AN EXPLORATORY STUDY OF HIV POSITIVE EMPLOYEES' PERCEPTIONS ON THE PREVALENCE OF HIV-RELATED STIGMA IN WORKPLACES OF JOHANNESBURG, SOUTH AFRICA

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Dedication

To my mother, and my best friend, Veronica Ramrajh: Thank you for your consistent support and undying love. I am forever grateful. You have inspired and motivated me every single day, and I am thankful for that. Thank you for your patience, and your wisdom. Thank you for your guidance. I love you with every single piece of my heart.

To my loving father in Heaven, Dennis Ganess. Thank you for being an awesome dad. I hope that I have made you proud. I love you.

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List of Abbreviations

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral therapy

ARV: Antiretroviral

CDC: Centre for Disease Control and Prevention

COVID-19: Coronavirus Disease 2019

EEA: Employment Equity Act

GBV: Gender-Based Violence

HIV: Human Immunodeficiency Virus

LGBTQIA+: Lesbian, gay, bisexual, transgender, Queer, Intersex, Agender and other queer-identifying communities

MSN: Men who have sex with men

MSW: Men who have sex with women

PLWHA: People Living With HIV/Aids

TB: Tuberculosis

UNAIDS: United Nations Program on HIV/AIDS

WHO: World Health Organization

ZNNP+: Zimbabwean National Network of People Living with HIV

Definition of Terms

For the purpose of this study the following phrases and terms were used to mean the following:

Felt stigma: refers to internalised HIV-related stigmatization, which results in stigmatizing against oneself.

Enacted stigma: in this study refers to the experiences of discrimination and Othering in the form of HIV-related stigmatization in the workplace which is manifested as being socially excluded, experiencing job exclusions, being judged, being gossiped about, discriminated against, experiencing friendship losses, and as well as loss of job opportunities in the workplace.

HIV/AIDS-related stigma: refers to discrimination and unfavourable attitudes and beliefs directed toward people living with HIV/AIDS due to the fact that they are HIV positive.

Internalised stigma: refers to a process where the individual internalises society's discriminatory narrative, regarding HIV and begins to view oneself through the eyes of the oppressor, and self-stigmatize.

Symbolic stigma: refers to experiences of stigmatization based on religion, morality and sexuality.

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1.1. Chapter 1: Introduction

1.2. Introducing HIV and HIV-related Stigma

http://www.statssa.gov.za/publications/P0302/P03022021.pdf

In South Africa the estimated overall HIV prevalence rate is approximately 13,1% among the South African population (Statssa, 2021). (According to the UNAIDS, 2020) of all people with HIV worldwide: 84% knew their HIV status, and 73% of PLWHA had access to ART. There are approximately 37.6 million people across the globe with HIV in 2020 (UNAIDS, 2020).

According to Niehaus (2007) the HIV transmission has traditionally been perceived as infectious, and has been associated with a painful form of death, which is known as 'wasting syndrome'. Similarly, according to Alonzo and Reynolds (1995) the virus has historically been poorly understood and negatively viewed by community members as well as health care providers. Nyblade et al. (2009) stated that the epidemic of the human immunodeficiency virus (HIV) results in social responses of enacted stigma, denial, fear, and discrimination against people who live with HIV. In addition, Alonzo & Reynolds (1995) stated that people who are HIV positive are stigmatized against because individuals in society view HIV as a virus that is acquired through engaging in immoral acts, such as drug use, sex work and unprotected sex. The available literature reviews on HIV-related stigma has demonstrated that stigma caused by being HIV positive is a barrier to HIV prevention, treating and providing care for people who live with HIV (PWLHV), and accessing HIV testing services due to the experience of enacted, felt and symbolic stigma (UNAIDS, 2010).

The fear of being stigmatized due to being HIV positive prevents HIV positive individuals from disclosing their status to others, testing themselves, knowing their HIV status, and being initiated to antiretroviral therapy (ART) (Avert, 2011; UNAIDS, 2010). Therefore, many people who live with HIV refuse to get tested for HIV until they have clinically progressed to

acquired immunodeficiency syndrome (AIDS), which has negative impacts on the fight against HIV/AIDS and treatment outcomes (Avert, 2011).

1.2.1. Overview of HIV/AIDS

According to Avert (2011) HIV is an incurable virus and an abbreviation for human immunodeficiency virus. Avert (2011) states that HIV attacks the immune system, which hinders a person's defence against illnesses. If HIV is not treated, the immune system will get deteriorate and weaken until it can no longer protect the body from infections and diseases (Avert, 2019).

HIV is found in blood, breastmilk, semen, as well as vaginal and anal fluids (Avert, 2019). The medication that is used to manage HIV is called antiretroviral therapy (ART) (Avert, 2019). Unfortunately, HIV does not have a cure (Avert, 2019). However, by accessing ARV's, HIV becomes manageable (Avert, 2019). If an HIV positive individual is not taking antiretroviral treatment, they will find it exceedingly difficult to overcome any life-threatening infections and diseases (Avert, 2019). If an HIV positive person does not seek treatment, there is a possibility that their immune system gets damaged and weakens to a point where it can no longer function (UNAIDS, 2010). The sooner HIV positive people receive a diagnosis, the sooner they can start a treatment program, which results in better long-term health for the HIV positive individual (Avert, 2018).

Fortunately, people who are HIV positive can enjoy health and longevity by taking antiretroviral treatment which is available and effective to all HIV positive people at no cost to the infected individual (Avert, 2019). Furthermore, long-term use of ARV treatment decreases the level of the virus in the body so that it becomes undetectable in blood tests (Avert, 2018). Additionally, people who are HIV positive and whose viral load is undetectable are unable to transfer the virus to others (Avert, 2018). Therefore, HIV positive individuals are able to live normal lives, and should thus not be stigmatized.

However, HIV can result in acquired immunodeficiency syndrome (AIDS) if it is left untreated (Avert, 2018). Furthermore, AIDS is an abbreviation that stands for acquired immune deficiency syndrome and is caused when HIV cases are left untreated (Avert, 2019).

Unfortunately, HIV positive individuals develop AIDS when the body's immune system is unable to overcome infections (Avert, 2018).

According to Avert (2018) AIDS is the last stage of HIV and if it is not treated the virus will unfortunately result in death. On the positive side, Avert (2018) states that fewer HIV positive people develop AIDS symptoms in modern society because of the availability of antiretroviral medicine, and as a consequence more people who are HIV positive remain healthy.

1.2.2. Overview of Stigma

Erving Goffman defines stigma as a concept which refers to either a 'burn', a 'cut', 'mark' or 'sign' on the body that positions the bearer of the mark as a person who is viewed as immoral (Goffman, 1963). In addition, Goffman (1963) defined stigma as a devalued and discrediting trait that is possessed by a stigmatized person. According to Lodder (2004) this may explain how stigmatizing attitudes and perceptions towards PWLHV could have been formed and enacted.

A number of authors have since elaborated on the definition of stigma proposed by Goffman (1963). Link and Phelan (2001) state that stigmatization that is caused by being HIV positive involves attaching a label to an individual or group of people, and connecting that label to immoral behaviour. The labelled individuals are clearly distinct and segregated from the general community as different and 'diseased' (Link & Phelan, 2001). According to Link and Phelan (2001) individuals who are negatively labelled usually experience stigmatization and a lowered social status.

Additionally, Gilmore and Somerville (1994) conceptualized four different stages of stigmatization that individuals experience due to being HIV positive in order to explain the four processes of the stigmatizing response. The first stage involves what Goffman (1963) described as the discredited attribute, which can also be described as an attribute that distinguishes those who have HIV from those who do not. The second stage involves identifying the people who live with HIV/AIDS for targeted discrimination (Gilmore & Somerville, 1994). This means that the discriminated individuals must be recognizable in the society with an easily identifiable characteristic which can then be used to label him or her,

such as a skin rash, cold sores, or a form of visible weight loss (Greeff et al., 2008). In the third stage, the target of the stigmatization is perceived as immoral and often blamed for their predicament (Gilmore & Somerville, 1994). The fourth and last stage deals with how the society responds to the stigmatized individual, and how the individual may be isolated, insulted, avoided and ostracized due to their assigned label (Gilmore & Somerville, 1994).

This research study will utilize Link and Phelan's (2001) definition of stigma, in order to view stigma holistically.

1.2.3. Overview of the Constructs of HIV-related Stigma

The human immunodeficiency virus has universally been viewed by society as a punishment for immoral acts (UNAIDS, 2010). Furthermore, the assumption that HIV is a morally defective disease has provided a strong foundation for stigmatization against HIV positive people to occur (Nyblade et al., 2009). In addition, South African and global literature on HIV suggests that people socially respond to people who live with HIV with fear and stigmatizing attitudes (Avert, 2019; Avert, 2018; Nyblade et al., 2009).

As indicated previously, the literature that is available on HIV-related stigma, globally and regionally, shows that stigma that is associated with HIV is a barrier to HIV treatment and prevention in the form of enacted and felt stigma (UNAIDS, 2010). Similarly, Letamo (2005) identified factors that contribute to stigmatization that is associated with being HIV positive. According to Letamo (2005) behaviours that are associated with HIV, such as MSM (men who have sex with other men), sex work, and the injecting of drugs are stigmatized in many communities, and therefore a positive HIV diagnosis is viewed as the responsibility of the HIV positive person. In addition, HIV is perceived to be contagious and people fear contact with an infected individual (Letamo, 2005). HIV is also stigmatized because a painful form of death is associated with the virus (Letamo, 2005).

In Africa HIV is mainly transmitted via sexual acts, which are viewed as voluntary as well as morally defective, especially if it includes sexual acts that are stigmatized like promiscuity, MSM, or sexual contact with sex workers (UNAIDS, 2012). Thus, individuals who have HIV are blamed for spreading HIV to other people and viewed as responsible for their health condition (Herek et al. 2005).

The available literature indicates that there is still anxiety that is caused by the belief that the virus is transferable through everyday casual social exchanges with individuals who are HIV positive (Ogden & Nyblade, 2005). In some communities, shaking hands with an individual who lives with HIV, sitting next to an HIV positive person, eating food that has been prepared by someone who has HIV, or using items that someone who has HIV handled is believed to cause HIV (Ogden & Nyblade, 2005).

According to Niehaus (2007) the media has shaped people's negative perceptions of the HIV epidemic, and while in the early 1990s AIDS was an imagined disease only read and seen on television, most started to experience the painful realities of the disease at the beginning of 2000. These first hand personal experiences of seeing and nursing an ill and dying relative became critical in shaping the way people perceived the disease (Niehaus, 2007).

Additionally, HIV-related stigma, both enacted and felt, may also arise from the way communities respond to and treat individuals with HIV (Greeff, 2008). Authors Herek and Capitanio (1998) coined the concept *instrumental stigma* which refers to intended discrimination directed at people who live with HIV because of the fear of being infected with the virus. Additionally, Herek & Capitanio (1998) who coined the term *symbolic stigma*, and state that the concept of symbolic stigma refers to stigma that is based on religious and sexual moral judgments that members of society formulates about those who are HIV positive.

In addition, Kohi et al. (2006) state that stigmatization caused from living with HIV is manifested in the violation of human rights, which can take the form of denying care to an HIV/AIDS positive person within health facilities; abusing HIV positive people; a denial of employment opportunities; and a denial of leadership positions due to living with HIV.

1.2.4. Overview of COVID-19

According to the WHO (2010) coronaviruses in human beings are common throughout the world, and has occurred in the past. According to the Department of Health Republic of South Africa (2020) in 2019 a new strain of the coronavirus disease was confirmed in 125 048 people worldwide, and had a mortality rate of approximately 3·7 % compared with the

mortality rate of less than 1% from influenza. According to Mehta et al. (2020) the majority of the patients initially identified to be COVID-19 (coronavirus disease 2019) positive were dealers and vendors at a wildlife wet market in Wuhan, China. Since then, the virus has spread to countries across the globe, including South Africa. Furthermore, elderly community members, people with compromised immune systems, and individuals with underlying illnesses have been found to be at a higher risk of death as (COVID-19 targets people who have compromised immune systems and underlying health conditions (Zheng et al., 2020). According to Avert (2011) people who are HIV positive have a weakened and compromised immune system, and this places them at a greater risk of contracting COVID-19. COVID-19 spreads through respiratory droplets in the air that is produced when an infected person coughs or sneezes without covering their mouth (WHO, 2020). To date, there is no treatment or cure available for COVID-19 (WHO, 2020). However, a vaccine for COVID-19 has been developed (Subbaraman, 2020).

1.3. Rationale

South Africa has an HIV/AIDS epidemic and approximately 7.1 million South African citizens are HIV positive (Avert, 2019). In 2018, approximately 240,000 South African people tested positive for HIV and approximately 71,000 citizens passed away due to illnesses related to HIV/AIDS, such as tuberculosis (TB) (Avert, 2019).

There is a cyclical interaction that occurs between the concepts of stigma and HIV, whereby individuals who are HIV positive are more prone to experiencing stigmatization, while individuals who experience stigma are marginalised which heightens their vulnerability to HIV (Avert, 2019). Furthermore, HIV has been associated with groups that are already socially marginalized, like men who have sex with men (MSM), sex workers, and young people (UNAIDS, 2010).

Additionally, Nyblade et al. (2009) observed that the history of the epidemic has always been associated with particular groups of people, for instance drug abusers, transgender individuals, women, MSM, and people involved in sex work. Unfortunately, stigmatization discourages individuals from getting HIV tested and accessing antiretroviral medication, which makes them more prone to transmitting the disease to other people in society. Furthermore, stigma is a barrier in the form of felt and enacted stigma (Avert, 2019). These terms will be elaborated on in the literature review.

This study is relevant to the industry as literature reviews on stigmatization and HIV in the workplace is limited, and furthermore research articles on stigma caused by being HIV positive in the workplace are not current. When searching for current literature on the perceptions of HIV positive individuals on the prevalence of stigma caused by living with HIV in the workplaces of Johannesburg, no evidence was located. Most research studies on stigma that is caused by HIV in the context of the worksite are conducted in Eurocentric countries and thus does not align with the South African context.

One positive aspect though, is that in post-apartheid South Africa, people who live with HIV are protected in the workplace through the policy of the Employment Equity Act (EEA) which prohibits unfair discrimination against employers who live with HIV, and prevents HIV-related stigma in the workplace (South African Government, 2019).

However, despite these policies, the few studies that could be located in South Africa disclosed that HIV positive people continue to feel and experience stigmatization in the workplace, globally and locally, by means of discriminatory practices, such as unfair termination and a denial of promotion opportunities (Avert, 2019; Dos Santos et al., 2014; Liu et al., 2012; Moalusi, 2018; Sprague et al., 2011; Weihs & Meyer-Weitz, 2016).

Due to limited current literature on this topic, specifically in Johannesburg, the following research study will highlight the prevalence of HIV-related stigmatization in the context of the workplaces of Johannesburg, South Africa utilizing an intersectional lens.

The overarching aim of this research is to explore whether stigmatization caused from being HIV positive is prevalent in the workplace. Underlying intentions or aims of the study are: to explore how HIV positive employees perceive the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa and what their meaning-making is around the topic, to discover if HIV-related stigma is prevalent in the workplace in 2020, to explore how various aspects of an HIV positive person’s identity contributes to overlapping stigmas, and to discover what interventions are in place and what policies affected employees feel are needed.

Findings of the research study could potentially contribute to the current body of knowledge on stigma experienced in the workplace due to living with HIV.

1.4. Research Aims

1.4.1. Superordinate Aim

The overarching aim of this study is to explore what the perceptions of people living with HIV/AIDS are with regards to the prevalence of HIV-related stigma in the workplace.

1.4.2. Subordinate Research Aims

The subordinate aims of the research are as follows:

- To explore how HIV positive employees perceive the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa and what their meaning-making is around the topic.
- To discover if HIV-related stigma is prevalent in the workplace in 2020.
- To explore how various aspects of an HIV positive person's identity contributes to overlapping stigmas
- To discover what interventions are in place and what policies affected employees feel are needed, and
- To discover if HIV is associated with COVID-19 in the workplace

1.5. Chapter Organisation

Chapter 1: This chapter introduces HIV and HIV-related stigmatization; provide an overview of HIV/AIDS, the concept of stigma, as well as discuss the constructs of HIV-related stigma. In addition, the chapter provides an overview of COVID-19 and how it relates to HIV. Additionally, in this chapter the rationale of the study, the research aims, the chapter organisation will be discussed, and chapter organisation are discussed.

Chapter 2: In this chapter the literature review and theoretical framework of the study are discussed, as well as the lancuna in literature.

Chapter 3: Chapter 3 discusses the methodology of the research study, the research questions, research design, procedure, sample and sampling, the data collection instruments used, the pilot study, method of data analysis, the 5 stages of thematic analysis, data quality, and lastly reflexivity.

Chapter 4: This chapter discusses the results of the study. In addition, the chapter contains a table illustrating the demographic data collected, and a diagram of the themes uncovered during the analysis of the data. The themes and sub-themes are then discussed in this chapter.

