: Harper and Row.



Maslow, A. H. 1962. *Towards a Psychology of Being*. Princeton, NJ: Van Nostrand.

Maslow, A. H. 1964. A Theory of Human Motivation. In H. J. Harold & L. R. Pondy (eds.), *Readings in Managerial Psychology*. Chicago: University of Chicago Press.

Maslow, A. H. 1968. *Toward a Psychology of Being*. 2<sup>nd</sup> ed. New York: Harper and Bros.

Maslow, A. H. 1970. *Motivation and Personality*. 2<sup>nd</sup> ed. New York: Van Nostrand.

Maslow, A. H. 1971. *The Farther Reaches of Human Nature*. New York: Viking Press.

Maslow, A. H. 1987. *Motivation and Personality*. 3<sup>rd</sup> ed. New York: Harper Collins.

Maslow, A. 1999. *Towards a Psychology of Being*. New York: Viking Press.

Mathews, C., Boon, H., Flisher, A. J & Schaalma, H. P. 2006. Factors Associated with Teachers' Implementation of HIV/AIDS Education in Secondary Schools in Cape Town, South Africa. *AIDS Care*, 18 (4): 388-397.

Matsau, N. 2001. Is Sex Worth Dying For? *Nursing Update* 25 (7): 20-22

- Mbilinyi, M. & Kaihula, N. 2000. 'Sinners and Outsiders: The Drama of AIDS in Rungwe', in C. Baylies & J. Bujra (eds.). *AIDS, Sexuality & Gender in Africa*. London: Routledge.
- Mbiti, J. S. 1970. *Concepts of God in Africa*. London: SPCK.
- Mbiti, J. S. 1990. *African Religions and Philosophy*. Oxford: Heinemann.
- McCormick, E. J & Ilgen, D. A. 1985. *Industrial and Organizational Psychology*. London: Allen and Urwin.
- McCormick, E. J & Ilgen, D. A 1989. *Industrial and Organizational Psychology*. (8<sup>th</sup> ed.). London: Urwin and Hyman.
- McCracken, G. 1988. *The Long Interview*. Newbury Park: Sage.
- McCuddy, M. K & Peery, B. L. 1996. Selected Individual Differences and Collegians' Ethical Beliefs. *Journal of Business Ethics*, 15: 261-272.
- McGuire, W. J. 1985. Attitudes and Attitude Change. In G. Lindzey and E. Aronson (eds.). *Handbook of Social Psychology: Theory and Method* vol. 1. New York: Random House.
- McNeil., D. Jr. 1998. Neighbours Kill an HIV-positive Activist in South Africa. *New York Times*, 28 December 1998.

- Medical Research Council of South Africa. 1999 *South Africa Demographic and Health Survey*. Pretoria: Department of Health.
- Medin, D. L., Schwartz, H. C., Block, S. V & Birnbaum, L. A. 1999. The Semantic Side of Decision Making. *Psycho-economic Bulletin and Review*, 6:562-569.
- Meyer, W. F., Moore, C & Viljoen, H. G. 1990. *Personality Theories from Freud to Frankl*. Johannesburg: Lexicon Publishers.
- Meyers, L. S & Wong, D. T. 1988. Validation of a New Test of Locus of Control: The Internal Control Index. *Educational and Psychological Measurement* 48 (3): 753-761.
- Midlarski, E & Midlarski, M. 1973. Some Determinants of Aiding Under Induced Stress. *Journal of Personality*, 41 (3): 305-327.
- Midlarski, E. 1971. Aiding Under Stress: The Effects of Competency, Dependency, Visibility and Fatalism. *Journal of Personality*, 39 (1): 132-149.
- Miles, M & Huberman, A. 1994. *Qualitative Data Analysis: An Expanded Sourcebook*. London: Sage.
- Miles, M. B & Huberman, A. M. 1994. *Qualitative Data Analysis*. Thousand Oaks, CA: Sage.

Miller, A. N. 2000. Preparing Future Managers to deal with HIV/AIDS in the Workplace. *Journal of Education for Business*, p.258.

Minehan, M. 1997. New AIDS Survival Rates Mean Patients Returning to Work. *HR Magazine*, Vol. 42.

Ministry of Education and Sports (MoES - Uganda). 2005. Unpublished Pre-final Draft of Education and Sports Sector Policy and Guidelines on HIV/AIDS (Republic of Uganda). Version: 11 (February).

Ministry of Health/Central Board of Health. 2002. Integrated technical guidelines for frontline health workers. 2<sup>nd</sup> edition. Lusaka: Ministry of Health and Central Board of Health

Mitchell, C. M& Kaufman, C. E. 2002. Structure of HIV Knowledge, Attitudes and Behaviours among American Indian Young Adults. *AIDS Education and Prevention*, 14 (5): 401-418.

Mitchell, C& Smith, A. 2001. Changing the Picture: Youth, Gender and HIV and AIDS Prevention Campaigns in South Africa. *Canadian Women Studies*, 21 (2): 56.

Mlamlali, O., Mabelane, P., Napo, V., Sibiyi, N & Free, V. 2000. Creating Programs for Safe Schools: Opportunities and Challenges in Relation to Gender-based Violence in South Africa. *McGill Journal of Education*, 35(3): 261-277.

Mndende, N. 1997. African Traditional Attitudes to Death and Dying. *CME* 15 (7):793-798.

Mogotlane, S. M., Hazell, E & Mthembu, B. 2007. Women's cultural perspectives on reasons for HIV/AIDS prevalence in a cultural area of the KwaZulu-Natal Province of South Africa. *Africa Journal of Nursing and Midwifery*, 9(2):35-43.

Mohapeloa, V. 2006. 'MultiplesexpartnersdrivingHIV.' *BuaNews*. 16 August 2006.

Moodley, R. 2000. Representation of Subjective Distress in Black and Ethnic Minority Patients: Constructing a Research Agenda. *Counseling Psychology Quarterly* 13: 159-175.

Motsei, M. 2007. *Burn the Bitch, the Kanga and the Kangaroo Court: A Reflection on the Rape Trial of Jacob Zuma*. Johannesburg: Jacana Media.

Mouton, J & Marais, H. C. 1994. *Basic Concepts in the Methodology of Social Sciences*. Pretoria: Human Sciences Research Council (HSRC).

Mouton, J & Marais, H. C. 1996. *Basic Concepts: Methodology of the Behavioural Sciences*. Pretoria : HSRC.

Mouton, J. 2001. *How to Succeed in your Master's and Doctoral Studies. A South African Guide and Resource Book*. Pretoria: Van Schaik.

Mqotsi, L. 2002). Science, Magic and Religion as Trajectories on the Psychology of Projection. In: C. A Odora–Hoppers, (ed.). *Indigenous Knowledgeandthe*

*Integrating of Knowledge Systems: Towards a Philosophy of Articulation.*

Claremont: African Books.

Mukasa Monico, S., Nuwagaba, A., Aggleton, P & Tyrer, P. 2001. Uganda: HIV and AIDS-related Discrimination, Stigmatization and Denial. UNAIDS Best Practice Collection. Available on: [www.unaids.org/publication/documents/human/law/HR-Uganda.pdf](http://www.unaids.org/publication/documents/human/law/HR-Uganda.pdf) [Accessed May 2006].

MTV. 2008. Basic HIV/AIDS fact sheet. Philippine Star SUPREME. Form: <http://supreme.ph/2008/12/01/mtvs-basic-hivaids-fact-sheet/> [Accessed: 08/07/2012].

Murray, C. J. L. 1996. Rethinking DALYs. In C. J. L. Murray & A. D. Lopez (eds.). *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020.* (Cambridge, MA: Harvard School of Public Health.

Muyinda, H., Seeley, J., Pickering, H & Barton, T. 1997. Social Aspects of AIDS -related Stigma in Rural Uganda. *Health and Place* 3:143-14.

NACA—see National AIDS Coordinating Agency. (Botswana).

Neema, S & Koster, W. 2007. The views of staff regarding HIV and AIDS in the workplace. In the SAN partner organisations in Uganda. Quantitative Report. Applied research Uganda, phase 1 of 3, Vol.2

Neuman, W. L. 2000. *Social research methods: qualitative and quantitative approaches*. Boston: Allyn and Bacon.

*New Vision*. 2000. 'HIV Status Key to Promoting UPDF Soldiers.

Ngubane, H. 1977. *Body and Mind in Zulu Medicine*. London: Academic Press.

Ngubane, H. 1992. Clinical Practice and Organization of Indigenous Healers in South Africa. In S. Feireman & M. Janzen (eds.). *The Social Basis of Health and Healing in Africa*. Berkeley: University of California Press.

Ngugi wa Thiongo' 1990. *Decolonizing the Mind: The Politics of Language in African Literature*. Nairobi: East African Education Publishers.

Nieuwmeyer, S. M. 2002. Women Storying HIV/AIDS in Community. An Unpublished dissertation for Master of Theology. Pretoria: University of South Africa.

Noky, H. 2002. "Understanding Gender Differences in Participation at an Urban HIV Care and Support Program" in Abstract book of third National AIDS Conference and first HIV/AIDS Partnership Forum.

Nunnally, J. C. 1978. *Psychometric Theory*. New York: McGraw-Hill.

Norman, I. R & Carr, R. 2003. The role of HIV knowledge on HIV related behaviours: A hierarchical analysis of adults in Trinidad. *Health Education*, 103(3): 145-155.

Nunnally, J. C. Jr. 1970. *Introduction to Psychological Measurement*. New York: McGraw-Hill.

Nunnally, J & Bernstein, L. H. 1994. *Psychometric Theory*, 3<sup>rd</sup> ed. New York: McGraw-Hill.

Nwachukwu, O. C. 1995. CEO Locus of Control, Strategic Planning, Differentiation, and Small Business Performance: A Test of a Path Analytic Model. *Journal of Applied Business Research*, 11 (4): 9-147.

Nzioka.C. 2000. The Social Meaning of Death from HIV/AIDS: An African Interpretive view. *Culture, Health and Society* 2: 1-14.

O'Connell, J & Price, J. 1985. Development of a Heart Disease Locus of Control Scale. *Psychological Reports*, 56, 159-164.

*Occupational Psychology*, 61 (4), 335-340.

Odwori, M et al. 2002. "Women Responding to the AIDS Epidemic" in Abstract book of third National AIDS Conference and first HIV/AIDS Partnership Forum.

Omizo, M. M., Omizo, S. A & Michael, W. B. 1987. Relationship of Locus of Control Inventory for Three Achievement Domains (LOCITAD) to Two Other Locus of Control Measures: A Construct Validity Study. *Educational and Psychological Measurement* 47 (3): 737-742.



Oppenheim, A. N. 1990. *Questionnaire Design and Attitude Measurement*. New York: Gower.

Orr, N& Patient, D. 2004. Stigma: Beliefs cause Behaviour. *AIDS Bulletin*, April.

Osgood, C. E & Tannenbaum, P. H. 1955. The Principle of Congruity in the Prediction of Attitude Change. *Psychological Review*, 62: 42-55.

Osgood, C. E., Suci, G. J & Tannenbaum, P. H. 1957. *The Measurement of Meaning*. Urbana: University of Illinois Press.

Oswald, E.M. 1996. Why Employers Should Manage AIDS-HIV Risk. *National Underwriter (Property & Causality, Risk & Benefits Management Edition)*. 100: 16-18.

