STIGMA AND DISCRIMINATION
THE EFFECT ON VOLUNTARY COUNSELING AND TESTING

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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Countries of the world have put in place various interventions in different sectors and categories of the communities to curb the spread of HIV and AIDS and mitigate its impact. Such interventions include prevention activities like HIV testing and counselling (HTC), care, and support and treatment to name a few. People's attitudes and perceptions as well as utilization of the services provided under these interventions have been influenced by different factors. One of these factors is stigma and discrimination.

Acts of stigma and discrimination have been observed in different settings, and people who are living with and affected by HIV have expressed the different degrees and forms that various groups and individuals have experienced. The study focused on HIV and AIDS related stigma and discrimination, investigated its degree and the extend in which it affects the utilization of Voluntary Counselling and Testing (VCT) services. The purpose of the study was to ascertain whether stigma and discrimination exists, and in what forms, who is being stigmatised and determine how stigma and discrimination affects the uptake or utilization of the Voluntary Counselling and Testing services at the place of work.

The study has revealed that stigma and discrimination exists although it is said to be reduced as expressed by the participants, people who are HIV infected continue to be blamed and labelled and subjected to gossips, rejection by co- workers, families. Self stigmatization has also come up clearly that it does prevail and it also undermines the efforts aim at involving PLHIV in the national response. These forms of discrimination create and fuel fear to those who have not tested. Those who have not tested have expressed fear of rejection, fear of blame, fear of losing lovers and partners and fear of not sure how they would cope with HIV positive status. The study has further revealed that stigma and discrimination still has direct link to the utilization of VCT services. It undermines the efforts intended to halt the spread of the infection, programmes aimed at providing care, support as well as treatment.

OPSOMMING

Wêreldlande plaas verskeie intervensies in verskillede sektore van die gemeenskap om beheer toe te pas in die verspreiding van MIV en vigs om die impak daarvan te verlig.

Mense se optrede en persepsie sowel as gebrukmaking van die dienste die intervinsie is beïnvloed deur verskeie faktore, waarvan een van die faktore stigma en diskriminasie is. Gevalle van stigma en diskriminasie is waargeneem in verskillende rigtings en mense met MIV betuig die verskillende grade en vorms wat elkeen ervaar het.

Die studie fokus op MIV en vigs wat verband hou met stigma en diskriminasie, ondersoeking en toetsing toon aan dat dit die graad van behandeling deur gewillige beraders erg affekteer.

Studies toon aan dat stigma en diskreminasie wel bestaan alhoewel daar gesê word dat dit minder word. Mense met MIV en vigs word kwaadwilliglik blameer en verwerp deur familie en mede-werkerkers.

Selfverwyt kom duidelik voor en kry die oorhand en ondemyn die pogings en doelwitte waarmee mense met MIV/vigs in die algemeen optree. Die wat nie getoes is toon duidelike tekens van angs, verwerping en vrees dat hul dalk `n geliefde gaan verloor, en weet nie hoe hul met MIV status gaan saamleef nie.

Die studie toon dat stigma en diskriminasie direk verband hou met die gemeeskap van vrywillige toetsing en berading. Dit ondermyn hul pogings om MIV-infeksie te keer, programme stel doelwitte om voorkomende sorg, hulp en ondersteuning sowel as behandeling.

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ABBREVIATIONS AND ACRONYMS

AIDS.....Acquired Immune Deficiency Syndrome

ALAFA..... Apparel Lesotho Alliance To Fight AIDS

ART..... Ati- Retroviral Therapy

HIV..... Acquire Immune Deficiency Virus

ILO..... International Labour Organization

VCT..... Voluntary Counselling and Testing

LENEPHWA .....Lesotho Network of People Living with HIV and AIDS

LIRAC..... Lesotho Inter- Religious Consortium

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UNAIDS..... United Nations

WHO..... World Health Organization

PMTCT..... Prevention of Mother to Child Transmission

MSM..... Men having Sex with Men

MOHSW..... Ministry of Health and Social Welfare

KYS.....Know your Status

PLWHIV.....People Living With HIV

GOL..... Government of Lesotho

OVC.....Orphans and Vulnerable Children.

STD…… Sexually transmitted Diseases

CHAPTER 1
INTRODUCTION

1.1 Background

The World is facing the worst recorded developmental and health challenge which has called for the nations to realign their health and developmental plans and programmes and policies to address HIV and AIDS. The countries populations are threatened by the pandemic, the economy and development are negatively affected and the health services are strained having great difficulty coping with the increased demand for services while children are orphaned and left behind by both parents to fan for themselves. "It is probably the biggest microbial pandemic to strike mankind in six centuries (Cameron 2007. P. 1) in the same paper Cameroon further emphasises that HIV and AIDS "is a big catastrophe" (p 1) and that its massive extend can not be ignored. The world of work is one of the areas that is devastated by low productivity absenteeism and lose of capable and trained manpower mainly due to HIV and AIDS.

The Chapter looks into the HIV and AIDS overview, starting with the global picture, followed by the Lesotho HIV and AIDS overview. In Lesotho specifically the achievements realized under the HIV and AIDS national response are examined as well as the legislative and the policy environment. The focus of the study is on the workplace. In order to appreciate the workplace situation, the study therefore briefly looks into HIV and AIDS at the workplace in general and further into the Lesotho situation. The study intends to examine the effects of stigma and discrimination on VCT, it is therefore critical that the study also reviews VCT in general and specifically VCT at the workplace in Lesotho is examined.

1.2 Global epidemiological overview

It is estimated that globally 33.2 million people (30.1- 36.1) of this 3.8 million are adults while 15.4 are women and the number of children under the age of 15 living with HIV is estimated to about 2.5 million. Sub – Sahara Africa being the worst affected region in the whole world with about 22.5 million people living with HIV. In 2007 alone the total number of newly infected people globally is 2.5 million, 2.1 million being adults while 420 000 are newly infected children under the age of 15. It

is further estimated that in the sub- Sahara the number of newly infected people is estimated to about 1.7 million. Furthermore 2007 alone registered about 2.1 million as the total number of people who died, 1.7 of which are adults , while 330,00 are children, with Sub – Sahara accounting for about 1.6 million of the total deaths recorded in 2007. It is critical to note that globally 6,800 persons are infected each day and all these according to UNAIDS/WHO (2007) is attributed to among others lack of access to prevention and treatment services. UNAIDS/ WHO further states that "HIV remains the most serious infectious disease challenges to Public Health." UNAIDS &WHO (2007, P.4).

Sub- Sahara Africa remains the epicentre of the epidemic with the countries within the region reporting the highest prevalence found globally. The World Bank as quoted by USAID (2000) claims that "The hyper epidemic in the countries at the epicentre is a continental and a global exception unlikely to occur elsewhere." Sub Sahara Africa is a home for the communities which are already in economically challenging situation and extreme poverty and hunger and above all HIV and AIDS. The region accounts for about 35% of the adults' population living with the HIV and 32% of the Worlds new infections. It is worth noting that the highest prevalence has been recorded among the sex workers in the Sub – Sahara (UNAIDS, 2008).

1.3 The overview- HIV and AIDS epidemic in Lesotho.

Lesotho is one of the hardest hit countries within the Sub- Sahara with adult HIV prevalence estimated to about 23.2% within a population of about 1.8 million. This puts Lesotho at the 3rd highest country with the highest infection rate. It is estimated that on a daily basis there are about 62 new infections and 50 deaths due to HIV and AIDS. The number of people living with the virus was estimated to about 270,273 at the end of 2007 of this total children are estimated to 11,801 while the number of adults is estimated to 258, 472. The situation in this country is such that the women are the worst affected with number of infected estimated to 153,581, which is about 56% of the total number. This is attributed to the women's vulnerability, the low and challenging economical and cultural status of basotho women within the society. The number of males infected on the other hand is estimated to 116,992. It is also estimated that the epidemic has orphaned about 108,000 children. (Source: UNAIDS, 2007 Lesotho, UNGASS, 2007).

Lesotho has seen an escalating rate of infection since 1986 when it reported the first case of HIV, with the highest prevalence recorded amongst the 15- 49 age groups. This is the economically productive and the most reproductive group of the society, therefore this situation is a threat to the economy and the population growth of the country. The 2007 sentinel survey shows HIV prevalence among the STI patients being the highest accounting for about 56% among age groups15- 49 and 20- 24. STIs facilitate HIV transmission through the lacerations and the sores that some of them are characterised with. This is one area that is of concern in HIV infection control (Ministry of Health and Social Welfare (MOHSW), 2008).

According to the HIV and AIDS Policy in Lesotho the following have been identified as the drivers of the epidemic in this country: unemployment coupled with high mobility whereby Basotho migrate to South Africa or migrate within the country from the rural areas to the urban centres in search of jobs. In this process in order to survive and cope with human basic needs some resort to sex work or other risky behaviour. Alcohol and drug abuse is another driver; it tends to influence risky sexual behaviour with a possibility of injecting drug usage. Multiple and concurrent as well as intergenerational sex, coupled with low level condom usage also contribute to the escalating infection rate. In Lesotho the groups that are identified as the most at risk are the women, the girls, prisoners, sex workers, factory as well as mine workers. (Lesotho HIV & AIDS Policy, 2006).

1.4 The HIV and AIDS National Response in Lesotho

In 1986 when the first case was reported, HIV and AIDS was viewed as the disease of the outsiders and this resulted into reluctance and slow action to tackle the challenge. As the years passed by the illness emerged as a threat and the infection rate increased, the country put in place strategies and plans to curb the spread of HIV infection. In 1996 an AIDS programme was established within the Ministry of Health. In 2001 the government realised that HIV and AIDS is not a health issue but a socio-economic, cultural and developmental issue that is beyond the scope and mandate of the Health sector and therefore established the Lesotho AIDS Programme Coordinating Authority (LAPCA) under the office of the Prime Minister. In the year 2000, His Majesty the king declared HIV and AIDS as the national Disaster. (Lesotho

UNGASS, 2007) And few other achievements that indicated political commitment were made and they are as follows:

-The establishment of the HIV/ AIDS Senate Committee

-The establishment of the National assembly Sub- committee on HIV and AIDS

-Turning the crisis into an opportunity. (Strategies for Scaling Up the National Response to the HIV and AIDS Pandemic in Lesotho)

(Source (GOL and UNAIDS, 2003).

Other areas that indicated chances for success included: Basotho are one people with one language and predominately one religion and existence of well established network of churches and other community based networks in the form of support groups and community health workers. Following the 2001 UNGASS declaration of the "three ones" principle, Lesotho in 2005 established one coordinating body- The National AIDS Commission. The commission went on and spearheaded the development of One National Strategic plan (2006- 2011), then one Monitoring and Evaluation Plan and the National HIV and AIDS policy.

1.5 The Lesotho legal and policy environment

The government of Lesotho has adopted different approaches with the intention to strengthening the national response against HIV and AIDS and mainstreaming the relevant activities into the developmental programs. According to the Lesotho HIV and AIDS Policy (2006) one of the areas in which some achievements have been made is the adoption of "A Gateway Approach" which is an approach that integrates HIV and AIDS activities through the local government system, at district, and community level as well as local government constituency level. The aim of the approach is to use the local government structures as a gateway to driving the response and touching people's lives through their participation from grassroots level. The Government of Lesotho has also launched the new HIV testing and counselling strategy namely "The Know Your Status" (KYS) campaign with the aim of scaling up the testing and counselling at health facilities and to take the HTC services to the door steps of every Mosotho.

The other areas in which there has been some progress include commitment of the church leadership to mainstream HIV and AIDS into the religious activities and these

churches are organized through one body called Lesotho Interreligious AIDS Consortium. (LIRAC). Greater involvement and participation of PLWHIV has been achieved mainly through the network of PLWHIV. The network has managed to support and guide community and district level PLWHIV networks and support structures. People Living with HIV through their network have participated in almost all spheres of the national response which includes among others the development of the National policy and The National Strategic Plan and active participation and involvement in the KYS campaign.

To level the ground and to facilitate legal framework for effective HIV and AIDS response the legislative and policy environment has been levelled through the establishment of the policies and legal framework such as the Labour code (Amendment) Act (2006). To guide workplaces to address HIV and AIDS issues at the world of work. The Gender and Development policy, (2003) which is intended to address the gender inequalities. Gender inequalities are some of the factors that at times put women at risk of HIV infection; The National Orphans and Vulnerable Children (OVC) Policy (2002). This policy is aimed at protecting the rights of OVCs against all types of abuse. The Sexual offences Act 29 2003: The Act serves to protect the rights of individuals and address the issue of sexual abuse and Sexual offences. The HIV and AIDS Policy 2006, The National HIV and AIDS strategic plan 2006 - 2011 and The Monitoring and Evaluation (M& E)Plan which the country has developed form part of the countries adherence to the international 3 one's principle. (UNAIDS, 2007- Lesotho UNGASS, 2007). Above all these there is Lesotho Constitution (1993) that among other things serves to protect the fundamental human rights of the citizens of Lesotho and protect people from all forms of discrimination.

1.6 HIV AIDS and the World of work

It is estimated that out of the 33.2 million people infected with HIV globally 9 out of 10 are adults in their productive and reproductive age. This is a similar pattern in majority of countries, the age group that is greatly affected is the age group 19- 49 (UNAIDS, 2008) This is the age group that is composed of able bodied men and women who are economically productive, those that the country depends on for social and economic development.

HIV and AIDS has adverse effects on the world of work, it affects both the employer and the employees. According to International Labour Organization (ILO) (2001) HIV and AIDS contributes to loss of skills and experience, disturbs production, weakens the economic growth and hinders sustainability of services. It is also said to have adverse effect on fundamental human rights especially with regard to discrimination and stigma. The pandemic also results into economic burden due to early retirements and early deaths. The UNAIDS's (2005) view is that within the world of work the pandemic affects staff morale, public perception of the organization, it also has adverse effects on the institutional memory and the labour relations as well as the impact to the community within which the workplace is located.

The magnitude of the pandemic at the world of work and its adverse impact on the workers and the business itself makes it a workplace issue. It is therefore critical that it is treated as a thread to the survival of business and the economic development and appropriate measures are put in place to deal with it. The world of work is an organized set up in which people whom it was indicated earlier that are mostly affected can be reached easily with different types of interventions.

1.7 The Workplace HIV situation in Lesotho

The focus of the study is on the textile industries in Lesotho, therefore the workplace issues reflected in this report are based on this sector. The textile industry is the largest employment sector in the country and the highest percentage of employees are women and one third of who are said to be HIV infected**.** Apparel Lesotho Alliance Fight against AIDS (ALAFA, 2006).There are fragmented HIV and AIDS interventions within this sector and such interventions include, peer education training, condom distribution, STI treatment, HIV care and treatment as well as provision of VCT. ALAFA is currently providing a comprehensive HIV and AIDS interventions covering about 75 % of the 46,000 textile workers, 50% of these have access to medical monitoring and treatment and the interventions include prevention of mother to child transmission (PMTCT). The programme intends to extend to spouses and dependants of the workers. The study conducted by ALAFA indicated that of the 2500 workers tested there is 43% HIV incidence and that there is low take up of VCT and HIV treatment within the sector. The reluctance in taking up VCT is attributed to fear. Source: (ALAFA, 2006).

It has been observed that in Lesotho majority of factories do not yet regard HIV and AIDS as a workplace issue. The country has however facilitated the workplace response with the enactment of the relevant legislation, The Labour code Amendment ACT of 2006. This legislation is intended to guide the national response at the workplaces, to curb stigma and discrimination and to ensure that the rights of PLWHIV at the workplaces are not violated. (Labour Code (Amendment) Act, 2006).

1.8 The Statement of the problem

Sexual transmission is regarded as the number one mode of HIV transmission in majority of countries. People who are HIV infected have therefore been viewed as people who sleep around, people of bad and immorally behaviour, people who have sinned and deserve punishment. This has brought about shame, despair, and lack of self worth to people who have been HIV infected (UNAIDS, 2002). All these coupled with lack of information and ignorance has brought about fear, self withdrawal, and social exclusion of those who are infected and to those who are affected by the virus.

Those who are infected with HIV have been labelled, called all different names, rejected by families and friends and they have also faced social exclusion, in different spheres of life. As a result of these those who have tested positive and their relatives developed fear and felt ashamed and worthless. HIV and AIDS have been regarded as a shameful illness, a punishment for bad behaviour, a crime and a disease of others. (LENEPWHA, unpublished). All these fuel stigma and discrimination, which in turn undermine the efforts aimed at curbing the pandemic. Stigma and discrimination have not only affected the infected and the affected communities but they have had negative impact on the provision of services related services. (UNAIDS, 2001).

Majority of countries have realized the importance of VCT, such services have been made available at facilities and workplaces, and however progress has been satisfactory. A challenge to any country is when people do not test it becomes difficult for the country to respond accordingly knowing how many are HIV infected, how many need, what kind of service. When people do not know whether they are infected or not it is not very easy to take protective measures, therefore, the rate of infection would also continue to rise. When a service is provided and there is no evidence of utilization or utilization is not evident or satisfactory it is essential to

investigate what could be wrong. The utilization of VCT services could be affected or influenced by various factors, stigma and discrimination is one of those factors. The study therefore focuses on the effects that stigma and discrimination have on VCT. This is to enable the government to understand stigma and discrimination, what effect it has on this service and develop appropriate strategies to deal with it and ultimately promote testing and counselling. The specific research problem discussed is: **Stigma and discrimination, what effect does it pose on voluntary counselling and testing?** The research question has two variables the independent and the dependent variables, a question is asked about the relationship; it is also stated in a question form to facilitate testing. (Christensen, 2007).

HIV and AIDS related stigma and discrimination is defined and different forms of discrimination were discussed. Because the effects of stigma and discrimination could be too broad in different situation within the spheres of HIV the focus has been operationalised as follows:

- The state of stigma and discrimination
- The existence of discrimination
- The causes of stigma and discrimination
- The forms of stigma and discrimination
- People who are being stigmatized
- The effects of stigma and discrimination

1.9 SIGNIFICANCE OF THE STUDY

People who are living with HIV and those that have been affected by AIDS are said to have been and are still being subjected to stigma and discrimination. Stigma and discrimination does not only affect the infected and the affected but has posed some challenges in the provision of HIV services such as VCT and in the HIV and AIDS response as a whole. It is therefore significant to study this area in order to inform decision making in developing appropriate strategies to curb stigma and discrimination and reduce its impact on VCT. It is also believed that the study will also contribute to the enhancement of the HIV and AIDS national response.

1.10 SCOPE OF THE STUDY

Stigma and discrimination prevails in different settings in life and in different degrees to different people who are infected by the HI virus and those that are affected by the pandemic. The study endeavours to establish the existence of stigma and discrimination, different forms in which it exists and the effects it could have on voluntary testing and counselling. The study focused on two garment industries in Lesotho within the two industrial sites of the capital city- Maseru. In order to consult and include PLWHIV, members of the Lesotho Network of people living with HIV (LENEPWHA) took part in the study.

1.11 The purpose of the study

The study intended to investigate the reality of stigma and discrimination, investigate who is or have been stigmatized. The study focused specifically on the effect that stigma and discrimination have on VCT. VCT is the gateway to majority of interventions of HIV and AIDS therefore, it is critical to investigate and reveal any barriers to it so that they can be dealt with accordingly.

The study aimed to answer the following specific questions:

- Does stigma and discrimination exist?
- What are the factors that contribute to stigma and discrimination
- What are the different forms of stigma
- Does stigma and discrimination have any impact on VCT?

1.11.1 Research objectives: The specific objectives of this study were:

- To determine if there are people that are being stigmatized
- .Determine who is being stigmatised
- Investigate the reasons for stigmatization and discrimination
- Ascertain the effect that stigma and discrimination have on VCT
- Recommend measures that can be taken to reduce stigma and discrimination

1.12 Conclusion

The introduction chapter introduced the study, covered the global and the Lesotho epidemiological situation. The study focuses on the workplace therefore to create more understanding of the workplace HIV and AIDS situation is presented and that entails the global and the Lesotho specific situation. The study also went on to state the problem being investigated and elaborated on the significance and the scope of then study. The purpose and the objectives have also been presented.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

This is the part of the report that reveals the views of some people who have done some work in the same or similar field. It allows the author to dig into what has already been done and how the subject has been tackled in order to learn from and to avoid duplication.

The literature review chapter looks into what stigma and discrimination is, the causes and determinants of stigma and discrimination and its different forms. The effects and the impact of stigma and discrimination as experienced by people living with HIV and AIDS and those documented by other authors are also looked into. The chapter also presents Lesotho's HIV Testing and counselling and focuses more on Voluntary Counselling and Testing (VCT).

Stigma is not a new term. People of different categories have been stigmatized in one way or the other due to different inclinations. Stigma has existed pre HIV and AIDS. It has brought about social exclusion, rejection and the exercise of power over certain individuals. Stigma is described as "An attribute that is significantly discrediting, which in the eyes of society serves to reduce the person who possesses it." (Aggleton, 2003. p.3) According to this definition any person whose physical makeup, psychological status and other status including behaviour is regarded by society as abnormal, unacceptable or socially deviant could be labelled and rejected and further subjected to stigma. Aggleton (2003) further beliefs that a person who is stigmatized is a person who possesses "undesirable difference which could lead to spoiled identity." (P. 3")

Discrimination: Discrimination is described as "an action of or omissions that are derived from stigma and directed towards individuals who are stigmatized" (UNAIDS, 2002, P. 9). In HIV and AIDS the discriminatory or unfair treatment is directed towards people who are HIV infected, their relatives and those that associate with them.

It is over decades now that majority of countries of the world have been experiencing the devastating effects of HIV and AIDS, however according to Brett (2003) there is a bigger challenge: "These days the biggest problem is not the virus, unfortunately, it's people." He further says it is easier to deal with the virus because it can be treated but very difficult to deal with a person. There are no pills for people's attitudes towards people living with HIV and AIDS. Some people are still full of ignorance and fears and react to someone with HIV in a negative manner.

Stigma and discrimination are said to create deep rooted fears and anxiety about germs and death, this are the same fears that were associated with other diseases that came before HIV and AIDS like Leprosy, TB and cancer (Aggleton et al, 2003). Aggleton et al further indicates that although stigma and discrimination have been existing but HIV and AIDS has given rise to high levels of both stigma and discrimination. HIV and AIDS have been in the world for more than two decades but it however continues to rise in different societies and countries and in different degrees. HIV and AIDS related stigma has brought about different attitudes and perceptions to different people. It has brought about fear, anger, confusion, denial and loss of hope to the infected and affected people and communities.

2.2 The causes of Stigma and discrimination

Globally HIV and AIDS had been in the past seen to trigger compassion, solidarity and support (www.avert.org/aids.org). This had resulted in the formation of support structure and groups and networks at village, community and national levels. All these structures were created with the intention of providing support, however it is within the same groups that negative attitudes that have lead to stigma have emerged. On the other hand HIV and AIDS have also triggered negative attitudes, anger, rejection, anxiety which contribute to stigma as well as discrimination. This negative response to HIV and AIDS is said to be common not only in the poor countries but in the rich countries too. According to Aggleton et. al (2003) HIV and AIDS has reinforced the existing prejudices, hatred and anxiety about certain groups of society. HIV and AIDS is said to bring about shame to those who have contracted it.

Stigma is described by Clay & Kidd (2005, P.1) as a process that devalues people who are infected "It involves rejecting, isolating, blaming and shaming." it is

followed by discrimination as mentioned above. Discrimination is viewed as "unfair and unjust treatment of an individual based on his or her real or perceived HIV status." www.icrw.org/docs/vietnamstigma. There are a lot of factors that are viewed to cause and fuel stigma and discrimination, in some communities HIV and AIDS is viewed as an illness of people of behaviour that is not socially acceptable for example, the sex workers and the injecting drug users and homosexuals.

In majority of countries HIV and AIDS emerged among men who have sex with other men, injecting drug users as well as sex workers. These are groups of society who even in the absence of HIV and AIDS are regarded as outcasts, people of immoral behaviour that is socially unacceptable. These groups have always been rejected and ostracized by society. This has contributed in the way people perceived those that are HIV infected and consequently rejected them. HIV and AIDS related stigma and discrimination is also associated with fear and ignorance. HIV related stigma and discrimination is also determined by two levels of HIV and AIDS information; One level is what one knows about the illness while the second level is what one does with the information they have (UNAIDS,2001). If one has little information about a subject he/she is likely to conceive and conceptualize it differently from the person who is well informed. However in Uganda for example in one of the studies that UNAIDS conducted although there has been widespread information dissemination and sensitization there were still reported cases of stigma and discrimination.

Stigma is a deep rooted act prevailing within all spheres of every day life; it has generated fear as it has always been associated with death, guilt, punishment, crime and horror. Religious perception of HIV and AIDS as punishment of sinful behaviour has also reinforced stigma and discrimination thereof (UNAIDS, 2005). Stigma on the other hand is said to be determined by the financial status, when an HIV infected person is well off and financially stable he/she is less stigmatized. (UNAUDS, 2001) On the same issue UNAIDS has further revealed that within families a person with HIV is blamed for family's poverty in that the family spent all its money for his/her medical expenses.

The key factors affecting the nature and the degree of HIV related stigma according to Hong and Anh (www.icrn.org) occurs within the society, communities and individual

families and it is caused by social, cultural, political and economic environment and these combined contribute to and determine the nature and the degree of stigma.: Other contributing factors are: The first being: the stage of the illness- those who are at the advanced stage are said to experience greater stigma, The second one is gender- women are by nature in some communities regarded as minors, therefore they are more adversely affected than men, while the third factor is the media: the negative messages reinforce fears and negative attitudes that exacerbates stigma and discrimination. In a study conducted by Hong and Anh at Vietnam It was revealed that some people believe that moral judgments against PLWHA should be based on how the virus was acquired and be classified into 2 categories: One being those that contracted the HI virus due to deviant behaviour and these are regarded as the group that deserves blame, suffering and stigma. In some societies these are said to have gone out to hunt or catch HIV. The second group being those that said to be "unlucky", these are those said to be infected by their wives and husbands, or infection through mother to child or blood transfusion: this is the group according to them the innocent group that deserves sympathy. (www.icrn.org).

There are numerous other factors that contribute to stigmatization and some of those are:

- HIV and AIDS is regarded as a life threatening disease therefore people are scarred to be infected or to know that they are infected
- Lack of in-depth knowledge about HIV transmission and HIV and AIDS in general.
- Negative and biased media messages such as: AIDS is a women's disease, disease of the prostitutes and a gay plague.
- The illness is mostly associated with behaviours that are either illegal, socially unacceptable such as prostitution or drug use.
- A perception that HIV infection is a product of personal choice such as bad behaviour or engaging in risky behaviour.

Source: Chaturvedi S.K. (slides) and Fredrikson and Kanabus.

- It is also believed that one other factor that contributes to stigma is the existing prejudice against people belonging to the groups that are already stigmatized on the basis of gender, race and sexual orientation. (www.multikulti.org.uk). Another factor that is worth noting is that HIV and AIDS in different countries, communities and within different age groups within societies is given different names: In Uganda for example people used to point fingers at the people who are HIV infected and call them people with "slim disease" or "moving corpses". (UNAIDS 2001).In Lesotho such names include: the modern illness, the disease of the youth, the disease from overseas or the disease of the prostitutes. All these and other names are in some way saying ".... is it not for me, it is not for us it is for those people" or it is a shameful disease. These names mostly express anger and judgment and this could fuel stigma against those that are infected with the HI virus.

Another contributing factor is inaccurate information about HIV infection and related myths that for example one can get HIV infection from a toilet seat or from the air, or shaking hands with an HIV infected person. Brett (2003) (P.25) on the other hand believes that peoples views about the illness contribute to stigma. "People view HIV and AIDS as a sex issue and not a health issue." On the other hand lack of effective policies and legal instruments to protect people living with HIV contributes to discrimination.

2.3 Forms of stigma and discrimination

It is said that people who are being stigmatized do not face the same level of stigma and discrimination. Stigma is said to occur in different settings such as clinics, police stations even in shops and all other spheres of life. Stigma and discrimination has been experienced within homes and communities, health care facilities and other services, schools and workplaces, It makes people that are stigmatised feel invisible, as if they do not matter or exist (Clay & kidd, 2005). It is worth noting that there is also self stigmatization. This is said to be a situation in which an HIV infected person blames oneself, keeps away and shuts herself/himself away from others. In this case such a person is internalizing stigma and self discriminating oneself from friends, family, and community as well as from supporters. "Self stigmatization is said to be

the commonest and the most difficult form of stigmatization to address." (UNAIDS, 2001. P21).

2.3.1 Home and community setting

At home setting, in families as well as within communities, PLWHIV have experienced rejection by their spouses, they are according to Clay & Kidd (2005) dehumanized, treated as outcasts, discredited and feels judged. Mostly if it is a woman who is infected or who shows signs of illness first she would be blamed for having brought the infection into the family, be blamed for the husband's death. In the process of blaming those infected within the families they are sometimes discriminated say for example in the distribution of family estates with the view that they are already dying (UNAIDS, 2001). Some women have even been chased away from homes after the death of the husband by the in-laws. At community level PLWHIV would even be blamed for bringing shame to the community and consequently be rejected or be assaulted and chased away from the community.

Discriminatory acts from the communities include rejection of PLWHA from community, denial of access to community properties and public places, while others have been rejected or chased away from public events. At community level stigma and discrimination arise in the act of care and support as a community response. The same group that is supposed to provide care has been reported in some communities as the same group that would gossip about the patient, breach confidentiality and this has lead to some patients rejecting community care. This has even lead to PLWHHIV pull out and disassociating themselves from the community associations (UNAIDS, 2001).These unjust discriminatory experiences have not only been encountered by people living with HIV but by their relatives and children too.

This unjust treatment has even affected the children whose parents have died of AIDS and those that are living with the HI virus. Such children are called "AIDS orphans". Such children get rejected from schools even by teachers. They would even be physically isolated by other children at school while in some settings the parents would demand that a child whose parent/s are HIV infected be expelled from school or else threaten the school that they are taking out their children from such a school.

2.2.2. Health care

Health care facilities have been recorded as the worst service setting where the acts of stigma and discrimination have been conspicuous. PLWHIV have been denied treatment, admission into hospital care, and access to clinical care. (UNAIDS, 2001) Patients have been neglected and this has contributed in fear and anxiety to patients and this could consequently lead to depression (UNAIDS, 2001). PLWHA have been rejected by hospital staff, they have faced physical isolation in wards, that is PLWHA would be kept in separate wards and their wards were labelled wards of AIDS. Those living with HIV would even be denied access to essential services or even be given restricted access to certain hospital services. The acts of stigma and discrimination have also been obvious in cases where health care workers would use excessive protective gear when caring for a person who is HIV infected as if HIV is the most contagious illness. In cases where a person who had AIDS has died the hospital would be unwilling to provide transport for such a corpse or if such a transport is provided extra precautions will be taken to wrap such a body with a plastic. The sad part is that at a health facility the workers are well informed about the mode of transmission and would have more caring attitudes towards PLWHA than at any setting. (UNAIDS, 2001). In a study conducted in Nigeria for example doctors and other health professionals admitted having refused care to the HIV infected people. With these "health professionals" the discrimination is fuelled by fear of exposure to HIV as though even the protective equipment is not sufficient (UNAIDS 2002).

2.2.3 Workplaces

At the workplaces too PLWHA face different forms of stigma and discrimination and such acts include denial for employment or promotion, forced resignation, request for HIV test prior to employment or promotion as well as denial of access to certain benefits and facilities within the workplace (UNAIDS, 2001) Unfortunately at the workplace stigma and discrimination could be from two sources, and these are the fellow employees and the employers. Employees enforce stigma and discrimination by gossips, refusing to work with or share tools with HIV infected person. The social exclusion and negative attitudes from fellow workers could result into unpleasant and unbearable state that one may decide to quit work. (www.multikulti.org.uk). One of the studies conducted by UNAIDS revealed that in some workplaces in addition to requiring HIV test for prospective employees the HIV test is required as a condition

prior to training. In the same study some employees revealed that the degree of discrimination is so bad at the workplaces that even if the employer does not terminate your employment, the rumours and gossips may force one out of employment. (UNAIDS, 2001).

2.2.4 Education

In the education sector both teachers and the learners have suffered discrimination, parents feared that their children could be infected by the children who are HIV positive by mere sitting or playing or even being in the same classroom with them. Parents would even demand that such a child. (UNAIDS, 2001). On the other hand the teacher can be forced to resign due to the fear that he/she may infect children or the parents force the school to get rid of such a teacher. Teachers in schools have been stigmatised by both co- workers and parents. There has been a media report where in one school parents took away their children on hearing that there is one child in the school who is HIV infected. At school HIV infected children can also be subjected to discrimination by fellow students by excluding her/him while playing or eating as well as learning.

Example of cases of HIV and AIDS related discrimination in the Americas: "In Peru, A soccer player was removed from the university soccer club professional team in January 1999 when it was discovered that he was HIV positive. The directors of the club argued that his presence in the locker room could endanger the rest of the players and that other teams would refuse to play against them." (Aggleton et. Al 2003. p.7).

In the religious institutions unfortunately stigma and discrimination do prevail. People with HIV are regarded as people of immoral behaviour and people who are promiscuous. This is mostly revealed in the negative messages delivered in some churches. One church leader in a study conducted in Uganda told researchers that "AIDS is an epidemic that has come to the world because of promiscuity and this has resulted into AIDS and other Sexually transmitted diseases (STDs)". (UNAIDS, 2001, P.20). It is legitimised and people say; "She was promiscuous and he deserves it" (Clay& kidd, 2005, p 2). They would even go further to say AIDS is a punishment from God.

All this forms of discriminatory acts bring about suffering, inflict pain and also discredit individuals and bring about shame to those that are infected and affected by HIV and AIDS.
Source (UNAIDS, 2001) and www: multikulti.org.uk

2.3 EFFECTS OF STIGMA AND DISCRIMINATION

Stigma and discrimination has inflicted fear and suffering not only to those that are infected but also to those that are related to or caring for them. Those that are stigmatized and discriminated face frustration, rejection; they despair and ultimately withdraw themselves from society. At times the society itself excludes them from social events. Stigma according to Aggleton et. al (2003. P.6) "it causes undue anxiety, and distress- factors that in themselves contribute to ill health." The stigma and discrimination could therefore contribute to deterioration of someone's health.

The infected feel guilty, ashamed and this prevents them from speaking freely, or expressing their views and fears. One of the effects of Stigma and discrimination is psychological in nature, may lead to depression, lack of self worth and despair. And when one is in this situation it becomes impossible to think in a rational or reasonable manner, to protect themselves, follow instructions or prescriptions and this could lead to further infections, re -infections, poor adherence to treatment or program that one may be enrolled into. Stigma also causes denial and this makes the people who are at risk or those infected not to protect themselves like practicing safe sex or taking other precautions. All these fuel the spread of HIV infection. In some cases people feel if they take precautions to protect themselves such actions and behaving differently they will be suspected of having the HI virus. (UNAIDS, 2002. p.5). UNAIDS further stated that Stigma and discrimination is also said "to cause people with HIV and AIDS erroneously to be seen as some kind of "problem" rather than part of the solution."

Stigma and discrimination on the other hand is said to be an act of violation of fundamental human rights of those that are infected or those presumed to be infected. Aggleton (2003) (P.5) views HIV related stigma as an act that reinforces the "existing social inequalities" such as wealth, the inferior status of women to men and other inequalities on nationality, ethnicity and sexuality. Women in some societies are

regarded as minors and also discriminated and this gender inequalities and discrimination against women is seen "as a basis for combustible fuel for the epidemic" (UNIDS, 2002, p.5). Where this gender equalities prevails women have no say or can not bring about the issue of safe sex, can not say no to sex even when they see the risk involved, the male partner has the control over how sex has to be done , the form and how often. Furthermore in cases like this it becomes very difficult for a female partner to reveal her HIV positive status to the partner and this means further infection. Stigma and discrimination reinforces dominance and power (UNAIDS 2005). Those who are stigmatized become powerless and those who stigmatize assume the control position. At the individual level PLWHA have reported fear of social isolation, judgmental attitudes, depression anxiety as well as suicidal thoughts, all these contribute to PLWHA fear and reluctance to access prevention, support and care. (UNAIDS, 2001).

Stigma result into hiding away and self isolation and contribute to what is termed the "hidden epidemic." The most worrying factor is what is termed the "silent spread of infection." (UNAIDS 2001, p.52). This is the situation in which those who are infected do not disclose their sero- positive status to their sexual or drug injecting partners due to fear and continue to infect them. With those that are at the a symptomatic stage, whom it may be difficult for them to conceal their health status or are already having obvious opportunistic infections, due to fear of being discriminated they delay seeking appropriate medical care or resort to alternative medical care such as purchasing medication over the counter or go for the common over advertised medicines which are said to boost the immune system. Unfortunately some of these mixtures are said to have harmful effects.

2.3.1.1Effects in service delivery

Stigma and discrimination is believed to have a negative impact on the success of the HIV and AIDS programs. It is said to be the greatest barrier to prevention, care and treatment .It threatens the effectiveness of the interventions against HIV and AIDS (www.multikulti.org.uk).And discourages people from utilizing and enrolling in HIV and AIDS programs. Societies which are willing to actively participate in the HIV and AIDS response are discouraged by fear due to stigma. The UN declaration says "Stigma, silence, discrimination and denial as well as lack of confidentiality,

undermine prevention, care ant treatment efforts and increase the impact of the epidemic on individuals, families and the nation." (UNAIDS, 2002, P.6) With this status any form of action by society or individuals as a response to the epidemic may be jeopardized.

In 2003, Population Council (2003) conducted a study on " exploring how to improve Eskom's HIV and AIDS program, including addressing stigma and discrimination in the workplace" and the study revealed that stigma has a role to play in the underutilization of the Eskom HIV and AIDS workplace program especially HIV testing and counselling. In addition to this the workers were reluctant to participate in the study for fear of .being associated with people who are involved in HIV and AIDS and be stigmatized. The following are some of the response captured by the study.

"Respondents agreed that if they were to be seen sitting next to someone with AIDS, then others would think that he or she has AIDS, too."

"HIV and AIDS program staff also told researchers that they experience stigma because they offer AIDS- related services."

Source: Population Council (2003) Horizons Report P.4

The following are some of the identified effects of stigma

- Discourages access to antenatal services
- Prevents access to counselling, HIV testing and Prevention of Mother to Child Transmission (MTCT) services.
- Discourages disclosure of HIV test results to partners
- Inhibits the use of safer infant feeding practices
- Inhibits adoption of safer sex practices
- It promotes silence about one's HIV status thus promoting infection
- Discourages HIV testing

Other that discouraging those who have to enrol on the HIV and AIDS programs it also has a negative impact on adherence to the programs such as Prevention of Mother to Child Transmission (PMTCT) or Antiretroviral Therapy (ART). Stigma and

discrimination has impact on the acceptance and utilization of HIV and AIDS services. It develops shame and fear in people living with HIV and AIDS and this result into resistance and reluctance to test for those who have not yet tested.

On the other hand stigma and discrimination is said to push the epidemic underground, it contributes to acceleration of infection and promotes denial (Aggleton et.al, 2003) Stigma and discrimination does not only affect individuals but it affects also the programs aimed at halting the spread of HIV and AIDS. It undermines the community and the national response such as prevention, treatment and care programs. www.multikulti Further more it results into poor care of people living with HIV because of rejection by the carers or relatives. It has a negative impact on the care that is normally provided by the families and the community (Aggleton. 2003).

The study conducted by Herek, et.al (2003) stigma and discrimination discourages disclosure of the HIV status; people interviewed have expressed concern about HIV testing for fear of being stigmatized. Stigma also undermines the efforts to strengthen Greater Involvement and Participation of people living with AIDS (GIPA) which is a strategy aimed at strengthening the voice of PLWHA and their meaningful participation in the HIV and AIDS response.

2.4 Background Voluntary HIV testing and counselling.

In the HIV and AIDS response HIV testing and counselling is regarded as the gateway to treatment care and support. Because it is only when one knows his or her HIV status that one can access appropriate services being it treatment or care. Testing also gives an opportunity to the health service provider to assess the state of health of the person tested in order to provide and or recommend appropriate care. Voluntary Counselling and Testing is "a process by which an individual undergoes confidentiality counselling to enable the individual to make an informed choice about his/her status and to take appropriate action" (UNFPA and IPPF, 2001 P.9). VCT involves, undergoing an HIV test to ascertain the presence of HIV antibodies in ones blood. When HIV infects the body, the body produces antibodies and the presence of the antibodies in the blood is a confirmation of HIV infection. Commonly it takes about 3 months from the time of infection to the time the antibodies can be detected from the blood. This is referred to as the window period. During this period the

infected person is highly infectious, unfortunately for majority of people there are no signs of infection.

The test is voluntary in nature, maintains high level of confidentiality, while pre and post test counselling are the integral part of the process. It entails informed consent prior to testing, referral when necessary, equality in the provision of the service and adherence to national standards. (UNFPA & IPPF, 2001).

The purpose of HIV Counselling and Testing.

- Testing is regarded as a behaviour change tool
- It allows individuals to take necessary steps to access the required HIV and AIDS services on time.
- It plays a critical role in prevention of mother to child or parent to child transmission.
- It plays a major role in halting the spread of HIV that is those who are found to be HIV infected are assisted to adopt safe lifestyles in order to prevent/ avoid re - infection and infecting others
- Provides an entry point for care and support.
- To help reduce stigma, fear and anxiety around HIV and AIDS and to increase openness in the community.

Source: (Jackson, 2002)

2.5 HIV testing and counselling services in Lesotho.

Lesotho like other countries, some decades ago started providing the HIV testing and counselling services and these started at the health facilities. In an attempt to adhere to the united nations commitment to ensuring universal access to care treatment and support and in compliance with the 3 by 5 initiative that aimed at enrolling 3 million people on treatment by 2005. Lesotho launched the "Know your status campaign" (KYS) in 2004. Lesotho was the first African Country and the 2nd to Brazil to launch such a campaign with the aim of providing an enabling environment for people to test and receive counselling. It is reported that the Lesotho Prime Minister followed by senior government officer tested first with the aim of setting an example. In this way this KYS is regarded as a Human right. The right to know one's status. The know

Your Status was to be achieved through intensified and vigorous provision of the testing services at the villages, in towns and in the rural areas and health facilities. Facilitating access to information and enabling one to know his/her status is regarded as a human right and a public health measure. (Jackson, 2002).

The campaign aimed at bringing the service to the doorstep of every Mosotho hence the training of the community care givers who were mainly trained and guided to conduct HTC through door to door approach public gatherings. It is important at this point to look into and understand why the government of Lesotho decided to put together the KYS campaign: The campaign was mainly driven by the devastating proportion of the epidemic. The country was also concerned about the status of the epidemic that one in every 3 Basotho (Lesotho people) is estimated to be HIV infected but still the main concern being the widespread lack of information and majority of people still not knowing their HIV status. The other reason for establishing KYS was to facilitate access to care, support and treatment on time to those that needed it.

