NEEDS ASSESSMENT FOR THE ESTABLISHMENT OF AN HIV AND AIDS SUPPORT GROUP PROGRAMME WITHIN THE SOUTH AFRICAN POLICE SERVICES: HEAD OFFICE DIVISIONS

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DECLARATION

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and has not been submitted previously at any other university for a degree.

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Signature

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Date

ABSTRACT

This study is a need assessment for the establishment of an HIV and AIDS support group within the South African Police Services (SAPS), Head Office Divisions and the purpose was to explore the extent to which an HIV and AIDS support group was needed for HIV and AIDS-infected and affected personnel within the South African Police Services (SAPS). The SAPS employees as well as HIV and AIDS programme managers participated in the study. A combination of quantitative and qualitative data was used in the study. The former was obtained from a survey of 90 SAPS personnel based at the SAPS Head Office Divisions in Pretoria. The latter, on the other hand, was obtained from in-depth interviews with five SAPS HIV and AIDS programme managers, also based at Head Office Divisions in Pretoria.

The overall results showed that an internal workplace HIV and AIDS support group for infected and affected employees was seen as necessary to deal with the psycho-social and emotional needs of the personnel. The study participants were generally of the view that such a support group would go a long way in addressing some of the challenges and obstacles – such as stigma, discrimination, judgement and so forth – faced by HIV and AIDS-infected and faced employees within the SAPS.

In general, it was envisaged that a workplace support group would create a warm and caring environment that would enable employees to feel safe and supported by their colleagues – including commanders and managers – in dealing with their HIV and AIDS situations.

KEY WORDS

Needs assessment, support group, discrimination, stigma, HIV, AIDS, Police Service, Employee Assistance Programme, employees, work place programme.

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CHAPTER 1: INTRODUCTION

1.1 Introduction

Although South Africa's HIV prevalence has stabilised over the last decade (Karim and Karim, 2010; Juma and Klot, 2011), the country remains one of the most affected by the HIV and AIDS pandemic in the world. Estimates from Statistics South Africa indicate that 5.1 million people (9.9% of the total population) were living with HIV in 2012. This is an increase from the four million HIV-positive people (8.7% of the total population) reported in 2002 (Statistics South Africa, 2013). The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that there were 270 000 deaths due to AIDS in South Africa in 2011 and that just over two million children aged 0-17 years had been orphaned by the pandemic by the same year (UNAIDS, 2012).

Although HIV and AIDS is fundamentally a health issue (Harman and Lisk, 2009), its impact goes far beyond health because of its widespread social and economic effects. According to UNAIDS (2010), the social impacts of HIV and AIDS are reflected in, among other things, many families being pushed into poverty as a result of loss of income as family breadwinners leave jobs or die from the epidemic, and due to increased cost of taking care of those who are sick. In addition to the increasing number of orphans, the pandemic has increased the care burden of families, particularly grandparents who are left with the responsibilities of being the breadwinners and care givers for their grandchildren whose parents have died due to AIDS (Page, Louw and Pakkiri, 2006).

Economically, HIV and AIDS have had a great impact on growth, income and development. It affects mostly the working-age group. Many workplaces have lost many experienced and skilled labour due to mortality or early retirement; have had increased incidences of staff morbidity and absenteeism, and increased need for training and replacement of staff (Department of Public Service and Administration, 2002).

HIV and AIDS can also be seen as a workplace issue because it affects workers and their families. HIV-infected employees, for example, often face potential stigma and discrimination, and the fear of these negative attitudes limits the possibility of disclosure, even to potential important sources of

support, such as family and friends (Skinner and Mfecane, 2004).

Similarly, Hope (1999) argues that it is often difficult for employees to admit that they are HIV positive or are suffering from AIDS due to fear of losing their jobs or being rejection by colleagues. The workplace is, therefore, one arena to address the broad issue of HIV and AIDS. To this end, HIV and AIDS workplaces programmes can discourage HIV and AIDS-related stigma and discrimination; improve workers' health, morale, and productivity; and help management minimise workplace costs (Slack, 1998)

It is largely against this background that the Department of Public Service and Administration (DPSA) in South Africa (the government entity mandated on fostering administration in the public service) has developed a policy framework that guides the management of HIV and AIDS in the workplace. As a government department, the South African Police Services (SAPS) is also mandated to take part in the fight against HIV and AIDS in accordance with this framework According to the Public Service Commission (2006), the framework:

> *Is a resource document to assist governments to plan, implement and monitor appropriate and effective responses to HIV/AIDS within the public service' working environment. As such, it focuses on internal workplace issues and contains guidelines on how to manage the impact of HIV/AIDS on the public service from an employment perspective.*

In line with this framework, the purpose of this study was to undertake a needs assessment for the establishment of an HIV and AIDS support group within the SAPS as part of the Police Services response to HIV and AIDS. The support group was intended for employees infected and affected by HIV and AIDS in the SAPS, Head Office Divisions.

The study was undertaken at the SAPS Head Office Divisions in Pretoria in 2012. The Head Office Divisions consist of different divisions that include human resource development, supply chain management; criminal record centre; detective services; personnel services; visible policing; finance and administration services; protection and security services; national inspectorate; among others.

1.2 Statement of the problem

At the time of the study the researcher was employed by the SAPS as a social worker where her key performance activities included providing psychosocial support to employees through assessments, counselling, and if deemed necessary, referral to relevant service resources for assistance. During the execution of these duties the researcher noted that the majority of her clients who disclosed their HIV-positive status, requested to be referred to external resources for support rather than to the SAPS' Employment Assistance Service (EAS).

According to Bruce (1990) an EAS is a programme aimed at improving the quality of life for troubled employees as well as their families by identifying those troubled employees and referring them to relevant resources. Anotehr role of EAS is to raise on-going awareness on different issues relating to employees such as HIV and AIDS, substance abuse, stress, mental health problems and others (Masi, 1990). The unavailability of EAS in the workplace therefore means that troubled employees may not be identified and assisted with psychosocial support. This, in turn, can result in the employees experiencing on-going problems and/or stress that can lead to chronic phase such as depression (Bamber, 2011).

According to Rajin (2012) EAS was introduced into the SAPS as a result of the operational nature of policing services as well as the demanding conditions under which police services are carried out. In the SAPS the EAS utilises social workers, psychologists and priests to assist employees to address personal problems. In turn, they achieve and maintain the highest level of job performance at the workplace.

As the departmental social worker, the researcher tried to complement the EAS by initiating the establishment of an HIV and AIDS support group that would, among other things, provide education resources related to HIV and AIDS for both employees and supervisors as recommended by Masi (1990). However, extremely few staff members showed interest. This is despite the available evidence which shows the major role that support groups can play in response to HIV and AIDS in the workplace. The researcher therefore deemed it important to establish:

- the reasons why the SAPS employees preferred external rather than internal

resources for psycho-social support

- the extent to which the SAPS employees at Head Office Divisions would support the establishment of an internal HIV and AIDS support group.

1.3 Objectives of the study

The **broad** objective of the study was to undertake a needs assessment for the establishment of an HIV and AIDS support group within the South African Police Services, with particular focus on Head Office Divisions in Pretoria. The **specific objectives** were as follows:

1. To document—through literature and document review—resources available within the SAPS to support HIV and AIDS infected and affected employees.
2. To explore factors that underlie SAPS employees' apparent preference for external rather than internal resources for their HIV and AIDS psychosocial support.
3. To explore the extent to which SAPS employees see the need for a workplace HIV and AIDS support group.
4. To make recommendations to encourage SAPS employees to use internal resources.

1.4 Research questions

1. What resources are available within the SAPS to support the employees infected and affected by HIV and AIDS?
2. What factors underlie SAPS employees' apparent preference for external rather than internal resources for their HIV and AIDS psychosocial support?
3. To what extent is an HIV and AIDS support group needed in the South African Police Services, Head Office Divisions?
4. What mechanisms can be used to encourage SAPS employees to use internal support group?

1.5 Rationale of the study

A support group can be described as an organised group of individuals who share a common experience, and meet to share experiences and to support one another (Johnston, 2006). According to Martin (1992) these groups help their members to discover their latent potentials, enabling them to be more effective in current living, and leading them to set positive goals for the future

rather than looking backward at failures, problems and sickness. These groups are also as an important way of providing emotional and other psychosocial support for HIV positive employees and their families (Johnston, 2006). Support groups have also been noted to have the potential to bolster self-esteem that is temporarily lowered and offer an opportunity for education for better understanding of the challenge or diseases addressed by the group (Sherr, 1995). It was envisaged that the overall results would:

- give guidance in terms of knowing why the SAPS staff members seem to prefer external resources than the internal ones.
- assist the SAPS to know which issues to be addressed in order to comply with the expectation from the Department of Public Service and Administration.
- benefit the SAPS by identifying the mechanism to encourage the employees to use internal resources.

1.6 Definition of key concepts

Concepts used consistently during the study and in the dissertation are conceptualised below:

1.6.1 Needs assessment

Altschuld and Witkin (2000) define needs assessment as a process of determining, analysing and prioritising needs, and in turn identifying and implementing solution and strategies to resolve high-priority needs.

1.6.2 Support group

An organised group of individuals who share a common experience, and meet regularly to share experiences and to support one another (Johnston, 2006).

1.6.3 Discrimination

Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group. In the case of HIV and AIDS, this characteristic will entail a person's confirmed or suspected positive status irrespective of whether or not there is any justification for these measures (UNAIDS, 2011).

1.6.6 Stigma

Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, whereby within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy and when stigma is acted upon, the result is discrimination that may take the form of actions or omissions (UNAIDS, 2011).

1.6.7 HIV

Human immunodeficiency virus which weakens the immune system (UNAIDS, 2011)

1.6.8 AIDS

A clinical syndrome caused by the HIV virus (UNAIDS, 2011).

1.6.9 Police service

A body of persons or an organisation empowered by the state to enforce the law, protect property, and limit civil disorder (Policy Studies Institute, 1996).

1.7 Structure of the dissertation

Chapter 1 (Introduction): This chapter has provided a background of the study, the problem statement, as well as the objectives and rationale for the study.

Chapter 2 (Literature Review): This chapter locates the reader in the current literature related to the study. The discussion in the chapter focuses on the support group as a source of psycho-social support to HIV and AIDS- infected and affected employees.

Chapter 3 (Methodology): This chapter discusses the methodology used during the study including the rationale for using it. The sampling procedures, ethical principles, as well as data collection tools, are dealt with herein.

Chapter 4 (Findings): The overall findings of the study are discussed in this chapter.