Chapter 5: This chapter contains a discussion of the major findings of the research study in relation to pertinent literature.

Chapter 6: This chapter provides the conclusions and recommendations of the study.

1.6. Conclusion

This chapter presented an introduction to HIV and HIV-related stigmatization. It was shown that people stigmatize HIV positive individuals due to the misconceptions that society harbours about HIV. In addition, this chapter introduces the topic area for the study, and presents the rationale for the study, the research aims and objectives. The next chapter focuses on the theoretical framework used to conceptualise the study and the review of existing literature.

2.1. Chapter 2: Literature review and Theoretical Framework

2.2. Introduction

This chapter presents a critical appraisal of scholars' previous works theorizing about stigma, as well as a description of the theoretical framework utilized in the study. The researcher will provide an account of theories on stigma from the oldest to the more recent. Furthermore, an inclusive review of research done on the topic, as well as a lacunas in literature, are presented. Thereafter, the next chapter will present the methodology and data quality of the research.

2.3. Conceptualizing the Constructs of Stigma

As stipulated in the introduction, stigma has traditionally been defined from various theoretical perceptions. Goffman (1963) was the first author to write about stigma and stated that stigma is a phenomenon whereby a person who possesses a specific attribute that is devalued by the community is rejected due to the attribute. Goffman (1963) stated that this attribute was dynamic and would therefore change with time (Imogen & Slate, 2018).

A criticism of Goffman's (1963) work on stigma comes from Gleeson (1999). Gleeson (1999) critiques Goffman for highlighting how stigma is produced in social settings without considering the wider society. According to Goffman (1963), social experiences with others in society are where stigma is formulated and learned. On the other hand, Gleeson states that Goffman (1963) ignores institutional aspects of the environment that mould notions of stigma. Contrary to Goffman (1963), Gleeson (1999) states that social experiences are the result of wider economic, political and social forces (Gleeson, 1999).

In addition, drawing from Goffman (1963) as well as Jones et al., (1984), Alonzo and Reynolds (1995) state that stigmatization occurs among people in the community who are shunned, devalued, or occupy a lowered social standing or tainted reputation.

Furthermore, Campbell et al. (2005) elaborated on Goffman's (1963) work and proposed a framework stipulating the contexts that stigma occurs in, namely: the organisational context,

the economic context, the local community contexts, and the political context (Stangle et al., 2019). This is similar to Gleeson's (1999) idea that stigma is systematically as well as socially constructed.

Additionally, Gerhard Falk (2001) elaborated on Goffman's (1963) ideas of stigma and coined the terms existential stigma and achieved stigma (Stangle et al., 2019). The first term, existential stigma, is stigmatization that arises from a condition that the person did not cause and has limited control over, for example being stigmatized for contacting HIV in the womb. The second term, achieved stigma, occurs due to one's conduct, for example contracting HIV due to being promiscuous (Stangle et al., 2019).

On the other hand, Goffman (1963) states that stigma arises when a person is negatively stereotyped and labelled as deviant, which results in individual's being discriminated against. According to Goffman (1963), the meaning attached to stigma is not an inherited trait of an individual, but rather an attribute that is socially constructed and changes with time (Imogen & Slate, 2018).

In addition, Gerhard Falk (2001) expanded on Goffman's (1963) notion of stigma by defining deviant as people who deviate from societal expectations. He also categorized deviance into two types (Krug & Drasch, 2019). The first type is social deviance and refers to a condition, for example HIV, which is widely perceived by society as being deviant and hence stigmatized. The second type is situational deviance, and refers to behaviours that are categorized as deviant and stigmatized in certain contexts, for example being an HIV positive priest (Krug & Drasch, 2019).

On the topic of deviance, Falk (2001) concluded that communities naturally stigmatize a behaviour or condition that deviates from the norm because it unifies the society by segregating those who conform to the rules of society from those who do not conform. Stigmatization challenges a person's humanity, in that the stigmatizer's identity is challenged when one deviates from the norm and this leads to the inhumane treatment of non-conformists (Falk, 2001).

When analysing literature on stigma, the researcher noted that Alonzo and Reynolds (1995), Campbell et al. (2005), Falk (2001), Goffman (1963), as well as Jones et al. (1984) all stated

that stigma is not a fixed attribute of an individual, but is rather a societal phenomenon that takes place due to a wider social system in which the individual is a part of.

In addition, Jones et al. (1984) elaborated on Goffman's (1963) work and added the six dimensions of stigma, namely: the peril, concealable, the origin, disruptiveness, the course of the mark, and aesthetics and correlated those to Goffman's (1963) two types of stigma, which are: discredited stigma and discreditable stigma (Stangle et al., 2019). The first dimension is concealable, which refers to the extent to which others can see the stigma. The second dimension is the course of the mark, which refers to whether the stigma's prominence increases, decreases, or disappears. The third dimension is disruptiveness, which is the degree to which the stigma and/or others' reaction to it impedes social interactions. The fourth dimension is aesthetics which refers to the subset of others' reactions to the stigma comprising reactions that are positive and approving or negative and disapproving. This dimension also represents estimations of qualities other than the stigmatized person's inherent worth or dignity. The fifth dimension is the origin which refers to whether others think the stigma was present at birth, accidental, or deliberate. The final and sixth dimension is the peril which is the danger that others perceive (whether accurately or inaccurately) the stigma to pose to them (Stangle et al., 2019).

Similarly to Campbell et al. (2005), Link and Phelan (2001) emphasized the societal, economical, and political role that power plays in stigmatization. Furthermore, Link and Phelan (2001) proposed a stigmatization model that suggests that stigma exists when specific components are met (Bracke et al., 2019; Link & Phelan, 2001).

Unfortunately, the majority of definitions of stigma do not consider how institutional power effects people. On the other hand, Link and Phelan (2001) examined the ways in which people in society are influenced by the wider societal systems. By including the aspect of power in their definition of stigma, Link and Phelan (2001) proposed a holistic approach of stigma that considers the wider social inequalities.

Additionally, authors Parker and Aggleton (2003) elaborated on Link and Phelan's (2001) ideas of stigma, power, and discrimination and offered a theoretical underpinning of societal inequality to explain the notion of stigma. According to Parker and Aggleton (2003), stigmatization is a societal process that can be understood by examining the influence that

institutional power and domination has on an individual. Parker and Aggleton (2003) further state that stigma is linked to the workings of social inequality. Theorizing stigma in this way highlights the role of power in the process of stigmatization.

For the purposes of this research study, the researcher will adhere to the definitions of stigma outlined by Link and Phelan (2001) and Parker and Aggleton (2003), as these authors note that stigma is linked to the wider system of the economy and linked to social inequality. This definition will be used in order to provide a holistic and inclusive view of HIV-related stigmatization that takes into account social inequality caused by economic and social factors.

2.3.1. Stigma, HIV and the South African context

In the following section, various studies by South African researchers will be iterated highlighting their specific focus.

In a study done by Visser et al. (2009) in South Africa, a third of the participants expressed negative emotions towards people who are HIV positive, and one in five participants admitted to excluding PLWHA. Additionally Visser et al. (2009) found that HIV positive people experienced personal stigma or felt stigma more often than perceived or attributed stigma.

Furthermore, Kalichman and Simbayi (2004) indicated that a small sample of participants associated HIV with witchcraft, and they experienced higher levels of stigma. The epidemic has created a culture of fear whereby people are fearful of PLWHA and being labelled as HIV positive (Masindi, 2004).

Literature on HIV-related stigma in the South African context shows that there is a consensus that stigma is an attribute that discredits the stigmatized groups. The diagnosis of HIV/AIDS intrinsically can be a discrediting attribute, and the beliefs that surround HIV may contribute to this stigmatizing process.

2.3.2. Types of Stigma

In the following section, two types of stigma are highlighted.

In research conducted in South Africa by Masindi (2004), and Herek and Capitanio (1998), the authors identified three types of stigma: the first type of stigma is called *Enacted Stigma*, and the second type of stigma is called *Felt Stigma*. The third type is called *Symbolic Stigma*.

The authors stated that enacted stigma is used to refer to external experiences of stigma which arise out of perceptions of PLWHA as morally defective (Masindi, 2004). Whereas, felt or internal stigma is used to refer to HIV positive individuals having self-shame and thus fearing the stigmatization that they may experience from others (Masindi, 2004). On the other hand, symbolic stigma refers to stigmatization based on religion, morality, and sexuality. Herek and Capitanio (1998) coined the concept of symbolic stigma and it refers to stigma that is based on moral judgments that others make about those who are HIV positive.

2.3.5. HIV-related Stigma and Gender

Studies conducted by Van Hollen (2010) in India showed that women who are HIV positive experience more HIV-related stigma than their male counterparts, and woman who are diagnosed with HIV are often blamed for transmitting the virus to their partners.

Additionally, according to Nkansa-Kyerematen and Attua (2013) females who are HIV positive are more stigmatized than their male counterparts. Furthermore, according to Avert (2019) the majority of PLWHA in South Africa are women. In addition, Avert (2019) states that approximately 20 percent of women acquire HIV as a result of gender based violence (GBV).

2.3.6. HIV-related Stigma and Sexual Orientation

The South African AIDS Council (2011) states that global literature as well as South African literature suggests that Lesbian, gay, bisexual, and transgender, Queer, intersex, Agender and other queer-identifying communities (LGBTQI+) are more prone to be diagnosed with HIV than their heterosexual counterparts.

Furthermore, a study done by Cloete et al. (2008) on HIV and sexual orientation in Cape Town, South Africa, found that men who have sex with women (MSW) as well as men who have sex with men (MSM) who are HIV positive both experience felt stigma.

In addition, Cloete et al. (2008) also discovered that HIV positive MSM experience more stigma than MSW who are HIV positive.

2.3.7. HIV-related Stigma in the Workplace

Studies show that enacted stigma is common in the workplace, internationally as well as nationally (WHO, 2009). Studies done with individuals who are HIV positive demonstrate that those who live with HIV are often threatened with job loss due to being HIV positive (Nkansa-Kyerematen & Attua, 2013).

Furthermore, in an international study done by Liu et al. (2012) quantitative interviews with regards to employing individuals who have HIV were conducted with participants who live in Europe. The study demonstrated that individuals who are HIV positive in these countries experience HIV-related stigma in the workplace due to the fear of contagion and perceived incompetence.

Additionally, research done in Africa by Sprague et al. (2011) found that HIV positive individuals are discriminated against in the workplace due to their HIV status. Participants expressed experiencing being excluded in the workplace due to being HIV positive, and terminations as well as refusals to be hired or promoted, due to their positive HIV status. In addition, studies done in Africa found that HIV positive individuals face stigma in the workplace.

In Zimbabwe, the Stigma index survey done in 2014 illustrated that more than 20.6% of the respondents lost sources of income, and 2.1% were denied employment opportunities because of their HIV status (ZNNP+, 2014). South African employees who are HIV positive are protected against unfair discrimination, such as termination or refusal to hire due to their status, in the Constitution of South Africa (South African Government, 2019).

However, multiple issues, such as the stigmatization of an HIV positive employee, can arise in the workplace despite the policies created to ensure that the rights of PLWHA are protected (Avert, 2019). This makes PLWHA vulnerable in the workplace.

Additionally, in a South African study, it was discovered that in the South African workplace PLWHA experienced felt stigma, and participants reported not applying for certain jobs as the participants expressed being scared of experiencing HIV-related stigma (Masindi, 2004).

In addition, in South Africa a study of stigma experienced by PLWHA in South Africa was conducted by Dos Santos et al. (2014) and findings show that PLWHA experience high amounts of stigma which prevented HIV positive people from accessing treatment and care. In addition, findings show that internalised stigma occurred frequently, as the majority of HIV positive people who took part in the study blamed themselves for contracting HIV.

Another South Africa study by Weihs and Meyer-Weitz (2016) showed that employees choose not to test themselves at their place of work when this option was made available to them, as they are scared of the stigmatization it may bring.

Furthermore, research done by Moalusi (2018) in the Western Cape, South Africa unveiled HIV positive employees' perceptions of HIV-related stigma in the workplace. Findings of the study show that the employees chose not to disclose their HIV status due to the fear of stigmatization (Moalusi, 2018). These studies highlight the importance of researching HIV-related stigma in the workplces of South Africa.

2.3.8. Effects of HIV-related Stigma

Studies show that stigma that is formulated due to being HIV positive creates life threatening barriers, which prevent HIV positive individuals from getting HIV tested and accessing ART (Avert, 2011).

In addition, the UNAIDS (2010) states that stigmatization that is caused by HIV prevents individuals from accessing HIV testing services, ART, as well as psychosocial support which could result in the development of depression and anxiety.

In studies done in South Africa by Mukasa (2008) findings show that stigmatization that is caused by being HIV positive discourages PWLHV to disclose to others that they live with the virus, which results in secrecy and deception.

2.4. Lacunas in the Literature

A review of the literature on stigmatization caused by being HIV positive shows that most literature related to HIV and gender risk for is more prone to acquiring HIV is contradictory and inconsistent. South African researchers showed that women are less likely to get an HIV test than men because of the internalized HIV-related stigma that they experience (Dunn et al., 2009).

However, contrary studies done by Simbayi et al. (2007) in South Africa show that South African men internalize HIV-related stigma more than their female counterparts. Thus research is contradictory with regards to which gender is consistently deterred by HIV-related stigma from using HIV preventative services.

Lastly, there are limited intersectional research studies that compare HIV-related stigma across factors. Therefore, this study will adhere to the theoretical framework of intersectionality in order to provide an intersectional review comparing HIV-related stigma across several variables.

Thus, this qualitative study, utilizing an intersectional lens, explored the perceptions of individuals who have HIV on the prevalence of stigmatization that they experience that is caused by being HIV positive in the workplaces of Johannesburg.

2.5. Theoretical Framework

The research study utilized an intersectional theoretical framework. Intersectionality was coined in 1989 by Kimberlé Crenshaw (Bauer & Scheim, 2019). The feminist theory of intersectionality seeks to analyze how various systems of oppression, which occur due to the wider social system, interact to institutionally disadvantage and benefit certain people

(Kiguwa, 2019). Intersectionality is significant for understanding the experiences of stigmatization that PLWHA (people who live with HIV) face in the place of work probably caused by being HIV positive. The theory takes into account a person's multiple and overlapping identities that may play a role in the degree of stigmatization experienced by the person due to being HIV positive (Bauer & Scheim, 2019; Kiguwa, 2006). Therefore, a person who lives with HIV influences and is influenced by others in society. Stigma may be higher in certain contexts and for certain identities, due to how those identities are perceived in the society that the person is a part of. Every HIV positive individual's experiences of stigma are unique and based on their multiple identities (Gopaldas, 2013). According to Eaves (2017) intersectionality is vague as well as open-ended, and lacks a precise definition which allows the theory to be used in a variety of context. Nevertheless intersectionality is an effective theoretical underpinning for understanding how the participant's various identities, for example race, class, gender, sexuality and age create intersecting experiences of stigma (Eaves, 2017). The researcher therefore took into consideration the multiple identities of a participant, and how these identities influence a participant's experiences to obtain a holistic understanding of the participant's experiences as an employee diagnosed with HIV and experiencing different forms of perceived discrimination because of their disclosed status. In addition, an interpretative approach was utilized for this research study. The interpretative approach focuses on meaning, the subjective understandings, as well as the subjective experiences of individuals and groups (Haradhan, 2018). An interpretative approach is effective in this research study as the approach requires taking individuals' subjective experiences as the essence of their reality (Haradhan, 2018). The approach also involves making meaning of the individuals' perceptions by conversing with participants, listening to what is said, analysing their body language, and utilizing qualitative methods to collect and analyse the information (Haradhan, 2018).

2.6. Conclusion

In summary, this section has provided a critical review of scholars' works theorizing about stigma, as well as a description of the theoretical framework utilized in the study. Furthermore, an inclusive review of research done on the topic, as well as the lacunas in literature was presented. In the next section the methodology and data quality of the research will be presented.

3.1. Chapter 3: Methodology

3.2. Introduction

In the following section the methodology of the research study is presented, including the research questions, research design, a detailed account of the procedure of the study, a description of the sample and sampling process, a review of the data collection instruments, a description of the pilot interview, and lastly an explanation of the data analysis. Additionally, the pilot study considerations related to and reflexivity are discussed. Thereafter, I describe the quality of data and ethical considerations. In the next section the findings of the study are presented.

3.4. Research Questions

3.4.1. The Overarching Question

The overarching research question is: what are HIV positive peoples' perceptions of the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa?

3.4.2. The Subordinate Aims of the Research are as Follows:

- To explore how HIV positive employees perceive the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa and what their meaning-making is around the topic.
- To discover if HIV-related stigma is prevalent in the workplace in 2020.
- To explore how various aspects of an HIV positive person's identity contributes to overlapping stigmas
- To discover what interventions are in place and what policies affected employees feel are needed, and
- To discover if HIV is associated with COVID-19 in the workplace

3.4.3. The Overarching Research Question was informed by the Following Research Questions, namely:

- How do HIV positive employees perceive the prevalence of HIV-related stigma in the workplace?
- Is HIV-related stigma prevalent in the workplace in 2020?
- How do various aspects of an HIV positive person's identity contribute to overlapping stigmas?
- What interventions are in place in the workplace. and how do HIV positive employees perceive HIV-related stigma in the workplace can be reduced?
- Do individuals in the workplace associate HIV with COVID-19?