*Oxford Advanced Learners Dictionary (OALD)*. 2000. Oxford: Oxford University Press.

Ortony, A., Clore, G. L& Collons, A. 1988. *The Cognitive Structure of Emotions*. Cambridge, England: Cambridge University Press.

Parker, R& Aggleton, P. 2003. HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and Implication for Action. *Social Science and Medicine*, 57: 13-24.

Parker, R., Aggleton, P., Attawell, K., Pulewitz, J & Brown, L. 2002. HIV/AIDS-related Stigma and discrimination: A Conceptual Framework and an Agenda for Action. Horizons Program, Washington, D.C.

<http://www.popcomail.org/horizons.html>. [Accessed 17 August, 2006].

Partridge, C& Johnston, M. 1989. Perceived Control of Recovery from Physical disability: Measurement and Prediction. *British Journal of Clinical Psychology* 28:53-59.

Patton, M. Q. 1987. *How to Use Qualitative Methods in Evaluation*. London: Sage.

Patton, C. 1990. *Inventing AIDS*. New York: Routledge.

Patton, M. Q. 1990. *Qualitative Evaluation and Research Methods*. (2<sup>nd</sup> ed.). Newbury Park, CA: Sage.

Paulhus, D. 1983. Sphere-specific measures of perceived control. *Journal of Personality and Social Psychology*, 44, 1253-1265.

Paulhus, D& Christie, R. 1981. Spheres of Control: An Interactionist Approach to Assessment of Perceived Control in H.M. Lefcourt (ed.). *Research with the Locus of Control Construct* (vol. 1.). New York: Academic Press.

Paxton, S., Gonzales, G., Uppakaew, K., Abraham, K. K., Kota, S., Green, C., Nair, K. S., Parwati Merati, T., Thephtien, B., Marin, M & Quesade, A. 2005. AIDS-related Discrimination in Asia. *AIDS Care*, 17 (4): 413-425.

Pearl, J. 2000. *Causality: Models, Reasoning and Influence*. Cambridge: Cambridge University Press.

Peltzer, K. 2003. HIV/AIDS Education in South Africa: Teacher Knowledge about HIV and AIDS: Teacher Attitude About and Control of HIV/AIDS Education. *Social Behaviour and Personality*, 8:162-166.

Peltzer, K& Seoka, P. 2002. HIV/AIDS/STD Knowledge, Attitudes, Beliefs and Behaviours in Rural South African Youth: Implications from Health Education. *African Journal for Physical, Health Education, Recreation and Dance*,8 (1): 1 - 25.

Pennebaker, J. W. 1990. *OpeningUp: The Healing Power of Confiding in Others*. New York, NY: Arson.

Pennebaker, J. W. 1997. Writing About Emotional Experiences as a Therapeutic Process. *Psychological Science*,8:162-166.

Person, B., Sy, F., Holton, K., Govert, B., Liang, A& National Center of Infectious Diseases/SARS Community Outreach Team. 2004. *Emerging Infectious Diseases*, 10: 358-335.

Petrak., J. A. Doyle., A. M. Smith. A., Skinner. C& Hedge. B. 2001. Factors Associated with Self-disclosure of HIV Sero-status to Significant Others. *British Journal of HealthPsychology*, 6:69-79.

Pettersen, N. 1985. Specific Versus Generalized Locus of Control Scales Related to Job Satisfaction. *Psychological Reports*, 56(1): 60-62.

Pettijohn, T. F. (ed.). 1991. *The Encyclopedic Dictionary of Psychology*. (4<sup>th</sup> ed.). Guildford, Connecticut: The Dushkin Publishing Group.

Pettit, P. 1993. Consequentialism. In *A Companion to Ethics* ed. P. Singer (pp. 230 - 240). Malden, MA: Blackwell.

Pharaoh, R. 2005. Not Business as Usual: Public Sector Response to HIV/AIDS in Southern Africa. Pretoria: Institute of Security studies.

Phares, E. J. 1976. *Locus of Control in Personality*. Morristown, NJ: General Learning Press.

Pheiffer, J. 1994. 'Psychological Optimality as a Conception Industrial Psychology'. Unpublished dissertation submitted as part fulfillment of the requirements for the degree of Master of Commerce (Industrial Psychology). Pretoria: University of South Africa.

Pidd, M. 2003. *Tools for Thinking: Modelling in Management Science*. (2<sup>nd</sup> ed.). London: Wiley.

Piot, P. 2001. World Conference against Racism, Racial Determination, Xenophobia and Related Intolerance. Durban. Available at:

<http://www.unaids.org/whatsnew/speeches/eng/piot040901racism.html>

[Accessed: 20<sup>th</sup> June 2007].

Piot, P. 2001. Stigma Bias: Present Barriers in the Fight against AIDS Pandemic. *AIDS Policy Law*, 16 (5).

Piot, P. 2002. Against the Grain. *Positive nation*. (The United Kingdom's HIV and sexual health magazine).

Plug, C., Meyer, W.F., Louw, D.A& Gouws, L.A. (1986). *Psigologiewoordeboek*. Johannesburg: McGraw-Hill.

Plug, C., Meyer, W.F., Louw, D.A & Gouws, L.A. (1991). *Psychology Dictionary*. Johannesburg: McGraw-Hill.

Poland, M& Hammond-Tooke, W. D. 2004. *The abundant Herds*. South Africa: FernwoodPress.

Polit, D. F& Beck, C. T. 2004. *Nursing research: principles and methods*. 7<sup>th</sup> edition. Philadelphia: Lippincott.

Pilot, D.F& Beck, C. T. 2006. *Essentials of nursing research: methods, appraisals, and utilization*. 6<sup>th</sup> edition. Philadelphia: J.B.Lippincott.

Pilot, D. F& Hungler, P. B. 1995. *Nursing research: principles and methods*. Philadelphia: J.B.Lippincott.

- Pilot, D. F & Hungler, P. B. 1999. *Nursing research: principles and methods*. 6<sup>th</sup> edition. Philadelphia: Lippincott.
- Polkinghorne, D. 1989. Phenomenological Research Methods. In R.S Valle & S. Halling (eds). *Essential phenomenological Perspective in Psychology*. London: Plenum Press.
- Pond, S. B. 2004. Industrial–organizational Psychology: The Psychology of People Working Together. Available: <http://www.psichi.org/pubs/articles/article.asp> [Date of access: 25 September, 2004].
- Pool, R., Nyanzi, S& Whitworth, J. A. 2001. Attitudes to Voluntary Counseling and Testing for HIV among Pregnant Women in Rural South-West Uganda. *AIDS Care* 13:605-615.
- Poplestone, J. A& McPherson, M. W. 1988. *Dictionary of Concepts in General Psychology*. New York: Greenwood Press.
- Pratkanis, A. R & Turner, M.E. 1994. Of What Value is a Job Attitude?: A Socio cognitive Analysis. *Human Relations* 47:1545-1576.
- Prentice, D. A. 1987. Psychological Correspondence of Possessions, Attitudes, and Values. *Journal of Personality and Social Psychology* 53: 993-1003.

- Preson, J& Epley, N. 2005. Explanations Versus Applications: The Explanatory Power of Valuable Beliefs. *American Psychological Society* 16(10): 826-831.
- Priya, R &Sathyamala, C. 2007. Contextualizing AIDS and Human Development: Long-term Illness and Death among Adults in Laboring Low-caste Groups in India. *AIDS Care* 19 (1): 535-543.
- Pruyun, J., Van der Borne, H., de Reuver, R., De Boer, M., Ter Pelkwijk, M & De Jong, P. 1988. The Locus of Control Scale for cancer Patients. *Tijdschrift voor Sociale Gezondheidszorg* 66: 404-408.
- Pryor, J. B., Reeder, G. D& Landau, S. 1999. A Social Psychosocial Analysis of HIV -related Stigma: A Two Factor Theory. *American Behavioural Scientist* 42:1193-1211.
- Quitmann, H. 1985. Humanistiese Psychologie-Gottiengen; Verlag fur Psychologie. In 'n intra- en inter-persoonlike verrying program vir verpleegkundiges, ed L. Terblanche (1995). Unpublished thesis submitted in accordance with the requirements of doctor of philosophy in the Department of Nursing. Potchefstroom: Potchefstroom University for Christian Higher Education.
- Rahim, M. A & Psericka, C. 1996. A Structural Equations Model of Stress, Locus of Control, Social Support, Psychiatric Symptoms, and Propensity to Leave a Job. *Journal of Social Psychology* 136 (1):69-84.

Ranis, G., Stewart, F & Samman, E. 2005. *Human development beyond the HDI*. Centre Discussion Paper 916. New Haven: Yale University: Available at [www.welldev.org.uk/news/news-pdfs/cdp916.pdf](http://www.welldev.org.uk/news/news-pdfs/cdp916.pdf). [Accessed on March 13, 2011].

Raveis, V. H., Siegel, K & Gorey, E. 1998. Factors Associated with HIV-infected Women's Delay in Seeking Medical Care. *AIDS Care*, 10:549-562.

Ray, B. C. 1976. *African Religions: Symbols, Rituals and Community*. New Jersey: Prentice-Hall.

Reber. A. S. 1985. *The Penguin Dictionary of Psychology*. London: Penguin.

Reidpath, D. D & Allotey, P. 2003. Infant Mortality as an Indicator of Population Health. *Journal of Epidemiology and Community Health*, 57 (5): 344-346.

Reidpath, D. D., Brijnath, B & Chan, K. Y. 2005. An Asia Pacific Six-country Study on HIV-related Discrimination: Introduction. *AIDS Care*.

Remenyi, D. 1996. So You Want to be an Academic Researcher in business and Management Studies! Where Do You Start and What are the Key Philosophical Issues to Think About? *Suid Afrikaanse Tydskrif Bedryfsleiding*, 27 (2).

Republic of Lesotho. Ministry of Finance and Planning 2001.

Republic of South Africa. Basic Conditions of Employment Act, No. 75 of 1997 (BCEA).



Republic of South Africa. *Occupational Health and Safety Act, No. 85 of 1993 (OHSA)*.  
URL: [http://www.info.gov.za/acts/1993/a\\_85-93](http://www.info.gov.za/acts/1993/a_85-93). [Accessed on 18 August 2005].

Richards, J. 2004. Paradigm for the development of South African prisoners in the post-apartheid dispensation. Unpublished doctoral thesis. Johannesburg: University of Johannesburg.

Richter, M. 2002. Certain Legal Aspects of AIDS Discrimination in South Africa. *AIDS Analysis Africa* 12 (5).

Rivot, L & Baron, J. 1990. Reluctance to Vaccinate: Omission Bias and Ambiguity. *Journal of Behavioural Decision Making* 54:263-277.

Rivot, I & Baron, J. 1999. Protected Values and Omission bias. *Organizational Behaviour and Human Decision Process* 79 (4).

Rohan, M. J. 2000. A Rose by Any Name? The Values Construct. *Personality and Social Psychology Review* 4:255-277.

Roscoe, J. T. 1975. *Fundamental Research Statistics for the Behavioural Sciences*. (2<sup>nd</sup> ed.). New York: Holt.

Rosenstock, I., Strecher, V. J & Becker, M. 1988. Social Learning and the Health Beliefs Model. *Health Education Quarterly* 15:175-183.