Chapter 5 (Summary and Conclusion): This chapter summarises the study results, makes conclusions based on the findings and presents policy recommendations.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter provides an overview of HIV and AIDS in the workplace, and the police service in particular. Common HIV and AIDS workplace programmes are also discussed. The chapter concludes with a discussion of the theoretical framework that underpins the study.

2.2 An overview of HIV and AIDS in the workplace

As discussed in Chapter 1, the social and economic impacts of HIV and AIDS include, among other things, negative impact on economic growth, incomes and general socio-economic development. Mukontsajera (2008) argues that HIV and AIDS is devastating in that it primarily affects the economically active members of the population, threatening the national and personal wellbeing by negatively impacting on individual health, life expectancy and productive capacity. Essentially, as Musingafi, Rogunye and Zebron (2012) posit, the combination of increased expenses and reduced income threatens the livelihood of families, their ability to secure food, to pay for education, and to save and invest.

HIV and AIDS also has an impact in the workplace. The Department of Public Service and Administration (2002), for example, argues that within workplaces the impact of the epidemic is reflected in many ways such as increased morbidity and mortality; more early retirements; reduced productivity; low staff morale; and increased costs for training of replacement of staff. In Malawi, for example, Chirambo (2008) noted that businesses incur financial loss from having to pay sick leave privileges and having to train replacement of staff due to the loss of young people to HIV and AIDS, which is heavily affecting the civil service. Sahn (2010) also asserts that when HIV-positive workers are at work, they are not doing much because managers tend to shift them to light duty as a result of morbidity. These can result in reduced productivity and/or loss of income for the person with HIV.

Lemelle, Jr, Harrington, LeBlanc (2000) argue that the impact of HIV and AIDS on productivity level is not only due to increasing morbidity and mortality, but also to rising levels of absenteeism among healthy workers due to their responsibilities for caring for the sick, visiting relatives and friends with AIDS

and attending funerals. Workplace productivity can also be negatively affected by AIDS-related discrimination which also threatens fundamental principles and rights at work and undermines efforts for prevention and care (Lemelle, Jr, et al., 2000; Magwaza, 2009; Stanley, 2012).

Overall, HIV and AIDS affects the workplace as human capital gets eroded at a productive age and rising rates of HIV and AIDS morbidity and mortality reduce the supply of labour (Ondimu, 2005; Condon and Sinha, 2008; Stanley, 2012). In other words, the epidemic affects the size, growth rate, as well as the age and skill composition of the future labour force, thus negatively affecting potential output and of productivity. In the long run, HIV and AIDS can trap a country into poverty for many generations (Condon and Sinha, 2008).

2.3 Impact of HIV and AIDS on employees and their families

2.3.1 Income loss

In addition to its workplace impact, the loss of skilled and unskilled labour due to HIV and AIDS-related illness and death has also been shown to lead to a reduction of household income per capita (Sahn, 2010). It has particularly been observed that HIV and AIDS affect the health and wealth of households, aggravating pre-existing poverty. Because of the loss of, or reduction in household income, children may receive poorer care and supervision at home, suffer from malnutrition, and have less access to health services (Page et al., 2006; World Bank, 2008). HIV infection and AIDS can, for example, drain a family's resources due to increased medical expenses and it can also leave a house with fewer or no income-earning adults (Carmody, 2011). Indeed, a World Bank (2009) study conducted in South Asia showed that many households experienced shortfalls in income, because of the increased demand for health services and expenditures on care and treatment for the household affected by HIV and AIDS. By the same token, a study in Kenya (Mukotsanjera, 2008) showed that showed that those infected by HIV spend over 60% of their income on medical bills. Many families were also found to be using their savings, while others were forced to borrow money or selling their assets in order to be able to pay for treatment.

There is also evidence that HIV and AIDS can limit supply of and access to food as AIDS-related illnesses and deaths leads to a loss of agricultural skills

and labour, resulting in households no longer being able to continue sustaining themselves through agriculture (Fourie and Meyer, 2010). In addition food insecurity is associated with increased gender inequality which is related to increased social vulnerability to transactional, commercial, coercive, and high risk sex (Brenton, Mazzeo, and Rödlach, 2011).

2.3.2 Increased care burden

To the extent that employees are part of societies and families, the social impacts of HIV and AIDS such as orphan-hood and increased care burden also affect them. Essentially, it is well-documented that the pandemic has increased the number of orphans and increased the care burden of families, particularly grandparents who are left with the responsibilities of being the bread winners and care givers to their grandchildren whose parents have died (Richter, Manegold and Pather, 2004; Jorens, 2013). Over and above caring for the sick, there are unpaid work activities which entail every day routine household maintenance, such as cooking, cleaning, shopping, doing the laundry, caring for children and others without being remunerated and much of the value of these activities—which are done mostly by women—has gone unrecognised (Akintola, 2004; Antonopoulos and Hirway; 2010).

Caregiving, according to Conrad and Doss (2012), involves physical and emotional costs as sometimes caregivers have to walk long distances to fetch water to patients' homes or carrying ill people on their back to toilets or health facilities. HIV and AIDS care-givers face a relatively higher risk of HIV infection and other infectious diseases such as tuberculosis.

2.3.3 Impact of HIV and AIDS on development of human capital

Researchers, (for example, Sahn, 2010; Conrad and Doss, 2012; Ondimu, 2005) indicate that the school attendance of children in HIV-affected households decline due to children being care givers to their parents and educational funds being redirected to other households needs. In the same vein, Hacker and Claeson (2009) posit that HIV and AIDS may affect the rate of accumulation of human capital, including through impaired access to education for an increasing number of orphans.

This means that orphaned children do not have access to education like any other children because the money for education can sometime be used to buy medication for sick parents or relatives. In addition to these issues,

Ndinga-Muvumba and Pharoah (2008) and Foster, Levine and Williamson (2005) argue that the illness and death of a caregiver may result in children experiencing growing poverty; the loss of parental affection; personal and material losses; trauma; stress; depression; and other related outcomes. In other words, Kalipeni, Craddock, Oppong, and Ghosh (2004) argue that HIV and AIDS puts pressure on both governments and households in terms of investing on human capital.

2.3.4 Stigma

Stigma includes both the individual internalized feelings regarding HIV status and external experiences of discrimination (Pribram, 2011, Waithera, 2011). It may result in the rejection of HIV-infected individuals by their families, partners and communities. According to Mahajan, Sayles and Patel (2008) cited in (Pribram, 2011), stigma is the significant contributor to the success or failure of HIV interventions. The fear of stigmatisation has been shown to reduce the likelihood of having HIV test or disclosing HIV status to relatives and sexual partners or engaging with HIV treatment services (Skinner and Mfecane, 2004).

Kalichman (2004) cited in Skinner and Mfecane (2004) argues that stigma impacts on the person living with HIV as it is internalised into their self-perception and sense of identity, impacting on the person's perceptions and how they interact in the world. Page et al (2006) proposed that to remove the stigma attached to people who are HIV-positive the organisations should try to get HIV –positive people to educate fellow workers. They further believe that if there is no proper education and awareness amongst employees, they will avoid working with HIV-positive colleagues.

2.3.5 Discrimination

According to UNAIDS (2011), discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group in the case of AIDS, a person's confirmed or suspected HIV positive status irrespective of whether or not there is any justification for these measures. It involves the group's initial reaction or interaction, influencing the individual's actual behaviour towards the group or the group leader,

restricting members of one group from opportunities or privileges that are available to another group, leading to the exclusion of the individual or entities based on logical or irrational decision making.

2.4 HIV and AIDS workplace programmes

To address the foregoing challenges faced by employees infected and affected by HIV and AIDS, employers can develop and implement HIV and AIDS workplace programmes. These are defined as coordinated proactive and reactive interventions developed to reduce new HIV infections, as well as the management of HIV and AIDS in the workplace (Magwaza, 2009).

According to The South African Guide for Government Departments (2002), HIV and AIDS workplace programme should:

- aim to prevent or reduce new HIV infections
- provide treatment and care
- support employees and their families who are infected or affected by HIV and AIDS.

Examples of the various HIV and AIDS workplace programme include Employee Assistance Programmes; peer education programmes; and support groups.

2.4.1 Employee assistance programme (EAP)

An EAP can be described as a systematic, organised and continuing provision of counselling, advice and assistance, provided or funded by the employer, designed to help employees and their families with problems arising from work-related and external sources (Cooper, Berridge and Highley-Marchington, 1997). According to Rajin (2012) EAP was first introduced in the United States of America were support programmes were only based on alcohol addicted employees. Rajin further indicate that during the 1960s, EAP became comprehensive and offered employee assistance services such as financial, marital, family, psychological, work-related stress, depression and other problems which may affect employee work performance.

Overall, an EAP can be viewed as a workplace resource that minimises employee stress and enhances stress management and coping skills through

programmes that encourage healthier lifestyle or provide education on coping strategies (Richter, Manegold and Pather, 2008; Thomas and Hersen, 2004; Werner and DeSimone, 2009; Daniello, 2011). It is designed to promote the physical and mental health as well as the wellbeing of the employees (Campbell and Langford, 1995; Ndhlovu, 2010). According to Campbell and Langford (1995) an EAP serves:

- to motivate employees to seek help before personal problems reach a severe or chronic stage that reduces the individual's ability to perform his/her job.
- to retain a valued employee.
- to restore employees' productivity and to enable them to lead meaningful and happy lives.
- to provide employees such help in a professional and confidential manner.

In the context of HIV and AIDS, EAPs typically include prevention, treatment, care and support services and programmes. Prevention programmes include awareness campaigns; education and training; prevention and treatment services for sexually transmitted infections; voluntary HIV counselling and testing; condom distribution; and so forth. The education programmes need to be on-going effort and scan use different dissemination methods such as brochures, video, posters, pamphlets, workshops and seminars (Masi, 1990).

2.4.2 HIV and AIDS Peer Education Programme

A peer education programme is defined by Chimsoro (2010) as a process whereby well-trained and motivated people undertake informed or organised educational activity with their peers (those similar to them in age, background, interests, and so forth).

In the context of HIV and AIDS, a workplace peer education programme entails the utilisation of a lay person to educate peers about how to prevent HIV infection, and how to deal with the disease, especially in the workplace (Dickingson, 2009). According to Deutsch and Swartz (2002) the following are the goals of an HIV and AIDS peer education programme:

- improving social learning about health issues through discussions and dialogue

- improving skills in recognition and referral of sexually transmitted infections to community clinics
- promoting abstinence
- distributing condoms and promoting condom usage among sexually active young people
- promoting awareness of making responsible decisions regarding sexual behaviour
- encouraging the uptake of HIV counselling and testing
- Increasing awareness of HIV and AIDS and care for those infected.

