HIV/AIDS stigma at the workplace: Exploratory findings from Pakistan

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Abstract

People living with HIV/AIDS (PLHA) are stigmatised socially. They are devalued and considered like outcasts by having lesser opportunities for education, treatment and housing, and in an organisational context they get reduced opportunities of selection, promotion and income. The phenomena have been extensively researched in developed countries but limited literature addresses the situation in underdeveloped countries like Pakistan, which is also facing spread of the HIV/AIDS epidemic. There are a number of groups who are carrying the disease but the problems being faced by PLHA employed in different organisations have rarely been analysed. Stigma at the workplace can generate a number of negative outcomes. The present study considers two such outcomes among stigmatised PLHA. These outcomes are organisational cynicism and breach of psychological contract. A questionnaire was used to collect data from a sample of 174 PLHA, having a work experience after identification of the epidemic, working in different organisations across Pakistan. These PLHA were identified and recruited through a scattered record available with some government/non-government organisations operating in Pakistan to control HIV/AIDS. Findings of the study extend the knowledge about HIV/AIDS stigma indicating that PLHA are subjected to stigma, which is significantly associated with a breach of psychological contract and organisational cynicism. There is a need at governmental and organisational level as well to increase awareness about the disease and formulate policies to reduce stigma against PLHA working in different organisations.

***Keywords**: workplace, PLHA, stigma, psychological contract, organisation cynicism.*

Résumé

Les personnes vivant avec le VIH/Sida (PVVS) sont socialement stigmatisées. Elles sont dévaluées et considérées comme des parias, disposant d'opportunités d'éducation, de traitement et de logement moindres et, dans un contexte organisationnel, bénéficient d'opportunités de sélection, de promotion et de revenus réduites. Bien que ce phénomène ait fait l'objet de nombreuses études dans les pays développées, un nombre limité de recherches sont consacrées à la situation dans des pays sous-développés comme le Pakistan, qui est également confronté à un élargissement de son épidémie de VIH/Sida. Plusieurs groupes sont porteurs de la maladie, mais les problèmes auxquels les PVVS employées dans différentes organisations font face ont rarement été analysés. La stigmatisation sur le lieu de travail peut donner lieu à divers résultats négatifs. Cette étude se penche sur deux de ces résultats pour les PVVS stigmatisées. Ces résultats sont le cynisme organisationnel et la rupture du contrat psychologique. Un questionnaire a été utilisé afin de rassembler des données à partir d'un échantillon de 174 PVVS, disposant d'une expérience professionnelle suite à l'identification de l'épidémie, et travaillant dans différentes organisations au Pakistan. Ces PVVS ont été identifiées et recrutées par le biais d'un fichier diffusé disponible auprès de certaines organisations gouvernementales/non gouvernementales opérant au Pakistan dans le but de contrôler le VIH/Sida. Les conclusions de l'étude permettent de développer les connaissances sur la stigmatisation associée au VIH/Sida indiquant que les PVVS sont stigmatisées, ceci étant dans psychologique large mesure associé à une rupture du contrat psychosocial et à un cynisme organisationnel. Au niveau gouvernemental comme au niveau des organisations, il est nécessaire d'accroître la sensibilisation sur la maladie et de formuler des politiques pouvant réduire la stigmatisation à l'encontre des PVVS et travaillant dans différentes organisations.

***Mots clés:** Lieu de travail, PVVS, stigmatisation, contrat psychologique, cynisme organisationnel.*

Introduction

HIV/AIDS has emerged as one of the greatest threats for people living across the globe. Apart from horrific medical complications, people living with HIV/AIDS are often disgraced and discriminated socially through HIV/AIDS stigma. Goffman (1963) considers stigma as a phenomenon through which a person is not socially accepted. It is an attribute real or perceived (Seale, 2004) through which HIV/AIDS-infected individuals are discriminated against and discredited socially (Herek & Capitanio, 1998). The phenomenon began simultaneously with the spread of the disease (Farmer, 1992). Social isolation is an eminent outcome of stigma since PLHA are considered like outcasts (Adewuya et al., 2009). People feel uncomfortable in the company of PLHA (Lee, Kochman & Sikkema, 2002). An important dimension of stigma is its social and psychological outcomes. Dlamini et al. (2007) consider it frightening that individuals who are possibly facing

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death are neglected by the community around them. A number of attempts have been made to highlight how miseries of patients are augmented manifold by HIV/AIDS stigma (Birmingham & Kippax, 1998; Link & Pehlan, 2002; Giuliani et.al. 2005; Olapegba, 2010 & Jin, Zhao, Zhang, Feng & Wu, 2010).

