

**MANAGING HIV AND AIDS STIGMA IN THE WORKPLACE CASE STUDY
OF THE EASTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT**

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Assignment presented in partial fulfillment of the requirements for the degree
of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University



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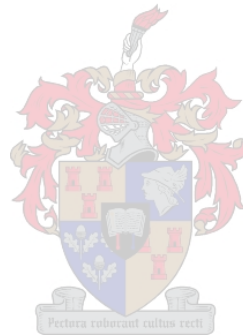
April 2006

Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it at any University for a degree.

Signature:

Date:



Acknowledgements

This work and resulting report would not have been possible without the contributions of numerous individuals. I would first of all give special thanks to my study leader, Prof. J.C.D. Augustyn for the guidance and continual support he has given me.

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Summary

HIV/AIDS remains the primary threat to South Africa's economic, social and political development. HIV and AIDS are serious public health problems, which have socio-economic, employment and human rights implications. It is recognised that the HIV/AIDS epidemic will affect every workplace, with prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale. Furthermore HIV/AIDS is still a disease surrounded by ignorance, prejudice, discrimination and stigma.

Despite the efforts being taken by DSD to remedy the situation, the department is confronted with challenges impeding its efforts because of HIV and AIDS related stigma. The main objective of the study is therefore to assess the impact of HIV and AIDS stigma on employees.

Whilst the literature study expressed HIV/AIDS to include ostracism, rejection, avoidance of people with HIV/AIDS, discrimination against people living with HIV/AIDS and violence against persons who are perceived to have AIDS or to be infected with HIV, in DSD the study indicated that the employees in the understand the meaning of HIV / AIDS stigma and have problem working with employees living with HIV or AIDS. The study also supports the fact that an employee who voluntarily discloses his/her HIV status should be kept confidential and not be divulged without his/ her consent as enshrined in the Bill of Rights of South African Constitution.

Conclusions have been derived from the study and recommendations offered to guide DSD to effectively and efficiently handle the problem of HIV and AIDS - related stigma.

Opsomming

Hierdie studie is binne die Departement van Sosiale Ontwikkeling onderneem en fokus op die probleemareas van stigma en diskriminasie. Hierdie studie bevind dat stigma en diskriminasie wel in die Department van Sosiale Ontwikkeling voorkom en 'n ernstige problem skep.

Die noodsaaklikheid van geheimhouding van toetsresultate van diegene wat hulle vrywillig aanmeld vir toetsing, word beklemtoon. Aksiestappe om diegene wat hulle vrywillig aanmeld vir toetsing te beskerm, word voorgestel

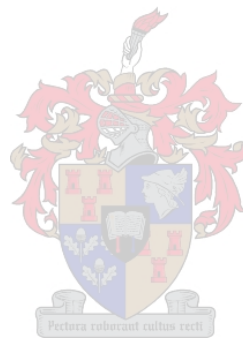


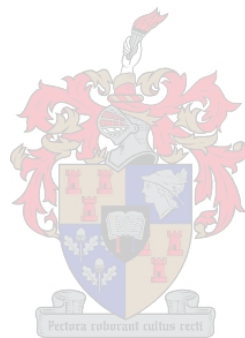
Table of Contents

Chapter 1: Introduction	1
1.1 Background	1
1.2 Research Problem	2
1.3 Research Objectives	5
1.4 Scope of the Study	6
1.5 Significance of the Study	6
1.6 Outline of Chapters	6
1.7 Summary	7
Chapter 2: Literature Review	8
2.1 Introduction	8
2.2 What is HIV/AIDS Stigma?	8
2.3 Impact of stigma on employees	11
2.4 Voluntary Counseling and Testing (VCT)	14
2.5 Barriers of testing and disclosure	15
2.6 Summary	17
Chapter 3: Research Methodology	18
3.1 Introduction	18
3.2 Research Design	19
3.3 Sampling	20
3.3.1 Population	20
3.3.2 Sampling Methods	20
3.3.3 Sampling Size	21
3.4 Data Collection Methods	21
3.4.1 Documentary Analysis	22
3.4.2 Survey Techniques	22
3.4.3 Interview Methods	23
3.4.4 Field Research	23
3.4.5 Focus groups Discussions	23
3.5 Data Analysis	23
3.6 Summary	24

Chapter 4: Analysis and Findings	25
4.1 Introduction	25
4.2 Brief Overview of the Department of Social Development	25
4.3 Demographic Profile	26
4.3.1 Total Population	26
4.3.2 Gender	26
4.3.3 Age Group	26
4.3.4 Marital Status	27
4.3.5 Race	27
4.3.6 Religion	27
4.3.7 Educational Level	27
4.3.8 Occupational Level	28
4.4 Understanding of HIV/AIDS Stigma	28
4.4.1 Understanding the meaning of stigma	28
4.4.2 Impact of HIV and AIDS Stigma on employees	31
4.4.3 The barriers to voluntary counseling and testing	32
4.5 Determining the barriers to treatment and care	33
4.6 Summary of the findings	34
Chapter 5: Discussion of the Findings	35
5.1 Introduction	35
5.2 Understanding of HIV & AIDS Stigma	35
5.3 Impact of HIV & AIDS Stigma on employees	35
5.4 Barriers to VCT	37
5.5 Barriers to treatment and care	38
5.6 Summary of Findings	39
Chapter 6: Conclusion and Recommendations	41
6.1 Introduction	41
6.2 Conclusion	41
6.3 Recommendations	41
References	44

List of Annexures

Annexure A – Questionnaires	50
Annexure B - Data Analysis	59



Chapter 1: Introduction

1.1 Background

According to UNAIDS Report (2004), almost five million people became newly infected with HIV in 2003, the greatest number in any one year since the beginning of the epidemic. At the global level, the number of people living with HIV continues to grow – from 35 million in 2001 to 38 million in 2003. In the same year, AIDS killed almost three million; over 20 million have died since the first cases of AIDS were identified in 1981 (UNAIDS Report, 2004).

The HIV/AIDS epidemic continues to spread, with the majority of infections occurring in sub-Saharan Africa. It is estimated that 25 million people are living with HIV in sub – Saharan Africa. There seems to be stabilization in HIV prevalence rates, but this is mainly due to a rise in AIDS deaths and a continued increase in new infections. UNAIDS Report (2004) states that prevalence is still rising in some countries such as Madagascar and Swaziland, and is declining nationwide in Uganda. It is estimated that in 2003, three million people became newly infected and 2.2 million died (75% of the three million AIDS deaths globally that year).



HIV knows no social, gender, age or racial boundaries, but it is accepted that socio-economic circumstances do influence the disease patterns. HIV thrives in an environment of poverty, rapid urbanisation, violence and destabilisation. Transmission is exacerbated by disparities in resources and patterns of migration from rural to urban areas. Women particularly are more vulnerable to infection in cultures and economic circumstances where they have little control over their lives.

The prevention of HIV infection remains the most important approach to the control of the epidemic, care and support for the infected and affected is becoming crucial. Therefore, HIV and AIDS and interventions must address prevention, care and support issues. (Development Gateway: 2004)

In South Africa, a survey is conducted annually to establish the prevalence of HIV infection amongst pregnant woman attending antenatal clinics.

Extrapolating from the 2001 antenatal survey, it is estimated that 4.7 million adults were infected with HIV – 2.65 million women between the ages of 15 and 49, and 2.09 million men in the same age group (Department of Public Service and Administration, 2002).

The impact of the HIV/AIDS epidemic is significant, affecting all spheres of life and all sectors. It has the potential to reverse many development gains. The Department of Social Development in the State of South Africa's Population Report 2000, estimates that:

- “Life expectancy has dropped from 63 years in 1990 to 56.5 years in 2000;
- Child mortality has increased from 75 per 1 000 in 1990 to 91 per 1 000 in 2000; and
- The probability of a 15 year old dying before the age of 60 was 27 per 1 000 in 1990 and has risen to 40 per 1 000 in 2000” (Department of Public Service and Administration, 2002:14).

1.2 Research Problem

HIV and AIDS are serious public health problems, which have socio-economic, employment and human rights implications. It is recognised that the HIV/AIDS epidemic will affect every workplace, with prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale (Code of Good Practice, 2000).

Furthermore HIV/AIDS is still a disease surrounded by ignorance, prejudice, discrimination and stigma. In the workplace unfair discrimination against people living with HIV and AIDS has been perpetuated through practices such as pre-employment HIV testing, dismissals for being HIV positive and the denial of employee benefits.

The epidemic also affects business in many ways, including increasing costs because of absenteeism, sickness and recruitment, organizational disruption and loss of skills, and increasing health expenses and funeral costs. (UNAIDS Report, 2004). The disease ultimately reduces company profits as expenses increase, production or service delivery fails to adhere to planned schedules, and customers change their purchasing plans because of the HIV/AIDS expenses they themselves incur.

HIV/AIDS not only affects workers on the job, it also causes a major drain on family savings and resources. Just as a company experiences increased expenses due to HIV/AIDS, so does a household when members are all ill with HIV/AIDS. One outcome is loss of wages, as a person becomes too weak to work. Another outcome is an increase in medical expenses to treat conditions associated with infection. Caring for a sick family member disrupts the work schedules of others, further income. (Workplace HIV/AIDS Programs)

One of the most effective ways of reducing and managing the impact of HIV/AIDS in the workplace is through the implementation of a workplace HIV/AIDS policy and prevention programmes.

The HIV/AIDS remains the primary threat to South Africa's economic, social and political development. According to Chetty & Michel (2005), the epidemic is maturing and infection rates still put South Africa squarely in the category of high prevalence countries. The Nelson Mandela/ HSRC study of HIV/AIDS (2002), revealed that South Africa, as a country, has the largest number of people living with HIV/AIDS in the world: 14, 4% of people living with HIV/AIDS live in South Africa. Dorrington et al. (2004) estimated that of the 5.6 million South Africans living with HIV/AIDS, the highest prevalence is among those aged 15 – 49 years with major differences for males and females. New AIDS cases during 2004 totalled 525 000. Total deaths were 701 000, of these non – AIDS deaths were 390 000 and AIDS deaths 311 000, and accumulated AIDS deaths mid – year were 1 212 000. The percentages of deaths due to HIV/AIDS were as follows: 70% for adults aged

15 – 49 years, 45% for adults aged 15 years and above, and 42% for children under 15 years of age (Department of Social Development, 2004).

While HIV is not transmitted in the majority of workplace settings, the supposed risk of transmission has been used by numerous employers to terminate or refuse employment. There is also evidence that if people living with HIV/AIDS are open about their status at work, they may well experience stigmatization and discrimination by others (www.avert.org/aidsstigma.htm)

Voluntary counselling and testing (VCT) is the entry point to know one's HIV status. VCT is now acknowledged within the international arena as an efficacious and pivotal strategy for both HIV/AIDS prevention and care. The need for VCT is increasingly compelling as HIV infection rates continue to soar, and an organization, such as Department of Social Development (DSD), the case study for this research, has recognized the need for its employees to know their sero – status as an important prevention and intervention tool. Those employees who learn that they are sero – negative can be empowered to remain disease – free. For those HIV- infected, there will be the development of less costly interventions to reduce repeated infection and maintain productivity. In addition, other medical and supportive services can help those living with HIV to live longer, healthier lives and prevent transmission to others.

Despite the efforts being taken by DSD to remedy the situation, the department is confronted with challenges impeding its efforts because of HIV and AIDS related stigma. It therefore important to first understand stigma, the impact of stigma on the lives of employees living with and affected by HIV/AIDS, the causes of employees to react in this way to other employees living with HIV/AIDS, employees who are suffering enough either physically or mentally to endure another challenge of being judged by their colleagues, and who should be supporting and giving them a shoulder to cry on. If the cause of stigma could be understood and its impacts properly handled, then employees would react differently and DSD will be able to overcome the fight against stigma. Interventions to reduce stigma are therefore crucial for

improving care, quality of life, and emotional health for people living with HIV and AIDS and eliminating stigma is a crucial element of global efforts.

