

**WORKPLACE HIV AND AIDS MANAGEMENT:
THE CASE OF THETSANE INDUSTRIAL AREA IN
MASERU, LESOTHO**

BY

NKEKA PETER T'SEOLE

**SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF POPULATION STUDIES
IN THE SCHOOL OF DEVELOPMENT STUDIES**

UNIVERSITY OF KWAZULU-NATAL

DURBAN

MARCH 2011

DECLARATION

Submitted in fulfilment / partial fulfilment of the requirements for the degree of
Masters in Population Studies, in the Graduate Programme in the School of
Development Studies, University of KwaZulu-Natal,
Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. I confirm that an external editor was/was not used and that my Supervisor was informed of the identity and details of my editor. It is being submitted for the degree of Masters in Population Studies in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

Student signature

Date

Lauren Boyle

Editor's name and surname

ACKNOWLEDGEMENTS

I would like to express my gratitude to:

- Each one of my friends for their moral support during the writing process of this dissertation, Dr. Matete, kea leboha!
- My colleagues, you guys have been wonderful and supportive all the way.
- Staff members in the School of Development Studies were amazing from the beginning of the journey, *thank you* so much for your assistance, support and encouragement.
- Dr Munyakazi and Dr Dutton, a *big thank* you to you two for your help and advice during the analysis stage of this research.
- A big thank you to Lauren Boyle for proofreading this dissertation.
- The government of Lesotho for sponsoring my studies throughout the years in the University of KwaZulu-Natal.
- My supervisor, Professor Julian May, thank you for believing in me, for your guidance throughout the journey. *You are the best.*
- My family! (Bo-T'seole le Bo - Khoaele), thanks for being there and for your support all the way. Sometimes you did not understand the process, but supported me anyway, ke leboha ho menahane. Malome Malilimale, le ka moso!
- All wisdom comes from you. You make all things possible. You are the source of strength, knowledge and all that man can ask for. Thank you LORD for making this possible. Thank you!

DEDICATION

This one is dedicated to my parents, Ntate Ntja le 'M'e 'Mankeka T'seole. Le ho baena ba ka; Khabea, 'Mamolefi, 'Mathabo le Relebohile! Kea lerata!

ABSTRACT

The aim of this study was to investigate outcomes of approaches used to mitigate the negative impacts of HIV and AIDS at workplaces in Lesotho using Thetsane Industrial Area as a case study. Garment industries in Lesotho are faced with a serious threat due to the HIV and AIDS prevalence in the country. A huge number of the labour force is leaving firms due to increased morbidity and mortality associated with HIV and AIDS. In view of this, this study investigated approaches used in managing HIV and AIDS in the workplace. In order to optimize the accuracy of the research results, a triangulation research method was utilized. The results indicate production levels to have improved since the advent of the Apparel Lesotho Alliance to Fight AIDS (ALAFA). The findings suggest ALAFA to have taken over the responsibility of HIV and AIDS prevention and management, especially in the garment industries, providing HIV and AIDS victims with all the necessary services needed to keep HIV and AIDS under control. These findings therefore suggest overdependence on ALAFA by the garment industries for HIV and AIDS management. The findings also imply that garment industries had no resources in the form of human capital specializing in the knowledge of HIV and AIDS management from the individual garment industries. Despite the fact that HIV and AIDS still spreads at an alarming rate, the larger implications of this research's findings, especially relating to the serious challenge faced by the garment industries of losing their labour force to HIV and AIDS, is that the pandemic has lately become manageable given that there are now ARVs and ART to be used as treatment by HIV and AIDS victims.

TABLE OF CONTENTS

	Page
Title page	
Declaration	
Acknowledgements	i
Dedication	ii
Abstract	iii
Table of contents	iv
List of tables	ix
List of figures	x

CHAPTER 1 - INTRODUCTION

1.1 Background	1
1.2 Context	1
1.3 Problem statement	5
1.4 Research questions	5
1.5 Objectives of the study	6
1.6 Significance of the study	6
1.7 Limitations of the study	7
1.8 Theoretical framework	7
1.8 Structure of the study	10
1.9 Summary	10

CHAPTER 2 - LITERATURE REVIEW

2.1 Introduction	11
2.2 Defining HIV and AIDS	11
2.3 HIV and AIDS in Sub-Saharan Africa	14
2.4 Impact of HIV and AIDS on business	16
2.4.1 Increased absenteeism	18
2.4.2 Labour turnover	20
2.5 Approaches to managing HIV and AIDS in the workplace	21
2.5.1 Policies	23
2.5.2 HIV and AIDS education and training	25
2.5.3 Condom distribution	27
2.5.4 Voluntary Counselling and testing (VCT)	28
2.5.5 Treatment	30
2.5.6 Care and support	31
2.6 The government s' response to workplace HIV and AIDS challenges	32
2.7 Summary	32

CHAPTER 3 - RESEARCH METHODOLOGY

3.1 Introduction	34
3.2 Research methods	34
3.3 Quantitative research method	35
3.4 Qualitative method	36
3.5 Data collection tools	36

3.1.1	Questionnaires	36
3.1.2	Structured interviews	38
3.6	Data analysis	38
3.6.1	Quantitative data analysis	38
3.6.2	Qualitative data analysis	39
3.7	Summary	39

CHAPTER 4 - QUANTITATIVE ANALYSIS

4.0	Introduction	40
4.1	Characteristics of the sample	41
4.1.1	Age	42
4.1.2	Gender	42
4.1.3	Marital status	43
4.1.4	Educational background	43
4.1.5	Wealth	45
4.1.6	Household size	45
4.2	Knowledge and attitudes concerning HIV and AIDS	47
4.2.1	Knowledge about HIV and AIDS	49
4.2.2	Attitudes towards HIV and AIDS	53
4.2.3	Knowledge about approaches used to manage HIV and AIDS at work	56
4.3	Testing, counselling and treatment	59
4.3.1	Voluntary Counselling and Testing	59

4.3.2 Antiretroviral Treatment	62
4.3.3 Condom distribution	65
4.3.4 Care and support	67
4.4 Opinions on effective approaches to manage HIV and AIDS at work	68
4.5 Summary	68

CHAPTER 5 - QUALITATIVE ANALYSIS

5.1 Introduction	70
5.2 Stakeholders	70
5.2.1 Government	70
5.2.2 ALAFA	71
5.2.3 LECAWU	75
5.3 Strategies used to manage HIV and AIDS in Thetsane Industrial Area	76
5.3.1 Workplace HIV and AIDS policy	76
5.3.2 HIV and AIDS awareness	77
5.3.3 Voluntary Counselling and Testing	80
5.3.4 Antiretroviral provision at work	81
5.3.5 Condom distribution	82
5.3.6 Care and support	84
5.4 Challenges in HIV and AIDS management in the workplace	86
5.5 Summary	88

CHAPTER 6 - CONCLUSION AND RECOMMENDATIONS

6.1 Introduction	89
6.2 Conclusion	89
6.2.1 Perceived impacts of HIV and AIDS on clothing firms	90
6.2.2 The policies used by firms in managing HIV and AIDS	90
6.2.3 The role played by interest groups in managing HIV and AIDS	91
6.3 Recommendations	93
6.3.1 HIV and AIDS education	93
6.3.2 Target groups	94
6.3.3 Health Insurance	94
6.3.4 Responsibility by factory management	94
6.3.5 Personnel	95
6.3.6 Coverage	95
6.3.7 Community involvement	95
6.3.8 Behaviour	96
6.3.9 Life skills	96
6.3.10 Implications for South Africa	97
6.3.11 Monitoring, evaluation and Impact	97
6.4 References	98
6.5 Appendix	103

LIST OF TABLES AND FIGURES

Tables

Table 4.1 – Background information of the respondents	44
Table 4.2 – Respondents’ households	46
Table 4.3 – Hypothesis	48
Table 4.4: Prevention of Mother to Child Transmission (PMTCT)	50
Table 4.5 – Condoms protect one from contracting HIV	51
Table 4.6 - Attitudes towards HIV and AIDS and towards HIV positive employees	54
Table 4.7 - Attitudes towards HIV and AIDS and towards HIV positive employees	55
Table 4.8 – Awareness by employees about approaches used in HIV and AIDS management in Thetsane Industrial Area	57
Table 4.9 – Knowledge about approaches used in HIV and AIDS management in Thetsane Industrial Area	58
Table 4.10 - Respondents who tested in the previous year of the study (2008) by selected socio-demographic characteristics	60
Table 4.11: Respondents who took a HIV test in the previous year of the study (2008)	61
Table 4.12 - Frequencies on risk of contracting HIV at work	62
Table 4.13 - Respondents who were aware that ARVs are readily available on site by selected characteristics	63
Table 4.14 - Respondents who believe condoms can protect one from getting HIV and AIDS by selected characteristics	66

Figures

Figure 1.1 - Map of Lesotho	4
Figure 1.2 – The PRECED-PROCEED model	9
Figure 2.1: Estimated adult (15-49 years) HIV prevalence rate (%) globally and in Sub-Saharan Africa, 1990-2007	15
Figure 4.1 – ARVs readily available at workplace	64
Figure 4.2 – Respondents’ opinions on HIV and AIDS management at work	68

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ART	Antiretroviral Treatment
ARV	Antiretroviral Therapy
CD4	Cluster of Differentiation 4
HIV	Human Immunodeficiency Virus
HTC HIV	Testing and Counselling
KYS	Know Your Status
LECAWU	Lesotho Clothing and Allied Workers Union
LEA	Lesotho Employers Association
LNDC	Lesotho National Development Cooperation
LTEA	Lesotho Textile Exporters Association
MOHSW	Ministry of Health and Social Welfare
NAC	Commission
NGO	Non-Governmental Organization
NTC	National Tripartite Committee
OR	Odds Ratio
PMTCT	Prevention of Mother to Child Transmission

PRB	Population Reference Bureau
PRECED	Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation
PROCEED	Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development
PSI	Population Services International
SADC	Southern African Development Community
STIs	Sexually transmitted Infections
TIA	Thetsane Industrial Area
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UN	United Nations
USAID	United State Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

1.1 Background

According to (UNAIDS/WHO 2002), HIV and AIDS has been the world's challenge for more than a decade. The entire world is in the toughest grips of the HIV and AIDS pandemic. This disease drives those who are in the prime of their life to the grave and the rate is accelerating rather than slowing down. Medical and other health experts from all the avenues of the globe have endeavoured to find solutions to this epidemic, but there has been limited success to date. The partial successes they have gained have managed only to produce palliative interventions which help to alleviate the impact of the HIV and AIDS epidemic. In addition to its impact on the lives of those afflicted and those affected, the endemic is a threat to the workplaces as it is mainly those in the productive age groups that are infected with the disease. The aim of this study was to investigate outcomes of approaches used to mitigate the negative impacts of HIV and AIDS at workplaces in Lesotho using Thetsane Industrial Area as a case study.

1.2 Context

Lesotho is a landlocked country surrounded completely by the Republic of South Africa. It is just over 30,000 km² in size. Three quarters of the country's area is the highlands and the remaining one quarter the lowlands. Lesotho is divided into 10 districts and further into four regions: the lowlands, foothills, mountains and Senqu River Valley. The country's terrain results in the country being referred to as "The Mountain Kingdom" or "The Kingdom in the Sky". The population of Lesotho is estimated at two million (BoS 2008). About 61% of the population in Lesotho resides in the urban areas while 32% of the population is in the rural areas (PRB 2006). There are two official languages in Lesotho; Sesotho and English.

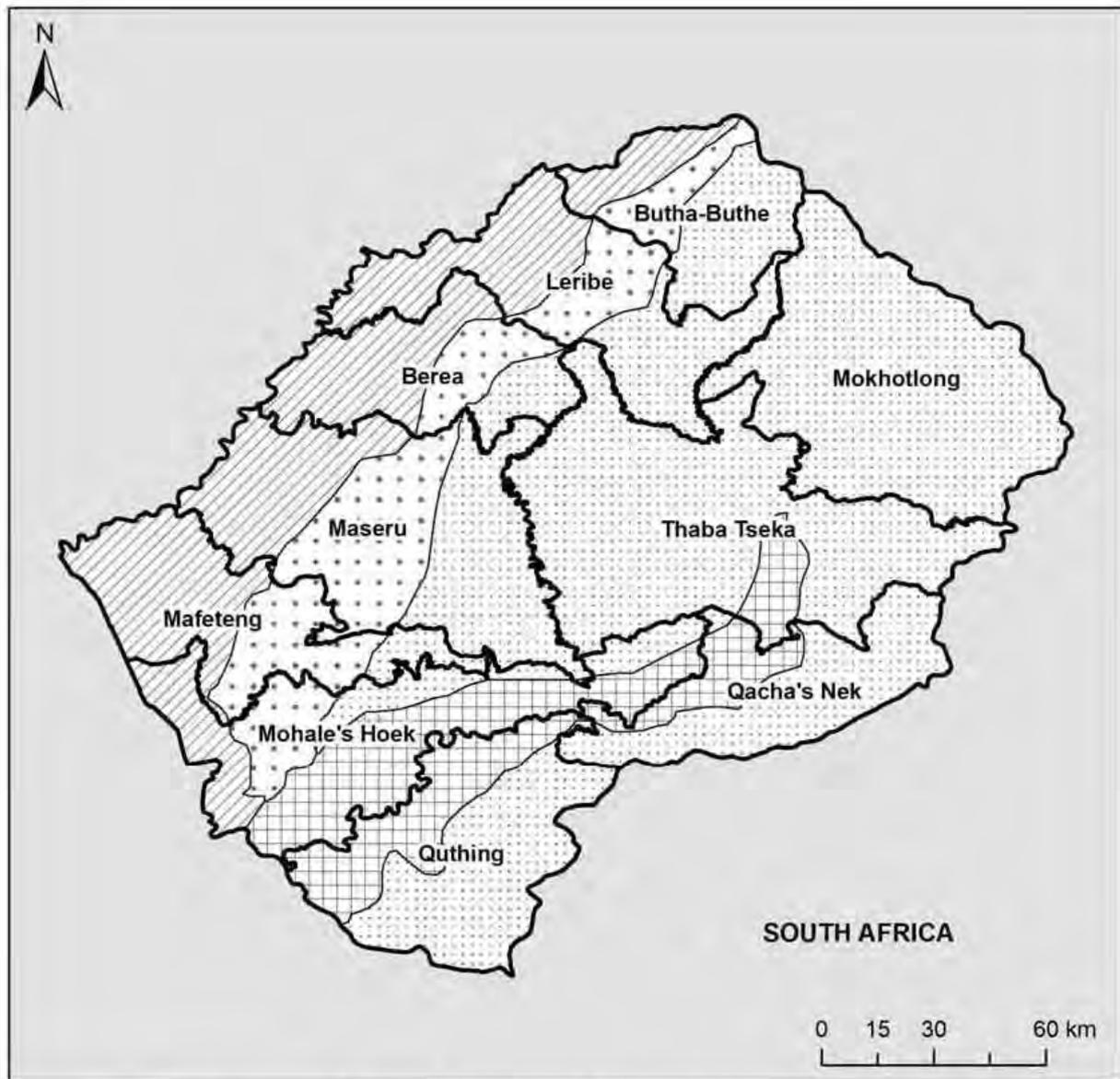
The country got its independence from the British colony on the 4th October 1966. The economy of Lesotho heavily relies on agriculture. Like most of the Southern African countries, Lesotho has recently experienced successive droughts. These droughts have led the country to experience acute shortages of food and severe famine. In addition to droughts experienced in the country, the HIV and AIDS pandemic has also affected most of the productive people leading to vast decline in production (LNHD 2007).

Lesotho is considered as one of the poor countries in Sub-Saharan Africa. The majority of Basotho, approximately 56% is poor and is living below the poverty line (PRB 2007). There is a high rate of unemployment in Lesotho which has been caused by, among other factors, a high retrenchment rate of the Basotho mine workers from the Republic of South Africa (FAO 2007). However, there has been an increase in the number of Basotho, especially women working in the clothing industries in three districts of Lesotho; Maseru, Leribe and Mafeteng. Lesotho's HIV and AIDS prevalence is about 23.2% ranking the third highest in the world (UNAIDS 2008). It is therefore one of the Sub-Saharan African countries intensely affected by the HIV and AIDS pandemic (UNAIDS 2008). HIV and AIDS is perceived as a huge challenge for garment industries in Lesotho (Grant *et al.*, 2001). The epidemic is negatively affecting workplaces in different firms and in different households in the country.

The government of Lesotho has taken tangible measures in addressing the epidemic. The pandemic was declared a national disaster by the government of Lesotho; the government developed the National AIDS Strategic Plan and also formed the National AIDS Commission (NAC) which coordinates the country's responses to the pandemic. In 2006, the government decided to embark on the "Know Your Status" campaign as one of the strategies used to combat the epidemic in the country. The government also works hand in hand with the non-governmental organisations interested in the fight against HIV and AIDS in Lesotho.

The study was based on Thetsane Industrial Area (TIA), found in the Southern part of the city of Maseru district (see figure 1.1). Almost all the firms found in this industrial site during the study were owned outside the country. The majority of the labour force in TIA is Basotho and predominantly women. The fact that there are more female workers than male employees in TIA can be attributed to the nature of the job done in these industries. Very few senior managers in these firms are citizens of Lesotho. Most of the senior managers are foreigners and the majority of the assistant managers are citizens of Lesotho. The majority of the firms found in TIA were garment industries while only three firms were non-garment industries. All the garment industries in TIA and one non-garment industry produce goods sold only outside the country and the remaining two non-garment industries sell their products both within and beyond the borders of Lesotho.

Figure 1.1 - Map of Lesotho



Topographic Regions

-  Foothills
-  Mountains
-  Lowlands
-  Senqu River Valley

Source: 2004 Lesotho Demographic Survey Report

1.3 Problem statement

The garment industries in Lesotho are faced with a serious danger due to the HIV and AIDS prevalence in the country (Grant *et al.*, 2001). Workers in different workplaces are infected by the HIV and AIDS pandemic every year. The effect of HIV infection among the labour force means a huge numbers of workers leave the labour market due to increased morbidity and mortality associated with the epidemic (Barnett and Whiteside 2002:283). The impact of HIV and AIDS is witnessed both by the firms and the workers' households. Different firms are losing skilled and experienced employees to HIV and AIDS thereby experiencing declines in production and incurring escalating production costs as they are forced to redirect some funds to replacing the labour force being lost (Arrehag *et al.*, 2006:116). The onus is on the individual workplaces to decide to work individually and cooperatively with other firms towards the management of the pandemic. Radical educational programmes on HIV and AIDS, treatment programmes, promotion of the voluntary counseling and testing, as well as awareness programmes, have the potential to help mitigate these challenges in the workplace.

1.4 Research questions

In order to address the aim of the thesis, which is to investigate outcomes of approaches used to mitigate the negative impacts of HIV and AIDS at workplaces in Lesotho, the following key questions would be addressed:

- What is the impact of HIV and AIDS in clothing firms perceived by management and employees in Thetsane Industrial Area in Maseru, Lesotho?

- What policies are firms using to manage HIV and AIDS or help employees live with HIV?
- What is the role of employees in managing HIV and AIDS at work?
- What is the role played by the government of Lesotho in controlling HIV and AIDS in firms in Thetsane Industrial Area in Maseru, Lesotho?
- What is the role played by NGOs in managing the challenges such as HIV and AIDS faced by firms and their employees in Thetsane Industrial Area in Maseru, Lesotho?

1.5 Objectives of the study

This study aims to:

- Determine the knowledge and attitudes of firm workers towards HIV and AIDS.
- Examine the impacts of HIV and AIDS perceived by managers and employees in clothing firms in Thetsane Industrial Area Maseru, Lesotho.
- Analyse the role played by workers and employers in managing HIV and AIDS in the workplace.
- Find out how the governments of Lesotho, the private sector and NGOs have responded to the HIV and AIDS management challenge in the workplace.

1.6 Significance of the study

This study contributes to the body of knowledge about HIV and AIDS in the workplace. It is further trusted that it will contribute to the understanding of how the HIV and AIDS pandemic is dealt with in different industries. It may be pointed out as well that the

study will promote consciousness on AIDS-related matters among the employers and the employees thereby empowering both parties meaningfully through shared knowledge.

1.7 Limitations of the study

The study sample was not big enough to represent the workplace population from different industries in Lesotho. The size of the sample also affected the statistical analysis of the quantitative data collected. Furthermore, the questionnaires were all written in English, which might have restricted the research subjects from freely expressing themselves well enough even though they were encouraged to feel free to respond in any language they felt comfortable with. It was also realized that with the subjects who did not understand the English language the session took longer because the researcher had to translate each one of the questions into Sesotho, the implication of questionnaire translation was that a relatively small number of employees were interviewed in an hour's time (lunch time for employees). Very few of the subjects were interviewed during their work hours with permission from their managers, this suggests that time for interviews with most of the subjects was limited because they only had one hour for lunch during which they were interviewed. The time restriction for interviews might have deprived the workers a chance to explore the questions well enough before they could give their responses.