- Rosenberg, M. 1985. *Society and Adolescent Self Image*. Princeton, NJ: Princeton University Press.
- Rosenberg, M. J & Hovland. C. I. 1960. 'Cognitive, Affective and Behavioural Components of Attitude' In M. J. Rosenberg et al; (eds.), *Attitude Organisation and Change: An Analysis of Inconsistency among Attitude Components*. New Haven, CT: Yale University Press.
- Rothmann, S& Malan, H. 2003 Koherensiesin, Selfdoeltreffendheid, lokus van beheer en uitbranding by maatskaplike werkers. *SA Journal of Industrial Psychology* 29 (4):43-51.
- Rothmann, S& Van Resburg, P. 2002. Psychological Strengths, Coping and Suicide Ideation in the South African Police Services in the North West Province. *SA Journal of Industrial Psychology* 28 (3):39-49.
- Rothmann, S. 1996. 'Die samestelling en evaluering van 'ngroepfasiliteringskursus'. Unpublished PhD Dissertation. Potchefstroom:Potchefstroom University for Christian Higher Education.
- Rotter, J. B. 1954. *Social Learning and Clinical Psychology*. New York: Prentice-Hall.
- Rotter, J. B. 1966. Generalized Expectancies for Internal Versus External Reinforcement. *Psychological Monographs* 80 (1): 1-28.

Rotter, J. B. 1975. Some Problems and Misconceptions Related to the Construct of Internal Versus External Control of Reinforcement. *Journal of Consulting and Clinical Psychology*, 43:56-67.

Rotter, J. B., Chance, J. E & Phares, E. J. 1972. *Applications of a Social Learning Theory of Personality*. New York: Holt, Rinehart and Winston.

Rubin, A & Babbie, E. 2005. *Research Methods for Social Work*. 3<sup>rd</sup> edition. Pacific Grove: Brooks Cole.

Ruzindaza, C. 1999. *Living Positively with AIDS: An African experience*. Nairobi: Paulines Publications Africa.

Salkind, N. J. 2001. *Exploring Research*, (4<sup>th</sup> ed.). Upper Saddle River: Prentice Hall.

Saltzer, E. B. 1982. The Weight Locus of Control (WLC) Scale: A Specific Measure for Obesity Research. *Journal of Personality Assessment*. 46:620-628.

Sandelowski, M. 1986. The Problem of Rigor in Qualitative Research. *Advanced Nursing Science*, 8 (3):27-37.

Savage, L. J. 1954. *The Foundations of Statistics*. New York: John Wiley.

Schaap, P., Buys M. A & Olckers, C. 2003. The Construct Validity of Schepers' Locus of Control Inventory for Black and White Tertiary Students. *S.A Journal of Industrial Psychology*. 29 (1):32-43.

Schapera, I. 1952. Sorcery and witchcraft in Bechuanaland. *African Affairs* 51 (1):41 - 52.

Schapera, I. (1973). *The Tswana*. London: International African Institute.

Scheck, D. C. 1978. An Exploratory Investigation of the Interaction Effects of Three Childbearing Dimensions upon the Development of Internal–External Control Orientation in Adolescent Females. *Psychology*, 15:8-13.

Scheerhorn, M. 1995. Disclosure of Healthcare Workers with HIV or AIDS. *Nursing Management* 26 (10):48C-48G.

Schonb, B. D. 1999. *AIDS & HIV in Perspective*. 2<sup>nd</sup> ed. Cambridge: Cambridge University Press.

Scheper-Hughes, N. 1993. AIDS, Public Health and Human Rights in Cuba. *Lancet* 342:965-968.

Schepers, J. M. 1995. *Locus of Control Inventory*. Johannesburg: Rand African University (RAU).

Schepers, J. M. 2005. The Construction of a Normative Scale of Locus of Control. *South African Journal of Industrial Psychology*.31 (3):1-11.

Schiff, M., McKay, M., Bell, C., Baptiste, D., Madison, S & Paikoff, R. 2003. The Role of Personal Contact with HIV-infected People in Explaining Urban, African American Pre-adolescents' Attitudes Towards Peers with HIV and AIDS. *American Journal of Orthopsychiatry*, 71 (3):10-108.

Schwarz, N. 1998. Accessible Content and Accessibility Experience: The Interplay of Declarative and Experiential Information in Judgement. *Personality and Social Psychology Review*, 2:87-99.

Schwarzer, R. (ed.) 1993. *Self-efficacy: Thought Control of Action*. Washington: Hemisphere Publishing.

Seeman, M. 1967. On the Personal Consequences of Alienation in Work. *American Sociological Review*. 32:973-977.

Segal, R. D. 1996. 'The Early Adult Life Structure of Urban Black Men'. Unpublished doctoral dissertation. Pretoria: University of South Africa.

Seibert, S.E., Kraimer, M.L & Liden, R.C. 2001. A Social Capital Theory of Career Success. *Academy of Management Journal*, 44: 219-237.

Shaffer, M.A., Joplin, J.R.W., Bell, M.P., Lau, T.R& Oguz, C. 2000. Gender Discrimination and Job-related Outcomes: A Cross-cultural Comparison of Working Women in the United States and China. *Journal of Vocational Behaviour* 57:395-427.

Shaughnessy, J. J., Zechmeister, E. B & Zechmeister, J. S. 2003. *Research Methods in Psychology*, (6<sup>th</sup> ed.). New York: McGraw-Hill.

Shelton, S. H. 1990. Developing the Construct of General Self-efficacy. *Psychological Reports*, 66 (3): 987-994.

Sheppard, B. H., Hartwick, T & Warshaw, P. R. 1988. The Theory of Reasoned Action: A Meta-analysis of Past Research with Recommendations for Modifications and Future Research. *Journal of Consumer Research*, 15:325 - 343.

Sherer, M., Maddux, J. E., Mercandante, B., Prentice-Dunn, S., Jacobs, B & Rogers, R. 1982. The Self-efficacy Scale: Construction and Validation. *Psychological Reports*. 51 (2):663-671.

Shishana, O & Simbanyi, L. 2002. Nelson Mandela/HSRC study of HIV/AIDS: South Africa National HIV Prevalence, Behaviour Risks and Mass Media, Household survey, 2002. Cape Town: HSRC.

Shisana, O., Rehle, T., Simbanyi, L. C., Parker, W., Zuma, K., Bhana, A., Connolly, C., Jooste, S & Pillay, V. 2005. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Cape Town: HSRC Press.

Shutte, A. 1993. *Philosophy for Africa*. Rondebosch, South Africa: UCT Press.

- Shymansky, J., Yore, L., Treagust, D., Thiek, R., Harnson, A& Waldrip, B. 1997. Examining the construction process, *JournalofResearchinScienceTeaching* 34:571-593.
- Siegel, D., Di Clemente, R., Durbin, M., Krasnovsky, F& Saliba, P. 1995. Change in Junior High School Students' AIDS-related Knowledge, Misconceptions, Attitudes, and HIV-preventive Behaviours: *AIDS Education and Prevention* 7 (6):534-543
- Sikand, A., Fisher, M& Friedman, S. 1996. AIDS Knowledge, Concerns, Behaviour Changes among Inner-city High School Students. *Journal of Adolescent Health* 18:325-328.
- Simbanyi, L.C., Chauveau, J & Shisana, O. 2004. Behavioural Response of South African Youth to the HIV/AIDS Epidemic: A Nationwide Survey. *AIDS Care* 16 (5): 605-618.
- Simbanyi, L. C., Strebel, A., Andipatin, M., Msomi, N., Potgieter, C., Ratebe, K., Shefer, T& Wilson, T. 1999. Sexually Transmitted Diseases in the Public Sector in South Africa: Perceptions, Sexual Behaviour, Health Care-seeking Behaviour and Quality of Care. Pretoria: National Department of Health's Directorate of Health Systems Research and Epidemiology in conjunction with the Directorate of HIV/AIDS and STDs through the Medical Research Council.
- Singleton, R., Straits, B.C., Straits, M.M& McAllister, R.J. 1988. *Approaches to Social Research*. Oxford: Oxford University.

Slack, J.D.1995. The American with Disabilities Act and the Workplace: Management's Responsibility in AIDS-related Situations. *Public Administrative Review* 55 (4):365-370.

Slack, J.D. 1998.*HIV/AIDS and the Public Workplace: Local Government Preparedness in the 1990s*. Tuscalosa:University of Alabama Press.

Slack, J.D.2002. Zones of Indifference and the American Workforce: The Case of Persons with HIV/AIDS. *Public Administration Quarterly*; 25 (4):247-269.

Slikkerveer, L. J., Warren, M& Brokensha, D. 1995. *The Cultural Dimension of Development*. London: Intermediate Technology Publication.

Smart, R. 2004. *HIV/AIDS Guide for the Mining Sector: AResponse for Developing Stakeholder Competency and Compliance in Mining Communities in Southern Africa*. Washington: International Finance Corporation.

Smart, R& Strode, A. 1999. South African Labour Law and HIV/AIDS. *AIDS Analysis Africa*, 10 (3) Oct/Nov.

Smith Fauzi, M. C., Jagannathan, P., Cabral, J., Banares, R., Salazar, J., Farmer, P & Behforouz, H. 2006. Limitations in Knowledge of HIV Transmission among HIV -positive Patients Accessing Case Management Services in a Resource-poor Setting. *AIDS Care*,18 (7):764-771.



Soga, J. H. 1931. *The AmaXosa: Life and Customs*. Lovedale: Lovedale Press.

Sontag, S. 1978. *Illness as Metaphor*. London: Allen Lane.

Sontag, S. 1987. *AIDS and its Metaphors*. New York: Double-day.

Sonywathana, P & Manderson, L. 2001. Stigma and Rejection: Living with AIDS in Villages in Southern Thailand, *MedicalAnthropology*, 20:1-23.

South Africa. 2009. *United in achieving quality health care for all*. Department of Health. Eastern Cape. From: <http://www.ecdoh.gov.za/faqs.asp?cid=3> [Accessed: 06/07/2012].

South African Law Commission. 1997. *Aspects of the Law Relating to AIDS* Discussion paper 72. (Pre-employment HIV Testing). Pretoria: Government Printers.

Southern African Development Community (SADC): *Code on HIV/AIDS and employment in the Southern African Development Community, (Zambia)*. 1997.

Spector P. E. 1988. Development of the Work Locus of Control Scale. *Journal of Social Psychology*.

Sprance, M., Minsk, E & Baron, J. 1991. Omission and Commission in Judgment and Choice. *Journal of Experimental Social Psychology*, 27:76-105.

Statistical Package for Social Sciences (SPSS). 2003. *SPSSprofessionalstatistics*  
11.0.1. Chicago, 1L: SPSS International.

Stansfeld, S. A., Real, E. G. S., Head, J., Shipley, M & Marmot, M. 1997. Social Support and Psychiatric Sickness Absence: A Prospective Study of British Civil Servants. *Physiological Medicine*, 27:35-48.

Stein, J. 2003. Tackling Stigma Through Treatment and Advocacy. *AIDS Bulletin*: April 2-3.

Stevens, M., Weiner, R., Mapolisa., S. & Dickinson, D. 2005. Management responses to HIV/AIDS in South African workplaces. *South African Journal of Economic Management Sciences*, Johannesburg: University of Witwatersrand

Steyn, H. S. 1999. *Praktiese betekenisvolheid: Die gebruik van effekgroottes, Wetenskaplike bydraes--Reeks B: Natuurwetenskappe Nr. 117*. Potchefstroom: PV vir CHO.