The issue at hand, is that there are other chronic diseases like diabetes, hypertension, etc which can have similar adverse effects at workplaces like HIV and AIDS, but whose linkages with stigma and discrimination have been totally ignored. Flowing from the above, the key research question can thus be phrased as follows:

What can the Department of Social Development do to resolve the problem of stigma in order to reduce the negative impact associated with it? The above key research question, has, thus be broken down into manageable units for easy manipulation as follows:

- (i) What is our understanding of HIV/AIDS stigma?
- (ii) What is the impact of stigma on employees living with HIV/AIDS, and how do they respond to it?
- (iii) What are the barriers to treatment and care?
- (iv) What are the barriers to testing and disclosure?
- (v) How can our theoretical models of stigma be improved?

1.3 Research Objectives

To be able to answer the above research question, the following research objectives have been formulated:

- To analyse the content of the local beliefs around HIV/ AIDS
- To assess the impact of stigma on people living with HIV/AIDS and their response to the impact.
- To determine the barriers to treatment and care and not just to reduce stigma itself.
- To determine the barriers of testing and disclosure
- To assess the extent of theoretical models of stigma in the workplace.

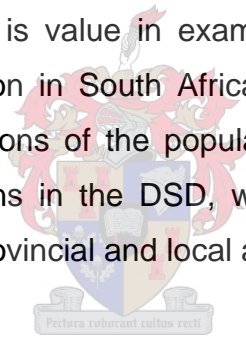
1.4 Scope of the Study

The study will be limited to the Head office of the Department of Social Development of the Eastern Cape Province, where the different categories of workers in the department are present. The study, thus, covered the top management, the middle management, supervisors / administrative staff and junior staff.

1.5 Significance of the Study

From a theoretical point of view, the research will fall into the current National focus area of "Employee Wellness Programme" that addresses HIV/AIDS pandemic. It is envisaged that the research will have the potential to make a significant contribution to the theoretical models of stigma in the workplace in South Africa.

On an empirical level, there is value in examining the notion of HIV/AIDS Programme and its application in South Africa, as it is a new approach to addressing the health conditions of the population. It will also represent a documentation of interventions in the DSD, which are currently influencing policy planning at national, provincial and local authority levels.



The Governments Departments, especially DSD, can make use of the findings of the research in addressing the HIV/AIDS pandemic issues in the department.

1.6 Outline of Chapters

The outline of the study is as follows;

As can be seen above, Chapter one contains the introduction to the study, statement of the research problem, objectives of the research, scope of the study as well as the significance of the study.

Chapter two contains a review of literature pertinent to stigma. This chapter explains what HIV/AIDS stigma is all about, impact of stigma on employees,

voluntary counseling and testing, barriers of testing and disclosure and summaries the chapter.

Chapter three contains the research methodology. This includes the research design, the population and population sample, data collection tools and method of data analysis.

Chapter four presents the analysis and discussion of data. It gives the findings of the study obtained through interviews, questionnaires and document analysis, etc. Specifically, a brief background of the DSD has been given. Additionally, employees understanding of stigma were sought. Other issues handled in this chapter included the impact of HIV/AIDS stigma on employees, barriers to voluntary counseling and testing, and determination of barriers to treatment and care.

Chapter six concludes the research with recommendations for the addressing the issue of stigma in the workplace.

1.7 Summary

This chapter has highlighted on the background to the research, the research problem and objectives, as well as the scope and significance of the study. In the next chapter, the review of existing literature on the topic has been undertaken.



Chapter 2: Literature Review

2.1 Introduction

When one looks at the experiences with HIV/AIDS, two things stand out, one is the diversity of people with HIV/AIDS, two is how often and in how many ways people with HIV/AIDS are stigmatized or discriminated against. It often appears that people with HIV/AIDS have two things in common namely HIV infection and HIV related stigma and discrimination. This chapter reviews the literature on the definitions of stigma, how it arises, how it works; the barriers of voluntary counselling and testing and disclosure; and the impact of stigma on the employees living with and affected by HIV/AIDS.

2.2 What is HIV/AIDS Stigma?

The Oxford Advanced Learner's dictionary (2002) defines stigma as the feelings of disapproval that people have about particular illnesses or ways of behaving. According to Harvey (2001), stigma is a Greek term denoting a mark that, in ancient times, was burned or cut into the flesh of an unsavoury character – a traitor, criminal, or a slave.

Alonzo and Reynolds (1995), refers to stigma as 'a construction of deviation from some ideal or expectation'. Herek (2002) defines HIV/AIDS stigma as an enduring attribute of an individual infected with HIV that is negatively valued by society and disadvantages people living with HIV/AIDS (PLHA). Stigma is defined as a powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons (Alexandrova et al., 2004). Herek et al. (1998) defines HIV-related stigma as prejudice, discounting, discrediting and discrimination directed at people perceived as having HIV or AIDS, and at individuals, groups, and communities with which they are associated. People who are stigmatized are usually considered deviant or shameful, and as a result are shunned, discredited, rejected or penalized.

Stigmatised groups in the US include women, minorities, such as people of colour, homosexuals, substance abusers, promiscuity and people who are


physically and /or mentally disabled (Corrigan et al.,2003; Harvey, 2001, Lee, Kochman & Sikkema, 2002). AIDS stigma represents a set of shared values, attitudes and beliefs that can be conceptualized at both cultural and individual levels. At the cultural level, AIDS stigma is manifested in laws, policies, popular discourse, and the social conditions of persons with HIV and those at risk for infection. Laws that insist on the compulsory giving of information on HIV/AIDS cases, and the person's right to anonymity and confidentiality, as well as the right to movement of those infected, have been justified on the grounds that the disease presents a public health risk. In response to these laws, (for instance) the Constitution of South Africa and Bill of Rights espouse human dignity and right to privacy which also applies to the people living with HIV/AIDS and protects them from discrimination. These legislations seek to rectify those laws that were promoting stigmatization by ensuring that people living with HIV/AIDS have a right to employment, education, privacy and confidentiality, as well as the right to access information, treatment and support (UNAIDS, 2004).

At the individual level, it takes the form of behaviours, thoughts, and feelings that express prejudices against persons infected with HIV. UNAIDS (2001) argues that HIV/AIDS- related stigma affects self- esteem, mental health, access to care, and providers' willingness to treat people with HIV, violence, and HIV incidence.

Alexandrova et al (2004), argues that studies of stigma related to HIV/AIDS, as well as other illnesses such as epilepsy, have drawn a distinction between 'felt' and 'enacted' stigma. Felt stigma according to them, refers to the shame associated with the illness and the fear of being discriminated against on account of the illness and Insideout Research (2003) refers to felt stigma as internal stigma which leads to unwillingness to seek help and access resources. Enacted stigma on the other hand refers to actual experience of discrimination. This is confirmed by Brown, Macintyre & Trujillo (2003), they argue that enacted stigma refers to the real experience of discrimination. Insideout Research (2003) refers to enacted stigma as external, leading to discrimination on the basis of HIV status or association with someone who is

living with HIV/AIDS. Discrimination constitutes acts or omissions in which the content of stigma is applied, either at an individual or community level. There are four components which have been identified as being part of stigma concept, which are: distinguishing and labelling differences, associating human differences with negative attributes, separating 'us' from 'them', and status loss. Stigma removes power from the stigmatised person, promoting differences and reducing the stigmatised group or person's social status and self worth (Link & Phelan, 2002)

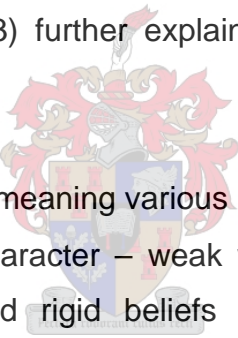
HIV/AIDS is not the only disease that is stigmatized; there are other conditions, such as epilepsy, mental illness, cancer, tuberculosis and syphilis that are also stigmatized both in the past and the present. What distinguishes HIV/AIDS from many illnesses and diseases, however, are the many dimensions of HIV/AIDS related stigma. According to De Bruyn (1999) and HealthInSite Article the factors which contribute to HIV/AIDS related stigma include the following:

- 
- HIV/AIDS is a life – threatening disease
 - People are scared of contracting HIV
 - The disease's association with behaviours (such as sex between men and injecting drug – use) that are already stigmatised in many societies
 - People living with HIV/AIDS are often thought of as being responsible for becoming infected
 - Religious or moral beliefs that lead some people to believe that having HIV/AIDS is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.
 - Insufficient knowledge, misperceptions and fears about how HIV is transmitted and the life potential or capacity of people living with HIV or AIDS.
 - Lack of recognition of stigma

It is the combination of these stigmas, together with their strength, that makes it so difficult to overcome HIV/AIDS related stigma.

Together with the widespread belief that HIV/AIDS is shameful, the above mentioned factors represent ready made but inaccurate explanations that provide a powerful basis for both stigma and discrimination. These stereotypes also enable some people to deny the fact that they are likely to be infected or affected.

As can be seen from above, there exist many definitions for the HIV related stigma but for the purposes of this study, the definition by Goffman (1963) has been seen to be more relevant. He defines stigma as a deeply discrediting attribute that reduces a person to someone who is in some way tainted and can therefore be denigrated. He suggested that people who possess a characteristic defined as socially undesirable (for example HIV/AIDS in this case), acquire a 'spoiled identity' which leads to social devaluation and discrimination. Goffman (1963) further explains that stigma falls into three categories namely:

- 
- Abominations of the body, meaning various physical deformities.
 - Blemishes of individual character – weak will, domineering or unnatural passions, treacherous and rigid beliefs or dishonesty. Blemishes of character are inferred from e.g. mental disorder, imprisonment, suicidal attempts or radical political behaviour.
 - Tribal stigma of race, nation and religion – beliefs that are transmitted through lineages and equally contaminate all members of a family.

Goffman's ideas are a common thread in much of the published research and provide the theoretical underpinnings for much of the literature on stigma and stereotyping (Brimlow et al.: 2003)

2.3 Impact of stigma on employees


Employees with HIV/AIDS often experience stigma and discrimination. Felt stigma or anticipated discrimination has an enormous impact on their lives. Discovering that one is HIV – positive brings with it a multitude of anxieties

and concerns that result from fear and uncertainty about how other people will react. These anxieties and concerns may prevent employees from disclosing their status to family or friends and benefiting from their support or the support from the department , from accessing health – care benefits, health – care services or other services (Alexandrova et al.: 2004)

The potential impact of stigma and discrimination has been of ongoing concern to those involved in addressing the HIV/AIDS epidemic. Jonathan Mann (1987) cited in Parker et al. (2001) spoke of a third epidemic of discrimination that would follow the HIV and then AIDS epidemics. He asserted that this third phase would be central to the global AIDS challenge as the disease itself. Sabatier (1998) predicted discrimination at individual, community and national levels, which would have major implications for the epidemic. Divisions would be created between those who are vulnerable to infection and those who are more distant and that the HIV epidemic has followed in many respects the trajectory of those who are most victimized by discrimination anyway has heightened that divide (Crewe: 1992).

For persons living with HIV/AIDS, stigma is one of the most insidious barriers affecting access to and provision of health services, particularly in Southern Africa and India (AIDS Alert, 2002). According to Aggleton and Parker (2002), the real battle against AIDS in Africa is being played out in the families and villages of Africa, where the authority of government rarely extends. Care for patients living with HIV/AIDS might be substandard because caregivers often fail to comply with universal precautions, maybe because of perceived stigma (Horsman & Sheeran: 1995). Some researchers have reported that health care personnel knew very little about the potential for HIV contamination in the workplace (Hossini et al.: 2000). It is quite surprising to learn that, even in the third decade of the pandemic, family doctors in Kuwait know very little about HIV issues as a result, they look negatively at HIV positive patients (Fido & Kazemi, 2002). The findings of Adebajo, Bamgbala and Oyediran (2003) also echoed Fido & Kazemi (2002) that in Nigeria, the results in Kuwait showed that nurses and laboratory technicians also had negative attitudes towards AIDS patients.