HIV/AIDS has become a reality of life in families, streets, in malls and at our workplaces. Advancements in health care have increased life expectancy, resulting in a desire among PLHA to continue their jobs (Ghaziani, 2004). Apart from social stigmatisation, at workplace PLHA face abuse by coworkers (Priscilla *et al.*, 2007) and discriminatory behaviour can result in their job loss (Corrigan & Penn, 1999; Earnshaw & Chaudoir, 2009). Employers are reluctant to hire PLHA at first and even decide to dismiss their employees as soon as HIV/AIDS is diagnosed (Lim & Loo, 2000). While a plethora of research focused on HIV/AIDS stigma in social context, limited research analysed the phenomena in a workplace setting (Wagner *et al.*, 1998). Studies like Stuart (2004) and Britt (2000) examined stigma at the workplace for different diseases/ disabilities but HIV/AIDS stigma was not analysed. Mahajan, Colvin, Rudatsikira, and Ettl (2007) discussed various workplace policies for HIV/AIDS in South Africa, while Tee and Huang (2009) addressed attitudes towards PLHA in Malaysian Universities. Vest, Brian and Vest (1990, 1991), Ghaziani (2004) and Rao, Angell, Lam and Corrigan (2008) specifically examined HIV/AIDS stigma at the workplace but discussion on its organisational outcomes was quite limited. How do organisations stigmatise PLHA and how do PLHA react against workplace stigma? What are the workplace outcomes of HIV/AIDS stigma? The lack of research in this area is astonishing given the implications of HIV/AIDS-related stigma in the workplace. The major objective of the present study is to answer these questions by specifically analysing stigma against PLHA at the workplace and employee reaction against this stigma.

Pakistan is facing a spread of HIV/AIDS epidemic (World Bank, 2006). The groups identified for this spread are commercial sex workers, intravenous drug users (IVDUs), individuals who received blood transfusions (WHO, 2008) and Pakistani workers deported from abroad (Sheikh, Khan, Mithani & Khurshid, 1994). An estimated 96 000 individuals are living with HIV, though the prevalence of 0.1% is relatively low (Rodrigo & Rajapakse, 2009). The factors which are considered to be restricting effective control of epidemic include illiteracy and lack of knowledge (Adewuya *et al.*, 2009). Pakistan is at very low on human development index including literacy (Kazi, Ghaffar & Salman, 2000) which makes Pakistan more vulnerable for having more HIV/AIDS stigmas. The stigma can be intensified because of having a negative perception in the region as Bhattacharya (2004) reports that in South Asia HIV/AIDS is considered a dirty disease. Despite its social and organisational implications, no study analysed the HIV/AIDS stigma in Pakistan and it is described as an under-researched country by Aycan *et al.* (2000).

Theoretically stigma can be associated with different organisational outcomes. Social identity theory suggests individuals carrying common characteristics are identified distinctly (Tajfel and Turner, 1985). As employees carrying HIV/AIDS are identified and stigmatised in the organisations with fewer opportunities for growth and other organisational benefits, there is the likelihood of that they could engage in behaviours which are harmful for the organisation. Ensher, Vallone and Donaldson (2001) believe that mistreatment of a group because they share common characteristics can result in negative work behaviours. Organisational cynicism is described as a negative attitude characterised by suspension, hopelessness and disgust (Andersson, 1996) and employees having cynicism think that an organisation lacks integrity (Dean *et al.,* 1998). We can theoretically relate workplace stigma with organisational cynicism using a breach of psychological contract framework. Psychological contract is an employee's expectations from the employer, and vice versa (Rosseau, 1995). Breach of psychological contract occurs when an employee feels that the organisation has failed to meet its obligation (Morrison & Robinson, 1997). Stigmatised actions in a workplace against PLHA, such as reduced opportunities for advancement or even a threat of job loss, constitute breach of psychological contract, which is a determinant of organisational cynicism (Johnson & O'Leary-Kelly, 2003). At a personal level HIV/AIDS stigma can be internalised and can be associated with feelings of shame and guilt (Lee, Kochman & Sikkema, 2002), stress (Riggs, Vosvick & Stallings, 2007) depression, anxiety (Sikema *et al.*, 2000), and post-traumatic stress disorder (PTSD) (Koopman *et al.*, 2002). Researchers also found internalised stigma to be strongly associated with a feeling of hopelessness (Lee, Kochman and Sikkema, 2002; Treisman and Angelino, 2004), an important characteristic of organisational cynicism (Dean *et al.,* 1998). Stigmatisation results in discriminatory and unjust decisions by the organisations and such decisions at a workplace can result in resentment, outrage, anger (Skarlicki, Folger & Tesluk, 1999) and frustration (Bateman *et al.*, 1992) among affected employees. Researchers have identified various factors which determine organisational cynicism (e.g. Johnson & O'Leary-Kelly, 2003). Frustration at the workplace is commonly referred to as organisational cynicism (Anderson, 1996). However, cynicism caused by workplace stigma has never attracted attention of researchers. Thus an attempt is being made to bridge the research gap by specifically analysing the impact of workplace stigmatisation on organisational cynicism.

