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An Investigation into the Effects of the Work Environment / Occupation on Hiv Related Stigma: A Case of Service Staff in Grahamstown: Eastern Cape, South Africa

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Abstract

Purpose - This paper investigates whether one's occupation influences one's attitude toward people with HIV/AIDS and suggests ways to counter HIV-related stigma in different work settings. Two samples comprising workers in different environments and occupations with contrasting personalities were chosen. Thus, security guards (authoritarian types) and catering workers (social types) were included.

Research design, data, and methodology - The sample comprised246 service staff from the Rhodes University Catering Division and the Hi-Tec Security company, both in Grahamstown, South Africa, a small Eastern Cape province town. All employees at these organizations during the survey were eligible to participate.

Results -The security sample displays 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, p=0.00). Similar results were found using Visser subscales.

Conclusions - This study shows that occupation is a strong predictor of HIV-related stigma in the workplace, suggesting that workplace settings, by attracting particular personalities and influencing workers, may shape attitudes towards those who are HIV positive.

Keywords: Human Immunodeficiency Virus Infection, Acquired Immunodeficiency Syndrome (HIV/AIDS), Stigma, Work Environment, Occupation.

JEL Classifications: J50, J58, J59.

1. Introduction

With the national rollout of antiretroviral medications, employees with Human immunodeficiency virus infection / acquired immunodeficiency syndrome (HIV/AIDS) are living longer and, according to Hunt, Jaques, Niles and Wierzalis (2003), while accepting that their lives have changed due to their diagnosis, should be entitled to continue working. Yet despite the much-improved outlook for people with HIV, there is much evidence to suggest that they continue to be stigmatised in the workplace (Hunt et al., 2003). According to South African Business Coalition on HIV/AIDS (2005), more than 75% companies surveyed indicated that stigma and discrimination has undermined the effectiveness of their HIV/AIDS programmes. Other research suggests that HIV-positive employees often suffer from various forms of HIV-related stigma from both their superiors and co-workers (Kauffman & Launder, 2004). Moreover, HIV-related stigma also has the power to weaken strong informal commercial networks. This suggests that a great deal needs to be done to counter HIV-related stigma in the workplace. Aworkplace is no doubt one of the ideal places for people to develop social networks that have an important impact on their lives. However, 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.

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, it is not easy to translate of theory into effective practice. This appears to be as great a challenge for companies as it is for government and other organisations.

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2. Literature Review

Disease stigma is an old concept that is not unique to HIV/AIDS, but is a common collective reaction to diseases associated with death, and it is in this context that the exploration of HIV-related stigma has now developed into a separate and important area of research in South Africa (Deacon et al., 2009). Previous studies show that South Africa is a country that has seen a large number of incidents of HIV stigma and discrimination compared to most other countries (Skinner & Mfecane, 2004), and also remains one of the countries with the highest prevalence of HIV in the world (UNAIDS, 2008). The murder of Gugu Dlamini in 1998 after she disclosed her HIV positive status and the refusal of SA Airways to employ Hoffman, a cabin attendant, on the basis of his HIV positive status are just two of the many examples of extreme manifestations of stigma in South Africa that received prominent attention in the media. There are of course, no doubt, many other examples that are less well known. However, HIV stigma does not need to result in discrimination to be harmful (Deacon, 2006): The fear of stigma can cause people to avoid knowing or disclosing their status and the negative judgments associated with stigma can be internalised with consequences for people's mental health and psychological wellbeing (Simbayi, 2008). Yet according to Deacon et al. (2009), HIV/AIDS-related stigma research in South Africa is 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 & Mfecane, 2004). Despite the South African legislation to protect people living with HIV/AIDS (PLWA), there is evidence that many cases of stigma and discrimination go unreported (Skinner & Mfecane, 2004). Yet, the workplace provides an ideal opportunity to address HIV-related stigma as it attracts people from diverse backgrounds (Southern Africa HIV/AIDS Information Dissemination Service, 2003). If indeed the workplace provides is an ideal place to fight HIV related stigma, it remains unknown whether organisations should make use of similar interventions. According to Odendaal et al. (2001), workplace environments or occupations shapes/affects workers attitudes. It remains unknown whether this also applies to HIV related stigma. Lorentzen and Morris (2003, as cited by Deacon et al., 2005), cited the lack of scientific research on stigma in Sub-Saharan Africa as one of the major challenges hampering progress in measuring and understanding stigma. More importantly, Currently, literature that demonstrates that research on HIV related stigma in the workplace is lacking in South Africa. Therefore this paper seeks to establish whether the type of occupation or workplace is a predictor of HIV related stigma.

