Perceived stigma and discrimination is the cause for employees not to participate on the HIV/AIDS work programme.
Employees in retail industry - South Africa

by

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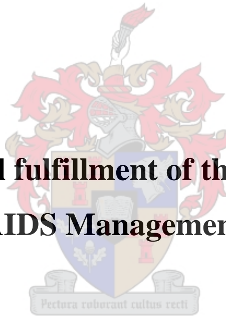

Assignment presented in partial fulfillment of the requirements for the degree of Master of Philosophy in HIV/AIDS Management at the Stellenbosch University

Supervisor: Prof. J.B. du Toit

March 2010

Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety, or in part, submitted it for obtaining any qualification.

Dainnah Sonto Mthombeni
17 February 2010

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Abstract

Background: What accounts for failure of employee to register on the workplace HIV/AIDS programme after testing positive? This could be associated with many things such as stigma and discrimination, fear of losing job because of HIV status, or even lack of knowledge about HIV/AIDS and about the workplace HIV/AIDS programme. A study within Edcon employees was designed to examine the cause of failure to register on workplace HIV/AIDS programme. Qualitative data were collected from four provinces, which are Gauteng, Empumalanga, North West and Limpopo. A 59 questions survey was given to 550 participants at different site during the morning briefing session. Participants were selected randomly irrespective of gender, age, cultural diversity, race, academic level, colour, creed or HIV status. Participants were briefed for five minutes and asked to answer questions based on the knowledge they had on HIV/AIDS. All questions were closed ended and was easy to answer and required fewer instructions and could be answered even by participants with lower educational level. Questionnaires were collected immediately after being filled and four hundred and twenty were correctly completed with no faults one hundred and thirty (130) were void because of errors. The levels of knowledge and attitudes held by the participants with regard to HIV/AIDS was high 69% but low with knowledge of workplace HIV/AIDS programme, which was 13.2%. According to results there was less or no discrimination in the workplace and even in the community in all participants this amounted to 10, 5%. Stigma is a serious problem which need to be addressed, fear of contracting HIV/AIDS, negative judgements about people living with HIV/AIDS and compounded stigma, is very high at 78%. Stigma creates barriers to HIV/AIDS, prevention and disease management, it makes people to be afraid of rejection and chose to keep their status to them self and not to seek help. The hypothesis of the study was not supported, even though there were respondents who said they could not stomach working, or living with HIV positive people, but it was difficult to measure the level of stigma and discrimination, the results were be weighed on the number of responses that indicated that there individual who have had secondary experience or directly involve with the acts of discrimination regard to stigma and discrimination. The level of stigma and discrimination could not be measured accurately.

Opsomming

Agtergrond: wat rekeninge vir mislukking van werker om te registreer op die werk plek HIV/VIGS program na toets positief? Hierdie kan geassosieer word met baie dinge hoe stigma en dikriminasie; vrees van verloor werk weens HIV status, of selfs tekort aan kennis omtrent HIV/VIGS en omtrent die werk plek HIV/VIGS program. 'n studie binne Edcon werkers was ontwerp om te ondersoek die oorsaak van mislukking om te registreer op werk plek HIV/VIGS program. Kwalitatief data was gekollekteer van vier provinsies, wat is Gauteng, Empumalanga, Noord Weste en Limpopo. 'n 59 vrae opname was gegee to 550 deelnemers tot verskillend werf gedurende die môre briefing sessie. Deelnemers was gekose wildweg afgesien van geslag, ouderdom, kultureel diversiteit, wedloop, akademiese vlak, kleur, geloofsbelydenis of HIV status. Deelnemers was saamgevat vir vyf minute en gevra om te antwoord vrae gebasseer op die kennis hulle het op HIV/VIGS. Almal vrae was gesluit op 'n end en was maklik om te antwoord en vereis minder instruksies en kan beantwoord word selfs|gelyk deur deelnemers met laer opleidings vlak. Vraelyste was gekollekteer onmiddellik nadat was gevul en vier honderd en twintig was reg voltooi met geen foute honderd en dertig (130) was leemte weens foute. Die vlakke van kennis en gesindhede gehou by die deelnemers met betrekking to HIV/VIGS was hoë 69% maar laemet kennis van werk plek HIV/VIGS program, wat was 13. 2%. Volgens uitslae daar was minder of geen dikriminasie in die werk plek en selfs|gelyk in die gemeenskap. In al deelnemers hierdie bygedra to 10.5%. Stigma is 'n ernstig (e) probleem wat benodig om te geadresseer wees, vrees van saamtrek HIV/VIGS, negatiewe veroordelings omtrent mense lewe met HIV/VIGS en het saamgestel stigma, is baie hoë tot 78%. Stigma skep hindernisse to HIV/VIGS, voorkoming en siekte hantering, dit maak mense om bang te wees van verwerping en verkies om te hou hul status hulle self en nie om te soek help. Die onderstelling van die studie was nie ondersteun, selfs alhoewel daar was repondente wie gesê hulle kan nie maag werk, of lewe met HIV positief mense, maar dit was moeilik om te meet die vlak van stigma en dikriminasie, die uitslae was wees geweeg op die aantal van antwoorde dat aangewys dat daar individuele wie het sekondêre ondervinding of direk omvat met die handelinge van dikriminasie betrekking to stigma en dikriminasie.

