

**AN INVESTIGATION INTO EMPLOYEES' PERCEPTIONS OF HIV/AIDS
STIGMA AND THEIR ATTITUDES AND BEHAVIOUR TOWARDS HIV POSITIVE
COLLEAGUES**

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DECLARATION

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Signed:

Date: March 2011

A handwritten signature in cursive script, appearing to read "Chilton", is written on a horizontal line. Below the signature, there is a horizontal line with a small upward tick on the left and a small downward tick on the right, resembling a bracket or a flourish.

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ABSTRACT

This research study investigated the perceptions of HIV/AIDS stigma and discrimination of employees in the Office of the Premier in the Northern Cape. The study made use of a mixed-method approach. Both quantitative and qualitative approaches were used. The quantitative approach entailed a survey and the qualitative approach, focus groups.

The findings indicate that stigma and discrimination is prevalent in the workplace. It showed that employees concur that stigma exists and that it results in discriminatory practices. As a result, attention is drawn away from the important issue of HIV/AIDS and emphasis is placed on the negative behavioural aspects that exist within the workplace.

OPSOMMING

Hierdie navorsingstudie ondersoek die persepsies van MIV/VIGS stigma en diskriminasie van werksnemers in die Kantoer van die Premier in die Noord-Kaap. Die studie het gebruik gemaak van 'n veelvuldige navorsingsmetode. Beide kwantitatiewe en kwalitatiewe metodes is gebruik. Die kwantitatiewe metode was 'n vraelys en die kwalitatiewe metode was 'n fokusgroep.

Die resultate dui daarop dat stigma en diskriminasie beduidend is in die werksplek. Dit dui ook aan dat werksnemers erken dat stigma wel bestaan en diskriminasie tot gevolg het. As gevolg daarvan word die aandag afgelei van die belangrike aspek van MIV/VIGS en die fokus word geplaas op die negatiewe gedragsaspekte wat in die werksplek ontstaan.

LIST OF ABBREVIATIONS

The following acronyms and terms are used throughout the thesis. They are listed here for reference and clarity.

AIDS	Acquired Immune Deficiency Syndrome
EHWP	Employee Health and Wellness Programme
EHWU	Employee Health and Wellness Unit
HIV	Human Immune Virus
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
HCT	HIV (Human Immune Virus) Counselling and Testing
ILO	International Labour Organisation
PLWHA	A person infected with HIV or AIDS commonly referred to as Person Living with HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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CHAPTER 1 INTRODUCTION

1.1 Background

Sub-Saharan Africa contains just over 10% of the world's population, yet it is home to nearly two thirds of the world's HIV/AIDS cases (Inungu & Karl, 2006). An estimated 1.9 million people in Africa became newly infected with HIV in 2008, while 1.4 million adults and children died of AIDS (UNAIDS, 2009). The total number of HIV infections in Sub-Saharan Africa accounts for 67% of all HIV infections world-wide and the number of deaths tally 72% of the world's AIDS-related deaths (UNAIDS, 2009).

From the above, it is clear that Sub-Saharan Africa is the part of the world that is hardest hit by the HIV/AIDS epidemic. In order to fight the spread of the disease; it is paramount to know, to understand and to effectively address the factors that drive the spread of the disease. It is postulated that one of the factors that fuel the spread of the disease in Africa is stigma associated with HIV/AIDS.

The president of South Africa, President Jacob Zuma, has announced in December 2009, a new focus in South Africa on HIV prevention, HIV testing campaigns and the roll-out of antiretroviral therapy. This new political mandate has also focused the attention on workplace intervention, and what organisations are doing to aid this venture.

The South African government has adopted the approach of renewed effort to strengthen the fight against the spread of HIV and AIDS. The nationwide incentive of the HIV counselling and testing campaign aims to strengthen the national response against HIV and AIDS. According the National Strategic Plan on STI and HIV infection 2007-2011, South Africa ambitiously aimed to reduce all new HIV infection by 50% by 2011. This strategy aims to integrate all HIV/AIDS activities through the local, provincial and national government structures. The launch of the HIV counselling and testing campaign aims to scale up the counselling and testing for HIV at health facilities and to make HCT accessible to each and every South African. The aim is also the reduction of stigma and discrimination associated with HIV-infection.

Since the beginning of the HIV/AIDS epidemic, stigma and discrimination has been barriers to service delivery, prevention strategies and the utilization of HIV/AIDS services. It is well documented that people living with HIV and AIDS (PLWHA) experience stigma and discrimination on an ongoing basis. These insidious impacts of stigma and discrimination must be acknowledged if the work to eradicate stigma and discrimination are to be taken seriously.

In the South African political landscape of a history riddled with discrimination, racism and stigmatizing beliefs, stigma has particular implications. Goffman (1963) as quoted in Molefe (2009) has defined stigma as a deeply discrediting attribute that reduces a person to someone who is in some way tainted and can thus be ridiculed. In the field of HIV/AIDS this is a pervasive problem globally and in particular in South Africa.

HIV/AIDS related stigma and discrimination take many forms and are manifested at different levels (individual, community and societal) and in different contexts. The workplace is often one of the contexts where HIV/AIDS stigma and discrimination manifest. However, it is also an arena with great potential for interventions to reduce or mitigate the stigma and discrimination. Workplaces and organizations have reported at times that colleagues have refused to work next to those with HIV or those that are perceived to be living with HIV/AIDS. However, few organizations have developed strategies to combat stigma and discrimination and have not clearly defined their responsibilities towards employees that have tested positive for HIV.

According to the UNAIDS (2007) "... understanding the causes and impacts of stigma and discrimination at a national level is key to knowing your epidemic." This is also true for understanding the causes and the impacts on a provincial as well as an organisational level.

Stigma and discrimination against HIV-positive individuals can aid in the spread of the disease. It can create barriers that inhibit people from accessing HIV services and information. According to the United Kingdom's department of health (2006), stigma may have a direct impact on individuals' willingness and also fear to test for HIV. This can have a negative impact on disease progression and life expectancy. It is for this reason that the issue of stigma and discrimination is a major health and economic concern for the workplace.

1.2 Statement of the problem

Clearly, stigma and discrimination influences the response to the HIV/AIDS epidemic. In the workplace under study, an HIV/AIDS workplace policy has been in draft form for the past two years without being signed off. There is widespread ignorance about the content of the policy and uncertainty about its implementation. There is also little confidence and widespread scepticism regarding the policy since it has not been “tested” through implementation in the workplace. There is also no policy in the workplace that formally deals with the issue of HIV/AIDS related stigma and discrimination in the workplace.

It has been recommended by USAID and the Policy project (2006) that before planning an intervention to address stigma, a department or organization should conduct a “stigma audit”. This is done to assess the extent of the problem as well as the local barriers to stigma reduction and to highlight the enhancing factors of stigma mitigation.

HIV/AIDS is a serious public health problem, with 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 cost and workplace morale (Code of Good Practice, 2000).

According to Milan (2004) not having a workplace policy preventing discrimination based on HIV/AIDS, sends the wrong message that HIV/AIDS stigma is acceptable in the workplace. He further states that “by not affirmatively addressing or supporting educational programs and health care initiatives concerning HIV/AIDS, workplaces allow stigma to flourish.” (p.2)

1.3 Significance of the study

An understanding and profile of stigma in the workplace would enhance better comprehension and awareness and also assist with planning proper intervention strategies. It would furthermore increase the workplace knowledge and expertise and ensure that interventions are outcomes based and scientific.

The research study would benefit the organization at large, the HIV-infected and affected employees and their families as well as the broader scientific community. Other researchers would be able to extend and augment their knowledge on the topic and even expand the range

of research on the issue. In addition, the research study would allow for recommendations to be made and would enable the implementation of these interventions.

1.4 Aim and objectives of the Study

The aim of the proposed study was to investigate the perceptions of employees to HIV/AIDS stigma and discrimination as well as their attitudes and behaviour towards fellow colleagues assumed to be HIV-positive in order to develop guidelines and strategies to mitigate the impact of the stigma and discrimination in the workplace.

The Objectives were to:

- assess employees' perceptions of HIV/AIDS stigma and discrimination;
- assess current attitudes to HIV/AIDS and colleagues perceived to be HIV-positive;
- assess current behaviour towards colleagues; and
- recommend guidelines or strategies to mitigate the impact of HIV/AIDS stigma and discrimination in the workplace.

1.5 The Developmental Relevance of the Study in South Africa

In view of the present and especially projected dramatic impacts of the HIV/AIDS epidemic in very high prevalence countries, the productive section of the country, the workforce will increasingly be impacted. According to Ellis, Smit and Laubscher (2003), 15% of the total South African labour force is already infected with HIV and they project that by 2015, 26% of the total labour force would be HIV-positive. In light of this, it is evident that more than a quarter of South Africa's workforce would eventually become ill. This would over time lead to increased absenteeism as well as an increase in granting temporary or permanent incapacity leave due to ill-health.

HIV/AIDS will continue its constraints and impacts on households and families. Should an HIV-positive employee become ill, he/she would no longer be able to continue work as previously and the ability to contribute as before will become diminished. This could ultimately lead to people losing their work because of the increased absenteeism. This would particularly be felt by individuals that are in the unskilled labour market where it is fairly easy to replace such a worker. Ellis et al. (2003, p. 11) state that "given South Africa's high unskilled unemployment rate, it can be assumed that an unskilled income earner could be

replaced fairly easily, so that the economic production and income will not be fully exposed to the impact of the deceased worker”.

According to the ILO report (2006), productivity losses and reduced production lead to a decline of profitability. As HIV/AIDS cause workers to become ill and absent from work, production will suffer and subsequently less revenue will be generated. This might ultimately lead to organisations downsizing and many employees losing their jobs. The impact of HIV/AIDS is seen to not only affect those that are infected, but others might also suffer the negative impact due to losses in company income and profit.

The World Economic Forum (2006) state the following as adequate responses from employers to mitigate the impact of HIV/AIDS in the workplace: To assess the risk; to develop an appropriate response; to start in the workplace; to link up with other stakeholders; to address stigma; to look to the long-term and not just immediate gains; and to monitor and evaluate HIV/AIDS programmes.

This is similar to what the UNAIDS proposes. According to the UNAIDS HIV in the Workplace: Technical Update (1998), the following measures are needed: Organisations need to develop a step-by-step action plan and has to formulate a sound HIV/AIDS policy. They have to develop a process for multi-sectoral involvement and ensure cooperation and sensitivity to the employees' culture. Furthermore, organisations have to establish a comprehensive HIV/AIDS prevention, care and support programme and monitor, evaluate and update the programme. They also have to forge alliances with outside networks and resources must extend the workplace interventions to include the local community.

Unlike other illnesses HIV/AIDS mainly affects young adults between 15 and 49 years of age. These include the breadwinners, the workers, the leaders and the parents of society. The research is relevant in South Africa because policy and resources need to be redirected to ensure that the economy of South Africa is not paralysed by this disease. Inactivity on the part of government and the continuing impact of HIV stigma and discrimination will in effect result in stunted economic growth.

1.6 Structure of the Research Report

Chapter 1: This chapter will include the background to the study, statement of the problem, the significance of the study, the aim and objectives of the study as well as the relevance of the study.

Chapter 2: In this chapter, a thorough review of the literature pertaining to the topic will be presented. It is in this chapter that information from prior studies will also be mentioned to highlight the relevance of the research topic. The review of literature will include broad commentary on some of the research conducted.

Chapter 3: The focus of this chapter is methodological. The study adopted a mixed-method approach. Both quantitative and qualitative approaches were used. The quantitative approach entailed a survey and the qualitative approach, focus groups. Procedures for sampling will be discussed as well as triangulation, data collection, and ethical issues.

Chapter 4: The description of the sample and the research findings of the study will be presented in this chapter in table format as well as graphically. The qualitative data will be presented with selective but relevant quotes from the participants,

Chapter 5: This chapter focuses on the discussion of the findings presented in the previous chapter. Comments are made regarding the study limitations.

