

**Examining Women's Vulnerability to HIV
Transmission and the Impact of AIDS: The role
of peer education/peer support in Lesotho's
garment industry**

Final Report for CARE Lesotho-South Africa Country Office

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ALE	Association of Lesotho Employers
ARVs	Antiretroviral treatments
HIV	Human immuno-deficiency virus
IOM	International Organisation for Migration
KI	Key Informant
PEP	Peer education programme
PLWH	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PSCAAL	Private Sector Coalition against AIDS in Lesotho
PSI	Population Services International
SSI	Semi-structured Interviews
STIs	Sexually transmitted infections
TEBA	The Employment Bureau for Africa
VCT	Voluntary Counselling & Testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

Introduction

The Child, Youth, Family and Social Development (CYFSD) programme of the Human Sciences Research Council of South Africa (HSRC) was commissioned by CARE Lesotho-South Africa Country Office to undertake a study entitled Examining Women's Vulnerability to HIV Transmission and the Impact of AIDS: The role of peer education/peer support in Lesotho's Garment Industry. Conducted between April and June 2008, the study was part of an international comparative study known as Gender, Sex and Power project, which was done in six other countries to address the following global research questions:

- How is the intervention related to empowerment?
- How is the intervention related to HIV risk?
- How is empowerment related to HIV risk?

The Lesotho study was particularly designed to understand if there were differences between women who were trained in peer education and those who did not participate in the intervention in terms of their empowerment to reduce the risk of HIV infection and behaviour in relation to seeking HIV/AIDS related services. CARE and their partners implemented the Private Sector Coalition against AIDS in Lesotho (PSCAAL) intervention in the workplace and trained workers in peer education. Another similar intervention which garment workers were exposed to after PSCAAL was the Apparel Lesotho Alliance to Fight AIDS (ALAFa). Of particular interest to the study were the following: (1) The women's perceptions of HIV risk factors and vulnerabilities as garment industry workers; (2) their perception of empowerment with respect to sexual and reproductive health, especially HIV prevention in their sexual relationships; and (3) their level of agency in preventing HIV infection and transmission and seeking services for HIV and AIDS care.

Methodology

Guided by the scope of work as provided and stipulated by the client in the terms of reference, the HSRC research team undertook a survey in the capital Maseru among 208 women working in two factories that had participated in the PSCAAL programme at different stages. Convenience sampling was used to select workers who were available and agreed to be interviewed during their lunch break and immediately after work in the evenings.

The data collection adopted both quantitative and qualitative approaches. The former entailed the use of a semi-structured interview schedule that sought the women's information on the women's socioeconomic and demographic characteristics including HIV awareness and testing, decision-making in sexual relationships, gender equality beliefs, sense of self efficacy and community.

The qualitative component of the study, on the other hand, entailed focus group discussions with the women to be able to understand, in more detail, the picture revealed in the quantitative component. Key informant interviews were also held with service providers who worked with CARE during the time of PSCAAL; human resource managers of the studied factories, personnel officers responsible for connecting the workers with management and who were also HIV and AIDS focal persons at the workplace and a health care provider who worked in an onsite clinic in one of the factories.

General findings

The overall pattern that emerged from the study was that the empowerment programme positively affected attitudes towards HIV and AIDS as well as behaviour in relation to seeking services such as HIV testing, obtaining medical treatment including ARVs and soliciting support at the workplace than in relation to adopting low risk behaviours. Further analysis of the survey results

however suggest that the skills the women learned in the peer education programmes did not seem to have trickled down to the traditionally entrenched gender beliefs. For example, while most women who had participated in the programme had correct knowledge about HIV and AIDS, and seemed to be aware of the sources of HIV risk in their context as garment workers, they did not differ much with non-participants in terms of risk behaviours and exposure to barriers to behaviour change. The following findings regarding each of the four local research questions asked illustrate:

What is the nature of vulnerabilities that women face which expose them to HIV risk?

Consistent with Parker et al's (2000) framework, the factors which increase the factory workers' vulnerability to HIV infection can be grouped into three categories: economic factors; migration; and gender inequalities. The study showed that the women's low wages and the resultant shortfalls in their monthly budget, particularly led many women to engage in sexual behaviours such as concurrent multiple partnerships and transactional sex as a coping strategy. The need to work overtime to augment the low wages also indirectly increased their risk of being raped, thus increasing their chances of negotiating condom use.

Against this background of the literature showing that migration can create situations that increase people's vulnerability and risk to HIV Infection, (for example Brummer, 2002; Santis et al, 2007), the women's vulnerability was also increased by their migration status: only 29 percent had Maseru as their home; the rest were migrants. Furthermore, due to gender inequality, women generally had limited ability to communicate their need for safer sex with partners and to refuse unsafe sex. For example, one of the recurring themes in the survey was respect for husbands which, if not observed, could lead to women losing some of the attributes fundamental to their identity and self esteem – being respectful wives and not facing criticism from extended family members. Showing lack of respect included disregarding men's preferences in sexual relationships,

unwillingness to respond positively to men's demands in sexual relationships or displaying knowledge about sexual matters because these were contrary to cultural values. Such behaviour could lead to physical abuse, loss of privileges such as financial support, which could affect their children negatively, or lead to women being abandoned.

What is the women's notion of "empowerment" and did the PSCAAL programme empower women? If so, in what ways?

For peer educators who participated in a focus group discussion, empowered women made decisions and acted in ways which did not suggest they were smarter than their partners but took responsibility in their relationships and used information they had to persuade their partners to change. Peer educators considered the work which they did in relation to peer education at the workplace as empowering because it provided women with information which they could use to prevent HIV infection. The participants, on the other hand, articulated their perception of what empowerment entailed within the three spheres of decision making: the domestic sphere, protected sex and reproductive roles. Although the women perceived "empowerment" in different ways, their descriptions highlighted some core behavioural and attitudinal traits as well as emotional tendencies which distinguished empowered women from others who were not so empowered.

What kind of critical decisions related to HIV infection or prevention can different categories of women, particularly those who were trained as peer educators and those who were exposed to peer education by the trained peers on the one hand; vis-à-vis those women who did not take part in peer education on the other, make in their sexual relationships?

Women who participated in the empowerment programme were more likely than those who did not participate to be the final decision-makers regarding condom use in their sexual relations. They were also more likely to be confident in obtaining condoms without feeling embarrassed, to refuse to have sex with their partners without a condom, and to suggest an HIV test to their partners and others. However, that a quarter of them feared losing their partners if they refused sex, further illustrates the prevailing dependency of the women on men for financial and material support. With regards to negotiation in, and communication about, sexual matters, the survey results show that the programme participants who felt confident discussing condoms use with their partners were, in the six months prior to the survey, significantly more likely than non-participants to have engaged in protective behaviours such as always using condoms and testing for HIV.

What are the opportunities which CARE could have lost through their previous programming?

The empowerment goal needed to be framed with the understanding that women negotiated safe sex in the context of skewed gender relations. Reasonable change in this respect has cost implications and requires development agencies to collaborate and create synergies which can enhance funding opportunities and service delivery which go beyond the groups which are identified as 'at high risk', for example, garment factory workers. This is because the behaviours which increase the risk for HIV in the case of the workers are not confined to any particular communities and are inherent in the mores of society and its structural aspects such as poverty, migration which does not include other workers' family members.

Conclusion

The peer education programme was intended to influence behaviour change among women who worked in the garment industry. This was done through an

HIV and AIDS peer education/support programme, by providing information and VCT services. Peer educators (few though) showed that information about HIV and AIDS did not only change their outlook but also empowered them to adopt low risk behaviours and sexual practices. However, for the majority of workers to experience empowerment and hence behaviour change, the programme needed to work on the basis of the socio-cultural and economic factors which could influence women's decision making in relationships with others, namely men. The multifaceted nature of the contextual factors which increase women's vulnerability need to inform the interventions which are intended to empower women and they should be assisted to understand how these factors reinforce one another in the transmission of HIV. Empowering women in the 21st century is likely to be even a difficult process because of the changed economic status of most men in Lesotho and the fact that male identity is under threat; resistance is inevitable unless men are made partners in truly gender mainstreamed programmes.

1.0 BACKGROUND AND CONTEXT OF THE RESEARCH

1.1 Research Mandate

The Child, Youth Family and Social Development (CYFSD) of the Human Sciences Research Council (HSRC) was commissioned by CARE-Lesotho-South Africa to undertake a study on “Women’s Vulnerability to HIV Transmission and the Impact of AIDS: The Role of Peer Education/Peer Support in Lesotho’s Garment Industry”. The study intended to understand the agency, structures, and relationships that influence the vulnerability of women to HIV infection. The research study explored the efficacy of CARE’s contribution through a peer education initiative to a larger HIV/AIDS workplace, and to reducing migrant women’s vulnerability to HIV infection and the impacts of AIDS.

This research is part of CARE International’s ‘Gender, Sex and Power’ project which is an “initiative to understand the nature of changes taking place for participants in its HIV-related programs: how strategies to reduce risk and promote empowerment of women are creating durable changes” (CARE International, 2007).

1.2 HIV and AIDS in Lesotho

Lesotho, with a population of 1.8 million has one of the highest HIV and AIDS prevalence in the world with an adult prevalence rate at 23.2. Lesotho’s epidemic is generalized and HIV is mainly spread through heterosexual intercourse which involves multiple partners and inconsistent use of condoms (Phela Health & Development Communications, 2007; UNAIDS, 2006). Earlier reports showed that men in military service, taxi and mining industries mostly reported having

multiple sexual partners (UNAIDS, 2005). The epidemic is also characterized by high HIV/TB co-infections among adults (WHO, 2008).

There is evidence that concurrent relationships coupled with reluctance to use condoms are widespread HIV risk practices especially in long term sexual relationships (Epstein, 2007; Phela, 2007; UNAIDS/WHO, 2008). Therefore HIV prevention within marriages and other long-term relationships remain of strategic importance. This is particularly so, given that for nearly 40% of couples only one partner of the couple is HIV-positive (Ministry of Health and

Social Welfare, 2004; UNAIDS/WHO, 2008). HIV testing is considered the entry point into the health care system, but in Lesotho testing coverage remains low. HIV testing and counselling coverage increased remarkably in the last four years (see Table 1 below) mainly due to availability of ARVs.