While there is a dearth of knowledge on HIV/AIDS stigma at workplace, the studies conducted in this regard mainly focus on developed countries (Keusch, Wilentz, & Kleinman, 2006) and underdeveloped countries generally remain ignored in the context of stigma-related intervention (Bos, Schaalma & Mbwambo, 2004). The social response towards people carrying HIV/AIDS varies in different cultures (Weiss, Ramakrishna, 2001). Pearson *et al.* (2009) even suggest that the stigma process cannot be understood without understanding culturally specific beliefs. Discrimination against PLHA varies between communities (Rao et al., 2008) while intensity of this stigma depends upon societal attitudes about the disease (Berger *et al.*, 2001), which can be due to variation in values and moral structures across cultures (Yang *et al.*, 2007). The spread of HIV/AIDS in different countries makes it necessary to study HIV/AIDS stigma within a local cultural context (Priscilla *et al.*, 2007), hence the present study attempts to examine the HIV/ AIDS stigma and its organisational outcomes in Pakistan.

Based on the theoretical relationship between stigma, organisational cynicism and breach of psychological contact, the hypotheses for the current study are:

- H1: Stigma against PLHA at the workplace is significantly associated with organisational cynicism.
- H2: Stigma against PLHA at the workplace results in a feeling of breach of psychological contract.

Method

From November 2009 to April 2010 the HIV/AIDS patients were contacted across Pakistan in cities like Karachi, Lahore, Faisalabad and Peshawar. The contact details were available with some government and Non-Government Organisations (NGOs) that are working for the prevention of HIV/AIDS in Pakistan. Finding PLHA who are working in organisations proved a challenging job. Initially 367 PLHA with work experience were identified but most of the PLHA did not agree to cooperate due to fears that information about them and their disease would be made available for research. As a result only 174 PLHA who had some work experience after disclosure of disease were convinced to respond to the questionnaire anonymously. Among this sample only 11 PLHA are still employed and this limitation forced the study to analyse the majority of opinion based on past experiences at the workplace.

To ensure anonymity the respondents were contacted through the organisations maintaining a database of PLHA. They were ensured that the data would only be used for academic purposes and that the identity of respondents would not be disclosed at any cost. The details were not made available to the author for directly contacting the respondents. The respondents filled in questionnaires themselves, but for illiterate respondents the questionnaires were read and responses were entered on the questionnaires.

Data were collected using a self-reported questionnaire. The questionnaire for HIV/AIDS stigma was adopted from Berger, Ferrans and Lashley (2001). The instrument was tested by Berger *et al.* (2001) on 318 PLHA. Factor analysis revealed four dimensions of stigma; these dimensions are personalised stigma, disclosure concerns, negative self-image, and public attitude towards PLHA. It is the most commonly used scale for measuring HIV stigma (Sayles *et al.,* 2010). Breach of psychological contract was measured using a scale developed by Robinson and Morrison (2000). This instrument has been used previously and tested by researchers (e.g. Johnson & O'Leary-Kelly, 2003). Oganisational cynicism was measured using a scale developed by Dean, Brandes and Dharwadkar (1998). The response was required on a five-point Likert scale with '1' representing strongly disagree and '5' representing strongly agree.

Table 1 gives the demographic details of the sample. Women talking about AIDS in Pakistan is quite unusual, and those who dare to talk about the disease become part of news headlines for taking such a courageous step. For example, a woman named Shukria Gul was diagnosed carrying HIV/AIDS and she was much appreciated when she publically announced to fight a war against HIV/AIDS in Pakistan (BBC, 2004), as this act is quite unusual in a Pakistani context. Since most of women with HIV/AIDS are reluctant to talk about the disease, the sample includes only 18 female respondents.