Chapter 6: This chapter focuses on the recommendations and conclusion of the study. Comments are made regarding recommendations for future studies.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The manifestation of stigma is as old as times gone by. According to Goffman (1963), the word “stigma”, dates back to ancient Greek times and refer to the physical mark made by fire or with knives on individuals or groups considered outsiders or inferiors. However, today the concept of stigma still appears universally across the continent. In ancient times, in different cultures and at different times, slaves, criminals and adulterers – or those suspected of being slaves, criminals and adulterers – have been branded or otherwise physically marked (Goffman, 1963). The physical markings of slaves, criminals and adulterers have gone, but stigma remains. Now, it is based on one or more factors, such as age, class, colour, disease, ethnicity, religious belief, sex and sexuality. Stigma is applied by society and possessed by groups and individuals. By defining deviance and confirming exclusion, stigma reinforces social norms (Foreman, 2003).

The consequence of stigma is discrimination (Deacon, 2005). The original meaning of the word was to note differences. Over time, however, it has come to mean to perpetrate an unjust action or some form of inaction against individuals who belong, or are perceived to belong to a stigmatised group (Foreman, 2003). According to Deacon (2005, p. ix) “stigma has come to mean almost anything people do or say that stands in the way of rational responses to public health campaigns on HIV/AIDS, or that restricts the access of people living with HIV/AIDS to employment, treatment and care, testing and a reasonable quality of life.” She further states that it is important to distinguish between stigma that is seen as “negative things people believe about HIV/AIDS and PLWHA” and discrimination that is seen as things “people do to unfairly disadvantage PLWHA”. Deacon defines stigma as an ideology that identifies and links the presence of a biological disease agent to negatively-defined behaviours or groups in society.

In most cultures, the perception of AIDS as a frightful contagious disease resulting from immoral behaviour, leads to the view that HIV/AIDS persons are “bad people” and responsible for their own illnesses (Qubuda, 2010; Phengjard, Brown, Swansen, & Schepp, 2002). All over the world, many HIV-positive individuals are abandoned by their families and by some societies. They are shunned by people around them because of the stigma that

AIDS is a disease that is thought to occur as a punishment for bad and immoral people (Phengjard et al., 2002). According to Qubuda (2010), this is a dominant reaction among South African people. However, it is not much different from other reactions around the world, where the HIV-infected are labelled as individuals with no moral values and with limited self control over their sexual urges (Foreman, 1999; Obbo, 1995; UNAIDS, 2000) or deviant (Alonzo & Reynolds, 1995; Freund & McGuire, 1991; Green, 1995). In South Africa, AIDS was also viewed as a disease related to dirt, danger, death, and a woman's disease, that is linked to prostitution (Songwathana & Manderson, 1998, Qubuda, 2010).

Goffman (1959) further describes stigma as an undesired differentness that labels a person as bad or unusual. Goffman goes on to discuss society's way of dealing with stigma as minimizing contact with those who are stigmatized in an attempt to avoid being stigmatized themselves and describes stigma as a shaming characteristic that an individual acquires (Goffman, 1963). Qubuda (2010) states that AIDS stigma is particularly intensified due to the nature and symptoms of the illness as well as the ever present ignorance with regards to the modes of transmission. Boer and Emons (2004) suggest that there may be an association between AIDS stigma and possible fear of or delusions about HIV/AIDS.

2.2 HIV/AIDS Globally

The World Health Organisation (WHO) (2010) statistics reveal that Eastern Europe and Central Asia are the world's fastest growing HIV/AIDS epidemic regions. The statistics further reveal that HIV-infection is also expanding rapidly in the Baltic States, the Russian Federation and several Central Asian republics, fuelled by high rates of injecting drug use among young people.

UN Secretary-General Ban Ki Moon says:

"Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."

A United Nations Country Team report noticed that there is a serious lack of information on the current situation of stigma and discrimination against those individuals living with

HIV/AIDS (UN Vietnam, 2004). However, a Survey Assessment of Vietnamese Youth found relative high levels of acceptance and understanding of people living with HIV/AIDS among youth aged 14 to 25 (Australian International Health Institute (AIHI), 2005). Only 13.4% of the young people in the survey said they would not help or support someone with HIV in their community. The rest of the sample said they would help and keep normal contact with a person with HIV/AIDS. Interestingly, negative attitudes were stronger among ethnic minority youth with 33.5% saying they would not help or support an HIV positive community member according to the Survey Assessment of Vietnamese Youth (AIHI, 2005).

The Department of Health in the United Kingdom (2006) argued that although HIV stigma and discrimination are issues that cut across all government policies, government action alone will not solve the problems of stigma and discrimination. The department further stated that historically stigma has not been a high priority issue and pressure on services and competition for resources will impact upon the ability for government to deliver change. Action by government may help to facilitate change but is not the only factor that can facilitate change. It would seem that other stakeholders would also need to get involved in the fight to eradicate HIV stigma and discrimination.

A study in South East Asia found that the workplace is just one of the different communities that individuals find themselves in and as a result the responses to HIV/AIDS in that specific community has to be scrutinized (Busza, 1999). Busza further found that effective responses to HIV/AIDS are framed within a model of prevention-to-care continuum or cycle. She states that this cycle relies on a supportive environment in which individuals feel they will receive help and understanding and in which behaviour change is promoted. Stigma and discrimination according to this study hinder the creation of such a supportive environment at all stages of the cycle.

Some studies have found that in many instances, employers refuse to hire people living with HIV/AIDS or terminate their employment because of the prejudice of the employers and others in the community (Corrigan, 2004; Ngamvithayapong-Yanai, 2005; Panos Institute, 1992). The HIV-positive individuals often conceal their diagnosis to avoid the stigma and discrimination that is associated with HIV infection (Mwinituo & Mill, 2006), and this phenomena occurs throughout the world community (Qubuda, 2010). These findings concur with the findings of Busza (1999) that stigma and discrimination will always hamper the

creation of a supportive environment that is conducive to care, understanding and the promotion of behaviour change.

According to Milan (2004) businesses and unions in the United States of America have to ensure that the workplace is a fair and effective environment that fosters productivity and creativity. He argues that HIV/AIDS workplace policies and programmes can reduce stigma of HIV/AIDS and create working environments where PLWHA or those affected by HIV/AIDS can be productive, contributing members of the workforce.

2.3 HIV/AIDS in Sub-Saharan Africa

Sub-Saharan Africa is more heavily affected by HIV/AIDS than any other region of the world (UNAIDS, 2008). An estimated 22.5 million people are living with HIV in this region, which are around two thirds of the global total of PLWHA. In 2009 approximately 1.3 million people died from AIDS in Sub-Saharan Africa and 1.8 million people became infected with HIV (Avert, 2010).

Ehiri, Anyanwu, Donath, Kanul and Jolly (2005) collected and reviewed published studies from standard research databases and reference lists of relevant articles and summarized the literature on barriers posed by stigma to HIV/AIDS prevention and care in sub-Saharan Africa. This was done to analyze the contexts in which AIDS-related stigma and discrimination are manifested, and to suggest potential prevention strategies. The study found the ways in which AIDS stigma is overtly or covertly expressed are shaped by a range of social, cultural, political, and economic factors.

According to Ehiri et al. (2005) stigma plays into existing social inequalities and is manifested at all levels: in the wider society, in institutions, in families, and at the individual level. They state that influences on AIDS-related stigma and discrimination are rooted in the structure of communities and societies, and therefore effective interventions should be based on a sound theoretical foundation and include attention to the individual as well social and structural barriers (Ehiri et al., 2005). Given the diversity of cultures among the various countries in Africa, interventions to reduce AIDS stigma are likely to be more effective if they are context-specific and sensitive to the prevailing socio-cultural and economic environment of each country (Qubuda, 2010; Ehiri et al., 2005).

2.4 HIV/AIDS in South Africa

Whilst Sub-Saharan Africa is affected by HIV in vast proportions, South Africa remains the country with the largest number of HIV infections in the world. South Africa accounts for more than 35% of all people living with AIDS (UNAIDS, 2008) with approximately 1000 AIDS-related deaths that occur daily (UNAIDS, 2008). It is estimated that approximately 39% of all people infected with HIV in South Africa reside in Kwa-Zulu Natal (UNAIDS, 2008). Thus the impact of HIV/AIDS in South Africa is abundantly clear.

The AIDS epidemic is without doubt becoming one of the most important factors shaping the social existence in South Africa (Qubuda, 2010). It stands to reason, therefore, that theorists and laymen alike consider HIV/AIDS and the accompanying demographic and socio-economic consequences to pose significant challenges to the South African society at large and the workplace in particular (Qubuda, 2010; Barnett & Whiteside, 2002).

In South Africa, in a study undertaken for a large mining organization, 11,339 employees were tested for HIV. A prevalence rate of 24.6% was found amongst the employees tested (Stevens, Apostolellis, Napier, Scott & Gresak, 2006). Although it is only one study, the results are shocking with approximately one quarter of staff infected with HIV. This study raises serious questions about potential risks for organizations.

2.5 Current Research on HIV Stigma and Discrimination

A South African workplace study conducted in 1992 found employees had an enormous compassion for colleagues who were HIV-positive, but that they also had a pressing need to know who were diagnosed with HIV (Miller & Mastrantonis, 1992). This finding points to the fact that although employees are sympathetic towards HIV-positive colleagues, there is a need to stay separate from them and also a fear of both the disease and the associated stigma.

Mnyanda (2006) found that employees with HIV/AIDS often experience stigma and discrimination in the workplace. In addition, another study has found that people with HIV/AIDS feel isolated, guilty, dirty and full of shame, which is incorporated into the identity (Kalichman, 2004). Stigma impacts on the PLWHA as it is internalised into their self-perceptions and their sense of identity (Kalichman, 2004). This furthermore impact on the person's insight and how they interact with the world and others. Goffman (1963) states that stigma results in the reduction of a person or group from a "whole" person to a person

that is discounted and tainted. He suggested that people, who possess a characteristic defined as socially undesirable such as HIV/AIDS, acquire a ‘spoiled identity’ which ultimately leads to social devaluation and discrimination.

Stigma and discrimination have implications for the implementation of prevention efforts and have reduced the possible impact of these interventions (Molofe, 2009). Molofe found that certain behaviours such as the use of condoms have become signifiers of the epidemic and could possibly lead to rejection of those who initiate their use. Furthermore, the option of being faithful can be stigmatised. The study revealed that in a community where multiple partners are seen as an indicator of success or a person’s manhood, an individual who has only one partner may be marginalised (Molofe, 2009).

Inungu and Karl (2006) reported that slow governmental response to HIV/AIDS can be explained by the view that HIV/AIDS is sometimes seen as a threat to investment and tourism. Furthermore, it is postulated that the lack of stability in certain African countries has also contributed to governments’ failure to generate an effective response to HIV/AIDS. Forsyth, Vandormael, Kershaw and Grobbelaar (2008) state that government policies and laws in South Africa have in the past directly promoted AIDS discrimination and stigmatisation.

The Employment Equity Act (No 55 of 1998), including the Equal Opportunities and Affirmative Action Policy, the Labour relations Act (No 66 of 1995), the Basic Conditions of Employment Act (No 75 of 1997) and other labour legislation and policies are geared towards fair labour practices and equal benefits for all employees. However, the reality is that in many instances employees are not treated fairly, nor with dignity and respect despite the legislation that is in place (Mphumela, 2009). Discriminatory practices such as pre-employment screening, denial of employment to individuals who test HIV-positive, termination of employment of PLWHA, and stigmatisation of PLWHA who are open about their HIV-status have been reported from both “first” and “third-world” countries (Panos, 1990; Shisam, 1993).

The Bill of Rights (1996) a human rights charter preserved in Chapter 2 of the Constitution of South Africa indicates that the workplace or employer shall not discriminate against employees who are HIV-positive. This highlights the fact that an HIV-positive employee can

be productive for many years if the correct lifestyle is followed; medical care is provided for optimally and if treatment is adhered to (Mphumela, 2009). The Bill of Rights further states that a person cannot be discriminated against when applying for employment. Thus no person be forced to undertake an HIV-test unless it is an inherent requirement of the job or unless the Labour Court has given the employer permission to do so.