Acknowledgements

This study was sponsored by the workplace HIV/AIDS (Employee Health Care programme). Views expressed are not necessarily of the company but of the study conductor (student)

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1. INTRODUCTION

Due to the taboo associated with HIV/AIDS most people find them selves unable to go and seek help with regard to their HIV/AIDS status. Some of them choose to die secretly without telling anyone living behind families with a lot of unanswered questions. Most of the people are young and matured adults and even old people, but these days also the number of children living with the virus is escalating at an alarming rate. These adults are either preparing to enter the employment sector or are already employed. The above number constitutes both men and women who are mostly breadwinners. At first the problem of HIV/AIDS was seen by employers as issue that was supposed to be addressed by solely the government, but as time goes on employers realised that the epidemic was claiming the best business leaders, managers and a great numbers of workers at all levels of the production system. Stigma and discrimination attached to AIDS have a greater impact on failure of people to seek help or even register on the workplace HIV/AIDS programme.

HIV/AIDS related morbidity, absenteeism, and mortality resulted in loss of productivity, and escalated the cost of replacing staff lost due AIDS. This is a serious threat in the survival of number of businesses who found it difficult to compete nationally and internationally. Businesses then realised that its survival depend on joining forces with government sector other countries, and communities and international communities in forming partnership to fight HIV/AIDS. This is then lead to business community implementing the HIV/AIDS work programme. Most of the big business companies in South Africa has comprehensive HIV/AIDS work programme which includes packages such as VCT, diseases management and other support system such call centres with trained case managers, others companies only provide free VCT and encourage employees to register on the medical aid, and utilised the chronic benefits.

One of the earliest scholars to write about disease was Erving Goffman (1963). Goffman suggested that people that people are stigmatized by others on the basis of being different, and this “deviance” results in “spoiled identity.” More recent research has described the

social processes that define stigma, including labeling, discrediting and ordering (Aggleton and Parker, 2002; Link and Phelan, 2001, 2006; Maluwa, Aggleton and Parker, 2002). A study by (D Skinner, S Mfecane, 2004) reveals that stigma also introduces a desire not to know one's own status, thus delaying testing and accessing treatment. At an individual level stigma undermines the person's identity and capacity to cope with the disease. Stigma and discrimination plays a significant role in the development and maintenance of the HIV epidemic. Another study by (Simbayi, L.C., Kalichman, S., Strebel, A., Cloete, A., Henda, N. & Mqeketo, A. 2007) was conducted to examined the prevalence of discrimination experiences and internalized stigmas among 420 HIV-positive men and 643 HIV-positive women recruited from AIDS services in Cape Town, South Africa. The anonymous surveys found that 40% of persons with HIV/AIDS had experienced discrimination resulting from having HIV infection and one in five had lost a place to stay or a job because of their HIV status. More than one in three participants indicated feeling dirty, ashamed, or guilty because of their HIV status. However, the effects of internalized/perceived AIDS stigmas have not been investigated in Africa, home to two-thirds of the more than 40 million people living with AIDS in the world.

In this workplace research I want to find out about what causes the failure or fear of employees in participating in the workplace programme after testing HIV positive. In order to assist employees with HIV/AIDS and AIDS related sickness, the company I work for took the decision to implement a comprehensive HIV/AIDS programme to assist all permanent employees and their spouses. The HIV/AIDS work programme was started in 2004, with aim of targeting 21 481 employees. To date 17 219 have undergone VCT and of which 3 946 are repeat. Before the programme was implemented, the company was experiencing high number of HIV/AIDS related deaths, which has not improved much since the inception of the work HIV/AIDS. On the hypothesis I have selected is to look more in detail about what causes reluctance in employees to utilise the HIV/AIDS work programme in full. According to the overall reports HIV/AIDS, we are doing well, but there has not been much improvement on mortality statistics. After 4 years we should have drastically dropped mortality statistics and having more HIV employees registered on the programme, see table 1.1 mortality data. Instead we have

HIV positive employees who we cannot account for with regard HIV management, not to say its compulsory for us to know but at least we should be in apposition give a valid report like "having them register on the external programme of their choice" This will help us to monitor them indirectly.

For every death of an employee the company losses more than having to keep our employee healthy and alive, the cost is calculated from sourcing process, training and placing of new employees. Even though we have a comprehensive HIV/AIDS work programme, we still losing a higher number of employees through HIV and HIV related illnesses under the 40 years age group, which is the category that has got a long time to spend at work before retirement, what or where is the problem? I have originated this problem from the workplace HIV programme, mortality and morbidity statistics and my observation as I interact with employees during their visits to the Wellness Centre and during our quarterly meetings with union's representatives and employees. This research proposes to explore the causes of failure of HIV positive employee to register on the workplace HIV/AIDS programme, in the context of:

- Enacted stigma/discrimination against people living with HIV/AIDS
- Inappropriate fear for contagion
- Is it negative judgment about people living with HIV /AIDS
- Enacted and compounded stigma?
- Knowledge of HIV/AIDS in the workplace

By comparing data across sites, I will emerge with understanding of what is the cause of failure of the workplace HIV/AIDS programme.

2. METHODS

The data for this study were collected among employees of Edcon retail industry in South Africa. This company has different chains of stores in nine provinces. Stores in the

South-Sub-Saharan African countries such as Lesotho, Swaziland, Botswana and Namibia were not included in the study.

