

**SOUTH AFRICAN POLICE SERVICE OFFICER'S PERCEPTIONS OF
HIV/AIDS FROM UMTATA CENTRAL POLICE STATION**

by

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DEDICATION

This research is dedicated to my late parents Thobela and Nomatshaka Titi who taught me values of rewarding hard work and for their loving upbringing; my brothers, Cameron, Loyiso, Siyabulela, Sibongile and Tandile for their support

and

To my family: Mcoseleli, Anda and Mila for their forbearance and support as I filled up the floors with reference materials and sat for so long reading and writing.

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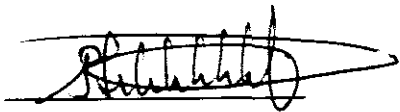
With gratitude I acknowledge the part played by Dr S. M. Seeletse for Statistical Analysis of the data.

I also wish to thank Dr M. T. Vambe for a skilled editing of my work.

My thanks extend to my husband Mcoseleli Dilaza for his continued support.

DECLARATION

I, Punyuzwa Titi, hereby declare that this dissertation "Perceptions of South African Police Service Officers towards HIV/AIDS: The Case Study of Mthatha Central Accountable Police Station towards HIV/AIDS" is my own unaided work. It is being submitted in partial fulfillment of the requirements for the degree of **MASTERS OF EDUCATION (EDUCATIONAL PSYCHOLOGY)** at the **UNIVERSITY OF ZULULAND**. It has not been submitted before, for any degree at any university or tertiary institution. *Sources that were consulted are acknowledged in the text just as the list of references.*



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Signed on the _____ of _____ 2007

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ABSTRACT

This study investigates the perceptions of South African Police Service officials towards HIV/AIDS at Mthatha Central Accounting Police Station towards HIV/AIDS. Selection of the respondents was done through stratified random sampling. Data was obtained from a sample of 115 police officials. These officials were of different ranks from the level of Constable up to that of the Director of the South African Police Service. Male respondents were in the majority, and Grade 12 was the dominant highest qualification amongst the police officials. The main research instrument was a questionnaire. The questionnaire had three sections: the first was compiling profile, the second poses closed-ended questions generally requiring "yes/no" responses, and the third asks open-ended questions requiring perceptions about HIV/AIDS. Collection of data was done through semi-structured interview schedule. Data were analysed using Excel where tables and graphs were used for closed-ended questions, while themes were formed in the analysis of open-ended questions. The findings of the study revealed that the police officials had different impressions about HIV/AIDS. Furthermore, police officials indicated that they would treat cases of HIV/AIDS differently and generally believe that condoms are not reliable.

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CHAPTER 1: INTRODUCTION

1.1 MOTIVATION FOR THE STUDY TO BE UNDERTAKEN

The main motivation for undertaking this study is to analyse South African Police Service officials' perceptions towards HIV/AIDS. Mthatha Accountable Police Station is used as the case study for the simple reason that the researcher is a Psychometrist and an Intern Psychologist working for the Department of South African Police Service in Mthatha. She is involved in the fight against Human Immuno Virus and Acquired Immuno Deficiency Syndrome (HIV/AIDS). The programme on HIV/AIDS was introduced to the South African Police Service in Mthatha by the office of Employee Assistance Services. The researcher is also interested in studying the perceptions of police officials working in Mthatha Central Accountable Police Station about the problem of HIV/AIDS in order to understand the source of the negative comments made by police officials about HIV/AIDS. This study will address the promotion of living a healthy lifestyle. This study intends to equip police officials with knowledge and skills to promote their well-being.

Van der Ryst, Joubert, Stein, Heunis, Le Roux and Williamson (2001) found that it is possible for a society to respond to HIV/AIDS as being foreign or specific to a race, culture or group. It is likely that attitudes to any disease can be negative and these negative attitudes may distort an individual's ability to think about a particular disease in a realistic way (De Villiers, 1992).

1.2 STATEMENT OF THE PROBLEM

The problem of HIV/AIDS has increased and it is one of the greatest threats to people. As HIV/AIDS infects more individuals, the number of police officials with HIV/AIDS will increase if they lack knowledge about HIV/AIDS. The ignorance of HIV/AIDS shows up

in the fears which people have as they try to come into terms with the disease (Campbell, 1996: 56).

In the work setting, fear about HIV/AIDS can generate negative behaviours such as discrimination of the co-worker with HIV/AIDS and anger (Journal of Public Health Policy 1994 Winter, 15 (4), p 460). It is important for the South African Police Service organization to be involved in corporate social responsibility within an HIV/AIDS perspective. The response to HIV/AIDS should be considered as a proactive approach. The South African Police Service as an organization should accept the responsibility for fighting against HIV/AIDS infection.

Police officials may be at greater risk of infection because of their lesser awareness of possible risks and misconceptions. Perceptions of police officials towards HIV/AIDS need to be explored. The assumption is that there is lack of knowledge about HIV/AIDS. In the Department of South African Police Services it is the duty of the Employee Assistance Services to implement effective programmes about HIV/AIDS. The present study tries to explore perceptions of police officials working in Mthatha Central Accountable Police Station towards HIV/AIDS.

Schoteich (2003) states that HIV/AIDS has an impact on the police and the capacity of the police to deliver an adequate service will be undermined as an increasing number of police officials succumb to the epidemic. The HIV/AIDS is a real threat to police members' ability to perform important functions effectively.

In the workplace, there may be injuries to workers whereby bleeding occurs and blood staining of clothes or tools may result. The possibility also exists that this blood may be infected with HIV. Many myths and misconceptions about HIV/AIDS in the workplace stem from an inadequate understanding of the true facts relating to the modes of spread of HIV.

There are many myths and misconceptions about HIV and because of these, individuals have tended to blame certain groups in our society for the disease, its spread and the misery it brings to families. As a result, people with HIV and AIDS have been at the receiving end of much discrimination and stigmatization. It is interesting to note that developing a concept of a high-risk group prompts others in society to distance themselves from the disease and feel safe from infection. This is clearly a dangerous attitude and the educational programmes should stress that the risk is to everyone. Fear and panic promotes and fuels the discriminatory and blame process. Ignorance and misunderstanding are the root causes of this fear and panic. For people with HIV and AIDS, the above issues can have devastating effects. These people are rejected by their colleagues and friends. For them, feelings of despair and alienation compound the already difficult problem of coping with the disease in general. There is no justification for discrimination against and blaming people for the HIV/AIDS epidemic. The problem of HIV/AIDS should be regarded as any other illness and people who are HIV positive or who have AIDS need empathy, warmth and caring. The many harmful attitudes described above will take a long time to fade. They are as prevalent in the workplace as anywhere (Clive, 1991).

1.3 AIMS / GOALS OF THE STUDY

The aims of this study are to:

- ◆ explore and analyse the perceptions of police officials working in Mthatha Central Accountable Police Station towards HIV/AIDS.
- ◆ explore the knowledge of police officers about HIV/AIDS.
- ◆ Recommend further proactive and intervention programmes to improve the awareness of the South African Police Service officers to the dangers of HIV/AIDS.

1.4 VALUE OF THE STUDY

The study of this nature is important because it can encourage the development of effective programs against HIV/AIDS. Education programmes can be effective in producing attitude change in police officials in relation to HIV/AIDS. Consequently, it is anticipated that the management of the Mthatha Central Accountable Police Station will take into kindness the findings and the recommendations of this study. It is important for the prevention of further spread of the virus and the disease. Although the study is based on South African Police Service official's Perceptions of HIV/AIDS, an extensive programme of evaluation is critical to measure the impact and improve the value of programmes if there is a need.

1.5 RESEARCH METHODOLOGY AND DESIGN

This study was conducted using both quantitative and qualitative methodology. A quantitative and qualitative study provides the opportunity for the investigator to describe and analyze individual's perceptions, actions, beliefs and thoughts (McMillian & Schumacher, 1997).

Due to the fact that police officials differ in ranks, stratified random sampling was used in the study. Stratified random sampling is a probability sampling procedure in which the population is first divided into strata, then sampling is conducted within each strata. Stratified random sampling is a useful technique when the investigator wants to make general statements about portions of the population that has been sampled (Shaughnessy & Zechmeister, 1990).

1.5.1 Procedure

The study was conducted on police officials working in Mthatha Central Accountable Police Station. Both males and females were included in the study. Police officials were divided according to their ranks. The investigator then selected every third police

official in the list for the study until equal sized samples of subjects from each rank are formed. The ages of subjects ranged from 21 to 60 years.

A semi-structured interview schedule was used in collecting data. Open-ended and closed- ended questions were asked. The semi-structured interview schedule sought to explore perceptions of police officials working in Mthatha Central Accountable Police Station towards HIV/AIDS.

The interview schedule covered the following themes:-

1. Biographical details
2. Knowledge about HIV/AIDS
3. Perceptions of police officials towards HIV/AIDS
4. Gender of the subject
5. Rank of the subject in the South African Police Service.

The investigator wrote a letter to seek permission to conduct the study from the Station Commissioner of Mthatha Central Accountable Police Station. Prior arrangements to conduct the interviews were made with the targeted respondents. These subjects were interviewed individually in their offices. Responses were written down in the spaces provided in the semi-structured interview schedule. Each interview took about 25 to 30 minutes. The subject's responses obtained during the investigation were kept both confidential and anonymous. An attempt was made to ask sensitive or embarrassing questions in a cautious manner. Personal interviews allowed the respondent to obtain clarification of unclear questions. The interviewer could ensure that most respondents complete the questionnaire in the same order (Shaughnessy & Zechmeister, 1990).

1.5.2 Results

Data were analyzed by frequency of occurrences and percentages and were presented in the form of tables and graphs. Frequency helps to systematize data and it is a simple and effective way to summarize the data. Percentages allow for easier comparison of results.

1.6 DEFINITION OF TERMS

The terms used commonly in this study are defined to clarify the context and bring about common understanding among the readers.

AIDS

It is the acronym for Acquired Immunodeficiency Syndrome, defined as the diagnosis given when a person has a certain set of symptoms which have resulted from damage to the human immune system caused by a virus known as HIV (the Human Immunodeficiency Virus (Aggleton, Rivers, Warwick & Whitty, 1994).

VIRUS

A clinical definition would describe a virus as a transmissible micro-organism that is responsible for a wide variety of human diseases with clinical presentations characteristic for each of the different viruses (Schoub, 1999).

CONDOM

It refers to a thin membrane tube, usually made from latex rubber, which covers the penis and prevents sperms from entering the vagina (Hubley, 1990).

IMMUNODEFICIENCY

This is a weakness in the human body's immune system which renders the body susceptible to infections and other disease conditions (Clive, 1991).

INCIDENCE

It is the number of new occurrences (infections) in a specified period of time, usually one calendar year (Muller, 2005).

STIGMA

It refers to prejudice and discrimination against a set of people who are regarded by others as being flawed, incapable, undesirable and who are treated in a negative way (Singhal & Rogers, 2003).

EPIDEMIC

It is an outbreak of a disease which spreads rapidly through a community (Clive, 1991).

SUSCEPTIBILITY TO HIV

It refers to the likelihood of an individual becoming infected with HIV and the likelihood of the spread of HIV infection within a country, a population group, an institution or at household level as determined by the interaction of a variety of societal attributes (Muller, 2005).

VULNERABILITY

It is the likelihood of significant physical, social and economic impact occurring at individual, household, community or societal level (Muller, 2005).

PREVALENCE

It refers to a pool of all infections at a given point in time, in the case of HIV/AIDS commonly measured as rate of infection among adult men and women aged 15 to 49 years (Muller, 2005).

POLICE OFFICIAL

It refers to any police official working at Mthatha Central Accountable Police Station from the rank of a Constable to the rank of a Director.

1.7 LAYOUT OF THE DISSERTATION

Chapter 1 justifies the study intentions, provided problem statement, defined aim and objectives, and outlined the anticipated contributions.

Chapter 2 presented the literature reviewed.

Chapter 3 presented the research methodology and design.

Chapter 4 presented the case study and discussed the study findings.

Chapter 5 closes with the study interpretations, recommendations and conclusions.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this chapter is to provide a review of literature on the perceptions towards Human Immuno Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS). Various findings by the various research reports on perceptions towards HIV/AIDS will be discussed. This chapter presents a theoretical and contextual foundation of the present study. Since this study is based on perceptions on HIV/AIDS, theoretical perspectives on perceptions towards HIV/AIDS will be examined in this chapter. A literature review will be conducted on perceptions about HIV/AIDS and also on topics related to the study.

2.2 PERCEPTIONS ABOUT HIV/AIDS

Schurink and Schurink (1990) state that public attitudes towards HIV/AIDS and individual perceptions are not shaped only by the media's sensational reporting of the subject or by awareness and educational campaigns, but also by individual beliefs on health matters. With regards to perceptions of people towards HIV/AIDS, they found that beliefs play an important role in people's attitudes and whether they regard themselves as being susceptible to the HIV and whether precautions should be taken to avoid contracting the disease.

These authors argues that the preventive care taken by a person to prevent a particular disease depends on his or her perception and recognition that he or she is personally susceptible and that the disease will have severe implications for him or her. Becker (in Schurink and Schurink, 1990) found that the perceived threat of HIV/AIDS does not provide sufficient motivation for preventive health action.

It has been stated that the idea of personal responsibility for preventive action depends on the individual's perceptions of the threat posed by the disease and this author also argues that if the threat of the disease remains high and if the individual believes he can still control his or her situation, he or she must weigh the perceived benefits of preventive action against the perceived costs.

The similarities in the findings of Becker (in Schurink and Schurink 1990) with those of Schurink and Schurink (1990) demonstrate the fact that the preventive care taken by a person to prevent HIV/AIDS infection depends on his or her perception and recognition that he and she is responsible for preventing and contracting the disease.

A finding similar to that of the same authors quoted above has been shown by Van Dyk (2003). He states that HIV/AIDS infection is perceived as related to social and economic factors such as culture, gender, level of education and lack of communication skills between partners with regard to the use of condoms during sexual intercourse. In a recent study of perceptions towards HIV/AIDS, these authors state that even more common is a kind of passive prejudice which label people with HIV/AIDS disease as if they were under an immediate death sentence.

It has been stated that in the Lebowa community, rumours are that HIV/AIDS was associated with local policemen who had brought it with them from Polokwane. A popular shebeen next to the police station was also associated with the disease, thus implicating both the policemen and the prostitutes who frequent it (Webb, 1997). In Mpolweni, HIV/AIDS was associated with prostitutes, in Durban and Polokwane it was associated with truck drivers, whose main route from the North passes some two kilometers from Lebowa.

De Villiers (1992) argues that perceptions give rise to patterns of behaviours which have implications for placing individuals at risk for treatment and for care of patients. With regards to HIV/AIDS, he suggested that it is necessary to determine perceptions of firstly, the disease because in some instances it is believed that HIV/AIDS was

introduced to South Africa by Whites in an attempt to reduce the population increase among Blacks.

To eliminate such misinformation will take time until people become aware that their chances of contracting the disease are primarily in their own hands.

De Villiers (1992) further views the above perception as complicating the implementation of risk-reduction education. He reported that the pathological aspects of HIV/AIDS infection indicate that both factors are typical of the progression of HIV/AIDS, which has the implication that an AIDS patient may consider the possibility of his condition being caused by witchcraft or sorcery. Such a view also is considered as having implications for treatment in that, conditions caused by witchcraft are generally not regarded as being responsive to biomedical treatment, and instead the patient will consult a non-Western practitioner for treatment.

Aggleton, Rivers, Warwick and Whitty (1994) found that although there are signs of improvements in some general attitudes towards people with HIV/AIDS, it is probably fair to say that what has been achieved is no more than the creation of safe havens where people with HIV/AIDS need not experience so directly the discrimination and harassment they encounter elsewhere. What could be described as medieval attitudes still prevail in many quarters with those affected being blamed for the health circumstances in which they find themselves (Aggleton et al., 1994a).

Aggleton et al. (1991b) state that attitudes to HIV/AIDS were generally negative among the groups in a study they conducted and also they found that HIV/AIDS was strongly associated with homosexuality and drug abuse.

On the other hand, they found that married women perceive HIV/AIDS as a disease that they have no power either to control or to run away from. These women directed blame at their husbands or men in general for bringing death into the bedroom. In their findings women were reported saying that they are unable to control men and

there is nothing they can do to stop the spread of HIV/AIDS infection. The women implied that it was through the behaviour of men that the disease is spread. In their findings, it has been stated that the problem of HIV/AIDS was also perceived as a disease that is related to social and economic environment.

In a study conducted by Kalipeni et al. (2004) the results show that behaviours that are labeled risky are shaped by the realities existing in the society and that the epidemic is spreading along the socio-economic fault lines. These authors also found the evidence that the spread of HIV/AIDS in Africa is a product of social factors upon which the virus has found a fertile ground. They argue that the extent of the problem varies from one society to the other, largely because the different societies are differentially susceptible to HIV/AIDS transmission. Results of the study that was conducted by the same authors show that people living with the pandemic see and explain it in a wider perspective that reflects the HIV/AIDS as a cross sectional issue rather than a narrow medical problem.

The same authors suggest that research and policies should address the problem of HIV/AIDS in a context that is similar to that perceived by those who live with it and, they argue that prevention efforts are likely to yield only partial success.

Where studies have involved the perceptions towards HIV/AIDS, the results have indicated that the findings of these authors are similar to the findings of Stark (in Kalipeni, 2004) who reported that the HIV/AIDS pandemic, just like many other diseases before is a social event.

Klouta and Gordon (1990) found that people believe that HIV/AIDS is a local disease caused by a spell out of an unfaithful woman by her jealous partner. They reported that people have fears, prejudices and beliefs about sexuality, risk, illness and death and these arise from the past experiences, present situations and culture. The same

authors suggest that people need to understand how feelings influence how they think about HIV/AIDS.

Singhal and Rogers (2003) showed that through an accident of history, HIV/AIDS became a disease of already stigmatized groups such as gay men, commercial sex workers and injecting drug users. In a recent study they revealed that gay men, commercial sex workers and injecting drug users were found to be heavily stigmatized by society and this prejudice was carried over and strengthened when such individuals became identified as carriers of HIV/AIDS. They found that the double stigma of HIV/AIDS stemmed from the identification of HIV/AIDS as a serious illness and from the identification of HIV/AIDS with already stigmatized groups.

According to Wiener (in Singhal and Rogers, 2003) in a study that was conducted in America, the results show that fifty percent of the Americans agreed that most people with HIV/AIDS have themselves to blame. The same author also found that those who contract HIV/AIDS through a behaviour that is controllable (for example, through commercial sex work or sharing needles) were perceived as guilty and hence assigned more blame, receive less sympathy and face more anger than those who were perceived as innocent victims (for example, individuals infected while receiving a blood transfusion).

The same authors found that personal characteristics associated the epidemic with people who were already perceived negatively, creating and strengthening the stigma of HIV/AIDS.

