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## Details for Manuscript Number SSM-D-07-01816R2 “Stigma in the workplace: Employer attitudes about people with HIV in Beijing, Hong Kong, and Chicago”

**Deepa Rao,**

Evanston Northwestern Healthcare Evanston, IL UNITED STATES, [deepa-rao@northwestern.edu](mailto:deepa-rao@northwestern.edu)

**Beth Angell, Ph.D.,**

The University of Chicago, [angell@uchicago.edu](mailto:angell@uchicago.edu)

**Chow Lam, Ph.D., and**

Illinois Institute of Technology, [lam@iit.edu](mailto:lam@iit.edu)

**Patrick Corrigan, Psy.D.**

Illinois Institute of Technology, [corrigan@iit.edu](mailto:corrigan@iit.edu)

### Abstract

Studies of HIV stigma in China are becoming more prevalent, but these studies have seldom involved direct cross-cultural comparisons. Moreover, although researchers consider employers to be a key power group whose practices can significantly impact the adjustment and recovery of people with HIV, the attitudes of employers in China towards people with HIV have rarely been studied. The present study sought to investigate employers' attitudes and hiring practices towards people with HIV across three culturally and linguistically distinct cities: Chicago, Beijing, and Hong Kong. One hundred employers from a broad spectrum of firm types were interviewed across the three cities, and their qualitative data were analyzed for information about the processes behind employer practices in hiring people with HIV. Employers from all three cities showed reluctance to hire people with HIV, but this trend was most pronounced with employers from Beijing and Hong Kong. Concerns about biological contagion were apparent in all three cities. Social contagion, or the belief that people with HIV could morally corrupt those around them, was a particular concern of employers from Beijing and Hong Kong. The concerns about hiring people with HIV in Hong Kong and Beijing may be related to specific cultural dynamics related to loss of 'face', level of contact and knowledge about people with HIV, and the psychological interconnectedness between people in society. In sum, employers in all three cities showed concerns about hiring people with HIV, but at the same time, their attitudes about discriminating against people with HIV differed widely across the cities.

### Keywords

China; Hong Kong; HIV; Stigma; Cross-cultural; Employment; USA; workplace

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Correspondence to: Deepa Rao.

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## INTRODUCTION

The pioneering sociologist Erving Goffman (1963) defined stigma as “the situation of the individual who is disqualified from full social acceptance” (Goffman, 1963, Preface, unpaginated). Sociologists that followed have viewed stigma as a reflection of societal attitudes within the individual, and explain stigma in terms of power differences and decrements in social status between members of society (Markowitz, 2005). Sociologists often discuss structural discrimination, or the stigmatizing and restrictive policies of institutions, that can influence peoples’ attitudes and exacerbate a person’s level of suffering (Corrigan, Markowitz, & Watson, 2004). Parker and Aggleton (2003) used sociological theories to explain why stigma is so difficult to overcome: stigma functions at the intersection of ‘culture, power, and difference’, and it is embedded within basic hierarchical social structures within a society. Link and Phelan (2001) extend sociological theories of stigma to the domain of the interpersonal by theorizing a process in which actors with a stigmatizing condition apply generalized negative judgments about the conditions to themselves, and therefore anticipate that others will devalue and reject them.

Alternatively, social psychological and the related social-cognitive models consider stigma to be an internal process that leads to stereotyping and discrimination. Social psychologists have examined stigma in terms of cognitive, affective, and behavioral aspects: stereotypes or beliefs, prejudicial attitudes or emotional feelings, and discriminating behaviors toward stigmatized individuals (Ottati, Bodenhausen, & Newman, 2005). Stigmatizing attitudes held by some members of the community, including employers and healthcare workers, are viewed as forms of public stigma, or the negative reactions to people with a stigmatizing condition (Rusch, Angermeyer, & Corrigan, 2005).

In addition to these sociological and psychological perspectives on stigma, a third perspective highlights the importance of culturally-specific beliefs and value systems on stigma processes. Stigma is viewed as universally occurring, with localized differences tied to personal meanings and behaviors, as well as societal values and morals that are embedded within a culture (Yang, Kleinman, Link, Phelan, Lee & Good, 2007). Stigma exists across cultures, although it can take more severe forms with marginalized and vulnerable groups in developing nations (Deng, Li, & Zhang, 2007; Lee, 2002).

Folk conceptualizations about illness, sometimes called explanatory models, can lead to stigmatizing attitudes (Kleinman & Cohen, 1997; Kleinman, Wang, Li, Cheng, Dai, Li et al., 1995). Attribution theory (Weiner, Perry, & Magnusson, 1988) applied in studies of explanatory models illustrate this point: when blame and responsibility are placed on the person with a particular illness, subsequent social exclusion and other discriminative behaviors often occur (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). For example, Mak and colleagues (2006) compared public attitudes about HIV/AIDS, SARS, and Tuberculosis and found that people with HIV were seen as more responsible for acquiring their illness than people with SARS or Tuberculosis. As a result, people were more likely to keep their distance from people with HIV (Mak, Mo, Cheung, Woo, Cheung & Lee, 2006). In the United States, the perspective that illnesses have a physical cause can also be stigmatizing. Explanatory models outlining that mental illness has a genetic or biological cause can suggest that people with mental illness are dangerous and their illness is serious and pervasive (Phelan, 2005).

