KNOWLEDGE OF AND EXPOSURE TO THE HIV/AIDS WORKPLACE PROGRAMME AND STIGMA AND DISCRIMINATION AMONGST EMPLOYEES OF THE SOUTH AFRICAN POLICE SERVICES (SAPS): A STUDY AT THE PRETORIA HEAD OFFICE

By

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DECLARATION

I declare that: ***KNOWLEDGE OF AND EXPOSURE TO THE HIV/AIDS WORKPLACE PROGRAMME AND STIGMA AND DISCRIMINATION AMONGST EMPLOYEES OF THE SOUTH AFRICAN POLICE SERVICES (SAPS): A STUDY AT THE PRETORIA HEAD OFFICE*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and this work has not been submitted before for any other degree at any other institution of higher learning.

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SUMMARY

This study investigated the exposure of employees in the South African Police Service (SAPS) to the HIV/AIDS workplace programme, levels of knowledge of HIV/AIDS, perceptions of stigma and discrimination and of participation by stakeholders in programme implementation. The researcher subscribes to the view that stigma and discrimination are major obstacles to the successful implementation of the HIV/AIDS workplace programme as this notion has been substantiated by numerous studies. Self-administered questionnaire was used as means of data collection. Findings suggest that the employees of SAPS based at the National Head Office have high levels of knowledge on HIV/AIDS. However, the majority of the respondents indicated that they would not feel comfortable to disclose their HIV positive status, fearing the consequences thereof

KEY WORDS

AIDS, Discrimination, Evaluation, HIV, Implementation, HIV/AIDS Programme, SAPS Workplace policy, Stigma

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretrovirals
CCMA	Commission for Conciliation, Mediation and Arbitration
DOH	Department of Health
DOTS	Directly Observed Treatment Short-course
DPSA	Department of Public Service and Administration
EAP	Employee Assistance Programme
ESKOM	Electricity Supply Commission
FHI	Family Health International
HIV	Human Immunodeficiency Virus
HR	Human resources
HSRC	Human Sciences Research Council
IDC	Interdepartmental Committee on HIV/AIDS
ILO	International Labour Organisation
KAP	Knowledge, attitudes and practices
M & E	Monitoring and evaluation
MRC	Medical Research Council
PLWHIV	Person living with HIV
PMTCT	Prevention of mother to child transmission
POLMED	Police Medical Aid Scheme
POPCRU	Police and Prisons Civil Rights Union
PSA	Public Servants Association
PSBC	Public Service Coordinating Bargaining Council
SAA	South African Airways
SANDF	South African National Defence Force
SAPS	South African Police Service
SAPU	South African Police Union
STI	Sexually transmitted infection
TAG	HIV and AIDS technical assistance guidelines
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS

UNISA	University of South Africa
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

CHAPTER 1:
ORIENTATION TO THE RESEARCH PROBLEM

1.1 INTRODUCTION

This study focuses on the South African Police Service's (SAPS's) HIV/AIDS[1] workplace programme, with special reference to SAPS personnel's level of exposure to the programme and to the levels of stigma and discrimination related to HIV and AIDS that exist among the personnel. Research suggests that workplaces are environments badly affected by HIV and AIDS and Bendell (2003:14), states that *"HIV/AIDS is reducing productivity and increasing costs, due to a fall in the supply of labour, the skills and experience, increasing absenteeism, reducing morale and growing needs for health care and training"*. SAPS (2002:4-11) proposes that police officers, due to their working conditions, are at a high risk of contracting HIV. Furthermore, the impact study conducted by the Police Medical Scheme (Polmed) projects that between 2000 and 2015 the SAPS will be severely affected by HIV and AIDS (SAPS 2002:4-16).

1.2 BACKGROUND AND PROBLEM STATEMENT

Statistics released by the UNAIDS and the World Health Organisation (2007:15) indicate that although Sub-Saharan Africa has approximately 10% of the world's population, it is home to more than 60% of the world's people living with HIV. According to this publication, by the end of 2005, an estimated 3,2 million people in the region became newly infected with HIV. UNAIDS (2006) suggests that HIV and AIDS have profound effects on the human resources of organisations and companies due to increased absenteeism, financial costs related to training or recruiting new staff, loss of institutional capacity and loss of productivity.

[1] Note that the researcher follows the convention as used in publications by the South African National Department of Health to refer to HIV and AIDS as "HIV/AIDS" and as "HIV and AIDS" intermittently, but connoting the same reference to HIV-infection as leading to AIDS. The acceptability of this convention and the use of HIV/AIDS to refer to the actual workplace programme of the SAPS have been extensively discussed and cleared by the National Department of Health and the SAPS.

Stigmatisation and discrimination of people living with HIV leads to some of them being reluctant to disclose their statuses and to a low uptake of HIV/AIDS- related services made available at workplaces (Mahajan, Colvin, Rudatsikira & Ettl 2007).

Colvin, Du Toit and Hadingham (2005:32) report on a survey in the KwaZulu Natal business sector which discovered that HIV and AIDS have a negative impact on many companies. More than half (58%) of the companies surveyed by these researchers experienced low productivity, whereas 48% of them reported a high rate of labour turnover, 42% reported loss of skills and experience, 39% reported increased training and recruitment costs and approximately 46% reported an increase in employee benefits costs, such as early retirement packages and medical expenses.

The South African Department of Public Service and Administration (2002:16) argues that in South Africa, the public service is the largest employer with approximately 1,1 million employees. This study further suggests that the impact of HIV and AIDS on the public service sector includes a loss in skills development, challenges in addressing employment equity, a decline in service delivery improvement and a slow-down in poverty alleviation. Concerning the SAPS, Whiteside and Sunter (2000:108) argue that, due to HIV and AIDS, *"the police and defence force may experience an increased mortality particularly at the middle levels, which could decrease stability"*. The implications of this could be an increase in the national crime rate (because of a decrease in the number of people deployed to fight crime) and a decline in the economy as foreign investors might be reluctant to invest in a country destabilised by rampant crime.

The Department of Public Service and Administration in conjunction with other stakeholders decided to develop a policy framework to guide all South African government departments on the minimum requirements to effectively manage HIV and AIDS in the workplace in order to ensure a coordinated public service response (The Department of Public Service and Administration 2002:1). In line with this policy framework, government departments such as the SAPS have established their own HIV/AIDS policies followed by the establishment of workplace HIV/AIDS programmes.

Although government departments such as the SAPS have implemented sound HIV/AIDS workplace programmes, they are challenged by the problem of stigma and discrimination. Dickinson (2003:25) declares that stigma and discrimination are particular barriers to any response to HIV/AIDS in the workplace. The SAPS's HIV/AIDS policy (2001:1) also states that *"HIV/AIDS is still a disease surrounded by ignorance, prejudice, discrimination and stigma"*. In addressing this matter SAPS's policy disapproves of stigmatisation and discrimination of employees infected and affected by HIV and AIDS. The policy expresses the commitment of the organisation to create an environment that is friendly and supportive to people living with HIV. However, SAPS's HIV/AIDS policy does not clearly outline strategies and programmes aimed at addressing stigma and discrimination.

This central concern about the role of stigma and discrimination in undermining initiatives in the workplace to address HIV and AIDS will be returned to later on. First, the impact of HIV and AIDS globally, in sub-Saharan Africa and in South Africa are considered below.

1.2.1 The global impact of HIV/AIDS

The impact of the HIV/AIDS pandemic is severely felt throughout the world. The estimated number of people living with HIV worldwide is about 33 million and 2, 7 million were newly infected with HIV in 2007 (USAID 2008:1). Research has shown that HIV-infection tends to follow the contours of poverty and vulnerability (Prentice 2004:4).

1.2.2 The impact of HIV/AIDS in Sub-Saharan Africa

Sub-Saharan Africa is the region worst affected by HIV/AIDS (Desmond, Karam & Steinberg 2003:1). A joint report by the International Federation of Red Cross and Red Crescent Societies, the Global Network of People Living with HIV/AIDS and UNAIDS (2004:1) indicates that although Sub-Saharan Africa has approximately 10% of the world population, however, it is home to 70% of all people living with HIV.

It has been observed that out of all people living with HIV in the whole world, six out of every ten men, five out of every ten women and nine out of ten children live in Sub-Saharan Africa (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay 2005).

1.2.3 The impact of HIV/AIDS in South Africa

Walker, Reid, and Cornell (2004:16-17) attribute the widespread prevalence of HIV-infection in South Africa to a number of phenomena such as poverty, illiteracy, the apartheid system, occupational health risks, migrant labour, overcrowded and unhygienic accommodation as well as the controversial stance of key political leaders in the fight against HIV/AIDS.

1.3 STATEMENT OF THE PROBLEM

According to Stewart (2003:1) stigma and discrimination are major challenges to the successful implementation of an HIV/AIDS workplace programme. He further argues that employees can be stigmatised by their fellow employees. Consequently, workers are discouraged from utilising services such as voluntary counselling and testing (VCT). Kauffman and Lindauer (2004:84) suggest that sexually transmitted infections (STIs), such as HIV are perceived as indicators of social transgression and violation of social norms of conduct. Thus, people infected and affected by HIV and AIDS are stigmatised. Moreover, this stigma and discrimination (or the fear of suffering stigmatisation and discrimination at the hands of others) may prevent people from accessing workplace services to get tested or to obtain information.

The Siyam'kela Project (Futures Group International, Policy Project & Siyam'kela 2003:5) conducted by the University of Pretoria identified two modes of stigma. The first type 'can be felt' (internal stigma), and is not exerted by external world onto an individual, but is generated within the person who is infected with HIV or affected by HIV and AIDS. Attitudes and stereotypes of the broader community cause the infected or affected person to feel guilty and ashamed.

The implication of this state of affairs in the workplace such as the SAPS is that despite efforts to address stigma and discrimination in the workplace, some employees may still suffer from self-imposed stigma. People experiencing this mode of stigma choose to withdraw from social interaction and become reluctant to access resources that would help them to manage their HIV-status.

Another mode of stigma, according to Siyam'kela Project (Futures Group International, Policy Project & Siyam'kela 2003:5), is 'enacted' (external stigma). This type of stigma is imposed by the external environment such as communities, friends, family and colleagues at the workplace. External stigma can lead to discrimination. SAPS (2002:3-8) concurs with the findings of Siyam'kela Project by stating *"Police personnel, like the general population, may feel fear, stigma and discrimination towards an HIV-infected individual. In fact, HIV-infected police personnel are often subjected to severe sanctions from their colleagues. As a result, many police personnel are reluctant to be tested and to enter into counselling, treatment and care"*. The implications of this mode of stigma are avoidance, rejection, moral judgment and eventually discrimination of people living with HIV. Stigma and discrimination are counteractive to prevention and care of people living with HIV.

According to Walsh (2001:25), one of the factors influencing the choice of a research topic is *"solving problems and influencing policy"*. Inspired by this notion, the problem that this study set out to address was to discover what the current state of stigma and discrimination around HIV and AIDS and the use of VCT at the workplace is, specifically at the SAPS. By understanding whether stigma and discrimination still exist despite programmes designed to address this, the researcher hoped to make a contribution to further enhance the SAPS's HIV/AIDS workplace programme.

1.4 AIM AND PURPOSE OF THE STUDY

The purpose of this study was to assess the knowledge and exposure of the SAPS employees to the HIV/AIDS workplace programme and to determine current levels of stigma and discrimination. The study focused on the National Office of the SAPS and was descriptive in nature.

1.5 OBJECTIVES OF THE STUDY

Following a general aim to describe the employees' exposure to the SAPS's HIV/AIDS workplace programme and their current levels of stigma and discrimination, this study set out to meet the following specific objectives:

(1) To determine the level of exposure of the SAPS's employees to the HIV/AIDS workplace programme
(2) To assess levels of knowledge of HIV and AIDS among the SAPS's personnel
(3) To assess the levels of stigma and discrimination among the SAPS's personnel
(4) To measure the interviewees' perceptions of participation by stakeholders in the implementation of the programme.

1.6 RESEARCH DESIGN AND METHOD

A cross-sectional survey methodology employing semi-structured, self-administered questionnaires was used to meet the above stated objectives[2]. The SAPS consists of approximately 25 304 employees. The majority of these personnel are young people who are in their prime working ages. Statistics have shown the prevalence of HIV and AIDS rate is very high in these age groups. Also, the working conditions of police members, such as deployment to perform duties relating to peace keeping, attending to accident scenes as well as apprehending violent and non-complying criminals expose police and civilian SAPS employees to the possibility of HIV-infections.

[2] Sloan and Myers (2005) employed a similar methodology in their assessment of peer education workplace programmes in the South African retail sector.

This research project was conducted at the SAPS's National Office, based in Pretoria. Random sampling was used to select the research participants. It is the view of the researcher that although the findings of his study cannot be generalised in its entirety to the whole personnel complement of the SAPS, general recommendations stemming from the findings apply to the broader community of the SAPS.

Full details on the methodology followed and the ethical considerations are discussed in Chapter 3 of this dissertation. The limitations of the study are reflected upon in Chapter 5.

1.7 ASSUMPTIONS

The researcher as an employee of the SAPS and as a key role player in the implementation of the HIV/AIDS workplace programme, assumed that exposure to the HIV/AIDS workplace programme (due to the educational role) should contribute to a reduction in HIV/AIDS-related stigma and discrimination. Moreover, the researcher regarded stigma and discrimination as important barriers to the continued success of HIV and AIDS workplace programmes. Existing literature on HIV/AIDS-related stigma and discrimination and on health-related decision-making as well as consultations with key personnel in the SAPS guided the choice of the methodology and the investigation.

1.8 DEFINITIONS OF KEY TERMS

Some of the key concepts as used in this study are defined in this section. Other important concepts are defined in the text where they are discussed and the section here is therefore not a definitive list. The definitions below act as sensitising explorations of the meanings of certain key notions.

1.8.1 Discrimination

In this study, discrimination means treating someone differently and unfairly because of his or her HIV status or perceived status as being affected by HIV and AIDS.

According to UNAIDS (2008:1) *"People living with the virus are frequently subjected to discrimination and human rights abuses: many have been thrown out of jobs and homes, rejected by family and friends, and some have even been killed"*. Pisani, Ghys and Jenkins (2000:43) suggest that discrimination can be *"defined more in terms of legal and human rights when a person loses a job because of the negative connotation or impression of HIV"*.

1.8.2 Employees

Employees as referred to in this dissertation means all full time personnel of the South African Police Service employed both under Police Act and Public Service Act.

1.8.3 Evaluation

Bertrand and Solis (2000:9) describe evaluation as the *"systematic application of quantitative research techniques to determine the appropriateness and effectiveness of the design and implementation of social programs"*. This study can be regarded as an evaluation of the SAPS's HIV/AIDS workplace programme in terms of addressing stigma and discrimination.

1.8.4 HIV/AIDS workplace programme

An HIV/AIDS workplace programme is a co-ordinated reactive as well proactive intervention developed to reduce new HIV-infections and to manage HIV/AIDS in the work environment. Rau, Roberts & Emery (2002:15) define an HIV/AIDS workplace programme in terms of the following characteristics:

- "*Creation of a company policy on HIV/AIDS, its dissemination to all employees, its implementation and occasional updating.*
- *Information on HIV/AIDS, ways of preventing transmission, places to seek further information, services and ongoing company as well as union support for responsible sexual behaviour.*
- *Condom distribution at readily accessible points around the workplace."*

Therefore, an HIV/AIDS workplace programme is the organisation's response to the threat posed by the pandemic to all spheres of life including the workplace.

1.8.5 Implementation

Barnhart (1996) defines implementation as the application of *"power and authority to accomplish or put something into effect"*. Therefore, throughout this dissertation this term is used in reference to putting the SAPS's HIV/AIDS workplace policy into effect.

Implementation is the process of putting a plan into action with the aim of achieving intended results. A programme can be said to have achieved successful implementation if the intended objectives and goals are met. This study was motivated by a need to evaluate whether the SAPS's HIV/AIDS workplace programme has been successful in addressing stigma and discrimination related to HIV and AIDS.

1.8.6 Stakeholders

Stakeholders are specific people or groups who have a stake in the outcome of the programme. In this dissertation, stakeholders refer to all individuals and organisations playing a critical role in securing the successful implementation of the SAPS's HIV/AIDS workplace programme.

1.8.7 Stigma

Goffman (1963:6) defines stigma as an *"attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one"*. Being HIV-positive or a person affected by HIV and AIDS have become attributes which mark people as different from the rest of the community. Thus, HIV-positive people and others affected by HIV and AIDS are stigmatised and suffer degraded identities.

Massiah, Roach, Jacobs, St John, Walcott, Inniss and Blackwood (2004:396) state "*the stigma associated with HIV/AIDS is not one dimensional. Rather, it involves a variety of overlapping stigmas, many of which predate the HIV/AIDS epidemic. Reactions to people with HIV/AIDS vary according to their age, gender, sexual orientation, and mode of transmission"*.

1.9 OUTLINE OF THE DISSERTATION

Chapter 1 details the purpose, objectives and significance of the study and contains the problem statement, definitions of key terms and the background to the study. In Chapter 2 the researcher discusses the literature reviewed. Chapter 3 elaborates the research design and methodology chosen for the study. Chapter 4 is the presentation of the data, the analysis of data and the interpretation of the findings. Chapter 5 concludes the dissertation by summarising the findings of the study according to the set objectives, giving a reflexive account of the limitations of the study and suggesting recommendations for the purpose of enhancing the SAPS's HIV/AIDS workplace programme.

CHAPTER 2: REVIEW OF LITERATURE ON STIGMA AND DISCRIMINATION

2.1 INTRODUCTION

In the first chapter the researcher gave the background to the problem this study sought to address. This chapter is a report on literature reviewed on the subject of HIV/AIDS-related stigma and discrimination at the workplace. The chapter commences with a consideration of the purpose of the literature review for this dissertation and this is followed by a brief description of the context of the research problem and of three related studies that informed the orientation to this study. The third section of this chapter is an overview of the impact of HIV/AIDS in the workplace and this is followed by a discussion on why SAPS personnel can be at risk of HIV-infection. All of these sections lead up to the final part of this chapter which is a systematic discussion of stigma and discrimination and how this affects the workplace.

2.2 PURPOSE OF A LITERATURE REVIEW

Polit and Beck (2004:88) define the purpose of a literature review as an orientation to what is known and not known about the area of enquiry, to ascertain how research can best make a contribution to the existing body of knowledge. It is also a determination of any gaps or inconsistencies in a body of research on a particular topic and a determination of the need to replicate a prior study in different settings or with a different study population. In line with this explanation of the purpose of a literature review, the researcher embarked on a review of literature to discover existing views and theories in relation to the scope of his research.

Neuman (1997:89) suggests that "*Scientific research is not an activity of isolated hermits who ignore others' findings. Rather it is a collective effort of many researchers who share their results with one another and who pursue knowledge as a community*".

To concur with Neuman, the researcher consulted and acknowledged the work of other researchers in the field of HIV/AIDS-related stigma and discrimination as well as HIV/AIDS in the workplace. This enabled him to avoid repetition of the findings of other researchers and assisted him to build on the previous work, identify gaps and to link other findings to the research problem. Sources for this literature review consist of both theoretical and empirical literature.

As HIV/AIDS is a dynamic field, the researcher endeavoured to make use of the most recent literature; however, some older works deemed to bear an impact on the research were also used.

2.3 A CONSIDERATION OF THE CONTEXT AND OF RECENT RESEARCH ON HIV/AIDS WORKPLACE PROGRAMMES

The aim of this study was to assess the knowledge and exposure of employees of the South African Police Service to the HIV/AIDS workplace programme as well as their levels of stigma and discrimination. Stigma and discrimination are regarded as the major obstacles to a successful implementation of the HIV/AIDS workplace programme (Mahajan *et al* 2007; Population Council 2002:1). So, this study sought to determine whether the SAPS's HIV/AIDS workplace programme has been successful in raising HIV/AIDS awareness and in reducing stigma and discrimination among SAPS employees.

It is necessary for any company to; once it has implemented an HIV/AIDS workplace programme, embark on an evaluation process of that intervention. The reason for this is to determine if the programme is addressing the issues that it was intended to deal with (Esu-Williams, Pulerwitz & Mgilane 2005:1). The researcher uncovered only three studies done on the implementation of the SAPS's HIV/AIDS workplace programme and policy. The first one was jointly undertaken by the Policy Project, the Centre for the Study of HIV/AIDS at the University of Pretoria, The United States

Agency for International Development (USAID) and the Chief Directorate: HIV/AIDS & TB of the South African National Department of Health.

The participants in this research were union representatives, national government HIV/AIDS co-ordinators and directors or their representatives of all national governmental departments including the SAPS (Futures Group International, POLICY Project & Siyam'kela 2003:5). In this study the research team discovered that HIV/AIDS workplace policies have been implemented by most government departments. However, it surfaced that there was still much ignorance about the content of these policies and a great degree of uncertainty about its implementation. This study also uncovered that most (if not all) government departments do not have policies that explicitly deal with the issue of HIV/AIDS-related stigma (Futures Group International, POLICY Project & Siyam'kela 2003:5).