2.1. Value of the study

This study in general, opposes the notion of applying the same HIV/AIDS stigma intervention in different work settings. This study therefore has the potential to go a long way in assisting managers and policy makers in making tailor made interventions that takes into cognisance the use of different interventions to different work settings. Furthermore, the study opens up new avenues of research as it shows that there is a link between one's occupation, personality and HIV/AIDS related stigma. This will assist managers and policy makers not to only focus on popular determinants of HIV/AIDS related stigma such as gender, age, and race but widen their spectrum of attention so as to formulate effective interventions (Maugan–Brown, 2004).

3. Methodology

This section outlines the aims and methods of this study, including a detailed description of the objectives of the study, the research setting, the measurement used, the sample used, statistical analysis used, and the research ethics that were followed.

3.1. Objectives of the study

- To establish whether the type of workplace or occupation that one holds has an impact on his/her attitudes towards people with HIV/AIDS.
- To suggest possible ways to counter HIV/AIDS-related stigma in different work settings based on research findings.

3.2. The research setting

The two samples selected for the study are located in Grahamstown in the Eastern Cape Province. The research is relevant particularly to our local context in that the two organisations are among the largest employers in town and this might open opportunities for intervention. 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%). 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).

3.3. Research participants

Two hundred and fourty-six participants took part in this study; security guards (n=120) and caterers (n=126). These participants were provided with questionnaires which they completed in their respective workplaces. In this study all participants had equal chances of participating. In most studies, re-

searchers 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 advantage of using the entire population in this research is obviously to minimize the probability of sampling bias or sampling error.

3.4. Measuring instrument

A scale developed to measure HIV related stigma in the South African by Visser et al. (2008) was used. This scale was chosen because of its reliability and validity across settings (Mazorodze, 2011). This is a 12-item Visser scales which include three parallel measures: (1) personal stigma, (2) attributed stigma and (3) internalized stigma experienced by HIV-infected individuals. The personal stigma scale measures stigmatising attitudes reported by the individual while the 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).

3.5. Statistical analysis

Quantitative research methods were employed in this study. statistical analysis was utilisedto provide a sound quantitative measurement of HIV/AIDS-related stigma levels among the two samples under study. The data was captured onto a spread sheet so that the analysis could be performed. Statistica Version 9 (a statistics and analytics software package that provides data analysis, data management, data mining, and data visualization procedures) and Microsoft Excel were used to conduct the analyses. This included both descriptive and inferential statistical analyses. 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. T-tests (sometimes with adjustments for unequal variances) and ANOVA were used to compare means between stigma scores, while the general linear model was used to assess whether there were differences among the means of stigma scores with regard to demographic. The general linear model is a generalisation of the linear regression model that offers aset of techniques to analyse any univariate or multivariate ANOVA, 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.

3.6. Ethical standards

The research proposal was approved by Rhodes University Research Ethics Proposal Review Committee in the Psychology Department and then by the Humanities Faculty Higher Degrees Committee. Ethical considerations are an essential part of any research design as they serve to protect participants from being ill treated or harmed by researchers. One of the fundamental principles of research ethics, beneficence, obligates researchers to maximize possible benefits from the research and minimize harms and risks to their subjects (Frankel & Siang, 1999). This research project has the potential to add value to existing literature by expanding our understanding of HIV and AIDS stigma. Researchers' claims about the benefits of their research will rest in large part on their ability to collect useful data (Frankel & Siang, 1999).

Permission to carry out the research within the Hi-tech Security premises and Rhodes University Catering was sought from the management of both organisations. Mindful of the fact that many participants would feel obliged to complete the questionnaire because the research had the support of the management, the participants were explicitly assured of their right not to participate and withdraw their participation at any time should they wish to do so. The researcher ensured that data collection was done anonymously and the raw data was kept confidential. To maximise anonymity, questionnaires did not bear any name of participants. The management and staff will be able to access a copy of the anonymised final report should they wish to see the results, but not the raw data. The participants were assured that there were no right or wrong answers, and thus encouraged to freely express their views.