What is stigmatised and how stigma is manifested may be different from various cultures (Weiss & Ramakrishna: 2001). Some authors have observed that stigma may also be different from men and women (Bunting: 1996; Vlassoff et al, 2000). Men are likely to be 'excused' for their behaviour that resulted in their infection, whereas women are not. Men blame women for infecting them and spreading the virus (Leclerc – Madlala. 1997, 2002; Shefer, 1999). In couples, it can lead to violence against the woman or her exclusion from the household (Strebel: 1993). The impact of HIV/AIDS on women is particularly acute. In many developing countries, women are often economically, culturally and socially disadvantaged and lack equal access to treatment, financial support and education. In a number of societies, women are mistakenly perceived as the main transmitters of sexually transmitted diseases (STDs). Traditional beliefs about sex, blood and the transmission of other diseases have played a big role in promoting stigma on women within the context of HIV and AIDS.



Stigma around disease often attaches itself to existing frameworks (Sontag, 1988; van der Vliet, 1996), in South Africa for example, AIDS has been associated mainly with black people and women. The effect of stigma is to marginalize and exclude people with HIV/AIDS. Those who are already marginalized are pushed further from the support of human society (Alexandrova et al.:2004).

As with quality of care issues, few empirical studies explored stigma's relationship to quality of life, and most information about stigma's negative impact on quality of life as perceived by persons with HIV/AIDS is in the form of testimonials: 'It's so hard', said a tearful Rita. 'The moment people learn I'm HIV – positive, they treat me differently. Neighbours shun me. Children avoid touching me. The landlord finds an excuse to kick me out of my room' (IRIN, 2002).

Ayarza and Reyes (2002) described the traumatic effect that stigmatization and lack of pretest counselling had on the quality of persons with HIV/AIDS in Ecuador. Studies by Castle et al. (2002) and Ortega, Gonzales and Liwanag

(2002) found that such persons had both positive and negative experiences when they became involved in community – based programmes. According to these researchers, access to services that offer peer support ends self – isolation and reduces stigma, and thus promotes quality of life.

2.4 Voluntary Counselling and Testing (VCT)

UNAIDS (2003) states that the issue of VCT emerged in the context of great fear about HIV/AIDS and about how to prevent HIV infected individuals from transmitting the virus. As testing methods were developed, HIV testing assumed an important role in epidemiological surveillance and as treatment became available on individual testing for clinical purposes. As responses to HIV/AIDS unfolded, some countries argued that the protection of public health warranted compulsory testing requirements of certain populations perceived to be at high risk, mandatory testing for access to certain goods and services, named reporting of those found to be infected and sometimes contact tracing and mandatory notification of partners, family, employers or community members (UNAIDS: 2003).

The realities of stigma, discrimination and the neglect of human rights protections were recognized to keep people away from prevention and care, and creating fertile ground for people not to get tested and unaware of their HIV status, to further the spread of HIV. The recognition led to a bridge between those concerned with human rights protections and those concerned with public health imperatives (UNAIDS: 2003).

As time went by, the components of supportive testing became clearer, the concept of voluntary counselling and testing was promulgated and a policy driven by GPA/WHO was formulated, enabling VCT an important focus of all national responses to the HIV/AIDS epidemics (UNAIDS: 2003). VCT for HIV is now acknowledged within the international arena as an efficacious and pivotal strategy for both HIV/AIDS prevention and care. Research conducted in Kenya, Tanzania and Trinidad by Family Health International in collaboration with UNAIDS, WHO and the Center for AIDS Prevention Studies at the University of California at San Francisco has provided strong evidence

to support the tenet that VCT is both effective and cost – effective as a strategy for facilitating behaviour change (www.fhi.org/en/hivaids/pub/fact/vctforhiv.htm) VCT is considered as an entry point to knowing one's HIV status.

HIV testing in the workplace is typically done for one of three reasons; for surveillance purposes to establish the HIV prevalence in the workforce; as part of a voluntary counselling and testing service that is available to employees; or for diagnostic purposes within an occupational health service. In the Hoffmann v South African Airways case, however, HIV testing was part of SAA's pre- employment screening

The rationale for VCT includes the following points:

- It is a vital point of entry to other HIV/AIDS services including prevention of mother – to – child transmission; prevention and clinical management of HIV related illnesses, tuberculosis control, and psychosocial and legal support.
- There is demand or demand can be created when comprehensive services are made available.
- VCT provides benefits for those who test positive as well as those who test negative.
- VCT offers a holistic approach that can address HIV in the broader context of peoples' lives, including the context of poverty and its relationship to risk practice.

2.5 Barriers of testing and disclosure

Most reports on challenges of VCT are gender related in that, women become scared to inform the male partners because of fear of violent reaction due to a positive result. This behaviour becomes a barrier to both VCT and subsequent disclosure of results to male partners. USAID has sponsored research examining the implications of partner violence and HIV on VCT programmes. Most women who disclosed said that their partners showed support and

understanding. A woman's HIV status was found to be strongly associated with partner violence, which raises important questions about violence in the lives of HIV positive women (USAID: 2003).

It is important to examine the relationship between denial, stigma, absence of treatment options or a cure and financial issues in understanding people's failure to go for VCT. Stigma is one of the variables people take into consideration when they have to deal with issues related to HIV/AIDS. Fear of negative consequences of testing also had an effect in finding out why American college students did not go timeously to Sexually Transmitted Infection (STI) Clinics for VCT and treatment of STIs in general (Barth et al., 2002).

Disclosure is a complex problem. According to HRSC research (2005), non – disclosure of HIV – positive status has been ascribed to stigma (e.g. Kilewo et al., 2001 in Tanzania; Black & Miles, 2002 in the US; Chandra et al., 2003 in India and encouraging HIV – positive people to come out, has been seen as a means of challenging stigma (Paxton, 2002). South African research on testing and disclosure suggests that people only test or disclose if they perceive stigma to be at acceptable levels (Etiebet, Fransman, Forsyth, Coetzee & Hussey, 2004; Kalichman & Simbayi, 2003). Some think that going through the process of VCT and disclosure reduces the people's perceptions of stigma. Levels of disclosure are very low because of fear of stigma and discrimination. According to Pawinski & Laloo (2001), a survey of 726 HIV – positive patients at two sites in KwaZulu – Natal found that 65 per cent and 92 per cent respectively, had not disclosed their statuses to anyone. These percentages show very high levels of non – disclosure as compared to 5 per cent of non – disclosure of their statuses in a UK study (Pettrak, Doyle, Smith, Skinner & Hedge, 2001 – this was a volunteer sample). What has been established in South Africa is that, ever since the roll – out of ARV, disclosure is a condition of receiving treatment than to disclose generally.

Testing and disclosure are key elements of prevention and treatment for HIV/AIDS in terms of healthcare and prevention, but can have serious

consequences for individuals in a highly stigmatising environment. Jennings et al., (2002) & Skinner (2002) argue that negative consequences of disclosure are common in South Africa. The victims of these consequences are women, who test through antenatal services. They are always blamed for infecting the partner and because the mother is highlighted as the recipient of treatment in Prevention of Mother to Child Transmission (PMTCT) programmes, mothers are always blamed of infecting children (Policy project et al, 2003a). Disclosure is done indirectly when the mother is using infant formula milk for children, suggesting the use of condom, going to an AIDS or TB clinic, or taking certain pills. These activities are stigmatised by association, and thus avoided, in spite of their potentially positive impact on health so as to avoid unintentional disclosure (Skinner, 2002).

2.6 Summary

This chapter has reviewed the literature on the definitions of stigma, how it arises and how it works. Many definitions for the HIV related stigma exist, but the definition by Goffman (1963) has been seen to be more relevant. He defines stigma as a deeply discrediting attribute that reduces a person to someone who is some way tainted and can therefore be denigrated (Goffman, 1963).



The literature on the impact of stigma on the employees living with and affected by HIV/AIDS has been reviewed. Research has found that people with HIV or AIDS feel isolated, guilty, dirty and full of shame, which is incorporated into identity (Kalichman, 2004).

According to HRSC research (2005), non – disclosure of HIV – positive status has been attributed to stigma, lack of confidentiality and the human rights that are not respected. The next chapter deals with the research methodology done in DSD.

Chapter 3: Research Methodology

3.1 Introduction

In order for a research study to be successful, it needs to establish a methodological approach and develop a research design. This chapter considers the research methodology of the research: the research design; what type of approach was adopted, what sampling method was used and what that sample size taken, data collection of types; who was involved and how it was collected, and finally how the data was analyzed and assessed.

Mouton and Marias (1990) stress that any methodological approach needs to be seen in light of the fact that specific choices will result depending on methods of data collection, data analysis and inference depending on the methodology that is chosen. In this particular study, the research design and methodology is geared towards both quantitative and qualitative analysis (Pillay, 2003). Chapter 3 can thus be outlined as shown in figure 3.1 below.

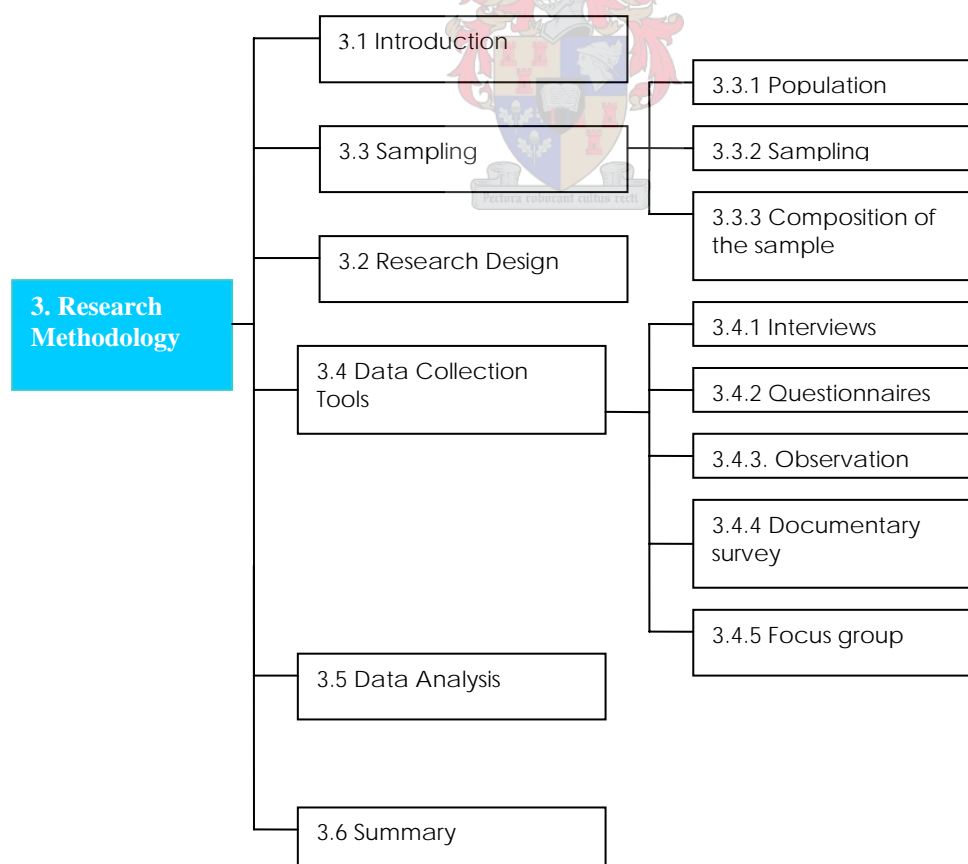


Figure 3.1: Outline of Chapter 3 - Methodology

3.2 Research Design

Christensen (2004) defines research design as the outline, plan, or strategy specifying the procedure to be used in seeking an answer to the research question. It specifies such things as how to collect and analyse the data.