In addition, misinformation about an illness can distort conceptualizations about illness and lead to stigmatizing attitudes. In China, the prevalence rate of HIV has been relatively low (0.1% in China and 0.6% in the United States for people aged 15 to 49 (UNAIDS, 2006)). Areas with high rates of intravenous drug use or commercial blood donation have had higher rates of HIV infection than other areas (Wu, Sullivan, Wang, Rotheram-Borus, & Detels,

2007). Despite these low rates, misinformation, fear, and stigma around HIV have been high. Programs aimed at educating the public about HIV and its prevention have been a low priority in China (UNAIDS, 2002). As a result, a 2005 survey revealed that 63% of respondents believed that it was unsafe to work beside a person with HIV (Yimin, Xin, Ying, Na, Xianmi, Junqing et al., 2005). Furthermore, the news media in China recently ran multiple stories about 'AIDS needles' and 'AIDS criminals' which perpetuated the notion that people with HIV were dangerous and intensified the public's fears of people with HIV (Jing, 2006).

Yang and Kleinman (2008) present a model that seeks to explain how stigma cuts across interpersonal and societal levels in Chinese society, which includes the cities of Beijing and Hong Kong. At the interpersonal level, stigma is a social-cognitive phenomenon concerning attributions of blame and responsibility and at the societal or institutional level, stigma is reflected in the laws and regulations that are enforced or not enforced. The Yang and Kleinman model proposes that the notion of 'face' and its associated social capital, mediate the relationship between interpersonal and societal factors (Yang & Kleinman, 2008). The concept of 'face' represents social power and capital, a person's value in society, and a person's ability to negotiate social networks (*guanxi*) in a Chinese system of ethics (*renqing*) (Hu, 1944; Hwang, 1987). A stigmatized person loses 'face', or social standing, and the moral implications reflect "what is most at stake" in Chinese society (Yang et al., 2007).

### Studies of HIV Stigma in the United States and China

The stigma associated with HIV/AIDS has been heavily researched within the United States, and studies have shown that the public viewed HIV/AIDS more negatively than many other mental and physical illnesses (Corrigan, River, Lundin, Wasowski, Campion & Mathisen, 2000; Crawford, 1996). In a U.S. national survey conducted between 1991 and 1999, one third of American adults reported negative attitudes towards people with HIV (Herek, Capitanio, & Widaman, 2002).

In China, a recent study of urban market workers found that the majority of their participants thought that people with HIV should not be allowed to take care of other people's children and should be isolated and punished (Lee, Wu, Rotheram-Borus, Detels, Guan & Li, 2005). Another study found that healthcare workers suffered a stigma by association, or 'courtesy stigma', because they cared for people with HIV (Li, Lin, Wu, Wu, Rotheram-Borus, & Detels, 2007). Likewise, people with HIV in the newly annexed Hong Kong have experienced stigma and discrimination primarily within their social support systems and workplace (Lau, Tsui, Li, Chung, Chan & Molassiotis, 2003). Two other studies found that training programs did not influence healthcare workers' attitudes about people with HIV, and these studies concluded that healthcare workers had insufficient knowledge of HIV/AIDS (Anderson, Qingsi, Guanglin, Zhijun, & Wei, 2003; Li, Wu, Wu, Zhaoc, Jia & Yan, 2007).

### Employment Discrimination

Public stigma influences recovery from illness and the reintegration of people with disabilities into communities (Corrigan et al., 2004). Persons with disabilities often experience discrimination in hiring and employment, which contributes to social isolation and can further exacerbate symptoms of illness (Perlick, Rosenheck, Clarkin, Sirey, Salahi & Struening, 2001). People with HIV/AIDS often lose jobs when co-workers discover their HIV status. In China and the United States, this can mean that people with HIV without jobs may have difficulty meeting their basic needs. In the United States, this can result in a loss of health insurance benefits, which can impact access to treatment and, ultimately, survival (Kass, Munoz, Chen, Zucconi, Bing & Kass, 1994). Despite the fact that employers are a key power group, there are few studies of Chinese or U.S. employers' attitudes towards people with HIV/AIDS.