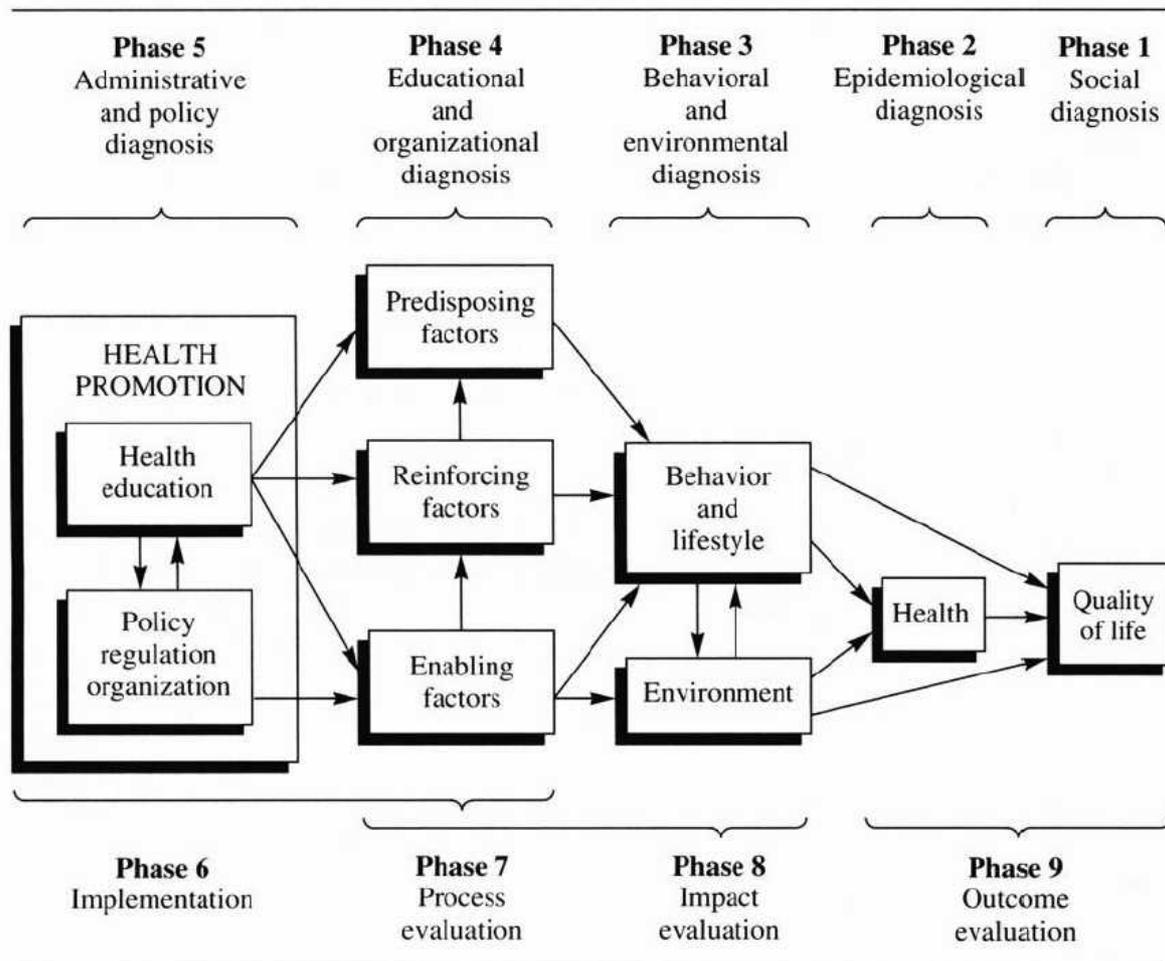
1.8 Theoretical framework

The study was informed by two theoretical frameworks. The Social learning theory and the PRECED-PROCED model for health promotion planning and evaluation. The social learning theory considers opinions, thoughts and behaviour by different individuals to be influenced to

a great extent by their social environment (Croyle 2005). Learning would be difficult if people were to rely only on their individual experiences. The social learning theory asserts that human beings learn by observing actions of others and not only from their own experiences (Horizons 2006). In the context of HIV and AIDS management, the social learning theory maybe functional as an effective approach to educate people about the pandemic and to talk to them about skills and approaches which can lead to behavioural change. The skills development in the application of the learning theory would include proper use of condoms, how to negotiate for safer sexual intercourse as well as teaching people about the importance of knowing their HIV status.

The PRECED-PROCEED model developed in order to effectively study a range of community health issues. PRECED is an acronym for Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation and PROCEED is an acronym for Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development.

Figure 1.2 – The PRECED-PROCEED model



Source: *Health Promotion Planning: An Educational and Environmental Approach* by Lawrence W. Green and Marshall W. Kreuter.

The model (PRECEDE-PROCEED) realises that health behaviours are complicated and are a result of multiple factors. The willingness and determination of the clients in the application of the PRECEDE-PROCEED model plays a critical role. The success in managing any health issue using this model is dependent on the cooperation as well as positive participation of the client in the process (Green 1992). The undertaken study in Thetsane Industrial Area analysed approaches used in controlling the HIV epidemic in Thetsane Industrial Area, the application of the Precede-Proceed model was perceived relevant in investigating HIV and

AIDS management approaches in the workplace as it encourages more responsibility on the clients (on HIV and AIDS management in this context) and not on the researcher.

1.9 Structure of the study

Chapter one comprises the general introduction, which will provide an overview of the entire study. Chapter two will be a literature review of the main debates around the management of the HIV and AIDS pandemic in the workplace. Chapter three will be an outline of the methodology and methods that will be used in this research. Chapter four will provide the quantitative findings of this research. Chapter five will discuss the qualitative findings of this study. The final chapter will summarize the study; provide the conclusion and present recommendations.

1.10 Summary

This chapter has outlined the background of this study. It has stated the purpose of the study as well as the objectives and critical questions explored by the study. The problem statement has been outlined in this chapter, the importance and limitations of the study have been highlighted. The chapter has also provided the theoretical framework applied for the success of the current study. Finally the chapter has outlined the structure of the report.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature relevant for this topic to develop the conceptual and analytical framework which will inform the research methodology, as well as to define the terms used in this dissertation.

2.2 Defining HIV and AIDS

Human Immunodeficiency Virus (HIV) is a virus which causes the illness classified as the Acquired Immune Deficiency Syndrome (AIDS). (Lynch1983: 3) defines HIV as “*a disease-causing agent, or pathogen, which primarily targets cells of the immune system, our bodies’ natural defense against infection and disease*”. HIV attacks the body's immune system by attaching to the Cluster of Differentiation 4 (CD4) cells, and eventually weakening the body's natural ability to fight off infections (Epstein 2007:15). The CD4 cells:

“... are vital to the body’s defenses against disease. HIV targets them. Because it cannot replicate on its own, the virus enters the helper T cells – the very cells that produce the body’s defense mechanisms against disease and cannibalises the cell mechanisms to produce itself” (Cameron 2005:10).

The immune deficiency leads to vulnerability to infections which would not develop in the presence of a healthy immune system. The human’s immune system weakened by HIV becomes less able to resist infections (Page et al., 2006:2, Cameron 2005:10, Barnett and Whiteside 2002 and Lynch 1983). At this stage, many illnesses which the body would normally fight off have the opportunity to infect the person. Research reveals that people infected with HIV and AIDS show symptoms of different diseases (Page *et al.*, 2006:2).

“AIDS is a disease. It is an infection, a syndrome, an illness, a disorder, a condition threatening to human life. It is an epidemic – a social crisis, an economic catastrophe, a political challenge, a human disaster,” (Cameron 2005). Discovered around 1979/80 in the United States of America where most cases were found among homosexual men, the HIV and AIDS pandemic has and continues to affect people in all walks of life (Barnett and Whiteside 2002:28). At around the same time (1979/80), the disease was discovered in central Africa among the heterosexual people and health service providers referred to it as a “slim disease” because its patients severely lost weight (Page *et al.*, 2006:1). An individual tested HIV positive faces a life-long condition which goes through several stages and has numerous consequences.

HIV is transmitted from one person to the other through an exchange of bodily fluids. These fluids include semen as well as blood of an infected person. An exchange of bodily fluids which transmit the HIV infection can also take place through unprotected oral, vaginal and anal sexual intercourse with an infected person (Arrehag *et al.*, 2006). Moreover, the HI Virus can be transmitted through the use of needles or other skin-piercing instruments with contaminated blood. Arrehag and colleagues further argue that the virus can be transmitted through blood transfusion of HIV contaminated blood, and to the unborn baby during pregnancy, at birth, or during breastfeeding (Arrehag *et al.*, 2006). According to (UNAIDS/WHO 2002), heterosexual sex is the major mode of HIV transmission in Sub-Saharan African countries where the modes of transmission comprise unprotected sexual intercourse, multiple sex partners and sexually transmitted diseases (STDs).

HIV and AIDS has reached all the countries in the world since its discovery. Even though the pandemic has reached all the countries, Merli and other scholars contends that Sub-Saharan African region is the home of the largest number of HIV infections and deaths caused by the pandemic as compared with other regions in the world (Merli *et al.*, 2006:1).

The number of people living with HIV and AIDS in Sub-Saharan Africa is estimated at 22.4 million (UNAIDS/WHO 2002:11). The reported number of the AIDS victims includes the number of the new infections which are estimated at 1.9 million people (UNAIDS/WHO 2002:11). In comparing the Sub-Saharan Africa and Latin America, UNAIDS/WHO estimated two million people to be living with HIV and AIDS in Latin America with the new infections at 170 000 (UNAIDS/WHO 2002:11).

The HIV and AIDS epidemic has turned into a humanitarian crisis worldwide found in all societies in all countries (Naidu 2003). The pandemic impacts different countries and regions differently. The widespread impact for both the rich and the poor countries is that the pandemic strains health care budgets. Most studies, as indicated earlier, point out Sub-Saharan Africa as the most negatively impacted region (UNAIDS/WHO 2002). The death of the people in their prime and productive ages seems to be the most obvious impact of HIV and AIDS, especially in the workplace. Many young and productive employees die leaving positions not easy to fill in their workplaces. According to UNAIDS, in 2007 three-quarters (75%) of deaths caused by HIV and AIDS were in Africa (UNAIDS 2008). The increased death rates due to HIV and AIDS often lead to the escalating numbers of orphans in the region as well as to the eroded ability of different communities to provide and care for both children and the elderly.

Life expectancy in many countries hard hit by HIV and AIDS has fallen drastically. According to UNAIDS, in countries most heavily affected, HIV and AIDS has reduced life expectancy by more than 20 years (UNAIDS 2008:13). Obviously the decreased life expectancy at birth has a negative impact on the productivity levels of different workplaces because the people who are expected to produce die too early. HIV and AIDS pandemic in Southern Africa is not only a major public health crisis, but also a threat to economic development, as it reduces the young and skilled labour force (Nattrass 2004 and Arrehag et

al., 2006). The consequences of the decrease in life expectancy thus include the slow economic growth which further worsens the households' poverty levels.

HIV infections of the age groups between 15 and 49 suggest serious negative effects on the firms in which these people work as well as for individual workers and their families. The repercussion of HIV infection is that the victims would not be able to contribute much to the economic well-being of their families and in their countries' economic growth because they are expected to die early from HIV and AIDS-related illnesses.

2.3 HIV and AIDS in Sub-Saharan Africa

Mounting literature report Sub-Saharan Africa as the region hardest hit by HIV and AIDS in the world. Generally, the Southern African Development Community (SADC) countries are the hardest hit by HIV and AIDS (Zungu-Dirwayi 2004). Different factors have been argued by different authors as reasons why the African population is more susceptible to HIV and AIDS. Concurrent or simultaneous sexual intercourse practices (especially by African men) is argued as a major role player in the vast spread of HIV in Sub-Saharan African countries as opposed to developed countries characterized by serial monogamy practices (Epstein 2007:55). Concurrent sexual intercourse practices are risky as they link different people up in a 'giant web' of sexual relationships creating an ideal condition for HIV to spread (Epstein 2007:55) .

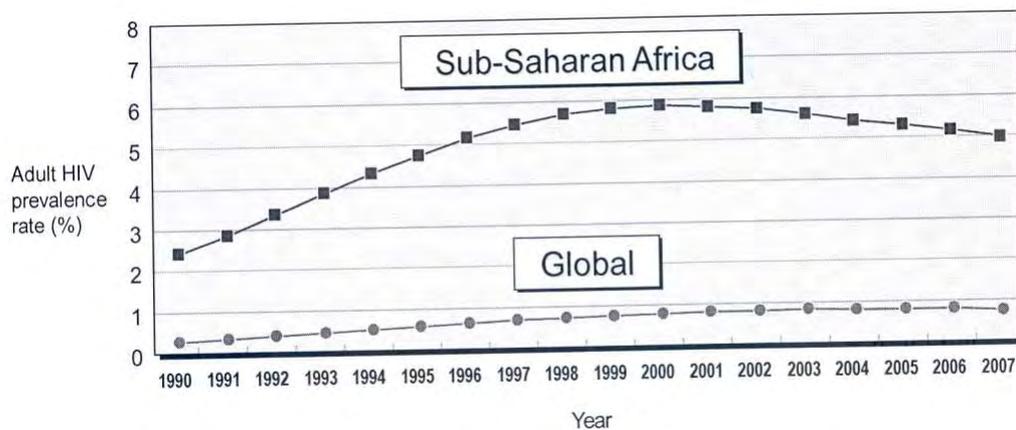
The 2009 AIDS epidemic update stated that HIV and AIDS continue to have an enormous negative impact on business, households, communities and national economies in Sub-Saharan Africa. Research points out Africa as having the biggest share of the 40 million people currently living with HIV and AIDS in the world (Page *et al.*, 2006 and UNAIDS 2008). Political instability, underdevelopment, widespread poverty and poor infrastructure are

argued as the major reasons for the rapid spread of HIV in African countries (UNAIDS 2008). These factors combined may perhaps be argued to have intensified the spread of the disease in Africa. For example:

“Poverty and its associated factors, low education and decreased decision-making power, can indeed increase the risk of HIV infection. Low socio-economic status robs the poor of the knowledge necessary for the prevention of infection with HIV/AIDS, and also increases susceptibility to infection by making the poor more likely to practise unsafe sexual behaviour” (Tladi 2006:380).

Unsafe and risky sexual practices by the poor include the practice of unprotected sexual intercourse with those who are in the position to provide the poor with an income for survival. Unprotected sexual intercourse could be a risk factor for the escalating HIV prevalence in many countries. HIV prevalence has stabilized globally and in Sub-Saharan Africa as shown in Figure 2.1 (UNAIDS 2008).

Figure 2.1: Estimated adult (15-49 years) HIV prevalence rate (%) globally and in Sub-Saharan Africa, 1990-2007



Source: UNAIDS (2008)

Despite the stabilizing HIV and AIDS prevalence globally and in Sub-Saharan Africa, new infection incidences of the pandemic are argued to still be high. An increase in mortality

rate caused by AIDS is argued as the reason why the prevalence of HIV and AIDS has leveled off in several countries (Arrehag *et al.*, 2006:29).

HIV and AIDS can be managed very well (UNAIDS 2008) . It is possible to keep the pandemic under control if victims follow instructions from their medical practitioners providing them with medication. Managing HIV and AIDS pandemic, especially in the workplace, calls for effective workplace HIV and AIDS policy, knowledge of the disease and adherence to treatment by victims. Employers must be approached and be meaningfully work-shopped on how they should handle their employees who are HIV positive (Vass 2008). In his fervent support of the above profession, Vass paints a clear picture that mutual co-operation between employers and employees in workplaces can substantially help to reduce high death rates of HIV and AIDS victims (Vass 2008). For instance, smooth communication between an employer and his employees would lead to the employer allowing the infected employees to attend check-up sessions with their doctors and also grant them the time needed to take their medication during work hours.

2.4 Impact of HIV and AIDS on business

HIV and AIDS in Africa seems to be causing a greater loss of productivity in the workplace than any other disease. The pandemic creates fear and anxiety in different firms and households. HIV and AIDS are believed to be a serious threat to the world of work. It impacts negatively on all businesses at macro-economic and micro-economic levels with increased absenteeism by workers, increased labour turnover, and deaths of employees, increased costs of production and reduced productivity and profitability (Asian Business Coalition on AIDS 2002). It is therefore critical that managing the HIV and AIDS pandemic in the workplace gets prioritized in order to effectively and successfully control the risks

related to its spread. Companies are warned to execute the necessary contingency plans to mitigate the impact of HIV and AIDS in order to mitigate the likelihood of paying heavy penalties in lost productivity due to absenteeism, the death of skilled employees, increased recruitment costs, training of new employees and shrinking consumer markets (Jean-Pierre 2004 and Barnett and Whiteside 2002:242). Successful management of the epidemic will not only benefit the employees and their households, but also the companies affected as they will be able to deal with the HIV and AIDS-related issues in a fair manner that will cater for both the employer and the employee's needs.

From the literature reviewed, the cases of HIV and AIDS are increasing at an alarming rate in Lesotho with the urban areas being the worst affected, and Maseru urban at the forefront (CARE 2001 and Sechaba 2000). In Lesotho, the first HIV and AIDS case was reported in 1986. Since then, a striking increase in the number of HIV and AIDS infections has become a serious threat to the entire nation and to the different firms operating in the country. Close to one quarter of the adult population in Lesotho is estimated to be living with HI Virus (USAID/Lesotho 2008).

Due to the HIV and AIDS pandemic, life expectancy at birth has declined tremendously in Lesotho. Life expectancy at birth is currently 35 years for males and 36 for females (PRB 2006). The country's HIV and AIDS prevalence was estimated at 23.2% in 2007 which claimed at least 18 000 lives (Avert 2007). The high prevalence of the HIV and AIDS epidemic led to His Majesty King Letsie III declaring HIV and AIDS a national disaster in Lesotho in the year 2000.

Based on the information on HIV and AIDS prevalence in the country, there is no doubt that the workplaces in Lesotho are occupied by many people living with HIV and AIDS and many more affected by the pandemic, and that the country has, and continues to

be, negatively impacted by the HIV and AIDS pandemic. HIV and AIDS have serious effects on employees and on the duties they perform in the workplace. The decreasing ability of workers to carry out their assigned tasks has ripple effects on different companies' outputs.

2.4.1 Increased absenteeism

As time progresses, HIV progresses to the stage of AIDS and the effect of its progression may lead to an increased level of absenteeism by the affected workers. The periods of absenteeism may well affect the firms negatively, and the situation gets worse if the victims are skilled or hold important positions in the firm because it is difficult to replace them. High levels of absenteeism disrupt production flow resulting in failure to meet deadlines. It is difficult for people with AIDS to work effectively because they often feel very tired and usually sick (Page *et al.*, 2006:21). Frequent sicknesses accompanied by frequent and long sick leaves increase absenteeism of workers in workplaces. Visits to health centers during work hours by the workers, or employees taking their family members to health centers, can be argued to be another factor influencing absenteeism from work. Furthermore, business expenditure caused by the workers' absence from work has long been a worry for employers (Page *et al.*, 2006). It seems therefore that absenteeism is a major challenge facing different companies with HIV infected and affected employees.

Absenteeism from work is not only caused by the worker's sickness. Research highlights that sometimes other employees take time off from work to attend funerals of their colleagues or of the workers' close relatives and friends (Barnett 2002 and Whiteside 2002:244). Their absence from work also has a negative impact on the business especially if it happens repeatedly. Excessive absenteeism in workplaces hinders sustainable delivery of goods and services. It results in low productivity and profitability of the company. During the

absence of some workers at work, other employees are forced to fill in or multi-task in order to cover the work that should be done by the absent workers. Absenteeism from work suggests therefore that other workers are overworked. The results of overworking the labour force are often a decline in workers' morale. Again, *"In businesses where workers are becoming ill and dying, there is likely to be a declining employee morale"* (Forsyth 2002). HIV and AIDS affect the 'heart' of the business world, and that the pandemic has a detrimental effect on morale and motivation of those who work in the same environment with HIV positive colleagues (Rick 2004). In some instances temporary workers are employed by the companies to fill in for the sick employees thus adding up to the production costs of the company. For example, a study undertaken in Ethiopia found 53% of the reported HIV and AIDS-related illnesses which caused absenteeism in at least 15 establishments respectively. The employees' absenteeism in these establishments was reported to have totaled to 15 363 incidences of absenteeism in five years only in these 15 establishments (USAID 2001). One of the largest Namibian water purification company announced HIV and AIDS to have crippled the company in 2000. The company reported an increasing absenteeism level from work by workers which led to a general loss in productivity (Angula 2002). A similar occurrence of an increase in absenteeism from work is reported in Zambia's largest cement company between 1992 and 1995 which was a result of HIV and AIDS-related deaths (Barnett 2002 and Whiteside 2002:244).