2.1 Study sites

A mini study was conducted among Edcon retail employees in one company among males and females in four provinces of South Africa which are: Gauteng, Limpopo, North West and Empumalanga. The selected provinces are all having borders linked to Gauteng province and it is easy to travel from one province to the other, and they also has high VCT conducted from 2004 to 2008, see table 1. The study sites are urban, semi-urban and rural areas. Gauteng has a large number of chain stores situated mostly in towns and shopping malls and it is easy to move from one store to the other. It consist of urban and semi urban areas which constitutes of a lot undeveloped settlements. Though it looks small on the map, most of the participants for the study came from Gauteng province.
1000 participants were requested to complete a five paged questionnaire.

Table 1 provides a total of employees who participated in VCT in the four selected provinces from 2004 to 2009.

Table 1: VCT totals from 2004 to 2008 December.

Provinces		**2004**	**2005**	**2006**	**2007**	**2008**	**Total VCT**
	Gauteng	460	509	1590	690	2400	**5649**
	North West	57	250	770	300	560	**1867**
	Empumalanga	98	400	678	840	400	**2416**
	Limpopo	199	509	650	600	599	**2557**

2.2 Study Sample

The data were collected using structured questionnaires with a sample of employees selected randomly. It was not known whether the participants did go for VCT and what was their HIV status. The participants had to be between 20 and 60 years of age, male and female, currently employed by Edcon retail industry. To select participants for the

study, I stratified the baseline survey sample into a combination of four demographic categories according to age, gender, race, academic level, relationship status and sexual orientation.

I felt it was important to have representation across these demographic categories because I anticipated that it will give me a broader perspective with the results. I randomly asked ten to fifty at a time to participate in the study; depending on the number that could be released at a time. Seven hundred and eight five participated in the study in all the four provinces. Participants were asked to fill in the questionnaire once at the morning training sessions at different stores. The data presented in this paper were drawn from the baseline qualitative collected between July to September 2009. In total Five hundred fifty (550) employees participated on the study across all four provinces, four hundred and twenty (420) questionnaires were correctly filled; one hundred and twenty nine were void (130). The baseline data were as follows as per province Gauteng with 150, Empumalanga 125, Limpopo 65 and North West 80.

2.3 Data collection methods

I made appointments with different stores and asked them to fill in a five page questionnaire which would take fifteen minutes. I handed in the questionnaires to all participants during the morning training session which lasted for thirty minutes and questionnaires were completed in the presence of the interviewer. The participants were expected to fill in the questionnaire with no help from the interviewer or the store human resource manager. The questions were closed ended and it was easy for even employees with low level education to answer as long as they understand the questions. The answers to the questions were standard and participants were asked to choose one answer per question by putting a cross around the selected answer. The questions were based on the following five sub-themes:

- Enacted stigma/discrimination against people living with HIV/AIDS
- Inappropriate fear for contagion
- Is it negative judgment about people living with HIV /AIDS

- Enacted and compounded stigma?
- Knowledge of HIV/AIDS in the workplace

Questionnaires we collected immediately after they were filled. Below are the guidelines sent with the questionnaires.

2.3.1 Guidelines

Thank you for your willingness to complete the questionnaire.

Please answer ALL questions and choose only ONE answer per question. Please be as honest as you can in answering these questions

To ensure confidentiality, you are not required to fill in your personal details only you cost centre number and name.

Please read each question and respond by answering with a cross (X) in the relevant number you have selected as per the example below. You can only respond once to a question. Please ensure that your response remains on the number you have selected. After completion please hand this to your HR Manager or Store Manager.

<u>EXAMPLE:</u>

QUESTION 1: I believe that HIV/AIDS can be transmitted by shaking hands with an HIV/AIDS patient.

If you <u>Disagree</u> with this statement, place a cross over the number below Disagree

Agree	**Partially Agree**	**Disagree**	**Completely disagree**	**Not Sure**
		X		

2.4 Data processing and analysis

The main aim of this study was to prove if there is a relationship between the two variables which are perceived stigma and failure for employees to register on the workplace. From the data received from four provinces from respondents from sixteen stores will be used as inferential statistics, which will be used to infer the truth or falsity of this hypothesis.

All questions were pre-coded and this helped the researcher to save tremendous time.
With the help of two Casual workers we managed to capture four hundred twenty questionnaires due to pre-coding the questionnaires served as code book that define the meaning of each code. All forms with two responses on one question were regarded as void. On the first phase, Casual workers were expected to sort questionnaires per regions and per gender. On the second phase all responses were captured on a spread sheet according to the answers given, based on the sub-themes of the questionnaires which were:

- Enacted stigma/discrimination against people living with HIV/AIDS
- Inappropriate fear for contagion
- Is it negative judgment about people living with HIV /AIDS
- Enacted and compounded stigma?
- Knowledge of HIV/AIDS in the workplace
- And demographic information

Perceived stigma and discrimination, this is the independent variable, will be verified under these domains- enacted stigma/discrimination against people living with HIV/AIDS, inappropriate fear for contagion, negative judgment about people living with HIV /AIDS and enacted and compounded stigma? Fear of employee to participate in the workplace HIV/AIDS programme, which is the dependent variable will verified under domain, knowledge of HIV/AIDS in the workplace.

3. RESULTS

My goal is to hypothesize a relationship between the two variables and then endeavor to show through statistical analysis of my data that such a relationship actually exists or not. Although I can never prove my hypothesis "beyond the shadow of doubt" the statistical of probability does allow me to prove the hypothesis within a specified margin of error.