Peer education programme – as part of an HIV and AIDS workplace programme – is used as a prevention strategy to promote behavioural change through the distribution of accurate information on the prevention and the spread of HIV and AIDS, difference between facts and myths, misconceptions, stigma and discrimination (Page *et al.,* 2006).

Over and above supporting the company's HIV and AIDS programme, Dickinson (2006), believe that peer educators are also responsible for the following tasks: they need to be the influencers, advisers, stigma busters, normalisers, sex talkers, family builders, condom kings and others.

Influencers

By engaging with co-workers and all others who work alongside them such as neighbours and friends, HIV and AIDS peer educators influence people's understanding of the epidemic and provide them with alternative behavioural choices (Dickinson, 2006). Peer educators also mobilise others to take up HIV test which is the basis for treatment and prevention measures (Sibanda, 2011).

Advisers

Beyond the awareness raising and shifting of understanding, peer educators deal with specific requests for advice or assistance by people who are infected or affected by HIV and AIDS (Sibanda, 2011). Rujumba, Mbasaalaki-Mwaka and Ndeezi (2010) posit that peer educators negotiate with colleagues, spelling out the importance of HIV testing, and the context under which testing takes place.

Stigma busters

Dickinson (2006) argues that although it is difficult to tackle stigma, peer educators are in a strong position to confront it. According to Sibanda (2011), good communication skills enables peer educators to find the right ways of saying what peers are supposed to hear and on occasions challenging peers' beliefs and assumptions.

Normalisers

Peer educators often expressed a desire that HIV and AIDS could be treated at work and in the community for what it is, not for what it might say about a person and not for what people might wrongly fear about the disease (Dickinson, 2006).

Sex talkers

Dickinson (2006), highlights that it is necessary for the peer educators to openly talk about sex. They need to be able to clarify what safer sex entails. In other words, they need to have a good understanding of the three methods which is abstinence, be faithful and condomisation.

Family builders

Many peer educators draw into the centre of their work the importance of the family and the need to actively address personal relationships between men and women in particular. Such an approach allows for a holistic understanding of the causes of a range of problems (not only HIV and AIDS) that are encountered by people at work and in communities (Dickingson, 2009).

Condom kings

Most peer educators see the need to promote condoms within the workplace environment, even if personally they do not believe in this method of prevention due to religious grounds. Such an activity is very much in line with company's HIV and AIDS programmes that promote the use of condoms. Peer educators need to also be able to openly do condom demonstration (Dickinson, 2006).

Sibanda (2011) is of the opinion that despite the good work which peer educators are doing in the workplace, they face certain challenges such as

environmental, programmatic and socio-interactional as well as perceptional factors. Environmental factors are macro in nature and they define and determine the conditions and context under which testing take place. Programmatic factors look at the technical aspects in the design of wellness programme and how such factors affect HIV test uptake. Socio-interactional and perceptional are micro factors which deal with the way social interactive and perceptive issues between or among peer educators and their peers, emanating either from society or workplace impeding the smooth uptake of HIV test.

2.4.3 Support groups

Randall (2010) defines support group as a place for people to give and receive both emotional and practical support as well as to exchange information. Randall further cites that support is made up of group of people coming together to share common interest and experiences. Support groups allow people to expand their relationships and receive support and encouragement without being judged (Jarrett, 2007).

According to Lopez and Getzel (1984) cited in Grief and Ephross (1997), support groups have for a long time been recognised as an important normalising experience for people living with HIV and AIDS. Indeed in South Africa, the Guide for Government Departments by the Department of Public Service and Administration (2002) recognises support groups as one pathway of providing HIV and AIDS-affected persons with an opportunity of meeting people in similar circumstances to share experiences and support one another. This is well supported by researchers such as Jarret (2007) who posit that support groups create a place where people can meet, and be themselves without being judged. When group members get support, they overcome the feeling of isolation, discrimination and stigmatisation. When an infected person is part of a support network, they gain a more positive sense of themselves and live positively in the meantime (Department of Public Service and Administration, 2002).

While negative aspects of support groups such as scapegoating, silence, dominant members, subgroups, dependency on leaders, conflict between members or with the leaders have been noted (Preston-Shoot, 1987; Kurtz, 1997; Garvin, Gutie'rez and Galinsky, 2004), support groups are generally cited as highly effective support mechanisms for people with chronic illnesses.

Jarrett (2007), for example, noted the effectiveness of support groups in a study of women who had breast cancer highlighting that the willingness of members of the group to share experiences within the group environment not only enabled people to feel supported but led to solid practical advice so that people could feel more involved in their medical care. Some group members reported forming friendships which impacted outside the group such as offering practical assistance with visiting, shopping, or invitations to social occasions. The support group provided the women with an opportunity to learn more about their illness, to speak confidently to families and friends about the illness, to make some inquiries from medical practitioners whenever the women were uncertain about treatment, or any other related information (Jarrett, 2007).

According to Grief and Ephross (1997) there are three types of support groups in the context of HIV and AIDS: orientation; quality of life; and relationship support groups.

2.4.3.1 Orientation support group

According to Grief and Ephross (1997) orientation support groups comprised of newly diagnosed people living with HIV and AIDS. This group's primary focus is to assist members to cope with the issue of recognising themselves as persons with HIV by understanding the practical and emotional consequences of the disease for their future. It also addresses the management of different aspects of everyday life.

2.4.3.2 Quality of life support group

Grief and Ephross (1997) state that in the quality of life support group, the group gives support and guidance as members confront humiliating severe symptoms. The quality of life support groups are typically found in the AIDS community-based organisations, hospitals, hospices, religious organisations, local health and social service agencies. Group members, in sharing their experiences and giving honest, direct responses to one another, bring richness of information and understanding to others.

2.4.3.3 Relationship support group

This type of support group focuses on the significant changes in the quantity and quality of interpersonal relationships. It explores the current stresses in these relationships arising from being a person with AIDS or a caregiver (Grief

and Ephross, 1997). One objective of these groups is to maximise the autonomy and self-determination of the members as they make choices between the demands originating from the disease and those arising from day-to-day living.

2.5 HIV and AIDS workplace programmes in the police services

HIV and AIDS workplace programmes are particularly important in disciplined or uniformed forces such as defence forces and the police given the well-documented relatively higher incidence of HIV and AIDS in this security sector (Pearce, 2007; Poku, Whiteside and Sandkjaer, 2007).

According to Pearce (2007), uniformed services are highly vulnerable group to sexually transmitted infections including HIV due, largely, to the nature of their work which typically entails a lot of mobility.

For example, security personnel are generally and regularly placed in single-sex barracks or hostels away from their families for considerable periods of time (Aginam and Rupiya, 2012; Magwaza, 2009). Magwaza (2009) further argues that members of the disciplined forces are often called upon to take part in peace-keeping missions in remote locations and high-risk environments where recreational activities are limited, alcohol and drug use are common, sex workers are abundant, and exposure to HIV is generally heightened.

In Zambia, for example, Aginam and Rupiya (2012) assert that the police service is hit hard by HIV and AIDS because among other factors, policemen can target and afford sex workers since they work at night and often for long hours. In addition to the above-mentioned facts, Juma and Klot (2011) are of the opinion that officers frequently do not wear condoms during sexual encounter with sex workers.

Furthermore the working conditions of police members, such as attendance to accident scenes as well as apprehending violent and non-complying criminals expose police to the possibility of HIV-infections (Magwaza, 2009). Gisselquist (2007), for example noted that Thailand's HIV epidemic was most intense in rural areas of remote provinces where the blood exposure have been ignored and that this exposed the Thai army to HIV infection (Gisselquist, 2007). Juma and Klot (2011) argue that due to the violent nature of South African crimes exerted against women and men, it is likely that the SAPS comes into the contact with blood and furthermore, because South

Africa has one of the highest infection rates worldwide, the likelihood of officers coming into contact with someone who is infected is greater than that in other countries. They further argue that this risk is further increased if police officers do not take the precautionary measures at a crime scene where bodily fluids are present. This generally means that an exposure to blood during the performing of work by the police may pose a harmful and dangerous risk of HIV infection as police officers can be infected if they do not apply precautionary measures.

Juma and Klot (2011) are also of the opinion that the recruitment process can also place police services at risk as persons aged 18 to 29 years are the most employable in this sector, and at the same time are the most vulnerable group to HIV infection. These young people might also join the service when already infected especially that HIV is not tested during the recruitment process. Juma and Klot (2011) further indicate that race, culture and religious practises can also make the police to identify with the communities they serve and, therefore, develop a sense of belonging and may start practising unprotected sex in those communities and become infected. All this is in addition to the socio-cultural pressure prevalent in many societies for men to engage in high level of sexual activity as a proof of their masculinity or strength (Ostergard Jr, 2007).

In addition to the abovementioned facts, Aginam and Rupiya (2012) argue that the military uniform is, in some instances, considered to be highly attractive and those wearing it are generally admired by civilian women who flock to them for security. Given that it is not uncommon for members of the uniformed forces to have sex with same partners while on operation, they become vulnerable to unprotected sex with those women (Aginam and Rupiya, 2012).

2.6 Theoretical framework

This study was guided by the Social Support Theory which is one of the theoretical perspectives applicable to the psychosocial needs of people living with HIV. Albrecht and Adelman (1987) define social support as any type of verbal and non-verbal communication between support recipients and providers that reduces uncertainty about the situation, self, other, relationships, and functions to enhance a perception of personal control in one's life experience. In addition to this definition, Barker (2007) define social

support as a range of interpersonal relationships or connections that have an impact on the individual's functioning and includes support provided by individuals and social institutions. The purpose of the provision of social support is to help an individual to cope with the psychosocial problems and help them maintain a sense of who they are and where they belong (Vaux, 1988). In the context of this study, psychosocial problems refer to the psychological and social challenges and difficulties experienced by personnel infected and affected by HIV and AIDS (Mampane, 2011).

According to Albrecht and Adelman (1987) and Cutrona (1996), there are five different types of social support: emotional, esteem, network, informational, and tangible.

2.6.1 The emotional social support

Albrecht and Adelman (1987) believe that emotional social support is about meeting an individual's emotional or affectionate needs. Affective functions (Vaux, 1988; House, 1981 and Antonopoulos and Hirway, 2010) include meeting needs for love and affection, understanding, compassion and tolerance, esteem and identity, belonging and companionship and it also involves being there for the patients, having contact and spending time with them as well as engaging them in conversation and listening to them. In addition to the abovementioned facts, Barker (2007) is of the opinion that emotional support includes close friends or family members or professionals who provide help for emotional needs or personal crises.