Table 1 Lesotho HIV and AIDS indicators, 2003 – 2005

HIV/AIDS in Lesotho	Statistics
Adult HIV prevalence % (15-49 years) , 2003	31%
Est. number of people in need of ARVs, 2003	54,000
Est. number of people receiving ARVs, 2003	1000
People living with HIV/AIDS, 2005	270,000
Women aged 15+ living with HIV/AIDS, 2005	150,000
Adult HIV prevalence %, 2005	23.2
AIDS deaths, 2005	23, 000
Children with HIV/AIDS, 2005	18,000
New HIV infections, 2005	25,000
HIV counselling and testing coverage %, 2004	2.7
HIV counselling and testing coverage %, 2007	17.2
Est. number of people receiving ARVs, 2007	22,000

Sources: www.who.int/hiv/HIVCP_LSO.pdf; WHO (2008) "[Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector](#)", Progress Report, Geneva, June 2008; <http://hivinsite.ucsf.edu/global?page=cr09-lt-00>

The government of Lesotho, in collaboration with various development partners including United Nations agencies has implemented various HIV prevention strategies. These include workplace initiatives incorporating IEC activities. A major turning-point was the replacement of the Lesotho AIDS Programme Coordinating Authority (LAPCA) by the National AIDS Commission in 2005. The latter was established to implement the new National AIDS Policy and Strategic Plan for 2006-2011 which is intended to reduce the spread of HIV through the promotion of condom use, prevention of mother-to-child transmission (PMTCT) and provision of antiretroviral therapies for the 58,000 people living with HIV in the country (Government of Lesotho, 2006).

In 2006 PMTCT services were only received by 5% of HIV positive mothers (UNAIDS 2007) as majority of primary health care facilities used by most women for antenatal care services do not provide PMTCT. Although ARVs have been available since 2001 in Lesotho, they remained the privilege of only a minority of the population who could afford treatment services provided by the private sector. In 2004 the government launched a free ARV programme leading to more than 8,000 members of society receiving treatment by the end of 2005 and, as shown in Table 1, to 22,000 in 2007 (WHO, 2008).

1.2 *Women and HIV*

About 57% of people living with HIV in Lesotho are women (WHO, 2008). The recent Demographic and Health Survey (Ministry of Health & Social Welfare, 2004) showed higher HIV prevalence rate among younger women aged 20 – 29 (about 38%) as compared to their male counterparts (18%). This is an indicator of women's vulnerability to HIV transmission which can be attributed to many factors including greater biological susceptibility. However, in Lesotho gender-related socio-cultural and economic inequalities as well as financial insecurity affect women negatively and may increase their vulnerability to HIV transmission (Physicians for Human Rights, 2007, Ministry of Health and Social Welfare, 2004). Gender, understood as the range of societal beliefs, norms,

customs and practices that define masculine and feminine qualities and behaviours in men and women in various spheres of life including sexual relationships is crucial in influencing individuals' exposure to HIV transmission (Mattheyse, 2007).

Due to gender norms young women are particularly vulnerable to HIV infection as they may lack communication and decision-making skills which could help them avoid HIV infection in their sexual relations (UNAIDS, 2005). This may be exacerbated by intergenerational sexual relationships and women's economic disempowerment. Women may also use sexual activity to access various resources which they need for themselves and their children. Indeed Cashdan (1996:1) emphasises the agency of women in their reproductive practices: "Because acquiring resources for her offspring is of paramount importance, a woman will try to attract wealthy, high-status men who are willing and able to help her". Therefore, high risk behaviour such as having sexual intercourse with a non-marital or non-cohabiting partner may not entirely be the result of women's lack of information or lack of power in their sexual relationships.

1.3 *Changing Livelihoods and HIV/AIDS*

Despite Lesotho's predominantly agrarian base, rural livelihoods in the 20th century became dependent upon remittances earned through men's migration to South African mines (Abbot, Lenka et al, 2005). This situation changed significantly in the 21st century because employment opportunities for men in the mining industry declined leading to massive retrenchments of male labour which could not be effectively absorbed in the domestic economy especially following the completion of labour intensive construction activities under the Lesotho Highlands Water Project (Phase 1A & B). Most women responded to declined incomes by migrating to the urban centres to work in the informal sector, as domestic helpers but mainly as workers in the garment industries in Maseru. The textile industry is therefore the largest employment sector for

women. However it is realised by various stakeholders including government and the private sector (Association of Lesotho Employers or ALE) that HIV and AIDS are serious threats to production in the sector (Ruscombe-King, 2008). For example, it has been estimated that more than one third of the 45 000 mainly women Basotho workers in the garment industry (44% of females) and about 35.6% employees are infected with HIV and that more than 2000 workers in the industry are killed by AIDS annually (ALAFA, 2006; UNAIDS, 2008). Women's migration to urban areas is certainly contributing to family welfare through food security but without adequate services, it has also contributed to high HIV infections in the country.

1.4 DESCRIPTION OF THE PEER EDUCATION INTERVENTION IN LESOTHO

The Private Sector Coalition against AIDS in Lesotho (PSCAAL) was implemented in 2002 and operated until 2005. It was managed by CARE Lesotho and entailed collaboration between the Association of Lesotho Employers (ALE), Sechaba Consultants, The Employment Bureau for Africa (TEBA) and the International Organisation for Migration (IOM). The main goal of the initiative was to facilitate a partnership among private sector companies in the fight against HIV/AIDS in Lesotho. Various companies in the garment sector formed part of the sites where PSCAAL activities, particularly peer education and mobile voluntary counselling and testing clinic for HIV were conducted by CARE.

PSCAAL activities included peer education for the workforce in the private sector in Lesotho. The intention was mainly to raise awareness and increase demand for services which would help workers infected and affected by HIV and AIDS to cope. It involved training workers to conduct peer education and

provide peer counselling to fellow workers in order to influence behaviour change. The programme also facilitated provision of care and support through formation of support groups to encourage workers to talk about HIV and AIDS.

Of relevance to this study also was the HIV voluntary counselling and testing (VCT) components of the programmes in the form of mobile services at the workplace. The initiative also included a resource centre away from the factories where workers could access information and VCT services. CARE mobilized workers to undertake confidential HIV testing and collaborated with the Population Services International (PSI) to provide VCT services to the garment industry workers. The third component entailed CARE training in workplace HIV and AIDS policies which would assist companies to institutionalise their response to HIV.

Given its activities, especially peer education and promotion of VCT at the workplace, it was assumed that regular training and exposure to the programme activities would lead to “a shift from risk behaviours contributing to HIV/AIDS towards risk-avoiding strategies in the workforce” (Hanisch, 2006: p.4). Also, the programme aimed to educate and encourage the workforce to undertake HIV testing and to know their status. Katzenstein, MacFarland, et al. (1998) in a study among factory workers in Zimbabwe documented evidence on the effectiveness of a workplace intervention programme which included HIV counselling and testing as well as peer education. Various studies found that workplace intervention programmes significantly reduced HIV incidence among workers as compared to interventions which entailed HIV counselling and testing only.

Notwithstanding the lack of an explicit statement of empowerment as the goal of PSCAAL, the study was guided by an assumption that the intervention was designed to bring about empowerment and hence behaviour changes among the garment industry workers.

Concept of “Empowerment”

Empowerment of people is a goal in development work. It is viewed as a multi-dimensional social process that enables people in relationships with others gain control over their own lives by acting on issues that they consider as important through sharing in decision making and negotiation (Linhorst, 2005; Page & Czuba, 1999). The concept assumes that actors who are empowered develop a stronger sense of personal control or influence which gives them competence and influence in daily life as they pursue their aspirations and goals in their environments. Empowered actors become partners with external agencies to bring about personal change but they promote their concerns and can influence others to act in ways in which they would not ordinarily behave. Empowerment would entail an actor embracing new ways, having a capacity to influence ways in which others think and encourage actions and outcomes which are consistent with the desired change (Adamson & Bromiley, 2008). In this sense empowerment in the context of HIV risk reduction would lead to workers developing skills and capacity which helped them develop awareness about their vulnerability and shift from risk behaviours contributing to HIV transmission. Confidence and effective communication strategies in sexual relationships in ways that influence others to adopt low risk practices are crucial outcomes of such personal change. In addition, empowerment would enable the workers to influence workplace HIV and AIDS policy including how to access appropriate care and treatment services. It could also be possible that the benefits of empowerment would be easily noticed where peer educators and recipients of peer education were acknowledged by their peers and partners as possessing risk avoiding skills. Furthermore, with the rapidly changing care and treatment environment, empowerment would be associated with the workers’ agency to use HIV and AIDS care services.

1.5 THE ROLE OF INTER-AGENCY PARTNERSHIPS

CARE-Lesotho South Africa observed as one of its key lessons in combating HIV/AIDS that partnerships were essential to achieving HIV/AIDS mainstreaming (Abbot, Lenka, Lerotholi, Mahao & Mokhamaleli, 2005). The Livelihoods Recovery through Agricultural Production (LRAP) entailed collaboration with other agencies – the Ministry of Agriculture and Food Security and civil society organizations and had various benefits including increased funding opportunities, enhanced capacity for service delivery and mobilizing communities. Although PSCAAL also involved partnerships within the business sector, it would seem other key partners who could have provided essential support in the peer education programme, for example, the health service providers within the civil society and public sectors were not part of the initiative.

1.6 RESEARCH QUESTIONS

As with other participating countries in the ‘Gender, Sex and Power’ project, the study addressed the following global research questions which were used to build the comparative analysis across the six research sites, namely:

- How is the intervention related to empowerment?
- How is the intervention related to HIV risk?
- How is empowerment related to HIV risk?

In particular, the Lesotho study sought to understand if there were differences between women who were trained under PSCAAL as peer educators and women who participated in peer education at the workplace and those who did not participate in peer education with respect to the following:

- Their perceptions of HIV risk factors and vulnerabilities as garment industry workers.

- Their perception of empowerment with respect to sexual and reproductive health, especially HIV prevention in their sexual relationships.
- Their level of agency in preventing HIV infection and transmission and seeking services for HIV and AIDS care.

This inquiry also addressed the following three local research questions:

1. What is the nature of vulnerabilities that women face which expose them to HIV risk?
2. What is the women's notion of "empowerment" and did the PSCAAL programme empower women? If so, in what ways?
3. What kind of critical decisions related to HIV infection or prevention can different categories of women, particularly those who were trained as peer educators during PSCAAL and those who were exposed to peer education by the trained peers on the one hand; vis-à-vis those women who did not take part in peer education on the other, make in their sexual relationships?
4. What are the opportunities which CARE could have lost through their previous programming?

