

*Full Length Research Paper*

# **An investigation into the determinants of HIV-related stigma in the workplace: A case of service staff in the Eastern Cape**

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Accepted 26 July, 2012

The far reaching implication of HIV-related stigma in the society shows that it has undoubtedly become more dangerous than the pandemic itself. The workplace, like any other institutions, is not immune to disastrous implications of HIV-related stigma. Given that HIV-related stigma is a complex social phenomenon which is sometimes moulded by cultural and contextual factors; this paper seeks to investigate the potential determinants of HIV-related stigma in the workplace in the South African context. It is hoped that once the critical determinants of HIV-related stigma are known, tailor made interventions can thus be implemented. In this paper the following variables were investigated; gender vs. HIV-related stigma, education vs. HIV-related stigma, Race vs. HIV-related stigma, workplace/occupation vs. HIV-related stigma, HIV testing vs. HIV-related stigma, Knowledge of someone infected vs. HIV-related stigma and the practice of safe sex vs. HIV-related stigma. The sample consisted of 246 service staff employed at either Rhodes University Catering Division or the Hi-Tec Security company, both organisations located in Grahamstown, a small town in the Eastern Cape, South Africa. Both organisations are major employers of semi-skilled workers in this local context. Results suggested that while there is no significant difference between gender, race, education and HIV related stigma, a significant difference was found between HIV-related stigma and other aforementioned variables.

**Key words:** HIV-Related stigma, Workplace, Determinants of HIV- related stigma.

## **INTRODUCTION**

Stigma has been associated with Human immunodeficiency virus infection/Acquired immunodeficiency syndrome (HIV/AIDS) since the eruption of the pandemic in the early 1980s. Previous studies show that HIV was first identified amongst already stigmatised groups such as gay men and injecting drug users in western countries (Rohleder et al., 2009; Herek and Capitano, 1998; Herek, 1999; Devine et al., 1999), and the lingering association of HIV with such marginalised groups results in the double stigmatisation of people with HIV (Parker and Aggleton, 2003). In African societies where Acquired immunodeficiency syndrome (AIDS) is in most cases spread through heterosexual sex, people with HIV are often viewed as promiscuous, sinners and responsible for their illness (Devine et al., 1999). Indeed, the multiple layers to HIV stigma make it a complex topic

of study.

HIV related stigma poses a big threat to all sectors of the society including the workplace where people develop social networks that have an important impact on their lives. Research has shown that HIV-related stigma has the potential to destroy these social networks. According to Key and DeNoon (1997), employees often find it difficult to work besides a colleague with HIV/AIDS because of the fear that they might contract the disease. In another study by Steward et al. (2002), similar results were found: most employees who displayed stigmatising attitudes towards their colleagues were uncertain about how HIV can be transmitted. In light of these findings, it is clear people living with AIDS (PLWA) can be victims of isolation and rejection in the workplace, and that implicated in this stigma is poor knowledge, suggesting

that the provision of accurate information has some role to play.

While it is evident that HIV-related stigma has negative implications for many companies in South Africa, research also suggests that little is being done to effectively reduce HIV-related stigma (Horizons, 2002). As Dickinson (2005) suggests, many companies are finding it difficult to translate theory into effective practice. This appears to be as great a challenge for companies as it is for government and other organisations.

### Statement of problem

HIV-related stigma has undoubtedly become a topical issue in the workplace as it mostly affects workers who are the valuable assets in any work setting. Despite the South African legislation to protect PLWA, there is evidence that many cases of stigma and discrimination go unreported. Yet, according to a study by Southern Africa HIV/AIDS Information Dissemination Service (2003), the workplace provides an ideal opportunity to address HIV-related stigma as it attracts people from diverse backgrounds. The workplace also provides a captive audience for educational programmes that aim to dispel the myth that there is a need for people to be afraid of PLWA (International Finance Corporation, 2002).

HIV-related research has been recently reported to be on the rise in South Africa to the extent that it has now been developed into a separate and important area of research (Deacon et al., 2009). Nevertheless, Deacon et al. (2009) also argues that although HIV-related stigma research is on the rise, it is still in its infancy compared to the research in some of the other psychosocial aspects of HIV/AIDS, despite the high incidence of stigma in Africa (Skinner and Mfecane, 2004). According to Deacon et al. (2005), although there is a great deal of literature on the nature, causes and effects of HIV related stigma, little is being done to reduce it. The paper at hand is aimed at examining the most critical determinants of HIV-related stigma and assist managers in coming up with tailor made interventions to reduce the effects of HIV-related stigma.

