



**THE PERCEPTIONS OF EMPLOYEE WELLNESS PROGRAMME PRACTITIONERS  
CONCERNING HIV AND AIDS WORKPLACE STIGMA IN THE GAUTENG  
PROVINCIAL GOVERNMENT**

**by**

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## DECLARATION

I hereby declare that this empirical report entitled "The perceptions of Employee Wellness Programme practitioners concerning HIV and AIDS workplace stigma in the Gauteng Provincial Government" is entirely my own work and that the report has not been previously submitted by me for a degree at any university. All sources of information used in this study have been acknowledged.

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Tshilidzi Alfred Thavhanyedza

## **ABSTRACT**

### **THE PERCEPTIONS OF EMPLOYEE WELLNESS PROGRAMME PRACTITIONERS CONCERNING HIV AND AIDS WORKPLACE STIGMA**

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HIV and AIDS stigma has become a vital challenge for all stakeholders in the workplace. Although government has developed policies on managing HIV and AIDS, indications are that the implementation of these policies and strategies has not been effective in mitigating HIV and AIDS workplace stigma.

The key thrust for conducting this qualitative study was to explore the perceptions of Employee Wellness Practitioners concerning HIV and AIDS stigma in the Gauteng Provincial Government [GPG] departments. The study was geared towards ascertaining empirically the Employee Wellness Programme [EWP] practitioners' perceptions regarding the manifestation of HIV and AIDS stigma, the context of stigma in a government department, and insight into whether workplace interventions have been effective in mitigating stigma.

The general orientation to the study in Chapter 1 provides an overview of the definition of the problem of stigma, and also of the goals and objectives of the study, the research question, empirical approach, research design and methodologies used, pilot testing of data collection instrument, research population, sampling methods, ethical considerations and the structure of the study report. Fourteen EWP practitioners from the 13 GPG departments were interviewed by the researcher.

The literature review in Chapter 2 theoretically scrutinises the problem of HIV and AIDS stigma with specific reference to the types, forms sources, causes and consequences of stigma. The conjectural context of HIV and AIDS stigma in the workplace is expounded and workplace interventions are explored.

Chapter 3 of this study presents and analyses the data collected from the respondents. Findings indicate that HIV and AIDS stigma is widespread in the GPG departments and that workplace responses as per EWP practitioners' perceptions are diverse. HIV and AIDS stigma mitigation strategies necessitate the use of multi-dimensional, multi-disciplinary and multi-sectoral approaches which should be tailored to address the challenges and needs of relevant stakeholders.

From the results of this study it is apparent that HIV and AIDS stigma has an immense impact on the performance of government employees, and that current HIV and Employee Wellness policies are not sufficient to enhance stigma mitigation in the workplace. Lack of support, commitment and visionary leadership in government departments impede the hard EWP practitioners' efforts to de-stigmatise HIV and AIDS in the GPG. Chapter 4 presents the conclusions and recommendations for prioritisation and implementation through workplace interventions.

## CHAPTER 1: GENERAL ORIENTATION AND RESEARCH METHODOLOGY

### 1.1. INTRODUCTION

The Acquired Immune Deficiency Syndrome (AIDS) epidemic was identified in 1981 in the United States of America (Van Dyk, 2001:5). The world is now in its 27<sup>th</sup> year since the first cases of the Human Immune Virus (HIV) and AIDS were identified, and still no cure has been found. It is estimated that over 40 million people are living with HIV and AIDS globally.

According to Jennings, Mulaudzi and Everatt (2002:5), the latest estimates are that one out of every nine South Africans, or 4.47 million South Africans were infected with HIV by the end of 2001. This means that a vast number of people in South Africa could already have experienced some form of discrimination based on their HIV status, and that many more have the potential of becoming vulnerable to rejection, stigma and prejudice, once their status becomes known to others. South Africa has about 5.7 million people living with HIV, with an average of 72.9% pregnant women testing positive at antenatal clinics (Department of Health, 2005). About 20% of the South African workforce is HIV positive and it was estimated by Epicentre (2005:127) that by 2007, this would rise to 30%. The Gauteng AIDS programme was initiated a number of years ago. Despite all the efforts to reduce new HIV and AIDS infections, employees continue to be stigmatised and discriminated against on the basis of their HIV and AIDS status.

Because HIV was first identified in the developed countries in communities that were marginalised [gays, sex workers and drug-using communities], it quickly became a disease that was stigmatised. One of the reasons for the stigma attached to AIDS, based in large part on ignorance of the means of transmission, is a common fear that by associating with people living with AIDS, individuals might put themselves at a risk (Singhal & Rogers, 2003:251).

In the 1980's, the stigma attached to HIV, although undeserved, was at least a little more understandable, as people knew very little about the disease. Fear of being infected from holding hands, kissing or sharing a cup with an HIV positive person, was still prevalent. Brand (2006:1) states that in the 1980's it was very common for doctors and other health care workers to refuse to see patients who were HIV positive.

The HIV and AIDS epidemic poses one of the greatest challenges to business development in Africa. Recognising the serious nature of the pandemic, the Department of Public Service and Administration [DPSA] has developed a guide for government departments on how to manage HIV and AIDS in the workplace. The researcher is of the view that the Employee Wellness Programme (EWP) practitioners, as part of the health care team, should provide social health care services and work with HIV and AIDS infected individuals, groups and families who are stigmatised and discriminated against on the basis of their HIV status. People with HIV and AIDS face isolation, disruption of their social and sexual relationships, lack of required services, fear, ignorance, negative attitudes and behaviour on the part of the helping professionals, loss of jobs, housing and alienation from friends and families (Aronstein & Thomson, 1998:xxi).

There is an ongoing global call for research about the HIV and AIDS workplace stigma because this stigma undermines the prevention efforts and is counter-productive from a public health perspective. From the literature reviewed, there has not been a recorded previous study on the perceptions of stigma in the workplace. While one can easily identify conditions such as disability on the basis of obvious characteristics, an HIV positive employee cannot be easily identified; hence, the HIV and AIDS stigma constitutes a public health threat.

Most of the research on stigma has been done in the United States of America, a country with many varied research resources. Lorentzen and Morris (2003:27)

claim, “the relative lack of scientific research on the manifestation of HIV and AIDS related stigma in Sub-Saharan Africa presents a serious challenge to the understanding, alleviation and prevention of HIV and AIDS stigma”.

This study will have a number of benefits to the employer, employees and the profession in the various ways set out by local HIV and AIDS experts below.

- ✚ Employers should acknowledge the existence of stigma in the workplace, and should ensure that workplace policies and strategies on HIV and AIDS address how this stigma would be combated (Pretorius, 2006).
  
- ✚ Employees need to be educated and empowered to identify any form of discrimination and stigma and be able to report such without fear of being labelled. The representatives of organised labour/shop stewards should also understand HIV and AIDS policies and be able to lobby for their members’ rights relating to stigma in the workplace (Marais, 2006).
  
- ✚ The EWP practitioners need to acknowledge that no one is immune to being HIV positive. This study will produce recommendations on how practitioners can come to terms with their own fears and prejudices relating to HIV stigma in the workplace. EWP practitioners will further need to understand the need to verbalise their anxiety, anger, sorrow, guilt or shame based on their own perceptions of stigma in the workplace (Mabele, 2006).

## **1.2. PROBLEM FORMULATION**

Mark (1996:364) indicates that the researcher should ensure that the problem has been defined specifically enough for the reader to understand what the proposed research study includes and what it omits.

The researcher is an EWP professional employed by the Gauteng Provincial Government (GPG) as a manager for employees' health and well-being. The researcher, as an employee, received a number of referrals (both formal and informal) from employees and line managers who had been stigmatised and or discriminated against on the basis of their HIV status. They also found themselves subjected to mental abuse such as discrimination (Shelton, 2003:172). Some of them were professionals with specialised and scarce skills that are indispensable to the socio-economic development of South Africa. Most employees ended up taking unpaid long leave of absence because of fear that people would have pre-conceived ideas about their health and well-being.

HIV and AIDS continue to dominate the lives of many populations served by EWP practitioners. Gant, cited in Aronstein and Thomson (1998:20), asserts that the profession of social work may well be judged by future generations in part by its collective response to the HIV pandemic. Whether or not EWP practitioners and the profession realise it, the professional legacy is being written, as EWP practitioners currently respond to the pandemic. It remains to be seen whether the profession responds to the stigma suffered by many people in the workplace. Support services for people living with HIV and AIDS have improved and a number of organisations provide care and support for people in the communities. All GPG departments have Employee Assistance Programmes (EAP) which are geared towards enhancing the well-being of employees through various interventions.

The rejection of HIV and AIDS stigma is based on the understanding that all acts of social exclusion relating to HIV and AIDS are not only morally wrong, but also counter-productive to effective HIV and AIDS prevention and treatment (Stein, 2003:95). South African research regarding HIV and AIDS stigma has been extremely limited, and comparisons of stigma levels over time have been based largely on anecdotal evidence.

There are several barriers to treatment and care in the workplace. One important gap in the perception of barriers to care in South Africa is that South Africans have little knowledge about how healthcare workers think and engage with people living with HIV and AIDS. Sadow, Ryder and Webster (2002:663) highlight the need for a better understanding of the beliefs health professionals develop about HIV and AIDS through medical education and general socialisation, including factors such as resources within the workplace. Thus EWP practitioners need to know how stigma affects people living with HIV and AIDS.

Bollinger (2002:15) argues that there is a need to implement new kinds of anti-stigma interventions within an integrated and holistic approach. Brown, Trujillo and Macintyre (2001:26) emphasise the combination of educational programmes with counselling, coping skills and contact with people living with HIV and AIDS. Deacon, Stephney and Prosalendis (2005:4) insist that it is important to understand HIV and AIDS stigma in relation to the broader social, political, economic and cultural context, and to address stigma as one of a number of causes of discrimination, reluctance to test, and therapeutic non-compliance. The researcher intends to explore the perceptions of EWP practitioners concerning stigma with the purpose of generating recommendations that will ensure that EWP practitioners know how to deal with stigma in the workplace. The World Health Organisation (1998:2) is of the opinion that an HIV infected health care professional generally does not pose a risk to patients and need not withdraw himself or herself from patient care services.

Some of the employees at GPG found themselves ostracised, isolated, gossiped about and rejected by their colleagues and managers. While the extent of this problem of HIV stigma has not explicitly been recorded in South African literature, its impact could be great. To this end, the researcher is of the view that the study will deliver findings and recommendations that will assist government to implement HIV and AIDS stigma mitigation workplace programmes.

### **1.3. GOALS AND OBJECTIVES OF THE STUDY**

Fouché and De Vos (2005:104) indicate that the goal, purpose or aim is a dream. According to Babbie (2005:88), three of the most common and useful purposes of research are exploration, description and explanation. In the view of Bless and Higson-Smith (2000:41), exploratory research is conducted to gain insight into a situation or phenomenon. Exploratory designs are used when little is known regarding the topic being researched. Babbie (2005:89) indicates that an exploratory study occurs when:

The subject of study is relatively new. Exploratory studies are conducted to satisfy the researcher's curiosity and desire for better understanding, to test the feasibility of undertaking a more extensive study and to develop the methods to be used in any subsequent study.

It is against this background that the researcher used an exploratory design. EWP practitioners' perceptions regarding HIV and AIDS stigma are a new concept, particularly amongst those employed by the Gauteng Provincial Government. It was therefore imperative to explore the perceptions of EWP practitioners relating to the HIV and AIDS workplace stigma.

#### **1.3.1. Goal of the study**

The goal of the study was to explore the perceptions of EWP practitioners concerning HIV and AIDS workplace stigma.

#### **1.3.2. Objectives of the study**

Fouché and De Vos (2005:104) indicate that the objectives are steps one has to take, one by one, realistically at grassroots level within a certain time span in order to attain the dream.

These objectives were:

- ✚ to conduct an in-depth literature review on the manifestation of HIV and AIDS stigma as a problem and challenge in the workplace;
- ✚ to ascertain empirically EWP practitioners' understanding and perceptions of HIV and AIDS stigma and discrimination manifestations in the workplace;
- ✚ to establish from EWP practitioners, the nature of workplace interventions and whether such interventions were addressing HIV and AIDS stigma efficiently;
- ✚ to establish from EWP practitioners, the effectiveness of workplace interventions and whether such interventions were addressing the HIV and AIDS stigma efficiently; and
- ✚ to make recommendations to health care practitioners who work with employees who are victims of HIV and AIDS stigma, with the purpose of enhancing compliance with relevant legislations.

#### **1.4. RESEARCH QUESTION**

Cresswell (1998:16) indicates that in a qualitative study, the nature of a research question relates to “how or what” pertinent to the underlying study. Fouché and De Vos (2005:103) state that if a qualitative study is opted for, the researcher will formulate a research question carefully.

This researcher was curious about the perceptions of EWP practitioners pertaining to the HIV and AIDS stigma in the workplace. The rationale for the researcher to use research questions was to generate answers pertinent to the perceptions of stigma by EWP practitioners. Bless and Higson-Smith (2000:41) claim that an exploratory study is conducted to gain insight into a situation, phenomenon, community or individual. In the current study there was insufficient information pertinent to EWP practitioners' perceptions of stigma manifestations in the workplace.

At the end of the study the researcher seeks to have answers to the following question:

What are the perceptions of EWP practitioners relating to HIV and AIDS workplace stigma?

## **1.5. RESEARCH APPROACH**

There are two kinds of recognised research approaches, namely quantitative and qualitative research paradigms. Fouché and Delport (2005:74) define the qualitative research paradigm as “research that elicits participant accounts of meaning, experience or perceptions. It produces descriptive data in the participant’s own written or spoken words”. Burns (2000:11) maintains that the role of a qualitative methodologist is to capture what people say and do as a product of how they interpret the complexity of their world, to understand events from the viewpoints of the participants.

This researcher utilised the qualitative research methodology because it is the approach that seeks to understand the meaning people attach to their daily life, including perceptions and experiences. The qualitative approach is applicable in the proposed study because Deacon *et al.* (2005:65) recommend that the qualitative approach is the most appropriate method for researching stigma.

## **1.6. TYPE OF RESEARCH**

There are two types of research, namely basic [pure] and applied research. Bless and Higson-Smith (2002:153) indicate that applied research “has the primary aim of finding solutions to specific concerns or problems facing particular groups of people”. Babbie (2005:25) elaborates on this view that researchers doing applied research should be committed to having what they learn make a difference, to seeing their knowledge of society put into action. This researcher used applied research because he intended recording the perspectives of EWP practitioners pertinent to HIV and AIDS workplace stigma.

## **1.7. RESEARCH DESIGN AND METHODOLOGY**

### **1.7.1. Conceptualising Research Design**

Mouton (2001:55) defines research design as a blueprint of how one intends conducting research. Padgett (1998:28) states that research design refers to the plan or procedures that allow the goals of the study to be achieved. Creswell (1998:2) stipulates that a qualitative research design implies the entire process of research from conceptualising a problem to writing the narrative.