The second study was done by Van der Velden [sa] and her aim was to explore the impact of HIV/AIDS within the SAPS in Pretoria as well as to critically analyse cooperation between the SAPS and the police unions such as the South African Police Union (SAPU), the Police and Prisons Civil Rights Union (POPCRU), the Public Servants Association (PSA) and Solidarity. Thus, it was beyond the scope of van der Velden's study to comprehensively analyse stigma and discrimination at the SAPS with a special reference to the national Head Office. Nonetheless, Van der Velden [sa:25] names stigma and discrimination as obstacles in the successful implementation of the SAPS's HIV/AIDS workplace programme. Her respondents indicated that employees are afraid of the negative implications in the workplace if they were to associate themselves with any HIV/AIDS-related activities.

The third study reviewed by the researcher was done by Masuku in May 2007. . This study uncovered that there are sporadic manifestations of HIV/AIDS –related stigma and discrimination in the SAPS (Masuku 2007:78). These three studies found that although the SAPS, like most other government departments, has implemented its HIV/AIDS workplace programme, HIV/AIDS-related stigma and discrimination among the employees are still challenges that should be addressed. Also, the above-mentioned studies did not focus on the evaluation of the HIV/AIDS workplace

programme or on assessing the levels of HIV/AIDS-related stigma and discrimination among the SAPS personnel. Therefore; the aim of this study is to fill this gap in the knowledge.

Also, the researcher was of a view that being part of the South African Police Service; especially being part of the team responsible for the implementation of the HIV/AIDS programme, puts him in an ideal position to offer an insider's view on the issues surrounding HIV/AIDS in the SAPS.

2.4 THE IMPACT OF HIV/AIDS IN SUB-SAHARAN AFRICA, IN SOUTH AFRICA AND IN THE WORKPLACE

Developing countries have been severely affected by HIV and AIDS. Sub-Saharan Africa has been declared as the region most severely hit by HIV and AIDS as it is home to six percent of the world population but, statistics indicate that two thirds of all the people living with HIV worldwide is found in Sub-Saharan Africa (Desmond, Karam & Steinberg 2003:1).

Dr. EM Samba (2000:1), the director of the World Health Organisation's Regional Office in Africa says the following regarding the impact of HIV/AIDS on the African continent "*the sad and gloomy scenario is becoming even more painfully familiar: everyday, cemeteries and funeral service outfits in rural and urban Africa brim with business – welcoming and handling new arrivals…in some of our countries, at least 2 000 people are buried every week, victims, we now know of the HIV/AIDS pandemic"*. Emanating from the guidelines set by United Nations and the World Health Organisation, different continents and regions have crafted their own strategies applicable to their respective regions to address the spread of HIV and the eventual severe impact of the AIDS pandemic. South Africa has been declared as the country worst affected by HIV/AIDS and Kauffman and Lindauer (2004:17) go as far as referring to South Africa as "*the HIV capital of the world*".

Research has shown that HIV/AIDS and other infectious diseases thrive in the communities where there is much poverty (Bendell 2003:6).

People from environments that are poverty-stricken cannot afford basic needs, such as healthy food and clean water. The observations of Kauffman and Lindauer (2004:1) concur that poverty exacerbates HIV and AIDS. Moreover, HIV/AIDS affects all spheres of life including the workplace.

Page, Louw, Pakkiri and Jacobs (2006:96) say that HIV/AIDS affect people in their economically active years which are mostly the ages of 25- to 49-years. The HIV-infected person - depending on the individual's lifestyle, access to treatment and the progression of the viral load - can become less productive as fatigue and opportunistic infections set in. Should the HIV-infected person die, his or her knowledge, training and experience will also be lost to the workplace. In view of the foregoing points, the International Labour Organisation (ILO) declared HIV/AIDS as a workplace issue (ILO 2001:3). The effects of HIV/AIDS on the work environment prompted the ILO to outline guidelines to be followed by its member states in the mitigation of the impact of HIV/AIDS in the workplace.

Page *et al* (2006:104) further observe that HIV/AIDS is a concern for the workplace because of the following:

i. The consequences of HIV and AIDS, such as an inability to work due to poor health and eventually death.
ii. The financial constraints placed on companies due to medical aid claims absenteeism and loss of employees.
iii. The stress and trauma experienced by employees due to the illness and deaths of colleagues.
iv. Morale degeneration due to the loss of colleagues.
v. Burnout experienced by the remaining employees due to ever growing amounts of work.
vi. A potential decrease in productivity.
vii. The loss of skills.
viii. Stigmatisation and discrimination against people suspected to be infected or affected by HIV and AIDS.

2.5 THE RISK OF HIV INFECTION AMONG SAPS PERSONNEL

The nature of the work that police do exposes them to the risk of being infected with HIV, as police are required to be deployed in dangerous situations anywhere at any time as the need arises. In addition, the study by Zuma, Gouws, Williams and Lurie (2003:421) uncovered that the risk of sexually transmitted infections (STIs) including HIV is high among migrant workers. With regard to the SAPS; members are often called upon to take part in international peace-keeping intervention programmes in Africa and overseas for deployment, thus they do become migrant workers for certain periods of time. The period of time they spend away from their spouses and families can vary from one day to approximately six months. During these operations, spouses and consensual partners are left behind and they are exposed to temptation of having casual sexual partners. The study by Family Health International (FHI 2006:1-3) established that the armed forces, police and other uniformed services throughout the world are at a higher risk of contracting HIV and STIs than the general population. Also, Pharoah and Schonteich (2006:1) argue that in the SAPS police officers spend lengthy periods of time away from home performing special duties and in tactical deployment such as policing major public events and on special in-service training interventions.

In the event whereby police officers execute an arrest of a non-compliant suspect, chances exist for the police officers to contract the HI-virus. Weber (2001:1) reports on an incident in Boston in which a man's blood was spattered over three police officers during an arrest. The court ruled in favour of the suspect that according to law he was not compelled to disclose his HIV-status. It thus seems that SAPS personnel are at risk due to the migrant nature of some of their duties and also because they might come into contact with contaminated blood and other bodily fluids in the execution of their duties.

2.6 AN OVERVIEW OF STIGMA

Research shows that stigma and discrimination are not new concepts, but have been around long before the discovery of HIV. The sociologist, Erving Goffman is regarded as the pioneer scholar to critically analyse stigma as a social concept (Gonzalez-Torres, Oora, Aristegui, Fernandez-Rivas & Guimon 2007:14).

In explicating the roots of stigma as a social phenomenon, Goffman (1963:1) points out that the Greeks were the first nation in the recorded history to develop the notion of stigma from its ideological state to a working concept. He writes "*the Greeks, who were apparently strong on visual aids, originated the term stigma to refer to bodily signs designated to expose something unusual and bad about the moral status of the signifier"*. According to Goffman a person with such stigma was regarded as blemished, ritually polluted and thus as someone to be avoided by the rest of the community.

Stigma and discrimination are critical issues to address in dealing with HIV/AIDS. The International Centre for Research on Women (2006:2), quoting an HIV positive activist, Reverend Byamugisha, declares *"Everyone is now mobilized around universal acces*s [to antiretroviral therapy], *which is great…universal access by 2010 is a good goal. But no one is talking about the fact that to reach this goal we need to eliminate stigma, shame, denial, discrimination, inaction and misaction before 2010"*. In order to deal with HIV/AIDS-related stigma and discrimination, however, a clear understanding of these concepts is needed.

UNAIDS (2007:8) defines stigma as a *"process of devaluation of people either living with or associated with HIV and AIDS*". Stigma and discrimination are obstacles to the fight against the HIV/AIDS pandemic (International Centre for Research on Women 2006:1). Ogden and Nyblade (2003:25-29) suggest that major expressions of stigma are as follows:

- Physical stigma, which can take the form of physical violence against the stigmatised person or isolation of people infected with HIV (PLWHIV) or affected by HIV and AIDS.

- Social stigma expressed mainly as the social isolation of the person usually by friends, family and colleagues.
- Verbal stigma, such as gossip and rumours as well as insults.
- Institutional stigma, which is differential treatment of PLWHIV in an institution environment like the workplace.

UNAIDS (2004:2) says that "*discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status*". In view of this definition, stigma associated with HIV/AIDS instigates discrimination, because if one does not attach any stigma to HIV/AIDS, he or she would not discriminate against an individual who is (actually or perceived to be) infected with HIV or affected by the HIV/AIDS epidemic.

2.6.1 The evolution of stigma and discrimination

Madru (2003:48) argues that pre-modern societies introduced certain taboos to maintain social cohesion in their own communities, such as for example forbidding contact with other communities. She defines stigma as partly of the ability to identify others and argues that stigma is a prehistoric, evolutionary adaptation necessary for survival. In this context, stigma is not used in a degrading or judgmental way, but instead more as a way of differentiating various human groups.

During the period of the Ancient Greeks (1100 BC to 146 BC) the concept of stigma was further developed closer to its contemporary understanding. The Ancient Greeks are regarded as the first people in recorded history to use the term stigma and to act on it by turning it into inflicting cuts or burns to physically mark people to denote the difference between various groups in society. The people with such marks were regarded as slaves, criminals and/or traitors. People with these marks on their bodies were avoided by and isolated from the rest of the community (Madru 2003:48).

Madru (2003:48) further suggests that during the Judeo-Christian era (1500 BC to 40 AD) the concept of stigma was dramatically developed so that: *"stigma eventually evolved from referring to the physical sign to its current reference to the actual behaviour, for example, promiscuity, adultery, and illegal drug use"*. These religions maintained a belief that illnesses and people born with some form of deformity was a sign of the wrath of or punishment from God for their sins. Venereal diseases were perceived as the results of promiscuity and prostitution and as deserving of punishment from God.

History suggests that prior to the discovery of HIV/AIDS and its impact on international communities stigma had already been in existence and manifested itself through the following conditions:

(a) Mental illness

Bjorkman, Svensson and Lundberg (2007:332) report that people with mental illnesses have long been vulnerable to many forms of stigmatisation and discrimination solely because of their afflictions. According to Gonzalez-Torres *et al* (2007:14) people with schizophrenia are the most stigmatised category of individuals with mental illnesses. Buizza, Schulze, Betrocchi Rossi, Ghilardi and Pioli (2007:5) observe that people with mental illnesses are discriminated against and that their occupational and professional opportunities are extremely compromised after the public have learnt about their mental challenges.

(b) Tuberculosis (TB)

TB is one of the major causes of death worldwide with a death toll within the range of 1.7 million people per year. Baral, Karki and Newell (2007:1) are of the view that TB is a highly stigmatised sickness, partly because it does not require close contact between its carrier and the recipient to have it transmitted from one person to another. New trends of TB and HIV/AIDS show that people living with HIV are more susceptible to TB infection than HIV-negative individuals.

The World Health Organisation (2008) suggests that "*an estimate of one third of the 40 million people living with HIV/AIDS worldwide is co-infected with TB. Furthermore, without proper treatment, approximately 90% of those living with HIV die within months of contracting TB".* This co-existence of HIV/AIDS and TB exacerbates the stigma associated with each of these diseases. The findings of research carried out in Hong Kong on the comparability of stigma associated with TB and HIV/AIDS suggest that these two diseases are highly stigmatised (Mak, Mo, Cheung, Woo, Cheung & Lee 2006).

(c) Leprosy

In the times of the Old Testament, leprosy was a prominent disease, and its victims were generally stigmatised and discriminated against. Chitando and Gunda (2007:184) write "*in Leviticus 13, leprosy is stigmatized and requires a period of quarantine for it to heal. People diagnosed to be with leprosy were not allowed to be members of the community until after they are healed".*

People suffering from leprosy were ostracized even from their own families and loved ones. Similarly to leprosy, there have been calls from various circles for the quarantine of people living with HIV in order to contain the transmission of HIV (Desclaux 2003:2).

(d) Cancer

Fife "and" Wright (2000) conducted a study aimed at the comparison of the effects of the stigma associated with HIV/AIDS and cancer on self-esteem, body image, and personal control. They (Fife & Wright 2000:51) discovered that illnesses such as cancer are stigmatised because they impose physical limitations on the sufferer and because the disease itself is associated with certain images and myths. They further discovered that the stigma associated with cancer has been less overt and manifest at varying extents in the lives of the sufferers. HIV/AIDS stigma is much more severe than the above-mentioned types of stigma because there is a moral issue attached to it, and also because it is viewed as deadly, preventable as well as transmitted from one person to another.

2.6.2 Types of HIV/AIDS-related stigma

Stigma and discrimination manifest themselves in a variety of ways depending on each particular circumstance. Holzemer, Uys, Makoae, Stewart, Phethu, Dlamini, Greeff, Kohi, Chirwa, Cuca and Naidoo (2007:547) describe ***received stigma*** as "*all types of stigmatizing behaviour towards a person living with HIV/AIDS by other people*". The reason this type of stigma is referred to as received, is because its victim receives stigmatising treatment from the surrounding environment and thus the individual has no contribution to the process, but is only on the receiving side.

Internalised stigma (also called self-stigma) occurs when a person infected with HIV reaches a stage whereby he or she imposes stigmatisation upon him- or herself. This usually takes the form of thoughts and behaviours emanating from the individual's own negative perceptions about themselves based on their HIV status (Ogden & Nyblade 2003:2). In this case, unlike in the above scenario, the stigmatised individual is in full control of the process of stigmatisation. Some of the causes of an internalised stigma and discrimination are the environment that has a negative attitude towards HIV/AIDS to such an extent that this is inculcated in people's minds.

Associated stigma occurs when an individual is stigmatised as a result of his or her association with someone living with, working with or otherwise associated with people living with HIV. This kind of stigma is based purely on assumptions and perceptions which results in drawing unfounded conclusions that an individual is HIV positive just by merely associating himself/herself with people living with HIV, which could be friends, family members or colleagues at the workplace (Ndivhuwo 2004:17).

This study focused on associated stigma as the goal was to measure the attitudes of SAPS employees regarding stigma and discrimination, based on the assumption that HIV/AIDS-related stigma can act as a deterrent against employees accessing voluntary testing and counselling for HIV. As the interviewees were not asked to disclose their own VCT use or their health statuses, the study did not aim to make any conclusions about internalised stigma.

However, there is a mutually constituting relationship between associated stigma and internalised stigma. If an environment or context is prejudiced against people living with HIV or affected by HIV and AIDS, then internalised stigma is also highly likely to occur. On the other hand, by educating people about the true facts of HIV-transmission, generalised stigmatisation of HIV/AIDS can be addressed. Thus, if enabling and embracing workplace environments can be created, then those living with HIV or affected by HIV and AIDS can be helped to overcome self-stigmatisation. In the section below, the causes of stigmatisation of PLWHIV and ways in which PLWHIV cope with it are explored.

2.6.3 Causes of stigma and discrimination against PLWHIV and ways of coping

There are many causes that result in people having negative attitudes towards HIV and AIDS. One of the major reasons for the stigmatisation and discrimination of the people infected or affected by HIV and AIDS is related to the manner in which this disease is transmitted (Mak *et al* 2006**:**1). Many commentators link HIV/AIDS-related stigma to the way that the disease has been named and framed by the biomedical discourse. In other words, HIV/AIDS is stigmatised as signifying moral decay (McGrath 1990; Turner 1992). Some people associate HIV/AIDS with irresponsible lifestyles such as promiscuity and/or engaging in sexual relationship with people of the same sex and/or illegal drug use. After intensive research on stigma and discrimination, Ndivhuwo (2004:2) concludes that in many cases stigma and discrimination emanates from unfounded fears and from perceptions that people living with HIV are immoral or dirty. Such fears may even make some people reluctant to share the same dwelling, office space, toilet or eating utensils with a person living with HIV.

Walker, Reid and Cornell (2004:90-91) are of the opinion that the belief systems of various cultural groups dictate the way people explain and comprehend things happening in their daily lives, including HIV/AIDS. Peter Piot (UNAIDS 2004:4), the Executive Director of the UNAIDS, suggests *"HIV stigma comes from the powerful combination of fear and shame because the sex or drug injection that transmit HIV are surrounded by taboo and moral judgment"*.

In this case, people infected by HIV are regarded as having failed to comply with the norms and standards of the wider community. These stereotypes make the situation even worse if the infected person happens to be a woman because in many cultures it is only men who are permitted to have more than one partner (Mboi 1996:97; Ndiaye 2000:58).

Thus, people living with HIV are viewed as receiving just punishment for their unacceptable behaviour. Stigmatisation inevitably leads to discrimination and a vicious cycle starts in which people are afraid to talk about the disease and to disclose their statuses. HIV/AIDS-related stigma and discrimination build on pre-existing forms of stigma and discrimination associated with sexuality, gender, race, and poverty. It deepens pre-existing fears about contagion and disease. The discourse about AIDS as punishment, guilt, shame, and otherness has intensified these fears, reinforcing and legitimising stigmatisation and discrimination (Herek 2002).

Heatherton, Kleck, Hebl, and Hull (2003:88) state that stereotypes play a major role in perpetuating HIV/AIDS stigma and discrimination. They argue that the danger of stereotyping is that "*stereotypes have historically been viewed as unjustified because they reflect faulty thought processes or overgeneralization, factual incorrectness, inordinate rigidity, an inappropriate pattern of attribution, or rationalization for a prejudiced attitude or discriminatory behavior"*.

The researcher has for the past ten years been working in the field of HIV/AIDS, is also affected by the epidemic and has, on a number of occasions observed that an individual's physical appearance such as weight loss can prompt others to conclude that such a person is HIV positive. Such assumptions generally are followed by stigma and discrimination against the individual perceived as infected or affected by HIV/AIDS.

Heatherton *et al* (2003:252) suggest two strategies that may enhance the coping mechanism of people infected or affected by HIV/AIDS. These problem-focused strategies can be directed at the self or the situation/context.

The self-focussed strategy is where the stigmatised individual refuses to succumb to the dehumanising effect of stigma. This kind of resilience is best demonstrated by support groups formed by people infected or affected by HIV and AIDS. In these support groups members come together and share their experiences and coping skills. Between 2004 and 2006 the researcher worked with such support groups and took part in the establishment of support groups for people living with HIV. During this period he observed how these support groups assist their members to cope with stress and feelings of hopelessness. The researcher observed how people taking part in these support groups refused to be regarded as victims deserving of hand-outs thereby resisting stigma directed at the self and also slowly addressing stigma in the situation or context.

This second strategy directed at the situation or context is more complex as it involves efforts by the stigmatised individual to transform his or her surrounding to address the cause of the stigma. This entails altering beliefs, perceptions and stereotypes of the perpetrators of stigma and discrimination.

Organisations like the Treatment Action Campaign and AIDS Law Project and other small and regional or community-based organisations are examples of groups working according to this strategy. Their mission is to educate societies on issues of HIV and AIDS so that they should stop stigmatising and discriminating against people infected and affected by HIV/AIDS.

Nyablade (2003:36) suggests that another way of coping with stigma and discrimination for people living with HIV is disclosure in order to seek support and participation in PLWHIV networks and seeking work in the area of HIV/AIDS advocacy. In this study, the notion of situation/context-directed strategies to address HIV/AIDS-related stigma and discrimination is followed up on in that the levels of stigma and discrimination are measured among employees in a work context in which programmes were introduced to educate people about HIV and AIDS. To further assist in this aim, the researcher also explored what the literature has to say about how HIV/AIDS-related stigma and discrimination manifests itself in the workplace and this is detailed in the section below.

2.6.4 The manifestation of HIV/AIDS-related stigma and discrimination in the workplace

It has been observed that stigma and discrimination associated with HIV/AIDS are major obstacles in the fight against the epidemic. The head of UNAIDS, Jonathan Mann describes the impact of stigma and discrimination as the third epidemic that would follow HIV and then AIDS epidemic (Skinner & Mfecane 2004:1). Gashishiri, Ssempebwa, Kitimbo and Byakika (2003:1) concur with Skinner and Mfecane about the challenge posed by stigma and discrimination by observing that "*stigma and discrimination are recognized as major factors fuelling the global HIV epidemic, creating a climate for fear and ignorance and a reluctance to confront rising infection rate"*.

Furthermore, Nyblade (2003:4) raises concern that although HIV and AIDS have been around for more than a decade, stigma and discrimination attached to people living with HIV still occur. An international study by the Centre for Research on Women (2006:1) in various countries found that *"HIV-related stigma exists in workplaces across the globe and there were several accounts of serious workplace discrimination and violations of employees' rights"*.

Irin (2002:1) uncovered that although South African laws expressly outlaw stigma and discrimination in the workplace, and strive to protect people living with HIV; stigma still exists in the workplace. The study by Pulerwitzer, Greene, Esu-William and Stewart (2004:1) on the Electricity Supply Commission's (ESKOM's) HIV/AIDS Workplace Programme uncovered that "*stigma is most prevalent at ESKOM; in everyday social interactions within the workplace"*. Fear of stigma and discrimination discourage ESKOM employees from disclosing their HIV status as well as from utilisation services made available by this HIV/AIDS Workplace Programme.

HIV/AIDS-related stigma and discrimination manifest themselves in various ways in the workplace.

Stigmatisation and discrimination against people living with HIV and those perceived to be affected by HIV/AIDS occur despite legislation against it and policies introduced by different member states of the United Nations to address it. The degree of stigmatisation and discrimination varies from country to country, depending on the laws and the extent of the enforcement of such laws as well as other HIV/AIDS intervention programmes.

A study in Brazil uncovered that although there is a policy prohibiting stigmatisation and discrimination against employees infected and affected by HIV/AIDS, a number of Brazilian companies still conducted pre-employment HIV testing, did not promote employees living with HIV and in extreme cases even dismissed HIV-positive employees (Ivers 2004:10).