In spite of this legislation, there have been reports of workers refusing to work next to those with HIV/AIDS or those perceived to be living with HIV/AIDS (Whiteside, 1993; Mphumela, 2009). In addition to this, medical aid schemes and pension funds have come under increasing pressure in countries that are seriously affected by HIV/AIDS and some companies have used this as a reason to deny employment to PLWHA (Williams & Ray, 1993; Whiteside, 1993). Very few companies have developed strategies to combat stigma and discrimination in the workplace or have defined their responsibilities towards employees with HIV.

This highlights the case of Hoffman versus South African Airways (SAA) (2000). Mr Hoffmann, the appellant was refused employment as a cabin attendant by SAA because of his HIV-positive status. Justice Ngcobo ruled that SAA had infringed the plaintiff's constitutional rights not to be unfairly discriminated against. He underlined that only HIV-positive people, who are at the immunosuppressed stage of the disease, pose the risks that were alleged by SAA. The plaintiff was not immunosuppressed, either at the time he applied for the position of cabin attendant or at the time when he brought the lawsuit against SAA. The judgment held that, while legitimate commercial requirements are important, they cannot serve to disguise stereotyping and prejudice. It also held that people with HIV, as one of the most disadvantaged groups in society, deserve special protection from the law. The Supreme Court ordered SAA to make an immediate offer of employment to the plaintiff and to pay his legal costs. (Standley, 2000)

Another study in South Africa (Policy Project, 2006) found that in terms of human rights, individuals had limited knowledge about what human rights were, what rights they had and what recourses they had when rights were violated. In addition, the study found that although the South African government guarantees access to health services and treatment, that in practice it did not work like that. The study showed that in the application of laws, policies and regulations, there were many omissions and negligence that included unequal application

of these legislation and loss of confidentiality. In certain instances, practice clearly contravened written policies (Policy Project, 2006).

According to Skinner and Mfecane (2004) there is a clear need to establish a research agenda for HIV-related stigma in South Africa. They state that such a research agenda is a real and centrally important challenge for reigning in the HIV epidemic and has to be taken seriously. The biggest role that stigma play in society is to create difference and social hierarchy and then in turn “legitimising and perpetuating the social inequality” (Skinner and Mfecane, 2004).

2.6 Current Research Gaps

HIV/AIDS stigma is pervasive and persistent. Its ways of enduring are not well understood, although there is a growing body of evidence documenting stigma's tragic impact on individual's and their health. Even less understood is the role the workplace plays in perpetuating the stigma associated with HIV/AIDS. It is evident that more people with HIV/AIDS live longer and healthier lives as a result of treatment. Studies have shown that more and more, people want to understand and acknowledge their personal connections to friends and family living with HIV/AIDS. The increasing presence of all these factors in the workforce demands that employers and employees alike understand and address HIV/AIDS stigma in the workplace.

It appears from the literature review that there already is a lot of relevant research on issues related to the situation of HIV/AIDS. However, what remains strikingly minimal and/or absent from the literature is research on stigma and discrimination in the workplace and the responses to stigma and discrimination (Wijngaarden, 2001). According to Wijngaarden (2001) research agendas might include the following:

- Proper, in-depth evaluative research of current approaches and strategies for reducing HIV/AIDS stigma and discrimination
- Research on the communication processes within behaviour change or awareness raising programs themselves, especially between staff of projects and their target audiences. This type of research could advice on how to improve the process of the

design and implementation of projects, making them more ‘user friendly’, more efficient and, ultimately, more effective (Wijngaarden, 2001).

- Research on the usefulness and effectiveness of processes of involvement of target audiences in program and strategy design.

2.7 Conclusion

The review of literature looked at stigma and discrimination in general; and it focused on the research on HIV/AIDS stigma and discrimination in the South African context specifically. The fact that the disease seems to target mostly the productive section of the population exacerbates the need to research the phenomenon of stigma and discrimination and how it impacts on the working individual. The absence of positive approaches to HIV/AIDS also promotes stigma. Not having a workplace policy prohibiting discrimination based on HIV/AIDS sends the wrong message that HIV/AIDS stigma is acceptable in the workplace. It is evident that having the legislation in place is not the only answer but how that legislation is implemented to reduce stigma and discrimination.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

Chapter three outlines the research design and the research method used in this study, the population in terms of selection and the sample size. The chapter further elaborates on the research instruments used; the questionnaire distributed; the focus groups facilitated; the data collection process; and the ethical issues considered by the researcher.

3.2 Research Design

This research project made use of a mixed-method approach. Both quantitative and qualitative approaches were used. The quantitative approach entailed a survey and the qualitative approach, focus groups. According to Matveev (2002), applying both quantitative and qualitative methods in research has certain advantages. He states that quantitative methods ensure high reliability of data gathered and qualitative methods allow for obtaining more in-depth information about the phenomena under study. The quantitative research design consisted of a survey. Surveys allow for standardized questions to be asked. This ensures precision by enforcing uniform definitions on the participants (Colorado State University, 2010). In addition, a high reliability can be obtained through surveys and the subjectivity of the researcher is greatly eliminated. In addition, surveys have the advantage of being able to identify both factual and attitudinal data (Mnyanda, 2006).

The qualitative method allowed the researcher to obtain an in-depth knowledge about the study area. According to Myers (1997), qualitative methods are extremely useful when the study area is not well understood, complex, sensitive and requiring lots of detail. This method was useful as it provided an in-depth analysis about the perceptions and attitudes of employees towards HIV-positive colleagues. The qualitative research design conducted (focus groups) was content analyzed to expand on the knowledge that was gathered through the survey.

3.2.1 Rationale for Research Design

The mixed-method approach is a form of triangulation. Triangulation is a technique used in research that facilitates cross-checking or the validation of results (O'Donoghue & Punch, 2003). The purpose is to increase the credibility of the results. In this research study,

methodological triangulation was used, which involved using more than one method to gather data. In this instance both questionnaires and focus group discussions were used. The use of more than one method to investigate a research question enhances confidence in the findings of the study. The use of triangulation is also likely to increase the quality of the final results and to provide a more comprehensive understanding of the analysed phenomena (Greene & Caracelli, 1997).

3.3 Data Collection Methods

3.3.1 Population

The population in research methodology refers to the total group of subjects that would need to be assessed if the views of everyone in a particular situation were to be measured (Christensen, 2007). However, investigating the views of an entire population is not always possible due various factors such as time constraints, financial constraints and availability of researchers (Mnyanda, 2006). In this research study, the population consisted of the total number of employees in the Premier's office. The population amounted to 228 employees. This office is situated in the capital of the Northern Cape Province, Kimberley.

3.3.2 Sampling Method

A stratified sampling method was used. The employees fall within different staff levels (levels 1-8; levels 9-12; levels 13-16) and thus a stratified sampling method ensured representivity from each of the three different staff levels. Fifteen percent of employees were selected from the different stratified groups. After stratified sampling, participants were randomly selected from the different stratified groups. Thus, a random sample of specific size was drawn from each of the different groups of stratum of the population.

3.4 Measuring Instruments

3.4.1. Questionnaire

The first measuring instrument utilised was a self-administered questionnaire with limited open-ended questions. The questionnaire contained 21 questions of which six of the questions were open-ended.

3.4.2 Focus Groups

In order to supplement the data gathered through the questionnaire, a focus group was conducted. The focus group consisted of eight employees and a semi-structured interview guide was used to facilitate the process. According to Morgan (1993), focus groups are methods of interviewing groups and the interaction between the facilitator and the groups as well as the interaction between groups members, allow for information and insights to be elicited in response to well-designed questions asked by the facilitator. Morgan also states that focus groups are useful in finding out the nature of consensus derived from a questionnaire. Focus groups may reveal fundamental differences in participants' agreement to a statement in a questionnaire and is thus useful in determining the conditions of agreement. The participants for the focus group were selected based on willingness to participate and availability. Thus, a convenience sample was used. According to Christensen (2007), the advantage of using such a sample is that less time is spend to select the sample as the sample includes individuals that are readily available.

3.5 Data Analysis

The collected data was analysed in two stages. The first stage involved the descriptive compilation of data collected through the questionnaires, and the second stage involved the content analysis of data collected through the focus group sittings. The results of the survey were captured manually, using tallying to determine the frequency of responses from the questionnaires. The qualitative data was analyzed with the view to gain an in-depth understanding of the perspectives of employees on the topic of HIV stigma and discrimination. The data from the research tools (open-ended questions and focus group guide) was summarized in themes that emerged. The analysis of the obtained information were captured the perspectives of the employees. Agreements and conflicts on the issues were documented.

3.6 Informed Consent

Prior to the start of the study, a research proposal was submitted to the University of Stellenbosch's Ethics Committee for approval of the intended study. An informed consent process informed the participants about the nature of the research, and protected participants' rights to confidentiality, and their ability to terminate involvement in the study at any time. More specifically, the informed consent outlined the nature of the study, and the risks of participating in the study. It gave a full explanation of the purposes of the research; an

expected time commitment of the participant; a description of the procedures of the study; a statement of potential benefits of contributing to research on stigma and discrimination in the workplace; a statement regarding the confidentiality of participation (as described above); a listing of the researcher's name, telephone numbers, and address, as well as those of the research supervisor and the University of Stellenbosch Ethics Committee, if the respondents had any questions about the study and their rights as participants; and a clear statement that participation in the study was voluntary and participants could elect not to participate at any time without any penalty. The above protocol for informed consent was submitted and approved by the University of Stellenbosch.

3.7 Ethical Considerations

The study was dependent on the use of human subjects for completion. The issue of ethics as well as respect for human rights and dignity had to be considered carefully. The stigma of HIV/AIDS is such that HIV-positive participants may fear discrimination, rejection or even violence if their HIV status is revealed (Qubuda, 2010). Morse and Richards (2002, p 205) in Qubuda (2010) identify the following ethical principles regarding participants' rights:

- The right to be informed of the purpose of the study as well as what is expected during the research process. The amount of participation and time required. What information will be obtained and who will have access to it. Finally what the information will be used for.
- The right to confidentiality and anonymity.
- The right to ask questions of the researcher.
- The right to refuse to answer questions the researcher may ask, without negative ramifications.
- The right to withdraw from the study at any time without negative ramifications.

In consideration of ethical issues related to the selection of the sample, participation was voluntary, and any of the potential participants were free to decline to take part. Participation in the study was confidential. Study participants signed informed consent forms and also allowed audiotape of the focus groups. Confidentiality was maintained throughout the study, and potential study participants were informed of the intentions of the study. Participants were given resources in the form of counselling, if emotional upset and unintended injury

resulted. Participants were able to terminate their participation at any time, without harm or consequence. The focus group questions did pose a risk of emotionally upsetting the participants as there were questions that may have aroused anxiety or sadness within the participant.

Permission to conduct this study was approved by the Ethics committee of the Stellenbosch University and the relevant workplace (the Office of the Premier). Informed consent was obtained from all participants before the study began. Participants had the right to withdraw from the study or stop their participation at any time during the process. This study maintained the participants' anonymity and privacy. The names of participants were coded to protect their identity in all written reports. The names were also removed from the master copy of the demographic information after being coded and only the researcher was able to identify the participant.

Only the researcher had access to the list that linked participants' names with codes. Research participants were assured that their identity would be kept confidential and that the completed questionnaires and all collected data would be securely filed and locked with access limited to the researcher and the supervisor. Numerical codes were used for ease of processing the data. The participants were assured that the data would be presented in an overall picture of the research which would be beneficial for further social science research and HIV/AIDS management practice. All data were kept in the researcher's office in a locked cabinet. The consent forms were filed separately from the data. The audiotape-recording of the focus group sessions were erased at the end of study. Data was not shared with anyone except the researcher's supervisor.

CHAPTER 4

RESEARCH FINDINGS AND ANALYSIS

4.1 Introduction

This chapter focuses on the findings of the study as well as the analysis thereof. It portrays a qualitative analysis and interpretation of the data collected. The results are presented in chart and table format. Analysis according to Blatex, Hughes and Tight (1996) is a process that allows the researcher to seek understanding of the data and arrive at his own assessment of what the results mean and relate his/her work to what has been done by others in the relevant field.

4.2 Biographical Information

The socio-demographic information is represented below under its respective headings.