1.7 CONCEPTUAL FRAMEWORK

The cultural and traditional practices of the Basotho are deeply patriarchal and most decision-making is done through male-dominated structures. There are several cultural practices and norms that render women subordinate to men and some of these practices are drivers of HIV infection. Customarily, women have been considered perpetual legal minors and did not have a say in decision making irrespective of their age and marital status (Makoa, 1997). The Government of Lesotho has been responsive to the different international and regional declarations and commitments on gender equality even though implementation has been slow. For example, Lesotho ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1995 subsequent to which various legislative measures, policy and institutional frameworks to protect women's rights were adopted and implemented. Lesotho is also a signatory to the SADC Addendum on the Prevention and Eradication of

Violence against Women and Children. Following the review of the laws in conflict with the Constitution including those laws that discriminate against women in 1997, only ten years later (2006) did the Parliament of Lesotho enact a law ending the minority status of married women, which is indeed a key milestone in gender equality advocacy. The Sexual Offences Act 2002 has also been enacted while the Domestic Violence Bill is still to be transformed into law.

Prior to these reforms, married women in Lesotho were denied the right to sign legal documents or own property without the consent of their husbands. Laws and customs which tend to discriminate against women will continue to influence relationships between men and women especially in the rural areas unless there are efforts to provide communities with the necessary information about such legal reforms. This is important considering that the common-law principle of marital power which reduced women to minors and gave husbands control over women was entrenched in various institutions in society.

Gender relations and the economic dependence of most women on men are recognized as important in the transmission of HIV through heterosexual contact (Bond and Dover, 1997). Women's poverty and social inequalities between men and women in the family and at work are considered to be the main reasons for women's exposure to the risk of HIV infection (Zierler and Krieger, 1997; Freudenthal, 2001), leading to the 'feminization' of the HIV/AIDS epidemic.

Other studies in sub-Saharan Africa countries with similarly high HIV prevalence as Lesotho show that holding gender discriminatory beliefs and lack of control in sexual decision making were associated with risk behaviour which increased vulnerability to HIV, such as multiple sexual partners and having unprotected sex (Physicians for Human Rights, 2007).

Power relations between men and women may also be expressed through sexual violence mostly against women and this includes rape. In some countries between 20 and 48 percent of young women aged 10-25 years have experienced forced sex (Global Coalition of Women and AIDS). Women's exposure to sexual violence increases their susceptibility to HIV infection and is a matter of concern globally.

1.8 PRACTICAL CONSIDERATIONS AND CONSTRAINTS

Guided by the universal logic of peer education (PE) at the workplace in the context of HIV and AIDS, the study explored how PSCAAL could have empowered women workers and how such empowerment influenced their vulnerability to HIV infection with the view to make recommendation to CARE to strengthen current and future work. Studies evaluating the impact of PE on various outcomes among workplace populations suggest that this strategy could improve knowledge, attitudes and practices in ways that reduce the risk of HIV infection (Bessett, 1998; Hope, 2003) as well as improving the confidence of women in relation to condom use (Norr, Norr, McElmurray, Tlou & Moeti, 2004).

For this study, the three domains in which change was expected to have occurred were in relation to the women's agency and skills which enabled them to negotiate their needs, safeguard their interests and rights within relationships (e.g. social relationships – familial, sexual, labour and care relationships); within the larger structural aspects of society and norms at workplace and in the family.

1.9 DESCRIPTION OF KEY CONCEPTS

Agency – refers to the capacity of individual humans to act independently and to make their own free choices.

Structure – refers to those factors such as social class, religion, gender, ethnicity, cultural norms and customs which may constrain or influence the opportunities that individuals have.

Gender – the range of societal beliefs, norms, customs and practices that define masculine and feminine qualities and behaviours in men and women.

Peer education – has become one of the most widely adopted strategies to prevent the spread of the HIV/AIDS epidemic. The primary goal of peer education is to effect change by training and supporting members of a particular group to bring about changes in knowledge, attitudes, beliefs, and behaviours through information sharing.

Empowerment – is considered the outcome of education which is based on participatory approaches and is intended to influence the response of groups assumed to be powerless to the social and economic risk factors that affect the health conditions, in this case, risk to HIV infection.

Participation – participation means exposure to peer education programmes (PEP) irrespective of whether they were facilitated by PSCAAL or ALAFA.

2.0 METHODOLOGY

2.1 RESEARCH DESIGN

CARE Lesotho staff identified two factories in Maseru that had participated in the PSCAAL programme at different stages. The factories were selected on the basis of the size of the work force and were those which were characterized as large factories (more than 2500 workers), their level of participation in PSCAAL and eventually the willingness of management to allow the interviews to take place on the premises.

Two hundred and eight interviews were conducted with a sample of workers who were selected using a non-probability sampling method from the two factories. Convenience sampling was used to select workers who were available and agreed to be interviewed during their lunch break and immediately after work in the evenings. It was considered that given the time limitations for the study, it would be challenging to obtain comprehensive sampling frames from management and peer educators to generate a representative sample for purposes of random sampling. The efficiency of random sampling would also be undermined by non-response because workers faced time pressure at work as they might use lunch breaks to meet production targets and eat. Therefore, the workers' participation was voluntary and it depended on their availability.

2.2 DATA COLLECTION

Quantitative data was collected using a semi-structured interview schedule. The interview schedule covered background demographic and socioeconomic information, HIV awareness and testing, decision-making in sexual relationships, gender equality beliefs, sense of self efficacy and community. Interviews were

conducted in Sesotho and responses recorded in questionnaires ready for data entry. Qualitative data was collected using focus group (FG) discussions with women who participated in the peer education programme and those who did not; in-depth interviews were conducted with key informants.

All interviews and focus group discussions with workers and key informants took place on their work premises. Interviews with workers took place during lunch hour and for one hour after the women finished work in the evenings. Each interviewer handled only one interview in one hour, and focus group discussions were also approximately one hour long.

Constituting two groups of workers who participated in peer education, that is both peer educators who were trained in peer education and the workers who participated in peer education activities, was a challenge. There were only a few of peer educators in both factories who were trained under PSCAAL (7 in all). It was assumed that attrition of this group was due to mobility between factories while some could have left factory jobs for different reasons.

In both factories, current personnel officers who were selected as key informants had also been PSCAAL peer educators. Some of the peer educators in one of the factories who had promised to participate changed their minds at a later stage. Consequently, in one of the factories we did not conduct a focus group discussion with peer educators; instead we interviewed a member of the peer education group as a key informant. Other key informants included service providers who worked with CARE during the time of PSCAAL (PSI/New Start); human resource managers of the studied factories, personnel officers responsible for connecting the workers with management and who were also HIV and AIDS focal persons at the workplace and a health care provider who worked in an onsite clinic in one of the factories which currently has a clinic on-site and where PSCAAL had peer education activities.

2.3 RECRUITMENT STRATEGY

Following introduction of the project to the management and initial contact with the women who were trained under PSCAAL and ALAFA as peer educators, the research team embarked on workers' mobilisation and peer educators were also requested to encourage other workers' participation in the study. This strategy attracted many workers who were willing to participate in one-to-one interviews during their lunch breaks as well as after work in the evenings. The women were individually recruited by the interviewers on the premises during the lunch breaks on the basis of their availability.

There were more women who were available for one-on-one interviews and had participated in either of the two peer education programmes than those who had not participated in peer education. The reasons for low participation in the study, however, included lack of time as the sessions took place during lunch hour – the time which workers used to make up for their unmet daily targets and also for eating and relaxing. Reluctance on the part of women who had not been exposed to HIV and AIDS peer education could be their unwillingness to participate in AIDS-related activities as some support group¹ members suggested.

For focus groups, the team described the different categories of workers who they needed for interviewing and sought the assistance of the peer educators in constituting the groups. The categories were described as: 1) those women who were trained as peer educators, 2) those who participated in peer education sessions and 3) those who did not take part in peer education.

¹ Some of the women interviewed disclosed that they members of a support group of people living with HIV. There were no deliberate efforts to interview support group members as a group.

2.4 DATA ANALYSIS

Analysis of quantitative data was done using SPSS (Version 16). Guided by the research questions and goal of the study, the analysis provided characterization of the studied sample in terms of the following domains: socio-economic and household characteristics, work and finances; HIV and AIDS awareness; testing and access to care; stigma and discrimination; decision making in sexual relationships; gender equality beliefs and norms; gender violence; self efficacy and sense of community. Univariate analysis was mainly used to show patterns in the data. Bivariate analyses were carried out to determine associations between the independent variable (participation in the PEP) and selected dependent variables within the specified domains. This was intended to delineate the pathways and relationships between empowerment and HIV risk. Qualitative data from different sources was analysed thematically using the local and global research questions as the framework.

2.5 LIMITATIONS

The major limitation of the study is related to the fact that it was not clearly specified in PSCAAL project documents as to what domains would be monitored to determine the impact of the programme and empowerment was not an explicit project goal. This aspect also means that observed associations between level of participation in peer education and other workers' attributes have to be interpreted cautiously as there were no baseline measures to compare against.

In addition, the study was asking participants to recall events and experiences which could easily have been affected by several rapid developments which have taken place in the HIV and AIDS environment in Lesotho since PSCAAL and after the programme was phased out. The differences between participants and non-participants may be the effect of other environmental changes, therefore establishing the significance of the differences is important.

The conclusions regarding the impact of peer education need to be interpreted carefully. It was impossible to measure the extent to which the intensity of involvement in peer education along the crude scale of “observing”, “participated rarely”, “frequently” made any difference in terms of behaviour outcomes. This was because of a small sample and limited number of respondents across the different categories of participation.

Finally, findings from the analysis may not be generalized to other populations similar to the studied workers because the sample was not selected using probability strategies.

2.6 VALIDATION, TRIANGULATION, SYNTHESIS PROCESSES

Contrary to the proposed global approach in which definitions of concepts such as vulnerability and empowerment had to emerge from focus groups prior to administering the interview schedule, the process was reversed as it became easier to mobilize workers for one-to-one interviews than focus groups. Triangulation was pursued by following up in focus groups and key informant interviews issues which workers raised in one-to-one interviews. For example, questions about HIV risk and access to treatment for people living with HIV and a range of factors which could influence access were pursued with different sources. Overall, the approach did not compromise the quality of data as participants' definitions of the key concepts in the framework were broader but similar to those which guided one-to-one semi-structured questions.