3.5. Research Design

A research design highlights the steps that the researcher of the study will adhere to in order to gather information, analyse the information that is gathered, and provide an interpretation of the data (Creswell, 1994).

This research study was conducted within a qualitative paradigm that employed an interpretive approach, to ensure a holistic interpretation of the perceptions of people who are HIV positive on the prevalence of stigmatization that is caused by being HIV positive in the workplaces of Johannesburg.

Qualitative approaches are focused on understanding and exploring the ways in which participants perceive their natural environment, as well as the meanings that participants attach to their perceptions (Atkinson et al., 2001). Therefore, the most appropriate approach for this study was the qualitative approach as the aim of this study was to understand the perceptions of people who are HIV positive on the prevalence of stigmatization caused by being HIV positive in the workplaces of Johannesburg.

The researcher chose the qualitative approach because it is flexible and gives the researcher an opportunity to explore the themes that are discovered (Creswell, 2015). Using the

qualitative technique also helped the researcher to semi-structure the interviews and allow the process of data gathering to unfold in a natural setting, thus providing flexibility to gather data in an exploratory manner (Haradhan, 2018). According to Gill (2020).
inductive reasoning begins from a specific conclusion to a conclusion that can be generalized, in contrast deductive reasoning begins from a conclusion that is generalized to a conclusion that is specific (Gill, 2020).

For this study the researcher used inductive reasoning, thus the researcher did not begin with determined themes but rather allowed the natural emergence of themes from the data collected (Haradhan, 2018). In addition, this research study adopted a phenomenological approach so as to acquire a holistic picture of HIV positive participants' perceptions of stigma in the workplaces of Johannesburg, South Africa. According to Gill (2020) phenomenology involves studying perceptions and phenomena, as well as the assigned meaning given to these perceptions and phenomena from the viewpoint of the participant. It is helpful in understanding the participants' personal experiences and meanings attached to them.

3.6. Procedure

Participants were recruited for the study once the research proposal was approved by the Human Research Ethics Committee at the University of the Witwatersrand.

Prerequisites for participation included participants varying in age, race, class, gender, and sexual orientation. Additionally, participants were required to be proficient in English, have access to Skype, Zoom, Microsoft Teams or WhatsApp, and be available for 50 to 60 minutes for an individual interview.

Invitations were sent out on social media to invite people who have HIV and work in Johannesburg, and a snowball strategy was utilized. Thus, everyone who received the invite was asked to forward it to anyone who they knew who was also HIV positive and working in Johannesburg, South Africa.

This method was utilised until a diverse sample was saturated. The researcher scheduled individual, online semi-structured interviews with 2 HIV positive participants separately for

individual pilot interviews. Consent for participation and consent for the interviews to be audio-recorded was granted prior to the interviews taking place. Interviews took place online via Zoom, Skype, Microsoft Teams meeting or WhatsApp, whichever option was more convenient for the participant.

Participants in the pilot interview provided feedback which was used to refine the interview questions. Thereafter, a further 10 participants were interviewed online with the refined interview schedule. All consent forms were read and signed electronically by all participants before their interviews took place.

Participants were interviewed in English and interviews required 50-60 minutes of the participants' time. The researcher recorded the interviews via the researcher's cell phone as well as laptop. During interviews, the researcher had a journal in which participants' non-verbal data was recorded, for example their facial expressions, tone of voice, and upper body language.

In addition, a reflexive journal was kept in order to record the researchers own thoughts, biases and perceptions so that it made the researcher aware of potential biases. After each interview, data was transcribed and coded using thematic analysis.

The researcher informed the participants that the research report will be made available on the Wits wired space should they want to access it.

3.7. Sample and Sampling

Initial participants were identified on social media as the researcher utilised social media as a tool to recruit initial participants. The researcher utilised Facebook, Twitter, as well as Instagram to invite participants to partake in the study. Thereafter, the researcher employed a non-probability snowball sampling method in order to locate appropriate participants for this qualitative research study. Snowball sampling is a process whereby research participants help the researcher to recruit other potential participants for a study by asking potential candidates who they know to partake in the study with them. A non-probability sampling method is utilized when the participants are difficult to locate (Magani et al., 2005).

This strategy was repeated until the needed sample saturation point was reached. In addition, the researcher used the snowball method as participants for this study were challenging to find and the snowball method is useful in locating hard to reach participants (Magani et al., 2005; Sagalnik & Heckathorn, 2004).

A further requirement was that participants needed to be over 18 years of age. The sample size consisted of 12 participants. The population target of this study consisted of HIV positive people who work in Johannesburg, South Africa, and whose workplace was aware that they are HIV positive. Furthermore, the sample needed to be representative of different ages, races, genders, classes and sexual orientations.

The purpose of this was to collect a diverse sample so as to analyze the diverse intersections of power across HIV-related stigma in the workplace and examine if HIV positive people are stigmatized at work. In addition, other inclusion criteria of participants were that they were proficient in English, had internet access for online interviews and the signing of consent forms virtually, and were diverse in sex, age, race, sexual orientation, and class. 2 participants were involved in individual pilot interviews, thereafter the interview schedule was be refined and a further 10 participants were interviewed individually online.

The researcher asked the participants to refer the researcher to other potential participants, and this process was followed until the desired number of participants for the study was achieved. In addition, the researcher informed the participants of the purpose and aim of the research study and individual interviews were arranged with each participant at a time and through an interviewing medium that was most suitable for them.

3.8. Data Collection Instruments

The interview schedule was the main instrument in data collection (Cohen, 2013). The researcher was the secondary instrument in data collection (Wethington, 2015). In qualitative studies, the researcher's role is to collect data that will later be analyzed (Simon, 2011). Therefore, it is important that the researcher discloses any bias and assumptions they might harbour with regards to the study (Simon, 2011).

The researcher should also disclose if their role is emic, namely an insider's role or etic, which is an outsider's role (Simon, 2011). It is useful for the researcher to keep a journal to record their reflections and insights, as this is effective in guarding against any biases from the researcher influencing the study (Simon, 2011).

In addition to the researcher as an instrument, 12 semi-structured online interviews were used as a tool for the collection of data since the researcher intended to gather detailed information regarding the perceptions' of PWLHV on the prevalence of stigmatization in the workplace caused by being HIV positive.

According to Wethington (2015), semi-structured interviews are utilized when researchers only need a single interview with the participants to collect data. This method for collecting data was chosen because the interview questions were structured clearly (Wethington, 2015). Furthermore, this method for collecting data was flexible with regards to the sequence of the questions that were asked by the researcher (Wethington, 2015).

In addition, Wethington (2015) states that interviewees are provided with an opportunity to speak more broadly which allows for the generation of richer data. Additionally, interview questions were formulated prior to the actual interview, which ensured that the researcher was fully prepared for the interview (Wethington, 2015). This approach provided participants with an opportunity to freely express themselves, thus interviews elicited reliable data to be analyzed and compared (Wethington, 2015).

Additionally, utilizing the method of semi-structured interviews allowed the researcher to probe, and this was useful in the case of one line responses from participnts (Greenstein et al., 2003). Furthermore, interviews took approximately 50-60 minutes and were conducted in English.

The interviews were online and individual, and the researcher was able to observe the facial expressions of the participant (Sommer & Sommer, 1997). After consent had been obtained from the participants, the researcher recorded the interviews with a cell phone as well as a laptop.

Additionally, the researcher made field notes of all observations made during the interviews. According to De Vos et al. (2005) field notes help the researcher trace the steps of the interview process and take note of the participant's non-verbal body language (Denscombe, 2003).

Interviews were conducted online via Zoom, Skype, Microsoft Teams or WhatsApp, whichever option was more convenient for the participant, and at a time that was most convenient for the participants. Furthermore, participants were refunded for the data used in the duration of the interview. However, this was not to be used to coerce the participants.

3.9. Pilot Study

The researcher used a pilot study to determine whether interview questions could be understood or needed to be re-worded or modified, and to determine if the interview schedule elicited valuable data.

According to Mitchell and Jolley (2001), a pilot study is used to determine whether the interview schedule produces data of value. In addition, a pilot study is utilized to refine the study and to test for problems that are unanticipated which could be encountered by the researcher in the actual study (Mitchell & Jolley, 2001).

Pilot studies help researchers to iron out any difficulties prior to the main study. Additionally, according to De Vos et al. (2005), a pilot study is valuable because it enables researchers to: evaluate the study by scrutinizing the feasibility of the interview schedule, test and adapt the measuring instruments, assess if the sample of the study is correct, estimate the length of the interview, and ensure the involvement of the researcher. Furthermore, according to De Vos et al. (2005) a pilot study provides the researcher with a warning of where methods for collecting or analysing data are not appropriate.

Additionally, the researcher kept a reflexive journal and a record of any field notes, insights, assumptions, or reflections made during the process of data collection, so as to prevent the researcher's bias from having an influence on the study (De Vos et al., 2005).

After the first pilot interview it became apparent that the first interview question was too deep for the first question. The researcher had to re-arrange the questions starting from lighter, easier to answer questions, to the deeper and challenging questions. This helped to serve as a warm-up to the questions that were more sensitive and difficult to answer, enabling the participants to feel more at ease and comfortable to discuss challenging topics.

After the second pilot interview the researcher noted that a question needed to be re-worded as it was difficult to understand. The question was rephrased and shortened to make it more understandable.

3.10. Data Analysis

According to Babbie (2007) analyzing qualitative research involves the interpretation of the collected data, and gaining an understanding of the meaning of the data. Additionally, according to Babbie and Mouton (2001) analyzing qualitative data involves dividing parts of the collected data into whole themes to examine the connections between concepts and to see whether there are any patterns.

The goal of the researcher was to bring order and meaning to the qualitative data gathered from the interviews (Greenstein et al., 2003). Thus, for this particular study, thematic content analysis was utilized to analyse data.

The process of thematic analysis is utilised in qualitative studies, and is a process whereby themes as well as patterns are identified for the purpose of further systematic interpretations of research data (Marshall & Rossman, 1998).

Van Manen (1990) additionally states that there are three thematic approaches to the process of analysing data. The first approach involves a holistic reading approach, whereby the researcher formulates a single sentence which constitutes the entire meaning in relation to the research question. The second approach involves reading the data collected line-by-line and in detail, whereby the researcher is required to look at each sentence and understand its meaning in relation to the research question (Van Manen, 1990). The final approach is the selective reading approach, and in this approach the researcher is required to read the text

several times and to look for statements, words or phrases that seem to provide information about the phenomenon in the research study (Van Manen, 1990).

The current study utilized the selective reading approach, because the selective reading approach permitted the researcher to organise the data into categories and then search for patterns and links between the categories as the themes arose from the text (Van Manen, 1990).

The advantage of this approach was that it is flexible and easy to use for those who are new to research, and the disadvantage of using this approach is that researchers will often try to force the excerpts into themes that the researcher already has in mind rather than allowing the themes to arise naturally from the interviews (Van Manen, 1990). However, the awareness of this disadvantage helped the researcher to guard against this shortcoming.

Additionally, the researcher immersed themselves into the interview transcripts, and by not forcing themes and categories, the latter was free to emerge on their own (Charmaz, 2003).

The process of thematic analysis involves five stages according to Braun and Clarke (2006):

3.10.1. The 5 Stages of Thematic Analysis

Stage 1: In this stage the researcher arranged the data and this involved the transformation of the recorded interviews into a written transcript by means of transcribing.

Stage 2: This stage involved choosing a unit (a word, sentence, paragraph, phrase, whole text or theme).

Stage 3: This stage involved coding schemes.

Stage 4: This stage involved discovering categories.

Stage 5: The final stage of thematic analysis involved drawing conclusions, making inferences as well as drawing meaning from the themes and categories that were generated.

3.11. Data Quality

In this section data quality, including trustworthiness and the four criteria of trustworthiness, which are: credibility, dependability, conformability and transferability will be discussed. Thereafter, ethical considerations will be illuminated in the next section.

According to Koch and Harrington (1998) qualitative research adheres to multiple standards of quality, known as trustworthiness, validity, rigor or credibility. According to Matusov et al (2019) these terms rely on a positivist conception of research, which describes a study of how society operates which relies on scientific evidence, for instance statistics and experiments. For data to be beneficial it needs to be of a high quality (Koch & Harrington, 1998). If the data is of a low quality, it can produce inaccurate results; on the other hand the more accurate the data is, the more information can be derived from the data (Koch & Harrington, 1998).

3.1.2. Trustworthiness

According to Lincoln and Guba (1985) when trustworthiness of the data is established, it ensures reliability and validity. The trustworthiness of this data was increased by making use of the four aspects of trustworthiness proposed by Lincoln and Guba (1985), which are: credibility, dependability, confirmability and transferability.

3.1.3. Credibility

Credibility is a facet of trustworthiness and involves the researcher's credence in the validity of the collected data and the findings that the researcher has made from them (Mertens, 1998). Additionally, in this research study the credibility was emphasized by encouraging participants to remain open with regards to the sharing of information. Furthermore, the credibility of the study was enhanced by the pilot interview, and by comparing and analysing the data received from the 10 interviews with one another.

3.1.4. Dependability

Dependability is a term that is used to define the extent in which the readers can be convinced that the interpretations occurred exactly as the researcher states that they did (Lincoln & Guba, 1985). To ensure the dependability of the study, the researcher made use of an audit trail. Lincoln and Guba (1985) state that an audit trail enhances dependability and involves a description of the research steps that the researcher will take from the onset of the research study to the end of the research study.

3.1.5. Confirmability

Confirmability ensures that the collected data and their findings were created by the researcher in a neutral manner and not forced (De Vos, 1990). Confirmability was enhanced in this study due to the raw data that was available on the audio-recorder and the availability of the transcripts to show validity of the themes. Furthermore, the 12 interviews with the participants were recorded to capture their perceptions verbatim. Therefore, when the data was analysed the facts were captured.

3.1.6. Transferability

According to Kelly (2006) transferability refers to the extent to which interpretations from the collected data can be applied to a similar study. To ensure transferability of the study verbatim quotations were taken from the interviews, and a detailed review of the context of the research study was provided (Kelly, 2006). In addition, a detailed description of the research methodology provides sufficient information for the study to be replicated in a context that is similar to the original study (Kelly, 2006).

In summary, in this section data quality, including trustworthiness and the four aspects of trustworthiness, which are: transferability, dependability, credibility, and conformability were discussed. In the next section the ethical deliberations will be discussed.

4.1. Ethical Considerations

In this section the ethical considerations will be presented. Ethics are defined as rules of the research process which stipulate the researcher's behaviour towards the participants. The participants that were involved in this study are a part of the vulnerable category of people as they are HIV positive (WHO, 2011). Therefore, the researcher was cognisant of this fact and the researcher ensured that the participants' rights were protected throughout the duration of this study.

4.1.1. Informed Consent

Informed consent is obtained from participants who give their permission to take part in the study willingly without any coercion taking place (Kaewkungwal, 2019). The researcher collected the signed consent forms from participants before conducting the study (See Appendix).

Furthermore, the informed consent was in a language and format that the participants could understand, and the informed consent clarified that taking part in the study was voluntary and not participating would not negatively influence the participants (Lemon & Hayes, 2020).

Additionally, the researcher ensured that participants knew that non-participation would have no adverse consequences. In addition, the participants were made aware that data collected in the study would only be utilized for the purposes of the study, and that an audio-recorder would be used during the interview process (Kaewkungwal, 2019).

In addition, participants were made aware that the data collected from this research project would be stored on a password protected computer for research purposes only, and the full research report would be available on the Wits website or wired space upon the candidate's completion of the degree.

Furthermore, participants were made aware that there were no benefits to participation and there were no costs, as participants were reimbursed for data usage. In addition, the researcher informed participants that results derived from the research study could be presented at conferences and could be written up in a publication.

Consent forms and participation information sheets detailing the nature of the research, their rights and role were provided. A disclaimer was provided at the beginning of the interview stating that the topic is a sensitive one. Data collected from the research was locked away and kept where nobody had access to it, as the information is sensitive. The researcher had referral contact details of free counselling services, who specialise in HIV counselling services, that participants could have required after the interview to further explore this topic, however none of the participants made a request for counselling services.

4.1.2. Confidentiality and Anonymity

Confidentiality creates an atmosphere of trust during the research process, which allows the participant to be more open about themselves, and enables the researcher to uncover subjective truths, as pertains to this specific research study (Lemon & Hayes, 2020). The researcher did not disclose the participants' identities. Furthermore, the participants remained anonymous and pseudonyms were used to protect their privacy.

Additionally, the consent forms are only be available to the researcher and the researcher's supervisor, and the forms are locked in a cupboard to protect the participants' privacy (Kaewkungwal, 2019). Furthermore, participants were told that the research report will be available upon the candidate's completion of the degree on Wits Wired Space, and that participants can request a summary of research results upon completion of the study.