2.6.2 The esteem social support

The esteem social support is about encouraging individuals to take needed actions and convince them that they have the ability to confront difficult situations. Cutrona and Russell (1990) posit that affirmation support, which is also called esteem support, validates, reassures, or relives the focal individual of blame.

2.6.3 The network social support

The network social support is about the communication that affirms an individual's belonging to a network and serves as an extension of the individual's resources (Vaux, 1988). The network social support assures the individuals that they are not alone in whatever situation they are facing. Barker (2007) shares the same thinking with Vaux that affiliative support is about being with other individuals who have mutual interests.

2.6.4 The informational social support

The informational social support provides the useful or needed information to the individuals regarding the situation at hand. Cutrona and Russell, (1990) believe that its intent is to give the focal individual a means to help themselves; for example, many times it is given when the focal individual is struggling with a problem or making a decision. Not knowing the details of what one is facing can create stress. Evian (2002) argues that infected and affected people should receive social support as they have fears, anxieties, worries and other concerns about their situation especially if they are not well informed. Antonopoulos and Hirway (2010) add that caregivers can link the patients and their families with clergy and sources of spiritual support such as churches or mosques.

2.6.5 The tangible social support

The tangible social support is about providing physical support to needy individuals. According to Vaux (1988) tangible social support can serve an instrumental function as it provides goods, money or any material aid. It can also provide advices, guidance, give suggestions and can also clarify issues. Barker (2007) adds that instrumental support can also offer skills training, health services, transportation and others. For Cutrona and Russell (1990), tangible social support involves rides to the doctor, providing housing, and cooking meals. In a health context, tangible support acts directly on something that is causing stress for the individual who is ill.

This theoretical framework was deemed relevant to this study because the function of the support group is to provide psychosocial support. All four types of social support (emotional, esteem, network, informational) are necessary and relevant to an HIV and AIDS support group in the workplace such as in the SAPS as they provide psychosocial and emotional support and a sense of belonging. The necessary information regarding HIV and AIDS situation could be provided to the personnel through a workplace support group. This will enable them to know their expectations and how to plan for their future.

2.7 Conclusion

This chapter gave a general overview of the literature on the impact of HIV and AIDS among uniformed services personnel, particularly, police services, their families and their workplace. HIV and AIDS was noted to have the potential to increase the care burden and poverty within families as family members who are breadwinners resign or die because of the pandemic. Workplace programmes such as Employee Assistance Services, peer education, and support groups were highlighted as some of the common

workplace interventions. According to the Guide for Government Departments by the Department of Public Service and Administration (2002), support groups has been recognised as one pathway of providing HIV and AIDS-affected persons with an opportunity of meeting people in similar circumstances to share experiences and support one another. This is well supported by researchers such as Jarret (2007) who posit that support groups create a place where people can meet, and be themselves without being judged. Based on the overall literature review the Social Support Theory was deemed to be relevant to the study as it outlines the provision of psycho-social support to people in need.

Despite the great efforts of the HIV and AIDS workplace programme and the peer educators going extra mile to promote and support their peers, employees continue to be sceptical or afraid of testing for HIV and AIDS due to the fear of lack of confidentiality which might lead to stigma, judgement and discrimination. The establishment of the support group programme in the workplace can assist in alleviating those fears which some employees are having.

Throughout the study, the researcher observed that there is little research done in the police and this argument was well supported by Pearce (2008) that there is lack of research about HIV and AIDS in the police, its impact, as well as lessons learned. On the other hand, the researcher is of the opinion that different types of social support as already discussed, are not always the resources which can render support services to the individuals in need, such as the family supporting the member who turned to be HIV positive. In addition to the researcher's opinion, Walker, Hart and D'Silva (2012) believe that although social support is needed to manage a variety of health threats, but individuals infected with HIV and AIDS may not receive this support from their families, neighbours, friends and co-workers. They further believe that as the individuals disclose their diagnosis, instead of help, they may face stigma and discrimination. For an example, Waithera (2011) believes that women are more vulnerable to HIV especially if they are part of polygynous relationships in their own homes from their husbands or partners. It has been observed that men's behaviour is often over-looked and the blame is shifted onto women who are often portrayed as the agents of HIV transmission (Waithera, 2011). In other words, woman as a family member might be rejected due to her HIV status, irrespective of how the virus was transmitted to her. The other reason for women's rejection is that sexual transmitted diseases including HIV continue to be associated with promiscuity and immoral

behaviour and the family cannot be associated with that type of a person (Seely, 2014).

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter outlines the methodology used during the study including the sampling procedures, how data was collected and analysed, and the ethical principles adhered to during the data collection process.

3.2 Research design

Mouton (1996) defines a research design as a set of guidelines and instructions to be followed in addressing a research problem. He further elaborates that the main function of a research design is to enable the researcher to anticipate what the appropriate research decisions should be to maximise the validity of the eventual results. Alston and Bowles (2003) add to Mouton's view that a research design indicates how one's data will be collected, analysed, reported, and it includes the types of sampling and the methods of data collection.

Against this background, the research design for this study can be described as mixed method, using a combination of quantitative and qualitative research. According to Wheeldon and Ahlberg (2012), quantitative research methods focus on gathering, analysing, interpreting and presenting numeric information and/or quantities. This type of research uses more formal measures of behaviour including questionnaires and systematic observation of behaviour which are designed to be subjected to statistical analysis (Stangor, 2011; Marvasti, 2004). Qualitative research, on the other hand, uses non-numerical data to probe into attitudes, values, beliefs and other issues that would otherwise be difficult to obtain or explain from quantitative data (Oni and Oguntimehim, 1996).

3.3 Approach to the study

In terms of approach, the study can be described as exploratory. Exploratory research is conducted for a problem that has not been clearly defined, with the main goal being to discover ideas and insights (Babbie, 2007; Neuman, 2006). The choice of this approach is based on the fact that an HIV and AIDS support groups have not been considered or implemented as plausible HIV and AIDS workplace strategy in the South African Police Service (SAPS). Therefore a mixed methods exploratory approach was deemed the most

appropriate to undertake a needs assessment for the establishment of an HIV and AIDS support groups within the SAPS.

3.4 Study area

Although the SAPS also consist of area and provincial offices, the study was conducted only at the Pretoria Head Office Divisions, where the researcher worked as an occupational social worker at the time of the study. The choice of the Pretoria Head Office Divisions as the study site was largely due to time and budgetary constraints. Furthermore, given that the study was exploratory in nature, the need for a large nationally representative sample was not deemed imperative.

3.5 Data collection

According to Burns and Grove (2005) cited in Muthoka (2012) data collection refers to the collection of precise information relevant to the objectives of the study. This section describes the data collection methods used to collect quantitative and qualitative data in the two components of the study.

3.3.1 Quantitative component

The quantitative data for the study were collected during a small survey undertaken in at the Head Office Divisions of the SAPS in Pretoria in May and June 2012.

Study population

A study population is defined by Arkava and Lane (1983) cited in De Vos, Strydom, Fouche and Delport (2002) as the potential subjects who have the specific characteristics related to a study. For the purpose of this study the population for the quantitative component was drawn from the SAPS personnel. It is noteworthy that these personnel can be categorised into two broad groups: (1) those employed under the South African Police Services Act and (2) those employed under the Public Service Act. The former are functional members who were trained in different SAPS colleges to become police men and women. For the purpose of this study, they will be referred to as "police officers". The latter, on the other hand, refers to those who provide administrative and other support to functional members. For the purpose of this study they will be referred to as "support staff".

Sample selection

According to De Vos, Strydom, Fouché and Delport (2011), sampling means taking a portion or a smaller number of units of a population as representative or having particular characteristics of that total population. To select the sample, the researcher used the ethics approval letters from the Higher Degree Committee of the Department of Sociology at the University of South Africa as well as that of the Pretoria Head Office Divisions (see Section 3.6) to approach the different heads of divisions (financial and administration; personnel services; career management; supply chain management, human resource development, detective services, human resource development, and others) to request that they inform the SAPS staff members in their divisions about the study and to invite them to participate. Each head of division was given a brief synopsis of the study to assist in their recruitment of staff.

A total of 104 staff members responded that they wished to participate. All of them were then given, through their heads of divisions, questionnaires to hand to the interested staff members so that they could complete them and rerun in a sealed envelopes by a set deadline. Only 90 questionnaires were returned, and it is these that were analysed for this study. The staff members who returned the questionnaires were from both police officers (49) and support staff (41) as shown below:

Staff Category	**Number**
Police officers	
Constables	14
Sergeants	11
Warrant officers	9
Captains	7
Majors	6
Brigadiers	2
Support staff	
Cleaners	4
Messengers	8
Personnel officers	12
Administration officers	17
Total	**90**

Data collection instruments

Data was collected by using a questionnaire that included both close-ended and open-ended questions (Annexure A). The close-ended questions were designed to solicit the respondents' basic socio-economic and demographic background; their knowledge of HIV and AIDS; their attitudes towards different HIV prevention strategies; and their views regarding a number of aspects related to support groups as a HIV and AIDS workplace intervention. The open-ended questions, on the other hand, were aimed at exploring the factors that underlie the SAPS employees' preference for external rather than internal resources for their HIV and AIDS psychosocial support (objective 3 of the study). The data instruments were printed and administered in English only, which is the main medium of official communication in the SAPS workplace.

3.3.2 Qualitative component

The qualitative component of the study entailed the conducting of in-depth interviews with managers of the HIV and AIDS programme. In-depth interviews are characterised by open-ended questions presented in a semi-structured format in the discussion (which almost resembles a natural conversation) with the aim being to seek the respondent's understanding, interpretation, observations and reflections on the subject under study (Damar, 2008). The main aim of the in-depth interviews in this study was to gain the insight of the programme, as well as to determine the available resources for SAPS employees in support of the programme, as well as to solicit the managers' recommendations for encouraging SAPS employees to use internal resources.

Five (5) managers were purposively selected to participate in the interviews. These were from: (1) Chief Directorate-Employee Health and Wellness; (2) Social work services; (3) Psychological services; (4) spiritual services; and (5) Quality of Life Management. According to Alston and Bowles (2003), purposive sampling allows researchers to select the sample for a particular purpose as researchers have prior knowledge that indicated that a particular group is important to the study. The managers were purposively selected because of their in-depth knowledge and expertise in the programme and were deemed to be the most appropriate to provide the first-hand

information on the specific questions. Annexure B shows the list of questions that were posed to the managers.