### Objectives of the study

1. To establish the most critical determinants of HIV-related stigma in amongst service staff in Grahamstown.
2. To suggest possible ways to counter HIV-related stigma in the workplace.

### Value of the study

This study is of paramount importance to managers and

to policy makers in that it informs them to make tailor made interventions and effective policies that are aimed at reducing HIV-related stigma. The study opens up new avenues of research in that it shows that some popular determinants of HIV related such as gender and education were found not to be statistically significant whilst the effect of the workplace/occupation was found to be significant. Perhaps this explains the dynamic and unique nature of stigma which therefore gives a clue to researchers that they must not take only a specific set of stigma determinants for granted as it varies across contexts and this also implies to managers and policy makers that they should make tailor made interventions. Given the fact that the study at hand shows that HIV-related stigma is high among security guards than catering staff, the results are important particularly to the Hi-Tech and possibly other security companies to bolster their anti-stigma interventions as they may wish to reinvigorate anti-stigma interventions.

## METHODOLOGY

### Research participants

The total sample comprised 246 security guards (n=120) and caterers (n=126) who completed the questionnaires at their workplace. In most studies, researchers rarely survey the entire population for reasons related to costs and accessibility of participants. In this study, the whole population was approached since the total combined population is small enough to manage and locally accessible (though, as it turns out, the security guards were more difficult to access than the caterers), yet large enough to perform an appropriate statistical analysis. The approach of the entire population in this research will obviously minimise the probability of sampling bias or sampling error.

Security guards and caterers as part of the semi-skilled workforce are at high risk of contracting HIV. According to SABCOHA (2005), it is believed HIV/AIDS prevalence is significantly higher among semi- and unskilled workers than among highly skilled and white-collar workers. In a study done by Higher Education Sector (2010), of the 21 Higher Education Institutions surveyed, it was found that the service staff had a higher prevalence of HIV (12%) as compared to academic staff (1.5%) and students (3.4%). Research suggests that HIV related stigma is also found to be high in areas with high HIV prevalence; hence the inclusion of the samples in this study is supported by Brown et al. (2003). The ubiquity of HIV-related stigma and its persistence even in areas where HIV/AIDS prevalence is high makes it an extraordinarily important yet difficult area of research (Brown et al. 2003).

### Measuring instruments

Two recent and competing scales that have been developed in South Africa were used to measure HIV-related stigma levels among participants: The Kalichman scale and the Visser scales. The 12-item Visser scales include three parallel measures: (1) personal stigma, (2) attributed stigma and (3) internalised stigma experienced by HIV-infected individuals. The personal stigma scale measures stigmatising attitudes reported by the individual while the

**Table 1.** HIV testing vs. HIV-related stigma.

Parameter	Kalichman scale					Visser scale				
	Mean scores	t	df	p	Mean scores	t	df	p		
HIV testing vs. HIV-related stigma	2.34	3.13	-2.94	244	0.00*	2.36	3.26	-2.79	244	0.01*
Social distancing sub-scale	-	-	-	-	-	1.17	1.72	-2.80	244	0.01*
Blame and judgment subscale	-	-	-	-	-	1.19	1.54	1.86	244	0.06

**Table 2.** Safe sex vs. HIV-related stigma.

Parameter	Kalichman scale					Visser scale				
	Mean scores	t	df	p	Mean scores	t	df	p		
Safe sex vs. HIV-related stigma	2.46	3.20	2.29	244	0.02*	2.50	3.35	2.18	244	0.03*
Blame and judgment subscale	-	-	-	-	-	1.25	1.54	2.34	244	0.02*
Interpersonal distancing sub-scale	-	-	-	-	-	1.25	1.80	-2.34	244	0.02*

attributed stigma scale measures stigma that individuals attribute to their community. The internal consistencies of these two relevant Visser scales across two samples ranges from 0.73 to 0.75 for the personal stigma scale and is 0.87 for both samples for the attributed stigma scale (Visser et al., 2008). Evidence of validity was reported for both measures (Visser et al., 2008). An exploratory factor analysis identified two factors for the personal stigma scale that are labelled as Blame and Judgment (6 items) and Interpersonal Distancing (6 items) (Visser et al., 2008). A two-point (agree or disagree) response format was adopted after researchers noticed that participants tended to only select either the agree or disagree options of their original four-point format (Visser et al., 2008).