In South Africa the prominent court case relating to stigma and discrimination in the workplace is the one between Hoffmann and the South African Airways (Hoffmann Versus SAA 2001, SA 1 cc). In this case Hoffmann applied for a post as cabin attendant. The applicant went through a four stage selection process consisting of a pre-screening interview, psychometric tests, a formal interview and a final process involving role-play with the other eleven applicants.

The appointment in these posts was subject to pre-employment medical examination involving a blood test for HIV. The medical examination detected that Hoffmann was HIV positive, however, at the time Hoffmann was still clinically fit and suitable for employment as a cabin attendant. Due to his HIV positive status, Hoffmann was not appointed. The matter was taken to the Constitutional Court for unfair labour discrimination and the Court ruled in favour of Hoffmann. The Court's ruling served as a benchmark case discouraging HIV/AIDS discrimination in the workplace.

The South African National Defence Force (SANDF) took a leading role among government departments in implementing an HIV/AIDS Workplace Programme. However, the SANDF was regarded as discriminating against people living with HIV (Earthtimes 2007) because in 2002 it introduced a comprehensive medical examination programme.

In this programme the members were subjected to a medical examination at least once a year. New recruits had to go through a medical examination as part of the conditions for their appointment. Also, the former Minister of Defence, Mr. Lekota, is quoted as having made a statement suggesting that there is no point in recruiting people living with HIV into the Defence Force because they are ill. The reasons cited by the SANDF for not recruiting and deploying their personnel living with HIV were that:

- They were considered as not physically fit to execute strenuous duties
- Their immune systems were deemed to have been compromised
- Stress linked to deployment would exacerbate their HIV-related condition
- The progress of the disease is unpredictable and this could be worsened by deployment outside of the country
- The authorities were not convinced that antiretrovirals (ARVs) are adequate to address their health problems.

The unions and the AIDS Law Project took this matter to court disputing the above-mentioned reasons as grounds to exclude people living with HIV from being part of the SANDF. The court declared the reasons cited by the SANDF as unconstitutional and discriminating against people living with HIV.

The argument of the judge was that the practices of the SANDF could set an undesirable precedent for other workplaces if the court allowed them to continue with their discriminatory policies (Mail & Guardian 2008).

2.6.5 Responses to HIV/AIDS and stigma and discrimination in the workplace

In many affected countries, the business sector has risen to the challenge posed by HIV and AIDS in many different ways. The initial step throughout the world has been the formulation of HIV and AIDS workplace policies and programmes.

The International Labour Organisation (ILO 2001:6) encourages its member states to consult with their workers and their representatives in order to develop and implement appropriate policies for their respective workplaces.

In this regard the ILO (2001:3) concludes that "*discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention"*. In order to address this, the ILO crafted a code of practice regarding HIV/AIDS for the world of work to serve as guidelines to its member states. This document outlines objectives which serve as blueprints to assist companies in their endeavours to address stigma and discrimination emanating from real and perceived HIV statuses.

The following section details some of the interventions implemented in South Africa as measures to reduce the repercussions of HIV/AIDS in the workplace in line with the code of practice as suggested by the ILO.

(a) The South African Department of Labour

In response to the above-mentioned ILO code of conduct, the South African government, through the National Department of Labour, in May 16, 2000 launched a draft code of good practice regarding HIV/AIDS to guide employers on how to ensure that employees living with HIV are not discriminated against at their respective workplaces. As part of the implementation of this draft code, the minister (Minister Membathisi Mdladlana) further declared that public hearings were to be held in four strategic cities, namely Cape Town, Durban, Johannesburg and Pietersburg (Business Day, 17 May 2000).

These efforts culminated in the publication "*HIV and AIDS technical assistance guidelines*" abbreviated as TAG. In his address on the role of TAG (South Africa, Department of Labour.2003:1), the minister of Labour, Mr Mdladlana, stated that "*the government's approach is based on the international best labour practices"*. Although the TAG does not explicitly mention the word stigma, the words "discrimination" and "non-discriminatory workplace environment" are used throughout the document and it is stated that (South Africa, Department of Labour.2003:5) "*the code provides a framework for the promotion of equality and non-discrimination against individuals with HIV infection, as well as HIV/AIDS and other comparable medical and health conditions"*.

The TAG (South Africa, Department of Labour.2003:1) notes that people living with HIV should not be discriminated against, but should be treated the same as the rest of the employees living with other health conditions.

(b) The South African Department of Public Service and Administration (DPSA)

The role of the Department of Public Service and Administration is to co-ordinate the activities of all South African government departments. In line with its mandate, the DPSA developed a policy framework called "*Managing HIV/AIDS in the workplace, a guide for government departments"* (South Africa, DPSA 2002).

This document clearly spells out the minimum requirements set for government departments to effectively manage HIV and AIDS in the workplace and also to ensure the co-ordination of the Public Service's response to challenges posed by HIV and AIDS in the workplace. The DPSA's HIV/AIDS Policy Framework does not explicitly mention stigma as part of its list of issues pertaining to the minimum standards for addressing HIV and AIDS nor does it not include stigma, only discrimination (South Africa: DPSA 2002:31). However, in the collective agreement between the DPSA and the Public Service Coordinating Bargaining Council (PSBC), the conclusion was reached (South Africa, DPSA 2002:135) that it is crucial to prevent "*unfair discrimination and stigmatization of people living with HIV or AIDS through the development of HIV/AIDS policies and programmes for the workplace"*.

(c) The South African Police Service (SAPS)

Whiteside and Sunter (2000:108) warn that the effects of AIDS on the SAPS could compromise the stability of the country. The HIV/AIDS policy of the SAPS (2001:7) suggests that there is a need to incorporate programmes such as "*strategies to combat discrimination and irrational responses to HIV/AIDS in a non-stigmatizing manner"*. In addition to the policy the SAPS training manual (SAPS 2002:4-14) lists stigma and discrimination as some of the challenges the organisation must address.

This training manual further indicates that because of stigma and discrimination, the society in general, including SAPS employees are reluctant to access HIV-testing and to disclose an HIV positive status for fear of stigma, discrimination, violence and isolation.

2.7 CONCLUSION

HIV and AIDS affect all spheres of life including the workplace. There is a dire demand for each work environment to develop its respective HIV/AIDS policy and eventually implement HIV/AIDS programme to mitigate the impact of the epidemic. However, stigma and discrimination are major challenges to be tackled as part of a successful implementation of the workplace programme.

The literature review done in this study suggests that although most workplaces do have HIV/AIDS policies and have implemented workplace programmes, stigma and discrimination are still predominant, thus, compromising efforts made to implement such HIV/AIDS Workplace Programmes. Chapter three will focus on the research methodology used by the researcher in gathering data for this research.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter the research methodology followed in this study is presented. The focus of the study was on the assessment of the knowledge and exposure of the SAPS employees to the HIV/AIDS Workplace Programme as well as their levels of stigma and discrimination. The aim was to gather knowledge that would assist the management of the SAPS and those involved in the implementation of the HIV/AIDS Programme by identifying what the employees knew and felt about HIV and AIDS in their workplace.

3.2 DELIMITATION OF THE STUDY

The chosen research site was confined to the SAPS's National Head Office based in Pretoria. The head office consists of thirteen divisions and more than 95 % of these divisions participated in this research project.

3.3 THE CHOSEN RESEARCH APPROACH

The approach of the study was mainly quantitative. In addition insider perspective and key informants were used as means of enhancing data-gathering. Vithal and Jansen (1997:20) describe the data collection plan as a concise introduction and orientation into the methodological process of information gathering. It sets out constraints and parameters within which the research process would unfold and the research instruments would be developed and employed. This section outlines the data collection plan, the parameters of the research and instruments used by the researcher in gathering the data.

Harvey (2002:5) suggests that "*quantitative data are data which can be sorted, classified, measured in a strictly objective way- they are capable of being accurately described by a set of rules or formulae or strict procedures which then make their definition (if not always their interpretation) unambiguous and independent of individual judgements"*.

In this study the researcher chose to use self-administered questionnaires distributed to a group of randomly sampled employees of the SAPS as a method to generate quantitative data. The questionnaire was designed by the researcher with the assistance of his supervisors and other stakeholders. It was also influenced by the literature review as described in Chapter two of this dissertation.

LoBiondo-Wood and Haber (2002:301) state that "*questionnaires are paper-and-pencil instruments designed to gather data from individuals about knowledge, attitudes, beliefs, and feelings"*. To minimise misunderstanding and misinterpretation, the questionnaire was pre-tested. Since these were self-administered questionnaires, they were distributed and collected at central, secure points. The anonymity of the respondents was protected as they were not required to write their names on the questionnaires. Self-reported answers on sensitive issues have limited trustworthiness in self-administered questionnaires, but because this study did not focus on risk behaviour, identifying populations at risk for HIV infection or on evaluating the effectiveness of HIV-risk-reduction interventions, such risks were minimized. Self-administered questionnaires also address the problem of reactivity caused by the characteristics of the interviewer (Weinhardt, Forsyth, Carey, Jaworski & Durant1998). This methodology chosen by the researcher also permitted the respondents to complete the questionnaire in their own time (Bless & Higson-Smith 1995:111-112).

The researcher was aware of some of the possible limitations related to the research design he chose. Firstly, the survey-type design cannot provide an in-depth picture of the issues as compared to a qualitative approach which is better able to provide rich descriptions.

Secondly, the aggregated nature of the analysis implied that some individual motivations, feelings, opinions, and attitudes of the respondents could not be captured or expressed in the presentation of the findings.Thirdly, there might be a low response rate. Two divisions of the SAPS had a low return rate of completed questionnaires, but this was due to reasons well beyond the control of the researcher and did not compromise the degree of quality of the data.

Rooyen (2008:6) says that "*the term insider research is used to describe projects where the researcher has a direct involvement or connection with the research setting…There are various ways in which researcher can be categorised as an insider. For an example; professionals may carry out a study in their own work - also called practitioner research"*. The researcher has been part of the personnel of the SAPS from the beginning of January 2006 and therefore, qualifies as an insider researcher.

During this period, the researcher has been working in the component responsible for the management of the HIV/AIDS workplace programme as one of the project managers. Bartunek and Louis (1996:V) describe the advantage of insider research this way "*much social research is premised on the idea that to understand a group (be it large or small, formal or informal, homogeneous or heterogeneous) requires coming to know what is it that insiders believe, value, practice, and expect"*. In this kind of setting, the researcher is in a better position to view the problem being researched through the eyes of the people within the environment and accurately understands the issues research subjects are grappling with (Babbie & Mouton 2001:271).

However, insider research can be biased. This researcher guarded against such pitfalls by adhering to recommendations as expressed by Coghlan and Brannick (2005:67) who say that the insider researcher must be able to "*stand back from the situation and question his or her assumptions"*.

In order to maximise the trustworthiness of the findings, the researcher verified his observations and findings with experts who are not part of the South African Police Service. Such independent scholars are best represented by one of the authors of the report '*South African national HIV prevalence, HIV incidence, behaviour and communication survey'* (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay. 2005).

These academics as personnel of the Human Sciences Research Council (HSRC) have been conducting numerous HIV/AIDS research projects both locally and internationally, are well versed in research ethics as well as experts in field of the scope of this research project. Other external critical corroborators of the researcher's observations are represented by Mr Maphalne from Polmed which is one of the key stakeholders in the implementation of SAPS HIV/AIDS workplace programme. The assistance acquired by the researcher enhanced his objectivity and criticality in scrutinising his observations and findings of this research project. The researcher also measured his observations and findings with the research projects done prior to this one on SAPS HIV/AIDS workplace programme, referred to in his literature review, such as those of Van der Velden (2004) and Masuku (2007).

3.4 THE CONSTRUCTION, TESTING AND ADMINISTRATION OF THE QUESTIONNAIRES

The researcher designed the questionnaire after completing a review of literature on stigma and discrimination as well as on HIV/AIDS workplace programmes and related fields. The drafts of the questionnaire were presented to various people for comments and were pre-tested. The self-administered questionnaire consisted of the following sections:

- Section A: Biographical data of the respondents which included gender, age, race, rank, years of service, employment category (whether appointed under Police Act or Public Service Act). This background information was used to contrast and compare the participants' responses. In Chapter 2, stigma and discrimination by gender was explored under subsection 2.6.3. These biographical details were regarded as important independent variables.

- Section B: Participants' levels of exposure to the SAPS's HIV/AIDS workplace programme. This section included questions aimed at determining the respondent's frequency in attending activities pertaining the workplace programme and reasons of not attending such events. This relates to the first objective as stated under sub-heading 1.5 in Chapter 1.
- Section C: Participants' levels of knowledge and understanding of HIV/AIDS. The focus of this section was to establish the respondents' knowledge of key issues pertaining to HIV/AIDS.

  In Chapter 2 it has been explained that the HIV/AIDS workplace programme for the SAPS has been in existence for some time now. This relates to the second objective as stated under sub-heading 1.5 in Chapter 1.
- Section D: Questions on stigma and discrimination. The core purpose of the section was to determine participants' general levels of stigma and discrimination attached to HIV/AIDS. It was also intended to establish whether the participants personally observed behaviour displaying stigma and discrimination against fellow employees infected or affected by HIV/AIDS. Question items for this section were derived from the literature review as discussed in Chapter 2. This relates to the third objective as stated under sub-heading 1.5 in Chapter 1.
- Section E: Questions regarding the participation by stakeholders in the implementation of the workplace programme. The aim of this section was to determine the role played by labour unions, the management of the SAPS and the medical scheme organisation in the provision of medical care for the personnel infected by HIV and affected by HV and AIDS. This relates to the fourth objective as stated under sub-heading 1.5 in Chapter 1.
- Section F: Questions regarding the effectiveness of the workplace policy to bring about changes and to address stigma and discrimination. This should be regarded as an elaboration of the fourth objective as stated under sub-heading 1.5 in Chapter 1, since the goal of this final section of the questionnaire was to invite the research participants to express their views on how they perceive the effectives of their workplace programme.

Kruger (1994:31) states that "*validity is the degree to which the procedure really measures what it proposes to measure"*. The researcher guarded the validity of the data-gathering instrument by asking individuals who are well versed with the issues of HIV/AIDS workplace programme and stigma and discrimination to comment on the face validity of the various question items.

Dörnyei (2003:70) suggests that "*one area in which a questionnaire study can go very wrong concerns the procedure used to administer the questionnaire …there is ample evidence in the measurement literature to suggest that questionnaire administration procedures play a significant role in affecting the quality of the elicited responses"*. In compliance with the requirements for research protocols; the researcher wrote a letter to the Head of Research Unit of the South African Police Service introducing the research protocol and explaining the objectives of the study and asking for comments, input and access to the employees. After access has been granted, this was followed up with letters addressed to all commanders or supervisors of units and to potential research participants. These letters formally stated the aim of the study as well as how the anticipated outcome of the research would be of benefit to the organisation and to individual employees. This was followed by on-site visits to the different units where the purpose of the study and the ethical considerations such as confidentiality, anonymity, and voluntary participation were articulately expressed to the participants in the form of a personal address by the researcher. The structure of the SAPS includes division (like departments), sections (or directorates), and sub-sections (sub-directorates). The divisions operate in a unique way depending on their respective mandates. The researcher strived to have his questionnaires distributed to each division so that he could acquire adequate representativeness.

For convenience and accessibility reasons, the researcher involved the peer educators in each division or section to assist in the distribution and collection of the questionnaires. The peer educators are responsible for the running of all HIV/AIDS activities in their respective divisions, sections or work stations.

A pre-test is a trial run of the actual study to be undertaken. Its primary aim is to establish the time taken to complete the questionnaire to determine whether it was too long, too short, too difficult or too easy and to check the clarity of the questionnaire items as well as to eliminate ambiguities or complexities in wording (Brink, Van der Walt & Van Rensburg 2006:206). The reliability of the questionnaires was reviewed by the pre-test in which two potential respondents completed and commented on items that were conspicuous to them.

The researcher carefully scrutinised and analysed the responses to the questionnaire and addressed suggested alterations. This was carried out with individuals who were not going to be part of the actual study sample. The feedback of the pre-test trial affirmed the clarity of the questions asked in the questionnaire and that it is not a tedious exercise.

3.5 SAMPLING

The researcher observed that the population of the SAPS personnel at the National Office is too large to include each member in this study. A random sampling method was used to select every second SAPS employee stationed at the National Office. Using a randomised (that is non-systemised) personnel list as a sampling frame and starting at a random point on the list, every second staff member was selected as a respondent. Prior to the selection of the sample, the researcher had a number of meetings with key leaders and people in influential positions to secure their buy-in and authorisation to allow the study to take place. During these meetings the researcher explained the purpose of his study and how it might benefit the organisation and its employees.

The questionnaires were distributed (via the peer educators and others) during the month of August 2008. They were delivered to contact persons in each work station, so that a 50% sample could be realised. The questionnaires were handed to divisional/unit/sectional commanders (managers) or peer educators who then distributed them to the selected (or sampled) colleagues.

These questionnaires were distributed amongst both Police Act and Public Act personnel of all levels, ages, races and genders and identical questionnaires in English (the medium used for written communication in the organisation) were given to each selected staff member.

Due to working conditions of the research participants, such as deployment and mobility, collection of completed questionnaires were spread over the entire month of September 2008. Five hundred (500) questionnaires were given out and three hundred (387) were returned. Hundred and thirteen (113) questionnaires were not returned.

The non-return of some of the questionnaires was partly due to lack of commitment and assertiveness by the peer educators responsible for the distribution and collection of the questionnaires, and partly due to the institutional hierarchy of the SAPS. A 77,4% return rate on the questionnaires was deemed suitable for this mini dissertation.

3.6 DATA ANALYSIS

LoBiondo-Wood and Haber (2002:332) state that after the researcher has collected all raw data, he or she is faced with the responsibility of organising and synthesising the pieces of information and make sense out of it in such a way that even a lay person could be in a position to understand it. The data of this research project were analysed during the month of September and October 2008. The completed questionnaires were captured and the data analysed using SPSS 16.0.

3.7 ETHICAL CONSIDERATONS

Pera and Van Tonder (2005:149), argue that "*there is no doubt about the fact that research is an ethically significant activity, and any research project must be pursued in an ethically reflective manner. Nurses face ethical dilemmas in their daily duties, as do researchers when humans are used as study participants in a research investigation. Care must be exercised that rights of those individuals are protected*".

In order to adhere to ethical conduct of research, the researcher observed the principles as set out below.

The researcher in this study followed principles as defined by Burns and Grove (2005:180), such as beneficence, which means respect for human dignity and justice. These scholars define the principle of beneficence as freedom from harm and exploitation. In line with the above-mentioned ethical principles, no physical or psychological harm was caused to any of the respondents in this study.
According to Burns and Grove (2005), the principle of justice embraces the right to fair treatment and the right to privacy.

All of the participants in this study were treated with great respect regardless of the individual's social standing or SAPS ranking. The researcher wrote a letter to supervisors and commanders for each section in the SAPS's Head Office introducing himself and requesting permission to carry out his research within their area of jurisdiction. The researcher also introduced himself to potential research participants at meetings, as circumstances permitted. Verbal and written informed consent was acquired from each sampled research participant. The cover page for the questionnaire clearly stated that responses from the participants will be treated anonymously and confidentially. Completed questionnaires were returned in envelopes to the people who distributed them and collected by the researcher at the end of September 2008. These questionnaires were then checked and numbered and taken to UNISA where the computerisation took place. No one else except the respondents, the researcher and his supervisors had access to the completed questionnaires and there were no names or office numbers on the questionnaires to identify the respondents by. Currently the completed questionnaires are still stored at UNISA's Department of Sociology.

Grbich (1999:82-83) suggests that research participants have the right to decline to participate in research or to withdraw consent at any time during the study. In view of this principle, the researcher compiled an informed consent form.

Hence, the 113 employees who did not return their completed questionnaires were regarded by the researcher as having exercised their right not to participate in the study and, except for one more appeal in September 2008 for all sampled respondents to please complete and return their questionnaires, no pressure was placed on people to comply.

The researcher made a full disclosure about the aim of his study to the participants and their expected role, including an explanation of the process and the purpose of the study. The aim of disclosure was to guarantee that all the participants could make an informed decision before participating in the study. Another aim of the disclosure was also to maximise co-operation of the respondents as well as dispelling any false expectations that they might have had regarding the study.

3.8 SUMMARY

This chapter is a description of the research methodology followed by the researcher towards achieving the objectives of this study. It also outlines the data collection method, population investigated for the purposes of this study, and the instrument used to collect data. A quantitative descriptive approach was used. The study was confined to the South African Police Service HIV/AIDS Workplace Programme with special reference to stigma and discrimination in the workplace.

The next chapter comprises a discussion of the analysis of data.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 INTRODUCTION

In Chapter 3 the research methods used in this study were outlined. This chapter explores the analyses and interpretation of the data collected through self-administered questionnaires. The findings presented and discussed in this chapter are based on the analysis of data derived from 387 research participants who are employees of the SAPS who were randomly selected in the divisions based at the National Head Office in Pretoria.

The focus of this study was on the assessment of the knowledge and exposure of the SAPS employees to the HIV/AIDS workplace programme as well as their levels of HIV/AIDS-related stigma and discrimination. The study aimed to achieve the following objectives:

- To determine the level of exposure of SAPS employees to the HIV/AIDS workplace programme.
- To assess current levels of HIV/AIDS knowledge among SAPS personnel.
- To assess the effects of stigma and discrimination on the implementation of HIV/AIDS Programme among SAPS personnel.
- To measure the interviewees' perceptions of participation by stakeholders in the implementation of the programme
- To identify strengths and weaknesses of the SAPS's HIV/AIDS workplace programme in addressing stigma and discrimination amongst employees.