Employees who are ill due to HIV and AIDS will need more sick leaves and may work less efficiently. The employees' illness related to HIV and AIDS may be pointed out as one of the factors adding to the high levels of absenteeism experienced by many firms. The result of the increased absenteeism is a decrease in productivity of the company because sick employees will not be able to focus on their work, but will be worrying about their health condition. For example, a study in Kenya in 2003 revealed that HIV positive workers were

less productive at work. From a tea estate in Kenya, managers reported that the supervisors for HIV and AIDS patients often had to shift them and give them light duties in the firm because they became less productive as the disease progressed in their bodies (Fox *et al.*, 2004 and Arrehag *et al.*, 2006:116). A company with sick employees due to HIV and AIDS is faced with a need for temporary labour for the continuation of the production process. Hiring temporary labour increases production costs of the company. For instance, the repeated training of new employees to fill the company skills gaps is costly. The South African Business Coalition on AIDS revealed at least 24% of companies in the manufacturing, retail, wholesale, motor vehicle and construction sectors to have incurred increased recruitment and training costs due to HIV and AIDS (South African Business Coalition on AIDS 2004).

2.4.2 Labour turnover

Many countries, especially those found in the Sub-Saharan African countries, have and continue to experience a severe erosion of skilled and experienced labour force in the firms due to HIV and AIDS-related deaths. The loss of an employee through death has various negative implications in the workplace. For Chetty, death increases the workload of other workers in the firm (2002:30). High death rates in the workplace negatively affect the labour force, and this has been found to be widespread. In Debswana diamond firm in Botswana, the employee deaths related to HIV and AIDS increased from 37.5% of all employee deaths in 1996, to 48.3% in 1997 and rose to 59.1% in 1999 (Barks-Rugglesf 2001). In South Africa, the revealed at least 27% of companies in the manufacturing, retail, wholesale, motor vehicle and construction sectors to have indicated that they had lost experienced and skilled labour as their employees died of HIV and AIDS-related illnesses

(South African Business Coalition on AIDS 2004).

In relation to HIV and AIDS in the workplace, poor morale and low levels of motivation within the workforce could be linked to the causes of high labour turnover (Asian Business Coalition on AIDS 2002). The South African Business Coalition on AIDS revealed at least 30% of companies in the manufacturing, retail, wholesale, motor vehicle and construction sectors to have reported higher labour turnover rates because of HIV and AIDS (South African Business Coalition on AIDS 2004). The HIV and AIDS pandemic seems to influence labour patterns in the workplace. HIV and AIDS is affecting the productive working age population thereby challenging different countries' potential to grow economically as the levels of production in the firms decrease. Recruiting new workers in order to replace employees who are very sick and those who have died has been argued as an expensive process for companies (Arrehag *et al.*, 2006:93). Recruitment costs may be acknowledged as one of the major challenges for many companies as they cannot afford to employ workers who are on sick leave most of the time due to the illnesses often associated with HIV and AIDS.

2.5 Approaches to managing HIV and AIDS in the workplace

The literature suggests that an understanding by the firms' management of the cost associated with HIV and AIDS on their business is critical. Arrehag and colleagues argue: "*Deteriorating health reduces labour productivity*" (Arrehag *et al.*, 2006:93). Reduced productivity experienced by different companies is often seen when companies lose experienced workers who die or become very ill from HIV and AIDS. It can be pointed out that it is difficult to fill the positions of the experienced workers. The loss of other employees

automatically leads to the reduction of the number of workers in the firm as well as the increased cost for the company as it replaces the ill or dead workers. After losing the employees to death or serious illness related to AIDS, the firms are forced to recruit and train new staff members in order to replace the lost workers. The new employees are usually young and lack experience; the effects of new employees may also result in reduction of productivity and profitability of the affected company. It is imperative for the firms' management to understand that HIV and AIDS infections occur mostly among the young and productive people aged 15-49 years. These people, if in good health, are to be considered assets for each firm aiming to produce more and for a longer period of time. An understanding by the top management of the problems associated with the HIV and AIDS epidemic determines the success of HIV and AIDS management programmes in the workplace (Chetty 2002). If the top management themselves do not understand or realize the impact that HIV and AIDS has on their companies, it becomes difficult to implement policies and programmes that would help in managing the pandemic.

Scholars argue stigmatizing HIV and AIDS victims as a key driver of the epidemic in Sub-Saharan Africa (Campbell et al., 2006 and Arrehag et al., 2006). HIV and AIDS-related stigma is argued as one of the main challenges in combating the epidemic worldwide (UNAIDS/WHO 2002). Stigmatization of AIDS victims is seen as a challenge because it undermines HIV prevention as well as the care and treatment of people living with HIV and AIDS. It can therefore be argued that without proper management strategies, there is an indirect promotion of inequality and discrimination against those living with HIV and AIDS. It is of critical importance that firms develop and implement effective and appropriate strategies of managing the pandemic in the workplace. HIV and AIDS victims exposed to stigma suffer depression, despair and lack of self worth (UNAIDS/WHO 2002). The involvement of the companies' management teams in managing the epidemic in the

workplace therefore makes it possible to create a supportive environment for those employees living with the virus. Again, involving management from the companies assists in eradicating the stigma associated with AIDS in the workplace because it creates an open communication environment on AIDS-related issues. Formulation of the HIV and AIDS policy providing both the employers and the employees with the guidelines in terms of handling HIV and AIDS in the workplace, may be argued critical strategies for different companies to use in managing the epidemic in the workplace. Cameron believes “. . . *this pandemic demands action in the same way that the struggle against apartheid [in South Africa] demanded action*” (Cameron 2005:7).

2.5.1 Policies

An HIV and AIDS policy provides a framework for action and defines the company's position in management of HIV and AIDS at work (Sooklal 2001:17). Risk management pertaining to HIV and AIDS in the workplace requires an establishment of a secure working environment which can be provided by the workplace HIV and AIDS policy for both the infected and other employees. An HIV and AIDS workplace policy describes how a company will consistently and fairly take care of employees who are living with HIV and AIDS, and employees who are indirectly affected by the epidemic. According to different researchers, the best workplace policies explicitly define the management of HIV and AIDS infection and prevention for both the employers and the employees (Allen 2001). The policy helps in managing sensitive issues such as confidentiality of medical information and continuation of employment for HIV positive staff. It also should declare that all testing and counseling services performed on a voluntary rather than mandatory basis (Asian Business Coalition on AIDS 2002).

It is through the effective implementation of an HIV and AIDS policy in the workplace that the companies are able to encourage behavioural standards for all employers and employees. Companies are able to set the standard for communication about HIV and AIDS and to provide a good foundation upon which to build an HIV and AIDS workplace programmes. In this way, employees get to be informed about the help available at work for those infected and affected by HIV and AIDS. An effective implementation of policies is usually a major challenge. In order to overcome this challenge, managers in the workplace should consult and be involved with different levels of employees in the firm to discuss ways the policy would be implemented effectively (Sooklal 2001). The involvement of the employees ensures a successful implementation process of the workplace HIV and AIDS policy because the workers will feel part of the programme rather than the programme being imposed on them by the management.

There is a need for companies to take action in the fight against the HIV and AIDS pandemic because of the direct and indirect impacts the disease has on business as discussed earlier. In response to the impacts of the HIV and AIDS epidemic in the workplace, different companies from different countries have formulated workplace HIV and AIDS policies. Access to information and education are critical in reducing vulnerability to HIV and AIDS. Education and knowledge are keys to reducing the rate in which HIV spreads and the stigma attached to AIDS (Page *et al.*, 2006). The implementation of effective HIV and AIDS programmes in the workplace should be aimed at preserving the non-infected workforce, minimizing the impact of HIV and AIDS on infected workers and considering ways to prolong the lifespan of those employees living with the virus (Naidu 2003).

According to Naidu (2003:77), sustainability in implementing HIV and AIDS programmes in the workplace is one of the challenges that firms should overcome in order to successfully manage the pandemic (Naidu 2003). Successful HIV and AIDS programmes in

the workplace are expected to result in workers volunteering to undertake voluntary counseling and testing in order to know their HIV status. These programmes should further provide employees with the necessary information that will enhance their understanding of HIV and AIDS.

2.5.2 HIV and AIDS education and training

HIV and AIDS education for both skilled and unskilled workers is a key tool that can be used to manage the epidemic in the working world. It has also been realized that the employers should be proactive in handling HIV and AIDS issues in the workplace. The employees' participation in all the phases of the HIV and AIDS management programmes is critical for the success of the management of the pandemic. The workers' involvement empowers them in many ways; they feel part of the programmes therefore take responsibility for the success of such programmes. HIV and AIDS committees made up of volunteering employees are suggested as effective strategies which could be used by different companies in involving their employees in participating in the company's initiatives to manage the HIV and AIDS pandemic at their workplace (Vass 2008).

Lack of knowledge and incorrect information are the reasons why people living with HIV and AIDS are often stigmatized and do not receive the support they need, both at work and at home. Lack of knowledge and incorrect information may also be pointed out to contribute to the spread of HIV and AIDS in different communities. Education of employees about HIV and AIDS is argued to be an essential management tool for the epidemic (Asian Business Coalition on AIDS 2002). Ignorance about HIV and AIDS stimulates the widespread stigma attached to HIV and AIDS which results in rejection and sometimes violence against those who are known to be HIV positive (Page *et al.*, 2006:58). By providing

employees at work with accurate information on HIV and AIDS, the company would have helped both the employers and the employees to address problems associated with HIV and AIDS. Accurate information has the potential to eradicate many myths about HIV and AIDS, as well as reduce the level of HIV infections in the workplace and also help in managing various HIV and AIDS workplace-related issues more effectively.

Peer educators form a significant part of a company's response to HIV and AIDS. In their foreword, Gibney and colleagues emphasise that peer education "*impart[s] knowledge, counter[s] stigma, create[s] social consensus on safer behaviour, and boost[s] AIDS prevention and care skills*" (Gibney *et al.*, 1999). HIV and AIDS peer education provided in the workplace presents an important component of the response to HIV and AIDS in the workplace. "*Peer education relies on the benefits of utilising peers as change agents since people are more comfortable with, and pay greater attention to, persons who are similar to themselves,*" (Dickson 2007:6). A study which was based on 25 companies in Zimbabwe, aimed at providing the firm managers with an action guide to successfully combat HIV and AIDS at work, revealed that peer education and HIV and AIDS awareness programmes helped in reducing HIV incidences among workers (Rau 2002). The idea of peer education is about using employees to educate, inform and advise their co-workers on HIV and AIDS, provided they are correctly trained (Page *et al.*, 2006). Employees are often at ease talking to their co-workers about anything, and getting advice from them rather than talking to their managers and supervisors. The use of peer educators is argued as the most effective and most cost effective way of educating employees on HIV and AIDS at work as they are sourced from within the company (Page *et al.*, 2006:100).

2.5.3 Condom distribution

Condoms may be argued as the most reliable preventive measure in managing the spread of HIV. Condoms are argued to be about 90% effective in preventing HIV transmission (Hearst and Chen 2004:39). Moreover, “. . . condoms are the most effective means of avoiding HIV infection, in the absence of abstinence” (Tladi 2006:373). Using condoms during sexual intercourse minimizes the chance of transmitting HIV and AIDS to the next partner. Both male and female condoms play a significant role in preventing the spread of HIV and all other sexually transmitted infections (STIs) if consistently and correctly used. Consistent use of condoms does not only benefit those who are HIV negative, but also those who are HIV positive from being re-infected with HIV (Hearst and Chen 2004:44). Research suggests inconsistent use of condoms during sexual intercourse to lead to the increased risk of contracting STIs and HIV infections among the youth in South Africa (Brook 2006).

The UNAIDS/WHO study in 2005 revealed Kenya as one of the successful case studies where the distributed condoms were used to help in mitigating the impact of HIV and AIDS. The study points out an estimation of 24% of women who reported to have used condoms in their previous casual sexual intercourse. The reported percentage of condom use was perceived as an improvement as compared to the discovery of the study carried out during 1998 which revealed only 15% of women who reported to have used condoms during their last sexual intercourse activity. In 2007, the UNAIDS/WHO report still shows an increase in condom use in Kenya and other African countries among both men and women. Lesotho's formal comparative study has not been provided in the study to provide the information on condom use in the country.

Having multiple sexual partners has been seen as one of the modes through which HIV is spread, especially in Sub-Saharan Africa (UNAIDS/WHO 2002). Making condoms freely available to both the employees and visitors to the workplace is one strategy through which

the spread of HIV and STIs can be reduced. While some of the employees and visitors to workplaces might not use condoms, they will be reminded of the practice of safe, protected sex every time they see these condoms. Availability of free condoms within the company's premises will also demonstrate the company's commitment to HIV and AIDS prevention. Condoms can be easily distributed by installing dispensers in the company's toilet areas and cloakrooms used by visitors to the company, in the staff commons, as well as using peer educators to distribute them on the site and in their communities (Gitari 2007:21).

Criticism on condom use include that they might increase sexual activity instead of abstinence especially among the youth. This concern advocates that condom promotion will do more harm than good in different societies (Hearst 2004:44). However, research on sex education provided for the youth shows no causal effect related to an increase in sexual activity resulting from the use and promotion of condoms. Sex education programmes are rather argued to encourage delayed sexual intercourse initiation (Hearst 2004:44).

2.5.4 Voluntary Counseling and Testing (VCT)

People decide on taking an HIV test for different reasons. VCT is very important because testing is the only way through which one can know his or her HIV status. It also provides an individual a chance to think about his or her lifestyle options and make appropriate choices. VCT programmes is argued to have a potential to adjust people's sexual behaviour (Nattrass 2004:102). People who know that they are HIV positive need to change their lifestyles in order to ensure that they stay healthy for as long as possible. Change of lifestyle is also critical for people who have tested HIV negative. In order for them to stay negative, they need to live risk free lives. Furthermore, argues that VCT can assist in the early detection of one's HIV status (Ndobo 2006). An early detection of a positive HIV status gives the victim a

chance to access treatment early. VCT comprise confidential HIV testing, together with pre-test and post-test counseling. Various strategies can be used to encourage workers to go for VCT. In the workplace, employees can be encouraged to go for VCT either by bringing a VCT service on-site, or by transporting them to and from the VCT centre. In order for VCT programmes to succeed, it is critical that the company's management, as well as the HIV and AIDS coordinators, task teams and peer educators, set the example by undertaking VCT.

The government of Lesotho embarked on a campaign called “Know Your Status” (KYS) which the government introduced as one of the strategies to use in reversing the impact of the pandemic in the country. The objective of the campaign was to make sure that by the year 2007 all members of the population aged 12 upwards know their HIV status so that those who tested positive could be helped in time in order for them to be able to live longer by the use of HIV treatment (MOHSW 2006). *“As a result of the implementation of the two-year “Know Your Status” (KYS) campaign between 2006 and 2008, the number of individuals in Lesotho seeking HIV Testing and Counselling (HTC) has increased significantly from year to year,”* (UNAIDS 2008).

VCT has been proven to be one of the effective approaches to use in managing HIV. It is equally important to also look into the negative effect that might result from VCT. Adequate counseling processes play a critical role in VCT. If it happens that counseling is inadequate, depression, suicide and sometimes “revenge” behaviours by those who tested HIV positive are highly possible (Gibney 1999:88). Looking at the possible “revenge” behaviours that could result from inadequate counseling, the effect realised is an increase in the spread of HIV as opposed to a decrease.

2.5.5 Treatment

It is imperative that the individuals diagnosed HIV positive start their treatment as early as possible in order to successfully manage the HI Virus in their bodies. The Lesotho UNGASS country report estimated at least 2 224 pregnant women who tested HIV positive in 2006 to have been provided with Anti-retroviral Therapy (ART) for prevention of mother-to-child-transmission of HIV (PMTCT) (Lesotho UNGASS Country Report 2009). It is argued that *“Mother-to-child transmission, also called MTCT, or vertical transmission is common today, resulting in millions of pediatric AIDS cases”* (Singhal 2003). The number is said to have increased in 2007 whereby 5 538 pregnant women who tested HIV positive also started to take ART treatment. Men are not included in these figures because their figures are not in the report. It can be argued, as the UNAIDS report for 2008 has highlighted, that the number of people receiving treatment for HIV and AIDS has increased. ART has changed the concern about HIV and AIDS infection into a manageable chronic illness. ART improves the health of persons with HIV by slowing the development of the disease to AIDS. The UNAIDS World AIDS Day report in 2008 also revealed that the number of HIV and AIDS patients who die from different opportunistic diseases decreased from 2.2 million in 2005 to 2.0 million worldwide in 2007 because of the treatment (ART) used to mitigate the effects of the HIV and AIDS pandemic. An HIV positive person who uses the Anti-retroviral therapy correctly and at the right time is anticipated to live longer and to have a better quality of life and still be able to work productively. ART is therefore beneficial to both the HIV positive employees and the company. Provision of ART in the workplace would demonstrate support towards the company’s employees living with HIV and AIDS and has the potential to advance prevention efforts.

2.5.6 Care and support

Care and an efficient provision of support for people living with AIDS require sufficient long term resources. The number of people living with AIDS who need to be supported and cared for is increasing (Storti 2004). It is crucial for HIV and AIDS patients to be taught about the disease and different ways through which the disease can be managed. This teaching includes promotion of safe sexual behavior, education on nutrition and the reduction of risky behaviour activities such as injecting drugs. Lack of resources is argued to be the main challenge for the provision of care and support needed by workers living with HIV and AIDS especially in developing countries such as Lesotho (Gitari 2007:28).

Provision of support for the employees affected by HIV and AIDS is perceived as an effective approach to follow in mitigating the impact of HIV and AIDS in the workplace (Gitari 2007:28). Educational support is one of the ways through which support to the infected can be shown. Through relevant education, the infected workers are made aware of the need to avoid risky behaviours such as unprotected sexual intercourse practices, avoiding drug injections, as well as provision of information on healthy eating practices. The other way of supporting the HIV positive employees is psychological. Emotional support and provision of counseling to the affected workers and their households is critical. In developing countries such as Lesotho, the support for HIV positive persons is mainly provided by the development agencies in their effort to implement their programmes (Gitari 2007:28). The current provision of support by development agencies is not enough; more people should be provided with skills and knowledge on ways through which the impact of HIV and AIDS can be mitigated. Promotion of healthy eating habits is another way through which impact mitigation for HIV and AIDS victims can be achieved. It is critical for people living with HIV to eat healthy food at all times. A healthy diet is a valuable tool for HIV and AIDS management (Giffort *et al.*, 2005).

2.6 The government's response to workplace HIV and AIDS challenges

The government is one of the major role players in the management of HIV and AIDS in the workplace. The government of Lesotho is committed to the fight against the HIV and AIDS pandemic (Makeka 2006). The government's commitment is seen in different intervention programmes intended to control the pandemic. Such initiatives include the revised HIV and AIDS policy by the government in reversing the spread of the epidemic. Governments in different countries determine the policy frameworks leading to fight HIV and AIDS (Chetty 2002). As an example, the National Tripartite Committee (NTC), (2004), in collaboration with Ghana AIDS Commission, worked together to develop the national workplace HIV and AIDS policy for Ghana. The policy serves as a statement of commitment by the government of Ghana for protection and support of the people living with HIV and AIDS in the workplace. Research shows that there is support and promotion of HIV and AIDS prevention programmes from different governments of different countries (Chetty 2002). The support from the governments is the reformation of legislation to promote protection against discrimination and ensure privacy for those living with AIDS. However, there are challenges facing governments especially in the developing countries in regards to the fight against HIV and AIDS. These challenges include lack of enough resources needed to keep the epidemic under control. It is crucial for governments to increase efforts on HIV prevention, care and support for those already infected and for those not yet infected to remain so.

2.7 Summary

It is apparent from this review that HIV and AIDS has severe social and economic effects which impact negatively on companies, workers and their families. Behavioural change promoted and influenced by the formulation, as well as the implementation of workplace HIV

and AIDS policy in workplaces, is crucial in combating HIV and AIDS. “*Changes in sexual behavior could prevent most HIV infection and dramatically undercut the potency of the pandemic,*” (Dickinson 2009:5). If people do not decide to change their risky behaviours which lead to their vulnerability to contract and spread HIV and AIDS, the management of the epidemic is impossible. Changing risky behaviour is critical in the management of HIV and AIDS and rests largely on individuals. One route in which behavioural change can be induced is through the initiatives designed by firms to manage the pandemic in the workplace. The functions of the HIV and AIDS workplace policy include, among other programmes, the HIV and AIDS education, awareness and training programmes, condom distribution within the workplace premises to promote safer sexual intercourse practices, as well as the voluntary testing and counseling programmes.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methods employed during the study in Thetsane Industrial Area. The main purpose of the study was to analyse approaches used to manage HIV and AIDS in the firms found in the study area. The study realised this aim through an investigation of the approaches used in Thetsane Industrial Area in managing the impact of HIV and AIDS on employees and on business. In this chapter, the tools used to collect the primary data are described together with the approaches used in analysing data collected.