The aim of the study is to research the attitude and behaviour of DSD employees towards HIV related stigma, therefore, the survey method has been used. “Surveys can be used to explore, describe, or explain respondents’ knowledge about a particular subject, their past or current behaviour, or their attitudes and beliefs concerning a particular subject” (Guy et al, 1987: 220). Surveys have the advantage of being able to identify both factual and attitudinal data. Kerlinger (1992), as cited in Du Toit and De Villiers (undated), states that surveys are appropriate for gathering data regarding opinions and attitudes on the one hand, and behaviour on the other.

In other cases, the use of ‘key’ subjects, which involves the deliberate targeting of individuals for survey, is justified on the grounds of their unique knowledge and leadership position, which they play. In this study, the focus will be on the interview of key subjects in DSD with adequate knowledge in HIV/AIDS related stigma, backed by a questionnaire surveys, group and individual interviews.

The study was of both qualitative and quantitative approach. This approach was used because qualitative methods allow the researcher to obtain an in-depth knowledge about the study whereas quantitative methods make use of a standardized approach to obtain responses from a larger number of individuals. Myers (1997) mentions that qualitative methods are particularly useful where the subject is not well-understood, complex, sensitive, and requires details. From the research purpose stated above the qualitative approach was appropriate because it enabled the researcher gain in-depth analysis about the attitudes and perceptions employees of DSD towards HIV/AIDS positive people.

3.3 Sampling

3.3.1 Population

Population in research methodology is the total group of subjects that would need to be assessed if the views of everyone in a particular situation were to be measured (Grein et al, 2004). In this study, however, researching the views of the total population of DSD staff is not possible due to constraint of time, manpower and financial resources.

This study considers the attitudes and perceptions of employees of DSD on HIV positive and AIDS stigma. Therefore, the population group in this study would be the entire employees in the Head Office of DSD, including Senior Managers, Middle Managers, Junior Staff and General Workers and totalling 502.

3.3.2 Sampling Methods

There are two types of sampling techniques, namely probability and non-probability sampling. In the probability sampling, each subject of the total population has the equal chance of being selected for the sample. In the non-probability sampling however, each subject of the population does not have an equal chance of being selected as sample subjects (Grein et al, 2004). Probability sample design are used where representatives of the sample is of importance for purpose of wider generalization (Sekaran, 1992). The non-probability sampling is used when generalization is not the primary purpose (Kerlinger, 1992).

In this study a non-probability techniques called convenience sampling was used. This method involved collecting information from people who were conveniently available at the time of the survey. The main reason for choosing the convenience sampling method was that there was no intention to generalize the results to the entire population, but to gain more insight into the subject of inquiry. Also, it appeared to be the fastest approach considering the short period of time available for the research.

In this study, the sample consisted of 250 employees of DSD of sample size from various Directorates (Administration, Social Security, Social Welfare Services, Development and Support Services and Population and Development Trends).

3.3.3 Sampling Size

250 employees out of the 502 were interviewed. This represents, approximately, 50%, sample size.

3.4 Data Collection Methods

The study aimed to obtain different viewpoints of employees on attitudes and perceptions on HIV and AIDS stigma in DSD. For this reason, various methods of data collection were used, allowing a process of 'triangulation'. This included questionnaires, documentary analysis, interviews, direct observation, participation observation, and where appropriate, other techniques were used as when deemed necessary. Thus, as Yin (1994: 78) stipulates: "multiple sources of evidence that entails a variety of data collection techniques, which are highly complementary in nature, will result in a good research study". Moreover, it promotes the development of converging lines of inquiry. Findings are more convincing and accurate when based on several different sources of information.

The need for triangulation, according to Stake (1995), arises from the ethical need to confirm the validity of the processes. Triangulation is the combination of qualitative and quantitative methods in the study of the same phenomenon. Jick (1979) as cited in Amaranunga and Baldry (2001), suggests that the fundamental notion of triangulation technique is that qualitative and quantitative methods should be viewed as complementary rather than as rival camps. Its effectiveness lies on the premise that the weaknesses in each single method will be compensated by the counter-balancing strengths of another.

The various data collection methods are explained below:

3.4.1 Documentary Analysis

Documentation is one appropriate data collection technique because of its strengths, which include broad coverage of events and many settings. This approach is also referred to as obtaining information through ‘unobstructive research’. A number of HIV/AIDS policy documents, relevant legislation, plans and programmes that are in place were reviewed. This includes the archival records, secondary source material, data-tables and newspapers. Documentary evidence on HIV/AIDS also played a role and it was confined to extracting information from reports, minutes and newspaper articles.

The primary source of documentary data was the East London Health Resource Centre library, commissioned reports, etc. Secondary source material (including material for the literature review) was obtained from various books, reports, policy documents, plans and programmes on HIV and AIDS.



3.4.2 Survey Techniques

One of the fundamental methods of data collection in social sciences is that of the survey. “Surveys can be used to explore, describe, or explain respondents’ knowledge about a particular subject, their past or current behaviour, or their attitudes and beliefs concerning a particular subject” (Guy et al, 1987: 220). Surveys have the advantage of being able to identify both factual and attitudinal data. Key issues include questionnaire design and administration and the various types of interviews, which were utilised. Administration often requires the selection of appropriate sampling procedures, and in this case convenience sampling procedure was used to gain group representative cross – section of the study population of DSD.

In other cases, the use of ‘key’ subjects, which involved the deliberate targeting of individuals for the survey, was justified on the grounds of their unique knowledge and leadership position, which they play. In this study, the focus was on the interview of key subjects in the DSD with adequate

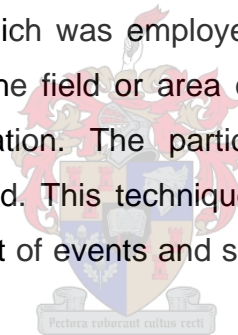
knowledge in HIV/AIDS, backed up by questionnaire surveys, group and individual interviews.

3.4.3 Interview Methods

Closed – ended, structured and focused interviews and surveys formed the thrust in information gathering for this research. The study was both interactive and research based and hence the formulation of interviews and relevant questionnaires. Interviews involved direct contact between, myself as the researcher, and the researched. Questions were presented orally and responses were recorded as given. The interview method allowed the researcher to clarify issues and correct misunderstandings, which arose during the interview period.

3.4.4 Field Research

Another broad technique, which was employed, is the field research, which involved active research in the field or area of enquiry. Specific techniques included participant observation. The participant–observation as a data collection technique was used. This technique presented an opportunity for me as a researcher to be part of events and situations at hand, since I was a member of DSD.



3.4.5 Focus groups Discussion

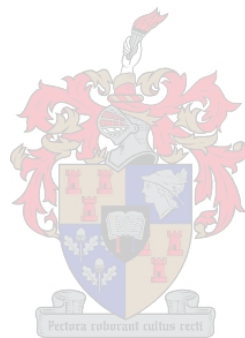
Finally, focus groups discussion was used to gather information on the attitudes and perception of some of the employees in the District Offices. This approach, like informal interviews, provided an excellent way of getting rich response information in the areas, apart from the Head Office.

3.5 Data Analysis

The results of the survey were captured manually, using tallying method to determine the frequency of responses from the questionnaires. All the information collected from the questionnaires was analysed and the results were presented in various media, such as tables, charts, etc.

3.6 Summary

As indicated above, various data collection instruments including interviews, documentation, focus group discussions, questionnaires and observation have been used and have allowed triangulation. The next chapter deals with the analysis of the data collected in DSD.




Chapter 4: Analysis and Findings

4.1 Introduction

This chapter makes a quantitative analysis and interpretation of the data collected from the field. The chapter begins with a brief overview of the Department of Social Development. Answers to critical questions from respondents, comprising Senior Managers, Middle Managers, Junior Staff and General Workers are covered in this chapter.

4.2 Brief Overview of the Department of Social Development

The Eastern Cape Department of Social Development (DSD) with a staff compliment of 2017 has been chosen as the case study for this assignment. It is stated that the establishment of DSD as an independent service delivery mechanism represented a bold act of recognition of the integrity as well as the central role of the welfare sector within the context of the historically given peculiarities of the Province.



The vision of DSD “is a proactive and dynamic department striving towards self-reliant individuals and communities within a secure socio-economic environment” (Department of Social Development, Strategic Plan, 2004 – 2007). One of the mission statements of the department is to provide comprehensive, equitable, accessible and caring social services. Amongst the core objectives of the department is the development and implementation of a comprehensive community development strategy focusing on healthy livelihoods, social inclusion, improved nutritional and social status of individuals infected and affected by HIV/AIDS (Department of Social Development, Strategic Plan, 2004 – 2007).

In DSD, programmes, such as, awareness, education and training, and condom promotion and distribution, have been implemented for some time with the aim of preventing or reducing new HIV infections, providing care and support for employees and their families who are infected or affected and managing the impact of the epidemic in the organisation. The information

below represents the results of the survey conducted to determine the attitudes and perceptions of employees towards HIV and AIDS stigma.

4.3 Demographic Profile

4.3.1 Total Population

As indicated above, the total population of DSD is 2017, of which 502 are in the Head Office. The rest are distributed among the various District Offices within the Province.

4.3.2 Gender

The study established that 78.95% of the sampled population are females while 21.05% are males. The ratio of male : female in DSD is approximately 1:4. This is represented in the Figure 4.1 below.

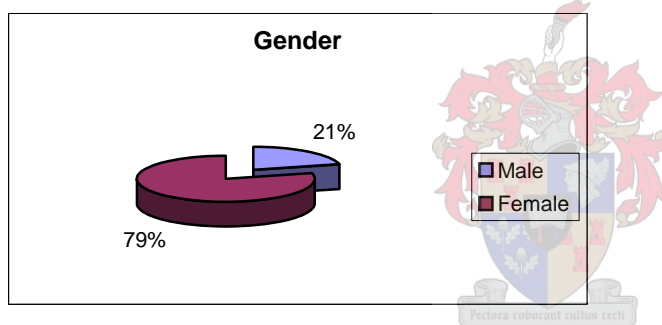


Fig 4.1: Gender

4.3.3 Age Group

It is revealed from the study that 65.79% of the employees are between the ages of 25 – 44 years, 31.58% are between 45 – 60 years and only 2.63% are below 25 years. This is shown in Figure 4.2

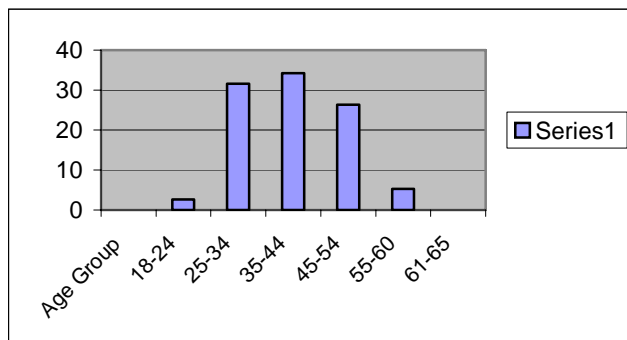
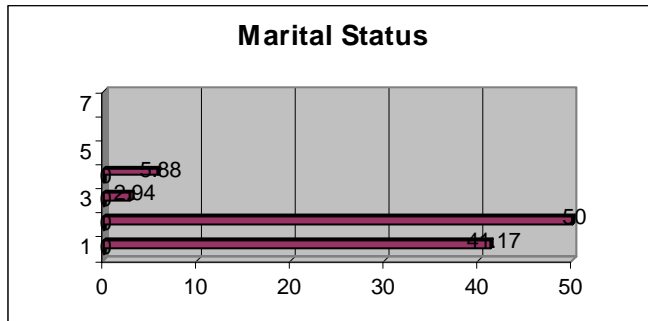


Figure 4.2: Age Group

4.3.4 Marital Status

Married employees dominate. They account for 50% of the employees in DSD. Single amounts to 41.17% while the rest are either divorced or widowed.