3.4 Data analysis

For De Vos (2002), data analysis refers to the breaking down of data into constituent parts to obtain answers to research questions and to test research hypothesis. Kerlinger, as cited in De Vos (2002), elaborates that collected data is categorised, manipulated and summarised into an intelligible and interpretable form so that the relations of the research problems can be studied, tested and conclusions drawn.

3.4.1 Quantitative data analysis

Quantitative data analysis according to Rubin and Babbie (2005) cited in De Vos et al, (2011) can be regarded as the techniques by which researchers convert data to a numerical form and subject it to statistical analysis. The purpose of analysis is to reduce data to an intelligible and interpretable form so that the relations of research problems ca be studied and tested, and conclusions drawn (De Vos et al, 2011). Univariate analysis, which involves describing a case in terms of a single variable, was used to analyse the quantitative data. The analysis in this study was done manually. All the attributes for each case under study in terms of the variable in question were listed. The coding as the first step was done and all the biographical information was individually recorded, counted and compared in terms of the answers provided. The second part of the questionnaire consisted of the "yes" and "no" questions which made the recording and counting easier as all the responses given were recorded and counted according to the answer provided. The third part of the questionnaire consisted of the open-ended questions. Each and every response was recorded, classified, summarised and generalised. The data obtained from open-ended questions was used to support and provide understanding of the close-ended questions and percentages were allocated depending on the number of the similar responses obtained and generalised. All the answers provided were counted in terms of the number of respondents who answered the question and percentage was worked out of those numbers of responses.

3.4.2 Qualitative data analysis

Babbie (2001) defines qualitative data analysis as a non-numerical assessment of observations. The information gathered from HIV and AIDS workplace managers was recorded through note-taking. Thematic analysis was undertaken. This entails the data categorised into themes and interpreted in order to make sense.

3.5 Reliability and validity

3.5.1 Reliability

According to Mouton (1996), reliability refers to the fact that different research participants being tested by the same instrument at different times should respond identically to the instrument. It is well supported by De Vos (2002) that reliability means consistency of the measurement. It does not fluctuate unless there are variations in the variable being measured. In this study, the same questionnaires were given to the research respondents to ensure that every respondent is answering the same questionnaire with the same instructions.

3.5.2 Validity

Babbie (2004) defines validity as the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration. The research instruments, and questions posed towards the respondents in the study should bring forth the similar responses, if repeated in future studies. The good working relationship assisted the interview process not to be influenced by the managers' subjective perceptions.

3.6 Ethical considerations

Ethical considerations refer to the principles and guidelines that the researcher must follow during the data collection process to ensure that they do not violate the physical, psychological and emotional states of the participants. Approval to undertake the study was granted by the then supervisor in accordance with the University of South Africa regulations at the time (see Annexure C). Permission was also sought from, and granted by, the executive management of the Pretoria Head Office Division of the SAPS (see Annexure D). Overall, the basic principles of ethical research in social

sciences described below were adhered to throughout the study, including the writing of this dissertation.

3.6.1 Confidentiality

According to Neuman (2000), confidentiality means that information may have names attached to it, but the researcher keeps it secret from the public. He further emphasises that the information is not released in a way that permits linking specific individuals to responses. This is well supported by Babbie (2001) that the clearest concern in the protection of the subjects' wellbeing is the protection of their identity. It was clearly written on the consent forms, as well as on the questionnaires, that the respondents' names should not form part or be written anywhere for the purpose of confidentiality. Indeed, the names of the study participants do not appear anywhere in this dissertation.

3.6.2 Informed consent

Informed consent is perceived by Neuman (2000) as a basic ethical tenet of scientific research on human populations. Respondents were given all the necessary information regarding the research process in order for them to make informed consent to participate in the study. Research respondents were not forced to participate on the research if they did not want and they were allowed to withdraw at any time if they felt that they did not want to continue anymore. Consent forms (see Annexure E) were first signed by the research participants as an indication that they participated voluntarily, as Esterberg (2002) emphasises, researchers should ensure that participants participate freely in the research. Verbal consent was obtained from the five (5) managers to audio-recording the interview.

3.6.3 Harm to subjects

The fundamental ethical rule of social research is that it must bring no harm to participants (De Vos et al, 2011). This refers to the process of discomfort that the respondents might go through during the interviews. Since human beings can react towards research, they might go through psychological and emotional harm when they try to impress the researcher with certain responses. HIV and AIDS is a very sensitive issue, which the majority of the people do not want to be engaged in and might trigger some of the respondents' personal issues and experiences. No personal questions were asked from the respondents during the study. However, as a qualified social

worker, the researcher had referral networks available that she would use in case the research participants' emotions would have been elicited by the questions asked. The referral networks are responsible for debriefing and counselling services.

3.6.4 Provision of debriefing

According to De Vos (2002), debriefing refers to the session during which subjects are given the opportunity after the study to work through their experiences and aftermaths in order to minimise the harm. Problems generated or triggered by the research questions and experiences can be corrected through the process of debriefing. Debriefing was done immediately to the five (5) managers of the HIV and AIDS programme after the research interviews.

3.7. Conclusion

This research design was exploratory because HIV and AIDS in SAPS had not received enough attention at the time of the study. Probability and non-probability sampling were employed, since both ninety (90) employees and the five (5) managers of HIV and AIDS programme were involved. Triangulation of methods has been used and it has been identified that both qualitative and quantitative methods complement each other and improves accuracy.

Closed-ended questionnaires, as well as in-depth interviews, were used to collect data from the respondents, but the questionnaires carried more weight than the in-depth interviews, as ninety (90) employees participated in the study than five (5) managers.

Quantitative and qualitative data analysis techniques were used to interpret the collected data. Confidentiality, as one of the ethical principles, was emphasised prior to and during data collection process to protect the identities of the participants. The research participants' completion of consent forms ensured that their participation in the study was voluntary.

CHAPTER 4: PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the key findings of the study. The chapter begins with an overview of the basic characteristics of the respondents in the main component of the study: the quantitative. This is followed by three subsections aimed at achieving objectives 1, 2 and 3 of the study (see section 1.3 in the introductory chapter).

These are: the discussion of resources within the SAPS to support employees infected and affected by HIV and AIDS; the exploration of factors that underlie the employees' preference for external rather than internal resources for their HIV and AIDS psychosocial needs; and the extent to which SAPS employees see the need for a workplace HIV and AIDS support group.

4.2. Background characteristics of respondents

Table 4.1 below shows the basic socio-economic and demographic characteristics of the 90 respondents in the quantitative component of the study. The table shows that the sample was almost equally distributed in terms of gender with females accounting for 51% and males for the remaining 49%. In terms of age, the majority (49%) of the respondents were in their 30s, followed by those in their 40s who accounted for 29%. Respondents aged 50 years and above accounted for the smallest proportion. Other characteristics in the table are marital status, home language and religious affiliation.

4.2.1 Marital status

Employees go through daily stressors and it often helps to share those stressors with partners and significant others outside the workplace. Challis (1998) defines stressor as a stimulus that evokes an abnormal physiological response which originates from past material stored in the organism such as unresolved distress. To this end, the social support available for every employee infected and affected by HIV and AIDS was deemed critical in dealing with the impact of the epidemic on individual employees. Therefore, as a proxy for the availability of social support, marital status was deemed an important variable in this study. The results, as presented in Table 4.1, showed that more than half (55%) were married, 34% were never married, and 10% were either divorced or separated.

According to the information received from the study, there was no indication of any widow, widower or cohabitant. It is noteworthy, however that one respondent did not indicate their marital status, whether married, never married, divorced or separated.

Table 4.1: Basic characteristics of respondents in quantitative component of study

Characteristic	Number	Percentage (%)
Gender		
Male	44	51
Female	46	49
Age group		
21-30	16	18
31-40	44	49
41-50	26	29
51-60	3	3
60+	1	1
Marital Status		
Married	49	55
Never married	31	34
Divorced/separated	9	10
Did not indicate	1	1
Home language		
Afrikaans	19	21
English	17	19
Ndebele	3	3
Northern Sotho	16	18
Sotho	2	2
Swati	2	2
Tsonga	6	7
Tswana	8	9
Xhosa	4	4
Zulu	10	12
Did not indicate	1	1
Religious affiliation		
Christianity	75	83
Hinduism	4	5
Islam	2	2
Did not indicate	9	10
Total	**90**	**100**

4.2.2 Home Language

Language is a very powerful tool for communication (Pearson, 1994). In the context of HIV and AIDS in the workplace when colleagues are speaking the same language they tend to experience a sense of belonging, and it becomes easier for them to understand and support each other (Nichols and Jenkinson, 2006). To this end, the respondents were asked to indicate their home languages – from among the 11 official languages in South Africa – so as to explore the extent to which they could support each other in cases of need.

The assumption was that even though English is the official medium for communication in the SAPS, a common linguistic understanding is very critical in terms of providing psycho-social and emotional support and a sense of belonging.

The results showed that 21% of the respondents spoke Afrikaans as a home language; 19% spoke English; 18% spoke Northern Sotho; while 12%, spoke Zulu (Table 4.1). All other languages were spoken by less than 10% of the respondents. In addition to the fact that most South Africans can speak more than one language (McFarlin and Sweeney, 2011), a key implication of these results is that all the 11 official languages in South Africa are represented within the SAPS Head Office Divisions. There is a high possibility that in the case of the need for support and/or a sense of belonging, a staff member is likely to find someone who can speak the same language as themselves.

As stated earlier, the questionnaires were written and administered in English and not in other languages as English is the main official medium of communication in the SAPS.