3.2 Research methods

In order to optimize the accuracy of the research results, a combination of quantitative and qualitative research methods was utilized. The combination of these different approaches was anticipated to yield greater and favourable results. Quantitative data was gathered from the randomly selected firm employees while qualitative information was collected from the firm managers and from two of the interest groups in Thetsane Industrial Area. A research method which combines the qualitative and the quantitative method is referred to as triangulation (Jick 1997). This approach has the potential to address sensitive and personal issues and can help in understanding the research subjects' behaviours in a holistic manner (Rehle and Hassig 2003). It is in this light that the triangulation method was considered relevant for the present study because it investigates an HIV and AIDS-related issue which can be sensitive for some people.

3.3 Quantitative research method

Quantitative research methodology may be defined as an organised experimental study of quantitative properties and events and their relationships. The quantitative research method is in the form of numbers representing concepts that may take greater and lesser values aimed at developing and employing mathematical models, theories, and hypotheses about a phenomenon under study (Lynch 1983). Quantitative research provides fundamental correlation between empirical observations and mathematical expressions of quantitative relationships (Murray 2003). There are various advantages associated with the use of a quantitative research method. These advantages include that it is less time consuming thereby giving the researcher a chance to explore large samples as opposed to qualitative research.

Quantitative data can be analysed with a high confidence level because it is easy to predict any association between large populations when using a quantitative approach (Holland 2005). Furthermore, with quantitative data it is easy to predict the future and make assumptions. Since qualitative research produces information only on particular case studies and not the hypotheses about a phenomenon, a quantitative approach may be used to verify which of the hypotheses are actually true from the more general conclusions.

Disadvantages of a quantitative research approach include that it is limited to numeric descriptions, not the detailed human perceptions on issues being studied. In a quantitative approach, a set of questions asked becomes limited due to predetermined categories in the study, therefore issues are not studied in depth (Patton 2002). In addition to Patton's (2002) argument, O'Neill adds that a quantitative research approach sometimes produces a narrower and superficial data set (O'Neill 2006). For this particular study, the quantitative data relied on data collected using the questionnaire among the employees in Thetsane Industrial Area.

3.4 Qualitative method

Qualitative data usually exists in the form of words and often consists of detailed descriptions thereby providing the researcher with the in-depth information (Lynch 1983). This data investigates the why and how responses from the informants and not just the what, where and when questions investigated in a quantitative approach. Unlike quantitative research, qualitative research embarks on discovery and not on verifications; therefore it focuses on smaller samples as opposed to large samples in quantitative research. The nature of qualitative research could serve to validate the quantitative data collected during the field work. The qualitative research for this study was derived from structured interviews with some of the managers in the firms in Thetsane Industrial Area. Some of the disadvantages of the qualitative research include that it is costly and time consuming.

3.5 Data collection tools

3.5.1 Questionnaires

There are various approaches that can be used in collecting data (Pallant 2007:5). This process also depends on the nature of the research. The questionnaire used during data collection for this study was a combination of closed and open-ended questions. Long and complex questions were avoided in the questionnaire structured. The questionnaire used during the data collection was written in English although in most instances questions were posed in Sesotho, the dominant language in Lesotho. A pilot-test was done to ensure that questions and instructions in the questionnaire were clear. Designed pilot-test questionnaires were distributed to 10 people from different companies and they were requested to comment on the value of the questionnaire, source of confusion found while responding to the questions asked, gaps in question coverage, any ambiguity in the questions, questions with

the potential to offend the respondents, and the time taken to complete the questionnaire. Comments made by the different candidates were incorporated in the questionnaire which was used during the data collection process. Primary data was collected using a pre-designed questionnaire from the firms' employees during December 2009 through to January 2010 (see appendix 2). The initial plan was to focus only on garment industries in the study area, however, on arrival at the site, only three non-garment industries were discovered. It was then decided to co-opt the employees from these enterprises into the study. All research subjects were willing to participate in the study, however, the firms' employees were restricted by time, given that the majority of them were available for interviews only during their lunch hour.

Request for permission from the firms' management was made in order to gain access to the firms and to the working staff from different firms. These employees were requested to participate in the study by filling in and completing questionnaires in the presence of the researcher where possible in order to be able to clarify any queries while they responded to the questions asked. The plan was to collect the information within the premises of each firm where possible and during the employees' lunch hour. The subjects who wanted to have a longer time on their own to explore the questions asked were allowed to do so. Respondents were allowed to take questionnaires home on consensus that questionnaires were to be collected back within one week (self administered). Questionnaires were administered to 100 workers from different firms in Thetsane Industrial Area. Out of the 100 questionnaires administered, 70 questionnaires were successfully completed.

3.5.2 Structured interviews

Structured interviews were conducted to gather information related to HIV and AIDS management in the workplace from different firm managers in Thetsane Industrial Area. Later in the process (during May 2010), other interviews were organised with representatives of ALAFA and LECAWU respectively.

3.6 Data analysis

3.6.1 Quantitative data analysis

The primary data was captured and analysed using standard descriptive procedures as well as a logistic regression model to test the hypothesis that age, gender, marital status, education and wealth determine the employees' knowledge and attitudes about HIV and AIDS. One of the reasons for using the logistic model was the fact that the dependent variables in the data used have a dichotomous response¹. Moreover, a logistic regression model measures change in odds providing a useful way of describing the relationship between the dependent and independent variables (Field 2000). The odds ratio and the chi-square tests were used where necessary to test for dependence between variables. Descriptive statistics were generated, and used to describe the characteristics of the research sample. Descriptive statistics were used to determine relevant cross tabulations and frequencies from the collected data.

¹ The independent variables could have either a positive or a negative influence on the knowledge and attitude towards HIV and AIDS.

3.6.2 Qualitative data analysis

A grounded theory was used to analyse data collected. The stated methodology was chosen over the content analysis approach for its relevance to the current study. Content analysis is different from other approaches in that it analyses texts in the contexts of their use and quantifies words and concepts in a text (Krippendorff 2004). Again in content analysis, inferences about the messages within the text are made based on occurrence, meaning and relationships of such words and concepts.

On the other hand, grounded theory is a good, well respected type of thematic analysis which was developed with the aim to develop theory systematically from data (Glaser and Strauss 1967). A grounded theory approach offers a set of general principles rather than fixed rules as it might be the case in content analysis. Unlike content analysis, grounded theory is not theory driven; it fits empirical situations and is easy to understand (Charmaz 2006; Glaser and Strauss 1967; Corbin and Strauss 2008). Three steps in grounded theory, namely primary coding, axial coding and selective coding, were followed during the current study.

3.7 Summary

This chapter discussed the methods used during data collection for the current study. The study used a triangular research approach which combined both the quantitative and qualitative research methods. An approach referred to as grounded theory was used to collect qualitative data from the firm managers and from the two representatives of two interest groups in HIV and AIDS-related issues in Thetsane Industrial Area, while qualitative data was collected from the firm employees using a pre-designed questionnaire.

CHAPTER 4: QUANTITATIVE ANALYSIS

4.1 Introduction

This chapter presents quantitative findings from Thetsane Industrial Area with respect to HIV and AIDS management in the workplace. Primary data was collected using a pre-designed questionnaire from the firms' employees during December 2009 through to January 2010 (see appendix 2). The initial plan was to focus only on garment industries in the study area, however, on arrival at the site, only three non-garment industries were discovered. It was then decided to co-opt the employees from these enterprises into the study. All research subjects were willing to participate in the study, however, the firms' employees were restricted by time given that the majority of them were available for interviews only during their lunch hour. Three concepts were of critical importance in this analysis: the *employees' knowledge about HIV and AIDS*, respondents' *attitudes towards HIV and AIDS*, as well as *attitudes towards HIV positive colleagues and the workers' knowledge about approaches used to manage HIV and AIDS* in the workplace.

a. Knowledge about HIV and AIDS

Different variables related to the nature and transmission of HIV and AIDS determined the knowledge of the employees about HIV and AIDS. One variable (ever heard about HIV and AIDS) was used in a binary logistic regression model as there was sufficient variation in the results. The information collected made it possible to determine whether the research subjects had ever heard about HIV and AIDS or not. Respondents were requested to tick a 'yes' (coded 1) if they identified with the statement given and a 'no' (coded 2) if they disagreed with the given statement in the questionnaire. Furthermore, data collected indicated respondents' ability to distinguish between HIV and AIDS as well as their ability to identify ways through which the virus causing AIDS is transmitted.

b. Attitudes towards HIV and AIDS and HIV positive workers

Three variables were used to determine the attitudes the employees had towards HIV and AIDS, and towards their colleagues who live with the AIDS virus. These variables included preparedness to work with a known HIV positive colleague, the type of a job assumed by respondents to be suitable for HIV positive workers, and whether positive employees were to be blamed for having brought the AIDS virus to the workplace or not. A negative response to the given statements suggested a negative attitude while a positive response indicated a positive attitude by respondents towards HIV and AIDS as well as towards colleagues living with the AIDS virus. The questionnaire did not provide a chance for respondents to indicate their HIV status due to confidentiality, therefore the present study could not determine attitudes perceived by HIV positive employees from their colleagues.

c. Knowledge about approaches to managing HIV and AIDS

Three variables were selected to determine the employees' knowledge about approaches used in their firms to manage HIV and AIDS. The encouragement in the workplace for the use of ARVs, condom distribution and the awareness of VCT services provided at work were the variables used in the current study to determine the workers' knowledge about approaches used in the firms in managing HIV and AIDS. These seven variables will be used as dependent variables in the subsequent analysis.

4.2 Characteristics of the sample

This section describes and provides demographic information from the study sample. A total of 70 employees took part in the present study. Questionnaires were distributed to respondents on site (within the firms' premises during working hours and outside the firms'

premises during lunch time). The characteristics of the sample discussed below (age, gender, marital status, education and wealth) will be used as predictor variables in the subsequent analysis.

4.2.1 Age

Table 4.1 on page 40 shows the sample to comprise 99% black employees (and 1% from other races) whose ages ranged between 19 and 57 with the mean age of 31.5 years. The sample does reflect the demography on the population in Lesotho where the population structure is almost entirely Basotho. The ages were self reported and could not be verified. The majority of the respondents (47%) were aged between 19 and 30 years of age. Under normal circumstances, this cohort is the most productive age group of young people who have just finished high school and tertiary education. Due to a small sample size (70 people), the employees' age groups for both male and female respondents were grouped into four categories, i.e. <20, 21-30, 31-40 and 40+.

4.2.2 Gender

A balance between both sexes was desired, but the female respondents out-numbered the male respondents. This could perhaps be attributed to the fact that the sex distribution of the population of Lesotho is made up of more females than males (UNAIDS 2008). The other reason for this could be the fact that the garment industry in Lesotho is largely a female domain. This particular characteristic of the garment industries could perhaps be linked to the nature of work done in the garment industries (Wallengren 2009).

4.2.3 Marital status

In regards to marital status, there were initially five categories coded. These were compressed to two categories 'never married' and 'ever married' (coded 1 and 2 respectively) because of the low counts noticed in other categories especially of the respondents who were once married but got divorced, separated or widowed. All the respondents who were at one point married were categorized as 'ever married'. The findings revealed 53% of the male respondents as married, compared to 47% of their female counterparts who were married. Based on this finding, it could be argued that the respondents had married early, especially the male subjects. Early marriages could be linked to the workers' migration from family members to the city of Maseru for employment.

Migration from a family setting in a way isolates the workers from their families exposing them to being alone (Asian Business Coalition on AIDS 2002). Being alone has the potential to lead workers into early marriages or co-habitation relationships for companionship. A study conducted by CARE international in Cambodia highlighted high levels of sexual risk taking behaviour among factory workers. Migration from home by workers leads them to access to cash income, increased dependence (without parental control). The same scenario maybe argued true for workers in Thetsane Industrial Area as the garment industry workers are mostly migrants to Maseru from other parts of the country.

4.2.4 Educational background

The level of education consisted of three categories, namely secondary school (Form 1 to Form 3 - post primary school in Lesotho) and less, high school (Form 4 and Form 5 in Lesotho), and tertiary level. Almost everybody in the sample had been to school, however, the majority of the respondents could only afford basic education and failed to proceed to

tertiary institutions. This finding could be attributed to poverty levels and the overall education profile of the country.

Table 4.1 – Background information of the respondents

Age	N	%	Total sample (n)
<20	2	3	
21-30	31	43	
31-40	31	44	
>40	6	9	70
Gender			
Male	31	44	
Female	39	56	70
Marital status			
Never married	23	33	
Ever married	47	67	70
Race			
Black	69	99	
Other	1	1	70
Educational background			
Secondary school and less	21	30	
High school	33	47	
Tertiary	16	23	70
Wealth			
Comfortable	11	17	
Reasonably comfortable	15	23	
Just getting along	30	45	
Poor	14	15	70

4.2.5 Wealth

The variable for self-reported wealth had five sub-categories which were compressed to four categories because respondents whose self-reported status was described as ‘wealthy’ were too few. It must be pointed out that a range in financial figures for each category would have helped in providing a clearer picture of the respondents’ wealth. For the purpose of this study, ‘comfortable’ designates the highest rank in terms of wealth, while ‘poor’ represents the lowest on the scale for wealth. Respondents were provided a list of words which they could use to describe their economic status. According to Table 4.1, the sample was dominated by respondents who perceived themselves as ‘just getting along’ at the time of the present study.

Respondents were further requested to choose a word that best described the houses they lived in, and 69% of them indicated that their houses needed to be repaired. Most of these houses were discovered during conversations with the respondents to be rented as the majority of the respondents were migrants from other parts of the country outside Maseru. The fact that most respondents were ‘just getting along’ and living in houses which needed to be repaired, could be argued as an indication of the likely poverty experienced by this population.

4.2.6 Household size

The size of a family can serve as an economic indicator for the household under study. The biggest family in Table 4.2 had seven members. Most (39 out of 63 respondents) of the respondents’ households had two or more people who were working at the time of the study. The fact that most household members were working could be linked to the

respondents' self reported state of wealth which suggested that the households were 'just getting along' not necessarily affording to meet their households' daily needs effectively.

Table 4.2 – Respondents' households

	Sample size (n)	Percent %
Number of people in each household		
1-3 people	70	54
4-7 people	70	44
Number of people working in each household		
1 person	70	34
2 or more people	70	56
Number of own children in the household		
0 children	70	31
1-2 children	70	59
3 or more children	70	10
Number of children in a household		
0 children	70	20
1-2 children	70	54
3 or more children	70	14

Respondents were asked to indicate the number of years and months they had worked for their current companies. Of the 70 respondents, 92% had been in their current companies for approximately 10 years and less. The reason for this short period of time in the current companies by the employees was that the labour force was predominantly young people between 19 and 30 years of age and had recently joined the labour force. Again, some of these workers reported to have been working elsewhere before joining the current company. The other likely reason for employees to have worked in their current companies for the mentioned period of time could be the fact that Thetsane Industrial Area was quite recently

established. The estate was only established in 1987 (Lesotho National Development Co-operation 2005).

4.3 Knowledge and attitudes concerning HIV and AIDS

In an attempt to explain the relationship between the dependent and independent variables regarding knowledge and attitudes towards HIV and AIDS, a logistic regression model was employed. The analyses presented here have provided the p -values rather than the co-efficients. It was seen during the analysis that standard error figures were most of the time greater than the co-efficients. Standard error values which are greater than the co-efficients imply that the results are less likely to be statistically significant. The standard error figures were most of the time greater than the co-efficients also because of a small sample size used in the study. The reason for smaller co-efficients obtained in the analysis was the small sample size used in the study. Despite the consequences resulting from a small sample size observed during the analysis of the primary data collected, statistical tests were run for completeness of data analysis in the present study. Descriptive and inferential statistics which have allowed conclusions to be drawn on relationships observed between variables which could not simply be attributed to chance were the basis of this chapter. The statistical significance between dependent and independent variables was determined by a 95% confidence interval. In addition, odds ratios are provided as they are easy to interpret and are more appropriate for multiplicative comparisons as compared to interpretations of co-efficients (Allison (1990)).

The logistic regression model is expressed as follows:

$$\ln\left(\frac{p_i}{1-p_i}\right) = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \beta_3 x_3 + \beta_4 x_4 + \beta_5 x_5$$

Where, p_i is the probability that $y_1 = 1$, representing dependent variables being predicted (knowledge about HIV and AIDS, attitudes towards HIV and AIDS and knowledge about approaches used in the firms to manage HIV and AIDS). β_1, β_2 and so on represent the coefficients used to describe the size of the effect the independent variables have on the dependent variables (y), while x_1, x_2 and so on, represent the independent variables, (age, gender, marital status, education and wealth respectively).

The formulated null-hypothesis stated: age, gender, marital status, wealth and the level of education determine the employees' knowledge about HIV and AIDS; they also determine attitudes towards HIV and AIDS and towards those who are afflicted, as well as knowledge about approaches used to manage HIV and AIDS in the workplace. The logistic regression model permits testing the null-hypotheses against the alternative hypotheses stated in Table 4.3.

Table 4.3 - Hypothesis

Socio-demographic characteristics	
Age	$H_0: \mu_1 = \mu_2 = \mu_3$ vs. $H_a: \text{at least 2 pairs}$
Gender	$H_0: \mu_m = \mu_f$ vs. $H_a: \mu_m \neq \mu_f$
Marital status	$H_0: \mu_{nm} = \mu_{em}$ vs. $H_a: \mu_{nm} \neq \mu_{em}$
Education	$H_0: \mu_1 = \mu_2 = \mu_3$ vs. $H_a: \text{at least 2 pairs}$
Wealth	$H_0: \mu_1 = \mu_2 = \mu_3 + \mu_4 + \mu_5$ vs. $H_a: \text{at least 3 pairs}$

H_0 : Null hypothesis

H_a : Alternative hypothesis

m : Male

f : Female

nm : Never married

em : Ever married

Table 4.3 on page 43 presents the hypothesis used in analysing the quantitative data in this study. Dummy variables for gender were generated and re-coded as '0' for male and '1' for female. Dummy variables for marital status were created and coded as 'never married'

(0), and 'ever married' coded '1'. For education, dummy variables secondary school education and less were re-coded as '0', high school level of education as code '1', and tertiary level of education coded '2'. Dummy variables which were created for wealth were re-coded as '0' in the variable wealth, 'just getting along' as code '1' and 'poor' re-coded '2'.

4.3.1 Knowledge about HIV and AIDS

The findings imply HIV and AIDS to be known and to have become one of the manageable chronic illnesses in Thetsane Industrial Area in Maseru, Lesotho. Respondents were asked if they had ever heard about HIV and AIDS. Almost everybody (99%) had heard about HIV and AIDS regardless of the individuals' socio-demographic background. It was not worth running a logistic regression for this variable because there is no variation in the dependent variable given that 99% of the respondents had heard about HIV and AIDS. A composite variable referred to as knowledge was created from the three variables (difference between HIV and AIDS, looking and feeling healthy, and modes of transmission). Coding for these variables was done in such a way that the respondents who got any answer right were coded '0', while those who got any answer wrong were coded '1'. A variable for modes of HIV transmission was made up of eight variables (witchcraft, touch, utensils, working together, unprotected sex, sharing a toilet, mosquito bites and sharing food).

Respondents were further asked if HIV can be transmitted from a positive mother to her baby during child birth (delivery). As expected, the majority of the female respondents (95%) than males (71%) pointed out that HIV transmission from a positive mother is possible during birth. Similarly, when asked about the possibility of HIV transmission from a positive mother to her baby during breastfeeding, more females (92%) as opposed to 86% of the male respondents indicated that HIV transmission is possible during breastfeeding. Generally,

respondents were aware of the possibility of HIV transmission from a positive mother to her baby during pregnancy, at birth and during breastfeeding. During the interviews, most respondents mentioned that there is a drug, but they could not remember its name (nevirapine), which can be used to reduce the risk of HIV transmission from a positive mother to her baby during pregnancy and at birth. Most women also mentioned that after birth, the positive mothers are encouraged to decide on exclusively breastfeeding their children or exclusively bottle-feeding their children on baby formula milk for at least six months after birth (the time when a child can start to be fed solid food). They highlighted that HIV positive mothers are strongly discouraged from mixing the two ways of feeding their babies in order to ensure PMTCT.