4.2 THE BIOGRAPHICAL CHARACTERISTICS OF THE RESPONDENTS

This section describes, in the form of univariate percentage distribution tables, the ages, genders, ranks and the nature of the research participants' appointment to SAPS as well as the number of years of services.

Table 4.1: Respondents' biographical characteristics

Characteristic		Frequency	%
Age group			
	20-24	22	5,7
	25-29	67	17,3
	30-34	74	19,1
	35-39	94	24,3
	40-44	67	17,3
	45-49	40	10,3
	50-54	14	3,6
	55 and older	9	2,3
	Total	387	100,0
Gender			
	Female	220	56,8
	Male	167	43,2
	Total	387	100,0
Rank level			
	1-4	147	38,0
	5-7	120	31,0
	8	76	19,6
	9-10	29	7,5
	11-12	12	3,1
	13-15	3	0,8
	Total	387	100,0
Nature of appointment			
	Police act	108	27,9
	Public Service act	279	72,1
	Total	387	100,0
Years of service			
	0-1 year	28	7,2
	2-3 years	65	16,8
	4-5 years	51	13,2
	6-7 years	52	13,4
	8-10 years	42	10,9
	More than 10 years	149	38,5
	Total	387	100,0

Table 4.1 indicates that the majority of the respondents were in the age groups of 25- to 49-years. Using the statistical technique for estimating means from grouped data, a mean of 36,87 years (standard deviation 8,21) was calculated.

These age groups (mid-twenties to mid- thirties) are the worst affected by HIV/AIDS (Whiteside & Sunter 2000:37). Moreover, as far as the SAPS's personnel is concerned, projections from a survey done by Polmed indicate that the HIV-infection rates amongst 25- to 29-year-olds and 30- to 34-year olds would increase from 15% to 17% in 2000 to approximately 35% and 45% respectively by 2015 (SAPS 2002:4-16).

More than half (56,8%) of the respondents were female and 43,2% were male. The actual gender breakdown of employees at SAPS's Head Office is 68,04% men and 31,97% females, but more women participated in the study than males. The majority of the respondents were at the rank of non-commissioned officers, which are level 1-4 and 5-7. This could be due to the fact that the majority of the SAPS personnel are below the age of forty years and are still rising within the ranks of the organisation. Another contributing factor could be that the individuals responsible for the distribution of the questionnaires were more comfortable in approaching the members on junior positions than those in managerial positions as the organisation is rank rooted.

The majority of the respondents were appointed as civilians and only 27,9% of the respondents were employed under the Police Act. It appears that during the distribution of the questionnaires to each division, component, section or sub-section, the personnel who happened to be more accessible were the civilians employed under Public Service Act. In addition, it has been observed that when it comes to HIV/AIDS activities, the personnel who participate most are those appointed under Public Service Act. This perception was endorsed by the fact that at a meeting held in September 2006 to make preparations for the recording of a programme for POLTV for World AIDS Day, the representative of Polmed mentioned that the majority of SAPS employees who attended HIV/AIDS-related events were those appointed as civilians. Moreover a study by Masuku (2007:51) in Johannesburg indicates a similar trend.

To address the issue of the poor attendance by Police Act employees, the Divisional Commissioner of Personnel Service has decided that financial applications for HIV/AIDS activities should reflect an 80% attendance by Police Act personnel (personal observations). The researcher has observed that the organisers of the HIV/AIDS activities at times battle to secure 80% of their attendees from amongst the Police Act members. In some instances such activities had to be cancelled or postponed in cases whereby the organiser could not furnish a convincing reason why the 80%-target could not be reached.

The majority of the respondents have been working for the South African Police Service for more than a year. This means that they should be familiar with the HIV/AIDS workplace programme. Also, these respondents should have attended at least one of the SAPS's HIV/AIDS workshops or events.

4.3 THE RESPONDENTS' EXPOSURE TO THE SAPS's HIV/AIDS-WORKPLACE PROGRAMME

One of the objectives of this study was to establish the level of exposure of SAPS employees to the HIV/AIDS workplace programme. To measure exposure, a series of questions were asked and the responses are given in Tables 4.2, 4.3, 4.4 and 4.5 below.

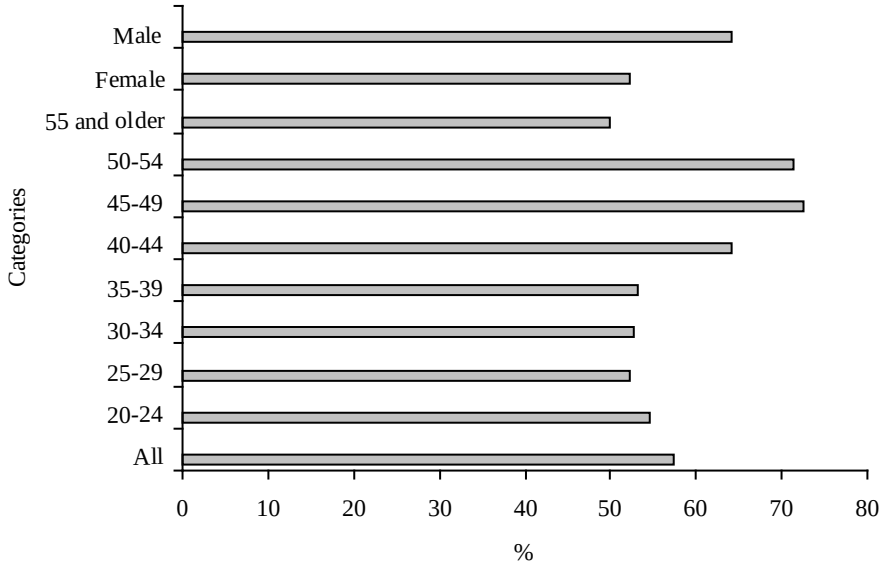
As can be seen in Table 4.2, more than half (57,3%) of the respondents indicated that they knew the SAPS's HIV/AIDS programme well–13% agreed strongly with this statement whereas 44% agreed. However, a large proportion (42,7%) of all the respondents, reported that they were not well acquainted with the programme (this includes those who disagreed and strongly disagreed with the statement and those who indicated that they did not know the programme at all). This is an unacceptably high proportion, as the majority of respondents have been in the employment of SAPS for more than 12 months and should have been exposed to the programme in some way or another.

Table 4.2: Respondents' statements about their familiarity with the SAPS's HIV/AIDS workplace programme

Statement: " **I know the programme well"**	Frequency	%
Strongly agree	52	13,4
Agree	170	43,9
Disagree	46	11,9
Strongly disagree	10	2,6
Don't know it at all	109	28,2
Total	387	100,0

In a subsequent analysis, the "strongly agree" and "agree" categories were collated and analysed in order to find out whether the different age and gender groups differed in their responses about knowing the SAPS's HIV/AIDS workplace programme well. The results can be seen in Figure 4.1. It seems that more work can be done to reach the younger age groups and women in order for them to become more familiar with the programme.

Figure 4.1: Percentages of respondents who knows the HIV/AIDS programme well in each age group and by gender



The following table 4,3 reflects the attendance of respondents to the workplace programme. Less than half (46,5%) of the participants attended HIV/AIDS workshop(s), whereas more than half (53,5%) of the respondents indicated that they did not attend workshops.

The 30- to 39- year age groups, women and those with 6 to 10 years' of service in the SAPS revealed smaller proportions of people attending workshops than what was found for the whole sample. This means that SAPS have not yet reached all of their personnel with information on HIV/AIDS. This is contrary to the view held by the management and some of the implementers that the organisation has done enough in reaching its personnel with HIV/AIDS awareness intervention programmes. In 2008 SAPS decided to put more efforts on other aspects of the South Africa's HIV and AIDS and STIs 2007-2011 National Strategic Plan (Department of Health 2007), which are; prevention, treatment, care and support, human and legal rights, monitoring, research and surveillance.

Table 4.3: Attendance of HIV/AIDS workshops

Characteristics	Frequency	%
Workshop attendance		
Attended a workshop in last 12 months	180	46,5
Did not attend a workshop in last 12 months	207	53,5
Total	387	100,0
Number of workshops attended*		
1-2 workshops	147	81,7
3 or more workshops	33	18,3
Total	180	100,0
Workshop attendance by age group		
20-24	13	59,1
25-29	32	47,8
30-34	33	44,6
35-39	40	42,6
40-44	33	49,3
45-49	19	47,5
50-54	7	50,0
55 and older	3	37,5
Total	180	100,0
Workshop attendance by gender		
Female	100	45,5
Male	80	47,9
Total	180	100,0
Workshop attendance by years' of service		
0-1 year	15	53,6
2-3 years	32	49,2
3-5 years	26	51,0
6-10 years	38	40,4
More than 10 years	69	46,3
Total	180	100,0

* The mean number of workshops attended was 1,91.

Those respondents who had not attended an HIV/AIDS workshop in the last past12 months were asked to mention the main reason for their non-attendance. As can been seen in Table 4.4, more than one tenth (11,6%) of the 207 respondents who did not attend did not furnish a reason for this, whereas almost one out of every ten who did not attend (10,9%) cited work-related responsibilities or "*being too busy"* as the main issues which kept them from attending workshops. Large proportions of respondents mentioned that they were not nominated to attend (9,6%), and that no workshops had been arranged for them to attend (10,6%). A smaller proportion (2,8%) indicated that they were not interested in attending any workshops and said that they did not know how to access the workshops (0,3%).

A small group indicated that they had been on leave when the workshops were arranged for them, that they have disabilities that precluded attendance, that they had not yet been in the employ of SAPS when the last workshop was arranged and that workshop attendance would not have made any difference. As indicated above, most respondents were not explicitly against the HIV/AIDS workplace programme. A reasonable percentage (10,9%) of the respondents indicated that they could not attend awareness workshops, citing work as the main obstacle for not attending. This state of affairs suggests that more opportunities should be frequently created to ensure that everyone is in a better position to attend the workshops. On the other hand a small percentage of the SAPS employees still do not regard attendance of workshops on HIV/AIDS as a priority. This might be an indication of a degree of ignorance about the implications of HIV/AIDS in the workplace, or that SAPS has not yet been successful in mainstreaming HIV/AIDS to such an extent that all employees become aware that HIV/AIDS is part of the core business of SAPS.

Table 4.4: Respondents' reasons for not attending workshops*

Reason for not attending	Frequency	%
No reason given	45	11,6
Work responsibilities/too busy	42	10,9
No communication	22	5,7
Not selected/nominated	37	9,6
Not interested	11	2,8
No workshops offered	41	10,6
Don't know how to apply	1	0,3
Was on leave	2	0,5
Don't know	2	0,5
Disability	1	0,3
Did not work for SAPS then	2	0,5
It would make no difference	1	0,3
Total	207	100,0

* Calculated from those respondents who did not attend.

Table 4.5: Responses to statements about wanting to know more about the SAPS's HIV/AIDS workplace programme

Statement		**Frequency**	**%**
I would like to know more			
	Strongly agree	82	21,2
	Agree	186	48,1
	Disagree	25	6,5
	Strongly disagree	19	4,9
	Don't know	75	19,4
	Total	387	100,0
I wouldn't like to know more			
	Strongly agree	22	5,7
	Agree	58	15,0
	Disagree	135	34,9
	Strongly disagree	101	26,1
	Don't know	71	18,3
	Total	387	100,0

Respondents were also asked to indicate on a scale their willingness to learn more about the SAPS's HIV/AIDS workplace programme.

As can be seen in the breakdown of the responses to two statements as indicated in Table 4.5, the majority of the respondents (69,3%) indicated that they would like to know more about the SAPS's HIV/AIDS workplace programme, whereas 19,4% were undecided about whether they needed more exposure to the programme. The latter seems to indicate that the awareness creation phase of convincing SAPS employees of the importance of the workplace programme and of working against apathy should not be regarded as concluded, but that new efforts should be mounted to convince the employees that HIV/AIDS affects everyone. Only 21% of the respondents indicated that they did not want to know more about the HIV/AIDS workplace programme. This result indicates a positive attitude towards the programme.

4.4 RESPONDENTS' LEVELS OF KNOWLEDGE AND UNDERSTANDING OF PEOPLE LIVING WITH HIV

In this section the researcher sought to assess the respondents' levels of knowledge and understanding of people living with HIV, anti-retroviral treatment (ART) and its effects, myths about the cure for HIV/AIDS and the impact of the HIV/AIDS workplace programme on personnel.

The respondents' perceptions about PLWHIV were tested. As can be seen from Table 4.6, the majority of the respondents felt that PLWHIV are treated as outcasts with the largest proportion (48, 6%) suggesting that this happens sometimes and 10, 1% felt this happens rarely. More than a quarter (25,8%) of the respondents indicated that PLWHIV are often rejected and a further 42,4% said PLWHIV are sometimes rejected. A smaller proportion (12, 7%) of the respondents felt that such rejection rarely happens, whereas 13,4% were of the view that it never happens and 5,7% did not give their views. As the majority view seems to favour a view that suggests that PLWHIV are socially isolated, ostracised and rejected, it seems that fear about reactions to an HIV-positive disclosure may negatively impact on employees' willingness to fully embrace the workplace programme. At the same time, however, the majority of the respondents (79, 8%) were of the view that PLWHIV can live long and healthy lives.

Table 4.6: Perceptions about PLWHIV

Reactions to statements about people living with HIV	Frequency	%
Statement: "**PLWHIV are treated as outcasts"**		
Often	..81	20,9
Sometimes	188	48,6
Rarely	..39	10,1
Never	..52	13,4
No answer	..27	7,0
Total	387	100,0
Statement: **"PLWHIV are rejected"**		
Often	100	25,8
Sometimes	164	42,4
Rarely	49	12,7
Never	52	13,4
No answer	22	5,7
Total	387	100,0
Statement: **"PLWHIV can live a long life"**		
True	309	79,8
False	26	6,7
Don't know	52	13,4
Total	387	100,0
Statement: "PLWHIV lose their jobs"		
Often	48	12,4
Sometimes	147	38,0
Rarely	71	18,3
Never	99	25,6
No answer	22	5,7
Total	387	100,0
Statement**: "AIDS should be treated like any chronic disease"**	197	50,9
	112	28,9
Strongly agree	36	9,3
Agree	21	5,4
Disagree	21	5,4
Strongly disagree	387	100,0
Don't know		
Total		
	347	89,7
Statement: "**Will you care for a family member with AIDS?"**	35	9,0
	5	1,3
Yes	387	100,0
No		
Don't know/No answer		
Total		

Respondents were asked if people living with HIV lose their employment and 12,4% said that this often happens, 38,0% said that this sometimes occurred, 18,3% said that this was rarely the case, 25,6% said this has never happens and 5,7% did not know. The responses to the fourth statement shown in Table 4.6 also shows that the majority of the participants held favourable views regarding the treatment of AIDS as just like all other chronic diseases. As far as caring for a family member with AIDS, the majority of respondents (almost 90%) also indicated that they would do so. It would therefore seem that the majority of the respondents in this study did not harbour negative views about people living with HIV or about AIDS *per se*, but that their anticipated fears of stigmatisation by others (as shown in the responses to the first statement about PLWHIV being treated as outcasts) still prevail.

Table 4.7: Perceptions about effects and efficacy of ART

Statements about ART	**Frequency**	**%**
Statement: "**People on ART die sooner"**		
True	29	7,5
False	282	72,9
Don't know	76	19,6
Total	387	100,0
Statement: "**People on ART are not infective** "		
True	36	9,3
False	280	72,4
Don't know	71	18,3
Total	387	100,0
Statement: **"ART reduces the viral load of HIV in the person**"		
True	211	54,5
False	78	20,2
Don't know	98	25,3
Total	387	100,0

Table 4.7 shows that the majority of the respondents (72, 9%) were of the opinion that ART prolongs the life of an HIV-infected person, whereas 19, 6% of the respondents indicated that they did not know what the effects of ART might be. The majority of the respondents (72,4%) also knew that an HIV-positive person on ART can still transmit the virus, yet almost a tenth of the respondents suggested that a person on ART is not infective whereas 18, 3% did not know how to respond to the statement.

As far as the actual clinical workings of ART is concerned (the third statement in Table 4.7) almost a quarter of the respondents were not able to give an answer whereas more than half of the respondents knew that ART reduces the quantity of the viral load in the body of a person living with HIV.

Table 4.8: Myths surrounding HIV

Statement: "Sex with a virgin cures HIV"	**Frequency**	**%**
True	20	5,2
False	324	83,7
Don't know	43	11,1
Total	387	100,0

The participants' reactions to the statement that having sex with a virgin can cure HIV were tested. As can be seen in Table 4.8, the majority (83,7%) of the respondents correctly refuted this myth. However, the fact that almost 16% of the respondents either thought that this myth was true or were unable to give an answer is a cause for concern because it shows that although SAPS have implemented an HIV/AIDS workplace programme, some of the employees are still ignorant about crucial facts about HIV/AIDS which could endanger their lives and those of others. More than half of the respondents (59,4%) felt that the SAPS's HIV/AIDS workplace programme has enhanced their knowledge of HIV/AIDS, yet more than a quarter of the respondents (26,4%) were unable to give an answer whereas 14,2% said the programme did not increase their knowledge of HIV/AIDS.

Table 4.9: Perceptions of the impact of the SAPS's HIV/AIDS Programme

Statement: The SAPS's programme increased knowledge	Frequency	%
True	230	59,4
False	55	14,2
Don't know	102	26,4
Total	387	100,0

4.5 RESPONDENTS' STATEMENTS ABOUT HIV/AIDS-RELATED STIGMA AND DISCRIMINATION

In this study the researcher sought to assess the levels of stigma and discrimination as experienced by the SAPS employees.

In the first part of this section, views about disclosure of an HIV-positive status and the perceived consequences of such actions are discussed in Tables 4.10, 4.11, 4.12, 4.13, 4.14 and 4.15. This is followed by a discussion of the views of the respondents on how stigma affects the health-seeking behaviour and propensity to join support groups of HIV-infected employees and people affected by HIV/AIDS in the SAPS (Table 4.16 and 4.17). The third section of this sub-section deals with HIV/AIDS-related stigma and discrimination, responses to question items on the employment, development and promotion of PLWHIV in the SAPS (Table 4.18) and perceptions of discrimination against PLWHIV by SAPS employees (Table 4.19). The fourth section deals with the respondents' views on their particular work environments and in particular whether open discussions about HIV/AIDS takes place in their workplaces (Table 4.20) and whether they are willing to share amenities at work with someone who is HIV-positive (Table 4.21). Still remaining with respondents' more direct views and experiences in their workplaces, Table 4.22 shows responses to a question item measuring the first-hand observation of someone being discriminated against because of an HIV-positive status in the workplace.

This section concludes with the results of a question about the respondents' views of the Polmed HIV-programme (Table 4.23) and of whether HIV-testing is a prerequisite for employment in the SAPS (Table 4.24).

Table 4.10: Perceptions regarding disclosure of an HIV-positive status in the workplace

Statement: "If an employee discloses is it a mistake"	**Frequency**	**%**
Yes	82	21,2
No	297	76,7
Don't know/No answer	8	2,1
Total	387	100,0

As can be seen in Table 4.10, more than three-quarters of the respondents indicated that a SAPS employee who discloses his or her status at work will not be making a regrettable mistake, whereas 21, 2% did not agree and 2,1% was not sure whether it is wrong or right to disclose.

Table 4.11: Perceptions about the likely consequences of disclosing an HIV-positive status in the workplace

Statements about disclosure in the workplace	**Frequency**	**%**
Statement**: "PLWHIV regret having disclosed their status in the workplace"**		
Often	92	23,8
Sometimes	151	39,0
Rarely	53	13,7
Never	58	15,0
No answer	33	8,5
Total	387	100,0
Statement: **"It is risky to disclose one's status in the workplace"**		
Often	71	18,3
Sometimes	170	43,9
Rarely	34	8,8
Never	92	23,8
No answer	20	5,2
Total	387	100,0

In the questionnaire, respondents were asked to express their views on statements regarding disclosure in the workplace. As is evident from Table 4.11, just below a quarter (23,8%) of the respondents said that PLWHIV often regret their decisions to disclose their HIV status in the workplace, 39% said that this sometimes occurred, 13,7% suggested that it rarely happened, 15,0% was of the opinion that it never happened and 8,5% could not give their views.

Table 4.11 also shows that 18,3% of the respondents agreed that it is often quite risky for the PLWHIV to disclose, whereas 43,9% said it is sometimes risky to do so, bringing the total proportion of respondents who expressed possible negative consequences of disclosure in the workplace to more than half of the sample. Only 8,8% of the respondents thought that disclosure is rarely risky and 23,8% felt that disclosure is never risky.

Table 4.12: Perceptions about disclosing one's own HIV-status in the workplace

Statement: "Would you disclose your HIV-status at work?"	**Frequency**	**%**
Definitely yes	68	17,6
Yes under certain circumstances	118	30,5
Definitely no	85	22,0
Don't know	116	30,0
Total	387	100,0

According to Table 4.12, only 17,6% of the respondents said they would definitely disclose their HIV-statuses at work, whereas about a third (30,5%) responded that they would only disclose under certain circumstances, whereas 22% said they would definitely not disclose and 30% were not sure if they would disclose their status at work. Again, it seems that fears about the attitudes of others in the workplace play an important role in the respondents' perceptions about how accepting their work environments would be of people openly living with HIV.