### Statistical analysis

In this study, statistical analysis was employed to provide a sound quantitative measurement of HIV-related stigma levels among the two samples of service staff. The general linear model was used to assess whether there were differences among the means of stigma scores with regard to demographic and social distance variables. The general linear model is a generalisation of the linear regression model that offers a set of techniques to analyse any univariate or multivariate analysis of variance (ANOVA), analysis of covariance (ANCOVA) or regression designs (Howell, 1997). Once regarded as impractical, this more general approach has become possible in recent years with the increasing power of modern desktop computers and computer statistical packages.

## RESULTS

### Having tested for HIV/AIDS vs. HIV related stigma

The means for both the Kalichman scale and the Visser personal stigma scale for those who report having been tested were significantly lower than those who report having not been tested. The social distancing sub-scale

of the Visser scale also showed a similar pattern of results but the differences in the blame and judgment subscale were not statistically significant (Table 1).

### Practising of safe sex vs. HIV-related stigma

Participants who confirmed that they practice safe sex reported statistically significantly lower scores on the Kalichman and the Visser personal stigma scale. Furthermore, the differences for the interpersonal distancing sub-scale are significant but for the blame and judgment subscale the differences are not significant (Table 2).

### Knowledge of someone affected by HIV/AIDS vs. HIV related stigma

Participants who confirmed that they know people affected by HIV/AIDS showed statistically significantly lower stigma scores as measured by the Visser personal stigma scale. This pattern is repeated for both of the Visser sub-scales: interpersonal distancing subscale blame and judgement scale. However, the differences in the scores obtained on the Kalichman scale were not statistically significant (Table 3).

### Workplace / occupation vs. HIV-related stigma

The security sample reports statistically significantly higher personal stigma scores than the catering sample according to the Visser personal stigma scale (mean scores of 4.01 and 1.37 respectively;  $t=10.30$ ,  $df=244$ ,

**Table 3.** Knowledge of someone affected by HIV/AIDS vs. HIV related stigma.

Parameter	Kalichman scale					Visser scale				
	Mean scores	t	df	p	Mean scores	t	df	p		
Knowledge of someone affected by HIV/AIDS vs. HIV related stigma	2.53	2.76	t=-0.76	243	0.45	2.41	3.40	-2.78	243	0.01*
Interpersonal distancing subscale						1.24	1.69	2.09	2.43	0.04
Blame and judgement scale						1.17	1.71	2.59	243	0.01

$p=0.00$ ). It is very clear that the majority of the catering participants are women and the majority of the security guards are men, and because HIV/AIDS stigma is likely to be gendered (Valdiserri, 2002), it is important to determine whether the difference reported between the two samples is the result of the different work contexts or the result of different proportions of men and women in each sample. To do this a factorial ANOVA was calculated with personalised stigma scores as the dependent variable and sex and workplace as categorical predictors. The main effect of sex was found to be not significant ( $F(1, 242) = 0.74, p = 0.39$ ) while the main effect of workplace was found to be significant ( $F(1, 242) = 82.25, p = 0.00$ ). There was no significant interaction between sex and workplace. These findings indicate that the difference in stigma scores between the two samples is to do with workplace rather than a difference resulting from uneven gender proportions. Figure 1 displays this finding.

#### Age and gender vs. HIV related stigma

A factorial ANOVA was calculated with personalized stigma scores as the dependent variable and demographic variables (age, race and gender) as categorical predictors. The main effect of all these variables were found to be not

significant gender ( $F(1, 242) = 0.74, p = 0.39$ ), Race ( $F(1, 222) = 0.72, p = 0.59$ ) and age ( $F(1, 252) = 0.76, p = 0.49$ )

## DISCUSSION

### Having tested for HIV/AIDS vs. HIV-related stigma

The two personal stigma scales (Visser personal stigma scale and Kalichman personal stigma scales report statistically significant en tested for HIV/AIDS. In this study about two thirds of the participants report that differences according to how the participants answer the question of whether they had undergone HIV/AIDS testing, while the remaining third have not been tested for HIV/AIDS. Results suggest that participants who were tested for HIV/AIDS displayed statistically significantly lower levels of stigma than participants who were not tested. This is consistent with what one would expect and is evidence for the validity of both the personal stigma scales.