4.1.3. Autonomy

The researcher notified participants about the purpose of the study. Furthermore, the participants were informed about what the research study is about, and the requirements of the participants', including the approximate time the interview is expected to take (Resnik, 2015). Participants were notified that they can withdraw from the study at any time with no adverse consequences (Kaewkungwal, 2019). The researcher ensured that participants were fully aware of the nature and purpose of the research so that they willingly participated with an awareness of the risks and benefits.

4.1.4. Beneficence / non-maleficence

The researcher was obligated to do good, and not harm the researcher participants under any circumstances (Kaewkungwal, 2019). Therefore, the researcher ensured that the participants were not harmed in the process of this study by breaching confidentiality.

4.1.5. Justice

The principle of justice is conceptualized as fairness in the context of research, thus research participants were treated fairly, and the researcher ensured that participants were fully aware of the natue of the study, and participated voluntarily (Kaewkungwal, 2019).

4.1.6. Recording

The participants were notified that their interview was being recorded, and that they had the freedom to stop the recordings if it made them feel uncomfortable. Participants could choose whether they wanted to answer certain questions or not, and could disengage from the study at any time if they felt uncomfortable.

4.2. Reflexivity

Researcher reflexivity is a process whereby the researcher acknowledges that their actions as well as their decisions have an impact on the meaning and context of the data (Braun & Clarke, 2021; Kleinsasser, 2000). Thus, the researcher acknowledged the fact that their own ideas and beliefs may influence the study.

Additionally, in accordance with an interpretive perspective, the researcher acknowledged that the findings of this study were open to other potentially equal and valid findings. Furthermore, the researcher conducted the interviews with an open mind and attempted to maintain a neutral, unbiased position throughout the research process. The researcher acknowledged the sensitivities that participants may have developed through personal experiences of HIV/AIDS and took into consideration the possibility of certain biases that the researcher may have towards HIV.

Furthermore, the researcher acknowledged the need to be aware of these sensitivities and biases that could have arisen in the process of completing this research, because it could influence the data collection and analysis process. Therefore, the researcher managed their personal biases with the use of supervision as well as by keeping a reflexive journal where any thoughts and feelings that arose from the process of this study was recorded. Additionally, the researcher constantly practiced reflectivity of their feelings, beliefs, and values so that these did not influence the study (Braun & Clarke, 2021)

4.4. Conclusion

In conclusion, this chapter has presented the methodology of the research study, including the research design, a detailed account of the procedure of the study, a description of the sample and sampling process, a review of the data collection instruments, a description of the pilot interview, and lastly an explanation of the data analysis. Thereafter, the quality of data and ethical considerations were discussed. In addition, the pilot study and issues related to reflexivity were presented. The next chapter presents the findings of the study.

4.1. Chapter 4: Results

4.2. Introduction

In this chapter, the results arepresented. The findings illustrated in this chapter are based on the overarching question and sub-questions, as well as the aims and objectives of the study. The overarching research question was: what are HIV positive peoples' perceptions of the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa?

The sub-questions of the study were: How do HIV positive employees perceive the prevalence of HIV-related stigma in the workplace? Is HIV-related stigma prevalent in the workplace in 2020? How do various aspects of an HIV positive person's identity contribute to overlapping stigmas? What interventions are in place in the workplace and how do HIV positive employees perceive HIV-related stigma in the workplace can be reduced? Do individuals in the workplace associate HIV with COVID-19?

The overarching aim of this study was to explore what the perceptions of people living with HIV/AIDS are with regards to the prevalence of HIV-related stigma in the workplace. The subordinate aims of the research were to explore how HIV positive employees perceive the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa and what their meaning-making is around the topic, to discover if HIV-related stigma is prevalent in the workplace in 2020, to explore how various aspects of an HIV positive person's identity contributes to overlapping stigmas, to discover what interventions are in place and what policies affected employees feel are needed, and to discover if HIV is associated with COVID-19 in the workplace.

To meet the aims of the study 12 participants were interviewed utilising semi-structured interviews. 2 participants were interviewed utilising a pilot interview in order to determine whether interview questions could be understood or needed to be re-worded or modified, and to determine if the interview schedule elicited valuable data. A qualitative approach was utilised, as well as an interpretive approach. The study utilized an intersectional lens, and the findings were analysed using thematic analysis.

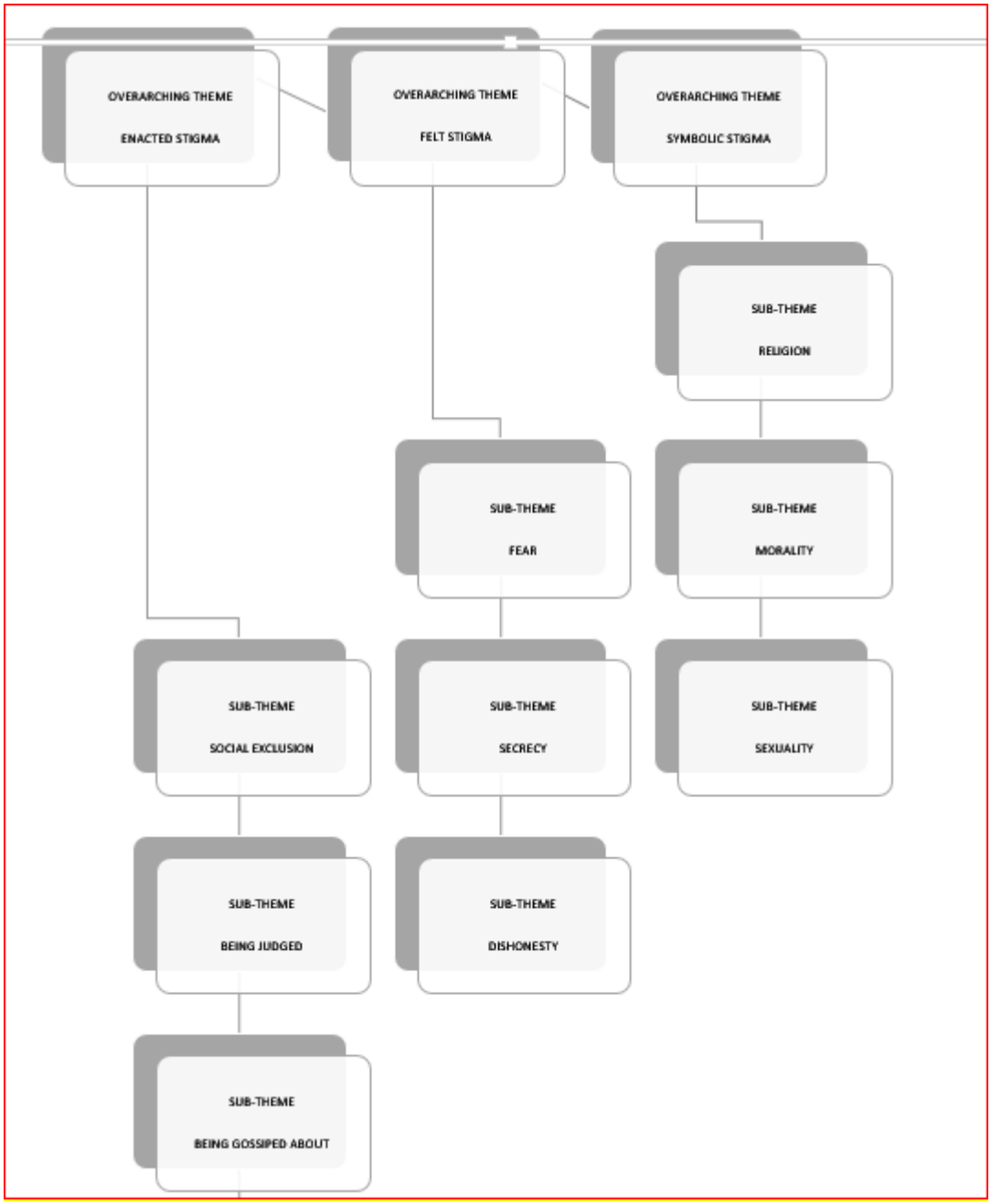
3 overarching main themes emerged from the data: *Enacted stigma*, *Felt stigma* and *Symbolic Stigma*. 7 sub-themes emerged from Enacted Stigma: social exclusion, being judged, being gossiped about, refusing to eat food prepared by HIV positive employees, refusal to participate in contact-based activities with HIV positive employees, friendship losses, job exclusions and loss of opportunities. In addition, 6 sub-subordinate themes emerged from enacted stigma, namely: *Insufficient HIV-related interventions at work, COVID-19 and HIV, Forced disclosure, Gender* and lastly, *MSM and HIV*. 3 subordinate themes emerged from Symbolic Stigma, namely: *Religion, Morality and Sexuality*. Additionally, 3 subordinate themes emerged from felt stigma, namely: *Fear, Secrecy and Dishonesty*.

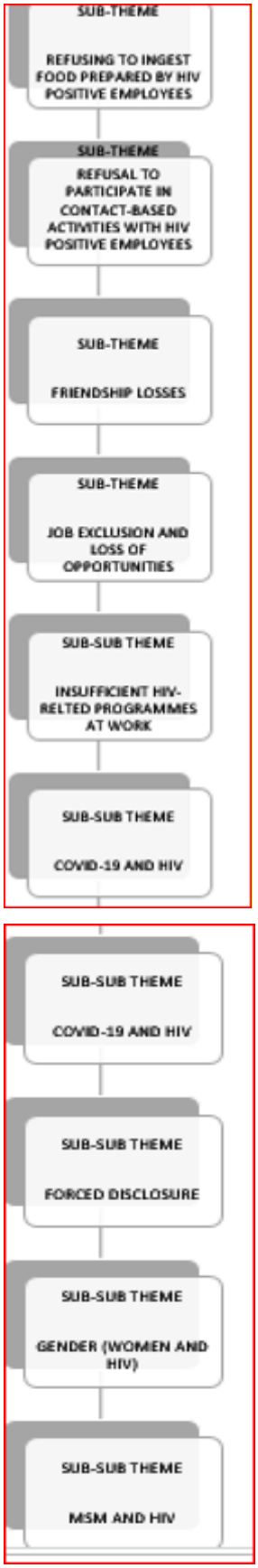
4.3. A Table Illustrating the Demographic Data of the Participants' (Appendix A)

Participant	Demographic Data						
	Age	Race	Socio-economic Status	Gender	Sexual orientation	Nationality	Disabilities
Participant 1	40	Indian	Middle Class	Female	Straight	South African	Yes
Participant two	32	White	Middle Class	Female	Straight	South African	No
Participant three	30	Black	Middle Class	Male	Gay MSM	South African	No
Participant four	25	Black	Lower Class	Male	Straight	South African	No
Participant five	22	Black	Middle Class	Male	Gay MSM	South African	No
Participant six	55	Black	Upper Class	Male	Bi-sexual	South African	No
Participant seven	34	White	Middle Class	Female	Gay MSM	South African	No
Participant eight	25	Indian	Middle Class	Male	Gay MSM	South African	No
Participant nine	59	White	Middle Class	Transgender Women	A transgender women who is attracted	South African	Yes

					to other lesbian or transgender women.		
Participant 10	33	Coloured	Middle Class	Male	Straight	South African	No
Participant 11	20	Coloured	Middle Class	Female	Straight	South African	No
Participant 12	46	Black	Upper Class	female	Lesbian	South African	No

4.3. A Diagrram of the Themes (Appendix B)




SUB-THEME
REFUSING TO INGEST FOOD PREPARED BY HIV POSITIVE EMPLOYEES
SUB-THEME
REFUSAL TO PARTICIPATE IN CONTACT-BASED ACTIVITIES WITH HIV POSITIVE EMPLOYEES
SUB-THEME
FRIENDSHIP LOSSES
SUB-THEME
JOB EXCLUSION AND LOSS OF OPPORTUNITIES
SUB-SUB THEME
INSUFFICIENT HIV-RELTED PROGRAMMES AT WORK
SUB-SUB THEME
COVID-19 AND HIV

SUB-SUB THEME
COVID-19 AND HIV
SUB-SUB THEME
FORCED DISCLOSURE
SUB-SUB THEME
GENDER (WOMEN AND HIV)
SUB-SUB THEME
MSM AND HIV

These themes are discussed in the following chapter, and illustrated with verbatim quotations from the participants. In order to protect the identity of the participants their real names were not used, and each participant was given a pseudonym. Enacted Stigma was a dominant theme in this study.

4.4. Enacted Stigma

According to Nkansa-Kyerematen and Attua (2013), HIV-related enacted stigma refers to stigma that stems from other individuals in a society and is directed towards the HIV positive person. All of the participants experienced enacted stigmatization in the workplace which manifested in being socially excluded, excluded in job opportunities, judged as sexually irresponsible, being gossiped about, discriminated against, experiencing losses of friendships in the workplace.

4.4.1. Social Exclusion

Some participants expressed being excluded and left out of certain activities due to being HIV positive. Partici one(female, 40) and participant nine (male, 59) describes being excluded from certain conversations by fellow colleagues due to being HIV positive. Participant nine said:

"Well the guys were planning a party, and decided to exclude me because they assumed that I would not be interested in the party. I don't buy this. Ever since they found out about my HIV positive status they have been weird with me. Before this, they would invite me to everything. They only exclude me now, since they know about my HIV positive status." (male, 59)

4.4.2. Job Exclusion

In addition, some participants perceived to have experienced job exclusions due to the fact that they are HIV positive. Participant six (male, 55) reports being excluded from a job opportunity because his perception is that his employer perceives him as weaker than his HIV negative colleagues. The following extract highlights his sentiments:

"One time my boss got a big job, and there was going to be a big payment of money, but he only chose certain people for the job. I was left out because of my HIV status, and I was told no they only want the strong people. So they think because now I have HIV I am not strong, you see." (male, 55)

4.4.3. Being Judged

Participant four (male, 25) expressed being harshly and negatively judged by his fellow co-workers as being a sexually irresponsible individual due to being HIV positive. He iterated the following:

"When my work colleagues told me that most HIV positive people got HIV from being sexually irresponsible knowing I have HIV I felt hurt. They automatically assume that you did something to get the virus, therefore it is your fault." (male, 25)

4.4.4. *Being Gossiped About*

Participant 12 (female, 46) expressed experiencing being gossiped about regarding her HIV status. She highlighted a time she walked in on two colleagues bad-mouthing her in the bathroom. She remarked:

"One time I went to the bathroom, and while in the cubicle I could hear two women that I work with gossiping about me. They were saying that I was probably having unprotected sex, and a lot of other things that aren't true." (female, 46)

4.4.5. Refusing to Ingest Food Made by the HIV Positive Employees

Some participants were discriminated by their fellow co-workers as they refused to ingest food that was prepared by the participant. Participant two (female, 32) discussed experiencing stigmatization from colleagues at an end of year work function, as certain individuals refused to ingest the food that the participant had prepared simply because of her HIV status. She states:

"There was an end of year work function, and we were all told to cook a traditional meal for our colleagues. I made a chicken soup. Some people ate my food but some refused to. I found out from a colleague that they had found out that I was HIV positive through my Facebook posts and decided that they would get HIV if they ate my food." (female, 32)

4.4.6. Refusal to Participate in Contact-Based Activities with HIV Positive Employees

Additionally, participant seven (female, 37) described being stigmatized against during a team-building exercise. Colleagues who were ill informed on HIV refused to complete group or contact-based activities with the HIV positive participant as they were concerned about contracting HIV from the participants spit. She posited:

"There was a time when we were at a team building workshop and had to complete certain activities. One of the activities was dunking your head in a bucket to grab as many apples as you can using only your teeth. I noticed how some people did not want to participate after me, and asked if they can get any viruses from spit." (female, 37)

4.4.7. Friendship Losses

Furthermore, some participants lost friendships due to their HIV positive status. Participant three (male, 30) experienced friendship losses once his colleagues found out about his positive HIV status. He said:

"I felt unfairly treated in the workplace when I began losing friendships with people after they found out about my HIV status." (male, 30)

In this section the overarching theme Enacted Stigma was discussed. The 7 sub-themes of enacted stigma were also discussed. Namely*; Social Exclusion, Job Exclusion, being judged, Being Gossiped About, Refusing to Ingest Food made by HIV positive employees, Refusal to take part in Contact-Based activities with HIV positive employees, and Friendship Losses*. In the next section the sub-sub themes of enacted stigma will be discussed. Namely; *Insufficient HIV-related interventions at work, COVID-19 and HIV, Forced disclosure, Gender* and lastly, *MSM and HIV*.

4.4.8. Insufficient HIV-related Interventions at Work

Most of the participants said that their workplaces do not have adequate and sufficient HIV-related interventions at work. They indicated that there is a lack of programmes that offer support and assistance to HIV positive staff members. Additionally, there also seems to be a limited number of programmes that create HIV-related awareness in the workplace.