Table 4.4 - Prevention of mother-to-child transmission (PMTCT)

Parameters	During pregnancy P value	At birth (P value)	Breastfeeding (P value)
Age	0.560	0.388	0.159
Gender (Female = 1)	0.001***	0.006**	0.890
Marital status (Married = 1)	0.939	0.733	0.154
Wealth	0.624	0.982	0.931
Education	0.018**	0.498	0.251

***p-value < 0.01*

****p-value < 0.001*

Women are the ones who fall pregnant, give birth and breastfeed children. It is assumed that during their pre-natal and post-natal visitations to clinics they get empowered with information related to HIV and AIDS. For this reason, it was expected that women who participated in this study had more knowledge as opposed to their male colleagues on PMTCT. With reference to Table 4.4 on page 45, gender had very very significant impact while education had very significant impacts regarding the knowledge pertaining to HIV

transmission from the HIV positive to her unborn baby during pregnancy ($p=0.001$). Gender also showed a very significant influence on knowledge about HIV transmission from a HIV positive mother to her baby at birth ($p=0.01$). The odds ratio demonstrated that women were more likely to hold views on PMTCT during pregnancy (OR = 11) than men, implying that pregnant women become cautious in matters related to HIV transmission to their unborn children. These results were expected because women are the ones who attend pre-natal health services where they are exposed to information related to PMTCT as opposed to men. The odds ratio indicated equal likelihood of holding views on PMTCT during breastfeeding between men and women (OR = 1). Holding views on PMTCT at birth seemed less likely among male respondents as opposed to female respondents (OR = 0.06).

Correct and consistent use of condoms has been argued in chapter two as critical in preventing the spread of the virus that causes AIDS. Participants in the current study were asked if condoms can protect one from getting HIV and AIDS. From a total of 70 respondents, 94% pointed out that condoms can protect one from getting HIV and AIDS. Looking at the age, gender, marital status and the level of education of the subjects, the findings provided percentages above 80% of the respondents in each category who indicated condoms as the preventive measure from contracting HIV.

Table 4.5 – Condoms protect one from contracting HIV

Parameters	Condoms protect one from getting HIV (p-value)
Age	0.563
Gender	0.098
Marital status	0.26
Wealth	0.562
Education	0.923

All tests were non-significant ($\alpha = 0.05$)

Based on the information gathered, there is knowledge about HIV and AIDS and how to prevent it among the employees in Thetsane Industrial Area. However, their knowledge is not complete. When asked whether HIV is a virus just like other disease-causing viruses, 50% and 60% of the male and female respondents respectively indicated that HIV is a virus just like other viruses. The response by the majority of the respondents suggests a need to deepen the level of HIV and AIDS education on how the nature of the HI Virus is different from other disease-causing viruses. Both male and female respondents' perceptions of the HI Virus is the same because the difference seen on the percentages of their responses is not significant ($\chi^2 = 0.6537, p\text{-value} = 0.419$). Respondents' age and marital status as seen in Table 4.4 also did not show any significant relationship to respondents' knowledge about HIV and AIDS.

In order to determine the effectiveness of HIV and AIDS awareness programmes, respondents were asked if people can get the AIDS virus through witchcraft. The majority of the subjects (77% and 81% of male and female respondents respectively) pointed out that witchcraft had no role in transmitting HIV from one person to the other. The contrast was true in Durban, South Africa, where Chetty (2002:67) reports incidences from some firms where witchcraft was believed to be one of the modes of transmission for HIV. Nullification of similar myths in Thetsane Industrial Area could be attributed to the effective HIV and AIDS awareness programmes and to the disseminated workshops, trainings, and informal teachings provided in the firms during awareness campaigns on site.

4.3.2 Attitudes towards HIV and AIDS

As seen in the second chapter, the nature of HIV and AIDS as a life threatening illness can result in negative attitudes towards the disease and towards the infected (Campbell *et al.*, 2006). For example, AIDS victims may find it difficult to come to terms with their condition and be reluctant to have access to treatment due to fear of stigma and discrimination.

In laying a foundation to determining the existence of negative attitudes towards HIV and AIDS, and towards employees living with HIV in Thetsane Industrial Area, respondents were asked if they would want the sickness of their family members infected with HIV to remain a secret. The majority of them (85% and 60% of female and male respondents respectively) mainly aged between 19 and 40 years indicated that they would not want to keep their family members' sickness resulting from HIV infection a secret. The respondents' comments as they filled in the questionnaires included that HIV and AIDS would successfully be managed in different communities if it was openly talked about. It was discovered during the study that respondents who would want to keep their family members' sickness a secret (if caused by HIV and AIDS) would do so in favour of the family and the victim's dignity in the society due to the misconceptions about people who contract HIV.

Respondents were asked if they would be prepared to work with someone if they knew that the other person had the AIDS virus. Almost all the respondents (99%) reported that they were prepared to work with HIV positive colleagues. Most of the workers did not want to blame HIV positive colleagues for bringing HIV into the workplace or make them feel ashamed of themselves for having contracted the AIDS causing virus.

In Table 4.6 age, marital status and the level of education were the only parameters which showed reliable test results. According to the information provided in Table 4.6,

respondents' age, marital status and the level of education had no significant influence in attitudes towards HIV and AIDS or attitudes towards HIV positive colleagues. The standard error values for all parameters in this model are all greater than the coefficient values because of a small size of the sample used for this study.

Table 4.6 - Attitudes towards HIV and AIDS and towards HIV positive employees

Parameters	Prepared to work with HIV positive colleagues (p value)	Kind of work to give to HIV positive workers (p value)	Blame HIV and AIDS victims (p value)
Age	0.746	0.212	0.732
Gender	0.245	0.109	0.876
Marital status	0.954	0.586	0.707
Wealth	0.097	0.014**	0.970
Education	0.949	0.001***	0.020**

***p-value < 0.01*

****p-value < 0.001*

From the table above, responses to questions which showed a negative attitude towards HIV and AIDS and towards HIV positive employees were coded '0'. Responses to questions which indicated no negative attitude were coded '1'. More than three quarters of the respondents and mostly women showed no negative attitude. Wealth and education appeared to have had very significant influence regarding the kind of work to give to the HIV positive employees ($p=0.01$ and 0.001 respectively). The level of education also had very significant association (p-value of 0.020) regarding whether to blame the HIV positive victims for bringing the virus into the workplace. The positive attitude shown by respondents towards AIDS and its victims is good for both the company and the employees and shows some level of success in eradicating stigma and discrimination against employees living with the HI Virus.

Table 4.7 presents results on attitude towards HIV and AIDS in the workplace. The results suggest more factors to have had a significant influence towards the attitudes towards HIV and AIDS and its victims especially at the 0.1 level of significance. Table 4.7 also

provides the odds ratio² of the attitudes towards HIV and AIDS and towards HIV positive employees at their workplace. Different from Table 4.6, in Table 4.7 an odds ratio as opposed to *p*-values was used to interpret attitudes towards HIV and AIDS and its victims in the workplace. In Table 4.7, two parameters (education and wealth) used to measure the attitudes towards HIV and AIDS, and towards its victims, indicated a significant influence. The reason for a few parameters showing some level of significance may be attributed to the small sample used in this study.

Table 4.7 - Attitudes towards HIV and AIDS and towards HIV positive employees

Parameters	Prepared to work with HIV positive colleagues	Kind of work for HIV positive workers	Blame HIV positive workers for HIV transmission at work
Age	0.0505 (1.052) ^a	-0.0727 (0.930) ^a	0.0482 (1.049) ^a
Gender	-	-0.9338 (0.393) ^a	0.9240 (2.519) ^a
Marital status	-0.0588 (0.943) ^a	-0.2291 (0.795) ^a	0.1509 (1.163) ^a
Wealth	-	0.8653 (2.376) ^a	0.3414 (1.407) ^a
Education	0.1383 (1.148) ^a	-1.5496 (0.212) ^a	-1.4404 (0.237) ^a

All tests were non-significant (= 0.05)

(a) = Odds ratios

From Table 4.7 above, looking at the odds ratio, preparedness to work with HIV positive colleagues was equally likely in both male and female employees from different age groups (OR = 1.1) and education levels (OR = 1.1). Dummy variables were created for the kind of job that the workers believed would be suitable for HIV victims. Odds ratio (2.4) for wealth as an independent variable indicated that the employees living with HIV can be given any kind of a job (re-coded '0').

The findings generally suggest acceptance of the existence of HIV and AIDS and its victims in Thetsane Industrial Area. When asked about the job that should be given to HIV

² An odds ratio is a way of comparing whether the probability of a certain event is the same for two groups. An odds ratio of 1 implies that the event is equally likely in both groups. The implication of the odds ratio greater than 1 is that the event is more likely in the first group, while an odds ratio less than 1 implies that the event is less likely in the first group.

positive employees, 83% of the respondents indicated that HIV positive employees should be tasked for any job in the company they are working for. Comments by respondents included that a HIV positive employee is able and not 'sick', therefore they could do any job that could be done by a HIV negative employee as long as they qualify for such a job. As shown in Table 4.7 above, all the parameters had no significant influence on the type of job to be given to HIV positive employees. This may be argued as evidence for acceptance at work of the employees living with the virus that causes AIDS.

Respondents were provided a range of codes from 1 to 5 representing 'strongly disagree' to 'strongly agree' related to promoting a HIV positive worker. Results from this question supported the respondents' feelings that HIV positive workers should be tasked for any job. Most of them (70%) strongly disagreed that promoting a HIV positive employee does not benefit the company. Reasons from those who agreed with the statement included that the firms would run a loss if they promote HIV positive employees especially for the demanding managerial positions which can also be stressful for a HIV positive employee. The other reason was that HIV positive workers often go for their frequent medical check-ups during work hours. This would mean that HIV positive managers would often leave their offices for health reasons thereby potentially compromising their office duties.

4.3.3 Knowledge about approaches used to manage HIV and AIDS at work

One of the contributing factors to the vast spread of HIV is lack of adequate knowledge as seen in the literature review chapter. HIV and AIDS awareness programmes are therefore critical in preventing the spread of the virus causing AIDS (Ekanem and Gbadegesin, 2004). HIV and AIDS awareness programmes may be critical as they help individuals to take the necessary precautions leading to the successful management of the

epidemic. Employees in Thetsane Industrial Area were aware of the HIV and AIDS awareness programmes being implemented on site. The majority of the respondents (68%), consisting of more female respondents (72%) as opposed to 62% of the male respondents, who were mostly married, indicated that sex education can reduce the spread of HIV. Sex education was reported to be delivered through pamphlets and presentations during HIV and AIDS awareness campaigns.

The negative impacts of HIV and AIDS on firms could be argued to have influenced the formulation and adoption of workplace HIV and AIDS policy used in the firms as a guide to manage HIV and AIDS. Businesses are increasingly becoming aware of the impact the pandemic has on their productivity and profitability as seen in the second chapter. There are different approaches used to mitigate the impact of HIV and AIDS in Thetsane Industrial Area and in order to determine the firms' reactions to the overwhelming impacts of HIV and AIDS, respondents were asked if their companies had plans in place for HIV and AIDS management. Out of 66 respondents, 74% indicated that their firms had HIV and AIDS policies guiding their firms in HIV and AIDS management programmes. Table 4.8 highlights those approaches found to be known by the research subjects in Thetsane Industrial Area.

Table 4.8 – Awareness by employees about approaches used in HIV and AIDS management in Thetsane Industrial Area

	Yes in %
HIV and AIDS awareness	66
Voluntary Counseling and Testing (VCT)	72
Anti-retroviral provision	40
Condom distribution	90
Promoting healthy eating habits	56

The majority (74%) of the employees pointed out that the approaches listed above in managing HIV and AIDS were effectively implemented by the non-governmental organisations. The questionnaire did not give the subjects an option to mention the names of the organizations involved in HIV and AIDS management on site, but almost all the respondents mentioned Apparel Lesotho Alliance to Fight AIDS (ALAFA) as the key role player in implementing different strategies leading to the control of the epidemic in Thetsane Industrial Area. Very few respondents (26%) indicated the involvement of the government in HIV and AIDS related issues in the firms.

Table 4.9 – Knowledge about approaches used in HIV and AIDS management in Thetsane Industrial Area

Parameters	ARVs encouraged	Condom distribution	Voluntary Counseling and Testing
Age	0.0215 (1.022) ^a	0.0985* (1.104) ^a	-0.0344 (0.966) ^a
Gender	-0.4011 (0.670) ^a	0.5461 (1.727) ^a	-0.7146 (0.489) ^a
Marital status	-0.2300 (0.795) ^a	0.00686 (1.007) ^a	0.00913 (1.009) ^a
Wealth	-0.0783 (0.925) ^a	-0.9159 (0.400) ^a	0.4190 (1.520) ^a
Education	0.2219 (1.248) ^a	0.4830 (1.621) ^a	0.3575 (1.430) ^a

**p-value* < 0.10

(a) *Odds ratios*

The following regression model was used in order to get the results presented in Table 4.9. The independent variables (Y) used in the model were age, gender, marital status, wealth and level of education. Dependent variables (encouragement of the use of ARVs at work for the infected workers, condom distribution and VCT) were used to test the employees' knowledge about approaches used in their firms in managing HIV and AIDS.

$$\ln\left(\frac{p_i}{1-p_i}\right) = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \beta_3 x_3 + \beta_4 x_4 + \beta_5 x_5$$

From the results presented in Table 4.9, there is a significant relationship between age and knowledge about the distribution of condoms among the respondents, with younger

respondents who are more aware of the distribution of condoms. Odds ratio (OR) for age (OR = 1.1) and marital status (OR = 1.0) from the logistic regression on condom distribution indicated both 'never married' and 'ever married' respondents were likely to know about the distribution of condoms in their workplaces. The odds ratio for gender (1.7) and education (1.6) provided results which were very close to two when rounded off to the whole number. This odds ratio suggests that awareness on condom distribution at work was more likely among male respondents than female respondents, perhaps because the male condoms were the only condoms distributed during the study. Awareness of the distribution of condoms at work may be associated with the use of condoms. Lack of awareness of the condom distribution may therefore suggest that they are not used. This could perhaps be associated with the findings which revealed age as one of the determinants for condom use (Rotemann 2005). Condom use declines with age regardless of the individuals' marital status (Rotemann 2005). Results from other variables in this model do not show any significant association and this is good because it suggests that the companies' employees were aware of the distribution of condoms in their place of work regardless of their gender, marital status, wealth and their level of education.

4.4 Testing, counseling and treatment

4.4.1 Voluntary Counseling and Testing

VCT has various benefits to those who access it (Mothibeli 2009). VCT is argued to be an entry point for prevention of HIV and AIDS and an entry point for treatment and support for the epidemic's victims (UNAIDS/WHO 2002). It is through VCT that people are provided an opportunity to understand to a greater level the nature of the HIV and AIDS pandemic. It may also be pointed out that VCT helps those who choose to take their HIV test

to know their status, and if tested HIV positive, get to be encouraged to start their treatment in order to put the virus under control as early as possible.

Respondents were asked to indicate if they had been tested for HIV and AIDS in the last 12 months. Out of 69 respondents, 52% and 63% male and female respondents respectively had gone for HIV testing in the previous year. The majority of the respondents who had gone for HIV testing in the previous year were married, mostly aged between 23 and 40 years and many of them had secondary education and less.

Table 4.10 - Respondents who tested in the previous year of the study (2008) by selected socio-demographic characteristics

	Yes in	%
Age		
19 – 30	45	
31 – 40	50	
> 40	5	
Gender		
Male	40	
Female	60	
Marital status		
Never married	28	
Ever married	72	
Wealth		
Comfortable	22	
Reasonably comfortable	23	
Just getting along	40	
Poor	16	
Level of education		
Secondary school and less	40*	
High school	45	
Tertiary	15	

**p-value < 0.10*

From Table 4.10 above, it is only the secondary and less level of education which has a significant relationship with having undertaken a HIV test in the previous year (2008). The observed chi-square test result is 4.1128 and there is 1 degree of freedom since secondary and

less is a dummy variable. The associated p -value is reported as 0.043 which is less than 5% cut off point. This finding suggests lower levels of education of respondents to have influenced reluctance to undertaking a HIV test in the previous year. From a logistic regression in Table 4.11, the odds ratio of interest would be those related to wealth (2.4) and education (2.8). The odds ratio for wealth indicates respondents who reported ‘comfortable’ were more likely to have tested for HIV in the previous year as opposed to other respondents. Looking at the level of education, the odds ratio of 2.8 implies the likelihood of more respondents who had secondary school education and less to have undergone HIV in the previous year as compared to other groups. These results were expected because the majority of the employees in the study area were those with secondary school education and less as compared to other groups.

Table 4.11: Respondents who took a HIV test in the previous year of the study (2008)

Parameters	Tested for HIV in the previous year
Age	0.960 (1.029) ^a
Gender	0.143 (0.441) ^a
Marital status	0.369 (0.680) ^a
Wealth	0.596 (2.387) ^a
Education	1.244 (2.792) ^a

All tests were non-significant ($\alpha = 0.05$)

(a) Odds ratios

There is no benefit attained by taking an HIV test if one does not get the result. Respondents who indicated not to have gone for HIV testing during the last 12 months of the study were requested to indicate if they had ever been tested for HIV before, and 68% of them (mostly female) had undergone HIV testing before. In the same manner, these respondents were asked if they got their results after testing. Almost all respondents (91% of 58 respondents) got their results after testing. Furthermore, respondents were asked to indicate if their firms encourage VCT for workers. The findings suggest both male and female workers equally

(80%) to have witnessed their firms encouraging workers to go for VCT. Based on these findings, the implementation of VCT is evident in Thetsane Industrial Area. It could be argued therefore that the employees in Thetsane Industrial Area are provided an opportunity to reduce the risk of acquiring and transmitting the AIDS virus.

Table 4.12 - Frequencies on risk of contracting HIV at work

Frequencies	Yes %	No%
Risky behaviour (perceived at work)	51.7	48.2
Feel at risk (of contracting HIV)	64.1	35.9

All tests were non-significant ($\alpha = 0.05$)

Responses regarding the question concerning being at risk of HIV and AIDS indicated that employees felt at risk of contracting the AIDS virus. More than 50% of the respondents indicated that there are risky behaviours they perceived at work which might lead them to contracting the AIDS virus. Again, more than 50% of the respondents indicated that they felt at risk of being infected with HIV. Results from the regression model were all non-significant and thus are not reported.

4.4.2 Anti-retroviral treatment

Respondents were asked to point out if they had ever heard about anti-retroviral drugs that people infected with the AIDS virus can get from a medical doctor or a nurse in a health clinic or hospital to help them live longer. The study findings indicated 87% of the respondents had heard about ARVs with a higher percentage from women and the married respondents. Looking at the respondents' educational background, high percentages from all the sub groups were seen to have known about ARVs. The least was 76% of the respondents with secondary education and less. This suggests no significant impact of the level of education on the knowledge about ARVs in Thetsane Industrial Area.

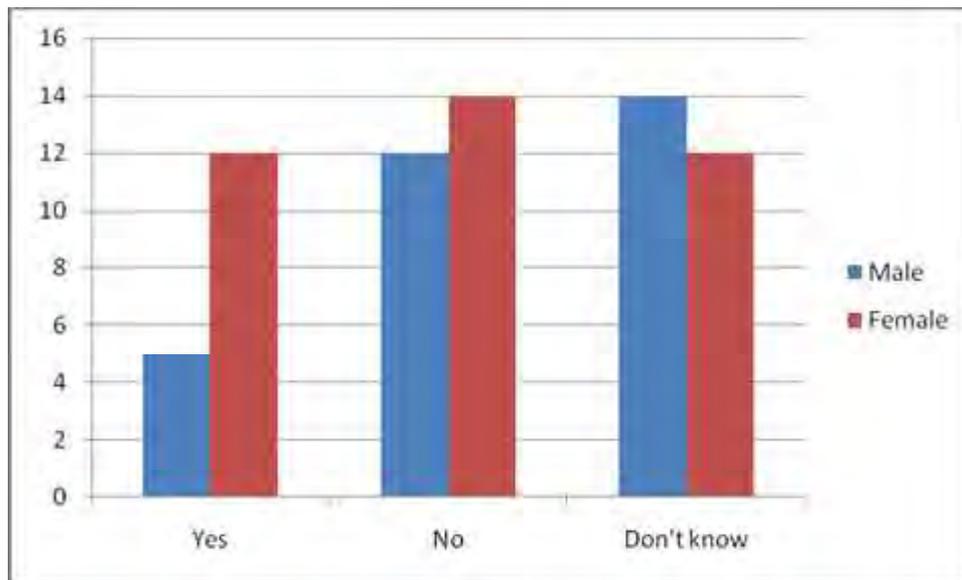
Table 4.13 - Respondents who were aware that ARVs are readily available on site by selected characteristics

	Yes in %
Age	
19 – 30	59
31 – 40	41
> 40	-
Gender	
Male	29
Female	71
Marital status	
Never married	35
Ever married	65
Wealth	
Comfortable	40
Just getting along	47
Poor	13
Level of education	
Secondary school and less	29
High school	53
Tertiary	18

All tests were non-significant ($\alpha = 0.05$)

Lack of knowledge about any services provided in one’s environment can prevent one from accessing such services. The research subjects in Thetsane Industrial Area were asked if ARVs were readily available at their workplaces. Only 25% of the respondents pointed out that ARVs were readily available on site. According to the p-values observed in Table 4.13 above, there is no significant relationship between awareness by respondents about the availability of ARVs on site and each of the observed characteristics. Factors other than gender (not observed), marital status and the respondents’ level of education, might have caused the lack of awareness about the provision of ARVs on site.