One investigative team examined employer policies and practices around people with HIV globally and outlined forms of employment discrimination: mandatory testing at recruitment, mandatory testing during employment, questions on recruitment forms, lack of confidentiality, dismissal, restriction in job duties, and denial of employment (Reidpath, Brijnath, & Chan, 2005). In a similar analysis, Saich (2006) found a discrepancy between public policy and local practices in his analysis of social policies towards the employment of people with HIV in China. He outlined that China has regulations similar to the United States' Americans with Disabilities Act. The 'Law of the People's Republic of China on the Protection of Disabled Persons' protects people with disabilities and contains special clauses mandating employment rights for people with disabilities. The Chinese law states, "No discrimination shall be practiced against disabled persons in recruitment, employment, obtainment of permanent status, promotion, determining technical or professional titles, payment, welfare, labor insurance or in other aspects" (Disability Rights Education and Defense Fund, 2008). Some employers may not consider people with HIV/AIDS to be 'disabled', and so regulations were implemented in 2006 and 2008 to protect people with HIV from employment discrimination in China (Lauffs, 2007). Furthermore, in the city of Suzhou in Jiangsu province, officials passed regulations protecting people with HIV from employment discrimination locally (Human Rights Watch, 2002). In Hong Kong, there is a separate policy on disability discrimination called the "Disability Discrimination Ordinance (DDO)", which protects people with HIV and other disabilities from employment discrimination (Hong Kong Equal Opportunities Commission, 1998). Although China has promoted such policies that prohibit employment discrimination of disabled persons, Saich concluded that the Chinese government has had trouble implementing and enforcing such policies (Saich, 2006).

Given these studies of governmental policies and local practices, we set out to explore employer attitudes behind these practices in three culturally distinct cities: Chicago, Beijing, and Hong Kong. The study presented here is part of a larger, cross-cultural study of employers' attitudes and hiring practices with people with mental and physical illnesses (Tsang, Angell, Corrigan, Lee, Shi, Lam et al., 2007). The purpose of the present report was to explore and make cross-cultural comparisons of employers' attitudes about hiring people with HIV. We primarily used qualitative methodologies, from which we expected that details about any stigmatizing processes involved in employers' hiring practices would emerge.

## METHODS

### Participants

Our methodology was shaped by the Grounded Theory perspective (Glaser & Strauss, 1967; Corbin & Strauss, 2008). We conducted our study in the three major urban centers of Chicago, Beijing, and Hong Kong in order to assess small business owners about their attitudes about disability and their hiring practices. We chose to assess small business owners, rather than human resources department personnel, in order to examine the attitudes of employers who had maximum discretion in hiring. Employers were recruited for this study using representative sampling procedures in order to assure that the study included employers from a broad spectrum of firm types. Our multisite design precluded the use of theoretical sampling to select firms and their employers. In Chicago, employers were selected from a small business owners' directory; in Beijing and Hong Kong, small business owners were selected from a list of trade association members. Stratified sampling procedures were used in all three cities in order to over-sample women and minorities, and include 4 to 6 employers from industry categories (business, education, manufacturing, healthcare, and the high/low technology industries) selected from the Standard Industrial Classification system (U.S. Department of Labor, 2008). For example, an employer from the business category owned an air freight business, from the education category owned a computer training facility, from the manufacturing

category owned a toy assembly plant, in healthcare owned an assisted living home, in high technology was an information technology consultant, and in low technology owned a travel agency.

Each prospective participant was sent a letter that described the project as a study of hiring decisions in the small business environment, which was subsequently followed by a telephone call in which the business was screened for eligibility (firm size of fewer than 100 employees and no human resource department). To protect participant anonymity, employers were asked to provide verbal consent and no identifying information was retained following the collection of data.

### Data Collection Procedures

The interviews were administered in person by trained research assistants in Chicago, Hong Kong, and Beijing in 2004 and 2005. In Beijing and Hong Kong, the research assistants were students at local universities and bilingual. They spoke English, were native speakers of Mandarin (in Beijing) or Cantonese (in Hong Kong), and conducted the interviews in these languages. In Chicago, the research assistant had obtained her masters' degree and conducted the interviews in English. Each research assistant (8 in Beijing, 1 in Hong Kong, and 1 in Chicago) trained by reading background material on interviewing in research, reading a training manual, and watching a videotape of a model interview being performed by a study investigator (B.A.). The research assistant in Hong Kong flew to Chicago and was trained directly by this investigator. Then, the research assistant from Hong Kong flew to Beijing and personally trained the Beijing research assistants. The assistants were given a script to follow, which contained semi-structured interview questions. They were encouraged to probe participants further when responses were vague or unclear. The interview questions inquired about employers' attitudes about hiring, disability, and 4 specific health conditions: mental illness, chronic illness, alcohol and drug abuse, and HIV/AIDS. The interviews took approximately one hour to complete, and participants were paid 75 USD (approximately 585 HKD and 621 RMB in 2004 and 2005) for their participation. Each interview was audio-taped and professionally transcribed verbatim in the native language of the site. The interviews from Beijing and Hong Kong were then translated from Mandarin and Cantonese into English by certified translators. For purposes of this report, we analyzed data from responses to questions about HIV/AIDS listed in Table 1.

### Data Analysis

**Qualitative Analysis**—We used dimensional analyses frameworks to guide our data analysis procedures (Schatzman, 1991; Corbin & Strauss, 2008). Dimensional analysis was developed by Schatzman (1991) as a more flexible approach to grounded theory analysis. It involves scrutinizing qualitative texts (e.g., interview transcripts) and designating conceptual labels (codes) for all aspects of a phenomenon of interest in order to organize the resulting concepts into a theoretical explanation of that phenomenon (Kools, McCarthy, Durham, & Robrecht, 1996).