Participant 11 (female, 20), participant three (male, 30), participant nine (male, 59), and participant four (male, 25) stated that at their workplaces there are no programmes that promote HIV-related awareness. Participant four (male, 25) suggested that his workplace introduce an anonymous complaints department for HIV positive staff members who experience stigmatization and discrimination and want to submit complains related to HIV-related stigmatization, as there is currently no place for HIV positive employers to complain about HIV-related stigma. He said:

"My workplace needs an anonymous complaints department for those of us who are HIV positive and are experiencing discrimination. We do not have anywhere to go. If we have an issue with regard to discrimination and HIV-related stigma there is nowhere to go." (male, 25)

Participant six (male, 55), participant seven (female, 34), and partici one (female, 40) similarly stated that there are no sufficient HIV-related support programmes for staff members who are HIV positive. Partici one(female, 40) said that workplaces need more

wellness programmes that support HIV positive staff members in the form of funds to assist with medical fees. She posited:

"They [HIV-related work-based programmes] are not sufficient to support people with HIV. We need more support in the form of wellness programmes and HIV funds where the company assists with medical fees." (female, 40)

Similarly, participant eight (male, 25) stated that there are no support programmes for HIV positive staff members at his place of work, however he stated that it is vital that HIV-related support programmes are introduced to the workplace, in order to ensure an inclusive and supportive work environment for all staff members. Additionally, participant eight (male, 25) states that the introduction of HIV-related awareness programmes in the workplace would promote tolerance, and HIV positive employees would experience less negativity due to their HIV status. She remarked:

"If we received some support, we would feel more included in the workplace. There is sadly no HIV awareness programmes at my work and it's sad. I really think if we had those programmes, there would be less negative attitudes towards me." (male, 25)

In this section the sub-sub theme of Enacted Stigma, Insufficient HIV-related interventions at work, was discussed. In the next section the sub-sub theme of Enacted Stigma, COVID-19 and HIV, will be discussed.

4.4.9. COVID-19 and HIV

Participants expressed being fearful of the possible connotation between COVID-19 and HIV. The participants stated that the stigmatization that they experience due to being HIV positive is multiplied due to the global pandemic of COVID-19, as employers view the participants as high-risk employees who are at a greater risk of contracting COVID-19 due to their compromised immune-system.

This assumption results in employers and colleagues treating HIV positive participants as vulnerable, fragile, and weaker than HIV negative employers. The assumption that HIV positive employers are at a high-risk of contracting COVID-19 resulted in the participants losing out on work opportunities, and being treated differently than HIV negative employers. This caused the participants to feel stigmatized against due to their HIV status.

Participant two (female, 32) stated that she is fearful of the link between COVID-19 and HIV and the added stigmatisation caused by this link, because research confirms that those with compromised health are at a greater risk of contracting COVID-19. Due to the fact that those with HIV are at a higher risk of contracting COVID-19 she states that people will begin to associate HIV with death. She said:

*"…research shows that those who have HIV are more at risk of COVID-19 than those who do not have HIV…people will associate HIV with death." (*female, 32)

Additionally, participant three (male, 30) stated that his employer and colleagues treated him as though he was more fragile than HIV negative employers, and less competent due to his condition. This negative perception of the participant resulted in the workplace giving him less responsibilities than the HIV negative employers. He posited:

"…people will think that I have a higher chance of getting COVID-19 simply because I am HIV positive, so they might discriminate against me…They do at times treat me like I am more fragile and less competent. I began to notice this when I found out that they give other colleagues more responsibilities than myself." (male, 30)

Participant four (male, 25) said that colleagues treat him like he will be the first to contract COVID-19 due to his positive HIV status. Participant four reported that his colleagues

question him on whether he is worried about contracting COVID-19 because he is HIV positive. He said:

"…people have already began asking me if I am worried that I will get COVID-19 because of my HIV status. They treat me as though I will be the first to get COVID-19 just because I am HIV positive." (male, 25)

Participant eight (male, 25) mentioned being terrified of people assuming that he has a greater risk of contracting COVID-19 than HIV negative employers. He stated that he does not want people to view him as dangerous to be around or view him as a COVID-19 carrier. He said that he now experiences a double stigmatization from being HIV positive, and from the assumption that HIV positive people are potential COVID-19 carriers who have a higher risk of contracting COVID-19, and infecting others with COVID-19, than HIV negative people. He remarked:

"I am terrified that people will associate HIV with getting COVID-19 easier. People may assume that since I am HIV positive, I have a higher chance of getting COVID-19 and also affecting others. I just don't want people to see me as a walking ticking time bomb, ready to infect everyone at any time. It is the added burden of a double stigmatization that I now have to carry." (male, 25)

According to participant nine (male, 59) his employer treats him differently compared to the treatment of HIV negative colleagues. According to participant nine (male, 59) his perception is that his employer asks him how he is more often than HIV negative employers are asked how they are. Although the participants employer means well, the difference in treatment results in the participant feeling discriminated against. He posited:

"Yes they do. Like my boss asks me how I am more than others, and although it seems nice, when it is done in front of others it makes you feel like a burden. Like the sick one. The one who is different. I am just tired of being treated like I am different." (male, 59)

In this section the sub-sub theme of Enacted Stigma, COVID-19 and HIV, was discussed. In the next section the sub-sub theme of Enacted Stigma, Forced Disclosure, will be discussed.

4.4.10. Forced Disclosure

Some participants reiterated feeling being put in a situation where they felt forced to disclose their HIV status to the workplace. After the pandemic of COVID-19, many workplaces requested employees to formally disclose any underlying conditions that they may have in order to take the necessary precautions to protect them from contracting COVID-19. This process has been anxiety-provoking for many of the participants, and they describe the experience as a forced disclosure of their HIV status.

Participant three (male, 30) and partici one(female, 40) described feeling conflicted about disclosing her HIV status to her workplace. If partici onedid not disclose her HIV status she would have been at a health risk going to work. However, by disclosing her HIV status she could be opening herself to stigmatization and a state of vulnerability. Vulnerability includes experiencing discomfort, possible discrimination, and a state of unreadiness. She said:

"I feel forced to disclose my status in order to protect my health. If I do not disclose my status then I will have to go to work, but if I disclose my status I will be singled out as someone who is vulnerable." (female, 40)

Similarly, participant nine (male, 59) described the pandemic of COVID-19 as an unforeseen event that forced his hand to disclose his HIV status to the workplace. Since disclosing, his colleagues have been treating him differently. Had it not been for the current climate of COVID-19 he would have chosen not to disclose his HIV status to the workplace. He said*:*

"I almost feel like I was forced to out myself and disclose, because if I didn't then I would have to be at work and risk my health. So in order to stay safe, I feel like I had to disclose

even though I did not want to. This is where all the problems started. Before this nobody knew about my HIV status, now everyone knows and treats me differently than before. This whole pandemic has literally forced my hand." (male, 59)

In this section the sub-sub theme of Enacted Stigma, Forced Disclosure, was discussed. In the next section the sub-sub theme of Enacted Stigma, Gender (Women and HIV), will be discussed.

4.4.11. Gender (women and HIV)

Some female participants described societal punitive action and blaming due to their HIV status. The participants reiterated that society members viewed them as promiscuous, sexual, sexually irresponsible, and unfaithful upon learning about their positive HIV status.

Partici one(female, 40) stated that she felt like she is blamed for being HIV positive by members of society because she is a women. She reiterated that women who are HIV positive are judged as promiscuous and blamed for their condition, whereas men are treated with more understanding and sympathy. She said:

"I feel like as a women with HIV I am blamed for my HIV positive status, because people view me as a fast women, and someone who is loose. I hear people being more sympathetic to men who have HIV, even if he is promiscuous. But a women is always to blame. I am used to it now." (female, 40)

Participant 11 (female, 20) described being treated in a highly sexualized manner by men when they found out about her HIV status. She was perceived and stigmatized as highly sexual and easy, thus many conversations with men took on a sexual tone. She described women as being judgmental of her, as they stigmatized her as sexually irresponsible and blamed her for being HIV positive. She remarked:

"They judge me for having HIV. They view me as a sexually promiscuous person. I have experienced people talking negatively about me, spreading rumours about me, and judging me before knowing me. I am not supported as a HIV positive female." (female, 20)

In this section the sub-sub theme of Enacted Stigma, Gender (Women and HIV), was discussed. In the next section the sub-sub theme of Enacted Stigma, MSM (Men who have sex with other men and HIV), will be discussed.

4.4.12. Msm (Men Who Have Sex with Other Men) and HIV

Some participants who are gay MSM (men who sleep with other men) reiterated that society members were less sympathetic towards them upon finding out their HIV status, due to their sexual orientation. Participants stated that society members stigmatized gay MSM (men who sleep with other men) as sexually deviant and irresponsible, and associated homosexuality with HIV.

Participant three (male, 30) expressed that there is added stigmatization when one is gay as well as HIV positive. He stated that HIV gay MSM (men who sleep with other men) are blamed for their condition simply because of their lifestyle. Due to their sexuality members of society put the blame on them for contracting the life-threatening virus. However, he stated that in his experience society is more sympathetic towards straight men who sleep with women. He said:

"I believe that being gay and having HIV on top of that makes it 100 times as worse, with regard to stigma. The stigma is worse for MSM because they blame us for getting infected. It is almost like a given that you will get HIV if you are gay. I think people look at me like I deserved to contract HIV. If a straight guy gets HIV, then people say it's probably because he slept with a hoe, but if it's a gay guy who gets HIV then it was just a matter of time." (male, 30)

Similarly, participant four (male, 25) expressed that society views homosexuality as the root and cause of HIV. He reiterated that people tend to blame his positive HIV status on his sexuality, and stigmatize him as being irresponsible and promiscuous. He stated:

"I find that when people find out that I am gay and HIV they seem to place the blame of my HIV status on my sexuality. I am blamed for getting HIV simply because I am gay. I am a MSM and I think that we get the most heat for being HIV positive than any other group. People just automatically assume that I was irresponsible and promiscuous. They view gayness as the root and cause of HIV." (male, 25)

Participant eight (male, 25) expressed being fed up of colleagues gossiping about him, and associating HIV with homosexuality. He reiterated that being HIV positive as a gay MSM (man who sleeps with other men) is challenging because he is blamed for his condition. On the other hand, straight men who are HIV positive receive more sympathy and understanding. He remarked:

"People always assume that all gay men have HIV and so it is a norm. Nobody is sad for you or feels bad for you. It is seen as your fault for participating in haram sexual practices. When a straight guy tells people he is HIV positive, then the whole world is sympathetic. Straight men aren't supposed to get HIV. It must be the women's fault right? Straight men are never to blame." (male, 25)

In this section the sub-sub themes of Enacted Stigma were discussed. Namely; *Insufficient HIV-related interventions at work*, *COVID-19 and HIV*, *Forced disclosure*, *Gender* and lastly, *MSM and HIV*. In the next section the overarching theme Symbolic Stigma will be discussed, as well as the sub-themes of Symbolic Stigma. Namely; Religion, Morality and Sexuality.

4.5. Symbolic Stigma

Symbolic stigma refers to stigmatization based on religion, morality, and sexuality. Herek and Capitanio (1998) coined the concept of symbolic stigma and it refers to stigma that is based on moral judgments that others make about those who are HIV positive.

Some of the participants reiterated feeling judged by co-workers as immoral and sexually irresponsible because they are HIV positive. In addition, participants who are gay MSM (men who sleep with other men) expressed being positioned by those who are religious as sinners who are being punished by a higher power.

4.5.1. Religion

Participant eight (male, 25) and participant three (male, 30) stated that in his experience colleagues at work judge him for being gay, and cite religion and cite religion as a reason for their critiques of his lifestyle, as homosexuality is perceived as going against the fundamental values of certain religions. He posited:

"I feel that the fact that I am gay and HIV people tend to think that I somehow deserve to die of HIV. People at my work are always like how can I be gay when God created man and women? They try and ask it as a joke and they smile at me, but they are actually telling me that they think I am sinning and going against the will of God." (male, 30)

4.5.2. Morality

Similarly, Participant eight (male, 25) described his experience of being stigmatized as an immoral sinner who is being punished by God for transgressing. He stated:

"I work around a lot of cig-gendered men, and they are aware that I am HIV positive and gay. So sometimes I notice the negative way that they gossip about the gay community. They often bring a religious perspective to the conversation, and say that it is sinful. They also say that HIV is a punishment from God to all the sinful and immoral gays. "

(male, 25)

4.5.2. Sexuality

Likewise, participant four (male, 25) reiterated experiencing being blamed for being HIV positive and judged for being sexually irresponsible. He said:

"People I work with tend to associate HIV with being a bad human being. They believe that it is caused by being sexually irresponsible, and place the blame of being HIV positive on the victim. People speak about HIV as though it is a punishment for being immoral." (male, 25)

In this section the overarching theme Symbolic Stigma was discussed, as well as the sub-themes of Symbolic Stigma – Religion, Morality and Sexuality. In the next section the overarching theme Felt Stigma will be discussed. Additionally, the sub-themes of Felt Stigma will be discussed. Namely; Fear, Secrecy and Dishonesty.

4.6. Felt Stigma

Felt stigma refers to stigma that stems from the self, and is directed towards oneself through the act of self-stigmatization (Nkansa-Kyerematen & Attua, 2013). Most of the participants experienced felt stigma in the form of being fearful of potentially being stigmatized against because of their HIV status. Many participants self-stigmatized as well as self-rejected due to the fear of stigmatization. Participants began to internalise the stigma and view themselves as the Other, through the eyes of the oppressive and judgmental society, and self-judge.

4.6.1. Fear

The participants in the study reported feeling scared to disclose their HIV positive status to their co-workers, due to the anticipated judgment that they believed they would receive. Participants feared being judged as the other by fellow work colleagues due to being HIV positive.

Participant seven (female, 34), and partici one(female, 40) stated that she was fearful to disclose her HIV status to her workplace because she assumed that if people knew the truth they would judge her harshly. She said:

"I was afraid to let people know that I have HIV during the first 2 years of my employment because I assumed that people would judge me." (female, 40)

Similarly, participant seven (female, 34) expressed hiding her HIV status from people due to the fear of being judged by her colleagues. Participant seven describes her fear of being judged, and likens disclosing her status to providing people with ammunition to judge her. In her own words she said:

"I am always scared that people will think negative things about me so now days I hide my HIV status. I am scared of being judged. People will always judge you, you can be perfect and they will still find something wrong, but when you have HIV well that's just like giving society the ammunition to blow you to hell." (female, 34)

4.6.2. Secrecy

Participants in the study reported being secretive regarding their HIV status. Some participants chose to keep their HIV status to themselves due to the anticipated stigmatization experienced. Some participants reiterated hiding their HIV status due to the fear of being rejected or losing the respect of colleagues. Participant five (male, 22) describes hiding his HIV status from colleagues due to the fear of losing their respect and being rejected. He said:

"I used to think that people would view me as disgusting if they knew that I was HIV positive so I used to hide my HIV status. I was scared to be rejected, and I was anxious about how people would react to me if they knew. I thought that I would lose my colleagues' respect." (male, 22)

Likewise, participant seven (female, 34) reported being secretive due to her positive HIV status. She hides her positive HIV status because she fears being judged for her condition. In her own words she says:

"I am always scared that people will think negative things about me so now days I hide my HIV status. I am scared of being judged." (female, 34)

Similarly, participant five (male, 22) reiterated hiding his HIV status from others due to the fear of being stigmatized as disgusting. He said:

"I used to think that people would view me as disgusting if they knew that I was HIV positive so I used to hide my HIV status." (male, 22)

4.6.3. Dishonesty

A significant number of participants expressed being dishonest about their HIV positive status, and how they contracted HIV due to the anticipated stigmatization experienced. Participants believed that if colleagues and employers knew that they were HIV positive – they would be discriminated against and stigmatized. Some participants believed that if their colleagues or employers knew how they contracted the virus, they would judge them as promiscuous and sexually irresponsible.

Participant 10 (male, 33) expressed being dishonest due to the fear of being negatively stigmatized by colleagues. The participant told colleagues that he contracted the virus from injecting drugs rather than from unprotected sex. He posited:

"When I first came out as HIV positive, I told people I contracted the virus from drugs. I was scared to say that I had unprotected sex because I did not want people to judge me as sexually irresponsible. I was scared I would be seen as a bad person." (male, 33)

In addition, participant 12 (female, 46) also admitted that she is dishonest about how she contracted the virus due to the anticipated stigma experienced. She stated:

"I often tell people who I work with that I got HIV from a blood transfusion…" (female, 46)

Likewise, participant 11 (female, 20) expressed being dishonest about being HIV positive. She reiterated that she once told a colleague that she was HIV negative. She said:

"I once lied to a colleague and pretended like I was HIV negative." (female, 20)

In this section the overarching theme Felt Stigma was discussed. In addition, the sub-themes of Felt Stigma, namely, Fear, Secrecy, and Dishonesty were also discussed.