Steyn, H. S. 2001. Practically Significant Relationships Between Two Variables. *South African Journal of Industrial Psychology*, 28 (3):10-15.

Stodghill, R., Michell, R., Thurston, K & Del Valle, C. 1993. Why AIDS Policy must be a Special Policy: Fear and Misunderstanding of the Virus can Disrupt Workplace. *Business Week*, 53-54.

Stotland, S& Zuroff, D.C. 1990. A New Measure of Weight Locus of Control: The Dieting Beliefs Scale. *Journal of Personality Assessment*, 54:191-203.

Strauss, A & Corbin, 1990. *Basics of Qualitative Research: Grounded Theory, Procedures and Techniques*, Newburg Park: Sage.

Strebel, A. 1997. Putting Discourse Analysis to Work in AIDS Prevention, in Levett, A. *et al;* (Eds). *Culture, power and difference: Discourse analysis in SouthAfrica*, 109-122. Cape Town: University of Cape Town Press.

Suneil, R., Ramchandani, M. D., Shruti, H., Mehta., Dattatray, G. *et al.* 2007. Knowledge, Attitudes, and Practice Related to Antiretroviral Therapy among HIV -infected Adults Attending private and public clinics in India. *AIDS Patient Care & STDs*, 21 (2).

Sutherland, S. (ed). 1995. *The Macmillan Dictionary of Psychology* (2<sup>nd</sup> ed.). Hants: The Macmillan Press.

Sykes, W. 1991. Taking Stock: Issues from the Literature of Validity and Reliability in Qualitative Research. *Journal of the Market Research Society*, 33 (1):3-12.

Tang, T. L., Baldwin, L. J& Frost, A. G. 1997. Locus of Control as a Moderator of the Self-reported Performance Feedback-personal Sacrifice Relationship. *Journal of Market Research Society*, 33 (1):3-12.

Tarkang, T. T. 2009. *Knowledge, attitudes and perceptions regarding HIV/AIDS and sexual behaviours among senior secondary school learners in Kumba, Cameroon*. Unpublished Doctoral Thesis. Pretoria: Unisa.

Tavoosi, A., Zaferani, A., Enzevaei, A., Tajik, P & Ahmadinezhad, Z. 2004. Knowledge and Attitude towards HIV and AIDS among Iranian Students. *BioMed Central Public Health*,4:17-22.

Terry, D. J., Hogg, M. A & White, K. M. 1999. The Theory of Planned Behaviour: Self - Identity, Social Identity and Group Norms. *British Journal of Social Psychology*, 38:225-244.

Temu, F., Karlesson, K., Mhalu, F. & Biberfeld., G. 2001. HIV counseling and testing.

Tetlock, P. E., Kristel, O.V., Elson, S. B., Green, M. C & Lerner, J. 2000. The Psychology of the Unthinkable: Taboo Trade-Offs, Forbidden Base Rates, and Heretical Counterfactuals. *Journal of Personality and Social Psychology*, 78:853-870.

Tetlock, P. E. 2002. Social Functionalist Framework for Judgment and Choice: Intuitive Politicians, Theologians, and Prosecutors. *Psychological Review*, 109:451-471.

Thagard, P. 1989. Explanatory Coherence. *Behavioural and Brain Sciences*, 12:435-467.

*The Budget*.2005. National Treasury, Pretoria.

*The HIV/AIDS Department of Education Guidelines for Educators (see National Policy on HIV/AIDS for Learners and Educators in Public Schools, Students and Educators in Further Education and Training Institutions of the Department of Education)*. *Government Gazette*, No. 20372, August 1999.

THETA – Working with Traditional Healers to Increase Access to HIV/AIDS prevention and care in Uganda. *UNESCO News*, 5: 6-8.

Thurstone, L.L. 1931. The Measurement of Social Attitudes. *Journal of Abnormal and Social Psychology*,26: 249-269.

Thurstone, L. L. 1932. Primary Mental Abilities. *Psychometric Monographs* 1. *New York Times*. Issue 51792, Volume 150.

Tlou, S. D. 1996. Empowering Older Women in AIDS Prevention: The Case of Botswana. *Southern African Journal of Gerontology*, 5 (2):27-32.

Trice, A., Haine, J& Elliot, K. 1989. A Career Locus of Control Scale for Undergraduate Students. *Perceptual and Motor Skills*, 69:555-561.

Trussell, J& Vaughan, B. 1999. Contraceptive failure, method-related discontinuation and resumption of use: results from the 1995 national survey of family growth. *Society in Transition*.31(2):64-72 & 93.

Tseng, M. S. 1970. Locus of Control as a Determinant of Job Proficiency, Employability, and Training Satisfaction of Vocational Rehabilitation Students. *Journal of Counseling Psychology*, 17:487-491.

Tshabalala, M.1992. Multicultural Social Work Practice: Alternative Options for Social Work Practice in South Africa. *Journal of Multicultural Social Work*, 2 (2):65-79.

Tshihamba, M. 2001. 'Discrimination of People Living with HIV/AIDS in Uganda', 3 April, [www.afronets.org/archive/200104/msg\\_00012.php](http://www.afronets.org/archive/200104/msg_00012.php), [Accessed 21 June 2005].

Tubbs, W. 1994. The Roots of Stress–Death and Juvenile Delinquency in Japan: Disciplinary Ambivalence and Perceived Locus of Control. *Journal of Business Ethics*, 13 (7):507-522.

Tumashabe, J. 2005 *The Politics of HIV/AIDS in Uganda*. Paper for the United Nations Research Institute for Social Development, July.

Tumashabe, J. 2006 *The Politics of HIV/AIDS in Uganda*. Paper for the United Nations Research Institute for Social Development, August.

Tutu, D. 1999. *No Future without Forgiveness*. London: Rider.

Uganda Network of AIDS Service Organisations. 2002. 5: 6-8.

Uchino, B. N., Cacioppo, J. T & Kiecolt-Glaser, J. K. (1996). The Relationship between Social Support and Physiological Processes: A Review with Emphasis on Underlying Mechanisms and Implications for Health. *Physiological Bulletin*, 119:488-531.

UNAIDS. 1999. *Sexual Behavioural Changes For HIV: Where Have Theories Taken Us?* Geneva: UNAIDS.

UNAIDS. 2000a. *Gender and AIDS Almanac*. Geneva: UNAIDS.

UNAIDS. 2000b. *HIV/AIDS-related stigmatization, discrimination and denial: Forms, contexts and determinants. Research studies from Uganda and India*. Geneva, Switzerland.

UNAIDS. 2000c. *National AIDS programmes: A guide to monitoring and evaluating*. Geneva: UNAIDS.

UNAIDS. 2000d. *Protocol for the Identification of Discrimination against People Living with HIV*. Geneva: UNAIDS.

UNAIDS. 2000e. *Report on the global HIV/AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2000f. *The Business Response to HIV/AIDS: Impact And Lessons Learned*. Geneva: UNAIDS, The Global Business Council on HIV/AIDS and The Prince of Wales Business Leaders Forum.

UNAIDS. 2000g. *The Private Sector Response to the Epidemic: Debatswana – a Global Benchmark*. Geneva: UNAIDS Best Practice Collection.

UNAIDS 2001. *The Global Strategy Framework on HIV/AIDS*. Geneva: UNAIDS

UNAIDS 2002a. *HIV/AIDS, Human Resource and Sustainable Development*. Geneva: UNAIDS.

UNAIDS/WHO. 2002b. *AIDS Epidemic Update 2002*. Geneva: UNAIDS.

UNAIDS. 2003a. *AIDSEpidemicUpdate*. Available: [www.unaids.org](http://www.unaids.org) [Accessed August 24, 2004].

UNAIDS. 2003b. *Progress report on the Global Response to the HIV/AIDS Epidemic, 2003. Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS*. Geneva: UNAIDS.

UNAIDS.2003c. *Combating Stigma and Discrimination is Vital to Improving Access to AIDS Care*. Available: <http://www.unaids.org> [Accessed May 28, 2004].

UNAIDS. 2004. *Basic Facts about the AIDS Epidemic and its Impact: Questions and Answers*, July 2004. Geneva: UNAIDS.



UNAIDS. 2006. *Report on Global HIV/ AIDS Epidemic: Ungass and Toronto Report*. Available at <http://www.unaids.org/en/HIV-data/2006GlobalReport/default.asp>.

[Accessed 13 June 2011].

UNAIDS/WHO. 2003. *Aids Epidemic Update*. Joint United Nations Programme on HIV/AIDS and World Health Organisation at <http://www.unaids.com> [Accessed 12 December 2003].

UNDP. 2000a. *An Impact Assessment of HIV/AIDS on Current and Future Population Characteristics and Demographics in Botswana*. Gaborone: UNDP & Government of Botswana.

UNDP. 2003. *Human Development Report 2003, Millennium Development Goals: A Pact among Nations to End Human Poverty*. New York: UNDP.

United Nations General Assembly Declaration of Commitment on HIV/AIDS, 25-27 June 2001.

USAID. 2000. USAID Concept Paper: Combating HIV/AIDS Stigma, Discrimination and Denial: What Way Forward? Unpublished paper, 23 June.

Valentine, S., Silver, L & Twigg, N. 1999. Locus of Control, Job Satisfaction, and Job Complexity: The Role of Perceived Race Discrimination. *Psychological Reports*, 84 (3):1267-1273.

Valle, R., King, M & Halling, S. 1989. 'An Introduction to Existential Phenomenological Thought in Psychology. In R. S. Valle. & S. Halling (eds). *Existential-Phenomenological Perspective in Psychology*. London: Plenum Press.

Van Daalen, H. J., Van Niekerk, E. C. & Pottas, C. D. (1989). The Validation of Furnham's Locus of Control Scale for a Black South African Group. *Journal of Industrial Psychology*, 15 (1):12-21.

Van Dyk, A. 2001. *HIV/AIDS Care and Counseling: A Multidisciplinary Approach*. Cape Town: Pearson Education.

Van Wyk, R., Boshoff, A. B & Cilliers, F.V.N. 2003. The Prediction of Job Involvement for Pharmacists and Accountants. *South African Journal of Industrial Psychology*, 29 (3):61-67.

Venter, L. 1997. *When Mandela Goes: The Coming of South Africa's Second Revolution*, Doubleday, Trans-world Publishers.

Villarruel, A. M. 1998. Cultural Influences on the Sexual Attitudes, Beliefs and Norms of Young Latino Adolescents. *Journal of the Society of Pediatric Nurses*, 3:69 - 81.

Vygotsky, L. 1986. *Thought and Language*. Boston: MIT Press.