There are different types of research design, namely, biography, phenomenology, grounded theory, ethnography and case studies in the qualitative approach. Creswell (1998:61) indicates that a case study is an exploration or in-depth analysis of a bounded system, or a single or multiple cases over a period of time. Fouché (2005:272) elaborates further by saying that case study may also refer to a process, activity, programme or individuals. In the context of a qualitative exploratory design, the researcher applied the collective case study approach. Mark (in Fouché, 2005:272), believes that the collective case study “furthers the understanding of the researcher about a social issue or population being studied”. To this end the researcher intended enhancing his understanding of the perceptions of EWP practitioners concerning HIV and AIDS workplace stigma.

### **1.7.2. Data Collection Method**

An interview is the predominant mode of data or information collection in qualitative research (Greeff, 2005:287). Babbie (2005:484) defines an interview as “a data collection encounter in which one person [an interviewer] asks questions of another [a respondent]”. The dominance of interviews and media analysis in qualitative studies is the consequence of the focus on asking people what they think and do, rather than observing what happens, using less direct

techniques to access information from people, or investigating the social context in which something manifests itself (Deacon *et al.*, 2005:65). It is against this background that the researcher chose an interview as a method of data collection to be able to understand the HIV and AIDS stigma, as perceived by the respondents.

According to Greeff (2005:292), there are three types of one-to-one interviews, namely, unstructured, semi-structured and ethnographic interviews. Greeff (2005:297) reports that qualitative studies usually use semi-structured interviews. Semi-structured interviews are used to acquire a detailed picture of a participant's beliefs about something, or perceptions or accounts of a particular phenomenon or topic. Semi-structured interviews are applicable in instances where one is studying personal, controversial and complex issues (Greeff, 2005:296). Given the controversy attached to the HIV and AIDS stigma in South Africa, the researcher believed that a semi-structured interview was an appropriate method of data collection in this study.

The researcher prepared an interview schedule. A questionnaire formulated to guide interviews is called an interview schedule or guide (Greeff, 2005:296). The interview schedule was focused on a few concise questions or themes. Questions were logically and sequentially formulated. Open-ended questions were asked, and follow-up questions were developed on an interesting issue that was relevant to the study. Permission to take notes during the interview processes was requested from the respondents for ethical compliance [See Appendix C].

### 1.7.3. Data Analysis

Qualitative data analysis transforms data into findings. Babbie (2001:10) defines data analysis as “a process of making sense of what has been observed”. De Vos (2005:333) adds that data analysis is a process of bringing order, structure and meaning to the mass of collected data.

Data was recorded in notebooks (a separate notebook for each interview) and notes were taken during the interview. Field notes on important aspects were recorded by the researcher and were used for further probing. The notes were very useful during the analysis of data. After each interview the researcher transcribed the interview; writing a verbatim record of the interview in order to preserve the information.

The researcher used the integrated model of Creswell of data analysis, as described by De Vos (2005:334). This was done manually due to constraints imposed upon the researcher’s consistent access to a computer software programme to analyse the data. The nine steps are listed in Table 1.

**Table 1: Nine step procedure for data analysis**

<p>Step 1: Planning for recording of data</p> <p>The researcher planned how data was to be recorded and used field notes as explained in 1.7.3.</p>
<p>Step 2: Data Collection and preliminary analysis</p> <p>The researcher analysed the data during the interview process with respondents. After conducting the interview, data collected from each interview was analysed.</p>
<p>Step 3: Managing or organising the data</p> <p>The researcher developed a data inventory system. He correlated the field notes and transcripts. The transcripts were done by the researcher himself. The transcripts were kept electronically and in print at home and at work [back-up] to</p>

prevent loss of data.
<p><b>Step 4: Reading and writing memos</b></p> <p>After writing the transcripts, the researcher read the materials several times in order to gain insight into the respondents' answers. The reading was done in order to generate categories or themes. The researcher wrote memos in the margins of field notes.</p>
<p><b>Step 5: Generating categories, patterns and themes</b></p> <p>The researcher utilised his intellectual skills to identify the main themes identified in the perceptions of EWP practitioners relating to the HIV and AIDS stigma in the workplace. Sub-themes, patterns and categories were identified and outlined.</p>
<p><b>Step 6: Coding the data</b></p> <p>The researcher applied the coding schemes to the identified themes and sub-themes. The researcher used numbers to code the themes and sub-themes.</p>
<p><b>Step 7: Testing emergent understandings</b></p> <p>The researcher evaluated the usefulness and centrality of the data presented in the themes and sub-themes.</p>
<p><b>Step 8: Searching for alternative explanations</b></p> <p>The researcher used his critical analytical competence to identify and document alternative explanations, thereby justifying any apparent plausible explanation.</p>
<p><b>Step 9: Writing a report [Visualising/Representing]</b></p> <p>The data analysed was presented, and packaged through the identified themes/categories or patterns.</p>

## 1.8. PILOT STUDY

Bless and Higson-Smith (2000:155) define a pilot study as a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. Strydom (2005a:210) outlines the value of the pilot study as that of improving the success and effectiveness of the investigation.

### **1.8.1. Pilot testing of data collection instrument**

Singleton *et al.*, as quoted by Strydom (2005a:206), define a pilot study as a pre-testing of a measuring instrument. The process consists of “trying it out on a small number of persons having characteristics similar to those of the target group of respondents”. The researcher interviewed two EWP practitioners working for the GPG who were not part of the main study. The researcher selected one EWP practitioner from the Gauteng Shared Services Centre [GSSC] external and another practitioner from the Multi-Sectoral AIDS Unit [MSAU] in the Gauteng Provincial Government. According to Strydom (2005a:208), it is necessary to obtain an overview of the actual, practical situation where the prospective investigation will be executed.

After conducting the pilot testing, the researcher identified the need to request more time for the actual study because, during the pilot testing, all the respondents exceeded the time scheduled for the research. The pilot testing resulted in the researcher modifying some of the questions as there appeared to be contextual repetition of some questions. New questions were also incorporated into the interview schedule in order for the researcher to gain a clear overview of the perceptions of EWP practitioners on HIV and AIDS workplace stigma.

### **1.8.2. Feasibility of the study**

The Gauteng Shared Services Centre [GSSC] granted the researcher formal permission to conduct the study [see Appendix B]. The GSSC is custodian and convenor of the Gauteng Provincial Government Employee Wellness Programme Forum. The forum is responsible for the development, implementation and monitoring of the Employee Wellness Programme strategies and policies in the province. The forum is an official entity comprised of Employee Wellness

Programme practitioners from the 13 provincial departments. Participating EWP practitioners from all departments were requested to co-operate, as the researcher intended presenting the findings to the GPG.

The researcher believed that the study was feasible because all respondents were based in the Johannesburg Central Business District, and it was easy for the researcher to reach out to them for the interviews. The researcher walked to the respondents' workstations to conduct interviews. The researcher incurred costs for the proofreading, language, style and grammar editing. All the costs were budgeted for by the researcher prior to the study. The researcher's employer provided resources such as computer and printing services, thus making the study feasible.

## **1.9. RESEARCH POPULATION, SAMPLE AND SAMPLING METHODS**

### **1.9.1. Research Population**

According to Burns (2000:83), a population is an entire group of people, or objects or events, which all have at least one characteristic in common and must be defined specifically and unambiguously. Rossouw (2003:103) defines a population as a collectivity that a researcher plans to study, and about which he/she wants to make a statement. For the purpose of this study the population included 22 EWP practitioners who were employed by the GPG to manage and coordinate the EWP at the 13 departments and who were members of the GPG Employee Wellness Program Forum.

### **1.9.2. Sample**

Soanes (2002:794) defines a sample as a small part or quantity intended to show what the whole is like. For the purpose of this study, a sample will be defined as a representative of the population. In a non-probability sampling, a small number

of research participants are recommended, hence only 14 respondents participated in the study. Since some departments have more than one EWP practitioners, the researcher selected only those who were active members of the GPG EWP forum. To this end, those EWP practitioners with the most years of experience in the management of HIV and AIDS workplace programmes were sampled for the study. One respondent from each of the respective 13 departments was considered for the study. The additional [14<sup>th</sup>] respondent was taken from the external programme at the Gauteng Shared Services Centre, as the external programme at the GSSC is responsible for providing account management services, policy and strategy development and coordination of the provincial EWP at all the 13 departments. In order to avoid inherent bias, the researcher ensured that EWP practitioners from diverse cultures, language, race and gender were included in the study. This was done to avoid further stigmatisation of a specific target group.

### **1.9.3. Sampling method**

Sampling is a process of selecting part of the group under study (Rossouw, 2003:103). There are different kinds of sampling, namely, probability and non-probability sampling. Vadum and Gregoria (1998:249) point out that, in a non-probability sampling, there is no way of estimating the probability that each element will be selected or included in the sample and no assurance that every element has a chance of being selected.

The researcher preferred the non-probability sampling because it does not promote randomisation. In the context of non-probability sampling of the qualitative study on HIV and AIDS workplace stigma, the researcher used purposive or judgmental sampling. Babbie (2005:486) defines purposive sampling as a type of non-probability sampling in which one selects the units to be observed on the basis of one's own judgment about which ones will be the most representative or useful. Babbie (2001:179) indicates that purposive

sampling is selected on the basis of the researcher's knowledge of the population and purpose of the study. Neuman (2000:198) supports the use of purposive sampling in exploratory studies.

The researcher used purposive sampling because the subjects of the proposed study were easily available, and the researcher had knowledge and information about general perceptions relating to HIV and AIDS stigma within the GPG.

### **1.10. ETHICAL ASPECTS**

Burns (2000:17) indicates that ethical principles, rules and conventions distinguish socially acceptable behaviour from that which is considered to be socially unacceptable. Babbie (2001:470) elaborates by stating that anyone involved in research needs to be aware of the general agreement about what is proper and improper in scientific research. Levy, quoted in Strydom (2005b:57), defines ethics as preferences that influence behaviour in human relations. Various authors (Burns, 2000:18-22; Strydom, 2005b:58-69) contend that it is important to consider ethical aspects, in order to do the following: avoid physical or emotional harm; obtain informed consent; avoid any deception of respondents; maintain confidentiality; enhance the researcher's competencies; debrief respondents and ensure cooperation with contributors. The significant ethical aspects considered in the current study are discussed below.

#### **✚ Voluntary Participation of Respondents**

Burns (2000:18) emphasises that voluntary participation of respondents in social science research is important, although in some instances it reduces the external validity. The researcher ensured that no EWP practitioner was forced to participate by informing them all that they could withdraw from participating in the study at any time. The researcher briefed all EWP practitioners about the rationale for the study and encouraged them to participate voluntarily. Letters of

consent were circulated to the respondents prior to the administration of an interview schedule and were duly signed by the respondents [See Appendix C]. According to Strydom (2005b:59), there must be adequate opportunity for research participants to ask questions before the study commences.

#### **Avoidance of harm**

Strydom (2005b:58) indicates that harm to respondents in social sciences will be mainly of an emotional nature, although physical injury cannot be ruled out completely. The researcher took into account the feelings of the EWP practitioners concerning HIV and AIDS workplace stigma by thoroughly informing them beforehand of the potential impact of the study.

#### **Privacy, anonymity and confidentiality**

Strydom (2005b:61) mentions that privacy implies the element of personal privacy, while confidentiality indicates the handling of information in a confidential manner. The researcher used audiotapes to record interview proceedings during the administration of the interview schedule. Written consent to use audiotapes was requested from participants. The researcher believed that confidentiality could only be achieved if no names of respondents were revealed.

#### **Deception of respondents**

Loewenberg and Dolgoff, quoted in Strydom (2005b:60), define the deception of respondents as deliberately misrepresenting facts in order to make another person believe what is not true, violating the respect to which every person is entitled. Burns (2000:19) indicates that the primary justification for deception is that knowledge of the purpose of the investigation may contaminate results; subjects who are not aware of the real purpose will behave more naturally. The purpose of the study was elucidated, and voluntary participation sought from

respondents. Respondents were told in writing that the research was part of the researcher's MSW (Health Care) degree requirement.

#### **Cooperation with contributors**

Research projects are often so expensive and comprehensive that the researcher cannot handle them either financially or in terms of time, on his or her own (Strydom, 2005b:64). This researcher wrote a letter to the GSSC requesting permission to conduct the study and stating that he would also provide feedback on completion of the study [see Appendix A]. The request included a detailed proposal describing how the study was to be conducted.

#### **Actions and competence of the researcher**

Strydom (2005b:63) indicates that researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation. The researcher has nine years of experience in the field of employee health and wellness which, inter alia, include the management, implementation, monitoring and evaluation of HIV and AIDS interventions in the workplace. The researcher had also successfully completed the module on research methodology at the University of Pretoria.

#### **Release or publication of the findings**

Burns (2000:21) states that researchers should be open with their results, allowing disinterested colleagues to vet the research and its implications, because no one wants newspapers to seize on half-truths, misinterpreting information and causing unnecessary concern, particularly if the issue affects people's lives. Strydom (2005b:65) supports this and further stipulates that the findings of the study must be introduced to the reading public in written form; otherwise even a particularly scientific investigation will mean very little and will

not be viewed as research. In order to contribute significantly to social science, the researcher compiled a written report that is accurate, clear, and objective and contains all essential information regarding the perceptions of EWP practitioners relating to HIV and AIDS workplace stigma. All relevant errors and shortcomings of the underlying study were acknowledged and recorded in the study report. To avoid plagiarism, the researcher acknowledged all sources used and all the people who collaborated in the study, and this was done in accordance with guidelines laid down by the University of Pretoria.

### **Debriefing of the respondents**

Debriefing sessions after the study, during which subjects have the opportunity to work through their experience and its aftermath, are one way in which any researcher can assist subjects in minimising any possible harm which may have been done, in spite of all his or her precautions against such harm (Strydom, 2005b:67). In this study on the perceptions of EWP practitioners on HIV and AIDS workplace stigma, no harm was inflicted, and consequently debriefing of respondents after the interview was not fundamental.

## **1.11. DEFINITION OF KEY CONCEPTS**

### **Perceptions**

Soanes (2002:660) defines perception as “the ability to understand the true nature of something or as insight”. Encarta (2007:1) considers perception to imply a view or picture. For the purpose of this study, perceptions are defined as the manner in which EWP practitioners view stigma at work.

## **Employee Wellness Programme [EWP]**

The Department of Public Service and Administration (2002:4) defines a wellness programme as: “A programme designed to promote the physical and mental health as well as the well-being of employees, including components such as counselling, support groups, nutritional supplements, provision of treatment for opportunistic infections, and or provision of anti-retroviral therapy”. It is an intervention aimed at addressing a specific issue within the workplace, for example, providing staff access to a voluntary HIV counselling and testing programme (Department of Public Service and Administration, 2002:4). Herlihy and Attridge (2005:71) elaborate further that a wellness programme is a “worksite-based programme that focuses on physical fitness and health-related activities”.

## **EWP practitioner**

EAPA SA (2005:7) defines a practitioner as “a person, not necessarily a professionally trained person, performing employee assistance programme specific or related tasks, i.e. referral, liaison or training”. In this study the EWP practitioner refers to an employee whose task is to coordinate, manage, monitor and evaluate the implementation of employee wellness or HIV and AIDS workplace programmes/interventions.