3.1 Stigma –Inappropriate fear of contagion

Table 2 shows that respondent generally had a lot of fear with regard to contracting the HIV/AIDS. They were also afraid of interacting or even receiving anything from people living with the HIV virus. Despite widespread and accurate knowledge of transmission, participants in all four provinces shows fear of transmission from casual contact and worse with physical contact. This is the fear that leads to social isolation and neglect of people living with HIV/AIDS. Only a few knew that HIV could not be transmitted through casual contact, thus they had little fear of socializing with friends who may be HIV positive.

There is a lot of stigma –of inappropriate fear of contagion attached to the disease than to people living with HIV/AIDS. If you look coding no **5, table 2** which is lots of fear, you will realize that people are more afraid of the virus than to deal or interact with people living with the virus, for example: 99.4 % said they cannot share a glass with a person who is positive, but they are willing to work next to a person living with HIV/AIDS. It is because of the factors that contribute to HIV/AIDS *inter alia* such as: HIV/AIDS is a life threatening disease and is behaviours such as homosexuality and drug addiction. Blaming and othering is most of the time directed to a group of sexual orientations such as prostitution and homosexuality. Lack of knowledge and ignorance can also play a huge part with regard to inappropriate fear of contagion, respondents also feared to buy sweets or chocolates from HIV positive colleagues, even if they know it will never harm them.

Table 2: **Stigma–Inappropriate fear of contagion**

Respondents from retail industry (n=420)

Variable/inappropriate fear of contagion	Lots of fear	Little fear	No Fear	Don't know	Not sure
Hug a person with HIV					
Male & Female	98.2	0	2	0	0
Share a drinking glass with person with HIV					
Male & Female	99.4	0	1.6	0	0
Work Next to a person with HIV					
Male & Female	27.8	0	72,2	0	0
Care for a person with HIV					
Male & Female	83.5	0	16.5	0	0
Have sex without condom with a person with HIV					
Male & Female	99.2	0	0	0	0.8
Share injecting needles with a person with HIV					
Male & Female	100	0	0	0	0
I am afraid of people with HIV/AIDS					
Male & Female	78.9	2.3	18.8	0	0

Variable/inappropriate fear of contagion	Will never	No	Yes	Don't know	Not Sure
Would you buy sweets or chocolates from your colleague you knew had HIV					
Male & Female	99.1	0	1.9	0	0
Would you rather not touch your colleague with HIV because you are scared of infection					
Male & Female	81.2	18.2	0	0	0

3.2 Responses to individual attitudinal statements about HIV/AIDS from respondents from retail industry (n=420) Attitudinal statement

Table 3 shows that the majority of respondents have sympathy or even neutral attitudes. The sympathy could be associated with the suffering that they witnessed among people living with HIV from their families or community members. The negative attitudes found were that large proportion of respondents 71% either unsure or said AIDS is a punishment for bad behavior or a person with AIDS must have done something wrong. There were a high number of respondents who indicated that prefer people living with HIV to be social distant from the rest of the community. There was also a high issue of behavior, such as people who HIV through sex or drugs use have gotten what they deserve. 41% were either unsure or said they would feel ashamed if their family member contracted HIV.

There was an interesting connection in the responses between blame, which people associated with getting infected with AIDS. Its amazing to see such a high number of respondents (60.2%) associating AIDS as a punishment from GOD and 5.1 % agreeing that people are not responsible for contracting HIV.

Table 3: Responses to individual attitudinal statements about HIV/AIDS

Respondents from retail industry (n=420)

Variable/Attitudes towards PLWHIV	Agree	Partially Agree	Disagree	Completely disagree	Don't know
AIDS is a punishment for bad behavior.	**13.6**	**0**	**74.5**	**0**	**11.9**
People with HIV should be ashamed of themselves.	**44.5**	**0**	**40.7**	**0**	**14.8**
A person with HIV must have done something wrong.	**10.5**	**0**	**78.8**	**0**	**10.7**
People who got HIV through sex or drug use have gotten what they deserve.	**77.5**	**0**	**9.6**	**0**	**12.9**
AIDS is a punishment from God.	**60.2**	**0**	**26.1**	**0**	**13.6**
We should be disgusted at people that are infected with HIV/AIDS	**13.6**	**0**	**84.5**	**0**	**1,9**
Homosexuality is the cause of HIV/AIDS	**95.5**	**0**	**3.5**	**0**	**1**
People with HIV/AIDS are responsible for contracting it	**5.1**	**0**	**87.1**	**0**	**3.8**
People with HIV/AIDS should be separated from	**9.2**	**0**	**90.8**	**0**	**0**

the rest of the community					
I would feel ashamed if my family member contracted HIV	**16.6**	**0**	**68.5**	**0**	**14.9**

3.3 Responses about compounded stigma – on PLWHIV from respondents from retail industry

The respondent in this section show an overwhelming response of blame to people living with HIV. 79% associated HIV with gender especially women who are in the sex industry and women were highly rated as prostitutes by male gender. 31% respondents completely disagreed with the facts on HIV/AIDS with regard to compound stigma.