It has also been shown that another important reason for the stigma attached to HIV/AIDS, based in large part on ignorance of the means of transmission is a common fear that by associating with people living with HIV/AIDS, individuals might put themselves at risk. Such fear of infection, even among people who know and understand the actual means of transmission may be based on an irrational reaction.

It was discovered by the same authors that the lethal nature of HIV/AIDS undoubtedly raises the level of fear.

Singhal and Rogers (2003) state that only providing knowledge about the means of virus transmission, as social psychologists of prejudice have found, is seldom sufficient to change such strongly held attitudes as stigma. They argue that prejudice and discrimination are emotional matters and are not based on facts alone. A recent study by the same authors has revealed that in Columbia, a 2001 national health survey revealed that sixty percent of women had positive attitudes towards people living with HIV/AIDS. They also found that eighty five percent of the respondents in their study felt that HIV positive people should not have sex even with condom protection. It was their suggestion that interventions to overcome the stigma of HIV/AIDS must attack emotionally-based, strongly held attitudes and behaviours. The same authors argue that HIV/AIDS is a disease of ignorance and intolerance and HIV - positive people are often defined by the people as "the other" and they are treated accordingly as an out-group.

With regard to perceptions of people towards HIV/AIDS, they reported that a center for HIV-positive people was opened in Bangkok and the community opposed its establishment. The residents expressed fear about the centre's water and garbage disposal, fearing that HIV/AIDS infection might spread via these means. Shots were fired into the building and they were followed by verbal abuse, intimidation and bomb attacks. After nine months of operation, the center closed its doors to people living with HIV/AIDS and the local government ordered the center to move out of the community. They argued that in the case of this center, increased knowledge about HIV/AIDS transmission might have lessened the stigma but it was more a matter of irrational fear than ignorance.

Singhal and Rogers (2003) reported that there was a sad case of Gugu Dlamini, a young woman living in a Durban township in South Africa who was stoned and

stabbed to death after she declared her HIV-status in a radio broadcast on world AIDS Day in 1998. The same authors also reported a case of a little four year old girl that was rejected for admission because she was HIV positive at a Jesuit School in Sao Paulo. Her parents sued the school and won the case.

Singhal and Rogers (2003) argue that HIV/AIDS stigma evokes negative reactions such as denial, shame, fear, anger, prejudice and discrimination that manifest them in interpersonal and group relationships and they suggested that communication strategies need to be at the heart of all efforts to overcome the stigma of HIV/AIDS.

A recent study by Singhal and Rogers (2003) reveal that a sample of the audience in Nalamdana's drama's was asked whether mosquito bites could transmit HIV and the individuals with the lowest levels of formal education increased their knowledge of HIV/AIDS transmission. The increased knowledge was found to be a result of Nalamdana's shows. Both of them reported that self-reported attitudes towards people living with HIV/AIDS improved, showing that the Nalamdana's drama decreased stigma.

With regard to perceptions towards HIV/AIDS and cultural beliefs, they found that certain cultural beliefs in Zambia encouraged the epidemic. For example, it has been reported that when a married man dies, his widow must cleanse herself of his spirit by having sexual intercourse with one of her late husband's brothers or other male relatives. Singhal and Rogers (2003) found that this traditional belief about the purification is particularly dangerous in spreading HIV/AIDS infection because if the husband died from HIV/AIDS and his widow is HIV positive, she may infect his brother or other male relative who may in turn infect his wife and future children.

A similar cultural belief among the Luo in Kenya was reported by the same authors and they argue that it is thought to be one reason for the extremely high rates of HIV/AIDS among the ethnic group that live along the banks of Lake Victoria. These

authors found that in Zambia, people expressed a high degree of stigma towards HIV-positive individuals. According to them the strength of the stigma attached to HIV/AIDS inhibited people from taking HIV tests or from providing information about their sero-positive status to the survey interviewers. Where samples have involved samples containing large numbers of people from Zambia the results have indicated that many Zambians, especially women who perceive that they were at risk felt that they were helpless to prevent infection. The same authors for instance found that some of the women did not believe they could negotiate with their husbands or partners. Their general finding that people have no control over HIV/AIDS and the belief that they do not have power to communicate and negotiate condom use is supported by Aggleton, Hart and Davies (1991), Webb (1997) and Van Dyk (2007).

These authors in the study of perceptions towards HIV/AIDS discovered that almost sixty percent of the respondents felt that reducing their number of sexual partners was ineffective in preventing HIV/AIDS and also they found that thirty percent of adult Zambians thought that HIV was transmitted by witchcraft.

According to Paiva (in Singhal and Rogers, 2003) HIV/AIDS is perceived as a life threatening disease that is to be feared and it results from the promiscuous and deviant behaviours of the high-risk groups. Singhal and Rogers (2003) reported that Thai people view HIV/AIDS – afflicted people with pity and think they are bad or promiscuous and they reported that in every nation and among the members of every culture, the stigmatization of people living with HIV/AIDS is a severe problem.

With regard to how people perceive HIV/AIDS, the same authors argue that no illness in the history of humankind has generated such a strong stigma as has HIV/AIDS with the possible exception of leprosy in Biblical times. They found that the stigma associated with HIV/AIDS has interfered with the gathering of accurate information about the extent of the infection and it is a barrier to prevention programs. According to these authors the stigma inhibits effective testing and counseling and in many

cases it interferes with effective treatment and care. Singhal and Rogers (2003) suggest that a fundamental step is to realize that HIV/AIDS epidemic is not just a biomedical and health problem and they view it as representing a political, cultural and a socio-economic problem. With regards to behaviour change, they found that behaviour change communication can help to address and possibly solve the problem. In another study of the perceptions of people towards HIV/AIDS, the same authors found that stigma is everywhere. For example, at an international conference on HIV/AIDS and African Children held at Ohio University in April 2002, a participant shared with the audience the plight of a fourth grade student in a Soweto school on the outskirts of Johannesburg. The student was an AIDS orphan and her friends were laughing at her because her parents died of AIDS. This shows how the society stigmatizes those afflicted and those affected by it, including orphaned children. This is confirmed by many people in many countries in Sub-Saharan Africa where a woman who does not breastfeed her baby is assumed by her neighbours to be HIV infected. They shun her due to the stigma of HIV/AIDS. The self-organization of people living with HIV/AIDS to combat stigma is seen as a promising strategy.

This implies that people living with HIV/AIDS are stigmatized because it became a disease of already stigmatized groups. In the initial era of the epidemic in most countries, HIV infection spread through sexual networks of gay men, commercial sex workers and injecting drug users. These marginalized groups were already heavily stigmatized by the society and this prejudice was carried over and strengthened when such individuals became identified as carriers of HIV/AIDS. Therefore this double stigma stemmed from the identification of HIV/AIDS with already stigmatized groups. (Singhal & Rogers, 2003).

McKeganey and Barnard (1993) state that it is impossible to overstate the sense of fear, which HIV/AIDS generated amongst the overwhelming majority of drug injectors they contacted. These authors reported that many people described themselves as

feeling paranoid at anything having to do with HIV/AIDS. Therefore, such feelings led some people deliberately to avoid any information relating to HIV/AIDS.

They found that for some people the fear of HIV/AIDS has led them to avoid even discussing the disease with friends and family. With regard to knowledge about HIV/AIDS, they reported that while most people seemed to have an accurate knowledge of how the virus is transmitted, their attitudes also seemed to have been shaped in part by possibly apocryphal stories of deliberate revenge infection.

Van der Ryst, Joubert, Steyn, Heunis, le Roux and Williamson (2001) in the study of assessment of the level of HIV – related knowledge, as well as high-risk behaviour and attitudes towards HIV in a group of South African National Defence Force recruits found that some of the respondents indicated that they did not believe that HIV/AIDS exist and other respondents were found to be uncertain. The same authors found that the most prevalent misconception was that HIV/AIDS, could be cured and they also found that six percent of the respondents felt that HIV/AIDS could not be prevented by condom use.

With regard to transmission of HIV/AIDS, they found that the majority of the respondents in the survey indicated that they know what HIV/AIDS is, which explains the majority's indication that HIV/AIDS has influenced their attitudes towards sex and has led to behaviour change and they discovered that fear of HIV/AIDS is an important factor in changing attitudes towards sex. Such fear is seen as an automatic response and it is related to the perceived threat of contracting the virus.

Van der Ryst et al. (2001) found that many negative perceptions about the use of condoms were found to exist although condom use remains one of the most important preventive measures. In the results of the survey it is indicated that attitudes towards condoms and risk activities influence their practical use. Results of the study show

that some more attitudes and beliefs of the respondents are still based on ignorance and possible fear.

The same authors, Van der Ryst et al. (2001) reported that attitudes towards HIV/AIDS have not changed much as a result and it is especially the infected person who suffers the consequences of ungrounded fears and stigmatization.

A recent study of HIV-related knowledge, as well as high-risk behaviour and attitudes towards HIV/AIDS showed that one-quarter of the respondents stated that they were not willing to live in the same house with a person who has HIV/AIDS. However, a lower percentage indicated that people with HIV/AIDS should be kept in isolation. A high percentage of the respondents stated that people with HIV/AIDS should not have the right to normal sex lives.

2.3 KNOWLEDGE OF HIV/AIDS AND CHANGING ATTITUDES

Nyamati, Bennett, Leake, Lewis and Flaskerud (1993) found that there were differences in HIV/AIDS knowledge and attitudes based on race, education and cultural background. Nyamati et al. (1993) state that people showed a greater number of misconceptions about the transmission of HIV/AIDS. Other people were found not to be aware that healthy people could be HIV infected. Although awareness of HIV transmission through sexual contact, needle sharing and breastfeeding was found to be high among other people, misconceptions relating to the fear of HIV /AIDS transmission through casual contact were found to be prevalent. This was found to be particularly true in a study of low acculturated Hispanics.

Gellert, Maxwell, Higgins and Barnard (1994) in a survey on knowledge and attitudes of police officials in United States of America towards HIV/AIDS found that respondents had accurate knowledge about HIV/AIDS but several perceptions about HIV/AIDS were found to exist. Gellert et al. (1994) stated that a substantial proportion

believed that HIV/AIDS could be contracted from casual contact. These authors found that self-assessment of HIV/AIDS risk was medium to high risk in one-third of respondents and was largely attributable to fear of occupational exposure.

Kalipeni, Craddock, Oppong, and Ghosh (2004) analyzed the perspectives of the people affected by HIV /AIDS in order to understand the context in which the epidemic occurs. The same authors found that the way local people talk about the epidemic reflects their perceptions and definition of the pandemic and it shows not only the way they perceive the epidemic but more importantly the way they live with it.

It implies the way behaviours are negotiated, risks are taken or avoided, care given to the sick, funerals are organized and consequences mitigated or not. Kalipeni et al. (2004) state that the analysis of the language of HIV / AIDS as coined and used by the lay people is very relevant in the understanding, control and mitigation of the epidemic and it helps in the understanding of the social construction of the epidemic. Kalipeni et al. (2004) found that the social construction of the disease is understood as a product of institutionalization. With regard to HIV/AIDS, Kalipeni et al. (2004) reported that differences in perception of the epidemic by different social categories of people (based on gender, class, age and ethnicity) should not be that surprising and as discussed shortly, the scientific discourse of HIV/AIDS is quite different from the lay discourse of the same epidemic.

Secondly, the analysis of the language of HIV/AIDS as coined and used by lay people, according to Kalipeni et al. (2004) is useful in predetermining response because the way people respond to a phenomenon is mostly foreclosed by what they make it and how they perceive it. Kalipeni and fellow researchers reported that in the context of HIV/AIDS, people of different cultural backgrounds have responded to the epidemic in the way that makes sense to them. In the way they define the epidemic, they found that presently, there is little if any exchange of ideas between the scientific perception of the epidemic and they lay perception.

With regards to language, the same authors, Kalipeni et al. (2004) found that language like society, is organic and dynamic and that the lay language of HIV /AIDS has been changing over time to reflect either the lay-defined risk environment or both. Therefore, they reported that the time dimension is an important aspect in the analysis of people's perspective of the epidemic as old terminology becomes modified or discarded as a result of changing perceptions conditioned by changing terms.

In another study that was conducted in Tanzania by Kalipeni et al. (2004) it was found that the term HIV/AIDS is widely known to the people living in the Buhaya Village. In that village, a variety of locally coined terms and euphemisms were found to be used and they reflected changes in the perception of HIV/AIDS over time. According to the findings of these authors, the HIV/AIDS was perceived as the exterminator of human beings and it was also perceived as the disease that deprives parents of their children. Also the HIV/AIDS was seen as the disease that is exposing the elderly to insecurity in their old age because under normal circumstances elderly parents are cared for by their adult children.

2.4 HIV/AIDS AND SOCIO-ECONOMIC STATUS

It has been stated that socio-economic factors are the key determinants of the differences in the perception of the epidemic within the communities and they also found that women and men, the young and the old have different perspectives of HIV/AIDS.

In another study of the perceptions of people towards HIV/AIDS. Van Dyk (2003) has similar findings with Kalipeni et al. (2004) where it has been reported that socio-economic factors are the key determinants of differences in the perception of HIV/AIDS.

It was found that the age differences have a bearing on how individuals define risk environment and take risks and these authors also found that the same is true in respect of gender because men and women have different constructions of the epidemic that are mainly based on their gendered socialization, occupations, access to social and economic resources and information on HIV/AIDS.

2.5 MISCONCEPTIONS ABOUT HIV/AIDS

In a study that was conducted in Kenya and Tanzania, Kalipeni et al. (2004) found that local construction of the epidemic contains some myths, inaccuracies and misinformation and it was suggested that inaccuracies, misinformation and myths need to be corrected and demystified. In those studies, the perspectives of people living with HIV/AIDS in Kenya and Tanzania were described and analyzed. Kalipeni et al. (2004) found that it became apparent that there was a gap between the professionals and the lay explanations of the epidemic. With regards to the perceptions, Kalipeni et al. (2004) thought that it was necessary to collect information pertaining to lay explanation of HIV/AIDS in different localities for their study. The results of the study that was conducted reveal that HIV/AIDS was viewed as a disorder of social relations and that sexual behaviour and the risk taking were found to be related from such relations.

Studies by Van Dyk (2007) have shown that witchcraft is believed by some to be the casual agent in HIV/AIDS transmission in many African countries, especially among the rural poor or people with least education. This finding has been reported also by Klouda and Gordon (1990), Kalipeni et al. (2004) and Singhal and Rogers (2003). Van Dyk (2007) states that the belief that everything that happens to a person can be attributed to external, supernatural beings or powers implies that individuals cannot be held responsible or accountable for their own behaviour. This finding has been confirmed by Boaheme (in Van Dyk, 2003) who also found that many people in Africa do not consider their own behaviour as a possible reason for contracting HIV/AIDS

infection and this misconception can cause them not to appreciate the need for using HIV-preventive methods.

Van Dyk (2003) found that there are some truly horrifying myths circulating in some communities about how to avoid HIV/AIDS infection. In a recent study of perceptions towards HIV/AIDS, he found that some people mistakenly believe that they will not get HIV/AIDS or that HIV/AIDS can actually be cured if they have sex with very fat women who do not have the HIV/ AIDS disease or virgins or girls younger than twelve years of age. The same author states that beliefs such as these can be the cause of abhorrent criminal behaviour and can also cause HIV/AIDS infection to spread like wildfire.

With regard to the relationship between the spread of HIV/AIDS and socio-economic status (Singhal and Rogers, 2003) reported that in later eras of the epidemic in each country, people living with HIV/AIDS were perceived as people of lower socio-economic status. A similar finding has been reported by Kalipeni et al. (2004) and also it has been reported by Stark in Kalipeni et al. (2004) that there is a relationship between the lower socio-economic status and the spread of HIV/AIDS.

One of the outstanding misconceptions is that HIV/AIDS affects only gay men and other high-risk people such as sex workers and drug users. Also many incorrectly believe that the disease affects only black or only white people. It has been found that many of the misconceptions exist in the workplace (Clive, 1991).

2.6 HIV/AIDS AND STIGMA

Van der Ryst et al. (2001) argue that the HIV/AIDS stigma exist around the world in a variety of ways including ostracism, rejection, discrimination and avoidance of the HIV infected people, compulsory HIV testing without prior consent or protection of confidentiality, violence against HIV infected individuals or people who are perceived

to be infected with the HIV/AIDS and the isolation of HIV infected individuals. In a recent study of HIV/AIDS knowledge and high-risk behaviour and attitudes towards HIV/AIDS they found that stigma-related violence or the fear of violence prevents many people from seeking HIV testing, returning for their results or securing treatment possibly turning what could be a manageable chronic illness into a death sentence and perpetuating the spread of HIV/AIDS.

Again, Van der Ryst et al. (2001) stated that the HIV/AIDS stigma has been further divided into three categories. The first category is the instrumental HIV/AIDS stigma that refers to a reflection of the fear and apprehension that is likely to be associated with any deadly and transmissible illness. The second category is the symbolic HIV/AIDS stigma that refers to the use of HIV/AIDS to express attitudes towards the social groups or lifestyles perceived to be associated with the disease. The third category is courtesy HIV/AIDS stigma that refers to stigmatization of people connected to the issue of HIV/AIDS or HIV-positive people.

These same authors reported that often, HIV/AIDS stigma is expressed in conjunction with the one or more other stigmas, particularly those associated with homosexuality, bisexuality, promiscuity and intravenous drug use. According to Van der Ryst et al. (2001) in many developed countries, there is an association between HIV/AIDS and homosexuality or bisexuality and this association is correlated with higher levels of sexual prejudice such as anti-homosexual attitudes. In a recent study of knowledge as well as high-risk behaviour and attitudes towards HIV/AIDS they found that there is also a perceived association between all male-male sexual behaviour and HIV/AIDS, even sex between two uninfected men.

Cummings, Gobin, Narine, Ramlall, Parsram, Glasglow, Reddy and Chee (2006) in a study of attitudes and perceptions among medical practitioners, nurses and the general population towards persons affected with HIV/AIDS found that generally there is still a lot of stigma and discrimination towards people infected with HIV/AIDS.

Cummings et al. (2001) also found that there is still a perception that HIV/AIDS can be cured by having sex with a virgin, using traditional medicine and that HIV/AIDS is more common among certain ethnic groups. This finding has also been shown by Singhal and Rogers (2003).

They reported that fear of being stigmatized by one's HIV status or perceived HIV status appears to have at least some relationship to people's decisions about whether or not to get tested for HIV/AIDS. In the results of the study that was conducted by these authors it is reported that some of the respondents felt that if they were to be tested for HIV/AIDS, people they know would think less of them.

In 1994, a little less than half (forty five percent) said that there was a lot of discrimination, an additional thirty eight percent of the respondents said that they think there has been some discrimination against people with HIV/AIDS. It has been reported as interesting to note that the forty five percent of the people who said that there is a lot of discrimination against people with HIV/AIDS remained virtually the same over the twenty year period from 1986 to 2006.