## **HIV**

Van Dyk (2001:423) defines the Human Immunodeficiency Virus [HIV] as a virus which causes AIDS. Singhal and Rogers (2003:391) defines HIV as an organism that causes an infection that depletes white blood cells and leads to lessened immunity. This researcher defines HIV as a virus which attacks the human immune system, resulting in AIDS.

## **AIDS [Acquired Immune Deficiency Syndrome]**

AIDS is defined as a syndrome [collection of diseases] that results from infection by the Human Immunodeficiency Virus [HIV] (Department of Public Service and Administration, 2002:3). Van Dyk (2001:423) emphasises that AIDS is acquired and not inherited, and that it is caused by a virus that invades the body, ultimately attacking the body's immune system and making it so weak and ineffectual that it is unable to protect the body from both serious and common infections and pathogens. Singhal and Rogers (2003:390) state that AIDS occurs when an HIV-positive person has such diminished immune levels that he/she falls prey to a variety of opportunistic infections. The researcher defines AIDS as a collection of various diseases emanating from a person's infection by the Human Immune Virus resulting in a weakened immune system which puts an individual at risk of opportunistic infections.

## **Stigma**

Stigma is prejudice and discrimination against a set of people who are regarded and treated in a negative way (Singhal & Rogers, 2003:392). The Foundation for Professional Development (2006:117) defines stigma as a status ascribed to someone that denotes disgrace or discredit, and states that "in HIV and AIDS it can be described as attaching a negative label or passing judgment on someone because they are perceived to be different or to have done something wrong." For the purpose of this study, HIV and AIDS stigma implies the holding of derogatory social attitudes or beliefs, the expression of negative and unreceptive attitudes, or the display of hostile or discriminatory behaviour towards people infected with HIV and AIDS.

## 1.12. LIMITATIONS OF THE STUDY

The study has the following limitation.

- ✚ The researcher did not make use of audio recording devices as initially planned due to the fact that the audio recorders were being used consistently by the employer during working hours. This prolonged the interview sessions as the researcher had to take notes during the interview processes.

## 1.13. CONTENTS OF RESEARCH REPORT

The contents of the research report are structured as follows:

### **Chapter 1**

General Orientation and Research Methodology.

### **Chapter 2**

Literature study on HIV and AIDS stigma as a problem and challenge in the workplace.

### **Chapter 3**

Empirical findings, analysis and interpretation of data.

### **Chapter 4**

Conclusions and recommendations.

## 1.14. SUMMARY

This chapter focused on the general overview of the research project, goals and objectives, the process of scientific data collection, analysis and reporting. The next chapter will focus on the theoretical observations regarding the HIV and AIDS stigma as a predicament and challenge in the workplace. The literature study on HIV and AIDS workplace stigma provides the basis for the necessity of this empirical research project.

## **CHAPTER 2: HIV AND AIDS STIGMA AS A PROBLEM AND CHALLENGE IN THE WORKPLACE**

### **2.1. INTRODUCTION**

The HIV and AIDS epidemic has already impacted significantly on the South African society. Piot, quoted in Parker and Aggleton (2002:1), has identified stigma as a continuing challenge that prevents concerted action at community, national and global levels. HIV and AIDS stigma is rooted in both fear and ignorance. Kidd and Clay (2003:17) stress that research has shown that everyone has some information about HIV and AIDS, but few have enough information to overcome the irrational fears associated with its transmission. The nature of stigma remains an enigma even after more than two decades of experience with the HIV and AIDS epidemic. These challenges demand that employers and employees understand and address stigma in the workplace.

Milan (2007:4) states that, although business and organised labour are not responsible for the attitudes and beliefs of their employees and members, they are responsible for ensuring that the workplace is a fair and effective environment that fosters productivity and creativity. Government departments have Employee Wellness Programmes which are geared towards improving employees' wellbeing in all dimensions. To this end, the researcher is of the view that employers have an obligation to educate employees on behaviour change, based on the impact of HIV and AIDS on productivity.

This chapter reviews in depth the literature dealing with HIV and AIDS workplace stigma by defining stigma, outlining the stigma typology and forms, causes and consequences of workplace stigma. This chapter further provides an exploration of HIV and AIDS workplace stigma and various interventions aimed at mitigating workplace HIV and AIDS stigma.

## 2.2. DEFINING STIGMA

Despite international efforts to tackle HIV and AIDS since its discovery, stigma and discrimination remain amongst the most poorly understood aspects of the epidemic (Parker & Aggleton, 2002:1). The University of Cape Town HIV and AIDS Unit (2007:1) defines stigma as the negative value and meaning attached to certain conditions, statuses or attributes, which discredit a person. The UNAIDS (2001:1) defines stigma in the context of HIV and AIDS as the negative thoughts about a person or group based solely on prejudice. Milan (2007:15) refers to stigma as the unfavourable attitudes, beliefs, and policies directed toward people perceived to have HIV and AIDS, as well as their loved ones, associates, social groups and communities. The Foundation for Professional Development (2006:117) indicates that stigma is the status ascribed to someone that, disgrace or discredit and it can be described as attaching a negative label to or passing judgment on, someone because they are perceived to be different or to have done something wrong.

In the light of the above definitions, the researcher deduces that HIV and AIDS workplace stigma has the following characteristics:

- + negative attitudes, beliefs and statuses;
- + rejection;
- + denial;
- + discrediting;
- + disregarding;
- + underrating;
- + social distance ;and
- + labelling and passing judgment related to HIV and AIDS.

To this end, the researcher asserts that HIV and AIDS workplace stigma refers to the negative attitudes, beliefs and statuses, rejection, denial, isolation, condemning, blaming, discrediting, shunning, underrating, social distancing,

scapegoating, teasing, ridiculing, suspecting, labelling and passing judgment on employees who are HIV-positive or are perceived to be HIV-positive.

### **2.3. TYPES OF HIV AND AIDS STIGMA**

There are different types of HIV and AIDS workplace stigma and they are discussed below.

#### **✚ Internal /self stigma**

The Foundation for Professional Development (2006:118) defines internal stigma as that which comes from within a person. Employees believe that they deserve to be treated differently because what they are facing is their own fault. Kidd and Clay (2003:12) state that self-stigma is characterised by self-hatred, shame and blame. The researcher has commonly observed examples of employees who feel that they are being judged by others, so they isolate themselves from colleagues, families and communities.

#### **✚ External /felt stigma**

The Foundation for Professional Development (2006:117) stipulates that “the external stigma is aimed at the individual and comes from others [external] such as neighbours, friends, parents, doctors or nurses”. Kidd and Clay (2003:12) mention that the felt stigma is characterised by the perceptions and feelings towards the persons living with HIV or AIDS. The researcher has provided counselling services to a number of employees who were stigmatised by colleagues, families, friends and parents.

### ✚ **Enacted stigma or discrimination**

The International Council of Nurses (2003:10) defines the enacted stigma as the actual experiences of discrimination, such as loss of a job, denial of health benefits, or refusal of health insurance. The researcher, during his normal course of work, had consultations with employees who have been refused health insurance and those who have been re-deployed unjustifiably after disclosing their HIV and AIDS status to their supervisors. These employees ultimately lose their rights and decision-making powers.

### ✚ **Other forms of stigma**

Kidd and Clay (2003:2) identify the following other forms of stigmas which are related to those aforementioned.

- ✚ physical and social isolation from family, friends and community;
- ✚ gossip, name calling and condemnation;
- ✚ stigma by association-the whole family affected by stigma; and
- ✚ stigma by looks/appearance/type of occupation.

The researcher is of the view that the above-mentioned forms could be easily integrated into the forms of stigma which have previously been described.

## **2.4. SOURCES OF HIV AND AIDS STIGMA**

According to Parker and Aggleton (2002:2), there are various sources of HIV and AIDS stigma. These focus on sexuality, gender, race and ethnicity, class and fear of contagion of the disease, to mention only a few factors. These sources are discussed below.

## **Sexuality**

Parker and Aggleton (2002:2) indicate that HIV and AIDS are most frequently related to sexual stigma. This is attributed to the fact that HIV is sexually transmitted and in most areas of the world, the epidemic initially affected populations whose sexual practices or identities are different from the “norm”. Weeks (in Parker & Aggleton, 2002:2) emphasises that the main sources of sexual stigma are the pre-existing notion of sexual stigma associated with sexually transmitted diseases, homosexuality, prostitution, promiscuity and sexual deviance. There are general beliefs that AIDS is a gay plague, and that it is spread by sex workers. Promiscuous sexual behaviour by women is commonly believed to be responsible for the heterosexual epidemic, regardless of the epidemiological reality.

## **Gender**

Angleton and Warwick (1999:4) indicate that the impact of HIV and AIDS related stigma on women reinforces pre-existing economic, educational, cultural, and social disadvantages and unequal access to information and services. Parker and Aggleton (2002:2) provide the following examples of gender related stigma.

-  In certain settings where heterosexual transmission is significant, the spread of HIV infection has been associated with female sexual behaviour that is not consistent with gender norms. AIDS is generally believed to be a “woman’s disease”.
-  Equally, in many settings, men are blamed for heterosexual transmission, because of assumptions about male sexual behaviour, such as men’s preference, or need, for multiple sexual partners.
-  Williams (quoted in Engelbrecht, 2006:2) noted the following significant findings regarding gender stigma. Male employees perceive their co-workers to be the main source of HIV and AIDS workplace stigma and are less worried about discrimination compared to stigma. Female employees have

greater fear concerning HIV and AIDS related rejection and violence in their communities, and experience more stigma and discrimination than men.

The researcher is of the view that gender equality permits males and females equal enjoyment of human rights, socially valued goods, opportunities, resources, and the benefits arising from development results.

## **Race and ethnicity**

Parker and Aggleton (2002:2) indicate that racial and ethnic stigma also interact with HIV and AIDS related stigma and the epidemic has been characterised by both racial assumptions about “African sexuality” and by perceptions in the developing world of the West’s “immoral behaviour”. The researcher’s view is that some racial and ethnic groups believe that AIDS is a disease introduced by white men, while others believe it is an African disease.

- **Class**

Castells, quoted in Parker and Aggleton (2002:2), highlight that the HIV and AIDS epidemic has developed during the period of rapid globalisation and growing popularisation between rich and poor. New forms of social exclusions have resulted in the stigmatisation of the poor, homeless, landless and jobless. To this end, poor people consider AIDS to be the disease of the rich, while the rich consider it to be the disease of the poor. The researcher contends with Parker, Easton and Klein (2000:23) that poverty increases vulnerability to HIV and AIDS, and that the epidemic exacerbates poverty.

- **Fear of contagion of the disease**

HIV and AIDS is a life-threatening illness that people are afraid of contracting (Parker & Aggleton, 2002:3). These authors assert that HIV and AIDS stigma is

the result of the interaction between diverse pre-existing sources of stigma and fear of contagion and disease. AIDS is associated with marginalised behaviours, and people living with HIV and AIDS are stigmatised because they are assumed to be from marginalised groups. To this end the researcher believes that marginalised groups are further marginalised because they are assumed to be suffering from HIV and AIDS.

## **2.5. CAUSES OF HIV AND AIDS WORKPLACE STIGMA**

HIV and AIDS are closely linked with sex and death. In the following section, the researcher highlights the major causes of HIV and AIDS workplace stigma.

- **Lack of knowledge about HIV and AIDS**

Viljoen (2005:32) indicates that in some studies groups ascribed the stigmatisation associated with alleged HIV status to ignorance: ignorance of how the disease was transmitted, how it progressed to AIDS and the association with negative attributes such as death and promiscuity. The lack of knowledge about the transmission of HIV extended to behaviours such as coughing, shaking hands, sharing food or other utensils, and eating beetroot at funerals. According to the International Centre for Research on Women (2003:15), most people know how HIV is transmitted, but more detailed knowledge of other aspects of HIV and AIDS is incomplete or missing altogether.

Viljoen (2005:32) further states that the ignorance is seen by most people as self-imposed, in other words, the information on HIV and AIDS is available, but people choose to ignore it. In South Africa various modes of communication are used to disseminate HIV and AIDS information, for example on television, radios and newspapers. In the workplace, most organisations put information on intranet; have information sessions on HIV and AIDS, as well as peer educators who provide information by word of mouth.

- **Fear**

Viljoen (2005:32) mentions that, related to the lack of knowledge and ignorance, is fear: the fear that accompanies having a person living with HIV or AIDS at home or at work. The International Centre for Research on Women (2003:17) outline two types of fears namely fear of causal transmissions and fear of death.

- ✚ Fears of casual transmissions - In high prevalence situations, people's assumption that HIV can be casually transmitted is not surprising. For example, people combine their knowledge of the sexual transmission of HIV with the incorrect belief that a condom used by someone with HIV can transmit the infection through even casual contact. Such fears result in stigma. Cultural perceptions can further enhance stigma, e.g. beliefs in witchcraft as a cause of HIV, and traditional beliefs about afflictions that people may suffer if they have sex with prohibited partners, or come into contact with infected people.

- ✚ Fear of death - In most African states, HIV is referred to as a killer disease.

- **Sex, morality , shame and blame**

As stated before, the fact that HIV can be sexually transmitted bestows upon it a separate status from that of other conditions. According to the International Centre for Research on Women (2003:18), respondents in three African states report that having HIV is a result of deviant behaviour, and people with HIV and AIDS are regarded as adulterers, prostitutes and generally immoral or shameful.

The HIV related stigma associated with breaking sexual norms is heightened by the fact that people with HIV and AIDS are considered to be responsible for their deviant sexual behaviour. The International Centre for Research on Women (2003:19) indicates that the interplay of sex with concepts of sin further contributes to sexually associated HIV stigma.

## Limited recognition of stigma

The International Centre for Research on Women (2003:21) asserts that people often do not recognise when their words, actions or beliefs are stigmatising or discriminating against persons living with HIV or AIDS. People talk about how significant it is not to stigmatise and insist that they would not do it, yet at the same time describe how people who get HIV are promiscuous, or indulge in other immoral behaviours, and deserve what they get.

### **2.6. CONSEQUENCES OF HIV AND AIDS WORKPLACE STIGMA**

Stigma and discrimination fuel the HIV and AIDS epidemic by creating a culture of secrecy, silence, ignorance, blame, shame and victimisation (International Centre for Research on Women, 2003:18). This causes increased pain and suffering and devastating social and economic consequences for the people living with HIV and AIDS, as well as their families and communities. The International Centre for Research on Women (2003:18) further state that stigma and discrimination felt by individuals are major barriers to utilising health services for prevention, diagnosis and treatment. The shame associated with felt stigma discourages individuals from seeking Voluntary Counselling and Testing [VCT] and treatment. It further impairs employees' ability to access care or participate in research related to HIV and AIDS. As a result some employees prefer not knowing their status for fear of exposure and the associated risk of stigma, loss of job, break-up of relationships, social ostracism, or even violence. The researcher, as an Employee Wellness professional has interviewed a number of employees who did not take precautionary measures to protect themselves and their partners from HIV infection.