4.2.1 Number of Participants

A total number of 34 participants took part in the study by completing the questionnaires. The different salary levels are divided into 3 distinct groups: Group 1 – salary levels 1 – 8; Group 2: salary levels 9 – 12; and Group 3: salary levels 13 – 16. Group 2 is also referred to as the middle management group and group 3 as the senior management group. The groups were stratified and 15% of each group were selected. Secondly, participants were randomly selected from the stratified sample. The number of participants in the different groups amounted to 20, 10 and 4 respectively.

Table 1: Number of Participants

	Salary Level 1-8	Salary Level 9-12	Salary Level 13-16
Number of Participants	20	10	4

4.2.2 Age Distribution.

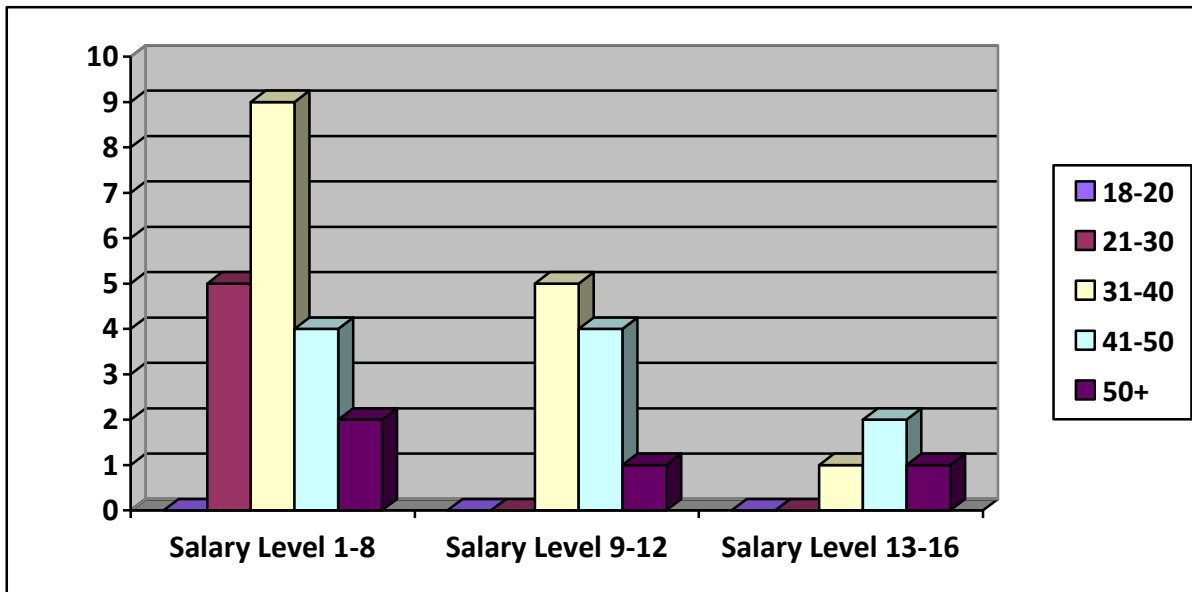


Figure 1: Age Distribution

The age distribution of the participants was as follows. In the salary level 1-8 there were 5 participants between the ages of 21-30; 9 participants between the ages of 31-40; 4 participants between the ages 41-50 and 2 participants in the age group 50+. In the salary level 9-12 group there were 5 participants in the age group 31-40; 4 participants in the age group 41-50 and 1 participant that was over 50 years old. In the salary level 13-16 group 1 participant was in the age group 31-40 years; 2 participants in the age group 41-50 years and 1 participant that was over 50 years old.

4.2.3 Gender Distribution.

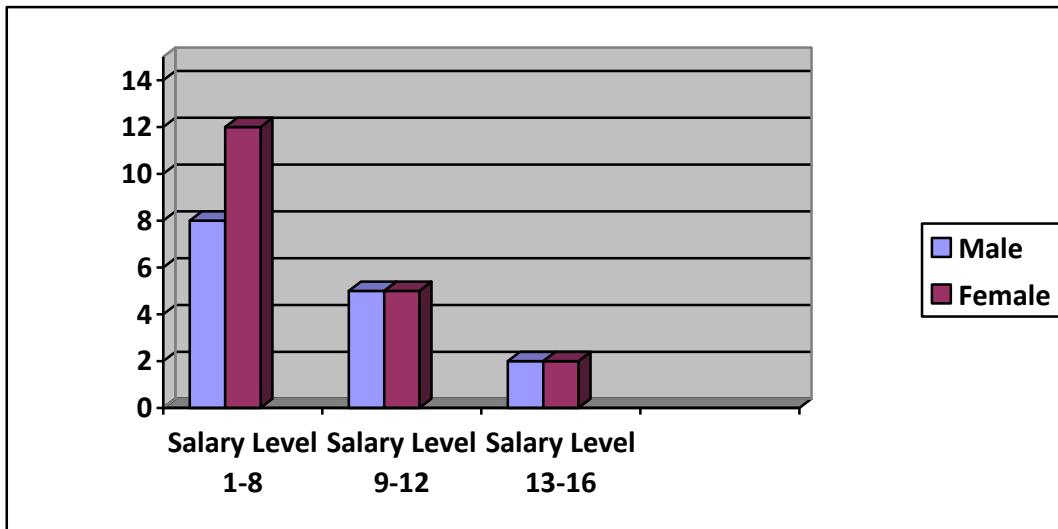


Figure 2: Gender Distribution

The gender distribution was almost equal in the different salary groups except in the salary level 1-8 group. In this group there were 8 male participants and 12 female participants. Thus the male and female gender was equally distributed in this survey. No attempt was made to manipulate the gender numbers of the participants. This also reflects the trend in the population of 119 females and 109 males in the Office of the Premier.

4.2.4 Marital Status.

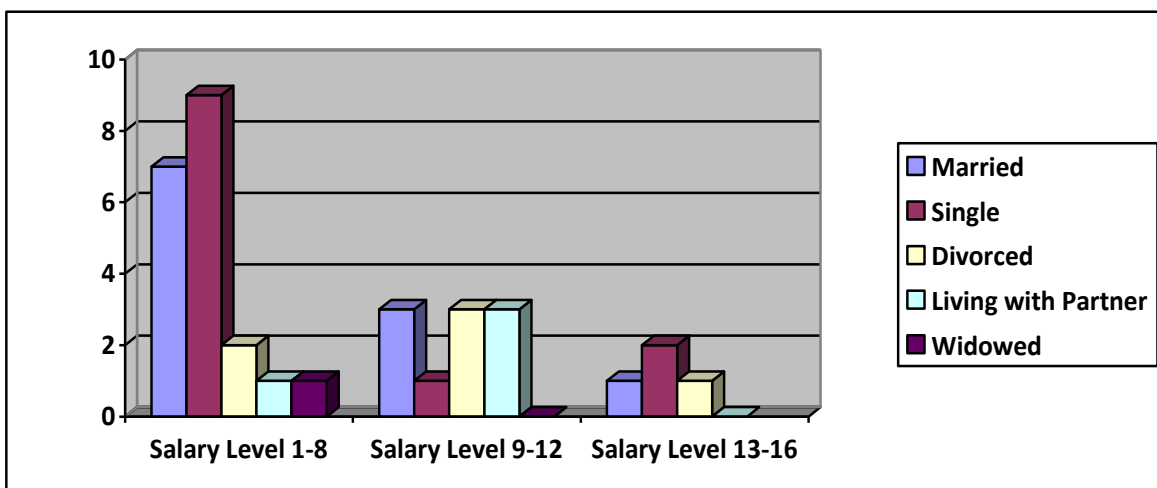


Figure 3: Marital Status

The marital status of participants was equally split between married and single participants with the total number married participants amounted to eleven and 12 participants were single. Only one participant was widowed. Six participants were divorced, and 4 participants indicated that they were co-habiting with a partner.

4.2.5 Educational Level.

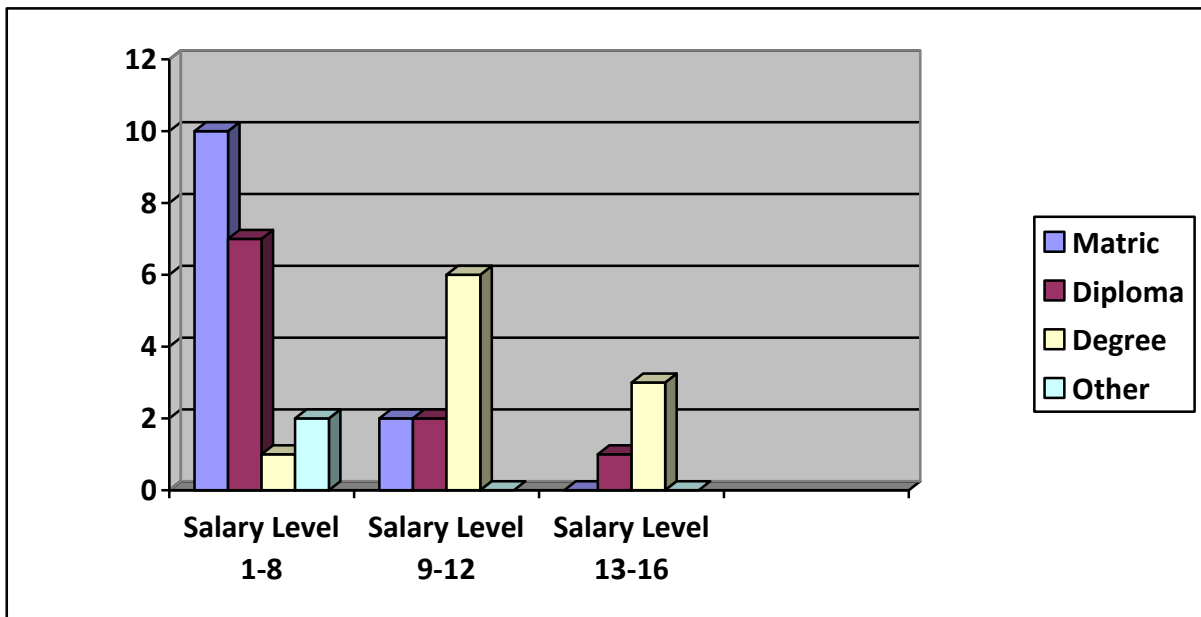


Figure 4: Educational Level

Twelve participants reported having obtained a matric qualification, with ten participants indicated that they had at least one degree. Ten participants had obtained a diploma and two indicated other and specified a grade ten school qualification (thus did not have a matriculation certificate). These two participants were also in the lower earning group.

4.2.6 Race.

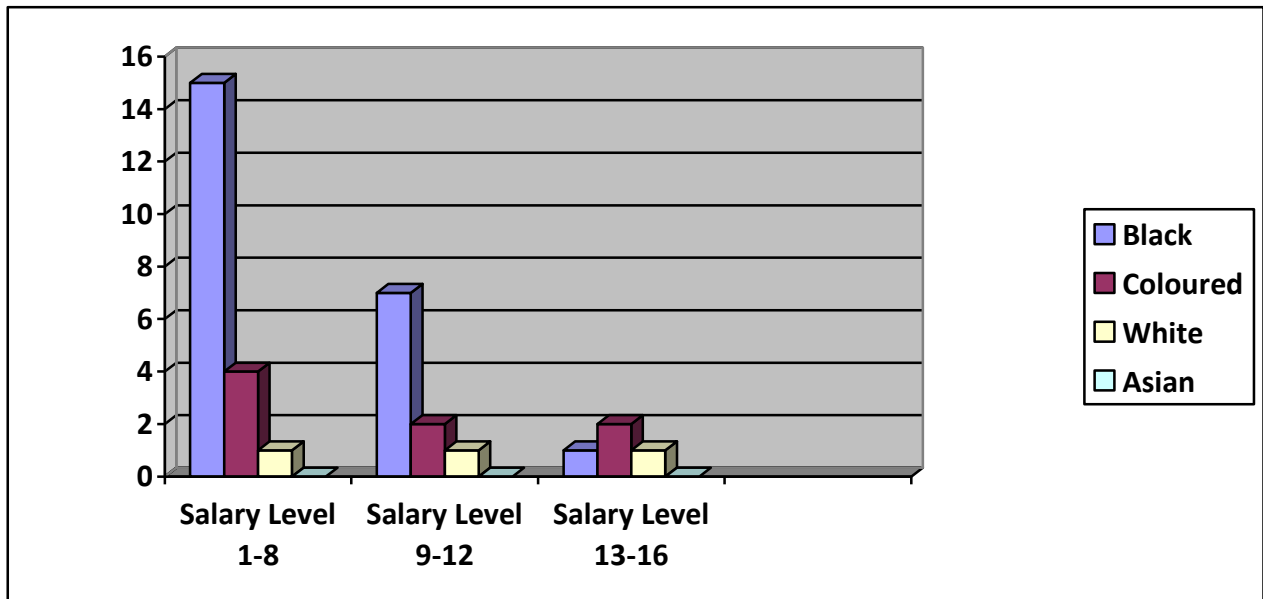


Figure 5: Race

The different racial groups were proportionately represented according to the demographics of the organisation. The total number of black participants amounted to 23. Eight participants indicated their racial groups as coloured and three indicated their race as white. No Asian participants were part of the study. According to the organisation demographics, only one employee from the Asian grouping is employed by the organisation. Thus the likelihood of this employee being selected through randomization would be minimised.