The primary data analyst (D.R.), who had prior training in qualitative data analysis, began this analysis by reading through the English translations of the participants' transcripts from all three cities in their entirety in order to familiarize herself with the employers' views on disability and hiring. She then read through the sections in which participants responded to questions about HIV/AIDS and made notes on the responses provided in the transcripts (Corbin & Strauss, 2008; Miles & Huberman, 1994). She read through the transcripts again to code the initial themes and sub-themes, and again to collapse categories that appeared similar. The primary data analyst met once with the investigator on the project (B.A.), who has expertise in qualitative data analysis. The investigator read through, and was familiar with, the participant

responses in each of the transcripts. The analyst and the investigator reviewed the initial codes and themes that emerged from the first set of analyses. Through this review, the investigator helped to check for biases in the analysis. She and the data analyst discussed the interrelations between the themes that emerged from the data. This set of themes was then presented to the larger group of study investigators, who made suggestions on renaming, collapsing certain themes, and modeling the relationships between the themes. Points of disagreement were resolved by consensus. The result of these discussions was the final set of themes and subthemes listed in Figure 1.

**Quantitative Analysis**—We were interested examining the statistical significance of differences in the distribution of themes across cities, and so the employer responses were further coded to reflect 4 variables: whether or not the employer (1) made reference to knowing someone with HIV, (2) would hire someone with HIV, and referenced (3) biological contagion or (4) social contagion themes. We limited our coding to these four themes because these themes were the most widely discussed of the set of seven themes extracted from the employers' responses. Coding of the first two variables (employer referenced knowing someone with HIV; employer would hire someone with HIV) were based on responses to closed ended questions and thus the answers to these questions directly led to each code. Similarly, the coding of a response as referring to biological or social contagion was also straightforward. These dichotomous codes were entered into a Statistical Program for the Social Sciences (SPSS, 2002) database. Chi square tests of significance with these 4 variables were performed in order to examine the statistical significance of thematic differences across the 3 cities and 6 industry categories. A Chi Square distribution was used to analyze this data because of its ease of use with small or large sample sizes (Daniel, 1999).

## RESULTS

In all, 100 employers were interviewed in Hong Kong (N=30), Beijing (N=30), and Chicago (N=40). In Chicago, participants were primarily from African-American, Hispanic/Latino, and Asian ethnic minority backgrounds. The employers came from the business, education, manufacturing, healthcare, and the high/low technology industries, and the employers' industries were evenly distributed across the three cities. Demographic and employment characteristics for the participants are detailed in Table 2.

### Contact with People with HIV

Remarkably, 18% of the employers in Chicago indicated that they knew a person with HIV/AIDS, whereas 0% of the employers in Hong Kong and Beijing indicated that they knew a person with HIV/AIDS, either professionally or personally. However, the employers in Hong Kong and Beijing had knowledge of HIV/AIDS and knew there were people affected by the illness living in China. In Chicago, employers who knew people with HIV connected their experience of people with HIV with their duties as employers. For example, a male real estate employer stated, "I've had a friend for the past 15 years who lives with HIV and she performs like nothing. What would she have done? Not had a job for the last 15 years?" In this case, having contact with a person with HIV was related to an increase in sympathy and openness to hire a person with HIV.

### Likelihood of Hiring

In all three cities, employers across the healthcare, manufacturing, and technology fields questioned whether a person with HIV could handle the workload, both physically and psychologically. After expressing these concerns, each of the 100 employers interviewed chose which type of potential employee they were most and least likely to hire: a person with chronic illness, mental illness, substance dependence, or HIV/AIDS. More employers from Beijing

(47%) and Hong Kong (37%) indicated that they were least likely to employ a person with HIV than employers from Chicago (15%). Chi square tests indicated that these differences were significant across cities ( $\chi^2 = 8.68, p < 0.05$ ). In Chicago, concerns about hiring a person with substance dependence were more common than concerns about hiring a person with HIV/AIDS. As a female home healthcare employer from Chicago explained, "Hiring someone with HIV isn't really an issue because all of my nurses are supposed to use universal precautions and you can't catch it from breathing or touching". Thus, in Chicago, healthcare employees' confidence that fellow employees used universal precautions likely influenced this employer to convey that she would hire a person with HIV.

## Contagion

In all three cities, the employers appeared to have concerns about the contagiousness of HIV/AIDS. Notions of contagion took on two forms: social and biological. In terms of biological contagion, employers had concerns about becoming infected themselves, and about their employees' fear of becoming infected. Employers who described social contagion were concerned that persons with HIV might negatively influence others around them and lower the social status of those associated with them.

**Biological Contagion**—In Beijing, Hong Kong, and Chicago, 23%, 40%, and 20% of employers mentioned biological contagion respectively. Chi square tests showed no significant differences in references to biological contagion across the three cities or across industries, indicating that concerns about biological contagion came from employers in all three cities and all five industries. However, in Chicago, a trend was noted in which employers referencing biological contagion tended to be from the educational and low technology fields ( $\chi^2 = 9.36, p = 0.096$ ).