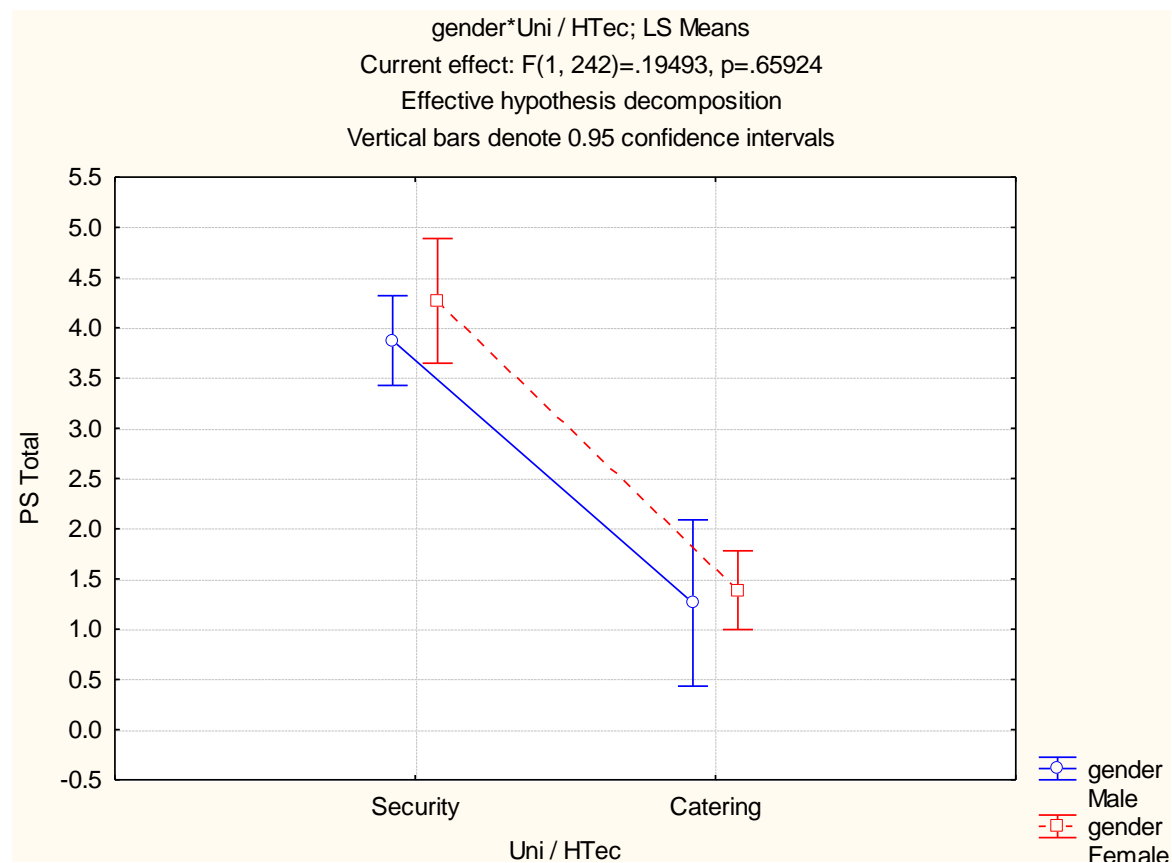
Furthermore, people who are not tested for HIV/AIDS scored statistically significantly higher in interpersonal distancing (one of the two subscales of the Visser personal stigma scale) than people who reported that they had been tested for HIV/AIDS. This is possibly because they perceive

themselves as socially distant from people with HIV/AIDS and therefore do not perceive themselves to be at risk of HIV infection and do not need to be tested.

While testing history showed differences on the social distancing subscale, no significant differences were found for the blame and judgment subscale (the second subscale of the Visser personal stigma scale). So while those who seek HIV testing might not perceive themselves to be socially distant from those who are HIV positive, they seemingly hold similar views to those who do not report being tested with regards to the blameworthiness of those who are infected. Perhaps they regard their own behaviour in being tested as evidence of their responsibility and position themselves in contrast to those who are perceived to be less responsible. This would suggest that reducing perceived social distance between those who are infected by HIV/AIDS and those who assume (rightly or wrongly) that they are not infected might reduce stigma and facilitate greater uptake of HIV testing. In other words, social distancing inhibits HIV/AIDS testing.

### Practice of safe sex HIV-related stigma

In this study, the majority of participants in both samples report that they practice safe sex. The results indicate the participants who practice safe



**Figure 1.** Hi-Tec and Rhodes catering scores.

sex report lower scores on both personal stigma scales than those who do not report that they practice safe sex. Again, this is as one would expect and further evidence for the validity of both the personal stigma scales.

Also, those who practice safe sex report significantly lower scores on the interpersonal distancing subscale of the Visser personal stigma scale but not the blame and judgment subscale. The assumption is that people who practice safe sex must perceive themselves to be at some risk of contracting HIV and, thus, do not perceive themselves to be socially distant from those who have been infected by HIV, which is reflected in lower interpersonal distancing scores. However, some of those same people might regard those who are infected as being blameworthy for not similarly practicing safe sex.