In a follow-up question, respondents were asked to state possible reasons why an employee might opt for disclosure or non-disclosure of an HIV-positive status in the workplace.

As can be seen in Table 4.13, almost a third (32,%) of the respondents were unable to give reasons, whereas a tenth (10,6%) of the respondents felt that disclosure or non-disclosure are matters of individual choice and another 11,9% of the respondents felt that people should disclose their statuses so that they can access treatment, care and support,. For almost a quarter of the respondents (25,8%) the main reason for non-disclosure is fear of discrimination, whereas 4,7% felt that the need for self-protection is one of the causes for non-disclosure.

A small proportion of respondents (2,3%) felt that people who disclose their status will feel a sense of relief or (2,8%) that disclosure will send a message to others infected with HIV or affected by HIV/AIDS that open discussion and disclosure is safe.

Table 4.13: Reasons for disclosure or non-disclosure of an HIV-positive status in the workplace

Reason for disclosure/ non-disclosure	Frequency	%
No answer given	124	32,0
Personal choice	41	10,6
To access treatment, care and support	46	11,9
Fear of discrimination	100	25,8
To protect others	18	4,7
You never know how people react	3	0,8
The truth will set you free	9	2,3
Not necessary	2	0,5
To send a message that it's OK to disclose	11	2,8
HIV is no longer a death sentence	6	1,6
Never thought about it	6	1,6
Everyone must know her or his status	2	0,5
Employers need to know	14	3,6
SAPS is not supportive	2	0,5
Disclosure will increase my illness	1	0,3
I will lose my job	1	0,3
Doesn't matter, because you'll die anyway	1	0,3
Total	387	100,0

Table 4.14: Views about disclosing one's HIV-positive status to one's commander

Statement "People can safely disclose their HIV-status to the commander"	Frequency	%
Strongly agree	62	16,0
Agree	122	31,5
Disagree	67	17,3
Strongly disagree	44	11,4
Don't know	92	23,8
Total	387	100,0

Almost 48% of the respondents (16% of who strongly agreed and 32% who agreed) expressed positive views about disclosing a positive HIV-status to the commander.

As can be seen in Table 4.14, 17,3% disagreed, 11,4% strongly disagreed and 23,8% had no idea as to whether an HIV positive SAPS employee should disclose that information to their commanders.

Table 4.15: Knowledge of someone who has disclosed his /her status HIV-status in the workplace

Statement: "Do you know someone who has disclosed their HIV-status in the workplace?"	**Frequency**	**%**
Yes	47	12,1
No	336	86,8
Don't know/No answer	4	1,0
Total	387	100,0

As can be seen in Table 4.15, only 12,1% of the respondents had personal knowledge of someone who disclosed their status in the workplace.

Table 4.16: Perceptions about the effects of stigma on employees' health seeking behaviour

Statement: "Stigma prevents people in SAPS seeking treatment for HIV/AIDS"	**Frequency**	**%**
Strongly agree	118	30,5
Agree	117	30,2
Disagree	48	12,4
Strongly disagree	30	7,8
Don't know	74	19,1
Total	387	100,0

According to Table 4.16, the majority (60,7%) of the respondents either strongly agree or agree with the statement that the fear of stigma acts as a strong deterrent against SAPS employees seeking treatment, education and information about HIV/AIDS. Again this seems to support the findings discussed earlier on in this chapter that, when it comes to anticipated fears and ideas about what other social actors feel and fear about HIV/AIDS, the majority of respondents seem to feel that this becomes a major obstacle in the desired health behaviour and in accessing the available workplace services.

With regard to stigma as one of the contributing factors that discourage members from joining support groups for people living with HIV, Table 4.17 shows that more than a quarter of the respondents (26,1%) strongly agreed and a further 31% agreed that stigma prevents people from joining support groups. Thus, more than half (56.6%) of all the respondents felt that stigma would deter participation in support groups.

Table 4.17: Perceptions regarding the impact of stigma and discrimination on SAPS employees' propensity to join support groups

Statement: "Stigma prevents people in SAPS infected with HIV and affected by HIV/AIDS from joining support groups"	**Frequency**	**%**
Strongly agree	101	26,1
Agree	118	30,5
Disagree	57	14,7
Strongly disagree	22	5,7
Don't know	89	23,0
Total	387	100,0

Table 4.18 shows that almost two thirds (63,6%) of the respondents felt that the SAPS should employ PLWHIV, while 16,3% responded that this should only happen under certain circumstances. A small proportion of the respondents (5,7%) said that PLWHIV should not be employed in the SAPS and 14,5% were undecided on the matter. In Table 4.18 it is also shown that the majority of the respondents (77%) disagreed with the statement that the development of HIV-positive employees in the SAPS was a waste of the institution's resources, whereas 8, 3% agreed that it is a waste of resources for SAPS to develop employees living with HIV and 14, 7% were not able to form an opinion on this.

In the questionnaire, respondents were also asked to give their opinion on the issue of the promotion to senior position of PLWHIV at SAPS. As can be seen in Table 4.18, almost two thirds (66,4%) of the respondents indicated that deserving employees living with HIV should definitely be considered for promotion, whereas 15,8% said that this should only be considered under certain circumstances, 5,9% said that HIV positive people should not be promoted and 11,9% were not sure whether people living with HIV should be promoted.

Table 4.18: Perceptions about the employment, development and promotion of HIV-positive persons in SAPS

Statements	Frequency	%
Statement: **"Should PLWHIV be employed at SAPS?"**		
Definitely yes	246	63,6
Yes under certain circumstances	63	16,3
Definitely no	22	5,7
Don't know	56	14,5
Total	387	100,0
Statement: **"SAPS wastes resources to develop HIV-positive employees"**		
Strongly agree	10	2,6
Agree	22	5,7
Disagree	126	32,6
Strongly disagree	172	44,4
Don't know	57	14,7
Total	387	100,0
Statement: **"PLWHIV in the SAPS should be promoted just like other deserving employees"**		
Definitely yes	257	66,4
Yes under certain circumstances	61	15,8
Definitely no	23	5,9
Don't know	46	11,9
Total	387	100,0

Just below half (48%) of all the respondents felt that some SAPS employees discriminate against people living with HIV, whereas about 20% of the respondents disagreed with the statement as depicted in Table 4.19 and 32,8% could not give an opinion on this statement.

Table 4.19 also shows the respondents' reactions when asked whether their work environment is accommodative of people living with HIV. Just below a quarter of the respondents (24,5%) gave a positive response, whereas 19,4% indicated that this only happened under certain circumstances, 15,5% felt that their work environment is not friendly to PLWHIV and a staggering 40,6% said they did not know.

Table 4.19: Perceptions of discrimination against PLWHIV by SAPS employees

Statements about PLWHIV in SAPS	Frequency	%
Statement: "Some SAPS employees discriminate against PLWHIV"		
Strongly agree	60	15,5
Agree	124	32,0
Disagree	42	10,9
Strongly disagree	34	8,8
Don't know	127	3,8
Total	387	100,0
Statement: "The SAPS work environment is accepting of PLWHIV"		
Definitely yes	95	24,5
Yes under certain circumstances	75	19,4
Definitely no	60	15,5
Don't know	157	40,6
Total	387	100,0

Respondents were also asked to comment on the statement that people at SAPS talk openly about HIV/AIDS in the work environment. As can be seen in Table 4.20, the majority of respondents denied that this is the state of affairs, whereas only 12,7% said that this definitely happened and 18,3% replied that such open talks between colleagues only happen under certain circumstances. Just below a quarter (22,5%) of the respondents could not give an answer to the statement. It therefore seems that a general, open culture in which sensitive matters such as HIV/AIDS can be discussed has not yet developed in the study environment.

Table 4.20: Perceptions about open discussions of HIV/AIDS in the workplace

Statement: "People talk openly at work about HIV/AIDS"	Frequency	%
Definitely yes	49	12,7
Yes under certain circumstances	71	18,3
Definitely no	180	46,5
Don't know	87	22,5
Total	387	100,0

Table 4.21 shows responses to a statement that again takes the issue of stigma to a typical workplace scenario in which the respondents were asked about their own possible reactions to sharing amenities such as the toilet or a kitchen with an HIV-positive colleague.

As with most of the reactions to question items intended to measure personal reactions, the vast majority of the respondents (73,6%) indicated that they have no problems sharing such amenities with HIV-positive co-workers. Only 4,9% of the respondents strongly disagreed, 13,4% disagreed and 8,0% selected “Don’t know” the question.

Table 4.21: Perceptions about sharing of amenities at work with someone who is HIV-positive

Statement: “I will share a toilet or a kitchen at work with an HIV-positive co-worker”	Frequency	%
Strongly agree	156	40,3
Agree	129	33,3
Disagree	52	13,4
Strongly disagree	19	4,9
Don't know	31	8,0
Total	387	100,0

Table 4.22: First-hand observation of someone being discriminated against because of an HIV-positive status in the workplace

Statement: “I saw an incident of discrimination against a PLHIV in my workplace	**Frequency**	**%**
Yes	..50	..12,9
No	313	..80,9
Decline to answer	..24	…6,2
Total	387	100,0

In sharp contrast with the results as shown in Table 4.21 in which most respondents reported non-discriminatory intentions, the results as shown in Table 4.22, reveal that 12,9% of the respondents reported that they have personally observed an incident in the workplace where a person was discriminated against because of his or her HIV-positive status, whereas 80,9% said they have never witnessed such an incident in the workplace and 6,2% declined to comment.

Table 4.23: Respondents' views of the Polmed HIV-programme

Statement: "Would you enrol for Polmed HIV programme?"	Frequency	%
Yes	253	65,4
No	26	6,7
Decline to answer	108	27,9
Total	387	100,0

Respondents were asked whether they would enrol for the Polmed Disease Management Programme designed to cater for HIV-positive SAPS members appointed in terms of Police Act. As can be seen in Table 4.23, more than half (65%) of the respondents said they would register, whereas only 6,7% indicated that they would not enrol for the programme and 27,9% declined to air their view.

Table 4.24: Perceptions about HIV-testing as prerequisite for employment at the SAPS

Statement: "Is an HIV-test a prerequisite for employment in SAPS?"	Frequency	%
Yes	154	39,8
No	132	34,1
Decline to answer	101	26,1
Total	387	100,0

According to Table 4.24, more than a third (39,8%) of the respondents erroneously assumed that an HIV-test is a prerequisite for employment in the SAPS, whereas 34,1% said HIV testing should not be part of the requirements for employment at the SAPS and 26,1% opted not to comment.

4.6 PARTICIPATION BY STAKEHOLDERS IN THE IMPLEMENTATION OF THE SAPS's HIV/AIDS WORKPLACE PROGRAMME

In this study the researcher sought to find out if various key stakeholders play their part in the implementation of the SAPS's HIV/AIDS workplace programme and in particular to measure the respondents' perceptions of the participation by stakeholders in the implementation of the programme.

In this section, this objective is discussed in terms of the responses to the various question items pertaining to implementation and the roles played by labour unions, SAPS management, Polmed, commanders and HIV/AIDS-awareness creation programmes.

More than half of the respondents either strongly agreed or agreed with the statement shown in Table 4.25 that the labour unions support the implementation of the SAPS's HIV/AIDS workplace programme. Only 5,7% of the respondents disagreed and 2,3% strongly felt that the labour unions were not playing an active role. More than a third (36,7%) of the respondents did not know whether the unions played a significant role. In the study the participants were also asked to comment on whether management is setting a good example in the roll-out of the HIV/AIDS programme. As shown in Table 4.26, 19,9% of the respondents said they strongly agree that management is playing a key role, 32,6% agreed, 8,8% disagreed, 15% strongly disagreed and 23,8% did not know whether management is exemplary in the running of the SAPS's HIV/AIDS workplace programme.

Table 4.25: Views on the role of the labour unions in the SAPS's HIV/AIDS workplace programme

Statement: "Labour unions support the workplace programme"	**Frequency**	**%**
Strongly agree	92	23,8
Agree	122	31,5
Disagree	22	5,7
Strongly disagree	9	2,3
Don't know	142	36,7
Total	387	100,0

Table 4.26: Views about the role of management in the SAPS's HIV/AIDS workplace programme

Statement: "Management sets a good example"	**Frequency**	**%**
Strongly agree	77	19,9
Agree	126	32,6
Disagree	34	8,8
Strongly disagree	58	15,0
Don't know	92	23,8
Total	387	100,0

Table 4.27: Views about the role of Polmed in the SAPS's HIV/AIDS workplace programme

Statement: "Polmed plays a crucial role in fight against HIV/AIDS"	Frequency	%
Strongly agree	111	28,7
Agree	126	32,6
Disagree	15	3,9
Strongly disagree	11	2,8
Don't know	124	32,0
Total	387	100,0

In Table 4.27 it is reported that 28,7% of the respondents indicated that they strongly felt that Polmed is doing its part in the fight against HIV/AIDS, 32, 6% agreed, Only 3,9% disagreed, while 2,8% strongly disagreed and 32,0% chose not to give an answer.

Table 4.28: Views about the role of commanders in the SAPS's HIV/AIDS workplace programme

Statement: "Commanders regard HIV/AIDS as a core part of the business of SAPS"	Frequency	%
Yes	31	8,0
No	74	19,1
Not sure	282	72,9
Total	387	100,0

Respondents were asked to give their views on whether commanders regard HIV/AIDS as part of the core business of SAPS. As shown in Table 4.28, only 8% of the respondents answered that commanders regard the SAPS's HIV/AIDS workplace programme as part of the core business of the institution and 19,1% of the respondents felt that commanders are not doing enough to support the implementation of the programme. A fairly large proportion (72,9%) of the respondents did not know whether commanders played a significant role in this regard.

In the questionnaire, the views of respondents about the effects of HIV/AIDS-awareness-creating programmes in the workplace on reducing the number of new HIV infections amongst employees were tested.

As is shown in Table 4.29, less than half of the respondents (46%) affirmed the statement, whereas 14% were of the opinion that awareness-creating programmes are not curbing the spread of HIV and another 40% of the respondents were unsure about the effects of such interventions.

Table 4.29: Views on the effects of HIV/AIDS awareness-creation programmes in the workplace

Statement: "HIV/AIDS awareness-creating programmes in the workplace are effective in stemming new HIV infections"	**Frequency**	**%**
Yes	178	46,0
No	54	14,0
Not sure	155	40,0
Total	387	100,0

4.7 CHALLENGES PERTAINING TO THE SAPS's HIV/AIDS WORKPLACE PROGRAMME'S ABILITY TO ADDRESS STIGMA AND DISCRIMINATION

In this final section of the discussion of the findings, the researcher aims to identify challenges and gaps that might exist in the implementation of the SAPS's HIV/AIDS workplace programme. This was described as the fifth objective in Chapter 1, namely the study aimed at identifying strengths and weaknesses of the SAPS's HIV/AIDS workplace programme in addressing stigma and discrimination amongst employees. Three question items in the questionnaire aimed at eliciting responses to cover this objective and the results of the responses by the research participants are discussed in Tables 4.30, 4.31 and 4.32 below.

In Table 4.30 the views of the respondents regarding the success of the SAPS's HIV/AIDS workplace programme in reducing stigma in SAPS are given.

Only 8,3% of the respondents strongly agreed that the programme has reduced stigma and 26,1% agreed, bringing the total for a favourable assessment of the programme's success in addressing stigma to a mere 34,4% or just more than a third of all the respondents. The largest group, 45%, answered that they did not know, whereas 12,1% disagreed and 8,5% strongly disagreed.

As can be seen in Table 4.31, the majority (48,1%) of the respondents were unable to venture an opinion about the success of the SAPS's HIV/AIDS policy to give clear direction to the programmes or strategies that follow from it, whereas 39,8% agreed and only 12,1% disagreed.

Table 4.30: Views about the effects of the SAPS's HIV/AIDS workplace programme in reducing stigma

Statement: "The SAPS's HIV/AIDS workplace programme reduced HIV/AIDS-related stigma among personnel"	**Frequency**	**%**
Strongly agree	32	8,3
Agree	101	26,1
Disagree	47	12,1
Strongly disagree	33	8,5
Don't know	174	45,0
Total	387	100,0

Table 4.31: Views on whether the SAPS's HIV/AIDS policy provides clear direction to the workplace programme

Statement: "The SAPS's HIV/AIDS workplace policy gives clear direction to the HIV/AIDS workplace programme"	**Frequency**	**%**
Yes	154	39,8
No	47	12,1
Not sure	186	48,1
Total	387	100,0

According to the results given in Table 4.32, more than a third (34,6%) of the respondents felt that the policy has been successful in providing guidelines do that stigma can be reduced, 16,5% disagreed with this view and just below half (48,8%) of the respondents were not sure.

Table 4.32: Views on the impact of the SAPS's HIV/AIDS policy in reducing stigma in the workplace

Statement: "The SAPS's HIV/AIDS policy is successful in providing guidelines directed at reducing stigma in the workplace"	**Frequency**	**%**
Yes	134	34,6
No	64	16,5
Not sure	189	48,8
Total	387	100,0

4.8 SUMMARY OF KNOWLEDGE AND PERCEPTIONS OF STIGMA AND DISCRIMINATION

The following 5 question items pertaining to knowledge about HIV/AIDS and ART were scored together as a composite measure of knowledge in this study:

1. Whether the respondents knew that ART can prolong the life expectancy of the person living with HIV
2. Whether the respondents knew that people on ART can still transmit HIV through the usual transmission modes
3. Whether the respondents knew that ART can reduce the viral loads of HIV in the infected individual
4. Whether the respondents knew that sex with a virgin cannot cure HIV/AIDS
5. Whether the respondents knew that HIV-positive people can still live an active and productive life.

Responses to these question items were re-coded as dummy variables with a code 1 for a correct response and 0 for all other responses. Thus, a person who correctly responded to all five these question items could get 100% on this composite score, whereas someone who gave incorrect answers to all these items would have received a score of zero. Given the small number of respondents in this study, the researcher relied on theoretical significance to cluster these five question items together instead of running factor analyses to include only those items with similar factor loadings.

The mean scores for this measure of knowledge according to the age groups, race and sex of the respondents, the test for normality, the F-ratios and the exact significances produced by SPSS 16.0 are depicted in Table 4.33.

The mean score for the total sample on the knowledge items was 72,66, indicating relatively high levels of knowledge. The Kolmogorov-Smimov test is highly significant, indicating that the distribution of scores for knowledge does not resemble a normal distribution (see Field 2009:144-148). This can, however, be due to the small sample size of 387 respondents and Field (2009:359) states that the robustness of ANOVA implies that it can be used even though the assumption of a normal distribution in the scores for the dependent variable cannot be satisfied.

Table 4.33 Mean scores on knowledge by age group, race and sex of the respondents

Biographical variables and tests	**Mean**	**Number of cases**
All respondents	72,66	387
Kolmogorov-Smimov test for normality	0,201	Significance =0,000
20-24	80,00	22
25-29	75,82	67
30-34	73,24	74
35-39	72,98	94
40-44	72,24	67
45-49	66,00	40
50 and older	67,14	23
F-ratio for age group as the independent variable	0,724	Significance =0,670
African	71,93	285
White	74,79	73
Coloured	74,74	19
Indian	74,00	10
F-ratio for race as the independent variable	0,238	Significance =0,870
Female	73,64	220
Male	71,38	167
F-ratio for sex as the independent variable	0,596	Significance =0,441

As can be seen in Table 4.33, there seems to be an inverse relationship between scores on the knowledge items and the age groups of the respondents with the younger respondents scoring better on these knowledge items than their older counterparts.

The F-ratio of the within-group and inside group variance in the mean knowledge scores by age group, however, is not significant, indicating that age group did not have a significant effect on the knowledge scores. In fact, the F-ratios for all the independent variables in Table 4.33 are smaller than 1 and not statistically significant. The differences in the mean scores for knowledge according to the race group of the respondents were slight and not statistically significant. Female respondents had a slightly higher mean score for the knowledge items than their male counterparts, but this difference was not statistically significant.

The following 5 question items pertaining to HIV/AIDS-related stigma and discrimination were scored together as a composite measure of stigma and discrimination in this study:

1. Whether the respondents felt that developing HIV-positive employees was or was not a waste of SAPS's resources
2. Whether the respondents felt that people living with HIV should be employed at SAPS
3. Whether the respondents felt that HIV-positive employees should be promoted to senior positions in SAPS
4. Whether the respondents felt that /AIDS should be treated like all other chronic diseases
5. Whether the respondents indicated that they would feel comfortable in sharing office space, toilets and kitchens with HIV-positive employees.

Responses to these question items were re-coded as dummy variables with a code 1 for responses indicating the absence of stigma and discrimination and 0 for all other responses. Thus, a person who scored high on positive, non-discriminatory question items could get 100% on this composite score, whereas someone who gave answers to all these items that was indicative of stigma would have received a score of zero. Given the small number of respondents in this study, the researcher relied on theoretical significance to cluster these five question items together instead of running factor analyses to include only those items with similar factor loadings.

The mean scores for this measure of stigma and discrimination according to the age groups, race and sex of the respondents, the test for normality, the F-ratios and the exact significances produced by SPSS 16.0 are depicted in Table 4.34.