In all three cities, concerns about biological contagion stemmed from lack of knowledge and misinformation about how HIV is transmitted. For example, a female kindergarten employer from Beijing stated, "[HIV/AIDS] can be spread by body fluid, what about saliva? Tears can also spread AIDS, I read about it two days ago. If AIDS can really be spread by tears, does it imply that it can also be spread by saliva?" Similarly, a male manufacturing employer from Chicago stated, "From what I understand it can be passed through blood and saliva. What if this guy is drinking water? Maybe he goes in the refrigerator and drinks out of a bottle and puts it back and the next guy comes in." In providing inaccurate information about how HIV is spread, these respondents demonstrated that people from all three cities continue to have misinformation about how HIV is spread.

Most employers gave measured responses about the biological contagiousness of people with HIV. For example, a computer training employer from Hong Kong stated, "You can say it's an emotional or unreasonable or irrational worry, even if we know that mist wouldn't spread the virus, we would still worry about it. But because the consequence is big, you still have worries. Maybe it's because we don't know much about AIDS. I think AIDS is a high risk disease". This employer acknowledged that he doesn't have much knowledge about HIV/AIDS, and related his lack of knowledge to his concern about becoming infected.

**Social Contagion**—In addition to these biological concerns, employers in all three cities discussed the method by which one could become infected with HIV, a person's responsibility for contracting their illness, a person with HIV's potential for malevolently influencing those around them, and a need for distance from people with HIV because of this potential. Chi square tests showed that themes of social contagion were more prevalent in Beijing and Hong Kong than Chicago ( $\chi^2 = 6.7, p < 0.05$ ). In Beijing and Hong Kong, 27% and 13% of employers

mentioned social contagion, whereas only 5% of employers from Chicago mentioned social contagion.

Employers in our sample who discussed social contagion often assigned judgments to people with HIV based on the manner in which they became infected. For example, a male retirement home employer from Hong Kong stated, “It is totally two different stories whether one gets the disease because one misbehaves or if one gets it simply because one is unlucky. If, within my capacity, I know that one gets the disease because of his/her immoral life, I will try to see how I can stand by him/ her as a friend. Yet, I don’t want to see my children having anything to do with people of this kind. I think it is morally incorrect.” A vocational school employer from Beijing connected responsibility for illness to hiring practices, “Well, if he [contracts HIV/AIDS] passively, I think there is no problem at all. It is because I understand that AIDS is not risky in daily contacts...However, if he contracts HIV/AIDS by himself, I would definitely not hire him. Our first concern is about hiring a person is his personality; skill is the second thing only. Hence, I emphasize how he lives as a person”. These statements appear to reflect negative moral judgments made about people with HIV based on what some consider ‘deviant’ behaviors associated with routes of HIV transmission (e.g. commercial sex work or intravenous drug use). These employers expressed a desire to distance themselves from people with HIV because of a perception that people with HIV were responsible for acquiring HIV and could negatively influence those around them. These employers communicated a concern that people with HIV would engage in behaviors that would set a poor example for others.

Several employers from Beijing and Hong Kong discussed the importance of morality as a factor in hiring, reflecting that the Chinese system of ethics (*renqing*) has a role in the workplace. Employers in Beijing and Hong Kong defined immorality in terms of ‘deviant’ behaviors such as abuse of narcotics or alcohol. Similarly, a Chicago employer defined morality as “doing right when no one was looking”. In Beijing, moral behavior as it related to HIV transmission was defined as acquiring HIV through blood transfusion or needle stick. In Beijing, if a person was seen as responsible for acquiring an illness, such as in the case of intravenous drug use, then their behaviors were seen as immoral and their character seen as flawed.

### Workplace Harmony

In Beijing and Hong Kong, employers focused on the possibility that their current employees would have concerns about working beside a person with HIV/AIDS. An employer from Hong Kong stated, “The colleagues will wish to leave the company because they may be afraid of being infected—this is my main concern”. A female sales employer from Hong Kong explained, “I cannot ignore other people’s thoughts because of one single colleague. It is because this would break what I emphasize most: harmony”. Similarly, a female kindergarten employer in Beijing stated, “If he is my relative, and he says to me ‘I have no job, I need your help otherwise I cannot live on.’ I won’t give him the job...it is selfish to do that. You may be sympathetic for him but you cannot offer him the job, otherwise he may cause fear to the staff.” These Beijing and Hong Kong employers appear to be concerned about relationships between employees within the workplace, and specifically, they expressed a desire to keep fear and mistrust between employees at a minimum.

Moreover, employers in all three cities expressed feelings of obligation to tell current employees of the company that they were thinking of hiring a person with HIV. A male manufacturing employer from Chicago stated, “I think [the other employees] have a right to know that this person has this problem”. Surprisingly, the employers who felt the need to tell others about potential job candidate’s HIV status made no mention of regulations around a person’s right to confidentiality about his or her health status.