4.2.3 Religious affiliation of the respondents

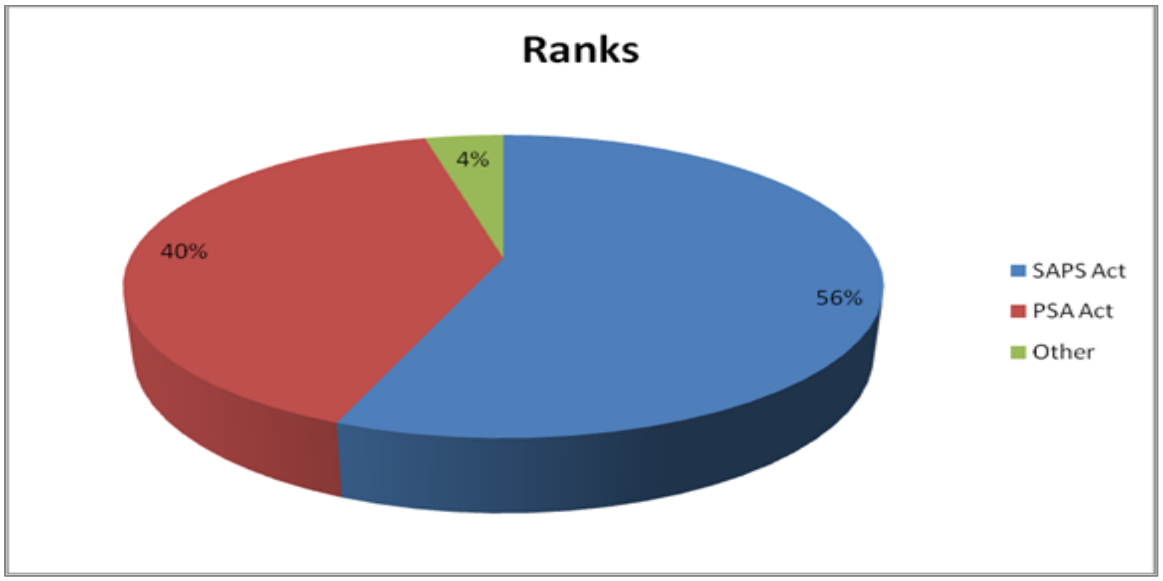
There is a general relationship between religion and HIV and AIDS (Haddad, 2011; Stanley, 2012). Some people believe that HIV and AIDS is a punishment from God as it is a sin which is associated with extramarital affairs or promiscuity (Trinitapoli and Weinreb, 2012). Others are of the opinion that it is the devil's spirit and requires prayer, and others see it as a sickness, which can bring somebody closer to God (Stanley, 2012; Squire, 2007). Contrary to the above-mentioned statement, Squire (2007) is of the opinion that HIV and AIDS is not a punishment from God, it is a disease that is treatable, manageable and can be prevented. A church can also be seen as a support system to individuals. It was against this background that the respondents' religious affiliation was explored so as to determine the extent to which they had spiritual support systems as far as their HIV and AIDS issues are concerned.

Consistent with the national pattern where the majority of South Africans identify themselves as Christians (Landman, 2009), 83% of the respondents were Christians, 5% were Hindu, 2% were Muslim and 10% did not indicate their religious affiliation.

4.2.4 Employment type

As stated in Chapter 3, the SAPS personnel can be categorised into two broad groups: (1) those employed under the South African Police Services Act (police officers) and (2) those employed under the Public Service Act (support staff). Figure 4.1 below shows that the majority of the respondents (56%) were police officers while 40% were support staff. Four per cent of the respondents did not indicate whether they were police officers or support staff.

Figure 4.1 Proportion of employees by employment type



4.2.5 Knowledge of HIV and AIDS

According to Jensen (2011), knowledge about HIV and AIDS is important for HIV prevention as well as for reducing HIV and AIDS-related stigma. The respondents were thus asked if they knew about HIV and AIDS. Consistent with the national pattern where 87% of South Africans know about the epidemic (Damar, 2008), 96% of the respondents indicated that they were knowledgeable about HIV and AIDS.

4.2.6 Attitudes towards preventive strategies for, HIV and AIDS

The respondent's attitudes towards the epidemic were also explored. To do this, questions were asked about the respondents' willingness to receive information on HIV and AIDS in the future. Perhaps a reflection of interest in keeping abreast with developments in HIV and AIDS, over half (54%) of the respondents indicated that they were interested in receiving HIV and AIDS

information and gave their addresses for the information to be sent to. Less than half (43%) indicated that they were not interested in receiving HIV and AIDS information.

4.2.7 HIV Counselling and testing

Against evidence showing that HIV counselling and testing is an important opportunity to reinforce and share prevention messaging and diminishes the stigma associated with knowing one's status (Carmody, 2011), the respondents were also asked if they had ever taken an HIV test. In further suggestion of a positive attitude towards HIV and AIDS, the majority (93%) of the respondents indicated that they had undertaken an HIV test; only 7% indicated that they have never undertaken any HIV test. Overall the 93% shows that a high number of participants were concerned about their HIV status and wanted to take the responsibility of knowing it.

The high proportion (93%) of employees that had taken an HIV test may also be a reflection of the positive impact of the knowledge provided by peer educators in the SAPS (as discussed in Section 2.4.2) In general the peer educators' on-going awareness-raising about the prevention and spread of HIV and AIDS seem to have influenced the employees to take the responsibility of taking HIV counselling and testing to know their status.

Those who had tested were asked if they went through pre-testing counselling. Its purpose includes providing clients with information on the technical aspects of testing; providing information on possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV positive or negative; finding out why one wants to be tested; as well as to assess the nature and extent of the client's past and present high-risk behaviour and the steps that need to be taken to prevent him/her from becoming infected or from transmitting the HIV infection (Page *et al.,* 2006).

Obtaining this information from the respondents was deemed imperative to assist them to realise their risky behaviours and the possibility of being infected with HIV and AIDS. The results showed that the majority (81%) of the respondents who had undertaken an HIV test did receive pre-test counselling.

In addition to pre-testing counselling, HIV testing should be followed by post-test counselling, irrespective of whether the result is positive or negative (Uys 2002; Swartz, Della Rey, Duncan, Townsend and O'neil, 2011). Post-test counselling assists in reducing the stigma and discrimination by providing factual information and increasing awareness about HIV and AIDS. It also assists healthcare providers and clients to ascertain the latter's level of risk of HIV. It will further enable healthcare providers and clients to discuss and identify the client's potential coping mechanisms if they were to test HIV positive (Swartz *et al.,* 2011; Sibanda, 2008; Sherr, 1991). In this study, about two-thirds (66%) of the respondents indicated that they did receive post-test counselling.

4.3. HIV and AIDS resources available within the SAPS

To achieve objective 1 of the study, resources available within the SAPS to support employees infected and affected by HIV and AIDS were explored and eventually categorised into two main groups: (1) policies and guidelines and (2) services.

4.3.1 Policies and guidelines

In addition to the policy framework that guides the management of HIV and AIDS in the workplace (Public Service Commission, 2006), it emerged from the study that the SAPS is guided by other key documents that include the National HIV and AIDS Strategic Plan; the Managing HIV/AIDS in the Workplace: A Guide for Government Departments (or simple "A Guide for Government Departments'); and the SAPS Policy on HIV and AIDS in the workplace.

4.3.1.1 National Strategic Plan

As a South African entity, the SAPS was, at the time of the study, guided by the National Strategic Plan on HIV, STIs and TB (2012 – 2016) which flows from the HIV and AIDS Strategic Plan for South Africa (2007 – 2011) and the National Strategic Plan (NSP) of 2000 – 2005. Like its predecessors, the purpose of the current National Strategic Plan is to guide the country's overall response to the pandemic. It is a statement of intent for the country as a whole, both within and outside the government. It is envisaged that all government departments, organisations and stakeholders will use it as the basis to develop their own strategies and operational plans to maximise efficiency and effectiveness in the fight against HIV and AIDS.

4.3.1.2 Managing HIV/AIDS in the Workplace: A Guide for Government Departments

This document provides guidelines relating to HIV and AIDS policy and planning, workplace, and encourages all government departments to have an HIV and AIDS Workplace Programme to address factors that prevent employees from knowing their status. It also emphasises that the workplace is an ideal place to have this programme as the employees spend most of their time there.

4.3.1.3 SAPS Policy on HIV and AIDS in the workplace

The purpose of the policy is to provide employment practices and procedures which ensure that employees with HIV and AIDS are not unfairly discriminated in the workplace, all within the framework on the National Strategic Plan and the Guide for Government Departments discussed above. The policy acknowledges the seriousness of HIV and AIDS as well as the impact of the epidemic on individuals as reflected in, among other things, prolonged staff illnesses; frequent absenteeism; poor service delivery; reduced workplace morale; and decreased operational effectiveness and efficiency. The policy further acknowledges the ignorance, discrimination, prejudice, and stigma surrounding HIV and AIDS. Though the policy, the SAPS commits itself to promote equal opportunities and fair treatment for all its employees by treating all life threatening conditions in the same way. The policy is applicable to all employees: police officers and support staff. The following areas are covered in terms if policy provisions:

4.3.2 Services

In terms of services, the SAPS has an Employee Assistance Services (EAS) and a peer education programme.

4.3.2.1 Employee Assistance Services

The Employee Assistance Services programme is responsible for the wellbeing of the personnel. It consists of professionals such as social workers, psychologists and pastors who render different services to SAPS personnel and their families. Possible resources such as boardrooms, vehicles to transport the personnel to acquire services or for referrals; computers; and time to seek assistance from the EAS are availed to all personnel by the

managers. The employees need to take the responsibility of making their managers aware when they want to go and use those available resources.

The EAS programme also partners with other external service providers to render HIV and AIDS programmes and services. These include medical aids such as the Police Medical Aid (Polmed), Government Employees Medical Services (GEMS), Discovery and other different medical aids for public service servants. Other government departments such as the Department of Health and the Department Social Development are important stakeholders. The Department of Health is responsible for the provision of HIV testing, pre- and post-test counselling and referral of individuals to the relevant resources depending on the need while the Department of Social Development is responsible for the provision of psycho-social and emotional support to the individuals, families and groups.

The EAS programme also encourages the SAPS to make use of external resources, including community services that are available for their convenience, especially when they are outside the workplace.

4.3.2.2 Peer education programme

The peer education within the SAPS comprises of peer educators recruited from the various cadres of the SAPS personnel and from different ages and races. These educators market and promote HIV and AIDS-related activities such as sexually transmitted infections, condom week, candle light memorials and voluntary HIV testing and counselling. They also participate in awareness raising events and activities such as distributing promotional material to the personnel prior to and during events; condom distribution by filling condom dispensers. The educators further identify personnel in need of professional service and refer them to appropriate professional or hold one-to-one information sessions with them.

Despite the available policy framework within the SAPS, few challenges were identified during the research process. For example, the current policy on the management of HIV and AIDS in the workplace does not make provision for compulsory testing for HIV and other related activities. The commanders are making it their subordinates' task to attend HIV and AIDS-related activities, and sometimes they make the subordinates think that HIV and AIDS-related

issues have nothing to do with the employer and workplace. As a result, peer educators and other subordinates are often reprimanded and warned that their work is delayed because of those HIV related activities.