Table 4.34 Mean scores on stigma and discrimination by age group, race and sex of the respondents

Biographical variables and tests	Mean	Number of cases
All respondents	78,50	387
Kolmogorov-Smimov test for normality	0,291	Significance =0,000
20-24	79,09	22
25-29	81,19	67
30-34	80,81	74
35-39	78,72	94
40-44	75,82	67
45-49	81,00	40
50 and older	68,57	23
F-ratio for age group as the independent variable	1,079	Significance =0,377
African	83,92	285
White	58,35	73
Coloured	76,84	19
Indian	74,00	10
F-ratio for race as the independent variable	15,52	Significance =0,000
Female	78,82	220
Male	78,08	167
F-ratio for sex as the independent variable	0,560	Significance =0,813

The mean score for the total sample on the stigma and discrimination items was 78,50 indicating relatively low levels of stigma and discrimination. The Kolmogorov-Smimov test is highly significant, indicating that the distribution of scores for stigma and discrimination does not resemble a normal distribution. This can, however, be due to the small sample size of 387 respondents. As can be seen in Table 4.34, there seems to be no relationship between scores on the stigma and discrimination items and the age groups of the respondents. Although the F-ratio for the mean stigma and discrimination scores by age group is larger than 1, it not significant, indicating that age group did not have a significant effect on these scores. The differences in the mean scores for stigma and discrimination according to the race group of the respondents showed much lower scores for the white and Indian employees than for the African and Coloured employees and the F-ratio for these scores by race was larger than 1 and was statistically significant at the 0,01 level.

It thus seems that race had a significant effect on the stigma and discrimination scores of the respondents suggesting that future changes to the HIV/AIDS workplace programme for the SAPS should take this into account. Female respondents had a slightly higher mean score for the stigma and discrimination items than their male counterparts, but this difference was not statistically significant.

Since neither of the two created scores (the knowledge score and the stigma and discrimination scores) were normal distributions, the researcher did not attempt to investigate whether knowledge is correlated with stigma and discrimination. However, this study, based on a review of the literature, assumed that stigma and discrimination can act as powerful deterrents against people accessing the health care information and services they need. Thus the presence of stigma and discrimination, despite almost a decade of implementation of a workplace programme in the SAPS, intended to impart knowledge and inculcate accepting attitudes towards PLWHIV, is a cause for concern.

4.9 CONCLUSION

In this chapter data analysis and interpretation was extensively discussed as well as interpreted with the use of frequency tables. Approximately half of the research participants showed that they are aware about SAPS HIV/AIDS programmes. 46.5 percent of the respondents indicated that they have attended HIV/AIDS workshops. The majority of the research participants felt that PLWHIV are treated as outcasts. The study reflects that more than half of the research subjects perceive stigma as a major deterrent against SAPS personnel seeking for treatment and information on HIV/AIDS. More than 50 percent of the participants expressed their uncertainty on whether the SAPS HIV/AIDS workplace programme has been successful in addressing stigma and discrimination.

CHAPTER 5:
CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of the study was to assess the knowledge and the exposure of the SAPS employees to the HIV/AIDS Workplace Programme as well as levels of stigma and discrimination. This final chapter comprises a review of the main findings, a discussion of the limitations of the study, recommendations and strategies to improve knowledge and exposure of the SAPS personnel to the HIV/AIDS Workplace Programme. The interventions to reduce stigma and discrimination and also to enhance the participation of all key stakeholders are discussed.

5.2 FINDINGS

The main findings are summarised in terms of the stated objectives and sub-sections of the questionnaire.

5.2.1 Section A: Biographical data

All of the respondents were employees of the South African Police Services based at the National Office. The age distribution was from twenty to sixty. Slightly more women responded than men. The number years of service were from less than one year to ten years and above.

5.2.2 Objective 1 (Section B): Level of exposure to the workplace programme

Although the majority of the respondents agreed that they are aware of the existence of the HIV/AIDS workplace programme within the SAPS, only 47% of the respondents have attended HIV/AIDS awareness programmes offered through the SAPS's HIV/AIDS workplace programme.

Responses on the number of workshops attended seem to indicate that not enough efforts have been made to ensure that each employee is afforded an opportunity to attend at least one workshop and that some individuals attend all the workshops.

Some of the main reasons cited for not attending workshops were working conditions, being too busy, that there were no workshops arranged for the respondent's office or that they have never been nominated to attend workshops. These obstacles to workshop attendance can be addressed as they are related to the operation of the Head Office and not to the reluctance or resistance of personnel against such offerings. This conclusion is further supported by the fact that more than half of the respondents reported that they would like to attended more workshops. Only 21% said that they would not attend any more workshops even if they were offered such an opportunity.

5.2.3 Objective 2 (Section C): Levels of knowledge and understanding of HIV/AIDS

It was found that the majority of the respondents were knowledgeable about HIV/AIDS, but many were unclear about the impact of anti-retroviral treatment. The majority of the respondents also correctly answered question items intended to measure their perceptions of myths surrounding HIV/AIDS, such as that having sex with a virgin as a cure for HV/AIDS (84% answered correctly that it does not cure HIV/AIDS) and that PLWHIV can live long and productive lives (80% affirmed this statement), that AIDS should be treated like any other chronic disease (80% felt that this should be done). Just more than half of the respondents (59%) felt that the SAPS's HIV/AIDS workplace programme had increased their knowledge of HIV/AIDS. It can be concluded from these findings that the respondents displayed a high level of correct knowledge about HIV and AIDS but that they lacked correct and current information on antiretroviral treatment.

5.2.4 Objective 3 (Section D): Stigma and discrimination

Four interrelated issues were tested by various question items pertaining to stigma and discrimination. Below, these issues are discussed in turn. Firstly, perceptions about disclosure of an HIV-positive status are considered.

Secondly, responses to question items about caring for a relative infected with HIV or affected by HIV/AIDS and sharing workplace amenities with an HIV-positive colleague are summarised. Thirdly, the potential consequences of stigma and discrimination are considered. Fourthly, perceptions of how receptive the SAPS are to invest in and promote HIV-positive employees and of discrimination in the workplace are summarised.

The fifth point below summarises responses to question items directed at gauging respondents' perceptions of the policies and programmes offered in the SAPS and via Polmed.

i. *Disclosure of an HIV positive status*. With regard to disclosing one's HIV/AIDS status, 77% of the respondents felt that it is a good thing for an employee to disclose his or her status at work and only 21% viewed it as a gross mistake. When asked whether people should be encouraged to disclose their serostatus at work, 48% said definitely so or under certain circumstances, whereas 22% disagreed with this notion and 30% reported that they are not sure whether people should disclose at work. Regarding the statement that people living with HIV regret having disclosed their status; 24% indicated that this occurs often, 39% said that this happened sometimes, 14% thought that this rarely happened, 15% were of the opinion that this never happens and 9% declined to comment on the statement. On the question whether people should disclose their HIV/AIDS status to their immediate commanders or mangers; 48% of the respondents agreed, 29% did not recommend this and 24% did not know.

Thus, even though the majority of the respondents felt that disclosure is a positive move, they were less confident that disclosure at work or to commanders or managers would be a good thing.

ii. *Caring for a relative infected with HIV or affected by HIV/AIDS and sharing workplace amenities with an HIV-positive colleague.* A large percentage (90%) of the respondents indicated that they would care for a family member living with HIV.

iii. With regard to the sharing of resources such as toilets or kitchens with an HIV positive fellow employee, 73% of the respondents said that they do not have any problems to do so and only 18% said that they would not share with an HIV positive co-worker. These responses seem to indicate that the respondents in this study displayed low personal stigmatising views of PLWHIV.

iv. *The potential consequences of stigma and discrimination.* With regard to stigma as a deterrent for SAPS employees to seek treatment 61% of respondents concurred that stigma is a major obstacle. More than half of the respondents (57%) were of the opinion that stigma and discrimination discourage employees from joining the SAPS's Support Groups for people living with HIV. More than a quarter of the respondents (26%) said that PLWHIV are often rejected and a further 42% said that PLWHIV are sometimes rejected.

v. With regard to discrimination resulting in PLWHIV losing their jobs; 13% said that this happens often, 38% said that this sometimes happen, 18% were of the view that this kind of discrimination is very rare, and 26% stated that in their opinion this has never happened in their environment. These responses seem to indicate that fears about the potential negative consequences of stigma and discrimination are still rife.

vi. *Whether the SAPS should invest in and promote HIV-positive employees and whether discrimination occurs in the workplace.*

More than three quarters of the respondents (77%) viewed the development of PLWHIV in the SAPS as an investment. With regard to discrimination against PLWHIV, 48% of the respondents said that some of the employees of the SAPS discriminate against fellow employees living with HIV. Just below half of all the respondents (47%) said that SAPS employees do not openly talk about HIV/AIDS in the workplace. About HIV testing as a requirement for employment at the SAPS; 40% agreed, 34% disagreed and 26% declined to answer.

vii. With regard to the employment of employees living with HIV, 64% of the respondents declared that PLWHIV should definitely be employed and 16% said under certain circumstances. In connection with promotion, 66% of the respondents were of the view that PLWHIV should definitely be promoted and 16% said only under certain circumstances. When asked whether they have observed an HIV infected or affected person being discriminated against, only 13% of the respondents agreed. With regard to their opinion on whether the SAPS work environment is friendly to PLWHIV, 25% said that this is definitely the case, 19% agreed that this occurred under certain circumstances, 16% said that this is definitely not the case and 41% indicated that they did not know. It thus seemed that the study revealed general positive perceptions regarding the appointment, promotion and investment of PLWHIV in the SAPS and that very few people actually witnessed incidents of stigma and discrimination in the workplace.

viii. *Perceptions of the policies and programmes offered in the SAPS and via Polmed.* Regarding registration on the Polmed HIV/AIDS Programme catering for SAPS HIV positive members; 65% said that they would not have any to problem to enrol in this programme, 7% said they would not enrol 28% declined to answer.

With regard to their perception whether the SAPS's HIV/AIDS policy have been successful in reducing stigma and discrimination; 35% agreed, 17% said that it has not been successful and 49% were unsure.

It can be concluded from these results that the majority of the respondents in this study displayed positive attitudes towards PLWHIV, but that some fears still existed about the possible consequences of disclosure in the workplace. A composite score for stigma and discrimination from various question items showed relatively low levels of stigma and discrimination. The differences in the mean scores for this stigma and discrimination score according to the race group of the respondents showed much lower scores for the white and Indian employees than for the African and Coloured employees and these differences were found to be statistically significant.

5.2.5 Objective 4 (Section E): Participation by stakeholders in the implementation of the workplace programme

With regard to the participation by stakeholders such as the unions; 55% of the respondents agreed that unions are playing their role in implementing the HIV/AIDS workplace programme. Moreover 53% of the respondents were of the view that management are playing a major role in the implementation of the workplace programme. An even larger percentage of the respondents (61%) agreed that Polmed is playing a crucial role in the implementation of the SAPS's HIV/AIDS workplace programme. However the respondents were less confident about the role of the commanders/managers; since only 8% said they are playing their part. Less than half of the respondents (46%) felt that awareness programmes are effective, 14% felt that awareness programmes are not effective and 40% were unsure about the effectiveness of such interventions. It can be concluded from these results that whereas respondents in this study were positive about the role played by the unions, Polmed and the general management of the SAPS in establishing and implementing an HIV/AIDS workplace programme, feedback on the role and prominence of direct line managers and commanders and on the effectiveness of awareness programmes requires attention.

5.2.6 Elaboration of objective 4 (Section F): Effectiveness of the workplace programme to address stigma and discrimination

When the respondents were asked to state whether the HIV/AIDS workplace programme was successful in reducing stigma and discrimination; 34% affirmed that this was indeed so, 21% felt that the programme did not reduce stigma and discrimination and 45% did not know whether the HIV/AIDS programme was successful in reducing stigma and discrimination.

Concerning whether the HIV/AIDS policy gives clear direction to mitigate stigma and discrimination; 40% affirmed that this is so, 12% felt that the policy is not clear enough and 48% indicated uncertainty about the clarity of the policy in providing direction on how to reduce stigma and discrimination.

It can be concluded from this evidence that the respondents in this study were not clear on the success of the programme in reducing HIV/AIDS-related stigma and discrimination in the workplace or on the ability of the policy on which the programme is based to provide clear directives to do so.

5.3 CONCLUSIONS

This study set out to survey the views and perceptions of randomly sampled respondents on the HIV/AIDS workplace programme of the SAPS. To accomplish this, the researcher chose a quantitative research orientation and developed and employed a structured, self-administered questionnaire in which each objective was covered by various question items. A realised sample size of 387 respondents at the SAPS National Office had been achieved and the coded responses to the questionnaires were computerised and analysed using SPSS 16.0. The data were presented as univariate and bivariate tables and summaries per objective were given in this chapter. The following recommendations are based on the evidence as presented in Chapter 4 and 5.

5.4 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for enhancing knowledge and exposure of the SAPS employees to the HIV/AIDS workplace programme and for reducing stigma and discrimination, taking into consideration the effects of stigma and discrimination in hampering a successful implementation of the HIV/AIDS workplace programme.

5.4.1 Policy review

The policy has not been reviewed over the past seven years. HIV/AIDS is a dynamic field and there are many new developments that have taken place since the formulation of the SAPS HIV/AIDS policy.

5.4.2 Nomination of workshops attendees

Many respondents indicated that they would have loved to attend the SAPS HIV/AIDS workshops and some reported that the reason they did not attend was that they were not invited or nominated to attend the workshops. The research uncovered that the number of respondents that have attended more than one workshop was almost the same as of those that had not attended any at all. This suggests that the nomination of attendees should be done in a strategic manner.

5.4.3 Induction programme on HIV/AIDS

The SAPS does not have a special programme tailored to introduce newly recruited personnel to its stance on issues of HIV/AIDS. There are many respondents who indicated that HIV/AIDS workshops were last held at their respective workplaces prior to their employment at the SAPS.

5.4.4 Updating of HIV/AIDS material

The training manuals of the SAPS have not been updated and thus the content does not speak to issues such as the antiretroviral therapy. Since the study has shown that many respondents are still not fully knowledgeable about antiretroviral therapy, such updating is recommended. In addition, the content should keep the current levels of knowledge at a peak and be accessible and acceptable for all personnel to address gender and racial differences in knowledge levels of HIV/AIDS.

5.4.5 Accessibility of HIV/AIDS Policy

The SAPS HIV/AIDS policy is accessible only to personnel who have access to the intranet and this is a small percentage and mostly the senior members. Many of the respondents in this study were unsure of how the policy provides directives to address HIV/AIDS related stigma and discrimination.

This problem was further highlighted by an incident reported on in the media where the national spokesperson of the SAPS was interviewed by the media (Pharaoh & Schonteich 2006:1) and he responded that he did not know the SAPS HIV/AIDS policy.

It is thus recommended that the policy should be made available to SAPS members and that they should be encouraged to become familiar with its contents. Regular road shows to establish and maintain such knowledge and to encourage feedback and ownership are recommended.

5.4.6 Promoting disclosure and protecting confidentiality

This study uncovered that many respondents were apprehensive and unsure about disclosure fearing stigma and discrimination.

It is the view of the researcher that HIV/AIDS programme implementers and management need to invent intervention programmes that will promote a culture of disclosure and confidentiality. This will encourage members to utilize services made available to them by the SAPS HIV/AIDS workplace programme.

5.4.7 Strategies to address stigma and discrimination

The SAPS does have a specific strategy aimed at addressing stigma and discrimination against personnel living with HIV. The policy and other SAPS HIV/AIDS manuals do condemn stigma and discrimination, but there are no clear intervention programmes to mitigate stigma and discrimination. So it would be recommended that SAPS management and programme implementers craft clear HIV/AIDS stigma and discrimination indicators. The Futures Group International, POLICY Project & Siyam'kela (2004:4,8) defines HIV/AIDS stigma indicators as measures which alert project managers to changes and progress of their project. This would assist them by highlighting the successes and challenges of the HIV/AIDS workplace programme in reducing stigma and discrimination.

5.4.8 Mainstreaming of HIV/AIDS

Research has shown that HIV/AIDS has negative impacts in any organisation. Each organisation needs to determine policies, strategies and actions that need to be implemented to prevent and mitigate these negative impacts. The findings of this study seem to suggest that the mainstreaming of HIV/AIDS has not yet been achieved. Mainstreaming in this context implies integrating HIV and AIDS into functions relevant to the core mandate of the organisation. This approach will make HIV and AIDS part of the core business of the SAPS. This will assist in avoiding situations where commanders say that their core business is to combat crime and not to address issues pertaining to HIV/AIDS. Also, the mainstreaming of HIV and AIDS will assist the SAPS in identifying the specific impacts of HIV/AIDS on the organisation and on its ability to achieve its goals.

5.4.9 Sensitizing commanders regarding the importance of addressing HIV/AIDS

Some respondents stated that they could not attend workshops because their commanders did not release them to attend HIV/AIDS workshops. The reasons cited were that the nature of work done by some of the units does not allow them time off to attend workshops of such a nature. This finding corroborates with the findings of Masuku (2007) carried out in the Johannesburg area. Some of the commanders interviewed by Masuku (2007: 13) stated that HIV/AIDS is not their responsibility. They stated that their core business is to combat crime and that they generally do not even read the HIV/AIDS policy. They also indicated that their members are too busy to be released to attend HIV/AIDS workshops. Such members need to be sensitized about the following potential impact of HIV/AIDS in workplace:

i. *Increased absenteeism.* Research has shown that due to prolonged HIV/AIDS related sicknesses more employees will intermittently take sick leave or family responsibility leave to look after their sick family members and to attend funerals.

ii. *Low productivity.* HIV/AIDS related illnesses may result in reduced productivity due to, for example, poor health and psychological and other concerns.

iii. *Replacement of staff.* Some employees might leave their jobs or die prematurely which implies loss of skills and experience and costs in the replacement, recruitment and employment of new staff.

5.5 FURTHER RESEARCH

Further research in order to enhance the SAPS HIV/AIDS Workplace Programme is recommended on the following topics:

i. An investigation into the development of effective intervention programmes to address fears of possible stigma and discrimination in the workplace.

ii. An assessment of the employees' understanding of antiretroviral therapy.
iii. An investigation into the causes of poor workshop attendance by functional members.

5.6 LIMITATIONS OF THE STUDY

The limitations of the study are discussed below. :

5.6.1 The researcher's working conditions

The researcher was required to travel to various places over most of the research period to perform his duties and such interruptions made it very difficult for him to work continuously on his dissertation and to stick to time frames.

5.6.2 The nature of subject (HIV/AIDS)

HIV/AIDS is still a sensitive issue because of existing perceptions pertaining to its major modes of transmission.

5.6.3 The SAPS environment

The SAPS as a law-enforcing organ of the state tends to be conservative when it comes to the disclosure of information. This transpired in the way that some of the respondents evaded some of the questions by choosing *"I don't know"* or *"I'm not sure"* as response options. Whereas such options may indicate an actual lack of knowledge or the inability to form an opinion, it is the researcher's contention that some respondents selected such options in order to evade the questions despite assurances of confidentiality.

5.6.4 Hierarchy and organisational culture

The SAPS is a rank-rooted, hierarchical organisation and this notion permeates the culture and operation of the organisation. The HIV/AIDS peer educators were tasked to distribute and collect the questionnaires according to the sampling instructions set up by the researcher. In practice, some peer educators found it difficult to receive completed questionnaires back from their senior colleagues.

5.7 CONCLUDING REMARKS

This study set out to find information on four issues, namely to determine the level of exposure of the SAPS's employees to the HIV/AIDS workplace programme, to assess levels of knowledge of HIV and AIDS among the SAPS's personnel, to assess the levels of stigma and discrimination among the SAPS's personnel and to measure the interviewees' perceptions of participation by stakeholders in the implementation of the programme. These objectives and the general approach to the study were informed by an extensive review of literature which included a review of three related studies in the field and of theoretical perspectives on stigma and discrimination. Using a quantitative approach with a structured, self-administered questionnaire, the researcher was able to find evidence that although the levels of knowledge (regarding HIV/AIDS) are high, SAPS employees require information about antiretroviral therapy. He also found evidence that although SAPS employees display low levels of personal bias against PLWHIV, they still fear the possible negative consequences of disclosure in the workplace and of stigma from other people. He found that SAPS employees generally regarded the efforts of Polmed, the unions and the general management of the SAPS as positive and conducive to a supporting environment, they were less confident about the role played by their direct commanders or line managers. On the basis of such evidence, the researcher was able to make specific recommendations for the future of the SAPS's HIV/AIDS workplace programme.

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APPENDIX A

PERMISSION LETTER FROM SAPS

SAP 21

SOUTH AFRICAN POLICE SERVICE — SUID AFRIKAANSE POLISIE DIENS

Verwysing Reference	9/7/4
Navrae Enquiries	CAPT B MAGWAZA
Telefoon Telephone	(012) 393 5180
Faksnommer Fax number	(012) 393 5252

EMPLOYEE ASSISTANCE SERVICE
PRIVATE BAG X 94
PRETORIA
0001

2006-07-19

The Head: Snr Supt Snetler

Research Unit

SA Police Service

HEAD OFFICE

APPLICATION FOR RESEARCH: SAPS HIV / AIDS WORKPLACE PROGRAMME

1. Captain BW Magwaza hereby request authorization to use SAPS HIV and AIDS Workplace Programme in his research.
2. This MA programme covers the following modules:
   -Advanced HIV \AIDS Policy and Programme Development.
   -Advanced Social Policy Research in HIV /AIDS.
   -Advance Research Technologies in HIV / AIDS.
   -Ethics and History of HIV / AIDS.
   -Dissertation
3. Doing this study will broaden my scope of HIV / AIDS.
4. Thus, this will equip me with skills to excel in my work as SAPS HIV / AIDS Workplace Project Manager.
5. Attached, please find supporting letter from Unisa.
6. Your positive recommendation/approval will be highly appreciated.