#### **Knowledge of someone affected by HIV/AIDS vs. HIV-related stigma**

Participants who confirmed that they know people affected by HIV/AIDS reported statistically significant lower stigma scores as measured by the Visser personal

stigma scale. This finding is in line with Goffman's (1963) idea that a disability becomes normalised in people's minds the more contact they have with the disability. Again, this appears to be further evidence supporting the validity of the scale.

Similar results were found in a study done by Visser et al. (2009). In this study, it was found that people with high levels of exposure to HIV/AIDS develop a better understanding of the fears and stigmatising attitudes HIV-positive people anticipate or experience. This finding was also corroborated by the HSRC study (Shisana and Simbayi, 2002), which found that acceptance of people with HIV/AIDS results from personal contact with people with HIV/AIDS. A comparison of the Visser subscales reveal that participants who claim not to know someone infected with HIV/AIDS scored higher in interpersonal distancing and blame and judgment than participants who report knowing someone affected with HIV/AIDS.

It seems reasonable to assume, then, that by knowing someone who is HIV positive, people are able to develop less stereotypical and more sympathetic views of what it entails to be infected with HIV. However, research also suggests that HIV/AIDS-related stigma is even more

pronounced in areas where HIV/AIDS is prevalent (Brown et al., 2003), which contradicts this contact hypothesis. In fact, South Africa reports both high prevalence of HIV/AIDS infections (UNAIDS, 2008) and widespread stigma (Skinner and Mfecane, 2004).

### Workplace/ occupation vs. HIV-Related stigma

Considering the fact that the majority of participants from the Hi-Tec Security sample are men and the majority of the Rhodes catering samples are women, one might have concluded that the results from the present study are a reflection of the gendered nature of stigma (Valdiserri, 2002). In this study, however, the main effect of gender was found not to be statistically significant, while the main effect of workplace was found to be significant, thereby suggesting that the difference in stigma scores between two samples might not be a result of the uneven gender proportions but instead the result of the workplace context. Women from the Rhodes catering sample showed lower levels of stigma than women from Hi-Tec security, and, similarly, men from the catering sample also displayed lower levels of stigma than men from the Hi-Tec security sample.

As mentioned briefly before, this suggests that in this research, the workplace setting, either by attracting particular personalities or by influencing the people who work there, may shape the attitudes that people hold towards those who are HIV positive. Although the relationship between personality and occupational choice is contested, there is compelling evidence that suggests that personality might be a good predictor of occupational choice (Holland, 1997; Tokar et al., 1998). Therefore, because of the authoritarian nature of their jobs (Rubinstein, 2006), security guards are likely to be tough, strict and perhaps have an authoritarian personality. Authoritarianism, according to a study by Lippa and Arad (1999), has been found to be highly correlated with prejudice. Therefore, from this point of departure, it is reasonable, perhaps, to expect security guards to be more judgmental and thus more stigmatising towards people with HIV/AIDS than the catering sample.

On the other hand, working as caterer is socially demanding and might attract personalities referred by Holland (1997) as 'social types' who are helpful, supportive and who enjoy working with people. It is interesting to note that social types, according to Tokar et al. (1998), score high in agreeableness, which, according to McCrae et al. (2007), is associated with lower levels of stigma towards people with HIV/AIDS.

### Age and gender vs. HIV related stigma

A factorial ANOVA showed that the aforementioned

demographic variables were not critical determinants of HIV related stigma. While this result is contrary to previous studies (Valdiserri, 2002; Maugan-Brown, 2004) that suggested that these demographic variables influence one's attitude towards PLWAs this might reinforce the dynamic nature of HIV related stigma.

### LIMITATIONS AND FUTURE RESEARCH DIRECTIONS

Given the sensitive nature of the study, some participants might be inclined to offer responses that are socially acceptable rather than factually correct (this is known as social desirability bias). To minimize this bias, participants were not asked to write their names on the questionnaires so as to ensure neutrality, detachment, and reassurance of anonymity. Furthermore, the sample at hand was not equally represented in terms of gender, age and race therefore making it difficult to generalize the results across settings.

Given that differences in stigma between the two samples might reflect occupational personality types, then more research into the relationship between organizational setting, occupational roles, and HIV-related stigma is warranted, so as to be able to devise specific interventions for different occupational categories. The relationship between increasing visibility of HIV and stigma also warrants further research. This would need to include longitudinal studies that track stigma levels over time so as to explore its dynamic nature.

### ACKNOWLEDGEMENT

This research was funded by the Govan Mbeki fund from Fort Hare University, South Africa.

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