- Wade, B. L. 2009. *Unisa social work students' experiences of trauma: an exploratory study from a person-centred perspective*. Unpublished Doctoral Thesis, Pretoria: Unisa.
- Walker, C. R., Guest, R. H & Turner, E. N. 1956. *The Foreman on the Assembly Line*. Cambridge: Harvard University Press.
- Wallston, B. S., Wallston, K. A., Kaplan, G. D & Maides, S. A. 1976. Development and Validation of the Health Locus of Control (HLC) Scale. *Journal of Consulting and Clinical Psychology*, 44 (4): 580-585.
- Wallston, K. A., Wallston, B. S & De Vellis, R. 1978. Development of the Multi-dimensional Health Locus of Control (MHLC) Scale. *Health Education Monographs*, 6:160-170.
- Wegner, D. W. 2002. *The Illusion of Conscious Will*. Cambridge: MIT Press.
- Welch, J. 1998. Employers Must Face Up to AIDS in the Workplace. *People Management* 4 (18): 14-15.
- Wellman, J. C & Kruger, S. J. 2002. *Research Methodology*. Oxford: Oxford University Press.
- Whiteside, A., Mattes, R., Willan, S & Manning, R. 2004. 'What People Really Believe about HIV/AIDS in Southern Africa', in Pokum K. N. & A. Whiteside. (eds). *The Political Economy of AIDS in Africa*, Aldershot: Ashgate Publishing.

- Whiteside, A & Sunter, C. 2000. *AIDS: The Challenge for South Africa*. Tafelberg: Human & Rousseau.
- Whiteside, A & Sunter, C. 2002. *AIDS: The Challenge for South Africa*. Tafelberg: Human & Rousseau
- Whitman, L., Desmond, S & Price, J. 1987. Development of Depression Locus of Control Scale. *Psychological Reports*, 60:583-589.
- Williams, G & Ray, S. 1993. *Work Against AIDS: Workplace-based AIDS initiatives in Zimbabwe*. ActionAid (AMREF).
- Wilson, T. D., Gilbert, D. T & Centerbar, D. B. 2003. Making Sense: The Causes of Emotional Evanescence. In I. Brocas & J. Carrillo (Eds.), *The Psychology of Economic Decisions: Vol. 1. Rationality and Well-being*. New York: Oxford University Press
- Wissing. M. P. & Van Eeden, C. 2002. Empirical Classification of the Nature of Psychological Well-being. *South African Journal of Psychology*, 32 (1):32-44.
- Wolfe, S. L., Nordstrom, C. R & Williams, K. B. 1998. The Effect of Enhancing Self-efficacy Prior to Job Training. *Journal of Social Behaviour and Personality*, 13 (4):633-650.

Wood, D& Letak J. 1982. A Mental Health Locus of Control Scale. *Personality and Individual Differences*,3: 83-87.

Woodruff, S. L& Cashman, J. F. 1993. Task, Domain and General Efficacy: A Re - examination of the Self-efficacy Scale. *Psychological Reports*, 72 (2):423-432.

World Health Organisation (WHO). 2002a. *Implications of the Doha Declaration on the TRIPS Agreement and Public Health*. Geneva:WHO

World Health Organisation (WHO). 2002b.Traditional Medicine Strategy, 2002-2005. Available: [www.who.org](http://www.who.org) [Accessed 24 June 2007].

Wortman, C. B., Silver, R. C& Kessler, R. C. 1993. The Meaning of Loss and Adjustment to Bereavement. In M. S. Stroebe, W. Stroebe & R. O. Hanson (eds.), *Handbook of Bereavement: Theory, Research, and Intervention*. New York: Cambridge University Press.

Wulf, R. 1996. *The Historical Roots of Gestalt Therapy Theory*. [http://: www.gestalt.org/wulf.htm](http://www.gestalt.org/wulf.htm) [Accessed 8 August 2004].


Ya Salaam, K. 2006. 'Debunking the Myths'. *Chicken bones: A Journal for Literacy and Artistic African–American Themes*. [www.nathanieltturner.com/debunkingmyths.htm](http://www.nathanieltturner.com/debunkingmyths.htm). [ Accessed 12/12/2008].

Yamba, C. B. 1997. Cosmologies in Turmoil: Witch-finding and AIDS in Chiawa, Zambia. *Africa* 67:200-223.

Zalenski, R& Raspa, R. 2006. 'Maslow's hierarchy of needs: A framework for achieving human potential in hospice'. *Journal of Palliative Medicine*, 9(50):1120-1127.

# APPENDICES

## APPENDIX I: PERMISSION TO CONDUCT RESEARCH

  
NORTH WEST PROVINCE

**Lefapha la Thuto**  
*Departement van Onderwys*

Private Bag X2044  
MMAABA 1210  
Tel: (+27) 51 387 3429  
Fax: (+27) 51 387 3410  
E-Mail: [ijonesm@nwerg.gov.za](mailto:ijonesm@nwerg.gov.za)

**OFFICE OF THE SUPERINTENDENT GENERAL**

Enquiries P. Tyatya  
Telephone: 016 357 3071  
Fax no: 016 – 367 3430  
Email: [sg@nw.gov.za](mailto:sg@nw.gov.za)

**To: Mukasa S.J.W.  
c/o Reebone Secondary School**

**From: Mr. H.M. Mwele  
Acting Superintendent – General**

**Date: 02 November 2005**


**Subject: REQUEST TO CONDUCT RESEARCH**

Permission is herewith granted to you to conduct research among teachers in selected schools, subject to the following provisions: -


- i. That you alert the Heads of Institutions in advance of your pending visits for research purposes.
- ii. That your research project should not tamper with the normal processes of learning and teaching or upset the Examinations taking place in schools.
- iii. That you share your research product with my office for record purposes.

Wishing you well in your endeavours.

Yours sincerely

  
Mr. H.M. MWELI  
ACTING SUPERINTENDENT-GENERAL

Re a soma dikoloni • Re a nna me dikoloni • Ons werk in ons skole • We are working in our schools  
• Re a sece, ka dikoloni • Siyasebani, azikoleli • Re tšona eswikholeli • Re a stuma zikholeli  
• Re a sebana kholeli • Siyasebani, azikholeli • Siya beanga ezikholeli



## APPENDIX II: INTRODUCTORY LETTER

c/o REEBONE S.S  
P.O.BOX 576  
SWARTRUGGENS  
CELL: 083 368 6284  
25-MAY - 2006

THE PRINCIPAL  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dear Sir/Madam,

**REQUEST TO CONDUCT RESEARCH FOR ACADEMIC PURPOSE**

I humbly wish to submit my request to you to let me conduct research among educators in your institution.

So far, the Department of Education, North West Government, has granted me permission to go ahead on this matter after perusing through my proposal; and has advised me to contact you.

Hoping that we shall be able to work out the modalities of the actual research with minimum disruption to the normal running of your institution which has been randomly drawn, I intend to have a questionnaire for each consenting educator; and a semi-structured interview for one member from the School Management Team (SMT) and one from the rest of teaching staff, all drawn randomly.

As for the time of actual research, I propose mid-June to early Sept , 2006 since now teachers/educators are too busy with end of year examinations.

Finally, I will keep you informed of any new developments once I get a go ahead from you.

Thanking you in advance.

Yours faithfully,

\_\_\_\_\_  
MUKASA S.J.W  
RESEARCHER/DOCTORAL CANDIDATE



### **APPENDIX III: LETTER TO RESPONDENT**

S.J.W Mukasa

c/o Reebone S.S

P.O. Box 576

SWARTRUGGENS 2835

Tel: +27-14-5440466

Cell: +27-83 368 6284

Dear Sir/Madam

I am presently undertaking research to determine and to explain which factor is of paramount importance in the prevalence of workplace HIV AND AIDS-related discrimination.

I, therefore, request your assistance in participating in this survey by completing the attached questionnaire as sincerely as possible. Please be assured of the confidentiality with which your responses will be treated and be assured that this questionnaire is to be used for study purpose only. To guarantee anonymity, therefore, do not fill in your name or the name of your organisation and not even a stamp of your organisation should be endorsed on the questionnaire.

Please complete the questionnaire and hand it to your contact person as soon as you possibly can. In the event of you having received this questionnaire by mail, kindly use the stamped self-addressed envelope and mail it back to me.

Permission to conduct this study in your organization has been granted by the management of your institution.

Allow me to thank you in advance for taking your time, thought and your co-operation on this crucial issue.

Yours sincerely

S.J.W. MUKASA RESEARCHER

NB: RESPOND WITH SINCERITY AND FOLLOW INSTRUCTIONS IN EACH SECTION

## **APPENDIX IV: QUESTIONNAIRE (UGANDA VERSION)**

Please provide your answer by writing 'X' in the particular space provided.

### **SECTION A**

KNOWLEDGE ITEMS; Bio-medical knowledge

Mark with an 'X' for any one of the appropriate alternative response out of the five given.

Please, your sincerity is very essential.

		Definitely	Probably	Uncertain	Probably	Definitely	
1	To have HIV means you have AIDS.						(1)
2	There is no known cure of HIV and AIDS to date.						(2)
3	HIV and AIDS can be cured by traditional medicines.						(3)
4	HIV causes AIDS.						(4)
5	Mosquitoes can transmit HIV.						(5)
6	HIV does not spread through casual contact with an HIV-positive person.						(6)
7	HIV can be transmitted through sneezing.						(7)
8	Effective and regular condom use is hundred percent (100 %) perfect in preventing HIV transmission.						(8)
9	It takes several years for those infected with HIV to show symptoms of the disease (AIDS).						(9)
10	HIV and AIDS is a preventable infectious disease.						(10)
11	A man can get HIV by having sex with a woman who has the virus.						(11)
12	You can reduce the risks of getting HIV from sharing needles by cleaning the needles with bleach.						(12)
13	A pregnant woman with HIV cannot infect her baby if she does not have a full-blown case of AIDS.						(13)
14	A person can get HIV from giving blood or plasma.						(14)
15	You can tell if a person has HIV just by looking at him or her.						(15)
16	A person can get HIV by using public toilet seats.						(16)

Fill in the words represented by the acronyms below:

17. HIV stands for:

---

(17)

18. AIDS stands for:

---

(18)

		Definitely	Probably	Uncertain	Probably	Definitely	
1	It's illegal to test employees for HIV against their will.						(19)
2	An HIV-positive person (employee) is considered to be able to work if he/she can do the essential part(s) of the job.						(20)
3	HIV testing for job-applicants is illegal.						(21)
4	HIV-positive employees must not mix or associate with their uninfected colleagues.						(22)
5	Employment organisations are obliged to provide reasonable accommodation (e.g. Longer work breaks for medication and flexible working time) to HIV-infected employees in AIDS.						(23)
6	It's illegal to refuse to work with an HIV-infected colleague.						(24)
7	It's illegal for an employee to seek to know a colleague's HIV status.						(25)
8	Some legal provision is made for some jobs to demand an HIV test with consent before employment.						(26)
9	Every employee has a right to fair treatment at work.						(27)

10	Every employee has a right to be provided with medical treatment.						(28)
11	Every individual has a right to some but NOT all information.						(29)
12	Not revealing one's HIV status is a basic right.						(30)
13	It is illegal to test an employee for HIV without first counseling him/her.						(31)
14	It is against the law to leak information regarding colleagues HIV and AIDS–status to any						(32)

LEGAL KNOWLEDGE (ABOUT HIV AND AIDS)

**SECTION B**

ATTITUDES

Check off with an 'X' for the appropriate degree to which you agree or disagree with the following statements.

- SA– (Strongly agree)
- A– (Agree)
- N/U– (Neutral/Undecided)
- DA– (Disagree)
- SDA– (Strongly Disagree).

No answers are wrong or correct, all that is expressed is your own view expressed accurately.