Capt BW MAGWAZA

APPROVED / ~~NOT APPROVED~~

Snr Supt
SUB-SECTION HEAD : HIV/AIDS WORKPLACE PROGRAMME
MM LAUBSCHER

APPROVED / ~~NOT APPROVED~~

HEAD : RESEARCH UNIT
J ~~SNETLER~~
SCHNETLER

Snr Supt

Nat. Instr. 1/2006 must be adhered to.

APPENDIX B

UNISA LETTER

UNISA university of south africa

Tel: 012 352 4116
Fax:012 352 4117
E-mail: Roetshjl@unisa.ac.za
Uvudec21@unisa.ac.za

05 June 2006

To Whom It May Concern:

Dear Sir or Madam:

RE: ACCESS TO THE LIBRARY

I would like to inform you that B I W Magwaza (student number: 31011667) is currently a registered student at UNISA for 2006 in the course MA Social Behaviour Studies in HIV/AIDS.

From time to time the students need to go out into the field to collect material for their assignments. Therefore, we would like you to allow Mr Magwaza to have access to your library.

Thank you for your cooperation in this matter.

Yours truly,

LEON ROETS
Programme Coordinator: Social Behaviour Studies in HIV/AIDS & Health

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APPENDIX C

LETTER TO SAPS COMMANDERS

Informed consent

2008/7/18

Dear: Commander (Manager) / Research Participant

I am a graduate 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 the knowledge and exposure of the SAPS employees to the HIV/AIDS Workplace Programme as well as levels of stigma and discrimination. Research suggests that the workplace is one of the environments badly affected by AIDS pandemic. As a participant, you would be involved in completing a questionnaire.

You have been randomly selected for participation in this study. You will not have to answer any question you do not wish to answer. Only I will have access to the completed questionnaires. Your identity will be kept confidential to the extent provided by law and your identity will not be revealed in the final manuscript. There are no anticipated risks, compensation or other direct benefits to you as a participant in this study. You are free to withdraw your consent to participate and may discontinue your participation in the study at any time without consequence.

If you have any questions about this research protocol, please contact me at 012-393 5186 or 083 595 3894.

Yours sincerely

_____

BONGANI W MAGWAZA (CAPTAIN)

DIVISION: PERSONNEL SERVICES

EMPLOYEE ASSISTANCE SERVICES (E.A.S.)

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 your consent for participating in this study.

I have read the procedure described above for the proposed research study. I voluntarily agree to participate in the study and I have received a copy of this description.

_____ _____

Signature of participant Date

APPENDIX D

PARTICIPANT CONSENT FORM

Date ----------Organization ----------

- The purpose of the research has been explained to me, and I choose to participate by filling in of the questionnaire.
- I understand that my participation in this research project is voluntary.
- I have the right to not answer any question I do not like, or withdraw at any stage without having to explain the reason.
- I agree to some of my comments or statements being quoted in the report.
- I understand that if I have any further queries I can contact the researcher.

Declaration:

I agree to take part in this research exercise; signature (not full name) ----------
date ----------

APPENDIX E

QUESTIONNAIRE

Dear research participant,

Captain Magwaza is carrying out a study on the HIV/AIDS workplace programme among employees of the South African Police Services as part of his Masters' studies at the University of South Africa. The purpose of this research is to assess the effects of the SAPS HIV/AIDS workplace programme which have been implemented for the past seven years.

The envisaged outcome of this study is to identify gaps in the programme, and thus assist its implementers to consider addressing required improvements in order to enhance the programme so that it can achieve its goals. For this purpose, your kind co-operation is needed. You have been randomly selected for participation in this study. Your knowledge and views are crucially important in this study. The researcher and UNISA undertake that all information provided by you will be treated as strictly confidential. Please do not write your name anywhere on this questionnaire.

SECTION A: BIOGRAPHICAL DATA

Please tick in the relevant box

1. To which of the following age groups do you belong?

20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
1	2	3	4	5	6	7	8	9

2. What is your race?

African	White	Coloured	Indian	Other
1	2	3	4	5

3. What is your gender?

Female	Male
1	2

4. What is you rank or level?

1-4	5-7	8	9-10	11-12	13-15
1	2	3	4	5	6

5. Under which Act are you appointed by SAPS?

Police Act	Public Service Act
1	2

6. How many years of service do you have in SAPS?

0-1 years	1-3 years	3-5 Years	5-7 Years	7-10 Years	More than 10 years
1	2	3	4	5	6

SECTION B: LEVEL OF EXPOSURE TO THE WORKPLACE PROGRAMME

THE NEXT SECTION CONTAINS QUESTIONS ABOUT YOUR EXPOSURE TO SAPS HIV/AIDS WORKPLACE PROGRAMME. PLEASE THE BOX AT EACH STATEMENT THAT BEST DESCRIBES YOUR VIEW.

7. Think about your familiarity with the SAPS HIV/AIDS workplace programme, and then indicate whether you agree or disagree with the following statements:

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
7.1. I know the SAPS HIV/AIDS workplace very well	1	2	3	4	5
7.2 I know some of the details of the HIV/AIDS workplace programme, but would like to know more about it	1	2	3	4	5
7.3. I am not familiar with the SAPS workplace programme and do not wish to know more about it	1	2	3	4	5

8. Have you attended any of the SAPS HIV workshops or awareness campaigns in the last 12 months?

Yes	No
1	2

9. If "yes" at Question 8, how many of these awareness campaigns have you attended in the last 12 months?

_____Awareness campaigns attended in the last 12 months

10. If "no" at Question 8, please tell me the MAIN reason why you have not attended any HIV/AIDS awareness campaign in the last 12 months.

Main reason for not attending:

SECTION C: LEVELS OF KNOWLEDGE AND UNDERSTANDING OF HIV/AIDS

11. IN THIS SECTION I AM GOING TO ASK YOU A FEW QUESTIONS ABOUT YOUR KNOWLEDGE OF HIV/AIDS, PLEASE TICK EITHER TRUE OR FALSE

	True	False	Don't know
11.1. People on antiretroviral treatment die sooner than those not taking them.	1	2	3
11.2. HIV-infected person cannot transmit the virus when taking antiretroviral treatment	1	2	3
11.3. Antiretroviral treatment reduces the quantity of the HI virus in the person's body	1	2	3
11.4. Having sex with a virgin can cure HIV/AIDS	1	2	3
11.5. A person can be infected with HIV and still live a long and healthy and productive life	1	2	3
11.6. The SAPS HIV/AIDS programme increased my knowledge of HIV/AIDS	1	2	3

SECTION D: STIGMA AND DISCRIMINATION

I AM NOW GOING TO ASK YOU QUESTIONS ON STIGMA AND DISCRIMINATION. PLEASE TICK THE BOX WHICH INDICATES YOUR OPINION, FEELING OR EXPERIENCE.

12. Do you know someone who has regretted their decision to disclose his/her HIV status?

YES	NO
1	2

13. Do you think that an employee who tells his/her employer about his/her HIV- positive status is making a big mistake?

YES	NO
1	2

14. Would you be willing to care for a family member with AIDS?

YES	NO
1	2

15. Do you agree or disagree with the following statement: ***Fear of stigma and discrimination at the workplace prevents people in SAPS from seeking treatment for HIV and AIDS.***

Strongly agree	Agree	Disagree	Strongly disagree	Unsure/Don't know
1	2	3	4	5

16. Do you agree or disagree with the following statement: ***SAPS employees are reluctant to join HIV/AIDS support groups because of fear of stigma and discrimination.***

Strongly agree	Agree	Disagree	Strongly disagree	Unsure/Don't know
1	2	3	4	5

17. Do you agree or disagree with the following statement: ***The SAPS HIV/AIDS workplace programme has remarkably reduced stigma and discrimination amongst the personnel.***

Strongly agree	Agree	Disagree	Strongly disagree	Unsure/Don't know
1	2	3	4	5

18. Do you agree or disagree with the following statement: ***It is a waste of resources for SAPS to develop employees living with HIV/AIDS.***

Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1	2	3	4	5

19. Do you agree or disagree with the following statement: ***Some of SAPS personnel display negative attitudes towards people living with HIV.***

20. If you were living with HIV would you disclose your status at work?

Definitely yes	Yes, under certain circumstances	Definitely no	Don't know/ Undecided
1	2	3	4

21. Please give me the main reason for your answer in Question 20:

_____

_____

_____

22. Is your work environment friendly to (that is accepting and embracing of) people living with HIV and AIDS?

Definitely yes	Yes, under certain circumstances	Definitely no	Don't know/ Undecided
1	2	3	4

23. Do people openly talk about their HIV/AIDS status at the workplace?

Definitely yes	Yes, under certain circumstances	Definitely no	Don't know/ Undecided
1	2	3	4

24. Should people living with HIV and AIDS be employed at SAPS?

Definitely yes	Yes, under certain circumstances	Definitely no	Don't know/ Undecided
1	2	3	4

25. Do you think an HIV positive employees should be promoted to senior positions?

Definitely yes	Yes, under certain circumstances	Definitely no	Don't know/ Undecided
1	2	3	4

26. Tell me whether you agree or disagree with the following statement: ***AIDS should be treated like all other chronic diseases.***

Definitely yes	Yes, under certain circumstances	Definitely no	Don't know/ Undecided
1	2	3	4

27. Tell me whether you agree or disagree with the following statement***: I feel comfortable sharing resources such as an office, the toilet and the kitchen with fellow employees living with HIV.***

Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1	2	3	4	5

28. In the last 2 years (24 months) have you personally observed an incident where a person was stigmatized or discriminated against at SAPS because he or she is infected with HIV?

Yes	No
1	2

29. If you were diagnosed as HIV positive, would you enrol for the Polmed HIV programme which is offered at no extra cost to Polmed members?

Yes	No	Don't know
1	2	3

30. Do you personally feel that an HIV-test should be a prerequisite for employment in SAPS?

Yes	No	Don't know
1	2	3

31. What is your view about the following statements?

	Often	Sometimes	Rarely	Never
31.1 People with HIV/AIDS are treated as outcast	1	2	3	4
31.2. People with HIV/AIDS lose their jobs	1	2	3	4
31.3 Most people with HIV/AIDS are rejected when others learn about their status	1	2	3	4
31.4. PLWA at times regret having told some people that they are living with HIV	1	2	3	4

31.5 It is risky for a person to tell others that he or she is HIV-positive	1	2	3	4

SECTION E: PARTICIPATION BY STAKEHOLDERS IN THE IMPLEMENTATION OF THE WORKPLACE PROGRAMME

THE FOLLOWING SECTION FOCUSES ON THE INVOLVEMENT OF ALL ROLE-PLAYERS IN THE IMPLEMENTATION OF SAPS HIV/AIDS WORKPLACE PROGRAMME. PLEASE TICK IN THE BOX NEXT TO THE MOST APPROPRIATE ANSWER.

	Strongly Agree	Agree	Disagree	Strongly disagree	Don't know
32.1 Labour unions are in full support of the HIV/AIDS workplace programme	1	2	3	4	5
32.2 The management set a good example by attending HIV/AIDS activities.	1	2	3	4	5
32.3 Any employees of SAPS should not hesitate to disclose his/her HIV-positive status to the immediate supervisor / commander	1	2	3	4	5
32.5 Polmed and other medical aid schemes play a crucial role in the fight against HIV/AIDS	1	2	3	4	5

SECTION F: CHANGES TO THE WORKPLACE PROGRAMME IN ORDER TO ADDRESS STIGMA AND DISCRIMINATION

I AM NOW GOING TO ASK A FEW QUESTIONS ABOUT THE IMPLEMENTATION OF THE HIV/AIDS WORKPLACE PROGRAMME TO REDUCE STIGMA AND DISCRIMINATION. PLEASE INDICATE IN THE BOX OPPOSITE THE STATEMENT YOU FEEL EXPRESSES YOUR OPINION REGARDING THE PROGRAMME THE BEST.

33. Are you of the opinion that the SAPS HIV/AIDS policy outlines clear programmes to reduce stigma and discrimination?

Yes	No	Not sure
1	2	3

34. Do you think that the SAPS HIV/AIDS workplace programme has been successful in reducing stigma and discrimination?

Yes	No	Not sure
1	2	3

35. In your opinion, do commanders / supervisors regard HIV/AIDS as part of their business in SAPS?

Often	Sometimes	Rarely	Never	Don't know
1	2	3	4	5

36. Do you think SAPS HIV/AIDS awareness programmes are effective in preventing the spread of new HIV-infections amongst SAPS employees?

Yes	No	Not sure
1	2	3

THANK YOU VERY MUCH FOR AGREEING TO PARTICIPATE!

APPENDIX F

SAPS HIV/AIDS POLICY

SAPS HIV/AIDS POLICY

AGREEMENT

SAFETY AND SECURITY SECTORAL BARGAINING COUNCIL AGREEMENT NO 13/2001

DATE: 20 AUGUST 2001

EMPLOYEES OF THE SOUTH AFRICAN POLICE SERVICE LIVING WITH HIV / AIDS POLICY

1. The parties agree to the policy: Employees of the South African Police Service Living with HIV / AIDS policy, attached hereto.

2. The parties further agree that agreement 7/99: HIV Policy is hereby revoked.

3. This agreement binds the parties to the agreement and all employees who are not members of a registered trade union admitted to this Sectoral Bargaining Council, as well as members of registered trade unions admitted to this Sectoral Bargaining Council who is not parties to this agreement.

4. This agreement shall be valid and implemented as from 20/8/01 until it is either amended or revoked in the Safety and Security Sectoral Bargaining Council.

5. This agreement shall be subject to the provisions of any applicable Act of Parliament, or secondary legislation promulgated in terms thereof.

6. The representatives of all the parties concerned undertake to take every reasonable step necessary to ensure the implementation of this agreement.

7. Amendments to this agreement shall not be in force of effect unless they have been reduced to writing and signed by all the parties concerned.

8. This agreement signed on behalf of the South African Police Service, as the employer, and the relevant recognised employee organisations, all signatories being duly authorised thereto, at PRETORIA on the 20th day of August 2001.

Signature of representative of employer.

SIGNED

.....

SOUTH AFRICAN POLICE SERVICE

Signature of representative of recognised employee organisations.

SIGNED

.....

SOUTH AFRICAN POLICE UNION

SIGNED

.....

POLICE AND PRISONS CIVIL RIGHTS UNION

EMPLOYEES OF THE SOUTH AFRICAN POLICE SERVICE LIVING WITH HIV/AIDS POLICY

1. Preamble

1.1_ The Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) are serious health problems which have socio-economic, employment and human rights implications.

1.2_ It is recognised that HIV/AIDS epidemic will affect every workplace, with prolonged staff illness, absenteeism and death impacting on service delivery, employee benefits, occupational health and safety, operational effectiveness and efficiency and workplace morale.

1.3_ Furthermore, HIV/AIDS is still a disease surrounded by ignorance, prejudice, discrimination and stigma. In the workplace, unfair discrimination against people living with HIV and Aids has been perpetuated through practices such as pre-employment HIV testing, dismissals for being HIV positive and the denial of employee benefits.

1.4_ The South African Police Service is committed to promoting equal opportunities and fair treatment in employment for all its employees, through the elimination of unfair discrimination in all policing policies and practices.

1.5_ In recognition of the fact that employees living with HIV/AIDS should not be treated different from employees inflicted with other life threatening conditions, it must be ensured that such employees or those with any other sexually transmitted diseases carry no special burden.

1.6_ It is acknowledged that continued employment opportunities are the therapeutic value for an employee living with a life-threatening condition, and any form of unfair discrimination against such employee is prohibited.

2. Purpose

To provide employment practices and procedures which ensure that employees with HIV/Aids are not unfairly discriminated against in the workplace, by-

- creating a safe working environment for all employees;
- promoting a supportive work environment in which employees living with HIV/Aids are able to be open about their HIV/Aids status without fear of stigma and rejection;
- developing procedures to manage occupational incidents and claims for compensation;
- introducing measures to prevent the spread of HIV;
- developing strategies to assess and reduce the impact of the epidemic on the workplace and service delivery; and
- supporting those employees who are infected or affected by HIV/Aids so that they may continue to work productively for as long as possible.

3. Authorisation

The provisions of the Constitution of South Africa Act, 1996 Employment Equity Act, 1998, Labour Relations Act, 1995; Basic Conditions of Employment Act, 1997; Medical Schemes Act, 1998; Promotion of Equality and Prevention of Unfair Discrimination Act, 2000, Occupational Health and Safety Act, 1993, Compensation for Occupational Injuries and Diseases Act, 1993, Codes of Good Practice and relevant collective agreements provide the framework and authorisation.

4. Scope of application

This policy is applicable to all employees appointed in terms of the South African Police Service Act, 1995 (Act no 68 of 1995) and the Public Service Act, 1994 (Act no 103 van 1994).

5. Policy provisions

5.1 Medical testing

5.1.1 No employee or prospective employee shall, be required to undergo any medical examination to assess their immune/HIV/AIDS status, unless the Labour Court has declared such testing to be justifiable.

Any medical examination undertaken either before employment or thereafter shall be solely to determine the functional performance of an employee, and offer a prognosis on the fitness for work of the employee. Indirect screening methods such as inquiries regarding previous testing or an assessment of risk behaviour are prohibited.

5.1.2 Employees must be advised of the advantages of voluntary testing should they suspect that they have been exposed to infection, as the early initiation of aggressive treatment regimens offer a better long-term prognosis for persons living with HIV/AIDS.

5.1.3 An employer may provide testing to an employee who has requested a test in the following circumstances:

- As part of a health care service provided in the workplace;
- In the event of an occupational accident carrying a risk of exposure to blood or other body fluids;
- For the purposes of applying for compensation following an occupational accident involving a risk of exposure to blood or other body fluids.

5.1.4 Subject to the provisions of paragraph 5.1.1 supra testing may be done only at the initiative of an employee. Such testing must be carried out by a suitably qualified person or institution registered with the Medical and Dental Control Council, and with observance to the following-

- Express written consent by the employee shall be obtained before a test for HIV/AIDS is undertaken;
- no testing shall be undertaken without pre- and post-test counselling by a suitably qualified person or helping professional as defined by the Department of Health's national Policy on Testing of HIV;
    - Results shall be treated confidentially; and
    - Results will only be conveyed to the employee concerned.

5.1.5 Voluntary testing by an employee must be based on her/his informed consent. This implies that the employee has been provided with information, understands it, and based on this has agreed to undertake the HIV test. The employee understands what the test is, why it is necessary, the benefits, risks, alternatives and any possible social implications of the outcome.

5.1.6 Surveillance testing, the anonymous unlinked testing done to determine the prevalence of HIV to provide information on its control, prevention and management, and the epidemiological study of HIV patterns, causes, distribution and mechanisms of control, may be undertaken if in accordance with ethical and legal principles regarding such research. Where such research is done, the information obtained may not be used to unfairly discriminate against any employee. Testing will be considered anonymous if there is a reasonable possibility that an employee's HIV status can be deducted from the results.

5.2 Confidentiality

5.2.1 Employees have the right to confidentiality regarding their HIV/AIDS status and cannot be compelled to disclose their HIV/AIDS status to SAPS or any other employee.

5.2.2 Where an employee chooses to voluntarily disclose her/his HIV status to any other employee, this information may not be disclosed to others without the employee's express written consent. Where written consent is not possible, steps must be taken to confirm that the employee wishes to disclose her/his status.

5.2.3 Medical information regarding the HIV/AIDS status of an employee or prospective employee gained by a medical, dental or helping professional under contract to the employer, pension fund trustee or any other person, shall not be disclosed without the consent of the employee concerned.

5.2.4 No flags of any other type of indicator shall be used on employee's personal files to indicate the employee's HIV/AIDS status.

5.3 Employment

5.3.1 Employees living with HIV/AIDS shall be governed by the same contractual obligations as all other employees.

5.3.2 No employee with HIV/AIDS shall be unfairly discriminated against within the employment relationship or any other employment policies or practices with regard to -

- Recruitment procedures, advertising and selection criteria;
- Appointments, and the appointment process, including job placement;
- Job classification or grading;
- Remuneration, employment benefits and terms and conditions of employment;
- Employee assistance programme;
- Job assignments;
- Training and development;
- Performance evaluation systems;
- Promotion, transfer and demotion;
- Termination of services.

5.3.3 The HIV/AIDS status of an employee, whether it is voluntarily made known by the employee or not, shall be a basis for refusing to conclude or to continue or to renew an employment contract.

5.3.4 HIV infected employees must be able to continue working under normal conditions under their current employment for as ling as they are medically fit to do so.

Their utilization must be determined by their health condition in relation to the operational requirements of the respective job. Any changes in the nature of the job shall be based on existing criteria of equality of opportunity, merit and capacity to perform to expected standards.

5.3.5 HIV/AIDS status shall not be used as a justification for the exclusion of an employee from performing any particular duty.