Figure 4.1 – ARVs readily available at workplace



According to Figure 4.1, the vast majority of respondents either did not know or indicated that ARVs are not provided in Thetsane Industrial Area. These findings were not expected because during data collection, most of the respondents had informally mentioned to the researcher that ARVs were readily available on site. When asked if their companies encouraged the use of ARVs for those living with the AIDS virus, 60% of the respondents, mostly women, pointed out that the use of ARVs was encouraged at work.

In addition to the questions about ARVs, respondents were asked if there were drugs that a medical doctor or a nurse at the hospital or health clinic can give to a pregnant HIV positive woman in order to reduce the risk of HIV transmission to the baby. Almost all respondents (90% and 97% of male and female respondents respectively) reported that there are drugs that can be used to prevent mother-to-child transmission (PMTCT) of HIV. The chi-square test probability ($\chi^2 = 2.1760, p = 0.703$) indicated no significant impact by marital status on the knowledge about the existence of drugs used for PMTCT.

When asked if the virus that causes AIDS can be transmitted from a mother to her unborn baby during pregnancy, unexpected outcome of more men (81%) as compared to women (49%) indicated that HIV transmission is possible during pregnancy. However, this might have been the case because most women did mention during the administration of the questionnaire that there are lower chances for HIV transmission from a pregnant woman to her unborn baby *as long as* the necessary measures for prevention are realized.

4.4.3 Condom distribution

Consistent use of condoms during sexual intercourse remains crucial in the fight against the vast spread of HIV. Many young people today believe that condoms can protect them from contracting HIV as seen in Table 4.14 that follows (between the ages of 19 and 40 among the respondents in this research). There is an increase in condom use especially with non-regular sexual partners among both men and women (USAID/Lesotho 2008). For this reason, it is important that condoms are consistently distributed in the workplaces in order to successfully reduce the spread of HIV.

Table 4.14 - Respondents who believe condoms can protect one from getting HIV and AIDS by selected characteristics

	Yes in %
Age	
19 – 30	48
31 – 40	42
> 40	10
Gender	
Male	44
Female	56
Marital status	
Never married	32
Ever married	68
Wealth	
Comfortable	18
Reasonably comfortable	23
Just getting along	47
Poor	13
Level of education	
Secondary school and less	30
High school	48
Tertiary	22

All tests were non-significant ($\alpha = 0.05$)

According to the results in Table 4.14, a belief that condoms are capable of protecting one from getting HIV and AIDS is not related to any of the parameters (age, gender, marital status or the level of education and wealth) of the respondents. The observed p -values were greater than 95% interval confidence suggesting no relationship between these variables.

During data collection, respondents were asked what their companies did in promoting the use of condoms. More male respondents (92%) mentioned that they are always being encouraged especially during peer education sessions to use condoms every time they engage in sexual intercourse. Most respondents pointed out that they have free male condoms being supplied at their workplaces by different interest groups interested in fighting the spread of HIV. Gender inequality is evident in this regard. It appears as though the males' health needs in terms of protection from contracting sexually transmitted infections including

HIV and AIDS are catered for while female condoms were reported not to be available on site.

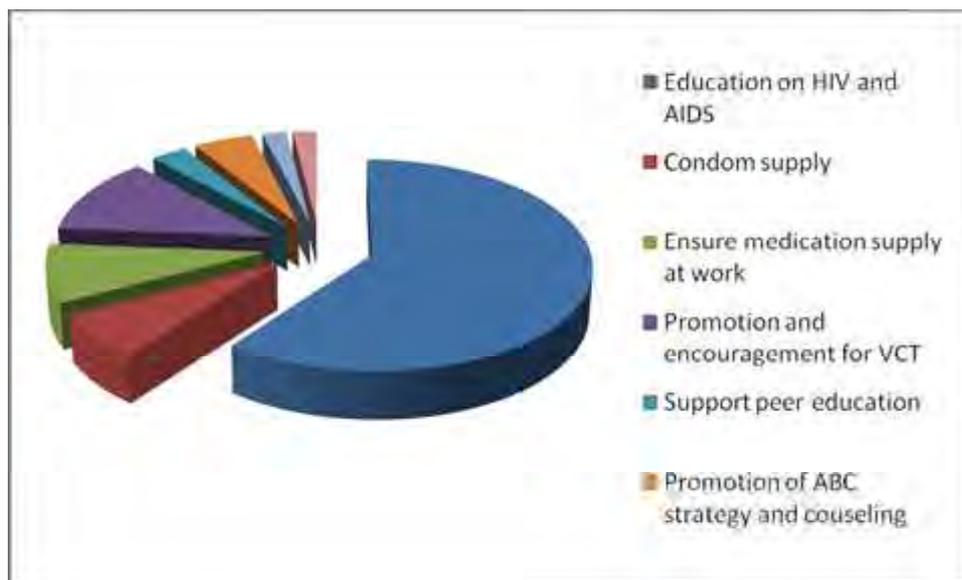
4.4.4 Care and support

Provision of effective care and support measures is critical in the workplaces especially for HIV positive employees. Respondents were asked if firms should offer financial support for families of workers living with HIV. They were also asked if the companies they work for should offer financial support for families of workers who die due to HIV and AIDS. With respect to the former question, 67% of the employees indicated that the firms should offer financial support for families of workers living with HIV. Reasons given for this included that it is costly for HIV positive people to lead a healthy life, therefore financial assistance from their firms would make it possible for them and their families to afford healthy eating practices. The same response was shown in regard to the latter question; 66% of the respondents indicated that their companies should financially support families of the workers who die of HIV and AIDS because sometimes the dead would have been the sole bread winners of their households. There were some respondents who mentioned that offering financial support to the family members of the AIDS victims or of the dead worker would lead to firms running losses as it would be an expensive practice perhaps due to the magnitude of the employees who would be offered financial assistance if that was to be put in practice.

4.5 Opinions on effective approaches to manage HIV and AIDS at work

The last question asked the research participants what they would do to control HIV and AIDS in their firms if they were the firm managers. Figure 4.2 provides a summary of the opinions from respondents on how to successfully manage HIV and AIDS in the workplace.

Figure 4.2 – Respondents’ opinions on HIV and AIDS management at work



Lack of knowledge and incorrect information leads to the vast spread of HIV as shown in the second chapter. Based on respondents’ opinions in Figure 4.2 above, education on HIV and AIDS came out strongly. A well informed labour force on HIV and AIDS-related issues would engage in safe practices which would not put them in danger of contracting HIV and AIDS.

4.6 Summary

This chapter of the report has analysed the quantitative findings related to approaches used in Thetsane Industrial Area to manage HIV and AIDS. The findings have suggested that

the Thetsane Industrial Area offers a successful case study in HIV and AIDS management in the workplace. Evidence provided has pointed out the employees in Thetsane Industrial Area have heard and know about HIV and AIDS and ways through which the pandemic can successfully be managed at work. Approaches to managing HIV and AIDS highlighted include the workplace HIV and AIDS policy which almost all the firms seemed to have in place. It has also been seen that there are effective awareness programmes implemented on site which have promoted more knowledge on HIV and AIDS, and have influenced many workers to undergo HIV testing in order to know their HIV status. Qualitative data will now be examined to explore the reasons for this apparent success.

CHAPTER 5: QUALITATIVE ANALYSIS

5.1 Introduction

This chapter presents qualitative findings of a study undertaken in Thetsane Industrial Area in Maseru, Lesotho. The qualitative data, as mentioned in chapter three, was collected from the firm managers and the two organisations interested in the firm workers' well-being. The chapter attempts to describe the contribution of the different stakeholders in HIV and AIDS management in the firms, and then provides an analysis of various approaches used in the firms to effectively manage the HIV and AIDS pandemic.

5.2 Stakeholders

The government of Lesotho and the Apparel Lesotho Alliance to Fight AIDS (ALAFA) were found to be the main interest groups in HIV and AIDS management in the garment industries in the study area. Collaboration by different interest groups in the fight against HIV and AIDS has the potential to reduce and to prevent the effect of HIV and AIDS in different societies. According to one of the firm managers interviewed, "*[The] HIV and AIDS issue needs everybody to take responsibility. It is not one man's challenge. We should all come together and fight this monster.*"

5.2.1 Government

The government of Lesotho, through the Ministry of Health, the private sector, and the non-governmental organisations, are some of the interest groups involved in HIV and AIDS management in the study area. The government is often expected to play a key role in

addressing the social ills because it has the capacity to influence other interest groups and provide them with the support they need in order to embark on projects and programmes needed to handle such challenges. During an interview with a representative from ALAFA, he stated:

“In regard to HIV and AIDS management in the workplace, the government of Lesotho has developed national guidelines to HIV and AIDS education programmes. The government has also amended the country’s Labour Code to include policies and standards in order to successfully manage HIV and AIDS in the workplace.”

Through an active participation of the government in HIV and AIDS management in the workplace, especially in the textile industries, ALAFA was established with its primary purpose being the provision of a workplace HIV programme.

5.2.2 ALAFA

ALAFA is a project hosted by Lesotho Textile Exporters Association (LTEA) with the government of Lesotho joining hands together to fight HIV and AIDS. The ALAFA board was formed and is chaired by the government through the minister of health, and representatives from all interest groups in the textile industries have a seat on this board. ALAFA was established in 2006 in response to the negative impacts of HIV and AIDS observed in the apparel industries in Lesotho. The key responsibilities for ALAFA include prevention, care and treatment of HIV and AIDS for textile and apparel industry employees in Lesotho. It is important to point out that the textile industry is the largest employment sector in Lesotho with women being the majority of the workers. During an interview with a representative from this organisation, he pointed out:

“Funders of the project are interested in the garment industries. The garment industries are the majority of the firms operating in the four industrial sites in the country. These firms are women-dominated and funders are interested in empowering female workers. There are plans made to expand coverage to all other industries in the future based on the success of the current project.”

The above quote was a response to a question on why the organisation’s focus is only on the garment industries. When asked about the role of the government of Lesotho in ALAFA and in managing HIV and AIDS in the firms, the representative noted:

“It (referring to the government) is the key stakeholder in ALAFA. It provides funding and support in various forms. The government, with the support from other private funders, assumes the key responsibility for the costs involved in the implementation of the programmes in the garment industries in the country. The full cost of treatment (ARVs) is covered by the government and the HIV and AIDS victims are provided this treatment free of charge.”

Based on the quote above, the government of Lesotho plays an important role in HIV and AIDS management programmes done in Thetsane Industrial Area. This part of the findings differs from the findings in the quantitative analysis where very few respondents indicated that the government is involved in providing HIV and AIDS management services in the firms. For them ALAFA appeared to be an independent organisation. This lack of knowledge and understanding in regard to ALAFA may indicate that there was a communication gap between the service providers and the workers during the introduction of ALAFA in the firms.

Acceptance of ALAFA especially by the firm owners was not easy in the beginning. According to ALAFA’s representative, the firm owners were initially reluctant to allow the proposed HIV and AIDS programmes in the firms, but ultimately allowed ALAFA to start with the proposed programmes. The representative revealed:

“The firms’ owners’ reluctance was not caused by them not liking the programmes we (referring to ALAFA) had proposed. Their reluctance was rather caused by their fear of their firms running losses or wasting production time while workers attend programmes by ALAFA. For them this was going to result in declines in production and their failure to meet production deadlines.”

The positive results on the firms’ production by the project have contributed to the current acceptance of ALAFA in the firms by both the firm managers and the firm owners. Increased absenteeism was seen in chapter two as one of the major challenges for firms with HIV positive workers. Absenteeism by employees in Thetsane Industrial Area was reported to have declined significantly since HIV positive workers started to collect their medication on site instead of going elsewhere.

“Things have changed a lot since ALAFA came to our rescue, there used to be times when we would fail to meet our production targets due to high levels of absenteeism by our workers living with this terrible disease. HIV positive workers no longer spend the whole day absent from work just because they have gone to collect their medication from a far off place,” stated one manager.

According to LECAWU, acceptance of ALAFA in the firms in Lesotho is not only a result of the benefits the firms got from the programmes implemented, but also rests heavily on the commitment required from the firm owners by the LTEA. LECAWU’s representative mentioned:

“Whether they like it or not, as long as they are in the firm industry business in Lesotho, they have to accept the LEA’s decisions and not interfere with whatever agreement is made at the level of the exporters’ association. The function of ALAFA in the firms is one such [an] agreement that has been made and signed for at the exporters’ association level by the employers or firm owners and all of them should embrace its presence (referring to ALAFA) in their firms.”

From the above quote, firm owners appear to have no choice, but to accept and allow ALAFA to operate HIV and AIDS programmes in their firms. The ‘forced’ acceptance of ALAFA in the garment industries could have negative implications in the long run especially if the firm owners feel obligated to accept ALAFA in their firms. It could result in firm owners not initiating anything related to HIV and AIDS management in their firms, distancing themselves from being actively involved in HIV and AIDS management programmes. During the study there was no sign of any negative implication that could be related to the acceptance of ALAFA in Thetsane Industrial Area. The present study revealed the garment industries to be totally dependent on ALAFA for HIV and AIDS management. One of the firm managers confirmed their total dependency on ALAFA:

“All HIV and AIDS issues in this firm are dealt with by ALAFA which has been allowed by the government to help in HIV and AIDS management in the place of work (referring to garment industries in Lesotho). We as the managers just support them (referring to ALAFA) in whatever they want to do in the firm relating to HIV and AIDS.”

The main focus of the firm owners is on production, and not necessarily on the well-being of the employees. *“The firm owners are interested in production in their firms and would not have time to run HIV and AIDS management programmes effectively,”* stated LECAWU’s representative. Based on this information, the other reason for total dependence by firms on ALAFA for HIV and AIDS management could perhaps be that the business owners are not yet aware of the role they can play in managing HIV and AIDS in their workplace. Discussions with the firm managers revealed that there are other non-governmental organisations involved in HIV and AIDS management programmes in Thetsane Industrial Area especially with the non-garment industries. These included CARE International and Population Services International (PSI). Services provided by these organisations include VCT services administration, condom distribution in the firms and

dissemination of HIV and AIDS education for firm workers. It was not possible to witness the implementation of these programmes in the firms during the study because none of them with an exception of condom distribution was active.

5.2.3 LECAWU

According to the organisation's representative, Lesotho Clothing and Allied Workers Union (LECAWU) was formed in 1994 as a breakaway from the Lesotho Amalgamated Clothing and Textile Workers Union. *"The union was developed with an intention to organise a model with shop stewards playing an active role in shop floor struggles,"* he reported. The union generally organises manufacturing workers, but the bulk of the membership is found in the garment industries. The objectives of the union include trying to establish a central negotiation forum with employers to set minimum wages for employees. Other objectives of this organisation include striving for a just standard of general welfare and treatment for employees in the firms. The union works towards ensuring that the workers' rights are realised at their workplaces. The representative mentioned, *"Much support in terms of recruitment drives and assistance with developing proposals for central forums and recognition agreements was reported to be offered by international organisations."* In relation to HIV and AIDS, the union contributed in persuading the government and the firm owners to respond to the HIV and AIDS challenge which negatively affected its members. It was mentioned by one of the firm managers that *"the workers' unions such as LECAWU had had an influence in challenging the firm owners to engage in HIV and AIDS management programmes."* These programmes were indicated to have assisted the garment industries by mitigating the impact the pandemic has on the labour force.

5.3 Strategies used to manage HIV and AIDS in Thetsane Industrial Area

Similar concepts to those analysed in the quantitative findings (see chapter 4) for HIV and AIDS management will be looked into in this chapter based on the qualitative information collected. These are the workplace HIV and AIDS policy, HIV and AIDS awareness programmes, Voluntary Counseling and Testing for HIV, anti-retroviral provision at work, condom distribution and promotion of healthy eating habits.

5.3.1 Workplace HIV and AIDS policy

A workplace HIV and AIDS policy, as seen in the literature reviewed, is a tool used in the workplace to provide a framework on different ways to manage HIV and AIDS (Sooklal, 2001). Managers from different firms acknowledged that they perceive HIV and AIDS as one of their major challenges and all the managers interviewed reported that there were HIV positive workers in their firms. Almost all the managers interviewed indicated that they have a workplace HIV and AIDS management plan in their firms except for one non-garment industry whose manager pointed out that they are in the planning stage to having a HIV and AIDS management plan. The manager from this firm said:

“We do not have a plan on HIV and AIDS management in our firm yet, but we do realise that AIDS is a big challenge for us. We are working on it (referring to a workplace HIV and AIDS management plan). Very soon we will have it in place.”

Different factors were found to have influenced the adoption and implementation of a workplace HIV and AIDS management policy in Thetsane Industrial Area. Besides the fact that a workplace HIV and AIDS management policy was reported mandatory for firms, the buyers from the firms have also pressurised the firm owners to make sure that their firms have a HIV and AIDS management plan in place. The influence by the firms' buyers on firms

to have a HIV and AIDS policy in place was established during the interviews with the firm managers and with the workers' union (LECAWU) representative.

“Our buyers also demanded that we formulate and implement an HIV and AIDS policy in the running of our firms. According to them [buyers], the formulation and implementation of an HIV and AIDS workplace policy shows the level of commitment and responsibility by the firms to their labour force's health issues,” reported one of the firm managers.

The finding that a workplace HIV and AIDS policy was mandatory for firms did not apply to all the firms in the study area. There was one non-apparel industry which was found not to have such a policy yet. In regard to HIV and AIDS management, the firm was just distributing the male condoms which were put in all the bathrooms in the firm. It was then assumed that the responsible department in making follow-ups for the existence of HIV and AIDS management plans in the firms had not done an effective follow-up in this particular firm in regard to HIV and AIDS management.

Besides the workplace HIV and AIDS management policy in the pipeline for this firm, the firms' plan in managing HIV and AIDS, as the manager stated, included connecting with and enquiring from the neighbouring firms, which were already running successful programmes on HIV and AIDS, in order to learn from them as to how to effectively implement HIV and AIDS programmes in the firm.

5.3.2 HIV and AIDS awareness

Lack of awareness as argued in Asian Business Coalition on AIDS (2002) may lead to critical workplace conflict and disruption at the managerial levels. In Thailand production stoppages occurred due to lack of knowledge and understanding of the ways through which

HIV gets transmitted from one person to the other (Asian Business Coalition on AIDS 2002). Ignorance about HIV and AIDS was seen in chapter two to contribute to the vast spread of HIV and AIDS (Page *et al.*, 2006). A study by Mondal and colleagues in Gazipur district in Bangladesh recognized a need for increased education and awareness about HIV and AIDS among the garment employees for successful HIV and AIDS management programmes at work (Mondal *et al.*, 2008). It may be pointed out that HIV and AIDS awareness programmes at work do not benefit only the workplaces, but also the societies in which the workers live.

Educational HIV and AIDS awareness programmes have the potential to eradicate myths surrounding HIV and AIDS (Gitari 2007). Progress towards this ideal seems to have been made in Thetsane Industrial Area. Different strategies are used for HIV and AIDS awareness on site. These strategies include peer education sessions during lunch time, educational posters on HIV and AIDS within the firms' premises, and awareness presentations by different guests on HIV and AIDS.

The firm managers in Thetsane Industrial Area, especially from the apparel industries, confirmed the importance of peer education. One of the firm managers stated, "*It is easy for peers to engage in discussions related to any issue of life including HIV and AIDS.*" Through peer education, change of behaviour is effected among the members of a group. According to the firm managers, a group of male and female employees is taken at least once in six months for peer education training facilitated by ALAFA. During these sessions, trainees get educated on HIV and AIDS and are equipped on effective strategies they can use during peer education session at their places of work.

It became clear during data collection that firm owners and managers are not directly involved in peer education. The role of the firm managers was reported as provision of support for their employees trained by ALAFA. Their firms allow them to attend training

workshops and during this time they are considered on duty by their respective firms. At work the firm managers encourage workers to attend the peer education sessions which were reported to take place during lunch breaks. In order for peer education sessions to be successful, the time and the environment at which they are carried out have to be conducive. According to LECAWU's representative, the lunch time peer education sessions are effective in conveying the desired message to the workers. According to him, there is no need for formal sessions on HIV and AIDS education or awareness in the workplace. He stated:

“If the workers are taught about HIV and AIDS in a formal school-like environment, it would not be effective. They will be bored and decide not to attend them. We have mobilized the same workers for strikes during their lunch hour in the firms and they (referring to the contests organised by the union) were all successful. The same goes for peer education in the firms. Those peer educators should be creative enough to be able to keep the workers' attention and to convey their message during the workers' lunch time and not working hours.”

When asked to comment on the impact ALAFA has had through HIV and AIDS awareness programmes in the firms, LECAWU's representative commented:

“It is not yet enough, but a large percentage of workers in the firms now know their HIV status. Before the introduction of the programmes by ALAFA, few workers had been tested. Those who had been tested were scared or ashamed to tell even their close friends about their HIV status. People in the firms are now free and bold [enough] to tell their colleagues about their status without fear of being treated differently. They even encourage each other to go for testing, that's how successful the programme is as compared to the time before introducing the ALAFA programme. If there are those who do not know their status now, I think they are a very small number.”