4.3 Results of Questionnaire

Participants were requested to respond to 9 questions pertaining to working with a colleague that is HIV-positive or has AIDS. The responses to the questions are discussed with an analysis of the response. The items of the 9 questions also illustrate the participants' behavioural response as either avoidant or supportive and also looks at the intentions of the behaviour.

Table 2: Responses to Behaviour and Intention Items

Responses to Behaviour and Intention Items		
Avoidant Behavioural Intentions	% Avoidant	% Supportive
1. Willing to work with him/her	0	100
2. Ask to work in different office	0	100
3. Ask to work with someone else	0	100
4. Go out of your way to assist him/her	97	3
5. Try to avoid contact with him/her	3	97
6. Treat him/her the same as before	94	6
7. Would your boss dismiss you if s/he knew you were HIV-positive	3	97
8. Would you tell anyone if you became HIV infected	24	76
9. Would you tell your partner if you became HIV-positive	3	97
<u>n</u> = 34.		

4.3.1 Working with an HIV-positive colleague

One hundred percent of participants indicated that they would be willing to work with an employee that is HIV-positive. This could be an indication of employees feeling comfortable to work with others that might be infected with HIV. The same response was indicated on the following two questions on whether employees would request that an HIV-positive colleague be moved to another unit or office or whether they would request to work with HIV-negative employees. All of the participants indicated that they would not request that the colleague be

moved to another unit or office. One hundred percent of participants also indicated that they would not request to work with an HIV-negative colleague instead of an HIV-positive colleague. All of the participants also indicated that they would not avoid having contact with an HIV-positive colleague.

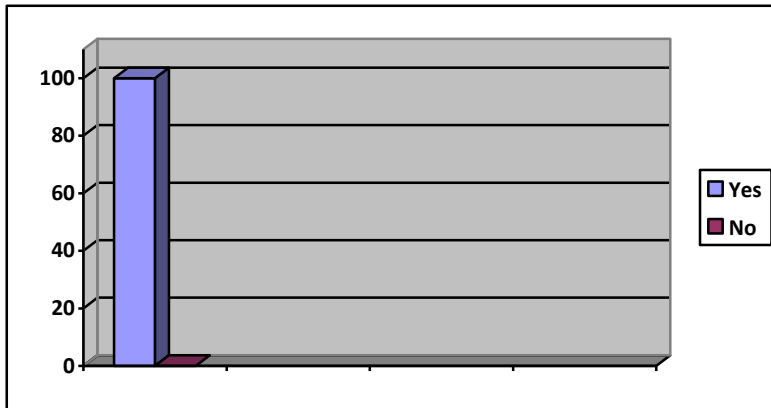


Figure 6: Working with HIV-positive Colleague

4.3.2 Assisting an HIV-positive colleague

In contrast to the above answers, ninety seven percent of participants stated that they would not go out of their way to assist an HIV-positive employee if they needed help with their work. This is in direct opposition with the preceding responses that reflected a more liberal and accommodative stance to working with HIV-positive employees. It would seem that even though employees would work with an HIV-positive employee, they would not actively assist them when needing help. It would appear as if there is a passive aggressive attitude towards HIV-positive employees.

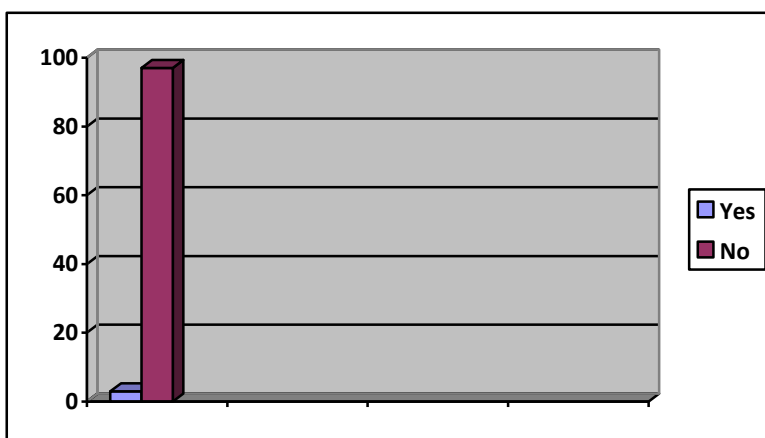


Figure 7: Assisting an HIV-positive Colleague

4.3.3 Behaviour towards and HIV-positive colleague

Ninety four percent of participants indicated that they would not treat an HIV-positive colleague the same way as before knowing his/her status. Only six percent of participants indicated that they would.

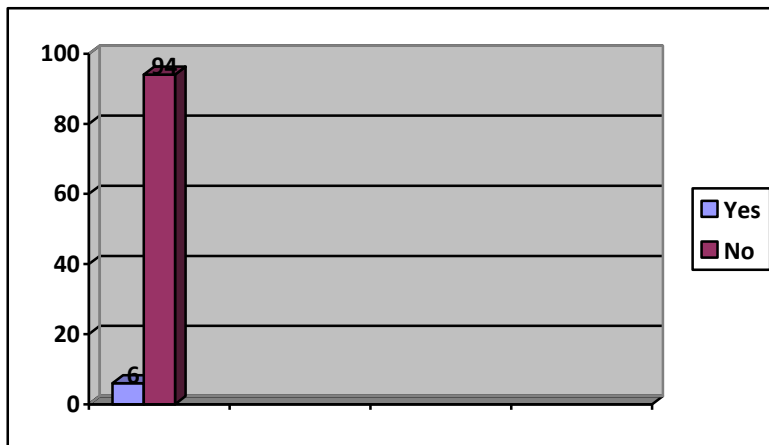


Figure 8: Behaviour towards HIV-positive Colleague

4.3.4 Dismissal due to HIV-positive status

Ninety seven percent of participants indicated they thought their boss would not attempt to dismiss them if their status became known. However, three percent of participants differed and thought that they would be dismissed if their HIV status were to become known.

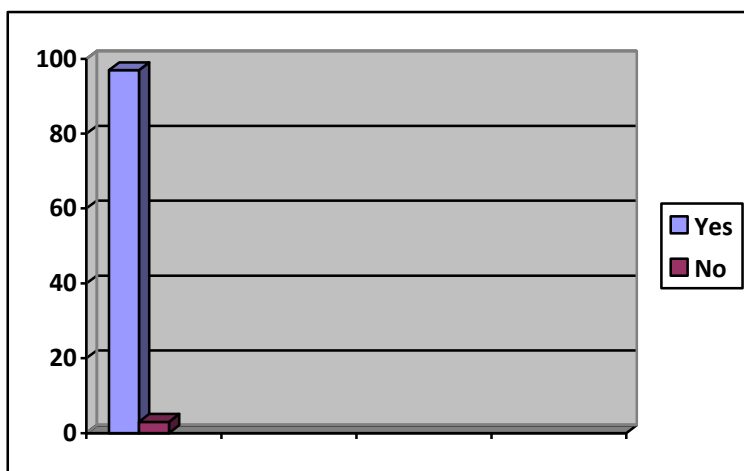


Figure 9: Dismissal due to HIV status

4.3.5 Disclosure of HIV status

Seventy six percent of participants indicated that should they become infected with HIV, they would disclose their status to someone. Twenty four percent indicated that they would not disclose their status to anyone. Contrary to the above answer, ninety seven percent of participants stated that they would inform their partner should they become infected with HIV. Three percent stated that they would not inform their partners.

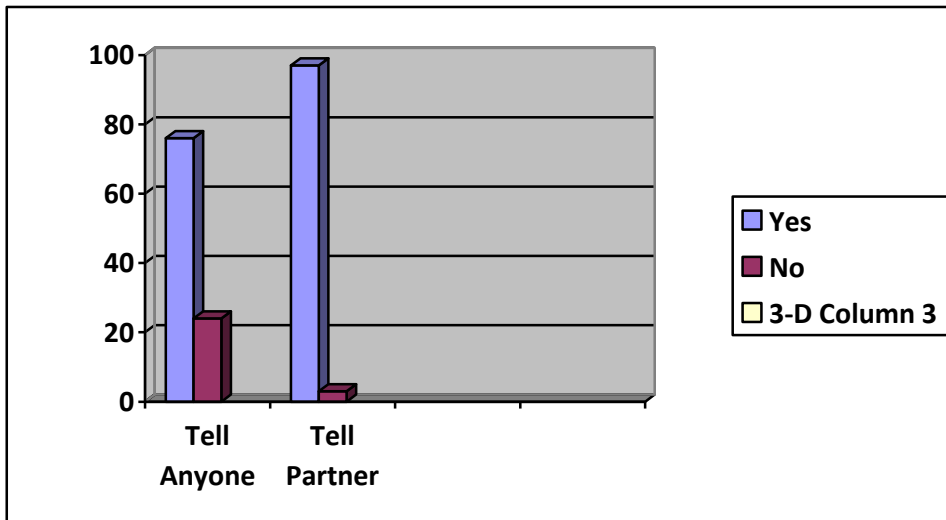


Figure 10: Disclosure of HIV status

Table 3: Responses to Stigma Items

Responses to Stigma Items		
Feelings	% "Very" or "Somewhat"	% "Not at All" or "A Little"
10. Angry	26	74
11. Disgusted	3	97
12. Afraid	21	79
Coercive Attitudes	% "Strongly" or somewhat Agree	% "Strongly" or somewhat Disagree
13. Legally separated	9	91
14. Make names public	3	97
Blame	% "Strongly" or somewhat Agree	% "Strongly" or somewhat Disagree
15. Gotten what they deserve	41	59
<p>$n = 34$. The category of <u>Agree</u> combines the responses of "agree strongly" and "agree somewhat." Similarly, the category of <u>Disagree</u> combines the responses of "disagree strongly" and "disagree somewhat."</p>		

4.3.6 Anger towards people living with HIV/AIDS (PLWHA)

Seventy one percent of participants indicated that they were not angry at all with people living with HIV/AIDS and 3% reported feeling somewhat angry (Total of 74%). Twenty three percent stated they were a little angry, with 3% indicating feeling very angry with people living with HIV/AIDS (Total of 26%).

4.3.7 Scared of PLWHA

Responses indicated 76% of participants not feeling scared of people living with HIV/AIDS and 3% feeling somewhat scared. Eighteen percent stated feeling a little scared with three percent reported feeling very scared.

4.3.8 Disgusted with PLWHA

In this category, 82% of participants reported feeling not disgusted at all with people living with HIV/AIDS and 15 % reported feeling a little disgusted. Only 3% indicated feeling very or somewhat disgusted.

4.3.9 Legal Separation of PLWHA

The responses from this item indicated 91% of participants felt they strongly disagree with the legal separation of HIV-positive employees from other employees. Only 9% of participants indicated they strongly agree or agree somewhat.

4.3.10 Public Announcement of PLWHA

The results from this item showed that 97% of participants indicated that they strongly disagree that the names of HIV-positive employees be made public. It was shown that merely 3% of participants indicated that they agree somewhat with the statement.