In addition to discrimination against people with HIV/AIDS, Cummings et al. (2006) reported that in the early years of the epidemic, many people indicated that they believe that the fear of HIV/AIDS was causing unfair discrimination against all gays and lesbians. In 2006, about seven in ten people reported that they would be comfortable working with someone who is infected with the HIV/AIDS. Lingering misconceptions about how HIV/AIDS is transmitted were found to be a contributing factor to prejudice against HIV-positive individuals and the people with misconception were found to be more likely to express discomfort about working with someone who has HIV/AIDS than those who know that HIV/AIDS cannot be transmitted in these ways. With regard to perceptions of HIV/AIDS, they found that the results of the study show that there is a relationship between stigma and HIV testing. These authors

reported that fear of being stigmatized by HIV/AIDS was found to have at least some relationship to people's decisions about whether or not to get tested for HIV/AIDS.

Van Dyk (2007) argues that HIV/AIDS related stigma and discrimination remain the greatest obstacles to people living with HIV/AIDS infection. Stigma and discrimination increase people's vulnerability, isolate them, deprive them of their basic human rights, care and support and worsen the impact of infection. Stigma and concerns about discrimination are the main reasons why people do not come forward to have an HIV test, to access antiretroviral drugs, to adopt safe feeding methods for their babies or to change high-risk sexual behaviour. But stigma and discrimination do not arise in a vacuum. They emerge from and reinforce other stereotypes, prejudices and social inequalities relating to gender, nationality, ethnicity and sexuality.

It was discovered that in few other areas, such victim blaming still occurs and also they found that it is easy for self-blame to develop, leading to lowered self-esteem and further health problems.

Ng'weshemi, Boerma, Bennet and Schapink (1997) argue that people's behaviours that lead to infection of HIV/AIDS provoke social, moral judgments and discrimination against those that are infected. Ng'weshemi et al. (1997) found that irrational fears of becoming infected through social contact or through caring for the sick person may lead to ostracism and isolation of the infected person by family members or the surrounding community and the health care workers. With regard to HIV/AIDS the same authors described it as a condition associated with emotions of psychosocial distress, denial, blaming others for the infection and feelings of hopelessness about the future.

Fear and discriminatory control measures drive HIV/AIDS even further underground, increasing stigma and making both HIV/AIDS prevention and support for patients and their families far harder to achieve. Stigma occurs because HIV/AIDS has long been associated with sex, blood, death, disease and behaviours that may be illegal or

perceived as immoral such as pre-marital sex, extra-marital sex, sex work, men having sex with men and injecting drug use. In addition to stigma itself, HIV/AIDS poses genuinely difficult issues around the rights of people with HIV, the rights of those without and the rights of those whose status is unknown. An extreme example was the proposal of segregating people with HIV/AIDS by Prince Tfohlongwane of Swaziland. This proves that stigma and discrimination remain problems in many countries (Jackson, 2002).

2.8 HIV/AIDS AND BEHAVIOUR CHANGE

According to Van Dyk (2007) the intention to change sexual behaviour (by using condoms, for instance) depends on a person's attitudes towards that particular behaviour (for example, condom use). He argues that if people truly believe that condoms will have a positive outcome for them, the probability that they will actually use them will be much greater. However, if they feel negative about using condoms (or find the use of condoms problematic, for whatever reason), a great deal of explanation, negotiation and persuasion may be required before they will actually use condoms. Behaviour change can be predicted more accurately by considering attitudes to alternative courses of action.

Van Dyk (2007) argues that for predictions based on attitudes to be accurate, we must also know what a person's attitude is to all alternative forms of behaviour. He identified low self-efficacy that has been identified by many researchers as an obstacle to sexual behaviour change. Low self-esteem has been found to correlate positively with high-risk sexual behaviour practices, an unwillingness to change behaviour and with relapses from low to high-risk behaviour. On the other hand, the same author found that subjects who were categorized as being in the lowest category of risk for HIV/AIDS infection generated the highest self-efficacy scores. He suggests that the person's belief in his or her ability to use a condom and to discuss condom use with partners should also be reinforced.

This author reported that researchers found that the intention to change behaviour, along with the perception that the behaviour can be controlled significantly increased the probability that behaviour could be changed for the better. This implies that the chances that a person will change his or her behaviour by using condoms are much better if that person forms a strong intention to use condoms and also demonstrate a favourable attitude towards condom use. He also regarded a high level of self-efficacy and a perception that a person can control behaviour is regarded as important in behaviour change.

2.9 OBSTACLES TO BEHAVIOR CHANGE

Van Dyk (2007) reported that research into the prevention of HIV infection identified the following factors as obstacles that hindered sexual behaviour change.

- People abandon all attempts to use condoms if they find it stressful to initiate or to maintain the behaviour.
- Society's intolerance towards certain sex practices and safer sex makes it more difficult for people to change their behaviour.
- Unsupportive sex partners and peers led to the abandonment of all attempts at safer sex.
- Research found that people often do not use condoms because they do not want to offend their sex partners because their sex partners do not like condoms or they are afraid that the partner will leave them. Partners refuse to use condoms because it feels different and because of the stigma attached to the use of condoms. Condoms are often associated with unfaithfulness and family planning.
- People find it difficult to handle a partner's refusal to use condoms.

The lack of communication skills is one of the greatest obstacles in the way of behaviour change. People find it difficult to ask partners to use condoms, especially, if they do not know the partner well. They are also afraid that the partner may think that

they have HIV/AIDS. Women in many cases do not have the power to negotiate condom use with their husbands or partners. It was also found that women perceived condom use in marriage as doing an abortion.

In a Zimbabwean study of perceptions of students towards condoms, Van Dyk (2003) found that the students reported that condoms are inaccessible. The inability to communicate with their partners regarding condom use was found to be another obstacle. Also the students reported that they have problems with storing condoms.

He also found that the use of alcohol and recreational drugs diminishes the power of individuals to make responsible decisions and the subjects who had often used condoms in the past reported that they often had sex without condoms when they were under the influence of alcohol or drugs. With regard to the availability and accessibility of condoms, the same author found that people, especially young people, do not use condoms if they are not readily available and they are either ashamed to ask for condoms over the counter or they do not have money to buy them. Cultural norms and religious beliefs were found not conducive to condom use. Van Dyk (2003) reported that condoms have not been popular everywhere in Africa.

In a study of condom promotion and distribution, Nyonyo and Schapink (in Ng'weshemi et al. (1997) found that there were obstacles to condom use and these include personal dislike of condoms by men and women, the association of condoms with promiscuity, the lack of negotiation power of women, religious opposition, misconceptions on the effectiveness of condoms and the link between risk-taking behaviour and alcohol abuse. These findings are similar with findings of Van Dyk 2003, Taylor (in van Dyk, 2007), Webb 1997, Aggleton et al. (1994) and Kalipeni et al. (2004).

2.10 ATTITUDES AND BELIEFS TOWARDS VOLUNTARY COUNSELING AND TESTING

In a South African Voluntary Counselling and Testing study (Van Dyk, 2003) found that psychosocial barriers to voluntary HIV counselling and testing that the participants expressed their needs, attitudes and beliefs about VCT as follows:

- They felt that they had no treatment options.
- They feared prejudice and rejection by loved ones, health care workers and the community.
- They believed that knowledge of their HIV status would lead to depression, despair and an early death.

Of those who were prepared to go for Voluntary Counselling and Testing the same author reported that they said that they would go only to a clinic, hospital or doctor where absolutely nobody knew them. The main reasons being:

- Lack of trust in the health care system.
- Fear that confidentiality will not be observed and
- Fear of prejudice and rejection by health care professionals and by loved ones.

With regard to attitudes to disclosure, Van Dyk (2007) reported that eighty-four percent of the participants reported that they would disclose their HIV-positive status but not necessarily to sex partners and sixteen percent said that they would keep their results secret. Thirteen percent of married participants and mainly men indicated that they would keep their results secret. It was noted that fear of rejection was the main reason for both men and women for not being prepared to inform sex partners.

The same author discovered that the source of fear was different for men and women and it was also found that while women's fears were based on powerlessness, loss of security and the possibility of violence, men most feared the loss of their sexuality and sex appeal to women. Men also feared that nobody would take care of them

when they were sick. Similar findings has also been reported by Kalipeni et al. (2004), Singhal and Rogers (2003) and Klouda and Gordon (1990)

2.11 USE OF CONDOMS AS A METHOD OF PREVENTING HIV/AIDS

With regard to cultural reasons for not using condoms, (Taylor in Van Dyk, 2003) found that the resistance to condom use in Rwanda had nothing to do with ignorance, but with a very specific social and cultural dimension of Rwandan sexuality. For example, many Rwandans were found to believe that the flow of fluids involved in sexual intercourse and reproduction represents the exchange of gifts of self which they regard as being of the utmost importance in a relationship. Therefore, the use of condoms is thought to block this vital flow between two partners, and such a blockage is seen as preventing fertility and also causing all sorts of illnesses.

Taylor (in Van Dyk, 2003) also found that many Rwandan women fear that the condom might remain in the vagina and they therefore risk becoming blocked beings. Zazayokwe (in Van Dyk, 2003) has similar findings with Taylor (in Van Dyk, 2003) in their studies and he found that some women in South Africa expressed similar fears because they were afraid to use condoms due to the belief that the condom might remain behind in the vagina and eventually suffocate them by moving through the body to the throat. This misconception was ascribed to a lack of basic anatomical knowledge and was corrected by explaining the reproductive system to the women with the aid of models. With regard to the misconception that condoms prevent the ripening of the fetus, the same authors found that there is a widespread belief in many parts of Africa that repeated contributions of semen are needed to form or ripen the growing fetus in the womb.

One of the objections often raised against condoms is that condoms are not natural, not only because they inhibit pleasure, but also because they interfere in the process of natural fetal development. Many people believed that semen contains important

nutrients necessary for the continued physical and mental health, beauty and future fertility of women.

It was found that although HIV/AIDS awareness was reasonably high in Uganda as far back as 1993, and although millions of condoms had been distributed, only about three percent of Ugandan men were regularly using condoms. Taylor (in Van Dyk, 2007) has similar findings. In a recent study of attitudes of the people of Rwanda towards condoms he found that although the people of Rwanda were well informed about HIV/AIDS and had modified their sexual behaviour on the basis of their perceptions, none of the people in his study reported that they are using condoms.

Apart from social and political problems, the same author found that there are deep-rooted cultural beliefs against the use of condoms in some parts of Africa. Scott and Mercer (in Van Dyk, 2007) suggested that the challenge is not to condemn Africa but to make the hidden cultural logic behind the resistance to condoms known and thereafter find ways to work with or around it.

2.12 TRANSMISSION OF HIV/AIDS

Webb (1997) reported that in a study that was conducted in Southern Africa, respondents' comments indicate the community perception of multi-partnering behaviour. He also reported that people do not stick to one partner. With regard to alcohol and drug abuse, Webb (1997) found that alcohol and drug abuse have been linked to HIV/AIDS transmission in that unsafe sexual activity is increased by their use. In a study that was conducted in Soweto, the same author found that the desire to kill people with HIV/AIDS infection was an extreme response and it indicated very high levels of stigma.

Crepaz (2001) conducted a study in the United States of America and found that unprotected sex was associated with having less knowledge about HIV/AIDS. its

transmission and health risks. He found that the respondents believed that safer sex decreases sexual pleasure and they reported having less intention to engage in safer sex, having little commitment to self or others to practice safer sex. The lack of confidence in one's ability to enact safer sex was also reported.

In a recent study by Crepaz (2001) results show that the respondents perceived that they have little behavioural control over condom use and also they perceived barriers such as having problems in communicating to partners about safe sex and fear of negative consequences such as refusal to have sex, loss of privacy and stigmatization if they disclose their status. This was found to be the one of the reasons for the transmission of HIV/AIDS. The author associated unprotected sex with being impulsive and among women it was related to being less empathetic, less assertive and more rebellious. Unprotected sex was also associated with having less knowledge about HIV/AIDS, its transmission and health risks.

Crepaz (2001) reported that interestingly, although several studies indicated that having problems in communicating with partners was associated with unprotected sex and they found that there was little evidence that withholding disclosure of one's seropositive status from sex partners was associated with risky sexual behaviour. With regard to widows in relation to the interviews that were conducted by the same author it has been reported that widows indicated that they longed for remarriage or some kind of relationship that would help them to weather the difficulties imposed by widowhood. These authors found that this is a cycle in which HIV/AIDS infection in the village goes around. This author found that the prevalence of safer sex among disclosures was very similar to the prevalence of safer sex among disclosures. His findings show that gender power differences in controlling sexual situations may contribute to unsafe sex.

2.13 HIV/AIDS AND THE PREVENTION PROGRAMS IN THE WORKPLACE

Bakari, Lyamuya, Mugusi, Aris, Chale, Magao, Jossia, Tanabi, Swai, Pallangyo, Mhalu, Biberfeld and Pallangyo (2000) found that all employees valued the workplace programs as more informative than the media and the officers were knowledgeable about the spread of HIV/AIDS. Those who were more knowledgeable had more positive attitudes towards infected co-workers.

Sykes (2000) found that the workplace can be the scene of prejudice, discrimination and even harassment for people affected by HIV/AIDS, fuelled by ignorance and fear of infection. He reported that the workplace offers many opportunities to change attitudes provide support to HIV positive people and raise awareness amongst employers and employees about the virus.

In a recent study Sykes (2000) found that many people affected by HIV/AIDS still face stigma, prejudice and even serious infringements of their human rights in the workplace. He suggested that the key to change lies in accurate information and informed discussion because many people rely on the mass media, family and friends for the information on HIV and AIDS.

Young (2000) conducted a survey on the perceptions of employers about HIV/AIDS in the world of work and he found that more than sixty percent of people considered HIV/AIDS to be a very serious threat at the workplace.

In this study, he found that ninety percent of people considered that unskilled workers were the ones most affected by HIV/AIDS. Only eight percent of the employees were equally affected at all levels while thirteen percent identified skilled workers as most vulnerable to HIV/AIDS.

2.4 CONCLUSION

The chapter presented literature to set a theoretical platform for the empirical study. It gathered information mainly from recent books, journal articles, the internet and peer reviewed magazines. The topics covered in the chapter are the perceptions about HIV/AIDS, knowledge of HIV/AIDS and changing attitudes, HIV/AIDS and socio-economic status, misconceptions about HIV/AIDS, HIV/AIDS stigma, HIV/AIDS and behaviour change, obstacles to behaviour change, attitudes and beliefs towards voluntary counseling and testing, use of condoms as a method of preventing HIV/AIDS, and transmission of HIV/AIDS. The next section discusses research methodology and design for this study.

Out of all the literature review that has been discussed, my own opinion about perceptions of people towards HIV/AIDS is that, they are changing. Looking back since the discovery of HIV, people's initial reaction was fear, rejection and an unwillingness to disclose their HIV status. But due to numerous training courses, television advertisements and public service announcements the perceptions are slowly but surely changing for the better.

CHAPTER 3: RESEARCH METHODOLOGY AND DESIGN

3.1 Introduction

The purpose of this chapter is to examine the research methodology, that is how is one going to go about conducting the proposed research. Therefore this chapter examines the methodology utilized in the study. It will focus on sampling design, research design, data collection, data analysis and study limitations were discussed. Whenever one embarks upon any study, one of the questions which need to be addressed immediately is the issue of methodology, that is, how is one going to go about conducting the proposed study. This chapter explains the methods and procedures used in this study. The investigation was conducted using both quantitative and qualitative methodology. The quantitative and qualitative methodology provided the opportunity for the investigator to describe and analyze respondent's perceptions, actions, beliefs and thoughts about HIV/AIDS.

3.2 Case study methodology

3.2.1 Sampling Technique

Stratified random sampling was used in the study. Stratified random sampling is a type of a probability sample that involves dividing the population into homogenous groups having subjects with similar characteristics. The rationale for using stratified random sampling is that, it is a useful blend of randomization and categorization and it enables both quantitative and qualitative research to be undertaken. Stratified random sampling assures representation of all groups and the characteristics of each stratum can be estimated and comparisons also be made. The population consisted of Eight hundred police officials who were divided into homogenous groups of subjects with similar characteristics. A sample representative of the whole population was obtained by using a random selection of subjects from the list. The sample consisted

of one hundred and fifteen police officials from Mthatha Central Accountable Police Station. Both males and females were included in the sample. The sample was divided into strata, then sampling was conducted within each strata. Police officials were listed down according to their ranks. The investigator selected every third police official in the list for the study until equal sized samples of the subjects from each rank were formed. The ages of the subjects who participated in the study ranged between thirty and sixty years. Stratified random sampling helped in the generalization of the results to the entire population because the wider population was represented.

3.2.1 Research type

Various authors (Creswell, 1994; Denzin & Lincoln, 1994; Lee, 1999; Miles & Huberman, 1994; Stroecker, 1991; Swanborn, 1996; Verschuren, 2001;) among others accept the categorization of research into qualitative and quantitative types. In general, if a study requires responses that require numeric responses, it is called a quantitative study while that which requires non-numeric responses is called a qualitative study (Clarke & Dawson, 1999: 65; Hatton, 2004: 48; Smith, 1990: 123; Winter & Munn-Giddings, 2001: 14). The answers required in this research were mainly of a strategic nature, and issues of nominal form were required to determine the perceptions of the police official in Mthatha regarding HIV/AIDS. Thus, this study required a qualitative approach.

The essence of this research is to elucidate the level of awareness about HIV issues. According to Angrosino (2004: 167), Daymon & Holloway (2002: 105), Yin (1994: 12) and Verschuren (2003: 125), among others, the approach described defines a case study. In addition to the types described, the study was an applied one with the intention to assist the South African Police Services to determine ways to defend themselves against HIV/AIDS. The problem being attended to was a truly existing problem and was addressed directly. Such an approach is called action research (Cohen & Manion, 1994: 116; Schalock & Felce, 2004: 271) which, in formal terms, is defined as a small-scale intervention in the functioning of the real world and a close examination of the effects of such intervention. In addition to

intervention, action research is considered an inclusive approach to help keep up with the times (Arnkil, 2004; Ballantyne, 2004; Brandt, 2004; Conwill, 2003; Cook, 2004; Vallaster, 2004).

3.2.2 Population and sample

The study population refers to the entire group of people or items that would be available to provide the responses required in the study (Chia, 1995: 580; Eden & Huxham, 1996: 79; Hand, 1997: 129; Hassard, 1991; Putnam, 1999). In many cases, the population is so large that it cannot be used due to inability of a researcher to handle it. In this case some subset of the population is used for the study. A subset of the population that is used for the study is called a sample (Crombie & Davies, 1996: 88).

Initially, police officials in the Mthatha Central Police Station served as possible elements that might be included in the research sample. However, the study focused on Mthatha.

The police at Mthatha Central Police Station were the ones from which the final sample was selected. Therefore, these people formed a sampling frame, which is that portion of the population from which the sample would be selected (Daymon & Holloway, 2002: 157; Grubbs, 2001; Haslam & McGarthy, 2003: 110; Johnson & Cassell, 2001). The research sample was selected from the sample frame. A sample of size 115 police officials were selected for the study.

3.2.3 Sampling methods

Probability sampling was used and all the categories of police officials available in Mthatha Central Accountable Station were represented. It guaranteed the inclusion and use of all the police officials (Haslam & McGarty, 2003: 110). A stratified sampling was used, and proportional sampling performed except on strata like Director where there was only one only one unit.

3.3 RESEARCH DESIGN

3.3.1 Study coverage / Scope

This research focused on police officials in Mthatha Central Police Station. The reason was that it was intended to establish their perceptions about HIV/AIDS. Literature was reviewed to observe the HIV/AIDS issues in developed and developing countries outside South Africa. This was pursued in order to develop benchmarks with the hope of customizing useful methods from other nations for dealing with HIV/AIDS issues.

3.3.2 Instrumentation

A questionnaire and unstructured interviews were used to collect information that would corroborate and/or justify the various issues interrogated in this research. It was not easy, and sometimes it was impossible to find accurate information from the respondents seemingly because such information was considered sensitive and/or exclusive to the respondents.

Questionnaire development was an important task because the questionnaire was informal. The questions prepared were written down as a guideline for the unstructured interviews. In the act of piloting the questionnaire, the copies of the questionnaire were sent to, and thereafter discussed with colleagues at work.

3.4 The Instruments

The interview schedule was used in the study for collecting data. This interview schedule comprised of open-ended and closed - ended questions. The interview schedule incorporated the following areas of concern:

- Knowledge about HIV/AIDS
- perceptions towards HIV/AIDS

- use and effectiveness of condoms in preventing HIV/AIDS

It also covered the following themes.

Biographical details of the subjects such as:-

Gender of the subjects

Rank of the subjects

Age of the subjects

Level of education

Marital status of the subjects

Race of the subjects

Home language of the subjects

3.5 Procedure

The investigator obtained the permission to conduct the investigation from the Station Commissioner of Mthatha Central Accountable Police Station. Arrangements about when the study will be conducted were made. Subjects were interviewed individually in their offices. Responses were written down in the spaces provided in the semi-structured interview schedule. The investigator selected every third police official in the list of establishment for the study until equal sized samples of subjects from each rank were formed. The ages of subjects ranged from thirty to sixty years.

A semi-structured interview schedule was used in collecting data. Both open-ended and closed-ended questions were asked. The interview took about 25 to 30 minutes

per subject. The subject's responses obtained during the investigation were kept confidential. Sensitive or embarrassing questions were asked in a cautious manner.

3.6 DATA COLLECTION

3.6.1 Data gathering methods

Clarke & Dawson (1999: 67) and Yin (1994: 78) point out that the six major possible sources of evidence for a case study are documentation, archival records, interviews, direct observation, participant-observation and physical artefacts. This study depended on face-to-face interviews. Direct observation and participant-observation were limited to events that took place during the duration of the study. Physical artefacts did not apply to this study. Hence, the major methods used were interviews, even though unstructured and documentation in the form of business plans and recent reports.

At the beginning of data gathering a protocol was prepared to set a stage for the process. The nucleus of the protocol was a set of substantive questions reflecting the actual inquiry, which, according to Yin (1994: 69), should have two characteristics. These were that the questions were posed to the researcher to find out about the information required and the reasons for it. The other was that the questions were accompanied by a list of probable sources of evidence. The latter included the names and profiles of the individuals targeted for the unstructured interviews and discussions, as well as the documents required for the information needed.

3.6.2 Persons involved

The respondents in this study were consisted of members coming from the various strata in the police service. This study managed to make use of Constables, Sergeants, Inspectors, Captains, Superintendents, Senior Superintendent and Directors participated in this study. A total number of 115 respondents participated in the study.

3.6.3 Data gathering management

Management of the data gathering process is important because relevant data is needed to produce useful results. For example, literature review on HIV/AIDS was limited to recent sources because there has been many researches recently and HIV/AIDS is not a very old problem. Yin (1994: 90) provides three data gathering management principles. These are the use of multiple sources to gather evidence, create a database and maintain a chain of evidence. This study used multiple sources as evidence. They were informal interviews, informal questionnaires. Use of multiple sources was done to ensure corroborations of the same facts and supplementing of other information where necessary. Further, a database in the form of study notes was also created to organise the data or evidence collected. Thirdly, a chain of evidence was maintained when the various sources of information were used to collect data and corroborate the evidence collected.

3.7 DATA ANALYSIS

3.7.1 Data analysis methods

Analysing data consists of examining, categorizing, tabulating or recombining the evidence to address the initial proposition of a study (Yin, 1994: 102). Winter and Munn-Giddings (2001: 20) pointed out that in action research, data analysis takes the open-ended critical reflection form which involves questioning the spontaneous interpretations of events, sharing and then comparing interpretations and questions to create the maximum opportunity for challenge, surprise and mutual learning.

Costello (2003: 57) pointed out that action research data analysis of many successful projects he witnessed were based on observation, questionnaire and interview. He suggested that this combination may be considered a framework for successful action research data analysis.

Holland, Daymon and Holloway (2002: 231) enlightened that data analysis does not take place in a single stage after data collection. In their description, it is a continuous, systematic process which runs simultaneously with data collection. It is in this sense that data analysis for this study started as preliminary stages since idea generation advanced more during literature review and reached its formal form when interviews took place within the South African Police Service.

Costello (2003: 70) insists that all the data collected should be discussed in the report. Where some data were not discussed, reasons for their collection must be given. Appendices should be used to offer the reader a more extensive account of the research where some useful information could not be permitted in the main text of the research. This may result when important issues arose in the study even though they were not in the scope. In this dissertation, appendices are included.

3.7.2 Data handling

Data handling of already collected data starts with data organisation, which involves putting data in a form that is appropriate for data analysis. This is done to align the study objectives (Crombie & Davies, 1996:251). Dennett (2001: 119) to assessment criterion used for data handling. This includes data checking, data editing such as reduction (if required), data coding and graph plotting. For this study, data handling involved arranging of facts from the various sources according to the themes in line with the literature review. The main purpose was to understand the perceptions of police officials regarding HIV/AIDS. There was limited editing to make. Reduction of data was not necessary. Since data was qualitative, there were no plotting of graphs. A senior statistician was requested to provide advice on this aspect.

As implied in Costello (2003: 70), data collected should be partitioned into two parts. One shall be for analysis and inclusion in the main body of the dissertation and the other for appendices. Data handling in this study covered this exercise.

3.7.3 Preliminary analysis

Preliminary data analysis refers to the initial stages of data analysis that involves finding out the indications of what the main findings would entail. It may start in an informal pattern, and this makes a research 'reflective' diary necessary to establish and use (Kemp, 2001: 90). The reflective diary is usually used to record personal assessment, feelings, reflection and interpretations. Preliminary data analysis assisted in determining the optimal approach to undertake the main data analysis. After the final main data analysis, the records from preliminary data analysis were then incorporated in, and consolidated with the main data analysis records to compile a complete report.

3.8 CONCLUSION

The study discussed sample designs, research designs, data collection methods, data analysis methods, and limitations of the study. In sampling design, research types, population, sample and sampling methods were discussed. Research design covered study coverage and instrumentation. Data collection included data gathering methods, persons involved, data gathering management and duration of data collection exercise. Data analysis covered the methods, data handling, preliminary analysis and computer programs. In addition to presenting the above in a more encompassing form, they were customized for this research. This was done in order to support the action research nature of this study. The next chapter focuses on the findings of the study.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

The research methodology was discussed in the previous chapter to inform on the resources utilised for the various roles. The data were gathered and the way the findings were derived from the questionnaires. In this chapter the actual findings are presented. Closed-ended questions were analysed using statistical methods. Excel was used for presenting tables and graphs, and for determining percentages where necessary. Scientific workplace was also used to confirm the results. A statistician supported the work by advising throughout the data analysis process. A total of 115 police officials were interviewed on a face-to-face basis to fill in the questionnaires. The pattern of the analysis in this question is as follows:

- The starting section consists of the respondents' profiles in which the biographical details of the respondents are provided.
- The second section presents the finding for the "yes-no" questions to provide thoughts and views about HIV/AIDS.
- The third section of findings presents the findings for the open-ended questions to explain the respondents' feelings.

4.2 RESPONDENTS' PROFILES

4.2.1 Gender

Table 4.1: Gender of respondents

	Male	Female
Frequencies	85	30
Percentages	73.9130	26.0870

Table 4. 1 shows the distribution of the sample according to gender

Figure 4.1: Gender of respondents

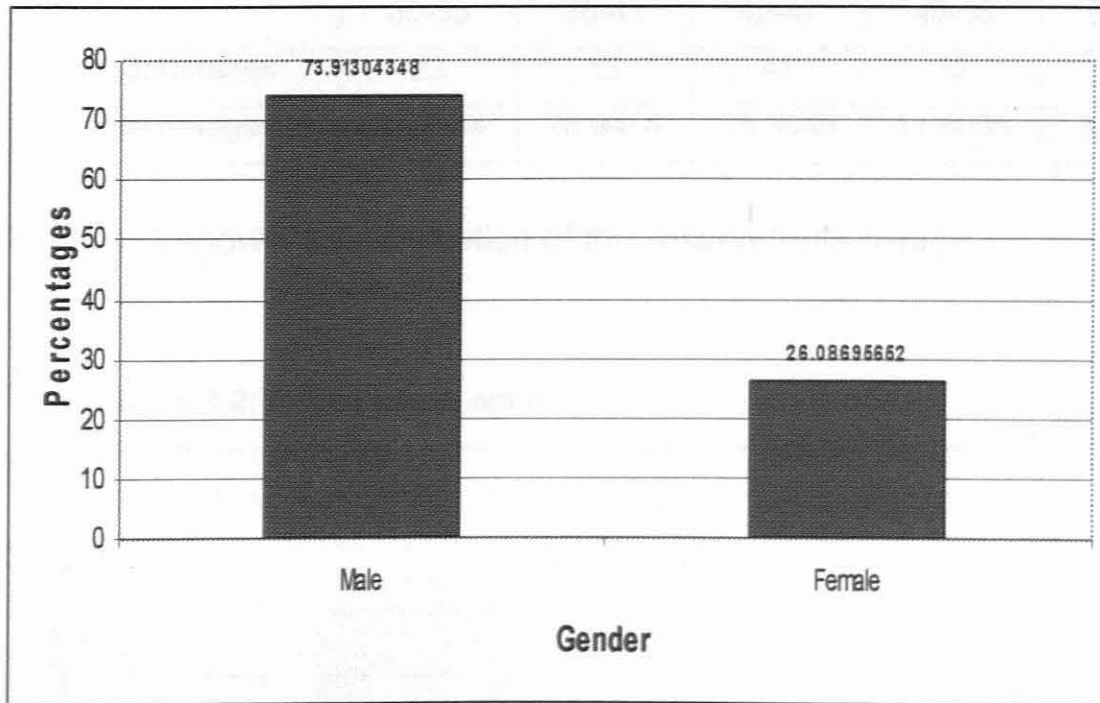


Figure 4.1 shows the distribution of the subjects according to gender.

The question wanted to determine the distribution of police officials who responded according to gender. All the 115 officers interviewed answered this question. The above visual displays indicate that 85 male police officials (73.9%) and 30 (26.1%) female police officials responded.

4.2.2 Ages of respondents

Table 4.2: Ages

	30-35	36-41	42-47	48-53	54-60
Frequencies	23	33	41	13	4
Percentages	20.1754	28.9474	35.9649	11.4035	3.5088

Table 4. 2 shows the distribution of the respondents by age

Figure 4.2: Histogram of ages

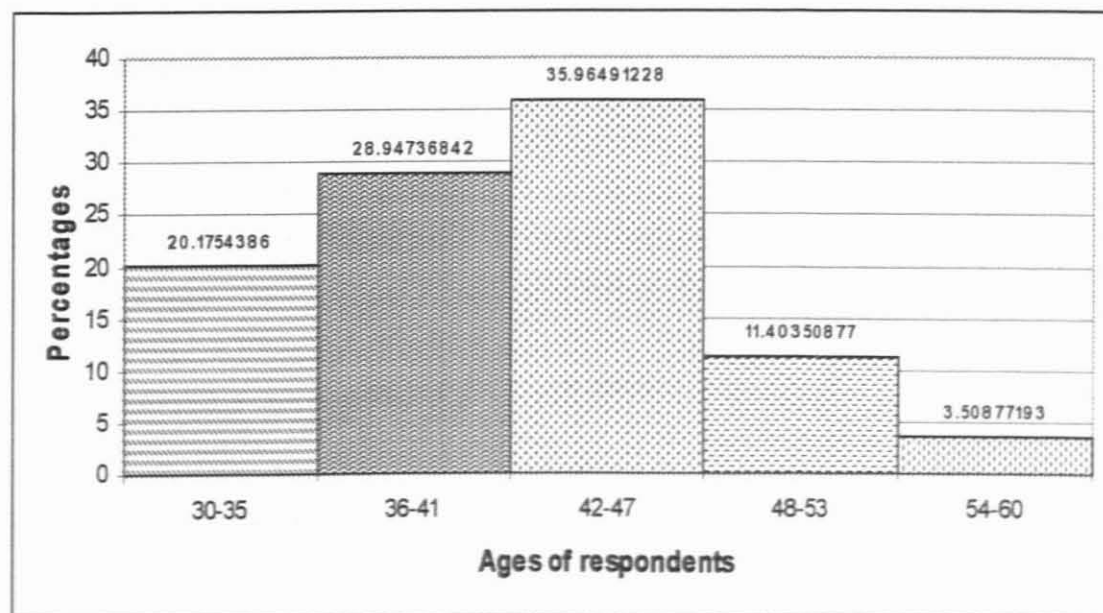


Figure 4. 2 shows the distribution of the respondents by age

For the question about their ages, 114 police officials responded. Figure 4.2 shows that the respondents were distributed as 23 (20.2%) who were aged from 30 to 35 years, 33 (28.9%) aged from 36 to 41 years, 41 (36.0%) aged from 42 to 47 years, 13 (11.4%) aged from 48 to 53 years and four (3.5%) aged from 54 to 60 years.

4.2.3 Ranks of respondents

Table 4.3: Ranks of respondents

	Const	Sergt	Insp	Capt	Supt	S/Supt	Dir
Frequency	16	20	51	21	6	0	1
Percentage	13.9130	17.3913	44.3478	18.2609	5.2174	0	0.8696

Key: Const = Constable, Sgt = Sergeant, Insp = Inspector, Capt = Captain, Supt = Superintendent
S/Supt = Senior Superintendent, Dir = Director

Table 4.3 shows the distribution of the sample according to ranks.

Figure 4.3: Ranks of respondents

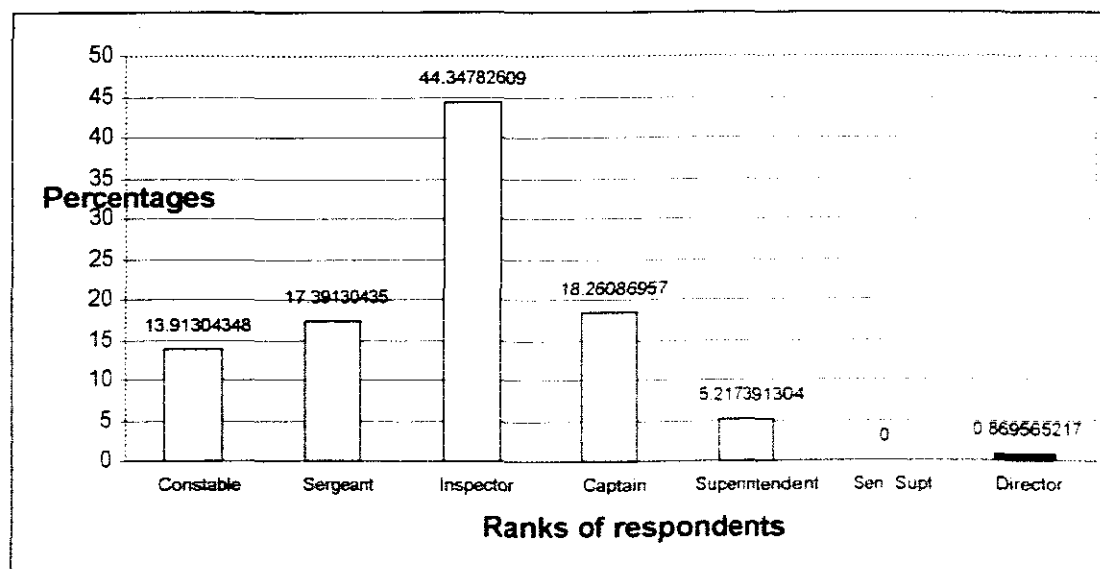


Figure 4.3 shows the distribution of the sample according to ranks.

The question was intended to determine the distribution of police officers according to their positions/ranks. All the 115 respondents answered this question. Table 4.3 and Figure 4.3 show that the distribution was 16 (13.9%) Constables, 20 (17.4%)

Sergeants, 51 (44.3%) Inspectors, 21 (18.3%) Captains, six (6.2%) Superintends, no Senior Superintends and one (0.9%) Director.

4.2.4 Level of education of respondents

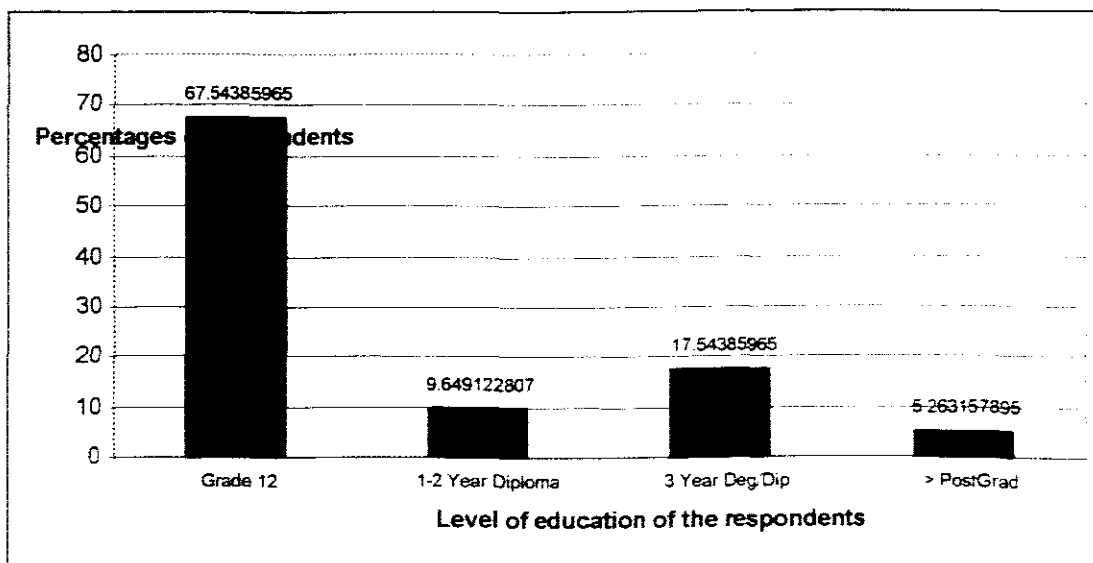
Table 4.4: Level of education

	Grade 12	1-2 year diploma	3 Year degree / diploma	Post Grad Degree*
Frequencies	77	11	20	6
Percentages	67.5439	9.6491	17.5439	5.26316

*Post Grad Degree includes four year degrees, honours and higher degree qualifications

Table 4.4 shows the distribution of the sample according to the level of education.

Figure 4.4: Level of education



The above graph shows the distribution of the sample according to the level of education of the respondents.

The question was interested to determine the highest qualifications that the police personnel had obtained. Table 4.4 and Figure 4.4 reveal that 114 police officers responded. Of these, 77 (67.5%) had up to Grade 12 (matric), 11 (9.6%) had one or two year diplomas, 20 (17.5%) had a three-year degree/diploma and six (5.3%) had postgraduate qualifications.

4.2.5 Marital status of respondents

Table 4.5: Marital status

	Single	Married	Widowed*	Other**
Frequencies	26	82	2	3
Percentages	23.0088	72.5664	1.7699	2.6549

*Widowed could be a widow or widower

**Other = separated or divorced

Table 4.5 shows the distribution of the sample according to marital status

Figure 4.5: Marital status

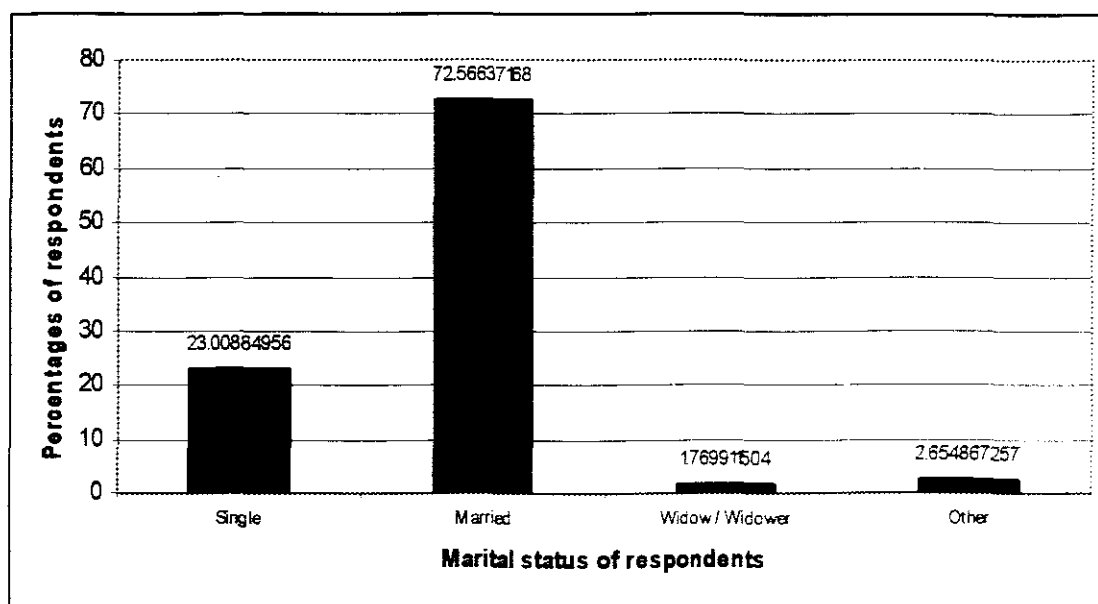


Figure 4.5 shows the distribution of the sample according to marital status of the respondents.

The question wanted to determine the marital status of the police officials. Table 4.5 and Figure 4.5 show that 113 of them responded. Of these, 26 (23.0%) were single, 82 (72.6%) were married, two (1.8%) were widowed and three (2.7%) gave their marital status as "Other". Additional information revealed that "Other" status was that the respondents were either divorced or separated from their spouses.

4.2.6 Race of respondents

Table 4.6: Race

	Black	White	Coloured	Indian
Frequencies	109	0	4	2
Percentages	96.4602	0	3.5398	1.7699

Table 4.6 shows the distribution of the sample according to the race of the respondents.

Figure 4.6: Race

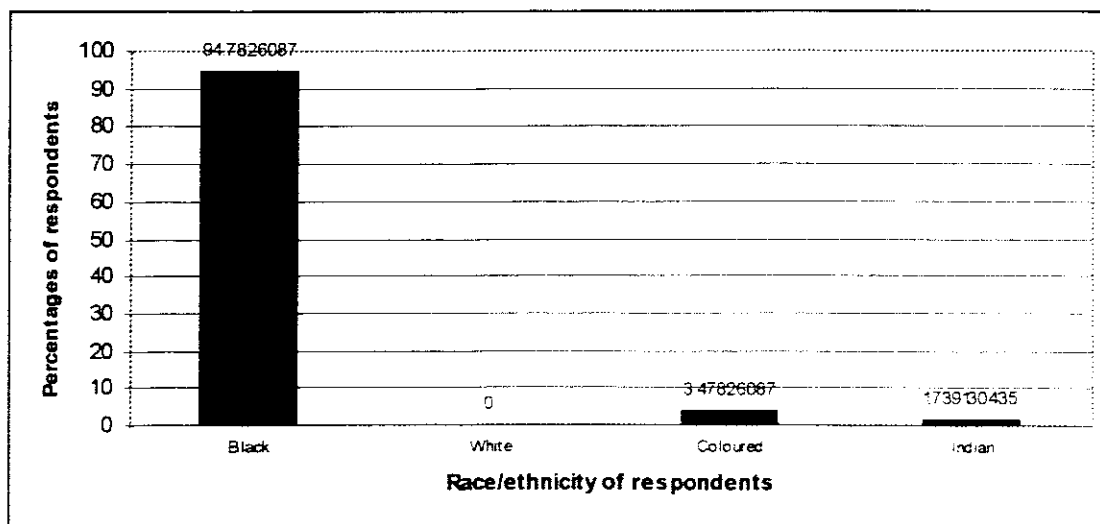


Figure 4.6 shows the distribution of the sample according to race of the respondents.

The question wanted distribution in terms of race. Table 4.6 and Figure 4.6 show that all the 115 respondents answered and 109 (94.8%) were Blacks, no one was White, four (3.8%) were Coloureds and two (1.7%) were Indians.

4.2.7 Home language of respondents

Table 4.7: Home language

Language	Frequency
English	2
Afrikaans	4
Xhosa	106
Zulu	
Sesotho	2
Setswana	
Swati	
Tsonga	
Venda	1
Ndebele	
Sepedi	
Other	

Table 4.7 shows the distribution of the sample according to home language.

Figure 4.7: Home language

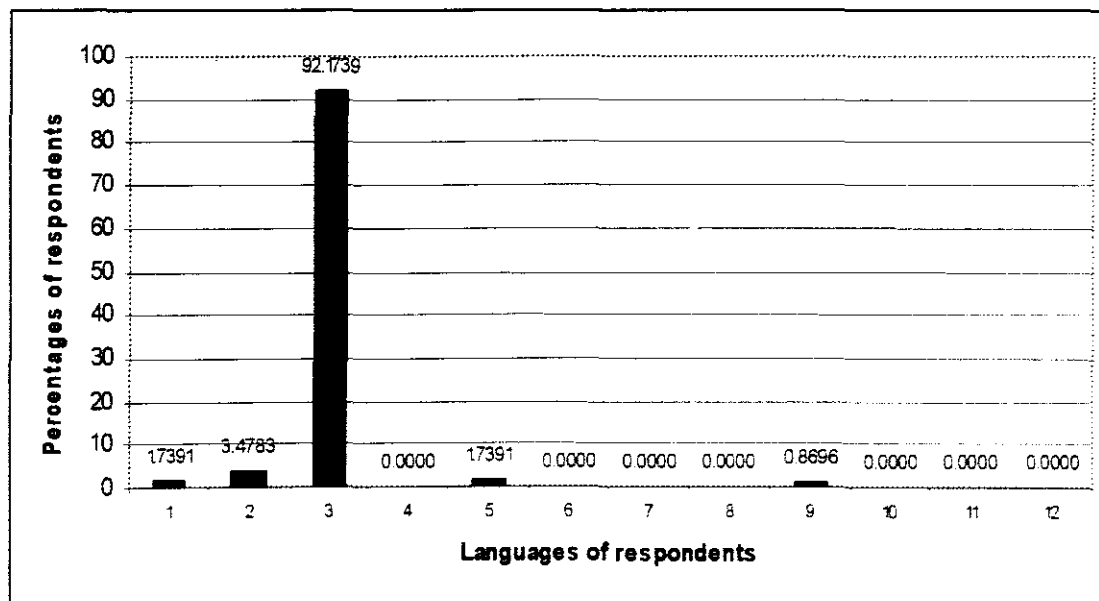


Figure 4.7 shows the distribution of the sample according to home language.

All the 115 answered the question about their home language. The displays indicate that Xhosa was the dominant language spoken by 106 (92.2%), followed by Afrikaans with four (3.5%) speaking it, then by English and Sesotho with two (1.7%) speaking each of them, and then Venda with one (0.9%) person speaking it. The languages not spoken by the respondents were Sesotho, Zulu, Swati, Tsonga, Ndebele and Sepedi.

4.2.8 Recap of respondents' profiles

The territory is dominated by males, Inspectors, married, Grade 12's certificated, 42 to 47 years of age, and black of Xhosa ethnicity.

4.3 AWARENESS ABOUT HIV/AIDS

The questions that were “yes-no” were grouped according to themes. The questions were therefore reorganised by changing the order of the original questions to suit the themes. Each theme also indicates the original question that was presented. The themes form the titles of the heading in the subsections presented in this section.

4.3.1 HIV/AIDS infection

This theme was formed from the two questions (Questions 1 and 2) in the original questionnaire. The first presentation gives tables with frequencies and percentages of the distribution of answers. Then the comparison of the responses from the two questions is made, presenting the bar chart.

Table 4.8: Use of same needle

	YES	NO
Frequencies	91	18
Percentages	83.4862	16.5138

A total of 109 respondents answered the question (Question 1) to determine if they believed that the *use of the same needle to transfuse blood from one patient to the other may spread HIV / AIDS*. Table 4.8 indicates that 91 (83.49%) believed that use of same needle may spread the virus, and 18 (16.52%) did not believe it can spread the virus.

Table 4.9: THE HIV AS THE CAUSE OF AIDS

	YES	NO
Frequencies	99	12
Percentages	89.1892	10.8108

Table 4.8 shows the extent to which people believed that HIV infection causes AIDS.

A total of 111 police officers responded to the question (Question 2) that wanted to know the respondents who believed that *HIV causes AIDS*. Table 4.9 indicates that 99 (89.19%) believed that HIV causes AIDS, while 12 (10.81.52%) did not believe that HIV causes AIDS.

Figure 4.8: Same needle vs. Cause

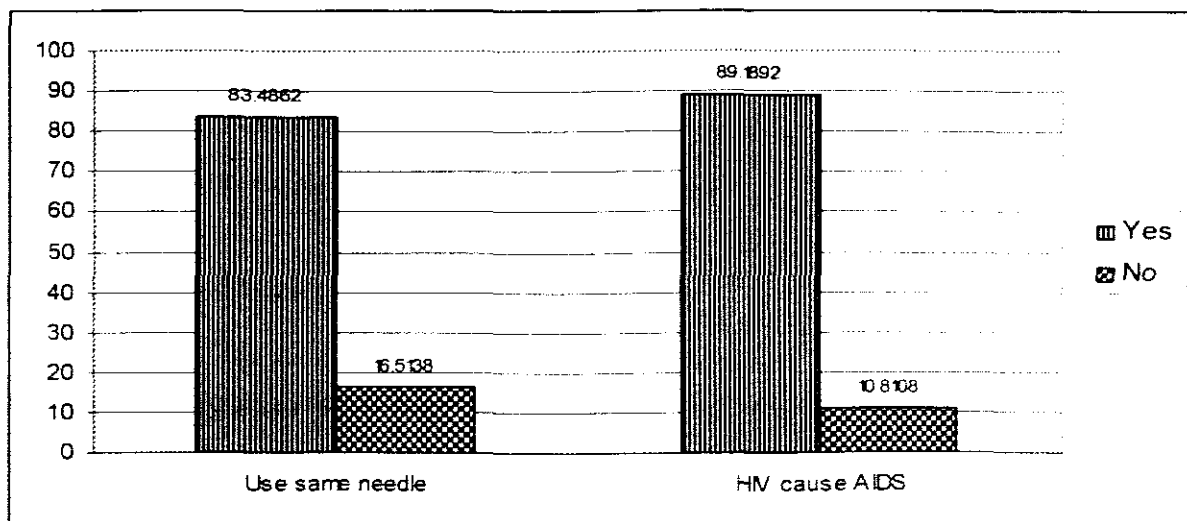


Figure 4.8 shows the extent to which people believed that the needle used on an HIV infected person can cause HIV against those with the thought that HIV causes AIDS.

Figure 4.8 was used to compare the extent to which people believed that the needle used on an HIV infected person can cause HIV against those with the thought that HIV causes AIDS. Comparison of the responses from the above two questions can be meaningfully done through percentages because the numbers of total responses were not the same. Those who thought HIV causes AIDS were more than those who thought needle used on HIV patient can cause AIDS.

4.3.2 Symptoms of sickness

This section was made of original Questions 3 and 5 of the closed-ended questions. The first question wanted to determine whether the police officials believed that an HIV infected person who did not show clear signs of AIDS would still not be having AIDS. The second wanted to determine if they thought that someone who was infected with HIV would have neither signs nor symptoms of AIDS.

Table 4.10: HIV infected may not necessarily look sick

	YES	NO
Frequencies	89	22
Percentages	80.1802	19.8198

Table 4. 10 shows the percentages and frequencies of police officials who considered that an HIV infected person may not necessarily look sick.

This question (Question 3) was intended to determine if police officials considered an HIV infected person as not necessarily sick with AIDS. Table 4.10 indicates that 111 responded, of which 89 (80.2%) believe that HIV does not imply AIDS sickness while 22 (19.8%) did not agree.

Table 4.11: HIV infected has no AIDS signs

	YES	NO
Frequencies	73	39
Percentages	69.95	34.08

Table 4. 11 shows the percentages and frequencies of police officers who considered that an HIV infected person have or does not have external indications of the virus.

This question (Question 5) was intended to determine if police officers considered that an HIV infected person do not have external indications of the virus. Table 4.11 indicates that 112 responded, of which 73 (70.0%) believe that HIV infection does not have external indication on the infected and 39 (34.1%) did not agree.

Figure 4.9: HIV is not AIDS vs. HIV has no external signs

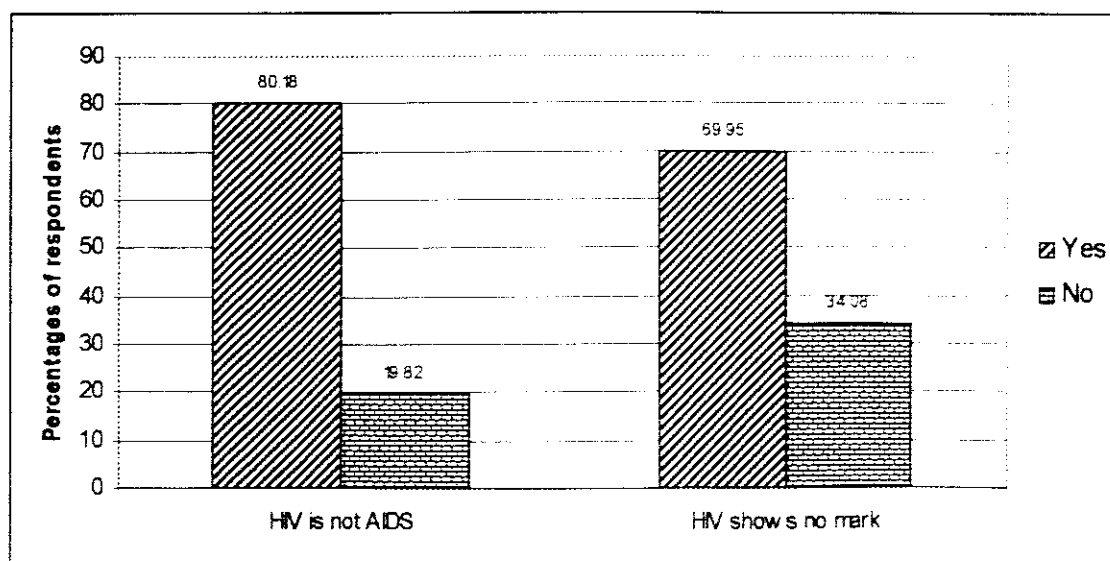


Figure 4. 11 shows the percentages and frequencies of police officers who considered that an HIV infected person have or does not have external indications of the virus.

Figure 4.9 indicates that a larger proportion believes that HIV is not necessarily the AIDS disease compared to a proportion who believes that infected people do not have

external indications of revealing the virus's presence in the body. On the other hand a larger proportion rejects that HIV has no external indications than that of those who reject that HIV is not necessarily the AIDS disease.

4.3.3 Cure for HIV/AIDS

This was Question 4 in the original questionnaire. The objective was to determine if the police officers believed that there was no cure for HIV/AIDS.

Table 4.12: No cure for HIV/AIDS

	YES	NO
Frequencies	98	15
Percentages	86.7257	13.2743

Table 4.12 shows the percentages and frequencies of the respondents who believe that HIV/ AIDS has no cure and those who believe that it can be cured.

Figure 4.10: No cure for HIV/AIDS

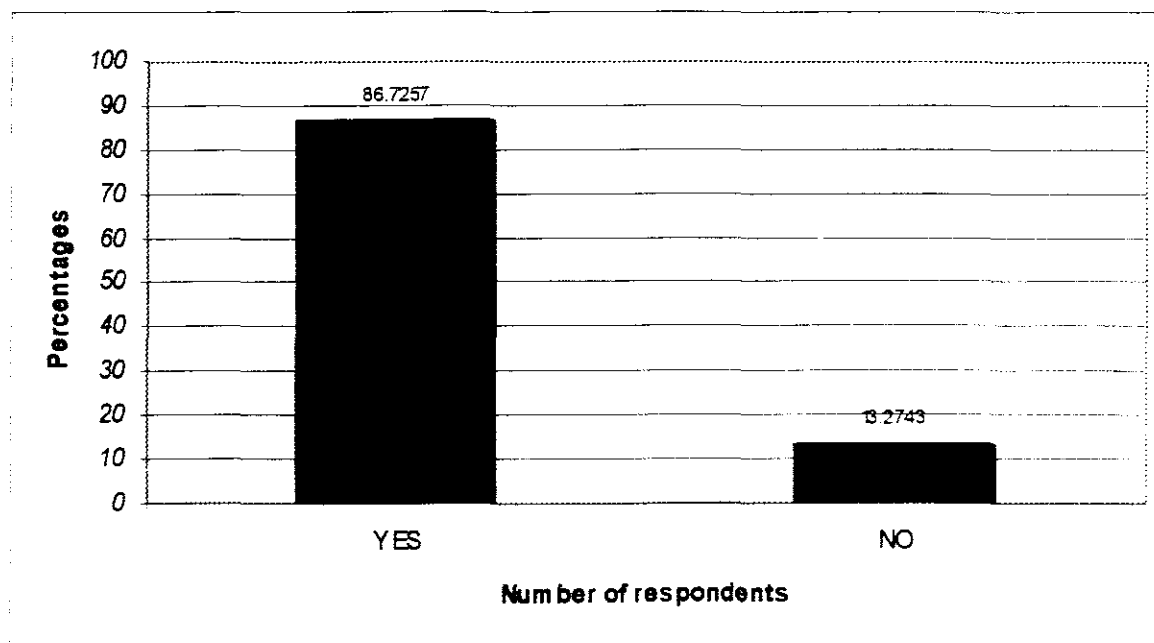


Figure 4.12 shows the percentages and frequencies of the respondents who believe that HIV/ AIDS has no cure and those who believe that it can be cured.

Table 12 and Figure 4.10 indicate that 113 police officials answered the question of whether HIV/AIDS has a cure. Of these, 98 (86.7) answered to the effect that it has no cure while 15 (13.3%) believe that it has a cure.

4.3.4 Care in the family

Table 4.13: Willing to care for infected family members

YES	NO
-----	----

Frequencies	107	5
Percentages	95.1613	4.8387

Table 4.13 shows the distribution of the sample according to the subjects who would be willing to take care of their family members on a daily basis if these members were infected with HIV.

Figure 4.11: Willing to care for infected family members

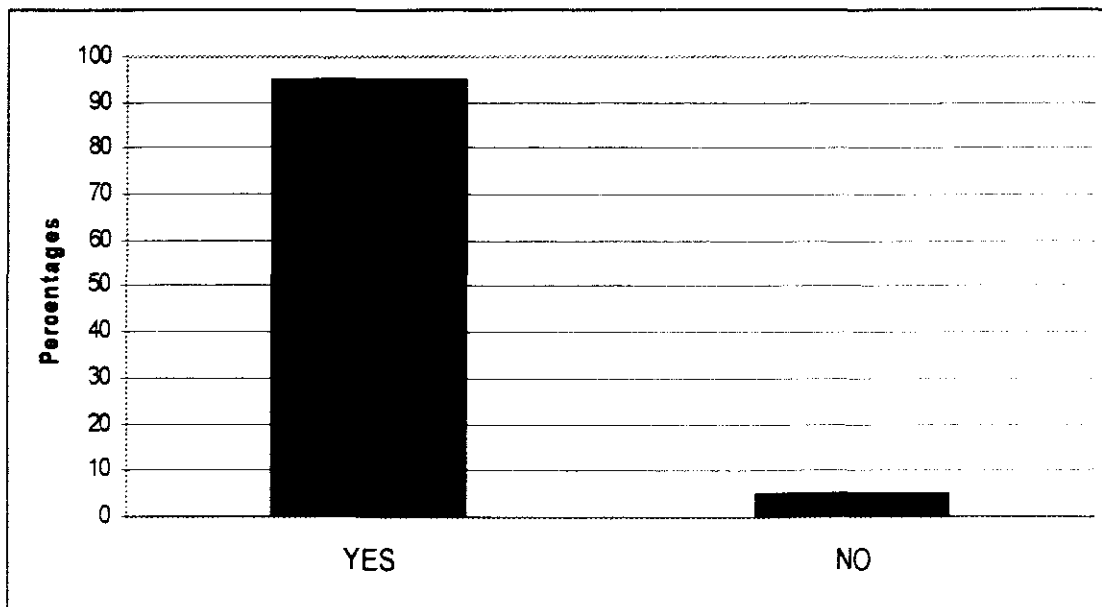


Figure 4.11 shows the distribution of the sample according to the subjects who would be willing to take care of their family members on a daily basis if these members were infected with HIV.

This question (Question 6) was interested in determining if police officials would be willing to take care of their family members on a daily basis if these members were infected with HIV. Table 4.13 and Figure 4.11 indicate that 107 (95.2%) claimed that they were willing to take daily care of such members while five (4.8%) stated that they would not.

4.3.5 Condom use

The questions about the use of condom were also an important theme that police officials were interested in for various reasons. Questions 7, 8 and 17 of the questionnaire were involved.

Table 4.14: Regrettable sexual experience that happened when one did not use a condom

	YES	NO
Frequencies	19	93
Percentages	16.9643	83.0357

Table 4.14 shows the distribution of the sample according to regrettable sexual experience that happened when the respondents did not use a condom.

This question (Question 7) was intended to determine the extent to which police officials were careless. They were requested to indicate if they ever had a sexual experience they later regretted because they did not use a condom. Table 4.14 shows that 19 (17.0%) had such an experience while 93 (83.0%) never had it.

Figure 4.12: Condom use

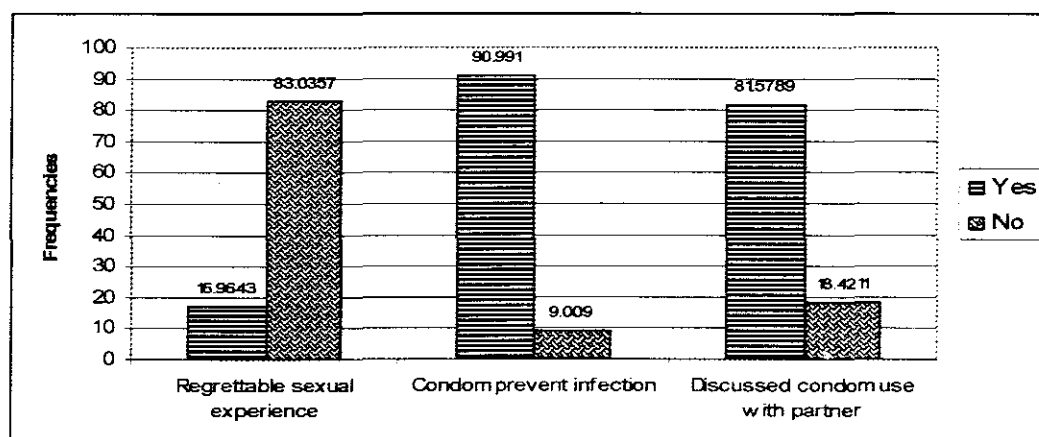


Figure 4.14 shows the distribution of the sample according to regrettable sexual experience that happened when the respondents did not use a condom.

Figure 4.12 shows that some police officials had risked being infected and they were more in proportion to those who did not believe that condom prevent infection and about equal to those who had not discussed the importance of condom use with their partners. Even though these are less than their direct counterparts who had done the right things, they are still many because “one infection too many”. That is, a single infection can lead to multiple infections in a long term.

Regrettable sexual experiences

The question was meant only for the respondents who had answered that they ever had regrettable sexual experiences. Not all of them answered, but the few who did gave answers in what could be grouped as the actual occurrence, the follow up they made, excuses, feelings and some form of advice to others. These are:

Actual occurrence

- The partner complained that she or he is not trusted when asked to use a condom.
- Too drunk, found someone to sleep with and there was no condom.
- Once engaged in intercourse with a close friend.

Follow up

- Some went for test and were relieved when it was negative.
- Tested once during window period came negative but still will go.

Excuses

- Partner never informed about status.
- The age was the time to test if I can have children.

Feelings

- After the act, I felt I had the virus and was worried that I could get AIDS.

Advice

- When trapped in situation of sexual intercourse, always use a condom with someone you do not know.
- Make efforts to abstain even when under pressure.
- After regrettable experience go for a test and/or protection exercise.

Table 4.15: Condoms prevent infection

	YES	NO
Frequencies	101	10
Percentages	90.9910	9.0090

Table 4.15 shows the distribution of a sample according to the respondents who believe that condoms prevent HIV infection and those who did not believe that condoms do not prevent HIV infection

The question was intended to determine if police officials were convinced that HIV infection can be successfully prevented using a condom (Question 8). Table 4.15

shows that 101 (91.0%) stated that they believed so while 19 (9.0%) did not believe that condoms prevent HIV infection.

Table 4.16: Discussed condom use with a partner or a spouse

	YES	NO
Frequencies	93	21
Percentages	81.5789	18.4211

Table 4.16 shows the distribution of a sample according to the respondents who discussed condom use with the partner or a spouse.

The question (Question 17) was intended to determine the extent to which police officials had discussed condom use importance with their partners or spouses. A total of 114 police officials answered the question. Of these, 93 (81.6%) stated that they had discussed with partners while 21 (18.4%) stated that they had not.

4.3.6 Willingness to know status

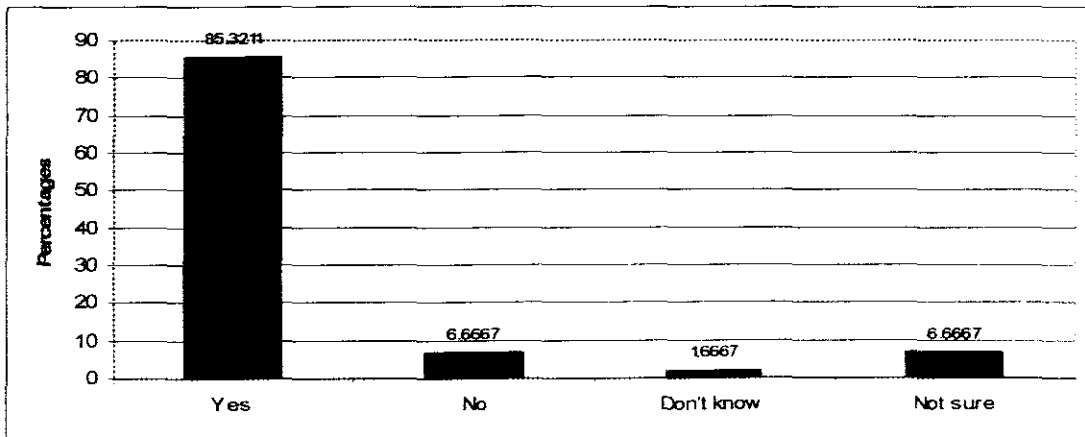
Three questions (Questions 9 and 10 or 16) of the questionnaire were grouped under this theme. (We note that Questions 10 and 16 were exactly the same question.)

Table 4.17: Willing to take HIV test

	Yes	No	Don't know	Not sure
Frequencies	93	7	2	7
Percentages	85.3211	6.6667	1.6667	6.6667

Table 4.17 shows the distribution of the sample according to the willingness to know HIV status.

Figure 4.13: Willing to test



The intention of Question 9 was to determine the extent to which police officials were willing to take HIV tests. Table 4.17 and Figure 4.13 show that 109 police officers answered the question. Of these, 93 (85.3%) stated that they were willing to take a test, seven (6.7%) indicated that they were not, two (1.7%) stated that they did not know and two (6.7%) said they were not sure.

Table 4.18: Willing to know HIV test results

	YES	NO
Frequencies	81	12
Percentages	87.1	12.9

Table 4.18 shows the distribution of the sample according to the willingness to know the test results.

Figure 4.14: Willing to know HIV test results

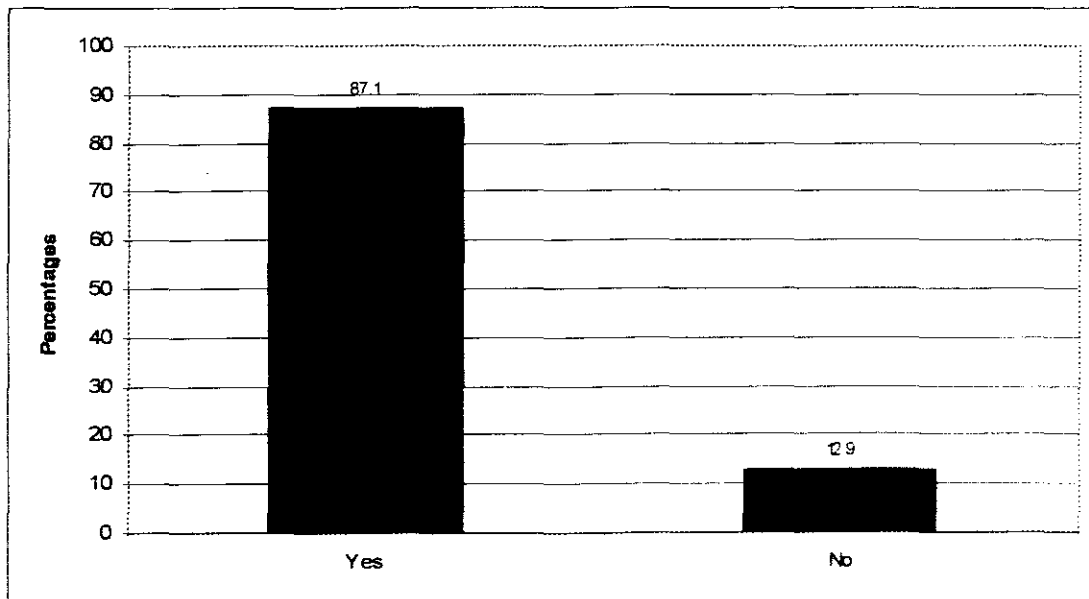


Figure 4.14 shows the distribution of the sample according to the willingness to know the HIV test results.

This question (Question 10 and 16) was intended to determine if the 93 police officials who stated that they were willing to take HIV tests were willing to know the results of those tests. Table 4.18 and Figure 4.14 show that 81 (87.1%) indicated that they were willing to take the tests and 12 (12.9%) stated that they were not willing to know the test results.

Table 4.19: Preferred communicator of test results

	Myself	Doctor	Don't know	Other
Frequencies	59	15	1	6
Percentages	72.8395	18.5185	1.2346	7.4074

Table 4.19 shows the distribution of the sample according to the respondent's preferred communicator of test results to their families.

Figure 4.15: Preferred communicator of status

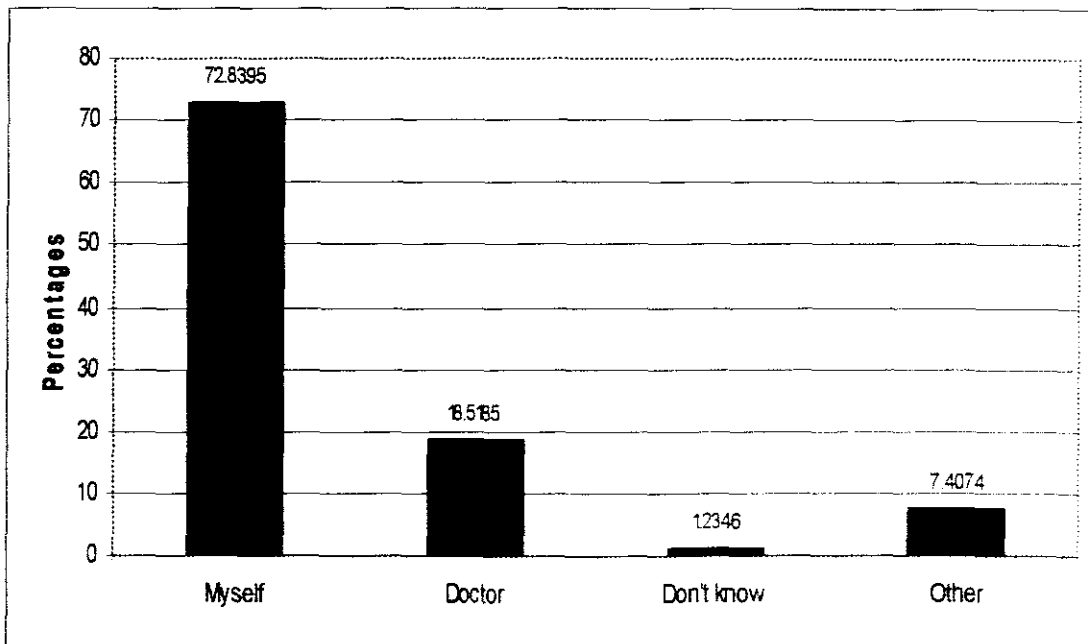


Figure 4.15 shows the distribution of the sample according to the respondent's preferred communicator of test results to their families.

This question was following up on those who had indicated that they were willing to know the test results. These 81 respondents were requested to indicate who they would trust telling their spouses about those test results once they were out. Of these, 59 (72.8%) indicated that they preferred to tell their partners by themselves, 15 (18.5%) stated that they would rather use doctors to convey the information to their partners, one (1.2%) did not know whom they would ask and six (7.4%) would involve somebody else not mentioned in this question.

4.3.7 Stigmatisation

The two questions that were used to form this theme are Questions 11 and 15.

Table 4.20: Fear of HIV leads to unfair discrimination

	YES	NO
Frequencies	84	26
Percentages	76.3636	23.6364

Table 4.20 shows the distribution of the sample according to the respondent's beliefs about what causes HIV/AIDS stigma.

Figure 4.16: Fearing HIV leads to stigma

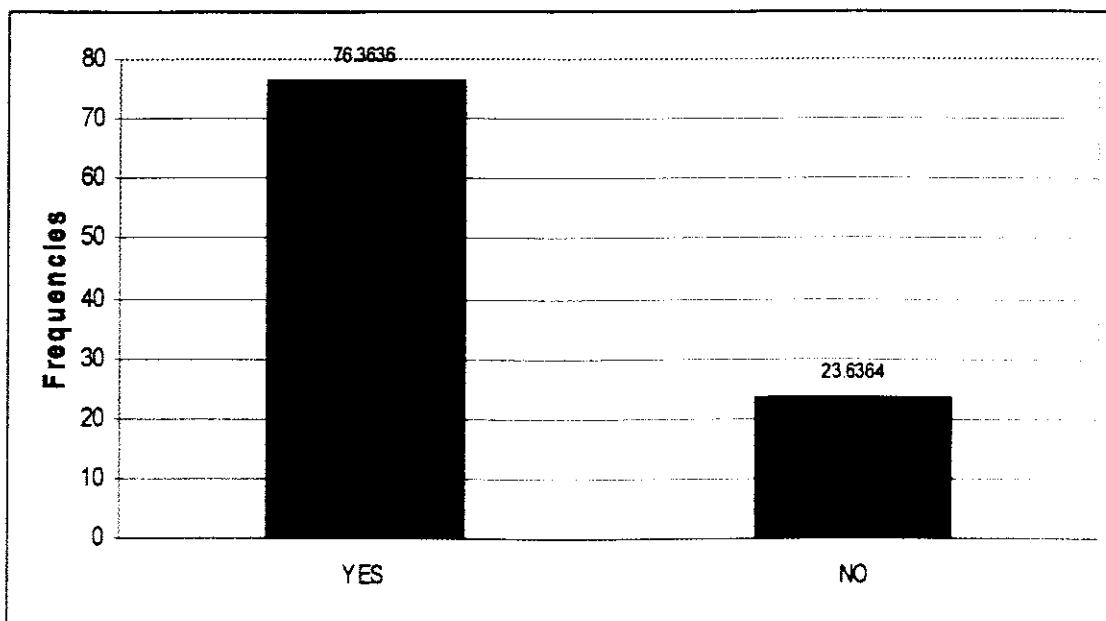


Figure 4.16 shows the distribution of the sample according to the respondent's beliefs about what causes HIV/AIDS stigma.

This question (Question 11) was intended to determine the extent to which the police officials believed that stigmatisation was a result of fear of HIV. They were asked to state if they believed that fear of HIV led to the carriers of the virus to be unfairly discriminated against. Table 4.20 and Figure 4.16 show that 110 police officers

responded. Of these, 84 (76.4%) stated that they believed that fearing HIV caused unfair discrimination against those who carried it, and 26 (23.6%) did not believe so.

Table 4.21: HIV/AIDS is individual's fault

	YES	NO
Frequencies	36	76
Percentages	32.1429	67.8571

Table 4.21 shows the distribution of the sample according to the respondent's beliefs that it is an individual's fault if someone contracts HIV/AIDS.

Figure 4.17: HIV infection is individual's fault

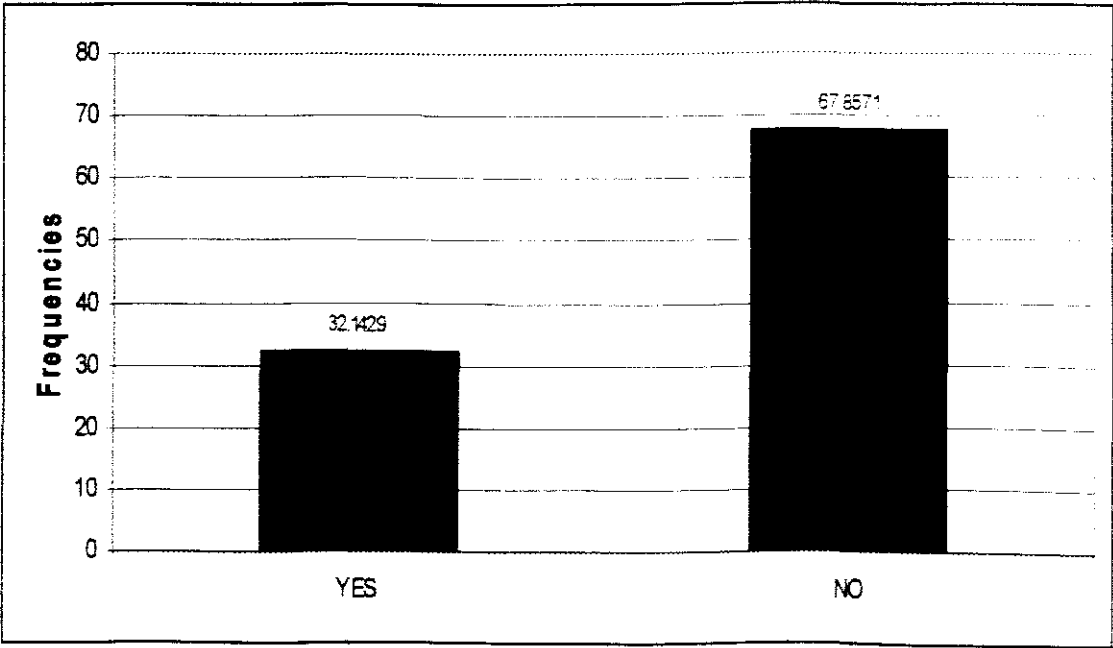


Figure 4.17 shows the distribution of the sample according to the respondent's beliefs that it is an individual's fault if someone contracts HIV/AIDS.

The question was intended to determine the extent to which police officials believed that it is "own fault" to have HIV (Question 15). Table 4.21 and Figure 4.17 show that 112 police officers responded. Of these, 36 (32.1%) believed that it is individual fault to contract HIV and 76 (67.9%) did not think so.

4.3.8 Hiding HIV status from spouse

This theme was composed of Question 12.

Table 4.22: HIV status be secret from spouse

	YES	NO
Frequencies	27	86
Percentages	23.8938	76.1062

Table 4.22 shows the distribution of the sample according to the respondent's beliefs about the extent at which their HIV status can be kept secret from spouse.

Figure 4.18: HIV status be kept secret from spouse

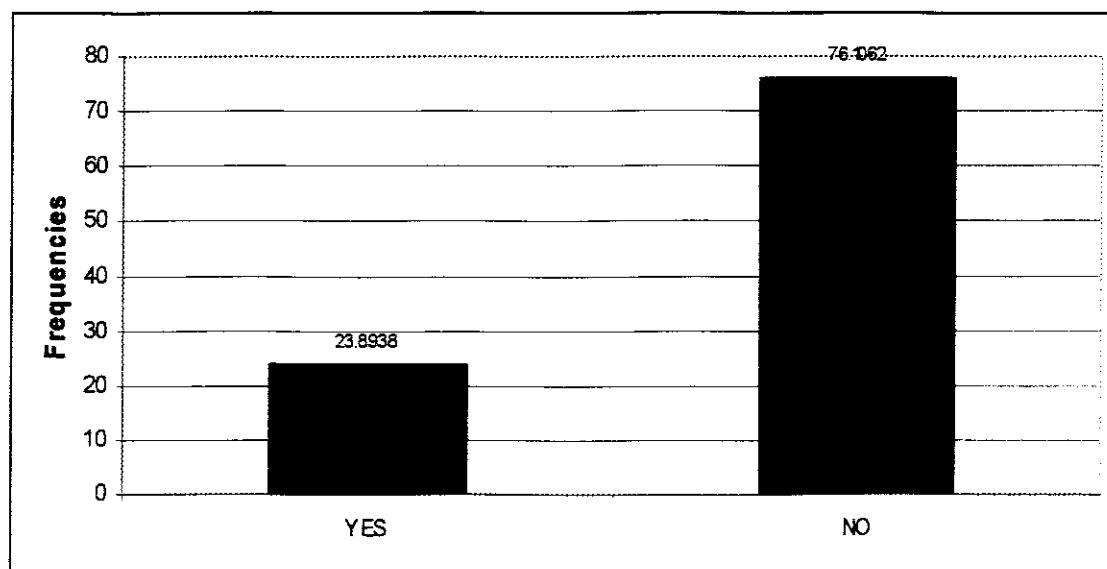


Figure 4.18 shows the distribution of the sample according to the respondent's beliefs about the extent at which their HIV status can be kept secret from spouse.

The question wanted to determine the respondent's beliefs about the extent at which their HIV status can be kept secret from spouse.

Table 4.22 and Figure 4.18 show that 113 respondents were involved, of which 27 (23.9%) stated that the secret should be kept from spouses while 86 (76.1%) did not agree with this idea.

4.3.9 Living with HIV infected person

This was formed by two questions (Questions 13 and 14).

Table 4.23: Comfortable living with infected roommate

	YES	NO
Frequencies	85	28
Percentages	75.2212	24.7788

Table 4. 23 shows the extent to which police officers would be comfortable to live with roommates who were infected with HIV.

The question (Question 13) was intended to determine the extent to which police officers would be comfortable to live with roommates who were infected with HIV. Table 4.23 indicates that 113 police officials answered, of whom 85 (75.2%) claimed that they would be comfortable living with an infected roommate while 28 (24.8%) stated that they would not be comfortable to live with a roommate infected with HIV/AIDS..

Table 4.24: Comfortable working with infected colleagues.

	YES	NO
Frequencies	96	17
Percentages	84.9557	15.0443

Table 4.24 shows the extent to which police officers would be comfortable to work with HIV infected colleagues.

The question (Question 14) was intended to determine the extent to which police officers would be comfortable to work with HIV infected colleagues. Table 4.24 shows that a total of 113 police officials answered the question, of whom 96 (85.0%) claimed that they would, while 17 (15.0%) stated that they would not.

Figure 4.19: Comfortable with infected roommate

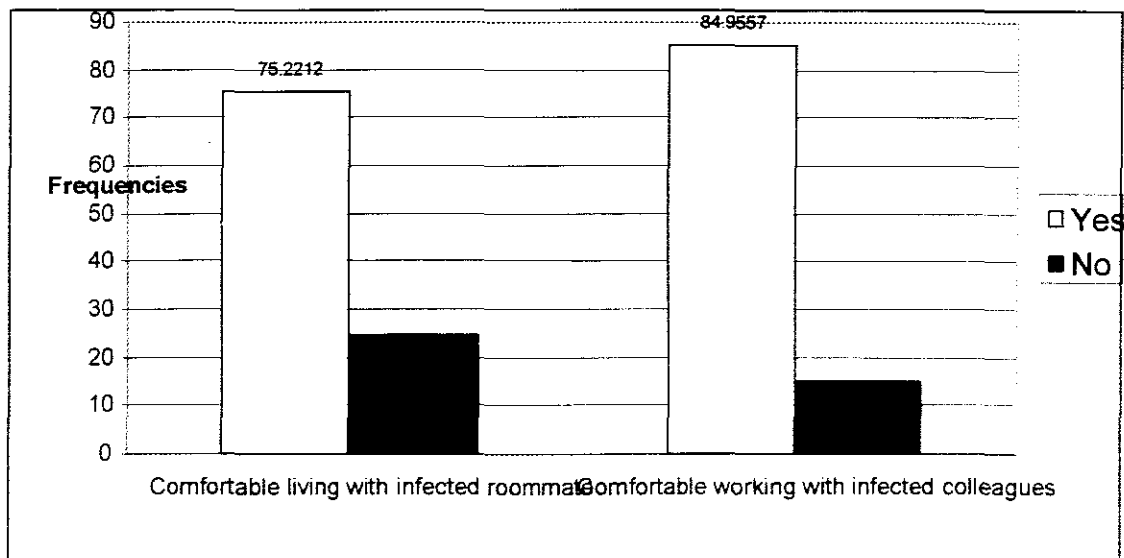


Figure 4.19 shows the extent to which the respondents who indicated that they would be comfortable living with HIV infected roommate with the extent to which they would be comfortable working with them.

Figure 4.19 was comparing the extent to which the respondents who indicated that they would be comfortable living with HIV infected roommate with the extent to which they would be comfortable working with infected colleagues. The indication from Figure 4.19 is that they would be more comfortable living with infected roommate than those who would not be comfortable in both cases. Further, respondents would be less comfortable living with them than working with them. This means that (also from chart) they would be more uncomfortable to live with HIV infected persons than to work with them. This shows that there is a need for more awareness programs.

4.3.10 HIV/AIDS as health threat

Two questions (Questions 18 and 19) were used to form the theme that HIV/AIDS is a health threat.

Table 4.25: HIV/AIDS a threat to your community

	YES	NO
Frequencies	106	7
Percentages	93.8053	6.1947

Table 4.25 shows the perceived threat of HIV/AIDS to the community.

The question (Question 18) was intended to determine if the police officials ever felt that HIV/AIDS was a threat to their communities. Table 4.25 show that 113 police officials answered, of whom 106 (93.8%) agreed that HIV/AIDS was a serious threat in their communities and seven (6.2%) did not believe that it was a serious threat to their communities.

Table 4.26: HIV/AIDS a threat to yourself

	YES	NO
Frequencies	89	23
Percentages	76.4643	20.5357

Table 4.26 shows the perceived threat of HIV/AIDS to the respondents.

The question (Question 19) aimed at determining if the police officials ever felt that HIV/AIDS was a serious threat to them. Table 4.26 indicates that 112 police officials answered, of whom 89 (76.5%) believed that HIV/AIDS was a serious threat to themselves and 23 (6.2%) did not believe it was a serious threat to themselves.

Figure 4.20: HIV/AIDS a threat

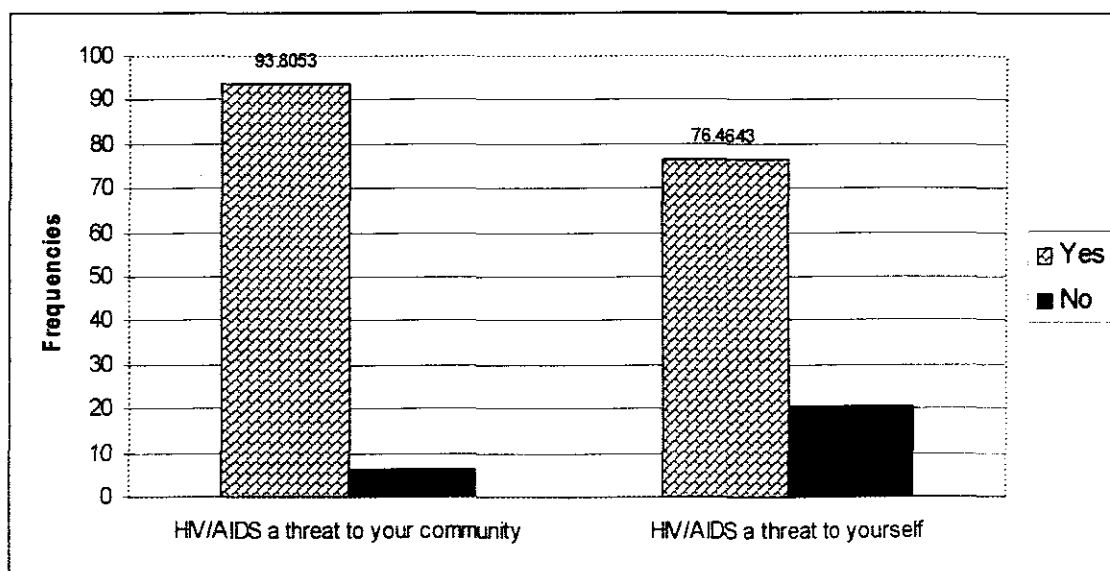


Figure 4.20 shows the extent to which the police officials were more worried about HIV/AIDS threat to themselves or their communities.

Figure 4.20 was intended to determine whether the police officials were more worried about HIV/AIDS threat to themselves or their communities. The proportions and bars in the figure show that the police officials considered HIV/AIDS to be a serious threat more to their communities than they considered it to be a threat to themselves.

4.3.11 Lifestyle and behavioural changes

This theme is a result of two questions (Questions 20 and 21).

Table 4.27: Change lifestyle to reduce infection risk

	YES	NO
Frequencies	97	15
Percentages	86.6071	13.3929

Table 4.27 shows the lifestyle and behavioural changes of the respondents.

The question (Question 20) was asked to determine if the police officials changed their lifestyles to reduce the risk of being infected. Table 4.27 shows that 112 police officials answered the question. Of these, 97 (86.6%) stated that they changed their lifestyles while 15 (13.4%) stated that they did not.

Table 4.28: AIDS education essential

	YES	NO
Frequencies	103	7
Percentages	93.6364	6.3636

Table 4.28 shows the respondent's belief about the importance of AIDS education in behaviour change.

The question (Question 21) was asked to determine if the police officials believed that AIDS education was primary to persuade individuals to modify risk behaviours and minimise fear and prejudice that is based on ignorance. Table 4.28 shows that 110 police officials answered the question. Of these, 103 (93.6%) indicated that they considered AIDS education as essential while seven (6.4%) stated that they did not believe AIDS education was necessary.

Figure 4.21: Lifestyle change vs. AIDS education

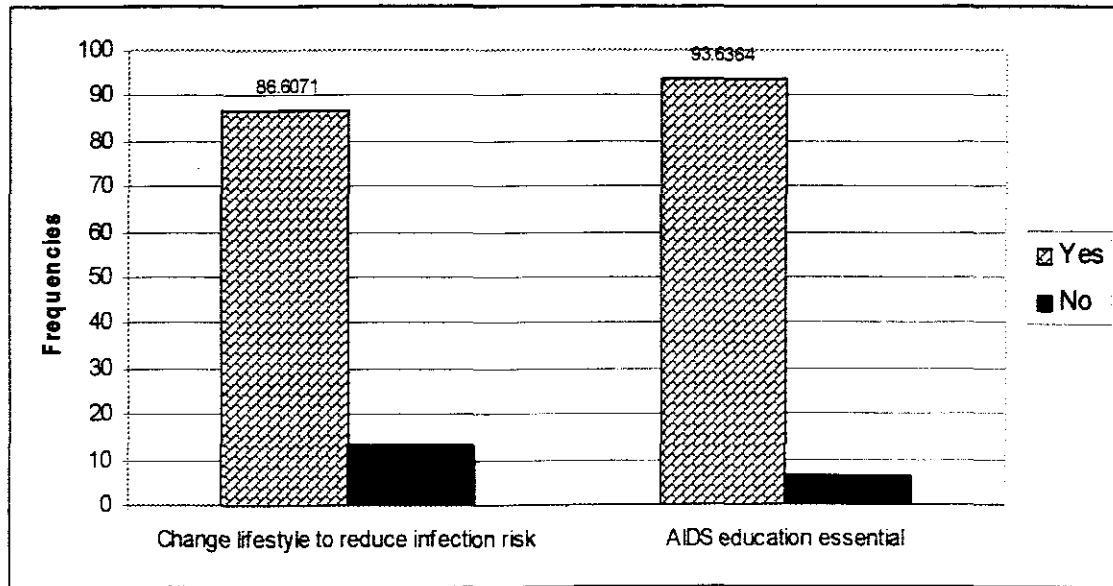


Figure 4.21 shows the extent to which AIDS education was favoured by the police officials as compared to the way they favoured changing lifestyles.

Figure 4.21 was used to determine the extent to which AIDS education was favoured by the police officials as compared to the way they favoured changing lifestyles. The figure shows that AIDS education is more preferred than lifestyle changes. This also means that fewer police officials would shun education as compared to those who would shun changing their lifestyles.

4.3.12 Summary of awareness about HIV/AIDS

This subsection summarises the most important points corresponding to each theme derived in the section.

- **HIV/AIDS infection**

More people believed that the needle used on an HIV infected person can cause HIV. Further, those who thought that HIV causes AIDS were more than those who

believed that HIV does not cause AIDS. Furthermore, those who believed that a needle used on HIV patient can cause HIV were less than those who believed that HIV causes AIDS.

- **Symptoms of sickness**

The respondents who said having HIV is not having AIDS were more than those who said HIV infection is not detectable from physical appearance. However, those who said that there are no indications on the body to confirm that a person is HIV infected.

- **Cure for HIV/AIDS**

Most respondents believed that there is no cure for AIDS but few believed that there could be a cure.

- **Care in the family**

Most respondents stated that they were willing to take daily care family members who are infected than those who said that they would not.

- **Condom use**

- Few of the police had previous sexual experiences that they regretted, which was risky towards HIV infection, but most had never had such experiences. The regrettable experiences were failure to use a condom and engaging in sexual intercourse because of being drunk. The involved officials made excuses, stated their feelings and had to undergo HIV tests
- Most believed that condoms prevent HIV infection and few did not think that a condom could prevent the infection.
- Most had discussed the importance of condom use with partners while few had not.