The researcher's view on the consequences of workplace stigma is that some employees do not believe in HIV testing because, they know that their employers

do not provide access to treatment for HIV and AIDS. The International Centre for Research on Women (2003:18-19) indicates that, even when individuals know they are HIV positive, they may not seek counselling or treatment from the sources nearest to them for fear of stigma by the health personnel known to them.

Viljoen (2005:33) outlines the following human rights issues as consequences of stigma.

- ✚ Privacy and disclosure-Employees who are HIV positive usually prefer their status to remain confidential and avoid sharing their status with anyone, including health care professionals do not provide a license to disclose their status.
- ✚ Informed consent and HIV testing-Most people, including health care workers shared stories of being tested without being told, giving consent or being subjected to pre- and post-test counselling.
- ✚ Access to health care services-Employees have to wait for long hours to access health care services and in some instances, there are few health care professionals to provide the relevant services to them.

## **2.7. CONTEXTUALIZING HIV AND AIDS WORKPLACE STIGMA**

In this study the researcher would explore the perceptions of Employee Wellness practitioners within the context of HIV and AIDS stigma in the workplace. HIV and AIDS workplace stigma, particularly the government sector, can be explained within the following contexts.

- **Employment practices**

According to the UNAIDS (2000:16), the most prominent form of discrimination in the workplace takes the form of termination of employment or refusal to offer employment based on the employees' alleged HIV status. There is also

extensive evidence that workers who are open in the workplace about their HIV status are more likely to experience stigmatization and ostracism from colleagues (UNAIDS 2000:18). Parker and Aggleton (2002:6) mention such discriminatory practices as: pre-employment screening; denial of employment who test positive; termination of employment of those who are HIV positive and stigmatisation of those who are open about their serostatus. Instances of these have been reported from developed and developing countries.

- **HIV and AIDS policies**

According to the Centre for the Study of AIDS (2003:8), HIV and AIDS policies have recently been finalised within many government departments. The Centre for the Study of AIDS (2003:8) further highlight the findings listed below.

- Although government employees were aware of the existence of the policies, there was often ignorance regarding the content of such policies and uncertainty about its implementation, resulting in low confidence in these documents.
- Director-Generals of government departments interviewed indicated that the policies focus on HIV and AIDS stigma education, awareness raising, prevention, voluntary counselling, and testing and referrals.
- No government departmental representatives mentioned policies that formally deal with the issue of stigma.
- The coordination of the implementation of policies is done by mid-level staff and there is no consistency in terms of staffing and staffing levels.
- Government employees distrust the HIV and AIDS policies due to a lack of awareness of the contents of these policies.
- Confidentiality maintenance was a challenge. Employee Assistance Professionals and medical professionals were not trusted to keep HIV information confidential. There was also a concern that management had access to employees' private files and as such they could know an employee's HIV status, thereby stigmatising him or her.

- **Leadership/management of the government departments**

The stigma associated with HIV and AIDS in the workplace can be linked to senior management's reluctance to prioritise HIV and AIDS workplace programmes. Richter (2001:32) stresses that the success of HIV and AIDS workplace programmes has often been associated with an individual in the company who happened to be passionate about the subject, but who is then perceived by other employees as being infected with HIV, whether or not this is true.

The Centre for the Study of AIDS (2003:10, 24-25) made the following findings regarding the measurement of HIV and AIDS stigma in the workplace.

- Senior management's commitment to HIV and AIDS was perceived to be poor. There was a perception that HIV and AIDS programmes were about keeping up appearances, rather than effecting genuine change.
- Senior managers were perceived as ignorant and uninterested in HIV and AIDS issues. Government employees, particularly the HIV and AIDS coordinators, perceived senior managers as being ignorant about HIV and AIDS issues, which further eroded their confidence in their departments' leadership.
- The responsibility for HIV and AIDS strategies was shifted to human resources business units, and senior management did not see the need for making inputs on the HIV and AIDS policies and strategies.
- Poor communication between HIV and AIDS coordinators and senior management has been reported.

- **Health care systems**

Ogola, quoted in Parker and Aggleton (2002:6), indicates that there have been many reports from health care settings of HIV testing without consent, breaches of confidentiality, and denial of treatment and care. The UNAIDS (2000:4) reports that stigmatisation by health care workers has been widely documented in various countries, including discrimination against people living with HIV and AIDS, and the withholding of treatment. Brown *et al.* (2002:13) state that health workers' fear of infection has jeopardise the quality of services and social support rendered to people living with HIV and AIDS.

## **2.8. HIV AND AIDS WORKPLACE INTERVENTIONS/PROGRAMS**

Parker and Aggleton (2002:6) assert that HIV and AIDS policies and programmes may inadvertently contribute to stigmatisation and discrimination by differentiating between the general population and high risk populations and prioritising actions to prevent the spread of HIV. The Foundation for Professional Development (2006:27) outlines the objectives of the Gauteng AIDS program strategy for 2004-2009 as follows.

- ✚ Continue to implement a comprehensive HIV and AIDS programme that addresses HIV prevention, comprehensive health care and social support.
- ✚ Develop community capacity through partnership with civil society and the private sector, coordinating all efforts and addressing the psycho-social and economic factors that drive HIV infection, and which also result from AIDS.
- ✚ Support AIDS affected families and address social cohesion.
- ✚ Reduce the impact of AIDS on the public service and on economic growth.
- ✚ Integrate the response to AIDS into departmental line functions, for example, children's services, community-based health care, life skills in schools, Employee Assistance Programme for government employees and social crime prevention.

For the purpose of this study, the researcher focused on the perceptions of Employee Wellness Practitioners on the following interventions:

- ✚ prevention;
- ✚ education and training;
- ✚ counselling;
- ✚ awareness raising;
- ✚ special events, e.g. World AIDS Day;
- ✚ support groups;
- ✚ formal HIV and AIDS messages; and
- ✚ employees' interests on HIV and AIDS issues.

## **2.9. SUMMARY**

Stigma is a complex concept that is often over-simplified, over-generalised and incorrectly utilised as a catch-all for understanding negative responses to HIV and AIDS and People Living with HIV and AIDS (Parker & Birdsall, 2005:26). Whilst there is much reference to stigma in different settings, the researcher has aligned the information on HIV and AIDS stigma to the workplace context or setting. Workplace interventions concerning HIV and AIDS should be reviewed to incorporate practical strategies of stigma mitigation.

The perceptions of health workers, particularly, Employee Wellness practitioners should be explored with the view of eradicating or minimizing HIV and AIDS workplace stigma. The impact of HIV and AIDS in the workplace is hard to predict and quantify. This can be attributed to the fact that the context of HIV and AIDS in most workplaces is shrouded by stigma.

The interaction between workplaces and community based stigma calls for a coordinated response, and Employee Wellness Programme practitioners are in a better position to network with relevant community resources for the mitigation of

HIV and AIDS stigma. In the next chapter the empirical findings relating to the perceptions of EWP practitioners concerning HIV and AIDS workplace stigma will be examined, analysed and interpreted.

## CHAPTER 3: EMPIRICAL FINDINGS, ANALYSIS AND INTERPETATION OF DATA

### 3.1. INTRODUCTION

In this chapter research findings gathered from the empirical study on the perceptions of the GPG Employee Wellness Programme practitioners on HIV and AIDS workplace stigma are analysed, interpreted and presented.

Data in this study was collected by means of a semi-structured interview schedule. The interview schedule was piloted with the EWP practitioner from the Gauteng Multi-Sectoral AIDS Unit [MSAU] and another from the Gauteng Shared Services Centre [GSSC]. The respondents within the pilot test were not included in the main study. Written permission to conduct the study was requested and granted by the GSSC. Consent forms were circulated and signed by the respondents prior to the commencement of the interviews.

Data was derived by the use of both closed and open-ended questions. Three categories of questions were used to identify the perceptions of EWP practitioners concerning HIV and AIDS stigma as follows:

- ✚ perceptions of EWP practitioners concerning the manifestation of HIV and AIDS workplace stigma;
- ✚ perceptions of EWP practitioners concerning the context of HIV and AIDS workplace stigma; and
- ✚ perceptions of EWP practitioners concerning workplace interventions/programs

The population consisted of 22 EWP practitioners from all GPG departments. Fourteen EWP practitioners from the 13 Gauteng Provincial Government departments were interviewed in the main study. The research findings will be

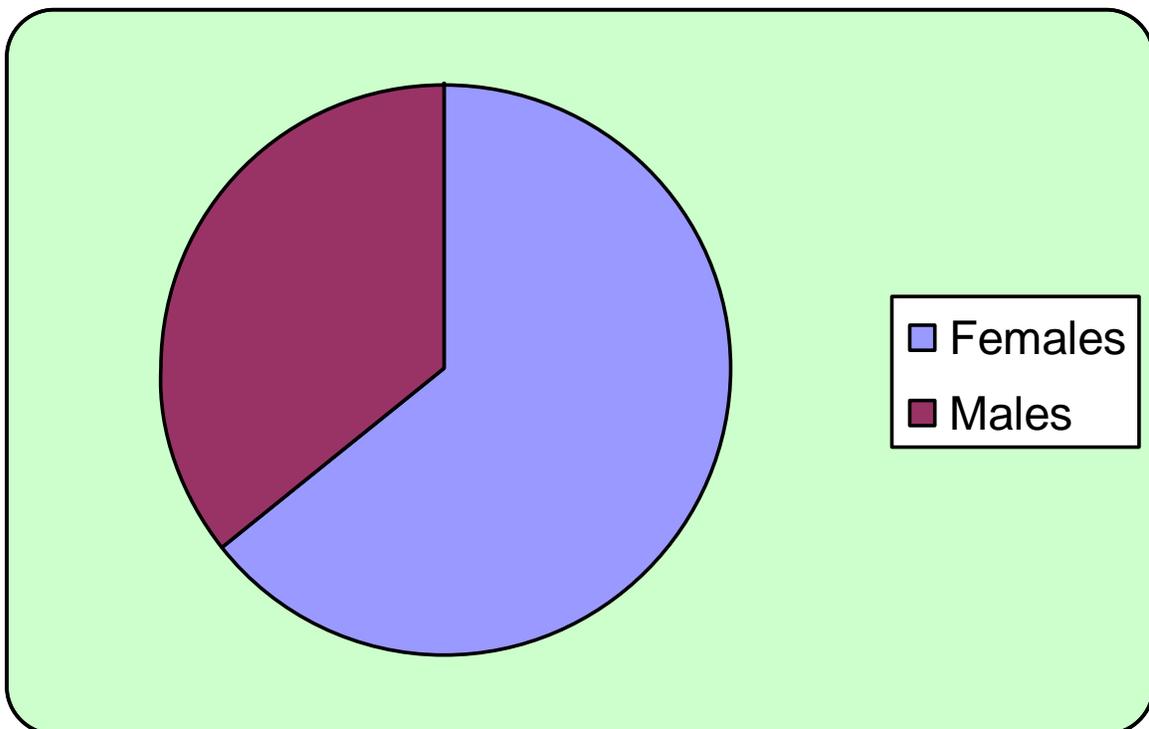
discussed in this chapter using themes extracted from the respondents' experiences.

### 3.2. PRESENTATION OF DATA

The demographic information of the respondents is presented in the form of figures and tables followed by a discussion and analysis of this information.

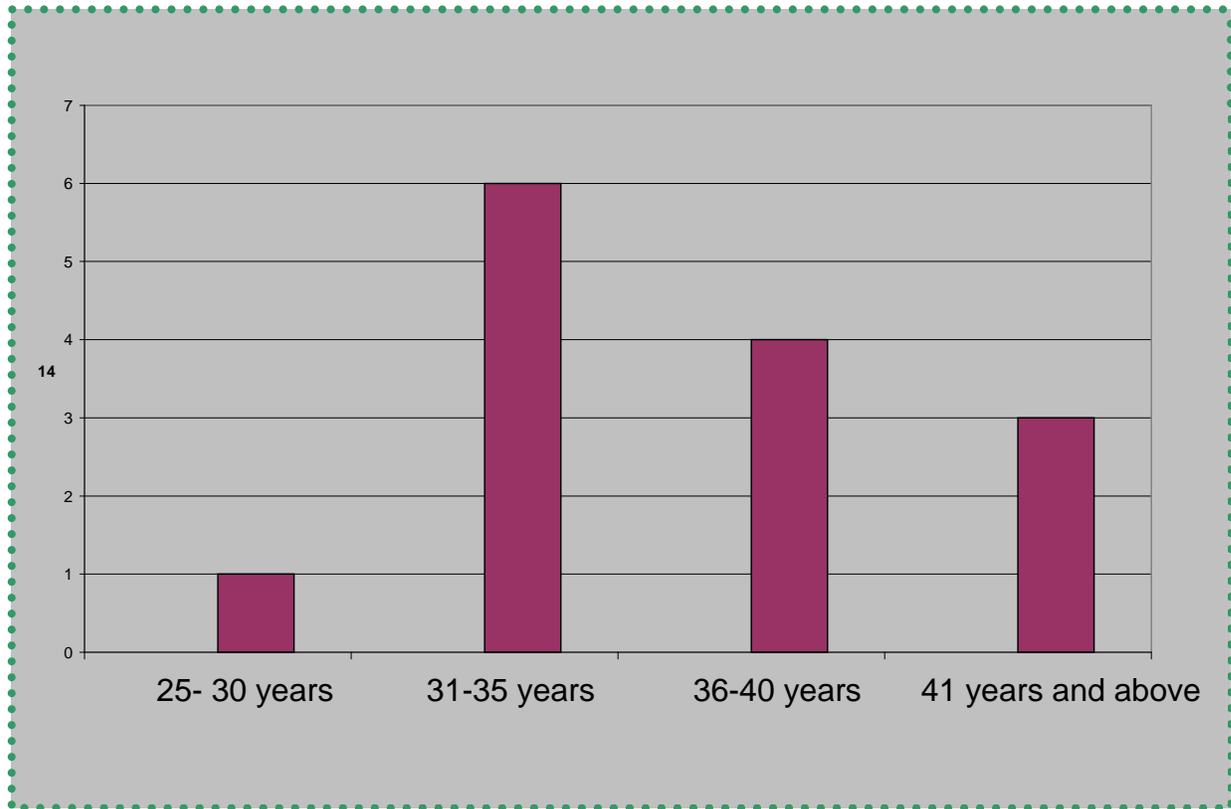
#### 3.2.1. Demographic information

**Figure 1: Gender of the respondents**



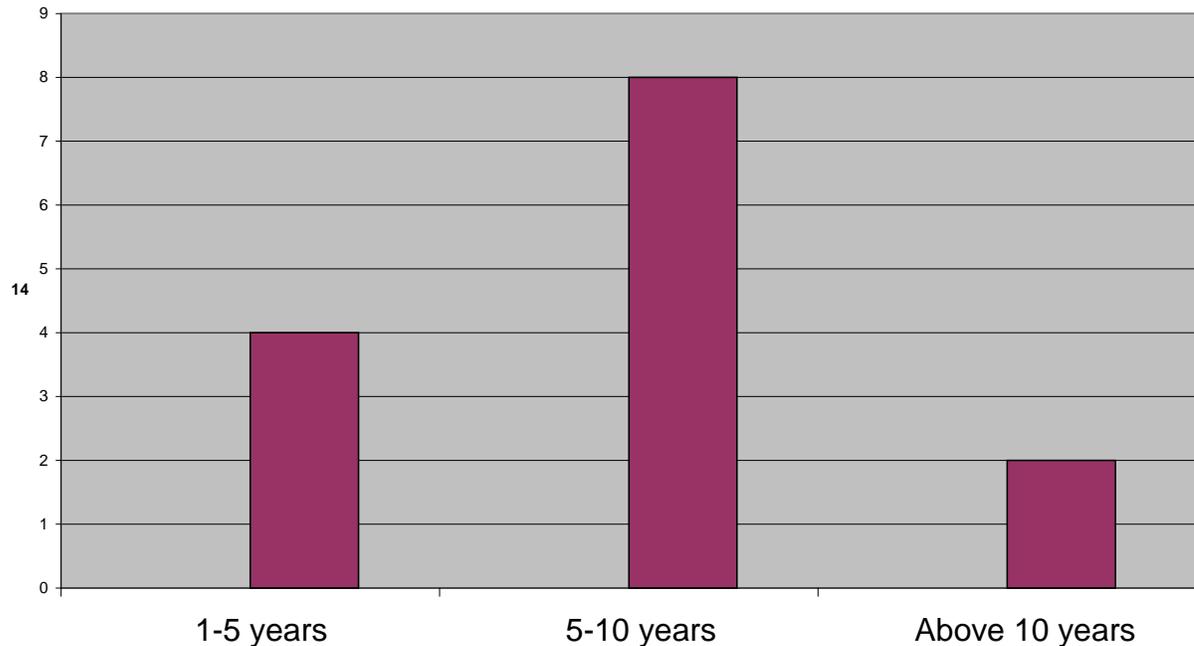
Sixty four percent of the respondents were females and 36% were males. The gender of the respondents reflects the EWP gender profile in the GPG EWP overall population. The researcher has observed that there are generally more females than males in the helping professions, particularly in the EWP industry.