4.3.11 PLWHA have gotten what they Deserve

The results from this item differed slightly from the previous responses. It was found that 59% of participants indicated they strongly disagree that employee who contracted HIV through unprotected sex or drug use have gotten what they deserve. On the other hand, 35% of participants stated they somewhat agree that employees have gotten what they deserve with 6% indicating they strongly agree with the statement.

4.4 Responses to Open-Ended Questions

The questionnaire contained six open-ended questions and participants were asked to complete the questions as well. The questions focused on possible reasons or explanations for stigmatizing behaviour; the impact of stigma and discrimination; how to deal with stigma and discrimination and personal factors that enable testing for HIV as well as living openly with a positive HIV status. Only five participants completed the open-ended questions. This could

possibly be ascribed to time as well as the fact that those questions were optional. The five participants that completed the questions were from group 2 (middle management). It could also be that the participants in the lower levels did not understand the questions or was unwilling to write down long answers, but preferred ticking off answers. Similarly in the senior management group, participants might have felt strained for time and only opted to answer those questions that they could tick off.

4.5 Responses to Focus Groups

In order to further understand stigma and discrimination and how those that are living with HIV are affected, focus group discussions were held. Initially the study aimed to have 3 focus group sessions of one and a half hour each. Due to the time of year as well as the availability of participants, only 2 focus group sessions were conducted. During the month of December, most public servants take their annual leave and thus many of the questionnaire participants approached, were not available or had limited time to participate in the focus groups. These constraints posed a challenge and thus the need to limit the focus groups session to one less than was initially anticipated and planned. However, eight participants did consent to partake in the focus groups and were present at both the sessions. Six of the participants were female and only two were male.

4.5.1 Existence of stigma and discrimination.

The participants were asked about the existence of HIV-related stigma and discrimination in the workplace. The majority of the members agreed that people who are infected with HIV and those affected by HIV are subjected to stigma and discrimination.

“They feel they’re not accepted by the society, by the workplace, they will try to commit suicide, their mind are suicidal..., they stressful, depressed, neglecting everything, not eating, drinking, ... cause she hear she is not accepting by society and the rest.” (Group member 3)

“They are isolated and it causes further withdrawal.” (Group member 8)

“This is a very negative thing, ... as they not only have to deal with their own issues and well-being and initial shock, but now the added issue of people’s ignorant perceptions and lack of compassion.” (Group member 1)

“Things are no different here at work. One would think that we are better, but it is even worse than at home. People are made to feel like nothing because they have HIV and we other do nothing ... we say nothing. So we also make it worse. But I can tell you, stigma exists here at work.” (Group member 5)

4.5.2 The causes of stigma and discrimination

On the question of what factors contribute to stigma and discrimination, the participants indicated that the negative views people have of HIV are huge factors. These views include HIV/AIDS is a result of unacceptable wrong behaviour, and the religious view that HIV is a punishment.

“Many feel that because they have slept around that God is punishing them and others also feel that they have got what they deserve... that makes people not want to associate with him.” (Group member 5)

“It is easy to say you will have sympathy, but when people do these wrong things and sleep around then it is not so easy to understand...” (Group member 8)

On the other hand, the majority of participants agreed that lack of information and blame for bad behaviour rank highest among the factors fuelling stigma and discrimination.

“People are afraid of talking of this killer disease” (Group member 7)

“People are most likely misinformed about the illness and that is why they see it as a “killer disease ... and do not want to be associated with that person cause they feel that they will get it too.” (Group member 1)

Those who are not well informed about HIV and its mode of transmission believe they can get infected by being for example in the same room with the infected people or drinking from the same mug of the infected person.

“For a very long time I did believe that you could get it from touching that person or drinking out of the same cup. I’m honest, I did feel like that ... and it took a long time and a

lot of convincing to make me think otherwise. But I also listened to lots of talks on the radio and read all these pamphlets at the Employee Health and Wellness unit.” (Group member 2)

4.5.3 Forms of Discrimination

People living with HIV are said to be discriminated against in different forms and in different situations.

Workplace issues

Participants were asked which ways they have observed discrimination in the workplace. It became apparent that employees are not always certain which of their colleagues are HIV-positive but it is evident that speculation about HIV-infection is rife irrespective of confirmation thereof. It seems that there is lots of gossip about colleagues that become ill or that are losing weight.

“... they don’t outright tell you if they are ill, but it is clear when you look at them. They become very thin sommer overnight and then you know... and they pretend that everything is okay when you can see that it is not so.” (Group member 2)

“Yes, you can see, because they don’t look well and they do lose a lot of weight.” (Group member 6)

Most of the participants agreed that discrimination existed in very subtle ways. They pointed out that some employees would refrain from using utensils previously used by an employee known or suspected to be HIV-positive.

“... they would make sure that they drink with the cup before the HIV-positive employee does ... that is now if there is only one cup, ... or they would make sure that they wash it thoroughly with boiling hot water before using it”. (Group member 4)

“I have seen how people all of a sudden don’t sit with a person anymore when it is lunch time or they suddenly have excuses of going to do errands in lunch time to avoid that person but then they just sit with others in another office and eat their lunch. If they do eat with that person they bring their own fork or spoon from the house and they no longer share from the same plate. They dish for that person in another plate and before they all used to eat from the same plate.” (Group member 7)

Discrimination at the workplace seems to be insinuating. Participants agreed that employees living with HIV/AIDS are given opportunities for employment and promotion. However, those employees are stigmatized when they have to be given time off to receive medical treatment and check-ups.

“You know, I sometimes feel these people want preferential treatment in the workplace... they always want to be given time off from work, and then they must be treated with gloves. We can’t complain about their time off or we get told that we are discriminating against them, but what about our rights?” (Group member 3)

It is all good and well to get time off and they should go to get their medication and see the doctor, but then it feels like the manager discriminates against us when we also asks for time off to go to the doctor. They [managers] made you feel as if you are lying and are not really ill. So we must all be treated the same way.” (Group member 1)

The participants also agreed that discrimination do exists when opportunities for employment, promotions; job allocations and training become available. It seems that the employer does not want to invest money into employees that are thought to be HIV-infected.

“Everybody knows that ABC is HIV-positive, and she has never denied it, so my boss did not want to send her on the management training and said what would happen if she become ill while away on the course.” (Group member 3)

“When it came to the vacant posts, she was not shortlisted although she was doing the job for a very long time. I can only think that it was because of her status but then they said it was because she did not have the necessary qualifications.” (Group member 2)

Group participants also expressed their thoughts on the issue of managers’ apparent lack of interest and discriminatory behaviour.

“In the workplaces it is like our managers feel AIDS is for the rest of the staff and not for them....” (Group member 6)

“When we had the day of testing, the managers stayed for the speeches, but when the actually testing came ... they got up and leave and just say that we must get tested... they say the people have come to test you”. (Group member 4)

Social Relations

During the focus group discussion, it became apparent that stigma and discrimination in relation to social relationships or social networks exist in the workplace. However, this seems to be at an almost inconspicuous rate. On a more palpable level the group revealed that employees do stigmatize and gossip about colleagues' HIV status.

Some colleagues have been blamed for a “suspected” HIV-status and other have been called derogatory names such as “slut” and “being loose”. It would seem that it is common for co-workers to talk about colleagues behind their backs speculating about their HIV status and mostly so in situations where they were simply hypothesizing and conjecturing that one might be infected. One of the participants said:

“you would often find groups together talking about this one and that one and what they were doing with who and that they could not be HIV-negative anymore, ... and that maybe they are doing what they are doing because they are positive ... and that one must be careful around them, not knowing ...” (Group member 4)

“It is common knowledge that he and his wife have been positive for years now.” (Group member 8)

Social rejection and exclusion is confirmed by Chaturvedi (2001) as one of the characteristics of discrimination. People sometimes diagnose other people and start to gossip about the person they suspect are infected.

“Both of them have been positive for years now... I don't know why she doesn't leave him when everybody knows that he is sleeping around and keep on infecting her. She acts like nobody knows about her status ... even going for the test ...” (Group member 5)

The participants revealed that although the majority of people would care for and support individuals who are HIV-positive; there are still those that have rejected friends that became

HIV-positive. All participants were in agreement that if confronted by an HIV-positive individual, people's initial feelings changed and they reacted to the individual in a stigmatized fashion.

“Our one colleague, who was HIV-positive, was admitted to hospital and we decided to visit him in hospital. It would be the first time we saw him after he was diagnosed. I was so scared to touch him because I thought I might get infected... I know how it sounds but I was really scared and I ended up not touching him and only staying in the background while the others talked to him. I did not know that I would feel like that, but it just happened.” (Group member 6)

“After work my kids were in the car with me and then this one colleague came to my car. I was really scared that he would try to touch my kids. This was after I heard that he was positive. I was checking whether he has a sore on his hand.” (Group member 7)

“This is happening to me all the time. If I am around someone that I have heard is positive, I don't feel the same as before. It is as if I am watching my step all the time. I know it is weird and I don't want to feel like this, but I really can't help it.” (Group member 1)

What was mostly gathered from the discussion was that people still label and gossip about those who are infected or those that they suspect are infected with HIV. The gossip seemed to have far reaching effects and cause employees to become fearful and act in discriminatory fashion towards colleagues.

Effects of stigma and discrimination on HIV Counselling and Testing (HCT)

During the focus group sessions, when asked if they think stigma and discrimination has any effect on HIV counselling and testing (HCT), the majority of the group members agreed that stigma and discrimination do have an effect. The reasons for the reluctance to test have been expressed in various ways. Many individuals fear labelling, losing friends or partners/lovers, and many fear death. The participants also indicated that some people believe that they may not cope with the stress of being told that they are HIV-positive and thus go into denial that they have to test.

“How would you be able to go on? How do you tell the people in your life in such a way that they will stand by you and not judge you and leave you?” (Group member 1)

“I must admit that deep down I firmly believe that it is better to not know at all.” (Group member 3)

“I think people only test when they have to take out insurance and then they hope for the best.” (Group member 5)

“I know of many men that get their girlfriends pregnant just so that she can go to the clinic and be tested for HIV. They know that the women get tested when they fall pregnant. That is how they take their tests.” (Group member 2)

The majority of the participants also stated that there are people whose health have deteriorated after being told that they are HIV infected, and who never recovered until they finally died.

“I have seen how fast people become seriously ill and die after they had the test. I feel that if they didn't take the test then maybe they would still be healthy and well.” (Group member 8)

“I would rather test when I am so ill and the doctors can't find out the cause, but not now ... it is really like a death sentence to be told you are positive.” (Group member 3)

The discussions confirmed that stigma seems to have a direct impact on HCT.

4.6 Conclusion

The chapter presented the findings and the analysis of data collected from the workplace under study. The findings were presented through a quantitative analysis and an interpretation of the qualitative data collected during the focus group discussions. The data has revealed that employees perceive that stigma and discrimination prevail in the workplace. It is evident that stigma and discrimination continue to pose a threat to the efforts aimed at halting the spread of HIV/AIDS. The evidence shows that stigma and discrimination instil fear in those who have not tested, they believe if they test positive they would lose friends and families

and be rejected within the workplaces. This ultimately affects the rate at which individuals decide to test.

CHAPTER 5

DISCUSSION OF THE RESEARCH FINDINGS

5.1 Introduction

This chapter discusses the findings of the research study. 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. The chapter concludes with a summary of the research findings.

5.2 Discussion of Findings of Quantitative Data

The study found that stigma levels amongst employees in the Office of the Premier were generally low. Most of the employees were supportive of HIV-positive colleagues. However, on two of the questions, the majority of employees indicated an avoidant behavioural intent towards colleagues that are HIV-positive. Approximately one quarter of the participants indicated avoidant intent on the question of whether they would tell anybody if they had to test positive for HIV. This would indicate that although disclosure levels amongst participants are high with 74% indicating an intention to disclose a positive HIV status, many still feel that there are barriers to disclose. It has been found that high levels of disclosure may break the cycle of stigma (Munyadzwe-Gabe, 2009) and could positively impact on the reduction of stigma in the workplace.