## Public Image of the Company

In all three cities, employers were concerned about disruptions that might occur in customer relationships if they hired a person with HIV. They showed concern that the reputation of their company would be affected by their personnel hiring decisions. For example, a retirement home employer in Chicago stated, “I don’t think they could have direct contact with patients anymore because of the lack of education a senior citizen has...I don’t think that a senior citizen could deal with being in direct contact with this person”. Similarly, a male hospital employer from Beijing stated, “If patients knew about a [staff member with HIV/AIDS], they will not have a good impression of our hospital”. In Beijing and Hong Kong, the employers may be concerned about the loss of ‘face’ associated with a person with HIV or the company’s loss of ‘face’ if that employee’s HIV status was known.

In Chicago, many employers were concerned about government regulations and potential lawsuits that may result from hiring a person with HIV/AIDS. Not surprisingly given the differences in the legal environment in China, employers in Beijing and Hong Kong were less concerned about this issue. In Chicago, a home healthcare employer stated, “even though we provide care for people with HIV, we wouldn’t put them in that risk or put the agency in jeopardy for a lawsuit...as far as state regulations are concerned, we could not knowingly hire someone with a disease of that nature to care for our patients”. Interestingly, this respondent seemed to misunderstand regulations around hiring discrimination. In the United States, a lawsuit can be filed if it became known that a job candidate was not hired because of their HIV status.

## Discrimination in Hiring

Notably, we found that some employers from Beijing were quite open about stigmatizing attitudes and discriminating behaviors. This openness was not found with employers from Hong Kong or Chicago. A technology employer in Beijing stated, “as long as [people with HIV] exist, they will be a big threat to everyone.” Some employers in Beijing conveyed that hiring discrimination was acceptable in their environment. For example, a Beijing store owner stated, “I think [people with HIV] are like a time bomb...I would not hire [a person with HIV] under any circumstances, unless everyone in the world were dead or had AIDS; people in this society should discriminate against them...the society requires stability and peace”. A kindergarten employer said, “[A person] has to bear the consequences of AIDS if he or she gets infected because of his or her improper behavior. I think that person deserves discrimination from society”. These responses from the Beijing employers seem related to the other themes highlighted here, such as social contagion, workplace harmony, and the public image of the company. The employers’ assumed that a person with HIV has engaged in immoral behaviors associated with HIV, and because of this, people with HIV should be kept separate from others. These beliefs appear to lead to the conclusion that hiring discrimination is acceptable and would preserve workplace harmony.

## DISCUSSION

Results from these analyses showed cross-cultural similarities and differences in the processes associated with HIV stigma and hiring practices. The most obvious similarity across sites was the general reluctance to hire people with HIV. However, this reluctance was more pronounced in the Beijing and Hong Kong sites. In addition, Chicago, Beijing, and Hong Kong employers differed in terms of knowing a person with HIV, comfort with hiring discrimination, and beliefs about the contagiousness of HIV/AIDS. Government regulations, level of contact with people with HIV, and certain socio-cultural and psychological factors likely influenced differences in employer attitudes and behaviors towards people with HIV. Additionally, we must consider that much of the Chinese government response to HIV/AIDS began in the late 1990s and

information on HIV/AIDS prevention and intervention is still becoming known to the general public (UNAIDS, 2002). As a result, many employers in China may still have misunderstandings about people with HIV and regulations around hiring people with HIV.

Our quantitative analyses suggested that employers from Beijing and Hong Kong would be least likely to hire a person with HIV and more likely to hire a person with another type of illness. Our qualitative analysis provided more insight into these cross-cultural differences by revealing the meaning behind the employers' responses. In Chicago, some of the employers were familiar with government regulations around infectious diseases such as taking 'universal precautions'. In China, most employers did not make reference to any government laws or guidelines around infectious disease or hiring discrimination. Thus, it seems likely that, although regulations similar to the Americans with Disabilities Act and 'universal precautions' exist in China, knowledge, practice, and enforcement of these policies may not be as widespread in Beijing as in the Chicago. This would be consistent with Saich's (2006) appraisal of China's difficulty in enacting government policies at the local level (Saich, 2006). Kohrman (2005) also discussed that despite recent governmental changes in policies towards people with disabilities, discrimination of the disabled continued (Kohrman, 2005).

The employers in Chicago stated that they had contact with people with HIV, whereas employers in Hong Kong and Beijing did not. Furthermore, contact with a person with HIV in Chicago was related to more sympathetic responses about hiring a person with HIV. This finding is consistent with research on the Contact Hypothesis, or the notion that contact under cooperative, personalizing conditions can help to promote sympathy and decrease hostility between them (Dixon, Durrheim, & Tredoux, 2005). Studies within our research group have suggested that negative attitudes towards a person with a stigmatizing condition can decrease with face-to-face contact (Corrigan, Larson, Sells, Niessen, & Watson, 2007; Rao, Feinglass, Corrigan, 2007). These studies imply that HIV education programs alone may not work to decrease stigma unless they incorporate face-to-face contact with a person with HIV. However, to date, there is no research on whether contact has such an impact on reducing stigma in non-Western cultures, and so further studies are needed to determine if educational programs that incorporate contact can reduce stigma in cities like Beijing and Hong Kong.