		SA	A	N/U	DA	SDA	
1	Training an HIV-infected employee is a mere waste of scarce resources (money, in particular).						(33)
2	Promotion to a higher position of an HIV-infected worker is a discouragement to non-infected employees						(34)
3	HIV-positive employees and their immediate family should get financial support for medication from the employing organisation						(35)
4	HIV-positive employees should be given social support by the employees in the workplace.						(36)
5	Every employee should be tested for HIV every six (6) months.						(37)
6	Every employee should declare his/her HIV-status.						(38)
7	My workplace is up-to-date with HIV and AIDS knowledge (especially information provision).						(39)
8	There is no need to declare one's HIV-status.						(40)
9	There is not much an individual employee can do to stop getting infected with HIV.						(41)
10	There is not much the employing organisation I work for can do to stop employees from getting infected with HIV						(42)
11	I believe individuals are to blame for the spread of HIV.						(43)
12	I believe employing organisations are to blame for the spread of HIV.						(44)
13	I am bothered by working for a colleague who is absent from work because he/she is HIV-positive.						(45)
14	I prefer my religious leader (e.g. a priest) to my supervisor in matters relating to HIV AND AIDS						(46)
15	Employees who are HIV-positive should be given alternative jobs in the employing organisation.						(47)
16	My employing organisation is doing enough for HIV-infected employees.						(48)
17	The HIV and AIDS policy in my workplace is hard to understand.						(49)
18	I have never lost a close relative because of HIV and AIDS.						(50)

19	HIV and AIDS is a disease like any other chronic diseases (e.g. Diabetes or asthma)								(51)
20	I feel comfortable wearing a T-shirt with the message such as 'Treat an HIV and AIDS-infected person with dignity'								(52)
21	It would be OK for me to donate a fraction of less than one percent (1 %) of my salary monthly for HIV AND AIDS activities								(53)
22	It would be nice in our department/section to have short breaks enjoying snacks with HIV-infected coworkers								(54)

### EMOTIONS

Indicate the degree of your reaction on the scale below:

Mark off with 'X' according to how you feel for 23 to 25.

NB: Where 1 is lowest and 7 is highest for this scale.

		1	2	3	4	5	6	7	
23	Whenever I think of working with an HIV-positive coworker, I feel ... fear								(55)
24	Whenever I imagine sharing work with an HIV-positive work, I get ... irritated.								(56)
25	Whenever I see an HIV-positive colleague, I feel ... pity								(57)



PERCEPTIONS

ONLY EDUCATORS (PL1)

Respond to this if you are classified as an educator (Post Level 1 (PLI)).

Tick off with an 'X' according to the degree of agreement or disagreement.

- SA– (Strongly agree)
- A– (Agree)
- N/U– (Neutral/Undecided)
- DA– (Disagree)
- SDA– (Strongly Disagree).

		SA	A	N/U	DA	SDA	
1	I was consulted in the development of our organisation's HIV and AIDS policy.						(58)
2	My HOD/supervisor(s) seem to be free to discuss HIV and AIDS with subordinates.						(59)
3	My HOD/supervisor(s) seem to be free to discuss HIV and AIDS with people of his/her rank only.						(60)
4	My HOD/supervisor(s) sexual behaviour seems to be in agreement with the message he/she delivers to subordinates.						(61)
5	My HOD/supervisor(s) seem to be co-operating and understanding when dealing with HIV AND AIDS infected colleagues' matters (including confidentiality).						(62)

6	My HOD/supervisor(s) and managers seem to appreciate what the educators are doing in the area of HIV AND AIDS							(63)
---	---	--	--	--	--	--	--	------

**RESPOND TO THE STATEMENTS BELOW ONLY IF YOU BELONG TO SCHOOL MANAGEMENT TEAM CATEGORY (ONLY SMT EDUCATORS)**

		SA	A	N/U	DA	SDA	
7	My subordinates seem to be co-operative in the way they handle HIV and AIDS issues of coworkers.						(64)
8	My subordinates seem to appreciate what management is doing as regards to HIV AND AIDS in our organisation						(65)
9	My subordinates seem to be free to discuss HIV and AIDS with their supervisors.						(67)
10	My subordinates seem to be free to discuss HIV and AIDS with people of the same rank.						(68)

**SECTION C**

**TRADITIONAL BELIEFS**

Tick anyone with 'X' the degree to which you believe the information below:

		SA	A	N/U	DA	SDA	
1	Traditional healers can treat HIV.						(69)
2	Traditional medicine can cure HIV.						(70)

3	Vitamins can cure HIV.									(71)
4	It is basically fate to contract HIV.									(72)
5	Deviating from God's prescribed ways of living brought the curse of HIV and AIDS to humans.									(73)
6	According to me, most diseases including HIV are due to witchcraft.									(74)
7	While I use medicine from modern doctors, I have to consult an inyanga/ sangoma/traditional healer to be sure of the actual cause of the disease.									(75)
8	Without appeasing ancestors through sacrifice of a beast, one will have many problems including diseases.									(76)
9	I consult my sangoma/ inyanga whenever I have a disease/sickness that does not cure easily.									(77)
10	I would direct a coworker to a traditional healer in case of his/her having an inexplicable health problem.									(78)
11	I trust a traditional healer more than a medical doctor in treating HIV and AIDS.									(79)
12	HIV and AIDS is an African disease.									(80)
13	Having sex with foreigners caused HIV and AIDS in our country.									(81)
14	I would do anything and everything a traditional healer told me to get cured (e.g. sleeping with a virgin, sleeping with a monkey, etc.).									(82)
15	One's ancestors control one's life pattern, including health pattern.									(83)
16	I would sacrifice a person if that is what it takes to get cured of HIV.									(84)
17	Having sexual intercourse helps in purifying blood to reduce chances of developing high blood pressure.									(85)
18	Breaking some sexual taboos can result in diseases like TB (tuberculosis) and HIV.									(86)

## SECTION D

### DISCRIMINATION

Check off the appropriate response with an 'X' in the space provided to express the degree to which you sincerely (from the bottom of your heart) agree or disagree with the following statements.

		SA	A	N/U	DA	SDA	
1	HIV-positive employees should not be given extra sick leave with pay.						(87)
2	HIV-positive employees should have their own separate common room.						(88)
3	No HIV-positive worker should be sent for further training.						(89)
4	No HIV-positive employee should be promoted.						(90)
5	No HIV-positive employment seeker should be interviewed for any job.						(91)
6	HIV-positive employees should declare their status to the employer.						(92)
7	Employees who contract HIV should be demoted.						(93)
8	Employees who test HIV-positive should be dismissed.						(94)
9	Job applicants should be tested for HIV.						(95)
10	There is no need to cater for special needs of an HIV-infected employee.						(96)
11	HIV-infected individuals should not have the same rights to health, information, housing, etc. as individuals who are not HI infected.						(97)
12	In the last 6 (six) months I have shared a work table with a colleague suspected of being HIV-positive						(98)
13	I can share a teaspoon with an HIV-infected coworker.						(99)
14	I can share a toilet with an HIV-infected coworker.						(100)
15	I can shake hands with a coworker who is HIV-positive.						(101)
16	I can kiss a coworker regardless of his/her HIV status.						(102)
17	In the last 3-12 months, I have shared a workplace table with an HIV-infected or HIV-suspected colleague.						(103)
18	In the last 3–12 months, I have dined with a coworker suspected to be HIV-positive.						(104)

19	In the last 3–12 months, I have used the same facilities (e.g., toilet, lounge,) with a co-worker suspected of HIV AND AIDS.						(105)
20	In the last 3–12 months, I have shunned (i.e. avoided) company of a coworker with AIDS symptoms.						(106)
21	In the last 3–12 months, I have kissed a coworker suspected of HIV and AIDS.						(107)
22	In the last 3–12 months, I have donated money to assist an HIV and AIDS infected colleague.						(108)
23	In the last 3–12 months, I have leaked information regarding the HIV status of a coworker to someone else in my workplace						(109)
24	In the last 3–12 months, I have leaked information about the sexual orientation (homosexual or bisexual) of a						(110)
25	In the last 3–12 months, I have done my coworker's job when she was away due to HIV AND AIDS-related						(111)
26	In the last 3–12 months, I have participated in HIV and AIDS activities like campaign to reduce HIV AND						(112)
27	In the last 3–12 months, I have parted ways (got detached) from someone due to fear of contracting HIV from						(113)
28	In the last 3 –12 months, I have offered transport to a colleague who is suspected to be HIV-positive. (Answer this ONLY if the vehicle exists)						(114)
29	In the past 3–12 months, I have avoided using the same phone with a colleague who is suspected to be HIV-						(115)
30	In the past 3 –12 months, I have not had a handshake with a colleague suspected to be affected with HIV						(116)

SELF-ESTEEM

SA	A	N/U	DA	SDA
----	---	-----	----	-----

1	I feel I have a number of good qualities.						(117)
2	All in all, I am inclined to feel that I am a failure.						(118)
3	I am able to do things as well as most other people.						(119)
4	I feel I do not have much to be proud of.						(120)
5	On the whole, I am satisfied with myself.						(121)
6	I have a positive attitude toward myself.						(122)
7	I certainly feel useless at times.						(123)

SELF-EFFICACY

Mark with 'X' which is most applicable and appropriate to you.

		Not	Quite	Certain	More	Very	
1	How certain are you that you could not shun an HIV and AND AIDS infected colleague in anyway?						(124)
2	How confident are you that you can eat from the same plate with a colleague suspected to be HIV positive?						(125)

SUBJECTIVE NORM

Mark with an 'X' which is appropriate for you.

SA	A	N/U	DA	SDA
----	---	-----	----	-----

1	On the whole people who are important to me think that I should not shun away from colleagues because they are HIV positive or suspected to be so						(128)
2	On the whole people who are important to me think that I should donate a small fraction of my income for HIV AND AIDS related activities						(129)
3	On the whole people who are important to me think is rather natural to have no casual contact like sharing a cup with HIV AND AIDS infected people						(130)

### LOCUS OF CONTROL (i.e. Scale)

Tick the most appropriate/applicable to you from each pair.

1. (a) Many people can be described as victims of circumstances   
(b) What happens to others is pretty much of their own making
  
2. (a) Much of what happens to me is probably a matter of luck   
(b) What happens to me is my own doing
  
3. (a) It is foolish to think one can really change another person's  
basic attitudes   
(b) When I am right I can convince others



SOCIO-DEMOGRAPHIC DATA/PERSONAL PARTICULARS

(Mark the applicable response by making a cross 'X')

1. Sex: Male  Female

(131)

2. Age: 20-25 years   
26-30 years   
31-40 years   
51-60 years   
+ 61 years

(132)

3. Marital Status: Married   
Divorced   
Separated   
Single   
Widowed

(133)

4. Religious affiliation: Christian   
Hindu   
Moslem   
SDA   
Any other  specify: \_\_\_\_\_

(134)

5. Education level: '0' Level + Teaching certificate   
(State the highest) 'A' Level + teaching certificate

- 2 year Diploma in Education
- 3 year University Degree
- 3 year degree
- 3 year degree + Teaching certificate
- Masters degree
- Any other

specify: \_\_\_\_\_

(135)

6. Job title: \_\_\_\_\_

7. Total carry home (income) per year: 1–2 million U. Sh.

3–4 million U. Sh.

5–6 million U. Sh.

7–12 million U. Sh.

+12 million U. Sh.