Most of the participants reported that a low level of stigma existed. This ranged between 100% en 96%. There is thus a high level of support indicated on the questions of behavioural intent towards those that are HIV-positive. The higher levels of supportive intent may be due to several reasons. These might include the presence of the Employee Health and Wellness unit, an intervention unit for all employees. This unit is aimed at education of, awareness raising, increasing HCT uptake and reducing stigma and discrimination in the workplace. Another possible reason may be the increased media campaigns around HCT and the need to know your status. The campaign's aim to have routine HIV testing may have indirectly reduced the levels of stigma. This may be possible due to the fact that making HIV testing routine coupled with other wellness test such as screening for diabetes and blood pressure could have resulted in stigma reduction by converting the HIV disease from a fatal disease to a controllable chronic illness. This possibility is alluded to by the findings of the study

investigating the practices, attitudes and human rights concerns to routine testing in Botswana where 60% of participants reported that routine testing would reduce stigma (Weiser, 2006).

In the current study it was revealed that 26% of participants indicated that they felt somewhat or very angry with HIV-positive colleagues, while 74% did not feel angry at all. The study also revealed that 21% of participants reported feeling scared of colleagues with HIV. These findings are in line with previous studies that the effect of stigma is to marginalize and exclude people with HIV/AIDS (Mnyanda, 2006; Somhlaba, 2008; Alexandrova, 2004).

This indicates that although the numbers are relatively low, stigma exists in the workplace albeit in very subtle form. This may explain the fall-outs on items four and six. It could be explained that although employees would like to be supportive and helpful, their preconceived perceptions takes control when they are actually confronted with an HIV-positive colleague. It is thus clear that the behavioural intent is somewhat different from what the person enacts. It would thus seem that enacted stigma is present albeit understated and inconspicuous.

Forty-one percent of participants indicated blame for a positive HIV status should be placed at the door of that individual. They felt that HIV-positive employees have gotten what they deserved. Weiner (1993) states that people who contract HIV/AIDS through behaviour that is perceived as controllable, (e.g. sex), are assigned more blame, and they receive less sympathy and more anger. Literature shows that people infected with HIV are often blamed for their condition and many people believe that HIV could be avoided if individuals made better moral decisions (Somhlaba, 2008; Herek, 1999).

Since HIV/AIDS is recognized as a sexually transmitted disease in South Africa, people with HIV/AIDS are often socially stigmatized as promiscuous, deviant, or immoral (Qubuda, 2010). Although literature shows that stigma has started to decline over the years (Strebel, Crawford and Shefer, 2006) in countries such as South Africa, it is nevertheless still highly present (Duffy, 2005; Visser, Makin, Vandormael, Sikkema and Forsyth, 2009). This study found that stigma and discrimination is also present within the work environment.

5.3 Discussion of Findings of Qualitative Data

5.3.1 Prevalence of Stigma

Findings obtained using the qualitative method of data collection (focus group), were slightly incongruent with the findings of the quantitative method of data collection (survey). The findings showed that stigma and discrimination are far more prevalent compared to the results obtained through the survey. The focus group discussion did however show consistency with items four and six of the questionnaire, as well as with items 10, 12 and 15 of the questionnaire. These items showed that participants exhibited stigma when dealing with HIV-positive colleagues and would not go out of their way to assist them and would treat them differently as before the discovery of the person's HIV status. The above mentioned five items of the questionnaire concur with the results of the focus group sessions as discussed below.

5.3.2 Lack of Information

The cause of stigma and discrimination were attributed to a number of factors. These were the negative people have of HIV and AIDS such as HIV is a result of engaging in unacceptable bad behaviour and is punishment from God. Significant causes of stigma that were highlighted in the discussions, were the lack of information about HIV/AIDS and blaming people for perceived bad behaviour. These findings are no different from results obtained in similar workplace studies (Mnyanda, 2008; Somhlaba, 2009). However, according to Deacon (2005) one should caution as not to define stigma solely as resulting from a process of individual ignorance. She states that stigma is also an intricate social process. The aim of which is the fight over power and dominance. This can be understood in the context of the workplace where individuals constantly vie over promotion and being elevated both hierarchically as well as financially. The added element of an HIV-positive colleague could be advantageous to those striving for ambition and authority. Thus the issue of HIV education in the workplace should address both the issues of ignorance (lack of power) as well as blame. This is important so that colleagues can gain insight and become aware of personal motivations.

5.3.3 Discrimination

Several workplace issues were emphasized during the discussions. Focal to the discussions was the issue of discrimination in the workplace that seems to be omnipresent. It was apparent that although incidents of discrimination were not overtly manifested, these incidents were definitely widespread. It has been found that although discrimination can result from stigma, it could just as easily result from “resource concerns, fear of infection, racism, sexism and so on.” (Deacon, 2005, p. ix). This finding has implications for the workplace and workplace interventions. Although all forms of discrimination are unacceptable, discrimination in the workplace should be carefully investigated to understand the rationale behind it, to address and to deal with each incident in its particular context.

5.3.4 Othering

Another key workplace issue was the perception of being “othered” and the existence of an “us” and “them” phenomenon. It would appear as if employees applied the concept of “discrimination” to others in order to see themselves as different to colleagues that are either HIV-positive or thought to be HIV-positive. Joffe (1999) suggests that people often blame social groups other than their own for being affected by diseases such as HIV/AIDS. He states that it is an emotional response rather than a cognitive response and that it seems to take effect on an unconscious level. As a direct consequence, people start to feel that they are less at risk for contracting HIV compared to the discriminated or “othered” group. This phenomenon also links with the previously discussed topic of lack of information as a social process rather than an individual practice. It strengthens the idea that a group will be “othered” so as to enhance and support the group that started the “othering”. It creates the two opposing camps of the “us” and “them” or the “sick” and the “healthy”. This automatically puts the contest for power in the playing field of the fittest and the powerful. Workplace interventions should focus on how to address and make conscious this process so that employees gain more insight into their behaviour and the effect on the “other”.

5.3.5 Denial

Stigmatisation of others allows people to deny their own risk by projecting this risk onto an out-group (Joffe, 1999; Deacon, 2005; Mnyanda, 2006; Somhlaba, 2008). In extension on the previous topic of othering, denial incorporates the idea that “others” are more at risk to experience negative events such as contracting HIV (Joffe, 1999). This has serious implication for denial of risk and subsequently taking protective measures. Once again,

workplace interventions should focus on addressing this level of unconscious denial of risk so that employees start to show more empathy and simultaneously take steps to protect themselves. According to Joffe (1999), people became “optimistically biased” and belief that they are not at risk. The issues of personal risk versus personal protective behaviour should be investigated and addressed when workplace interventions take place. The Employee Health and Wellness (EHW) units in the workplace should be actively engaged with these issues.

5.3.6 HIV Counselling and Testing (HCT)

Stigma was highlighted as a barrier to HIV Counselling and Testing. In this case it was not only the fear of being stigmatised, but also internalised stigma that seems to be a barrier to testing. According to Deacon (2005) if a person becomes aware that he/she may be HIV-positive, accepting the stigmatized ideas about HIV/AIDS may prevent him/her from testing. Thus people seem to start to internalise the preconceived ideas (social stigma) about the HIV-positive. It has also been found that denial can operate outside the scope of stigmatization of the disease (Deacon, 2005). She states that “even if people challenge the social stigma of HIV/AIDS, they may not wish to spoil the experience of feeling well by discovering they are HIV-positive” (Deacon, 2005, p. 60). This has serious implications not only for the workplace, but for the entire government HCT initiative. HCT is currently seen as the pathway to better HIV prevention, better treatment, care and support. On the other hand, stigma, internal stigma and discrimination are seen to be serious barriers to the prevention of further infections, and to providing adequate treatment, care and support as well as alleviating the impact of HIV/AIDS” (UNAIDS, 2002, p.5). It would appear as if there is still a long way ahead for these types of interventions to deliver impact in eradication stigmatised behaviour. The workplace HCT initiatives will have to be further marketed and better strategies will have to be put in place to counter the effect of stigma.

Other key reasons highlighted to explain the barriers to test for HIV have been expressed in various ways by the participants. Many participants fear labelling, losing friends or partners/lovers, and many fear death. The participants also indicated that some people believe that they may not cope with the stress of being told that they are HIV-positive. This has been expressed in literature stating that the fear of negative consequences is a powerful disincentive for HCT (Deacon, 2005).

5.4 Explanation of Incongruence of Results

It should be noted that the slight incongruence in the findings of the questionnaire compared to the focus group could be ascribed to various reasons. It may be attributed to the fact that during the focus group discussions, participants felt safe and thus were able to express their true thoughts and beliefs. The environment created during a focus group session is very important in allowing participants to freely express their thoughts and emotions without fear of being judged or ridiculed (Morgan, 1997). This could have aided open and free expression.

The focus group environment also allowed participants the freedom to ask for clarification on HIV-related issues. This provided an opportunity for education and for participants to enhance their knowledge about HIV/AIDS. Although this was not the aim of the focus group sessions, the divergence was allowed so that participants could also benefit and learn. Furthermore, it could also be that in completing the questionnaire, participants wanted to portray themselves in a certain manner for the sake of the researcher, but that true attitudes were highlighted by some of the questions posed.

5.5 Summary of the Research Findings

It is apparent from the findings of the study that results from the questionnaire and the focus group has similarities as well as contrast. The results of the questionnaire indicate that a low level of stigma and discrimination is prevalent in the Office of the Premier. It also indicated that OTP staff has a good understanding of the concept stigma. Although the questionnaire data indicate a low level of stigma with the exception of items number four and six, the focus group data delivered slight contrast. The qualitative data analysis showed that stigma and discrimination was prevalent and seen in various forms. The discussions of the results revealed that participants perceived HIV/AIDS stigma and discrimination as rife within the Office of the Premier. It highlighted the fact that employees engage in discriminatory behaviour towards fellow colleagues that are HIV-positive as well as colleagues just suspected of being HIV-positive. The general consensus of findings from this study concludes that stigma exists in subtle, inconspicuous forms in the workplace. It was stated that although the more overt forms of discrimination are not seen as often employees are well aware of the existence thereof.

5.6 Limitations of the Research Study

The study should be interpreted in the context of a number of limitations. Due to time constraints the sample was relatively small (it only investigated 15% of the total number of employees) and this may partially account for the discrepancy between the findings of the questionnaire and the focus group discussion. Selection biased could have occurred in the sample for the focus group. Due to time constraints a sample of convenience was selected based on availability. Consequently, the sample results may not be representative of the thoughts of all in the Office of the Premier. The study was conducted in one site only that limits the ability to generalise the results for the whole country or other to workplaces.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The concluding chapter finalizes the research study and offers recommendations that will assist the workplace to effectively and efficiently deal with the negative impact of HIV/AIDS stigma and discrimination.

6.2 Conclusion

This research report has explored the perceptions of OTP employees with regard to HIV/AIDS stigma as well as their attitudes and behaviour towards colleagues that are HIV-positive. The study further looked at the existence of stigma and discrimination in the workplace. Questions that relate to behaviour towards colleagues with HIV; disclosure of HIV status and HCT were explored. The research study highlights a range of issues relating to the broader context of stigma and discrimination in the workplace. It is important to note that while the concept of stigma can be clearly identified by participants, it was not always easy to understand and unpack its impact. This research study has attempted to underscore this issue.

Concurring with other studies on the topic, stigma and discrimination constitute the greatest barriers to dealing effectively with the HIV/AIDS epidemic. They discourage organizations, institutions and the government from acknowledging the epidemic and taking timely decisive action against the scourge of HIV/AIDS. Stigma and discrimination discourage individuals from finding out about their HIV status, and restrain those who know they are infected from sharing their diagnosis, disclosing to colleagues and taking action to protect others and from seeking treatment, care and for themselves.

Employee education and employee health and wellness programmes that do not discuss HIV/AIDS or that fail to encourage employees to know their personal HIV/AIDS status, implicitly suggest that having or knowing about HIV/AIDS is bad. By not affirmatively addressing or supporting HIV/AIDS educational programmes and healthcare initiatives concerning HIV/AIDS, workplaces actively allow stigma to flourish and prevail. This will ultimately break down the fibre of workplaces and reduce them to hostile environments with no empathy and support.