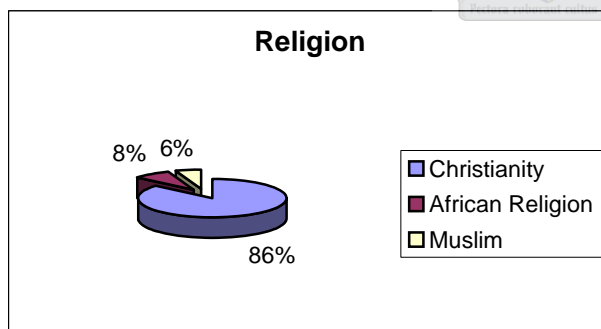


4.3.5 Race

About 94.88% of the employees are blacks, while 5.12% are other races.

4.3.6 Religion

The employees are mostly Christians, amounting to 86.12%. Others are African Religion and Moslems.



4.3.7 Educational Level

It has been established that 46.15% of the employees are diploma / degree holder. 17.95% are post-graduates, 25.65% are post matric while 5.13% have had no formal education.

4.3.8 Occupational Level

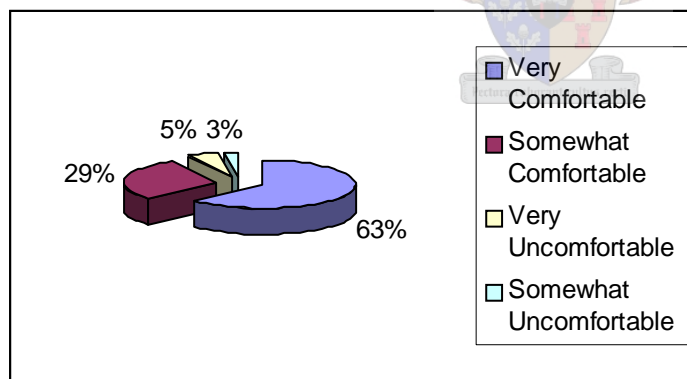
The composition of the occupational level of DSD indicates that 8.33% are in the Senior Management level, 19.44% are in the Middle Management, 66.67% are Junior Staff while 5.56% are General Workers.

4.4 Understanding of HIV and AIDS Stigma

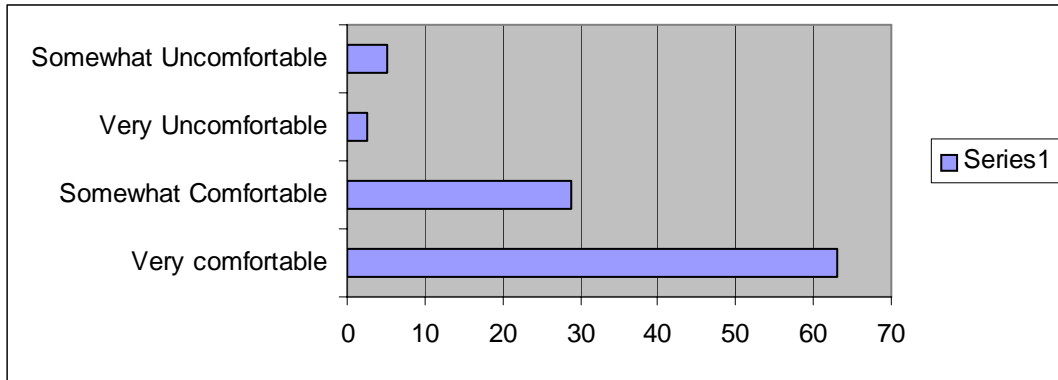
Four different manifestations of stigma were assessed: understanding the meaning of HIV and AIDS stigma, impact of HIV and AIDS stigma on employees, investigating the barriers of voluntary counselling and testing and determining the barriers to treatment and care. The questionnaire is attached as Appendix 1.

4.4.1 Understanding the meaning of stigma

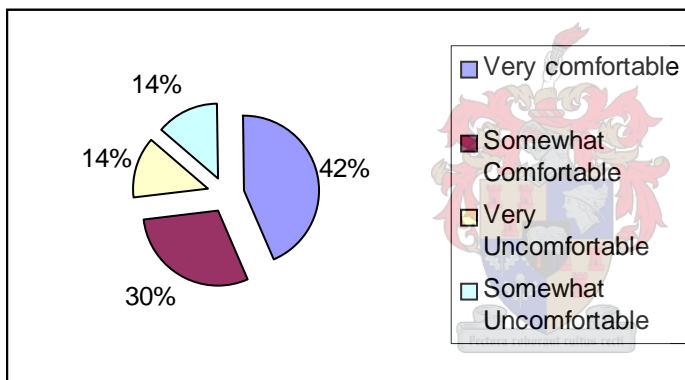
Respondents were asked to rate the extent to which they felt comfortable working with an HIV - positive employee. The study revealed that 63.16% felt very comfortable, 28.95% felt somewhat comfortable, 5.26% felt very uncomfortable and 2.63% felt somewhat uncomfortable.



Respondents were asked to rate the extent to which they felt comfortable working in an office where one of the employees working with them has been diagnosed HIV – positive or has AIDS. The study revealed that: 63.16% felt very comfortable, 28.95% felt somewhat comfortable, 2.63% felt very uncomfortable and 5.26% felt somewhat uncomfortable.



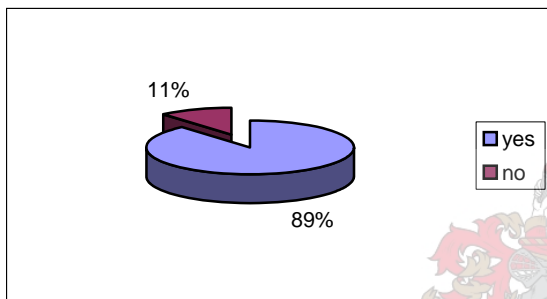
Respondents were asked to rate the extent to which they felt comfortable buying lunch from an HIV – positive owner of a cafeteria. The study revealed that: 43.25% felt very comfortable, 29.73% felt somewhat comfortable, 13.51% felt very uncomfortable and 13.51% felt somewhat uncomfortable.



Respondents were asked to predict own behaviour in each of eight different situations involving working and potential contact with a person living with HIV or AIDS. The situation was having an office job where one of the employees working with the respondent is HIV – positive or has AIDS, the respondent was asked to indicate whether:

- he/she would still be willing to work with the infected employee. The study revealed that 88.89% of the respondents were supportive and 11.11% were avoidant.

- he/she would ask to be assigned to work with someone else. The study revealed that 25.64% of the respondents were avoidant and 74.36% were supportive.
- he/she would ask that the employee be assigned to work in another office. The study revealed that 23.08% of respondents were avoidant and 76.92% were supportive.
- he/she would go out of his/her way to help the infected employee if he/she needed help. The study revealed that 88.57% of respondents were supportive and 11.42% were avoidant.

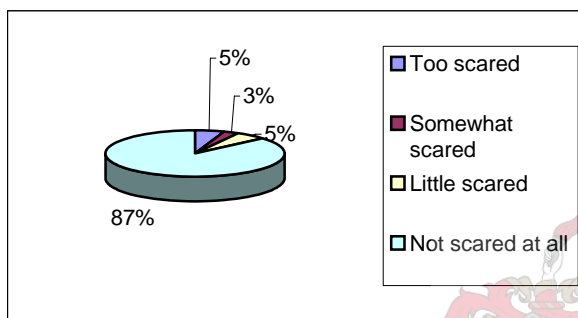


- he/she would try to avoid contact with him/her. The study revealed that 13.51% of the respondents were avoidant and 86.49% were supportive.
- he/she would treat the infected employee the same way as before. The study revealed that 90.24% of respondents were supportive and 9.76% were avoidant.
- the colleague whom the respondent always have lunch with is infected, would the respondent continue to have lunch with him/her. The study revealed that 86.11% of respondents were supportive and 13.89% were avoidant.
- would the respondent prefer to have lunch with someone else. The study revealed that 35% of respondents were avoidant and 65% were supportive.

4.4.2 Impact of HIV and AIDS Stigma on employees

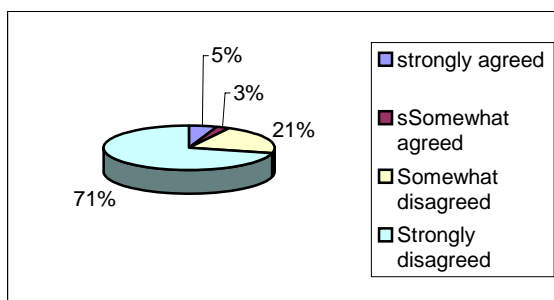
Respondents were asked to rate the extent to which they felt angry at employees who are living with HIV or AIDS. The study revealed that 10.53% felt very angry, 23.68% felt somewhat angry, 10.53% felt a little angry and 55.26% felt not at all angry.

Respondents were asked to rate the extent to which they felt scared of employees living with HIV or AIDS. The study revealed that 5.41% felt too scared, 18.91% felt somewhat scared, 5.41% felt a little scared and 70.27% felt not at all scared.

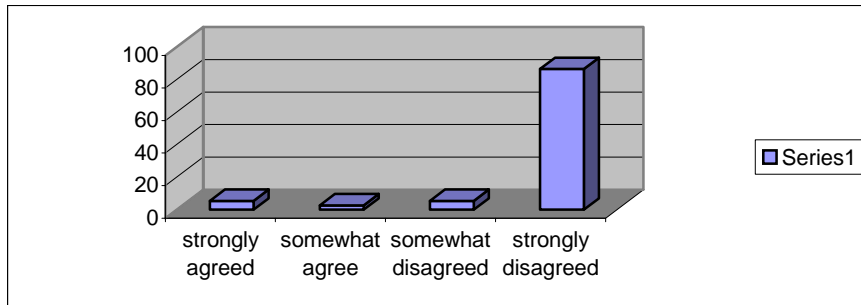


Respondents were asked to rate the extent to which they felt disgusted by people living with HIV or AIDS. The study revealed that 10.26% felt too disgusted, 12.82% felt somewhat disgusted, 7.69% felt a little disgusted and 69.23% felt not at all disgusted.

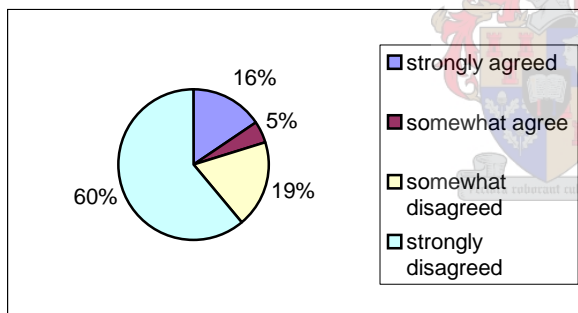
Respondents were asked how much they agreed or disagreed that people who are HIV – positive or have AIDS should be legally separated from others to protect other employees. The study revealed that 5.26% strongly agreed, 2.64% agreed somewhat, 21.05% disagreed somewhat and 71.05% disagreed strongly.



Respondents were asked how much they agreed or disagreed that the names of HIV – positive employees or those who have AIDS should be made public so that others can avoid them. The study revealed that 5.41% strongly agreed, 2.70% agreed somewhat, 5.41% disagreed somewhat and 86.48% disagreed strongly.

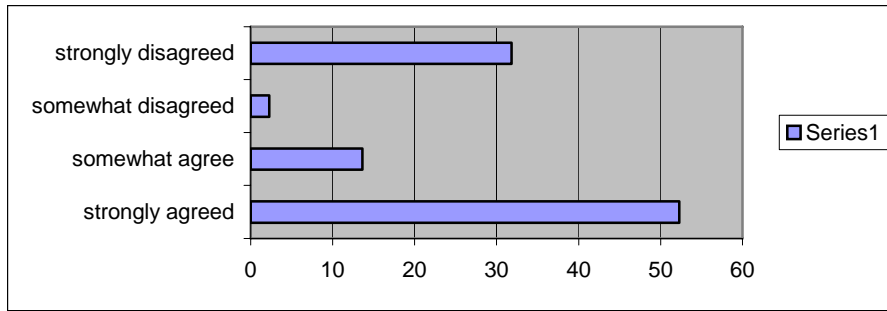


Respondents were asked how much they agreed or disagreed that employees who got HIV or AIDS through sex or drug use have gotten what they deserve. The study revealed that 8.11% strongly agreed, 5.41% agreed somewhat, 21.62% disagreed somewhat and 71.05% disagreed strongly.