Employer concerns of biological contagion existed across all three cities, but social contagion was a more prominent concern among employers in Beijing and Hong Kong. Employers in Beijing and Hong Kong held attitudes that people with HIV who acquired HIV/AIDS could socially corrupt people around them and suggested that hiring a person with HIV could disrupt workplace harmony. Haslam (2005) identified 'moralizing' as one of four dimensions that reflect essentialist thinking, tied to beliefs about responsibility, controllability, and intentionality for having a condition. Bastian and Haslam demonstrated that essentialist beliefs were predictive of stereotype endorsement (Bastian & Haslam, 2006). Accordingly, our data suggested that stereotyped thought about people with HIV is tied to beliefs about immorality.

Several other studies conducted in non-Western countries have identified concerns about social contagion. In India, studies have found that explanatory models dictated that family members of persons with mental illness experience courtesy stigma, and become socially contaminated (Phillips, Pearson, Li, Xu, & Yang, 2002; Raguram, Raghu, Vounatsou, & Weiss, 2004). In China, a recent study of healthcare workers found them to be stigmatized simply because they care for people with HIV (Li, Lin et al, 2007). Interestingly, these concepts of social contagion have appeared in studies conducted in countries with large populations, where proximity, interconnectedness, and collectivism may be important issues. Collectivist societies emphasize collective identity, interdependence, and duties/obligations to family and society, whereas individualist societies have members that emphasize emotional independence and privacy (Kim, Triandis, Kagitcibasi, Choi, & Yoon, 1994). A recent meta-analysis revealed that

collectivism is more prominent in China than other Asian countries (Oyserman, Coon, & Kimmelmeier, 2002). At the social-cognitive level, researchers have viewed the individualism-collectivism categorizations in terms of self construal. Markus and Kitayama (1991) attributed the ability to adjust, promote others' goals, and maintain harmony with the social context to the non-Western interdependent self construal and the ability to express oneself and promote one's own goals to the Western independent self construal. The present findings suggest that some employers from Beijing and Hong Kong would refrain from hiring a person with HIV to maintain workplace harmony, which may be a reflection of society's collectivist tendencies and a person's interdependent self construal (Markus & Kitayama, 1991).

Finally, Yang and Kleinman's (2008) model outlined the process of losing 'face', a concept that is fundamentally important to people in China. Even though HIV is less prevalent in Beijing and Hong Kong, the employers in these cities had concerns about hiring a person with HIV. Losing 'face', to these employers, reflected "what is most at stake" in Chinese society (Yang et al., 2007). To the employers in Beijing and Hong Kong, immoral behaviors associated with HIV led to the attitude that people with HIV were morally flawed. The Beijing and Hong Kong employers' responses implied that an association with a person with HIV can lead to loss of 'face' and a devaluation of the public image of their company. Yang and Kleinman (2008) described that these processes are an underwritten part of Chinese society, and as such, they can also affect the government's enforcement of policies and regulations that protect people with HIV.

Our study had limitations. First, the study was conducted in three major metropolitan cities, and our findings could have differed if we surveyed employers in rural areas of the United States and China. Therefore, our findings cannot be generalized beyond urban employers situated in Chicago, Beijing, and Hong Kong. Furthermore, we coded the transcripts based on English translations of the interviews, and as a result, certain phrases or explanations may have been difficult to translate and missed in the analysis.

Despite these limitations, our findings suggest that attitudes towards people with HIV are influenced by societal, cultural, and psychological factors, and that a culturally-specific, multidisciplinary theoretical model may be useful in understanding stigmatizing attitudes across cultures. Employers' attitudes about people with HIV in China appeared to be related to the interconnectedness between individuals, governmental policies, as well as their own individual conceptions and misconceptions about how HIV/AIDS is transmitted. Generally, the employers in all three cities showed concerns in hiring people with HIV and at the same time, their attitudes about discriminating against people with HIV differed widely across the three cities.

These findings also suggest that HIV stigma reduction intervention programs which include face-to-face contact with people with HIV, conducted at the institutional as well as individual levels, could be useful. However, given the culturally-specific processes involved in the formation of stigmatizing attitudes, it will likely be beneficial to modify programs based on these cultural differences. For example, in China, stigma reduction interventions could be designed to target culturally-specific phenomenon, like loss of 'face', or social standing, for people with HIV.