The synthesis provides findings on the basis of all the sources of data for each research question and domain of analysis.

2.7 ETHICAL ISSUES

The study was conducted among some of the disempowered and vulnerable populations in Lesotho. The degree of job insecurity and power relations between foreign employers and local workers form part of the environment within which workers negotiate their rights and wellbeing. We approached the workers with sensitivity and wanted to understand their perspectives. Participation in the study was voluntary. However to enable women to take part free transport was arranged for those who remained to be interviewed after working hours.

During interviews, some women disclosed their HIV status to the interviewers even though they were not asked to do so. It appeared that in most cases this was the first disclosure which led to overwhelming emotions. In anticipation that the

research subjects could suffer discomfort as a result of interviews, CARE had arranged counselling sessions with professionals and paid the fees.

2.8 PROJECT MANAGEMENT

The research team was led by researchers from the Human Sciences Research Council. The project was coordinated by CARE Lesotho staff who also managed the day-to-day data collection. Research questions, interview schedules and topics which were discussed in focus groups and with key informants were developed in consultation with CARE staff members. Data was collected by two field assistants and three CARE members of staff. Two day training on data collection tools was conducted for the interviewers. This was followed by piloting of the focus group discussion guide and semi-structured interview schedule. Data collection took approximately six weeks to complete.

3.0 FINDINGS

This study sought to establish whether intervention programmes which involved HIV counselling and testing as well as peer education in the workplace could contribute towards reducing HIV incidence among workers by helping programme participants to adopt practices which reduced the risk of HIV infection. This section discusses the findings of the study according to the global and local research questions which guided the inquiry.

3.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS

A total of 186 factory workers were successfully interviewed through the semi-structured questionnaire, thus yielding 89% response rate. Of these 126 (67.7%) had participated in the peer education programme (PEP) and assumed different roles – peer educators, peer counselors, trainer of trainers, trainees, and support group members; while the remaining 60 (32.3%) had not. Only 10 (7.9%) of the respondents who had participated in the PEP reported that they did so as peer educators trained under PSCAAL and the new initiative - ALAFA. Therefore, the initial idea to categorise the respondents into three groups (peer educators, programme participants, and non-participants) was abandoned as the number of peer educators was deemed too small to produce any statistically meaningful results as a separate category. The respondents were therefore categorized into only two groups: participants and non-participants, with the peer educators treated as participants.

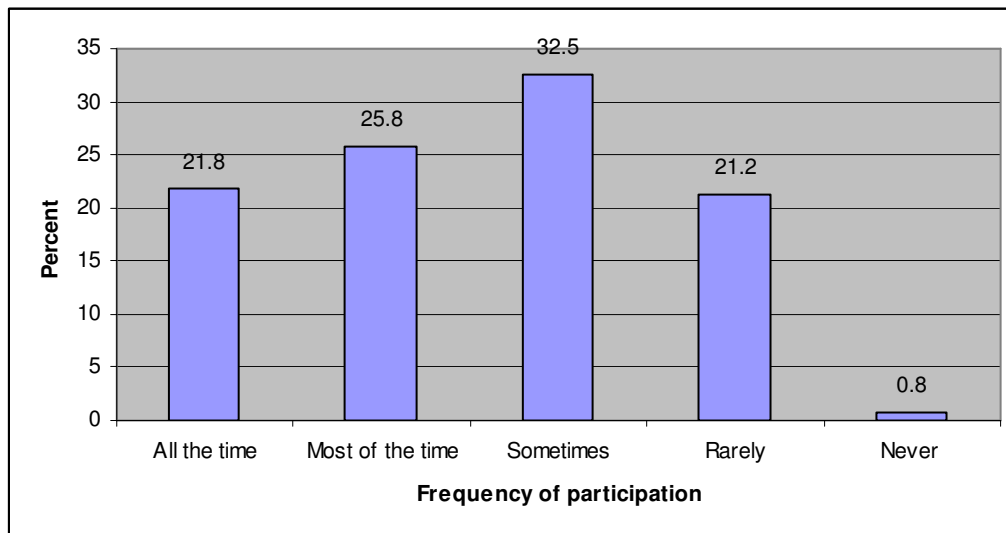
Table 2 below presents basic demographic characteristics of the sample categorized by participation in the PEP. Overall, majority of the women interviewed were middle-aged (in the 26-29 age group) and had secondary school education. Over one third (36.7% and 35%) were married, and never married respectively. Majority of the women worked as skilled workers in the factories and earned, on average, less than M800 per month.

Table 2: Percentage distribution of sample by selected background characteristics

Characteristic	Participants	Non-Participants
Age Group (years)		
18-25	15.1	20.0
26-29	31.0	28.3
30-34	25.4	23.3
35-39	20.6	15.0
40+	7.9	13.3
Highest Education		
Never attended school	0.8	1.7
Primary school	37.3	36.7
Secondary school	35.7	46.7
High school	23.8	13.3
Post-high school	2.4	1.7
Marital Status		
Never married	20.6	35.0
Married	51.6	36.7
Divorced/Separated/Deserted	15.1	15.0
Widowed	12.7	13.3
Position in Factory		
Skilled Worker	52.8	48.3
Administrator/receptionist /personnel	1.6	1.7
Unskilled worker	39.0	43.3
Supervisor	6.5	6.7
Monthly Wage		
Less than M800	82.4	73.3
M800-M1200	16.8	26.7
More than M1200	0.8	0.0
Total (%)	100	100
(N)	126	60

Of the 126 workers who participated in the programme, 7.1% did so as peer educators, 42.1% as trainees, 46.0% as observers and 4.8% as support group members. When asked about the frequency of their participation in the PEP, the pattern shown in Figure 1 below emerged.

Figure 1: Frequency of participation in PEP by female workers



3.2 NATURE OF WOMEN'S VULNERABILITY TO HIV INFECTION

In the context of HIV risk can be defined as the probability that a person may acquire infection (Wood et al, 2006) and, as stated earlier, in generalized epidemics such as Lesotho, the risk is perpetuated by behaviours such as having multiple unprotected sexual partnerships, and having unprotected sex with an infected partner or whose status is not known and (UNAIDS, 1998; Wood et al, 2006). According to UNAIDS, such behaviours may be influenced by an individual's inability to negotiate safe sex, low risk perception, or inaccessibility of condoms and other HIV services.

There is also a growing realisation of the key role that power relationships and social inequities play in influencing risk. Overarching the concept of risk is therefore the broader paradigm of vulnerability (UNAIDS, 1998). Among the broader forces structuring women's vulnerability are inequities of gender, sexuality, poverty and social exclusion. Using Parker et al's (2000) framework, the factors that increase the factory workers' vulnerability to HIV infection can be

grouped into three analytically distinct but interconnected categories: (1) economic factors; (2) migration; and (3) gender inequalities.

Economic factors

As shown in Table 2, the majority of women are in the lower-paid strata where they earn less than M800 per month. Further analysis of the data showed that for 81.4% of the women, this income was insufficient to meet their current needs, and many women mentioned that they experienced chronic shortfalls in their monthly budget because of the low wages. In addition to the fact that most of the women had no others sources of income and/or savings (Table 2), this economic difficulties are further aggravated by the women's responsibilities. For example 81.6% have at least one child, 76.7% had three or more dependents, and 66.6% stay in rented accommodation. Table 3 further shows that the women are also responsible for most of the purchases made for their households.

Table 3: Percentage distribution of sample by selected socioeconomic indicators

Characteristic	%
Number of children	
0	18.4
1	35.1
2	27.0
3+	19.5
Number of dependents	
0	2.2
1	8.6
2	12.4
3	20.0
4	20.5
5	13.5
6+	22.7
Type of accommodation	
Own house	19.9
Rented house/backyard	66.6
Parent's house	9.7
Cohabiting	0.5
Relative's house	1.6
Other	1.6
Main responsibility in household	
Food	96.7
Clothing	75.5
Rent	59.8
Health care	35.9
Transport	41.3
School fees	58.2
Insurance/Funeral policy	39.1
Total (%)	100
(N)	186

A compelling body of evidence has shown that women living in poverty, or facing the threat of poverty, may be particularly vulnerable to sexual exploitation through the need to trade or sell sex, or to engage in multiple concurrent relationships, in order to survive (Epstein, 2007). Indeed some women entered into relationships with the expectation that men would augment their budgets:

“We earn very little money here, this is what makes us easy prey and exposed to HIV infection. For example, if a man tells you he will drive on Mpilo Boulevard (an expression used to describe unprotected sex), just because you are at the mercy of this person, you agree to have unsafe sex in expectation that he will not withhold his money or other favours” (FG1- non peer education participants)

“There’s even a common saying that if a man visits his girlfriend, especially those who work in the factories, he should use a braai pack to (frozen chicken portions) to knock on the girlfriend’s door. This compromised many women’s life because they could not refuse to have unprotected sex for fear that the boyfriend would leave. But our education and encouragement have changed a lot of women’s attitudes and views” (Peer educator)

In fact, the expectation that a man should contribute to their lover’s wellbeing also influenced short-term relationships. In focus group discussions, women were depicted as constantly in search of men who were prepared to assist them financially. Such men were powerful in relationships; they cohabited with their lovers and determined the use of a condom – usually insisting on non-use of a condom if they supported women materially. These factors exacerbate women’s vulnerability by increasing their economic dependence on men who contributed to their living expenses.

Key informant interviews and focus group discussions also confirmed that multiple sex partners were a common phenomenon among female workers in the garment factories. Furthermore, participants in a focus group discussion categorized some of the sexual relationships prevalent among their peers as transactional. For example:

“There are all sorts of relationships going on in the factories; others involve money, sex, gifts and different kinds of favours. A woman can have as many boyfriends as possible

and each would have a duty to perform like buying groceries, clothes, providing transport or paying rent, etc.” (FG1 non peer education participants)

Women’s vulnerability is also exacerbated because most of them had sexual relationships with men who have similar risk factors. For example, men who worked in the taxi industry, in the army, police and migrant mine, due to their mobility are likely to have concurrent sexual relationships.