6.3 Recommendations

It is evident that stigma and discrimination are complex issues that affect individuals on different levels. The results of the study point to the complexity of the constructs and their manifestations as well as how they are made known. Thus, as a result of what this study has revealed, it is recommended that:

- Further research be conducted which is broader and more qualitative covering a broader area to further identify the social, cultural and individual factors that promote stigma and discrimination in the workplace;
- This study should be replicated to assess whether different results would be obtained that might explain the discrepancies observed in the survey and focus group data;
- The Office of the Premier should aim to implement an HIV/AIDS policy with urgency;
- In addition, it should conduct a policy analysis to assess the extent to which existing policies address and reinforce stigma and discrimination.
- Employees should be informed of HIV/AIDS policies and practices so that the consequences of stigmatization and discriminatory behaviour can be understood.
- Employees should be made aware of the legislation that protect the rights of PLWHA and the Labour Code Amendment Act (2006);
- Workplaces that do not have HIV/AIDS policies should develop it, implement it and make them known to workers.
- HIV/AIDS stigma mitigation policies should be mainstreamed into HR policies as well as into the performance agreements of all managers.
- Managers at all levels should be provided with clear guidelines on how to manage when confronted with issues relating to HIV/AIDS.
- Employee Health and Wellness Programmes should be developed that aim to combat stigma and discrimination in the workplace.
- Funds should be allocated to such programmes and vigorous involvement of all, especially senior management in the workplace is critical.

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APPENDIX A: LETTER OF INVITATION AND INFORMED CONSENT

AN INVESTIGATION INTO EMPLOYEES' PERCEPTIONS OF HIV/AIDS STIGMA AND THEIR ATTITUDES AND BEHAVIOUR TOWARDS COLLEAGUES INFECTED AND AFFECTED BY HIV/AIDS.

You are asked to participate in a research study conducted by Ms. Liezl Anthony, an MPhil Student in HIV/AIDS Management from the *AIDS Centre, Faculty of Economic and Management Science* and the Principal Investigator, Dr. Thozamile Qubuda at Stellenbosch University.

1. PURPOSE OF THE STUDY

An understanding and profile of stigma in the workplace would enhance better comprehension and awareness and also assist with planning proper intervention strategies. It would furthermore increase the workplace knowledge and expertise and ensure that interventions are outcomes based and scientific. The research study would benefit the organization at large, the HIV-infected and affected employees and their families as well as the broader scientific community. Other researchers would be able to extend and augment their knowledge on the topic and even expand the range of research on the issue. In addition, the research study would allow for recommendations to be made and would enable the implementation of these interventions.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things: Complete a questionnaire that would take approximately 15 – 30 minutes of your time. Participate in 3 focus group discussions that would be of approximately 1- 1½ hours long. The focus groups sessions will be conducted at the work place.

3. POTENTIAL RISKS AND DISCOMFORTS

There are no risks associated with the research questionnaire apart from certain questions that might be uncomfortable to answer. Additionally, the focus group might lead to personal questions being asked and the session being taped might cause a certain level of discomfort. The time spent in the focus group sessions might lead to an inconvenience for some (a total of 1 to 1½ hours per session for 3 sessions).

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You will derive no personal benefit from the study. Your participation will benefit others by enabling social scientists to learn about the experience more about HIV/AIDS stigma and discrimination in the workplace. Additionally, it may assist you to better understand stigma and discrimination in the workplace. This information may also help in the development of guidelines or strategies to mitigate the impact of HIV/AIDS stigma and discrimination in the workplace. You may request a copy of the study report.

5. PAYMENT FOR PARTICIPATION

There will be no reimbursement for participation, although the information you provide will benefit other by enabling social scientists to learn more about HIV/AIDS stigma and discrimination in the workplace. Additionally, it may assist you to better understand stigma and discrimination in the workplace.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means assigning codes or numbers to the questionnaires. Data will be stored in the researcher's office at work. The office is secure with controlled access. The filing cabinets are steel with a reinforced steel bar and lock. The key to the office is secure and only one person has access to the key. The investigators are the only people that will have access to the unprocessed data. The findings of the research study will be presented in a report without identifying the participants by name.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Ms. Liezl Anthony on (053) 802 5169 or 071 851 4994 or at e-mail: lanthony@ncpg.gov.za or Dr. Thozamile Qubuda on (021) 808 3999 or 072 477 5929 or at e-mail: tqubuda@sun.ac.za.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me, _____
by Ms. Liezl Anthony in Afrikaans/English and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Participant

Signature of Participant

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____.
He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans and English*]. *No translator was used/this conversation was translated into _____ by _____*].

Signature of Investigator

Date

APPENDIX B: QUESTIONNAIRE

Biographical Information

You are invited to participate in this survey and to fill in the form as truthfully as possible. All information will remain confidential and your identity will not be disclosed.

Gender	Male		Female						
Age Group	18-20		21-30		31-40		41-50		50 +
Marital Status	Single		Married		Living with a Partner		Widowed		Divorced
Race	Black		Coloured		Asian		White		
Highest Qualification	Matric		Diploma		Degree		Other (Specify)		
Salary Level (e.g. Level 6)									
Years with Organisation									

What do **you think** you would do if you are working in an office where one of your colleagues is HIV-positive or has AIDS:

1. Would you still be willing to work with him/her?
Yes/No
2. Would you ask that he/she be assigned to work in a different unit/office?
Yes/No
3. Would you ask to be assigned to work with someone else?
Yes/No
4. Would you go out of your way to help him/her if he/she needed help with their work?
Yes/No

5. Would you try to avoid contact with him/her?

Yes/No

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

Yes/No

7. Do you think your boss would attempt to dismiss you if they found out you were HIV-positive? Yes/No

8. Should you become infected with HIV, would you tell anyone?

Yes/No

9. Should you become infected with HIV would you tell your partner?

Yes/No

10. People have many different feelings/attitudes towards people living with HIV/AIDS.

How do you personally feel about people living with HIV/AIDS?

Very Angry 1

Somewhat Angry 2

A little Angry 3

Not Angry at all

11. People are scared of those living with HIV/AIDS. How do you feel about them?

Very Scared 1

Somewhat Scared 2

A little Scared 3

Not Scared at all 4

12. People are disgusted with people living with HIV/AIDS. How do you feel?

Very Disgusted 1

Somewhat Disgusted 2

A little Disgusted 3

Not Disgusted at all 4

13. 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

Strongly Disagree 4

14. The names of HIV-positive employees should be made public so that others can avoid them. Would you say you:

Strongly agree 1

Agree somewhat 2

Disagree somewhat 3

Strongly Disagree 4

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

Strongly agree 1

Agree somewhat 2

Disagree somewhat 3

Strongly Disagree 4

Open-Ended Questions

16. What causes people to display stigmatizing and discriminating behaviour towards their fellow human being?

17. What impact does stigma and discrimination have on people living with HIV/AIDS?

18. What approaches can be used to reduce stigma and discrimination?

19. What factors do you know of that can be implemented to overcome and move beyond stigmatizing and discriminating responses to HIV/AIDS?

20. What personal factors enable people to test for HIV?

21. What personal factors enable those who test positive to deal openly with their status?

Thank you for your time and patience in completing this form.

APPENDIX C: FOCUS GROUP DISCUSSION GUIDE

You are humbly requested to take part in this exercise. Please feel free to provide as much open discussion and honest information as possible.

Please note:

This is an academic exercise.

It is voluntary.

No names or identifying information will be disclosed.

The information you provide will be used for this research purpose only and confidentiality will be maintained.

The session will be taped to record the responses.

The tapes will be destroyed at completion of the research study.

Guiding questions have been designed and I will lead the discussion

Focus Group Discussion on the perceptions of employees on HIV/AIDS stigma and their attitudes and behaviour towards colleagues infected and affected by HIV/AIDS.

Location:

Moderator:

Number of Participants:

Date:

Time:

Documentation: Tape ID:

1. EXISTENCE OF STIGMA AND DISCRIMINATION

- a) Do you believe that stigma and discrimination exist in the workplace? Why? Give Examples?
- b) Who are stigmatized or discriminated against?
- c) What are some of the things that indicate stigma and discrimination?

2. CAUSES OF STIGMA AND DISCRIMINATION

- a) Why do you think people stigmatize and discriminate?

- e.g. Ignorance,
- Lack of information
- Fear to be infected
- Any other reasons/ contributing factors

3. FORMS OF DISCRIMINATION:

- a) What are the things that you have observed that indicate that one is being stigmatized and discriminated?
 - Refusing to eat with
 - Gossips about those that are suspected to be infected
 - Rejection by fellow employees
 - Loose of friends or partners as a result of HIV infection
- b) Any other actions observed that indicate being rejected and labelled?
- c) How can this be observed?

4. WORKPLACE ISSUES

- a) Workplace relations between PLWHA and those suspected of being infected and the rest of the work force and the employers or managers?
 - How are the relations in terms of sharing the equipment/tools?
 - Working together with PLWHA
- b) Is HIV status a determining factor for promotion, transfer and dismissal from work? Why?

5. EFFECTS OF STIGMA AND DISCRIMINATION ON VCT

- a) What are your thoughts on Voluntary Counselling and Testing (VCT) in the workplace? Have you tested? Why or Why not? Do you think people are willing to test? Why or Why not?
- b) Do you think stigma and discrimination can affect the rate at which people take up the test and how?

6. CHALLENGES AND EXPERIENCES OF PLWHA

- a) Share with us some of the experiences of stigma and discrimination of employees in the workplaces: What impact does stigma have on those living with HIV/AIDS?
- b) What effect do you think stigma and discrimination has on the national response against HIV and AIDS?

APPENDIX D: PERMISSION TO CONDUCT RESEARCH IN OFFICE OF THE PREMIER



OFFICE OF THE PREMIER

HUMAN RESOURCES MANAGEMENT

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Dipatlisiso : **(053) 838 2708**
Imibuzo :
Navrae :

Date : **21 May 2010**
Leshupelo :
Umhla :
Datum :

Reference :
Tshupelo :
Isalathiso :
Verwysings :

TO: THE ETHICS COMMITTEE
THE AFRICA CENTRE FOR HIV/AIDS MANAGEMENT
UNIVERSITY OF STELLENBOSCH
STELLENBOSCH

FROM: THE ACTING DIRECTOR-GENERAL
MS. P. MOKHALI
OFFICE OF THE PREMIER
KIMBERLEY

RE: APPROVAL OF AND PERMISSION GRANTED FOR THE RESEARCH PROJECT BY MS. L. ANTHONY

I hereby grant permission to Ms. L. E. Anthony to conduct and complete her research project in the Office of the Premier – Kimberley, in the Northern Cape.

Yours Sincerely

Ms. P. Mokhali
The Acting Director-General
Office of the Premier – Northern Cape



A SOCIETY FOR ALL

APPENDIX E: ETHICAL CLEARANCE BY THE RESEARCH ETHICS COMMITTEE



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

1 December 2010

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Enquiries: Sidney Engelbrecht
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Ms L Anthony
Centre for HIV/Aids Management
University of Stellenbosch
STELLENBOSCH
7602

Reference: 423/2010

Ms L Anthony

APPLICATION FOR ETHICAL CLEARANCE

With regards to your application, I would like to inform you that the project, *An investigation into employees' perceptions of HIV/Aids stigma and their attitudes and behaviour towards colleagues infected and affected by HIV/Aids*, has been approved on condition that:

1. The researcher/s remain within the procedures and protocols indicated in the proposal;
2. The researcher/s stay within the boundaries of applicable national legislation, institutional guidelines, and applicable standards of scientific rigor that are followed within this field of study and that
3. Any substantive changes to this research project should be brought to the attention of the Ethics Committee with a view to obtain ethical clearance for it.
4. The researcher/s implements the suggestions made by the mentioned by the Research Ethics Committee (Human Research) in order to reduce any ethical risks which may arise during the research.

We wish you success with your research activities.

Best regards



Sidney Engelbrecht

MR SF ENGELBRECHT

Secretary: Research Ethics Committee: Human Research (Non-Health)