**Figure 2: Age of the Respondents**



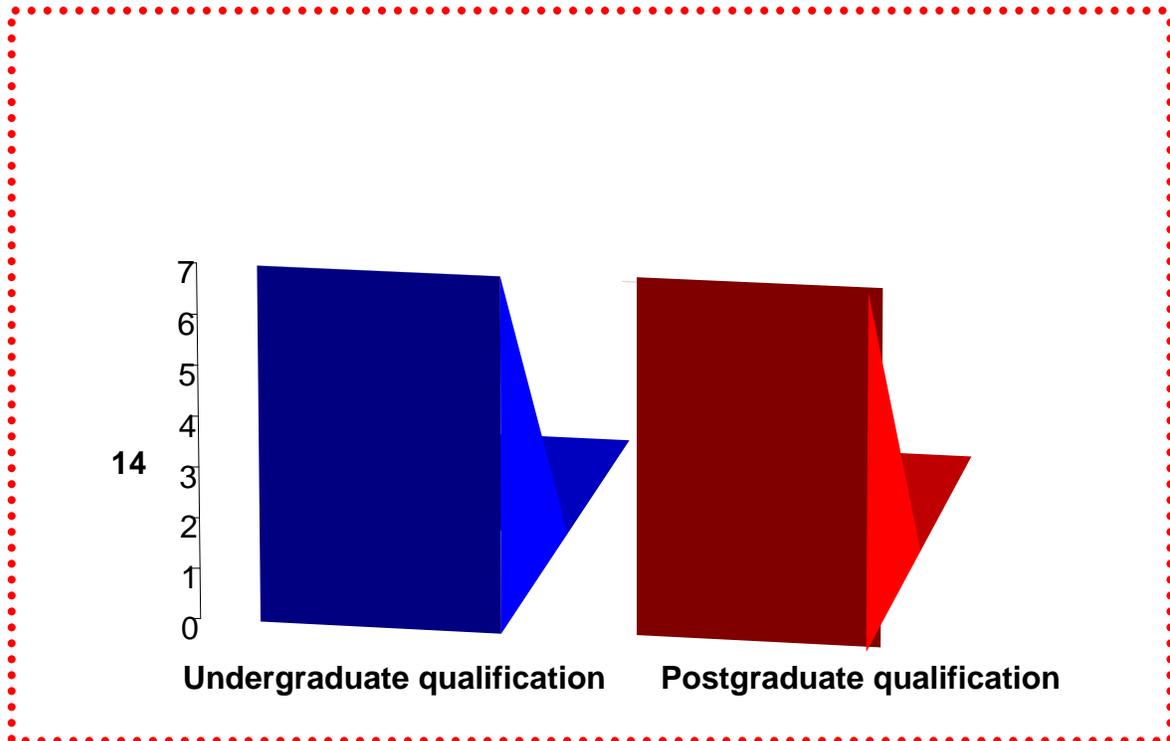
The above graph shows that the majority of respondents were in the age group of between 31-35 years. This generally implies that there are more mature EWP practitioners in the GPG. The researcher is of the view that when the EWP is managed by mature individuals its credibility is enhanced. The GPG, however, has an opportunity of recruiting young practitioners who can be mentored by the mature and experienced practitioners. This would gradually contribute to the skills development and skills transfer which are imperative for nation building.

**Figure 3: The Respondents' HIV and AIDS work experience**



Eight respondents were between five and 10 years in terms of their experience in the HIV and AIDS field. This convinced the researcher that the GPG had either retained or recruited experienced practitioners, particularly taking into account it is now almost 28 years since the discovery of HIV and AIDS. There is still concern about the four respondents who have one to five years of experience particularly because they are the only EWP practitioners in their respective departments. The finding that two respondents have more than 10 years of experience provides an opportunity for skills transfer amongst EWP practitioners at GPG.

**Figure 4: Qualifications of the Respondents**



The above chart shows that half of the respondents have undergraduate qualifications and another half have postgraduate qualifications. One remarkable finding was that the majority of those with undergraduate qualifications were studying or planning to do postgraduate studies, implying the dominance of social workers in the EWP field.

### **3.2.2. Central Themes**

De Vos (2005:338) indicates that “identifying salient themes, recurring ideas or language and patterns of belief that link people and settings is the most intellectually challenging phase of data analysis”. Information gathered from the main study was categorised into themes and sub-themes. The researcher identified the themes and sub-themes presented below.

**Table 2: Themes and Sub-themes**

Themes	Sub-themes
<p>Manifestation of HIV and AIDS stigma in the workplace</p>	<ul style="list-style-type: none"> <li data-bbox="824 363 1395 457">✚ Occurrence of stigma in the GPG departments</li> <li data-bbox="824 468 1395 562">✚ Causes of HIV and AIDS stigma in the workplace</li> <li data-bbox="824 573 1395 667">✚ Consequences of HIV and AIDS stigma at the GPG departments</li> </ul>
<p>Contextualisation of HIV and AIDS workplace stigma</p>	<ul style="list-style-type: none"> <li data-bbox="824 720 1395 751">✚ HIV and AIDS workplace policies</li> <li data-bbox="824 762 1395 856">✚ Monitoring the implementation of HIV and AIDS policies</li> </ul>
<p>Roles of leadership/management in mitigating HIV and AIDS stigma in the workplace</p>	<ul style="list-style-type: none"> <li data-bbox="824 940 1395 1035">✚ Support and commitment from senior management</li> <li data-bbox="824 1045 1395 1245">✚ Leadership training on HIV and AIDS and senior management commitment to attend training sessions</li> <li data-bbox="824 1255 1395 1350">✚ Senior management HIV and AIDS status disclosure trends</li> </ul>
<p>HIV and AIDS workplace interventions</p>	<ul style="list-style-type: none"> <li data-bbox="824 1381 1395 1476">✚ HIV and AIDS prevention strategies regarding traditional African beliefs</li> <li data-bbox="824 1486 1395 1518">✚ Education and training</li> <li data-bbox="824 1528 1395 1560">✚ Awareness raising strategies</li> <li data-bbox="824 1570 1395 1665">✚ Mainstreaming of HIV and AIDS stigma mitigation messages</li> </ul>

Counselling and support services	<ul style="list-style-type: none"> <li>✚ Reasons for the failure of conducting VCT</li> <li>✚ Challenges of VCT</li> <li>✚ Incorporation of HIV and AIDS into EWP</li> <li>✚ Effectiveness of counselling services</li> <li>✚ Support services</li> </ul>
Challenges of HIV and AIDS stigma mitigation	<ul style="list-style-type: none"> <li>✚ Barriers of HIV and AIDS status disclosure</li> <li>✚ Employees' interests in HIV and AIDS issues</li> <li>✚ Involvement of employees with HIV and AIDS in workplace programmes</li> <li>✚ HIV and AIDS stigma audit</li> </ul>

### **Theme 1: Manifestation of HIV and AIDS stigma in the workplace**

The first theme identified in the data collected was the respondents' perceptions of how HIV and AIDS workplace stigma is manifested in the GPG. The researcher incorporated the respondents' perceptions concerning the occurrence of stigma, the causes of HIV and AIDS stigma, and the consequences of HIV and AIDS stigma at the GPG departments.

#### **Sub-theme 1: The occurrence of HIV and AIDS stigma in the GPG departments**

All 14 respondents indicated that HIV and AIDS stigma occurred in their respective departments. The extracts below provided an indication of the

respondents' attitudes regarding the manifestation of HIV and AIDS workplace stigma.

- ✚ “Passing negative judgments, labels, distancing, diagnosing”.
- ✚ “HIV is treated differently from other chronic illnesses”.
- ✚ “Employees are discriminated against when they disclose their HIV status”.
- ✚ “Gossiping, misconceptions, lack of confidentiality and government’s protocols contribute to the manifestation of HIV workplace stigma”.
- ✚ “Stigma is also manifested through the use of third person when employees share or request information on HIV and AIDS”.
- ✚ “Members of the Wellness Committees are stigmatised for being vocal about HIV and AIDS”.
- ✚ “Loss of weight makes colleagues suspicious”.
- ✚ “Stigma is generally expressed through speech, i.e. it is verbally expressed”.

Viljoen (2005:9) indicates that “verbal expression of stigma may lead to gossip, defamation or hate speech”. The aforementioned findings confirm the researcher’s frequent observation of employees in his department who are suspected of being HIV-positive based on weight loss, active involvement in HIV and AIDS activities, and those associated with employees with TB or being HIV positive. The researcher further is of the view that the culture of subtle suspicion perpetuates HIV and AIDS stigma and results in non-disclosure for fear of prejudice.

## **Sub-theme 2: Causes of HIV and AIDS stigma in the workplace**

Different views were expressed concerning the causes of stigma in the departments and the extracts below present the responses.

- ✚ “Culture of the department, prestigious”.
- ✚ “Cliques, ignorance, we talk negatively about HIV”.
- ✚ “Lack of information on HIV and AIDS”.

- ✚ “The sexual mode of HIV and AIDS infection, employees don’t feel comfortable talking about sexual issues”.
- ✚ “The way HIV and AIDS messages are communicated. People associate it with death”.
- ✚ “Ignorance is the cause, lack of information, our social upbringing, a sense of entitlement and our attitudes”.

The researcher’s findings concurred with those of Viljoen (2005:31) who found that “people generally ascribed the stigmatisation associated with the alleged HIV status to ignorance; ignorance of how the disease was transmitted, how it progressed to AIDS and the association with negative attributes such as death and promiscuity”.

### **Sub-theme 3: Consequences of HIV and AIDS stigma at the GPG departments**

The following are the extracts from the responses explaining the consequences of HIV and AIDS stigma in the GPG departments.

- ✚ “Work conflicts, e.g. supervisor-subordinate”.
- ✚ “Increase in absenteeism resulting in low productivity”.
- ✚ “Stigma results in lack of confidence, esteem, fear of people”.
- ✚ “Stigma has negative consequences to the employee’s family households”.
- ✚ “Employees are prevented from getting information on available assistance due to fear of stigmatisation”.
- ✚ “Employees disclose due to desperation and being overwhelmed”.
- ✚ “Employees are not participating in HIV activities”.
- ✚ “Stigma affects EWP service utilisation, e.g. poor attendance resulting in fruitless expenditure”.
- ✚ “Departments don’t get the actual outputs on HIV and AIDS. Employees don’t know their rights”.

✚ “Stigma affects the disclosure rate. Due to stigma, the disclosure rate is low”.

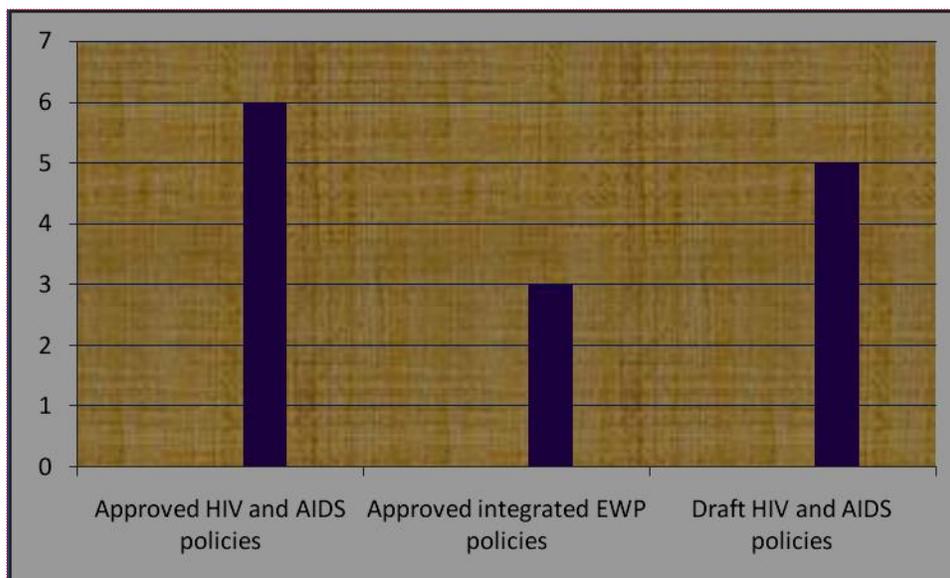
The researcher’s findings were in agreement with those of Viljoen (2005:33) who identified that “privacy and disclosure, informed consent and testing as well as access to health care” as the common human rights related consequences of stigmatisation. The research findings suggest that, although HIV and AIDS workplace stigma mitigation strategies have been put in place by the government departments, stigma still has profound effects on the health and wellbeing of employees.

## **Theme 2: Contextualisation of HIV and AIDS workplace stigma**

The second theme identified from the empirical data was the respondents’ perspectives regarding the context of HIV and AIDS workplace stigma. The following sub-themes were identified: HIV and AIDS workplace policies, and monitoring the implementation of HIV and AIDS policies.

### **Sub-theme 1: HIV and AIDS workplace policies**

**Figure 5: HIV and AIDS policies**



The above figure shows that 43% of the respondents indicated that their departments had approved HIV and AIDS policies and 36% had draft policies, while 21% indicated that their departments had approved integrated Employee Wellness Programme policies. The lack of HIV and AIDS policies at four provincial government departments could be attributed to ignorance and lack of visionary leadership and lack of accountability by departments as far as HIV and AIDS was concerned. The finding that three departments have integrated policies on the Employee Wellness Programme could be attributed to the global and South African trends of shifting from the traditional Employee Assistance Programmes into the holistic Employee Wellness Programmes. The shift could also be an attempt to comply with the recent Public Service Employee Health and Wellness Programme Strategic Framework crafted by the Department of Public Service and Administration.