- **Willingness to know status**

- Most respondents were willing to take an HIV test, very few were not, very few others were uncertain about their willingness.
- Most were willing to know the results of those tests, but few were not.
- Most preferred to be the ones telling their partners about their status, fewer than these stated that they would rather use doctors to convey the information to their partners, much fewer did not know whom they would ask and slightly more than these said that they would involve somebody else not mentioned above.

- **Stigmatisation**

- Most respondents believed that fearing HIV caused the stigma against those who carried it, and few did not believe so.
- Most did not believe that it was individual fault to contract HIV, but there were those (about only few) who still believed that HIV infection was an individual's own fault.

- **Hiding HIV status from spouse**

Few stated that they would keep it a secret from spouses if they were infected, but most indicated that they would reveal their status to them.

- **Living with HIV infected person**

More police officials indicated that they feel comfortable living with infected persons than those who would be uncomfortable. Further, more would be comfortable working with infected persons than those who would be uncomfortable. Furthermore, more would feel comfortable working with them than those who would be comfortable living with them.

- **HIV/AIDS as health threat**

More police officials believed HIV/AIDS was a threat to their communities than those who did not believe so. Also, more believed it was a threat to themselves than those who did not think so. Lastly, more considered HIV/AIDS to be a serious threat more to their communities than they considered it to be a threat to themselves.

- **Lifestyle and behavioural changes**

More respondents changed lifestyles to avoid HIV infection risk than those who did not change. Also, those who believe AIDS education would be more beneficial are more than those who did not think so. Lastly, more preferred AIDS education than lifestyle changes.

4.4 Miscellaneous perceptions about HIV/AIDS

The issues discussed in this section were derived from the questions in Section C of the questionnaire. Some police officials did not answer these questions. Others only answered some of the questions. Only a handful of police officials answered all the questions. The presentation of the section starts with lists of raw points provided by the respondents. Each list is then collated in a paragraph that links every narration into a connected clause. The paragraphs are the interpretations of the lists.

4.4.1 HIV/AIDS and its causes

The respondents were requested to inform what they believed HIV/AIDS to be and what they thought were its causes.

- What it is?
 - A disease that is deadly and contagious.
 - A disease that weakens the immune system.
 - An incurable disease.
 - A killer disease.

- A sexually transmitted disease.
- Virus getting into blood (e.g. use of needle that was used on HIV patient, or sleeping with an infected person).
- A disease believed to be a curse
- What causes it?
 - Sexual intercourse with an infected person.
 - Blood transfusion.
 - A motor vehicle accident may lead to HIV infection due to an infected blood coming into contact with an open wound of another person.
 - Involvement of oneself in sex with many people.

Interpretation

- HIV/AIDS
 - The respondents perceive HIV/AIDS as a disease that is deadly, contagious, incurable, sexually transmitted, that destroys the immune system and believed to be a curse. It is a killer disease that starts in the blood with a virus (HIV) and develops into AIDS, which is the disease.
- Causes of HIV/AIDS
 - They consider the cause of HIV/AIDS as an infection that may start with sexual intercourse or an accident when blood of an infected person gets into the blood system of the victim. That is the beginning of HIV/AIDS referred to as HIV infection, which may develop into AIDS later.

4.4.2 Ways of spreading HIV and ways of not spreading it

They were asked to mention what they believed were the ways HIV is spread and the ways they thought they could not be ways to spread it.

- Ways of spreading
 - Unprotected sex with an infected person

- As long as infected blood enters your blood you stand a big chance of being infected
- Use of toothbrush and needles (unless thoroughly cleaned) used by an infected person.
- Sexual intercourse with multiple partners where one is infected.
- Blood transfusion.
- Cuts or wounds that come into contact with infected blood.

▪ **Ways of not spreading**

- Kissing will not, unless there is blood in the mouth of an infected person who is kissing
- Use of utensils that are used by an infected person.
- Use of public facilities (such as toilets).
- Hugging will not cause infection.
- Working with infected people will not cause infection.
- Staying or living with infected people does not cause infection.
- Being faithful to your partner.
- Educating people about it.

Interpretation

▪ **Ways of spreading**

- The respondents believe that HIV/AIDS is spread when unprotected sexual intercourse takes place with an infected person, when blood of an infected person enters another person's blood system, through cuts and wounds, use of needle used earlier on an infected person and the use of toothbrush that was used earlier by an infected person.

- **Ways of not spreading**

- They believe that kissing, hugging, sharing facilities, working or staying with infected people and being faithful as ways that cannot spread the disease. They also believe that HIV/AIDS education is an important tool to help reduce the spread of the disease.

4.4.3 Avoiding HIV/AIDS

This question wanted the police officials to state the techniques to avoid contracting HIV/AIDS.

- Protected or safe sex using a condom (condomise)
- Engaging in one partner relationships (faithfulness)
- Abstaining from sex is the only guarantee (assuming that no rape incident takes place)
- Use gloves to avoid cuts and even when dealing with blood
- Educate those who do not know about preventing infection
- Test and know status, and then condomise
- Preaching safe sex

Interpretation

- The respondents believe that abstaining from sexual intercourse, condomising and being faithful to one's partners are essentials that can be followed to avoid contracting HIV/AIDS. They also believe that using gloves when working with blood, education on preventing infection, and testing to know HIV status are also crucial for controlling the disease.

4.4.4 Barriers to condom use

The respondents were asked to disclose what they believed were the barriers to use of a condom consistently.

- When drunk and having sex, one tends to forget.
- Sexual intercourse with a partner who does not appreciate using condom.
- Disagreements between parties in the intercourse.
- Lack of knowledge or ignorance.
- Attitude of some people towards the use of condoms.
- Absolutely no barrier, because condoms are freely and abundantly available.
- Traditional or conservative mind or approach.
- Dominated by a partner who hates condom use.
- Carelessness.
- Married people tend to trust each other, but there may be one who is not faithful.
- An attempt to fall pregnant.
- An excuse that it may break or tear.
- Some people do not like to use condom.
- Rape
- Fear to buy or carry condoms as one may be thought to be someone who likes having sexual intercourse a lot.

Interpretation

There were some respondents who mentioned various barriers to use condoms and those who believed that there were no barriers.

- Barriers
 - The respondents mentioned numerous barriers that could prevent people to use condoms when having sexual intercourse. They include having sex being drunk, one of the parties involved refusing to use a condom, attitude of one or both of the parties involved, traditional barriers that opposes artificial means. an excuse that the condom might break. lack of knowledge, dominance by the

party that does not want a condom, rape, carelessness, and fear to carry a condom fearing to be considered to like sex. Other barriers may be attempts to fall pregnant and married couples who tend to trust each other.

- Those for no barriers
 - These ones point out that condoms are freely available, or may be purchased at any shop inexpensively.

4.4.5 Reliability of the male condom

The question wanted the police officials to indicate what they believed was the extent of reliability of the male condom.

- It is safe.
- It is safe when used correctly.
- It is not reliable.
- It is not reliable as it can break/tear while having sex.
- Not reliable at all.
- *Choice* seems unreliable because it is very light, but *Lovers Plus* is thick enough to be trusted.
- Well designed ones may be fairly safe, but not the one that escaped the quality tests of SABS through bribery.

Interpretation

Some respondents stated that condom use is reliable while others stated that it is not reliable. These were their inputs.

- Not reliable
 - Some respondents point out that a condom can burst when sexual intercourse is taking place, which makes the exercise risky. They also point at the lack of quality of the condoms that were passed through quality checks of the South

African Bureau of Standards through bribery after failing proper tests. Lastly, they identify a thin condom by name, which they isolate as particularly unsafe because it is easy to tear.

- Reliable
 - These ones believe that condoms are safe. They mention a specific condom they claim to be reliable because it is thick and strong.

4.4.6 Recap of the section

- Everyone knows that HIV/AIDS is dangerous, that HIV can result from exchange of blood where there are open wounds, and that AIDS is a dangerous, incurable and contagious disease.
- Ways of spreading HIV are limited to sexual intercourse for most respondents, and ways of not transmitting it are generally not known because of misconceptions about the ways in which it can be spread.
- Ways to avoid unsafe sex emphasized abstinence, condom use and faithfulness to one partner.
- Barriers to consistent condom use ranged from forced ones (such as rape) to others that were due to ill-discipline of the people involved in sexual intercourse.
- Condom is generally believed to be unsafe, even though some people trust it.

4.5 CONCLUSION

The Section provided the findings and the interpretations. It covered the profiles, the perceptions from closed-ended section of the questionnaire and the descriptions in Section C of the questionnaire. The next chapter presents summaries, conclusions, and recommendations

CHAPTER 5: SUMMARY AND CONCLUSION

5.1 INTRODUCTION

This chapter reviews in the form of a summary the findings made from the previous chapter and then makes recommendations. These recommendations serve as a base for implementation for improvement. A brief implementation guideline is proposed later in the next chapter.

5.2 DISCUSSION OF MAIN FINDINGS

5.2.1 Respondents' profiles

The respondents from Mthatha Central Police Station were dominated by males, Inspectors, married, Grade 12's certificated, 42 to 47 years of age, and black of Xhosa ethnicity.

5.3.2 Awareness about *HIV/AIDS*

The summaries of findings were:

HIV/AIDS infection

- The respondents were not unanimous about the HIV/AIDS causes even though most knew a few specific causes of infection such as a needle used previously on an infected person.

Symptoms of sickness

- Some respondents believed that external signs can be used to detect that a person is HIV positive. There were inconsistencies here as well.

Cure for HIV/AIDS

- There were respondents who believed that there is a cure for AIDS but few believed that there could be no cure.

Care in the family

- Some respondents were willing to take daily care family members who are infected.

Condom use

- Few police officials had previous regrettable sexual experiences, which was risky towards HIV infection. The regrettable experiences were failure to use a condom and engaging in sexual intercourse because of being drunk. Most thought that condoms prevent can obstruct HIV infection and few did not think that a condom could prevent the infection. Most had discussed the importance of condom use with partners while few had not.

Willingness to know status

- Some respondents were willing to take an HIV test, very few were not, very few others were uncertain about their willingness. Some were willing to know the results of those tests, some preferred to tell their partners about their status, some would rather use doctors to convey the information to their partners.

Stigmatisation

- Some respondents believed that fearing HIV caused the stigma against those who carried it, and few did not believe so. Some respondents believed that HIV infection was an individual's own fault.

Hiding HIV status from spouse

- Few would keep it a secret from spouses if they were infected, but most would reveal their status to them.

Living with HIV infected person

- More police officials were comfortable living with infected persons, others would work with them.

HIV/AIDS as health threat

- Some police officials believed HIV/AIDS was a threat to their communities than those who did not believe so. Also, more believed it was a threat to themselves than those who did not think so. Lastly, more considered HIV/AIDS to be a serious

threat more to their communities than they considered it to be a threat to themselves.

Lifestyle and behavioral changes

- Some had changed lifestyles to avoid HIV, others would rather be educated.

5.4.3 More impressions about HIV/AIDS

- Police officials believe that HIV/AIDS is dangerous, that HIV results from blood transfusion, and that AIDS is a dangerous, incurable killer disease.
- They mostly believe that ways of spreading HIV are limited to sexual intercourse, and ways of not transmitting it are generally not known because of misconceptions about the ways in which it can be spread.
- Ways to avoid HIV/AIDS infection emphasized were abstinence, condom use and faithfulness to one's partner.
- Barriers to condom use ranged from forced ones to ill-discipline.
- Condom is generally believed to be unreliable, only a minority trusts it.

Gross inconsistencies occurred among the respondents regarding various HIV/AIDS aspects that were probed in this study.

5.3 LIMITATIONS AND IMPLICATIONS

5.3.1 Limitations

The study was limited to police officials in Mthatha, in particular, the Mthatha Central Police Station. The length of the dissertation had maximum quantities which may not be exceeded. First, the study was constrained within a fixed length. Second, there was also a time limit within which the study must be completed. The implication was about speeding up the research process so that the due date of the dissertation could be satisfied. Even though literature covered international literature, the empirical part of this research was limited to the South African environment.

5.3.2 Implications

This study cannot be extended to other sectors outside the police. It also cannot be generalised to areas outside Mthatha. The findings are directly applicable only to the police personnel in Mthatha Central Accountable Station. They imply the situation inside the police station. That is, programmes to address HIV/AIDS, which relate to the issues discussed in this study, can be initiated inside Mthatha Central Accountable Police Station. The study can serve as a benchmark for South African Police Services in other areas of South Africa outside Mthatha. It can also be a useful benchmark for other public sector departments.

5.4 RECOMMENDATIONS

It is recommended that:

- Mthatha Central Accountable Police Station should embark on awareness campaigns to enlighten the police officials about HIV/AIDS:
 - *what it is, its infection, symptoms, (lack of cure) cure, prevention,*
 - *benefits of knowing one's status, threats of HIV/AIDS*
 - *other relevant HIV/AIDS issues;*
- Mthatha Central Accountable Police Station police officials must be educated to care for people infected with HIV/AIDS at home and at work, and on the value of informing the next-of-kin (especially the spouse).
- Mthatha Central Police Station should hold workshops to train the police on life skills to be able to cope with HIV/AIDS, as well as to work and live with those with HIV/AIDS.
- Mthatha Central Police Station police should be given tasks to keep them busy and change to safer lifestyle if necessary, and develop monitoring systems to ensure that they do not abuse their police status for unethical conduct;

5.5 CONCLUSION

The study aimed to explore the level of awareness about HIV/AIDS in the Mthatha Central Accountable Police Station. The questionnaire was used, police officials responded to interviews, and data were analysed and interpreted. The findings revealed that most police officers are enlightened about the epidemic, but there are still many of them who do not know or have information. Further research may be undertaken in the other police stations about HIV/AIDS, especially upon realising that police officials in Mthatha Central Police Station had different views about the same important issues.

Chapter 1 reasoned the study intentions, provided problem statement, defined aims and objectives and also gave an outline of the value of the study.

Chapter 2 presented the literature reviewed on the perceptions towards HIV/AIDS. Various findings by the various research reports on perceptions towards HIV/AIDS were discussed. The information was gathered from recent books, journal articles and the internet. Chapter 2 covered the following themes:

Perceptions about HIV/AIDS.

Knowledge of HIV/AIDS and changing attitudes

HIV/AIDS and behaviour change.

Obstacles to behaviour change

Attitudes and beliefs towards voluntary counselling and testing.

Use of condoms as a method of preventing HIV/AIDS and transmission of HIV/AIDS.

Chapter 3 explained the research methods and procedures used in the study.

Chapter 4 presented the research findings and interpretations. Lastly, chapter 5 presented summaries, conclusions and recommendations.

The study therefore provided important information on the state of knowledge, attitudes, behaviours and practices concerning HIV/AIDS. Issues which need special attention are identified and also various myths and misconceptions and also knowledge gaps which need addressing were identified. Although it was discovered that police officials working at Mthatha Central Accountable Police Station are enlightened about HIV/AIDS (91 percent), there are a few (9 percent) who have informed perceptions about it and also about the effectiveness of condoms at preventing HIV/AIDS. Misapprehensions can be addressed by education, frank talk about sexuality and better marketing and distribution of condoms. Condom promotion should be part of any public health strategy. If condoms are used correctly and consistently, they can prevent HIV infection and save lives.

Most of the subjects reported that HIV/AIDS is transmitted through sexual intercourse with an infected partner, through blood transfusion, needles and syringes.

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APPENDIX A : RESEARCH QUESTIONNAIRE

Section A: Biographical Data of Respondents

1. GENDER

Male	Female

2. AGE

30-35	36-41	42-47	48-53	54-60

3. RANK

Constable	Sergeant	Inspector	Captain	Superintendent	Sen. Supt	Director

4. LEVEL OF EDUCATION

GRADE 12	1-2 YEAR DIPLOMA	3 YEAR DEGREE / DIPLOMA	POST GRAD DEGREE OR HIGHER

5. MARITAL STATUS

SINGLE	MARRIED	WIDOW / WIDOWER	OTHER

6. RACE

BLACK	WHITE	COLOURED	INDIAN

7. HOME LANGUAGE

LANGUAGE	FREQUENCY
ENGLISH	
AFRIKAANS	
XHOSA	
ZULU	
SESOTHO	
SETSWANA	
SWATI	
TSONGA	
VENDA	
NDEBELE	
SEPEDI	
OTHER	

Section B: Yes Or No Questions Either

1. Using the same needle to transfuse blood from one patient to the other may spread HIV / AIDS?

YES	NO

2. Acquired Immuno Deficiency Syndrome (AIDS) is caused by infection with the Human Immuno Virus (HIV)

YES	NO

3. An HIV-positive person may not necessarily feel or look sick.

YES	NO

4. There is no definite cure for HIV/AIDS infection.

YES	NO

5. An individual infected with HIV remain well with no clear signs or symptoms of the infection.

YES	NO

6. If your family member unfortunately contracts HIV, would you be willing to take care of him or her on a daily basis.

YES	NO

7. Have you ever had a sexual experience that you regretted later because you did not use a condom?

YES	NO

If yes tell me more.

8. Do condoms prevent HIV infection?

YES	NO

9. Doctors can tell if you have HIV/AIDS by carrying out a test on you.
Would you be willing to take this test?

YES	NO	DO NOT KNOW	NOT SURE

10. Would you be willing to know the results of your HIV test?

YES	NO

11. Some people think that the fear of HIV/AIDS is causing unfair discrimination against people who contracted the disease.

YES	NO

12. A man or woman is entitled to keep his or her HIV status a secret from his or her wife.

YES	NO

13. Would you be comfortable with living with a roommate who has HIV/AIDS infection?

YES	NO

14. Would you be comfortable working with a roommate who has HIV/AIDS infection?

YES	NO

15. In general, do you agree with the statement that it's a person's own fault if they get HIV/AIDS infection?

YES	NO

16. Would you be willing to know the results of your HIV test.

YES	NO

If yes, would you want to tell your family (that is, your spouse / partner, children and parents) or would you prefer someone else like your doctor to tell them?

MY SELF	DOCTOR	DO NOT KNOW	OTHER

17. Have you discussed the importance of condom use with your spouse or partner?

YES	NO

18. Do you think that HIV/AIDS is a serious threat to the health of your community?

YES	NO

19. Have you ever felt that HIV / AIDS is a threat to yourself?

YES	NO

20. Are there any changes to your lifestyle or sexual behaviour in order to reduce the risk of HIV/AIDS infection?

YES	NO

21. AIDS education is the effective means of persuading individuals to modify their risky behaviour and minimize fear and prejudice based on ignorance.

YES	NO

SECTION C: ANSWER THE FOLLOWING QUESTIONS

1. Can you tell me what HIV / AIDS is and what are its causes?
2. Which ways would you say they spread HIV / AIDS and which ones do not spread the pandemic?
3. Tell me how one can avoid contracting HIV/AIDS.
4. Tell me what the barriers to consistent condom use are.
5. Tell me how reliable the male condom is.