“Women mainly see policemen, soldiers and taxi drivers with the expectation that police and army men earn a lot of money and they are promiscuous. Taxi drivers are simply favoured because they provide lift to and from work. The problem is that if these men refuse to use condoms, there is nothing the women can do; they cannot refuse them sex because they have received material support from them... but the women here are also promiscuous” (Focus Group 2)

The study also showed that the women’s low wages and the need to work overtime indirectly increased their risk of being raped. In both focus groups of non-peer education participants, women showed that it was common in their communities to be raped by strangers within their homes and in public spaces. The need to travel early while it was still dark and quite especially during the winter months particularly increased the risk. Women in one focus group also felt that line managers coerced or manipulated them to work overtime in the evenings. They complied despite knowing that by staying till late they risked being raped.

“In the morning when you go out to empty your washing basin after bathing, when you enter your room, you find there a man on your bed ready to rape you”(FG1 non peer education participants).

“These wicked men have found dark spots along the paths we travel in the evening, and they wait there to rape us” (FG1 non peer education participants).

“Because of the little money we earn, most of the time we stay behind and work overtime. This is dangerous because when we finish at 6:00pm we are raped, especially in winter” (FG2 non peer education participants).

Migration

Although the causation patterns behind the population mobility/HIV connection are complex, it is shown that migration can create situations that increase people’s vulnerability and risks (Brummer, 2002; Santis et al, 2007). The most commonly cited post-migration characteristic is separation from a regular partner and family. This view posits that a new social environment can result in a lack of social support which, in turn, can be linked to risk-taking behaviour (Campbell, 2001). Another view is that by leaving their homes, migrants also leave their familiar environment with traditional norms and values and the anonymity of being a foreigner can increase risky sexual activities (Decosas et al, 1995; Girdker-Brown, 1998).

Against this background, the factory workers’ vulnerability to HIV infection is also increased by their migration status. 58.9% of the women had changed their residence to take up their current job and 29% were from places outside the Maseru urban area while 42.1% were from other districts. Twenty-nine percent reported that their home was within the Maseru urban area.

Unaccompanied migration of women particularly presented HIV risk because some women were involved in concurrent relationships yet other unsafe sexual practices such as inconsistent use of condoms were also common.

The women in focus groups categorized the common forms of dating relationships between men and women in the garment industries as follows:

- Women who were involved in casual relationships with married men
- Young women who got into relationships which eventually led to marriage
- Men and women who were seeing each other for sex only – *“ho itlosa bolutu”*
- Women and men who exchanged sex for material support (payment of accommodation expenses, children’s education, food and transport costs).

Gender inequality

As discussed earlier, unequal gender relations mean that women have little control over how, when and where sex takes place. Thus gender inequality exposed the women to the risk of sexually transmitted infections, including HIV. In particular, women are unlikely to be able to communicate their need for safer sex with partners and lack the ability to refuse unsafe sex. This situation was exacerbated by their economic status which influenced them to preserve marriage and relationships in the hope of continued material support.

One of the recurring themes was respect for husbands which, if not observed, could lead to women losing some of the attributes fundamental to their identity and self esteem – being respectful wives and not facing criticism from extended family members. Showing lack of respect included disregarding men's preferences in sexual relationships, unwillingness to respond positively to men's demands in sexual relationships or displaying knowledge about sexual matters because these were contrary to cultural values. Such behaviour could lead to physical abuse, loss of privileges such as financial support, which could affect their children negatively, or lead to women being abandoned. Fear of losing support was among the key factors which influenced women to display behaviours which were inconsistent with their knowledge about how HIV could be transmitted.

Interestingly, the participants' notions of respect for their partners did not include their own fidelity while they were away from their husbands. Infidelity and concurrent or serial multiple sexual partners among married and single workers were identified as a norm in these settings. Women were undoubtedly aware that practising safer sex by using condoms consistently prevented HIV transmission but non-use of condoms was considered a widespread practice. Condoms were perceived as an important factor which could impede women's access to material support by male partners or impact on stability in their

marriage and other sexual relationships. It was also alleged that there was a tendency among some men to use material support as bait to access unprotected sex. Consequently, most women did not use condoms consistently in their sexual relationships and the behaviour affected their health negatively.

“We don’t use condoms; that is why there are a lot of unwanted pregnancies, STIs and HIV/AIDS. More often, when a man dies of AIDS, the wife also follows and the girlfriends too” (FG2 -non peer education).

3.3 Perceived Meaning of Empowerment

A major breakthrough for PSCAAL was the introduction of HIV and AIDS programme to the management of the garment companies. This is critical because there is a common perception that power differentials between the employers and local employees lead to difficult relationships between them. There are important developments which have since happened in the factories and were linked to PSCAAL activities:

- Peer educators and support groups for people living with HIV were formed as new structures among employees
- Peer education could be provided on the factory premises at lunch breaks
- Personnel officers and supervisors were encouraged to interact with workers about HIV and AIDS issues and disclosure was encouraged and invariably, workers who disclosed their HIV status benefited (see Work-related benefits below) even though there was no policy which institutionalised practices in response to the epidemic.

Peer educators’ views on empowerment

According to a PSCAAL peer educator who was interviewed as a key informant, an empowered woman is:

“ a woman who knows her HIV status and a woman who stands up for what she believes in, a woman who is assertive and knows what she wants in life” (KI 2).

For peer educators who participated in a focus group discussion, empowered women made decisions and acted in ways which did not suggest they were smarter than their partners but took responsibility in their relationships and used information they had to persuade their partners to change.

“I describe her as a woman who is able to ask firmly but with respect that a condom should be used”

“Since men can listen, it is a woman who is able to teach her husband”

“It is a woman who cares about her own health and that of her partner”

“An empowered woman looks after her family, respects her husband”.

“It is a woman who does not wash her linen in public, respects her husband and humbles herself and discusses issues with her husband”.

Peer educators considered the work which they did in relation to peer education at the workplace as empowering because it provided women with information which they could use to prevent HIV infection. The education also helped women who participated to develop interest in HIV and AIDS matters as well as to develop skills which helped them discuss these issues freely. The peer educators reported, for example that they had provided women with

information on the benefits of testing for HIV even before they fell ill. They believed that information enabled women to seek HIV testing because they realised the benefits and developed understanding. The educators realised that over time their colleagues developed trust in them and approached them for advice on matters which affected their wellbeing other than HIV and AIDS. They however realised the following challenges and limitations in their activities:

- Their role as peer educators had expanded and they became lay counsellors in the workplace. Such matters included financial problems and domestic violence which they handled even though they felt less equipped to deal with them. This showed that the workers' status among their peers was enhanced because of their knowledge.
- Women had problems in persuading their partners to go for testing. The main problem was that the peer education programme for HIV and AIDS was workplace-based and did not target work with men in the communities or households. The strategy relied on women to persuade their partners to avoid high risk behaviour and go for HIV testing. Interviewed peer educators mentioned that there were challenges when people tested for HIV individually and not as couples.

These aspects could have been systematically integrated into peer education to include various challenges which produced women's vulnerability to HIV infection. Holistic peer education in the context of HIV and AIDS should ideally incorporate sexual and reproductive health including information on the relationship between sexually transmitted infections and HIV, prevention of mother to child transmission (PMTCT) gender issues and communication skills in addition to HIV/AIDS information.

What participants understand by “empowerment” in the context of HIV

The question of how the participants themselves defined women’s empowerment was also explored. The participants articulated their perception of what empowerment entailed within the three spheres of decision making: the domestic sphere, protected sex and reproductive roles. Although the women perceived “empowerment” in different ways, their descriptions highlighted some core behavioural and attitudinal traits as well as emotional tendencies which distinguished empowered women from others who were not so empowered. For example, women in non-peer educators’ focus groups emphasized that:

- Empowered women consistently made decisions on the basis of the information they had pertaining to HIV and they stood their ground about acting in ways which helped them prevent HIV infection.

“It is a woman who makes the right choices in regard to her sexual relations, goes for voluntary testing and counselling and does not practise unprotected sex” (FG – non peer education participants)

“It is a woman who always practises protected sex no matter who the partner is, even her own husband might be untrustworthy... that is why one must always choose protected sex” (FG – non peer education participants)

- Empowered women displayed behaviour which they believed had long-term benefits with respect to their health and reproductive role and they strove to change men’s behaviour.

- Some participants also suggested that empowered women could always practise protected sex irrespective of their marital status or partner.

“Men agree to use condoms if women persuade them. Our major problem as women is that when a man negotiates unsafe sex when we sleep for the first time, we agree; in that way there will never be a time when he agrees to use the condom thereafter” (FG – non peer education participants).

*“A woman who makes her own decisions and stands by them no matter what”
(FG – non peer education participants)*

The view that empowered women could make choices and pursue lifestyles which protected them from HIV was interesting. This was despite most women acknowledging that men would not readily agree to use condoms; but women who insisted on the use of condoms in their sexual relationships succeeded in changing men in the long run.

3.4 HOW IS THE INTERVENTION RELATED TO HIV RISK?

The positive response of management in the two factories to HIV and AIDS awareness campaigns and VCT services provided to employees was understandable given that HIV and AIDS were acknowledged as serious threats in the sector. The workers also recognised their risk with regard to HIV and AIDS. The following were some of the dimensions of the perceived risk pertaining to HIV infection as obtained from the different sources of information:

(a) In focus group discussions,

- women reported a realistic perception of risk in terms of the behaviours which increased HIV infection, such as multiple sex partners and inconsistent use of condoms with sexual partners as widespread;
- women regarded their male partners as reckless in their sexual behaviours yet men disliked condoms and would not ordinarily use them;
- women perceived HIV and AIDS-related illnesses to be common among the workforce; and
- many women found it difficult to persuade their male sexual partners to use condoms even though they were aware of the risk involved in not using condoms.

(b) Similarly, key informants – personnel officers and health service providers – pointed out that:

- *Previous VCT campaigns which led to the workers' voluntarily testing for HIV showed that there was a high prevalence rate among those who tested;*
- *A high number of workers presented with sexually transmitted infections and re-infection with STIs was a common problem. Indeed, data from*

semi-structured interviews show that 14% of the respondents had used STI treatment services in the six months preceding the survey.