Table 1 also highlights another important aspect, namely that 65% of the respondents were fired from their job after having been diagnosed with the disease while 29% were forced to resign. These figures reflect the level of HIV/AIDS stigma at the workplace in Pakistan. Similarly, 123 respondents worked for fewer than 3 years after diagnosis of the disease, indicating that job loss is an imminent outcome once an individual is diagnosed with HIV/AIDS in Pakistan.

Table 1. Demographic characteristics of sample

Variables	% (*N*)
Sex	
Male	82% (142)
Female	18% (32)
Marital status	
Single	35% (61)
Married	65% (113)
Children	
Having children	56% (98)
No children	44% (76)
Education	
Illiterate	13% (23)
High school	26% (45)
Bachelors	38% (67)
Masters	23% (39)
Current work status	
Employed	06% (11)
Fired/dismissed due to HIV/AIDS	65% (113)
Resigned due to HIV/AIDS	29% (50)
Work experience after identification of HIV/AIDS	
<1 year	25 %(44)
1 - 3 years	45 %(79)
4 - 6 years	25 %(44)
>6 years	5% (7)

Results

The SPSS software was used to analyse the relationship between variables. The results obtained are given in the Table 2, which presents descriptive statistics and correlation between variables. Correlation indicates that stigma is significantly associated with breach of psychological contract (0.42**, $p<0.01$) and stigma is also significantly associated with organisational cynicism (0.47**, $p<0.01$). Correlation analysis lends support to our hypothesis that stigma at the workplace results in negative organisational outcomes. The mean score for stigma breach of psychological contract and organisational cynicism is 3.00, 2.92 and 2.90 respectively. These averages indicate that majority of respondents (any score greater than 2.5 on these scales) have been subjected to stigma breach of psychological contract and organisational cynicism.

Regression analysis (Table 3) was used to test the hypothesis that stigma is associated with organisational cynicism and breach of psychological contract. The results of regression analysis for breach of psychological contract indicate that stigma at the workplace significantly predicts breach of psychological contract ($\beta=0.36$, *F=13.88, t=6.91, Sig=.000*), lending support to the first hypothesis of the study. While regression analysis for organisational cynicism also supports our argument that stigma in the workplace significantly predicts organisational cynicism ($\beta=0.70$, *F=10.80, t=5.91, Sig=.000*) which supports second hypothesis of the study.

Table 2. Means, standard deviations, correlations and reliabilities

Variable	Mean	SD	1	2	3	4	5
Age	30.66	7.93					
Tenure	2.28	5.89	0.11				
Stigma	3.00	0.53	0.03	-0.16*(0.81)			
Breach of psychological contract	2.92	0.46	0.10	-0.13	0.42**(0.73)		
Organisational cynicism	2.90	0.79	0.10	-0.09	0.47**	0.36**(0.79)	

*p<0.05

**p<0.01

Table 3. Results of regression analysis for breach of psychological contract and organisational cynicism

	Breach of psychological contract			Organisational cynicism		
Predictor	**β**	**R2**	**△R2**	**β**	**R2**	**△R2**
Step1: Control variables		0.03				0.03
Step 2: Stigma	0.36**	0.20	0.16	0.70**	0.24	0.21

N=174; control variables were age and tenure.

Discussion

HIV/AIDS stigma at the workplace remains an understudied area. This study was mainly aimed to theoretically link stigma with a couple of workplace outcomes and to analyse its outcomes in a workplace setting. Generally we found a good support for our hypotheses, which establish that HIV/AIDS stigma at the workplace can result in negative workplace outcomes. There is a significant relationship between stigma at the workplace against PLHA and organisational cynicism. Similarly, our results of the present study also support the hypothesis that this stigma is a significant predictor of breach of psychological contract.

The significant association between workplace stigma and psychological contract breach indicates that PLHA perceive that their organisations do not fulfill their part of promises after identification of epidemic. At this crucial time when PLHA need a social and organisational support, firing them from jobs is indicative of a hostile environment for the PLHA. An important question at this point is why organisations are forced to take discriminatory actions against employees with HIV/AIDS. Since HIV/AIDS-related health care programmes are a 'costly exercise' (George and Quinlan, 2009) organisations are reluctant to spend huge amounts on treatment of employees with HIV/AIDS as their chances of survival are quite low. Organisations must take steps to reduce this feeling of breach of psychological contract to enhance desirable outcomes like commitment (Raja, Johns & Ntalianis, 2004), organisational citizenship behaviour (OCB) (Robinson, 1996) and to reduce undesirable outcomes like cynicism (Johnson & O'Leary-Kelly, 2003).