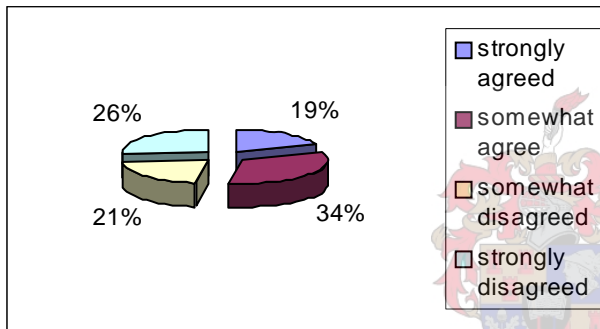


4.4.3 The barriers to voluntary counselling and testing

Respondents were asked how much they agreed or disagreed that the status of an employee who has voluntarily disclosed his/her status, this information should not be divulged without the employee's consent. The study revealed that 52.27% strongly agreed, 13.64% somewhat agreed, 2.27% somewhat disagreed and 31.82% strongly disagreed.



Respondents were asked how much they agreed or disagreed that if the written consent is not possible, it should be assumed that the employee wishes his/her status to be known. The study revealed that 19.05% strongly agreed, 33.33% agreed somewhat, 21.43% disagreed somewhat and 26.19% disagreed strongly.



Respondents were asked to rate the reasons resulting to the failure of people going for VCT. The reasons given were denial, which was rated 24.39%; stigma, which was rated 12.20%; absence of treatment options or cures, which was rated 7.32%; financial issues, which was rated 4.88%; ignorance, which was rated 26.82% and all of the above reasons were rated 24.39%.

4.5 Determining the barriers to treatment and care

Respondents were asked to rank the most appropriate reasons they consider to be barriers to treatment and care. The study revealed that stigma was ranked 4.76%, expected stigma and discrimination was ranked 19.05%, cost or poverty was ranked 19.05%, denial was ranked 7.14%, ignorance was ranked 7.14%, physical availability and accessibility of health care was ranked 11.91% and all of the above barriers were ranked 30.95%.

Respondents were asked to mark the most appropriate reason they consider to be barriers to treatment and care in relation to facilities or services. The study revealed that inaccessibility to HIV Clinics or Hospitals was marked 11.90%; lack of antiretroviral roll out in South Africa was marked 23.81%; attitudes of health care professionals towards people living with HIV or AIDS was marked 11.90%; inefficiency of health care professionals was marked 0% and all of the above barriers were marked 52.39%.

4.6 Summary of the Findings

It was found that the DSD staff understood meaning of stigma and they did not have a problem working with employees living with HIV or AIDS. The majority of the employees did not feel angry, scared or disgusted by employees living with HIV or AIDS. About 25% of employees thought that those employees who got HIV or AIDS through sex or drug use have gotten what they deserve whilst the rest did not agree with that statement.

The barriers to voluntary counselling and testing were found to be denial, stigma, ignorance, absence of treatment options or cure, financial issues. It was also found that people were not adhering to the Bill of rights which states that people have the right to privacy; therefore one cannot divulge information or the status of an HIV – positive employee without his/ her consent. The barriers to treatment and care were found to be stigma, expected stigma and discrimination, cost (poverty, denial, ignorance and physical availability and accessibility of health care. The next chapter deals with the discussion of the findings.

Chapter 5: Discussion of the Findings

5.1 Introduction

This chapter discusses the findings of the research in the context of the research objectives. The purpose of this section is to compare and contrast the research findings with available comparative literature. Discussions of the results include the interpretation of the findings subject to validity and reliability. The chapter concludes with a summary of the research findings.

5.2 Understanding of HIV and AIDS Stigma

It was found that 92.11% of workers surveyed reported that they felt comfortable working with an HIV – positive employee whilst 7.89% felt uncomfortable. The findings also revealed that 88.89% were willing to work with an infected employee whilst 11.11% were avoidant. The study conducted revealed that DSD staff understood the meaning of HIV and AIDS stigma and the majority of the employees did not have a problem with it. On the other hand, the literature in this regard states that stigma refers to all unfavourable attitudes, beliefs, and policies directed toward people perceived to have HIV/AIDS as well as toward their significant others and loved ones, close associates, social groups and communities (Goffman, 1963). It is also stated that people infected with HIV are often blamed for their condition and many people believe HIV could be avoided if individuals made better moral decisions. Although HIV is treatable, it is a progressive, incurable disease (Herek, 1999; Stoddard, 1994).

HIV/AIDS stigma is expressed around the world in different ways, which include ostracism, rejection, avoidance of people with HIV/AIDS, discrimination against people living with HIV/AIDS and violence against persons who are perceived to have AIDS or to be infected with HIV (www.AIDSstigma.net)

5.3 Impact of HIV and AIDS Stigma on employees

In the current study, the epidemic was found to have negative effect on the impact of HIV and AIDS stigma on employees as it was revealed that 34.21%

of employees felt somewhat or very angry at employees who are living with HIV or AIDS whilst 65.79% felt a little and not angry at all. The findings are in line with the previous studies that the effect of stigma is to marginalize and exclude people with HIV/AIDS. Those who were already marginalized and excluded are pushed even further from the support of human society (Alexandrova et al., 2004). This is also in line with the literature that states that stigma impacts on people living with HIV and AIDS themselves, as it is internalised into their self – perception and sense of identity, impacting on the person's perceptions and how they interact in the world (Skinner & Mfecane, 2004).

Research has found that people with HIV feel isolated, guilty, dirty and full of shame, which is then incorporated into identity (Kalichman, 2004). General participation in the activities of life is therefore restricted by stigmatisation (Sowell, Seals, Moneyham, Demi, Cohen & Brake, 1997).

About 25% of the employees strongly/ somewhat agreed that employees who got HIV or AIDS through sex or drug use have gotten what they deserve whilst 75% somewhat/ strongly disagreed. The findings are in line with Herek (1991), whereby 20.5% of respondents agreed that people with AIDS have gotten what they deserve. Herek (1997) states that 28% interviewed agreed with that statement, an increase of roughly 40% between 1001 and 1007. It is also stated that more of the 1997 respondents assigned some degree of responsibility when the question was framed less harshly.

According to Herek & Capitanio (1999), 55.1% agreed that most people with AIDS are responsible for having their illness. Weiner (1993) states that people who contract AIDS through behaviour that is perceived as controllable (e.g. sex, sharing needles) are assigned more blame, receive less sympathy and more anger, and are less likely to receive assistance than other PWAs who were infected through circumstances such as receiving blood transfusion.

Schellenberg, Keil & Bem (1995) state that it was evident in findings from their 1992 survey that 98% felt sympathy for a blood transfusion recipient and less than 1% felt no sympathy at all.

It was also established from the focus group discussion that the impact of HIV and AIDS stigma affected their work morale, absenteeism, and reduced productivity. This is in line with Siyam'kela study project USAID & Department of Health (2003a), which revealed that the effects of stigma in the workplace affect the worker morale, it can result in reduced productivity, and it can even result in the loss of manpower, if infected employees leave.

5.4 Barriers to voluntary counselling and testing.

The study has found that 65.91% of DSD employees strongly or somewhat agreed that an employee who voluntarily discloses his/ her HIV status should be kept confidential and not be divulged without his/ her consent. Only 34.09% strongly or somewhat disagreed with that. One should, however, note that in South Africa, it is illegal to disclose the HIV status of an employee, without his/ her consent. South Africa is a signatory to a number of international agreements, declarations and codes such as the International Labour Organization (ILO) Convention 111 on Discrimination (Employment and Occupation), 1958, the ILO Code of Practice on HIV/AIDS and the World of Work (2001) and the UNGASS Declaration of Commitment on HIV/AIDS (2001). At Regional level, the endorsement which relates specifically to HIV/AIDS in the workplace is the Southern African Development Community (SADC) Code on AIDS and Employment, which was approved by the Council of Ministers in September, 1997.

At National level, South African Constitution (Act 108 of 1996) is the supreme law of the country and all other laws must comply with it. The Bill of Rights within the Constitution sets out a number of provisions which protect the rights of employees, which include the right to equality and non – discrimination (section 9), privacy (section 14); fair labour practices (section 23 and access to information (section 32).

In this section, the findings are in line to the right to privacy, which means that every person is entitled to keep certain facts about themselves private. Furthermore, the employer, doctors, nurses, psychologists, dentists and other professional health care workers are both ethically and legally bound to keep all patient information confidential. In other words, any information regarding an employee's or a patient's medical treatment or illness may be disclosed with the patient's consent.

On the issue of the failure of people going for VCT, 24.39% reported the reasons as having a denial, 12.20% as stigma, 26.82% as ignorance, 7.32% as absence of treatment options or cures, 4.88% as financial issues, and 24.39% all of the above.

It is important to examine the relationship between denial, stigma, absence of treatment options or a cure and financial issues in understanding people's failure to go for VCT. Stigmatisation of others, allows people to deny their own risk by projecting risk onto outgroups. Denial encapsulates the idea that others are more likely to experience negative events than oneself (Joffe, 1999). Deacon et al, (2005) argues that, when an employee realises that they may be HIV - positive, acceptance of stigmatising ideas about illness, may prevent them from testing or going for treatment. However, denial can also operate outside of the ambit of stigmatisation of disease. They further state that even if people challenge the social stigma associated with HIV/AIDS, they may not wish to spoil the experience of feeling well by finding out they are HIV – positive, especially in the absence of a cure.

5.5 Barriers to treatment and care.

The study has established that the most appropriate reasons considered to be barriers to treatment and care are: stigma, expected stigma and discrimination, cost (poverty), denial, ignorance and physical availability and accessibility of health care. In terms of barriers to treatment and care in relation to facilities or services, 11.90% of response is related to inaccessibility to HIV Clinics or Hospitals, 23.81% was the lack of antiretroviral roll out in South Africa, 11.90% was attitudes of health care professionals

towards people living HIV or AIDS, inefficiency of health care professionals was not considered as an important factor in barriers to treatment and care as respondents gave a 0%. 52.39% of employees said all of the above reasons were applicable.

The findings support the previous studies by Antai – Oton, 2002; Bunting & Seaton, 1999; Coughlan, 2003; Heckman, Somlai, Peters, Walker, Thior, Gilbert, Makhema, Kebaabetswe, Dickenson, Mompati, Essex & Marlink, 2003 that barriers to treatment and care for a range of medical conditions include stigma, expected stigmatisation and discrimination, cost (poverty), denial, ignorance, cultural appropriateness of care, gender discrimination and physical availability and accessibility of healthcare. This research resorts to drawing up a list of different barriers to care, rather than calculating their relative weightings (Deacon et al., 2005).

5.6 Summary of Findings

The study has revealed that DSD staff understood the meaning of HIV and AIDS stigma and that the majority of the employees did not have a problem with it as against the literature that states that HIV and AIDS stigma has a negative impact on people living with HIV and AIDS. This therefore means that the mindsets of people in DSD are gradually changing, probably because of understanding of the epidemic.

HIV/AIDS stigma is expressed around the world in different ways, which include ostracism, rejection, avoidance of people with HIV/AIDS, discrimination against people living with HIV/AIDS and violence against persons who are perceived to have AIDS or to be infected with HIV

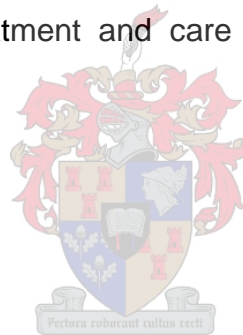
It has been established from the literature that people with HIV feel isolated, guilty, dirty and full of shame, which is then incorporated into identity. Additionally, general participation in the activities of life is restricted by stigmatisation but this current research at DSD revealed different results as about 66% of the respondents do not discriminate against employees living with HIV or AIDS.