4.7. Conclusion

In this chapter the findings of the study were discussed. The findings of the study are based on the research aims and questions. The researcher has demonstrated that 3 overarching main themes emerged from the data: *Enacted stigma* (social exclusion, being judged, being gossiped about, being discriminated against, friendship losses, job exclusions and loss of opportunities) *Felt stigma* (fear, secrecy, dishonesty) and Symbolic Stigma (Religion, Morality, Sexuality). 7 sub-themes emerged from Enacted Stigma: social exclusion, being judged, being gossiped about, refusing to eat food prepared by HIV positive employees, refusal to participate in contact-based activities with HIV positive employees, friendship losses, job exclusions and loss of opportunities. In addition, 6 subordinate themes emerged from enacted stigma, namely: *Insufficient HIV-related interventions at, COVID-19 and HIV, Forced disclosure, Gender* and lastly, *MSM*. Additionally, 3 subordinate themes emerged from felt stigma, namely: *Fear, Secrecy and Dishonesty*.

Participants in the study experienced enacted stigma in the form of Othering. In addition, participants experienced Felt Stigma in the form of self-stigmatization, and self-rejection due to internalised stigmatization.

In addition, participants reiterated that their places of work had insufficient HIV-related work programmes that focus on empowering and assisting HIV positive employers. In addition, participants reiterated experiencing Symbolic Stigma and being judged due to religious reasons as immoral and sexually irresponsible and inappropriate.

Ferthermore, the study also highlighted that women and MSM (men who have sex with other men) experience HIV-related stigmatization differently from cig-gendered male HIV positive participants. The study found that women and MSM experienced overlapping stigmas and oppressions. Participants who are female and MSM tended to experience more blame, shame and judgment for their condition than their cig-gendered male counterparts. Women are stigmatized for being women and HIV positive, and MSM are stigmatized for being MSM and HIV positive. Therefore, women and MSM experience intersecting and diverse stigmas.

The findings of the study also emphasized the link between COVID-19 and HIV. Participants reported feeling a double stigma: the stigma from being HIV positive, and the stigma from being labelled as a high-risk employee who has a greater probability of contracting and transmitting COVID-19.

In addition, due to COVID-19 work regulations participants expressed feeling forced to disclose their HIV status to their places of work before they were ready to come out as HIV positive. These findings highlight the challenges experienced by HIV positive employees in the workplaces of Johannesburg, South Africa, regarding HIV-related stigmatization.

5.1. Chapter 5: Discussion

5.2. Introduction

This study aimed to explore and describe HIV positive employees' perceptions on the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa. The present study utilised a qualitative research design and used an intersectional lens throughout the course of this study. An interpretive approach was adopted. Additionally, the present study utilised semi-structured online interviews to gather data, and thematic analysis to analyse the data collected to provide an account of how HIV-related stigmatization is perceived by HIV positive employees in the workplaces of Johannesburg, South Africa. The study utilised a pilot study to enhance the participants' understanding of the interview questions. In this chapter the findings of the study are discussed and linked to the research findings of various researchers and academics in the field regarding HIV-related stigmatization. The limitations of the study are also presented in this chapter.

The findings of the study show that HIV positive employees experienced three main forms of stigmatization, namely: *Enacted Stigma* (experiences of stigma that stems from other individuals in society), *Felt Stigma* (experiences of self-stigmatization and the fear of being stigmatized due to internalised stigma), and *Symbolic Stigma* (stigma based on morality, religion and sexuality). The present study adds to a growing body of research that suggests that HIV positive employees experience enacted stigma, felt and symbolic stigma in their places of work (Avert, 2019; Dos Santos et al., 2014; Liu et al., 2012; Moalusi, 2018; Sprague et al., 2011; Weihs and Meyer-Weitz, 2016).

Participants experienced: being socially excluded, being excluded in job opportunities, being judged harshly for being HIV positive, being gossiped about, their colleagues refusing to ingest food prepared by them and take part in contact-based activities with HIV positive employees, as well as friendship losses. In addition, participants expressed that there was a lack of sufficient HIV-related work programmes that offered support and assistance to HIV positive staff members. The study found that there is a connotation between COVID-19 and HIV. There is a double stigma: the stigma from being HIV positive, and the stigma from

being labelled as a high-risk employee who has a greater probability of contracting and transmitting COVID-19. Additionally, due to the current work regulations that resulted due to the pandemic, many participants were forced to disclose their HIV status to their places of work. Furthermore, the study highlighted that women and MSM experienced intersecting stigmas and oppressions when compared to their cis-gendered male counterparts. The study also found that HIV positive employers who are women and MSM are judged by fellow colleagues as immoral and sexually irresponsible, and the acquisition of HIV is perceived as a punishment for transgressing religion values.

3 overarching main themes emerged from the data: *Enacted stigma*, *Felt stigma* and *Symbolic Stigma*. 7 sub-themes emerged from Enacted Stigma: social exclusion, being judged, being gossiped about, refusing to eat food prepared by HIV positive employees, refusal to participate in contact-based activities with HIV positive employees, friendship losses, job exclusions and loss of opportunities. In addition, 6 sub-subordinate themes emerged from enacted stigma, namely: *Insufficient HIV-related interventions at work, COVID-19 and HIV, Forced disclosure, Gender* and lastly, *MSM and HIV*. 3 subordinate themes emerged from Symbolic Stigma, namely: *Religion, Morality and Sexuality*. Additionally, 3 subordinate themes emerged from felt stigma, namely: *Fear, Secrecy and Dishonesty*. These themes, sub-themes and sub-sub themes will be discussed with reference to related and connected to research studies conducted by previous researchers.

5.3. Enacted Stigma

Similarly to previous research conducted by researchers (Bharat, Aggleton, and Tyror, 2001; Greeff, 2008; Lodder, 2004; Nkansa-Kyeremateng and Attua, 2013), the present study demonstrated that HIV positive employees experience enacted stigma in the workplace. Enacted stigmatization is manifested in excluding HIV positive employees from after work social gatherings and work opportunities, judging and gossiping about HIV colleagues, refusing to share food with them or eat food prepared by them, colleagues refusing to take part in contact-based activities with HIV positive employees and friendship loses. These findings are consistent with research done in Africa by Sprague et al. (2011) who found that HIV positive individuals are stigmatized in the workplace due to their HIV status.

5.3.1. Social Exclusion

The present study found that HIV positive participants experienced being excluded by fellow colleagues from after-work gatherings, which caused the participants to feel excluded. These findings are parallel to the findings of a South African study conducted by Visser et al. (2009) who found that a third of the participants in the study expressed negative emotions towards people who are HIV positive, and one in five participants admitted to excluding HIV positive people due to their HIV status.

These findings are consistent with previous studies. Participants in the study conducted by Sprague et al. (2011) expressed experiencing being socially excluded in the workplace due to being HIV positive. Additionally, Authors Herek and Capitanio (1998) coined the concept instrumental stigma which refers to intended discrimination directed at people who live with HIV because of the fear of being infected with the virus. These findings are consistent with findings from the present study.

5.3.2. Job Exclusion

Participants in the present study reiterated experiencing work being taken away from them, and being excluded from work opportunities due to employees assuming that they are incompetent due to their positive HIV status. These findings are consistent with previous research done by Kohi et al. (2006) who found that stigmatization caused from living with HIV is manifested in the violation of human rights which can take the form of denying care to an HIV/AIDS positive person within health facilities, abusing HIV positive people, a denial of employment opportunities and a denial of leadership positions due to living with HIV.

Participants in the study conducted by Sprague et al. (2011) expressed experiencing terminations as well as refusals to be hired or promoted, due to their positive HIV status. In addition, studies that could be located in South Africa disclosed that HIV positive people continue to feel and experience stigmatization in the workplace, globally and locally, by means of discriminatory practices, such as unfair termination and a denial of promotion opportunities (Avert, 2019; Dos Santos et al., 2014; Liu et al., 2012; Moalusi, 2018; Sprague

et al., 2011; Weihs and Meyer-Weitz, 2016). These findings are consistent with the findings of the present research study.

5.3.3. Being Judged

Participants in the present study reiterated being judged in a negative and harsh manner by fellow colleagues at work due to being HIV positive. Participants were judged by colleagues as irresponsible. These findings are consistent with previous research studies. Studies conducted by Moalusi (2018); Sprague et al. (2011); and Weihs and Meyer-Weitz (2016) show that HIV positive employees experience being judged as irresponsible in the workplace due to their HIV positive status.

5.3.4. Being Gossiped About

Participants in the present study expressed being negatively gossiped about by colleagues due to being HIV positive. This is consistent with research conducted by Nkansa-Kyeremateng and Attua (2013) and Bharat, Aggleton, and Tyler (2001) who also found that HIV positive employees experienced being gossiped about by colleagues in the workplace due to being HIV positive.

5.3.4. Refusing to Ingest Food Made by HIV Positive Employees

In the present study participants stated that their colleagues refused to eat food that had been prepared by them because they were HIV positive. Furthermore, the present study also found that the colleagues of the participants refused to share the same food with them due to the fear of contracting HIV. These findings are consistent with research conducted by Ogeden and Nyblade (2005). Ogeden and Nyblade (2005) found that in some communities shaking hands with an individual who lives with HIV, sitting next to an HIV positive person, eating food that has been prepared by someone who has HIV, or using items that someone who has HIV handled is believed to cause HIV. Similarly, research conducted by Nyblade et al (2009) found that the epidemic of the human immunodeficiency virus (HIV) results in social responses of enacted stigma and discrimination against people who live with HIV.

5.3.5. Refusing to Participate in Contact-Based Activities with HIV-Positive Employees

In the present study the colleagues of the participants refused to take part in contact-based work related team building activities with HIV positive employees because of their HIV status. These findings are parallel to findings from previous studies. Ogeden and Nyblade (2005) found that participants' co-workers were reluctant to participate in contact-based work activities with HIV positive participants due to their HIV status.

5.3.6. Friendship Losses

Participants in the present study experienced losses of friendships with fellow colleagues as they became knowledgeable about the participants HIV status. These findings are similar to previous research studies. According to Nkansa-Kyerematenge and Attua (2013) employees who are HIV positive experienced losses of friendship due to their HIV status. In addition, Weihs and Meyer-Weitz (2016) found that 4 out of 6 HIV positive employees experienced losses of friendship in their places of work. These findings are consistent with the current study.

5.3.7. Insufficient HIV-related Programmes at Work

Consistent with previous studies (ART guidelines, 2013; Bhana, 2016; Mbonu et al., 2009; Miller & Rubin, 2007) the present study discovered that participants perceived the HIV-related programmes at work to be insufficient. A significant number of participants reiterated that the workplace lacked HIV-related awareness programmes, HIV-related support programmes and HIV-related treatment and care programmes. Additionally, the participants in the present study stated that there is a lack of HIV-related educational programmes targeted at HIV negative employees. Participants stated that the absence of these programmes in the workplace provide the conditions in which HIV-related stigmatization thrives. These findings are consistent with research conducted by (Nkansa-Kyerematenge and Attua, 2013) who found that an absence of HIV-related awareness, education and support programmes in the workplace increased HIV positive employees' chances of experiencing HIV-related stigma in the workplace.

Participants in the present study stated that the workplace needed to develop and implement, HIV awareness programmes, HIV support programmes, HIV treatment and care programmes, and HIV-related programmes focused on educating both HIV positive staff members and HIV negative staff members about HIV in order to reduce the HIV-related stigmatization in the workplace. Nkansa-Kyerematen and Attua (2013) found that the presence of HIV-related programmes at the workplace targeted at all employees decreased the amount of HIV-related stigma experienced by HIV positive employees.

5.3.7. Covid-19 and HIV

Participants in the present study reported experiencing a double stigmatization: stigma from being HIV positive, and stigma from being a high risk employee who has a higher percentage of being infected with COVID-19 and infecting fellow co-workers. Participants stated that due to the fact that HIV weakens the immune system, employers and colleagues treated them like high-risk employees. According to (Avert, 2011; Avert, 2019; Zheng et al., 2020) individuals who have compromised immune systems are more at risk for contracting COVID-19. In addition, participants in the present study expressed experiencing being discriminated against and stigmatized as most likely to contract COVID-19 due to being HIV positive, hence participants in the present study experienced a double stigmatization due to COVID-19.

5.3.8. Forced Disclosure

Consistent with numerous other studies (Fielden et al., 2010; Greeff et al., 2008; Maman et al., 2001; Moalusi, 2018; Okoror et al., 2007, Miller & Rubin 2007,) participants in the study reiterated feeling forced to disclose their HIV status to their places of work due to the new regulations put in place in light of the COVID-19 pandemic. Many participants reported not being ready to come out to their places of work as HIV positive, due to the fear of stigmatization. However, the participants were unable to work from home without disclosing their health status to their workplaces. Coming out to the participants' workplaces before they were ready caused the participants to experience a great deal of anxiety. These findings are

consistent with observations made by Nkansa-Kyerematenge and Attua (2013), Sambisa (2008), and Campbell et al. (2005), who found that the fear of stigmatization reduces the likely of accessing HIV testing services, ART treatment, care and psychosocial support and disclosure of HIV status to others. Findings of the current study are consistent with those of other studies (Greeff et al., 2008; Maman et al., 2001, Okoror et al., 2007, Miller & Rubin 2007) who found that participants who were forced to disclose their positive HIV status, and came out before they were ready, experienced anxiety, panic and stress which took a toll on the participants mental health.

5.3.9. Gender (women and HIV)

Participants in the present study reported that men and women experienced HIV-related stigmatization differently. The female participants involved in the study reported experiencing more HIV-related stigma than their male counterparts. Female participants reiterated having less social power than men, being judged as sexually promiscuous, sexually irresponsible, deviant and immoral. This is in line with available literature which suggests that the society is more tolerant of men who have HIV than women living with HIV (Bhana, 2016; Mfecane, 2012; Nkansa- Kyerematenge and Attua, 2013; Jewkes & Morrell, 2010, Parker & Aggleton, 2003).

Furthermore, in this present study female participants expressed experiencing more HIV-related stigmatization compared to their cis-gendered male counterparts. In addition, female participants described their experiences of being blamed for contracting HIV. These findings are consistent with research conducted by Van Hollen (2010) in India who showed that women who are HIV positive in India experience more HIV-related stigma than their male counterparts, and woman who are diagnosed with HIV are often blamed for contracting HIV and transmitting the virus to their partners. Additionally, in some African societies women are wrongly viewed as the vectors of STDs and STIs, and in some cases some individuals associate certain STDs and STIs with women (Chilikwela et al., 2003; Nkansa-Kyerematenge & Attua, 2013; Parker & Aggleton, 2003). The view of women as the vectors of STDs and STIs coupled with old and deep-seated traditional myths about blood, sex, and transmission

of infections, creates a discriminatory narrative that is utilised to further stigmatize HIV positive women. (Bhana, 2016; Chilikwela et al, 2003).

Additionally, female participants in the present study reiterated experiencing less sympathy about their condition from society than HIV positive males. According to Nkansa-Kyerematen and Attua (2013), females who are HIV positive receive less sympathetic responses from society, and are more stigmatized than their male counterparts. Research shows that while women tend to be blamed by members of society for contracting HIV, males are often forgiven by members of society (Jewkes & Morrell, 2010; Letamo, 2005; Parker & Aggleton, 2003).

Due to the fact that we live in a patriarchal society, women are viewed as the other. The unequal treatment of women can be traced to the social structures of our society. According to Hall (1996), the construction of identity is a process of accumulation or saturation, and our identities are formed through discourse, and influences how we position ourselves in society. Identity is constructed through difference and in relation to each other, as we find ourselves in what we lack, therefore an identity can only be formed when two different sides meet (Hall, 1996). Thus, identity exists because of its ability to exclude, and we cannot say who we are without reference to the other, thus for men to be viewed as powerful women are viewed as the powerless other (Hall, 1996). Therefore, women hold a subordinate position in society compared to the dominant position of men, which could explain why women receive less sympathy and understanding than their male counterparts.

Female participants in the study reiterated having less power in society than males. Mankayi (2008) states that gender is the way in which society is ordered. according to Ratele (2008) "… the body of facts in societies, in the form of institutions, traditions and contexts such as families, schools, workplaces, the media, and religious establishments, which generate and uphold the domination of males as a group over females as a group" (Ratele, 2008: p. 521). This demonstrates that the physical body is saturated with meaning that other people ascribe to it, and people make meaning of how a gendered body inhabits the world. Therefore, males in society hold more power than females.

According to Beauvoir (1986) women experience their bodies differently to men, and for women the body is experienced as an alien force that is outside of her control. These experiences are not biological or essential, but are rather formed due to socialization and upbringing, which society plays a significant role in (Beauvoir, 1986). In addition, Beauvoir (1986) states that men define women as the other. Womens' bodies are viewed as objects in a symbolic market (Bourdieu, 1986). Women are constituted as an object for a man's desires, and a companion to help men come to a self-realization (Beauvoir, 1986). In addition, Beauvoir (1986) states that women serve as a distraction for the amount of anxiety felt by competing with other males to establish and prove a successful masculinity. According to Bourdieu (2001) the female body is surveilled as well as self-serveilled, and the female body is a body for others, namely for men, which creates anxiety and insecurity in the women. Bourdieu (2001) states that the women's dependence on men positions them in a subordinate role to men, and women are constituted as a cheerleader, nurturing comforter, and support system to the man. These findings serve as an explanation as to why women and men are perceived and treated differently in society.