A strong positive association between HIV/AIDS stigma at the workplace and organisational cynicism indicates the level of frustration and feeling of hopelessness this stigma brings at the workplace. Since organisational cynicism serves as self-defense against unpleasant organisational actions (Reichers, Wanous & Austin, 1997) employees who face HIV/AIDS stigma are forced to have this negative attitude. In their comments on the questionnaires, the PLHA who left the organisations also reported that after identification of the disease the management of the organisations adopted a hostile attitude towards them. Most of the PLHA were assigned responsibilities in which there was no contact with customers or within the organisation, and no co-worker wanted to socialise with them. Some individuals reported extreme cases of stigma when they were not allowed to enter in a cafeteria. Not a single respondent was promoted after being diagnosed with the disease. Employers are free to take such discriminatory actions since there is no law or policy in Pakistan to protect PLHA. At individual organisation level, with few exceptions like Shell Pakistan, the author could not identify organisations having a documented policy for PLHA.

Co-worker pressure to remove PLHA from the workplace can also be a reason for discrimination against them. Hofstede (1980) considers Pakistan a highly collectivist society. The relationship among peers at the workplace can extend to personal lives where social and family interaction among peers is common. Workers are expected to participate in different social events involving a co-worker, like marriages, birthdays, deaths and illness. Due to a high social stigma in South Asia against PLHA (Bhattacharya, 2004) no employee would like to have a co-worker having the disease as it not only affects the work life but potentially personal life as well since the presence of PLHA in any social event is generally not desirable. When an employee is identified with HIV/AIDS the majority of employees and supervisors would forward their concerns about working with these individuals, which can ultimately force organisations to take discriminatory actions against PLHA.

Another aspect which possibly can result in HIV/AIDS-related stigma in the Pakistani workplace is a lack of knowledge about the disease, resulting in discriminatory actions against PLHA. Prostitution and homosexuality are present in Pakistan (Abdulla & Abdulla, 2007). However, being a predominantly Muslim country, hatred among the masses against people involved in such activities is very high and HIV/AIDS, for most of people, 'connotes homosexuality and sexual promiscuity' (Sikkema, Kochman,

DiFranceisco, Kelly & Hoffmann, 2003, p.166). HIV/AIDS does not spread through contact like hand shaking and hugging, which is culturally a mode of interaction even at the workplace in Pakistan. The majority of the population is generally unaware of modes of transmission of disease. The Pakistan demographic and health survey (2007) (Pakistan demographic and health survey, 2006-2007, available at http://www. measuredhs.com /pubs /pdf / FR200/FR200.pdf.) indicates a low level of awareness among the masses about transmission of HIV/AIDS. Workers who have daily interaction with one another might be afraid that they might get infected through hand-shaking, hugging or sharing toilets.

Conclusion

The highly active antiretroviral therapy (HAART) has increased the lifespan of PLHA and it has also enabled them to enjoy better health (Deeks , Smith & Holodniy, 1997), with the result that there are more people with HIV/AIDS who are employed by organisations. There is a need to protect their rights. At government level, there must be a comprehensive policy for protection of PLHA in the workplace while at organisational level policies must address grievances of PLHA by providing them job security and better health facilities. Since the major source of stigma comes from co-workers, extensive training sessions and awareness campaigns should be launched highlighting that HIV/AIDS does not spread through routine day-to-day contact at the workplace. The Government and other organisations can take an example of Shell Pakistan, who have initiated various programmes including strategic behavioural communications (SBC) to bring about positive behaviour and attitudinal changes towards HIV/AIDS. Through SBC, the company conducted various outreach and peer education activities on the issue by locally trained personnel.

Despite some significant findings, there are some limitations to the present study as well. The sample to some extent does not represent the population. There is no database of PLHA in Pakistan. The international and local agencies can provide a rough estimate of PLHA in Pakistan but no one maintains a proper database. One has to rely on limited information available in different organisations to find PLHA, hence the findings of the present study should only be generalised with caution. In future research, a more representative sample should be used to generalise the results. So far the author could not trace a scale developed specially to measure stigma at the workplace. Researchers should also try to address this issue in future research.

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