From the focus group discussion, it was revealed that the impact of HIV and AIDS stigma affected their work morale, absenteeism, and reduced productivity. This has been supported by the USAID & Department of Health's Siyam'kela study project in 2003.

The study supports the fact that an employee who voluntarily discloses his/her HIV status should be kept confidential and not be divulged without his/her consent as enshrined in the Bill of Rights of South African Constitution.

On the issue of the failure of people going for VCT, the reasons given were denial, stigma, ignorance, absence of treatment options or cures, as well as financial issues.

Stigma, expected stigma and discrimination, cost (poverty), denial, ignorance and physical availability and accessibility of health care have been identified as the main barriers to treatment and care and this is supported by the relevant literature study.



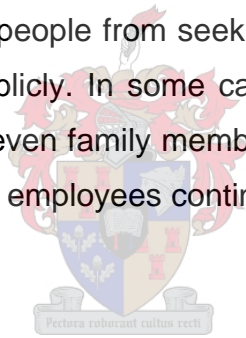
Chapter 6: Conclusion and Recommendations

6.1 Introduction

The concluding chapter reflects back to the objectives of the study. As noted in chapter one, the objective of the study was to determine the impact of HIV and AIDS stigma in DSD. The chapter therefore concludes the study and offers recommendations that will assist DSD to effectively and efficiently handle the negative impacts of HIV and AIDS stigma.

6.2 Conclusion

This study reviewed the literature on HIV and AIDS stigma, focusing on understanding of various definitions and conceptual models of stigma. The impact of stigma goes beyond the employee infected with HIV, to affect all those employees associated with the disease. Fear of stigma and discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly. In some cases, they may be rejected by their colleagues, friends and even family members. Denial goes hand in hand with discrimination, with many employees continuing to deny that HIV exists in DSD and their communities.



Instead of simply addressing stigma in general sense, focus should be on reducing the most critical negative impacts of stigmatisation, discrimination, and other factors on prevention, treatment and care. Interventions need to be introduced to reduce stigma and encourage acceptance.

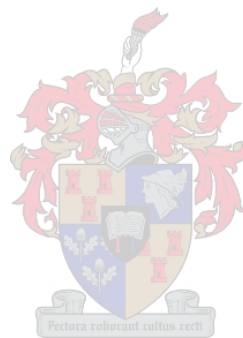
In DSD, it means that the staff should be vigilant that no employment relationship is dependent on an employee's actual or assumed HIV status; that basic human rights and human rights in general are respected; that protocols and practices to deal with instances of HIV/AIDS related stigma are developed and enforced.

6.3 Recommendations

On the basis of the above findings and conclusions reached, the following recommendations are made:

- Conduct an HIV and AIDS policy analysis to assess the extent to which the existing policy address or reinforce stigma and discrimination.
- Inform employees of HIV and AIDS stigma mitigation policies and practices so that the consequences of stigmatising behaviour will be understood.
- HIV and AIDS stigma mitigation policies should be mainstreamed into other functions such as into communication strategies and also into the performance agreements of the managers, work plan (for employees) and standard framework for the general assistants.
- The HIV and AIDS policies should be monitored. This should include the stigma mitigation aspects of the policies as well as the interventions for their sensitivity in relation to stigma.
- Employees, who are living with HIV or AIDS, need to be educated, in order for them to challenge the stigma, discrimination and denial that they meet in the department and society at large in line with Bill of Rights.
- The department should encourage understanding and sensitivity among co – workers regarding HIV and AIDS issues. This can be achieved through vigorous awareness campaigns, education and training on HIV and AIDS stigma.
- Institutional and other monitoring mechanisms can enforce the rights of employees living with HIV or AIDS and provide powerful means of mitigating the worst effects of stigma and discrimination.
- The department needs to protect the rights of employees who are assumed to be infected or infected with HIV and act decisively and consistently when cases of stigma occur.
- Managers at all levels should be provided with a clear guidance on which they can base managerial decisions when confronted with issues relating to HIV and AIDS.
- A more enabling environment needs to be created by increasing the visibility of people with HIV or AIDS as a normal part of the department. People living with HIV and AIDS should be involved in all workplace activities to encourage disclosure.

- HIV infected employees should be encouraged to disclose their status, within a safe, accepting and supportive environment.
- The department should ensure that confidentiality is practised at all times when dealing with HIV – related issues. This can be done signing an Oath of Secrecy which will be a binding document.
- The department should ensure that support groups are established for both infected and affected employees with HIV or AIDS to share their experiences and advice each other accordingly.



References

- Adebajo, S.B., Bamgabala, A.O. & Oyediran, M.A. (2003). Attitudes of health care providers to persons living with HIV/AIDS in Lagos State, Nigeria. *African Journal of Reproductive Health*, 7(1), 103 – 112.
- Aggleton, P. & Parker, R. (2002). A conceptual framework and basis for action: HIV/AIDS stigma and discrimination. Geneva: Joint United Nations Programme on HIV/AIDS.
- AIDS Alert (2002). AIDS stigma forms an insidious barrier to prevention/ care. HIV experts describe problem in India. Sept. 17(9), 111 – 113.
- Alexandrova, A., Alexondrova, A., Alexandrava, A. (2004). AIDS, Drugs and Society. International Debate Education Association. New York.
- Antai – Otong, D. (2002). Culturally sensitive treatment of African Americans with substance – related disorders. *Journal of Psychosocial Nursing and Mental Health Services* 40(7): 14 – 21.
- Barth, K. R., Cook, R.L., Switzer, G.E. & Fischhoff, B. (2002). Social stigma and negative consequences: Factors that influence college students' decisions to seek testing for sexually transmitted infections, *Journal of American College Health* 50(4): 153 – 159.
- Brimlow, D.L., Cook, J.S., Seaton, R. (2003). Stigma and HIV/AIDS. A Review of the literature. Draft. Health Resources and Services Administration. HIV/AIDS Bureau.
- Bunting, S. M. (1996). Sources of stigma association with women with HIV. *Advances in Nursing Science*, 19(2), 64 – 73.

- Bunting, S.M. & Seaton, R. (1999). Health care participation of perinatal women with HIV: What helps and what gets in the way? *Health Care Women International* 20(6): 563 – 578.
- Chetty, D. & Michel, B. (2005). Turning the tide: A strategic response to HIV and AIDS in South African Higher Education: HEAIDS Programme Report 2002 – 2004. SAUVA, Pretoria: Sunnyside.
- Christensen, L.B. (1985). *Experimental Methodology*. Boston: Allyn and Bacon, Inc.
- Corrigan, P.W., Bodenhausen, G., Markowitz, E. et al. (2003). Demonstrating translational research for mental health services: an example from stigma research. *Mental Health Services Research*.
- Coughlan, M. (2003). Pain and palliative care for people living with HIV/AIDS in Asia, *Journal of Pain and Palliative Care Pharmacotherapy* 17(3-4): 91 – 104.
- Crewe, M. (1992). *AIDS in South Africa: The myth and reality*. London: Penguin.
- Deacon, H., Stephney, I. & Prosalendis, S. (2005). Understanding HIV/AIDS Stigma. A theoretical and methodological analysis. Research programmes on Social Cohesion and Identity & the Social Aspects of HIV/AIDS and Health. HSRC Research Monograph.
- De Bryn, M. (1999). Intersecting health risks: adolescent unwanted pregnancy, unsafe abortion and AIDS. *Initiatives in Reproductive Health Policy*, 3(1), 4 – 5.
- Dorrington, R., Bradshaw, D., Johnson, L. & Budlender, D. (2004). The demographic impact of HIV/AIDS in South Africa: National indicators for

2004. Cape Town: Centre for Actuarial Research, South African Medical Research Council and Actuarial Society of South Africa.

Du toit, J.B. and De Villiers, R. (Undated): Role of Risk Perception in Internet Purchasing Behaviour and Intention. A Research Proposal.

Etibet, M.A., Fransman, D., Forsyth, B., Coetzee, N. & Hussey, G. (2004). Integrating prevention of mother – to – child HIV transmission into antenatal care: Learning from experiences of women in South Africa, *AIDS Care* 16(1): 37 – 46.

Fido, A. & Kazemi, R.A. (2002). Survey of HIV/AIDS knowledge and attitudes of Kuwaiti family physicians. *Family Practice*, 19(6), 682 – 684.

Guy, R.F., et al., (1987). *Social Research Methods: Puzzles and Solution*. Allyn and Bacon, Boston.

Harvey, R.D. (2001). Individual differences in phenomenological impact of social stigma. *Journal of Social Psychology*.



Herek, G.M. & Capitanio, J.P. (1999). AIDS stigma and knowledge about HIV transmission in the United States. Unpublished manuscript, University of California, Davis.

Heckman, T.G., Somlai, A.M., Peters, J., Walker, J., Otto – Salaj, L., Galdabini, C.A. & Kelly, J.A. (1998). Barriers to care among persons living with HIV/AIDS in urban and rural areas, *AIDS Care* 10(3): 365 – 375.

Horsman, J.M. & Sheeran, P. (1995). Health care workers and HIV/AIDS: a critical review of the literature. *Social Sciences and Medicine*, 41(11), 1535 – 1567.

Hossini, C.H., Tripodi, D., Rahhali, A.E. et al. (2000). Knowledge and attitudes of health care professionals with respect to AIDS and the risk of

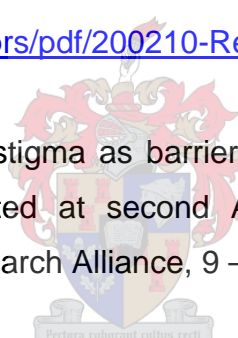
occupational transmission of HIV in 2 Moroccan hospitals. *Sante*, 10(5), 315 – 321.

Insideout Research (2003). *Siyam'kela: A report of the fieldwork leading to the development of HIV/AIDS stigma indicators and guidelines. A research report.* Retrieved from [www.policyproject.com/pubs/countryreports/ SA-Siyam-fieldwork.pdf](http://www.policyproject.com/pubs/countryreports/SA-Siyam-fieldwork.pdf)

Institute of Medicine, et al. (2001). *Stigma and HIV/AIDS: A Review of the Literature.*

Jennings, R., Mulaudzi, J., Evaratt, D., Heywood, M. & Richter, M. (2002). *Discrimination and HIV/AIDS, Paper for the Department of Health written by Strategy & Tactics and the AIDS Law Project.* Retrieved from www.alp.org.za/resctr/rpapers/pdf/200210-Research.pdf

Kalichman, S. (2004). *AIDS stigma as barriers to HIV prevention, diagnosis and care. Paper presented at second African Conference on Social Aspects of HIV/AIDS Research Alliance, 9 – 14 May, Cape Town.*



Kalichman, S.C. & Simbayi, L.C. (2003). *HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa, Sexually Transmitted Infections 79(6): 125 – 142.*

Kilewo, C., Massawe, A., Lyamuya, E., Semali, I., Kalokola, F., Urassa, E., Giattas, M., Temu, F., Karlsson, K., Mhalu, F., & Biberfeld, G. (2001). *HIV counselling 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 Immune Deficiency Syndromes 28(5): 458 – 462.*

Link, B. & Phelan, J. (2002). *On stigma and its public health implications.* Available at <http://www.stigmaconference.nih.gov/LinkPaper.htm>

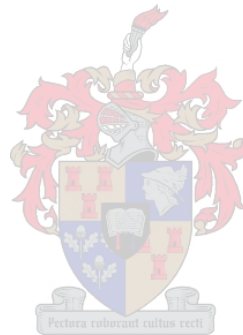
- Pawinski, R. & Lalloo, U. (2001). Community attitudes to HIV/AIDS, *South African Medical Journal* 91: 448.
- Paxton, S. (2002). The paradox of public disclosure, *AIDS Care* 14(4): 559 – 567.
- Petrak, J.A., Doyle, A.M., Smith, A., Skinner, C & Hedge, B. (2001). Factors associated with self – disclosure of HIV serostatus to significant others, *British Journal of Health Psychology* 6(1): 69 – 79.
- POLICY project, Centre for the Study of AIDS, USAID & Department of Health (2003a). *Siyam'kela: Measuring HIV/AIDS related stigma: A report on the fieldwork.*
- Sabatier, R. (1988). *Blaming others: Prejudice, race and world – wide AIDS.* London: Panos.
- Schellenberg, E.G., Keil, J.M., & Bem, S.L. (1995). “Innocent victims” of AIDS: Identifying the subtext. *Journal of Applied Social Psychology*, 25, 1790 – 1800.
- Shefer, T. (1999). *Discourses of heterosexual subjectivity and negotiation.* Unpublished PhD thesis. University of Western Cape.
- Skinner, D. (2002). *Stigma and the ABCD: A consideration in South Africa,* Unpublished paper, HSRC.
- Sontag, S. (1988). *AIDS and its metaphors.* London: Penguin Press.
- Sowell, R., Seals, B., Moneyham, L., Demi, A., Cohen, L. & Brake, S. (1997). Quality of life in HIV infected women in the south eastern United States. *AIDS Care*, 9(5), 501 – 512.