Table 4: Responses about compounded stigma – on PLWHIV from respondents from retail industry (n=420)

Variable/ compounded stigma	Agree	Partially Agree	Disagree	Completely disagree	Don't know
People with HIV are promiscuous	3.8	2.7	0	93.5	0
It is the female sex workers who spread HIV.	1.6	0	0	98.2	0
Women get HIV because they are prostitutes.	8.6	0	0	91.4	0
Homosexuality is the cause of HIV.	96.9	0	0	2.4	0.8
Injection drug users should be blamed for spreading HIV.	92.4	0	0	7.6	0
Men who have sex with other men should be put in jail for spreading HIV	98.3	0	0	1.7	0
People with HIV/AIDS are not fit enough to work.	9.3	0	0	75.9	14.8

3.4 Responses to experiences of discrimination towards PLWHIV-from retail industry employees

A high number of respondents said they have known someone who have been discriminated in one way or the other by the community member, or relative, or even family members and institution.

Table 5: Responses to experiences of discrimination towards PLWHIV-from retail industry employees

Variable/ experienced discrimination	yes	No	Don't know
Experienced or know someone who had been excluded from a social gathering	74.5	11.9	13.6
Experienced or know someone abandoned by spouse/partner	74	26	0
Experienced or know someone who had been verbally abused or teased	80	20	0
Experienced or know someone who had been physically assaulted.	92	8	0
Experienced or know someone who had been fired from work.	40.7	44.5	14.8
Experienced or know someone who had property taken away.	10	78.8	14.8
Experienced or know someone who had been denied health services	16.6	20	8

3.5 Demographic results

The following results are based on the demographic characteristics such as age, gender, relationship status and sexual orientation. Most of the employees in all four provinces were generally knowledgeable about HIV/AIDS, however only 30% had knowledge about the workplace HIV/AIDS programme. The rest did not know about what the company is doing for their employees with regard to HIV/AIDS. A high percentage also

shows not to trust the company even colleagues about disclosure and they high knowledge about safe sex practices.

Table 6: Demographic results

Variable/Knowledge of HIV/AIDS	Yes	No	Not sure
Knowledge about HIV/AIDS	96	4	0
Knowledge about workplace HIV/AIDS programme	30	70	0
Disclosure to company or, Health worker colleagues about HIV status	10	78	12
Safe sexual practices,	58	48	0

Table 7: Relationship status

Gender	M	LWP	NIR	NIRBS	IRNS	IITOMR
Male	70	7,9	0	13	0	9.1
Female	86	0	0	6	8.1	0

Abbreviations in table 7

M= Married

LWP=Living with Partner

NIR= Not in relationship

NIRBS= Not in relationship (but sexual)

IRNS= In relationship (non sexual)

IITMR= Involved in two or more relationship

Table 8: Sexual orientation

Variable Sexual orientation	Heterosexual	Bisexual	Homosexual
Male	84.4	6	10
Female	99.3	0	0.7
Total	**183.7**	**6**	**10.7**

The overwhelming majority of 96% respondents had a good knowledge about HIV/AIDS only 4 percent did not know a lot about HIV, which I doubt. The knowledge about the workplace programme was disappointing at 30% and 70 percent did not know anything about what their employer is doing about HIV/AIDS in the workplace. Disclosure to employer, colleague and health worker also showed a lot of concern with only 10% saying they are free to disclose their HIV status. An overwhelming 78 % said no the would not dare disclose and 12 % were neutral. Safe sexual practices was on the margin because it differ with 10% which means a lot has to been done with regard awareness of safe sex practices. Another interesting response was on sexual orientation, which showed that high percentage female 100% and male just above eighty percent.

The situation was opposite among females whereby 6% reported that they were not in relationships but sexual and 86 % females were sexually active with one partner. More interesting however was the finding that no female was involved in two or more sexual relationship. About tenth of the female respondents (9.8%) were in relationship but not sexual. The large majority of respondents both male and females (86. 6%) reported being sexually active as expected of normal adults. The results between the two gender with regard to sexual and relationship orientation (figure 1and 2) are almost at the same level, the highest percentage of males and females are involve with one partner and on heterosexual relationship. Less than 6% males are involved in bisexual relationship and 10% are homosexuals. All females are on heterosexual relationship with one partner or abstaining, others are in relationship but not sexual.

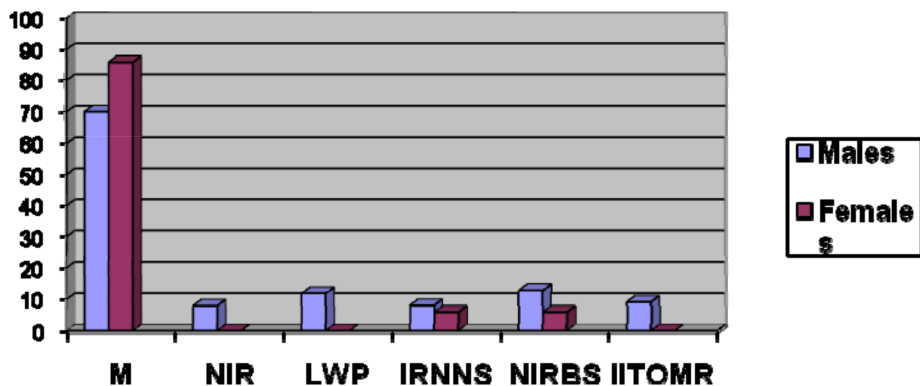

Figure 1: Demographic -gender and sexual drive- Retail industry employees (n=420)

Key words for figure 1:

Abbreviations on graphic 2e (ii)

M= Married

LWP=Living with Partner

NIR= Not in relationship

NIRBS= Not in relationship (but sexual)

IRNS= In relationship (non sexual)

IITMR= Involved in two or more relationship

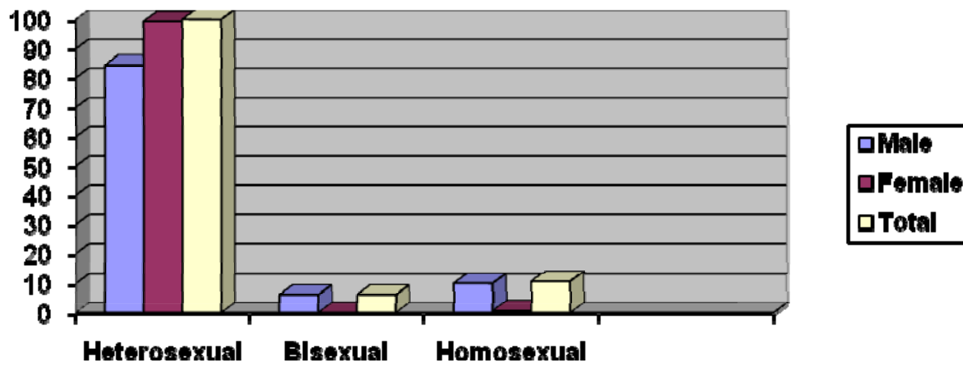

Figure 2: Demographic - sexual orientation -Retail industry employees (n=420)

4. DISCUSSION

These qualitative data from the retail industry participants in four provinces, in South Africa (Gauteng, Empumalanga, Limpopo and North West) illustrates the ways in which stigma and discrimination are expressed through attitudes and behaviours from employees in the workplace towards one another. The data also highlight the factors that contribute to failure to participate on the workplace HIV/AIDS programme which can be attributed to negative experiences suffered by People Living with HIV or their relatives or loved ones.

Through these individuals' reflections, one can begin to see the differences across settings in the extent and types of HIV stigma and discrimination that exists. We know that AIDS stigma and discrimination have been seen all over the world and manifest them themselves differently between countries, communities, religious group and individuals. Stigma directed to PLWHIV not only makes it more difficult for people trying to come to terms with their illness on personal level, it make individuals reluctant to access HIV testing, treatment and care, it also interferes with attempts to fight the AIDS epidemic as a whole.

The hypothesis of the study was not supported, even though there were respondents who said they could not stomach working, or living with HIV positive people, but it was difficult to measure the level of stigma and discrimination, the results were be weighed on the number of responses that indicated that there individual who have had secondary experience or directly involve with the acts of discrimination regard to stigma and discrimination. The other reason was that only 30% of employees new about the HIV/AIDS workplace programme, and this make me to come to the conclusion that there could a second or third variable for this behaviour.

Looking at **table 2** you will realize that respondent generally had a lot of fear with regard to contracting the HIV/AIDS. They were also afraid of interacting or even receiving

anything from people living with the HIV virus. Despite widespread and accurate knowledge of transmission, participants in all four provinces shows fear of transmission from casual contact and worse with physical contact. This is the fear that leads to social isolation and neglect of people living with HIV/AIDS. Only a few knew that HIV could not be transmitted through casual contact, thus they had little fear of socializing with friends who may be HIV positive. What does this mean? It clearly indicates that even if the stigma is not directly demonstrated toward people but to the disease itself, and at the end people will suffer because they are afraid to seek help.

There is a lot of stigma –of inappropriate fear of contagion attached to the disease than to people living with HIV/AIDS. If you look coding no 5 table 2 which is lots of fear, you will realize that people are more afraid of the virus than to deal or interact with people living with the virus, for example: 99.4 % said they cannot share a glass with a person who is positive, but they are willing to work next to a person living with HIV/AIDS. It is because of the factors that contribute to HIV/AIDS *inter alia* such as: HIV/AIDS is a life threatening disease and is behaviors such as homosexuality and drug addiction. Blaming and othering is most of the time directed to a group of sexual orientations such as prostitution and homosexuality. Lack of knowledge and ignorance can also play a huge part with regard to inappropriate fear of contagion, respondents also feared to buy sweets or chocolates from HIV positive colleagues, even if they know it will never harm them.

A number of small -scale studies have been conducted, with fairly positive results. A study of 1.268 adults in Botswana found out that stigmatizing attitudes had lessened three years after the national HIV/AIDS programme providing universal access to antiretroviral treatment was introduced. The study concluded that although antiretroviral therapy access may be a factor in reducing stigma towards people living with HIV, it does not straightforward eliminate stigma altogether and does not lessen the fear of stigma amongst HIV positive people. Fear of contagion is not around people without knowledge about HIV/AIDS but it also amongst the learned.

Table 3 shows that the majority of respondents have sympathy or even neutral attitudes, and if you compare with the results on **table 4** you will realize that it shows a caring blame on a certain group of sexual orientation, such as gays and drug users. The sympathy could be associated to different incidents; among others, it could be with the suffering that they witnessed among people living with HIV from their families or community members. The negative attitudes found were that large proportion of respondents 71% either unsure or said AIDS is a punishment for bad behavior or a person with AIDS must have done something wrong. There were a high number of respondents who indicated that prefer people living with HIV to be social distant from the rest of the community. There was also a high issue of behavior, such as people who HIV through sex or drugs use have gotten what they deserve. 41% were either unsure or said they would feel ashamed if their family member contracted HIV.

There was an interesting connection in the responses between blame, which people associated with getting infected with AIDS. Its amazing to see such a high number of respondents (60.2%) associating AIDS as a punishment from GOD and 5.1 % agreeing that people are not responsible for contracting HIV. Respondents show that they have attitudes towards certain forms of behaviour such as homosexual and drug addicts.

In the Human Science Research Council study conducted Cloete and Simbayi and Others, it was a study of male having sex with males (MSM), they found out that out 92 males sixty eight did report experiencing discrimination resulting from being HIV positive. Discrimination includes loss of housing or employment which was 45%. In this study 77.5 % said " people who got HIV through sex or drug use have gotten what they deserve," and 95.5% put the blame on homosexuality as the of HIV/AIDS. An overwhelming 60% percent shift the blame from their actions and said "AIDS is punishment from GOD." The latter are the three highest scores in attitudes towards people living with HIV/AIDS, the rest of the scores are below 50%.

The respondent in this section **(table 4)** show an overwhelming response of blame to people living with HIV. 79% associated HIV with gender especially women who are in

the sex industry and women were highly rated as prostitutes by male gender. 31% respondents completely disagreed with the facts on HIV/AIDS with regard to compound stigma. In this case we see that AIDS stigma can lead to discrimination towards people living with HIV/AIDS, in this case the blame is shifted to a group of certain sexual orientation or lifestyle, that is: homosexuals and drug addicts. According to the study conducted in Suzann Maman and others, under Human Science Research Council it was found that "the experience of caring for PLWHA with adequate external health and socioeconomic resources plays and important role in shaping attitudes and behaviours towards PLWHA. The blame that we that we found in this study, for example need to be understood in this specific context where this process is taking place., as it was indicated earlier that availability of resources in caring or treating people living with HIV will lessen or shape the attitudes towards people living with HIV/AIDS.

The demographic and biographical results shows that 96% had good knowledge about HIV/AIDS and only 30% knew about the company HIV/AIDS programme. The last percentage shows that there could be some other issues that cause employees not to register on the programme.

There were studies which were conducted before, (Dlamini et al.,2007; Mokae et al., 2008; Ogden & Nyblade,2005) These studies provide information on how stigma and discriminations are expressed and how PLWHA cope with stigma in different settings , but they are limited in their analysis of the factors that contribute to and protect against stigma and discrimination. One study that was carried out within the context of each of the four countries Zimbabwe (Duffy , 2005;Tarwireyi, 2005), Thailand-(Boer & Emons, 2003), South Africa –(Campbell, Nair, Maimane, & Nicholson, 2007), Tanzania (Nyblade et al., 2005)- have describe how incomplete knowledge related to HIV transmission is related to HIV stigma (Boer & Emons, 2003Ogden & Nyblade, 2005), how poor access to health –related resources is associated with stigma (Campbell et al., 2007), and how blame and othering is a powerful expression of stigma in settings where communities feel overwhelmed in caring for PLWHA(Duffy, 2005). The studies above

reinforce the associations and the comparative nature of the study allows them to further explain variation in HIV stigma across different high prevalence settings.

In my study I have found out that; there is a great element of stigma and discrimination towards the disease itself and to people living with HIV/AIDS. Even though there is high number of respondents who said they have great fear of contagion, attitudes towards people of certain sexual drive like homosexuals and sex workers, and some indicated that they have seen friends or relative,, or co-workers being discriminate because of their HIV status, but due to the fact that there is such a low percentage of employees who knows about the workplace HIV/AIDS programme. The level of stigma and discrimination could not be measured accurately. Hence I conclude that: perceived **stigma and discrimination is not the cause for employees not to register on the workplace HIV/AIDS programme**. There could be other variable which can cause employees to be reluctant to register on the workplace HIV/AIDS programme, we have seen that though employees had high knowledge on HIV/AIDS but a less percentage did not know about the. The company that I worked for provide comprehensive HIV/AIDS work programme to all permanent employees and I have learnt that from the study conducted by (Campbell et al., 2007) -how poor access to health –related resources is associated with stigma. In our case the resource are readily available and employees do not have to be on medical aid in other to register on the programme. As this study was conducted among work force there could be a lot that prevent them not to participate in the programme.

World Health Organisation (WHO) claimed that:
“As HIV/AIDS becomes that can be both prevented and treated, attitudes will change, and denial, stigma and discrimination will rapidly be reduced.” It is a profound statement but I think difficult to prove as it is difficult to measure the levels of stigma. We can only measure the levels by the amount of incidents relating to stigma and discrimination such as racism, xenophobia, and homophobia and murders for example the “murder of Gugu Dlamini after disclosing her status publicly, was brutally stoned to death by a mob of angry community members.)

4.1 Limitations

1. All questions were closed ended and the following were limitations experienced

- It was easy for respondent who does not know the answer or has no opinion to guess the appropriate answer or even answer randomly, as some of the respondent only made a tick on the same box through the questionnaire.
- The respondent may feel frustrated because the appropriate / category for his or her answer either is not provided in sufficient detail and there was no opportunity for respondent to clarify or qualify his or her answer, hence some of the questions were not answered.
- There was a lot of clerical error and more than hundred fifty forms were void/ scrapped.
- Limitations to variations in answers were another frustration experienced by respondents, some even tried to write notes next to the answer selected.
- Open ended questions would have allowed greater room for respondents to explain further instead of being limited in choosing amongst the answers provided.
- The questions asked could not probe respondent to give their view about perceive stigma and discrimination, it was more on compounded stigma, that is stigma from external forces rather than internalised stigma.

2. It is difficult to give levels in measuring stigma and discrimination, I did not have a clear point to say if so many respondents gave this answer it could mean that there is high level of stigma and discrimination, hence it was difficult to correlates the two variables; which are perceive stigma and discrimination and failure to register on the workplace programme.
3. The number of respondents who completed the questionnaire is not representative of the staff compliments, it was not even a quarter (421) this was because of the limited resources such time, finance and human resource. The total number of employee is twenty three thousand in all nine provinces of South Africa. Despite these limitations the data was collected in other to gain more understanding on stigma and discrimination and failure to register on the workplace HIV/AIDS programme. According to literature review I did this is the first qualitative study of its kind to can explore perceived stigma as cause of another variable.

5. RECOMMENDATIONS

I will suggest to the company to conduct awareness on stigma and discriminations across all levels of employee in the company. I will have short briefing sessions will employees and asked probing questions on HIV/AIDS, stigma and discrimination, failure for employees to register on the programme. All answers will be recorded and analysed and a strategy will be devised for way forward.

Address concerns raised by employees with queries relating to bad attitudes towards people living with HIV/AIDS; encourage them to report such cases. Conduct continuous HIV/AIDS and related topics in other to alleviate internalised or perceived stigma and discrimination. One employee once said "when *you are HIV positive, people can see through you, you feel and look dirty and useless and when people talk, you assume it has something to do with you*" AIDS is the greatest barrier that makes people to keep their status as secret because of being afraid to be ridiculed. Our company needs to market the workplace HIV/AIDS programme across all nine provinces, make employees aware of their benefits and constantly remind them by sending communication such as emails and put up relevant posters in most frequented places like canteen, toilets and coffee shops.

Invite speakers living with the virus to address workforce on HIV/AIDS and related topics. I will use this study as trial design in other to implement an advanced qualitative study that will provides critical input into the design, implementation, upgrade of the overall workplace HIV/AIDS programme and HIV/AIDS policy.

6. CONCLUSION

Providing comprehensive HIV/AIDS workplace programme is not enough, it might be the best plan from the employer, but it might not be perceived as a good gesture by employees. Whenever employers try to do their best in helping the work force, it is often

interpreted by many as “having motive behind”. This is the relationship that has been existing between employees and the employers for decades and can be attributed to previous primary or secondary experiences. A lot of work has to be done in educating the whole work force community about HIV/AIDS and making sure that all have access to care and treatment resources , so that people infected and affected can get help in what ever form to deal with HIV/AIDS effects.

Based on the data collected every employee is aware of HIV/AIDS as an infectious diseases, but culture and traditions and religion has great influence on how people react to people living with HIV. Stigmas vary depending on the dominant transmission routes in the country or region. In Sub-Saharan Africa, for example, heterosexual sex is the main route of infection, which means that AIDS-related stigma in this region, is mainly focused on promiscuity and sex work.

We need to come up with effective strategies to reduce stigma, one of them could be classifying HIV/AIDS like any other disease not like a death sentencing disease as it know. I should be treated like flu, diabetes and others, so that people can come forward and seek help. Stigma is not related to HIV/AIDS, but because of fear of contagion coupled with negative, value based assumptions about people who are infected, it leads to high levels of stigma surrounding HIV/AIDS. There are also factors that contribute to HIV/AIDS related stigma which needs to be addressed properly such as:

- HIV/AIDS is a life threatening disease
- HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity), that are already
- Most people become infected with HIV through sex. Sexually transmitted diseases are always highly stigmatized.
- There is a lot of inaccurate information about how HIV is transmitted.
- HIV infection is often thought to be the result of personal irresponsibility.

- Religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished. If these factors could be addressed it could lessen the impact attached to HIV/AIDS.

To date there is limited information on what intervention approaches work to reduce HIV/AIDS stigma (Brown et al., 2003; Mahajan et al., 2008), states that there is limited or little evidence that the predominant HIV stigma reduction strategies that have been evaluated, including the provision of information at the individual level and through mass media campaigns, has led to significant and sustained changes (Mahajan et al., 2008).

There is a need to evaluate the intervention strategies that targets the structural determinants of stigma within the work force. Workplace level of stigma and discrimination towards people living with HIV/AIDS is found all over the world and it can affect productivity if not addressed. A work force's reaction toward somebody living with HIV/AIDS can have a huge effect on that person's life, if the reaction is hostile a person may be ostracized and discriminated against and may be forced to leave their work or even take drastic steps against those pestering them. Workplace stigma and discrimination is usually not directly shown it will be shown in acts such as; denied promotions or training, forced to resigned or side line most of the time or even ostracism or verbal abuse. UN Secretary –General Ban Ki Moon says:

"Stigma remains the single most important barrier to public action. It is a main reason why to 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"
If we deal aggressively with issues perpetuating the AIDS epidemics such as factors contributing to high levels o stigma and discrimination, we will win the battle against AIDS.

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