3.5 EVIDENCE OF EMPOWERMENT: CHANGES ATTRIBUTED TO

PEER EDUCATION

It was expected that change as a result of peer education and VCT would be indicated by a high number of women in the garment industry who showed the ability to apply the information obtained in ways which prevented HIV infection and self-reported behaviours which did not place them at the risk of HIV infection regardless of their socio-cultural and economic contexts. From the empowerment perspective, it was important to examine the extent to which the existing environmental factors such as availability of VCT services and ARVs had translated into behavioural changes which showed that the workers realistically perceived their risk to HIV infection and believed there were services to help them cope with the infection.

Knowledge about HIV and AIDS

Overall, women's knowledge about HIV and AIDS was high, with 99.2% of PEP participants stating that they had ever heard of HIV or AIDS. The corresponding figure for non-participants was 96.6%. Although the results were not statistically significant, peer educators perceived themselves as different from their counterparts. This was because they felt they had correct information and had developed a particular consciousness about HIV and AIDS. This consciousness helped them behave differently by avoiding risk behaviours and being proactive in obtaining care services and support. The following statements illustrate:

"I have helped a lot of people by encouraging them to do an HIV test and to accept their status, even when they are positive. We also encouraged them to put aside some money in order to start a small business" (KI - Peer educator)

“We have lists of many people who wish to test because after talking to them, they now have understanding about the infection...It is easy for us even to tell our partners that we went for HIV test because we talk about it in our families” (FGD- Peer educators)

In the same vein, a key informant who acknowledged that peer education had empowered her compared her behaviour before training and after as follows:

“I know my HIV status, and many colleagues approach me for advice and guidance. When I was a young woman new in marriage, we practised unsafe sex with my husband. We never used condoms since my husband hated condoms and I felt compelled to do what he wanted even though I knew it was unsafe. Now, I know better and I always insist on condom use... I know how to say ‘no’ and stand by my decision” (KI - Peer educator).

These distinct qualities of peer educators were also acknowledged by non-peer educators.

Uptake of HIV and AIDS services

An overwhelming majority (97.6% and 91.7 % of participants and non-participants respectively) were of the view that knowing ones HIV status was important. While this view was not statistically significant, the advanced reasons were significant, with those who had participated in the PEP more likely to state the advantages of HIV testing than non-participants (Table 4). However, the common motive for both PEP participants and non-participants was to enable self-care.

Table 4: Percentage distribution of sample by perceived importance of HIV testing, and PEP participation

Reason	Participants	Non-Participants
So that I can take care of myself	55.2	40.0
To avoid being infected	8.0	10.0
To avoid infecting sexual partners	7.2	3.3
So that I can live longer	8.8	6.7
Avoid mother-to-child transmission	3.2	3.3
Other	17.6	36.7
Total (%)	100	100
(N)	125	60

Note: $p < 0.05$

Some of the key informants were also of the view that the availability of ARVs in the public health sector led to more people going for HIV testing and following-up on their CD4 count. For example,

“There is increase in the uptake of HIV testing among the workforce; workers are interested in knowing their HIV status following their exposure to peer education. More people come early even before they fall ill. Also because things have changed in HIV care – rapid testing ensures they know their status immediately. They make follow-ups after testing HIV positive and they willingly seek CD4 count assessment” (KI- VCT service provider)

HIV testing

Despite the high level of importance that the respondents placed on HIV testing, less than half of them, had taken an HIV test in the six months preceding the survey. The low number of women who had taken an HIV test in the six months preceding the survey could probably be the effect of the limitation of the questionnaire question which did not anticipate the possibility of women who would have taken an HIV test earlier. Nevertheless, a nurse clinician interviewed also mentioned that it was not common for pregnant women who worked in garment factories to seek HIV testing. This situation has implications for the

PMTCT strategy given that most women were at child bearing age and at risk of HIV infection. It is noteworthy, however that among those who had taken the test, participants in the PEP were significantly ($p<0.000$) more likely to have tested than those who were not participants (40.5% and 15.0% respectively).

Knowledge of sources of HIV/AIDS Services

Women who had participated in the PEP were, in general, also significantly more likely to know where to obtain most of the essential HIV and AIDS services (Table 5). There were however no significant differences in the knowledge of the sources of health monitoring services for HIV/AIDS and, of medical treatment for opportunistic infections.

Table 5 Proportion of sample who know where to obtain essential HIV/AIDS information and services, by PEP participation

HIV/AIDS service	Participants	Non-Participants
1. Information on HIV and AIDS**	81.0	61.7
2. Condoms**	93.7	85.0
3. VCT services*	92.9	68.3
4. Health monitoring services for HIV and AIDS ^{NS}	79.4	65.0
5. Medical treatment for opportunistic infections ^{NS}	81.0	71.7
6. ARVs**	91.3	71.2
Total (N)	126	60

Note: *: $p<0.000$ ** $p<0.05$ NS: Not statistically significant

It was also deemed important to find out of those who knew about the availability of HIV/STI services actually used the services. The results, shown in Table 6 below shows that those who participated in the PEP were significantly more likely to have had tested for HIV or used an STI treatment centre in the six months preceding the survey.

Table 6 Proportion of sample who know at least one source of HIV/STI service and who utilized an HIV/STI service in the last six months by PEP participation

HIV/AIDS service	Participants	Non-Participants	Total
Tested for HIV**	90.7	9.3	43
Used STI services**	100.0	0.0	13
Used TB services ^{NS}	88.9	11.1	9

Note: ** p<0.05 NS: Not statistically significant

Further analysis of the data showed that majority of the women who used STI treatment went to a government hospital or clinic, as opposed to other service providers such as traditional doctor, private doctors, and others.

Attitudes towards HIV

In general there seemed to be a positive attitude towards HIV and AIDS among the workers interviewed. For example, over 70% agreed with the statement that HIV was a terminal illness (Table 7) as opposed, presumably, to being a 'death sentence'.

Table 7 Percentage of sample who agreed and disagreed with various indicators of attitudes to HIV and AIDS, and PEP participation

Indicators of attitudes to HIV and AIDS	Participants	Non-Participants
Strongly agreed/agreed		
HIV infection is a terminal illness ^{NS}	77.8	78.3
I would tell a fellow support group member if I tested HIV positive ^{NS}	71.0	74.6
I would tell a member of my family if I tested HIV positive	91.3	95.0
I can talk freely to others about HIV and AIDS	92.7	84.7
I can encourage my family member or close friend to test for HIV	93.6	93.3
Strongly disagreed/disagreed		
HIV/AIDS is punishment for bad behaviour ^{NS}	82.5	78.0
I would be ashamed if a family member/close friend had HIV/AIDS ^{NS}	86.5	86.7
People with HIV or AIDS should feel ashamed of themselves ^{**}	89.7	88.3
I would not tell anyone if I tested HIV positive ^{NS}	69.0	55.9
I would be worried to take ARVs in the presence of other people who don't know about my HIV status ^{NS}	71.8	60.0
Total (%)	100	100
N	126	60

Note: ** p<0.05

NS: Not statistically significant

Other indicators of positive attitudes include high proportion who stated their ability to talk to various people about HIV and AIDS, their willingness to inform family members in case of a positive test, as well as the relatively high proportions that disagreed, or strongly disagreed, with negative statements such as “HIV/AIDS is punishment for bad behaviour” and “people with HIV or AIDS should feel ashamed of themselves”, among others. Overall women who participated in the PEP were generally less likely to agree with negative statements. These results, were however, not statistically significant. In Table A1 shown in the Annex, the positive and negative attitudes are used as an indicator of stigma. The results show that the stigma did not have any significant effect on the use of HIV/STI services.

3.6 HOW EMPOWERMENT INFLUENCED WOMEN IN OTHER LIFE SPHERES

It was also deemed important to determine if the peer programme had an impact in the women's other spheres of life, particularly in sexual relationships, the domestic sphere and the workplace.

Decision-making in sexual relationships

Women who participated in the PEP were more likely than those who did not participate to be the final decision-makers regarding condom use in their sexual relations. They were also more likely to be confident in obtaining condoms without feeling embarrassed, to refuse to have sex with their partners without a condom, and to suggest an HIV test to their partners and others (Table 8).

Table 8 Percentage of sample by selected indicators of sexual decision-making, and PEP participation

Indicators	Participants	Non-Participants
Main decision-maker regarding condom use^{NS}		
Woman	52.2	41.5
Partner	15.2	12.2
It's a joint decision	32.6	46.3
Total (n)	92	41
Can refuse to have sex in not feeling well		
All/most of the time	71.3	65.9
Sometimes	14.9	22.7
Rarely/never	13.8	11.4
Total (n)	94	44
Likely reaction if partner refuses condom^{NS}		
Refuse to have sex with him	72.9	70.5
Persuade him to use condom	6.2	18.2
Surrender and have unprotected sex	20.8	11.4
Total (n)	96	44

Table 8 (Cont'd) Percentage of sample by selected indicators of sexual decision-making, and PEP participation		
Indicators	Participants	Non-Participants
Reasons for surrendering to unprotected sex^{NS}		
Partner will not give money/material support	10.8	14.3
Partner will use violence	50.0	14.3
Will risk losing partner	25.0	42.9
Wants to respect partner's desires	15.0	26.6
Total (n)	20	7
Feel confident discussing condom use^{NS}		
All/most of the time	79.5	79.0
Sometimes	11.5	15.8
Rarely/never	9.0	5.3
Total (n)	122	57
Can convince partner and others to use condoms^{NS}		
All/most of the time	72.6	75.5
Sometimes	12.0	19.3
Rarely/never	9.0	5.3
Total (n)	117	57
Can suggest an HIV test to partner and others^{NS}		
All/most of the time	82.6	75.0
Sometimes	8.3	8.9
Rarely/never	9.1	16.1
Total (n)	121	56
Note: Some totals do not add to 186 due to missing values. Missing values could be individuals who used a condom all the time they had sex; those who were not in a relationship or were not sexually active		
NS: Not statistically significant		

The fact that a quarter of the respondents also feared the risk of losing their partners if they refused sex further illustrated the prevailing dependency of the women on men for financial and material support. The same could be said of the non-participants, whose main reason for surrendering to unprotected sex was the fear of losing their partners.

The PEP participants were, however, less likely to persuade their partners to use a condom and less likely to surrender and agree to have sex without a condom. These results are statistically significant (Table A2) and they could also be a reflection of the entrenched gender roles where married women (who, as seen in

Table 2, make up the majority of those who participated) may feel obliged to have sex with their spouses.