Strebel, A. (1993). Women and AIDS: A study of issues in the prevention of HIV infection. Unpublished PhD Thesis. University of Cape Town.

Vlassoff, C., Weiss, M., Ovuga, E.B. et al. (2000). Gender and stigma of onchocercal skin disease in Africa. *Social Sciences and Medicine*, 50(10), 1353 – 1368.

Yin, K. (1994). *Case Study Research, Design and Methods*, 2nd Edition, sage Publications.



ANNEXURE A

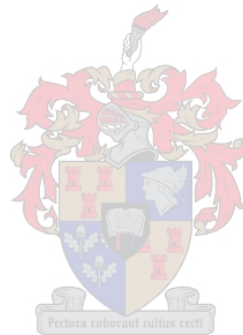
**MANAGING HIV AND AIDS STIGMA IN THE WORKPLACE
(DEPARTMENT OF SOCIAL DEVELOPMENT CASE STUDY)**

QUESTIONNAIRE FOR EMPLOYEES BY YOLISWA MNYANDA

SUPERVISOR: PROF. JOHAN AUGUSTYN

STELLENBOSCH UNIVERSITY

This interview is purely for research purposes and will be treated highly confidential. Your cooperation will be greatly appreciated.



1. AREA OF INTEREST: Identify the demographic profile of employee

Kindly respond to the following,

1.1 Sex

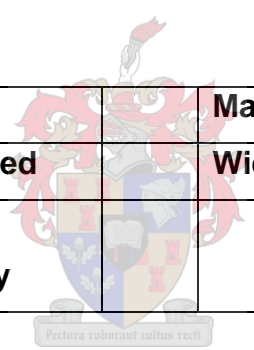
Male		Female	
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1.2 Age group

18 – 24		35 – 44	
25 - 34		45 – 54	
55 - 60		61 - 65	

1.3 Marital status

Single		Married	
Divorced		Widowed	
Other specify			



1.4 Race

Black		White	
Indian		Coloured	
Other specify			

1.5 Religion

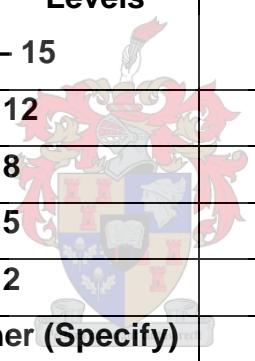
Christian	Muslim	
African religion	Others specify	

1.6 Educational background

No formal education	
Below matric	
Matric	
Diploma / Degree	
Post – graduate Diploma / Degree	
Others	

1.7 Occupational level

Levels	
13 – 15	
9 – 12	
6 – 8	
3 – 5	
1 – 2	
Other (Specify)	



2. AREA OF INTEREST: Understanding the meaning of HIV and AIDS Stigma

Please mark the appropriate column with a cross (X), which represents your response.

2.1 Suppose you are working with an employee who is known to be HIV positive or has AIDS. How would you feel about that?

Very comfortable	1	Somewhat comfortable	2	Very uncomfortable	3	Somewhat uncomfortable	4
------------------	---	----------------------	---	--------------------	---	------------------------	---

2.2 Suppose you worked in an office where one of the employees working with you has been diagnosed HIV positive or has developed AIDS. How would you feel about that?

Very comfortable	1	Somewhat comfortable	2	Very uncomfortable	3	Somewhat uncomfortable	4
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2.3 Suppose that you found out that the owner of a cafeteria where employees of DSD buy lunch is HIV positive or has AIDS. How would you feel about buying food from that cafeteria ?

Very comfortable	1	Somewhat comfortable	2	Very uncomfortable	3	Somewhat uncomfortable	4
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2.4 What do you think you would actually do if you had an office job where one of the employees working with you is HIV positive or has AIDS?

- Would you still be willing to work with him?

Yes	1	No	2
-----	---	----	---

- Would you ask that he be assigned to work in another office?

Yes	1	No	2
-----	---	----	---

- Would you ask that you yourself be assigned to work with someone else?

Yes	1	No	2
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- Would you go out of your way to help him/her if he needed help with his/her work?

Yes	1	No	2
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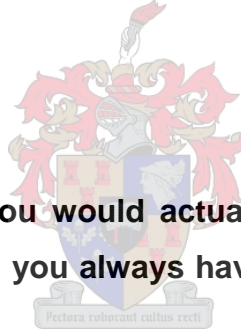
- Would you try to avoid contact with him?

Yes	1	No	2
-----	---	----	---

- Would you treat him /her the same way as before?

Yes	1	No	2
-----	---	----	---

2.5 What do you think you would actually do if you found out that your colleague whom you always have lunch with, is HIV positive or has AIDS?



- Would you continue to have lunch with him/ her?

Yes	1	No	2
-----	---	----	---

- Would you prefer to have lunch with someone else?

Yes	1	No	2
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3. AREA OF INTEREST: Impact of HIV and AIDS Stigma on employees.

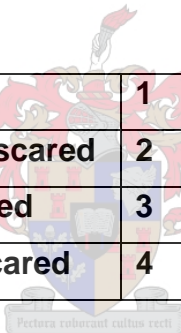
In this section, please tick the appropriate row, which represents your response.

3.1 People have many different feelings/ attitudes towards people living with HIV or AIDS. How do you personally feel about such people?

Very angry	1
Somewhat angry	2
A little angry	3
Not at all angry	4

3.2 People are scared of people living with HIV or AIDS. How do you feel about such people?

Too scared	1
Somewhat scared	2
A little scared	3
Not at all scared	4



3.3 People are disgusted by people living with HIV or AIDS. How do you feel?

Too disgusted	1
Somewhat disgusted	2
A little disgusted	3
Not at all disgusted	4

3.4 Employees who are HIV positive or have AIDS should be legally separated from others to protect the other employees. Would you say you:

Strongly agree	1
Agree somewhat	2
Disagree somewhat	3
Disagree strongly	4

3.3 The names of HIV positive employees or have AIDS should be made public so that others can avoid them. Would you say you:

Strongly agree	1
Agree somewhat	2
Disagree somewhat	3
Disagree strongly	4



3.4 Employees who got HIV or AIDS through sex or drug use have gotten what they deserve. Would you say you:

Strongly agree	1
Agree somewhat	2
Disagree somewhat	3
Disagree strongly	4

4 AREA OF INTEREST: Voluntary Counseling and Testing (VCT)

4.1 When an employee chooses to voluntarily disclose his/ her HIV status to the employer or other employees, this information should not be divulged without the employee's consent. Do you:

Strongly agree	1
Agree somewhat	2
Disagree somewhat	3
Disagree strongly	4

4.2 Where written consent is not possible, it is assumed that the employee wishes his/her status to be known. Do you:

Strongly agree	1
Agree somewhat	2
Disagree somewhat	3
Disagree strongly	4

4.3 To understand the failure of people to go for VCT

Denial	1
Stigma	2
Absence of treatment options or cure	3
Financial issues	4
Ignorance	5
All of the above	6

5. AREA OF INTEREST: Determining the barriers to treatment and care.

Please mark the most appropriate response.

5.1 What are the barriers to treatment and care to people living with HIV or AIDS?

Stigma	1
Expected stigma and discrimination	2
Cost (poverty)	3
Denial	4
Ignorance	5
Physical availability and accessibility of healthcare	6
All of the above	7

5.2 What are the barriers to treatment and care in relation to facilities/ services?

Inaccessibility to HIV Clinics or Hospitals	1
Lack of antiretroviral roll out in South Africa	2
Attitudes of health care professionals towards PLWA	3
Inefficiency of health care professionals	4
All of the above	5

THANK YOU FOR YOUR PATIENCE AND COOPERATION

ANNEXURE B

DATA ANALYSIS

1. Understanding the meaning of HIV/AIDS stigma

Feelings	% very comfortable	% somewhat comfortable	% very uncomfortable	% Somewhat uncomfortable
1.1 Working with an employee who is known to be HIV +	63.16	28.95	5.26	2.63
1.2 Working in an office with an employee who is HIV+ or has AIDS.	63.16	28.95	2.63	5.26
1.3 Buying food from an HIV+ owner of a cafeteria.	43.25	29.73	13.51	13.51

1.4 You had an office where one of employees working with you is HIV+ or has AIDS

Avoidant Behavioural intentions	% Supportive	% Avoidant
1.4.1 Willing to work with him/her	88.89	11.11
1.4.2 He is assigned to work in another office.	25.64	74.36
1.4.3 Respondent to be assigned to work with someone else.	23.08	76.92
1.4.4 Would the respondent help if the employee needed help	88.57	11.42
1.4.5 Avoid contact with him/her	13.51	86.49
1.4.6 Treat the employee the same way as before	90.24	9.76
1.4.7 Continue to have lunch with the employee	86.11	13.89
1.4.8 Prefer to have lunch with someone else	35	65

2. Impact of HIV and AIDS stigma on employees

Feelings	% Very angry	% Somewhat angry	% A little angry	% Not at all angry
2.1 Angry	10.53	23.68	10.53	55.26
2.2 Scared	5.41	18.91	5.41	70.27
2.3 Disgusted	10.26	12.82	7.69	69.23

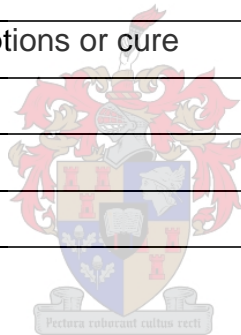
2.4 Attitudes	% Strongly agree	% Agree somewhat	% Disagree somewhat	% Strongly disagree
2.4.1 Legally separated	5.26	2.64	21.05	71.05
2.4.2 Make names public	5.41	2.70	5.41	86.48
2.4.3 Gotten what they deserve	8.11	5.41	21.62	64.86

3. Determining the barriers to VCT

Coercive attitudes	% Strongly agree	% Agree somewhat	% Disagree somewhat	% Disagree strongly
3.1 Divulge employee's HIV status	52.27	13.64	2.27	31.82
3.2 No written consent	19.05	33.33	21.43	26.19

3.4 Failure to go for VCT

Behavioural Intentions	%
3.4.1 Denial	24.39
3.4.2 Stigma	12.20
3.4.3 Absence of treatment options or cure	7.32
3.4.4 Financial issues	4.88
3.4.5 Ignorance	26.82
3.4.6 All of the above	24.39



4. Determining barriers to treatment and care

Behavioural Intentions	%
4.1 Stigma	4.76
4.2 Expected stigma and discrimination	19.05
4.3 Cost (poverty)	19.05
4.4 Denial	7.14
4.5 Ignorance	7.14
4.6 Physical availability and accessibility of healthcare	11.91
4.7 All of the above	30.95

5. Barriers to treatment and care in relation to facilities/ services

Facilities/ services	%
5.1 Inaccessibility to clinics or hospitals	11.90
5.2 Lack of ARV roll out in S.A.	23.81
5.3 Attitudes of Health care professionals towards PLWA	11.90
5.4 Inefficiency of Health care professionals	0
5.5 All of the above	52.39