With reference to the above quote, it may be pointed out that high levels of HIV and AIDS education and awareness have the potential to make the implementation of other HIV and AIDS-related programmes easy. It became evident that awareness programmes by

ALAFAs have positively impacted the garment industries in Thetsane Industrial Area. The awareness programmes implemented in the firms have also assisted the firms as well as the workers in reducing stigma against those living with the AIDS virus as their colleagues are now aware and more educated about HIV and AIDS. As seen in the above quote, some HIV positive workers even decide on disclosing their positive HIV status because they perceive that there is no fear of being discriminated against.

5.3.3 Voluntary Counseling and Testing

It has been shown in the literature review that VCT has the potential to adjust people's sexual behaviour (Nattrass 2004). Access to VCT in Thetsane Industrial Area was apparent during the study, resulting from the efforts by ALAFA and other organisations providing education and VCT services in Thetsane Industrial Area. It is important to mention that the success of VCT is dependent on successful HIV and AIDS awareness and education programmes. Most of the organisations providing VCT services are invited by different firm managers (especially the non-apparel industries) to offer their workers VCT services on site: *"Sometimes we encourage our workers to visit these organisations wherever they are based for VCT services,"* reported one non-garment industry manager. ALAFA was found to have a different approach in encouraging the garment firm workers to undergo VCT services. Such services are provided on site for workers to access everyday during the working hours. The firm managers reported that there are times when ALAFA go to a point of offering those who go for VCT services some incentives such as free air time, free T-shirts and other gifts in order to influence many workers to undertake a HIV test. One of the managers protested:

"In as much as I want our workers to test, I think that practice by ALAFA (referring to incentive provision) is in a way forcing our workers to test for this disease

(referring to HIV and AIDS). Some do it (referring to a HIV test) for the sake of the gifts they get there. If it's a voluntary action, then people shouldn't be bribed into doing it."

The quote suggests that the numbers of firm workers accessing VCT services provided by ALAFA in Thetsane Industrial Area would be less if it was not for the incentives provided. If this was the case, it would then suggest that people who go for HIV testing not "volunteering" would not be ready to accept their HIV test results, especially if they are positive. None of the managers reported cases where employees blamed the service providers for having coerced them into taking a HIV test they were not ready for. It therefore appears that ALAFA's strategy is working for the benefit of those who access the VCT services.

5.3.4 Anti-retroviral provision at work

As seen in chapter two, the discovery of ARVs has been one of the great achievements in managing HIV and AIDS. ARVs have turned AIDS into one of the manageable illnesses. In Asia many companies are reported to provide anti-retroviral drugs at work (Asian Business Coalition on AIDS 2002). The current study indicates that ARVs are administered on site in Thetsane Industrial Area. The rolling out of ARVs on site shows some progress since the study by Gitari in 2007 in Thetsane Industrial Area. Gitari reported no garment industry with facilities providing ARVs at work (Gitari 2007). However, it has been indicated that a programme by ALAFA was anticipated to help the firms by administering ARVs on site (Gitari 2007) . The research undertaken for this dissertation found that all the interviewees indicated that there were clinics on site from which ARVs were administered to the workers living with the AIDS virus. These clinics also provide all the primary health services needed in the firms. A representative from LECAWU highlighted that these clinics are only found on the premises of the firms which are more financially able in the area, he said:

“Some firms do not have clinics on their premises because they cannot afford to have them, so their workers go to the other firms having clinics on their premises. Some of those firms you see there (referring to Thetsane Industrial Area) are better off financially as compared to others.”

A representative from ALAFA was asked to comment on the response stated above. In his comment, he mentioned that there were only three clinics placed in Thetsane Industrial Area so far. For him the clinics were not placed in the firms which are financially better off than others. In ensuring active participation by employers in running the clinics in Thetsane Industrial Area, the clinic built-in facilities are sponsored by employers. *“A factory clinic is not expensive but just [a] small space with a plug, a light, and a wash basin. I honestly do not feel it is so expensive that factories cannot afford them,”* commended ALAFA’s representative. A comment from ALAFA’s representative confirms that there are few clinics operating in Thetsane Industrial Area to serve all the garment industry workers. Having just a few clinics on site makes economical sense because having a clinic placed in each of the firms with a permanent qualified nurse and a visiting doctor every week would be costly. According to ALAFA’s representative, the nurses and a visiting medical doctor are from the government hospitals, suggesting that the government is responsible for these service providers’ salaries.

5.3.5 Condom distribution

In chapter two, it was argued that condoms are preventive tools which minimize the chances of HIV transmission during sexual intercourse (Hearst and Chen 2004). The managers from all the firms reported condoms to be distributed frequently within the firms’ premises. *“We have them (referring to condoms) all the time in our male and female toilets,”* stated one of the managers. The firms did not purchase their own condoms, perhaps due to

lack of budget allocations for such. The findings of the current study in this regard are in line with Gitari's findings which indicated dependency by the firms in Thetsane Industrial Area on condom donations from outside sources (Gitari 2007). Besides the condom supply from the government through the Ministry of Health, condoms distributed in the firms were reported to be supplied by PSI and CARE International. When asked whether they get both male and female condoms distributed to their firms, all the managers pointed out that they are only supplied with the male condoms and could not remember when last they were supplied with the female condoms. One of the implications of this finding is that women are expected to rely on the willingness of their male sexual partners to use condoms for sex because the female condoms were argued not to be available.

Again, consistent distribution of only male condoms in the firms in Thetsane Industrial Area indicates power dynamics between the male and female sexual partners. The finding suggests that males are in control of the sexual activity and are the ones with the power to decide on safe sex practices. Contradictory to these findings, a follow-up HIV sero-prevalence study report by ALAFA reports on the availability of both the male and the female condoms in firms in Lesotho (Wallengren 2009). ALAFA is responsible for HIV and AIDS management in all the garment industries in the country. In reporting the availability of the female condoms in the firms, the report does not indicate the industrial areas in which the female condoms are provided. One of the possible reasons for the difference between the current study and a follow-up HIV sero-prevalence report by ALAFA could be that there are female condoms distributed in other industrial sites in the country not necessarily in Thetsane Industrial Area.

5.3.6 Care and support

Lack of resources is argued as a challenge to providing HIV positive people the support they need (Gitari 2007). Despite the fact that the situation is not perfect, there appears to have been an improvement in Thetsane Industrial Area in terms of resources used in the support and care of HIV positive workers. The placement of clinics on site to provide medication has been a great achievement in the area. Having clinics on site was highlighted as one of the great achievements in the history of the firms because before ALAFA was introduced, the firm workers living with the AIDS virus had to get their medication from clinics or hospitals far from their places of work. The non-apparel industry managers reported that they refer their HIV positive workers to the clinics in the city of Maseru because they do not provide medication on site and the clinics in Thetsane Industrial Area by ALAFA are assisting only the apparel industry workers and their spouses.

“It is only those workers from the garment firms who are provided medication from their on-site clinics because ALAFA is involved with their firms. They produce some identity cards from their firms which allow them and their spouses to be given the medication they need. Maybe as time goes we will also get services from ALAFA,” alleged one non-apparel industry manager.

All managers were aware of the need for effective provision of care and support measures in the workplace for HIV positive workers. The garment industry managers mentioned that there were support groups formed in their respective firms which provide an invaluable assistance for HIV positive workers. Support groups also help the HIV positive workers to be able to cope with their diagnosis of HIV. According to one manager, sometimes it becomes difficult for them as managers to fully show their support and care for their employees living with the HI Virus. He highlighted:

“These support groups play a significant role in providing care and support. Sometimes we as the management do not know how best we can support our workers living with this virus, but in these groups, they meet with other people living with HIV and get to share their experiences with other people who might understand them better because they are going through similar experiences.”

Almost all the managers confirmed that there is no financial support specifically planned for HIV and AIDS victims and their families by their firms. Some managers mentioned that they often advise their workers to invest with insurance companies which have low monthly premiums affordable for most of the low earners in order to be in the position to get financial assistance for their families in cases of death.

Other services which were mentioned by most of the firm managers included the provision of counseling for psychological support for HIV positive workers who need counseling in order to be able to cope with their HIV positive status. There are specific times at which people living with HIV who are on treatment should take their medication. A HIV and AIDS victim, Edwin Cameron stresses the importance of taking HIV treatment consistently: *“When the patient stops taking the drug combinations, the virus in most cases emerges, rampant once more,”* (Cameron 2005:14). The firm managers in Thetsane Industrial Area stated that they allow their employees who are on HIV treatment time off their duties to take their medication. On top of this, if HIV positive employees fall ill, they are allowed by the firm management to take paid sick leave as prescribed by their medical health practitioners. Managers further mentioned that they have observed that HIV positive workers on treatment need to eat frequently perhaps due to the nature of the medication they take, and they are therefore allowed snack times between meals. It was revealed during the study that HIV positive mothers with newly born babies are provided free NAN baby Nestle formula by ALAFA from clinics on site to assist them to be able to exclusively bottle-feed their babies in order to minimise the chances of HIV transmission from their positive mothers.

5.4 Challenges in HIV and AIDS management in the workplace

HIV and AIDS management is a challenge in most countries especially in Sub-Saharan Africa, as seen in the second chapter. In South Africa HIV and AIDS is considered a serious issue which companies should address in order to remain competitive (Gitari 2007). In comparing the situation in South African garment industries to those garment industries in Lesotho, LECAWU's representative said: "*We are better off in Lesotho as compared to South Africa.*" The comparison by LECAWU's representative was in the context of approaches used, especially now that medication is provided on site for HIV positive workers in the garment industries in Lesotho.

One of the huge challenges in HIV and AIDS management is stigma and discrimination against HIV positive people. Discrimination and stigmatization could be seen as global challenges which are difficult to fully eradicate. One of the managers who was asked to highlight some of the factors leading to stigmatization and discrimination against HIV positive employees responded:

"Some of the reasons for that (referring to stigma and discrimination) towards the AIDS victims include the fear of contagion of this incurable disease, perhaps due to the incorrect information that some workers might have about the disease. It (referring to stigmatization) can also be experienced due to lack of knowledge about the ways through which the virus that causes AIDS is transmitted from one person to the other."

It was revealed during the study in Thetsane Industrial Area that strict measures are in place for those who discriminate against or stigmatize workers living with HIV. All managers interviewed reported low incidences of stigmatization and discrimination of HIV positive workers. They pointed out that their firms have rules and regulations known by all their employees stating that those workers who are found to have discriminated against others

based on their HIV status will be taken for disciplinary hearing. Lack of behavioural change after the hearing was reported to lead to the dismissal from work.

The other challenge faced in managing HIV and AIDS in the workplace as highlighted by LECAWU's representative emerges from what he referred to as "*living in two different environments.*" This refers to the work environment and home environment which are totally different from each other. The two environments in which workers find themselves are seen by LECAWU as a stumbling block to managing HIV and AIDS successfully especially for women. According to LECAWU's representative:

"At work these women are taught and made aware of the dangers and challenges associated with HIV and AIDS. When they get home they are Basotho women [and are] expected culturally to obey and respect their spouses. Unfortunately some of them live with hostile and uneducated spouses in matters relating to HIV and AIDS who believe culturally that a woman should submit to the husband in all things. Sex is one of those aspects in which most women have no say in the country, but are expected to do it the way her husband wants it."

The situation explained above shows how vulnerable women employees are to contracting the AIDS virus if their spouses are left out of HIV and AIDS education. It also suggests gender inequality incidences as men are culturally perceived superior to their spouses. According to LECAWU, the two environments mentioned are a national challenge in Lesotho which has hindered the country's progress in managing HIV and AIDS because there is no balance in terms of HIV and AIDS education exposure especially for spouses. The wives cannot even negotiate the use of the female condom for sex because their husbands are not educated about them.

Sustainability of the current HIV and AIDS management programmes in Thetsane Industrial Area was perceived by the researcher as one of the potential challenges. The firm managers reported nothing which showed that they have a plan in regard to HIV and AIDS

management should ALAFA stop its operation in the firms. The implication of this is managing the impacts of HIV and AIDS, which are presently under control, because the program could fail if ALAFA were to stop operating. When asked about the long term plan of the workers' union and its involvement in HIV and AIDS management in the firms, a representative from LECAWU said:

“For now ALAFA is responsible, and it might be for a long time. If it gets replaced, at that time, the responsible people will have to look for the best alternative that could outshine ALAFA.”

Based on the above quote, there is no long-term plan for the management of HIV and AIDS management beyond ALAFA as yet. The same feeling was perceived among the firm managers. They are anticipating that ALAFA will continue to serve the firms in HIV and AIDS management.

5.5 Summary

In this chapter, qualitative research findings have been presented. Background information of the firms from which the managers were interviewed was provided. Most of the qualitative research findings presented in this chapter concur with the quantitative findings presented in chapter four. Based on these findings, HIV and AIDS has become manageable through the use of ARVs and various approaches used to mitigating the impact of HIV and AIDS on firms. It was observed in this chapter that different interest groups, in particular Apparel Lesotho Alliance to Fight AIDS (ALAFA), are playing a significant role in the successful management of HIV and AIDS in Thetsane Industrial Area.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

HIV and AIDS has been spreading at an alarming rate. In addition to the human and social cost, this alarming widespread of HIV also poses serious business challenges. The most productive and economically active population has been the most hit by the disease especially in the Sub-Saharan African countries. The main purpose of the present study was to investigate approaches used to manage HIV and AIDS in the workplace using Thetsane Industrial Area as a case study. This chapter will reflect back to the objectives of the present study providing a summary for both quantitative and qualitative research findings. In doing so, the chapter will discuss the main conclusions of the study and provide some recommendations on ways that could add to the improvement of the current approaches to workplace HIV and AIDS management.

6.2 Conclusion

The study was aimed at discovering the perceived impacts of HIV and AIDS on firms in Thetsane Industrial Area. In addition to discovering the perceived impacts of HIV and AIDS on firms, the study wanted to identify the policies used by firms in managing HIV and AIDS in the workplace. Furthermore, the study sought to determine the role played by different interest groups in the workplace (the government, NGOs, the managers and employees) in managing HIV and AIDS.

6.2.1 Perceived impacts of HIV and AIDS on clothing firms

The results of the study indicated that there was a decrease in the firms' production levels before the advent of ALAFA and its current intervention programmes in Thetsane Industrial Area. The decline in production levels was a result of absenteeism, sicknesses and death of the skilled and knowledgeable labour force caused by HIV and AIDS. The results have pointed out absenteeism to have been the major negative impact caused by HIV and AIDS in Thetsane Industrial Area.

From the results attained through this study, production levels have improved. Approaches currently used in the firms to put the pandemic under control were argued to have led to the success of mitigating the level of absenteeism experienced by the firms. It was mentioned during the study that HIV positive workers used to take a day off to go to clinics, hospitals and other places from which they collected their prescribed treatment (ARVs). The workers' absence from work was reported to have caused the firms to fail to meet the set production deadlines thereby failing to satisfy their customers before the intervention by ALAFA. The study revealed that there is no more need for employees to collect their medication away from their workplace because ARVs and other necessary services for HIV positive people are now accessible on-site. Rolling out ARVs on-site came out strongly as it has resulted in lower numbers of employees being absent from work. The results have provided some testimonies from the firm managers that there is a huge difference or change since the provision of ARVs on-site. The change has been brought by the fact that infected workers no longer report absent from work for medication collection.

6.2.2 The policies used by firms in managing HIV and AIDS

An understanding and a realisation of the impact of HIV and AIDS by the employers is critical. The efforts by employers towards mitigating the impacts of HIV and AIDS are very

much influenced by their attitude towards the disease and by the way they perceive the epidemic's impacts on their business. The results of the study revealed that HIV and AIDS workplace policies and strategies have been developed in almost all the garment industries in the study area. It is through the firm managers' facilitation that the majority of the firms in Thetsane Industrial Area were able to formulate and implement the workplace HIV and AIDS policies in their respective firms. Through these policies, they have been able to formulate rules and regulations to prevent stigmatisation and discrimination against HIV positive workers in the workplace.

6.2.3 The role played by interest groups in managing HIV and AIDS

It became evident from the current study that an intervention from outside the firms has been the key towards successful HIV and AIDS management programmes. The results of this research demonstrated that there is some level of commitment to HIV and AIDS management in Thetsane Industrial Area by different interest groups. The government, NGOs, the firms' management and the employees were found to have a role to play in managing the AIDS pandemic in the workplace.

The government of Lesotho was reported as the key stakeholder among the interest groups taking part in fighting HIV and AIDS in Thetsane Industrial Area. The current study realised the government to have responded positively to the HIV and AIDS management challenge in the workplace especially looking at the garment industries in Lesotho. The formation and the launch of ALAFA, with its board chaired by the Minister of Health, has been one of the effective approaches to mitigating the negative impacts of HIV and AIDS in the garment industries in Lesotho. Provision of ARVs to the AIDS victims through the on-site clinics monitored by ALAFA has been reported in the findings of this research as the greatest achievement in the history of a fight against HIV and AIDS in this area. The cost for

the ARVs provided for HIV positive workers is covered by the government. It is important to mention that the government of Lesotho is committed to covering the cost of ARVs for all HIV victims in the country and not only the firm workers.

The other NGOs such as PSI and CARE Lesotho were found to have contributed in providing services leading to the management of HIV and AIDS in Thetsane Industrial Area. Their contribution as opposed to the contribution by ALAFA was reported mainly by the non-garment industries found in the area. Services which were reported to be provided by these organisations included VCT, condom distribution, HIV and AIDS education and awareness programmes in these firms.

The current study also established that the firm managers in Thetsane Industrial Area were not directly involved in HIV and AIDS management in their workplaces. The role played by employers in managing HIV and AIDS in their workplaces was reported as provision of support especially to the peer educators and to ALAFA. The results have shown that the firm managers encouraged their employees in the firms to attend peer education sessions on-site. Moreover, the firm managers were reported in the study to allow the peer educators to attend training provided by ALAFA. During these training sessions, peer educators are considered by their managers to be on duty.

The role played by employees has been realised as critical in this study because HIV and AIDS awareness campaigns and programmes in the firms would not have been a success if the workers were not involved in planning and implementation phases of such programmes. The role played by workers in managing HIV and AIDS in the workplace was reported in peer education done in the firms. Some workers were reported to engage in teaching their colleagues about HIV and AIDS after being trained and work-shopped by ALAFA in this regard. Peer education has therefore been argued to have ensured knowledge about the disease and has also created a platform for workers to take responsibility in the approaches

used to manage the pandemic in their workplaces. The workers' involvement has also been seen from the reports about support group formations in the firms. These groups were reported to be mainly made up of the infected workers who provide support for each other. It was revealed that there are times when the firm managers fail to offer support to HIV positive workers, especially if they are not HIV positive, due to lack of full understanding of the experiences HIV positive workers go through.

6.3 Recommendations

In conclusion, HIV and AIDS still remains a global challenge especially for Sub-Saharan African countries. In Lesotho, the pandemic continues to be a challenge not only for individuals, but it also threatens businesses as well as the country's economy because the labour force is increasingly suffering from the effects of HIV and AIDS. The following are recommendations for successful approaches to mitigating the impact of HIV and AIDS in the workplace.

6.3.1 HIV and AIDS education

Some members of the labour force in the study area did not know that HIV and AIDS are different, for them HIV and AIDS meant the same thing. Knowledge about the difference between HIV and AIDS is important in broadening people's understanding of HIV and AIDS. A deepened HIV and AIDS education especially related to the nature of the AIDS virus and its transmission is still needed in the workplace. HIV and AIDS education has the potential to influence a positive behavioural change desired for successful management of HIV and AIDS. In addition to the awareness messages delivered during peer education forums, more information about HIV and AIDS can be provided in order to broaden the attendants' knowledge about HIV and AIDS.

6.3.2 Target groups

It was evident during the study that workers in Thetsane Industrial Area were encouraged to use condoms during sexual intercourse activities. Intervention messages should include more emphasis on delayed sexual debut for those workers who are not yet sexually active. For workers who are already sexually active, intervention messages should encourage delayed sexual intercourse encounters with new partners and encourage workers to have one sexual partner.

6.3.3 Health insurance

The majority of the workers in the garment industries are poor. The salaries they get from garment industries are usually not enough to meet all their needs. It would not be surprising to find out that the majority of these employees are not members of any of the health insurance companies because they cannot afford to pay the monthly premiums. Garment industries should find a way to negotiate with the health insurance companies operating in the country to set affordable premiums which would specifically be designed to cater for the garment industry workers in order to assist the workers and their families in cases of death.