With regards to negotiation in, and communication about, sexual matters, Tables A3 and A4 show that PEP participants who felt confident discussing condoms use with their partners were, in the six months prior to the survey, significantly more likely than non-participants to have engaged in protective behaviours such as always using condoms and testing for HIV.

Decision-making in the domestic sphere

Except for sending children to school there was no significant difference between women who went through the peer education programme and their counterparts who did not, in terms of decision making in the domestic sphere, (Table 9)

Table 9 Proportion of sample who made decisions regarding various household issues, by PEP participation

Indicators	Participants	Non-Participants
Large household purchases ^{NS}	52.8	52.5
Daily needs ^{NS}	81.6	66.7
Sending children to school ^{NS*}	55.7	52.7
Having children ^{**}	46.4	68.4
Spending money ^{NS}	67.7	69.5
Total (n)	125	60

Note: *The N for this variable 115 for participants and 50 for non participants because not all women had children or school going children

** p<0.05

NS: Not statistically significant

As Table 10 below shows, there was also no evidence that the peer education programme significantly influenced its participants' general sense of self-efficacy.

Table 10 Percentage of sample by selected indicators of self efficacy and PEP participation

Indicators	Participants	Non-Participants
Can solve problems if tries hard enough^{NS}		
All/most of the time	46.8	49.2
Sometimes	41.1	42.4
Rarely/never	12.1	8.5
<i>Total (n)</i>	124	59
Can always influence husband/partner's decision^{NS}		
All/most of the time	59.8	58.5
Sometimes	30.4	32.1
Rarely/never	9.8	9.5
<i>Total (n)</i>	112	53
Can influence important decisions in community^{NS}		
All/most of the time	25.6	11.9
Sometimes	9.9	13.6
Rarely/never	64.5	74.6
<i>Total (n)</i>	121	38

Note: NS: Not statistically significant

Gender norms and beliefs

Did the PEP have any impact on the women's gender beliefs and norms? To find out, all women were asked whether they agreed or disagreed with a number of statements. The overall pattern that emerged (Table 11) indicates that the skills the women learned in the peer education programme do not seem to have trickled down to the traditionally entrenched beliefs.

Table 11 Percentage of women who agreed or strongly agreed with various indicators of gender beliefs and norms by PEP participation

Indicators of gender beliefs and norms	Participants	Non-Participants
It is more important for a women to respect her spouse/partner than vice versa ^{NS}	39.2	46.7
A man may beat his spouse/partner if he believes she disrespects him**	4.8	13.3
A man may beat his spouse/partner if he believes she is having an affair ^{NS}	9.6	18.4
Man and women have equal responsibility to decide on condom use in their relationship**	94.3	84.2
Women have the same rights as men to study/work outside the home ^{NS}	83.6	83.4
A woman may tolerate violence in order to maintain stability in the household**	13.7	5.1
Women can be as good leaders at the workplace as men can ^{NS}	80.8	79.6
	88.0	91.7
Women should be able to own and control land and property ^{NS}	85.6	74.6
Community leaders must listen to women's opinions before making important decisions ^{NS}		
Total (%)	100	100
N	126	60

Note: ** p<0.05 NS: Not statistically significant

Gender-based violence

There is very little evidence of gender based violence from the survey data. Over 80% of the women interviewed, had not experienced any type of gender-based violence from their partners in the six months prior to the survey (Table 12). This observation is in contrast with the earlier discussion of women's vulnerability to rape by strangers which could also be attributed to their fear and perception of unsafe spaces more than incidence of rape, especially at personal level.

Table 12 Percentage distribution of sample by experience of gender-based violence from their partners in last six months

Gender-based violence	Participants	Non-Participants
Slapped/beaten/threatened with weapon	2.4	6.7
Sexually assaulted	0.8	0.0
Verbally assaulted	8.7	6.7
No gender based violence experienced	88.1	86.7
Total (n)	126	60

%	100	100
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Not surprisingly therefore, there was no significant difference noted regarding condom use and experience of gender-based violence among the two groups of women (Table A5).

General self efficacy

Analysis of the data showed that there was no significant difference in the general self-efficacy of PEP participants and non-participants. In the same vein, Tables A6-A8 show that there was generally no significant difference between the two groups of women with regards to general self-efficacy and decision-making in sexual relationships.

Level of agency in seeking support and services for HIV and AIDS care at work

At the workplace, empowered women living with HIV did not succumb to perceived HIV stigma especially because the participants believed stigma was not a serious problem at workplace. Indeed 88.1% of women who had participated in the PEP stated that they could introduce themselves to a PLWH support group. The corresponding figure for non-participants was 75%. The results were significant at the $p < 0.000$ level. The following statement affirms this point:

“Stigma is not present here; it starts with the infected person, many people speak about their status casually – in that way it becomes normal” (FG1 – non-peer education participants)

However, the situation may be different in the communities where attitudes about HIV/AIDS place individuals at risk of abuse and there are no similar support mechanisms for people living with HIV.

It was interesting that empowered women explored ways in which they could lessen the burden of living with the illness. Part of the proactive efforts was joining support groups and disclosing their status to immediate supervisors or personnel managers (who were also HIV and AIDS coordinators in these two factories). Line supervisors subsequently provided support and privileges to a worker, and could also protect such workers from harsh managerial decisions when they under-perform due to poor health.

Knowing one's HIV status is a necessary condition to maintaining good health in communities which are highly affected by HIV and AIDS. The study participants and key informants identified different ways in which HIV testing and knowing status benefited workers at the workplace and outside the employment setting.

Work-related benefits: Although there was not yet institutionalised practice regarding absenteeism due to chronic illness or HIV related illness, and in fact management were reluctant to have policy guidelines in this respect, there was consensus that supervisors and personnel officers showed compassion towards workers who were affected by frequent absenteeism. As a result peer educators and support groups encouraged workers who were living with HIV to disclose their status to their immediate Basotho supervisors or members of support groups to avoid unintended discrimination. When the supervisors were aware of the workers' HIV status, they tended to be lenient and allowed them breaks to take medication and light meals, and could also reorganize their production line and allow them to perform lighter tasks.

Key informants and women in focus groups reported that workers could also attend the clinic to obtain different medical services, conduct tests or attend sessions which would conventionally not warrant sick leave.

Although workers who missed work would not ordinarily be paid their wage, workers and management reported that there were significant changes which had been implemented in order to respond to the challenges presented by HIV and AIDS at the workplace, especially absenteeism due to other reasons apart from illness. With the availability of ARVs in the public health sector, HIV positive workers could seek health care services such as counselling, CD4 count monitoring and collect ARVs from health centres without fear of losing their jobs. Management had ceased penalizing such workers and serving them with warnings which would eventually lead to dismissal thus exacerbating the stress brought by HIV illness. In addition, in some cases they would be allowed to enter premises long after 7.00am or leave early in order to attend to their own care needs. CARE efforts through PSCAAL involved training personnel officers to develop workplace HIV/AIDS policies to assist towards institutionalizing the response to HIV and AIDS. Although HIV policies were not formally adopted at the time of the study and management did not intend to change regulations pertaining to absenteeism, the key informants confirmed that the current environment was not hostile to workers.

Outside work benefits: Disclosure to supervisors and personnel also helped workers to access medical care from service providers who had relationships with the garment industry. Workers approached ALAFA doctors without having to pay for consultation and ARVs.

Peer educators believed that from this perspective, women's sense of empowerment was critical because it enabled them to disregard any stigma associated with HIV and focus on their own health and the long-term benefits of disclosure.

4.0 CONCLUSIONS

HIV and AIDS programme which provided peer education/support, information and VCT services had a potential to influence reduction of HIV risk among participants. Peer educators (few though) showed that information about HIV and AIDS did not only change their outlook but also empowered them to adopt low risk behaviours and sexual practices. However, for the majority of workers to experience empowerment and hence behaviour change, the programme needed to have worked on the basis of the structural, socio-cultural and economic factors which influenced women's decision making in relationships with others, namely men.

The multifaceted nature of the contextual factors which increase women's vulnerability need to inform the interventions which are intended to empower women and they should be assisted to understand how these factors reinforce one another in the transmission of HIV. Empowering Basotho women in the 21st century is likely to be even a difficult process because of the changed economic status of most men in Lesotho and the fact that male identity is under threat; resistance is inevitable unless men are made partners in truly gender mainstreamed programmes.

The overall pattern that emerged from the study indicates that the skills the women learned in the peer education programmes did not seem to have trickled down to the traditionally entrenched gender beliefs. Most women had correct knowledge about HIV and AIDS and seemed to be aware of the sources of HIV risk in their context as garment workers. However, women reported virtually similar risk behaviours and barriers to behaviour change that would influence infection risk in their sexual relationships with men. For example, majority of women who participated in peer education programmes were not the main decision-makers regarding condom use and that their partners were. More than 30% of women (both participants and non-participants) would surrender if their

partners refused to use a condom and their main reason was that they feared that their partners would use violence. Certainly, the powerless position of women relative to men in society reduces the capacity of women to behave in ways which would prevent HIV infection regardless of their knowledge. HIV risk is high in sexual relationships dominated by gender inequality and gender beliefs which undermine women (Physicians for Human Rights, 2007). Epstein (2007) eloquently describes underlying structural factors (poverty, migration) and the mechanisms through which multiple concurrent relationships among sexually active members of societies in Southern Africa were pathways of HIV transmission. Interventions should build women's and families' resilience to the socioeconomic factors which influenced their vulnerability to HIV transmission and the impact of AIDS.

The empowerment goal needed to be framed with the understanding that women negotiated safe sex in the context of skewed gender relations. More importantly, the limitations of rational theories with regard to condom negotiation are more real when we take into account that women have aspirations and emotions which in some situations are not consistent with protecting oneself from HIV infection. This is true for women in more stable relationships.

Development agencies need to recognize that their interventions usually have components which require services of different providers. Reasonable change in this respect has high cost implications and requires agencies to collaborate and create synergies which can enhance funding opportunities and service delivery which go beyond the groups which are identified as at high risk, for example, garment factory workers. This is because the behaviours which increase the risk for HIV in the case of the workers are not confined to any particular communities and are inherent in the mores of society and its structural aspects such as poverty, migration which does not include other workers' family members.

Literature shows that a major breakthrough for Lesotho to realize substantial declines in HIV prevalence and incidence would be through acknowledging that the epidemic is thriving in long-term and marriage relationships (Epstein, 2007; Phela, 2007; UNAIDS/WHO, 2008); and address this reality through coherent strategies. One of the unfortunate characteristics of these forms of relationships is that communication about condom use may be difficult to realize without disturbing some of the core values – trust, monogamy and procreation and without creating conflict which most women avoided to secure their welfare and maintain their sense of identity. This inhibition could be experienced despite the fact that in most cases faithfulness and monogamy were not practiced by both partners. The consequence of this behaviour is the high prevalence of HIV discordant couples in Lesotho (Corno & De Walque, 2007). Patriarchal values regarding male control over women mean that condoms would be most likely used in relationships where the perception of risk is mutual and there is communication on reproduction which could prevent mother-to-child transmission.

Qualitative data supported the assumption that exposure to peer education influenced individuals who took part in the programme by enhancing their self esteem and recognition among their peer. Workers, irrespective of their participation or non-participation in a peer education had similar conceptions of empowerment but those who did not participate were more likely to find their economic circumstances and gender norms constraining than participants. This capacity among peer educators was recognized by non-participants in peer education and that change of attitude about taking HIV test was attributed to peer education.

It is encouraging that empowerment seemed to affect attitudes towards HIV and AIDS as well as behaviour in relation to seeking services such as HIV testing,

obtaining medical treatment including ARVs and soliciting support at the workplace than in relation to adopting low risk behaviours. However, this conclusion needs to be interpreted cautiously because the study neither established the workers' HIV status nor the point at which they became infected relative to their exposure to HIV and AIDS peer education.

Although the current developments regarding facilitating workers' access to health care services were not as a result of PSCAAL activities in the garment industry sector, through initiation of peer education the programme appeared to have laid a foundation for workers' activities on HIV and AIDS matters in the workplace. In that regard, empowered workers had become a resource for management and other women to pursue HIV and AIDS activities. Helping infected workers to start support groups and work towards normalizing HIV could be seen as an indirect consequence of the programme through peer education and VCT services. A high level of agency in seeking services for HIV and AIDS care is necessary for ensuring prolonged and quality life.

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Annex: Cross-tabulations

Table A1 Proportion of sample who know at least one source of HIV/STI service and who utilized an HIV/STI service in the last six months by PEP participation

HIV/AIDS service	Participants			Non-participants		
	Positive attitude	Negative attitude	Total	Positive attitude	Negative attitude	Total
Tested for HIV ^{NS}	45.1	54.9	51	33.3	66.7	9
Used STI services ^{NS}	45.5	54.5	22	50.0	50.0	2
Used TB services ^{NS}	44.4	55.6	9	33.3	66.7	3

Note: NS: Not statistically significant

TableA2 Proportion of sample by selected indicators of sexual decision-making and negotiation, by condom use in last six months

Indicator of decision-making in sexual relationships	Condom use in last six months							
	Participant				Non-Participant			
	All/ most of the time	Some- times	Rarely/ Never	Total (n)	All/ most of the time	Some- times	Rarely/ Never	Total (n)
Final decision-maker on condom use**	67.6	13.5	18.9	37	42.9	50.0	7.1	14
Participant	16.7	25.0	58.3	12	40.0	20.0	40.0	5
Partner	53.8	23.1	23.1	26	33.3	46.7	20.0	15
It's a joint decision								
Can refuse sex if not feeling well^{NS}								
Always	56.6	18.9	24.5	53	40.9	45.5	13.6	22
Sometimes	30.8	30.8	38.5	13	22.2	44.4	33.3	9
Never	58.3	0.0	41.7	12	40.0	40.0	20.0	5
Likely reaction if partner refuses condom*	66.1	16.1	17.9	56	41.7	50.0	8.3	24
Refuse to have sex with him	50.0	25.0	25.0	4	28.6	28.6	42.9	7
Persuade him to use a condom	10.5	21.1	68.4	19	20.0	40.0	40.0	5
Surrender and agree to have sex without condom								
Can convince partners to use condoms*	60.9	20.3	18.8	64	52.9	32.4	14.7	34
Always	18.2	45.5	36.4	11	12.5	62.5	25.0	8
Sometimes	16.7	16.7	66.7	18	0.0	33.3	67.7	3
Never								

Note: * p<0.000 ** p<0.050 NS: Not statistically significant

Table A3 Proportion of sample by ability to negotiate in sexual matters and condom use in last six months

Indicator of Communication in sexual relationships	Condom use in last six months							
	Participant				Non-Participant			
	All/ most of the time	Some- times	Rarely/ Never	Total (n)	All/ most of the time	Som e- times	Rarely/ Never	Total (n)
Feel confident discussing condom with partner*								
Always	55.4	23.0	21.6	74	50.0	27.8	22.2	36
Sometimes	2.7	23.1	69.2	13	0.0	85.7	14.3	7
Never	18.2	9.1	72.7	11	50.0	50.0	0.0	2
Can suggest HIV test to partner I^{NS}								
Always	51.3	20.5	28.2	78	50.0	38.2	11.8	34
Sometimes	22.2	33.2	44.4	9	0.0	50.0	50.0	2
Never	18.2	18.2	63.6	11	25.0	25.0	50.0	8

Note: * p<0.000 NS: Not statistically significant

Table A4 Proportion of sample by ability to communicate with partner and HIV testing in last six months

Indicator of Communication in sexual relationships	Tested for HIV in last six months					
	Participant			Non-Participant		
	Yes	No	Total (n)	Yes	No	Total (n)
Feel confident discussing condom with partner*						
Always	44.0	56.0	100	19.0	81.0	42
Sometimes	10.0	90.0	10	0.0	100.0	5
Never	27.3	72.7	11	11.1	88.9	9
Can suggest HIV test to partner I^{NS}						
Always	40.2	59.8	97	17.8	82.2	45
Sometimes	42.9	57.1	14	0.0	100.0	9
Never	36.4	63.6	11	33.3	66.7	3

Note: * p<0.000 NS: Not statistically significant

Table A5 Proportion of sample by experienced gender-based violence in last six months and condom use in last six months

Gender based violence ^{NS}	Condom use in last six months							
	Participant			Total (n)	Non-Participant			Total (n)
	All/most of the time	Some times	Rarely/ Never		All/most of the time	Some times	Rarely/ Never	
Yes	50.0	0.0	50.0	14	16.7	50.0	33.3	6
No	43.5	25.9	30.6	85	46.2	35.9	17.9	39

Notes: NS: Not statistically significant

Table A6 Proportion of sample by ability to solve problems, and sexual decision-making in relationships

Indicator of decision-making in sexual relationships	I can solve problems if I try hard enough							
	Participant				Non-Participant			
	All/most of the time	Some times	Rarely/ Never	Total (n)	All/most of the time	Some-times	Rarely/ Never	Total (n)
Final decision-maker on condom use^{NS}	37.5	52.1	10.4	48	58.8	29.4	11.8	17
Participant	38.5	61.5	0.0	13	20.0	80.0	0.0	5
Partner	53.3	33.3	13.3	30	31.6	57.9	10.5	19
It's a joint decision								
Can refuse sex if not feeling well^{NS}	40.9	48.5	10.6	66	48.3	37.9	13.8	29
Always	50.0	50.0	0.0	14	30.0	70.0	0.0	10
Sometimes	46.2	38.5	15.4	13	40.0	60.0	0.0	5
Never								
Likely reaction if partner refuses condom^{NS}	49.3	40.6	10.1	69	54.8	35.5	9.7	31
Refuse to have sex with him	66.7	33.3	0.0	6	25.0	75.0	0.0	8
Persuade him to use a condom	20.0	70.0	10.0	20	0.0	80.0	20.0	5
Surrender and agree to have sex without condom								

Notes: NS: Not statistically significant

Table A7: Proportion of sample by ability to influence partner's decisions, and sexual decision-making in relationships

Indicator of decision-making in sexual relationships	I can influence my husband/partner's decision							
	Participant				Non-Participant			
	All/most of the time	Some-times	Rarely/ Never	Total (n)	All/most of the time	Some-times	Rarely/ Never	Total (n)
Final decision-maker on condom use^{**}								
Participant								
Partner	59.6	27.7	12.8	47	66.7	22.2	11.1	18
It's a joint decision	33.3	4.0	26.7	15	40.0	20.0	40.0	5
Can refuse sex if not feeling well^{NS}	70.7	26.8	2.4	41	58.3	41.7	0.0	24
Always								
Sometimes	62.8	25.6	11.5	78	62.9	31.4	5.7	35
Never	52.6	36.8	10.5	19	63.6	36.4	0.0	11
Likely reaction if partner refuses condom^{NS}	53.8	46.2	0.0	13	33.3	33.3	33.3	6
Refuse to have sex with him								
Persuade him to use a condom	68.2	22.7	9.1	66	60.0	33.3	6.7	31
Surrender and agree to have sex without condom	60.0	40.0	0.0	5	37.5	62.5	0.0	8
	30.0	45.0	25.0	20	40.0	20.0	40.0	5

Notes: ** p<0.050

NS: Not statistically significant

Table A8: Proportion of sample by ability to influence important community decisions, and sexual decision-making in relationships

Indicator of decision-making in sexual relationships	I can influence important decisions in my community							
	Participant				Non-Participant			
	All/most of the time	Sometimes	Rarely/ Never	Total (n)	All/most of the time	Sometimes	Rarely/ Never	Total (n)
Final decision-maker on condom use^{NS}								
Participant	26.0	10.0	64.0	50	22.2	16.7	61.1	18
Partner	14.3	7.1	78.6	14	20.0	0.0	80.0	5
It's a joint decision	29.3	9.8	61.0	41	4.0	12.0	84.0	25
Can refuse sex if not feeling well^{NS}								
Always	30.6	9.4	60.0	85	15.4	10.3	74.4	39
Sometimes	15.8	15.8	68.4	19	9.1	27.3	63.6	11
Never	8.3	8.3	83.3	12	0.0	0.0	100.0	6
Likely reaction if partner refuses condom^{NS}								
Refuse to have sex with him	29.4	11.8	58.8	68	19.4	12.9	67.7	31
Persuade him to use a condom	0.0	16.7	83.3	6	0.0	12.5	87.5	8
Surrender and agree to have sex without condom	27.8	0.0	72.2	18	0.0	0.0	100.0	5

Notes:

NS: Not statistically significant