(136)

- 8. I am: a citizen of Uganda by birth
- a permanent resident of Uganda
- a non-resident of Uganda
- a citizen of Uganda by naturalization
- a citizen of Uganda by descent

(137)

- 9. I am classified as: Black
- Half-Cast
- Indian

(138)

10. How would you describe the place you grew up?

Traditional village

Town

Suburb

City

(139)

11. I traditionally belong to \_\_\_\_\_ region.

North East

Central

West

South West

East

North East

Any other  specify: \_\_\_\_\_

(140)

12. In about 20 words, state instances/circumstances in your workplace in which you have or would not share a cup, toilet or a work table with a coworker who is or suspected of having HIV and AIDS.

---

---

---

---

---

(141)

13. In about 30 words, WHY would you shun or avoid a coworker suspected to have HIV and AIDS?

---

---

---

---

---

\_\_\_\_\_ (142)

14. In about 30 words, WHY do you think some people tend to avoid/shun coworkers who are either HIV and AIDS infected or suspected to have HIV and AIDS?

---

---

---

---

---

\_\_\_\_\_ (143)

15. On a scale of 1 to 7, where 1 is the lowest and 7 is the highest, rate yourself on your ABILITY OF NOT REVEALING a coworker's HIV status if you knew it.

Tick the appropriate box:

1 2 3 4 5 6 7

(144)

16. Any other information you would like to share with us regarding this research.

---

---

---

---

---

\_\_\_\_\_ (145)

Please complete by 31/01/2007

THANK YOU

Thank you for having participated in this survey

May you please check to see if you have responded to all questions?

Mail or hand over the questionnaire to the appropriate person.

For any more clarification contact Mukasa SJW on 083 3686284

#### **APPENDIX IV: REQUEST TO PARTICIPATE IN SURVEY (SOUTH AFRICA)**

S.J.W Mukasa

c/o Reebone S.S

P.O. Box 576

SWARTRUGGENS 2835

Tel: +27-14-5440466

Cell: +27-83 368 6284

Dear Sir/Madam,

I am presently undertaking research to determine and to explain which factor is of paramount importance in the prevalence of workplace HIV and AIDS-related discrimination.

I, therefore, request your assistance in participating in this survey by completing the attached questionnaire as sincerely as possible. Please be assured of the confidentiality with which your responses will be treated and be assured that this questionnaire is to be used for study purpose only. To guarantee anonymity, therefore, do not fill in your name or the name of your organisation and not even a stamp of your organisation should be endorsed on the questionnaire.

Please complete the questionnaire and hand it to your contact person as soon as you possibly can. In the event of you having received this questionnaire by mail, kindly use the stamped self-addressed envelope and mail it back to me.

Permission to conduct this study in your organisation has been granted by the management of your institution.

Allow me to thank you in advance for taking your time, thought and your co-operation on this crucial issue.

Yours sincerely

SJ.W. MUKASA RESEARCHER

NB: RESPOND WITH SINCERITY AND FOLLOW INSTRUCTIONS IN EACH SECTION

## APPENDIX VI: QUESTIONNAIRE (SOUTH AFRICA VERSION)

Please provide your answer by writing 'X' in the particular space provided.

### SECTION A

#### KNOWLEDGE ITEMS: Bio-medical knowledge

Mark with an 'X' for any one of the appropriate alternative response out of the five given. Please, your sincerity is very essential.

		Definitel	Proba	Unc	Pro	D	
1	To have HIV means you have AIDS.						(1)
2	There is no known cure of HIV and AIDS to date.						(2)
3	HIV and AIDS can be cured by traditional medicines.						(3)
4	HIV causes AIDS.						(4)
5	Mosquitoes can transmit HIV.						(5)
6	HIV does not spread through casual contact with an HIV-positive co-worker.						(6)
7	HIV can be transmitted through sneezing.						(7)
8	Effective and regular condom use is hundred percent (100 %) perfect in preventing HIV transmission						(8)
9	It takes several years for those infected with HIV to show symptoms of the disease (AIDS)						(9)
10	HIV and AIDS is a preventable infectious disease.						(10)



11	A man can get HIV by having sex with a woman who has the virus.						(11)
12	You can reduce the risks of getting HIV from sharing needles by cleaning the needles with bleach.						(12)
13	A pregnant woman with HIV cannot infect her baby if she does not have a full-blown case of AIDS.						(13)
14	A person can get HIV from giving blood or plasma.						(14)
15	You can tell if a person has HIV just by looking at him or her.						(15)
16	A person can get HIV by using public toilet seats.						(16)

Fill in the words represented by the acronyms below:

		Definitely	Probably	Uncertain	Probably	Definitely	
1	It's illegal to test employees for HIV against their will.						(19)
2	An HIV-positive person (employee) is considered to be able to work if he/she can do the essential part(s) of the job.						(20)
3	HIV testing for job applicants is illegal.						(21)
4	HIV-positive employees must not mix or associate with their uninfected colleagues.						(22)
5	Employment organisations are obliged to provide reasonable accommodation (e.g. longer work breaks for medication and flexible working time) to HIV-infected employees in AIDS stage.						(23)
6	It's illegal to refuse to work with an HIV-infected colleague.						(24)
7	It's illegal for an employee to seek to know a colleague's HIV status.						(25)
8	Some legal provision is made for some jobs to demand an HIV test with consent before employment.						(26)
9	Every employee has a right to fair treatment at work.						(27)
10	Every employee has a right to be provided with medical treatment.						(28)
11	Every individual has a right to some but NOT all information.						(29)
12	Not revealing one's HIV status is a basic right.						(30)
13	It is illegal to test an employee for HIV without first counselling him/her.						(31)
14	It is against the law to leak information regarding colleagues HIV AND AIDS status to any person.						(32)

17. HIV stands for

---



---

(17)

18. AIDS stands for

---

---

LEGAL KNOWLEDGE (ABOUT HIV AND AIDS)

**SECTION B**

ATTITUDES

Check off with an 'X' for the appropriate degree to which you agree or disagree with the following statements.

- SA - (Strongly agree)
- A - (Agree)
- N/U - (Neutral/Undecided)
- DA - (Disagree)
- SDA - (Strongly Disagree)

No answers are wrong or correct, all that is expressed is your own view expressed accurately.

		SA	A	N/U	DA	SDA	
1	Training an HIV-infected employee is a mere waste of scarce resources (money, in particular).						(33)
2	Promotion to a higher position of an HIV-infected worker is a discouragement to non-infected						(34)
3	HIV-positive employees and their immediate family should get financial support for medication from the employing organisation.						(35)
4	HIV-positive employees should be given social support by the employees in the workplace.						(36)
5	Every employee should be tested for HIV every six (6) months.						(37)
6	Every employee should declare his/her HIV status.						(38)
7	My workplace is up-to-date with HIV and AIDS knowledge (especially information) provision.						(39)
8	There is no need to declare one's HIV status.						(40)
9	There is not much an individual employee can do to stop getting infected with HIV.						(41)
10	There is not much the employing organisation I work for can do to stop employees from getting infected with HIV						(42)
11	I believe individuals are to blame for the spread of HIV.						(43)
12	I believe employing organisations are to blame for the spread of HIV.						(44)
13	I am bothered by working for a colleague who is absent from work because he/she is HIV-positive						(45)
14	I prefer my religious leader (e.g. a priest) to my supervisor in matters relating to HIV AND AIDS						(46)
15	Employees who are HIV-positive should be given alternative jobs in the employing organisation.						(47)
16	My employing organisation is doing enough for HIV-infected employees.						(48)

17	The HIV and AIDS policy in my workplace is hard to understand.							(49)
18	I have never lost a close relative because of HIV and AIDS.							(50)
19	HIV and AIDS is a disease like any other chronic disease (e.g. diabetes or asthma).							(51)
20	I feel comfortable wearing a T-shirt with the message such as 'Treat an HIV AND AIDS-infected person with dignity'.							(52)
21	It would be OK for me to donate a fraction of less than one percent (1%) of my salary monthly for HIV AND AIDS activities.							(53)
22	It would be nice in our department/section to have short breaks enjoying snacks with HIV-infected coworkers.							(54)

### EMOTIONS

Indicate the degree of your reaction on the scale below:

Mark off with 'X' according to how you feel for 23 to 25.

NB: 1 is lowest and 7 is highest for this scale.

		1	2	3	4	5	6	7	
23	Whenever I think of working with an HIV-positive coworker, I have ... fear								(55)
24	Whenever I imagine sharing work with an HIV-positive work, I get ... irritation.								(56)
25	Whenever I see an HIV-positive colleague, I feel ... pity								(57)

PERCEPTIONS

ONLY EDUCATORS (PL1)

Respond to this if you are classified as an educator (Post Level 1 (PLI)).

Tick off with an 'X' according to the degree of agreement or disagreement.

- SA - (Strongly agree)
- A - (Agree)
- N/U - (Neutral/Undecided)
- DA - (Disagree)
- SDA - (Strongly Disagree).

		SA	A	N/U	DA	SDA	
1	I was consulted in the development of our organisation's HIV and AIDS policy.						(58)
2	My HOD/supervisor(s) seem to be free to discuss HIV and AIDS with subordinates.						(59)
3	My HOD/supervisor(s) seem to be free to discuss HIV and AIDS with people of his/her rank only.						(60)
4	My HOD/supervisor(s) sexual behaviour seems to be in agreement with the message he/she delivers to subordinates.						(61)
5	My HOD/supervisor(s) seem to be co-operating and understanding when dealing with HIV AND AIDS infected colleagues' matters (including confidentiality).						(62)
6	My HOD/supervisor(s) and managers seem to appreciate what the educators are doing in the area of HIV AND AIDS.						(63)

RESPOND TO THE STATEMENTS BELOW ONLY IF YOU BELONG TO SCHOOL MANAGEMENT TEAM CATEGORY  
(ONLY SMT EDUCATORS)

		SA	A	N/U	DA	SDA	
7	My subordinates seem to be co-operative in the way they handle coworkers' HIV and AIDS issues.						(64)
8	My subordinates seem to appreciate what management is doing as regards to HIV and AIDS in our organization						(65)
9	My subordinates seem to appreciate what management is doing as regards to HIV and AIDS in our organization						(66)
10	My subordinates seem to be free to discuss HIV and AIDS with their supervisors.						(67)
11	My subordinates seem to be free to discuss HIV and AIDS with people of the same rank.						(68)

### SECTION C

#### TRADITIONAL BELIEFS

Tick anyone with 'X' the degree to which you believe the information below:

		SA	A	N/U	DA	SDA	
1	Traditional healers can treat HIV.						(69)

2	Traditional medicine can cure HIV.									(70)
3	Vitamins can cure HIV.									(71)
4	It is basically fate to contract HIV.									(72)
5	Deviating from God's prescribed ways of living brought the curse of HIV and AIDS to humans.									(73)
6	According to me, most diseases including HIV are due to witchcraft.									(74)
7	While I use medicine from modern doctors, I have to consult an <i>inyanga/ sangoma</i> /traditional healer to be sure of the actual cause of the disease.									(75)
8	Without appeasing ancestors through sacrifice of a beast, one will have many problems including diseases.									(76)
9	I consult my <i>sangoma/ inyanga</i> whenever I have a disease/sickness that does not cure easily.									(77)
10	I would direct a coworker to a traditional healer in case of his/her having an inexplicable health problem.									(78)
11	I trust a traditional healer more than a medical doctor in treating HIV and AIDS.									(79)
12	HIV AND AIDS is an African disease.									(80)
13	Having sex with foreigners (Makwerekwere) caused HIV and AIDS in our country.									(81)
14	I would do anything and everything a traditional healer told me to get cured (e.g. sleeping with a virgin,									(82)
15	One's ancestors control one's life pattern, including health pattern.									(83)
16	I would sacrifice a person if that is what it takes to get cured of HIV.									(84)
17	Having sexual intercourse helps in purifying blood to reduce chances of developing high blood pressure.									(85)
18	Breaking some sexual taboos can result in diseases like TB (tuberculosis) and HIV.									(86)

## SECTION D

### DISCRIMINATION



Check off the appropriate response with an 'X' in the space provided to express the degree to which you sincerely (from the bottom of your heart) agree or disagree with the following statements.