## **Sub-theme 2: Monitoring the implementation of HIV and AIDS policies**

This sub-theme was identified when respondents were asked to explain their views on how monitoring and evaluation of the implementation of HIV and AIDS policies were done in their departments. The following extracts characterise the responses of respondents on monitoring and evaluation of the implementation of HIV and AIDS policies.

- ✚ “Operational plans are developed and aligned to the HIV and AIDS departmental, provincial and national priorities”.
- ✚ “Monthly reports are submitted to management and reflect progress, shortcomings, challenges and actions to address the challenges related to the implementation of the HIV and AIDS policy”.
- ✚ “Quarterly and annual reports are submitted to the respective departments’ management and the Multi-Sectoral AIDS Unit [MSAU]”.
- ✚ “Quarterly review meetings are held with MSAU to track progress on the implementation of planned activities”.

The Department of Health (2005:26) emphasises that “because stigma is complex, multi-faceted and constantly changing, we need to strive for greater understanding and to be alert to new forms and shapes of stigma”. The above findings suggest that a holistic monitoring and evaluation framework is indispensable for the GPG departments in order to mitigate HIV and AIDS workplace stigma.

### **Theme 3: Roles of leadership/management in mitigating HIV and AIDS stigma in the workplace**

The third theme identified from the data collected was the respondents’ perceptions of the roles of management in the mitigation of HIV and AIDS workplace stigma. Within this theme, the following sub-themes were identified, namely: support and commitment from senior management; leadership training on HIV and AIDS; and senior management commitment to attend training sessions and senior management HIV and AIDS status disclosure trends.

#### **Sub-theme 1: Support and commitment from senior management on HIV and AIDS issues**

It must be noted that there were different views on how the respondents perceived management support and commitment relating to HIV and AIDS issues. The extracts below present their responses.

- ✚ “I get adequate support from management”.
- ✚ “I don’t get sufficient support and commitment from management in my department”.
- ✚ “I did not get support from management during the initial stage, but after demonstrating the return on investment for EWP, management gave adequate support and commitment”.
- ✚ “The support and commitment is improving substantially”.

- ✚ “Senior managers talk about support and commitment but it doesn’t filter down”.
- ✚ “The commitment is generally outlined on papers, e.g. policy documents, but active physical involvement by senior managers is poor”.
- ✚ “The support and commitment of political office bearers such as Members of Executive Councils [MEC’S] and Heads of Departments [HOD’s] is limited to the signing of submissions on HIV and AIDS programmes, signing of policies and being available to talk about HIV and AIDS during special events like World AIDS Day”.
- ✚ “Senior managers are more concerned about their core business functions and generally don’t see HIV and AIDS as a priority”.

The researcher’s findings were in agreement with the Department of Health’s National Consultative Workshop on HIV and AIDS Stigma report (2005:16) which indicated that the “leaders need to be directly involved in a workplace HIV and AIDS programme, and to act as role models in reducing and addressing stigma”.

## **Sub-theme 2: Leadership training on HIV and AIDS and senior management commitment to attend training sessions**

The quotes below indicate the responses on leadership training and the extent to which senior managers are committed to attending the training sessions.

- ✚ “We source service providers to conduct leadership training on HIV and AIDS targeting senior managers and organised labour leadership”.
- ✚ “We only conduct EWP training entitled supervisory training on EWP”.
- ✚ “We have not started with leadership training although it will be prioritised in the next financial year”.
- ✚ “No leadership training on HIV and AIDS has been conducted in this department”.

- ✚ “There is generally poor attendance by senior managers”.
- ✚ There is a general tendency amongst senior managers to delegate middle and junior managers to attend HIV and AIDS related trainings”.

According to Siyamkela (2003:42), “Government employees’ feelings of alienation from management were strong and pervasive with regard to the issue of HIV and AIDS and senior managers were perceived as ignorant and uninterested in HIV and AIDS issues”. The view of Siyamkela is highlighted in this study by the senior managers’ tendency to delegate middle and junior managers to attend HIV and AIDS, related training. This may result in the disempowerment of managers in terms of knowledge and competencies on HIV and AIDS resulting in failure to provide the accurate information and support that may be required by employees. Furthermore, the persistent delegation may result in the "them and us" mentality which may hamper a conducive, caring and supportive work environment. This may gradually undermine the EWP practitioners’ efforts towards the mitigation of HIV and AIDS stigma in the workplace.

### **Sub-theme 3: Senior management HIV and AIDS status disclosure trends**

There seems to be noticeable trends regarding the HIV and AIDS status disclosure amongst GPG senior managers. The following are the extracts from the respondents’ responses.

- ✚ “No senior manager has disclosed his or her HIV and AIDS status”.
- ✚ “Senior managers are ignorant”.
- ✚ “No senior manager is known to be HIV positive although there are speculations based on weight loss and ill-health that some senior managers are HIV-positive”.

- ✚ “The senior managers earn enough money and all have medical aid cover. As a result of this, they may be able to take treatment and no one would be able to know their HIV status unless they decide to do so”.
- ✚ “Given the government culture, disclosure of HIV status by a senior manager may be perceived as a sense of irresponsibility which might bring shame to the senior manager”.

The research findings support Siyamkela’s (2003:24) study which found that “there was an erosion of employees’ confidence in senior management’s leadership in terms of dealing with HIV and a general perception that HIV and AIDS programmes were about keeping up appearances rather than effecting genuine change and that they are ignorant of HIV and AIDS issues”.

#### **Theme 4: HIV and AIDS workplace interventions**

The fourth theme identified from the data collected was the respondents’ perspectives concerning how HIV and AIDS workplace interventions address the problem of stigma in the workplace. In the context of this theme, the following sub-themes were identified: HIV and AIDS prevention strategies regarding traditional African beliefs, education and training, awareness raising strategies and mainstreaming of stigma mitigation messages.

##### **Sub-theme 1: HIV and AIDS prevention strategies regarding traditional African beliefs**

The majority of the respondents indicated that their departments’ HIV and AIDS prevention strategies did not incorporate traditional African beliefs such as witchcraft, ancestral beliefs and the traditional African perceptions of condoms.

The following are extracts of the responses.

- ✚ “Our department’s HIV and AIDS prevention incorporated traditional African beliefs such as witchcraft, ancestral beliefs and traditional African perceptions of condoms”.
- ✚ “My department’s view is that there is little research done on the significance of traditional beliefs on HIV prevention initiatives and therefore departments do not incorporate traditional beliefs in prevention strategies”.
- ✚ “The inclusion of traditional African beliefs is based on the number of employees in our department who consult traditional healers and submit sick notes from them”.

In a research report compiled by Siyamkela (2003:13), participants made mention of the perception of HIV as an African disease, as well as the apparent apathy in other communities, especially the white community. The researcher is of the view that, whether there is lack of adequate empirical evidence on the significance of traditional African perceptions, observations are that GPG employs more Africans than other racial groups. Inclusion of faith-based prevention programmes might assist to clarify the misconceptions and to enable employees to have dialogues on their beliefs.

## **Sub-theme 2: Education and Training**

The majority of the respondents indicated that their departments have trained peer educators who are empowered to deal with internal, external and enacted forms of stigma. One respondent indicated that “there were no trained HIV and AIDS peer educators in her department although she believes that peer educators can play a significant role in mitigating stigma in the workplace”. In the Technical Assistance Guideline document, Department of Labour (2003:59), the core of HIV and AIDS education and training is the use of peer educators who have either volunteered or been nominated to conduct HIV and AIDS education sessions.

The following are quotes from the respondents.

- ✚ “My department’s workplace training on HIV and AIDS has a strong focus on behaviour change geared at reducing the incidence of stigma”.
- ✚ “My department’s HIV and AIDS training was not focused on behaviour change aimed at reducing stigma in the workplace”.
- ✚ “The main thrust of any HIV and AIDS related training should be centred on behaviour change”.
- ✚ “My department has not done impact studies/assessments to determine the impact of training interventions on employees’ behaviour”.

The findings in this study support the recommendation of the Department of Health (2008:45) that “door to door education should be evaluated and there should be an increased mobilisation of civil society to address social factors driving HIV infections with focus on social values, include substance abuse multiple partners and transactional sex”.

### **Sub-theme 3: Awareness raising strategies**

Respondents were asked to indicate the strategies/mechanisms used by their departments to promote awareness of HIV and AIDS, and the effectiveness of such strategies in mitigating HIV and AIDS stigma. The following are extracts from their responses.

- ✚ “GPG departments follow the national health observance calendar to promote awareness about HIV and AIDS to employees”.
- ✚ “Promotional materials such as pamphlets, brochures, click clock tins”.
- ✚ “HIV and AIDS awareness raising done during women’s and men’s forums dialogues”.
- ✚ “Wellness day’s campaigns. During these campaigns employees are made aware of major common chronic diseases including HIV and AIDS”.

- ✦ “Awareness is done through the use of electronic media, e.g. intranet, internet and e-care programmes within the GPG”.
- ✦ “Health newsletters are also distributed to employees. Internal articles are published in the respective departmental newsletters”.
- ✦ “Information sessions are conducted to promote awareness about HIV and AIDS. The sessions include, inter alia, stigma mitigation sessions”.
- ✦ “EWP orientation sessions are conducted to promote HIV and AIDS as well as other health and wellness interventions”.
- ✦ “Awareness promotion is also done to new employees during the implementation of the Departments’ respective induction programmes”.
- ✦ “Focus groups established and sessions conducted on HIV and AIDS prevention targeting employees and managers”.
- ✦ “Awareness is also promoted through education and training interventions”.
- ✦ “Peer educators are used to promote awareness about HIV and AIDS using the above strategies and word of mouth”.
- ✦ “No impact study has been conducted in their departments to determine the effectiveness of the events in mitigating HIV and AIDS workplace stigma”.
- ✦ “The impact of events is generally difficult to measure”.
- ✦ “There is a culture of entitlement in their departments, i.e. employees who attend the events expect to be given promotional items, such as T-shirts. Employees associate HIV and an AIDS event with handouts and attendance at such events is usually poor once employees are told that no promotional materials other than pamphlets or brochures will be issued”.

The Department of Health (2008:19) indicates that a reduction of the number of new infections could be achieved through application of the principle of evidence-based information, education and communication. The findings in this study suggest the need for a shift from distributing condoms, pamphlets and other promotional items towards inculcating a culture of HIV status disclosure and acceptance.

#### **Sub-theme 4: Mainstreaming of HIV and AIDS stigma mitigation messages**

Respondents were asked to indicate how HIV and AIDS stigma mitigation messages are mainstreamed in their departments. The following are quotes from the respondents explaining how they mainstream HIV and AIDS stigma mitigation messages in the workplace.

- ✦ “Ongoing marketing of HIV and AIDS through different modes of communication”.
- ✦ “Presentations on HIV and AIDS are done during staff meetings of the departments’ business units/entities”.
- ✦ “Training on the stigma and management of HIV and AIDS status disclosure”
- ✦ “Mainstreaming done within the confines of departments’ transformation and special programmes, e.g. gender and disability mainstreaming”.
- ✦ “Through the effective deployment of HIV and AIDS peer educators”.
- ✦ “Mainstreaming is done by placing HIV and AIDS policy on the intranet”.
- ✦ “Integrated Employee Health and Wellness policy is the best way of mainstreaming HIV and AIDS”.
- ✦ “Working with Labour Relations, Human Resources and Facilities Management business entities to ensure mainstreaming of HIV and AIDS”.
- ✦ “Seminars, training and education and community based initiatives provide an excellent mainstreaming opportunity”.
- ✦ “Induction and orientation programmes provide a holistic framework for the mainstreaming of HIV and AIDS policies in the workplace”.
- ✦ “HIV and AIDS are incorporated in the work of other business units. The use of the teaming model is how we mainstream HIV and AIDS policy in this department”.
- ✦ “Mainstreaming is done within the confines of transformation programmes such as gender and wellness, safety, sexual harassment and disability”.
- ✦ “Through education, awareness and word of mouth”.
- ✦ “Through World AIDS Day [WAD], gender dialogues, wellness days”.

According to the Department of Health (2005:33) stigma mitigation should be geared towards raising awareness of HIV related stigma through campaigns, media, and publicity as well as dissemination of gender sensitive information. The Department of Health (2005: 25) further indicates that “mitigating stigma is not the preserve of any one agency, organisation or program and every opportunity should be used to address the issue and that organizations must move beyond having presentations to think about demonstrating how stigma is present in the way the organisation functions”.

### **Theme 5: Counselling and support services**

The fifth sub-theme identified from the data collected was the respondents’ views on the implementation of Voluntary Counselling and Testing [VCT]. The reasons for the failure of conducting VCT, its challenges, and the incorporation of HIV and AIDS into the EWP, the effectiveness of counselling and support services in mitigating stigma in the workplace, are the Sub-Themes identified.

#### **Sub-theme 1: Reasons for the failure of conducting VCT**

Although the majority of the respondents indicated that the VCT was implemented in their departments, reasons attributed to the failure of conducting VCT were cited as follows.

- ✚ “Employees were not ready for VCT due to a number of reported cases of discrimination on the basis of HIV status”.
- ✚ “There are perceptions that VCT in GPG departments is done to obtain statistics pertinent to the number of people testing positive and negative”.
- ✚ “What is the significance of conducting VCT when Departments’ interventions for employees testing positive are limited?”.

- ✦ “Employees in one department were said not to have requested VCT, hence it was not implemented”.
- ✦ “Although VCT is effective in mitigating stigma, it also increases/enhances stigma in the workplace”.
- ✦ “Once employees have tested positive, there is a general expectation that they should disclose their status to the employer, preventing employees from disclosing their status of their own free will”.
- ✦ “VCT mitigates and enhances stigma in the workplace”.

Viljoen (2005:107) states that the South African government and many international agencies hold the view that normalising HIV and AIDS will reduce stigma. He (Viljoen, 2005:107) further argues that this view means that, if more people are tested and know their serostatus, HIV can then be treated as a chronic illness instead of being viewed as a death sentence, thereby assisting in lifting the fear and stigma associated with HIV and AIDS. The research findings suggest that although VCT remains an important component of the HIV and AIDS workplace programme, lack of adequate support and treatment resources in the workplace may result in low uptake which may intensify stigma.

## **Sub-theme 2: Challenges of VCT**

The challenges of VCT were cited by the respondents as follows.

- ✦ “Lack of clarification of the rationale for VCT, i.e. VCT should not be conducted for statistical purposes, but to encourage employees to know their status”.
- ✦ “VCT can assist departments regarding establishing future planning and motivation/justification for more resources”.
- ✦ “VCT uptake in my departments can be attributed to the ongoing education and awareness on HIV and AIDS as well as my department’s successful peer education programmes”.

- ✚ “There are few senior managers in my department who participate in VCT”.
- ✚ “There is no senior manager in my department who has participated in departmental VCT initiatives”.
- ✚ “VCT is often seen as a program for junior and low levels staff members who are often victimised”.
- ✚ “Confidentiality and employees’ confidence in the VCT service providers and implementation processes and protocols are the cornerstone of a successful VCT”.
- ✚ “The fact that VCT is conducted in a confidential environment is further stigmatising employees who test positive”.
- ✚ “During our department’s wellness days, employees get tested for other chronic diseases and the tests are not done in a confidential environment resulting in a high uptake”.
- ✚ “The fact that the government departments don’t provide treatment for HIV and AIDS prevents employees from participating in the VCT initiatives”.

In view of the respondents’ diverse inputs regarding the support services, the researcher is of the view that the limitation in terms of support services to employees living with HIV and AIDS may have an impact on the VCT and disclosure uptake since employees may be sceptical about the benefits of testing and disclosing their status measured against the stigma and discrimination experienced in the workplace. The current study confirms the assertion by the Department of Health (2008:36) that, although several employers commissioned impact projections, low VCT uptake poses a major challenge to workplace programmes.

### **Sub-theme 3: Incorporation of HIV and AIDS into the EWP**

All respondents indicated that their HIV and AIDS programmes were incorporated in the Integrated Employee Wellness Programme through the following extracts.

- ✚ “Our HIV and AIDS programmes are further aligned to the Gauteng Provincial Government Employee Health and Wellness strategy and the Public Service Employee Health and Wellness Programme Framework”.
- ✚ “All HIV and AIDS Programmes are aligned to the HIV and AIDS the National Strategic Plan as amended from time to time”.
- ✚ “The incorporation of HIV and AIDS programmes into the holistic Employee Health and Wellness Programme is good for the destigmatisation of HIV and AIDS as well as the mitigation of HIV and AIDS stigma, and addresses challenges of VCT in their respective departments”.
- ✚ “Although the HIV and AIDS programmes are currently incorporated into the integrated Employee Health and Wellness Programme, I have a strong conviction that the separation of HIV and AIDS programmes from the integrated Employee Health and Wellness Programme would result in the implementation of more HIV and AIDS targeted interventions”.

Pillay (2007:119) concluded that integrated EWP policy:

Makes it easier for public officials to use Wellness Centres as opposed to HIV and AIDS Centres, thereby lessening the chance that a person will be labelled as a person living with HIV and AIDS or being discriminated against for his or her HIV and AIDS status.

The researcher is of the view that an integrated Employee Wellness Programme provides an opportunity for the reduction of HIV stigma on the basis of a holistic approach toward employee’s health.

#### **Sub-theme 4: Effectiveness of counselling services**

All respondents indicated that, although they receive monthly, quarterly and annual statistical data pertaining to the counselling services rendered externally, they remain uncertain as to the effectiveness of the impact of counselling

services in addressing HIV and AIDS workplace stigma. The following are extracts from the responses.

- ✚ “During counselling sessions employees are empowered on human rights issues, status disclosure, stigma, and provided information on the critical aspects of their HIV and AIDS or EWP policies”.
- ✚ “My clients indicated that the counselling helped them to know about the support services provided by the department”.
- ✚ “During counselling, employees are linked with relevant resources for assistance”.
- ✚ “Regular impact studies and client satisfaction surveys should be conducted to determine the effectiveness of counselling services”.

#### **Sub-theme 5: Support services**

Support services provided vary from one GPG department to the other and are outlined according to the following statements.

- ✚ “Counselling services are provided internally and externally”.
- ✚ “Support groups were established in my department”.
- ✚ “Wellness/lifestyle support groups were established in my department”.
- ✚ “A vegetable garden was initiated in my department and the vegetables are given to employees who are HIV positive”.
- ✚ “Networking was done with various service providers/stakeholders providing support to persons living with HIV and or AIDS”.
- ✚ “Peer educators provided peer counselling which is considered an effective support tool”.
- ✚ “Advice on nutrition was given during wellness days”.
- ✚ “My department ordered vitamins for employees with low immune system”.
- ✚ “Home based visits were made to employees with chronic conditions and who had been absent from work for a long time”.

- ✚ “Employees with chronic conditions and have exhausted their normal sick leave were assisted with the applications for temporary incapacity leave [short and long period] and ill-health retirement”.
- ✚ “During all HIV and AIDS-cum-Employee Wellness Programme interventions, employees were encouraged to have medical aid cover”.
- ✚ “Our department sets-up appointments with clinics for employees who needed to go for CD4 count check-ups”.
- ✚ “Personal financial management/life skills workshops were conducted to support employees with debt challenges”.
- ✚ “Referral for rehabilitation for employees who resort to drugs after knowing status was done”.

The study findings and researcher’s views support the assertion by the Soul City Institute for Health and Development Communication (2002:14) that provision of treatment, care and support help to reduce HIV and AIDS stigma. “With treatment and support, HIV and AIDS will become more like any other chronic disease which can be managed and lived with for long periods of time resulting in the normalisation of attitudes and perceptions (Soul City Institute for Health and Communication, 2002:14).

### **Theme 5: Challenges of HIV and AIDS stigma mitigation**

The final theme identified from the data collected was the respondents’ perceptions on the challenges attached to HIV and AIDS stigma mitigation in their departments. Within this theme, the following sub-themes were identified namely, barriers of HIV and AIDS status disclosure, employees’ interests in HIV and AIDS issues, involvement of employees with HIV and AIDS in workplace programmes and HIV and AIDS stigma audit.

## **Sub-theme 1: The barriers to HIV and AIDS status disclosure in the GPG departments**

The respondents outlined the barriers to HIV and AIDS status disclosure as follows.

- ✚ “HIV and AIDS stigma”.
- ✚ “Fear of unknown. Employees are anxious about how people would react after they disclose their status”.
- ✚ “Environment not conducive to disclosure, and lack of knowledge about the significance of disclosure”.
- ✚ “Discrimination by employees and management”.
- ✚ “Fear of rejection, isolation, loss of jobs, ridicule and victimisation”.
- ✚ “Lack of advocacy by management to encourage disclosure and to take decisive action against those who discriminate against others on the basis of their HIV and AIDS status”.
- ✚ “Lack of approved HIV and AIDS policies in some departments. Some approved policies are also not explicit on how to deal with disclosure, resulting in employees’ lack of trust in terms of the confidentiality and protection guaranteed in the policies”.
- ✚ “Ignorance”.
- ✚ “Employees use their cultural values to justify their unwillingness to disclose their status”.
- ✚ “There are organisational culture issues where employees stationed at head offices of the GPG departments believe that due to their occupational status, they are immune to being infected and, once they test positive, they lack the courage to disclose their status”.
- ✚ “Lack of adequate support systems/services prevents employees from disclosing. “They ask themselves if I disclose what is in there for me?”.
- ✚ “Employees fail to come to terms with the reality that they are HIV positive”.

The research findings are in agreement with Viljoen (2005:71) who indicated that “lack of disclosure causes the disease to be revealed only at its end stage, as full-blown AIDS, when there is nowhere left to hide, when, in the shadow of impending death, the body makes disclosure irrelevant”.

## **Sub-theme 2: Employees’ interest in HIV and AIDS issues**

This sub-theme was identified when respondents were asked to express their views on how employees conveyed HIV and AIDS apathy, and to outline the strategies of addressing stigma based on apathy amongst employees concerning HIV and AIDS issues. The following quotes reveal their responses.

- ✚ “Apathy by employees was based on their fear of knowing their status”.
- ✚ “Lack of management support, buy-in and commitment enhanced apathy amongst employees”.
- ✚ “HIV and AIDS information fatigue; employees are tired of being told the same information every year”.
- ✚ “Lack of cure for HIV and AIDS further contributed to the perpetuation of apathy amongst employees”.
- ✚ “HIV and AIDS are not prioritised in our department, as a result only employees infected or affected would want to attend HIV and AIDS sessions for their own personal empowerment”.
- ✚ “Initiating creative strategies on persuading employees to attend HIV and AIDS activities”.
- ✚ “The HIV and AIDS implementation strategies should go beyond awareness as employees are generally aware of how HIV is transmitted”.
- ✚ “HIV and AIDS should not only be confined to events such as Candle Light, Condom Week and World AIDS Day”.
- ✚ “The involvement of peer educators as HIV and AIDS programme champions”.

- ✚ “Conducting research in the workplace and presenting findings to employees. This should include regular client satisfaction surveys”.
- ✚ “Incorporating HIV and AIDS into the managers’ performance contracts”.
- ✚ “Reviewing HIV and AIDS policies with the intention of including provisions geared at ensuring compulsory employee attendance of all Health and Wellness activities”.

The findings in this study corroborate the conclusion by Siyamkela (2003:26) that the apathy amongst employees concerning HIV and AIDS was linked to the finding that employees were bored with the topic, and also because they perceived HIV and AIDS as someone else’s problem. The researcher is of the view that apathy amongst GPG employees could be attributed to a lack of creativity and new initiatives concerning HIV and AIDS promotion which could be addressed by garnering support and inputs from all stakeholders within the GPG.

### **Sub-theme 3: The involvement of employees with HIV and AIDS in workplace programmes**

The majority of the respondents indicated that they involve employees who have disclosed their HIV status to them in policy development, reviews, implementation and monitoring of all interventions. The following extracts present their responses.

- ✚ “It is important to involve employees living with HIV and AIDS as they have firsthand experience of the challenges faced by people living with HIV and AIDS”.
- ✚ “Some employees who have disclosed their HIV and AIDS status in public are involved in the implementation of the HIV and AIDS programmes, e.g. they address employees during special events”.

Siyamkela (2005:25) emphasises that the strategies on stigma mitigation should involve persons living with HIV and AIDS because “the voices of the People Living with HIV and AIDS [PLWA] remind us why we are working to mitigate stigma, and should be an integral part of planning, intervening and monitoring”. The researcher is of the view that the involvement of PLHA’s in policy development, implementation and evaluation may provide an opportunity for the implementation of responsive workplace interventions.

#### **Sub-theme 4: HIV and AIDS stigma audit**

All respondents indicated that they had not conducted the HIV and AIDS stigma audit in their departments. Some departments have however conducted studies such as Knowledge, Attitude, Behaviour and Perceptions studies, Behaviour Risks Management Audits and Client Satisfaction Surveys. All respondents believed that “an HIV and AIDS stigma audit is important and can indeed assist in the assessment of the extent of stigma as a problem and addressing the factors that would enhance stigma mitigation in the workplace”. The accounts of stigma by the EWP practitioners could be an indication of how rife stigma is in the GPG departments, and the researcher is of the view that a stigma audit could provide baseline information on stigma.

### **3.3. SUMMARY**

In this chapter the findings arising from the data collected from respondents through an interview schedule were presented and analysed according to the themes and sub-themes that emerged. The following chapter sets out the conclusions drawn and recommendations made by the researcher.

## **CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS**

### **4.1. INTRODUCTION**

The study has been able to generate valuable information in terms of the perceptions of Employee Wellness Programme practitioners concerning HIV and AIDS stigma in the workplace. This chapter will serve as the final evaluation of the research process and results. In order to enable the researcher to provide an effective research report, certain conclusions and recommendations will be made.

### **4.2. GOAL OF THE STUDY**

The goal of the study was to explore the perceptions of EWP practitioners concerning HIV and AIDS workplace stigma.

### **4.3. OBJECTIVES OF THE STUDY**

The following objectives were implemented successfully in order to achieve the goal of the study, namely:

- ✚ to conduct an in-depth literature review on the manifestation of HIV and AIDS stigma as a problem and challenge in the workplace [see Chapter 2: 31-45];
- ✚ to ascertain empirically EWP practitioners' understanding and perceptions of HIV and AIDS stigma and discrimination manifestations in the workplace [see Chapter 3: 50-60];
- ✚ to establish from EWP practitioners, the effectiveness of workplace interventions and whether such interventions were addressing the HIV and AIDS stigma efficiently [see Chapter 3: 60-65]; and

- ✦ to make recommendations to health care practitioners who work with employees who are victims of HIV and AIDS stigma, with the purpose of enhancing compliance with relevant legislation [see Chapter 4: 78-80].

#### 4.4. CONCLUSIONS

The following conclusions were made from the findings of the empirical study:

- ✦ The expression of stigma in the workplaces is a clear indication that employees are still subjected to human rights violations which may have a serious impact on the image and reputation of GPG.
- ✦ Lack of knowledge about HIV and AIDS, ignorance, fear of rejection and victimisation are the most frequent causes of HIV and AIDS stigma and result in employees not to disclosing their HIV status in the workplace.
- ✦ Stigma results in increased absenteeism. It has a negative impact on employees' access to EWP services resulting in underutilisation of services.
- ✦ Litigation based on stigma and discrimination as expressed by the EWP practitioners may further enhance stigma as employees would be subjected to enquiries which may embarrass them in case they do not win such cases. This may ultimately have a negative impact on employees' morale and general well-being.
- ✦ As there is a trend of shifting from having separate HIV and EAP policies towards integrated and holistic Employee Wellness Programmes policies, it seems that there is a lack of approved policies.
- ✦ There is generally poor attendance amongst senior managers at training on leadership and HIV and AIDS, who more often than not delegate middle and

junior staff members to attend scheduled sessions which may be an indication of their lack of commitment to the programme.

- ✚ Management do not lead by example as they are not willing to disclose their HIV status.
- ✚ As GPG employs more Africans than other racial groups, the inclusion of faith-based prevention programmes in departments is crucial.
- ✚ HIV and AIDS peer educators at the GPG departments are trained and empowered to deal with all forms of stigma, and there is a general perception that peer educators play an integral part in mitigating stigma in the workplace.
- ✚ Different strategies were used to promote HIV and AIDS awareness at the GPG departments, and there is a general view that strategies currently have been effective in mitigating HIV and AIDS workplace stigma.
- ✚ There was a general level of uncertainty on the effectiveness of HIV and AIDS related events in mitigating workplace stigma based of the fact that they have not conducted an impact study to determine their effectiveness.
- ✚ VCT is implemented in most GPG departments and there is a widespread view that the VCT has been ineffective in mitigating stigma in the workplace. VCT at most GPG departments is done both internally [within the departments' premises] and externally [through referral to external VCT service providers].
- ✚ Although not all departments involved employees living with HIV and AIDS, there is a view that the involvement of employees living with HIV and AIDS in policy development, implementation, monitoring and evaluation helps in addressing workplace stigma.

- ✦ No GPG department had conducted an HIV and AIDS stigma audit, although EWP practitioners have noted the significance of conducting an HIV and AIDS stigma audit aimed at assessing the extent of stigma as a problem as well as the barriers and factors enhancing stigma mitigation in the workplace.

#### 4.5. RECOMMENDATIONS

- ✦ The EWP interventions should include making employees aware of their rights, and providing proactive assistance to employees being stigmatised.
- ✦ HIV and AIDS workplace policies should provide explicit guidelines on how stigma is addressed in government.
- ✦ Government should have simple, measurable, achievable, and agreed upon business cases for stigma mitigation which must be geared towards addressing the consequences of stigma in the workplace.
- ✦ Employee Wellness Programme practitioners should implement both proactive and reactive interventions to address the consequences of stigma in the workplace.
- ✦ The GPG should develop and implement a single policy framework on Employee Health and Wellness which should be the overriding document which takes precedence over the customisation by member departments.
- ✦ Employee Health and Wellness Programme policies should acknowledge the existence of HIV and AIDS stigma as a challenge to business and establish clear procedures on how stigma and discrimination will be addressed.
- ✦ The GSSC [the convenor of the GPG Employee Wellness Programme Forum] and MSAU [the sponsor of the Gauteng HIV and AIDS programme]

should assist departments in developing, implementing, monitoring and evaluating HIV and AIDS policies. MSAU, GSSC and the EWP practitioners should involve PLWA in all policy development and analysis and should keep abreast of new legislation and regulations to ensure alignment and compliance of policies.

- ✚ Regular policy analysis should be done to identify the gaps with the aim of reducing stigma and discrimination in the workplace.
- ✚ Managers should be required to develop plans on how they are addressing the challenges of HIV and AIDS stigma and such plans should be monitored and evaluated regularly.
- ✚ A non-monetary incentive framework should be developed and implemented to recognise and reward business units that mainstream HIV and AIDS workplace programmes.
- ✚ Qualitative and quantitative monitoring of HIV and AIDS should be prioritised for implementation by the GPG departments. Efforts should be made to monitor the impact rather than the number of employees reached through various workplace interventions.
- ✚ Self and peer review/monitoring should be done regularly to determine the extent to which EWP practitioners are implementing HIV and AIDS policies and the extent to which stigma is being addressed in the GPG departments.
- ✚ GPG should implement programmes aimed at ensuring voluntary disclosure from employees or senior managers.
- ✚ EWP's which are located within Employee Relations should be moved to other business functions such as Human Resources or independent EWP directorates for ethical and confidentiality reasons.

- ✦ GPG departments' HIV and AIDS prevention strategies should incorporate traditional African beliefs such as witchcraft, ancestral beliefs and traditional African perceptions concerning condoms.
- ✦ A multi-sectoral approach to address HIV and AIDS prevention challenges should be applied and must include all stakeholders such as faith-based organisations.
- ✦ Workplace research should be done on the perceptions of employees concerning traditional African beliefs.
- ✦ Refresher courses should be arranged for peer educators to keep abreast of new skills on how to execute their duties. Peer educators functions should be incorporated into their performance contracts.
- ✦ Awareness strategies should be customised to suit the needs of employees and to reduce the incidents of stigma. Awareness should not only be limited to giving employees information, but legitimate information which create understanding of HIV and AIDS manifestations and linkage with appropriate resources for assistance.
- ✦ Government should explore the possibilities of offering support and treatment which may motivate employees to go for HIV testing.
- ✦ The effectiveness of support programmes could be ascertained through feedback from service users.
- ✦ Stigma audits should be conducted by GPG departments. Departments can commission MSAU and GSSC to conduct a provincial audit on stigma. The audit would yield findings that would most likely assist GPG to address HIV and AIDS workplace stigma.



#### **4.6. SUMMARY**

In the context of the conclusions and recommendations elucidated in this study, it can be concluded that the goals and objectives described in Chapter 1 have been achieved through this empirical study on the perceptions of EWP practitioners concerning HIV and AIDS workplace stigma.

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## APPENDIX A: LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH



### Department of Social Work and Criminology

The Manager EWP & Assessment  
Gauteng Shared Services Centre

Date: 27 November 2007

Ref: Dr FM Taute  
Tel: 012 420 4847  
Fax: 012 420 2093  
E-mail: florinda.taute@up.ac.za

Dear Ms. Mange

### REQUEST FOR PERMISSION TO PERFORM EMPIRICAL RESEARCH STUDENT'S NAME: ALFRED THAVHANYEDZA

The above-named student is registered for the following programme at the Department of Social Work, University of Pretoria: **MSD [Health Care]**

The student is required to write a **mini-dissertation**, resulting from a research project, under my supervision. The research will only proceed once a departmental Research Panel and the Faculty Research Proposal and Ethics Committee have approved the proposal and data collection instrument(s). The following information from the research proposal is shared with you, although a copy of the **research proposal** will be provided to you if needed:

The envisaged **title** of the study is: **The perceptions of Employee Wellness Programme [EWP] practitioners concerning HIV and AIDS workplace stigma.**

The **goal** of the study is: to explore the perceptions of EWP practitioners relating to HIV and AIDS workplace stigma.

The **objectives** of the study are as follows:

- ✚ to ascertain empirically whether EWP practitioners understand HIV/AIDS stigma and discrimination manifestations in the workplace;
- ✚ to establish from EWP practitioners, the effectiveness of workplace interventions and whether such interventions are addressing HIV/AIDS stigma efficiently and effectively;
- ✚ to conduct an in-depth literature review on the manifestation of HIV and AIDS stigma as a problem and challenge in the workplace; and
- ✚ to make recommendations to health care professionals who work with employees who are victims of HIV/AIDS stigma, with the purpose of enhancing compliance with relevant legislation.

The **envisaged target group** of the study is EWP practitioners from various departments in the Gauteng Provincial Government.

The student wishes to do the empirical part of the study by means of:

- ✚ a personal interview according to a semi-structured schedule with Employee Wellness Programme practitioners from your organisation as stipulated above.

This request will not result in any demands on you or your staff.

No **costs** will be incurred by this request.

Possible benefits for your organisation can be summarised as follows:

- ✚ Government should acknowledge the existence of stigma in the workplace and ensure that workplace policies and strategies on HIV and AIDS address how stigma could be combated.
- ✚ Employees need to be educated and empowered to divulge any form of discrimination and stigma and be able to report such without fear of being labelled. The representatives of organised labour/shop stewards should also understand HIV and AIDS policies and be able to advocate for their members' rights pertinent to stigma in the workplace.
- ✚ The EWP practitioners need to acknowledge that no one is immune to being HIV-positive. This study will yield recommendations on how practitioners can

come to terms with their own fears and prejudices relating to HIV stigma in the workplace. EWP practitioners will further need to understand the need to verbalise their anxiety, anger, sorrow, guilt or shame based on their own perceptions on stigma in the workplace.

This student undertakes responsibility to provide you with a copy of the final report.

It would be appreciated if you will seriously consider and grant **permission** to the student to proceed with the project, at your earliest convenient date. For your own convenience, the student undertakes to collect the letter of permission to conduct the empirical study from your office and he can be contacted on **011 355 9538**, email [alfredt@gpg.gov.za](mailto:alfredt@gpg.gov.za)

Regards

**Dr. Florinda Taute**  
**Student's Supervisor**

## APPENDIX B: PERMISSION TO CONDUCT THE STUDY FROM GSSC



GAUTENG SHARED SERVICE CENTRE  
ISIKHUNGO SASEGAUTENG SEZINSIZAKALO  
EZIHLANGANYELE  
SETSI SA DITSHEBELETSO TSE KOPANETSWENG TSA

Dr. F.M. Taute  
University of Pretoria  
Department of Social Work and Criminology  
Tel: 012 420 4847  
Fax: 012 420 2093  
Email: [florinda.taute@up.ac.za](mailto:florinda.taute@up.ac.za)

Dear Dr. Taute

**SUBJECT: REQUEST FOR PERMISSION TO PERFORM EMPIRICAL RESEARCH  
STUDENT'S NAME: ALFRED THAVHANYEDZA**

The request for the above-mentioned student to conduct research entitled “The perceptions of Employee Wellness Program [EWP] practitioners concerning HIV and AIDS workplace stigma” with EWP practitioners in the Gauteng Provincial Government Employee Wellness Forum is hereby granted.

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**NONDWE MANGE**

The Manager EWP and Development Centre  
Gauteng Shared Services Centre  
Date: 12/05/2008

## APPENDIX C: INFORMED CONSENT FORM

Researcher: Mr. Tshilidzi Alfred Thavhanyedza  
Tel: 011 355 9538

### Informed Consent

**Title of Study:** The perceptions of Employee Wellness Programme practitioners concerning HIV and AIDS workplace stigma.

**Purpose of the Study:** To explore the perceptions of EWP practitioners concerning HIV and AIDS workplace stigma.

**Procedures:** I will also be asked answer questions relating to my perceptions on HIV and AIDS workplace stigma at the organisation where I am employed. The interview questions will focus on the context of HIV and AIDS stigma in my department, how stigma is manifested and relevant HIV and AIDS interventions. The interview will take approximately one and half hours to complete. The interview will be scheduled at my convenience.

**Risks and Discomforts:** There are no known medical risks or discomforts associated with this project and I will be allowed to express my views without being judged.

**Benefits:** The results of the study may help researchers and myself gain a better understanding of how HIV and AIDS workplace stigma manifest itself and how government departments can implement effective programmes that would assist in mitigating stigma in the workplace.

**Participant's Rights:** I may withdraw from participating in the study at any time.

**Financial Compensation:** There will be no financial compensation for participation in this study.

**Confidentiality:** The names of the Government Department will not be disclosed in the study findings or the name and designation of the participant who completed the interview session. The results of this study may be published in professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.

I am aware that if there are any questions or concerns concerning the study I can call Mr. Tshilidzi Thavhanyedza. I understand my rights as a research respondent, and I voluntarily consent to my participation in this study, I understand what the study is about and how and why it is being done. I am fully



aware of the fact that all research data will be stored for 15 years. I will receive a signed copy of this consent form.

\_\_\_\_\_  
Name of respondent

\_\_\_\_\_  
Signature of the respondent      DATE      \_\_\_\_\_

\_\_\_\_\_  
Signature of researcher      DATE      \_\_\_\_\_

\_\_\_\_\_  
Signature of researcher' supervisor      DATE      \_\_\_\_\_

## **APPENDIX D. INTERVIEW SCHEDULE: SEMI-STRUCTURED INTERVIEW**

**Research title: The perceptions of Employee Wellness Programme [EWP] practitioners concerning HIV and AIDS workplace stigma**

### **Section A: Background information**

1. How old are you?
2. How long have been working in the HIV and AIDS/EWP field?
3. What are your qualifications?

### **Section B: Perceptions of EWP practitioners concerning the expression of HIV and AIDS workplace stigma**

1. Does HIV and AIDS stigma occur in your Department?
2. If yes, how is HIV and AIDS stigma manifested/expressed in your department?
3. What are the causes of HIV and AIDS stigma in your department?
4. What are the consequences of HIV and AIDS stigma in your department?

### **Section C: Perceptions of EWP practitioners about the context of HIV and AIDS workplace stigma**

1. Does your department have an HIV and AIDS policy?
2. Are your employees aware of the HIV and AIDS policy?
3. Has your department conducted an HIV and AIDS policy analysis to determine the extent to which it addresses HIV and AIDS stigma?
4. How do you mainstream HIV and AIDS policy to mitigate stigma in the workplace?
5. How do you monitor the implementation of your department's HIV and AIDS policy to ensure that it does not only exist on paper but is put into action?
6. Do all employees in your department have health care benefits, particularly medical aid?

7. Do you get sufficient support and commitment from senior managers concerning HIV and AIDS workplace issues?
8. Does senior management in your department take a lead in HIV and AIDS stigma mitigation? Are your senior managers the face of HIV and AIDS programmes and are they leading by example?
9. Does your department provide leadership training on HIV and AIDS and what is the quality of senior management commitment to attending training sessions?
10. Are there senior managers in your department living openly with HIV and AIDS?
11. Where is the EWP structurally positioned in your department. Do you believe that it is strategically located in such a way that it is easily mainstreamed, prioritised and well resourced?

**Section D: Perceptions of EWP practitioners concerning HIV and AIDS workplace interventions/programmes**

1. Do your department's HIV and AIDS prevention interventions incorporate traditional African beliefs, e.g. witchcraft, ancestral beliefs, and traditional African perceptions of condoms?
2. Does your department conduct training for employees at all levels to sensitise them about HIV and AIDS workplace stigma? Is the training participative or lecture-based?
3. Does your department have trained HIV and AIDS peer educators, and are they empowered to deal with the different forms of stigma, e.g. internal, external and enacted stigma?
4. Does HIV and AIDS workplace training focus on behaviour change aimed at reducing incidents of stigma in your department?
5. What are the strategies/mechanisms used by your department to promote awareness on HIV and AIDS, and how effective are they in mitigating HIV and AIDS stigma?

6. Does your department participate in special events like the condom week, the candle light ceremony and World AIDS Day and how effectively do these events mitigate the impact of HIV and AIDS stigma in your department?
7. How are the HIV and AIDS stigma mitigation messages mainstreamed in your department?
8. Does your department implement a Voluntary Counselling and Testing (VCT) programme and how effective is the VCT in mitigating HIV and AIDS workplace stigma?
9. Is the VCT conducted internally [in-house] or externally and what are the challenges of VCT in relation to stigma at your department?
10. Are your HIV and AIDS programmes incorporated into the integrated Employee Wellness Programme and do you think such incorporation addresses the HIV and AIDS stigma in your department?
11. Are counselling services rendered internally or are they outsourced to external service provider and how effective are they in addressing stigma in the workplace?
12. What support services are provided by the Employee Wellness Programme practitioners to employees living and working with HIV and AIDS and how effective are such interventions in addressing HIV and AIDS stigma in your department?
13. What are the barriers to HIV status disclosure in your department?
14. How is HIV and AIDS apathy expressed by employees in your department and what should be done to address stigma based on apathy amongst employees concerning HIV and AIDS related issues?
15. Are employees living with HIV and AIDS in your department involved in all HIV and AIDS related policies, implementation and monitoring of interventions? How do you perceive their involvement in addressing HIV and AIDS workplace stigma?
16. Has your department conducted an HIV and AIDS stigma audit and how can such an audit assess the extent of stigma as a problem, as well as the barriers and factors enhancing stigma mitigation in the workplace?

## APPENDIX E. LETTER FROM THE EDITOR

# BERNICE BRADE EDITING

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FREELANCE WRITER, PROOF READER AND EDITOR  
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### To whom it may concern

This letter serves to confirm that in February 2009 I did the proofreading and the language editing for the Research Report of

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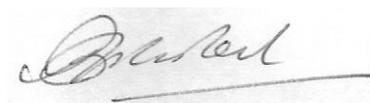
This document is being submitted in partial fulfilment of the requirements for the degree

### **MSW (HEALTH CARE)**

In the  
**Faculty of Humanities**  
In the  
**Department of Social Work and Criminology**  
At the  
**UNIVERSITY OF PRETORIA**

I have proofread and edited the whole work from the introductory pages to the bibliography and the appendices. This editing principally involves proofreading, language, style and grammar editing; and also checking the text for clarity of meaning, sequence of thought and expression and tenses. I have also noted any inconsistencies in thought, style or logic, and any ambiguities or repetitions of words and phrases, and have corrected those errors which creep into all writing. I have written the corrections on the hard copy and have returned the document to the author, who is responsible for inserting these.

*February 2009*



*Bernice McNeil*



Proprietor: Bernice McNeil BA Hons, NSTD <http://www.angelfire.com/journal/edit/aboutbba.html>