The other challenge is that some of the peer educators do not have peer education key performance areas written in their work plans. This gives commanders the opportunity to stop the peer educators from participating in HIV and AIDS-related activities. The researcher's observation was that the majority of the commanders and managers are not aware that HIV and AIDS programme is a presidential priority.

The referral mechanism of the SAPS personnel to the external resources for their psycho-social and emotional support was also identified as a challenge. The referral system is currently informal and no record has been kept for monitoring and evaluation purposes.

4.4 Preference for external vs. internal resources for HIV and AIDS psychosocial support

To achieve objective 2 of the study, the respondents were asked to state their preference for internal or external resources and the reasons for their preference. The results revealed that the majority (75%) of the SAPS personnel show a preference for internal resources. Overall, the respondents were of the opinion that internal resources will save them money, time and energy of travelling to external resources. They were of the opinion that travelling is expensive and can contribute to poor utilisation of resources outside the workplace. As one support staff indicated:

> *"I prefer an internal resource because there is no need for transport, since it will take place during working hours.*

Similarly, other police officers stated that:

> *"I prefer an internal resource due to the fact that an individual spends more or less 75% of the time at work and it would be good to have support at work."*

> *"Since internal people are the people who know me better than external, in that matter, they are the ones who will understand my situation better".*

"I feel comfortable with the people I know rather than strangers"

"Internal support is better, because you do not have to leave work or take a day off when you need help"

"It will reduce stigma and bring more education to Managers and Commanders"

"I prefer internal support group in order to assist those who see the disease as a killer machine to change their thinking"

"*SAPS members will be familiar with the subject. Ownership of the sickness will take place-there will be a lot of disclosure in the workplace"*

In essence, the common sentiment around this theme was that there is no need for transportation as the internal resource will be located within the SAPS offices and during working hours. The respondents thus believed that working and attending a support group is associated with the metaphor of killing two birds with one stone as the two will be done at once.

In terms of external resources, the few respondents who preferred these cited HIV and AIDS-related stigma and discrimination as the main factor underlying their preference. The following statements illustrate:

"I am avoiding stigma and to be discriminated against," (Support staff).

"I am worried that my colleagues and commanders will know my status and gossip about me and I'll lose respect," (Police officer).

"My HIV status will not be known in the workplace," (Police officer).

"I am not sure whether my Colleagues are going to accept my status, even if I am sick, they are going to think that it is because of HIV status even if it is a minor sickness," (Support staff)

"I am worried that my Colleagues will know my status and gossip about me and I lose respect," (Support staff)

"I do not want my colleagues to shame me because they know my status". (Police officer)

4.5 Perception of the need for an HIV and AIDS support group

As stated earlier in the dissertation, a support group is one of the most effective HIV and AIDS workplace programme intervention as it provide affected persons with an opportunity to meet people in similar circumstances to share experiences and support one another. Furthermore, the Guide for Government Departments of the Department of Public Service and Administration (2002) encourages public institutions to have support groups in the workplace as an internal resource available to all employees in order to reduce the employee's feelings of isolation and loneliness as it enables sharing of experiences and offers wide range of people with whom they can interact and solve problems.

To explore the extent to which the SAPS employees would support the establishment of such a group, the respondents were asked: "*In your opinion, should a support group for HIV and AIDS be established in the SAPS?"* An overwhelming majority (92%) responded in the affirmative. The reasons given can be categorised into four main groups: stigma and discrimination; education, time and transport; potential inclusion of other issues.

4.5.1 Stigma and discrimination

The common feeling was that a support group would play a very critical role in educating and empowering, especially the managers to understand and handle HIV issues better in the workplace as stigma remains the single most important barrier to public action (Stanley, 2012).

4.5.2 Education

Monnakgotla (2012) believes that prejudice and a lack of knowledge drive people to stigmatise and discriminate against people living with HIV and AIDS. Employees who are known to be HIV-positive often face stigma and discrimination from co-workers, supervisors and managers. One police official

and one support staff believes that support group will play a very critical role in educating their seniors and argue that:

> *"It will bring more awareness and knowledge to the SAPS personnel, particularly commanders and managers. It will also assist in reducing stigma and discrimination challenges and developing coping mechanism."*

> "*More education about the HIV will be provided"*

One HIV and AIDS manager supported the role of support group in bringing education to the SAPS and mentioned that:

> *"The SAPS members will be more familiar with the subject. Ownership of the sickness as a normal disease will take place and there will be a lot of disclosure and support from managers and commanders."*

One police official shared the same feeling about the positive contribution which the support group will make and said that:

> *"Colleagues and commanders will learn and stop judging others."*

In addition to this point, one support staff mentioned that:

"No extra time will be used as support group will be taking place at work"

One other support staff member felt that in order for the support group to be effective it must get the support from managers and mentioned that:

> *"Managers should support and endorse the support group programme. More people will get an opportunity to learn about HIV and stop discriminating."*

The common feeling from the above mentioned respondents was that the support group will play a big role in educating and empowering, especially the managers to understand and handle HIV issues better in the workplace as stigma remains the single most important barrier to public action (Stanley, 2012).

4.5.3 Time and transport

In line with the sentiments presented in Section 4.4, many respondents felt that an internal support group would save time as it would take place within the organisation.

One support staff member appreciated the internal support group and said:

"*It would be more convenient while I am at work.*"

Similarly, two more support staff indicated that: *"It will be easy for me to go and talk whenever I have a bad day as there will be a platform."*

"It will be more convenient as the support group will be at the workplace:"

4.5.4 Potential inclusion of other issues

HIV and AIDS workplace programme managers emphasised that the scope of HIV should be broadened in order to destigmatise HIV and AIDS. They further mentioned that there are critical issues which affect their lives such as substance abuse, financial management, stress and other things, which can also be discussed during support group sessions. The above-mentioned was supported by one police officer who said:

> *"I want the support group not to cater for HIV and AIDS only but other important issues as well, in that way it will combat stigma and discrimination."*

Another comment was made by the manager and said that:
"support group should be comprehensive and address all important issues being of concern to the participants"

4.5.5 Perceived role and participation in support group

Although the majority of the respondents showed approval for an internal support group, a relatively lower proportion (67%) stated that should they test positive for HIV they will join the workplace support group (Table 4.2).

Table 4.2: Views on an HIV and AIDS support group within the SAPS

Supporting the establishment of HIV and AIDS support group within SAPS	Number	Percentage (%)
In your opinion, should HIV and AIDS support group be established in the SAPS?		
Yes	83	92
No	7	8
Would you join an HIV and AIDS workplace support group should you ever test HIV positive?		
Yes	60	67
No	29	32
Not sure	1	1
Would you support an HIV-positive spouse or partner's referral to a workplace HIV and AIDS support?		
Yes	68	76
No	20	22
Not sure	2	2
Total	**90**	**100**

Although the respondents were not asked to provide reasons for this, a plausible explanation seemed to be the fear of being known to be HIV positive and/or being exposed to colleagues, commanders, and managers, as revoked by results in Section 4.4 above.

When asked what roles they would assume in the workplace support group, the majority (31%) of those who indicated that they would join such a group stated that they would be supporters; 21% stated that they would be support group members; 8% indicated that they would be volunteers; 15% stated that they would be peer educators, while 4% chose more than one task (Table 4.3).

Volunteers, in this context, can be described as carers who provide emotional support to peers infected or affected by HIV and AIDS (Bor and Elford, 1994). Support group members are ordinary members who join the group to receive support, while supporters are those who offer their various resources to ensure the sustenance of the group.

Table 4.3: Preferred role in workplace HIV and AIDS support

Preferred Role	Number	Percentage (%)
Support group member	19	21
Volunteer	7	8
Supporter	28	31
Peer educator	13	15
Multiple roles	4	4
Total	**83**	**100**

The support for the establishment of a support group was also evident during interviews with HIV and AIDS workplace managers in support of HIV and AIDS workplace programme for the benefit of the organisation and its employees. The HIV and AIDS workplace managers clearly indicated that the support group is a good initiative and needed to be available and accessible for the benefit of the organisation, including the personnel at Head Office Divisions. In other words, they want support group to be available in the SAPS and they are supporting that initiative. The managers further mentioned that they are in support of the Department of Public Services and Administration Guidelines and they are providing the necessary direction as far as HIV and AIDS in the workplace is concerned. They were also of the opinion that since HIV and AIDS is a presidential priority; they will ensure that it was well supported.

The managers also mentioned that the support group would run during working hours. The managers indicated that they would take it upon themselves to ensure that all the SAPS managers were trained and informed to acknowledge the presence of HIV and AIDS in their workplace, as well as the proposed support strategy-support group. More resources such as boardrooms, vehicles, the EAS programme, among others, were confirmed to be available to the personnel.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter present a summary of the key findings of the study and recommendations for encouraging the SAPS personnel's use of internal resources. The purpose of this study was to explore factors that underlie the SAPS personnel's preference for external rather than internal resources for their HIV and AIDS psychosocial support.

5.2 Summary of findings

It is evident that there are resources in the SAPS such as policies, guidelines and services. Policies and guidelines include (the SAPS Policy on HIV and AIDS in the workplace, the National Strategic Plan, the SAPS Policy on HIV and AIDS in the workplace, Managing HIV/AIDS in the Workplace: A Guide for Government Departments, and so forth). Services include the EAS programme, Peer Education, HIV Counselling and Testing, different medical Aids (Polmed, GEMS, Discovery), and others.

There are also board rooms, computers, vehicles to transport personnel to the support group sessions, time to seek EAS support, including partnerships from other departments such as the departments of health and social development. Other salient findings from the study are that:

- The majority of the respondents prefer internal resources and their main reasons are that it will save them time, money for transportation and it is also convenient for them as they spend a lot of their time at work. It was further clear that participants felt that their colleagues, who know them better, are the ones who will understand them better than strangers.
- In terms of an internal HIV and AIDS workplace support group, those who preferred the internal one mentioned that it would assist in bringing more education to the personnel, more especially the commanders and managers to reduce stigma and discrimination. This would also help them to understand and handle HIV and AIDS related issues better and would also be unconditionally supportive to the individuals who disclose their HIV status in the workplace. Some of the responses highlighted that the internal resource will normalise the HIV

and AIDS and it will be treated like any other disease. Others mentioned that they will benefit from the experts in the subject matter when sharing new information and developments as well as those who are living with the virus when called to share their experiences with the support group members. Page et al, (2006) mentioned that to remove the stigma attached to people who are HIV-positive, the organisation should try to get HIV-positive people to educate fellow workers.