6.3.4 Responsibility by factory management

There should be a greater leadership commitment from the firm managers. While a positive impact by ALAFA and other organisations was perceived during the study, the greatest challenge facing the companies is to protect their workforce against further spread of HIV and AIDS and to help the HIV positive staff to remain healthy and productive for many years. At the same time, the companies should encourage their staff members who are HIV negative to remain negative forever. Interventions aimed at the HIV negative employees are

critical. The firms would be able to effectively help both the HIV positive and HIV negative employees to manage and to prevent infection if they actively get involved in the HIV and AIDS management programmes and not rely only on ALAFA for such programmes.

6.3.5 Personnel

Most of the managers isolated themselves from the employees during the study. They sounded as though they were not affected by the pandemic in the same way as their employees. Again, management's participation in the HIV and AIDS programmes as members of the labour force was not clear during the study. Interventions for HIV and AIDS management in the firms should include all levels of the firms' personnel including management, supervisors, skilled and unskilled workers.

6.3.6 Coverage

During the study it became evident that ALAFA is engaged only with the garment industries in matters relating to HIV and AIDS. Expanding their coverage to all the firms in the area would be one of the approaches that the organisation can use in order to successfully mitigate the impacts the epidemic has on employees and business.

6.3.7 Community involvement

The study revealed the majority of the firms in Thetsane Industrial Area to have a HIV and AIDS policy which guides them in managing HIV and AIDS. However, the efforts devoted for HIV and AIDS management seemed to apply only at workplaces and not in the communities around the industrial area. There is a desperate need for community involvement in HIV and AIDS programmes run in the workplace in order to enhance the effectiveness of such programmes. In addition to implementing HIV and AIDS management

programmes in the workplace, firms can also engage in broader efforts to manage the epidemic through community partnerships. It is of critical importance that the policy formulated in regards to HIV and AIDS management encourages social responsibility. Active social responsibility actions could involve out-reaches sponsored by the firms in promoting HIV and AIDS awareness among the communities found in Thetsane Industrial Area. A successful community outreach programme on HIV and AIDS would in the long term address HIV and AIDS issues in the two environments where the firms' employees live. In addition to addressing the two environments for workers, through community outreach programmes, the workers' partners would be reached for the effectiveness of HIV and AIDS prevention interventions. The involvement of traditional and religious leaders from local communities is crucial. Involvement of these leaders in HIV and AIDS initiatives within their communities would improve community participation in all HIV and AIDS programmes implemented in their area.

6.3.8 Behaviour

Knowledge about HIV and AIDS by employees was good. Generally, reduction of risk behaviour should be encouraged. For example, in order to discourage the practice of multiple concurrent partners, education addressing the practice should target those mostly engaged in such behaviour as well as those with partners engaging in multiple concurrent partners.

6.3.9 Life skills

Most of the employees working in the garment industries such as Thetsane Industrial Area are the key breadwinners in their households. It is crucial that these employees, especially those living with the AIDS virus, are provided with other life skills such as

gardening, so as to enable them to produce their own fresh healthy food. If their production gets excessive, they would be able to increase their income through the sale of the excess production.

6.3.10 Implications for South Africa

Lesotho is totally surrounded by the Republic of South Africa. It is therefore possible that anything that affects Lesotho (positively or negatively) will eventually affect South Africa and vice versa. For this reason, collaboration by the two nations in the fight against HIV and AIDS is highly recommended.

6.3.11 Monitoring, evaluation and impact

ALAFAs were found to be responsible for planning, implementation and follow-up of the HIV and AIDS programmes in Thetsane Industrial Area while management from the firms seemed to support the organisation from a distance. Monitoring and evaluation systems of the HIV and AIDS interventions in the firms should be strengthened. It is critical again that the impacts of the current ALAFAs programmes are looked at in the longer term for the sake of sustainability. Collaboration between ALAFAs and the firms' management would strengthen monitoring and evaluation of HIV and AIDS initiatives in Thetsane Industrial Area.

References:

- Allen, N. J. (2001). HIV/AIDS in the cigar workplace: Model Policies and Practices.
- Allison, P. D. ((1990).). "Comparing logit and probit coefficients across groups." Sociological Methods and Research **28**(2): 189-208.
- Angula, C. (2002). How Does HIV/AIDS Affect African Businesses? The HIV/AIDS Crisis United States Agency for International Development. . Population, Health and Nutrition Information Project. Washington D.C.
- Arrehag, L., Vylder, S., Durevall and Sjoblom, M. (2006). The impact of HIV/AIDS on livelihoods, poverty and the economy in Malawi. Sweden.
- Asian Business Coalition on AIDS (2002) Business taking action to manage HIV/AIDS. A selection of business practices responding to HIV/AIDS in- and outside the Asian workplace.
- Avert (2007). HIV/AIDS in Lesotho.
- Barks-Rugglesf (2001). AIDS and Business in South Africa Washington D.C.
- Barnett, T., and Whiteside, A. (2002). AIDS in the Twenty-First Century. Disease and Globalization. New York, Palgrave Macmillan.
- BoS (2008). The Lesotho 2006 Preliminary Census Report. Maseru.
- Brook, D. W., Morojele, N.K., Zhang, S., Brook, J.S. (2006). "South African Adolescents: Pathways to risky sexual behaviour." AIDS education and prevention **18**(3): 259-272.
- Cameron, E. (2005). Witness to AIDS. Cape Town, Tafelberg Publishers.
- Campbell, C., Nair, Y., Maimane, S. (2006). "AIDS stigma, sexual moralities and the policing of women and youth in South Africa." Feminist Review **83**: 132-138.
- CARE (2001). Livelihood in Lesotho. Maseru.
- Charmaz, K. (2006). Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis. London, Sage Publishers.
- Chetty, E. (2002). Combating AIDS/HIV Spread in the workplace: A case study of the Durban Clothing Industry. Durban, University of Natal. **Masters**.
- Croyle, R. T. (2005). Theory at a Glance: A Guide For Health Promotion Practice. New York, United States Department of Health and Human Services.
- Dickinson, D. (2007). "Talking about AIDS: A study of informal activities undertaken by workplace HIV/AIDS peer educators in a South African company." University of Witwatersrand Business School Journal.

- Dickinson, D., and Duncan, K.K. (2009). "Workplace peer educators and stress." African Journal of AIDS Research 2008 7(3): 293-303.
- Epstein, H. (2007). The invisible cure: Africa the west and the fight against AIDS. London, Viking.
- FAO (2007). FAO Global Information and Early Warning System on Food and Agriculture World Food Programme Special Report. FAO/WFP Crop and Food Supply Assessment Mission to Lesotho. Maseru.
- Field, A. (2000). Discovering Statistics Using SPSS for Windows. London, SAGE Publishers.
- Forsyth, S. (2002). Assessment of private sector HIV/AIDS policies and activities in Tanzania.
- Fox, S., Rosen, W., MacLeod, M., Wasunna, M., Bii, G., Foglia, G., and Simon, J. (2004). "The impact of HIV/AIDS on labour productivity in Kenya." Tropical Medicine and International Health 9(3): 318-324.
- Gibney, L., DiClemente, R.J. and Vermund, S.H. (1999). Preventing HIV in Developing Countries: Biomedical and Behavioural Approaches. London, Plenum Publishers
- Giffort, A., Lorig, K, Laurent, D and Gonzalez, V. (2005). Living well with HIV and AIDS. Boulder, Colorado, Bull Publishing Company.
- Gitari, F. K. (2007). Investigating the potential role of Corporate Social Responsibility (CSR), in management of HIV/AIDS at workplace. A case of Garment Industries in Thetsane Maseru Cape Town, University of Stellenbosch. **Masters**.
- Glaser, B. G., and Strauss, A.L. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago, Aldine Publishing Company.
- Grant, B., Fine, D. Heywood, M., and Strode, A. (2001). South Africa: The AIDS Law Project. HIV/AIDS and Law. Johannesburg, University of Witwatersrand.
- Green, L. W. (1992). Prevention and Health Education. In Maxcy-Rosnau-Last: Public Health and Preventive Medicine, 13th edition, eds. J. M. Last and R. B. Wallace. Norwalk, CT: Appleton & Lange.
- Hearst, N., and Chen, S. (2004). "Condom promotion for AIDS prevention in the developing world: Is it working? ." Studies in Family Planning (35): 39-47.
- Holland, J., and J. Campbell. (2005). Methods in Development Research: Combining Qualitative and Quantitative Approaches, Rugby: ITDS Publishing.
- Horizons (2006). AIDSQuest: The HIV/AIDS Survey Library. Behavioural and Social Theories. Washington D.C, Horizons.

- Jean-Pierre, T. B. (2004). Mitigating the impact of HIV/AIDS in the workplace: a review of strategies deployed by 150 chemical, petroleum and pharmaceutical sector companies in South Africa. International Conference on AIDS (15th: 2004: Bangkok, Thailand). Johannesburg, South Africa.
- Jick, D. T. (1997). "Mixing Qualitative and Quantitative Methods: Triangulation in Action. Qualitative." Administrative Science Quarterly **24**(4): 602-611.
- Krippendorff, K. (2004). Content analysis: An introduction to its methodology. London, SAGE Publishers.
- Lesotho National Development Co-operation (2005). LNDC and the Long Walk to Industrial Development Maseru, Lesotho National Development Co-operation (LNDC).
- Lesotho UNGASS Country Report (2009). Status of the national response to the 2001 declaration of commitment on HIV and AIDS.
- LNHD (2007). The challenges of HIV and AIDS, Poverty and Food Insecurity. Report. Maseru.
- Lynch, B. K. (1983). "Qualitative and Quantitative Evaluation: Two Terms in search of meaning." Educational Evaluation and Policy Analysis **5**(4): 461-464
- Makeka, T. (2006). National AIDS Commission, Lesotho. Powered to conquer HIV and AIDS. Maseru, National AIDS Commission.
- Merli, G. M., Hertog, S., Wang, B., and Li, J. (2006). "Modelling the spread of HIV/AIDS in China: The role of sexual transmission." Population Studies: A Journal of Demography **60**: 1-22.
- MOHSW (2006). National Operational Plan 2006-2007. , Lesotho: . Know Your Status Campaign: Leave no Mosotho out. Every Life Counts. Maseru, Ministry of Health and Social Welfare.
- Mondal, N. I., Hossain, M., and Rahman, M. (2008). "Knowledge and awareness about HIV/AIDS among Garment Workers in Gazipur district in Bangladesh." Medwell Journals **3** (7): 528-530.
- Mothibeli, L. M. (2009). Factors influencing utilization of Voluntary Counselling and Testing of HIV among pregnant women in Lesotho. School of Development Studies. Durban, University of KwaZulu-Natal. . **Masters**.
- Murray, R. (2003). Blending qualitative and quantitative research methods in theses and dissertations. London, SAGE Publishers
- Naidu, N. (2003). HIV/AIDS and the implications for Management of the Corporate Sector in South Africa Durban, University of Natal. **Masters**.
- Natrass, N. (2004). The Moral Economy of AIDS in South Africa. Cape Town, Cambridge University Press.

- Ndobo, N. (2006). What impact does HIV/AIDS Workplace Policy have on HIV/AIDS Management in Mdantsane High Schools in East London? . Cape Town, University of Stellenbosch. **Masters**.
- O'neill, R. (2006). The advantages and disadvantages of qualitative and quantitative research methods. London, SAGE Publishers.
- Page, J., Louw, M., and Pakkiri, D. (2006). Working with HIV/AIDS. Cape Town, Lebone Publishing Services.
- Pallant, J. (2007). SPSS Survival Manual: A Step by Step Guide to Data Analysis using SPSS for Windows. London, University Press.
- Patton, M. Q. (2002). Qualitative research and evaluation methods (3rd edition). Newbury Park, CA: SAGE Publishers.
- PRB (2006). Population Reference Bureau 2006 World Population Data Site. Washington D.C.
- PRB (2007). Population Reference Bureau 2007 World Population Data Site. Washington D.C. .
- Rau, B. (2002). Workplace HIV/AIDS programmes: An action guide for managers. Washington D.C., USA: Family Health International Publication.
- Rehle, T., and Hassig, S. (2003) Role of Evaluation in HIV/AIDS Programs in Rehle T., Saidel, Hassig, S., Bouey, P. and Gaillard, E. (Eds.). Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries. 1998
- Rick, M. (2004). Supporting NGO partners affected by HIV/AIDS London, Routledge.
- Rotemann, M. (2005). "Sex, condoms and STDs among young people." Health Reports **16**(3): 39-46.
- Singhal, A., and Rogers, (2003). Combating AIDS: Communication strategies in action. New Delhi: Sage. New Delhi Sage.
- Sooklal, A. (2001). Knowledge, Attitudes and Perceptions of Small Business Managers Towards AIDS/HIV. Durban, University of Natal. **Masters**.
- South African Business Coalition on AIDS (2004). "The impact of HIV/Aids on the South African economy."
- Storti, C. (2004). HIV/AIDS Care and Treatment: A clinical course for people caring for persons living with HIV/AIDS.
- Tladi, L. S. (2006). "Poverty and HIV/AIDS in South Africa: an empirical contribution." Journal of Social Aspects of HIV/AIDS: 369-381.

UNAIDS (2008). Report on the global AIDS epidemic. , UNAIDS/08.27E.

UNAIDS/WHO (2002). AIDS epidemic update, UNAIDS/02.58E.

USAID (2001). How Does HIV/AIDS Affect African Businesses? The HIV/AIDS Crisis.

USAID/Lesotho (2008). HIV/AIDS Health profile. United State Agency, International Development

Vass, J. R. (2008). "The role of HIV/AIDS committees in effective workplace governance of HIV/AIDS in South African small and medium-sized enterprises (SMEs) " Sahara J: Journal of Social Aspects of HIV/AIDS 5(1): 2-10.

Wallengren, K. (2009). Follow-up HIV Sero-Prevalence Study Report. Data Collection. Maseru, Sechaba Consultant.

Zungu-Dirwayi, N. (2004). An audit of HIV/AIDS Policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe.

Appendix 1

Informed consent:

SCHOOL OF DEVELOPMENT STUDIES – 2009

Dear Participant

Informed Consent

You are invited to take part in the research outlined below by answering the questions on HIV and AIDS Management at your workplace.

I am a student in the above mentioned university, currently engaged in a research for a dissertation towards a Masters Degree in Population Studies. This research is intended to study approaches used by firms in managing HIV and AIDS at the workplace.

Research Title: Workplace HIV and AIDS Management: The Case of Thetsane Industrial Area in Maseru

Supervisor: Professor Julian May mayj@ukzn.ac.za

Researchers: Mr. Nkeka Tseole 205517499@ukzn.ac.za

You are not forced to take part in this study; participation is voluntary; however your contribution will be highly appreciated. You can end the interview at any time if you feel uncomfortable. Do not write your name or any information about your identity anywhere on the questionnaire; it is designed to be anonymous.

Your participation in this research will be highly appreciated.

Thanking you in anticipation

Researcher's signature

Date

Appendix 2:

Questionnaire

1. Age

I was ----- years old at my last birthday

2. Gender

Male

Female

3. Marital Status

Never Married

Married

Separated

Divorced

Widowed

4. How many children of your own do you have? -----

5. In your household (where you live)

No. of people

No. of children

No. working

6. Race

Black

White

Coloured

Asian

Other

7. Highest education qualification completed

None

Primary School

Secondary School

High School

College

University

Other: Specify

8. Would you say you and your household are at present (circle the number representing your best description):

1 = Wealthy

2 = Very comfortable

3 = Reasonably comfortable

4 = Just getting along

5 = Poor

6 = Very poor

9. Describe the house you live in

Good condition

Needs repairs

Dilapidated

10. I have worked for this company for ----- years ----- months

11. Did you have any relevant job experience before joining this firm?

Yes

No

12. What were you doing before you came to this company?

13. Have you ever heard about HIV and AIDS?

Yes

No

14. If a member of your family became sick with the virus that causes AIDS, would you want it to remain a secret?

Yes

No

15. Would you be willing to care for your family member who got infected with the virus that causes HIV and AIDS?

Yes

No

16. Does your company have a Plan for HIV and AIDS Management?

Yes

No

17. Does your company do any of the following?

Strategy	Tick the correct response	
	Yes	No
Promotion of Voluntary Counseling and Testing (VCT)	Yes	No
HIV and AIDS awareness campaigns e.g. posters	Yes	No
HIV and AIDS awareness e.g. talks / presentations	Yes	No
Sex education through posters	Yes	No
Sex education through talks / presentations	Yes	No
Encouraging the use of Antiretroviral (ARV)	Yes	No
Condom distribution in the firm	Yes	No
Promoting healthy eating habits (nutritious food)	Yes	No
Others (specify) -----		

18. What benefits / services are provided by your company for the employees who get sick from HIV and AIDS?

19. What benefits are provided by your company to the families of the employees who die of HIV and AIDS?

20. What does your company do in implementing the abstinence, be faithful and condomise (ABC) strategy to prevent the spread of HIV and AIDS?

Abstinence -----

 Be faithful -----

Condomise -----

21. Workers living with HIV and AIDS should be blamed for bringing the virus into the working place.

Yes

No

22. What does your company do in preventing the stigma against the employees who live with HIV and AIDS?

23. Do the non-governmental organizations provide HIV and AIDS Management services at your company?

Yes

No

24. Does the government provide HIV and AIDS Management services at your company?

Yes

No

Examples of services provided by the government or non-governmental organizations: -----

25. Attitudes on HIV and AIDS:

Place X in the box that best describes your answer

Statement	Yes	No	Don't know
HIV virus is a virus just like other viruses			
There is a difference between HIV and AIDS			
A person with HIV can look and feel healthy			
A person with fully blown AIDS can look and feel healthy			
Condoms can protect one from getting HIV and AIDS			
Sex education can reduce the spread of HIV			
There are many people in the firm living with AIDS			
There is a lot of risky behaviour in the industry that increases chances of being infected			
Can people get AIDS virus because of witchcraft?			
Can people reduce their chance of getting AIDS virus by not having sexual intercourse at all?			
Is it possible for a healthy looking person to have AIDS virus?			
Can the virus that causes AIDS be transmitted from a mother to her baby during pregnancy?			

Can the virus that causes AIDS be transmitted from a mother to her baby during delivery?			
Can the virus that causes AIDS be transmitted from a mother to her baby during breastfeeding?			
Are there any drugs that a doctor or a nurse can give to a pregnant woman to reduce the risk of transmission to the baby?			
Have you heard about the antiretroviral drugs that people infected with AIDS virus can get from a doctor or a nurse to help them live longer?			
People with HIV and AIDS should be ashamed of themselves			

26. I feel I am at risk of contracting HIV and AIDS

Yes

No

27. I have been tested for HIV and AIDS in the last 12 months:

Yes

No

If not, have you ever been tested? -----

28. If you have tested for HIV and AIDS before, did you get your results? I do not want to know what the result was, just whether you received them or not.

Yes

No

29. Are ARVs readily available for people with HIV and AIDS at your workplace?

Yes 1

No 2

Don't know 3

30. What kind of work / job should be given to HIV positive workers? Circle your response.

Any job (like other people without HIV and AIDS)	Yes	No
Clerk	Yes	No
Supervisor	Yes	No
Reception	Yes	No
Manager	Yes	No
Driver	Yes	No
Security Guard	Yes	No
Accountant	Yes	No
Cleaner	Yes	No
Food preparation	Yes	No
Other (specify) -----		

31. HIV and AIDS can be transmitted through (Circle your response)

Touching	Yes	No
Sharing kitchen utensils	Yes	No
Working together with infected persons	Yes	No
Unprotected sex	Yes	No
Sharing a toilet with infected persons	Yes	No
Mosquito bites	Yes	No
Sharing food with a HIV positive person	Yes	No

32. How has HIV and AIDS affected productivity levels of your company?

We work harder

Work fewer hours

Fewer orders

Downtime

33. Promoting an employee who is HIV positive does not benefit the company. Circle the number that best describe your feeling between 1 and 5

Strongly disagree 1 2 3 4 5 Strongly agree

Why? -----

34. My firm encourage voluntary HIV testing for workers

Yes

No

35. Is voluntary HIV testing necessary? Why do you say so?

36. Should firms offer financial support for families of workers who have HIV and AIDS?

Yes

No

Why? -----

37. Should firms offer financial support for families of workers who die due HIV and AIDS?

Yes

No

Why?

38. Should employers have a right to require selected applicants for work to undergo HIV screening before being offered a job?

Yes

No

Why?

39. Would you be prepared to work with someone if you knew that they had AIDS virus?

Yes

No

40. Managers should be allowed to reject applications for jobs from HIV Positive persons. Circle the number that describes your feeling better between 1 and 5.

Strongly disagree 1 2 3 4 5 Strongly agree

Why?

41. Do you personally know someone who was denied a job because he or she is infected with HIV and AIDS?

Yes

No

42. Do you have any colleagues / employers living with AIDS?

Yes

No

Don't know

If yes, how are they treated at work? -----

43. If you were a manager in the firm, what would you do to control AIDS in your firm?

Interviewer's observations

(To be filled in after completing an interview)

Comments about respondent

Comments on specific questions

Any other comments

Supervisor's observation

Signature ----- **Date** -----