4. Results

4.1. Demographic information

<Table 1> Demographic information for both samples

		Hi-Tec sample		Rhodes Catering		Total	
		n	%	N	%	N	%
Gender	Male	79	66%	23	18%	102	41%
	Female	41	34%	103	82%	144	59%

4.2. Personal stigma scale

<Table 2> Comparison between security and catering samples of proportions who endorse Visser personal stigma items

Personal stigma items	Security sample %	Catering sample %
1. I think getting HIV/AIDS is a punishment for bad behaviour	24%	11%
2. I would not like to sit next to someone with HIV/AIDS in public or private transport	18%	11%
3. I think less of someone because they have HIV/AIDS	34%	9%
4. I would not like someone with HIV/AIDS to be living next door	36%	8%
5. I would not like to be friends with someone with HIV/AIDS	42%	21%
6.I feel afraid to be around people with HIV/AIDS	48%	11%
7.People with HIV/AIDS have only themselves to blame	39%	17%
8.I would not employ someone with HIV/AIDS	41%	10%
9.I would not drink from a tap if a person with HIV/AIDS had just drunk from it	37%	8%
10.If you have HIV/AIDS you must have done something wrong to deserve it	35%	11%
11.People with HIV/AIDS should be ashamed of themselves	23%	10%
12. I feel uncomfortable around people with HIV/AIDS	24%	10%

4.3. Visser blame and judgment subscale

<Table 3> Blame and Judgement

	Rhodes Catering sample	Hi-Tec Security sample			
Parameter	Mean scores	Mean scores	t	df	p
Blame and judgement	1.93	0.70	7.76	244	0.00

Results show that the Hi-Tec Security sample score higher in blame and judgement than Rhodes Catering (mean scores of 1.93 and 0.70 respectively: t= 7.76, df=244, p=0.00).

4.4. Visser interpersonal distancing subscale

<Table 4> Interpersonal distancing subscale

	Rhodes Catering sample	Hi-Tec Security sample			
Parameter	Mean scores	Mean scores	t	df	p
Interpersonal distancing subscale	0.67	2.08	8.60	218	0.00

Similarly, participants from Hi-Tec Security sample score higher in interpersonal distancing than the Rhodes Catering sample (mean scores of 2.08 and 0.67 respectively; t=8.60, df=218.2, p=0.00 (t-test with separate variance estimates)

4.5. Workplace / Occupation vs HIV/AIDS-related stigma

Results show that security sample reports statistically significantly higher personal stigma scores than the catering sample (mean scores of 4.01 and 1.37 respectively; t=10.30, df=244, p=0.00). Since the majority of 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.

4.5.1. Hypothesis testing: HIV related stigma vs. work environment/occupation

A hypothesis is defined as a tentative explanation that accounts for a set of facts and can be tested by further investigation. The hypothesis in this regard is based on the premise that HIV related stigma varies according to occupation/work environment. Based on that premise, the null hypothesis is stated as follows:

H0- HIV related stigma does not vary according to work environment/occupation.

To test the null hypothesis, independent t-tests were done so as to assess whether HIV related stigma varies according to work environment/occupation. Results shows the main effect of workplace was found to be significant ($F(1, 242) = 82.25$, $p = 0.00$), thus indicating that the difference in stigma scores between the two samples is to do with workplace rather than a difference resulting from uneven gender proportions. Therefore we fail to accept the null hypothesis and conclude that HIV related stigma varies according to work environment/workplace.

Generally, men are more likely to be attracted to (and more likely to be hired in) jobs that require physical activity than women, thereby resulting in occupational segregation. An example of this is a study done by the Equal Opportunities Commission (2001) in the United Kingdom were gendered employment patterns were found to be a characteristic of the labour market, with women dominating in catering jobs while men dominated in jobs requiring physical activity such truck drivers. South Africa, as arguably a more patriarchal society than the UK, is likely to at least reflect these gendered employment patterns.

5.2. Personal stigma

A comparison of the two samples showed that the Hi-Tec Security guards obtained higher scores on the personal stigma scale than the Rhodes University Catering staff. These higher scores occur across both the subscales of the Visser personal stigma scale: these being the personal distancing and the blame and judgement subscales.

<Table 5> Workplace / Occupation vs HIV/AIDS-related stigma

	Hi-Tec Security sample	Rhodes Catering sample				
Parameter	Mean scores	Mean scores	t	df	p	F
HIV related stigma vs workplace	4.01	1.37	10.30	244	0.00	-
The main effect of Sex	-	-			0.74	1, 242
The main effect of workplace	-	-			0.00	1, 242

5. Discussion

5.1. Demographic results

Given that the majority of participants (66%) from the security sample are men and the majority of the participants (82%) from the catering sample are women, it was important to determine whether the notable differences of personal stigma scores between the two samples was the result of this gender bias. As will be discussed later, the results, however, suggest that the differences are the result of the different workplace setting rather than the sex of the participants. This is surprising as the literature would suggest that women would normally be more compassionate (which presumably means less stigmatising) towards people with HIV/AIDS (Valdiserri, 2002).

Both men and women in the security sample report higher personal stigma scores than the men and the women in the catering sample. The different proportions of men and women in each of the two samples may have to do with socially-constructed notions of masculinity and a resulting informal segregation of the labour market. Indeed, according to Cross and Bagilhole (2002), occupational segregation by sex is undoubtedly a universal characteristic of the labour market.

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 security sample.

As mentioned briefly above, this suggests that in this research, the workplace setting, by attracting particular personalities and by influencing the people who work there, may shape the attitudes that people hold towards those who are HIV positive. Although for some the relationship between personality and occupational choice is contested, there is compelling evidence that suggests that personality is a good predictor of occupational choice (Holland & Tokar, 1997 Tokar et al., 1998). Therefore, because of the authoritarian nature of their jobs,

Rubinstein (2006) points out that 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 judgemental and thus more stigmatising towards people with HIV/AIDS than the catering sample.

Generally working as caterer is a job that is often considered as socially demanding and has the potential to 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. Similarly, in a study by Kanengoni et al. (2011) caterers showed less stigmatising attitudes towards people with HIV/AIDS. Furthermore, it is also reasonable to argue that due to high levels of contact with people, caterers are likely to associate with people with HIV/AIDS more often than security guards. This therefore follows that caterers are likely to show sympathy towards people with HIV/AIDS than security guards. In support of this idea, Goffman (1963) argues that higher levels of involvement with people with a disability results in greater acceptance of those people, so the same might be true in the case of HIV/AIDS. Shisana and Simbayi (2002) also found that participants who scored higher in personal involvement with PLWA also reported lower levels of stigma towards PLWA.

Most security guards who participated in this study work under harsh conditions for instance those looking after buildings are exposed to all bad weather conditions and they spend the majority of their time without socialising with others thereby creating social distance. If indeed the working environment influence employees attitudes (Odendaal et al., 2001), it is reasonable to expect security guards in this case to be less sympathetic to people with HIV. Furthermore working as a security guard involves high levels of strictness and zero tolerance. This is because their job is to defend and protect assets and people. This therefore follows that they are most likely to treat people with suspicion and likely to be judgemental. This might also explain why security guards score higher in blame and judgement in this case.

6. Future Research Directions.

The research at hand only focused on two local samples. Future research can focus on many and perhaps bigger samples so as to increase the reliability of the results.

7. Limitations

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). 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. The planned use of the entire population in this study was based on the assumption that all participants would participate and be able to attend the relevant meetings. While the response rate of the caterers was excellent, the response rate of the security guards was lower than expected; the reason for this, though, was due to the daily, 24-hour operational requirements of the security company and there is no reason to think that attendance or non-attendance at the meetings had any relationship to people's views of HIV or people with HIV. However, although there may be no reason to think that the security sample is somehow biased, the possibility cannot be ruled out. A further issue is that the scales used in this study make use of a two-point response set rather than a five point option which provide a wider range of options, which might impact on the variability and reliability of the responses. However, the advantage of this format is that the scales are easy to complete in a context where there is pressure on the participants' time. Also, Visser at al. (2008) found that participants tend to only use the 'agree' or 'disagree' options of their original four-point response format.

Finally, as a cross sectional design, the study is unable to track how individuals' reported stigma scores vary across time. The tracking of stigma across time would be a very useful addition to the literature – but this sort of research should only bedone once good valid and reliable measures of stigma have been identified.

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