- Respondents identified stigma, discrimination, labelling and judgement as challenges, and if not properly addressed, they might be obstacles for most of the personnel to come forward regarding HIV and AIDS related issues in the workplace. The HIV and AIDS workplace programme might not serve any purpose if not fully utilised by personnel.
- Peer educators do not have key performance areas formally written to guide how they should perform their duties and this compromise their duties as sometimes they are not allowed to participate in those activities.
- Referral mechanisms were highlighted by HIV and AIDS workplace programme managers not to be in place as a lot of people become lost in the system of referral.

5.3 Recommendations

Based on the overall findings of the study, the following recommendations are made to guide the establishment of support group within the organisation.

1. Consideration should be made to establish an internal support group for HIV and AIDS infected and affected employees to address their psycho-social and emotional needs. The support group should also consider other important issues rather than HIV and AIDS only in order to destigmatise it. Issues such as alcohol, finances, relationships, substance abuse and dependency, behaviour, mental health and others should be considered for the wellbeing of the personnel. HIV and AIDS cannot be dealt with in isolation as they touch on a number of things affecting employees' lives in the workplace and personally. Therefore, the purpose of the support group should be to discuss issues pertaining to the SAPS personnel at National Head Office Divisions.

2. More education and learning is still needed in the SAPS to address stigma, discrimination, negativity and victimisation in the workplace. It is evident that more respondents want to participate in the support group, but the fear of the above-mentioned issues is still a challenge. It must also be emphasised that prior to each and every deployment, the police officials should receive an intensive preparatory session on HIV and AIDS.

3. Key performance areas must form part of the work plan of every peer educator. As already mentioned in Chapter 2, peer educators provide training pertaining HIV and AIDS to their peers and they are seen as change agents in the organisation. For them to be more effective and efficient, the necessary support should be provided.

4. Opportunity should be given to those who are willing to be involved in gaining and sharing their knowledge, information, experience, support, encouraging positive living and self-management to the infected and affected employees during the support group.

5. The referral systems should be in place to ensure on-going monitoring and evaluation of the referred personnel.

5. 4 Conclusion

There was generally a high level of knowledge about HIV and AIDS among the study respondents. The respondents also acknowledged that since they spent a lot of time in the workplace, the environment should be conducive and supportive in order for them to be productive for as long as they can still perform. To this end, a workplace HIV and AIDS support group was seen as necessary in the SAPS Head Office Divisions to provide psycho-social and emotional support to the personnel. Things like negative attitudes, stigma, discrimination and labeling were identified as some of the challenges that need to be addressed as they create a lot of fear for SAPS personnel to utilise internal HIV and AIDS services and support.

The study was conducted within the framework of the Social Support Theory. The theory was deemed appropriate since it focuses more on the acknowledgement of HIV positive results and the provision of psychosocial support for the personnel who found themselves HIV positive results.

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Annexure A: Quantitative *questionnaire*

NEED ASSESSMENT QUESTIONNAIRE

The purpose of this questionnaire is to determine the need for the establishment of an HIV and AIDS Support Group Programme within the SAPS, National Head Office Divisions (Pretoria).

A support group is a structure or a meeting wherein people with common challenges, concerns and needs come together to support one another in various aspects of daily living and functioning – emotional, physical and psychological – and to share information, knowledge, ideas and experiences. All completed questionnaires will be treated in the strictest confidence. The information given will only be used for research purposes.

Biographical Information

Name (pseudonym) ----------
Age ----------
Home language ----------
Gender ----------
Marital status ----------
Rank ----------
Religious affiliation ----------

Knowledgeable about HIV and AIDS

	Yes	No
Are you knowledgeable about HIV and AIDS?		
Would you like to receive information on HIV and AIDS? If yes		

Give address ----------

(INSTRUCTION: Please answer the question as honest as possible by ticking an appropriate box with x)

1. Have you ever undertaken HIV and AIDS test?

Yes	No

2. If yes to question 1, did you receive any pre-test counselling?

Yes	No

3. If yes to question 1, were you counselled after the test results were given to you?

Yes	No

4. Have you encouraged your partner to go for HIV testing?

Yes	No

5. Should you ever test positive for HIV, would you seek support?

Yes	No

6. Should you ever test positive for HIV, would you join an HIV and AIDS support group at the office?

Yes	No

7. If your partner or a member of your family tests positive for HIV, and is referred to a support group at workplace, will you support the idea?

Yes	No

8. In your opinion, should a support group for HIV and AIDS be established in the SAPS?

Yes	No

9. If there was a support group for HIV and AIDS in the SAPS, would you join as a**…**

Support group member----------	
Volunteer----------	
Supporter----------	
Peer educator----------	
I will not join----------	

10. If you prefer internal resources, what are your reasons?

---

11. If you do not want internal resources, what are your reasons?

---

12. If you prefer internal support group, what are your reasons?

---

13. If you do not want internal support group, what are your reasons?

---

14. If you should ever attend a support group for people living with HIV in SAPS, it would be to
---

THANK YOU FOR YOUR CONTRIBUTION

Annexure B: Qualitative questions for managers

1. I know that on a quarterly basis, you have voluntary counselling and testing, I don't want to know how many people are testing positive for HIV, but I am interested in the general participation rate of the personnel of Head Office Divisions on this programme.
2. People have their medical aids, which can assist them in having different options of who they want to see should they test positive for HIV. What do managers recommend to the personnel as the way forward?
3. Tell me about the options available to those who don't have medical aids or don't want external support services. Are they catered for internally?
4. Should somebody approach you for referral purposes after being diagnosed with HIV, where would you refer that person to?
5. I know that employee assistance services are available to SAPS personnel, but is there any other resource available for support services?
6. According to the Department of Public Service and Administration (DPSA) guidelines, the workplace is not only the optimum setting for HIV and AIDS prevention programme, but also an ideal setting for providing treatment, care and support services to the infected and affected employees. I would like to know if there is any support group programme for psycho-social and emotional support service in the workplace.
7. If "no" to question six, what is your opinion regarding this DPSA guideline?
8. What is your view regarding a support group programme?
9. The DPSA further indicates that public service managers have the responsibility to manage and coordinate these programme, (treatment, care and support) how far are you with the coordination process?
10. Taking into consideration the rights of the beneficiaries of the HIV and AIDS Programme confidentiality, how will it be protected, should people be interested in forming or joining support group?
11. As the managers of the HIV and AIDS programme, are you encouraging and supporting the establishment of the support group programme within the organisation? If "yes", how and if "no", why not?
12. If "yes" to question 11, what resources are available to the employees to use when attending or interested in support group programme?
13. According to you, if a support group programme can be established within the organisation, what can people benefit from it?
14. Looking at your monthly statistics, how can you explain the utilisation rate of the HIV and AIDS programme?
15. What is your overall comment regarding a support group programme?

Annexure C: Ethical Approval Memo

UNISA University of south africa

MEMO

TO WHOM IT MAY CONCERN

From: Mr Leon Roets
Post graduate Programme: Social Behaviour Studies (HIV/AIDS)
Department of Sociology
UNISA

CC: Dr ZL Jansen
M&D Coordinator
Department of Sociology
UNISA

18 November 2013

RE: APPROVAL OF ETHICAL CLEARANCE PRIOR 2010

Dear Sir/Madam

Mrs Moganedi MJ (30533538) did not receive a letter on ethical approval of her proposal. This is due to the fact that she was registered for the module (SB80P19) where the proposal was allocated before 2010 and it was only after 2010 when UNISA insisted that all M & D proposals must receive formal ethical clearance. During the period prior to 2010 the supervisor granted the approval of the proposal sends us a request for title registration and then gave permission to proceed with her studies.

I hope this is of assistance.

Should you have any further inquiries please do not hesitate to contact me.

Yours sincerely,

Leon Roets
Post graduate Programme: Social Behaviour Studies (HIV/AIDS)
Department of Sociology
UNISA

Annexure D: Approval letter from SAPS Senior Management

SUID-AFRIKAANSE POLISIEDIENS SOUTH AFRICAN POLICE SERVICE

Verwysing Reference	7008557-9
Navrae Enquiries	Capt M J Moganedi
Telefoon Telephone	012 393-5195/082 716 5981
Faksnommer Fax number	012 393- 5238

Social Work Services
Head Office
Private Bag X94
PRETORIA
0001

2008-03-25

Att: Snr Supt Schnetler

The Head
STRATEGIC Management
HEAD OFFICE

REQUEST FOR PERMISSION TO CONDUCT RESEARCH : NEED ASSESSMENT FOR THE ESTABLISHMENT OF HIV / AIDS SUPPORT GROUP WITHIN THE SAPS : NATIONAL HEAD OFFICE

1. I, Captain M J Moganedi, No: 7008557-9 would like to conduct research on the abovementioned topic at Head Office Divisions.
2. I am a HIV / AIDS Masters student at the University of South Africa and my student number is 30533538. My supervisor is Mr L Roets , cell : 082 443 9545 / office(012)352 4116.
3. I am currently employed as a Principal Social Worker at Social Work Services at the SAPS : National Head Office and serving a 30 days notice for inter-departmental transfer to Department of Social Development.
4. This research started in 2007 when the researcher identify the need to do need assessment on the establishment of the HIV / AIDS support group as it was one of her key performance areas.
5. Attached please find a copy of the research proposal.
6. I hope this study will add value to SAPS at large.

Recommended / Not Recommended

DIRECTOR
HEAD : SOCIAL WORK SERVICES
DR E STUTTERHEIM

Approved / Not Approved

SNR SUPT
HEAD: STRATERGIC RESEARCH
STRATERGIC MANAGEMENT
J SCHNETLER
Date 2008-04-02

Annexure E: Consent Form

2012-05-20

Dear Research participant

I am a student at the University of South Africa. As part of the requirements for my Master's Degree, I have to complete a research dissertation. I wish to study a need assessment for the establishment of an HIV and AIDS Support Group Programme within the SAPS, Head Office Divisions.

You have been purposefully selected to participate in this study due to your involvement in the SAPS as an employee. You will not have to participate if you are not interested.

There are no anticipated risks, compensation or other direct benefits to you as participant in this interview. You are free to withdraw your consent to participate and may discontinue your participation in the interview at any time without consequence.

If you have any questions about this research protocol, please contact me on 082 716 5981 or at 012 312 7262.

Yours sincerely

Ms M J Moganedi

Please sign and return this copy of the letter to me. A second copy is provided for your records. By signing this letter, you give me permission to report your responses anonymously in the final manuscript to be submitted to my supervisors.

I have read the procedure described above for the proposed research study. I voluntary agree to participate in the research.

Signature of participant Date: