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The Role of the Private Sector in HIV and AIDS Interventions in Developing Countries: The Case of Lesotho

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1. Introduction

The HIV and AIDS pandemic enters its fourth decade of expansion having undermined every aspect of society. This is particularly the case in sub-Saharan Africa, which remains the most heavily affected region, accounting for 72% of all new infections in 2008, and for 68% of the global number of people living with HIV in 2009 (United Nations, 2010; UNAIDS, 2010). UNAIDS further reports that during 2009 alone an estimated 1.3 million adults and children died as a result of AIDS in sub-Saharan Africa and that more than 15 million have died in the region since the beginning of the epidemic in the early 1980s (UNAIDS, 2008; 2010).

The impact of the epidemic in sub-Saharan Africa is widely felt in, among others, the health, education, agriculture, mining, transport and other production sectors. Furthermore, to the extent that the vast majority of people living with HIV and AIDS are between the ages of 15 and 49 years – in the prime of their working lives (International Labour Organisation, 2006), the epidemic weakens economic activity through decreased productivity due to absenteeism resulting from sickness, caring for family and dependents; and organizing and attending funerals; low morale at work due to losing family, friends and colleagues; increased costs due to rising health insurance, sick leave, funeral costs, recruiting and training skilled workers; and reduced labour supply due to increased mortality (Phororo, 2003; Sidhu, 2008). Government income also declines as tax revenues fall and governments are pressured to increase their spending to deal with the expanding epidemic (Avert, 2011).

It is largely against this background that the 2001 United Nations Declaration of Commitment on identified the private sector as an essential part of the national and global responses to [HIV and AIDS]. In line with this Declaration, and as the epidemic continues to affect the working population, the private sector in Africa has over the past years scaled up its response by complementing the work of the traditional public sector and civil society actors (Sidhu, 2008). Progressive companies throughout the region are putting in place a wide range of HIV and AIDS prevention, care, and treatment programmes. These include education and awareness campaigns; training of peer educators; distribution of condoms; promotion of HIV testing; and treatment of, and protection against, other sexually transmitted infections (Rosen et al, 2007). The prevention programmes are typically designed to reduce the incidence of the epidemic in the workplace. Care and treatment

programmes, on the other hand, are often meant to support employees who are infected with HIV and who have AIDS, with the objective of keeping these employees in the workforce, and delaying or avoiding the costs of AIDS (Rosen & Simon, 2003; Rosen et al, 2004; George et al, 2009)

An example of the African private sector engagement in national HIV and AIDS response is that of the Private Sector Coalition Against AIDS in Lesotho (PSCAAL) initiative that operated between 2002 and 2006 in the Southern African Kingdom. The main goal of the initiative—which was managed by CARE South Africa-Lesotho (hereafter to be referred to as ‘CARE’)—was to facilitate a partnership among private sector companies in the fight against HIV and AIDS in an environment characterized by a large female workforce and rural-urban migration. Largely based on evidence showing that HIV and AIDS was a serious threat to production in the textile industry (Ruscombe-King, 2008; UNAIDS, 2008), various companies in the textile sector formed part of the sites where PSCAAL activities were undertaken.

The activities included providing peer education for the workforce to raise awareness about, and increase demand for, HIV prevention services. Peer education is commonly used for promoting sexual and reproductive health, especially with regards to HIV prevention among youth by enhancing social learning and providing psychosocial support (Population Council, n.d; Swartz et al, 2010). A group of individuals recruited from among the target population is used as peer educators or agents of change in order to change social norms among peer targets (Chandan et al, 2008:12). The PSCAAL programme implementation involved: (1) training workers to conduct peer education and provide peer counselling to their colleagues in order to influence behaviour change; (2) facilitating the provision of care and support through formation of support groups to encourage workers to talk about HIV and AIDS; (3) using mobile services to encourage workers to utilise voluntary counselling and testing (VCT) services at the workplace; and (4) providing training in workplace HIV and AIDS policies to assist companies to institutionalise their response to the epidemic. Overall, PSCAAL’s approach was based on the assumption that exposure of workers to the programme activities would lead to “a shift from risk behaviours contributing to HIV and AIDS towards risk-avoiding strategies in the workforce” (Hanisch, 2006).

This chapter assesses the extent to which PSCAAL’s activities enhanced HIV and AIDS knowledge and behaviour changes among the female textile workers. The differences between workers who participated in the peer education programme (PEP) and those who did not participate are examined in terms of: (1) knowledge of HIV and AIDS; (2) preventive behaviour measured as uptake of HIV testing and consistent condom use; (3) attitudes towards HIV; and (4) level of self-efficacy in relation to HIV prevention. The opportunities which PSCAAL could have lost through their programming are also explored and recommendations for more effective private sector engagement in sub-Saharan Africa are given. Unlike previous studies that generally used secondary data to explore these issues, this current study obtained empirical data from workers themselves, and obtained their perspectives on the factors that increase their vulnerability to HIV and the suitability of available support and services.

2. Background

Lesotho is one of the five countries with the highest HIV prevalence in the world with about 23.6% of adults infected in 2008 (National AIDS Commission, 2008). Consistent with the

global pattern, women are disproportionately affected by HIV and AIDS, accounting for 57% of the total HIV-positive cases in Lesotho in 2007 (Khobotlo et al., 2009; UNAIDS, 2009), and most infections occur among young women aged 15-24 years. According to (Khobotlo et al, 2009), in 2007 young women had an HIV prevalence of 14.3% compared to 5.6% among men of the same age. Several factors underlie this pattern. These include the migration of young women from rural to urban to seek employment, particularly in the apparel industry. This was a major livelihood strategy following mass retrenchment of male workers from South African mining industry in the 1990s. While the women's migration certainly contributed to family welfare through food security, it also increased the women's vulnerability to HIV infections, as has been established in the literature. That is, 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).

Lesotho also has a long history of gender inequalities couched in the laws, traditions and social norms that shape relationships between males and females in different contexts. Despite increased female educational attainment, recent legislative reviews, and the country's ratification of international and regional commitments such as the 1995 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Southern Africa Development Community (SADC) Addendum on the Prevention and Eradication of Violence against Women and Children, the low status of women in society has remained almost unchanged (Makoa 1997), and gender inequalities continue to affect majority of women and to influence relationships between men and women. For example, although the Government of Lesotho enacted the Legal Capacity of Married Persons Act 9 of 2006 which provides women equality in marriage, inheritance and other spheres (Dube, 2008), the previous common-law principle of marital power which reduced women to minors and gave husbands control over women is still entrenched in various patriarchal institutions in the society. Overall, therefore, gender-related socio-cultural and economic inequalities as well as financial insecurity affect women negatively and may increase their vulnerability to HIV transmission (Ministry of Health and Social Welfare, 2004).

There is also wide empirical evidence showing that the socioeconomic determinants of HIV infection include the level of education and responsiveness to information intended to prevent the spread of HIV. De Walque (2007), for example, identifies several studies conducted in Africa showing a negative relationship between HIV prevalence and educational status. Low educational attainment can therefore be seen as one of the characteristics of the textile work force in Lesotho. It is estimated that more than one third of the 45 000 mainly Basotho women workers in the textile industry (44.0% of females) and about 35.6% employees are infected with HIV and that more than 2 000 workers in the industry are killed by AIDS annually (ALAFA, 2006; UNAIDS, 2008). To this end, the PSCAAL intervention was crucial because unlike most peer education interventions that target adolescents and youth, the target population was young female adults, most of them

in stable sexual relationships, who worked in the textile industry. The goal was to help participants develop the knowledge, attitudes, beliefs and life-skills required to engage in healthy behaviours that provide a buffer from HIV risk factors.

As part of the national response to the AIDS epidemic, the Government of Lesotho has adopted a multi-sectoral approach to address HIV and AIDS in the thematic areas of prevention; treatment, care and support; impact mitigation; and management and coordination. However, lack of a coordinated and adequately resourced response strategy for almost two decades of the epidemic led to the epidemic spreading and deepening poverty. PSCAAL was therefore implemented by CARE South Africa-Lesotho to enhance the response of the private sector to HIV and AIDS as part of CARE's strategy to address the epidemic as a developmental problem (Colvin, Lemmon & Naidoo, 2006).

3. Methodology

3.1 Study design

The data used are drawn from the results of a cross-sectional knowledge, attitudes, beliefs and practices study conducted between April and June 2008 among female workers in two textile factories that had participated in the PSCAAL programme in the Lesotho capital, Maseru. The study was done as part of the CARE's '*Gender, Sex and Power*' project - a research project undertaken to understand how strategies to reduce risk and promote empowerment of women were creating durable changes in their health behaviour (CARE International, 2007).

3.2 Data collection

Data was collected using a combination of quantitative and qualitative methods, namely:

- i. *Interviews*. These entailed the administering of questionnaires designed to collect information on the female workers' demographic and socio-economic characteristics, as well as their awareness of HIV and AIDS; uptake of HIV testing; decision-making in sexual relationships; gender equality beliefs; and sense of self-efficacy. Interviews were conducted in the vernacular (Sesotho), and respondents were selected using purposive sampling, based in the consent and availability of the workers during their lunch break and after work in the evenings. This sampling procedure yielded a total of 186 respondents.
- ii. *Focus group discussions*. A total of four focus group discussions (FGDs), two in each factory, were conducted. In each factory, one group consisted of with women who participated in the peer education programme (including peer educators) and those who did not. Each group had seven participants who were recruited with the assistance of the peer educators. The purpose of the FGDS was to enable women discuss what they considered as important practices and the factors that produce the reported behaviours following a guided conversation.
- iii. *Key informant interviews*. These entailed semi-structured interviews with service providers who worked with CARE during the time of PSCAAL, human resource managers of the studied factories, personnel officers who were also HIV and AIDS focal persons at the workplace, and a health care provider in an onsite clinic at one of the factories where PSCAAL had peer education activities. These interviews were aimed at obtaining an outsider's perspective on HIV risk in these settings.

Method 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. This approach helped to validate the data across different sources and contexts of interviewing.

3.3 Data analysis

The data analysis was guided by the main goal of the study: to understand if there were differences between women who participated in PSCAAL's peer education programme (PEP) at the workplace and those who did not participate in the PEP, with particular respect to the kind of critical decisions related to the prevention of HIV infection that the different categories of women make in their sexual relationships.

Quantitative analysis using SPSS provided characterization of the studied population in terms of the following domains: socio economic and household characteristics, work and finances; HIV and AIDS awareness; HIV testing; 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 analyses were used to show patterns in the data, while bivariate analyses were carried out to determine associations between the independent variable (participation in the PEP) and selected dependent variables within the specified domains. Qualitative data from the FGDs and the key-informant interviews was analysed thematically. The qualitative and quantitative results were synthesized to illustrate core issues to the participants' vulnerability to HIV infection.

4. Findings

4.1 Study population

Table 1 shows descriptive statistics for the study population. The key findings are that the majority (126 of the 186 women who were interviewed) had participated in the PEP, and were young, with over 70% aged below 35 years. Over half (51.6%) of the PEP participants were married, compared with 36.7% of non-participants. There was no difference between PEP participants and non-participants in terms of educational attainment: majority (61.9% and 61.7% respectively), had secondary school education and above, while about 38% of each sub-group had primary education or less. More than 70% of women in the two groups earned an average of M800 (approximately US\$80) per month.

4.2 Knowledge about HIV and AIDS and HIV prevention services

Sound knowledge about HIV has been widely documented as an essential pre-requisite albeit, often insufficient, condition for adoption of behaviours that reduce the risk of HIV transmission (UNAIDS 2009). It was therefore expected that the impact of the PEP's component of raising HIV and AIDS awareness among the female textile workers would be reflected in a high number of PEP participations who had knowledge about the epidemic and showed the ability to apply the information obtained in ways which prevented HIV infection.

The study results showed that, overall, knowledge about HIV and AIDS was high among all workers, 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

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	0.8	1.7
Never attended school	37.3	36.7
Primary school	35.7	46.7
Secondary school	23.8	13.3
High school	2.4	1.7
Post-high school	20.6	35.0
Marital Status	51.6	36.7
Never married	15.1	15.0
Married	12.7	13.3
Divorced/Separated/Deserted	52.8	48.3
Widowed	1.6	1.7
Position in Factory	39.0	43.3
Skilled Worker	6.5	6.7
Administrator/receptionist	82.4	73.3
/personnel	16.8	26.7
Unskilled worker	0.8	0.0
Supervisor		
Monthly Wage		
Less than M800		
M800-M1200		
More than M1200		
Total (%)	100	100
(N)	126	60

Table 1. Percentage distribution of sample by selected background characteristics

statistically significant, discussions with PEP participants suggested that they tended to have more accurate information and had developed a particular consciousness about HIV and AIDS which helped them behave differently by avoiding risk behaviours and being proactive in obtaining care services and support. For example, one of the interviewed peer educators identified the differences between PEP and non-PEP participants as the varying breadth and depth of information which, for the former, included other health issues not just HIV and AIDS, risk factors such as intimate partner violence and women abuse; as well as the ability to apply the acquired knowledge about HIV transmission and prevention in their intimate relationships.

“It has helped me a lot because I have acquired a lot of privileged information. For example, I know that condoms are not only used as a protection against HIV/AIDS and as a means of birth control, but can also be used to prevent transmission of STIs...Some [non-peer education participants] might have knowledge, but most might not... For example, if I am married to an abusive husband who does not treat me well, I know where I can go to get help” (Peer Educator, PEP participants’ focus group).

Although women in focus groups for non-PEP also displayed similar knowledge about prevention of HIV infection, their discussions also indicated a strong inclination to take their social and cultural roles into consideration when they make decisions in sexual relationships.

An empowered woman is a woman who looks after the needs of her children, for example, who sees that her children are properly fed and well clothed, especially during cold winter. A woman who looks after the affairs of her family; who takes good care of her husband and children ... who does not wash her linen in public, who respects her husband and humbles herself and discusses things with husband... (Non-PEP focus group)

Analysis of the quantitative data also suggested that women who had participated in the PEP were significantly more likely to know where to obtain most of the essential HIV and AIDS services such as condoms and VCT services (Table 2)

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

Table 2. Proportion of sample who know where to obtain essential HIV/ AIDS information and services, by PEP participation

Furthermore, PEP participants were also more likely than non-participants (97.6% and 91.7% respectively) to be of the correct view that knowing one’s HIV status was imperative. While this result was not statistically significant, the advanced reasons were significant, with those who had participated in the PEP more likely to state the more important advantages of HIV testing: to protect oneself and to prevent infecting others (UNAIDS, 2009). Table 3 shows these results.

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

Table 3. Percentage distribution of sample by perceived importance of HIV testing, and PEP participation

4.3 HIV testing

Consistent with their relatively greater recognition of the importance of testing, PEP participants were significantly more likely to have had tested for HIV and also to have used an STI treatment centre in the six months preceding the survey (Table 4).

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

Table 4. 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

The above results were further affirmed in the key informant interviews and FGDs. 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” (VCT service provider, key informant interview)

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 (Participant, PEP participants’ focus group)

4.4 Attitudes towards HIV

In general there seemed to be a positive attitude towards HIV and AIDS among the workers interviewed (both PEP participants and non-participants). For example, over 70% agreed with the statement that HIV was a terminal illness (Table 5) as opposed, presumably, to being a ‘death sentence’. 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. It is noteworthy, however, that women who participated in the PEP were generally less likely to agree with negative statements, even though the results were not statistically significant.

4.5 Condom use

Condom use is an important measure of protection against HIV. Its maximum protective effect is, however, achieved when the use is consistent rather than occasional (UNAIDS, 2009). The study results show that women who participated in the PEP were significantly 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 6).

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

Table 5. Percentage of sample who agreed and disagreed with various indicators of attitudes to HIV and AIDS, and PEP participation

Although the PEP participants were undoubtedly more aware that practising safer sex by using condoms consistently prevented HIV transmission, evidence from the key informant interviews and focus groups, however, shows that many of these women, just like their counterparts who did not participate in the PEP, are often placed at a higher risk of HIV infection through inconsistent use of condoms. For example, a nurse clinician mentioned that there were many workers who sought treatment for sexually transmitted infections (STI) because they did not use condoms consistently and re-infections were common. Overall condoms were perceived as an important factor which could influence women’s access to material support or 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.

In the focus group discussions, the women workers were generally depicted as constantly in search of men who were prepared to assist them financially. These men—many of whom belonged to similarly vulnerable communities such as the taxi industry, uniformed services and migrant mine workers—were powerful in relationships; they cohabited with their lovers and dictated the use of a condom – usually insisting on non-use if they supported women materially. The following statements illustrate:

Women mainly see policemen, soldiers and taxi drives with the expectation that police and army men earn a lot of money.... Taxi drivers are simply favoured because they provide lift to and from work.

Indicator of decision-making in sexual relationships	Condom use in last six months							
	Participant				Non-Participant			
	All or most of the time	Sometimes	Rarely or Never	N	All or most of the time	Sometimes	Rarely or Never	n
Final decision-maker on condom use**								
Participant	67.6	13.5	18.9	37	42.9	50.0	7.1	14
Partner	16.7	25.0	58.3	12	40.0	20.0	40.0	5
It's a joint decision	53.8	23.1	23.1	26	33.3	46.7	20.0	15
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*								
Refuse to have sex with him	66.1	16.1	17.9	56	41.7	50.0	8.3	24
Persuade him to use a condom	50.0	25.0	25.0	4	28.6	28.6	42.9	7
Surrender and agree to have sex without condom	10.5	21.1	68.4	19	20.0	40.0	40.0	5
Can convince partners to use condoms*								
Always	60.9	20.3	18.8	64	52.9	32.4	14.7	34
Sometimes	18.2	45.5	36.4	11	12.5	62.5	25.0	8
Never	16.7	16.7	66.7	18	0.0	33.3	67.7	3

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

Table 6. Proportion of sample by selected indicators of sexual decision-making and negotiation, by condom use in last six months

The problem is that if these men refuse to use condoms, the women cannot refuse them sex because they have received material support from them...but the women here are also promiscuous (Focus group, peer education participants).

“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).

The poor economic situation of the textile female workers as shown by low monthly wages (Table 1) and myriad responsibilities they had within the household (see Table 7) provide part of the answer to why their knowledge about HIV transmission did not produce the intended behavioural changes. 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 (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)

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

Table 7. Percentage distribution of sample by selected socioeconomic indicators

5. Conclusion

The PSCAAL programme was intended to influence behaviour change among women who worked in the textile industry through an HIV and AIDS peer education and support programme which provided information and voluntary counselling and testing services. The overall pattern that emerged from this study indicates that most women who participated in the programme had relatively higher knowledge about HIV and AIDS, and seemed to be more aware of the sources of essential HIV and AIDS prevention and treatment services, as well as the importance of preventive behaviours such as HIV testing and consistent condom use. Despite these achievements, the skills the women learned in the peer education programmes do not seem to have trickled down to the traditionally entrenched gender beliefs, or to have enhanced the programme participants' self efficacy in their sexual relationships. For example, majority of women who participated in peer education programmes were, just like their counterparts who did not participate in the programme, not the main decision-makers regarding condom use; their partners were. By the same token, more than a third of all women (both participants and non-participants) stated that they would surrender if their partners refused to use a condom, and their main reason was that they feared that their partners would use violence. Qualitative evidence shows that this can be largely attributed to skewed gender relations and women's lower economic status, as well as individualized approaches that target women and disregard the socioeconomic context of heterosexual relationships through which HIV infection mostly occur. These barriers have been noted in other sub-Saharan countries that have similarly high HIV prevalence like Lesotho, and have also been noted in the Millennium Project task Force report which stated, in part, that "Prevention and care programs will fail if they ignore the underlying determinants of the epidemic: poverty; gender inequality; and social dislocation" (Nelson, 2005:20).

Against this background, it is imperative for HIV and AIDS interventions in African countries to be framed with an in-depth understanding of the multifaceted nature of the contextual factors that increase HIV vulnerability, and build women's and families' resilience to the socioeconomic factors which influenced their vulnerability to HIV transmission and the impact of AIDS. Private companies and business have a unique role to play in this regard since they interact with people living and affected by HIV and AIDS directly through employment relations, and indirectly through customers, employees' families, and community members (Nankobogo, 2007). It should be recognised, however, that the core business of many private sector organisations is not HIV and AIDS, and their range of activity often extends beyond the scope of national HIV and AIDS strategic framework. As Nelson (2005:11) cautions, "The core business of business is, and must remain, the profitable production of goods and services ... (and) it is important not to create unrealistic expectations of what activities business can undertake in the fight against HIV/AIDS".

Nonetheless, the private sector can still make meaningful contributions that can help in achieving greater scale in national and community-level efforts against HIV infection and AIDS (Nelson, 2005). Drawing on the International Business leaders Forum Spheres of influence model and the Global Business Coalition's business action model, Nelson summarised the various ways in which the private sector can be involved into six 'building blocks of corporate engagement': (1) demonstrate good workplace programmes to other companies; (2) Extend internal programmes along corporate value chains; (3) share core

competencies and assets with other sectors; (4) make strategic philanthropic donations; (5) help build effective institutions; and (6) engage in public policy dialogue. Given the findings of this study on which this chapter is based, three of these building blocks are, perhaps, the most relevant for sub-Saharan African:

1. *Demonstrate good workplace programmes to other companies.* Workplace programmes in developing countries focus primarily in promoting behaviour change (Sai, 1995) through for example, creating awareness, and encouraging the workforce to undertake HIV testing and seek treatment. While these programmes are critical, they may have limited benefits in sub-Saharan Africa given the evidence that structural socio-economic and cultural factors are the key pathways of HIV transmission in the region. Therefore in addition to enhancing workers' health literacy and ability to obtain, process and understand basic health information and services needed to make appropriate health decisions (Sanders, 2007) in the context of HIV and AIDS, management in industries that employ women need to consider the broader socio-cultural factors that influence women's vulnerability. For example, to the extent that gender relations are to a large extent influenced by women's low economic status, female workers should be empowered economically by paying wages that take into account the cost of living in a country. Employers could also consider developing investment funds with the employees. There is also need to strengthen monitoring and evaluation of workplace programmes (Weston, et al, 2007) and to share the evidence of effectiveness with other companies particularly small and medium enterprises and those that are just straying out (Nelson, 2005).
2. *Share core competencies and assets.* Unique skills and capacities such as logistics and distribution resource management, communication and marketing that can be used effectively and creatively to respond to HIV and AIDS in behaviour change campaigns, procurement and distribution of commodities and information materials, and improved management of programmes. The private sector can share these competencies through effective partnerships with civil society, community organisations and the public sector. Not only will such partnerships contribute to the private sector's economic case for tackling HIV and AIDS, but they also have a business case. Studies indicate that employees strongly appreciate when their company and senior management are involved in social causes, and indeed, many companies working in high HIV prevalence countries have improvements in productivity, morale and staff turnover when they take an active, visible role in the AIDS response (UNAIDS, 2011).
3. *Help build effective institutions,* particularly Business Coalitions against HIV and AIDS. These Coalitions can be described as organisations of business that work together to address the issue of HIV and AIDS, and may include sectoral associations, chambers of commerce, labour unions, employer federations and other groups of companies that have committed themselves to addressing the issue of HIV and AIDS (Sidhu, 2008). National Business collation remove the need for private sector companies to act in isolation by providing a forum for cooperation and partnership, serving as a interlocutors between the private and public sector responses to HIV and AIDS (Nankobogo, 2007; Sidhu, 2008). Although Business Coalitions are a relatively new concept around the world, and still need more support to strengthen their organizations and fulfill their visions, their positive impact is already being felt in some countries (Sidhu, 2008). Therefore, given that as of January 2008, there were 25 national Business Coalitions in Africa and four were scheduled for launch in 2008/2009 (see Sidhu, 2008),

there should be increased advocacy for African business involvement in HIV and AIDS prevention through participation in local business coalitions. Through these coalitions private sector companies can for example, be linked with AIDS service organisations that are more experienced and better equipped to provide a range of HIV and AIDS related services such as information and prevention campaigns, and mitigation and care measures –such as medical and home-based care and financial advice—for those infected and affected by the epidemic (GTZ, 2005).

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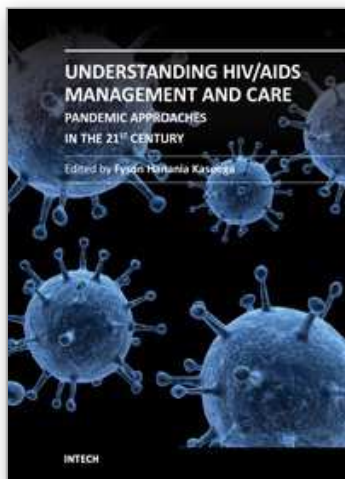
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