		SA	A	N/U	DA	SDA	
1	HIV-positive employees should not be given extra sick leave with pay.						(87)
2	HIV-positive employees should have their separate common room.						(88)
3	No HIV-positive worker should be sent for further training.						(89)
4	No HIV-positive employee should be promoted.						(90)
5	No HIV-positive employment seeker should be interviewed for any job.						(91)
6	HIV-positive employees should declare their status to the employer.						(92)
7	Employees who contract HIV should be demoted.						(93)
8	Employees who test HIV-positive should be dismissed.						(94)
9	Job applicants should be tested for HIV.						(95)
10	There is no need to cater for special needs of an HIV-infected employee.						(96)
11	HIV-infected individuals should not have the same rights to health, information, housing, etcetera as individuals who are not HIV-positive.						(97)
12	In the last 6 (six) months I have shared a work table with a colleague suspected of being HIV-positive						(98)
13	I can share a teaspoon with an HIV-infected coworker.						(99)
14	I can share a toilet with an HIV-infected coworker.						(100)
15	I can shake hands with a coworker who is HIV-positive.						(101)
16	I can kiss a coworker regardless of his/her HIV status.						(102)
17	In the last 3–12 months, I have shared a workplace table with an HIV-infected or HIV-suspected colleague.						(103)
18	In the last 3–12 months, I have dined with a coworker suspected to be HIV-positive.						(104)

19	In the last 3–12 months, I have used the same facilities (e.g., toilet, lounge) with a coworker suspected of HIV AND AIDS.						(105)
20	In the last 3–12 months, I have shunned (avoided) company of a coworker with AIDS symptoms.						(106)
21	In the last 3–12 months, I have kissed a coworker suspected of HIV and AIDS.						(107)
22	In the last 3–12 months, I have donated money to assist an HIV and AIDS infected colleague.						(108)
23	In the last 3–12 months, I have leaked information regarding the HIV status of a coworker to someone else in my workplace.						(109)
24	In the last 3–12 months, I have leaked information about the sexual orientation (homosexual or bisexual) of a coworker to another colleague.						(110)
25	In the last 3–12 months, I have done my coworker's job when she was away due to HIV AND AIDS-related illness.						(111)
26	In the last 3–12 months, I have participated in HIV and AIDS activities like campaigning to reduce HIV AND AIDS-related discrimination (e.g., name name name).						(112)
27	In the last 3–12 months, I have parted ways (got detached) from someone due to fear of contracting HIV from him/her/his/hers (if the vehicle exists).						(113)
28	In the last 3 -12 months, I have offered transport to a colleague who is suspected to be HIV-positive. (Answer this ONLY if the vehicle exists.)						(114)
29	In the past 3–12 months, I have avoided using the same phone with a colleague who is suspected to be HIV-positive.						(115)
30	In the past 3–12 months, I have not had a handshake with a colleague suspected to be affected with HIV and AIDS.						(116)

**SELF-ESTEEM**

		SA	A	N/U	DA	SDA	
1	I feel I have a number of good qualities.						(117)

2	All in all, I am inclined to feel that I am a failure.						(118)
3	I am able to do things as well as most other						(119)
4	I feel I do not have much to be proud of.						(120)
5	On the whole, I am satisfied with myself.						(121)
6	I take a positive attitude toward myself.						(122)
7	I certainly feel useless at times.						(123)

### SELF-EFFICACY

Mark with 'X' which is most applicable and appropriate to you.

		Not	Quite	Certain	More	Very	
1	How certain are you that you would not shun an HIV and AIDS infected colleague in any way?						(124)
		Not	Quite	Confident	More	Very	
2	How confident are you that you can eat from the same plate with a colleague suspected to be HIV positive?						(125)

### SUBJECTIVE NORM

Mark with an 'X' which is appropriate for you.

		SA	A	N/U	DA	SDA	
1	On the whole, people who are important to me think that I should not shun away from colleagues because they are HIV-positive or suspected to be so						(128)

2	On the whole, people who are important to me think that I should donate a small fraction of my income for HIV AND AIDS related activities						(129)
3	On the whole, people who are important to me think it is rather natural to have no casual contact like sharing a cup or toilet with an HIV/AIDS infected coworker						(130)

## LOCUS OF CONTROL (I.E. Scale)

Tick the most appropriate/applicable to you from each pair.

1. (a) Many people can be described as victims of circumstance   
(b) What happens to others is pretty much of their own making
2. (a) Much of what happens to me is probably a matter of luck   
(b) What happens to me is my own doing
3. (a) It is foolish to think one can really change another person's  
basic attitudes   
(b) When I am right I can convince others

## SOCIO-DEMOGRAPHIC DATA/PERSONAL PARTICULARS

(Mark the applicable response by making a cross – 'X')

1. Sex:                      Male                              Female

(131)

2. Age:                      20 – 25 years   
                                    26 – 30 years   
                                    31 – 40 years   
                                    51 – 60 years   
                                    61 years +

(132)

3. Marital Status: Married

Divorced

Separated

Single

Widowed

(133)

4. Religious affiliation: Christian

Hindu

Moslem

Jewish

ZCC

Any other

If any other, please specify: \_\_\_\_\_

(134)

5. Education level (State the highest level):

Grade 0 - 6

Grade 7 -12

3 year University Diploma

4 year University Degree

Honours Degree

Masters degree

Doctorate

Any other

If any other, please specify: \_\_\_\_\_

(135)

6. Job title: \_\_\_\_\_

7. Total carry home (income) per year: R10 000 – R15 000

R15 001 – R20 000

R20 001 – R30 000

R30 001 – R70 000

R70 001 – R120 000

R120 001 +

(136)

8. I am: a citizen of South Africa by birth

a permanent resident of South Africa

a non-resident of South Africa

a citizen of South Africa by naturalisation

a citizen of South Africa by decent

(137)

9. I am classified as: Black

Coloured

Indian

White

(138)

10. How would you describe the place you grew up?

Traditional village

Location

Suburb

City

(139)

11. I belong to:

- Tswana community  Venda
- Zulu community  Swazi
- Sotho (Southern Sotho)  Afrikaner
- Northern Sotho/Pedi  English
- Tsonga  Ndebele
- Xhosa
- Any other  specify: \_\_\_\_\_

(140)

12. In about 20 words, state instances/circumstances in your workplace in which you have or would not share a cup, toilet or a work table with a coworker who is or suspected of having HIV and AIDS.

---

---

---

(141)

13. In about 30 words, WHY would you shun or avoid a coworker suspected to have HIV and AIDS?

---

---

---

---

(142)

14. In about 30 words, WHY do you think some people tend to avoid/shun coworkers who are either HIV and AIDS infected or suspected to have HIV and AIDS?



---

---

---

---

(143)

15. On a scale of 1 to 7, where 1 is the lowest and 7 is the highest, rate yourself on how CAPABLE YOU ARE NOT REVEAL a coworker's HIV status if you knew it.

Tick the appropriate box:

1 2 3 4 5 6 7

(144)

16. Any other information you would like to share with us regarding this research.

---

---

---

---

(145)

Please complete by 15/09/2006

THANK YOU

Thank you for having participated in this survey

May you please check to see if you have responded to all questions?

Mail or hand over the questionnaire to the appropriate person.

For any more clarification contact Mukasa SJW on 083368 6284

## **APPENDIX VII: INTERVIEW GUIDE QUESTIONS FOR A TARGET SAMPLE**

- How has HIV and AIDS affected your organization in the past?
- Do you have any figures for the affected individuals?
- How do you view the relationship between the HIV and AIDS infected individuals and those not infected?
- Does your company have an HIV and AIDS policy?
- Who developed it?
- Were lower employees, top-and-middle level managers involved?
- Or was it developed by the Human Resources Department alone or with the Management and/or the Health Department?
- Do you perceive a change in attitudes ever since the HIV and AIDS campaigns started?
- How would you rate your level of biomedical HIV and AIDS knowledge?
- How would do you rate your level of legal HIV and AIDS knowledge?
- Do you perceive that there is a group of individuals who influence HIV and AIDS issues more than any others?
- What would you consider the greatest challenge to your company regarding to HIV and AIDS?
- Do you regard traditional beliefs to have any influence on HIV and AIDS-related discrimination?
- If yes, why? Illustrate with any one or two examples which readily come to your mind.

- What do you think about your subordinates or managers' perceptions of HIV and AIDS-related issues especially (1) confidentiality, (2) discrimination and (3) attitudes toward HIV and AIDS infected coworkers?
- Have you witnessed such incidents as:
  - Individuals shunning a co- worker because he/she was suspected to be HIV- positive.
  - Individuals refusing to eat with a colleague due to suspicion or effective HIV and AIDS status issues.
  - Individuals discussing HIV and AIDS in the workplace.
- Any question that you would like to get answered before we can end this interview?

THANK YOU FOR HAVING PARTICIPATED IN THIS INTERVIEW

## **APPENDIX VIII: CONSENT FORM**

### CONSENT FORM

Following reading and understanding the above introductory letter, please sign this consent form if you are okay with participating in the survey.

I, \_\_\_\_\_, have read and understood the introductory letter concerning the research on workplace HIV AND AIDS-related discrimination. I hereby accept to participate in this survey. I fully understanding that I can stop my participation at any time once I feel I cannot continue.

\_\_\_\_\_

SIGNATURE

## APPENDIX IX: DETERMINING SAMPLE SIZE

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	346
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	354
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	170	118	400	196	1300	297	7000	364
50	44	180	123	420	201	1400	302	8000	367
55	48	190	127	440	205	1500	306	9000	368
60	52	200	132	460	210	1600	310	10000	370
65	56	210	136	480	214	1700	313	15000	375
70	59	220	140	500	217	1800	317	20000	377
75	63	230	144	550	226	1900	320	30000	379
80	66	240	148	600	234	2000	322	40000	380
85	70	250	152	650	242	2200	327	50000	381

90	73	260	155	700	248	2400	331	75000	382
95	76	270	159	750	254	2600	335	100000	384

Figure 9b: Sample sizes (S) required for given population sizes (N)

From R.V. Krejcie and D.W. Morgan (1970), Determining sample size for research activities. *Educational and Psychological Measurement*, 30,608, Sage Publications.

Note: The larger the population size, the smaller the percentage of the population needed to get a representative sample. For smaller populations,  $N < 100$ , there is little point in sampling. Survey the entire population. If the population size is around 500, 50% of the population should be sampled. If the population size is around 1500, 20% should be sampled.

Beyond a certain point (about  $N = 5000$ ), the population size is almost irrelevant and a sample size of 400 will be adequate.