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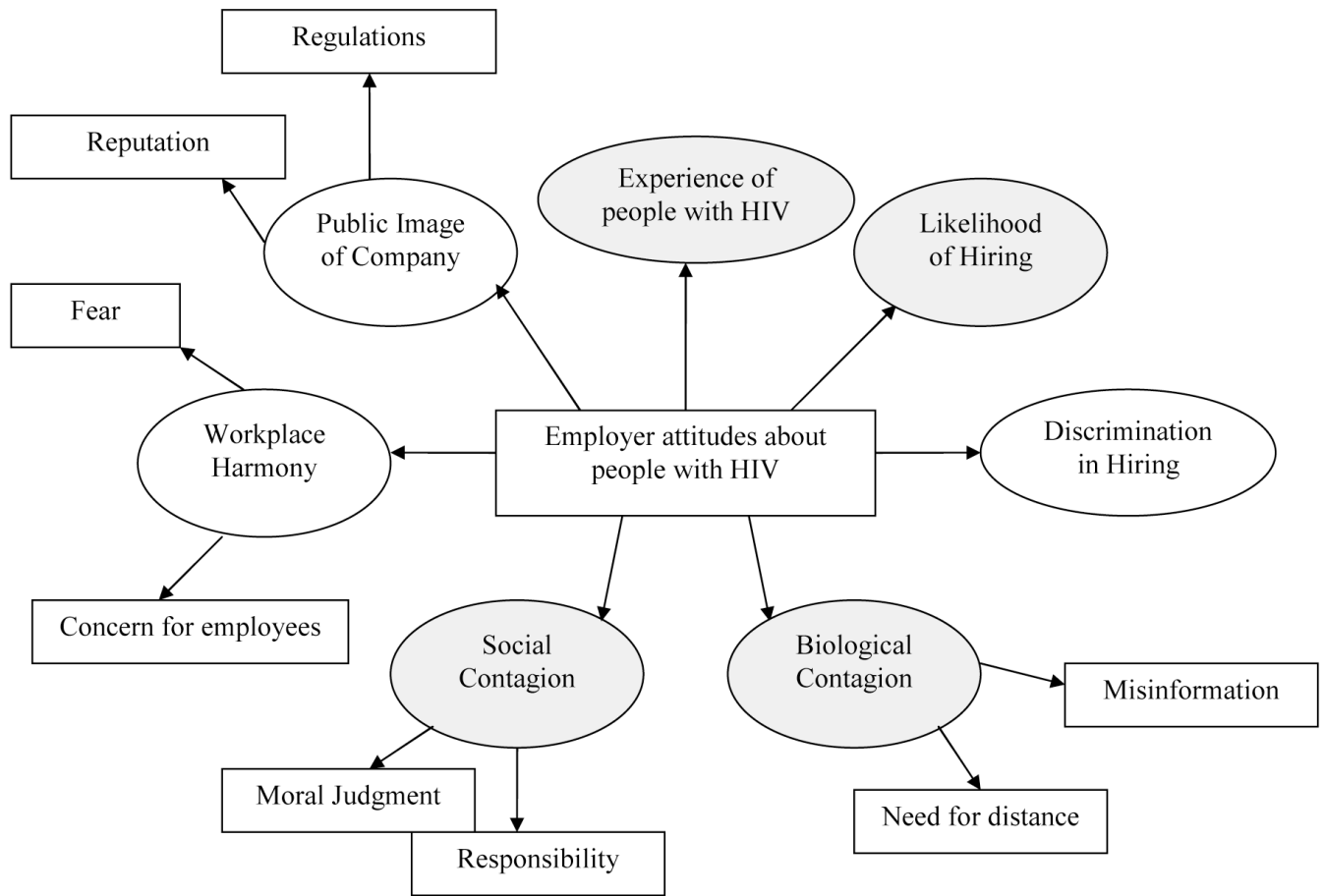
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**Figure 1.** Themes and subthemes derived from qualitative analysis of employer interview transcripts. The shaded areas represent themes that were further coded for quantitative analysis.

**Table 1**  
Interview questions related to people with HIV.

- 
1. What does HIV/AIDS mean to you? What does this term bring to mind?
  2. Have you ever had anyone with HIV/AIDS apply for jobs within your firm? (If yes, how did you know?)
  3. Have you found out that any of your employees had HIV/AIDS? (If yes, what happened next/what did you do?)
  4. Have you had any personal experience with people with HIV?
  5. What are your concerns about hiring people with HIV? (Specific probes about ability to handle job, performance, motivation, communication skills, getting along with other workers, tardiness/attendance)
  6. If you had candidates with each of the 4 conditions (mental illness, chronic illness, substance abuse, and HIV/AIDS), which person would you least prefer to hire? Most prefer to hire?
-



**Table 2**

Socio-demographic and employment characteristics of participants in Beijing (N=30), Hong Kong (N=30), and Chicago (N=40).

	<b>Beijing</b> Frequency (%)	<b>Hong</b> Frequency	<b>Chicago</b> Frequency (%)
<b>Race/Ethnicity</b>			
White	--	--	8 (20%)
African-American	--	--	16 (40%)
Hispanic/Latino	--	--	9 (22.5%)
Asian	30 (100%)	30 (100%)	7 (17.5%)
<b>Gender</b>			
Men	17 (56.7%)	13 (43.3%)	17 (42.5%)
Women	13 (43.3%)	17 (56.7%)	23 (57.5%)
<b>Industry</b>			
Business	7 (23.3%)	5 (16.7%)	7 (17.5%)
Education	6 (20%)	5 (16.7%)	6 (15%)
Manufacturing	4 (13.3%)	5 (16.7%)	5 (12.5%)
Health	4 (13.3%)	5 (16.7%)	9 (22.5%)
High Technology	5 (16.7%)	5 (16.7%)	6 (15%)
Low Technology	4 (13.3%)	5 (16.7%)	7 (17.5%)