Due to their submissive position in society women experience an extreme form of othering, as well as symbolic violence (Bourdieu, 2001). According to Bourdieu (2001) "…symbolic violence [is] a gentle violence, [that is] imperceptible and invisible even to its victims, [it is] exerted for the most part through the purely symbolic channels of communication and cognition (more precisely misrecognition), recognition, or even feeling (Bourdieu, 2001 [1998]:1-2). Symbolic violence involves the complicity of the women as they accept their oppressed and submissive position (Bourdieu, 2001)

According to Butler (1997) subjection involves being subordinated by power, as well as becoming a subject, and Butler (1997) states that "the master, who at first appears to be external to the slave, remerges as the slaves own conscience" (Butler, 1997: p. 3). According to Butler (1997) Althusser's concept of interpellation is effective in demonstrating how the social subject is produced through language and discourse. Butler (1997) states that "the subordination of the subject takes place through language, as the effect of the authoritative voice that hails the individual. In the infamous example that Althusser offers, a policeman

hails a passerby on the street, and the passerby turns and recognizes himself as the one who is hailed. In the exchange by which that recognition is preferred and accepted, interpellation, which is the discursive production of the social subject takes place" (Butler, 1997: p. 5).

Furthermore, according to Ratele (2008) the domination of women is supported by the structure of society, and hegemonic masculinity is a tool that is used to analyse this dominant position. Hegemonic masculinity is a combination of social practices that promote hierarchies of power in society based on gender, allows women to be in a subordinate position in society (Ratele, 2008). According to Morrell (1998), hegemonic masculinity is defined as "…the form of masculinity which is dominant in society… in addition to oppressing women, hegemonic masculinity silences or subordinates other masculinities, positioning these in relation to itself such that the values expressed by these other masculinities are not those that have currency or legitimacy. In turn it presents its own version of masculinity, of how men should behave and how putative real men do behave as the cultural ideal. [Therefore] the concept of hegemonic masculinity provides a way of explaining that though a number of masculinities coexist, a particular version of masculinity holds sway, bestowing power and privileged on men who espouse it and claim it as their own" (Morrell, 1994, p. 608). Therefore, women in society are treated as second-class citizens when compared to their male counterparts.

5.3.10. Msm (Msm and HIV)

Participants in the present study who are MSM (men who sleep with other men) expressed experiencing being stigmatized for having HIV, and reported experiencing more HIV-related stigmatization than their cis-gendered male counterparts. The participants in the present study experienced being blamed by members of society, including co-workers, for contracting HIV due to their sexual orientation. The participants' sexual orientation was perceived as a sin and immoral, therefore participants who are MSM were blamed for contracting HIV and received less sympathy from members of society. This is consistent with research done by Letamo (2005) who found that behaviours that are associated with HIV, such as MSM (men who have sex with other men), sex work, and the injecting of drugs are stigmatized in many

communities, and therefore a positive HIV diagnosis is viewed as the responsibility of the HIV positive person. In addition, in line with these findings Cloete et al. (2008) also discovered that HIV positive individuals who identify as MSM experience more stigma than MSW (men who sleep with women) who are HIV positive. Global literature as well as South African literature suggests that MSM (men who sleep with other men) experience HIV-related stigmatization more often than their cis-gendered male counterparts who receive more sympathetic responses (Bhana, 2016). In addition, a study done by Cloete et al. (2008) on HIV and sexual orientation in Cape Town, South Africa, found that men who have sex with women (MSW) as well as men who have sex with men (MSM) who are HIV positive both experience felt stigma. However, MSM experienced more stigmatization than MSW. MSM were perceived as sexually deviant and immoral, therefore MSM were blamed for contracting HIV and stigmatized for their condition.

In this section I have discussed MSM (men who sleep with other men) and HIV. In the next section the limitations of the study will be discussed.

5.4. Symbolic Stigma

Participants in the present study experienced symbolic stigmatization in the workplace. Symbolic stigmatization is stigma that is based on religion, morality or sexuality. Similarly to previous research (Alonzo & Reynolds, 1995; Bhana, 2016; Herek and Capitanio, 1998; Nkansa-Kyerematen & Attua, 2013; Nyblade et al., 2009), the present study demonstrated that HIV positive employees experience symbolic stigma in the workplace.

5.4.1. Religion

In the present study, participants reiterated being blamed for contracting HIV as a religious punishment for being sexually promiscuous, gay or using drugs. These findings are in line with findings extracted from research conducted by Alonzo and Reynolds (1995) who found that people who are HIV positive are stigmatized against because people in society view HIV as a virus that is acquired through engaging in immoral acts, such as drug use, sex work and unprotected sex.

5.4.2. Morality

Participants in the present study recalled their experiences of being judged as morally tainted, deviant, and immoral due to their positive HIV status. According to research done by Nyblade et al. (2009) the assumption that HIV is a morally defective disease has provides a strong foundation for stigmatization against HIV positive people to occur, thus HIV positive people often experience being judged as immoral. Herek and Capitanio (1998) stated that the concept of symbolic stigma refers to stigma that is based on moral judgments that others make about those who are HIV positive.

5.4.3. Sexuality

Additionally, participants in the present study reported experiencing being judged by co-workers as highly sexual, or sexually irresponsible. Research done by various researchers such as Bhana (2016) and Ogden and Nyblade (2005), shows that there is an assumption that people who get infected are associated with a deviant and highly sexualized lifestyle.

5.5. Felt Stigma

Consistent with other studies done by researchers (Avert, 2019; Dos Santos et al., 2014; Liu et al., 2012; Moalusi, 2018; Sprague et al., 2011; Weihs & Meyer-Weitz, 2016) the findings from the current study show that HIV positive employees experienced felt stigmatization which manifested in self-stigmatization, self-rejection, fear, and the participant anticipating discrimination and stigmatisation. This is consistent with observations made by Masindi (2004) who discovered that employers who are HIV positive experience felt stigma in the workplace, which causes employees to anticipate fear, become anxious and fearful, self-reject, self-blame and self-stigmatize. In addition, this is consistent with a South Africa study by Weihs and Meyer-Weitz (2016) who showed that employees experienced extreme fear and anticipated being stigmatized in the workplace due to their HIV positive status. The present study demonstrated that HIV positive participants experienced felt stigmatization, which

resulted in the participant self-isolating, keeping secrets from colleagues and keeping fellow colleagues at a distance. This is consistent with the findings of various researchers who show that HIV-related felt stigma results in the HIV positive person self-isolating and self-excluding (Avert, 2019; Moalusi, 2018; Nyblade et al., 2009; UNAIDS, 2009). Participants in the current study expressed experiencing a significant amount of anxiety and stress due to the felt stigmatization that the participants internalised. Studies show that the self-isolating that results from internalised felt stigma can have negative impacts on an individual's mental health and cause feelings of anxiety (Gilbert et al., 2009; Zuch et al., 2011).

Felt stigmatization experienced by the participants in the present study is a result of the participants viewing themselves through the eyes of the oppressive society. Participants view themselves through the eyes of the society due to the internalised habitus. Bourdieu (1986) states that the way an individual views themselves is a direct result of socialised norms that are passed down from one generation to another.

Bourdieu (1986) coined the term habitus to refer to the internalized social norms of a society that are unconsciously transferred from one individual in the society to another. According to Bourdieu (1984) habitus is "a structuring structure, which organises practices and the perceptions of practices." (Bourdieu, 1984, p. 178). In addition, habitus refers to unconscious cognitive structures that are codified within a person or community (Bourdieu, 1984). Furthermore, habitus is a link between the individual's inner emotional worlds and the external social and structural processes, and it shows the social in the psychosocial and enables us to understand how the psyche is formed through the social, as well as how the past plays a role in the present (Bourdieu, 1986). Habitus consists of thoughts, values, tastes, perceptions and beliefs which are transmitted to us through the process of primary socialisation, in the form of interacting with parents and family members (Navarro, 2006). Additionally, Bourdieu (1986) views power as culturally created and legitimized through the dominant capitalist and patriarchal structure of society. The values of the society are passed down to people, in the form of the habitus or socialised norms, which place certain people in a position of power and others in a position of subordination (Bourdieu, 1986).

According to Navarro (2006), habitus is "the way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel and act in determinant ways, which then guide them" (Navarro, 2006, p. 16). Bourdieu (1984) states that individuals wear their habitus and it is codified within them and determines their actions, behaviours, how they talk as well as walk, illustrating that habitus is embodied (Bourdieu, 1986). In addition, habitus "is not fixed or permanent, and can be changed under unexpected situations or over a long historical period" (Navarro, 2006, p. 16).

Furthermore, habitus is not a result of free will, and it is not created by structures, rather it is created by an interactions between free will and societal structures over time (Bourdieu, 1984). Therefore, habitus is determined and unconsciously reproduced "…without any deliberate pursuit of coherence… [And] without any conscious concentration" (Bourdieu, 1984: p. 170). Bourdieu (1986) states that there are different fields or environments in society which all have different rules or doxa, and people learn the cultural habitus of a specific society by interacting with others through discourse. Therefore, societal institutions, cultures, religious establishments, families, schools and workplaces all work together to generate and maintain doxa through language.

Thus, how one views themselves is a social process that involves interacting with others and internalising societal behaviours and traits. Since the society perceives HIV as immoral, deviant and a virus that effects sexually irresponsible individuals, these perceptions are internalised by the participants' habitus, and the result is experienced felt stigmatization.

Participants in the study expressed feeling fear, self-blame, self-rejection, self-stigmatization, and anxiety. These feelings are a result of the internalised habitus, and the history of the HIV epidemic. HIV has historically been viewed by others as a death sentence, and a virus that is acquired by immoral and sexually irresponsible means (Alonzo & Reynolds, 1995). Ahmed (2001) states that emotions are political, social, psychic, interlinked with history and located outside of the body. In addition, Ahmed (2004) states that discourse has the ability to evoke emotions in people, which influences their behaviour and causes them to adopt a certain positionality. For instance, discourse that connotes HIV to death causes people to fear and

stigmatize against HIV positive people. This leads to HIV positive people anticipating stigma and internalising negative stereotypes, through the societal habitus, and self-stigmatizing.

5.5.1 Fear

In this present study participants expressed feeling fearful about disclosing their HIV status to colleagues due to the anticipated and imagined backlash that they believed they would experience. This is consistent with research conducted by Avert (2011) and UNAIDS (2010) who found that the fear of being stigmatized due to being HIV positive prevents HIV positive individuals from disclosing their status to others, testing themselves, knowing their HIV status, and being initiated to antiretroviral therapy (ART).

5.5.2. Secrecy

Participants in the present study expressed keeping their HIV status a secret from employers and colleagues. These findings are in line with findings from research done by Nkansa-Kyerematen and Attua (2013) who found that 1 in 5 HIV positive participants kept their HIV status a secret from their workplace. Participants have every right to choose not to disclose their HIV status, however I think it is important to note that participants in the present study chose not to disclose their HIV status to their workplaces due to anticipated fear and stigmatization and a lack of a safe work environment.

5.5.3. Dishonesty

In the present study the participants expressed being dishonest in the workplace regarding their HIV status. Participants stated that they were dishonest about being HIV negative and how they contracted HIV due to felt stigma and a lack of a safe work environment. These findings are parallel to studies done by Avert (2019). Avert (2019) illustrated that felt stigma results in HIV positive employees being more likely to be dishonest, regarding their HIV status.

5.6. Limitations of the Study

There are several limitations to this study. Due to the current pandemic of COVID-19 interviews were conducted online via Zoom, Skype or Microsoft teams. As a result of the online interviews, the researcher's ability to analyse the participants' body language was hindered, as the researcher was only able to analyse the upper half of the participants' bodies. This resulted in lost data as the researcher was unable to record and analyse the participants' lower body movements. For example, leg shaking or foot tapping.

Furthermore, several participants in the study were postgraduates who were familiar with the research process. It is possible that questions were answered with answers the participants thought were most desirable to the study.

Additionally, the researcher conducting the interviews could have introduced their own perceptions and prejudices into the interviews. This could have led to some participants responding to some questions in a way they felt would be acceptable to the researcher.

In addition, the study was conducted in English only. It would have been more inclusive to include other languages, and ideally it would have been more beneficial to have had bilingual members in the research team to assist with translating. Due to limitations of time, the researcher did not utilize the services of an external coder nor utilize the methodology of triangulation. It is also important to note that there are no current studies available that show that there is a double stigmatization of HIV/AIDS and COVID-19. However, the participants expressed experiencing a double stigmatization.

Due to the participants' limited sample size and time, the researcher was not able to dissect and analyse all of the oppressive intersections of the participants'. Lastly, the findings of this study may not be transferred to HIV positive individuals who reside outside of South Africa, as the present research study used a sample of South African participants.

5.7. Conclusion

In summary, this research study explored and described HIV positive employees' perceptions on the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa. 3 overarching main themes were discussed: *Enacted stigma, Felt stigma* and *Symbolic Stigma*. 7 sub-themes emerged from Enacted Stigma: social exclusion, being judged, being gossiped about, refusing to eat food prepared by HIV positive employees, refusal to participate in contact-based activities with HIV positive employees, friendship losses, job exclusions and loss of opportunities. In addition, 6 sub-subordinate themes were discussed namely: *Insufficient HIV-related interventions at work, COVID-19 and HIV, Forced disclosure, Gender* and lastly, *MSM and HIV*. 3 subordinate themes from Symbolic Stigma were discussed, namely: *Religion, Morality and Sexuality*. Additionally, 3 subordinate themes that emerged from felt stigma, namely: *Fear, Secrecy and Dishonesty* were discussed in this chapter. The limitations of the study were also discussed in this chapter.

6.1. Chapter 6: Conclusions and Recommendations

6.2. Introduction

This research study utilised a qualitative research design to explore HIV positive employers' perceptions of HIV-related stigmatization in the workplaces of Johannesburg, South Africa. An interpretive approach was utilised. Additionally, an intersectional lens was used as a theoretical framework in this research study. Semi-structured interviews were used to collect data, and thematic analysis was used to analyse the data collected. In this chapter the concluding remarks on the themes that emerged in the duration of the process of thematic analysis are presented. In addition, recommendations and suggestions for further study are presented in this chapter.

6.3. Synopsis of the Study

3 overarching main themes emerged from the data: *Enacted stigma*, *Felt stigma* and *Symbolic Stigma*. 7 sub-themes emerged from Enacted Stigma: social exclusion, being judged, being gossiped about, refusing to eat food prepared by HIV positive employees, refusal to participate in contact-based activities with HIV positive employees, friendship losses, job exclusions and loss of opportunities. In addition, 6 sub-subordinate themes emerged from enacted stigma, namely: *Insufficient HIV-related Interventions at Work*, *COVID-19 and HIV*, *Forced Disclosure*, *Gender* (Women and HIV) and lastly, *MSM and HIV*. 3 subordinate themes emerged from Symbolic Stigma, namely: *Religion*, *Morality and Sexuality*. Additionally, 3 subordinate themes emerged from felt stigma, namely: *Fear, Secrecy and Dishonesty*.

The present research study was motivated by the fact that HIV-related stigmatization has adverse consequences on health outcomes, and discourages HIV positive individuals from accessing HIV-related treatment and care services, as well as getting HIV tested. Research on HIV-related stigma in the workplaces of Johannesburg, South Africa is limited. Research

from the present study shows that HIV positive people who experience stigma in the workplace are passed over for work opportunities, gossiped about, excluded by colleagues from after-work social gatherings and discriminated against. These findings are consistent with Bharat, Aggleton, and Tyror (2001), Greeff (2008), Lodder (2004) and Nkansa-Kyerematenge and Attua (2013).

The findings of the present study are significant as research on HIV-related stigmatization is limited, especially within the context of South African workplaces. There are also limited research studies conducted on HIV that utilise an intersectional lens. In addition, the current HIV-related interventions at workplaces in Johannesburg, South Africa are informed by limited empirical research. Thus, the current research study is significant in the field.

This study is significant in its contribution to the development of the body of knowledge on HIV and stigmatization. The present study offers insight on the experiences of HIV positive employers on HIV-related stigma in the workplaces of Johannesburg, South Africa. In addition, the current study utilized an intersectional theoretical framework, which was effective in analysing participants' experiences of overlapping oppressions.

The findings of the study show that HIV positive employers experience HIV-related stigmatization in their places of work. The three main types of stigma experienced by participants were enacted stigma, felt stigma, and symbolic stigma. The stigma experienced by participants resulted in the participants experiencing stress, panic and anxiety which had negative implications for their mental health.

In addition, findings from the study show that there is a link between COVID-19 and HIV. Participants experienced a double stigmatization: stigma from being HIV positive, and stigma from being a high risk employee who is perceived to have a higher percentage of being infected with COVID-19 and infecting fellow co-workers. Therefore, the study found a connotation between HIV-related stigma and COVID-19.