The campaign aimed to reach people through group education, individual counselling and it also aimed to utilise the children's vaccination community strategy. Some of the key issues of the campaign were intensive involvement of the communities in the modalities of the service. The community leader playing a leadership was critical. It was also critical to use community counsellors to ensure success.

There were three options put in place to ensure accessibility of the service and those include the health facility, the mobile clinic and testing by trained community based care givers within the community. The motto was "Take Control of Your Life – Take an HIV Test Today"

What next after the campaign? As the campaign was to reach every Mosotho, it was envisaged that all Basotho would have accessed the service and tested, those that need care, support and treatment would have been referred and accessed the required service and testing service to continue to be accessed at the HTC sites and community dialogue and education to continue

The situation now:

Mainly the rapid test was u In order to facilitate smooth implementation of the campaign the HTC policy and the operational plan were developed. The objectives of the policy were

- To create and sustain a favourable environment for HIV testing and counselling that encourages people of Lesotho to know their HIV status.
- To guide HTC service providers and clients.
- To create conditions for behaviour change in all areas of sexual and reproductive health.
- To ensure that behaviour change communication about HIV and AIDS is consistent
- To ensure that adequate attention is paid to vulnerable groups such as women youth and children.
- To create a climate of collaboration among stakeholders in the delivery oh HTC services.
- To provide linkages to relevant post test services

Source Government of Lesotho, HTC policy, 2004

Under the policy provisions the issue of stigma and discrimination is highlighted as one of the issues which could discourage people from accessing HTC services and defeat the purpose of halting the spread of HIV. The policy regards stigmatization as "…A powerful inhibition to changing knowledge and behaviour and/or the ability to take up preventive measures." (GOL, 2007, P…27) in foreseeing this challenge the policy made provision on how stigma and discrimination shall be discouraged and dealt with specifically at the workplaces and in schools.

Vigorous social mobilization at district and community level as well as at the workplaces together with commitment and dedication of other partners in the HIV and AIDS national response the campaign realized some successes. In addition to the efforts made to promote testing and counselling within the communities and the health facilities, the service has been extended to the textile industries to facilitate access.

2.6 Conclusion

Stigma discredits and significantly devalues people who are infected or suspected to be HIV infected, while discrimination occurs as a result of stigma. In discrimination individuals or groups are subjected to rejection, hatred, horror and even acts of violence or ill - treatment. HIV infected and the affected suffer the blame, are labelled as prostitutes or people of immoral behaviour who bring about disgrace to the families and societies. The literature reviewed has confirmed that HIV and AIDS related stigma do exist; they are perpetuated by numerous factors; occurs in different forms with adverse effects and in various spheres of life.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Introduction

Chapter three outlines the research design, research method used in the study, Population in terms of selection and sample size. It goes further to elaborate the research instruments used, the questionnaires, the manner in which data collection was conducted and the ethical issues considered by the researcher**.**

3.2 Research Design

The study aimed to gain in-depth understanding of stigma and discrimination ascertain their existence, the causes, and understand different forms of discrimination and investigate if they have impact on HIV voluntary counselling and testing. The study allowed quantitative data to be collected, on the other hand it also allowed participants to share their experiences, interpret what they have observed and felt and described different forms of stigma and discrimination that they have experienced. The participants were also allowed to tell their stories, interpreted what they have experienced and shared their views about the effect of stigma and discrimination.

This is a correlation type of study that has utilised the non – experimental quantitative design. The study is a descriptive quantitative type of approach that enables the researcher to collect standardized information. Correlation "examines the extent to which differences in one characteristic or variable are related in one or more other variables" (Leedy and Ormrod, 2001. P191). The two further indicate that this design enables the researcher to observe three scenarios: The extent to which the two variables are similar or different. Secondly; the degree to which the two variables correlate and thirdly enable the research to confirm or refute the hypothesis. Both quantitative and qualitative data was collected to enable the research to reveal the existence of stigma and discrimination appreciate different causes of stigma and discrimination, and the effects it has on those that are being stigmatised and specifically on VCT.

The design described the situation with regard to stigma and discrimination services and established the relationship that exists between the variables. The design also

enabled the researcher to attribute the effect of the stigma and discrimination on the VCT services. Two groups of research participants were used.

3.3 Research Area

The study focused on garment industries within one district of the country, Maseru, the capital City of Lesotho. There are two main industrial sites within this district. The study focused on two of those industries which provide VCT services to its employees. This was regardless of whether such the service is offered within the factory of through outsourced means.

3.4 The Approach

3.4.1Research Participants and sampling

Research participants or population are defined as a group of people or organisms that are of interest to the researcher or the organisms that can assist the researcher to answer the question asked. (Christenseen, 2007). Christenseen further states that other determining factors for selection of the research participants are the precedent and the research problem. Siegel's (http://www.delsiegel.com) view is that research population include the entire population on whom the researcher wishes to apply his findings. Human beings (factory employees) have therefore been used as participants. Two groups of research participants have been used. One group for one to one interview; this interview focused on selected number of employees regardless of their HIV status, while the other group participated in the focus group discussion. The participants of the focus group discussion were workers who are living with HIV drawn from two factories and organization of PLWHIV. Lesotho Network of People Living With HIV and AIDS (LENEPWHA).

3.4.2 Sampling Design

Sampling is described as "A useful shortcut, leading to the results that can almost be as accurate as that full census of the population being studied but for a fraction of the cost." Gorald, 2001. (p10). Sample is on the other hand stated as the people involved in the research that represents the population that the study is focusing on. (Siegel,) http://www.delsiegel.com further states that age, gender and number are important aspects of the sample. Garment industries are female dominated therefore gender balance in the sample could not be fully achieved. Age was not a critical issue as the

participants were drawn from the workers regardless of age and age had no impact on the views of the participants.

The study used both purposive sampling and simple random sampling. Purposive sampling is described by Caesar (1998. p.14) as "...The type of sampling in which the researcher selects samples based on a certain purpose." This technique is said to "increase the utility of the findings" The purpose was to use participants specifically from garment factories and the purpose was to focus on those factories that provide VCT services. Random sampling was used to select individuals within the selected factories to take part in the research. Random sampling enabled the study to pick up a representative group of garment industries employees; this is said to enable the generalization of the results. Random sampling reduces extraneous variables and also reduces the risk of biasness (Preece, 1964). Care was taken to avoid gender bias, however the garment industries' are mostly females, therefore this could not be fully achieved.

3.4.3 Sample size

The sample size is based on the research design and the variability of the data (christenseen, 2007) while on the other hand Creswell (2007), views analysis planned, accuracy of the results required and characteristics of the population are the determining factors for a sample size. The study sample size was guided by Goddard and Melville(2001) which states that the correlation research the minimum of number of people can be minimum 30, 15 for comparing group minimum is 15 while for major research could be 20 -50. The financial constraints, the importance of the study and homogeneity of the population are also regarded as the determining factors. The factory workers are a homogenous group. They have similar level of education; they work together and live in similar environment it was therefore assumed that they are influenced by the same workplace factors.

3.4.4 Ethical issues

The researcher utilised humans as participants in this study, therefore the issue of ethics and respect for human rights and dignity were carefully considered. According to Goddard and Melville (2001) care must be taken to ensure that there is no psychological or physical harm to the participants and privacy be maintained. The

purpose of the study was explained to each participant, the names of individuals were not required and the interview was conducted in a separate room away from the rest of the workers. Each participant was treated with respect and dignity.

3.4.5 Consent and confidentiality

A letter of request to conduct the study was written to management stating the purpose of the study and that the data collected shall be used for study purpose and not any other purpose. A consent form was attached to this letter and the form was read to each individual before the interview to ensure informed consent and it was stated that the exercise is voluntary and that the highest state of confidentiality were to be maintained. According to Salkind, (2006) provision of sufficient information enables one to make informed consent. "Ethics in research entails voluntarism, participants being informed and participant's consent." (Blatex et, al. 1996, p.145).

3.4.6 Research Instruments

The researcher employed two methods of data collection namely face to face interview and focus group discussion. The questionnaires were administered to the sample selected from the general workforce. As stated by Blatex (2006) questionnaires can be used as one of the techniques of collecting data and can be administered in a number of ways such as face to face, internet or post.

Face to Face Interview: Structured close ended questionnaires were developed and face to face interview was conducted. Face to face interview has a risk of experimenter effect which can affect the way the responses are recorded and the way the participants respond, however there are some advantages with face to face interview; it provides an opportunity to clarify unclear issues and ensures accurate recording of responses. (Christensen, 2007).

Questions that required yes or no and questions with a several options/ answers to choose from. Provision was made where necessary in the questionnaire for a brief comment. The questionnaire asked a general question about the fears of HIV testing and focused on stigma and discrimination. The questionnaire was translated into specifically Sesotho (the Local language) to ensure that it was well understood by the intended population.

Focus group discussion: Experience has shown that people who are in the same situation like those living with HIV when they are together they are more willing and free to reveal and share their problems and challenges. Focus group discussions of a group of members of group of people living with HIV and AIDS was conducted to gather additional information and to enrich the study with people who are HIV infected. A research guide was developed to guide the discussion. The focus group discussion sought to enable the participants to tell their stories, interpret what they have experienced and share their views about the causes and the effects of stigma and discrimination. Through this discussion qualitative data was collected.

3.5 Data Analysis:

Data analysis there is a critical issue, according to Blatex et.al (1996. p.197) "...is arriving at your own assessment of what the results mean and how they relate to other relevant research." It assists the researcher to seek explanation and develop more understanding on the subject studied. The Excel 97-2003 computer programme was used to analyse the quantitative data and this was presented in bar and pie charts and tables.

3.6 Conclusion

The chapter stated the research methodology the study utilized and this focused on the research design and the area of focus. The chapter also stated the research population and specifically the sample of the population that participated and the sampling design used. The ethical issues as well as the issues of consent and confidentiality have been stated. The chapter also stated the instruments used in the research, and the data analysis applied.

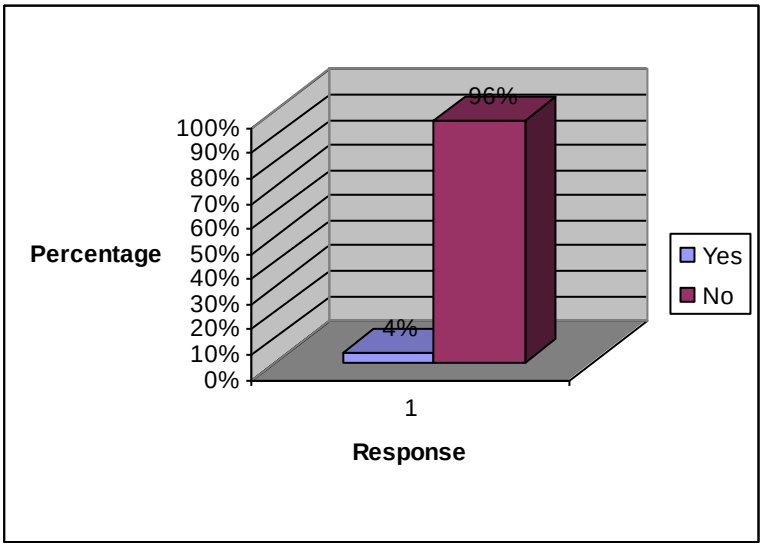
CHAPTER 4
ANALYSIS AND FINDINGS

4.1 Introduction

This chapter focuses on what the study reveals through the data that was collected from the research participants. The results are presented in charts and graphs as well as tables. Analysis according to Blatex et. Al (1996) is a process that allows the researcher to seek understanding of the data and arrive at his own assessment of what the results mean and relate his/ her work to what has been done by others in the relevant field. The total sample size for the study was 60.

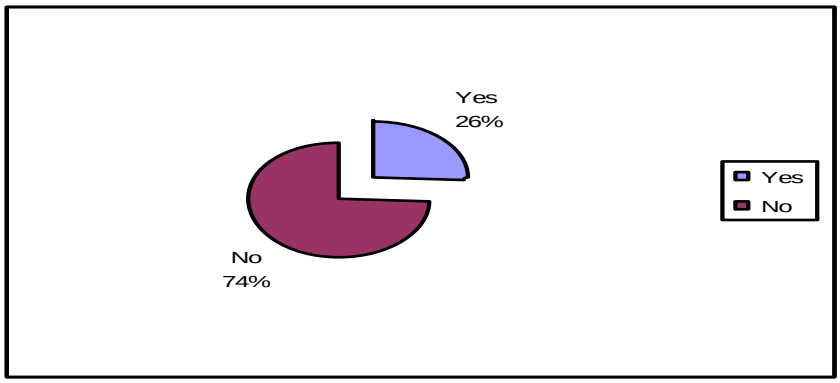
4.2 Analysis

Figure 4.1 Expulsion from work due to HIV and AIDS



A significantly high percentage 96% of workers have never heard any of anyone who has been expelled from work because they are HIV infected or suspected to be infected. This indicates the management at the work places does not practice discrimination; this could be attributed to among other things, adherence to the Labour code amendment Act (2006) which provides that there should be no discrimination due to HIV and AIDS at the workplace.

Figure 4.2.Percentage of people who have heard people who lost friends due to HIV and AIDS



As indicated on the table above 26 % of the employees have heard of someone who has lost friends because the friends Knew of his positive HIV status while 73% have never heard of a PLWHA who has lost friends. Although 26% is low compared to 73% it shows that a certain degree of discrimination is still practiced among the workers themselves. Lose of friends and relatives characterises stigma and discrimination (UNAIDS, 2000).

Resignation and desertion from work due to stigma

When asked if they know anyone who has been forced to leave work because of fear of being stigmatized or actual rejection about 94% have not heard of such an incident while lower percentage 5% know people who have decided to quit work for fear of being stigmatised. 1% is not sure if such incidences occur. On the other hand the respondents were further saying the incidence of desertion from work due to stigma used to be higher in the past when people lacked information about the illness. Senkhome (unpublished) in the workplace survey confirms that workers believe that workers could be forced to resign on the basis of being HIV infected and fear of being rejected. As stated by UNAIDS (2001) even if one is not expelled from work the rumours from other workers may force one to desert work.

Figure 4.3: No. of people in percentage that indicated that people have resigned as a result of stigma and discrimination.

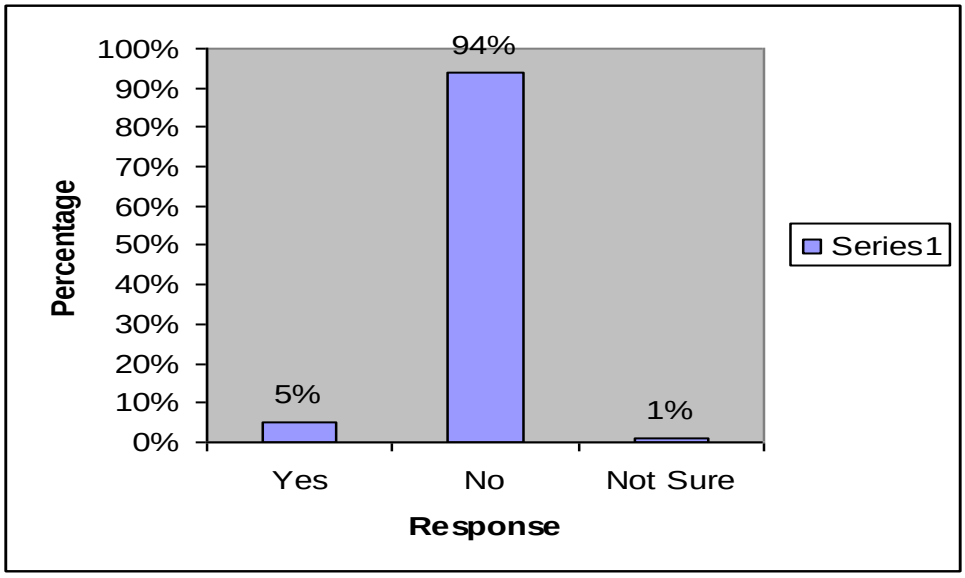
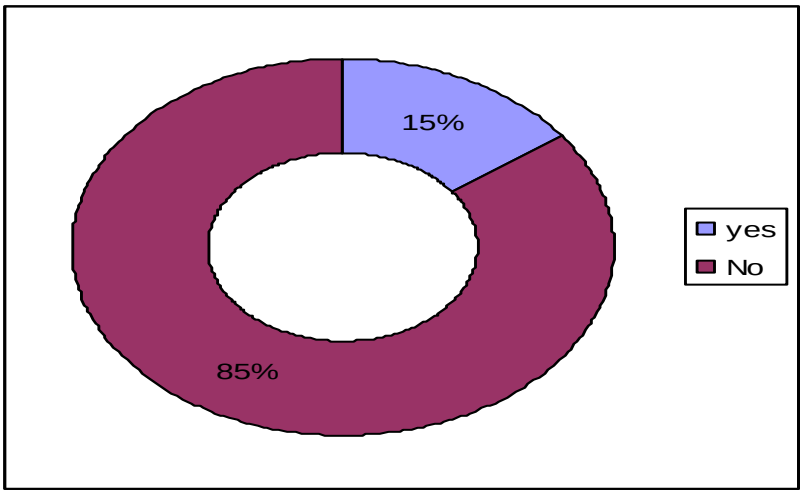


Table 4.1: Sharing of food or eating together with a an HIV infected person

Responses	Percentage of respondents
Yes	12%
No	88%

According to the table above a significantly higher percentage of workers about 88% do not know someone whose co- workers refused to eat with or share food with because such a person is HIV infected or suspected to be HIV infected.12% of the respondents know people whom co-workers refused the eat with. This shows that some discrimination is still being practiced although at a lower scale, workers are cautious about being infected and the level of information about the mode of transmission could be a factor. Lack of information and ignorance about HIV and AIDS is said to fuel the stigma and discrimination and the way people relate with people who are HIV infected. (UNAIDS, 2001).

Figure 4.4 Unfair allocation of jobs due to HIV and AIDS.



The respondents were asked if in their company they have heard anyone who has been unfairly treated in terms of allocation of the jobs due to their HIV status. 85% of the respondents have not heard of such treatment while 15 % know people who have been unfairly treated. This is a clear indication that workplace discrimination is low, this could be attributed to the fact that the two companies whose employees participated in the study are among the companies which are very much advanced in terms of implementation of HIV programmes. The respondents were recorded saying "our managers are very supportive; this factory is the most comfortable one to work in if you are HIV positive."

Table 4.2: Refusal by co. workers to work with PLWHIV

Response	Respondents	percentage
Yes	2	4%
No	58	96%

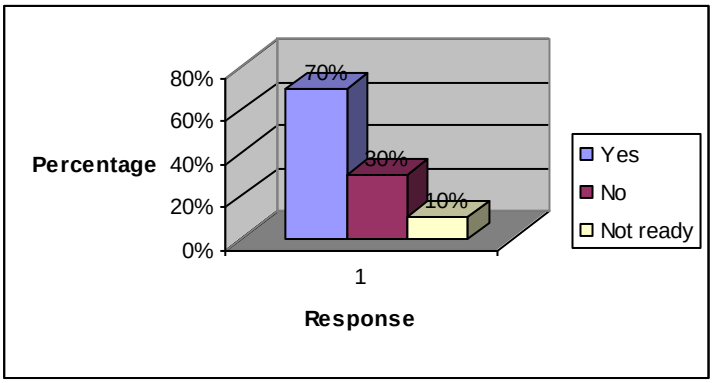
Table 4.2 presents the response on whether workers refuse to work with those that are HIV infected. Out of 60 only 2 people have heard of someone who has refused to work with a person who is HIV infected or those that are suspected to be, while the majority of respondents have not heard anyone who has refused to work with an HIV infected person. This indicates that in this regard discrimination is low, Aggleton and Parker (2002) confirms that where it exists people refuse to work with those that are HIV infected.

Table 4.3: The number of people that have heard people gossiping about PLWHIV

Response	Percentage
Yes	18.3%
No	81.7%

Gossiping entails expressing negative views, using unacceptable language or calling those who are infected with funny names. Those who have heard such gossips said they include, "they deserve it", "and the slim disease has caught her." Although this has been heard by a low percentage of the participants (18.3%), it is still an indication that workers still hold negative views about those infected. Those who said no (81.6 %) said there used to be more gossips in the past but as more people disclosed their status people are starting to consider HIV like any other illness.

Figure 4.5 Willingness to know ones HIV status or take up HIV testing



A question was asked to find out if the respondents are willing to test for HIV. Majority of them are willing about 70% while only 20% is not willing and on the other hand about 10 % are not sure about their readiness to test. This indicates that people are not totally discouraged by stigma to test for HIV. The 20% should however still cause concern. Stigma and discrimination instils fear in people, discrimination, rejection and stigmatization is said to be one of the reasons why people are reluctant to test for HIV. UNFPA and IPPF (www.icrn.org).

Figure 4.6: Reasons for fear to test for HIV

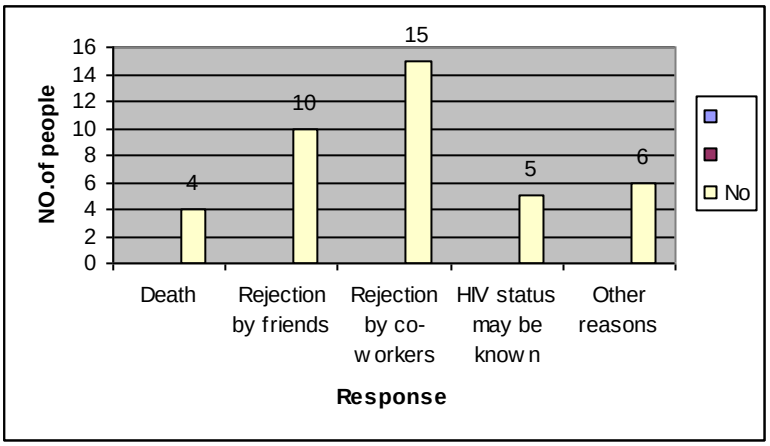
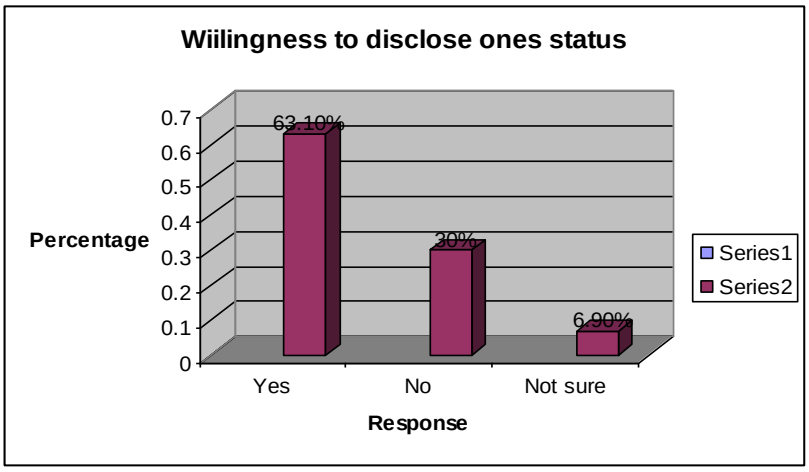


Figure 4.6 presents the number of people and the reasons they presented for not being willing to test for HIV. Those who had expressed fear to test were 40 (figure 4.6) above and these were the ones who were asked the reasons for their reluctance. 15 out of 40 feel they could be rejected by co- workers, 10 fear friends while those that fear that their HIV + status will be known and those who fear death rank lowest 5 and 6 respectfully. Other reasons include fear of stress, how one would cope with HIV status as well as how one would disclose the status to family or partner. This data indicates that a lot of fear still surrounds HIV testing; workers are still concerned about being stigmatized and rejected.

Figure 4.7: The number of participants who would be willing to disclose HIV status



The chart indicates that about 63.1 % of the respondents would be willing to disclose their HIV status as opposed to 30% who indicated that they would not disclose their status and a low number 6.9% not being sure how they can be accepted within their families.

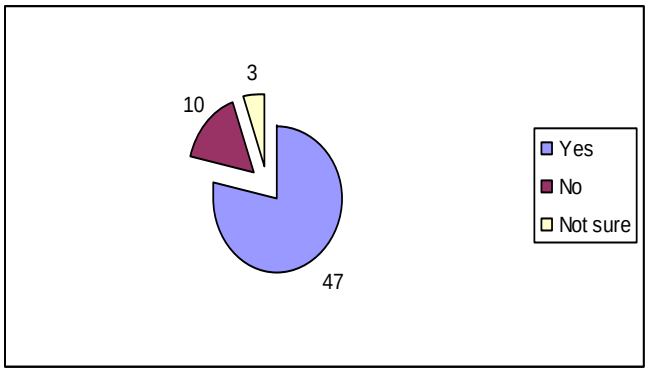
Table 4.4: Reasons for reluctance to disclose ones HIV status

Response	Percentage
Scarred of gossip/being labelled	28%
Fear of rejection	40%
Negative attitudes	30%
Discrimination by supervisors	2%

Although on the Table 4.4 the higher percentage of participants had indicated that they would not have a problem disclosing their HIV positive status, those who would not be willing have indicated fear of rejection (40) and this response ranks higher than other responses followed by fear to face negative attitudes (30%) followed by gossips and fear of being labelled 28%. When people still have these fears it is clear that discrimination still prevails and this situation is likely to have a negative impact on HIV testing. Fear of being rejected, blamed, victimised and fear of desertion are said to be the main reasons why people may not want to disclose their status and this affects HIV testing (UNAIDS, 2001).

VCT services are offered on site at the factories to promote accessibility of the service to the workers. The participants were asked if they think factory employees are willing to test or are taking up the HIV test as expected.

Figure 4.8: The No. of workers who are willing to take up the HIV test



According to the pie chart above about 78% of the research respondents believe people are taking up the test as expected while on the other hand few participants about 17% feel the factory workers do not enrol on the VCT service as expected. Only about 3% of the respondents were not sure. The data reveals that even though there

could be some factors which could affect testing workers are still willing to know their status however 17% is still a significant number that indicates that there are those employees who are still not willing to test for HIV.

Table 4.5 Factors that affect workers' willingness to test.

Response	Percentage
Fear to accept ones HIV + status	20
Fear of death	22
May loose friends/lover	31
Fear of loosing a job	10
Would not cope with stress	7
Fear of stigma	17

What are some of the factors that have been raised by the workers which contribute their reluctance to know their HIV status? Few of the respondents who indicated that workers are still reluctant to test were asked to share some of the reasons that have been advanced by workers as the reasons for not being willing to test for HIV. The table above indicates some of the issues raised by respondents.

Fear to accept ones HIV status, fear of death, fear to loose friends and fear of being stigmatized rank higher than other factors and these factors when summed up reveal that stigma and discrimination are still the main factors that could contribute to workers reluctance to test. Stigma and discrimination as stated by UNAIDS (2002) are the greatest barriers to prevention, care and treatment.

Some of the information revealed by the respondents is that people are not yet well informed about HIV and AIDS and what testing means, what it entails and what being HIV positive means while others are not willing to take responsibility for their lives. Lack of information is said to be a contributing factor to stigma and discrimination. Aggleton, Parker and Maluwa, 2003).

4.3 FOCUS GROUP DISCUSSIONS

In order to further understand stigma and discrimination and how those that are living with the HI virus are affected, focus group discussions were held for people living with HIV from the factories who participated in the study and the other group was members of LENEPWHA.

4.3.1 Existence of stigma and discrimination

The group was asked if there is HIV related stigma and discrimination, majority of the members agreed that people who are infected with HIV and those that are affected by HIV are subjected to stigma and discrimination. The National Strategic Plan (2006-2011) of the Government of Lesotho and the Constitution of LENEPWHA (2005) recognise the existence of stigma and discrimination and endeavour to eliminate it to ensure that human rights and dignity of PLWHIV are respected.

4.3.2 The causes of sigma and discrimination

On the question of what could be the contributing factors to stigma and discrimination, the few participants blame fear of becoming infected, self centeredness, the myths surrounding HIV infection, people's attitudes towards PLWHIV as the factors that rank low as the contributing factors to stigma and discrimination. The negative views that HIV is a result of unacceptable behaviour, the religious view that HIV is a punishment and the negative media views are said to contribute to stigma. While majority of the participants agreed that lack of information and blame for bad behaviour rank highest among the factors fuelling stigma and discrimination. Those who are not well informed about HIV and its mode of transmission believe they can get infected by being for example in the same room with the infected people or drinking with the same mug with the person who is infected. (LENEPHWA, unpublished study, 2009). Lack of understanding, myths about HIV transmission, prejudice and irresponsible reporting are said to trigger stigma and discrimination (Chaturvedi, 2001).

4.3.3 FORMS OF DISCRIMINATION

People living with HIV are said to be discriminated in different forms and at different set ups.

4.3.3.1 Workplace issues

When members of the group were asked the forms in which they have observed discrimination they said to a low level however there are workers who would refuse to use the utensils used by PLWHIV one of the members was quoted saying "they would make sure that they drink with the cup before I do if we have to use one mug, or if I use it before them they make sure that they wash the mug thoroughly before using it". At the places of work discrimination is said to be prevailing at a low level in terms of being given opportunities for employment and with regard to promotion. PLWHIV are given opportunities like others. PLWHIV, however face stigma when they have to be released to attend to medical check ups; "These people with AIDS are lazy they hide behind AIDS, they always want to be released from work". (One of the group members quoted a supervisor. On the other hand majority of the members expressed that in terms discrimination, opportunities for employment, promotions and job allocation it is there, but prevails at a low rate. The labour Code amendment Act (2006) provides that there should be no HIV and AIDS related discrimination at the workplaces.

It was revealed by the discussion that self stigmatization and discrimination also prevails. This is said to be "The most common and difficult form of stigmatization to address." (UNAIDS, 2001, p.21).

4.3.3.2 Social relations

In terms of social relations, the discussion revealed that stigma and discrimination although at a low rate compared to what use to happen in the past still exist. According to them there are people that stigmatize and gossip about PLWHIV, others have been blamed and called names. The co-workers, friends and relatives have talked behind their backs about their HIV status and even in situations where they were suspecting that one might be infected.

One of the participants said "I lost a boyfriend myself, the minute I told him I am HIV positive he started dogging my calls and ultimately disappeared for good." Social rejection and exclusion is confirmed by Chaturvedi (2001) as one of the characteristics of discrimination.

People sometimes diagnose other people and started gossiping about the person they suspect could be infected. “He has a slim disease, the disease of fashion.”The participants revealed that although majority of people care and support the PLWHIV, there are still those that have rejected friends, stopped eating together with them and sharing of utensils with those who are HIV infected. They would gossip and the gossip goes like “How do you afford to stay in the same room with PLWHIV or if they enter such a room they would leave the door open when they are inside the same room with PLWHIV.” What was mostly gathered from the discussion was that people still label and gossip about those who are infected or those that they suspect are infected with HIV. The issue of gossips and social exclusion is confirmed to have prevailed in Uganda where the citizens had access to information (UNAIDS, 2001).

4.3.4 Effects of stigma and discrimination on VCT

When asked if they think stigma and discrimination has any effect on VCT, majority of members of the group agreed that they do have an effect.

The reasons for reluctance to test have been expressed in different ways: people have fear to be labelled, fear of losing friends or lover, fear of death. The members revealed that some people believe that they may not cope with the stress of being told that they are HIV positive. They also believe that there are people whose health have deteriorated after being told that they are HIV infected, who never recovered until they finally died.

“I would rather test when I am terminally ill not now; it is like a death sentence to be told you are positive.” One of the members was quoting the expression of some workers during the VCT campaign. People feel they would be blamed for bad behaviour, others feel they would lose their jobs while others feel to be told one is HIV positive is very stressful and they would not cope with. The discussion confirmed that stigma and discrimination still have direct impact on VCT.

VCT is said to be the gateway to prevention, care and treatment while stigma and discrimination are said to be one of the greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating impact” (UNAIDS, 2002, p.5)

4.3.5 Experiences and challenges faced by PLWHIV

The grouped felt the establishment of the Lesotho Network of People Living with HIV and AIDS (LENEPWHA) has played a critical role in addressing stigma and discrimination the members expressed some of the experiences and challenges they faced. One of the members was called with funny names after disclosing to friends at the local bar. Some of the members are VCT service providers and they shared their experiences as follows:

"In the workplaces its like managers feel AIDS is for the rest of the staff and not them…."One member who is a VCT service provider told us. "When the service providers arrive to do testing they actually leave and do not attend the sessions saying: "those AIDS people have come to test you" (the workers). One of the experiences shared by members of the group was expressed as follows: "My brothers at home would not eat the bread I made", this she continued: "I sincerely thought they did out of ignorance." This was expressed by one of the group members who is a lady. This is also confirmed by UNAIDS (2002 p.10), "It reinforces social inequalities, It creates situation of devalue and shame to others …..)." It was also revealed that some PLWHIV were subjected to discrediting expressions like "These people with AIDS are not careful not to infect others, why do they continue to use our utensils, mugs."Some have been blamed for laziness and hiding behind AIDS at work.

4.3.6Conclusion

The chapter presented the findings and the analysis of data collect from the garment industries through a questionnaire and analysis of the qualitative data collected through focus group discussion. The data has revealed that although stigma and discrimination does prevail at a low rate it does prevail and continue to pose a threat to the efforts aimed at halting the spread of HIV. Stigma and discrimination instils fear on those who have not tested, they believe if they test positive they would loose friends and families and be rejected within the workplaces. This ultimately affects rate at which they may wish to test.

CHAPTER 5
SUMMARY, CONLUSION AND RECOMMENDATIONS

5.1 Summary of the results

Through the interviews conducted and the focus group discussion the study has revealed that people who are HIV infected continue to be subjected to stigma and that discrimination still prevails. The fear of rejection, loose of friends, partners and uncertainty on how one would cope with stress which result from knowing ones HIV positive status and the worrying effect on how one would be judged by other workers family and friends confirm that the acts of stigmatization and discrimination still exist. All these instil fear and uncertainty to those who wish to take up the HIV test.

The study has also revealed that issue of self stigmatization and self discrimination are a concern, this is mostly fuelled by self pity, low self esteem and the feeling of being negatively judged and treated as an outcast and an unwanted member of society who is of immoral behaviour that deserves to be ostracized.

The relationship between stigma and discrimination and HIV and AIDS VCT has been confirmed by the study. The act of stigma and discrimination which those who are infected and affected are subjected to, makes those who have not tested to be scarred of the humiliation, the blame and the stressful situation. To them it is like the world views HIV infected people as people who have sinned, the community outcast, people of immoral behaviour who do not deserve to be treated as human beings but who deserve punishment. As a result of stigma and discrimination PLWHIV are forced to refrain from enrolling into HIV and AIDS programmes like ART, it promotes withdraw and drop out from the services that one has enrolled into. It interferes with adherence to HIV and AIDS programmes and promotes negative perception about HIV and AIDS. VCT is a gateway to HIV and AIDS prevention, treatment, care and support and all these negative impacts of stigma and discrimination have direct relationship with VCT. It is worth noting that PLWHIV however have admitted that the rate at which stigma and discrimination prevails has been reduced as compared to what used to prevail. This is attributed to the support from the management at the workplaces and the effects of the HIV and AIDS interventions implemented in some of the garment industries.

5.2 Conclusion

The world is in a catastrophic situation due to HIV and AIDS. Lesotho like other countries within the Sub- Sahara region is greatly affected. Countries including Lesotho have put in place some measures to halt the spread of HIV and AIDS. Despite these efforts the progress is not satisfactory. The world of work is one of the sectors that are greatly affected and one of the interventions implemented through this sector is VCT. Some successes have been realized however there are still some challenges that have been identified as factors that impact negatively on VCT.

HIV related stigma is a deep rooted action that occurs in all spheres of life being family, community or home setting, at the workplaces, in churches, schools as well as health care facilities. And it occurs in different forms. It is said to be fuelled by among other things, lack of adequate information, misconceptions and cultural beliefs about the mode of transmission and the illness in general. Stigma and discrimination is said to impact negatively on the Interventions and programmes aimed at effectively responding to HIV and AIDS.

Stigma and discrimination reinforce violation of fundamental human rights. It makes people shy away or self isolate themselves. It also makes it difficult for those that are infected to disclose their status or take action to protect themselves and others. It also makes it difficult for people who do not know their HIV status to seek HIV testing and counselling services. Stigma and discrimination promote silence about the epidemic, halts community efforts to curb the spread of the infection and to provide care for those infected. Stigma and discrimination are said to be the barriers to effective prevention, care and treatment.

5.3 Limitations of the study

The study has achieved its objectives however some limitations were encountered:

- Accessibility of the research participants was a challenge; the study had intended to reach participants from 5 factories however permission was granted in only two of the factories.

- In the two factories which were accessible time to interview the participants was a challenge. In one of the factories participants were only allowed time at lunch to take part in the study.
- The study was gender biased; this was influenced by the fact that the garment industries are female dominated. The focus group discussions for LENEPWHA were also dominated by females because the network is also dominated by females.

5.4 Recommendations

As a result of what the study has revealed it is recommended that:

- Further research which is broader and more qualitative covering a broad area to further identify the social and cultural factors that promote stigma and discrimination and identify the role of confidentiality be conducted.
- Programmes that promote visibility of PLWHIV and greater involvement and participation of PLWHIV in the HIV and AIDS programmes specifically on VCT should be vigorously implemented.
- Policy and legal issues: Workers should be made aware of the legislation that protect the rights of PLWHIV, the Labour Code Amendment Act 2006 and those that do not have HIV and AIDS Policies should develop them, implement them and make them known to workers.
- There is need to develop programmes that aim to combat stigma and discrimination, funds be allocated to such programmes and vigorous involvement of the workplaces, churches and the media is critical.

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Appendices

Annexure A - Questionnaire for general workforce

Annexure B - Research focus group discussion guide

Annexure C - Letter to management seeking permission to conduct interviews

Appendix A

A QUESTIONARE FOR THE GENERALWORKFORCE

1.Do you know anyone that has been expelled from work because they are infected with HIV

(a)Yes ( )

(b)No ( )

2. Do you know any person who lost his friends or lover because they are HIV positive?

(a) Yes ( )

(b) No ( )

3. In your factory or any other workplace have you ever heard of a person who has been forced to resign because they are HIV infected?

(a)Yes ( )

(b)No ( )

4. Are you aware of any person whom the co- workers refused to eat with because the person has AIDS or is HIV infected.

(a) Yes ( )

(b)No ( )

5. Have you ever heard of anyone who has been treated unfairly in terms of job allocation because they are infected with HIV?

(a)Yes ( )

(b) No ( )

6. Do you know of any workers who refused to work with or use the same equipment with their HIV infected fellow employees?

(a)Yes ( )

(b) No ( )

7. Have you ever heard anyone gossip about people who are infected or those that are suspected to e infected?

(a) Yes ( )

(b) No ( )

8. Would you like to test for HIV?

(a) Yes ( )

(b)No ( )

9. What could be the factors that contribute to your fear to test for HIV?

Fear of death…….

Rejection by friends……..

Rejection by co-workers……..

Fear of HIV status known to others……..

Other……..

10. IF you test and test positive would you be willing to disclose your status

(c) Yes ( )

(d) No ( )

11. If your response is no what would be your reasons (fears) for not wanting to disclose your status

Fear of rejection	
Fear of gossips	
Fear of negative attitudes	
Fear of ill-treatment by supervisors	

12. VCT services are offered in the factories and offered free of charge, do you think people test at the high rate or in large numbers?

(a) Yes ( )

(b)No ( )

13. If the answer is no. What do you think are the main reasons why the general workforce in the factory is still reluctant to take up VCT?

Appendix B

Focus group Guide for LENEPHWHA

You are humbly requested to take part in this exercise and please feel free and provide information as much as you can afford

- Please note that this is an academic exercise
- It is voluntary
- You do not have to disclose your name
- The information provided will be used only for this purpose and confidentiality will be maintained
- I will be joined with three research assistants to record the responses

Guiding questions have been designed and I will lead the discussion

1. **SOCIAL RELATIONS ------ EXISTENCE OF STIGMA AND DISCRIMINATION**

a) Being an organization of PLWHIV do you think stigma and discrimination exist? At workplaces and social environment?

b) Is it related to HIV and AIDS?

c) At the places of work who are actually stigmatized or discriminated?

d) What are some of the things that indicate stigma and discrimination?

2. CAUSES OF STIGMA AND DISCRIMINATION

Why do you think people stigmatize and discriminate?

-e.g. Ignorance,

-lack of information

-Fear to be infected

-Any other reasons/ contributing factors

3**. FORMS OF DISCRIMINATION: What are the things that you have observed that indicate that one is being stigmatized and discriminated?**

Refusing to eat with

Gossips about PLWHIV or those that are suspected to be infected

Rejection by fellow employees

Loose of friends or partners as a result of HIV infection

- Any other actions observed that indicate being rejected and labelled?

- How can this be observed?

2. **Workplace Issues HIV and AIDS -**

a) Workplace relations between PLWHIV and those suspected and the rest of the work force and the employers or managers

-How are the relations in terms of sharing the equipment/tools?

-Working together with PLWHIV

-Is the HIV status a determining factor for promotion, transfer and dismissal from work?

4. EFFETS OF STIGMA AND DISCRIMINATION ON VCT

a) VCT services are widely offered at the garment industries and are free- Do you think people are willing to test

b)Do you think stigma and discrimination can affect the rate at which people take up the test and how

5. **CHALLENGES AND EXPERIENCES OF PLWHIV**

-Share with us some of the experiences of stigma and discrimination of your members at the workplaces: Verbal, social and others

- What effect do you think stigma and discrimination has on the national response against HIV and AIDS?

Appendix C

P.O. Box 10358
Maseru 100
Lesotho

The Human Resource Manager/ Personnel manager
Precious Garment/ C and Y garment
Maseru 100.
Dear Sir,

Request to collect data

I am a Mosotho woman currently pursuing Masters Degree in the Management of HIV and AIDS with the University of Stellenbosch, RSA. As part of the fulfillment of the course I am required to undertake a study in the relevant area. My area of study is stigma and discrimination and its impact on Voluntary Counselling and Testing and the focus is on the workplaces.

I wish to conduct my work through verbal interview to about 50 employees who may be willing to talk to me or as it may be arranged by your good office. It is estimated that the interview will last for about 10-15 minutes per person and be conducted in two days. If my request is accepted I could start at 9:00 am to 4:00pm, however it is believed that you will guide me how the business of this nature is conducted in your workplace. The date requested shall be communicated by phone.

The team to conduct the interview will be composed of me and 4 assistants. The data collected will be used only for study/school purpose only, will not be published, people interviewed will not be required to disclose their names or HIV status. Participation in this exercise is purely voluntary. The name of the company will not be mentioned if you prefer so.

You may wish to interview me or seek clarification on this matter, I am willing to come to your office and clarify issues that you need clarity on. My contacts **58857129 and 22334919** (Home)

Thank you in advance,

Yours faithfully,

Tlotliso Qobolo (Mrs)