5.3.6 Where it is necessary, employees living with HIV/AIDS shall, in consultation with the employee, be rotated to duties and working conditions that are more appropriate to the circumstances of the employee with minimal risk to their health condition.

5.3.7 All reasonable steps must be taken to accommodate an employee in a suitable post until it is necessary to convene a medical board.

5.4 Leave, absenteeism and ill-health

5.4.1 Employees who become ill with AIDS should be treated like any other employee with a comparable life threatening illness and be entitled without prejudice to available sick
Leave benefits.

5.4.2 Commanders and managers shall support employees living with HIV/AIDS in having access to appropriate health care. It must be ensure that medical aid schemes do not unfairly discriminate against employees of SAPS on the basis of their state of health.

5.4.3 Normal medical board rules and relevant codes of good practice shall apply.

5.5 Termination of employment

5.5.1 No employee shall be dismissed or have their employment terminated solely on the basis of their HIV/AIDS status.

5.5.2 However where there are valid reasons related to their capacity to continue working and fair procedures have been followed, their services may be terminated in terms of applicable Codes of Good Practice and prevailing instructions.

5.6 Counselling and support programmes

5.6.1 The SA Police Service is committed to provide counselling and support services to employees living with HIV/AIDS and their dependants through the Employee Assistance Programme. The SA Police Service shall, if requested, assist an employee living with HIV/AIDS and her/his dependants to obtain professional counselling.

5.6.2 All employees have the right to continuous education and information about the modes of transmission of HIV/AIDS, the means of preventing such transmission, the need for counselling and care, and the social impact of infection on those affected by HIV/AIDS.

5.6.3 The National Forum for HIV/AIDS, comprising representatives of the Helping Professions and union representatives, shall manage HIV/AIDS as a collective effort addressing policy issues, education and awareness campaigns, and the implementation of social programmes. This must be done in conjunction with government and nongovernmental organisations with expertise in HIV/AIDS education, counselling and care. The Department of Health's HIV/AIDS and Sexually Transmitted Diseases prevention campaign must be supported by making condoms, information brochures, posters, information on Post Exposure Prophylactics and details of local services for people affected by or living with HIV/AIDS available at the workplace.

5.6.4 Such programmes should incorporate-

- Ongoing sustained prevention of the spread of HIV among employees and their communities;
- Management of employees with HIV so that they are able to work productively for as long as possible;
- Strategies to deal with the direct and indirect costs of HIV/AIDS in the workplace; and
- Strategies to combat discrimination and irrational responses to HIV/AIDS in a non-stigmatising manner.

5.6.5 Awareness activists/peer educators, trained under the auspices of the National Forum, must be utilised in education and prevention programmes. As HIV/AIDS impacts disproportionately on women, this should be taken into account in the development of related programmes.

5.6.6 Mechanisms should be created to encourage openness, acceptance and support for those employees who voluntarily disclose their HIV status in the workplace, including -

- Encouraging employees openly living with HIV/AIDS to conduct or participate in education, prevention and awareness programmes;
- encouraging the development of support groups for employees living with HIV/AIDS;
- extending bereavement counselling to families; and

• ensuring that employees were open about their HIV/AIDS status are not unfairly discriminated against of stigmatised.

5.6.7 Compulsory education and prevention programmes for all employees (including management) shall be undertaken during paid working hours at all workplaces, taking into account the languages spoken and levels of education/literacy at each workplace. Employees must be informed of the provisions of employment codes on HIV/AIDS and the rights and duties of employees.

5.6.8 Regarding operational duties, working areas and specialised training courses where there is a possibility of accidental exposure, first aid instruction shall be prominently displayed explaining the universal precautions that need to be followed when dealing with blood and other bodily fluids and other precautionary measures that should be undertaken. Effective training of employees must minimise any potential hazards. Safe working conditions must be promoted and appropriate protective equipment must be provided in all relevant workplaces such as client service centres, police vehicles and first aid kits. Employees must be educated to treat all situations as potentially hazardous where bodily Fluids are exposed.

5.7 Exposure in the workplace

5.7.1 The National Commissioner shall provide guidelines regarding the implementation of precautionary health and safety measures to minimise the risk of exposure to HIV.

5.7.2 The provisions of the Compensation for Occupational Injuries and Diseases Act and Occupational Health and Safety Act must be followed with regard to infection with HIV in the course and scope of an employee's duties in order that such infection may qualify as an injury on duty. Where an employee is exposes to possible infection in the performance of her/his duties, such employee should report the accident and submit to a medical test to determine her/his baseline HIV status without delay - notwithstanding that such test is entirely voluntary. Testing must be pre-authorised and the incident reported in terms of current provisions regarding injuries on duty.

5.7.3 If the employee was negative at the time of the accident, she/he should be re-tested at three and six month's intervals after the incident.

5.7.4 If she/he sero-converts during this period, an application for compensation may be made.

5.7.5 Any employee of the SA Police Service who, in the course of performing their duties, is exposed to HIV shall be offered access within 24 hours to anti-retroviral medication (post exposure prophylactics) to reduce the incidence of sero-conversion in exposed persons.

5.7.6 Post-exposure prophylactics shall be provided to the employee and according to the Procedure on Post-Exposure Prophylactics, which provides for pre- and post-HIV test Counselling and support.

5.8 ASSESSING THE IMPACT OF HIV/AIDS ON THE WORKPLACE

5.8.1 Appropriate strategies must be developed to understand, assess and respond to the impact of HIV/AIDS on the effective delivery of policing services.

5.8.2 Such impact assessment should include -

- Risk profiles;
- Assessment of the direct and indirect cost of HIV/AIDS.

5.8.3 Risk profiles must include an assessment of -

- The vulnerability of individual employees or categories of employees to HIV infection;
- Potential risks related to infection during the performance of operational services and
- And assessment of the impact of HIV/AIDS on continued service delivery.

5.8.4 The assessment should also consider the impact of the HIV/AIDS epidemic on-

- direct costs such as costs to employee benefits, medical costs and increased costs related to staff turnover such as training and recruitment and the cost of implementing an HIV/AIDS programme; and
- indirect costs such as costs incurred as a result of increased absenteeism, employee morbidity, loss of productivity, a general decline in workplace morale and possible workplace disruption.

5.9 Grievance and disciplinary procedures

5.9.1 No person may be unfairly discriminated against on the basis of their HIV/Aids status.
Employees living with HIV/AIDS shall be protected from any form of stigmatisation or discrimination.

5.9.2 Any contravention of the provisions of this policy shall amount to unfair discrimination and must be addressed through the appropriate dispute resolution procedures.

Discrimination against an employee on the basis of that employee's HIV/AIDS status amounts to misconduct and appropriate disciplinary steps must be taken.
The confidentiality of any employee regarding their HIV/AIDS status involved in any grievance or disciplinary process must be protected.

6. Implementation

6.1 The application of this policy must be done in conjunction with the application of related Employment practices and procedures.

6.2 This policy is dynamic and must be reviewed annually in terms of operational needs and the development of codes of good practice on key aspects of HIV/AIDS and employment.

6.3 Related programmes must be reviewed on a regular basis to ensure their continued relevance and effectiveness.

6.4 A comprehensive communication and marketing strategy must be introduced in support of these policy provisions and related programmes.

APPENDIX G

SAPS HIV/AIDS STRATEGIC PLAN

SOUTH AFRICAN POLICE SERVICE HIV/AIDS STRATEGIC PLAN 2007-2011

THE SOUTH AFRICAN POLICE SERVICE

FIVE YEAR STRATEGIC PLAN

TO COMBAT HIV/AIDS: 2007 - 2011

1. AIM

THE AIM OF THE FIVE-YEAR STRATEGIC PLAN IS TO COMBAT THE PANDEMIC OF HIV/AIDS IN THE SAPS

2. GOALS: 2007-2011

2.1 Marketing and promotion of the Wellness programme (Voluntary Counselling and Testing.)

2.2 Conduct an Actuarial/ assessments on the effects of HIV/AIDS and align the results with the Human Resource Strategies.

2.3 Update and sustain HIV&AIDS Awareness Programmes and promote Positive Living.

2.4 Promotion and sustenance of adequate care and support.

2.5 Building and sustaining partnerships with relevant stakeholders, e.g. DPSA, Dept of Health, Polmed, Metropolitan Health Group (MHG) and GEMS.

2.6 Encourage registration on the Disease Management Programme.

2.7 To enhance SAPS members' knowledge and adherence to the legal (Chapter two of the Bill of Rights of the Constitution of RSA Act 108 0f 1996) and the policy provisions.

3. SITUATIONAL ANALYSIS

The SAPS has gone past its initial milestone on the implementation of its first Five Year Strategic Plan on HIV/AIDS for the period 2000 - 2005. A number of objectives set in the year 2000 - 2005 strategic plan have been achieved with mixed degree of success. Whilst some objectives were fully achieved, others were only partially met. These are set out below:

- to mobilize and organize response networks;
- prevent new infections;
- react of HIV&AIDS;
- capacity building and maintenance of a HIV/AIDS budget within the SAPS; and
- Monitoring impact of HIV on Human Resource and institutionalization for losses.

The following deliverables are regarded as highlights for the outgoing 2000-2005 strategic plan:

- the formulation, approval and implementation of the SAPS HIV/AIDS Policy;
- peer education, awareness programmes, condom procurement and distribution and VCT programmes were successfully implemented to reduce the rate of new infections and to promote knowledge and positive attitude regarding HIV&AIDS;
- training of Master trainers and Educational Officers in order to create capacity building within the SAPS; a budget allocation of R10 million per annum and securing a ring fenced budget for
  HIV&AIDS with POLMED
  the launch of HIV&AIDS National and Provincial Forums;
  the launch of Voluntary Counselling and Testing (VCT) by the Minister of Safety and Security in 2003; and
- The VCT was subsequently rolled out to all Provinces and Divisions.

AIDS will have maximum impact on infected families of police officers and this might negatively affect the work performance of these employees. Projections of HIV&AIDS impact on POLMED over the period 2000 to 2015 indicated that the expected overall percentage of POLMED principal members infected with HIV, will increase from 8% in 2000 to 14% by 2015 (1 out of 7 members will be infected). Age-specific prevalence projections indicate that HIV prevalence amongst 25-29 years old and 30-34 years old is expected to increase from 15% to 17% in 2000 to approximately 35% and 45% respectively by 2015. The workforce in all provinces will be affected by HIV&AIDS. In 2000 the HIV prevalence is the highest in KwaZulu-Natal, Mpumalanga, the North West and the Eastern Cape. These provinces are likely to remain the worst infected during the time period under consideration.
The South African Police Service is now facing a new challenge of scaling up its response on HIV&AIDS pandemic while building on the successes that have been achieved during the past five years. The SAPS is equally committed to address the challenges of HIV/AIDS extensively and vigorously, hence the 2007 - 2011 Strategic Plan. The SAPS Five Year Strategic Plan is aimed at synchronizing goals and objectives through a number of programmes such as Awareness Campaigns, Voluntary Counselling and Testing and or Surveillance Testing, Peer Education, Support Groups, etc. The dynamic nature of HIV&AIDS and its management has resulted in a need to review the current strategy and make adaptations where there is a need

GOAL 1: Marketing and promotion of SAPS Wellness Programme (Voluntary Counselling and Testing)

STRATEGIC OBJECTIVE	KEY ACTIONS	RESPONSIBILITY	TARGET DATE
Increase the number of HIV/AIDS workplace stations with on-site counselling and testing services including mobile Wellness units.	Do an audit on the availability of the current resources and service providers to ensure the accessibility of Wellness on site and on Wheels services (VCT) to all SAPS personnel	Social Work Services.	September 2007ongoing to 2010

	Develop a strategy for identifying a professional and credible service provider to promote the utilization of a standardized Wellness programme	Social Work Services and Wellness Task Teams.	November 2007
	Establish Wellness sites at identified stations, areas etc. to enhance awareness.	Wellness task team together with Division: Supply Chain Management.	2007 - 2011
	Obtain, adjust and equip mobile units for utilization in the Provinces.	Social Work Services Wellness task team together with Division: Supply Chain Management and Tender process.	June 2007 to June 2008
	Development of and training in the Wellness strategy of providing services to immediate family members	SWS	November 2007
	Pilot Wellness on Wheels strategy to identified areas	EAS together with Task team.	May 2007 to March 2008
	Roll-out of strategy to all 9 provinces	Social Work Services together with Task team.	March 2008
	Aggressive marketing strategy to mobilize all internal and external sectors for the effective communication of the SAPS HIV&AIDS Workplace programme.	EAS together with the Component: Communication and Liaison.	Ongoing

GOAL 2: Continuous implementation of the SAPS HIV&AIDS workplace programme.

STRATEGIC OBJECTIVE	**KEY ACTIONS**	**RESPONSIBILITY**	**TARGET DATE**
Ensure that SAPS is continually updated with new trends, developments on HIV/AIDS in the workplace	To continue internet research to keep track with new developments in the HIV&AIDS terrain.	EAS.	Ongoing
	Interact with national and international HIV/AIDS organizations regarding sharing best practices	EAS.	Ongoing
	Align the workplace programme with new developments	EAS (Social Work Services)	Ongoing

	Establish a research room/library regarding info on HIV/AIDS as received at national and international conferences	EAS (Social Work Services)	Ongoing

GOAL 3: Conduct an Actuarial analyses/Assessment on the effect of HIV/AIDS in SAPS and align the results with HR Strategies.

STRATEGIC OBJECTIVE	KEY ACTIONS	RESPONSIBILITY	TARGET DATE
Assessment and data collection on the spread and impact of the pandemic in the SAPS.	Conduct a need analysis for the Actuarial Assessments as well as the availability of the service providers. Financial authority for conducting the assessments. Conducting the first phase of the assessments	Social Work Services with the assistance of Actuarial Society of South Africa 2002 (ASSA 2002). Social Work Services and Division: Supply Chain Management for the execution of the Tender Process.	October 2007 November 2007 March 2008
	Monitor and evaluate the impact of HIV/ AIDS in the SAPS through the analysis of internal information e.g. absenteeism, service termination, personnel moral in the workplace of the existing personnel responsible to accept more responsibilities as a result of absenteeism, direct and indirect cost implications of HIV/AIDS(SAPS) Discretionary Budget	Social Work Services, Psychological Services. HR Planning	2008-2011

	Utilise the statistics on HIV/AIDS to determine the number of personnel with HIV/AIDS per race, gender, age, level and occupational category. Determine the impact of HIV/AIDS on the supply and demand. Determine the impact of HIV/AIDS on the recruitment, promotion, appointment drives. Determine the impact of HIV/AIDS on the competency levels of SAPS and align the WPSP accordingly. Utilize the absenteeism statistics to determine the impact of HIV/AIDS on productivity/ representivity. Align the enlistment plan, Equity plan and distribution of personnel to business units to supplement losses within the MTEF cycle.	EAS Section Personnel Planning and Utilization Directorate HIV/AIDS Section Service Termination and Absenteeism Management Section Promotions and Senior Appointments Section Equity	2007/2011

GOAL 4: Update and sustain HIV/AIDS Awareness Programmes and promote Positive Living.

STRATEGIC OBJECTIVE	**KEY ACTIONS**	**RESPONSIBILITY**	**TARGET DATE**
4. Strengthen and enhance AIDS workplace programme in order to facilitate the reduction and prevention of new infections and promote positive living	Training of Senior Management of the SAPS (Levels 13 and up) with more focus on socioeconomic impact and risk management strategies to overcome or reduce these risks.	EAS, in consultation with National Occupational Safety Association (NOSA) and Division: Training.	2007-2011
	Training of middle managers (Levels 8-12) with focus on implementation of the SAPS HIV&AIDS policy in their respective workstations	EAS and Division: Supply Chain Management (SHE). Division Training.	2007 - 2011
	Increase HIV/AIDS awareness raising workshops, projects and Wellness (VCT) testing sites.	EAS and Division: Supply Chain Management and Section: Communication.	Ongoing
	Presentation of Positive Living workshops and seminars to reduce re-infections to those who are already infected	EAS.	Ongoing

	Facilitate small group discussions to address the existing gaps in knowledge, behavior, stigma and attitude towards HIV/AIDS	EAS.	Ongoing
	Ensure availability of adequately trained peer-educators in SAPS	Social Work Services and Division: Training.	2007 - 1:150 2009 - 1:100 2011 - 1:50
	Ensure continuous availability of condom dispensers and condoms in all SAPS buildings	Social Work Services and Division: Supply Chain Management.	Ongoing
	Mainstream HIV&AIDS information within the existing pro-active programmes to promote healthy lifestyle.	EAS.	Ongoing
	Enhance and sustain the master trainers and educational facilitators	EAS and Division: Training.	On going
	Integrate HIV/AIDS prevention strategies in Occupational Health and Risk management.	EAS and Division: Supply Chain Management (SHE).	Ongoing

GOAL 5: Promotion and sustenance of adequate care and support.

STRATEGIC OBJECTIVES	KEY ACTIONS	RESPONSIBILITIES	TARGET DATE
5. The implementation of a trustworthy and effective care and support service to the infected and affected employees, including their immediate families	Individual HIV/AIDS counselling to all infected and affected employees, including their immediate family members	EAS.	Ongoing
	Enhance and sustain the current support groups for infected and affected employees, including their immediate family members	EAS.	Ongoing
	Encourage the establishment of additional support groups in all Provinces and Head Office Divisions	EAS.	On going
	Determine the needs of the infected; link them with available resources in their communities such as Provincial Hospitals, Clinics and Hospices.	EAS.	Ongoing

	Establish palliative care services in order to prolong and enhance the life of the infected members and their immediate families.	Outsourcing.	Dec 2008

GOAL 6: Building and sustaining partnerships with relevant stakeholders, e.g. DPSA, Dept of Health, Polmed, Metropolitan Health Group (MHG).

STRATEGIC OBJECTIVE	KEY ACTIONS	RESPONSIBILITIES	TARGET DATES
6. Strengthen and sustain HIV/AIDS National and Provincial fora to enhance smooth collaboration and partnerships on strategic and operational issues e.g. DPSA, Dept of Health, POLMED MHG	Enhancement of roles and functions of the HIV/AIDS fora on all levels.	EAS	Ongoing
	Provide managers, supervisors, HIV/AIDS co-ordinators, union representatives with appropriate information and training to enable them to assess individual and group needs for educational interventions; and to carry out the expectations and mandates within the policy.	Social Work Services, National Forum and Division: Training.	Quarterly
	Conduct regular meetings to discuss strategic issues.	EAS and National Forum.	Bi-monthly
	Establish partnerships with other government Departments, Non-governmental departments, community based organizations and Faith base organizations	EAS.	Ongoing
	Strengthen the existing partnerships by attending meetings and attend conferences and workshops organized by other stake holders to enhance knowledge and share best practices.	EAS.	Ongoing

GOAL 7: Encourage registration on the Disease Management Programme.

STRATEGIC OBJECTIVE	KEY ACTIONS	RESPONSIBILITY	TARGET DATE

7.1 Promote and market Polmed and GEMS's Disease Management Programmes to the personnel.	Through marketing of the SAPS HIV&AIDS Policy, Wellness (VCT) and Awareness Programmes to motivate HIV+ members to register on the POLMED and GEMS Disease Management Programmes	Social Work Services Polmed MHG GEMS	Ongoing
7.2 To establish palliative care services in order to prolong and enhance the life of the infected	Monitor and evaluate the utilization of the programme and negotiate extended benefits with Polmed to cater for immune boosters and other related treatment services for Polmed members	Social Work Services and Psychological Services. HIV/AIDS National Forum.	Ongoing

GOAL 8 To enhance SAPS member's knowledge and adherence to the legal (chapter two of the Bill of Rights of the Constitution of RSA Act 108 of 1996) and the policy provisions.

STRATEGIC OBJECTIVE	KEY ACTIONS	RESPONSIBILITY	TARGET DATE
8.1 To empower the SAPS personnel and ensure their adherence to the existing legislation, the SAPS Workplace Policy on HIV&AIDS and the Occupational Health and Safety Act.	Adjust the current HIV&AIDS Awareness Programme to include all relevant legislation and prescripts.	Social Work Services	December 2007
	Identify the gaps in the existing HIV&AIDS Policy in terms of Human Relations elements.	Social Work Services in consultation with the Labour Unions and the Legal Division	March 2008
	Consultations with the Labour Unions concerning policy review.	Social Work Services	March 2008
	Policy reviewed and circulates for inputs.	Social Work Services Legal Division and the Labour Unions.	April 2008
	Policy finalized and distributed.	Task Team	May 2008
8.2 Ensure a supportive legal environment for the provision of HIV&AIDS services in the SAPS	Develop and distribute information on the rights to HIV prevention, treatment care and support that responds to special needs of the SAPS employees that are infected and affected with HIV&AIDS	Social Work Services	Ongoing

	To gather information on the available legal service providers in liaison with the SAPS Legal Services Division and develop a database to be accessed by employees.	Social Work SERVICES	April 2008

CONCLUSION

The HIV/AIDS strategic plan is a living document and therefore will be subject to a constant review and where necessary modification accordingly to accommodate the needs and goals of the Organization. Once again, it should be taken into consideration that HIV&AIDS strategy is essential process due to the rapidly changing nature of the epidemic, and should not be viewed merely as a process of identifying past errors and or inadequacies only. The effective implementation of the strategy will depend on the monitoring and evaluation of the activities as outlined in the strategy.