Participants experienced forced disclosure as new work regulations were implemented due to the pandemic of COVID-19. These new work regulations required the employees to disclose their health conditions to their workplaces. Many participants expressed feeling forced to disclose their status to their workplaces before they were ready to come out as HIV positive, which resulted in anxiety and fear.

In addition, the current study found that women, men and MSM experience stigma differently. Women and MSM experienced less sympathetic responses from colleagues, and were blamed for contracting HIV and viewed as immoral and promiscuous. Whereas, male participants expressed experiencing more sympathy and understanding from co-workers regarding their HIV status. Women and MSM experienced overlapping stigmas. Women were stigmatized for being women and HIV positive, and MSM were stigmatized for being MSM and HIV positive.

Moreover, participants also reported that their workplaces had insufficient HIV-related programmes to support HIV positive employers. Participants recommended that all workplaces in Johannesburg, South Africa be required by the state to develop and implement mandatorily HIV awareness programmes, HIV education programmes, and HIV support programs at work spaces to lessen the stigma experienced by HIV positive employees.

Additionally, participants experienced Othering in the workplace in the form of enacted stigma. This lead to the participants internalizing stigmatization, being fearful, anticipating discrimination, and being secretive and dishonest with regards to their HIV status. Therefore, the current research study illustrates that there are limitations to the present HIV-related programmes at workplaces in Johannesburg, South Africa, and it is recommended that workplaces implement more HIV focused programmes at work that offer support and care to HIV positive employees.

In the next section the recommendations and suggestions for further study will be discussed.

6.7. Recommendations

Consistent with previous studies done (e.g. Avert, 2019; Dos Santos et al., 2014; Liu et al., 2012; Moalusi, 2018; Sprague et al., 2011; Weihs and Meyer-Weitz, 2016), the current research study found that HIV positive employees experience HIV-related stigmatization in the workplaces of Johannesburg, South Africa. The following recommendations emanate from the findings of the present research study, and are specific to addressing the concerns of the participants. The recommendations of this research study can be utilised by policy makers, HIV-related organisations, workplaces in Johannesburg, and researchers to assist in the eradication of HIV-related stigmatization in the work space, and every other space.

6.7.1. Anti-stigma Interventions

The findings of the study support the development and implementation of HIV-related programmes at work that support HIV positive employees and educate staff on HIV. It is recommended that workplaces offer HIV-specific counselling services that offer guidance, care and support to HIV positive staff members, or have the appropriate referrals available that will not cost employers out of pocket.

Additionally, it is recommended that workplaces implement and strengthen existing HIV awareness and education programmes, and provide access to these programmes to all staff members. This can be achieved through implementing HIV-related workshops that offer anti HIV-related stigma training and sensitivity training. It is also recommended that posters that educate about HIV be placed strategically in the workplace, in order to enlighten staff members about HIV and lessen the stigma experienced by HIV positive employers.

It is also recommended that the South African Government, Health Ministers, institutions and companies in South Africa, Johannesburg, collaborate to improve and build-on the current policies in work spaces, in order to develop and implement policies that prohibit HIV stigmatization in the workplace. It is recommended that HIV-related sensitivity and

awareness programmes become mandatory in all work spaces for all employers. These policies may reduce the amount of HIV-related stigmatization cases in the work space.

6.8. Suggestions for Further Study

It is important that longitudinal studies, with a larger sample size, be carried out on HIV positive employers in Johannesburg, South Africa, to assess whether findings are replicated in long-term research studies. Additionally, it could be of value to carry out a research study to explore and understand the perceptions of HIV negative employers who stigmatize fellow co-workers due to their positive HIV status. This may shed some light on how to improve HIV-related anti-stigma programmes in the workplace.

6.9. Conclusion

In this chapter, the concluding remarks on the themes that emerged in the duration of the process of thematic analysis have been presented. In addition, recommendations and suggestions for further study have also been presented. The researcher has demonstrated that 3 main types of HIV-related stigmatization are experienced by HIV positive employees who reside in Johannesburg, South Africa. Namely: Enacted stigmatization, Felt stigmatization, and Symbolic Stigmatization. Enacted Stigmatization was the most dominant overarching theme. Enacted stigmatization was manifested by excluding HIV positive employees from after work social gatherings and work opportunities, judging and gossiping about HIV colleagues, refusing to share food with them or eat food prepared by them, colleagues refusing to take part in contact-based activities with HIV positive employees and friendship loses. These findings are consistent with research done in Africa by Sprague et al. (2011) who found that HIV positive individuals are stigmatized in the workplace due to their HIV status.

Consistent with other studies (e.g. Avert, 2019; Dos Santos et al., 2014; Liu et al., 2012; Moalusi, 2018; Sprague et al., 2011; Weihs & Meyer-Weitz, 2016), the findings from the

current study show that HIV positive employees experienced felt stigmatization which manifested in self-stigmatization, self-rejection, fear, and the participant anticipating discrimination and stigmatisation. This is consistent with observations made by Masindi (2004) who discovered that employers who are HIV positive experience felt stigma in the workplace, which causes employees to anticipate fear, become anxious and fearful, self-reject, self-blame and self-stigmatize.

Symbolic stigma refers to stigmatization based on religion, morality, and sexuality. The term was coined by Herek and Capitanio in 1998, and the concept of symbolic stigma refers to stigma that is based on moral judgments that others make about those who are HIV positive. Similarly to previous research conducted (e.g. Alonzo & Reynolds, 1995; Bhana, 2016; Herek & Capitanio, 1998; Nkansa-Kyeremateng & Attua, 2013; Nyblade et al., 2009), the present study highlighted that HIV positive employees experience symbolic stigma in the workplace, and illustrated the need for the development of existing HIV workplace policies in Johannesburg, South Africa. A portion of the participants reiterated feeling judged by co-workers as immoral and sexually irresponsible because they are HIV positive. In addition, participants who are gay MSM (men who sleep with other men) expressed being positioned by those who are religious as sinners who are being punished by a higher power.

Participants in the present study reported experiencing a double stigmatization: stigma from being HIV positive, and stigma from being a high risk employee, who has a higher percentage of being infected with COVID-19 and infecting fellow co-workers. The majority of the participants experienced employers and colleagues treating them like high-risk employees.

Consistent with numerous other studies (e.g. Greeff et al., 2008; Fielden et al., 2010; Maman et al., 2001; Moalusi, 2018; Okoror et al., 2007, Miller & Rubin, 2007), participants in the study reiterated feeling forced to disclose their HIV status to their places of work due to the new regulations put in place in light of the COVID-19 pandemic. Many participants reported not being ready to ‘come out’ to their places of work as HIV positive, due to the anticipation and fear of being stigmatized. However, the participants were unable to work from home

without disclosing their health status to their workplaces. Coming out to the participants' workplaces before they were ready caused the participants to experience a great deal of anxiety.

Participants in the present study who are MSM (men who sleep with other men) expressed experiencing stigmatization in their places of work due to being HIV positive, and reported experiencing more HIV-related stigmatization than their cis-gendered male counterparts. The participants in the present study experienced being blamed by members of society, including co-workers, for contracting HIV due to their sexual orientation. The participants' sexual orientation was perceived as a sin and immoral, therefore participants who are MSM were blamed for contracting HIV and received less sympathy from members of society. Participants in the present study who are MSM reiterated being stigmatized for being MSM, as well as for having HIV.

The research study found that men and women experienced HIV-related stigmatization differently. The female participants involved in the study reported experiencing more HIV-related stigma than their male counterparts. Female participants reiterated having less social power than men, and being judged as sexually promiscuous, sexually irresponsible, deviant and immoral. Female participants in the study experienced stigmatization for being a women, as well as experienced stigma for being an HIV positive women. This demonstrates that there are different degrees of oppression that diverse individuals encounter. It highlights that it is important to be mindful of the intersecting oppressions at play, to be able to fully comprehend the degree of oppression experienced.

In summary, this research study highlights the need for the development and implementation of evidence-based HIV-related programmes at all work spaces that support and assist HIV positive employees, as well as awareness campaigns targeting all employees. In addition, the enactment and implementation of work policies are recommended, in order to ensure an inclusive and safe working environment for all HIV positive employees.

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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT
PSYCHOLOGY

Appendix C

PARTICIPANT INFORMATION SHEET

Good day

My name is Daelene Noelle Ganess and I am a Masters student in the Psychology Department at the University of the Witwatersrand, Johannesburg. As part of my studies, I have to undertake a research project, and I am investigating the perceptions of HIV positive employees on HIV-related stigma in the workplace under the supervision of Prof. Daleen Alexander. The purpose of the study is to explore what the perceptions of HIV positive people are on the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa. The title of my research is: An exploratory study of HIV positive employees' perceptions on the prevalence of HIV-related stigma in workplaces of Johannesburg, South Africa.

As part of this project, I would like to invite you to take part in a semi-structured interview. This activity will involve answering a series of questions and will take approximately 50-60 minutes of your time. With your permission, I would also like to record the interview using a cell phone and a laptop.

There will be no personal costs to you if you participate in this project, and you will receive a voucher for data to participate in the interview. Participation will require you to participate in an online, individual, semi-structured interview led by the researcher. You are required to

have access to Zoom, Skype, Microsoft Teams, or WhatsApp. Participation will also require the participant to: be proficient in English, and choose a private, confidential and quiet space for the online interview to take place. You will not receive any direct benefits from participation but there are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential and anonymous as I will not be asking for your name or any identifying information, and the information you give to me will be locked in a cupboard and not be disclosed to anyone else. I will be using a pseudonym, which is a false name, to represent your participation in my final research report. If you experience any distress or discomfort at any point in this process, we will stop the interview or resume at another time. If you need some support or counselling services following the interview, these are available at the bottom of the form. The national Toll free HIV/AIDS 24-hour helpline is run by Lifeline in partnership with the Department of Health. It is manned by trained lay-counsellors and receives an average of 3000 calls per day. The objective of the line is to provide free anonymous, confidential, accessible information, counselling and referral telephone services in all eleven official languages in South Africa. Participants may call the HIV/AIDS Helpline on 0800 012 322 for HIV specific counselling services, regardless of their physical location.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. The full research report will be available on the Wits website or wired space upon the candidate's completion of the degree. If you wish to receive a summary of this report, I will be happy to send it to you. The data collected from this research project will be stored on a password protected computer for research purposes only. With your permission the data collected from this research project may be used by other researchers. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za.

Yours sincerely,

Daelene

DETAILS OF THE RESEARCHER

If you have any questions or concerns about the research, please feel free to contact me:

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DETAILS OF THE SUPERVISOR

Prof. Daleen Alexander

Email: daleen.alexander@wits.ac.za
Cell: 011 717 4526

DETAILS OF THE COUNCELLING SERVICES

The national Toll free HIV/AIDS 24-hour helpline

Cell: 0800 012 322

The National Association of People Living with AIDS (NAPWA)

Cell: 011 073 7156

Appendix D

CONSENT FORM FOR THE PARTICIPANTS TO BE INTERVIEWED

Title of project: An exploratory study of HIV positive employees' perceptions on the prevalence of HIV-related stigma in workplaces of Johannesburg, South Africa. The purpose of the study is to explore what the perceptions of HIV positive people are on the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa.

Name of researcher: Daelene Noelle Ganess

I, _____ agree to participate in this research project. The research has been explained to me and I understand what my participation will involve.

You have the right to refuse to participate in this study, and agreement to participate may be withdrawn at any time. Furthermore, no negative implications will result from a decision to withdraw. You can request a summary of research results upon completion of the study, should you wish to do so. The full research report will be available on Wits website or wired space upon the candidate's completion of the degree space. Should you feel uncomfortable with a specific question during the interview, you have the right not to answer.

I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	YES	NO

I agree that the researcher may use anonymous quotes in his / her research report	YES	NO
I agree that the interview may be audio recorded	YES	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.	YES	NO
I agree that the information provided may be used in presentations or written up in articles.	YES	NO

I have read the above as well as the attached letter/s and understand the nature, purpose and procedure of this research. I hereby give my consent to be a participant in the research study that is being conducted to explore the perceptions of people who are HIV positive on the prevalence of HIV-related stigma in the workplaces of Johannesburg, South Africa.

Signed: _____ Date: _____

Umthombo Building – 2nd Floor, Room U211, Braamfontein East Campus, Private Bag 3, WITS 2050
T +27 11 717 4503/53 | **E** psych.SHCD@wits.ac.za | www.wits.ac.za/shcd/psychology/

Appendix E

INTERVIEW SCHEDULE

PART A: Demographic Data

Is your workplace aware that you are HIV positive?	
How long have you been working at your place of work?	
Age:	
Race:	
How would you describe your socioeconomic status?	
Gender:	
Sexual orientation:	
Nationality:	
Disabilities:	

PART B: Interview Schedule

Information about the self in the workplace

- **(Icebreaker)** can you please tell me about your work?
- Question: how would you describe your general experience as an HIV positive employee in your workplace?
- Probe: What are some of the high and low points of being an HIV positive employee in your workplace?
- Probe: Did you overcome these low points? If so, how did you overcome them? If not, what are you still struggling with?

Stigma and the workplace

- Question: How would you describe your experiences with HIV-related stigma in the workplace? Please explain your answer.

HIV/AIDS and the workplace

- Question: What is your perception about your workplace's support/wellness programmes for people living with HIV/AIDS?
- Probe: Do you think that your workplace has an effective HIV awareness program for staff? Please give a reason for your answer.
- Probe: Do you think that your co-workers have adequate awareness and knowledge of HIV/AIDS? Please explain why you think this

HIV/AIDS and COVID-19

- Question: Are you fearful that people who you work with will associate HIV with COVID-19? Please explain your answer.
- Probe: Are you fearful of the added stigmatization that associations of HIV with COVID-19 in the workplace could bring? Please explain your answer.
- Question: Do you feel compelled to disclose your HIV status to the workplace in order to not expose yourself to unnecessary risk by returning to work in light of the COVID-19 pandemic? Please explain your answer.
- Question: Does your workplace treat you differently than HIV negative employees with regards to COVID-19? Please explain your answer.

Enacted and felt stigmatization

- Question: Can you please describe an event in the workplace in which you felt unfairly treated due to your positive HIV status?
- Question: Can you please describe an event in the workplace whereby your own thoughts and feelings about how people would react to your positive HIV status influenced your behaviour?
- **(Closure)** is there anything else you would like to say before we conclude the interview?

Appendix F

REVISED INTERVIEW SCHEDULE

PART A: Demographic Data

How old are you?	
What is your race?	
What is your gender?	
What is your sexual orientation?	
What is your nationality?	
Do you have any disabilities?	
How would you describe your socioeconomic status?	
How long have you been working at your place of work?	
Is your workplace aware that you are HIV positive?	

PART B: Interview Schedule

Information about the self in the workplace

- **(Icebreaker)** can you please tell me about your work?
- Question: how would you describe your general experience as an HIV positive employee in your workplace?
- Probe: What are some of the high and low points of being an HIV positive employee in your workplace?
- Probe: Did you overcome these low points? If so, how did you overcome them? If not, what are you still struggling with?

Stigma and the workplace

- Question: How would you describe your experiences with HIV-related stigma in the workplace? Please explain your answer.

HIV/AIDS and the workplace

- Question: What is your perception about your workplace's support/wellness programmes for people living with HIV/AIDS?
- Probe: Do you think that your workplace has an effective HIV awareness program for staff? Please give a reason for your answer.
- Probe: Do you think that your co-workers have adequate awareness and knowledge of HIV/AIDS? Please explain why you think this

HIV/AIDS and COVID-19

- Question: Are you fearful that people who you work with will associate HIV with COVID-19? Please explain your answer.
- Probe: Are you fearful of the added stigmatization that associations of HIV with COVID-19 in the workplace could bring? Please explain your answer.
- Question: Do you feel compelled to disclose your HIV status to the workplace in order to not expose yourself to unnecessary risk by returning to work in light of the COVID-19 pandemic? Please explain your answer.
- Question: Does your place of work treat you differently, with regard to COVID-19, compared to their treatment of HIV negative employees?

Enacted and felt stigmatization

- Question: Can you please describe an event in the workplace in which you felt unfairly treated due to your positive HIV status?
- Question: Can you please describe an event in the workplace whereby your own thoughts and feelings about how people would react to your positive HIV status influenced your behaviour?
- **(Closure)** is there anything else you would like to say before we conclude the interview?

Appendix G

ETHICAL CLEARANCE LETTER

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Ganess

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H20/06/10**
PROJECT TITLE	An exploratory study of HIV positive employees' perceptions on the prevalence of HIV-related stigma in workplaces of Johannesburg, South Africa
INVESTIGATOR(S)	Ms D Ganess
SCHOOL/DEPARTMENT	Human and Community Development/
DATE CONSIDERED	19 June 2020
DECISION OF THE COMMITTEE	Approved Risk level: Medium
EXPIRY DATE	16 August 2023

DATE 17 August 2020 **CHAIRPERSON** _____
(Professor J Knight)

cc: Supervisor : Professor D Alexander

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to complete a six (6) month progress report.**

_____ _____/_____/_____
Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES