# *"A Mountain to Climb"*

## An Assessment of the Impact of HIV/AIDS on the Institutional Capacity of the Lesotho Mounted Police Service

**Themba Masuku and Per Strand**

**A publication of the Centre for the Study of Violence and Reconciliation**
**Produced in collaboration with the Lesotho Mounted Police Service**

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**Themba Masuku and Per Strand**

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**Centre for the Study of Violence and Reconciliation**

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Themba Masuku was overall manager of the project, carried out the field research and wrote the initial draft of this report. Dr. Per Strand provided assistance throughout project including with conceptualising the research, finalizing the research instruments and writing the final report.

Themba Masuku was previously a senior researcher at CSVR and is now a private consultant. Dr. Strand is a political scientist and manager of the AIDS, Democracy and Governance research project in the Democracy in Africa Research Unit at the Centre for Social Science Research at the University of Cape Town.

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This research report is dedicated to Sergeant Motuba and all the police officers in the LMPS who have and continue to play a positive role in the fight against HIV/AIDS in the police services.

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# FOREWORD

The Lesotho Mounted Police Service (LMPS) is deployed throughout Lesotho for the maintenance of law and order, for preserving peace, the protection of life and property, and for the apprehension of offenders against public peace. One of the major challenges to the LMPS in achieving this noble mission is the vulnerability of LMPS personnel to the scourge of HIV and AIDS.

The first case of Acquired Immune Deficiency Syndrome (AIDS) in Lesotho was reported in 1986. The prevalence of HIV and AIDS among the adult population in Lesotho is reported as 23.3%, a statistic which calls for the strengthening of the containment efforts towards prevention, mitigation, treatment, care, and support of those affected and infected by HIV and AIDS. The LMPS personnel are not an exception in these figures since they form part of the Basotho nation. Reports show that the HIV and AIDS pandemic has become the leading cause of morbidity and mortality in Lesotho as well as increasing the risk and impact of infection by tuberculosis (TB).

An assessment of the impact of HIV and AIDS interventions in the LMPS will assist the organization to better understand how HIV and AIDS is manifesting within its ranks, and how it impacts on the operations and the delivery of policing services. The issues underpinning the impact must be addressed through strategic, evidenced-based, theory-driven, results-oriented, organization-driven, and well-coordinated interventions.

The factors which have reinforced unsafe sex derive from behavioral, technical, and biological dimensions of the LMPS population. In order to contain and limit staff turnover, as a result of the large number of those who are infected, or otherwise affected, by HIV and AIDS, an aggressive implementation of an embracing prevention strategy is to be fully engaged by this organization, including all elements of HIV and AIDS containment, namely: prevention, mitigation, treatment, care, and support.

In 2008, a study was undertaken by the Center for the Study of Violence and Reconciliation (CSVR) in conjunction with the LMPS to understand how HIV/AIDS is manifesting in the organisation and to inform the organisation how it needs to respond to the challenge. This report contributes to the LMPS's ability to strengthen its efforts at containment in line with those outlined in the NATIONAL HIV and AIDS Prevention Plan 2006 – 2011, as well as Strategy # 7 of the LMPS Strategic Plan 2006 – 2009.

I will therefore, like to emphasize that, this study is a guiding tool that will among others assist the LMPS to identify the gaps and good practices in its intervention programs, while utilizing the limited resources in the containment of HIV and AIDS. I strongly urge you all to use it and guard it jealously as it provides useful information which is crucial towards addressing the challenge that HIV/AIDS poses to the LMPS.

Yours sincerely

_____________

*E.M. Letooane*

# EXECUTIVE SUMMARY AND RECOMMENDATIONS

1. The Lesotho Mounted Police Service (LMPS) is tasked with maintaining law and order and providing a range of services despite the fact that, according to national prevalence figures, approximately 23 percent of its officers are HIV positive. AIDS-related illnesses and deaths are bound to reduce the capacity of the LMPS to some extent. This report is intended to support engagement with the problem of HIV/AIDS in the LMPS. With this in mind it has two main purpose: (i) to assess the nature and degree of the impact from HIV/AIDS on the institutional capacity of the LMPS; (ii) to examine and analyse the perceptions of LMPS officers relating to the impact of AIDS, the causes of HIV infection, and the response to HIV/AIDS within the LMPS.

2. The field work was carried out in Lesotho over a few weeks in the latter part of 2008. A survey was handed out to 508 LMPS officers with a fair distribution across the country, gender, age and rank. In addition, a number of focus group discussions were arranged and several key-informant interviews were held. This material was collected on the basis of an analytical framework that had been generated from the most influential academic literature in the field. The research was conceptualized and carried out with the full support of the LMPS Commissioner of Police.

3. Key findings of the research that relate to questions about the impact of HIV-AIDS on the LMPS and of HIV prevalence amongst members of the LMPS are that among the respondents to the survey:
   - A large majority know that there are LMPS officers who are HIV positive and think that AIDS often or very often is the cause of death of LMPS officers.
   - A majority feel an increasing need to cover for colleagues who are absent due to illness.

4. Key findings of the research that relate to questions about the beliefs and behaviors of LMPS members relating to HIV-AIDS are that:
   - When asked what they thought were the two most common ways for LMPS members to get infected with HIV, 46% of respondents indicated that they thought that having multiple concurrent sexual partners was one of the most common ways for, and 16% also indicated that they thought that it was common for LMPS members to be infected by their spouse or regular partner. Over one third of respondents (38%) indicated that they thought that one of the most common ways was ‘through their LMPS work’.
   - A majority have two or more concurrent sexual relationships.
   - A majority never use condoms or use them only sometimes;
   - A large majority feel that LMPS work often or sometimes is stressful.
   - A minority have taken an HIV test and know their HIV status, and.
   - A majority of those who have tested did so over a year ago.

5. The qualitative material gathered through interviews and discussions added considerable context and depth to these general findings. In explaining their involvement in multiple concurrent relationships or casual sex police officers talked about a number of factors including boredom when stationed away from home, dynamics to do with peer pressure and earning respect from colleagues, as a means for accessing food and accommodation while on deployment away from the home area, and as a way of getting away from the stress of LMPS work. Those who had not taken HIV tests indicated that this was partly because of the possibility of finding out that they are HIV positive and because they anticipated that they would feel uncomfortable about sharing the results with their partners. The qualitative material relating to the various issues covered in the general survey clearly show that there are no quick fixes for unsafe sexual behaviours and no simple information campaign will alter perceptions that hamper better prevention of AIDS within the LMPS.

6. The report concludes that there is overwhelming support in the material for the hypothesis that AIDS is undermining the institutional capacity of the LMPS, although there is no way of quantifying the exact level of its impact on the basis of this research.

7. On the issue of causes of HIV infection the report makes references to evidence from research conducted in various countries, that the risk of infection by police officers when on duty is minimal. Alongside the evidence of low work-related risk of infection, the report also refers to the evidence provided by this study of widespread behavior which is high-risk for HIV infection including multiple concurrent partners often accompanied by little or no condom use. The report therefore concludes that there can be little doubt that high-risk sexual behavior by police officers and/or their spouses or regular partners is overwhelmingly the main cause of HIV infection amongst members of the LMPS.

8. In related to the risk of occupational exposure the report emphasizes that most studies which have been done have indicated that the risk faced by police officers of contracting HIV through work related exposure is negligible and can almost be regarded as insignificant. However the report notes that it is possible that such risk if marginally greater in Lesotho as a result of the high rates of infection amongst the population that LMPS officers come into contact with. Though the report emphasizes that the key issues are to do with high risk sexual conduct, it nevertheless motivates that the issue of the provision of protective equipment needs to be taken seriously by the LMPS. This is necessary to reassure LMPS members that they can carry out their work safely. Even if the risk of occupational exposure is quite low, concern about the risk of occupational exposure linked to beliefs that occupational exposure is common, are likely to be widespread.

## Recommendations

9. The report makes the following recommendations:

I. The LMPS and its senior staff have done much to respond to AIDS on the basis of the general policy template provided by the National AIDS Commission. However the LMPS should consider developing its own specific HIV/AIDS policy. Such a policy should be developed through a participatory process that would allow for broad deliberation among all LMPS staff so as to ensure that the process sows the seeds for a new institutional culture that embraces those officers who are HIV positive and those who take active steps to know their status and live a life that prevents the further spread of HIV in Lesotho.

II. The LMPS should explore ways of strengthening systems of support to police, including the provision of food and shelter to officers on patrol or deployment away from the stations where they are based. The police officers on deployment rely on the relationships they create with locals for support and this may dispose them to become involved in sexual relationships in order to survive while working away from home. Options that might be considered might include shorter deployment periods for police officers and/or the provision of accommodation and meals to them when they are on deployment.

III. The LMPS should publish information on staff-turnover and the reasons for this in order to improve public knowledge and avoid misperceptions about this.

IV. The LMPS should explore ways of monitoring levels of HIV and AIDS among police officers and other civilian staff, and evaluate their impact on staff turn-over.

V. The LMPS should streamline procedures and facilitate access to protective gear as much as possible, and then inform officers of the limited administration needed to access the equipment.

VI. The LMPS should collect quality information from police officers who are living openly with HIV/AIDS in order to understand their challenges and in order to improve HIV/AIDS programmes as well as care and support.

VII. The LMPS should explore regional cooperation with police forces in countries with similar problems to share insights in formulating policy and developing interventions based on best practices in similar contexts.

VIII. Government should examine concerns about the quality of condoms issued by government. These concerns are one of the impediments to the use of government issued condoms and feed into justifications for not using them. If these concerns are valid better quality condoms should be provided. Otherwise steps should be taken to reassure police and others about the quality of government condoms.

# ABBREVIATIONS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ART** | Antiretroviral Treatment |
| **CSVR** | Centre for the Study of Violence and Reconciliation |
| **CJP** | Criminal Justice Program |
| **HIV** | Human Immunodeficiency Virus |
| **LMPS** | Lesotho Mounted Police Services |
| **PTC** | Police Training College |
| **PTSD** | Post Traumatic Stress Disorder |
| **RBF** | Rockefeller Brother Fund |
| **SAPS** | South African Police Services |
| **UNAIDS** | Joint UN Programme for HIV/AIDS |
| **UNGASS** | United Nations General Assembly Special Session [on HIV/AIDS] |

# 1. INTRODUCTION

In all countries, the police force is an essential state institution for reducing crime, upholding law and order, and assisting communities and individuals with a wide range of functions and services. In the context of a developing country, the police may be the only manifestation of the state with which communities have some direct and regular interaction, especially in rural areas. The professionalism, resources and overall capacity that the police force holds are therefore critical in shaping popular perceptions of the state and its quality of governance, and for ensuring that the state and the government have de facto control over public affairs in the country. So, what happens if the police get sick?

In the context of the alarming HIV/AIDS epidemic in most countries in Southern Africa, the question is not as far-fetched as it first might appear. As we shall see below, some ten years ago, both individual analysts and institutional stakeholders developed apocalyptic scenarios suggesting that AIDS alone would cause the worst affected states to either collapse dramatically or fade away over time as their capacity was eroded by AIDS-related deaths among key staff, especially within the uniformed services. Such predictions have proven mistaken due to interventions in terms of prevention and treatment, as well as due to some flawed assumptions. But this should be no cause for complacency. On the basis of empirical evidence from Lesotho, this analysis argues that HIV/AIDS epidemic is likely to be a threat to the institutional capacity of the state due to an increased level of absenteeism and turn-over of staff, and the consequent loss of institutional memory and capacity. While AIDS is unlikely to cause state collapse, it is likely to undermine the quality of governance and democracy to an extent that the overriding political project of lifting communities out of poverty will become more difficult to realise.

While the paragraphs above set out the broad context for the analysis that is presented in this report, its precise objective is more specific. The purpose of this analysis is to: *(i)* assess the nature and degree of the impact from HIV/AIDS on the institutional capacity of the LMPS; and *(ii)* examine and analyse the perceptions of LMPS officers relating to the impact of AIDS, the causes of HIV infection, and the response to HIV/AIDS within the LMPS.

The research was conducted by the Centre for the Study of Violence and Reconciliation (CSVR), in partnership with the LMPS Commissioner of Police and the LMPS Counselling Unit. The rationale for doing this research was to generate new information that will assist the LMPS in understanding how and why the epidemic is impacting on the ability of the police service to fulfill its constitutional obligations, so that the LMPS can reduce this impact through various interventions.

The LMPS Police Commissioner and other senior staff are strongly committed to understanding the problem of HIV/AIDS in the LMPS and identifying effective prevention interventions among LMPS officers and other staff. For example, the LMPS has instituted a workshop programme to increase the knowledge and awareness of HIV and AIDS among its personnel.

The Centre for the Study of Violence and Reconciliation (CSVR) started developing analytical expertise in this field through a report on the impact of AIDS on the police in a district in Johannesburg, South Africa.[1] Once this report was concluded, the CSVR started planning for a comparative research project on the same theme in the Southern Africa region. After initial contacts had been made, the CSVR and the LMPS Police Commissioner soon developed a common understanding of the mutual benefits that lay in a collaboration for developing a report of this nature. The two parties have discussed and agreed on both the methodological framework as well as the research process for this analysis.

Despite the recognition of an impact from AIDS on LMPS by its senior staff, the LMPS does not at this stage have an organisational policy and strategy to address the AIDS problem. The research was therefore designed to provide the LMPS management and Counselling Unit with useful information for developing policies for strategic interventions.

The report is structured in nine sections. After this introduction, the second section will provide the background necessary to grasp the extent of the problem with HIV/AIDS in Lesotho. The third section will introduce the theory and research methodology that provide the analytical framework for the report. The fourth section will present and discuss information on the perceptions of HIV/AIDS in LMPS. The fifth section will discuss perceptions of the risk of contracting HIV through police work in LMPS. The sixth section will discuss sexual relationships and condom use among LMPS officers and the seventh section will analyse perceptions of an impact from AIDS on the institutional capacity of LMPS. The eighth section will review three aspects of the response to AIDS by LMPS and its officers. The conclusions summarises the main findings and suggest some key implications for LMPS.

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[1] Masuku, 2008.

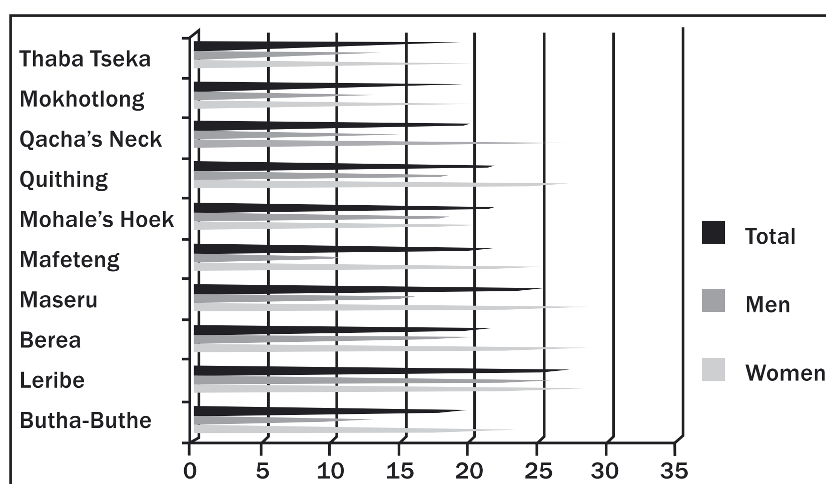
# 2. HIV AND AIDS IN LESOTHO – A BRIEF OVERVIEW

In the context of the global HIV/AIDS epidemic, Lesotho is a particularly severely affected country in a region that is the epicenter of the global epidemic. Lesotho is one of only seven countries that in 2008 were categorized as 'hyper-endemic', i.e. countries in which at least 15 percent of the adult population is estimated to be HIV positive.[2] At 23 percent, Lesotho's adult HIV prevalence is the world's third highest, after Swaziland and Botswana, at 26 and 24 percent respectively.[3] With a total of approximately 270 000 infected adults (15-49 years of age), out of a total population of about 1.9 million, Lesotho is under severe strain from HIV/AIDS. In 2007 the National AIDS Commission, the statutory body tasked with driving the response to AIDS, stated that HIV/AIDS "is creating a high burden of disease as well as severe adverse impact on the socio-economic indices on the population".[4]

When the national data is disaggregated on gender, urban/rural and age, we learn about some variations in the epidemic that are relevant for our analysis of HIV/AIDS in the LMPS. In accordance with a pattern across the region, more women than men are HIV infected in Lesotho. For every infected man there are roughly 1.3 infected women. While this difference to some extent reflects women's greater biological vulnerability to infection, it also reflects a vulnerability that has cultural roots in a patriarchal society where women have little if any control over the conditions and terms for sexual relations.

In terms of the urban/rural divide, HIV prevalence rates are somewhat higher in urban than in rural areas (28 and 21 percent respectively). For example, in terms of districts (see fig. 1), prevalence rates range from below 20 percent in rural Mokho-tlong and Thaba Tseka to over 30 percent in urban Leribe. Figure 1 displays additional variation within and between men and women across the ten districts.

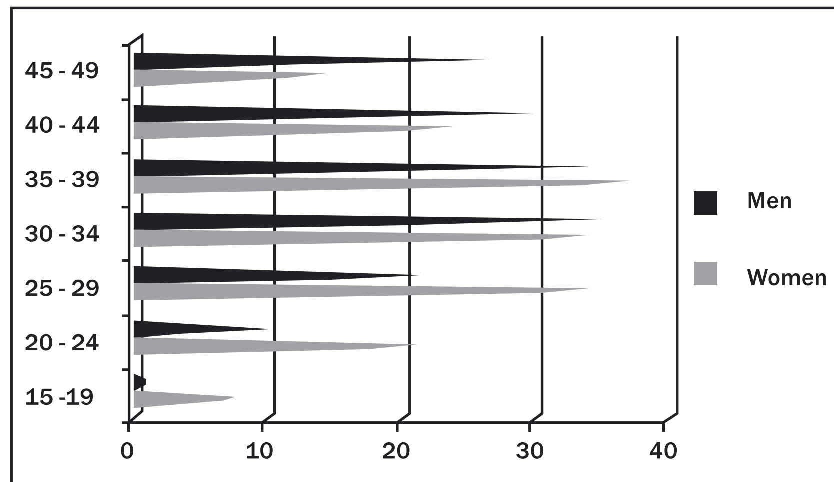
**Figure 1: Adult HIV Prevalence by District, 2007**[5]




Considerable differences between men and women are also evident when prevalence is disaggregated per five-year age cohorts. Here too we find a more general pattern: women become infected at a younger age than men (see Figure 2) on next page.

Of particular relevance for our analysis is that prevalence rates differ widely between men and women at different phases of their career in the LMPS. When first recruited at around the age of 20, HIV prevalence among women is more than twice that of men. Should any screening of new recruits be introduced in the LMPS, this may reduce the number of young women available to serve in the LMPS, as the LMPS already has difficulty finding female recruits. The fact that men have much higher HIV prevalence at a late stage in the career, when they are likely to hold more senior positions, place special responsibilities on them. By openly testing for HIV and disclosing their status they would show a quality of leadership that would help reduce HIV stigma within both the LMPS as well as the wider community. Secondly, as senior officers with some control over resources, men must resist the temptation to become 'sugar-daddies' for young female recruits in an unequal dependency where career opportunities are exchanged for sexual favours. Ethics aside, such gendered patronage networks will definitely hasten the speed at which AIDS undermines the capacity of the LMPS.

## Figure 2: Adult HIV Prevalence, age cohorts, 2007[6]




It is clear that the LMPS is functioning in a context of an alarmingly severe HIV/AIDS epidemic. The assumption is made in this research that HIV prevalence levels are, on the whole, no different within the LMPS than in the wider community. This assumption will be revised if, through the research and analysis conducted here, we learn that there are specific reasons to believe that police officers are more, or less, at risk than other members of the community. However, before we start exploring the data we need to review the theory and methodology that provides the analytical framework for the research for this report.

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[2] The other six countries in the region are Botswana, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

[3] UNAIDS., 2008:36.

[4] National AIDS Commission., 2006:3.

[5] Ibid.

[6] Ibid.

# 3. RESEARCH METHODOLOGY

This section will outline the theoretical reasoning that motivates the study as well as the methodology used to gather information with which one could test the central hypothesis that the theory generates.

## *Theory*

The basic realization that motivates this research is that since AIDS-related illnesses and deaths primarily affect people in the age cohorts that the state otherwise rely on for upholding its functions and services, it would be reasonable to assume that these deaths somehow affect the capacity and functionality of the state. Unless social science contributes research on the nature and level of these effects, states will have little knowledge of how to devise effective responses that can minimize this potentially destructive impact from AIDS. This general effect from AIDS on the state is likely to be a problem unique to the African countries that have experienced extraordinary high levels of HIV prevalence in the general adult population in the recent past – those countries that are currently called 'hyperendemic'. Only in these countries would the AIDS-related deaths among professional people employed by the state be numerous enough to generate an aggregate effect on the capacity of the state.

The scholarly contribution that formulates the nature of this effect most succinctly and elaborates on its implications is the article How will HIV/AIDS Transform African Governance, by Alex de Waal.[7] He argues that AIDS is likely to impact negatively on governance in Africa in the short, medium, and long term. In the short term, increased staff absenteeism and turn-over will put additional pressure on the already strained bureaucracy; loss of capacity and institutional memory will result in reduced level and quality of delivery of essential services. In the medium term, the cost of treatment and increased risk of AIDS-related illness and death will alter incentive structures for staff. The likely prospect of a drastically truncated career will make corruption and theft more likely as staff will try to provide for their families after their own premature demise. In the long term, AIDS is likely to undermine attempts to build a modern and effective state bureaucracy that can manage and deliver on political commitments to reduce poverty.

The article by De Waal appears to have been an attempt to bring some moderating theoretical reflection into an increasingly unfocused but intense discussion about AIDS as a threat to state security that had been set off by the UN Security Council Resolution 1308 (of 2000) that identified AIDS as a global security threat. On the back of this resolution, a number of academic studies elaborated scenarios where raging AIDS epidemics alone would set off wars as the balance of powers between

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[7] De Waal., 2003:1-23; See also Price-Smith., 2002 and 2007; Bartels., 2003:10.

enemy states were undermined by armies crumbling from AIDS-related deaths. The groundwork for this theoretical discussion, and for the UN SC Resolution, had been laid already in the mid- to late-1990s with reports from the US Central Intelligence Agency predicting chaos and anarchy in the worst affected areas as a result of AIDS that had gone out of control, leading to failed and collapsing states in Africa in particular.[8] As the epidemic has matured in Africa it is obvious that the predicted worst-case scenario has not materialized, for a range of different reasons. In a sobering review of the literature and some of the assumptions the more alarming arguments were based on, Whiteside, De Waal and Gebre-Tensae argue that concerns about AIDS undermining the state's uniformed services, leading to social unrest and war, were always exaggerated and based on a poor understanding of the tenacity of military and police hierarchies and bureaucratic structures.[9] It is still relevant to discuss the impact of AIDS on the uniformed services, but in doing so one should look for more finely tuned effects on institutional capacity and not expect signs of dramatic collapse.[10]

Studies have already suggested that such effects can be discerned in the capacity of police forces in Southern and Eastern Africa due to AIDS-related attrition and loss of staff [11]. Research in Mozambique, for example, indicates that despite the fact that new police recruits are screened for HIV; the Mozambican Police Services is losing members through AIDS-related deaths at a higher pace than they can be replaced. The National Statistics Institute in Mozambique put the HIV prevalence rate amongst police officials in Mozambique at about 15 percent, with at least 150 of them dying from AIDS related illnesses every year.[12] In South Africa, the South African Police Service (SAPS) has failed to curb the high crime rate and it has been suggested that a loss of capacity due to AIDS has been a contributing factor to this incapacity.[13]

But what, more precisely, is meant by 'loss of institutional capacity to AIDS' in the context of the police? Martin Schönteich has suggested the following forms of impact:[14]

- "Substantial increases in the numbers of police officials who leave the police as they fall ill or die as a result of the disease;
- Substantial increases in absence from work as police officers start to fall ill or need to take leave to care for sick or dying relatives;

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[8] Chow., 1996;
[9] Whiteside, De Waal & Gebre-Tensae., 2006.
[10] Rupiya., 2006.
[11] Garrett., 2005. Also see Pharaoh., 2005 .
[12] UNDP, 2001
[13] Schönteich., 2003.
[14] Ibid :4.

- Decreasing productivity and staff shortages as a result of the above factors leading to shortages of skills and experience;
- Declining morale amongst officers as colleagues fall ill or die, or those in their families experience the effects of the disease;
- Higher recruitment, training and medical insurance costs".

The suggested forms of impact indicate the complex and varying nature of the effects AIDS may have on the police in a high-prevalence country. Viewed separately, the impact would be limited, but the impact from AIDS could be considerable when they combine.

One of the central theoretical tasks with this analysis is to interrogate questions about the link between AIDS and institutional capacity of the LMPS. The literature reviewed above presents us with only one credible hypothesis on the nature of that link: that the impact of AIDS reduces the capacity of a complex institution like the LMPS. There would be several different ways of testing this hypothesis empirically. The method chosen for this report is more indirect and qualitative, in that we will base the discussion on information of the perceptions of an impact that are held by LMPS officers. We have two ways of accessing this information from the officers. Material gathered in a survey will provide a more general picture, and focus group discussions and interviews with key-informants will offer depth and context. The limitations of these methodologies will be discussed in the next section.

## *Fieldwork*

The fieldwork for this report was conducted in Lesotho in June, October and November 2008, and it consisted of a pilot study, a survey, focus group discussions, and a number of semi-structured interviews with key-informants. This section will discuss some methodological considerations regarding these efforts to collect the necessary data in Lesotho.

The fieldwork was done under the direction of CSVR. Ten fieldwork assistants who were all undergraduate- or post graduate students from University of Lesotho were recruited and trained. In addition, the LMPS provided two police researchers, one from the Counselling Unit and another from the Human Resources department who were involved in supporting the research fieldwork process.[15]

When doing social science empirical research on an issue as sensitive as HIV/AIDS it is critically

[15] The two police researchers were there to provide logistic support. They assisted with traveling to different police stations and introducing the CSVR researcher to station commanders. They did not conduct interviews or deal with respondents.

important to do so in an ethical manner. CSVR research is done in accordance with an ethical code which ensures that all individuals who contribute information to the research are informed as to the purpose of the research and participate voluntarily. Furthermore, the code stipulates that it is the responsibility of the researchers to ensure that no harm will come to the respondent while participating in the research, or as a consequence thereof.

The subject of HIV/AIDS is particularly sensitive and stigmatizing in Lesotho, as in all other countries in the region. For this reason, potential participants were forewarned about the sensitive nature of the research. They were advised to answer the questions honestly and not to answer questions they felt uncomfortable answering. All participants in both the survey and in-depth interviews were guaranteed anonymity so that what was said in the interview could not later be traced to the respondent. The researcher was also mindful not to make any remarks that could be construed as judgmental and to ask questions in an insensitive manner. At the end of the interview all respondents were given an opportunity to reflect on the interview process and to ask any questions they wanted. Every attempt was made to ensure that respondents felt comfortable during and after the interview process.

## *The Survey*

The overall design of the survey questionnaire and the formulation and selection of the questions were decided upon through a consultative process that, at different stages, included discussions with colleagues at the CSVR as well as a select group of LMPS Senior Staff. The consultant for this project, Dr. Per Strand, also contributed towards the finalization of the questionnaire. The final questionnaire was translated into Sesotho by a consultant in Johannesburg, and the translation was then verified by the LMPS. A pilot study involving 40 LMPS personnel was conducted during the month of June 2008 on a sample that included 20 officers at the LMPS head quarters and 20 officers from Maseru rural district headquarters. The pilot study was an essential step in the process of ensuring the validity of the survey instrument.[16]

The final survey questionnaire held 66 questions, three of which were basic questions on the location where the respondent worked, and 63 were close-ended questions that were grouped into the following six themes:

- background information on the respondent;
- awareness of HIV/AIDS in the LMPS;

[16] The pilot questionnaire included 60 questions and proved a critically important test of the survey instrument. For example, on the basis of the pilot, further nuance was given to the response options of two questions, and an additional three questions were added to the questionnaire.

- occupational risk factors;
- perceptions of the impact from HIV/AIDS on LMPS;
- occupational factors involving stress and trauma, and;
- the response to HIV/AIDS from LMPS.

The questionnaire provided response options to most of these questions in the form of a five point Likert scale where respondents had to choose the response that best correspond to their view or experience. On some questions, in addition to the given responses, respondents had the option to formulate their own answer.

The survey research done for the purposes of this report was not based on a nationally representative sample. After discussing alternative realistic sampling methods for the purposes of this explorative research, the CSVR and the LMPS agreed on a convenience sampling method that would seek to approximate representativeness in terms of gender, rank and location. This meant that whereas field workers would invite all police officers on duty at the selected police stations to participate by filling in the survey questionnaire, they would try to make sure that a sufficient number of women officers were included in the sample.

In June 2008, at the time of the fieldwork, the LMPS had a total of 3.439 employees, of whom 83 percent were male. All staff members at the selected police stations were informed of the research project and were encouraged to participate in this study. On arrival at the different stations, the field workers were welcomed by the station commander who then called all staff on duty into the charge office. At this stage, CSVR researchers explained the purpose of the visit and the study and invited people to ask questions. All this communication was done interchangeably in English and Sesotho in order to ensure that all understood the context and purpose of the survey. After the meeting CSVR would encourage police officers to take questionnaires. No money or any other form of reward was given to those who filled out the questionnaire. The field workers facilitated the process by distributing the questionnaires to the respondents, collecting them upon completion and answering any questions or resolving any problems relating to the survey questionnaire. Both the pilot and the final questionnaire were available in both English and Sesotho, thus allowing respondents to choose the language they were most comfortable with; about 80 percent of respondents used the English version.

The survey was conducted in 19 of Lesotho's 30 police stations, which were located in six out of the 14 police districts.[17] These locations were selected to ensure a geographical spread of the survey,

[17] The Police Head Quarters and the Police Training College are considered as districts on their own.

while taking time and resource constraints into account. A total of 510 police officials received the questionnaire. Of these, only two officials refused to fill in the questionnaire (citing 'personal reasons'), which left CSVR with 508 respondents to the survey, or approximately 15 percent of total LMPS staff. The question of selection bias in this sample will be addressed at the end of this section. Table 1 describes the distribution of respondents across location and gender.

## Table 1. Distribution of respondents across location and gender

| Police Station | Number of Respondents | | Respondents Gender (%) | |
|---|---|---|---|---|
| | Freq. | % | Male | Female |
| Maseru Central HQ | 89 | 17.5 | 63 | 37 |
| Lithoteng | 17 | 3.3 | 76 | 24 |
| Thetsane | 16 | 3.1 | 56 | 44 |
| Rural HQ | 47 | 9.3 | 72 | 28 |
| Morija | 15 | 3.0 | 80 | 20 |
| Roma | 20 | 3.9 | 75 | 25 |
| Botha Bothe HQ | 22 | 4.3 | 64 | 36 |
| Qholaqhoe | 7 | 1.4 | 86 | 14 |
| Muela | 6 | 1.4 | 83 | 17 |
| Leribe HQ | 34 | 6.7 | 79 | 21 |
| Maputsoe | 21 | 4.1 | 95 | 5 |
| Pitseng | 19 | 3.7 | 84 | 16 |
| Mohale Hoek HQ | 36 | 7.1 | 72 | 28 |
| Mpharane | 7 | 1.4 | 86 | 14 |
| Makhaleng | 3 | 0.6 | 67 | 33 |
| Mafeteng HQ | 59 | 11.6 | 81 | 19 |
| Tsupane | 3 | 0.6 | 67 | 33 |
| Matelile | 15 | 3.0 | 87 | 13 |
| P.T.C. | 26 | 5.1 | 62 | 38 |
| Missing Data | 46 | 9.1 | ... | ... |
| TOTAL | 508 | 100% | 76% | 24% |

We note that the distribution of respondents across the police stations varies considerably. Five stations account for more than 50 percent of the respondents. This is largely due to these being the bigger stations with more staff. We do not have the data to calculate what percentage of available staff at the different stations agreed to participate in the study. We note, further, that women are slightly over-represented in the sample, with 24 percent female respondents as opposed to 17 percent female staff in the LMPS as a whole. The vast majority of respondents (83%) are troopers – the 'ordinary' police officer that people in general are most likely to come into direct contact with. The percentage of troopers in the sample may accurately reflect the share of troopers in the LMPS, but the percentage of female troopers in the sample (24%) is an over-representation.

Table 2. **Distribution of respondents across rank and gender**

| Police Station | Number of Respondents | | Respondents Gender (%) | |
|---|---|---|---|---|
| | Freq | % | Male | Female |
| Trooper | 382 | 83 | 75 | 25 |
| Sergeant | 28 | 6 | 79 | 21 |
| Inspector | 36 | 8 | 61 | 39 |
| Senior Inspector | 11 | 2 | 73 | 27 |
| Senior-/Superintendent | 5 | 1 | 60 | 40 |
| Missing Data | 46 | 9.1 | ... | ... |
| TOTAL | 508 | 100 | ... | ... |

## *Qualitative Methods*

In addition to using the survey to gather data for statistical analyses, the project applied three different methods for collecting more nuanced and contextual information: in-depth interviews, participant observation, and focus group discussions. The combination of quantitative and qualitative research methods proved very fruitful; the information was complementary which assisted greatly in the interpretation of the information.

A total of twenty-one **interviews** were carried out with key informants, using a semi-structured questionnaire. The interviewees included senior police commanders, police personnel in the Human Resources Management department, police officials in the Counselling Unit, ordinary police officers, union representatives and representatives of an organisation which represents police officials living with HIV/AIDS. The questions for the interviews and focus groups were mostly derived from the results of the surveys. This was to allow the researcher to probe certain questions emanating from the survey results in order to better understand and interpret quantitative data and at the same time enable police officials to engage with this information.

**Participant observation** enabled researchers to collect information by keeping records of observations during field work. In the context of this study, this meant that researcher observed non-verbal cues when police officers discussed HIV/AIDS, but also verbal comments and speeches given at police funerals. Observation also implied that researchers recorded whether HIV/AIDS information was available at Police Stations and whether condoms dispensers contained a supply of condoms.

**Focus group** discussions were used to collect further information from the following six groups, each consisting of between 5 to 12 members:

- One group had only male officers;
- One group had only female officers;

- One group included only police officers who are living openly with HIV;
- One group had officers only from rural areas;
- One group had officers only from urban areas;
- One group consisted only of students from the Police Training College.

The focus group discussions were facilitated by CSVR researchers and recorded digitally. Material from these discussions will be used throughout the analysis, but none will be attributed to an identifiable individual.

## *Sampling Bias*

The selection of survey respondents, participants in the focus groups and interviewees was not done randomly but according to a strategy that sought to ensure that the views and experiences of as many of the relevant sub-groups of police officers as possible were consulted and recorded in one way or another. The relevant sub-groups were rank, gender, HIV status and geographic location. It should be noted that while the precise age of respondents were not noted, rank is a proxy for age, with troopers being, on the whole, younger than more senior officers. While this strategy arguably succeeded in gathering information from all the relevant sub-groups, the sample is still likely to hold some bias due to a more subtle dynamic.

All else being equal, it can be assumed that those officers who felt more threatened or intimidated by the topic and/or the methodology – for reasons of stigma or for not trusting that the promised anonymity would be respected – would have been less likely to participate. The relative lack of participation from officers who held such prejudice or had particular reasons to fear some form of social sanction should their information become known, would give the general picture a bias in favour of views that were informed on matters relating to HIV/AIDS and behaviors that were conscious of risk factors for contracting the infection. This general image would arguably be reinforced further since officers who already had a particular interest in HIV/AIDS and an acceptance for its implications, will have been more likely to participate since they had no fears and they wanted to share their experiences.

This interpretation of the bias seems to have support in the survey if we analyse responses to the question *How would you rate your knowledge and awareness of HIV/AIDS?* Seven percent of respondents stated their knowledge was ‘poor’ or ‘very poor’, 26 percent said ‘average’, and 54 percent said their knowledge and awareness of HIV/AIDS was ‘good’ or ‘very good’. The report will refer to this self-assessment as we review some of the other survey results further below.

There is no way of giving any precision as to the weight of this probable bias in the material. While it nevertheless will be taken into account in the analysis of the material and the formulation of conclusions, it is also up to the individual reader to develop his or her own assessment of the extent to which it may influence the results of the analysis and the validity of the report's conclusions.

# 4. PERCEPTIONS OF HIV AND AIDS IN THE LMPS

While this research could not access any HIV/AIDS prevalence estimates specific to the LMPS – to the best of our knowledge, no such data exists – it is clear that most police officers fall into age cohorts with exceptionally high HIV prevalence nationally. Since the LMPS does not conduct compulsory HIV test for new recruits, in order to screen out those who are HIV positive, it was a basic assumption at the start of this research that levels of HIV infection in the LMPS approximate those in the general population. Many new recruits would join LMPS already infected and others, more senior officers, would become infected mainly through unsafe heterosexual sexual relations – the most common form of HIV transmission in the general population. It will be discussed throughout this report whether any of the research findings provided reasons to alter this basic assumption about the level of HIV prevalence in the LMPS.

The limited data on HIV prevalence in the LMPS that exists stems from a campaign – Know Your Status – that was launched by the LMPS Counselling Unit in December 2008. The campaign provides police officers with the opportunity to test and know their HIV status. At the time of the field research for this report (December 2008) the campaign had generated results from four districts.[18] Some 80 police officers agreed to test for HIV in the campaign and approximately 20 of them were HIV positive, a figure that corresponds with the national average of 23.4 percent. Due to the self-selection of officers who were tested in the campaign one cannot draw any valid general conclusions about the level of HIV prevalence on the basis of this data, but it is nevertheless safe to say that it does not suggest that this report is mistaken in assuming very high levels of HIV prevalence in LMPS.

Of the LMPS officers who took part in the CSVR survey, a full 77.6 percent thinks there are HIV positive officers in the LMPS, (see Table 3).[19] Consistent with the survey results, the majority of respondents in the in-depth interviews also thought that the HIV prevalence rate in the LMPS was very high. The following quotations illustrate this belief:

**Table 3. Are there LMPS Officers who are HIV positive?**

| Response | Number of respondents | |
|---|---|---|
| | Freq | % |
| Yes | 394 | 77.6 |
| No | 12 | 2.4 |
| Do not know | 82 | 16.1 |
| Missing Data | 20 | 3.9 |
| TOTAL | 508 | 100 |

*We have police officers that have been sick for more than 2 years not coming to work. So to answer*

[18] Berea, Leribe, Butha-Buthe and Mokohlongo.

[19] The survey question was: *Do you think there are police officers in the LMPS who are infected with HIV?*

*your question directly, I think we have a lot of police officers who are carrying this epidemic, although I can't tell you how many. Lately, since the commissioner introduced Ha Re Pheleng (Let us live) support programme for police officers living with the disease, we have seen an increase of people joining but many more are still hesitant to come forward.* (Female, LPMS HQ).

There is also a perception that HIV prevalence is higher in some policing districts than in others. The quotations that follow also illustrate the fact that in high HIV prevalence regions the problem of stigma is also likely to emerge.

*There is one district which I think is affected more than others and that is Maseru rural district. Right now it has over thirty people who are working in the police charge office who are all HIV positive. Now people refer to the charge office as Ward 6 because Ward 6 in the military hospital caters for the very sick including people with TB or HIV positive people. Now only HIV positive people work in the charge office alone because they cannot be deployed to remote areas in the mountains or rural areas.* (Male, Maseru Rural District).

*I think there are many police officers who are HIV positive although most of them have not come like people in this room. In every police district you are likely to find that half the stations have more than half their police personnel who are HIV positive.* (Female, Maseru Urban)

Some respondents also suggested that the prevalence rate was not isolated to junior members of the police but was also high amongst senior and high ranking police officers, as stated below:

*The HIV/AIDS prevalent rate in this organisation is very high and it is not limited only to junior ranking police officers. We have a number of senior police officers who are sick from this disease. In this organisation there is no rank which is not affected and the problem is ever increasing. You actually see this problem more clearly during winter when it is freezing cold. Most people who request not to work when it is freezing cold are mostly HIV positive people. You see even senior police officers applying for compassionate leave. Compassionate leave allows them to be away until they have fully recovered.* (Female, LMPS HQ)

Returning to the survey results, we can see that the perception that there are HIV positive officers is more common than the actual knowledge of an HIV positive officer: 77.6 percent (see Table 3 on previous page) as opposed to 45.1 percent (see Table 4 on next page). Since police officers are not required to disclose their HIV status it is not possible to know the HIV status of a colleague unless he or she reveals it privately, or discloses it openly, as is the case with about 50 police officers who are members of the LMPS support group, Ha Re Pheleng. But it is interesting to note that the personal knowing one or more HIV positive colleagues vary considerably between different sub-groups of officer. The percentage

increased with higher rank, and considerably more senior ranking officers [20] (78.2%) than junior ranking officers [21] (43.6%) knew such colleagues. More women (54 percent) than men (40 percent) also knew of such colleagues. Percentages also increased with the level of self-assessed knowledge of HIV/AIDS: from 26 percent among those with 'very poor/poor knowledge' to 63 percent among those with 'very good/good knowledge'.

### Table 4. Do you know a colleague in the LMPS who is HIV positive?

| Response | Number of respondents | |
|---|---|---|
| | Freq | % |
| Yes | 229 | 45.1 |
| No | 170 | 33.5 |
| I think so | 27 | 5.3 |
| Do not know | 58 | 11.4 |
| Missing Data | 24 | 4.7 |
| TOTAL | 508 | 100 |

The following quotations give some important context and texture to the percentages that emerged from analyzing the survey results.

> *We as police officers know each other and at times confide to each other. Besides the people that are living openly with their HIV status there are many more police officers who are HIV positive but are not ready to come out. Some are not yet on treatment and some are already on treatment. At times we meet each other at the clinic when we go for check-ups or collect ARVs.*
> (Female, Trooper)

> *There are many police officers who are living openly with the HIV disease and have started a support group called Ha Re Pheleng (Lets live). These guys are real brave because everyone knows about their status. There are many police officers who belong to that support group.*
> (Male, Trooper)

> *There are many police officers at this station who are HIV positive. I am even aware that there are many people that have not yet disclosed their HIV status but I am sure that they will when they are ready to do so. We do encourage our members to disclose so that we can support them better. At the moment there are plus or minus 5 people that I know at this station that are HIV positive.*
> (Male, Senior Inspector)

Both the quantitative and qualitative information reviewed above reflect perceptions and experiences

[20] Senior ranking officers refer to police officers of the rank of Inspector to the rank of Assistant Commissioner, unless specified otherwise.

[21] Junior ranking officers refer to police officers within the rank of sergeant, trooper and student.

that are only proxy indicators on the actual level of HIV prevalence in the LMPS. In lieu of specific prevalence data, this is the best anyone can do. With that caveat stated we can conclude that both types of information appear to confirm the assumption that the HIV prevalence rate in the LMPS is high. But what is the impact of this HIV prevalence on the institutional capacity of LMPS? The survey held a number of indicators that capture perceptions of different kinds of such impact, all of which will be discussed in the next few sections. The first question refers to staff turn-over caused by AIDS-related illness.[22]

Table 5 shows that just under a quarter of the respondents felt that AIDS had caused an increase in staff turn-over during the last three years. A slightly higher percentage of respondents felt this had not been the case, but just under half of the respondents felt they did not know whether or not this had been the case. The high percentage of officers who say they do not know would seem to signal an opportunity for LMPS to share whatever information they have on the likely causes of a possible increase in staff turn-over, so as to be able to address the problem openly in order to avoid an increase in apprehension and stigma due to misperceptions. The previous question is quite complex is that it effectively asks both about knowledge of trends in staff turnover and the causes of such turnover. For this reason it is perhaps not strange that so many officers answered 'do not know'. A less complex question that captures some of the same information was to ask for personal knowledge of one or more officers who had died or had left the LMPS due to AIDS.

## Table 5. Has LMPS staff turn-over increased due to AIDS-related illness over last three years?

| Response | Number of respondents | |
|---|---|---|
| | Freq | % |
| Yes | 118 | 23.2 |
| No | 129 | 25.4 |
| Do not know | 232 | 45.7 |
| Missing Data | 29 | 5.7 |
| TOTAL | 508 | 100 |

Table 6 shows a much reduced level of uncertainty on this question. A third of respondents knew of one or more such colleagues, and a slightly higher percentage of respondents did not. LMPS troopers were more likely to answer 'no' to this question (31% answered yes and 46% no), which is understandable since they have spent less time in LMPS and do not manage personnel or direct access to information about the reasons why personnel leave the LMPS.

[22] The question was: *Do you believe that the number of police officers who have resigned from LMPS due to HIV/AIDS related illness has increased in the past three years?*

Conversely, more senior staff were considerably more likely to answer 'yes' (60% answered yes and 32% no). But the fact that male police officers were much more likely to answer 'no' (31% answered yes and 48% no), and that female police officers were much more likely to answer 'yes' (47% answered yes and 29% no), suggests that other mechanisms are also at play. One can only speculate, but it may be that women build more trusting collegial relationships in the LMPS through which they would learn the true reasons for why colleges leave the LMPS.[23]

**Table 6. Do you know an LMPS colleague who died or had to take early retirement due to AIDS?**

| Response | Number of respondents | |
|---|---|---|
| | Freq | % |
| Yes | 167 | 32.9 |
| No | 200 | 39.4 |
| I think so | 17 | 3.3 |
| Do not know | 89 | 17.5 |
| Missing Data | 35 | 6.9 |
| TOTAL | 508 | 100 |

However, general awareness of HIV/AIDS also appears to have something to do with the difference. Officers who have 'poor' HIV/AIDS knowledge are much more likely (70%) to answer 'no', whereas a majority of those with 'average' or 'good' knowledge affirm that they do know colleagues who have died or left the LMPS due to AIDS. It could be that once you know more about AIDS you are more likely to see the signs of it, and/or more likely to accept those signs for what they are.

As a way of further exploring what perceptions officers hold about the direct impact from AIDS on the health of their colleagues the survey asked about AIDS as a cause of death more directly, see Table 7.[24]

A large majority (almost 70%) of respondents thinks that AIDS is often or very often the cause of death for those officers who die of natural causes. When these findings are compared to the two previous tables it becomes clear that, in terms of perceptions that can be more or less based in correct knowledge, officers see the impact from AIDS in terms of death rather than illness, even if they may not have personal knowledge of such cases. Responses to a further question also indicate that, a full two-thirds of officers think that the number of AIDS-related deaths has increased over the last three years, whereas

[23] Although some of this difference will be explained by the fact that, relative to their number in survey sample, female officers were more likely to hold positions of seniority through which they would be more likely to know about the causes of staff turn-over, this would not explain the whole difference.

[24] The question was: *How often is AIDS the cause of death among police officers who die of natural causes?*

six percent think not, and some 23 percent of respondents 'do not know'.

### Table 7. AIDS as cause of natural death of LMPS staff

| Response | Number of respondents | |
|---|---|---|
| | Freq | % |
| Very Often | 263 | 51.8 |
| Often | 87 | 17.1 |
| Sometimes | 86 | 16.9 |
| Seldom | 8 | 1.6 |
| Do not know | 37 | 7.3 |
| Missing Data | 27 | 5.3 |
| TOTAL | 508 | 100 |

The confidentiality around the HIV status makes it difficult to establish whether AIDS is the cause of death or of someone's early retirement. In fact, AIDS is never stated as the cause of death. It is similar with medical boards. When a police officer is 'forced' to take early retirement, 'poor health reason' is often given as reason for the decision. It is clear from the analysis above that these sensitivities have done little to stem perceptions of AIDS as the true cause of death of LMPS colleagues. The truthfulness of this perception appear to be confirmed by several of the more senior officers, who are likely to have some confidential information on the true causes of death, as the following quotations illustrate:

*In the past 5 years I will say that we have witnessed an increased in number of police officers dying or leaving the LMPS because of AIDS. In fact, every month if not week, this office is very busy because we have to organize transport for police officers who have to go and bury their colleagues who have died. AIDS is the biggest killer because most of our members die after prolonged illness. Besides death, we have seen a lot of people leave the LMPS because of health related reasons. AIDS is one of the main reasons why police officers are discharged from the police service.* (Female, Senior Inspector)

*My members do open up to me at times and tell me about their HIV status. Some have come to me and say I am HIV positive, please do not send me to on patrol or please I cannot come to work because it is too cold.* (Male, Senior Inspector)

*Our members are forced to disclose their HIV status so that we do not send them on patrol. If they did not disclose their HIV status it will be difficult for them to justify when there are away for a long time because of illness. Some, unfortunately, we have had to recommend that they get discharged because of health related reasons. We have instances where a member has been away at times for a long time and when you are of the view that the member will not fully recover we recommend that the member be discharged. There are many procedures that the member will have to go through before he/she is finally discharged.* (Male, Senior Inspector)

On the other hand some respondents indicated that they did not know a police officer who had died or had to take early retirement because of AIDS:

> *It's very difficult to associate someone's death or his/her reasons of leaving with AIDS, it's difficult. We have a lot of police officers who die or leave the service every week but I cannot say for certain that they left because of AIDS. These things are often very confidential between the doctor and patient. I am yet to encounter a situation in which the reason for the death of a police officer is AIDS. Look, I am not saying AIDS is not a factor, but that I have never encountered such a situation.* (Trooper, male)

> *The reason why police officers leave the police service is not limited to AIDS. We have people who leave because there have found a better paying job somewhere. The salary of police officers is very little and many police officers find it difficult to live on this salary. We also have people who decide to take early retirement because police work is a very stressful job. So we cannot limit the reasons of why people leave to AIDS. We do have people who get discharged from the police for health reasons not limited to AIDS. I think at times people overemphasize the issue of AIDS and I don't know for what reason.* (Inspector, male)

## Comments

It is clear that different perception of the impact of AIDS on the LMPS co-exist among police officers. However, while this report cannot generalize statistically from the findings we have reported in this section, it would seem likely that a considerable majority of LMPS staff feel this impact is problematic. Most importantly, a large majority of survey respondents think that AIDS is often or very often a cause of (natural) death among LMPS staff. Some interviewees also indicated that they believed that these deaths had increased over the past few years. Given the magnitude of HIV/AIDS in Lesotho as a whole, and the dominance of these perceptions in the LMPS, it would be fair to assume that these perceptions are causing considerable concerns and perhaps even stress among LMPS officers.

While it is important that LMPS maintains policies that respect the rights of the individual LMPS officer to confidentiality about his or her HIV status and, for the family, cause of death, these findings would suggest that the LMPS should explore ways of monitoring HIV and AIDS among police officers and other staff, and to evaluate its impact on staff turn-over. The possibility that such research might confirm worst-case scenarios for the LMPS should not be a reason to avoid establishing such M&E systems.

Only once the LMPS has gained sufficient knowledge about the nature of the epidemic among its staff can it institute effective counter-measures in terms of prevention and facilitate access to treatment. Whatever those interventions might be, it is essential that they do not depart from respecting the right of infected officers, and that they address the culture of silence in the LMPS around HIV/AIDS.

It is natural that any existing prejudice and stigma in the general Lesotho society are reflected also in the LMPS. However, due to the nature of the police service as an organization and its unique mandate to uphold public order, one could argue that the LMPS should rise above such perceptions and not be limited by them. Interventions to deal with all aspects of HIV/AIDS in the police should be inspirational in the sense that they set examples for the broader society to follow. In order to get such ambitious interventions right, the LMPS would need to know more about perceptions of causes of HIV infection among LMPS officers, and the extent to which officers place themselves at risk of infection through occupational hazards and sexual practices. Over the next few chapters we will discuss these issues in turn.

# 5. IS CONTRACTING HIV A WORK HAZARD IN THE LMPS?

The previous section concluded that a large majority of LMPS officers in the CSVR survey sample think that many of their colleagues die from AIDS-related illnesses and that the number of such deaths have increased during the last few years. The same view also dominated responses in the more qualitative interviews and discussions. It is therefore natural to ask the follow-up question in this section: how do respondents think LMPS officers become infected by HIV?

Various international studies, mainly from developed countries such as the United States of America and United Kingdom have concluded that officers run very low risks of contracting HIV as a result of their policing duties.[25] A more recent study in a Johannesburg policing area came to the same conclusion: there was no record of a police officer having contracted HIV from performing his or her duties.[26] This result suggests that policing may be a low risk occupation for contracting HIV even in countries with very high HIV prevalent rates.

We shall see in this section that these research findings are not reflected in the perceptions of LMPS staff. On the contrary, there is a sharp disconnect between research and perceptions on this issue. We need to clearly state the caveat that no research has been done on the number of LMPS officers, if any, who may have become HIV infected through their police work. However, existing literature should at the very least guide our assumption about the level of risk of HIV infection that officers are exposed to.

This section will start with a brief review of what risk factors police officers may become exposed to, and we will then discuss the perceptions of risk held by LMPS officers, as expressed both in the survey and through interviews and discussions.

## *Occupational Exposure through Policing*

Many police organisations regard police work as presenting a risk for contracting HIV and have developed policies, guidelines, strategies and HIV/AIDS programmes in order to address the risk factors within the work environment. While this is sound policy across the world, it is clear that levels of risk vary considerably between officers, and between policing in different epidemiological and socio-economic contexts. These varying degrees of risk become clear if we identify the five factors that make up the risk-function for a police officer to contract HIV through his or her duties:

**1) The likelihood that an officer come into contact with bodily fluids.**[27] The duties of different

[25] Blumberg, 1997. Also see Chambers., 2005 and also Hoffman, Henderson, O'Keefe & Woods., 1994.
[26] Masuku., 2008.
[27]Blumberg., 1997.

officers will vary in this regard, and there is variation also between similar types of officers in different regions and countries.

2) **The likelihood that the bodily fluids an officer comes into contact with is infected with HIV.**[28] For this reason alone it is obvious that an officer in high-prevalence Lesotho is more at risk than an officer in low-prevalence UK. But if this is a 'structural' risk factor over which the police have no control, its effect on the actual risk of infection is dependent on three factors that have everything to do with resources and training – factors over which the police do have considerable control.

3) **Access to effective protective gear.**[29] If an officer, when engaging in situations with a risk of exposure to bodily fluids, has access to high-quality and functioning protective gear such as rubber gloves and face masks, the risk of infection even in a high-prevalence context is reduced significantly, possibly removed completely.

4) **Knowledge of how to use the gear correctly.**[30] High availability of protective gear is of no use to an officer if he or she has not been trained in using them correctly.

5) **Access to post-exposure prophylaxis.**[31] Even in cases where an officer has been directly exposed to infected bodily fluids, the risk of HIV infection can be reduced significantly if the officers can access antiretroviral treatment during a few days after exposure.

The factors identified above can be related to arguments and findings in the relevant international literature. In 2002, the Scottish Police Federation petitioned the Scottish Parliament, claiming that its members "are at special and increasing risk when dealing with the very large number of sex workers, criminals and drug addicts who are at higher risk of being HIV positive".[32] However, a study conducted in 2003/2004 amongst 13 000 Scottish police officials concluded that there was no evidence that police officials are at increased risk of becoming infected with HIV or other blood-borne disease despite exposure to blood. The study found that of the 229 reported incidents in which police officials were exposed to blood, there was only one reported incident of possible infection with Hepatitis B, and there was no single case of HIV reported.[33] Another example is a study from the US which found that police work was generally low risk for HIV infection. The study investigated 42 cases

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[28] Ibid.
[29] Ibid.
[30] Masuku., 2008.
[31] Chambers., 2005.
[32] Chambers., 2005: 116.
[33] Ibid.

of reported exposures to blood and found no evidence to establish a link between exposure to blood and HIV infection.[34] They analysed cases of exposure to blood related to circumstances where there was little or no time for the officer to put on protective gear before, for example, being stabbed with a sharp object or needle during a fight. The study found a number of HIV positive officials but could not conclusively determine that they had contracted the infection in the course of their police work.

Significantly, the US study concluded that officers serving on medium and high-risk assignments had been exposed to HIV-infected blood only once per 100 000 person-days, arguably a low risk by any count. And even though officers very rarely were exposed to blood through punctures in their skin or directly on their mucus membranes, when such contact did occur, there was low risk of HIV-transmission.[35] In yet another study, which was conducted in Amsterdam, three out of 88 officers who had been exposed to blood between the years 2000 and 2003 were HIV positive, but there was no way of knowing that the work-related instances of blood exposure were indeed when the officers had first become infected.[36]

In the South Africa Police Service, police officers who can prove that they were infected by HIV while performing their police duties are entitled to launch a claim for compensation. If the claim is proven, such a police officer will be compensated a monetary compensation of up to R200 000 including receiving medical HIV/AIDS treatment for life. However, despite the high HIV/AIDS rate in the SAPS, there are no records of any police officer having launched a successful claim for compensation.[37]

In the context of these findings in the international literature, and the perceptions of high incidence of AIDS-related mortality in LMPS, we will now review the information gained through the CSVR survey, interviews and focus group discussions. The first question asked respondents how often they had been exposed to blood or other bodily fluids.[38] Table 8 shows that almost two thirds of respondents

## Table 8. Frequency of exposure

| Response | Number of respondents | |
|---|---|---|
| | Freq | % |
| Very Often | 147 | 28.9 |
| Often | 171 | 33.7 |
| Seldom | 101 | 19.9 |
| Never | 43 | 8.5 |
| Do not know | 22 | 4.3 |
| Missing Data | 24 | 4.7 |
| TOTAL | 508 | 100 |

[34] Hoffman, Henderson, O'Keefe & Wood., 1994.

[35] Ibid,1.

[36] Sonder, Bovee, Coutinho, Baayen, Spaargaren & Van der Hoek., 2005.

[37] Masuku, 2008.

[38] The question was: *How often are you exposed to blood or bodily fluids while performing police duties?* For purposes of clarification interviewees were informed that 'being exposed to blood' related to situations where police officers were victims of assault or stabbing, or dealt with situations which forced them to touch blood or blood stained objects or injured people. Mere seeing blood did not qualify as exposure.

were exposed 'very often' or 'often', and that only less than ten percent had 'never' been exposed.

These answers would seem to place LMPS officers at considerably higher risk than what the literature concludes is the case for their European colleagues. This frequency of exposure is linked to a high perception of risk of infection. In response to the question do you think LMPS officers' risk being HIV infected through their work? As many as 75 percent of the respondents said 'yes' and only 7.5 percent said 'no'. The high frequency of exposure was also often referred to in the interviews and discussions, and three areas of work that represent the greatest risk of exposure were suggested: in dealing with motor vehicle accidents; while performing autopsies, and; at scenes of violent crimes.

The following quotations illustrate this point:

*Definitely, I think police work is a high risk job because it exposes us to a lot of blood and body fluids. Police officers are required to attend to all .. motor vehicle accidents[scenes] as well as crime scenes. At times they are forced [by circumstances] to work without wearing proper protective clothing because there is none provided to them. I think we need to have a major campaign in which we will highlight the challenge faced by police officers. For example, in Lesotho police are also required to perform autopsy on dead bodies and this exposes them to blood and body fluids which may be contaminated. I also think police work is indeed a high risk job.* (Inspector, male)

*Unlike in other countries police work in Lesotho is a high risk job. To start with, police officers in Lesotho are expected to attend to vehicle accidents or victims that have been stabbed and are injured. Even in radios, you will hear the radio controller asking for police assistance and not ambulance and normally we are first on the scene when we are called. In other countries, that role is left to paramedics and ambulance people to do that job but in Lesotho it is the police who do that job. Therefore, given the HIV infection rate in the population, there are chances of infection when police officers touch blood during accidents. Some time, police officers have to do their work without wearing gloves to protect themselves. Some time a police have to intervene when two people are fighting and in the process can become stabbed as well which may result in him becoming infected with HIV infected blood. Some of our police officers are aware of what to do when approaching accidents scenes and are required to protect themselves.*
(Senior Inspector, male)

*I once attended a scene of crime scene involving a group of people fighting and stabbing each other. Many of these guys did not realize that we were police officers and they fought back and we had to fight as well. In the end there was a lot of blood because these guys were injured when we were arresting them and some had been stabbed by sharp objects. If any of the police officers had been stabbed there would have been a risk of HIV transmission. There are many cases similar to*

*this one where our lives are in danger but also risk HIV infection. When we arrest, suspect fight back and that increases the risk of getting infected. If you get stabbed by a contaminated knife or a sharp object you face the risk of also contracting the disease.* (Trooper, male)

Several respondents however noted that not all police officers are involved in policing duties that involve the risk of exposure to HIV infected blood:

*It does not mean that if you are employed in the police and then you will do policing work. Here at Police Training College we are not exposed to blood because we do not do operational duties. I have never encountered a situation involving blood or body fluid as a result.* (Inspector, male)

*Women police officers do not go on patrols except during elections or bigger national events. As a result, we are not exposed to blood like our male counterparts. I would say that in the 8 years as a police officer I have never dealt with a situation involving blood. I mostly do administrative work and I seldom go on patrols.* (Trooper, female)

It is clear from these analyses and excerpts that some LMPS officers think that LMPS work places them at considerable risk of contracting HIV. The next question will explore this perception further by asking officers to assess how common it is that LMPS officers do indeed contract HIV infection through their duties?[39]

Due to the fact that each of the respondents could give up to two responses the options reflected in Table 9 are not mutually exclusive. A total 46% of respondents indicated that they believed that HIV prevalence levels in the LMPS were connected to officers' sexual behavior with 16% also indicating that they thought officers were infected by their spouse or regular partner (these issues are discussed further below). However what is particularly interesting in terms of the question being examined here is that as many as 38 percent of respondents thought that it was also common for LMPS officers to contract HIV through their police work. And one out of every eight respondents (13) also indicated that they thought that it was fairly common for police to 'get infected through blood transfusion' a perception which generally makes people hesitant to donate blood.

Excerpts from the interviews indicating why LMPS officers believe shows that responses to this

[39] The questionnaire asked respondents to, List the two most common causes for police officers in the LMPS to get infected. A number of response options were given, but respondents also had the opportunity to add their own suggestions. Because respondents were asked for the 'two most common causes' the total number of possible responses was 1016. However note that the percentages in Table 9 are a percentage of 508.

## Table 9. What is the most common way for LMPS staff to get infected by HIV?

| Response | Number of Respondents | |
|---|---|---|
| | Freq | % |
| They are infected when they join the LMPS | 9 | 1.77 |
| They get infected through their LMPS work | 194 | 38.2 |
| They get infected by their spouse or regular partner | 81 | 15.95 |
| They get infected by having multiple concurrent sexual partners | 236 | 46.4 |
| The get infected through blood transfusion | 66 | 13 |
| Other | 7 | 1.38 |
| Do not know | 12 | 2.36 |
| Missing Data | 411 | 80.9 |
| TOTAL | 1016 | 100 |

question were varied and pointed to different ways in which police officers became infected with HIV as reflected below.

> *I think the risk amongst police officials is indeed high if you consider that police officers in Lesotho are required to attend to accident scenes and work in the mortuaries. This is not something we are trained in because we are not doctors so the risk of cutting yourself and becoming infected is really high. I do however agree that in most instances police officers require gloves to eliminate any chances of getting infected unless if one is stabbed while trying to arrest a suspect.*
> (Trooper, male)

> *I think that police work has increasingly become a high risk because we are working in an environment which has high levels of HIV infection. Many people in Lesotho are HIV positive. There is almost a high chance that the person who you are going to help in a motor vehicle accident or in a case of stabbing that the person will be HIV positive.* (Trooper, male)

> *I think the LMPS is really not doing enough to ensure that police officers are safe when doing their work. There is also risk of being stabbed or injured by a suspect and if the weapon used is contaminated with HIV blood it may spread the virus to the police officer. As police officers we are poorly equipped because at times we have to confront armed criminals with nothing but our uniform.* (Trooper, female)

## *Comments*

This section of the research generated new information about a dominant perception among LMPS officers that, arguably, was startling. Contrary to two sets of international research literature, more than a third of LMPS officers think that police work is a high-risk activity, and that officers who are HIV positive are most likely to have contracted HIV in the course of their policing duties. As we review information on sexual behaviours and forms of relationships among LMPS officers in the next section we shall see that the understanding that officers contract HIV through their professional duties is most likely gravely mistaken. Any efforts to inform officers of sex being the more likely cause (and what this implies for behaviour change) will first have to challenge the perception of HIV as a considerable work-hazard. Any such effort is likely to be resisted by officers as the perception of HIV as a work-hazard absolves the individual from personal responsibility and social stigma.

# 6. SEXUAL BEHAVIOUR AND GENDER ATTITUDES AMONG LMPS OFFICERS

It is clear from the data described above that a substantial number of LMPS members recognize that the nature of officers' sexual relationships were key to understanding the HIV problem.[40] Consider these excerpts making this point:

*I agree that our work is high risk but I do not think that police officers are getting infected while doing their work. I don't think so, if there are police officers who were infected because they were doing their work, there will be very few. I think police officers just like many Basotho people who are being killed by this epidemic were infected through sexual intercourse. In other words, while I agree that police work is a high risk, it is not a high risk when it comes to HIV infection.*
(Female, Sergeant)

Another respondent concurred and argued:

*I have been in the police now for close to 8 years and I have never encountered a situation in which I was exposed to HIV while I was doing police work. I have never met a police officer who came and said the work that I am doing exposes me to too much blood and I am at risk of contracting HIV. You can be 20 years in the police service and the risk will be low. It's a fact that police officers contract HIV when they have sex with prostitutes and not when they do police work. People must take responsibility instead of shifting the blame to others.* (Female, Trooper)

The questionnaire, interviews and focus group discussions therefore sought to explore this culturally sensitive issue in ways that would shed further light on the degree to which the problem of HIV in LMPS should be understood as a consequence of individual behaviour rather than institutional and resource-related problems with LMPS work duties. In this report, 'sexual behaviour' refers to having multiple concurrent sexual relationships and condom use. We will start reviewing the information relating to relationships.

## *Multiple Concurrent Relationships*

Table 10 indicates that half (49.6%) of respondents were involved in two or more sexual relationships.[41] The percentage was somewhat higher (55%) among troopers and lower among higher ranking officers,

Table 10. **Number of current sexual relationships**

| Response | Number of Respondents | |
|---|---|---|
| | Freq | % |
| One | 209 | 41.4 |
| Two | 93 | 18.3 |
| Three | 41 | 8.1 |
| Four | 26 | 5.1 |
| Five or more | 92 | 18.1 |
| Not in a relationship | 18 | 3.5 |
| Do not know | 6 | 1.2 |
| Missing Data | 23 | 4.5 |
| TOTAL | 508 | 100 |

and it was higher among men (63%) than among women (26%). It was 48 percent among married officers and slightly higher (55%) among those officers who thought that having multiple sexual relationships is a main cause of HIV infection in the LMPS. It is perhaps particularly problematic that almost one fifth of the respondents have as many as five or more concurrent sexual relationships. A number of comments were made in the interviews that spoke to this practice among LMPS officers:

> *I am from Roma and I am working here at Maseru rural district. I go home maybe twice a month. It is difficult to live alone because you get bored and think of other things and also you friends can influence you as to what to do. It is difficult to say no when you are alone and you are bored when others are going to have a nice time. I am not saying that it is a good thing but we are forced by circumstances to get involved with many women at the same time.* (Male, Trooper)

The issue of peer pressure also emerged as one of the reasons police officers engaged in multiple concurrent partners:

> *I was saying that it is not entirely easy to stay alone and not have sex especially when you are young and still sexual active. I have three girl friends but I can sleep with more depending on the situation. I know it is wrong and high risk but the reality is that we often find ourselves doing it because others are doing it. At times when you have many girl friends your friends respect you. We want to do the right things but there is a lot of [peer] pressure which often is more powerful and difficult to control.* (Male, Trooper)

Others have many concurrent sexual partners because it gives them power and prestige amongst friends and colleagues as illustrated below;

> *You know what Ntate Themba, we enjoy having too many women and bragging about it. We like showing off our women like trophies because it makes us feel proud of ourselves and be regarded as real man. You are always scared that other police officers will think that you are scared of women or you're not man enough. There is pressure to have many women. For example, I was working at the district of Leribe at Stock Theft. We used to go on patrol for days away from home and when we are away we need people who will care for us, by giving us food and shelter. In the police we say, the blanket of a police officer is on his waist.* (Male, Trooper)

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[40] The text that most clearly make this case, and that is the central reference on the nature and consequences of multiple concurrent relationships is James & Matikanya, 2006.

[41] The question was: *How many sexual relationships are you currently involved in?*

Many female officers criticized the dominant view among their male colleagues, whom they regarded as womanizers, as illustrated by the quote below:

> *What I know is that male police officers are womanizers. Police officers like having too many girlfriends at the same time. It's like when you are a cop you must have many girl friends. Police officers that are decent at college change when they graduate because they start having too many girl friends and they like bragging about it. For guys, it's more like a competition because the way guys are crazy about women makes you ask whether there are women left out there who are single.* (Female, Trooper)

The argument by several men that having multiple concurrent partners is a practice in 'traditional' culture was also disputed by many women:

> *It's an outdated cultural practice which was relevant during that time. It's plain stupidity to have multiple partners these days because of the diseases around. Besides, why would anyone have two partners, it's just too demanding having one, so what about two ... [laughs] ... People do not want to take responsibility for their actions. They want to blame something, not them. Besides, my understanding of polygamy was that it was something practiced openly and not in secrecy as is the case. People who have multiple partners do not do it openly because they know that what they are doing is wrong. It's just lust and nothing else* (Female, Trooper).

On the basis of the survey and the interviews it would seem likely that the practice of having multiple concurrent sexual relationships is quite widespread among LMPS officers. The reasons for this vary from not being able to abstain from sex during longer periods of work away from home and the regular partner, to a culture among male officers that brings respect and status (among fellow men) to the man who has several partners.

But multiple concurrent sexual relationships are of course only a risk-factor for contracting HIV infection if the sex that is practiced is unsafe, which leads us to questions of condom use.

## *Condom Use*

Before we review data on the use of condoms we need to establish what officers think about their effectiveness as protection against contracting HIV.[42] Table 11 shows that over 80 percent of the respondents are certain or think condoms will protect from infection. Fewer than 10 percent think or are certain of the opposite. Only 5 percent say they 'do not know'. All of this is good news as

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[42] The questions was: *Do you think condom use will prevent HIV transmission during sexual intercourse?*

it indicates that perhaps the main point in many prevention programmes has been understood intellectually. The picture gets more complicated when we review further below to what extent this understanding has also changed behaviour. But before we get there we will review some responses that add further contextual understanding to this issue:

## Table 11. Condom effectiveness

| Response | Number of Respondents | |
|---|---|---|
| | Freq | % |
| Yes, I am very confident | 135 | 26.6 |
| Yes, I think so | 283 | 55.7 |
| No, I don't think so | 45 | 8.9 |
| Never, I know they will not | 4 | 0.8 |
| Do not know | 25 | 4.9 |
| Missing Data | 16 | 3.1 |
| TOTAL | 508 | 100 |

> *Condoms are effective in preventing HIV transmission because as an HIV positive that has a husband who is HIV negative we rely a great deal on condoms to prevent transmission. I have been married for more than 5 years and have been using condoms since. We have invested a lot of money in buying good quality condoms instead on relying on government condoms. We don't trust those and we have never used them.* (Female, Trooper)

Another respondent concurred but with a qualification;

> *Condoms are effective in preventing HIV transmissions when they are used properly. If condoms are not used properly they are not effective and HIV transmission may occur. Just like most things that are effective, a condom is only effective when it is used correctly.* (Male, Inspector)

Another respondent also pointed out the following;

> *There aren't many preventative methods available out there except for abstention or sticking with one partner who you know his/her HIV status. Condoms are the only methods that we know to be effective in preventing HIV infection. I am confident that even the condoms that the government supplies are effective as long as they have not expired and used incorrectly. The other important thing about condoms is that you need to be consistent in using them. There is no point of using a condom today and the next day you don't because it will not be effective. We still have a long way to go to get to a stage in which we are conscious about protecting ourselves and those we love.* (Male, Senior Inspector)

A few respondents however dismissed condoms outright as a method for preventing the transmission of HIV during sexual intercourse. One theme that emerged around condoms was the perception that

condoms do not provide 100 percent protection, and as a result there was no need to use them:

> *Why should I use something that cannot guarantee protection? I know that condoms are not 100 percent that is why I don't use government free condoms. The quality ones are very expensive. I can't afford to buy them. It's like fetching water from a river with a bucket which has holes under it. By the time you arrive home you will be carrying an empty bucket with no water. This is how I see condoms because even when you wear them you still get infected because there are not 100% safe, so what*'s the point of using them? (Male, Trooper)

One view was that condoms are already infected by the HIV virus as a racial conspiracy from white people against black people:

> *We don't trust using condoms because there have been infected with the HIV virus in order to spread the virus amongst black people. Basotho people do not manufacture condoms there are manufactured by white people. In fact, white people do not use condoms but they want black people to use condoms. People in Lesotho have been infected more with the virus found in the condoms than the virus on sexual partners.* (Male, Police Student)

Another respondent developed a similar point:

> *I would like to agree with this guy because why should we black people use condoms and not them (white people). I agree that HIV/AIDS was brought by white people in this country. Our grand-parents lived a happy life and never had to use condoms in their lives. I am not sure though whether condoms have been infected with HIV but I don't agree that only black people should wear condoms...Well, that is what most people think in Lesotho that condoms are infected with HIV. Basotho think that white people do not like blacks hence do not want anything to do with condoms.* (Male, Police Student)

Although several issues relating to condoms in the context of HIV/AIDS are very complex there is, as we saw above, a dominant understanding among respondents in the CSVR survey that condoms protect against contracting HIV – so does this understanding translate into safe behaviour. If this was the case, the high frequency of multiple concurrent relationships would be much less of a problem, if a problem at all, since universal and correct condom use would prevent the spread of HIV within the networks of sexual relationships which are associated with multiple concurrent relationships. However, if frequency and consistency of condom use are reported to be low, this would signal a likely cause of HIV infection among LMPS staff.

The first question on condom use in the survey referred generally to sexual intercourse, whereas the second question specified intercourse with the regular partner (see below). In answering the first more general question, only just over a third of respondents stated they always use a condom, and as many as 10 percent said they never do.[43] Almost half of the respondents said they do sometimes. These percentages differed somewhat between groups of respondents, most notably in that a majority (55%) of respondents who are single always uses condoms and that respondents that were mistaken on how HIV can get transmitted were twice as likely (20%) to never use condoms.[44]

## Table 12. Frequency of condom use

| Response | Number of Respondents | |
|---|---|---|
| | Freq | % |
| All the time | 184 | 36.2 |
| Sometimes | 245 | 48.2 |
| Never | 52 | 10.2 |
| Missing Data | 27 | 5.3 |
| TOTAL | 508 | 100 |

Several reasons for not using condoms were given in interviews and focus group discussions, ranging from the poor quality, exorbitant costs, custom, calculated risk-taking, and religion, as exemplified in the following comments:

*Let me also say that women play a major role in the decision whether to use a condom or not. At times I hear women say I don't like a condom because I do not enjoy sex or feel my partner. At times they will say I do not want a cheap government condom in my body and that makes it easy for men not to wear a condom. I have also noticed that nurses can also discourage people who want government condoms because they will comment and say "why are you using a cheap condom, don't you have money to buy condoms". If you are a man then you feel small and if you are a woman you are made to feel like you are a slut... I suppose no one wants to be associated with cheap stuff and people will rather risk infection than to use cheap condoms. People like rough riders but these are expensive so you will find people buying condoms once or twice and reverting back to having sex without condoms.* (Female, Trooper)

*The real answer to this question is that sex is nice to have without a condom. It is a natural thing to do. When you do flesh to flesh you feel the excitement and fun but when you use a condom it is really like sucking wrapped sweat in a plastic. I suppose when you suck sweets in a wrapper,*

[43] The question was: *How often do you use a condom during sexual intercourse?*

[44] This refers to responses to a question on 'How can a person get infected by HIV?' which are not reported on in this report. Respondents who were mistaken were respondents who indicated, for instance, that people may be infected through insect bites or coughing and sneezing for instance.

*you will certainly enjoy the sweet in your mind by simply visualizing how it will feel to suck the real thing. I think the same can be said about using condoms because condoms are really a compromise because sex was never meant to be done with a condom on. So what I am trying to say is that, it is unnatural to have sex with condom on.* (Male, Trooper)

*There is no doubt that sex without a condom is more enjoyable and the reason why people generally have sex is so that they can enjoy it. It is like saying why do people drink hot tea, alcohol and cigarette, given the dangers associated with them. The reality is that people will have sex without condoms not because they do not know the risk associated with it but because they simply want to enjoy themselves. HIV/AIDS is part of the risk, just like pregnancy and sexual transmitted diseases or disease caused by the food we eat. Heart disease and other diseases are killing our people more yet there is no campaign to say people must not eat.* (Male, Sergeant)

*You must know that the use of condoms is un-Godly in terms of the teaching from my church, the Roman Catholic Church. The preachers in my church discourage people from using condoms because that is like fornication. You must understand that Lesotho is a Christian dominated country and the church is central to many Basotho. It's difficult to go against what the church says and maybe if the church started saying people should use condoms, I am sure most people will follow that teaching, I don't know. When someone says he or she is using condoms it sounds strange because that person does not trust his/her partner. How does one justify use of condoms unless one is sleeping around?* (Male, Trooper)

But condom use is also interlinked with perceptions about acceptable gender-roles in the context of sexual relationships and intercourse. Women feel pressure not to show any interest in sex or express their feelings about it. As a result, women are likely to hide their true feelings from their partners to avoid being labeled or insulted for being too interested in sex, as illustrated by this comment:

*The other problem is that if as a woman show a lot of interest in sex or advice my partner on how to use a condom he might think that I am having an affair somewhere and might be very angry why I am telling him what to do. It's even difficult to speak to our partners about sex because that will be considered to be immoral. Basotho men enjoy sex and would insist on having flesh to flesh. If you insist that your partner uses a condom he will accuse you of cheating and that can get you into serious trouble. In many cases, as a woman you just lie down and allow your partner to decide whether he wants to use a condom or not.* (Female, Trooper)

In the second question on condom use, respondents were asked whether they use condoms with their regular partner.[45] There is some ambiguity in this question. Whereas the intention was to capture frequency of condom use in relationships that to some extent are build on notions of fidelity and trust, we recognize that the question does not capture only monogamous relationships (or relationships that the respondent at least thinks are monogamous).

As could be expected, compared to the more general question above, a somewhat smaller percentage of all respondents always use condoms with their regular partner, and twice as many never do. Married respondents were more likely (27%) to never use condom with their spouses, respondents with good HIV/AIDS knowledge were more likely (37%) to always do so, and a majority of single respondents (53%) would always use condoms.

## Table 13. Frequency of condom use with regular partner

| Response | Number of Respondents | |
|---|---|---|
| | Freq | % |
| All the time | 157 | 30.9 |
| Sometimes | 217 | 42.7 |
| Never | 104 | 20.5 |
| Missing Data | 30 | 5.9 |
| TOTAL | 508 | 100 |

The following comments illustrate the difficulties with requesting condom use with the regular partner:

> *To be really honest with you, it is difficult to use a condom with your wife otherwise why get married in the first place. I believe that sex was never meant to have it with a condom…Sex was meant to be enjoyed by couples not using condoms and it is not enjoyable when you use a condom. Besides, it is often difficult to justify the use of a condom to regular partners. It is perhaps easier to justify to a prostitute or someone who knows that you are married who simply want to sleep with you.* (Trooper, male).

> *I can't come home to my wife and say 'sweetheart let's start using a condom' because it will be obvious that there is something fishy going on. The truth is, even if I was cheating as is the case with many of us, I can't go home and suggest a condom. Besides, you could easily have two or three regular sexual partners at the same time and treat them as if there were the only ones in your life. For us police officers because we do not stay in a an area for a long time because of transfers and deployments, it is easy to pretend as if you are single and get what you want from a*

[45] The question was: *How often do you use a condom with your regular sexual partner?*

*woman. You can't say to a woman you are married or you have another partner otherwise she will say then what do you want from me, you want to use me and that will be the end. So, you have to treat that woman like she was the only one in your life.* (Trooper, male).

*The other difficulty for most people is to justify the use of a condom with a regular sex partner unless there is a compelling reason to do so. I will be suspicious if one day my husband comes home and suggest that we use condoms because the first question I will have is why? I will ask why are we using condoms today?, What is the problem?, because you can't just say that without a good reason. If I have also cheated, I simply go home and make love to my husband and pretend as if nothing happened...It makes sense to suggest a condom on the first day when you meet not when you have been having sex all along. It is difficult to just come from the blue and say I think we should use a condom... I agree with people who say marriage is not a safeguard because that is where there is most risk. You can insist on a condom with a stranger but you cannot have good reasons to insist on a condom with your husband or wife*. (Trooper, female).

Clearly, a number of factors contribute towards the relatively low frequency of condom use among the respondents of the CSVR survey, despite the fact that a large majority of them know that condoms protect against HIV infection. Whereas cultural notions of masculinity as well as assumptions of marital sex as safe by definition would be harder to change in the short term. Though it also implies an investment of resources, clarifying questions to do with the quality of free condoms, and if necessary taking steps to improve their reliability or improve the affordability of popular brands might be considered as short term measures.

## *Comments*

At this stage of the analysis we would argue that the information provided in this study about the sexual behaviour of the respondents – in terms of a high frequency of multiple concurrent sexual relationships and low levels of consistent condom use – suggests strongly that sexual transmission of HIV is the main cause of infection among LMPS officers. Given the high rate of infection in Lesotho and lack of protective clothing in the LMPS it is possible that there is a risk of occupational exposure but that more research is required to test whether there is a link. In this research the conclusion we make is that occupational exposure is negligible and can almost be regarded as insignificant. These findings, and the argument they motivate, are a challenge to the perception among many respondents that HIV infection among LMPS staff is mainly due to officers contracting HIV in the line of duty. Instead of structural or institutional factors linked to the nature of police work or resource-constraints of the LMPS, our analysis focuses attention to decisions and actions relating to safe sex by individual officers. But these decisions and actions are never taken in isolation from the gendered

culture and socio-economic context within which LMPS officers live and work. Nor are they insulated from the stigma of HIV/AIDS itself. In this section we will elaborate somewhat further on some of these contextual factors on the basis of comments made by individual LMPS officers in interviews and group discussions.

Going back to the initial question of the main cause of HIV infection among LMPS officers, this respondent elaborates on the importance and frequency of multiple concurrent sexual relationships:

> *I will be careful with the statement that suggests that police work poses a risk to HIV infection. I have been a police officer for 7 years now and I am yet to encounter a situation that poses a risk while performing police duties. What I am certain about is that most police officers have multiple concurrent partners; some have sexual partners in every district. If police officers are educated about AIDS there is no way that anything we do can increase the risk of becoming infected. I really will want to differ on this one with my colleagues because I do not see police work being too risky to HIV infection.* (Trooper, female).

Another respondent concurred and suggested a way of 'proving' the frequency of multiple concurrent sexual relationships among LMPS officers:

> *I do not want to be controversial or provocative to my colleagues but if all had to be honest we should come to a conclusion that the biggest problem which increases HIV infection is because many police officers are womanizers, especially men. It's a fact that many police officers have many relationships all over the country. If you had to go to the HRM office and investigate how many police officers are paying for maintenance you will understand what I am talking about. If truth be told as it is, most police officers are having sex without using condoms hence there have many children all over the place and that is how they contract the virus.* (Sergeant, female).

A female officer clarified that not only male LMPS officers have multiple concurrent sexual relationships but that women too have their reasons to sustain sexual networks:

> *The behaviour is likely different but we have females who also have multiple partners. When its women it is more like cheating because there is an expectation that a woman should be faithful. Women cheat mostly with rich people or influential people in society. It's more discreet than obvious when it comes to women.* (Trooper, female).

Even if individual sexual behaviour and not work hazards is the main reason for HIV infection in the LMPS, this does not mean that LMPS officers engage in sex only as private civilians in their spare time.

On the contrary, as these comments illustrate, male officers sometimes corrupt their professional role by using it to access sex:

> *I once went on patrol with police officers during the elections.  After hours police officers were spending most of their free time with prostitutes and women in the community.  You know that police officers in Lesotho are respected and feared and most unemployed women are attracted to them.  There are feared by prostitutes because it is an illegal practice in Lesotho, so they provide police officers free sex in order to evade arrest.  I was shocked that most male police officers had girl-friends on the first night that they had sex with.  Given that condoms are expensive and most of them don't like using Trust (government supplied) condoms, it is likely that most police officers had sex without putting on a condom.* (Trooper, female)

The problem of exploitation of sex workers by police officers is an international phenomenon widely recognised by police organisations.[46] Police are known to create concurrent sexual relationships whenever they are away on patrols. This theme came out very strongly during interviews with police officers in Lesotho as illustrated by the following comments:

> *When you join the police you must know that you will be sent on patrols for weeks, especially in the rural areas or mountains.  You can be sent on patrols which can last a week to two weeks or even a month.  While on patrol the LMPS does not provide you with accommodation or food and you will have to rely on your charm to get that.  In the LMPS we are told that the blanket of a police officer is on his waist, which means that for you to get shelter and accommodation you will have to fall in love with a local woman who can then provide you with food and accommodation and warmth while you are on patrol duties.*  (Trooper, female)

The social status and relative affluence of police officers in Lesotho was also considered by some as an important issue which makes it easier for police officers to be involved in many sexual relationships especially with poor and marginalised women:

> *It's very difficult to blame women because these women (sex workers) are vulnerable because of the situations they find themselves in. Some of them have been abused and left to look after children and some are hungry and have responsibilities they need to be met. To many poor women police officers have become a source of income and basically look forward to police officers coming to patrol in their areas.* (Trooper, female)

[46] Jackman.,2006.

A number of these comments directly reflect some key points made in the international literature on gender and HIV/AIDS in Africa. Cleaver[47] argues that police organisations are traditionally male dominated and tend to exhibit a 'militarised masculinity', which is associated with power, dominance, obedience to orders and protocols, bravery and risk taking. This masculinity amongst police personnel is further reinforced by the police culture which also associates policing with power, privilege, and dominance. The 'blue light syndrome' epitomizes state power, dominance and privilege that is closely associated with police officials. For male police officers, this type of masculine culture and the power derived from their position as police officers combine to potentially place them at increased risk of engaging in multiple sexual relationships or transactions thereby placing them at increased risk of HIV infection.

Though factors associated with the police occupation may place them at greater risk of contracting HIV the principal issue is one of addressing widespread patterns of male sexual behaviour.[48] As a result of the pride and ego embedded in manhood, argues Bujra, it is difficult for men to take responsibility for the spread of sexually transmitted diseases.[49] Young women in particular are likely to be blamed for 'immoral' activities such as promiscuity and spreading the disease. Further, as control is an important attribute of manhood, men oppose the idea of women taking control of their sexuality by denying sexual advances or insisting on condoms. However, Bujra continues, the "growing awareness amongst men that their gendered identity is in question and that their mode of self definition as men is linked to the spread of the AIDS disease, directly or indirectly" can be used to change high risk behaviour amongst men. For example, the determination by most men to become real men should be reinforced by positive messages which require 'real men' to take responsibility in preventing the spread of sexual transmitted diseases, including HIV/AIDS.[50]

[47] Cleaver., 2002.
[48] Ibid.
[49] Bujra, J., 2002.
[50] Jackman.,2006.

# 7. IMPACT OF HIV/AIDS ON THE POLICE SERVICES

Our research has so far established that there are both theoretical and empirical reasons to expect an impact on the institutional capacity of the LMPS from AIDS-related morbidity and mortality. But we took the analysis one step further by asking respondents to share their perceptions of such an impact. In terms of research evidence of impact it would have been ideal to detail a causal link from AIDS-related stress, absence and turnover among staff (the independent variable) and lower capacity (the dependent variable), but this was impossible due both to practical resource constraints of this research as well as ethical considerations. To ask for perceptions of impact among staff is therefore arguably an acceptable proxy indicator.

The first question was more general and asked for the frequency of illness-related work absence among LMPS colleagues (see Table 14).[51] The fact that a clear majority (61%) of respondents say that colleagues are absent due to illness either 'often' or 'very often' is arguably quite alarming. While we need to emphasise that the perceived level of absence can be caused by other illnesses than AIDS, this was the main cause that officers mentioned in interviews and discussions, as illustrated by these comments:

**Table 14. Work absence due to illness**

| | Number of Respondents | |
|---|---|---|
| | Freq | % |
| Very often | 135 | 26.6 |
| Often | 174 | 34.3 |
| Sometimes | 111 | 21.9 |
| Seldom | 21 | 4.1 |
| Do not know | 46 | 9.1 |
| Missing Data | 21 | 4.1 |
| TOTAL | 508 | 100 |

*...what we see is that the impact of HIV/AIDS results in many police officials being away from work often and this tends to place a burden on those that are healthy. The problem is greater during winter because of the cold most HIV positive police officers cannot come to work. The problem is severe and it impacts on deployment and service delivery.* (Trooper, female)

*I think HIV/AIDS is impacting on the LMPS because we have a lot of police officers who are sick and are staying at home. Some have been away from work for up to 2 years. We do go and visit them just to give them support to fight on but you can see that some are really dying. Some have died already and some are very sick. It is even worse when it is cold because most people who are HIV positive do not come to work.* (Trooper, female)

[51] The question was: *Are one or more of your colleagues often off from work due to illness?*

*I think this is the worst affected district. We have many police officers who have developed AIDS; hence they are on special leave, or police officers who are sick but still come to work on some days. We have police officers that have been away for a long time and that affects our deployment and operations.* (Senior Officer, male)

The next questions specified AIDS as the cause of illness and asked further if AIDS-related absence had increased in frequency over the last 3-4 years.[52] Some 40 percent of respondents in the CSVR survey answered that there had been an increase in AIDS-related illnesses, while half that number said there had not been an increase. In interviews with senior police officers (who would have an overview over the frequency of illness-related absence over the last several years, and possibly even knowledge of its cause) most of them identified AIDS as the clear reasons behind a marked increase in frequency, as illustrated by these comments:

*The problem has definitely increased fourfold in the last year compared to 3 to 4 years ago. We are seeing a lot more police officers become sick more often than before. It's hard to establish the reasons for the increase but may be that police officers are not taking their medicine to prevent becoming sick. In winter the problem is greater because people who are HIV positive become sick easily and as a result stay at home for the duration of the winter. Unfortunately, we have to allow them to stay at home because we do not have enough winter clothes to give everyone. In winter this place freezes and that makes it difficult for many people to work. So I will say HIV/AIDS is really impacting on the service delivery and deployment of police officers particularly to rural areas.* (Senior Officer, female)

*I would say the problem particularly in this district has increase in the past year compared to say to say 3 to 4 years. I think this has been partly as a result of more HIV positive police officers being transferred to this district. Every year we receive many police officers who are HIV positive because they need to be closer to health facilities and their doctors. I have never seen some of them because since they arrived here they became sick. This problem is definitely on the increase and we are seeing more police officers leaving the police service for health reasons or staying at home because they are unable to come to work. The problem is compounded the fact that we are also losing our officers through death. Almost every week we are burying a police officer in Lesotho.* (Senior Officer, male)

*A couple of months ago we assisted about 12 police officers to be placed on compassionate leave because of being too sick. The HR office does not require anyone on compassionate leave to apply*

[52] The question was: *Do you think colleagues have been off from work due to illness more often this last year than what was the case 3-4 years ago?*

*for leave. Instead one is required to stay at home until there are fully recovered, something which can take months or even years. The problem of police officers being placed on compassionate leave is not only limited to junior police officers but also involves even very senior officers. They can be on compassionate leave for a year and others have already been on compassionate leave for 2 and others three years and others are senior officers who leave their junior members without proper supervision... Of course the other problem it creates is that the remaining police officers have to cover up and do work that would have been done by many people and they are not compensated for taking on extra work... When that happens it creates other problems because in the LMPS there are few senior officers. It creates problems with supervision, performance and service delivery as junior police officers are likely to work unsupervised by a senior officer but have to supervise each other.* (Sergeant, female)

When police officers are not at work the work-load and levels of stress for those who are healthy and at work would increase. In order to test this assumption we asked respondents how often they have to cover for a sick colleague.[53]

Table 15 shows that some 38 percent of survey respondents have had to cover for a sick colleague 'often' or 'very often' – a percentage that increases to a full 70 percent if we include also those who responded 'sometimes'. Further, in a follow-up question, as many as 60 percent of respondents said that the need for them to cover for sick colleagues had increased 'a little' or 'very much' over the last few years. Several comments made in interviews and discussions confirm the findings from the survey:

## Table 15. Cover for a sick colleague

| | Number of Respondents | |
|---|---|---|
| | Freq | % |
| Very often | 103 | 20.3 |
| Often | 91 | 17.9 |
| Sometimes | 162 | 31.9 |
| Seldom | 78 | 15.4 |
| Do not know | 43 | 8.5 |
| Missing Data | 31 | 6.1 |
| TOTAL | 508 | 100 |

*Yes we have a problem of increased numbers of police officers who do not come to work because there are sick. When they are absent we have to take over their responsibilities because we cannot sit and wait for them to come back while communities are waiting for services to be delivered. I would say that in the last five years I have seen an increased in the number of responsibilities that I have to take because of shortage of manpower. The absenteeism as a result of HIV has also*

[53] The question was: *Do you ever need to do extra work to cover for a colleague who is off due to illness?*

*increased amongst police officers because if it is not them [police officers] who are sick it will be a close relative who will force them [police officers] to stay at home and take care of their loved ones who will be sick.* (Inspector, male)

*I will say about 30 to 40 percent in this district are not doing normal police duties because they are HIV positive. When police officers notify us that they are HIV positive we deal with them as per instruction from the commissioner of police that HIV positive people should be given lighter work. So we send them to the charge office or to do some administrative work… It is a serious problem when you have 20 and more people in the charge office because you cannot deploy them to do other tasks. We are therefore stretched thin in our operations because we have to use the few police officers who are fit to do tasks that are often done by many people.* (Senior Officer, male)

*The issue of deployment of police officers is not the only issue but what we see is that the impact of HIV/AIDS results in many police officials being away from police work and this tends to place a burden on those that are healthy. The work load becomes too much which also results in burnout or stress. There is one district … which has about 30 police officers who are HIV positive and are working in the charge office. All these people work in the charge office because they cannot be deployed to other police duties. Now people refer to the charge office as Ward 6 because Ward 6 at the Military hospital caters for very sick patients. So what we find is that healthy police officers are being required to really double their efforts because of police officers being sick or being HIV positive.* (Trooper, female)

It is clear that survey respondents feel an increased level of work pressure and that they ascribe this at least partially to levels of AIDS-related illness and death among LMPS officers. These findings motivate further exploration of the levels and nature of work-related stress in the LMPS, and how this stress may be linked to sexual behaviours that put officers at risk of HIV infection.

## *Levels of stress in the LMPS*

Police work is widely considered to be one of the most stressful occupations. For this reason, police officers experience higher rates of divorce, alcoholism, suicide and other emotional and health problems compared to most other professionals.[54] Police work often involves working shifts and away from home, working conditions that disrupt establishing and consolidating normal social connections, the routines of family life, as well as sleeping patterns and eating habits of police officers.[55] In the context of South and Southern Africa, Geldenhuys argues that police work is an emotionally and

[54] Finn., 1997.
[55] Figley cited in Mayhew, 2001.

physically dangerous job as a result of the ever present danger of physical violence, potential sudden death and exposure to HIV/AIDS.[56]

These factors may expose police officers to traumatic situations which can result in Post Traumatic Stress Disorder (PTSD), or other conditions such as chronic fatigue, burnout or other conditions which are manifestations of stress.[57] Police work which exposes police officers to fatal motor vehicle accidents, death, victims of serious crime and violence, which are inherently part of policing, may result in PTSD if police officers are not given psychological counselling. However, despite the fact that stress and PTSD can be treated using clinical psychological interventions police officials are often fearful of seeking psychological help from within the police organisation.[58]

Mounting levels of stress are further caused, argues Geldenhuys, by the fact that police officers are trained to hide their emotions, right from day one at the Police Training College.[59] They see emotions as getting in the way of the job they are performing. As a result, emotional stress is suppressed daily for many years until a point when it starts impacting on officers' psychological health, either incrementally or quite dramatically, sometimes resulting in adverse consequences in the form of deteriorating mental or even physical health. Some of the inability to deal constructively with emotions and stress is explained in the masculinity literature by a prevailing 'superman mentality' and a dominant 'macho image' among officers – a work ethic that portrays emotions and stress-symptoms as weaknesses. But behind those images of invincibility, the stress often undermines the health of officers as they resort to high-risk activities such as alcohol and drug abuse, and having sex with multiple partners to 'let off steam' or suppress recurring mental images of traumatic events they have experienced.[60] In communities with high HIV prevalence rates, such behaviour can have serious consequences. To the extent stress and suppressed emotions cause such behaviours among LMPS officers, poor psychological health among LMPS staff can be said to be a cause contributing to HIV infections among LMPS officers.

In order to capture some information on the level of stress felt by LMPS officers, the CSVR survey, interviews and discussions covered the subject. The survey responses show that a large majority of respondents feel that their work is stressful.[61]

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[56] Geldenhuys, 2003.
[57] Mayhew, 2001.
[58] Paton, Vialonti, 1996; Also see Paton., 1997.
[59] Geldenhuys., 2003.
[60] Bazergan cited in Pharaoh., 2005: 89; Chilvers cited Mayhew., 2001.
[61] The question was: *Is your work in LMPS stressful for you?*

Roughly a third of respondents often feel stressed at work and as many as 84 percent of respondents feel stressed at least sometimes. While this statistical information is sufficient to indicate the scope of the problem, the contextual information we gained from interviews and focus group discussions gave further cause for concern. Consistent with the arguments and findings in the literature reviewed above, interviews with LMPS officials suggested a widespread practice to engage in high-risk sexual relations when police officers were off duty, in conjunction with alcohol and drug abuse – all of which were said to be ways to 'unwind' from their highly stressed work situation. Since many of them are posted far away from spouses or regular partners for extended periods of time, casual sexual relations are the only option. The following quotations illustrate this point.

## Table 16. Stress caused by LMPS work

| | Number of Respondents | |
|---|---|---|
| | Freq | % |
| Yes, often | 184 | 36.2 |
| Yes, sometimes | 245 | 48.2 |
| No | 62 | 12.2 |
| Do not know | 2 | 0.4 |
| Missing Data | 15 | 3.0 |
| TOTAL | 508 | 100 |

*Police work is very stressful and most police officers deal with it obviously by having sex with many women. The high stress level make many police officers to want to have sex a lot. Most people feel better after having sexual intercourse. To many police officers sex has become a drug to make them feel better and a way to address the problem of stress.* (Trooper, male).

*When you have more than one girlfriend in different districts you are guaranteed that the stress level will be low and that you will have accommodation and food and of course warm blankets and sexual favours. When the LMPS sends you on patrol you are only given one loaf of bread, tin of beef and few other items and you have to look for your accommodation. Police officers starve when away on patrol and end up having relationships because it's strategic for them to do that. In that way, police officers rely a great deal from the support of ordinary people.* (Trooper, female)

*I think the problem with police officers having too many relationships is made worse by the fact that most police officers do not stay together with their wives. When police officers are away for a long time it increases stress and people become lonely after work. You will find that the husband stays in Roma and the wife is in Mohale and they sometimes see each other once a month. If the police were stationed where their families are staying, I am sure the problem will be minimized. I am not saying that if you are staying with your partner there is no cheating, people do cheat but not as much as when there are away. When people are highly stressed at times prefer to go elsewhere and deal with stress instead of bringing it home.* (Trooper, male)

Although this research has no way of verifying these statements or establishing the frequency of this form of stress-related behaviour, the fact that officers speak this openly about it would suggest that it is quite accepted and widespread. While it would be mistaken to suggest that all instances of casual and multiple concurrent sexual relations by LMPS officers can be explained by high level of work-related stress, it would seem reasonable to assume – in line with the international research on the topic – that any suppressed emotions and stress caused by work-pressures and traumas that officers experience will make such sexual relationships more likely as ways of 'escaping' from the stress.

## *Comments*

It is clear that a majority of CSVR survey respondents think there is some impact from AIDS on their work situation in terms of having to cover for absent colleagues, and that the frequency of this impact has increased over the last few years. It would be safe to say that, at least in terms of respondents' perceptions, AIDS has increased the levels of stress among LMPS officers.

Given the stressful nature of police work and the associated occupational hazards, it becomes critical for police management to devise support programmes that help officers to deal constructively with any experienced traumas and to reduce levels of stress. For police officers to use casual sexual relationships either as a way to cope with stress or as a way to access accommodation or other services and necessities while working away from home should be unacceptable in any police force, but in a hyper-endemic country like Lesotho it is no less than a public health calamity. LMPS officers are not only contracting HIV through this behaviour, but they are also helping to spread the virus to previously uninfected individuals across Lesotho.

To the extent it is true that AIDS causes more stress among LMPS officers by increasing the workload, it also seems to be the case that stress indirectly puts LMPS officers and their sexual partners at risk of contracting HIV. This is a vicious cycle that has to be broken.

If the LMPS could reduce the frequency of this behaviour among its officers it would not only protect its officers, but also make an important contribution to Lesotho's overall response to HIV/AIDS. The remaining sections of this report will explore three different notions of the response to HIV/AIDS within the LMPS. At the level of individual officers we will review and discuss findings about whether or not they know their HIV status, and at the level of the LMPS we will analyse perceptions of the supply and quality of protective gear necessary to avoid direct contact with blood or other bodily fluids, as well as some aspects of its HIV/AIDS workshops.

# 8. THE RESPONSE TO HIV/AIDS WITHIN THE LMPS

There is much that can and must be done in order to prevent further HIV infections in Lesotho. At the level of the individual, the first line of defense would be to avoid unsafe sexual relations and direct contact with other bodily fluids. In the sections above we discussed research findings on multiple concurrent relationships and condom use that suggested behaviours by a majority of LMPS officers that were cause for concern in this regard. In this section we will ask how many of them have taken the further steps to test for HIV and to learn more about the epidemic by participating in the HIV/AIDS workshops that have been organised by the LMPS. At the institutional level of the LMPS, the response would have at least two components. The first would be to ensure that officers have a basic knowledge about HIV/AIDS so as to know how to protect themselves both privately and while on duty, and the second would be to provide the necessary protective gear – in terms of both gloves, masks and condoms (for private use) – to ensure that officers can put that knowledge into practice.

## *Do LMPS Officers Know Their HIV Status?*

Testing for HIV is the only way in which someone can accurately know his/her HIV status. Not knowing one's status may expose sexual partners to a high risk of infection and will, at an aggregate level, accelerate the spread of HIV in a population. In Lesotho, only 6 percent of people aged 15-49 years received an HIV test during 2007 and knew the result.[62] This very low level of knowledge is a serious problem hampering programmes aimed at reducing the further spread of HIV. Does the CSVR survey suggest that LMPS officers who responded differ from the national average in any way?[63]

Table 17. **Do you know your HIV status?**

| | Number of Respondents | |
|---|---|---|
| | Freq | % |
| Yes | 191 | 37.6 |
| No | 294 | 57.9 |
| Missing Data | 23 | 4.5 |
| TOTAL | 508 | 100 |

Table 17 shows that just over a third of respondents know their HIV status, while a majority of 58 percent said they did not. While this would suggest that LMPS officers have far better knowledge of their HIV status than the average Lesotho adult, this would be misleading since respondents who answer yes may have had the test earlier than 2007, and, as discussed in the methodology section above, the selection process of respondents may have been biased towards those who had taken the test. Before we explore the information about when tests were taken, we can find substantial variation between different categories of respondents. More senior staff was more likely to know their status. As could be expected, officers with good (self-

[62] UNGASS report., 2008.

[63] The question was: *Do you know your HIV/AIDS status?*

proclaimed) HIV knowledge were more likely to know their status (39% knew their status), whereas those with average or poor knowledge were considerably more likely not to (72% did not know).

But the survey question on whether officers know their status from taking an HIV test has little validity as an indicator of knowledge of their own HIV status unless we have a sense of when they last tested. Given the high frequency of multiple concurrent sexual relationships and the low use of condoms, one could argue that an officer with that pattern of sexual behaviour, who takes his/her HIV status seriously, should test for HIV regularly at least every three months. This is not the case. To start with, the data shows that officers who have more than one sexual partner are less likely to know their HIV status; almost three quarters of the officers with four or more partners do not know their status.

The survey went on to ask the subgroup of 191 respondents who claimed to know their HIV status when they had their latest HIV test, and 56 percent had their test more than a year ago, 12 percent less than a year ago, and only 20 percent did so less than three months ago. This statistic varied somewhat between categories of respondents. More senior officers were more likely to have had a test more recently whereas a full two-thirds of troopers had their test over a year ago. This pattern may be caused less by the seniority of the individual officer than his/her gender. As many as 70 percent of male officers had their test done over a year ago, as opposed to 54 percent of the female officers. Most problematic, yet again, were the officers with average or poor knowledge of HIV: a full 72 percent had their test over 12 months ago.

If we compare these statistics with the data on HIV testing in the adult population that Lesotho submitted to UNAIDS (see above), we find that almost twice the share, or 12 percent of CSVR survey respondents, tested less than a year ago. While this is a result pointing in the right direction, it is clearly not enough. If, as argued above, we raise the bar even higher and argue that due to the frequency of unsafe sex among LMPS officers they should test every three months, the percentage is even lower with about 8 percent of all respondents having tested in the last three months.[64] We turn to the interviews and focus group discussions to learn about some of the reasons behind this poor level of knowledge of individual HIV status – fear of knowing appears to be a main reason:

> *To be honest with you, I don't know my status; I have never tested for HIV. My main problem is that I am just too scared to know my status. I have come here at counselling and spoken to Counsellers but I have not come to test despite all the advice that these guys have given me. I am a married man and I want to know my status, but another problem is that it seems my wife does not want to know her status. My sense is that if my wife is not ready to know her status and I know my status*

[64] This is 20% of 37.6% (see Table 17).

*it will be difficult to live together and have sex. Just imagine if I test and I am found to be HIV positive, it will be difficult to say I am HIV positive please let's have condoms. The first question will be how you become HIV positive, which means you were sleeping around. And, if she goes and tests and find out that she is also HIV positive she will blame me simply because I tested first and there will be finger pointing and counter accusations about who infected who.* (Trooper, male)

*I do not know my HIV status and I have never tested. It's very scary and I am not yet ready to know my status. I have heard people say your life stops immediately you know that you are HIV positive. I am not a virgin anymore and there is a chance that if I test I will know my HIV status. I know it is wrong but every time I think about testing, my body freezes with fear. I am sure I will test when I am ready to face the results.* (Trooper, female)

*I have kids and I am married and it's difficult for me to test when my wife is not ready to test because how do we plan for the future together. How do we have sex when I know my status and she does not know? It's a difficult thing and there is no easy answers, may be you can give me some ideas. I have therefore decided not to test until my wife is ready to also test so that we can know our HIV status at the same time.* (Trooper, male)

*I don't think I am ready yet to test for HIV, hence I have never tested and I don't know my status. I will test when I am ready because at the moment I am very scared of knowing that I may be HIV positive. This is not to say that I don't know the benefits of testing, I know them but I think the knowledge of being HIV positive will kill me. I have seen that happen to a lot of people who immediately on knowing their HIV status die soon. Many police have died within 12 months after knowing their HIV status. Conducting HIV when you are not ready is just the same as committing suicide because if you don't kill yourself you will die slowly. I am not yet ready to die hence I think it is ok for me not to know my HIV status at this stage.* (Trooper, male)

Apart from fear of knowing, several respondents gave poor counselling resources within LMPS as a reason for not testing:

*Testing for HIV is serious commitment and those who decide to test often have good reasons for doing so. I will say to people, please don't take a test until and unless you are ready to face your results… It's a different thing when you have received positive results because you will require on going counselling and support. I don't think that the LMPS has enough resources to provide people who have been diagnosed HIV positive on-going professional care and counselling. I think people make a mistake when they simply encourage people to simply go out there and test without considering what ongoing support they will receive and who will provide it. I am not ready to know my HIV status hence I will not test.* (Trooper, male)

*I do not know my HIV status because I have not tested yet. I must also say that the challenge that we face in the LMPS is that there are no proper structures or facilities for counselling and testing. For example, at this station we do not have a counselling room where one can sit down with the HIV counsellor and receive counselling. So before we conclude that police officer do not want to test, we also have to consider whether it is possible for testing to take place in the first place.* (Trooper, male)

*I must say that although I tested during the LMPS organized 'Know your status campaign' the lack of counselling facilities will discourage many people. The lack of proper and adequate testing and counselling facilities is a serious cause for concern. I would say this challenge alone discourages people who would like to test from doing so. People are concerned whether after testing they will receive adequate psychological and emotional support from the counsellors we have. For example, at this station we do not have a Counselling room and that raises serious questions about what kind of Counselling one will receive after being diagnosed with HIV. Having tested negative myself that did not become an issue. But I am well aware had I been tested positive I am sure that without adequate psychological support I may have not coped well.* (Sergeant, male)

But there were exceptions to this dominant pattern. Some officers have taken their responsibility seriously and tested, and they live confidently with a positive result:

*Yes I have tested and I know my HIV status. I had been sick and my doctor suggested that I should test and when I tested I discovered that I was HIV positive. I have been living openly with the HI virus since I discovered my HIV status. I am also a member of Ha Re Pheleng.*[65] (Trooper, male)

With knowledge of being HIV positive, and proper Counselling, LMPS officers could perform most normal police duties as long as their health allowed them to do so. Once at the stage of needing ARV treatment they will, like all Lesotho citizens, receive it free of charge from public health facilities and local hospitals. The HIV positive police officers interviewed for this research all confirmed they have access to treatment.

While there are strong and positive examples of courageous officers who face up to the challenge of HIV/AIDS on an individual level by getting themselves tested frequently, and some living openly with a positive result as constructive examples for others to follow, the dominant picture was nevertheless

[65] Ha Re Pheleng, which means 'Let's live', is a support group for LMPS officers who are living openly with HIV/AIDS. The group is recognized and supported by the Commissioner of Police. The LMPS supports the group by providing it with the venue for meetings and workshops, transport and refreshments. The executive members of the group meet on a monthly basis to discuss a variety of topics related to HIV/AIDS and concerns from their members. These concerns are then discussed with the Counselling Unit or the commander of the Human Resources and Management Unit.

problematic. Far too few officers get themselves tested frequently enough to equip them with the knowledge they need to live responsibly in the hyper-endemic epidemiological context of Lesotho. We can conclude that more is needed in terms of the response to AIDS at the level of individual officers, but what does the research tell us about the institutional response from LMPS? In the next two sections we will explore issues relating to protective gear and the LMPS HIV/AIDS workshops; two interventions intended to prevent infection and empower officers to get tested and live responsibly.

## *Information and Availability of Protective Gear*

In line with the UNAIDS policy prescription of the 'Three Ones' – one national HIV/AIDS framework, one national authority, and one national monitoring and evaluation system – Lesotho created a National AIDS Commission (NAC) in 2005. The NAC is an independent statutory body tasked with leading the fight against the epidemic. State institutions, such as the LMPS, are compelled to implement the broad and general HIV/AIDS policy and strategy that has been formulated and adopted by the NAC. To date, LMPS relies only on the more general policy generated by the NAC and has not developed its own more precise policy and HIV/AIDS strategy specifically tailored for LMPS.

The survey asked whether LMPS is doing enough to prevent such infections in terms of informing officers of those risks and how to avoid them.[66]

Table 18 shows that over 60 percent of respondents do not think the LMPS is doing enough to make police officers understand how to prevent themselves from becoming infected with HIV while performing their police duties, and less than a third think they receive sufficient information.

**Table 18. Is the LMPS offering sufficient information about work-related risks?**

| | Number of Respondents | |
|---|---|---|
| | Freq | % |
| Yes | 142 | 28.0 |
| No | 317 | 62.4 |
| Do not know | 27 | 5.3 |
| Missing Data | 22 | 4.3 |
| TOTAL | 508 | 100 |

The following comments elaborate on this point:

> *I don't think the LMPS management is doing enough to prevent us from becoming infected with HIV while performing police duties. You basically have to use your own logic and understanding*

[66] The question was: *Do you think the LMPS has done enough to help police officials understand how to prevent HIV infection while performing police duties?*

*of the epidemic to protect yourself. We are not provided with gloves or protective gear to wear to prevent exposure to blood. The training that we get at PTC is so basic that there is nothing new that one learns. You are not prepared of what you will experience and how you must deal with high risk situations.* (Trooper, male)

*I don't think the LMPS is doing enough in the area of HIV/AIDS prevention. The training and workshops provided are often about basic knowledge of the disease which has nothing to do with police work. I suspect that the LMPS fears that if there were to do a lot they will be forced to provide things like gloves to police officers. I think they know what to do but they won't do it until we start making serious demands.* (Trooper, male)

Whilst the overwhelming view was that the LMPS was not providing enough information, some respondents recognised the efforts made by LMPS:

*Well, the LMPS is doing all it can to address the problem. There are health talks at this station where we also talk about HIV/AIDS issues, there are workshops that we attend and every district has a HIV/AIDS Counseller. Recently, we also had a campaign at the station 'the Know your status campaign' where police officials were encouraged to test. However, this is not just an LMPS issue alone. Police officers should take even greater responsibility for their health.* (Trooper, female)

*My view is that the LMPS is doing a lot and it needs to do more. For example, madam commissioner started a support group, 'Ha Re Pheleng', comprising of HIV positive people. In my view, this was meant to give people who are HIV positive a platform to shape policing practices and policies. It is for this reason that madam commissioner issued an instruction requesting commanders not to deploy police officers who are HIV positive.* (Trooper, male)

*We have opportunities to attend HIV conferences and workshops but often we do not implement what we learn. I cannot say that I don't have the necessary knowledge to do the right thing because that is not true. No police officer can come here and say, "I don't know how HIV is transmitted" because we learn these things from the time we are at college.* (Trooper, female)

Whereas the perception of more than 60 percent of the respondents should be a clear indication that many feel there is a shortage of information, the fact that such information is in fact provided to those who are ready to receive it would signal that some other mechanism is at play among those that criticize LMPS on this point. We shall return to this issue in our comments further below. First we need to review the perceptions of what LMPS is doing in terms of providing the necessary equipment to protect officers from exposure to blood or other bodily fluids.[67]

Notwithstanding uncertainty as to how exactly to quantify the risk of work related HIV infection on the part of LMPS officers, and the information from other countries to the effect that the risk of work related HIV infection is relatively small, there is nevertheless an identifiable risk. In addition whatever the actual risk it is apparent that members of the LMPS regard themselves as facing a significant risk of work related HIV infection. Partly to protect LMPS members but also in order to enable them to enable them to do their work with a sense of confidence and without continual anxieties that they are at risk of contracting HIV from their work it would appear important to provide LMPS with protective equipment.

Just over 70 percent of respondents thought that the LMPS was not providing police officials with the necessary protective equipment and only just below 20 percent of respondents felt that such equipment was provided. A similar pattern of perceptions was evident in the material gained from interviews and focus group discussions. The following examples illustrate this perspective.

### Table 19. Is the LMPS providing the necessary protective equipment?

| | Number of Respondents | |
|---|---|---|
| | Freq | % |
| Yes | 95 | 18.7 |
| No | 365 | 71.9 |
| Do not know | 14 | 2.8 |
| Missing Data | 34 | 6.7 |
| TOTAL | 508 | 100 |

*Absolutely NO!! The LMPS does not provide police officers with equipment to prevent HIV infections. I have been in the LMPS for 10 years and I have never received a glove from the LMPS to wear to prevent HIV infection. I am sure that you can ask any police officer in the LMPS, no one will tell you that they have ever received anything to prevent HIV infection.* (Trooper, male)

*I agree the LMPS is doing its best and we have a very supportive Commissioner of Police. What I want to say is that the LMPS should do more especially on the side of prevention because we do not get resources we require. We are always short of things like condoms for police officers, gloves and masks. In fact, I have never seen a mask in the LMPS yet we do attend to emergencies.* (Trooper, male)

*The organization is doing nothing, absolutely nothing to ensure that the police officers are given the necessary equipment to use while dealing with high risk motor vehicle accidents. We have*

[67] The questions was: *Does the LMPS provide officers with the necessary equipment to prevent exposure to blood or bodily fluids?*

*AIDS Counsellers who can't see anyone or provide Counselling because there are police officers who are required to do normal police duties, like I am doing. You will never hear our Counsellers say today we are issuing gloves please come and receive them or we are visiting our sick members or we are doing a campaign because there are always occupied with normal police duties like me and GS are doing. That is why I am saying the organization is doing nothing but they would like to be seen to be doing something.* (Sergeant, male)

The predominant experience among troopers (72%) was that the equipment was difficult to access when needed:

*It is just impossible to access a simple thing such as a glove to protect yourself. I have never received a glove ever since I was in the LMPS.* (Trooper, male)

*The truth is that the LMPS does not have gloves so the question does not even arise because you cannot access something that is not there. There are no gloves at all you can check yourself at the district office yet gloves are not that expensive at all. We have asked for gloves and we have been sent from pillar to post and never received any.* (Trooper, male)

However, more senior LMPS officers did not accept this criticism:

*We have stores at every district and we make sure that police station have the necessary equipment to do their work. Getting the equipment simply requires one to call or visit the district and make the request. I am surprised that people are saying it is difficult because it is so easy. Unfortunately, you cannot expect to be supplied with gloves or condoms unless you have made the request.* (Senior Police Officer, male)

*It's easy to get equipment that you require because all you have to do is to ask. There is no way any commander will refuse you a glove to do your work. We have gloves at every police station in this district and I will be surprised if station commanders are refusing to give these to police officers because that will be a violation of our policy.* (Senior Police Officer, female)

This research is in no position to comment on the veracity of any statements about the availability or lack of protective gear at the various police stations across Lesotho. However, given the predominant perception of risk of infection through police work, it would seem understandable why the perceived lack of equipment would cause considerable stress and frustration among LMPS officers. To the extent this perception of unavailability is mistaken, and the protective gear is in fact available, albeit only through some routine administrative steps, it would seem important for the LMPS to streamline those procedures and facilitate access as far as possible, and then inform officers of the limited administration needed to access the equipment.

## LMPS' HIV/AIDS Workshops

The LMPS provides information on HIV/AIDS and training in how to use protective gear through two initiatives: learning modules for new recruits at the Police Training College, and HIV/AIDS workshops for officers already deployed across the country. These initiatives are important means through which LMPS can reinforce any general prevention messages that officers would receive as citizens, but, more importantly, they are essential for empowering officers with information and training that is particular and specific to the potential risk factors they face in the line of duty as LMPS officers. In a narrow sense, these specific risk factors would refer to the availability and correct use of the protective gear, but in a more general sense they would also include the risks connected with officers establishing networks of multiple concurrent sexual relations while on deployment far away from spouses and regular partners. However, as this research has no information on the content of this training, our analysis here is limited to the frequency of attendance in the HIV/AIDS workshops among the CSVR survey respondents and to explore whether or not workshop attendance appear to make a difference to officers' perceptions and behaviours across a range of issues.

Just under half of the respondents (47%) had attended an HIV/AIDS workshop, and equally many had not. More women than men had attended (53% as opposed to 46%), and attendance was also higher among more senior staff; a majority of troopers (54%) had not attended a workshop. Further, attendance was higher among those who claimed good knowledge of HIV, and non-attendance was particularly high (61%) among those that claimed poor knowledge of HIV. This last statistic would make sense, although this research cannot prove that poor or good HIV knowledge is a result of whether or not officers attended the HIV/AIDS workshops. This research is not in a position to evaluate these attendance figures against any performance criteria, other than to say that, to the extent our survey respondents somewhat approximate a random national sample, the LMPS obviously have some way to go before these workshops have achieved complete coverage.

The follow-up question is whether the fact that an officer has attended a workshop appears to make a difference in his or her perception and understanding of risk factors either through police work or through the practice of safe sex and the nature of sexual relationships he or she engages in. The important caveat here is to state that our test of any such links is a rather blunt test for statistical correlation. We cannot say whether officers hold certain views already before attending the workshops or if views and behaviours were shaped by what they learned at the workshop, nor can we control for other possible explanations to the statistical association. For this and other reasons, the generated results should be viewed as indicative explorations rather than authoritative statement of facts – explorations that hopefully will motivate a more thorough evaluation of the effectiveness of

the workshops in order to ensure that they are powerful and constructive interventions that reduce HIV infections and risky behaviours among LMPS officers.

### *Multiple Concurrent Sexual Relationships*

The analysis can identify a weak but nevertheless noteworthy association that suggests that officers who have attended HIV/AIDS workshops are less likely to engage in multiple concurrent sexual relationships. When the analysis is conducted on the different categories of respondents we find that this link is specific to younger officers, defined either as troopers or officers aged 21-30 years.[68] This might suggest that younger officers who perhaps are not yet so set in their ways of relating sexually, and also who to a large extent have grown up with AIDS as a serious health issue, are more impressionable to the information provided in the workshops.

### *Condom Use*

Only one weak but statistically significant association was found in relation to condom use: female officers who attended the workshops were more likely to use condom with their regular partner.[69] The lack of any other association, as well as a complete lack of association in relation to condom use with casual partners, is problematic. If we had no other information the result could mean that officers were so well informed about the need to use condoms that the additional information provided in the LMPS workshop made little difference to their behaviour. But this does not seem to be the case since we know that levels of condom use are relatively low. It would seem that whatever information is provided in the LMPS workshop on the need to use condoms makes little difference on the behaviour of the attending officers.

### *HIV Testing, Risk Perception, Use Of Protective Gear*

It is similarly problematic that no statistically significant associations at all were found between workshop attendance and whether officers had tested for HIV, whether they thought LMPS work was high-risk for contracting HIV, or whether they use protective gear when at risk of coming into direct contact with blood or other bodily fluids.

Clearly, a more thorough evaluation of the impact of workshop attendance on perceptions and behaviours among attending officers would be necessary in order to draw any more confident conclusions about the effectiveness of the workshop intervention. The results we have generated here can nevertheless be regarded as first exploration that suggest a lower than expected level of effectiveness. An alternative view was expressed in interviews with some more senior LMPS officers,

[68] *Chi-square 8.5**** for officers aged 21-30 years.
[69] Chi-square 8.4***.

but also with a few of the troopers, as exemplified by these comments:

> *I don't think the LMPS can do anything else with regards to HIV/AIDS because you must remember that we are police officers not health workers or social workers. We are training our people to fight crime not to know how to treat HIV/AIDS. However, because the issue of HIV/AIDS is affecting every police officer, the LMPS has decided to ensure that police officers receive some kind of education on this epidemic while there are still at college. Those that are outside of college attend workshops and station lectures where we deal with these issues. Surely, the LMPS is not going to send their members to a medical school to learn about HIV/AIDS because we are not doctors we are police.* (Senior Police Commander, male)

> *I think police officer must learn to take responsibility for their action instead of blaming the LMPS. I can tell you now that all police officers at this police station know what they need to do to stay safe and free from HIV. They know that, I can call all of them for you to interview and they will confirm that. The fact that most police officers are not testing or are sleeping around is not because they don't know what to do. Everybody knows but not everyone is prepared to implement what they know and have been taught and the LMPS cannot be blamed for that.* (Trooper, male)

Both these comments make the point that while the interventions by LMPS are necessarily limited in some regards, it is not and it should not be the responsibility of the LMPS to ensure that individual officers behave responsibly in their private sexual relations. The LMPS, as well as any other employer or state institution, has a responsibility to provide information and any necessary protective equipment. Beyond this point the ultimate responsibility to internalize that information and use that equipment rests with the individual officers. This research raises questions about whether the way in which information is provided needs to be examined in order to try and ensure that such information has more of an impact on police officer behavior. It also raises questions about whether there is adequate access to protective equipment. But it is not intended to suggest that the issue is only one of organisational responsibility. There would also appear to be issues to of individual responsibility which are also of concern.

## Comments

This concluding section of data analysis was presented as a discussion of the response to HIV/AIDS, by individual officers and by the LMPS respectively. In both respects, the response was found wanting. Far too few officers know their HIV status. It may be even more problematic that many of those who claim to know their status most probably do not, since a large majority of them tested more than three months ago, after which they are likely to have had several sexual relations through which

they may have contracted HIV. Any efforts to increase the frequency of testing among LMPS officers would need to be based on incentives that can overcome the considerable levels of fear that is felt by officers for knowing the truth about their status.

The institutional response from LMPS is in many ways defined by the overall national response that is decided by the National AIDS Commission. A HIV/AIDS policy specifically for the LMPS would perhaps overcome the apparent problems with informing officers about the necessary administrative steps to access the gear that can protect them against HIV infection in the line of duty. The policy would also identify an accountability mechanism that would ensure that the responsible senior officer is held accountable if the protective gear is not speedily made available to officers who correctly have applied for access.

In addition to the protective gear, the LMPS HIV/AIDS workshops are an essential intervention to ensure that officers are well informed about different aspects of the epidemic and of how to avoid infection both privately and in the line of duty. The explorative form of evaluation we undertook, however, suggested that the workshops are not very effective in changing participants' perceptions or sexual behaviours. However, this conclusion should not be the final word on the quality of the workshops, but rather motivate a more thorough evaluation that can identify strengths and weaknesses and ways of improving them further so as to ensure they become a powerful intervention that help change mistaken perceptions and unsafe sexual behaviours among LMPS officers.

# 9. CONCLUSIONS

The situation relating to HIV/AIDS within the LMPS reflect the situation that Lesotho as a whole is facing: it is extraordinarily serious and alarming. On the assumption that the material gathered for this research did not completely misconstrue the behaviours and perceptions held generally by LMPS officers across Lesotho, there is nothing in the material to suggest that HIV prevalence levels among officers should be substantially lower than the national average for adults at some 23 percent. There is overwhelming support in the material for the hypothesis that AIDS is undermining the institutional capacity of the LMPS, although there is no way of quantifying this effect on the basis of this research.

The research can establish that a majority of officers acknowledge HIV/AIDS within LMPS ranks, which certainly is better than denial of this fact. But there is still denial. The fact that about a third of respondents cling to the notion that HIV positive officers commonly contract AIDS through their work duties appear to signal denial of the personal responsibility we all have to avoid the unsafe sexual relationships that place us at high risk of contracting HIV. Any such apparent 'irrationality' in terms of perceptions and behaviours can be better understood by further exploration of the many complex and culturally loaded notions of gender roles, sex and dependencies that emerged through this research.

Many police obviously do have good knowledge yet it does not seem to translate to an awareness of the need to lead lifestyles which involve safe sexual practices to avoid becoming infected. This may be an indication of the problem of stigma and discrimination associated with the disease which prevents police officers from engaging with each other and encouraging each other to lead 'safe' lives. Alongside this the culture in terms of which police officers earn respect and status amongst their peers for being involved in multiple relationships continues to have more power than a culture of encouraging responsible sexual behavior. These issues highlight the fact that creating an LMPS which is less vulnerable to HIV/AIDS is about cultural change – specifically the creation of a culture within the LMPS in which stigma and fear of discrimination are not prominent factors and in which officers are respected for adhering to high standards of conduct in relation to their sexual practices rather than for the number of sexual partners which they have.

An additional factor that adds further complexity needs to be emphasized even though it did not feature prominently in the material: poverty and resource scarcity. Unless the analysis is sensitive to the socio-economic context of LMPS officers while on deployment, any interventions are likely to be mistaken. In the context of sufficient information about how to avoid contracting HIV, seemingly irrational unsafe behaviour can often be explained by the fact that individuals, due to poverty, can actually not afford the safe option. Interventions must ensure that LMPS officers have a realistic chance of making the right choice.

Whereas the LMPS and its senior staff have done much to respond to AIDS on the basis of the general policy template provided by the National AIDS Commission, the LMPS should consider developing its own specific HIV/AIDS policy. Such a policy should be developed through a participatory process that would allow for broad deliberation among all LMPS staff so as to ensure that the process sows the seeds for a new institutional culture that embraces those officers who are HIV positive and those who take active steps to know their status and live a life that prevents the further spread of HIV in Lesotho

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