

**INVESTIGATING FACTORS ASSOCIATED WITH
HIV RISK TAKING BEHAVIOURS AMONGST
PEOPLE LIVING WITH HIV AND AIDS (PLWHA) IN LESOTHO**

by

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requirements for the degree**

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DECLARATION

I hereby declare that the work submitted here is the result of my own independent investigation. Where help was sought, it was acknowledged. I further declare that this work is submitted for the first time at this university/faculty towards a Masters degree in Health Professions Education and that it has never been submitted to any other university/faculty for the purpose of obtaining a degree.

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DEDICATION

**I would like to dedicate this thesis to
my loving children Khahliso and Nthabiseng.
Thank you for your support and understanding especially during the time
I spent away from home due to my studies.**

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LIST OF ACRONYMS

AED	Academy for Educational Development
AIDS	Acquired Immunodeficiency Syndrome
ALAFA	ALAFA Apparel Lesotho Alliance to fight AIDS
ARRM	ARRM AIDS Risk Reduction Model
ART	Antiretroviral Treatment
ARV	Antiretroviral
BCC	Behaviour change communication
CCL	Christian Council of Lesotho
CDC	Centre's for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
COREQ	The Consolidated Criteria For Reporting Qualitative Research
DHS	Demographic and Health Survey
DPP	Director of Policy Prevention
EFA	Education for All
ECUFS	An Ethics Committee of the UFS
ESSP	Education Sector Strategic Plan
PWG	Global HIV Prevention Working Group
GNP	The Global Network of People Living with HIV
GOL	GOL: Government of Lesotho
HAART	HAART Highly Active Antiretroviral Therapy
HBM	HBM Health Belief Model
HIV:	HIV: Human Immunodeficiency Virus
HPE	Health Professions Education
IEC	Information And Education Communication
ILO	International Labour Organisation
IOM	International Organization for Migration
IATT	Inter-Agency Task Team on Education
LBGTI	Lesbian, Bisexual, Gay, Transgender and Intersex
LENEPWHA	Lesotho Network of People Living with HIV and AIDS
MOET	Ministry of Education and Training
MOHSW	Ministry of Health and Social Welfare

MDG	Millennium Development Goal
MSM	Men having Sex with Men
MTCT	Mother-To-Child Transmission
NAC	National AIDS commission
OSISA	Open Society Initiative of Southern Africa
PLWHA:	People living with HIV and AIDS
PMTCT	Prevention from mother to child
SADC	Southern African Development Community
SCT	Social Cognitive Theory
SDGs	sustainable Development Goals
STIs	Sexually transmitted infections
TB	Tuberculosis
UFS	University of the Free State
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNGASS:	United Nations General Assembly Special Session
UNICEF	United Nations Children’s Fund
UNAIDS	Joint United Nations programme on HIV and AIDS
UNDP	United Nations Development Programme
UN-INSTRAW	United Nations International Research and Training Institute for the Advancement of Women
VCT	Voluntary Counselling And Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

SUMMARY

Key terms: HIV prevention, HIV and AIDS in Lesotho, People living with HIV and AIDS, Risk factors, Risky behaviour.

Preventive programmes addressing Human Immune Deficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) should focus on, and specifically address people living with HIV and AIDS (PLWHA). In Lesotho several successful preventive programmes have already been put in place, but nevertheless Lesotho still remains one of the countries in Sub-Saharan Africa with the highest HIV prevalence.

The main focus of this study was to identify factors associated with HIV risk-taking behaviours, amongst PLWHA in Lesotho. The overall goal of the study was to provide baseline information on the factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho, as to ultimately use the information in educational materials about HIV transmission and also re-infection in PLWHA.

A literature study was done to conceptualise and contextualize HIV risk taking behaviours amongst PLWHA. Semi-structured interviews were used to identify the HIV risk taking behaviours of PLWHA in Lesotho.

The study revealed that the HIV risk taking behaviours of PLWHA are very similar to those already described in the literature. Within Lesotho specifically socioeconomic factors and cultural factors remain the most commonly associated with HIV re-infection and transmission. The study therefore highlighted areas where HIV preventive programmes could strategically serve the Lesotho population more decisively in the campaign against HIV and AIDS.

OPSOMMING

Sleuterterme : MIV voorkoming, MIV en VIGS in Lesotho, Mense wat leef met MIV en VIGS, risikofaktore, riskante gedrag.

Voorkomende programme wat op Menslike Immuniteitsgebrek Virus (MIV) en Verworwe Immuniteitsgebreksindroom (VIGS) moet fokus, en spesifiek mense wat met MIV en vigs leef aanspreek. Verskeie suksesvolle voorkomende programme is reeds in Lesotho in plek gestel, maar desnieteenstaande, bly Lesotho een van die lande suid van die Sahara, in Afrika met die hoogste voorkoms van MIV.

Die hoofokus van hierdie studie was om verbandhoudende faktore met MIV-risiko-gedrag, onder mense wat met MIV en VIGS in Lesotho leef te identifiseer. Die oorkoepelende doel van die studie was om basislyn inligting oor die faktore wat met MIV-risiko'-Gedrag verband hou onder mense wat met MIV en VIGS in Lesotho leef te verskaf, om uiteindelik die inligting in opvoedkundige materiaal oor MIV-oordrag ,asook her-infeksie gefokus op diegene wat geaffekteer is, te gebruik.

'n Literatuurstudie om die faktore wat MIV risiko-gedrag beïnvloed onder mense wat met MIV en VIGS leef te konseptualiseer en te kontekstualiseer is gedoen. Semi-gestruktureerde onderhoude is gebruik om die MIV-risiko-gedrag van mense wat met MIV en VIGS in Lesotho leef te identifiseer.

Die studie het getoon dat die MIV-risiko- gedrag van mense met MIV en VIGS baie soortgelyk is aan dié wat reeds in die literatuur beskryf is. Spesifiek binne Lesotho word sosio-ekonomiese- en kulturele faktore mees algemeen met MIV herbesmetting en transmissie geassosieer. Die studie het dus areas waar MIV voorkomende programme strategies en meer deurslaggewend die Lesotho bevolking in die veldtog stryd teen MIV en VIGS kan dien.

INVESTIGATING FACTORS ASSOCIATED WITH HIV RISK TAKING BEHAVIOURS AMONGST PEOPLE LIVING WITH HIV AND AIDS (PLWHA) IN LESOTHO

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In this research project, a study was undertaken to identify factors associated with Human Immune Deficiency Virus (HIV) risk-taking behaviours, amongst people living with HIV and Acquired Immunodeficiency Syndrome (AIDS) in Lesotho. The acronym PLWHA is used for people living with HIV and AIDS.

According to Kennedy, Medley, Sweat and O'Reilly (2010:21) addressing the preventive needs of PLWHA are critical, as they are the most effective way of reducing HIV transmission. By fully understanding these factors a foundation for further research to develop appropriate and targeted positive, preventive educational programmes for PLWHA, aimed at reducing HIV transmission or re-infection can be initiated. Positive prevention refers to designed preventive programmes and strategies targeting specifically people living with HIV and AIDS and are aimed to reduce the risk of transmission, and to prevent re-infection for a better quality of life of PLWHA (AED Centre on AIDS & Community Health 2004:68).

Policy makers, programme planners and the community at large would benefit from the outcomes of positive preventive educational initiatives as they offer the potential to bring about behavioural change among PLWHA by increasing the levels of knowledge, enhancing assertion and critical thinking skills. According to Fisher and Smith (2009:3) critical behavioural skills involve increased assertive open communication about sexual activities as well as the ability to face real life issues such as negotiating safer sex, disclosing one's status, and to adhering to antiretroviral treatment (ART) which is designed to prevent viruses from damaging the body. The researcher believes that when an individual is informed about HIV transmission and re-infection as well as prevention

he/she will be motivated to practice preventive behaviour and subsequently they may enact critical skilled behaviours, while practising HIV preventive behaviour.

The study would therefore serve as important reference material, for personnel and decision-makers in health departments and community-based organisations enhancing their understanding of general information on the HIV risk-taking behaviours associated with PLWHA in Lesotho and with a view of developing or strengthening positive preventive educational programmes relevant to their lived experiences.

The aim of this first chapter is to orientate the reader to the study. It provides background to the research problem, followed by the problem statement, including the research questions, the overall goal, aim and objectives of the study. These are followed by a demarcation of the study and highlights the significance and value of the study. Thereafter a brief overview of the research design and methods of investigation are presented. The chapter is concluded by a lay-out of the subsequent chapters and a short, summative conclusion.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

According to the Joint United Nations Programme on HIV and AIDS (UNAIDS) 2011–2015 Getting to Zero, report that there are more than 7000 new HIV infections daily (UNAIDS 2010:7). This indicates that the HIV and AIDS epidemic still presents a real threat to the entire world's population more so, in some countries than others (cf. 2.3). With no cure available and treatment not necessarily reaching all PLWHA the HIV epidemic remains the most serious of infectious disease challenges, to public health (UNAIDS 2010:8). In view of this it is essential to reduce and eventually stop new HIV infections, with the aim to have fewer people newly infected than are newly placed on treatment, as a decisive action guided by the ground-breaking vision of *Zero new HIV infections, zero discrimination, and zero AIDS-related deaths* (UNAIDS 2010:21).

Of the nine Sub-Saharan African Countries, with prevalent HIV figures, namely: Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe; Lesotho has the second highest HIV prevalence rate (in adults) at 22.9% (commonly rounded off in the literature to 23%) (AVERTing HIV and AIDS 2015:online; UNAIDS Lesotho 2014:2; UNAIDS 2014:26, 30). The underlying reality is that the HIV epidemic in most of the Sub-Saharan African countries including Lesotho, is far from

over as the number of people newly infected with HIV is still growing with an estimated 62 new HIV infections each day (GoL MOHSW 2014:online). In the opinion of International HIV and AIDS Alliance (2003:11) one positive person is involved in each case of HIV transmission; as HIV infected individuals play a key role in the spread of HIV. In purely mathematical terms, as people living with HIV are increasing, it means that there are more people able to transmit HIV to others. The Global AIDS Response Progress Report refers to the latest estimates documented on the Lesotho HIV and AIDS Spectrum Estimates Report from 2015, however indicating a stabilisation of the HIV epidemic in Lesotho, at the 23% prevalence rate (GoL MOHSW 2015:online).

A major challenge in the health management for PLWHA is therefore, the vulnerability to re-infection in addition to transmitting HIV. The Government of Lesotho (GoL) are making extensive efforts to address HIV and AIDS in Lesotho, but regardless of these efforts the country remains one of the Sub-Saharan African countries worst affected by the HIV and AIDS epidemic. One such effort includes a focus on HIV and AIDS educational programmes to educate and disseminate information about HIV and AIDS. However, in spite of the recognised benefits of these HIV education programmes, new HIV infection rates are still reported.

For various reasons, regardless of the threat of this life threatening illness, PLWHA are still choosing to engage themselves in HIV risk-taking behaviours, and the contributing factors are not clearly understood. Various researchers around the world argue that treatment alone will not reverse the epidemic or motivate behavioural change among some persons at high risk of HIV infection (Bunnell, Mermin & De Cock 2006:857; Gilliam & Straub 2009:94; Kalichman, Cherry, Kalichman, Amaral, White, Swetzes, Eaton, Macy & Cain 2011:531; WHO 2011:19).

The Joint United Nations Programme on HIV and AIDS (UNAIDS) has recommended that comprehensive HIV prevention, should include preventive programs focusing on PLWHA (UNAIDS 2010:34). In order to design effective preventive strategies, it is essential to understand the HIV-related knowledge and behaviours among PLWHA and to assess their risk of HIV transmission to people who are not infected. Unless the key populations at risk and vulnerability factors are well researched and known, it may be impossible to plan, target and implement interventions that focus on the populations who most need them (GoL NAC 2009a:2). In the face of this reality, the researcher suggested that PLWHA in Lesotho must currently be prioritised as a target population to be educated

about the transmission and re-infection of HIV and AIDS as these pose a threat to the management of HIV and AIDS in the country.

In Sub-Saharan Africa, little is known about the pretext to why PLWHA might continue to engage in high risk behaviours. While research in this area is on-going, no research in Lesotho has yet investigated or documented factors, influencing risk-taking behaviours amongst PLWHA. It is argued that these underlying factors have, to date not been adequately identified in Lesotho. There is thus a need to understand what PLWHA perceive as behaviours which put people at risk of transmitting HIV and AIDS and the factors influencing risk-taking behaviours. This study was aimed to identify factors related to HIV risk-taking behaviours. The researcher felt that further research on the factors associated to risk-taking behaviours amongst PLWHA in Lesotho, will provide important information to inform future educational intervention and development.

1.3 PROBLEM STATEMENT AND RESEARCH QUESTIONS

The problem that was addressed in this study was the inadequate information available about HIV risk-taking behaviours, among PLWHA in Lesotho.

Previous HIV preventive programmes have been criticised for their predominant focus on HIV negative people (GoL NAC 2009:x, 2). At the time of this study positive prevention has not been a prominent concept – meaning that there should be more focus on positive preventive educational programmes targeting PLWHA (GoL NAC 2009a:x).

The starting point for developing a preventive programme, critically requires assessment of proven and effective strategies for populations at higher risk by understanding the HIV epidemic and the response. This can be interpreted as due to a seemingly absent base-line of information on factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho. No studies have been done before to assess and explain risk factors that could possibly lead to the transmission and re-infection of HIV and AIDS among PLWHA in Lesotho.

The researcher made use of a number of electronic databases using Google Scholar, PubMed, Science Direct and the University of Free State library search engines. The

result highlighted a lack of published literature on factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho.

In order to address the problem stated, the following research question was formulated:

1. What are the factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho?
2. How can the factors associated with HIV risk-taking behaviours amongst PLWHA be conceptualised and contextualised as a theoretical framework?; and

1.4 OVERALL GOAL, AIM AND OBJECTIVES OF THE STUDY

The overall goal, aim and objectives of the study were as follows:

1.4.1 Overall goal of the study

The overall goal of the study was to provide baseline information on the factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho, as to ultimately use the information in educational materials about HIV transmission and re-infection in PLWHA.

1.4.2 Aim of the study

The aim of the study was to investigate the factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho.

1.4.3 Objectives of the study

To achieve the aim, the following objectives were pursued:

1. To explore the factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho, semi-structured interviews were done; and
2. To conceptualise and contextualise the HIV and AIDS epidemic in Lesotho, a literature study was completed and this was triangulated with the research findings.

1.5 DEMARCATION OF THE FIELD AND THE SCOPE OF THE STUDY

Goddard and Melville (2001:12-16) note that proper demarcation of the research problem and a well-defined scope and boundaries are important to provide focus and direction to any proposed research activity.

The study fits into the field of Health Professions Education (HPE) and lies in the domain of educational programme development (in the field of HIV and AIDS). The study was conducted in Lesotho in the Maseru district and the semi-structured interview was limited to participants belonging to support groups in three larger textile and clothing factories that are in the Apparel Lesotho Alliance to Fight AIDS (ALAFA) prevention and treatment programme. The findings of this study will therefore be limited to these three large textile and clothing factories that are included in the ALAFA prevention and treatment programme.

In a personal context, the researcher holds a postgraduate diploma in HIV and AIDS management, obtained from the University of Stellenbosch. The researcher is a qualified HIV and AIDS educator and has been involved in HIV and AIDS education for the past 10 years. She is currently working in ALAFA, as education programme officer. In recent years, the researcher has found that there is a need to develop HIV and AIDS programmes specifically addressing PLWHA in Lesotho. In view of this she enrolled for a Master's degree in the HPE programme in order to conduct research in the future to address the educational needs of PLWHA in Lesotho.

As far as the timeframe is concerned, the study was conducted between November 2014 – January 2016, with the empirical research phase between November 2014 – May 2015.

1.6 SIGNIFICANCE AND VALUE OF THE STUDY

The present study is in line with the Lesotho Government's effort to reduce HIV transmissions and re-infections within the population for those who already suffer from HIV. The research hoped to address some of the gaps in HIV preventive programmes addressing HIV positive populations, in Lesotho.

The value of this research will be, to provide a basis for formulating strategies to strengthen HIV educational programmes by providing an understanding of factors associated with the HIV risk-taking behaviours among PLWHA. Educational contributions could be made to inform personnel and decision-makers in health departments and community-based organisations about factors associated with the HIV risk-taking behaviours among PLWHA. It is hoped to eventually result in a reduced incidence of HIV transmission and re-infection, in order to eventually lower the increasing budget for HIV care and treatment programs in this population.

It is hoped that the development of a positive preventive educational programme in Lesotho would bring about a sustained behavioural change that might enhance the quality of life of PLWHA by providing them, with the knowledge and critical skills (e.g. problem-solving and assertive listening) necessary to make informed decisions.

1.7 RESEARCH DESIGN AND METHODS OF INVESTIGATION

In this section the research design and methods used to conduct the research will be discussed:

1.7.1 Research design of the study

A qualitative research design was followed in this study. Qualitative research is an empirical inquiry that investigates a contemporary phenomenon within a real-life context using multiple data collection strategies such as semi-structured interviews, focus group interviews and/or observations (Cohen, Manion & Morrison & 2007:17). The qualitative research designed used in this study is described in more detail in Chapter 3.

1.7.2 Methods of investigation

The methods that were used and which formed the basis of the study comprised a literature study and semi-structured interviews.

1.7.2.1 *Literature study*

The literature study was used to formulate a conceptual framework to describe the HIV and AIDS epidemic in Lesotho. A comprehensive literature study was done after the findings of the study was summarised (cf. Chapter 2). The research findings was reported on and discussed in Chapter 4 and reference was made back to Chapter 2, where the literature was summarised.

1.7.2.2 *Semi-structured interviews*

Semi-structured interviews were conducted to give the researcher an opportunity to gain a detailed picture of the factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho.

The detailed description of the population, sampling methods, data collection techniques, data analysis and reporting are presented in Chapter 3. This also includes information about the insurance of trustworthiness in the current study. A schematic overview of the study is given in Figure 1.1.



FIGURE 1.1: A SCHEMATIC OVERVIEW OF THE STUDY

(Compiled by the researcher, Refiloe Mabathoana 2014)

1.8 IMPLIMENTATION OF THE FINDINGS

This report containing the findings of the research will be brought to the attention of the GoL Ministry of Health and Social Welfare (MOHSW) Policy makers, and programme planners to serve as important reference material to enhance their understanding of HIV risk-taking behaviours associated with PLWHA in Lesotho.

The research findings will be submitted to academic journals with a view of publication. The researcher hopes to make a contribution, to the developing or strengthening of a positive preventive educational programme relevant to lived experiences. The outcomes

of positive prevention education initiatives offer the potential to bring about behavioural change among PLWHA by increasing the levels of knowledge, enhancing assertion and critical thinking skills.

The research findings will also be presented at various national and international conferences.

1.9 ARRANGEMENT OF THE REPORT

The following section provides a brief outline of the study and layout of the dissertation. The layout of the dissertation follow a traditional layout followed in the Health Professions Education Programme in the Faculty of Health Sciences, University of the Free State. It aims to guide the reader through the initial examination of and background to the research questions, the methodology used in obtaining data, the analysis, interpretation and discussion of results, the use and application of research findings.

In this chapter (Chapter 1), **Orientation to the study**, the researcher provided an overview of background to the study, the research problem, and research questions. The overall goal, aim and objectives were stated and the research design as well as the methods that were employed. It further demarcated the field of the study and the significance of the study for HPE and HIV and AIDS preventive interventions in Lesotho. The chapter concluded with an overview of the research report and layout of the dissertation.

Chapter 2, **An overview of the HIV and AIDS epidemic in Lesotho**, provide the theoretical orientation to the study and deal with a study of literature that describes the publications and knowledge, regarding factors associated with HIV risk-taking behaviours amongst PLWHA. The literature study provides the theoretical framework underlying the research questions.

In Chapter 3, **Research methodology**, the research design and the methodology that were applied in this study are explained. The theoretical aspects of the methods used is discussed and the reasons for deciding on the approach and methods used, explained. Data collection is described with reference to the applicable literature, as well as the use of a semi-structured interview guide.

Chapter 4, **Results and discussion of the semi-structure interview findings**, reports on the findings of the interviews in the study and presenting a discussion on the interpreted findings from the semi-structure interviews.

Lastly in Chapter 5, **Conclusions, recommendations and limitations of the study**, provide an overview of the study, and draws conclusions together with a discussion of the limitations of the study, with recommendations.

1.10 CONCLUSION

Chapter 1, provided an orientation to the research undertaken regarding the factors associated with HIV risk-taking behaviours amongst PLWHA.

The next chapter, Chapter 2, entitled **Factors associated with HIV risk-taking behaviours amongst PLWHA** will summarise the relevant literature.

CHAPTER 2

AN OVERVIEW OF THE HIV AND AIDS EPIDEMIC IN LESOTHO

2.1 INTRODUCTION

This chapter presents an overview of the current literature on a description of the context of the study. It focus on the HIV and AIDS epidemic in Lesotho. Key issues include the epidemiology of HIV and AIDS Globally and Nationally, an overview of health problems of PLWHA, treatment in the management of HIV and AIDS, an overview of HIV and AIDS infection and transmission (prevention strategies), HIV prevention education programmes including the theories used to assess and explain HIV and AIDS transmission and spread behaviours. The literature study will be kept brief as it serves as a directive to present the necessary background and context of this study.

In Figure 2.1, an overview of the aspects which will be discussed in the current chapter is displayed.

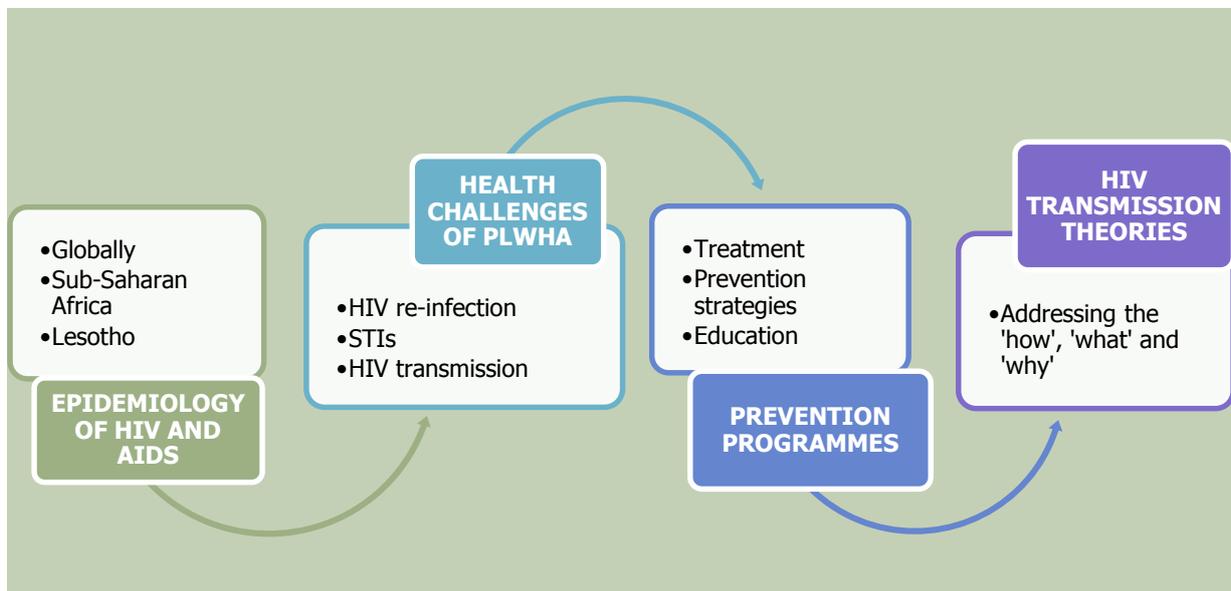


FIGURE 2.1: A SCHEMATIC OVERVIEW OF THE DIFFERENT ASPECTS THAT WILL BE ADDRESSED IN THIS CHAPTER

2.2 EPIDEMIOLOGY OF HIV AND AIDS

In this section the epidemiology of HIV and AIDS will be presented in the following sections: Global perspectives, Sub-Saharan African perspective, Lesotho perspective.

2.2.1 Global Perspective on HIV and AIDS

There has been a successful development seen in recent years in global efforts to fight HIV and AIDS. In the UNAIDS report: *On the Fast-Track to end AIDS* a strategic plan for 2016 up to 2021 is detailed for the management of HIV and AIDS (UNAIDS 2015a:12). Figures in this report show that there had been a significant decrease in the number of newly infected adults (35%) and children (58%) from the year 2000 to date. In view of the fact that 73% of pregnant women with HIV were able to use antiretroviral treatment during their pregnancies and deliveries, there were fewer babies who contracted HIV (UNAIDS 2015c:1). The latest available global statistics, at the time of writing this dissertation, were still figures from 2014, these figures are presented in Table 2.1 (UNAIDS 2015c:1). Comparisons to statistics from previous years show clear differences as fewer people are newly infected, treatment reaches more affected people and contribute to the decrease in numbers of AIDS related deaths.

TABLE 2.1 GLOBAL STATISTICS OF HIV

(Summarised by Mabathoana 2015; Source: UNAIDS 2015c:1;
UNAIDS 2014:26,30)

	Year	Per million	Progress compared to statistics from previous years
People living with HIV	December 2014	36.9 million [34.3 million–41.4 million]	38.1 million in 2000
Number of new infections	December 2014	2 million [1.9 million–2.2 million]	3.1 million in 2000.
Accessing antiretroviral therapy	June 2015	15.8 million	13.6 million in June 2014
AIDS related deaths	December 2014	1.2 million [980 000–1.6 million]	25.3 million in 2000 2 million in 2005

The Kaiser Family Foundation present the global prevalence rate amongst people between the ages of 15 to 49 years as 0.8% (cf. Figure 2.2) (Kaiser Family Foundation 2015:online). The estimates were derived from the UNAIDS *How AIDS changed everything* Report (UNAIDS 2015d:online).

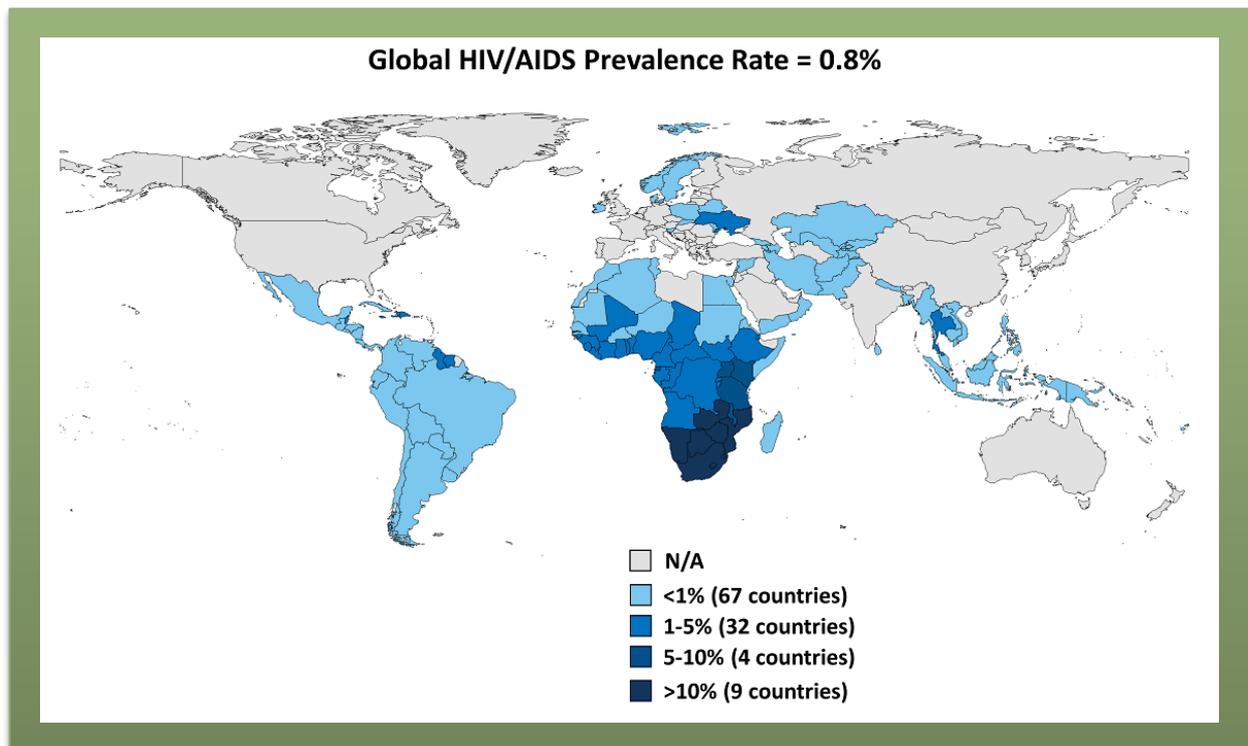


FIGURE 2.2 SCHEMATIC PRESENTATION OF THE GLOBAL HIV AND AIDS PREVALENCE RATE

(Source: Kaiser Family Foundation 2015:online)

Despite these reported successes the AIDS epidemic is still considered to be far from over; this is attributable to the “unacceptable number of new HIV infections each year” (UNAIDS 2015d:online).

The UNAIDS (2014:13) stipulate that there are noticeable gaps and shortcomings of HIV response as the rate of progress is significantly diverse across populations and locations. The response focussing on three strategic directions namely: “HIV prevention; treatment, care and support; and human rights and gender equality” within these populations should be tailored to best elicit the preferred response (UNAIDS 2014:12). This highlights the need for further research focused on the HIV response within different countries, especially those where the prevalence rate of HIV and AIDS remains the highest.

2.2.2 Sub-Saharan Africa Perspective on HIV and AIDS

As previously depicted (cf. 1.2) Sub-Saharan Africa is considered the region in the world with the largest burden of disease (HIV and AIDS) (UNAIDS 2015d:online). A total of 25.8 million PLWHA reside in Sub-Saharan Africa (cf. Table 2.2) compared to the 36.9 million worldwide (cf. 2.3.1)

It is estimated that 80% of PLWHA live in 20 countries of which 12 of these countries namely: South Africa, Nigeria, Zimbabwe, Mozambique, United Republic of Tanzania, Kenya, Zambia, Malawi, Ethiopia, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo are in Sub-Saharan Africa (UNAIDS 2015d:online).

Women account for more than half (59%) the total number of PLWHA in Sub-Saharan Africa which is possibly contributing to the higher number of children affected with HIV living in this part of the world (UNAIDS 2015c:2-3; UNAIDS 2015d:online). The Global Plan to eliminate new HIV infections among children and keeping their mothers alive by 2015 focussed specifically on several Sub-Saharan African countries and the response seems positive in view of the fact that 47% of women had access to ARTs by 2014 and a decrease of 48% of children newly infected were reported (UNAIDS 2011:38-39).

TABLE 2.2 SUB-SAHARAN AFRICAN STATISTICS OF HIV

(Summarised by Mabathoana 2015; Source: UNAIDS 2015c:2-3)

	Year	Per million	Progress compared to statistics from previous years
People living with HIV	December 2014	25.8 million [24.0 million–28.7 million]	
Number of new infections	December 2014	1.2 million [1.1 million– 1.3 million] (adults) 190 000 [170 000–230 000] (children)	Declined by 41% between 2000 and 2014 Decline by 48% since 2009
Accessing antiretroviral therapy	June 2015	10.7 million	Increase of 36% [34%-39%] of men and 47% [43%-55%] of women accessing antiretroviral therapy
AIDS related deaths	December 2014	790 000 [670 000–990 000]	Declined by 48% between 2004 and 2014

One of the countries also highly burdened by the HIV and AIDS pandemic is Lesotho. A small country situated in South Africa.

2.2.3 The Lesotho perspective on HIV and AIDS

In 2014 the last reported population estimate revealed that Lesotho has a population of 2.109 million people (World Bank Group 2016:online). The majority of the Lesotho population live in rural areas (77%) (UNAIDS Lesotho 2014:2). About 57% of the citizens of Lesotho live below the national poverty line (UNAIDS Lesotho 2014:2). There is widespread unemployment, inequality and poverty, particularly in rural areas.

Regardless of the small number of people living in Lesotho, the country was declared to have the second highest HIV-prevalence rate (in adults) at 23%, this after Swaziland with a prevalence rate of 27.4% in 2013 (AVERTing HIV and AIDS 2015a:online; AVERTing HIV and AIDS 2015b:online; GoL MOHSW 2015:online; UNAIDS 2014:26, 30). The country remains among nine others that still have adult prevalence rates of more than 10% (Makamure & Glenwright 2015:114) with a life expectancy of 49 years (World Bank Group 2016:online). Lesotho is among countries in South African Development Community (SADC) the region with the highest HIV related maternal mortality rate (GoL MOHSW 2011 in OSISA 2012:22).

An HIV epidemic of this magnitude affects not only individuals, but also threatens businesses and the country's economy as employees are increasingly suffering from the effects of HIV and AIDS. In spite of the proactive address of HIV and AIDS by the GoL and recognised benefits of HIV education programmes, the high HIV prevalence rate has not decreased for the last six years (from 2008 to 2014) (UNAIDS 2014:26, 30), although this seems positive the prevalence rate is still considered to be very high. With this in mind and taking into consideration the *Zero new HIV infections, zero discrimination, and zero AIDS-related deaths* vision (UNAIDS 2010:21), and the *UNAIDS 2016–2021 Strategy* (UNAIDS 2015a:15) which ultimately work towards a fast tracked response to address the HIV and AIDS pandemic with the view to end the AIDS epidemic by the year 2013, there exists an urgent need for increased efforts to be performed in Lesotho. Health practitioners and other stakeholders should strengthen their performance on HIV and AIDS in Lesotho in order to address the epidemic more effectively (Coburn, Okano & Blower 2013:236; Ntaote 2014:online).

According to a Lesotho Demographic and Health (DHS) Survey from 2009 (GoL MOHSW 2010:online) of HIV prevalence for women and men aged 15-49 it varies due to socioeconomic characteristics. HIV prevalence remains higher for urban women (31%) than rural women (25%). Among men, 21% in urban areas and 17% in rural areas are infected with HIV. The

latest statistics can be seen in Table 2.3. Maseru, Leribe, Berea, Mafeteng and Mohale's Hoek have the highest HIV prevalence in Lesotho (UNAIDS 2015b:61). This is mostly due to these places being larger towns, which offer work as the majority of apparel factories are situated at the towns which are continuously being developed (UNAIDS 2015b:61). The 2009 Lesotho DHS survey (GoL MOHSW 2010:online) presents statistics of PLWHA per district in Lesotho.

Various HIV prevention efforts (cf. 2.5.1) contributed to a reduction in the number of New HIV infections. Reports show a decline from 30,000 new infections in 2005 to 26,000 new infections in 2013 (cf. Table 2.3). One of the most positive efforts is the increase in the number of PLWHA who receive HIV treatment. This is partly due to an initiative taken, to allow nurses to administer ARTs especially in the remote areas of the country, where there are a limited number of doctors available (UNICEF 2012:online).

TABLE 2.3 LESOTHO STATISTICS OF HIV (2013)

(Summarised by Mabathoana 2015; Source: UNAIDS 2014:26-47)

	Per thousand
People living with HIV (all):	360,000 [350 000-380 000]
Adults aged 15-49	330 000 [310 000-350 000]
Women aged 15 and older	190 000 [180 000-200 000]
Children aged 0 to 14	36 000 [32 000-40 000]
Number of new infections(all)	26,000
Accessing antiretroviral therapy (all)	29%
AIDS related deaths:	16,000 [15 000-18 000]
Orphans due to AIDS aged 0 to 17	17 150 000 [130 000-160 000]

Considering the recommendation from UNAIDS (cf. 2.3.1) gaps and shortcomings of HIV progress should be evaluated within specific communities. In Lesotho, the contributing factors to the staggering numbers of PLWHA, and those newly affected, require further investigation; it is the researcher's view that one of the future starting endeavours, will be to investigate factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho.

2.3 OVERVIEW OF HEALTH CHALLENGES OF PEOPLE LIVING WITH HIV

In this section an overview of health challenges of people living with HIV will be presented. Global perspectives will be presented as it relate to the Lesotho perspective.

As mentioned before (cf. 1.2) a major challenge in the health management for PLWHA is their vulnerability to be re-infection with HIV, the vulnerability to contract various other diseases including sexually transmitted infections (STIs), in addition to transmitting HIV to others (including PLWHA and those not affected).

2.3.1 The risk of HIV re-infection

In accordance with Smith, Richman and Little (2005:438) re-infection also referred to as "super infection" implies that a person is being infected with a second commonly different strain of HIV after already having been infected with a first strain of HIV. The rate of re-infection was reported, to be more complex to identify (Smith *et al.* 2005:438). In 2004 authors Smith, Wong, Hightower *et al.* (2004) in Smith *et al.* (2005:438) contributed this to the difficulty of testing techniques available "to distinguish between different viral strains of the same clade". At that stage, clinically HIV re-infection did not seem to have an effect on disease progression however, it has been shown to accelerate the increase of viral load in patients (Ronen, Richardson, Graham, Jaoko, Mandaliya, McClelland & Overbaugh 2014:2281; Smith *et al.* 2005:441).

The most successful achievement in the field of HIV has been a significant change in the response to HIV rapid expansion of ART. Even though globally, HIV and AIDS still remain a public health problem, almost 12.9 million people (increase of 5.6 million from 2010) have been receiving ART therapy globally by the end of 2013 (UNAIDS 2014:14). This means that PLWHA now live longer and healthier lives due to the greater availability of ART, but re-infection and other diseases (especially STIs) again complicate treatment and results in a setback in the successful management of HIV and AIDS.

With advances in the medical field and continued research the re-infection rate was recorded as 0-7.7% per year (Redd, Quinn & Tobian 2013:622). Re-infection with a drug resistant HIV strain is reported to complicate ART and could potentially delay or even influence the success of vaccine research (Redd *et al.* 2013:622). International organisations including UNAIDS and the WHO stress the significance of preventing HIV re-infection (UNAIDS 2000:10), thus it is an ethical and public health imperative to development evidence based on preventive strategies (Bunnell *et al.* 2006:858; Cloete, Strebel, Simbayi, Van Wyk, Henda & Nqeketo 2010:1).

In view of the before mentioned, PLWHA should be informed of their risk to be re-infected and about the consequences related to that. Authors Redd *et al.* (2013:622) propose educating PLWHA about safe sex practices and the risk of unsafe practices of injected drug use.

2.3.2 The risk of HIV in accordance to other diseases

Tuberculosis (TB) is associated with the major cause of morbidity and mortality in Lesotho (GoL MOHSW 2010:online). According to the *Global Fact Sheet: HIV and AIDS* (UNAIDS 2013:4) people co-infected with HIV and TB are 21-34 times more likely to develop active TB disease than people living without HIV. Tuberculosis is the leading cause of death among PLWHA. In 2011, approximately 430 000 people died of HIV-associated TB, the majority of these deaths occurred in Africa, where the mortality rate from HIV-related TB is more than 20 times higher than in other world regions (UNAIDS 2013:4). The health sector is confronted to deal with the complexities of treating two infections requiring multidrug therapy simultaneously (CDC 2006:5).

Furthermore there is proven evidence that there is the link between HIV infection and STIs. According to the Centre for Disease Control and Prevention (CDC) individuals infected with STIs are at least 2 to 5 times more likely to acquire HIV than uninfected persons. There is substantial biological evidence showing that those with STIs - such as syphilis, herpes, or chancroid are more likely to both acquire and to transmit HIV to their partners (CDC 2010:online). This is mostly due to shared routes of transmission (Chun, Carpenter, Macalino & Crum-Cianflone 2013:1). It has scientifically been proven that when an HIV affected individual's immune system is compromised, the occurrence of multiple sexually transmitted conditions have a great impact on HIV progression. On account of these proven connections specific information about sources of STIs services should be disseminated to enhance STIs risk reduction of sexual behaviours (Fleming & Wasserheit 1999:15).

According to Redd *et al.* (2013:627) HIV re-infection and infection with other diseases can be reduced if PLWHA are informed about the potential effects of HIV re-infection and the complexities, in treating these patients especially those with both HIV and STIs. Redd *et al.* (2013:627) suggests that education about these topics should be incorporated into continual comprehensive counselling strategies.

2.3.3 The risk of HIV transmission

Immune deficiency virus transmission contributes to the burden that HIV and AIDS have on the world. Most HIV transmission in Africa occurs among HIV discordant couples (National Collaborating Centre for Infectious Diseases 2010:1). The couple is referred to as discordant when one partner is HIV-infected while the other one is not.

Immune deficiency virus transmission, commonly occur when a person does not know their HIV status. The UNAIDS Gap Report (2014:5) indicates that "Of the 35 million people living with HIV in the world, 19 million do not know their HIV-positive status".

In addition to the information above, HIV transmission still occurs regardless of whether people are aware of their HIV status, since non-disclosure has been reported to be associated, with HIV transmission risk behaviours (Simbayi, Kalichman, Strebel, Cloete, Henda & A-Mgeketo 2007:29). In this South African study mentioned before titled: "Disclosure of HIV status to sex partners and sexual risk behaviours among HIV-positive men and women, Cape Town, South Africa", 413 HIV-positive men and 641 HIV-positive women participated in a survey. The study found that 42% of the cohort had sex with a person without having disclosed their HIV status. Furthermore, non-disclosure was contributed to HIV-related stigma and discrimination.

Other studies also confirmed that HIV transmission occur, as a result of PLWHA still engaging in sexual practise that places their sex partners at risk (Cleary, Van Devanter, Rogers, Singer, Shipton-Levy, Stuart, Avorn & Pindyck 1991:158; Kalichman 2000:online; Robins, Dew, Davidson, Penkower, Becker & Kingsley 1994:1271). These behavioural epidemiology of continued risk practices among PLWHA and other risk factors contributing to HIV re-infection and transmission will be outlined in more detail later in this chapter (cf. 2.6). According to UNAIDS (2007:10) preventing HIV infection requires knowledge of the drivers of the HIV epidemic, including the factors that influence exposure to the virus within the population. Prior to the development of effective preventive interventions, it will therefore be important to understand the risk-taking behaviours that transmit HIV, including the modes of transmission (UNAIDS 2007:11; WHO 2010:online).

The Gap Report (UNAIDS 2014:118) highlights people who are more vulnerable and ultimately at increased risk for HIV infection including: Adolescent girls and young women; Prisoners;

Migrants; People who inject drugs; Gay men and other men who have sex with men; Transgender people; Children and pregnant women living with HIV; Displaced persons (e.g. people affected by forcible displacements as a result of conflicts or disasters, refugees, asylum seekers), People with disabilities (e.g. physical, sensory, intellectual or mental health disability); and People aged 50 years and older. This commonly being a result of limited access to HIV prevention, treatment and care services, gender norms, poverty as well as legal and social inequalities (UNAIDS 2014:118).

It is documented that “The forcible displacement of people through conflict or disaster is associated with increased food insecurity, the destruction of livelihoods and resulting poverty” and as a result of these “factors that increase a displaced person’s vulnerability to HIV include a breakdown in social structures, a lack of income and basic needs, sexual violence and abuse, increased drug use and a lack of health infrastructure and education”. In Sub-Saharan Africa 7% (1 500 000) PLWHA had been affected by emergencies in 2006 (Lowicki-Zucca, Spiegel, Kelly, Dehne, Walker & Gyhs 2008 in UNAIDS 2014:250). Globally the number of displaced persons increased by 24.2%—from 2006 to 2013. In Lesotho many men and women are commonly forced to move to larger towns and cities for financial reasons. A lack of income and basic needs in this population group has also been identified as contributors to the practices of unsafe transactional sex in order to survive (Choudhry, Ambresin, Nyakato & Agardh 2015:272; UNAIDS 2014:118).

Public health is currently faced with new challenges in mitigating the spread of the disease, such as tailoring appropriate positive preventive methods to diverse populations facing high HIV infection rates. Therefore, it is vital to prevent HIV transmission through education, which is often, coupled with behavioural change strategies (Kalichman, Rompa, Cage, DiFonzo, Simpson & Austin 2001:84; Bunnell *et al.* 2006:855; Kennedy *et al.* 2010:615). There are increasingly assumptions that quality education influences acquisition of knowledge which is necessary for the development of desired HIV preventative behaviours related to HIV transmission (DiClemente & Peterson 1994 in Blackwell-Hardie 2009:2). Educational interventions should however be directed at specific target groups and should ideally address the specific-risk taking behaviours of the group (IATT 2008:online). In addition gender norms, poverty as well as legal and social inequalities and the available HIV preventive, treatment and care services, should be taken into consideration as asserted by the Gap Report in view of successfully addressing the HIV pandemic (UNAIDS 2014:118).

2.4 TREATMENT IN THE MANAGEMENT OF HIV AND AIDS

For a number of years, there has been a growing awareness that HIV treatment brings benefits for HIV and AIDS management and prevention initiatives. Currently there is no cure for HIV and AIDS, to date; but the available ARTs have been developed to slow down viral replication in PLWHA. Immune deficiency virus infectiousness relates to viral load, meaning a measurement of the amount of virus in the body, ARTs reduces viral load, therefore reduces infectiousness and risk of HIV transmission (Smith, Cambiano, O'Connor, Nakagawa, Lodwick, Rodger, Lampe & Phillips 2012:7). The effects of ARTs in turn prolong the lives of PLWHA who are compliant with treatment. Authors Mahy, Stover, Stanecki, Stoneburner and Tassie (2010:67) describe that people infected with HIV are living healthy and longer lives. Sadly however, treatment still does not reach all PLWHA in need. There are still countries (or PLWHA within some countries) with high HIV prevalence rates who do not have access to treatment mostly, due to the costs involved (Fang, Chang and Hsu *et al.* 2007 in Baidooobonso 2013:1; UNAIDS in Wainberg & Jeang 2008:4).

Vaccine studies have not been successful to date, and currently there is no medical cure for HIV and AIDS. However, according to numerous studies undertaken, it is projected that it will take years to find a cure for HIV (Dieffenbach & Fauci 2011 in Baidooobonso 2013:8). With this being said phase two HIV vaccine clinical trials that was evaluated in 2009, showed promising results: "vaccine recipients had a 31 percent lower risk of becoming infected with HIV, the virus that causes AIDS, compared to placebo recipients" (Andersson & Stover 2011 in Baidooobonso 2013:8). This led to HIV vaccination clinical trials launched in South Africa, where it is hoped to start with initial testing phases in late 2016-2017 (Engel 2015:online).

It is the researcher's point of view that even though antiretroviral therapy extends life expectancy and contribute to a reduction in the risk of HIV transmission, it does not overcome all of the health management challenges in PLWHA, nor does it completely reduce the number of new infections. Hence; safe, efficacious, and effective preventive interventions are still necessary for controlling HIV (for now and in the long-term) (WHO 2010:online).

2.4.1 Non Adherence to treatment

Effective HIV treatment is dependent on strict and accurate adherence to the prescribed treatment. Levels of adherence in excess of 95% are required to ensure treatment success,

adequate viral load suppression, improved immune status and slowing of the disease progression (Indian Engender Health Society 2006:36).

Many PLWHA are unable to adhere sufficiently to HIV treatment for various reasons such as the availability of treatment, nutrition required with the use of HIV treatment and also because of the many contra-indications associated with the medication. Furthermore studies have shown that several factors (e.g. the ability to cope with stressful life events, depression, anxiety, psychosis, a feeling of hopelessness, having no or little social support, being less knowledgeable about HIV, decreased access to health care, low self-efficacy toward adherence; or the use of recreational substances) are shown to have an effect on the adherence to HIV treatment (Halkitis, Kutnick & Slater 2005:545; Riera, La Fuente, Castanyer, Puigventós, Villalonga, Ribas, Pareja, Leyes & Salas 2002:286; Tyler-Viola, Corless, Webel, Reid, Sullivan, Nichols & International Nursing Network for HIV/AIDS Research 2014:168).

It has been established that if HIV treatment is missed, drug resistance is likely to develop, and when a person does not adhere there will be treatment failure and an increased risk of illness (Indian Engender Health Society 2006:36; Little, Holte, Routy, Daar, Markowitz, Collier, Koup, Mellors, Connick, Conway, Kilby, Wang, Whitcomb, Hellmann & Richmann 2002:385). Greater efforts are needed to promote education about the importance of adherence to HIV treatment. When such approaches are developed they can be used to reinforce and support the behavioural change efforts of HIV-positive persons seen in health care and AIDS service settings (Kelly & Kalichman 2000:636).

2.5 OVERVIEW OF HIV AND AIDS PREVENTION STRATEGIES

In this section an overview of HIV and AIDS prevention strategies will be presented. Global perspectives will be presented as it relate to the Lesotho perspective, with several examples from the Lesotho context.

The latest “visionary goal” in addressing the HIV and AIDS epidemic works towards ending the AIDS epidemic by 2030 (UNAIDS 2015a:3). With this in mind the UNAIDS developed the UNAIDS 2016–2021 Strategy with predetermined targets to be reached by 2020, which are aligned with the Sustainable Development Goals (SDGs). The strategy holds a 90-90-90 vision plan which include: 90% of PLWHA knowing their status, 90% of those having access to treatment and 90% of PLWHA on treatment showing a suppressed viral load. Furthermore the

aims include the reduction of new HIV infections (of up to 75%) and to completely eliminate HIV related discrimination (UNAIDS 2015a:12).

The success of this strategy will be dependent on “cities, towns and communities to take charge of their HIV responses by analysing the nature of their epidemic and then using a location–population approach, to focus their resources on evidence-informed high-impact programmes in the geographical areas and among the populations in greatest need. The key is to do the right things at the right place, for the right people and in the right way” (UNAIDS 2015a:12).

Preventive interventions proved successful in 2012 since the incidence of new HIV infections were reduced in low- and middle-income countries (UNAIDS 2013:12). Although numerous HIV prevention programmes have been mounted to varying degrees of success, there is evidence that many programmes fail to reach or impact upon, many populations highly vulnerable to HIV infection, such as PLWHA (UNAIDS 2005:25).

With this in mind further investigations into the HIV and AIDS epidemic within specific populations are warranted. Hence the focus of this study. In this section attention will be given to some HIV preventive programmes and/or strategies. It should be highlighted that there are many priority interventions for HIV/AIDS prevention, treatment and care and the specific interventions differ from country to country (WHO 2010:online). A comprehensive list of priority interventions for HIV/AIDS prevention, treatment and care and more detailed descriptions of each can be obtained from the WHO report: Priority interventions HIV/AIDS prevention, treatment and care in the health sector (WHO 2009:online; WHO 2010:online). For the purpose of the current study HIV preventive educational programmes have been focussed on.

2.5.1 HIV and AIDS prevention strategies in Lesotho

The first time that the international community mobilised and worked with individual countries (including Lesotho) was in 2001, during the United Nations General Assembly Special Session (UNGASS) where a number of goals and targets were set to respond to the challenges of HIV and AIDS (GoL NAC n.d:1-81). Since then most of the governments of the Sub-Saharan countries, Lesotho included, have remained focused and committed to national responses to HIV and AIDS targeted at attainment of universal access to HIV prevention, care and

treatment and also ensuring accessibility and affordability of HIV and AIDS services to all disadvantaged members of the community. In Lesotho various stakeholders including non-governmental organisations, the private sector, and a network for PLWHA are involved in the fight against the HIV and AIDS epidemic.

The epidemic of HIV and AIDS is an area where high political commitment coupled with policies, legislation and action that have led to put in place necessary mechanisms in the fight against HIV and AIDS. The GoL health policies promote "good health for all" (GoL MOHSW n.d.:1) and in view of these goals were set in line with the global vision: *zero new HIV infections, zero discrimination and zero AIDS-related deaths* (UNAIDS 2010:21).

The following GoL policies offer a framework for addressing HIV prevention in the country namely: The Health Sector Policy on Comprehensive HIV Prevention; The Adolescent Draft Health Policy; and The Workplace HIV/AIDS policy. From this the following strategies emerged: The National Action Plan on Women, Girls and HIV and AIDS (2012-2017); The Mother-to-Child Transmission strategy; The National HIV Prevention Strategy for a Multi-Sectoral Response; and The Operational guidelines for comprehensive HIV prevention interventions within the Health Sector (Makamure & Glenwright 2015:online).

Many of the strategies mentioned before focus their intervention specifically at high risk groups. These include: factory workers, migrant workers, taxi and truck drivers, sex workers and increasingly members of the Lesbian, Bisexual, Gay, Transgender and Intersex (LBGTI) communities (Makamure & Glenwright 2015:online).

2.5.1.1 HIV and AIDS prevention strategies in the workplace

In responding to the HIV and AIDS epidemic the GoL implemented several HIV and AIDS prevention strategies, including the enactment of the Labour Code (Amendment) Act 5 of 2006 which require all employers to have workplace HIV and AIDS policies and programmes in place (Mosito 2014:1583).

The Workplace HIV/AIDS policy led to public service workplaces that budget for HIV and AIDS care and treatment, however the policy still exclude some key workers (e.g. domestic workers) in the government sector (Makamure & Glenwright 2015:online).

In response to addressing HIV and AIDS in the workplace, the Apparel and Textile Industry intervention service was launched in May 2006. The industry provides over 80% of employment (including many women of reproductive age). A broad and integrated approach to healthcare is taken by ALAFA. This includes HIV and AIDS education, HIV policy development & implementation, HIV and AIDS treatment and support services to those affected by AIDS-related illnesses. Support groups in the factories are an example of one of the interventions positively contributing to the welfare of PLWHA, by increasing knowledge, treatment acceptability and improved adherence (ALAFA 2009:11).

2.5.1.2 HIV and AIDS prevention strategies for pregnant women

The National Guidelines for Prevention of Mother to Child Transmission (PMTCT) of HIV include four focus areas namely: "Primary prevention of HIV infections among women of child-bearing age; Prevention of unintended pregnancies among HIV infected women; Prevention of HIV transmission from infected mothers to their children; and Provision of continuous care, treatment and support for infected mothers, their partners and children" (GoL MOHSW 2011:online; WHO 2000:1).

As a result of the guidelines all women who attend antenatal care during pregnancy is counselled and tested for HIV. Those who are found to be HIV positive are then managed accordingly in order to reduce the risk of Mother-To-Child Transmission (MTCT). In 2009 42% of HIV positive pregnant women (increase of 37% from 2006) had access to PMTCT services in 180/207 health facilities in Lesotho (Li 2009:online). The most recent figures show that a total of 62% of HIV positive pregnant women receive treatment (Makamure & Glenwright 2015:online).

2.5.1.3 HIV and AIDS prevention strategies for men

In terms of HIV prevention strategies for males, male circumcision was found to significantly reduce heterosexual transmission of HIV. Studies from the year 2000 estimated a reduction in the HIV transmission rate by 60% (Auvert, Taljaard, Lagarde, Sobngwi-Tambekou, Sitta & Puren 2005:e298). In view of this voluntary medical male circumcision (VMMC) was supported by the WHO and UNAIDS as a recommended prevention strategy.

A 2013 study conducted in Lesotho reported that fewer than 5% of men had been medically circumcised as opposed to 50% who had been circumcised using traditional methods (Coburn *et al.* 2013:224). In 2015 the latest numbers showed that over 100,000 males had been medically circumcised, according to Cheli (2015:online) this constitute 40% of a target to circumcise 80% of males in the country. The slow uptake may in part be due to the great variation in acceptability of being circumcised (Bulled 2015:761-764). Studies have shown that in certain cultures in Sub-Saharan Africa cultural circumcision remains more acceptable regardless of the benefits that VMMC offers (MacDonald & Njeuhmeli 2014 in Bulled 2015:758; Mark, Middelkoop, Black, Roux, Fleurs, Wood & Bekker 2012 in Bulled 2015:758). This is an aspect which HIV policy makers and governments should carefully consider (Bulled 2015:758).

2.6 HIV PREVENTION EDUCATION PROGRAMMES (EDUCATION AS A SOCIAL VACCINE)

In this section, education as preventive measure in the fight against HIV and AIDS will be summarised.

2.6.1 Rationale for HIV and AIDS Education

As there is currently no known cure for HIV and AIDS, education has been referred to as a 'social vaccine' against HIV and AIDS with a general preventive impact, to reach an entire population (World Bank 2002:8). The World Bank (2002:8) further adds that education is highly cost-effective as a preventive mechanism as it empowers individuals with appropriate knowledge, skills, and values to promote healthy decisions making concerning their own lives to ultimately act on knowledge to protect themselves against infection. The Dakar Framework for Action stressed that "education is a human right that is key to sustainable development. It also noted that HIV and AIDS is an enormous challenge to education but also noted 'the enormous potential that the education system offers as a vehicle to help reduce the incidence of HIV and AIDS and to alleviate its impact on society'" (IATT 2008:online; UNESCO 2000:23). Well planned and delivered HIV and sexuality education increases knowledge, develops skills, generates positive attitudes and can modify or reduce risk taking behaviour (UNESCO 2011:12).

2.6.2 International and Regional commitment to HIV and AIDS education

HIV is spread primarily through sexual intercourse, education to promote safer sexual behaviour is expressed in international and regional policies and strategies e.g. the UNAIDS Getting to Zero 2011–2015 Strategy (2010:34); the UNESCO strategy for HIV prevention education strategy (2004:13); the UNGASS Southern African Development Community (SADC) HIV and AIDS strategic framework 2010-2015 (SADC 2009:19); the World bank (2002:8); An ILO code of practice on HIV and AIDS and the world of work (ILO 2001:9) & finally the UNESCO's The Dakar Framework for Action on Education for All (EFA) goal by 2015 (2000:20).

Despite the apparent political commitment demonstrated, most governments including Lesotho failed to achieve the agreed-upon set both international and national indicators about fulfilling UNAIDS getting to Zero 2011–2015 Strategy, the document did mention the concept of vulnerable groups including PLWHA and proposed political and programmatic commitment to affected communities by intensifying efforts to eliminate removing barriers to access, uptake and sustained use of high-quality HIV prevention services and programmes (UNAIDS 2010:34).

2.6.3 Formal Education Sector response to HIV and AIDS

The majority of young people, who are at high risk of HIV, can be found in schools. It is therefore postulated that if AIDS information and sex education is provided at schools, it captures a larger population of young people at risk of HIV, therefore schools are perceived as a public institution with a broad opportunity and responsibility for addressing and reducing sexual risk-taking behaviours (Clarke & Aggleton 2012:7; Kelly 2000:22; UNESCO 2001:11; UNESCO 2008:online). Education policies, procedures and regulations should ideally by and large be reformulated to take into account HIV and AIDS (Kelly 2004:42). Education equips optimistic and hopeful young people with affection, morale and intellect to make sound and healthy decisions concerning their own lives, dealing with pressure and remaining free from being infected with HIV (Kirby 2011:online; World Bank 2002:8). The enormous potential of the education system helps to reduce the incidence and transmission of HIV and AIDS and to alleviate its impact on society (Kirby 2011:online; UNESCO 2000:20). It is UNESCO's (2000:20) view that the rationale for HIV and AIDS education revolves around prevention of occurrence of new infections, and improvement of the quality of life for PLHWA.

2.6.3.1 *Teaching HIV and AIDS Education and the Curriculum*

In Sub-Saharan Africa, HIV and AIDS education has not achieved significant behavioural change, despite high levels of knowledge, it has been shown that there are a number of constraints to the effective delivery of the HIV and AIDS curriculum (Bennell, Hyde, Swainson 2002:34). In a South African study, authors Pelzer and Promtussananon (2003:394) researched the knowledge and attitudes of second grade teachers. Findings showed that teachers have ample knowledge of HIV and they are moderately comfortable to teach students about HIV which will be more successful if they have the correct materials and support from the community (Pelzer & Promtussananon 2003:394). This willingness and positive attitudes was also shown in a study by Kachingwe, Norr, Kaponda, Norr, Mbweza & Magai (2005:193). The authors offer recommendations in the improvement of HIV and AIDS education initiatives in schools (Kachingwe *et al.* 2005:203).

Evidence shows that since the main form of HIV transmission worldwide is unprotected heterosexual intercourse, a discussion on HIV and AIDS without talking about sex will be inherently be limited (Boler 2003:32). Additionally, in the same study, teachers expressed concern that parents would disapprove if they knew that the students were being taught about sex. To date life skills programmes have not been straightforwardly implemented in Lesotho schools. There are practical difficulties in integrating the form of education envisaged into a very conventional, didactic style of schooling (Ansell 2009:16). Life skills education, as delivered through school curricula, still emphasises information delivery (teacher centred methodology), and relatively little attention has been given to pedagogy (student centred methodology) (Ansell 2009:17).

This makes it important for HIV and AIDS education in Lesotho to take a participatory approach that gives individuals opportunity to seek answers to their questions. The supportive environment that enables free interaction is important in motivating change in behaviour.

2.6.3.2 *The role of formal and informal Education Sector response to HIV and AIDS*

It is suggested that HIV and AIDS education must go beyond the formal educational system, the education sector is challenged to design and facilitate intervention programmes that effectively address the management of the epidemic. In recognition of this, one of UNESCO's

aims is to give close attention to the provision of both formal and non-formal education programmes (UNESCO 2001:40).

According to the World Bank (2002:8) for HIV and AIDS education programmes to be successful, they need to strike a balance between knowledge, life-skills, values and attitudes. The World Bank (2002:8) further asserts that a mere imparting of information, while necessary, seems insufficient as it results in a gap between information and action which can best be filled through the exploration of feelings, attitudes, values, choices and responsibility. The scientific literature clearly demonstrates the effectiveness of HIV prevention in changing sexual and drug-using behaviours Global HIV Prevention Working Group (PWG 2008:9).

A behavioural intervention is a specific collection of preventive activities developed or implemented with a clear aim to promote positive changes in behaviours, they promote accurate individual knowledge and perception of risk and increase individual motivation to avoid risky behaviour or effectively negotiate risky situations. Behavioural HIV prevention programs can target individuals, families, communities, entire societies, or (ideally) a combination of all these (Global HIV Prevention Working Group 2008:9; Rural Centre for AIDS/STD prevention 2007:1).

Peer education is one of the key strategies in HIV prevention programmes, all of which are aimed at addressing the pandemic by achieving behavioural change (ALAFA 2006:n.p). Peer education typically involves the use of members of a given group to effect change among other members of the same group to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. Experience has shown that when peer education programmes are well designed and well implemented - as a component of an overall HIV prevention strategy - they can contribute towards increasing basic knowledge on HIV and AIDS , develop life skills such as self-awareness, interpersonal communication skills, and negotiating skills on condom usage (The International Federation of Red Cross and Red Crescent Societies 2009:8).

Life skills education are now widespread across Africa (Boler & Aggleton 2005; James, Reddy, Ruiters, McCauley & Van Den Borne 2006:281-294; Magnani, Macintyre, Karim, Brown, Hutchinson, Kaufman, Rutenburg, Hallman, May, Dallimore & Transitions Study Team 2005:289-304; Visser 2005:203-216; Yankah & Aggleton 2008:465-468). In the context of HIV prevention, life skills equip children, young people and adults to make better decisions

where personal health and well-being choices are concerned, help them to recognize and avoid situations and behaviours that place them and others at risk of HIV infection, and to manage challenging situations (The International Federation of Red Cross and Red Crescent Societies 2009:12).

Good quality life skills education should be learner-centred, needs-based with interactive teaching methods. Through this interactive process the target population is provided with basic facts about HIV and AIDS, given opportunities to develop skills for personal protection and encouraged to access appropriate services and products in order to maintain and develop safer practices (The International Federation of Red Cross and Red Crescent Societies 2009:11).

2.6.4 The Lesotho Education Sector response to HIV and AIDS

Despite the efforts against HIV and AIDS, the number of new HIV infections in Lesotho and the HIV prevalence rate still remain too high (cf. 2.3.3). The Lesotho Ministry of Education and training (MOET) is concerned about HIV and AIDS and its negative impact to the education system hence their ten-year Education Sector Strategic Plan (ESSP) for the period 2005 –2015 has been developed. It is the Government's plan to develop schools centres for sexual and reproductive health education by creating HIV and AIDS awareness in all aspects of school life and incorporating HIV and AIDS education in the school curriculum (GoL MOET 2005:51). Among the Ministry's priority over the period 2005-2015 has been the development and implementation of the HIV and AIDS co-ordination programme of HIV and AIDS interventions (GoL MOET 2005:65).

2.6.4.1 *Multi-sectoral Approach and HIV/AIDS Education in Lesotho*

Lesotho adopted the National Multi-Sectoral HIV Prevention Strategy 2011–2015 that recognises national response by sectoral ministries and organisations (expanded broad-base of Basotho stakeholders) after realising that the impact of the epidemic went beyond the domains of health and cut across all aspects of individual, family, community and national life. The strategy offers guidance in scaling-up existing and effective HIV prevention programming interventions (GoL NAC n.d.b:online).

In Lesotho, peer education is one of the non-formal key strategies in the HIV prevention programme, all of which are aimed at addressing the pandemic by achieving behavioural change. The initial attempts to introduce peer education through schools have not been successful in Lesotho (GoL NAC 2012:online). The education strategies have not adequately addressed cultural barriers (such as parents and young people discussing sex, sexuality and reproductive health) and it is found that not all schools have teachers who are adequately trained in life-skills-based HIV and AIDS education (GoL NAC 2012:online).

Another very important component is the role faith based organisations play, the Christian Council of Lesotho (CCL) trains youth as peer educators and offers training for women and men to care for the sick and those orphaned. Other religions present in Lesotho are also initiating HIV and AIDS related activities, yet they work mostly in isolation. Despite these positive examples, religious organisations and religious leaders in general have been slow to take an active part in the national response to HIV and AIDS (Kimaryo, Okpaku, Githuku-Shongwe & Feeney 2014:196).

When undertaking a peer education programme, the overall goal is to develop a recommended behaviour or to change risky behaviour in a target group. Significant changes in the education programme are necessary to reflect the realities of at risk-populations including of PLWHA. Unfortunately the level of awareness and knowledge of HIV and AIDS has not translated into desired behavioural change as demonstrated by the increase numbers of new infections.

A review of the National HIV and AIDS Strategic Plan 2006/2011 reflects gaps which are likely to be contributing to this situation. The gaps include weak implementation capacity, the interventions remain fragmented, which is a key factor of failure to reach individuals and targeted communities with the level of coverage and intensity required to make an impact; most information and education communication (IEC) materials are produced in English and are inaccessible to minority and marginalised groups. Given the weak system for quality control some communication materials give the mixed messages (GoL NAC 2009b:34).

Bandura (1990:9) asserts that if people are informed adequately about the AIDS infections it may increase knowledge and awareness of health risks and enable individuals to take appropriate actions to avoid risky behaviour. The author further argues that a mere imparting of information is not enough to convince people to change their risky habits, most of them

still need guidance to encourage compliance on how to translate their concerns into efficacious actions (Bandura 1990:9).

2.6.4.2 *Reasons for Advancing HIV Education Strategies in Lesotho*

In spite of the large amount of HIV and AIDS interventions in Lesotho, there is still a need for effective HIV and AIDS prevention education programmes addressing the needs of the diverse populations within the country. Efforts should also be made to employ a multi-sectorial approach that links educational interventions to proximate factors to all at-risk populations as well as reaching all communities in Lesotho especially those in rural and far off settlements.

The current state of research on HIV prevention has advocated for a paradigm shift from traditional prevention programmes to PLWHA prevention curriculum reform associated with behavioural change towards PLWHA (Global HIV Prevention Working Group 2008:14). Prevention strategies that increasingly target PLWHA are known as positive prevention. Several approaches to positive prevention have proven their efficaciousness (Crepaz, Lyles, Wolitski *et al.* 2006 in Bunnell *et al.* 2006:855) therefore positive prevention has been recommended by UNAIDS (2005:25). A central focus of education for PLWHA needs to support them to develop HIV prevention skills that reduce vulnerability and risk-taking behaviour that contributes to HIV transmission and re-infection (Gordillo, Fekete, Platteau, Antoni, Schneiderman, Nöstlinger & Eurosupport Study Group 2009:253)..

2.7 FACTORS RELATED TO HIV RISK-TAKING BEHAVIOURS AMONGST PLWHA

There are many factors contributing to HIV risk-taking behaviours amongst PLWHA. Many studies have focussed their efforts to identify these risk factors and how they relate to one another in order to better understand the distribution of HIV infection (cf. 2.7.1- 2.7.2). Risk is defined by UNAIDS (2007b:4) as the probability that a person may acquire an HIV infection, in the context of PLWHA risk will include transmitting the disease. Risk factors are “conditions or variables associated with a lower likelihood of positive outcomes and a higher likelihood of negative or socially undesirable outcomes” (Jessor, Turbin & Costa 1998:online). Lastly the online oxford dictionary define behaviour as “the way in which one acts or conducts oneself, especially towards others” (Oxford dictionary 2016:online). In view of this HIV risk-taking behaviours are behaviours that enhance and perpetuate risk.

These risk-taking behaviours commonly focus on the behaviours of individuals (individual risk taking behaviours such as unprotected sex, transactional sex, substance abuse etc.) and sometimes neglect the larger context referred to by authors as "social context", contributing to risk-taking behaviours (Israel, Laudari & Simonetti 2008:10; Poundstone, Strathdee & Celentano 2004:22).

Boerma & Weir (2005:s61) propose a determinants framework which use demographic and epidemiologic approaches to understand the distribution and determinants of HIV infection. In the three groups namely: underlying determinants, proximate determinants and biological determinants (Boerma & Weir 2005:s65). The first two determinants is of significance in the current study and will therefore be focused on in the remainder of this section. For detailed discussions about the whole framework and how the determinants affect and relate to one another the article of authors Boerma and Weir (2005:s61) can be referred to. More details about this framework can also be referred to as it was utilised in other studies (Baidooonso 2013:1; Lewis, Donnelly, Mare, Mupambireyi, Garnett & Gregson 2007:61-69).

With reference to the two determinants to be considered in this study. The underlying determinants take into consideration "demographic (e.g., sex, age, marital status, mobility, and residence), socioeconomic (e.g., income, education, and occupation), and sociocultural (e.g., religion and ethnicity) characteristics of individuals" (Boerma & Weir 2005:s65). Proximate determinants on the other hand take into consideration "risky sexual behaviour and practices (e.g. number of sex partners, type of sex partners, condom use and STI history)" (Boerma & Weir 2005:s65). They are summarised in Figure 2.3.

From the figure can be seen that the underlying determinants relate to the proximate determinants, leading to the biological determinants, health outcome and eventually demographic outcome. It can be postulated that some proximal determinants might be a direct result of an underlying determinant (e.g. poverty is commonly associated with risk taking practices such as transactional sex; or some cultural beliefs and practices commonly force or encourage unprotected sexual practices). Some factors associated with HIV risks-taking behaviours of PLWHA will be presented in the two determinants which primarily include a focus on Lesotho.

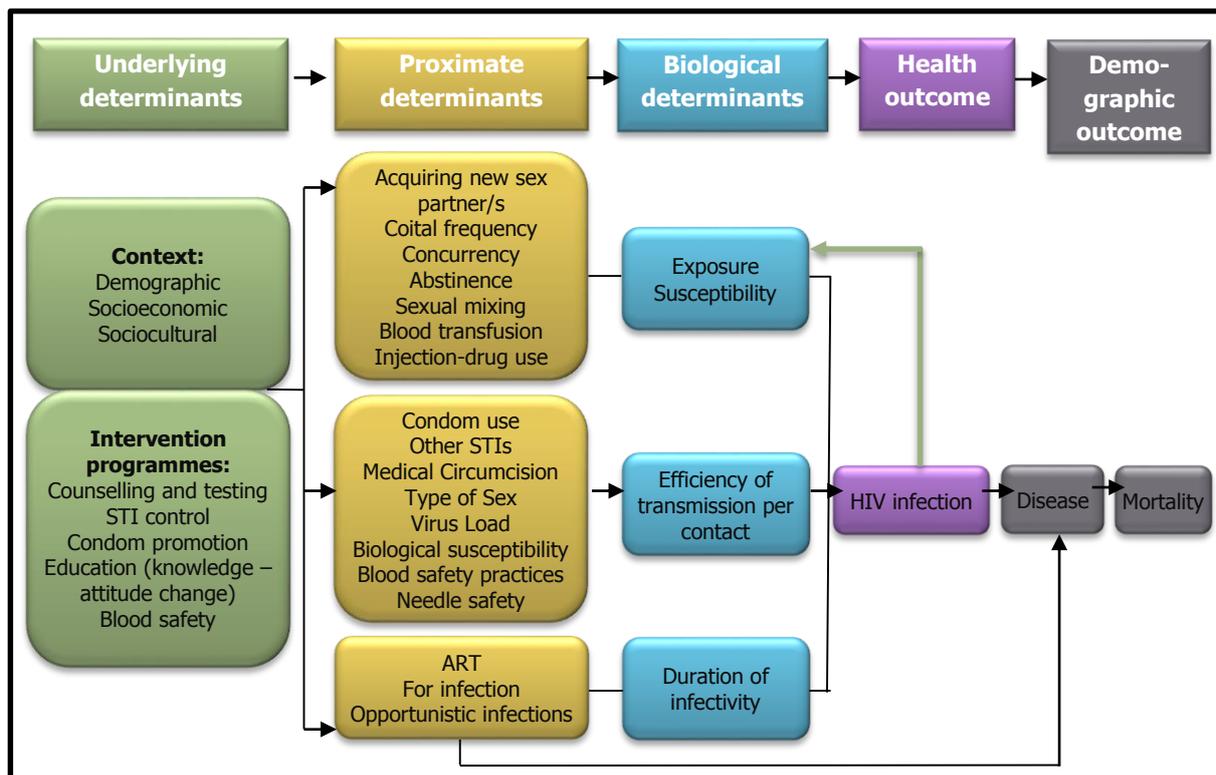


FIGURE 2.3: THE PROXIMATE-DETERMINANTS FRAMEWORK FOR HIV INFECTION

(Designed by the researcher Mabathoana 2016; Content derived, source: Boerma & Weir 2005:s63)

2.7.1 The underlying determinants

The underlying determinant constitutes three components: demographics, socioeconomic and cultural. Within each of the approaches, the distribution and determinants of HIV infection are discussed to determine which of them associate with which risk-taking behaviours.

2.7.1.1 Demographics

Demographics include sex (male or female), age, marital status, mobility and residence (Boerma & Weir 2005:191).

Women are disproportionately affected by HIV and AIDS in Lesotho. Women are the most vulnerable because of unequal access to economic resources, thus they are forced to involve into transactional sex and have little control over their sexual lives (Kesby, Fenton, Boyle & Power 2003:1589). In this context women lack skills to make the right decision to practice safe sex as well as lack of skills to negotiate condom use (Temah 2007:5). This will be further explained in later sections (cf. 2.7.1.2)

In Lesotho 2% of girls are married by the age of 15 and 19% are married aged 18. Child marriage has devastating and long term effects on the lives and the futures of girls. Child marriage involves human rights, gender, health and culture, as well as a development issue. We do know that in several countries, including Lesotho, girls and women are the face of the HIV and AIDS epidemic, they bear the brunt of the epidemic more than their male counterparts; and needless to say, girls who are forced into marriage at a young age are at greater risk of HIV infection than sexually active, unmarried girls in Lesotho (Lesotho Joint Un Team On AIDS 2015:1). The Children's Protection and Welfare Act of 2011 defines the minimum age for entering marriage as 18 (Zizzo 2011:12).

Residence

In Lesotho geographic factors play an important role in the spread of the HIV and high prevalence levels which is concentrated in urban areas. Lesotho's HIV infection is pronounced in nearly every socio-demographic and geographic subpopulation, women have a higher infection rate than men, and the urban areas carry more burden than rural with a prevalence of 27% and 21% respectively (GOL MOHSW 2010:2). In this scourge, women are more affected by the epidemic with a prevalence of 27% while among men the prevalence is 18% according to the LDHS 2009 (GOL MOHSW 2010:2).

Furthermore infrastructure and human resources: Health services are largely inaccessible, especially for people living in the mountainous areas, due to (a) a shortage of skilled staff at all levels of the health system, (b) insufficient health promotion and (c) poor infrastructure (inadequate road networks, lack of ambulances and insufficient two-way communication (Miller 2013:40).

2.7.1.2 Socioeconomic

According to Boerma and Weir (2005:191) the socioeconomic determinants include income, education, and occupation. In a South African study the three factors (income, education and occupation) were investigated to establish their role as determinant of HIV risk. The results showed that the association between these factors and HIV risk was not always clear (Johnson and Budlender 2002:14).

Income

A study done in 1990 showed that poor people have a higher risk for HIV because of the “physical and social circumstances in which their poverty places them” (Krueger, Wood, Diehr & Maxwell 1990:811).

Poverty contributes both to ill health and death. In most cases ill health among the poor arises from the lack of access to food and clean water, health care facilities, education, employment, housing sanitary facilities and arable-land. Lesotho is one of the countries experiencing extreme incidences of poverty and deteriorating health status due to poorly functioning health and social welfare system, high cost of medical care, long distances to medical facilities, insufficient numbers of health personnel especially in rural areas and only one referral hospital in Maseru (Mokhothu 2004:13).

About 57% of the citizens of Lesotho live below the national poverty line (UNAIDS Lesotho 2014:2). There is widespread unemployment, inequality and poverty, particularly in rural areas. According to a Millennium Development Goal report on the country (GoL 2014:online) the ratio of very poor household members has increased from 34% in 2003 to 35.1% in 2013, while the percentage of poor household members increased from 56.6% in 2003 to 57.1% in 2013. The poverty head-count rate is higher in rural areas than in urban areas, because of the low performance of agriculture, the main source of income in rural areas (Millennium Development Goal Report on the Country 2014:11; Nseera & Bhatia 2014:online).

Ezeokana, Nnedum and Madu (2009:156) indicated that poverty, especially shortage of money to cover basic living costs and family expenses, perpetuate PLWHA to engage in risky sexual practices. One such example is the participation of both men and women in transactional sex.

Education

Williams *et al.* (2000 in Johnson & Budlender 2002:16) indicated that the level of education of an individual is not a simple determinant of HIV risk. Therefore an education level of a person probably does not affect their risk for HIV (Johnson & Budlender 2002:17).

The gender situation in Lesotho is unique in many respects. Many women have had more opportunities for education than men in contrast to what is found in many African countries,

Additionally, there is a predominance of female students across all levels of education including primary, secondary and university (Zizzo 2011:11). However, despite higher levels of education, women continue to experience limited access to productive resources, and many women suffer from STIs, HIV and AIDS (Mokhothu 2004:18; Zizzo 2011:11).

Occupation

It is postulated that migrant labour almost always results in prolonged spousal separation that disrupts normal family life, encouraging marital infidelity and lead to risk-taking practices that increase risk and vulnerability to HIV (Miller 2013:53). These contexts tend to increase vulnerability to HIV because people in unstable living contexts often exhibit higher risk-taking behaviours such as transactional sex (Miller 2013:53).

Lesotho is geographically surrounded by South Africa and economically integrated with it as well. Initially, the source of employment in South Africa for male migrant workers from Lesotho was entirely the mining industry and Corno and De Walque (2007:4) reported that "60% of the total Lesotho workforce was employed in the mines in South Africa". It was therefore common for young Basotho men to migrate across the border to work in the South African mines; women and children were barred from accompanying migrant miners to their place of work (The United Nations International Research and Training Institute for the Advancement of Women (UN-INSTRAW) & UNDP 2010:17).

There are many factors that may exacerbate the HIV vulnerability of mine workers including staying in single-sex hostels, the sex industry working in and around the mines and having limited home-leave (Corno & De Walque 2012:465, 472). These circumstances may lead some workers to seek (multiple) sexual relationships. When HIV is then contracted by men working in mines their partners at home will then be at an increased risk to contract HIV. It has been shown that miners and their wives are less likely to adopt safer sexual behaviours because miners are less likely to abstain and to use condoms, in particular during occasional sexual intercourse (Corno & De Walque 2012:468). Similarly, female partners of miners are also less likely to abstain from sex and also involve themselves with extra-marital relationships (Corno & De Walque 2012:468).

Opposite to the situation for men, female workers in Lesotho were highly needed and employed when the textile industrial sector in Lesotho expanded. The textile industry has

become the largest private employer in the country involving a workforce of about 47,000 (UN-INSTRAW & UNDP 2010:17), again mostly employing women. This initiated migration of females from their families in small towns and rural sites to larger cities where the industrial plants were, which offered an income (IOM n.d.:online). This again placed them into a higher risk category to partake in extra-marital relationships and/or transactional sexual relationships.

2.7.1.3 Sociocultural

Socioculture includes the following aspects: ethnicity, culture (with gender inequalities) and religion (Boerma and Weir 2005:191). The effects of HIV associated stigma and discrimination were also included in this section.

Ethnicity

In the review of HIV-risk factors conducted by Johnson and Budlender (2002:17) the prevalence of HIV is highest in Black Africans followed by people from the Asian, Coloured and White race. The Lesotho population constitutes of mostly Basotho people with very few other races. Johnson and Budlender (2002:17) contribute the following factors to HIV being more prevalent in the Black population: "the social effects of forced removals, the nature of township lifestyles, the migrant labour system, and the gradual breakdown of transitional society". All of these factors are present in Lesotho.

Culture (with gender inequalities)

Culture is often shown to have an effect on HIV risk-taking behaviours. The existing societal and cultural norms of men's and women's rights as well as sexuality, create unequal power dynamics in intimate heterosexual relationships and therefore are found to contribute to increased HIV vulnerability of women (Ricardo & Barker 2008:4).

Gender inequalities were identified over a decade ago as a fundamental driver of HIV, and epidemiological data still demonstrates a gendered epidemic in Southern Africa. In Lesotho, as in other Southern African countries, gender inequality has hampered HIV and AIDS prevention efforts (Hlalele & Letsie 2011:163).

According to Hlalele and Letsie (2011:163) the gender roles prescribed for women can demand a submissive role, passivity in sexual relations, and ignorance about sex. They can also restrain women from seeking and receiving information related to HIV prevention.

It is a well-known fact that women and girls in developing countries are more vulnerable to HIV. In African, including Lesotho culture, sexual relationships are dominated by men, meaning that women cannot always practice safe sex even when they know the risk involved (Parker & Aggleton 2003:57). Hlalele and Letsie (2011:163) furthermore describe that masculinity requires men to be more dominating, knowledgeable and experienced about sex. This assumption puts many young men at risk of HIV infection as such norms that prevent them from seeking information or admitting their lack of knowledge about sex or methods of protection. Gender inequality and patriarchy generally encourage multiple sexual partners for men inside and outside of marriage, while women are required to be faithful and monogamous. Such sociocultural practices and norms make men and their partners especially vulnerable to HIV. In this context, the dangers of multiple sexual partners relate to more than one sexual partner at the same time, and then become part of a sex network. If one person in the sex network becomes infected with HIV, all the people in the sex network can be infected. Multiple and concurrent partners refer to people who have sex with a number of others, not only in a series of monogamous relationships, but in overlapping relationships that persist over time, often over a very long time (long-term MCP). In other words, lovers may move within and between a small or larger set of other lovers over much of their lives. If each set of exchanges is limited to a small group, as in strict polygamy (formal and exclusive marriage) (Thornton 2009:3) the risk of transmission and new infections becomes smaller.

Van Dyk (2005:89) observes that "if education and prevention programmes are to be successful in Africa, it is important for us to understand and appreciate the traditional African world-view of sexuality. This links with one of the UNESCO aims for HIV programme designers: to pay close attention to the provision of culturally appropriate education, utilising accurate information within using well adapted methods and contents about HIV transmission, safe sex practices and drug abuse (UNESCO 2001:20).

Gender inequalities in Lesotho

Lesotho faces a number of challenges in achieving equality between men and women. The subordination of women is deeply ingrained in Basotho culture with the minor status whilst

legislation has increased rights for women on paper, there is still a long way to go before this makes a difference to women on the ground (UN Convention on the Elimination of All Forms of Discrimination against Women 2011:3). This, therefore, makes it difficult for women to negotiate safer or protected sex within their relationships. As a consequence, women face increased chances of contracting sexually transmitted infections (STIs), HIV and AIDS on top of having unplanned and undesired pregnancies. Women's vulnerability to HIV is further increased by cultural perceptions of women's sexual and reproductive obligations, payment of a bride price (*bohali*) gives men the impression that they 'own' their wives (Hlalele & Letsie 2011:162; UN Convention on the Elimination of All Forms of Discrimination against Women 2011:5).

In addition to cultural beliefs and norms gender violence also seem to pose a problem in the management of HIV and AIDS in Lesotho. Chipatiso, Machisa, Nyambo and Chiramba (2014:8) revealed that 62% of women in Lesotho had experienced intimate partner violence over their lifetime and 86% had experienced gender-based violence. The same study revealed that 8% of women had experienced rape, while 16% of men admitted to committing rape. The same report indicated that 68% of physically abused women spent days in bed due to their injuries, and 24% had to miss work due to injuries. Amongst women in this study who had been abused by intimate partners, 7% had attempted suicide. Of women who had been raped by non-partners, 12% had attempted suicide (Chipatiso *et al.* 2014:12).

Lesotho has made some considerable efforts to attain gender equity and equality though there are still some glaring challenges facing the country in terms of its gender dynamics, as well as in terms of its policy and legal frameworks. The country has ratified and is signatory to many international commitments to advance the rights of women, Lesotho became a party to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995 and ratified the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women in 2004 (Zizzo 2011:12).

Political leadership to implement new policies is still lacking in most countries and there are significant gaps between what is promised and what is delivered (Zizzo 2011:14). Lesotho applies both customary law (administered through traditional chief courts) and the general law side by side. Lesotho has a strong practiced and not displayed culture pertaining its women and girl children. Both the statutory and the customary laws have noticeable negative implications concerning the status of women.

Many African countries including Lesotho have constitutions that guarantee the right to equality and non-discrimination for all people, including in some cases specific protection from discrimination on the basis of gender or sex. The Amended Constitution of Lesotho (1993) section 4 (1) guarantees every person in Lesotho human rights and freedom despite their race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Zizzo 2011:13).

Sexual Offences Act (2003) This Act protects the victims/survivors of sexual violence. It recognizes the wilful exposure of a person to HIV and provides for increased punishment in such cases, identifying a link between sexual violence and the spread of HIV/AIDS. The Sexual Offences Act protects women from the injustices that had been socialised into society. The Sexual Offences Act of 2003 was further complemented by the Legal Capacity of Married Persons Act of 2006 and Children s protection and welfare act (Hlalele & Letsie 2011:161).

The legal capacity of married persons 2006, removes the minority status of women married in community of property, and provides equal rights. Prior to this act, married women were relegated to the status of a minor during the lifetime of her husband and not allowed to enter legally binding contracts without his consent. The Legal Capacity of Married Persons Act grants married women the legal rights to make a will, sue for divorce, obtain loans without the consent of her husband, and enjoy full economic rights under the law.

At present gender discrepancies remain a concern in the successful treatment and management of HIV and AIDS and HIV preventive programmes should help women to understand their rights, both within the workplace and in their communities, and empower them to protect themselves.

Religion and spirituality

Johnson and Budlender (2002:34) reported on two studies considering the effects of religion on HIV, these were the works of Garner conducted in 2000 and Gregson *et al.* in 1999. Johnson and Budlender (2002:35).

There are a number of benefits associated with spirituality and religion for PLWHA. Religion and spirituality remain important forces in PLWHA's lives, both dimensions have been found to have a number of beneficial psychosocial measures (distress, hope, optimism, less anxiety),

and desired behaviours (safe sex, less use of alcohol, less smoking, more willingness to full disclosure of an HIV status (Cotton, Puchalski, Sherman, Mrus, Peterman, Feinberg, Pargament, Justice, Leonard & Tsevat 2006:S11). In conclusion, both religiousness and spirituality, although rarely assessed, remain an important force in the lives of those with HIV, regardless of many of these people having been rejected by traditional religion; they still remain religious or spiritual, and this religiousness/spirituality is related to a number of beneficial outcomes including less affective distress, lower cortisol, and long survival (Cotton *et al.* 2006:S11; Ironson, Solomon, Balbin, O'Cleirigh, George, Kumar & Arson 2002: 47).

A study conducted by Gerbi, Habatemariam, Robnett, Nganwa and Tamaru (2012:136) showed that religion and frequently participating in the religion (e.g. going to church) is associated with PLWHA taking fewer risks (reduced HIV risky behaviours).

HIV related stigma and discrimination

Although more efforts have been made to fight against HIV and AIDS-related in Sub-Saharan Africa stigma and discrimination still remain dominant affecting the lives of PLWHA negatively (UNAIDS & OHCHR 2007:10). Stigma and discrimination are closely linked concepts, but, Parker and Aggleton (2003:14) assert that lack of understanding the complexity surrounding the two issues would result from weaknesses to employ appropriate stigma and discrimination reduction approaches. In order to identify potential solutions to HIV-related stigma and discrimination, it is necessary to understand what is meant by these concepts, to describe how they are manifested, and to analyse the relationships between the two (Parker & Aggleton 2003:14).

Stigma can be explained as "a significantly discrediting attribute possessed by a person with an undesired difference (UNAIDS Best Practice Collection 2000:online as cited by UNAIDS & OHCHR 2007:11). The authors explain that those being stigmatised are commonly blamed for causing their infection and as a result they are disliked, harassed and isolated from their place of living and work; caused by those who instigate stigma having been un- or misinformed about HIV and AIDS (UNAIDS & OHCHR 2007:11). Stigma is deeply rooted, operating within the values of everyday life, it plays a key role in producing and reproducing relations of power and control (Parker & Aggleton 2003:14). These inequalities particularly include those linked to gender, women are more likely to be blamed even when the source of

her infection is her husband, and infected women may be less likely to be accepted by their communities (Parker & Aggleton 2003:14).

Stigmatisation can also occur on another level. Internal stigma is where PLWHA may themselves internalize the negative responses and reactions of others (Apanga 2014:43). Self-stigmatisation primarily affects an individual's sense of pride and worth, for PLWHA, this may be manifested in feelings of shame, self-blame, and worthlessness, which, combined with feelings of being isolated from society, can lead to depression, self-imposed withdrawal and even suicidal feelings (Apanga 2014:43).

Discrimination on the other hand concerns the manner in which people are treated. It is shown that HIV and AIDS-related discrimination has resulted in loss of jobs and accommodation as well as difficulty in accessing healthcare and education among PLWHA (Apanga 2014:41; UNAIDS & OHCHR 2007:10). The report UNAIDS and OHCHR (2007:10) shows that certain groups of people are commonly discriminated against more than others including: "women, migrants, refugees, prisoners, internally displaced people, ethnic minorities, the poor and young people".

Stigma and discrimination is also a sociocultural issue which undermines HIV prevention efforts by making people afraid to find out whether or not they are infected, to seek out information about how to reduce their risk of exposure to HIV and to change their behaviour to a safer behaviour lest it raises suspicion about their HIV status (UNAIDS & OHCHR 2007:11). Fear of stigma and discrimination also discourages people living with HIV from disclosing their HIV status, even to family members and sexual partners (Cloete *et al.* 2011:290).

There is much to be done to intensify educational programmes focussing on changing people's attitudes towards PLWHA (Apanga 2014:45; IATT 2008:online).

The GoL was aware of the problem that HIV and AIDS-related stigma and discrimination posed and as a result set the Millennium Development Goal (MDG) number 6 of halting and reversing the spread of HIV/AIDS by 2015 whereby the issues surrounding HIV and AIDS stigma should be known and effectively dealt with. Various laws including the Legal Capacity of Married Person's Act (2006), the Sexual Offences Act (2003), and the amended Labour Code No. 5 of 2006, have been developed. The 2011 report by the UN Committee on the Elimination of

Discrimination against Women urges the state of Lesotho to take action to 'fully incorporate the convention (CEDAW) into the domestic legal system in order to give central importance to the Convention' to ensure discrimination against women is eliminated (UN Convention on the Elimination of All Forms of Discrimination against Women 2011:13).

However, despite the government's will and commitment to end stigma and discrimination, it has continued to manifest (Lesotho Network of People Living with HIV and AIDS 2013:8). Miller (2013:51) is of the opinion that Lesotho still needs to perfect its strategies in the fight against the epidemic.

2.7.1.4 *Psychosocial implications resulting from HIV*

PLWHA experience depression and stress once they realise that they are HIV positive mostly because of fearing the impact of infection, fear of isolation by family and friends, and worries about infecting others (Ownby, Jacobs, Waldrop-Valverde & Gould 2010:online).

Depression specifically was shown to be associated with increased sexual risk taking behaviour (Kelly, Murphy, Bahr, Koob, Morgan, Kalichman, Stevenson, Brasfield, Bernstein & St Lawrence 1993:215) and as indicated earlier it also plays a major role in adherence to HIV treatment (Tyler-Viola *et al.* 2014:168) (cf. 2.4).

McKirnan, Ostrow and Hope (1996:655) explained that sexual risk stem from "a desire to escape cognitive awareness of very rigorous norms and standards. Being self-aware of the HIV risk arouses anxiety and precludes highly-desired activities: fatigue, fatalism, or other negative affects over HIV may lead people to 'cognitively disengage' within the sexual situation, and not to follow their norms or intentions toward safety. We propose that both substance use and the approach of high stimulation or other sexual settings facilitates this cognitive disengagement, wherein people enact 'automatic' sexual scripts and or become more responsive to external pressures toward risk".

In view of the above both psychosocial predictors as well as personality attributes contributing to HIV risk-taking behaviours should be considered in the explanations as to why PLWHA continue to engage in risky behaviours.

2.7.2 The proximate determinants

The proximate determinants include risky sexual behaviour and practices (e.g. number of sex partners, type of sex partners, condom use and STI history (Boerma & Weir 2005:s65).). Many of these factors have already been described in previous sections (cf. 7.2.1.1-7.2.1.4). It seem that they can be directly associated with several underlying determinants. For this reason some proximate determinants which deemed important to include in this study will be mentioned in this session.

Unprotected sex, multiple sexual partners and substance abuse

Sexual risk-taking has been associated with multiple factors like engaging in unprotected sex or low condom usage, transactional sex and substance abuse. In most cases people who are practising these behaviours are not likely to disclose their HIV status to their sex partners (Gerbi, Habtemariam, Tameru, Nganwa & Robnett 2011:online; Simbayi *et al.* 2007:21

In relation to this a series of reports are showing higher levels of psychosocial problems associated with risk-taking behaviours, including non-adherence to medication, substance abuse, and practising unprotected sex (Gerbi, Habtemariam, Tameru, Nganwa, & Robnett 2012:1; Ownby, Jacobs, Waldrop-Valverde, Gould 2011:81; Ownby *et al.* 2012:online).

In the literature, there is a general consensus that alcohol and/or drug use result in unprotected sex with multiple partners contributing to HIV re-infection (Gerbi *et al.* 2011:Online; Scott-Sheldon, Carey, Carey, Cain, Harel, Mehlomakulu, Mwamba, Simbayi & Kalichman 2012:492; Tameru, Gerbi, Nganwa, Bogale, Robnett & Habtemariam *et al.* 2012:6; cf. 2.7.2). Shapiro and Ray (2007:68) describe the following "The sexuality of men and women with HIV is diminished by the fear of infecting others and being infected, as well as guilt, anger and ill health resulting in negative physical and psychological effects on sexual desire". Sexual dysfunction was found to be associated with HIV risk-taking behaviours such as using recreational drugs and experimenting with sexual encounters which lead to opportunistic infections (Shapiro & Ray 2007:68).

Unprotected sexual risk taking related to HIV or other STIs, and the number of sexual partners in a specified time interval. Multiple and concurrent partnerships have been identified as an important contributor to the high levels of HIV across the Southern African region (SADC

2009:online), thus the existence of multiple and concurrent sexual partnerships are often denied. The reason for this denial for those who are practicing multiple and concurrent partnerships is often associated with promiscuity, people do not think of themselves as promiscuous because this undermines their own sense of personal value and moral worth in the community (Thornton 2009:4)

Behavioural factors also play a role in the decisions to participate in risky sexual practices. Shapiro and Ray (2007:67) describe a scenario where more sexually experienced persons of both sexes commonly have multiple sex partners. Practices of selling sex for money or even changing relationships (and ultimately sex partners) are also common under these circumstances (Shapiro & Ray 2007:68). Ray, van der Wijgert, Mason et al. (2002 in Shapiro & Ray 2007:68) describe the practices of sex workers of not using condoms when they have sex with their partners, the reason for this being to "differentiate them from commercial clients".

Previously it was seen that discrimination and stigmatisation is associated with HIV risk-taking behaviours of PLWHA (cf. 2.7.1.3). Jolly (2003 in Shapiro & Ray 2007:68) further address occurrences that are criminalised as well as stigmatised in some areas of the world – this include homosexuality and people who are transgender. In view of the laws and these groups of people being outcast they hide their relationships, practice sex (commonly unprotected sex) in secrecy and seclusion (Jolly 2003 in Shapiro & Ray 2007:68) which ultimately lead to increased risk for HIV and AIDS infection and transmission.

The UNICEF Lesotho country programme document from 2013-2017 (2012:3) asserts that multiple factors are major drivers of the epidemic including: Multiple concurrent partnerships, low levels of consistent and correct condom use, as well as low levels of medical male circumcision.

Non-adherence to medication resulting in risky sexual behaviour

The use of antiretroviral therapy has been the most consistently shown to correlate with high-risk-taking behaviour among HIV and AIDS patients (cf. 2.4). Treatment with highly active antiretroviral therapy (HAART) has been associated with many benefits, like significant reduction of patients' viral loads, which often lead to undetectable viral load levels and prolonging PLWHA quality of life (cf. 2.4). Several studies provide evidence that individuals

on effective HIV treatment and especially those with undetectable viral loads have the misperception that they are safe and no longer infectious (the term treatment optimism is commonly used in such cases), and as a result they continue to practice sexual transmission risk behaviours (Crepaz & Marks 2002:135; Peterson, Miner, Brennan & Rosser 2012:91; Gerbi *et al.* 2012:1; Remien, Halkitis, O'Leary, Wolitski & Gómez 2005:167; Vanable, Ostrow, McKiran, Taywaditep & Hope 2000:134).

Having knowledge of HIV and AIDS

Tameru *et al.* (2012:1) showed that there is also an association between interrelationships and linkages of the knowledge about HIV and AIDS to PLWHA practising risk-taking behaviours. The authors suggested that PLWHA should have more access to HIV and AIDS education.

Misleading information, factual incorrect information, beliefs (cultural or otherwise) and religion are also associated with HIV risk-taking behaviours (Shapiro & Ray 2007:68) (cf. 2.7.1.3).

On the other hand (as previously described), not knowing (not wanting to know) a HIV status also contributes to someone infected with HIV continuing to practice high-risk behaviours (Jaffe, Valdiserri & De Cock 2007:2412). Similarly a sexual partner may be aware of their status but be in denial about it and as a result not disclose it.

2.8 THEORIES USED TO ASSESS AND EXPLAIN HIV AND AIDS TRANSMISSION AND SPREAD BEHAVIOURS

According to Glanz, Rimer and Lewis (2008:online) theories are conceptual frameworks within which researchers seek: (1) why people behave in ways that put their health at risk; (2) why they are, or are not, following public health and medical advice; and (3) why they do not adopt healthy and protective behaviour. There remained three commonly cited theories previously used to assess and explain behaviours that could possibly lead to HIV and AIDS transmission and spread in populations. They include the Social Cognitive Theory (SCT), Health Belief Model (HBM) as well as the Risk Reduction Model (ARRM).

Other theories for behavioural health can be found in Traube, Holloway & Smith (2011:663).

2.8.1 Social Cognitive Theory (SCT)

Latka, Hagan, Kapadia, Golub, Bonner, Campbell, *et al.* (2008 in Wagner, Unger, Bluthenthal, Andreeva & Pentz 2010:504) used cognitive behavioural theories to understand injection risk behaviour among injection drug users in sixteen epidemiological studies conducted in the United States of America, Canada, Hungary, Pakistan, Ireland, Scotland, Thailand, India, Australia, and the Netherlands. The authors investigated whether the following concepts (as investigated by the above mentioned studies) had an association with injection drug use (to either encourage or discourage the use): self-efficacy; response efficacy; perceived susceptibility; perceived severity, perceived social or subjective norms; knowledge; behavioural skills; behavioural intentions; perceived barriers, benefits; and behavioural control.

The findings showed that self-efficacy and social norms yielded a consistent association; whereas perceived susceptibility, knowledge, behavioural intentions, perceived barriers, perceived benefits, response efficacy, and perceived severity yielded inconsistent results (association and non-association). The authors suggested further research in the field and to look also at environmental structures that influence risky behaviours (Wagner *et al.* 2010:504).

Behavioural interventions have demonstrated some success in reducing risk behaviour among injection drug users, associated with increased self-efficacy. This theory puts emphasis on self-efficacy which is the belief that one can influence things that happen in everyday life (Bandura 1990:10).

When applied to HIV prevention Bandura (1990:10) assert that efficacious people exercise their personal controls, protect themselves by communicating assertively about sexual matters, protective sexual methods and ensuring safe practices. In contrast to the above the author shows that those who lack a sense of self-efficacy, fails to protect themselves, they are unable to manage challenging situations effectively regardless of knowing what to do and having the required skills to do so (Bandura 1990:10).

2.8.2 Health Belief Model (HBM)

The Health Belief Model was developed in the 1950s, the HBM has been proposed as a framework to conceptualize HIV and AIDS preventive behaviours because of its success in

explaining health conditions and health related behaviours. The model also has been used to gain a better understanding relationship of sexual risk behaviours HIV and AIDS infection, the uses of attitudes and beliefs of an individual that predict behaviours (Rosenstock, Strecher & Becker 1994 in Family Life International 1996:2). Other significant HBM concept is perceived susceptibility, which is identified as significant variable, Bandura (1989) as referenced online in Family Life International (1996:3) proved that an individual's perceived ability to successfully carry out a health strategy, for example people who perceive themselves to be at risk of negative outcomes are more likely to reduce risk behaviours than those who do not see themselves at risk - using a condom consistently, greatly influences his/ her decision and ability to enact and sustain a changed behaviour.

Limitations of the HBM include: not testing the usefulness of the model as a whole, not taking into consideration other factors, such as environmental or economic factors and the model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviours (Family Life International 1996:6).

As the HBM was originally developed to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals in an effort to understand people's preventive health behaviour. This model was shown to be effective (Family Life International 1996:6). Therefore HBM has been proposed as a framework to conceptualise HIV and AIDS preventive behaviours because of its success in explaining health conditions and health related behaviours.

2.8.3 Risk Reduction Model (ARRM)

The ARRM was described by Catania, Kegeles and Coates (1990:53-72) to examine HIV risk behaviours and for preventive behaviour.

According to Fisher and Fisher (2000:15) numerous studies have proven the usefulness of the theory, used to elicit information in several populations and proven to provide a number of insights concerning HIV preventive behaviour. The UNAIDS (1999:8) assert that the AIDS risk reduction model conceptualises HIV prevention as a process of change by which people move from one stage to the next that include (1) behaviour labelling (2) commitment to change and (3) taking action ,which are processes which individuals or groups of individuals will pass through, while changing behaviour regarding HIV risk.

According to Fisher and Fisher (2000:15) ARRM variables include perceived susceptibility, HIV and AIDS knowledge, peer pressure, self-efficacy, sexual response efficacy, behavioural intentions, and intrinsic rewards. It is one of the researcher's views to include some of ARRM variables in this study in the Lesotho context. Since there are other factors contributing to the risk-taking behaviour than those of the ARRM model, this study will also consider other factors related to HIV risk-taking behaviours among PLWHA which will shortly be described.

2.9 RATIONALE OF THE STUDY

The majority of the reported studies were conducted in developed countries, where the positive prevention issue received greater attention. Research showed that interventions provided skills that included technical, personal or interpersonal skills enabling individuals to maintain healthier and safer behaviours (Crepaz, Lyles, Wolitski, Passin, Rama, Herbst, Purcell, Malow & Stall 2005:146).

Overall, the majority of research on sexual risk taking practices in PLWHA has explored the role of a limited set of factors such as psychological and interpersonal factors. However, research around the world, in this field, is currently at various stages of investigation. It is this principle that reinforces the present study to respond to the HIV and AIDS preventive programmes inadequacies and providing valid scientific information needed to guide the review of current peer education curriculum and integrate positive preventive educational efforts for PLWHA.

This research addresses some of the gaps in HIV preventive research for PLWHA in Lesotho. As more Basotho become aware of their HIV status and access HIV treatment, greater efforts are needed to adapt or create preventive programmes that meet their specific needs. According to GoL NAC Lesotho National AIDS Policy (GoL NAC 2006:6) Lesotho's HIV epidemic continues to be fuelled by inter-relationships between both behavioural and structural factors such as: poverty and food insecurity, alcohol and drug abuse, multiple concurrent sexual relationships, migrant labour to South African mines, gender inequality and gender-based violence as well as intergenerational sex.

In Sub-Saharan Africa, little is known about the extent to why PLWHA might continue to engage in high risk taking behaviours, while research in this area is on-going, no research in Lesotho had looked and documented the specific factors influencing risk-taking behaviours

amongst PLWHA. Authors DiClemente, Wingood, Rio & Crosby (2002:393) highlights that HIV prevention efforts should be intensified and focussed on those individuals living with HIV. In order to appropriately address HIV within the current specified context of HIV and AIDS in the Lesotho, it is necessary to design prevention strategies that are appropriate for PLWHA, and this might require designing targeted prevention strategies or tailoring available strategies to meet specific preventive needs in these populations (USAID 2013:4).

This study can possibly enhance an understanding of the local epidemic, which makes it more likely that the appropriate preventive intervention will be developed and that the services delivered will be appropriate for PLWHA who are facing multiple challenges related to health and other factors.

Thus, studies are needed to uncover barriers specific to PLWHA that might undermine their ability to adopt and maintain healthy behaviours over time. The starting point for developing a preventive programme critically requires assessment of proven and effective strategies for populations at higher risk by understanding of the HIV epidemic and the response. The approach often referred to as "Know Your Epidemic and know your current Response" (UNAIDS 2007a,b:10).

Researchers are beginning to understand that HIV is not distributed evenly, realizing that to understand factors associated with HIV risk-taking behaviours, programme planners must take a closer look at who is primarily being affected and how. The observations of reduction in certain risk behaviours in some groups but not in others, may indicate impact of previous preventive programmes, but even more importantly, reveal current challenges in prevention. Mawar, Paranjapea & Khan (2011:96) assert that for HIV preventive programs to be successful in the long-term, they must address the sociocultural realities keeping in mind social cultural realities for both HIV prevention and treatment that are influencing the ability of PLWHA to protect themselves. Positive prevention programmes must thus be culturally sensitive (Rose, Gutin & Reyes 2010:38).

Previous HIV prevention has been criticized for its narrow focus on risk reduction. Cloete *et al.* (2010:7) strongly believe that the HIV preventions programmes should set realistic behavioural changed goals focusing the risk reduction interventions of PLWHA which may contribute to prevent HIV transmission and re-infection among PLWHA. Unless the key populations at risk and vulnerability factors are well researched and known, it is impossible to

plan, target and implement interventions that focus on the populations that most need them (GoL NAC 2009a:2).

It is argued that these underlying factors have not been adequately identified to date in Lesotho. There is a need to understand what PLWHA perceive as behaviours that put people at risk of contracting HIV and AIDS and the factors influencing risk-taking behaviours.

This study will identify factors related to HIV risk-taking in order to possibly explore why PLWHA keep on engaging themselves in risky sexual behaviours, thus putting them at risk of re-infection. The researcher feels that further research on the factors associated with risk-taking behaviours amongst PLWHA in Lesotho will provide important information to inform educational intervention development.

2.10 CONCLUSION

This chapter provided the theoretical orientation to the study. It started with a description of the HIV epidemic, health challenges for PLWHA, treatment and preventive initiatives and concluded with factors associated with HIV risk-taking behaviours amongst PLWHA.

In Chapter 3, **Research design and methodology**, the research design and the methodology will be explained.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter deals with the research design and research methodology in the study. In the first place, theoretical perspectives on the research design are provided. Secondly, a discussion follows on the methods used in this study comprising a literature study and semi-structured interviews. Information on the process of the sample selection, exploratory interview (pilot study), data collection, and data analysis will be provided. Finally issues of trustworthiness, as well as ethical considerations are discussed.

3.2 THEORETICAL PERSPECTIVES ON THE RESEARCH DESIGN

In this section the research design in this study and particular methods used will be described.

3.2.1 The research design

Burns and Grove (2009:218) distinguish between the terms, research design and the research methodology. The research design, which is commonly referred to as "a plan or blueprint" for how a researcher intends to conduct the study, focuses on the end-product with the research problem as point of departure (Burns and Grove 2009:218; De Vos, Strydom, Fouché and Delport 2011:307). The research method focuses on the research process, including specific tasks (involving the forms of data collection, analysis and interpretation) with the purpose to employ the most "objective" procedures (Creswell 2014:16).

This study is qualitative of nature. De Vos *et al.* (2011:312) highlight the fact that the research design in qualitative studies differs greatly from those in quantitative studies. The authors explain that quantitative research designs are commonly followed in a fixed manner where in qualitative research the design and processes follow more flexibly depending on the research strategy followed (Burns & Grove 2009:51; De Vos *et al.* 2011:312).

De Vos *et al.* (2011:65), explain qualitative research as a social interaction that allows the researcher to study the participants in detail, thus interpreting the meanings they attach to their lives or a specific lived experience.

A qualitative research approach is appropriate when studying attitudes and behaviours of people as well as processes in their natural settings (Babbie & Mouton 2001:27; Burns & Grove 2009:51; Creswell 2013:45). Human emotions or experiences are not easy to quantify or assign numerically therefore a qualitative approach deems appropriate and useful in studying human action from the perspective of the participants themselves (Babbie & Mouton 2001:270; Burns & Grove 2009:532).

The specific qualitative research design in this study includes a phenomenological research design. In a phenomenology study the researcher tries to understand a specific phenomenon from the perspectives of people involved (Welman, Kruger & Mitchell 2010:n.p.; Creswell 2014:57). Qualitative research investigating a specific phenomenon within a real-life context can make use of several different data collection strategies such as semi-structured interviews, focus group interviews and/or observations (Cohen *et al.* 2007:17; Creswell 2014:191). When interviews are used the transcribed text from the interview can be analysed in conjunction with observational notes, commonly referred to as field notes (Maree 2010:100).

A qualitative research approach deemed best for research specifically focusing on controversial issues that have not been adequately explored in the past. It seemed appropriate since it enabled the researcher to gain greater insight into factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho. For the benefit of this study, the researcher used semi-structured interviews with the use of an interview schedule. The data collected through the semi-structured interviews provided information that assisted the researcher to understand the complexities of the topic. By conducting semi-structured interviews the researcher had the opportunity to interact with the participants and listen to their views in order to describe their specific lived experiences about a specific phenomenon. The data collection, analysis and interpretation of the current study are discussed, in more in detail, later in this chapter.

3.3 RESEARCH METHODS

The methods that were used and which formed the basis of this research comprised a literature study and semi-structured interviews.

3.3.1 Literature study

A literature study has the aim to contextualise a research problem against related theory and research, and to ensure that the researcher is sufficiently knowledgeable about the topic (able to investigate the topic in an informed manner) (De Vos *et al.* 2011:134, 302). Several authors suggest that the researcher should read extensively as that ensures an overview of the existing literature, of what had already been done and the research approaches to a particular topic (Bowen 2005:864; Maree 2010:169; Monette, Sullivan & De Jong 2008:81). De Vos *et al.* (2011:134-135) assert that it is common practice that literature studies serve to put a researcher's efforts into perspective, situating the topic in a larger knowledge pool, creating a foundation based on existing, and related knowledge.

The forms of literature investigated in a qualitative study include: (1) theoretical literature to contextualize the topic; (2) empirical literature considering prior research in the field; (3) methodological literature then refers to methodologies used in conducting research in the specific field; and (4) A combination of the first two forms of literature which then offer scope for associations or disassociations (Flick 2009:48). A literature study should be conducted in such a manner that the qualitative researcher does not become influenced by a specific theory or viewpoint of other researchers (Esterberg 2002:37). Considering this warning, the extent to which the literature is studied will differ from study to study.

In the current study a brief initial literature study helped to conceptualise the research problem by locating it in a body of theory where after areas for further research were identified. The second chapter in this dissertation provided an overview of the HIV and AIDS epidemic in Lesotho. On completion of the semi-structured interviews an in depth literature study was conducted to support the research findings.

3.3.2 Semi-structured interviews

The qualitative method that was used for data collection entailed semi-structured interviews. This section describes the process used in this study.

3.3.2.1 *Theoretical aspects*

The researcher used semi-structured interviews by means of using an interview schedule for the collection of data. Semi-structured interviews are defined as organised areas around a particular interest, to collect detailed information, while allowing flexibility to deeply understand the answers provided into a topic (De Vos *et al.* 2011:351-352; Diccio-Bloom & Grabtree 2006:315, Jarbandhan & Schutte 2006:678). In addition to that, semi-structured interviews also allow for the discovery of new aspects of the problem (De Vos *et al.* 2011:351), as the researcher hoped this study would do, by investigating further explanations given by participants in detail.

Semi-structured interviews comprise of common features/characteristics during preparation, and actual implementation of the interviews:

- Semi-structured interviews make use of an interview schedule. According to De Vos *et al.* (2011:352) an interview schedule (questionnaire) is an appropriate instrument which offers ample preparation for the researcher and is used to guide the way in which questions are asked. Even though a semi-structured interview schedule contains predetermined set questions, the interviewer can move away from the set question and probe more into specific aspects of the conversation if necessary (De Vos *et al.* 2011:352). The interview schedule thus helps the researcher to stay focused and offers opportunity for active engagement with the participants throughout the interview (Monette, Sullivan & De Jong 2008:178).
- Further Maree (2010:196) asserts that the interviewees should be clearly informed regarding all aspects of the proposed research. Thus the role of the qualitative researcher is to engage with the participant/s and build a trusting relationship in order to achieve an "insider" perspective (Babbie & Mouton 2001:271; De Vos *et al.* 2011:343).
- In semi-structured interviews, the interviewer and the interviewee are equal partners and even though an interview guide is followed the participant should still be allowed to tell his or her story (Jarbandhan & Schutte in De Vos *et al.* 2011:343).

- The interviewing techniques in semi-structured interviews are regarded to be open-ended or guided to invite the interviewee to participate in a conversation, rather than having discrete “yes” or “no” answers (Jarbandham and Schutte in De Vos *et al.* (2011:343). However, Sewell (2006:1) holds the view that in practice, open-ended, qualitative interview questions are often combined with more close-ended structured interview formats.
- Several communication techniques are used in interviews to obtain additional information e.g. probing, paraphrasing, clarifying, listening attentively, summarising reflectively (Babbie & Mouton 2001:289; De Vos *et al.* 2011:345). It is highly recommended that the required interview skills are obtained if an inexperienced researcher plans to perform his or her own interviews (De Vos *et al.* 2011:343).
- The interviews should be video- or audio recorded, with the knowledge and permission of the participants as a record of the conversation to ease the transcription for the purposes of data analysis (Creswell 2013:168, 174; De Vos *et al.* 2011:359). De Vos *et al.* (2011:359) further states that a voice recorder provides more concrete records than notes do during the interview, thereby allowing the researcher to concentrate on the interview process. The recordings and transcripts should be clearly marked, stored and backed up (Creswell 2013:175).
- The collection of additional data such as field notes regarding observations of events and activities is also important to collect when conducting qualitative research (Creswell 2013:168-169). Field notes are notations generally made to document observations during an interview (e.g. things the researcher hears, sees, experiences) (De Vos *et al.* 2011:359).
- The interviews should be held in natural, comfortable, non-threatening settings. According to De Vos *et al.* (2011:295), a quiet environment where no interruptions occur helps to facilitate the interview process. It is therefore the interviewer’s responsibility to create an atmosphere in which participants feel comfortable enough to talk freely and openly (Burs & Grove 2009:510) in addition to ensuring measures of sensitivity towards different cultures, genders and class are considered (Maree 2010:193). This is especially important when the topic of an interview is of a sensitive nature.
- With the semi-structured interviews, the number of the interviews continue until data saturation (when no new information, themes or topics, is identified) is reached (Charmaz 2006 in Creswell 2014:189). The amount of time that the interview takes will be dependent on the topic discussed (De Vos *et al.* 2011:353).

Semi-structured interviews are suitable in cases where the researcher is interested in an issue that is complex or personal, flexible to both the interviewer and the interviewee, provide a "greater breadth of data" because of its "qualitative nature" subsequently allow for the discovery of new aspects of the problem by investigating some explanations given by participants in detail (Denzin & Lincoln 2000:652; De Vos *et al.* 2011:352).

Since PLWHA are commonly stigmatized and discriminated against and due to the complexity and personal nature of this study; the use of semi-structured interviews was selected to enable the researcher to gain a better understanding of the factors related to HIV risk-taking behaviour amongst PLWHA in Lesotho.

3.3.2.2 Target population

A target population is the population with which the researcher would ideally like to conduct research, this group of individuals commonly consists of similar or specified characteristics (De Vos *et al.* 2011:223).

The target population in this study consist of individuals who are living with HIV and AIDS, who are on antiretroviral therapy belonging to support groups of, a preventive intervention service, supported by ALAFA. For the purpose of this study the researcher concentrated on three Maseru factories only. The names of the factories were not disclosed in this dissertation to ensure confidentiality and anonymity. The district was selected, because they are found to have the highest HIV and AIDS prevalence compared to all other districts in Lesotho (UNAIDS 2015:61). The target population was selected because they were a population which were easily accessible in the workplace of the researcher.

Therefore, the eligibility criteria for this study were those candidates who were:

- Textile workers within one of the before mentioned textile factories belonging to the ALAFA support group;
- male or female factory workers 18 years of age and older (as stipulated by Lesotho Labour code of 1992);
- who were infected with HIV; and
- were on ARV treatment.

3.3.2.3 Unit of analysis (description of the sample)

A sample is “a subset of the population that is selected for a particular study” (Burns & Grove 2009:42). The sample to be used in this study was detailed before (cf. 3.3.2.2).

Sampling on the other hand is a process of selecting the sample to be used in a study (Burns & Grove 2009:42). Polit, Beck and Hungler (2001:233) describe it as “the process of selecting a portion of the population to represent the entire population”. Ideally one would like to study the whole population to give more meaning to one’s findings, however this is not always possible and therefore we must mostly settle for a sample of that population.

For this study purposive and voluntary sampling were used by the researcher to select participants who met the eligibility criteria. A purposive sample is based on the judgment of the researcher regarding the participants to be selected who will be representative of the target population, who meet the eligibility criteria and will therefore be knowledgeable about the topic to be studied (Burns & Grove 2009:335; Creswell 2013:158; De Vos *et al.* 2011:392). In qualitative research persons to come forward voluntarily, will of course facilitate the task of the researcher and accelerate the process. The voluntary component refers to selection of participants who met the set criteria and were willing to participate (De Vos *et al.* 2011:394).

3.3.2.4 Sample Size

The most commonly used criterion for determining adequate sample size, was based on reaching the saturation point. Data saturation is the point in the analysis of the data when no new themes are discovered and when recurrent themes are observed commonly (Rabiee 2004:656; Charmaz 2006 in Creswell 2014:189). Patton (2002:244) shows that there are no rules for sample size in qualitative inquiry, thus the size is not statistically determined.

The researcher planned to interview about three to four individuals from each of the factories. After interviewing nine (three in each factory) participants data saturation was reached and the interviews ceased.

3.3.2.5 Exploratory interview (pilot study)

The purpose of an exploratory interview is to “determine whether the relevant data can be obtained from the respondents” (Royce 1995 in De Vos *et al.* 2011:394-395). It also helps to identify any problems that may arise, during the actual interviews before they can actually happen.

The exploratory interview in qualitative research allows the researcher to focus on specific areas that may have previously been unclear, which escaped scrutiny, such as: making contact and following the actual research process, test the questions on the interview schedule, assess the time and space and assess the interview skills of the person conducting the interview (De Vos *et al.* 2011:395).

De Vos *et al.* 2011:343 asserts that the quality of the interview depends mainly on the skills of the interviewer, thus the researcher as the main data collecting instrument in this research, underwent training on interviewing techniques prior to exploratory and final interviews.

The researcher conducted an explorative interview with one participant eligible participant within the C&Y Garments (Pty) Ltd factory. The exploratory interview was conducted in English. In the exploratory interview, the questions in the interview guide were tested and the outcome of pre-testing of the questions helped the researcher, to check the clarity of the wording of question items and areas in which to probe for more information.

The exploratory interview deemed helpful in estimating the time frame of 40-60 minutes. It further explored and determined the best space for the interview based on the characteristics of a relaxed, comfortable interview setting that facilitates private conversations. According to De Vos *et al.* (2011:332), a quiet environment where no interruptions occur, helps to facilitate the interview process.

The transcribed interview together with the relevant field notes were discussed with the study leader. No changes were made to the interview schedule as the exploratory interview elicited the relevant responses that enabled the researcher to meaningfully explore, describe and understand the phenomenon under study. In view of this the exploratory interview was included in the dataset.

3.3.2.6 Data collection

Data was collected through semi-structured interviews with the use of an interview schedule. The data collection process that was followed is summarized as follows:

Identification of volunteers to interview and the establishment of trusting relationships

Research in the field of HIV and AIDS is complex with pervasive ethical issues. Fisher and Foreit (2002:3) therefore asserts that data should never be obtained at the expense of human beings. To ensure that the research participants made an informed choice as to participate in this study, the following procedures were followed (within each one of the three factories):

- A briefing session was made available to all potential participants during an introductory meeting. The researcher briefed the group about the study and gave them an information sheet (cf. Appendix B1). The group were assured that their participation was voluntary. Furthermore the session also offered the opportunity for the group to ask questions and/or raise any concerns; and
- volunteers were identified and appointments were set up for the interview.

To ensure privacy and confidentiality, the interviews were carried out in a private, quiet room, which was identified by the researcher and factory health coordinators. The volunteers had to read through and sign a consent form (cf. Appendix B2) before the actual interview commenced.

Approaching the interview

The quality of data collected depends on the quality of interviews and observations made by the researcher and as De Vos *et al.* (2011:343) asserts this can only be achieved through the use of various interviewing skills and successful communication. The process of interviewing is a process of communicating, involving, asking, listening and talking, the premise for inclusion of these is that without communication there can be no interviews (Hesse-Biber & Leavy 2006:146). The following effective interviewing communicational skills were used in the interviews:

- **Listening:** According to De Vos *et al.* (2011:343, 445) the interviewer should have excellent listening skills to help the researcher to judge the reliability of verbal messages more readily, especially in the presence of mixed messages that include a wide range of non-verbal channels such as facial expressions, hand gestures, body movements, pitch and volume of the voice and many more. The researcher made use of words like "ah", "yes", "I hear what you say" and gestures like nodding her head as well as rephrasing what the participant was saying to ensure the participant that she was a good listener and that she was hearing what they were saying.
- **Probing:** De Vos *et al.* (2011:343) describes probing as the researcher's way of getting a participant to continue with, what he or she is talking about, to go further or to explain more, and deepen the response to the question. This was often used in the interviews in this study in order for the participants to say more about a specific topic.
- **Reflecting:** involves looking back on conversation in order to assist the participant expand, as well as to encourage the participant to make additional clarifying comments (De Vos *et al.* 2011:343). As mentioned before the skill was used to show the interviewee that the interviewer was listening attentively and was interested in what was being said. This was also commonly used, when the interviewer needed clarification on what was being said.
- **Clarifying:** According to De Vos *et al.* (2011:343) clarifying is an attempt to understand unclear statements or the basic nature of a participant's statement. In this study the researcher asked the participants to give an example to clarify a meaning and this helped the researcher to understand the participant's intended message better.
- **Summarizing the session:** Summarising can take place after sections in an interview or at the end. During the interview it stimulates the participant to give more information in order to keep the participant directed towards a goal. It is always good practice to be summarising the interview at the end. This could include highlights of the main ideas, thoughts and feelings expressed in the interview, but mostly it indicates the end of the interview. This was commonly used in the current study especially where a participant started talking about a different topic, the researcher summarised what was said and brought the participant back to the topic at hand.

Conducting the interviews

A semi-structured interview schedule was used to collect data, guiding the researcher when asking questions. All of the interview skills as described earlier were used to obtain as much information from the participants as possible.

The interview schedule (cf. Appendix B3) consisted of two sections: Section A collected demographic details and Section B consisted of several questions to address the research question in this study: What are the factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho?

In Section A, mostly closed ended questions were posed with predetermined responses to select from (but participants had the freedom to add more appropriate responses where necessary). There were also a few open ended questions. The following demographic details were obtained: Gender, age, educational background, marital status, family status (number of children in the family), geographic information their religion and information about their support structures.

Section B, consisted of eight questions which explored the following three areas: interpersonal factors, psychological/socio structural factors and HIV-related factors associated with HIV and AIDS.

The interviews were conducted according to planned schedule of predetermined appointments. The interviews were conducted for the period of two days per factory; the interviews lasted about 45-60 minutes each. All interviews were conducted in the local language of the respondents i.e. Sesotho. The interviews were all audio recorded. In addition to the audio recordings, field notes were taken in order to reflect on more details from each of the interviews. Immediately after each interview took place, the researcher reviewed all notes and listened to the audio recordings, which resulted in a process of concurrent data collection, preliminary analysis, reflection and progressive focusing to maximise the trustworthiness of the research. Furthermore a meeting was held with the research assistant (interview observer) at the end of each data collection day to go over the collected data and discuss any issues and/or interesting phenomena from the interviews, these too were documented.

3.3.2.7 *Data analysis and interpretation*

The purpose of qualitative data-analysis is to create order, structure and deduce meaning from a large amount of information therefore data analysis commences simultaneously with data collection in qualitative studies (De Vos *et al.* 2011:405). "Qualitative analysis involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveal" (De Vos *et al.* 2011:333). There are multiple ways to undertake qualitative data analysis, but as De Vos *et al.* (2011:405) suggests, the selected way will depend on the purpose of the research.

Data was analysed using the thematic content analysis method. Ezzy (2000:49) describes this method of data analysis as a way of analysing data by organising it into categories on the basis of themes (concepts or similar features) with categories and sub-categories in each theme. During the analysis of the data the following steps were followed:

- **Data collection and preliminary analysis:** as noted by De Vos *et al.* (2011:405) "data analysis in a qualitative inquiry necessitates a twofold approach", firstly data analysis during data collection and secondly analysis after data collection, away from interviewees. Kreuger & Neuman (2006:397) point out that as data is gathered it is analysed, meaning that data collection and data analysis thus typically go hand in hand in order to transform the data into credible evidence.
- **Transcribing of interviews:** Recorded interviews should be transcribed verbatim. The tone of voice and pauses should be indicated in the transcripts and the researcher could make notes next to certain areas in the transcripts. This will include incorporating the field notes where appropriate. The voice recordings should be re-listened to, whilst reading the transcripts to ensure that data has been captured correctly. An independent person, interview observer or even one of the interviewees could be asked to authenticate the transcripts as a further measure to ensure trustworthiness.
- **Organizing and managing data:** Both Creswell (2013:175) and De Vos *et al.* (2011:336) suggests that datasets should be clearly marked, well organised and carefully stored. This could be in hard copies or electronically. This part of the analysis process include the transcriptions and field notes.

- **Reducing data:** After data was organised, it should be categorised into patterns and themes using a coding system. Bogdan and Biklen in (De Vos *et al.* 2011:410) point out that developing a coding system employs a number of steps that include, searching data regularities and the relationship between major and sub-categories, and then recoding data in researchers' words and phrases to represent those topics and patterns.
- **Interpreting and developing typologies:** Interpretation involves making sense of data, the "lessons learned" (De Vos *et al.* 2011:416) whereas typologies is defined as "conceptual (framework in which phenomena are classified in terms of characteristics that they have in common with other phenomena)" (De Vos *et al.* 2011:36).
- **Presenting the data:** Warren and Karner (2005 in De Vos *et al.* 2011.419) suggest that the final phase in qualitative research is to "puzzle" together all the pieces of the research. The author suggests that "crafting a qualitative manuscript is a process through which the writer clarifies how his data and concepts fit together".

In this study the data collection and analysis occurred concurrently. The recordings were transcribed by the researcher. The transcriptions were then read while listening to the recordings. The researcher then translated the Sesotho transcripts into English for analysis. All the measures were in place in order to ensure data accuracy, consistency, completeness, and correction of mistakes as they occurred. The transcribed data in this study was analysed by the researcher and co-coded by the study leader to ensure trustworthiness. Electronic copies of transcripts were stored in separate word documents in one folder. The study leader kept a copy of the data as a backup.

The transcripts were used to identify the main themes in this study and in each theme categories and sub-categories were identified. These were grouped together in a Microsoft Word document. The process of reading the transcribed data was repeated sometimes and some sections were re-organised for a better fit within a particular theme. Interpretation and the developing of typologies were achieved by using the author's understanding of the themes that were presented. At this time a thorough literature study was conducted. The researcher was engaged in the interpretive act, lending shape and giving meaning to a massive amount of raw data. During the final stage of the data analysis process, the researcher attempted to support findings by integrating relevant literature, to answer the research questions and relate the findings to the aims and objectives of the research study. The study findings and interpretations are presented and discussed in Chapter 4. The 32-item checklist, the consolidated

criteria for reporting qualitative research (COREQ) was used to systematically report on three sections namely: The research team and reflexivity, the study design and finally the analysis and findings (Tong, Sainsbury & Craig 2007:349-357). In each section certain topics are proposed which should ideally be described in the final findings and interpreted data chapter, e.g. in the research team and reflexivity personal characteristics of all members involved in the study are described, as well as their relationship to the researcher. The study design had already been described in this chapter and the analysis and findings will follow.

3.4 ENSURING THE QUALITY OF THE STUDY

In this section trustworthiness as it is related to this study will be discussed.

3.4.1 Trustworthiness

Trustworthiness is best defined as the “believability” of a researcher’s findings (Maykut & Morehouse 1994:64). The key criterion or principle of good qualitative research is found in the notion of trustworthiness. Qualitative researchers use different criteria of trustworthiness when defining reliability and validity. The trustworthiness of this study was ensured by adhering to the criteria identified by Lincoln and Guba and includes the strategies for credibility (checking the truth value of the findings), transferability (ensuring applicability of the findings), dependability (ensuring consistency of the findings) and conformability (which was accomplished by using the criterion of neutrality or freedom from bias) (Lincoln & Guba 1985:290-327).

The researchers adhered to these principles by means of:

1. Credibility (truth value) was ensured by long term engagement with the field of study, triangulation of data collection methods and peer review.
2. Transferability was ensured by providing a dense description of the demographics of the participants, as well as rich description of the results supported by direct quotations from participants;
3. Dependability was ensured by providing a dense description of research methodology, step-wise replication of the research method, and following a code-recode procedure;
4. During this study, (confirmability/ neutrality) principles were adhered to by means of respondents’ examination and independent coding, the dense description of the

data, keeping of the raw material and applying the same procedure throughout, as well as the code–recode procedure. Furthermore, clearly describing each stage of the research process and explaining what was done and why?

Acknowledgement should be given to the viewpoint of Creswell (2013:250) that emphasizes a focus on a validation process as opposed to a verification process. The author stipulates that many researchers still choose to use terminology and processes of trustworthiness and suggested that if done so one should always reference their validation terms and strategies clearly, as already done in this study.

3.5 ETHICAL CONSIDERATIONS

Research ethic is referred to as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and sociological obligations to the study participant (Polit *et al.* 2004:36; Burns & Grove 2009:184). Babbie (2007:62) refers to ethics as “what’s proper and improper in the conduct of scientific enquiry”.

This study is about the lived experience of PLWHA with the implication that the researcher took special care to ensure that the general, accepted principles for ethical behaviour during research was adhered to.

3.5.1 Approval

A research proposal was submitted for peer evaluation in the Health Professions education programme and for review by the Ethics Committee of the Faculty of Health Sciences of the University of the Free State (UFS). An Ethics Committee of the UFS (ECUFS) number was allocated (ECUFS Nr 158/2014). The Dean of the Faculty of Health Sciences and Vice-Rector Academic were informed about the study.

In addition approval was obtained from the Director of Policy and Prevention ALAFA who assisted in writing the letter to the three identified factory health coordinators to request their assistance and support in this study.

3.5.2 Confidentiality and right to privacy

HIV and AIDS, and one's HIV status is a legal and very sensitive issue; it was essential that information was collected in such a way that confidentiality was guaranteed. Failure to honour promises of confidentiality by safeguarding the privacy and identity of participants is an obvious way in which participants can be harmed (De Vos *et al.* 2011:119).

In this study all information was managed in a strictly professional and confidential manner. The participants' privacy was protected at all cost. Number coding was used to ensure the anonymity of the participants' responses, therefore no names or personal identifiers appeared on any transcripts and the voice recordings were also marked with the same number and locked up.

3.5.3 Informed consent

Informed consent can only be obtained when a researcher fully discloses the most important aspects of the research study pertaining to the sample population. Examples include the goal of the study, the expectations for the sample population (including the expected duration of their involvement), the study procedures, any advantages, disadvantages or dangers important to take note of, and full disclosure of the researcher ensuring his or her credibility (Royce in De Vos *et al.* 2011:117).

Participants were provided with an information letter (cf. Appendix B1) providing relevant detailed information with regards to the aim and purpose of the study and how participants may volunteer to either participate or exercise their right to withdraw from the study at any point in time. All participants in this study gave informed consent to participate in the research (cf. Appendix B2).

3.6 CONCLUSION

Chapter 3 provided an overview of the research methodology involved in the study and the procedures that were followed.

In the next chapter, Chapter 4, entitled **Results and discussion of the semi-structure interview findings**, the results of the interview guide that was used to obtain data for this study will be reported and discussed.

CHAPTER 4

RESULTS AND INTERPRETATIONS OF THE SEMI-STRUCTURED INTERVIEWS

4.1 INTRODUCTION

The purpose of the chapter is to present the results of semi-structured interviews conducted for this study. As previously indicated, the main objective in conducting this study was to investigate factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho. Ten semi-structured interviews were conducted in this study in order to obtain information from individuals who are living with HIV and AIDS belonging to support groups, a preventive intervention service supported by ALAFA, in the textile and apparel industry-wide programme in Lesotho. The data collection process was detailed in Chapter 3 (cf. 3.3.2.6), as described in Chapter 3 the main aim of data analysis and interpretation was to categorise the data into themes, define the categories, identify the patterns in the categories and show the connection with the interview questions. The data will be presented in the sequence in which the interview questions were asked in the interview guide.

The interview guide (cf. Appendix B3) design included closed questions mostly used to obtain demographic information (Section A) of the participants that included factors such as age, gender, religion, level of education, marital status and the number of children their origin and home locations. The second section, Section B, consisted of 8 open ended questions to explore the following 8 themes: (1) Theme 1, Meaning of HIV risk-taking behaviour; (2) Theme 2, Risk for HIV re- infection; (3) Theme 3, HIV transmission risk behaviours; (4) Theme 4, Peer influence HIV risk behaviours; (5) Theme 5 Society influence HIV risk behaviours; (6) Theme 6, Beliefs about HIV treatment; (7) Theme 7, Beliefs about HIV cure/vaccine and (8) Theme 8, Healthy HIV behaviours to be taken into consideration.

4.1.1 Data analysis of the semi-structured interviews

The process of data collection was described in Chapter 3 (cf. 3.3.2.7). It can be summarised as follows: All interviews were conducted by the researcher; a semi-

structured interview guide was used for all interviews to collect data, guiding the researcher when asking questions (cf. Appendix B3). Transcriptions of the semi-structured interviews were typed and the transcriptions and audio tapes were checked and controlled by the researcher and an independent observer. The transcripts were also read by the study leader.

The qualitative data were analysed by the researcher by organising the data thematically and taking into consideration all aspects surrounding the interviews including the field notes. The study leader was involved in co-coding the analysed data. This process contributed to the trustworthiness of the research (cf. 3.4.1).

4.2 RESEARCH TEAM AND REFLEXIVITY

The quality of data is enhanced when a good relationship is maintained with all members of the community throughout the project; the researcher ensured that a relationship of trust was maintained (De Vos *et al.* 2011:334). Tong *et al.* (2007:351) asserts the importance of close engagement of all the parties in the qualitative research process, as it may have a direct effect on the way the data is collected, analysed, interpreted and finally presented. The authors further suggest, including information about gender, credentials, occupation and experience, as well as training. With this in mind, in Section 4.2 the personal characteristics of the researcher who was also the interviewer, the study leader, and the independent observer will be discussed. The discussion will include each of the before mentioned relationships with the participants.

4.2.1 Personal characteristics

This section includes the personal characteristics of the researcher, the research study leader, the semi-structured interview facilitator and the independent observer.

4.2.1.1 *Personal characteristics of the researcher/ interviewer*

The researcher endeavoured to be flexible, objective, and a favourable listener, all of which are good qualities of an interviewer (cf. 3.3.2.6). The researcher has been involved in implementing HIV and AIDS programmes for the previous five years (cf. 1.5). Regardless of having had training experience on interviewing techniques prior to the exploratory study an empirical phase of the study was undertaken by the researcher.

The knowledge and skills gained from interacting with lecturers and study material enabled the researcher to be more proficient at interviewing, especially in encouraging the participants to increase verbal communication and to interact more freely with the researcher.

Since HIV is a sensitive issue the researcher was flexible, objective, a good listener and due to a charismatic personality was able to interact effectively with the participants. This allowed for the use of clarification, summarising and probing questions, without any judgemental behaviour. The participants were therefore free to relate their personal and practical situations without any fear of doubts about their confidentiality. Another benefit was that the researcher was able to conduct the interviews in the language of choice of the interviewees. Interviewees could therefore express themselves in their own language. This led to a greater understanding of the participants' perceptions of HIV and AIDS risk-taking behaviours.

4.2.1.2 *Personal characteristics of the study leader*

The study leader is a lecturer within the Division Health Sciences Education in the Faculty of Health Sciences, University of the Free State, where she is involved in both undergraduate and postgraduate training of students. Additionally she is an experienced researcher and directly responsible for the supervision and mentoring of students in the Health Professions' Education programme, with previous supervisory experience in the field of genetic counselling. The study leader possesses skills that contribute to the success of postgraduate studies by facilitating an enabling environment, role modelling, careful listening, unprejudiced and unbiased prolific working relationships. In this study the study leader checked the transcripts and co-coded the analysed data which contributed to the trustworthiness of this study.

4.2.1.3 *Personal characteristics of the independent observer*

The independent observer selected for the current study held a post graduate degree in Public Health statistics, which included research as part of her studies. She has an elaborate understanding of the problem investigated, as she is the monitoring and evaluation officer at ALAFA responsible for providing monitoring and evaluating support in the implementation of HIV and AIDS prevention, care and treatment services. Among

her duties she is responsible for data collection, data analysis and she ensures proper patient recording and reporting systems.

Her sound understanding of factory workers' working conditions encouraged the participants to trust her almost immediately and as a result, they seemed to feel free to discuss their experiences and perceptions. After each interview the independent observer listened to the recordings and read through the transcripts which were transcribed by the researcher; this was done as the first confirmation that the transcriptions were correct.

4.2.2 Relationship with the participants

The researcher and the independent observer were familiar with the HIV and AIDS work place programme where the study was conducted, even though they were not directly working with the support groups involved in this study. With the assistance of the independent observer, participants were informed of the objectives and procedures of the study. The participants were further assured that the information provided would be kept confidential, throughout the research process. There was also sensitivity to each participant's specific situation. A non-threatening environment created the atmosphere where they were comfortable to share their experiences with the researcher since the study was being conducted among PLWHA.

4.3 THE INTERVIEW ENVIRONMENT

The Factory Health Coordinators in each factory assisted with the arrangements of the interview room. A private room was used which offered comfortable seating, was quiet and free from distractions (cf. 3.3.2.6).

A carefully considered physical setting was initiated by a process of establishing a cozy environment, where the participants felt confident, relaxed and comfortable when experiencing the atmosphere of the room. Special attention was paid to the climatic conditions and to establishing a relaxed environment. Most attention was paid to some other issues for example lighting and the arrangement of furniture. Sitting face to face made it easier to observe participants' facial expressions, while the independent observer sat near the facilitator in a position from where it was possible to observe the participants.

The interview environment therefore offered comfort and a proper place for the interviewees to talk freely.

4.4 REPORTING OF THE FINDINGS

The demographics of the interviewed participants, description of the time of interviews, and the analysed and interpreted findings as presented.

4.4.1 Demographics of the interviewed participants

Ten interviews were conducted, 7 participants were female and 3 males, between the ages of 18-31 years of age. The majority of participants were educated up to a primary and/or secondary level and one up to tertiary level.

In terms of the interviewees' marital status, seven were married to only one partner and three were unmarried, but reported being in a relationship with a single partner. Only one of the interviewees reported that he did not have children and when asked if he wanted children in the future he answered affirmatively and reported that he wished to have at least three children. The remaining nine interviewees all reported having between one to three children. When probed why they chose not to have more children the following were said: "We have enough children in the family"; "I have one boy and one girl, enough"; and "There is no money to raise more children". It was interesting to note that not one interviewee related their answer about not having more children to their HIV status. There was only one interviewee who indicated that she wanted more children.

The majority of the interviewees grew up living in a village or rural area and semi urban area. Whereas the majority of interviewees now reside in a big town (city area). In Lesotho the factories are situated in the bigger towns and semi urban areas and it is therefore expected that the interviewees would now reside in these areas. It could have been worthwhile to have asked them if their families still lived in the villages/rural areas in order to know how far away from their families and support systems they were living.

All the interviewees reported their religious beliefs as Christian. They were also asked if they had any other support system apart from the support group and reported the following: family, siblings, husband/wife, friends, co-workers or manager. It was good

to learn that the interviewees had support from family, friends and colleagues in the workplace. Of concern was that two interviewees mentioned that they only sometimes had support from a family member like a sibling. A study done in Yunnin, China looked at understanding family support for PLWHA (Li, Wu, Wu, Sun, Cui & Jia 2006:509). Their findings showed that PLWHA who participated in their study were in great need of support. The authors indicated that "When facing societal discrimination and other hardships related to HIV and AIDS, a strong and supportive family is one of the first lines of defence" (Li *et al.* 2006:510). Support can be in various forms e.g. medical and/or financial help, assistance in the person's daily routines, or emotional support through the diagnosis, disclosure and day to day living with the disease. Li *et al.* (2006:516) conclude with a statement that support from family members has a positive impact on the wellbeing of the person living with HIV and AIDS. In view of this it could be important for PLWHA to reach out to their family members for support.

4.4.2 Description of the interview time

The interviews were conducted over a period of 6 months (cf. 1.5). The interview sessions took place during lunch time and/or after work hours, and each interview lasted about 45 minutes up to one hour.

4.4.3 Analysed and interpreted findings of the interviews

The final analysed data revealed eight themes. The themes were categorised according to the predetermined question. Each of the eight themes with their categories and sub-categories will be presented in this section, although the themes are interdependent, they are discussed separately for analytical purposes. Verbatim texts as derived from the interviews were grouped in the according themes and are presented in the following section. After each section of verbatim text, in brackets a number and two letters are presented e.g.: [3CC]. This refer to the code of the interviewee from the original transcripts. It may be used to refer back to where and when necessary.

Each theme will be presented with a table summarising the theme, identified categories and sub categories. After each table a short summary of the main findings from the table will be presented, followed by a discussion of each category (including the sub-categories within each. In many themes the same categories and sub-categories were identified. In these cases the category and sub-category will be discussed when

identified the first time in the first theme. If there are no specific differences or meaning to the category or sub-category when repeated in the following themes, referral back to the initial discussion will be made instead of repeating the discussion.

4.4.3.1 Theme 1: The meaning of HIV risk-taking behaviours

Theme 1, was defined within two categories: Risk-taking behaviours (with five sub-categories) and knowledge (with three sub-categories) (cf. Table 4.1). Category 1, consisted of five sub-categories namely: (1.1) unprotected sex; (1.2) substance abuse; (1.3) multiple sexual partners; (1.4) transactional sex due to poverty; and (1.5) HIV status non-disclosure. Category 2, had three categories namely: (2.1) limited knowledge of HIV transmission; (2.2) HIV education; and (2.3) HIV status unknown.

TABLE 4.1 THEME 1: THE MEANING OF HIV RISK-TAKING BEHAVIOURS

Category 1 Risk-taking behaviours	
Sub-categories	
1.1 Unprotected sex	<ul style="list-style-type: none"> • "Not using protection during sexual act" [3CC] • "...having unprotected sex" [3CC] • "...unprotected, without use of condom" [2BB] • "...not protecting oneself for example having un-safe sex" [1AA] • "It means continued exposure to unprotected sexual practices" [5BB] • "...not protecting oneself for example not using condom" [5BB] • "...unsafe sexual behaviours among PLWHA" [5BB] • "Unprotected sex without use of condom" [4AA] • "People who are not using protection having sex" [6CC] • "Condoms should therefore be considered as a means of protection" [4 AA] • "...people do not (use) protection for various reasons, like satisfying a partner, longing to have children and belief that sex is enjoyable without condom" [4AA] • "...unprotected sex" [8BB] • "...negative attitudes toward condom use are common" [8BB] • "To me I think it means continued unprotected sexual practices among HIV positive individuals" [9CC] • "...this act of not protecting oneself is dangerous really to oneself and to others for example having un-safe sex" [9CC] • "...not protecting oneself when having sex" [10AA] • "often it is unprotected sex without use of condom" [10AA] • "For people practice unsafe sex, people do not use condoms, they are even afraid to pick them where they are placed the factories" [11BB]

1.2 Substance abuse	<ul style="list-style-type: none"> • "People are always drinking alcohol saying it solves problems, which creates more problems"[3CC] • "...specifically drugs and alcohol which will cause one to catch HIV" [1AA] • "People living with HIV have many problems and trying to cope with the disease is difficult to most people, are therefore seeking other means such as drinking alcohol which in return catches HIV are infection by having unprotected sex under the influence of drugs and alcohol"[5BB] • "...it is believed that the use of alcohol can increase the desire to have sex, one end up having sex with unknown partners merely without protection"[6CC] • "Abuse of alcohol increases chances for HIV and STI transmission. Alcohol increases sexual risk-taking, consumption of alcohol often increase sexual violence towards wives, girlfriends, therefore forces them to have unprotected sex" [6CC] • "Alcohol and drug abuse are commonly associated with unprotected sexual behaviours which lead to failure to use condoms"[8BB] • "We are aware that trying to cope with the disease is very difficult to most people are therefore many reasons why people always put their lives in danger especially seeking other means to cope such as drinking alcohol" [9CC] • "...do it under the influence of drugs and alcohol which will cause one to catch HIV"[10AA] • "People enjoy using alcohol and drugs which after forced them to do dirty things of just sleeping around"[11BB]
1.3 Multiple sexual partners	<ul style="list-style-type: none"> • "...sex with multiple sexual partners which are common here at work"[1AA] • "Those who are behaving well are those having fewer number of sex partners who are having a positive attitude toward condom use. Multiple concurrent partners is really not acceptable at all, HIV travels fast so many people get infected"[6CC] • "We are always warned to have many multiple sexual partners, doing so HIV travels so fast from one person to another and this behaviours kills a lot of our people"[10AA]
1.4 Transactional sex due to poverty	<ul style="list-style-type: none"> • "In young girls poverty often drives young girls to have transactional sex which often is unprotected sex"[3CC] • "...having sex in for exchange of money"[1AA] • "Number of HIV women engages in unprotected sex for money, drugs, or to meet other survival needs because our salaries are low"[8BB] • "having sex in for exchange of money"[10AA]
1.5 HIV status non-disclosure	<ul style="list-style-type: none"> • "Non-disclosure is serious problem among people living with HIV-AIDS"[8BB] • "Especially when people do not disclose their status to other people"[10AA]
Category 2 Knowledge	
Sub-Categories	
2.1 Limited knowledge of	<ul style="list-style-type: none"> • "...doing things that expose you to HIV and AIDS"[2BB]

HIV transmission	<ul style="list-style-type: none"> • <i>"Men do not want to know about HIV issues so many of them are still really ignorant do not have factual information and this put them in danger"</i>[5BB]
2.2 HIV Education	<ul style="list-style-type: none"> • <i>"We are told that everyone has both the rights and the responsibilities to protect self and other people especially when it comes to having safe sex from HIV and sexual transmitted infections"</i>[4AA] • <i>"A major barrier is to have insufficient or no clinics especially in the factories or rural areas"</i>[7AA] • <i>"People do not change at all, because they do not want to join education sessions in the factory"</i>[11BB]
2.3 HIV status unknown	<ul style="list-style-type: none"> • <i>"Men do not want to know about HIV, they also do not want to do anything like testing to know the status. This means there are men walking around re-infecting themselves and infecting other people. These people do not know that they have HIV"</i> [5BB] • <i>"Most mothers to be do not want test for HIV in order to prevent HIV from mother to child. It is very dangerous for mothers to not want to know their HIV status"</i>[7AA] • <i>"People do not test for HIV but still behaves in such a way that might result in contracting HIV or re-infection"</i>[11BB]

There are certain behaviours that place individuals in situations in which they may be exposed to HIV (cf. 2.7). The results of this study found that the participants described HIV risk-taking behaviours in PLWHA as actions that increase chances of becoming re-infected with HIV or passing it on to others. The participants used several examples (as to what kinds of HIV risk-taking behaviours and other factors lead to HIV re-infection and/or transmission) to explain their understanding of the term.

Category 1: Risk-taking behaviours

Most participants in this study perceived that PLWHA in Lesotho continue to engage in risky behaviours regardless of knowing their HIV-positive status (cf. 1.5 in Table 4.1). Similar challenges to HIV non-disclosure have also been noted by Mlambo and Peltzer (2011:29). Reason for non-disclosure include: fear for a relationship ending, not wanting to be blamed, increased risk for partner violence and not knowing how to disclose their status (Mlambo & Peltzer 2011:36).

Reflecting on the participants' views, PLWHA in Lesotho do not seem to take the necessary precautions such as using condoms and limiting the number of sex partners to decrease the risk for HIV transmission and/or their risk of re-infection (cf. 1.1, 1.3 in Table 4.1). Gerbi *et al.* (2011:online) also indicate that in spite of having knowledge of an HIV positive status there are a significant number of HIV positive individuals who

continue to engage in unsafe sexual practices. In the literature, there is a general consensus that alcohol and/or drug use result in unprotected sex with multiple partners contributing to HIV re-infection (Gerbi *et al.* 2011:online; Tameru *et al.* 2012:6; cf. 2.7.2) which also deems true for PLWHA in Lesotho (cf. 1.2 in Table 4.1). Of note, in this study, was that some PLWHA who turn to substance abuse do it because they perceive it as a means to cope with their positive status.

Furthermore, the effects of poverty also contribute to the practice of risk-taking behaviours practiced by PLWHA in Lesotho (cf. 1.4 in Table 4.1) (cf. 2.7.1.2), these concepts will be further clarified in the next theme (cf. 4.4.3.2).

Category 2: Knowledge

Another factor identified, that influences risky sexual practices was the lack of knowledge about HIV. During the interview the interviewees painted a picture of mostly men that are negatively affected as they seem to be more inclined to know about their status and to be informed by joining support groups. This put them at an increased risk for HIV re-infection, but also places others at risk for getting infected with HIV (cf. 2.1, 2.3 in Table 4.1).

Tameru *et al.* (2012:1) assert that high HIV and AIDS awareness through education should be of great advantage in reducing the transmission of HIV and AIDS. The authors further suggest that comprehensive knowledge of transmission, prevention and treatments of HIV and AIDS is required to adopt safer sex practices and equipping people to have a deeper understanding of HIV and AIDS and its transmission by taking preventive measures such as using condoms properly or getting tested for HIV (Tameru *et al.* 2012:1).

4.4.3.2 Theme 2: Risks for HIV re-infection

The second interview question was asked to establish whether participants knew that a person living with HIV can be re-infected, a phenomena clearly described in the literature (cf. 2.3.1). It was encouraging to determine that the study participants understood this concept. They were then asked: "what do you think people living with HIV do to get re-infected or super infected?".

In Theme 2, four categories emerged: Category 1: Risk-taking behaviours; Category 2: Knowledge; Category 3: Socioeconomic factors; and Category 4: Cultural factors. Table 4.2 shows the categories and sub categories in this theme.

TABLE 4.2 THEME 2: RISKS FOR HIV RE-INFECTION

Category 1 Risk-taking behaviours	
Sub-categories	
1.1 Unprotected sex	<ul style="list-style-type: none"> • <i>"Yes they can be re-infected some of PLWHA are justifying for unprotected sex, they feel they had nothing to lose..."[3CC]</i> • <i>"They are having unprotected sex, most male partners do not like using condoms"[3CC]</i> • <i>"...unsafe sex is not good"[2BB]</i> • <i>"Protection never ends"[1AA]</i> • <i>"they still need to condomise"[1AA]</i> • <i>"we are always advised continue to avoid unprotected sex to protect ourselves and others against HIV/AIDS" [5BB]</i> • <i>"...mmm, having unprotected sex (silent) sex without condom, is considered to be very risky sexual behaviours that are largely avoidable"[6CC]</i> • <i>"Correct and consistent use of condoms is recommended ..., however condoms are not consistently used among HIV positive individuals, furthermore there are some problems or errors in condom use among men and women"[6CC]</i> • <i>"In the act of having unprotected sex in order to have a baby they can be re-infected"[7AA]</i> • <i>"Here at work despite knowledge about the use of condoms, use is low"[7AA]</i> • <i>"...not practicing consistent condom use, unprotected sexual transmission is the most common and this is risky sexual behaviours that can be avoidable"[8BB]</i> • <i>"They can be re-infected continue to not to protect themselves" [10AA]</i> • <i>"...unprotected sex is not acceptable at all, it's a dangerous behaviour"[10AA]</i> • <i>"Protection should never stop"[10AA]</i> • <i>"...fear to request their husbands to use a condom. They are forced to unprotected sex by partners even if they insist to use a condom to avoid re-infection"[11BB]</i> • <i>"Yes, safe sex is still not practiced by many people in our own workplace with us HIV positive people, using condoms is a problem to most people"[11BB]</i>
1.2 Substance abuse	<ul style="list-style-type: none"> • <i>"There is generally an increase in alcohol use by young workers and women"[7AA]</i> • <i>"Among women, alcohol use increases involvement in risky sexual actions exposing them to the risk of unwanted pregnancies and sexual transmitted infections"[7AA]</i> • <i>"...people drink alcohol, but really it does not solve any problems" [10AA]</i> • <i>"...people enjoy to engage sex under the influence of alcohol" [11BB]</i>

	<ul style="list-style-type: none"> • "...they like alcohol, this put them in lot of troubles, of having sex with unknown people and even one night stand, really that's why HIV infection cannot stop"[11BB]
1.3 Multiple sex partners	<ul style="list-style-type: none"> • "And what is more worse is they get into practiced multi-partner sex and this not only exposes them to acquisition of super-infection but leads to infection of their partners therefore cause the ever increasing numbers of new infections and people with HIV in the country"[2BB] • "Having many partners"[1AA] • "Being away from home encourages one to have extra marital affairs because of boredom"[5BB] • "They can be re-infected because men do not change their behaviour of having many sex partners".[4AA] • "...people enjoy to have multiple sexual partners"[11BB] • "Men mostly enjoy having so many sexual partners" [11BB]
1.4 Transactional sex	<ul style="list-style-type: none"> • "...sell sex for money"[2BB] • "Men work away from home for long periods have a culture of purchasing sex from sex workers"[1AA] • "The fact that they (referring to men in their 20's-30's) are often away from home makes them more likely to use sex workers..." [5BB] • "Women especially the young ones tend to have many sex partners in exchange for money and practice unprotected sex with many different casual partners, in general, much higher sexual transmitted infections and HIV"[5BB] • "The women's living conditions both at rural and urban areas are terrible to attend to daily living needs such as basic needs e.g., finances, food, therefore women are at high risk to be re-infected because they are engaged in unprotected sex, multiple sex partner for, sex exchange for money"[4BB] • "The women's living conditions both at rural and urban areas are terrible to attend to daily living needs such as basic needs e.g., finances, food, therefore women are at high risk to be re-infected because they are engaged in unprotected sex, multiple sex partner for, sex exchange for money" [4BB] • "women working in the factories away from home for long periods...sometimes engage in transactional sex in order to increase money to send home...multi-partner sex exposes them to transmission of HIV and re-infection"[10AA]
1.5 HIV status non-disclosure	<ul style="list-style-type: none"> • "Also not disclosing ours status"[1AA] • "...secrecy about HIV status...some people who have HIV infection do not disclose their HIV status to their sex partners [8BB]
Category 2 Knowledge	
Sub-Categories	
2.1 Knowledge about HIV re-infection	<ul style="list-style-type: none"> • "...we are told in our workshops (referring to support group workshops) on HIV and AIDS that we can get re-infected when we do not take care of self"[5BB] • "Yes they can be re-infected different type of HIV can be passed to HIV infected individuals, we are always told at our education sessions that that this makes treatment less successful, we will have to change treatment which is more complicated and costly" [6CC]

	<ul style="list-style-type: none"> • "They can be re-infected people should protect themselves, HIV re-infection can lead to many deaths in our community" [4AA] • "In our support groups education sessions correct and consistent use of condoms is recommended especially among HIV positive individuals" [8BB] • "...to prevent re-infection, the condoms have to be used each time people really should not be ashamed to seek condoms because they provide protection" [9CC] • "The ideal situation is that HIV positive individuals should use condoms throughout their sexual life in view of preventing themselves from HIV re-infection" [9CC]
2.2 Unwillingness to attend HIV education sessions	<ul style="list-style-type: none"> • "Most often many people don't have enough information because of selfish reasons of not joining education sessions in the factory. Knowledge in HIV issues is essential on how to protect themselves"[10AA] • "...there is lack of knowledge on HIV and AIDs issues the ability to practice safer sex depends one HIV knowledge but most people do not want to attend HIV education sessions. I know if one has knowledge he or she can have confidence and communication in the relationship" [9CC] • "They can be re-infected because (of) having bad habit of failing to go HIV education sessions" [4AA] • "Knowledge and skills are needed, there should be education in this regard but people do not want to learn about HIV issues..." [6CC] • "...most people do not want to attend HIV education sessions." [9CC]
2.3 Not having HIV testing	<ul style="list-style-type: none"> • "young men do not want to go to the clinics to test for HIV, testing seem to be women things according to them"[3CC] • "Men do not want to know their status by going for HIV tests. They always rely on their partners results, saying when she know her status it means they are having the same results" [4AA]
Category 3 Socioeconomic factors	
Sub-Categories	
3.1 Poverty	<ul style="list-style-type: none"> • "Poverty result on job seeking, moving from rural areas looking for work in urban town can put people at risks to HIV infection" [5BB] • "...sometimes engage in transactional sex in order to increase money to send home"[10AA]
Category 4 Cultural factors	
Sub-Categories	
4.1 Stigma	<ul style="list-style-type: none"> • "They are always thinking of what people will say if they are found to be HIV positive"[4AA] • "I know that the stigmas are also associated to AIDS HIV transmission often result in secrecy about HIV status" [8BB]
4.2 Communicating about sex	<ul style="list-style-type: none"> • "...sex in most cases in our society may take place with little or no communication discussing sex as is taboo, making the discussion of safer sex with people very difficult" [9CC] • ...cultural values and social pressures strongly influence non-disclosure of HIV status [8BB]

4.3 Age discrepancies	<ul style="list-style-type: none"> • "...people at our age are worse from 20 to 30 years, pregnancy is common it is like farshion to the people we know are HIV positive"[2BB] • "Young men between the ages of 20 and 30, are the most likely to become infected with HIV and to infect others"[5BB] • "Sexual experimentation outside marriage is increasing among young people, this is the risky sexual behaviours among youth continue despite a confirmed sexually transmitted infections and HIV status"[7AA]
4.4 Gender discrepancies	<ul style="list-style-type: none"> • Many women fear they will be abused by their partners if they disclose their HIV status and many women actually experience such abuse in their families"[8BB] • "...women mostly lack of confidence and fear to request their husbands to use a condom, their partners would think that they are unfaithful, women, this makes more difficult especially when they want to protect themselves"[11BB]

Category 1: Risk-taking behaviours

Five sub-categories were identified in this category, all of which were closely similar to those previously discussed in Theme 1 (cf. Table 4.1). The sub-categories included unprotected sex, substance abuse, multiple sex partners, transactional sex and HIV status non-disclosure.

It is noted that practicing unsafe sex without using a condom was something that PLWHA do to get re-infected with HIV. The majority of participants only mentioned this as an example of how someone can be re-infected, but this section specifically highlighted strong feelings associated with the practice being wrong (cf. 1.1 Table 4.2). Some reasons which seemed to have an effect on the choice to use condoms during intercourse include: PLWHA feel that they have nothing more to lose, condom errors occur anyway, women are afraid to request this from their husbands and the need to have children. Several misconceptions about condom use and gender discrepancies were also highlighted in the literature (cf. 2.7.1, 2.7.2).

Once again substance abuse was highlighted as a factor which contribute to PLWHA behaving in ways which could lead to situations for re-infection (cf. 4.4.3.1; 7.2.1.1).

The findings of this study show that there are different reasons as to why men and women are involved in transactional sex and have multiple sex partners.

The sub-category of transactional sex was explained in the previous theme as being due to poverty and it was much focussed on why women especially young girls take part in it (cf. 4.4.3.1). Literature show that Basotho women, even if employed, mostly do not earn enough to successfully support their families and as a result are commonly forced into transactional sex practices (cf. 2.7.1.2).

In the current theme the same discussions followed in terms of why women practice transactional sex, but here a focus on men was highlighted (cf. 1.4, Table 4.2). Findings showed that the effects of frequently working away from home (especially for long periods of time) are commonly associated with a likelihood of purchasing sex from sex workers. This was also reported in other studies (cf. 2.7.1.2). Having multiple sex partners is closely associated with the practice of transactional sex for women, but the participants explained that for men it is just common practice which they often refuse to change (cf. 1.3, Table 4.2). This of course have detrimental consequences. The literature show that Basotho men who in particular work in South African mines are mostly at risk due to the sex industry working in and around the mines (cf. 2.7.1.1).

Category 2: Knowledge

As mentioned previously (cf. 4.4.3.1) there is a significant relationship between knowledge about HIV and AIDS and risk-taking behaviours.

The researcher noted that the participants' knowledge of HIV re-infection was gained through their involvement in the ALAFA support groups. The findings further showed that the participants believed that a lack of HIV and AIDS knowledge and inaccurate information are factors that lead to a risk for re-infection. What also contribute to this is the unwillingness of some PLWHA to attend educational sessions and support groups, in order to be more informed. This is a concern since there are so many well established educational and support services for HIV and AIDS in Lesotho, some even in workplaces (cf. 2.5.1). This highlights a need for more specific and tailored HIV and AIDS educational campaigns which will be presented in such a manner that they will be more visible, inviting and will reach the majority (cf. 2.5).

Knowledge of a HIV status, according to UNAIDS (2000:37), can enable people to seek appropriate emotional support and make informed choices for themselves and their partners in order to prevent HIV transmission and re-infection. Of concern was that the

participants in this study still perceived that men were often unwilling to be tested for HIV. More so is the misconception that they would know their HIV status through their partners being tested (cf. 2.3 in Table 4.2). In a study conducted by Chinyama (2013:38) it is shown that some people never choose to go for Voluntary HIV Counselling and Testing (VCT) unless forced to go or when compelled by other factors, like illness and pregnancy. There have been growing support and demand for Voluntary HIV Counselling and Testing (VCT) services in Lesotho that foster risk reduction behaviours (cf. 4.1).

Category 3: Socio-economic factors

In accordance with Ezeokana *et al.* (2009:156) the consequence of poverty is outstanding among PLWHA. The participants in the current study indicated that poverty, especially shortage of money to cover basic living costs and family expenses, perpetuate PLWHA to engage in risky sexual practices only because of desperation for money (cf. 3.1 in Table 4.2). These facts are aligned with findings in a study by Tladi (2006:380) which showed that poor people are therefore often sacrificing their general health in order to ensure better conditions for short term benefits. In view of Lesotho being a country where more than half of the population live under the poverty line (cf. 2.7.1.2) this is something that deserves much more focus in the fight against HIV and AIDS.

Another aspect to consider which leads to poverty includes job security for PLWHA. The Centre for Women and HIV Advocacy's HIV Law Project (2011:2) revealed that PLWHA often have difficulty in finding or securing work, because their health care needs are such that obtaining HIV therapy every month may result in work absenteeism. The difficulty of finding or securing work may then negatively impact the psychological well-being of PLWHA (The Centre for Women and HIV Advocacy's HIV Law Project 2011:2) contributing again to other risk-taking behaviours.

Category 4: Cultural factors

Stigma associated with HIV and AIDS continues to be a global threat to HIV care, treatment and prevention, especially in Sub-Saharan Africa (Apanga 2014:41) (cf. 2.7.1). Findings showed that the fear of being stigmatised was linked to why PLWHA kept their status a secret (cf. 4.1, Table 4.2). The researcher was of the opinion that when communities and especially co-workers were acting negatively after learning of their HIV

status, that could affect the overall normal life of PLWHA (cf. 3.2 in Table 4.2). Within particular communities, stigmatisation has been recognised as a major influence of non-adherence HIV treatment, for this reason it strongly relates the way PLWHA are viewed within their communities (Duffy 2005:14).

Furthermore this study found that talking about sex is taboo as it is shameful and strongly discouraged in the Lesotho community (cf. 4.2, Table 4.2). These cultural beliefs influence HIV risk-taking behaviours, because they discourage not only HIV status disclosure but also mostly discussions about safe sexual practices (cf. 2.7.1). Open communication about sex is regarded to be an important factor as it can enable sexual partners to discuss and negotiate safer sex practices (Knox, Reddy, Kaighobadi, Nel & Sandfort 2013:351). In view of the above, there seem to be a need to address this belief and practice in the Lesotho culture in a culturally sensitive manner. It is the belief of the researcher that the benefits of opening up discussions and freely communicating about sex will far outweigh the detriments.

A study in Bangladesh found that 88% of unmarried urban boys and 35% of unmarried urban girls had engaged in sexual activity by the time they were 18 (UNICEF, WHO & UNAIDS 2002:11). The participants in this study mentioned that young people between the ages of 20 and 30 have the highest risk for both HIV infection (re-infection) and in addition also infecting others (HIV transmission) due to sexual experimentation and teen pregnancies becoming more common in Lesotho (cf. 4.2 in Table 4.2). Authors Singh, Buckner, Tate, Ndubani and Kamwanga (2011:209) suggest comprehensive multifaceted interventions aimed at reaching individuals of all ages and educational backgrounds, with the advice of distributing condoms at the venues where young people gather.

Lesotho faces a number of challenges in achieving equality between men and women, as women are regarded as the minor in their community (cf. 2.7.1). Whilst legislation has increased rights for women on paper, there is still a long way to go before this will make a difference to women in Lesotho. In view of the, participants suggested that gender inequalities also contributes to HIV re-infection as women fear their husbands and the risk of being abused. "People's actions are influenced by power dynamics in our everyday environment, power relations affect the way we interact and respond to HIV and AIDS", this emphasises the importance of knowledge and education to ensure that women make wise decisions to protect themselves from infection (Hlalele & Letsie 2011:162).

To address the before mentioned, HIV prevention programs must be locally-adapted to promote protection of human rights including gender equality (UNAIDS 2005:17). The ILO (2001:9) recognises that gender inequality in the workplace is in respect of: HIV and AIDS by providing technical assistance to enforcing gender equality in the workplace under general ILO convention. This includes targeting both women and men in separate programmes, in recognition of the different types and degrees of risk for men and women workers. In addition programmes should help women to understand their rights, both within the workplace and in their communities, and empower them to protect themselves (cf. 2.5.1.2; 2.7.1.3).

4.4.3.3 Theme 3: HIV transmission risk behaviours

As reflected in Table 4.3 below Theme 3 are grouped into five categories: Category 1, Risk-taking behaviours; Category 2, Knowledge; Category 3, Socioeconomic factors; Category 4, Cultural factors; and Category 5, Psychosocial behaviours. As noted earlier, the participants had a good understanding of HIV risk behaviours in PLWHA. The first three questions were very similar and therefore it was expected that the same categories and sub-categories would have emerged. The finding in this theme did however reveal an additional category namely psychosocial behaviours.

TABLE 4.3 THEME 3: HIV TRANSMISSION RISK BEHAVIOURS

Category 1: Behavioural risk-taking behaviours	
Sub-categories	
1.1 Unprotected sex	<ul style="list-style-type: none"> • <i>"They are having unprotected sex"</i>[3CC] • <i>"...not to use of condoms"</i>[1AA] • <i>"...safe sex (referring to protected sex) is still not practiced enough within our own community with HIV positive people especially"</i>[5BB] • <i>"...not using condoms"</i>[5BB] • <i>"...unprotected sex"</i>[4AA] • <i>"HIV status men approaches to having purposeful unprotected sex. Bare backing"</i>[4AA] • <i>"Condom use"</i>[7AA] • <i>"Un-protected sex among PLWHA yes is happening people should also use protection"</i>[8BB] • <i>"...according to my experience negotiation of condom is still difficult to us women and young girls, our partners do not want us have a say in sex issues"</i>[8BB] • <i>"...the loss of self-control lead to unprotected sex"</i>[9CC] • <i>"...some reasons for not using a condom (pause), men's dislike of condoms"</i>[9CC] • <i>"...people do not want to use condoms especially men"</i> [10AA]

	<ul style="list-style-type: none"> • <i>"Yes people who have HIV still have desire for children, so they continue to have unprotected sex even if they know their status, in so doing so HIV can be transmitted to many people"[11BB]</i> • <i>"...people still do unprotected sex, proper and consistent use of condoms prevents transmission of HIV, but most of us do not do so"[11BB]</i>
1.2 Substance abuse	<ul style="list-style-type: none"> • <i>"Like young people are going to parties more often and using alcohol and drugs among young people who are positive is a fashion and these activities influence them not to use of condoms to protect themselves, they end up having sex with someone not known for which is a common behaviour that put one to get HIV and transmit HIV to other people"[1AA]</i> • <i>"...engaging in sex under the influence of alcohol"[5BB]</i> • <i>"...resort to use alcohol to cope, in doing so, may engage in unprotected sex"[4AA]</i> • <i>"...under the influence of alcohol or drugs"[9CC]</i> • <i>"...people knows that they have to take good care of themselves but are going to parties using alcohol and drugs, which is dangerous, after parties, when a person is drunk, the mind is not working, practicing unprotected sex is common, then after blames self for alcohol not self, which in-turn increases big chances of infecting sexual partner"[10AA]</i> • <i>"...some people purposely use alcohol during sexual activity and provide an excuse for unacceptable behaviour"[11BB]</i>
1.4 Multiple sexual partners	<ul style="list-style-type: none"> • <i>"...unprotected sex with more than one partner"[3CC]</i> • <i>"Having multiple concurrent partners. Men are expected to have more sexual activities and have more sexual prowess than females in the community"[1AA]</i> • <i>"...having multiple sexual partners"[5BB]</i> • <i>"...people enjoy having unprotected sex with more than one partner"[6CC]</i> • <i>"People living with HIV and AIDS are observed to indulge more into sexual risky behaviour of practicing multi-partner sex without the correct and consistent usage of condoms not only exposes them to acquisition of another HIV strain (re-infection) but leads to infection of their partners thereby driving the ever increasing numbers of new infections"[7AA]</i> • <i>"...having multiple partners"[8BB]</i> • <i>"Having multiple concurrent partners to young people is high, they are boasting about how many partners they have. This is how HIV is transmitted to many people. Men are expected to have many partners by their friends to show that they are really men they transmit or get re-infections"[10AA]</i> • <i>"...encouraged to have multiple partners"[11BB]</i>
1.5 Non- disclosure of HIV status	<ul style="list-style-type: none"> • <i>"They don't tell people that they have disease, telling people is important in the community"[2BB]</i> • <i>"In most cases they don't tell people about their status and they get re-infections"[1AA]</i> • <i>"...not telling people about the status could lead to unsafe sexual activities, which in-turn increases big chances of infecting sexual partner"[2BB]</i>

	<ul style="list-style-type: none"> • <i>"The issue of disclosing HIV status to the partner is always a problem, so this lead to non-status disclosure due for fear to loss of personal relationships"[5BB]</i> • <i>"Lack of knowledge of the partners' status is really happening and stills a problem PLWHA still do not want to be known, are afraid to disclose for various reasons" [7AA]</i> • <i>"Most people do not communicate about their life and sex issues, people living with HIV should communicate to determine their partner's status"[8BB]</i>
Category 2: Knowledge	
Sub-categories	
2.1 Lack of knowledge	<ul style="list-style-type: none"> • <i>"...lack of knowledge can transmit HIV/AIDS"[2BB]</i> • <i>"The lack of proper awareness and knowledge...may leave many people at risk to contract the HIV. Correct knowledge regarding the HIV/AIDS is a generally important for the prevention of HIV/AIDS" [6CC]</i> • <i>"Many youth are sexually active but lack life skills to deal with sexual negotiations, particularly about safer sex. There are insufficient education facilities; there is a lack of information about HIV/AIDS. For lack of recreation facilities, youth engage in sex for recreation" [4AA]</i> • <i>"Lack of knowledge on HIV issues is dangerous" [7AA]</i> • <i>"...sexually active people like us lack knowledge on HIV issues" [10AA]</i>
2.2 Unwillingness to attend HIV education sessions	<ul style="list-style-type: none"> • <i>"Men do not want to attend education sessions in the factory, the lack factual information. Inaccuracies in knowledge of HIV transmission may affect sexual practices to many people..."[6CC]</i> • <i>"Men should change, even though they do not want to attend HIV education sessions. They are still relying to wrong information being fed by the society. This wrong information can lead an individual away from taking the protective actions, If not attending support groups or education sessions in the factory especially men will have misleading information may affect sexual practices" [8BB]</i>
Category 3: Socioeconomic factors	
Sub-categories	
3.1 Treatment access	<ul style="list-style-type: none"> • <i>"Access to drug therapies in the rural areas, particularly for pregnant women, is limited or simply not available" [4AA]</i>
3.2 Poverty	<ul style="list-style-type: none"> • <i>"Lower salaries also lead PLWHA to engage in higher-risk behaviour such unprotected sex subsequently leading them to become HIV infected"[7AA]</i> • <i>"...women who are confronted with financial stress therefore resort to use alcohol to cope, in doing so, may engage in unprotected sex with her partner, she may also engage in other behaviours that do not promote health — that is, inattention to continue having healthy nutrition and adherence to medication" [4AA].</i>

Category 4: Cultural factors	
Sub-categories	
4.1 Gender discrepancies	<ul style="list-style-type: none"> • <i>"An accepted culture of silence about issues of sex is another problem to men and women"</i> [2BB] • <i>"...women are unable to enforce the use of condoms"</i> [4AA] • <i>"...women lack of sexual decision-making power always "</i> [9CC] • <i>"Many women also are afraid to request their husbands to use a condom while their partners would think that they were unfaithful or prostitutes"</i> [9CC] • <i>"Cultural norms to condom is always cause of HIV transmission, men do not want to use condoms, it seems as if they are not afraid of HIV"</i> [2BB] • <i>"Men are expected to have more sexual activities and have more sexual prowess than females in the community"</i> [1AA]
4.2 Peer pressure	<ul style="list-style-type: none"> • <i>"Men faces so many challenges putting themselves, pressure from their friends encouraged to have multiple partners, according to them men are expected to have many partners trying to please their friends"</i> [11BB]
4.2. Myths about a cure for HIV	<ul style="list-style-type: none"> • <i>"...men put them in danger...are intentionally seeking partners for unprotected sex having a believe that they will be cured. There is no cure for HIV and myths about HIV transmission should be avoided by all means"</i> [6CC] • <i>"Older men have strong motivations of having unprotected sex with younger women and children to cure HIV men claims that sex with a virgin will cure AIDS. Such myths make young women and babies particularly vulnerable to HIV infection in our communities. And this can also accelerate the progression of HIV disease and lead death"</i> [4AA] • <i>"...there is a strong tendency for older males to prefer sex with young women, because of the fear that older women are probably already infected with HIV/AIDS"</i> [4AA]
Category 5: Psychosocial behaviours	
Sub-categories	
5.1 Discrimination	<ul style="list-style-type: none"> • <i>"There is fear of divorce, fear of embarrassment, fear of being abandoned, fear of blame, fear of rejection, discrimination, verbal abuse from people we love"</i> [2BB]
5.2 Stress	<ul style="list-style-type: none"> • <i>"...stress and emotions thus lead the individual to more likely engage in high-risk behaviours"</i> [5BB] • <i>"...living under conditions, being positive, work stress with low income at factory work, family stress looking for undivided support, really makes us unsuccessfully take some sort of action to change to desired behaviour"</i> [9CC]
5.3 Ignorance	<ul style="list-style-type: none"> • <i>"Men are currently advised to go to voluntary medical male circumcision in order to minimise their chances of getting infected by HIV. But many of them do not want to go such service in order to minimise their chances of getting infected"</i> [8BB]
5.4 Low self-esteem and depression	<ul style="list-style-type: none"> • <i>" low self-esteem and depression can lead to unsafe sexual practices"</i> [5BB] • <i>"...loss of personal relationships, self-esteem, the need to love and the desire to feel loved therefore threaten the future of the relationship"</i> [5BB]

5.5 Desire for children	<ul style="list-style-type: none"> • <i>"Yes people who have HIV still have desire for children, so they continue to have unprotected sex even if they know their status, in so doing HIV can be transmitted to many people"[11BB]</i> • <i>"Some women who are HIV positive decide to have children on their own without clinic or doctors advices therefore will lead women who are HIV infected to transmit HIV to unborn baby"[4AA]</i> • <i>"...sometimes their marriage partners pressured them have children which is not your interest and it brings conflicts and disagreements therefore forces one to get involved in unprotected sexual act"[3CC]</i>
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Category 1: Behavioural risk-taking behaviours in HIV transmission

The UNICEF Lesotho country programme document from 2013-2017 (UNICEF 2012:3) assert that multiple factors are major drivers of the epidemic including: Multiple concurrent partnerships, low levels of consistent and correct condom use, as well as low levels of medical male circumcision. Participants in this study have repeatedly justified that unprotected sex still remains a HIV risk factor among PLWHA which is strongly linked with having multiple sexual partners, engagement in transactional sex and alcohol abuse as well as not disclosing their HIV status to their sexual partners closely what was discussed in Theme 1 (cf. 4.4.3.1) and the second theme (cf. 4.4.3.2). Further disclosure in Theme 3 revealed that there are some PLWHA who purposefully engage in unprotected sexual practices, even though the benefits of condom use is understood (cf. 1.1, Table 4.3). In a study assessing motivations to engage in condomless intercourse (although the focus was on men who have sex with men) the findings showed that condomless sex seemed to be a means to "achieve emotional and sexual connections" and to "provide sexual and emotional rewards which may not be present when using condoms" (Bauermeister, Carballo-Diéquez, Ventuneac & Dolezal 2010:167).

Once again the barriers that hinder HIV disclosure were highlighted in the findings showing that these still remain a critical challenge among PLWHA. This shows the importance that HIV prevention strategies should be intensified and sustained to promote safe sex practices amongst PLWHA, in addition policy makers have to create an enabling environment to protect PLWHA against discrimination and stigmatisation (Adebiyi & Ajuwon 2015:78) (cf. 2.7.1.3).

Category 2: Lack of knowledge

The participants spoke about a lack of knowledge which stems in part from unwillingness to attend support groups and peer education initiatives already offered in many

workplaces (cf. 2.6). The participants gave an example of men who are well-known to engage in high-risk sexual behaviours commonly because they are uninformed or often misinformed and unwilling to seek information. According to the interview findings women are generally viewed as health seekers, acquiring more knowledge and often having the responsibility of looking after family members, parents, children and relatives who might be ill, so health related knowledge can assist them in this role.

Of concern was one perspective from a participant who indicated that there is not enough attention given to educate youths and referred to the lack of recreational facilities, since it is perceived that youth engage in sex for recreational purposes. That was a perception of one individual. Lesotho has several initiatives to address the HIV and AIDS pandemic by offering educational and HIV services to the youth (cf. 2.6.4), but it has been acknowledged that more can be done (cf. 2.6.4.2).

The findings showed that knowledge is a key factor in the prevention of HIV infection since it associates with self-protective behaviours. This was also echoed in the literature as education was found to be strongly predictive of better knowledge, safer behaviour and reduced infection rates (World Bank 2002 in World Bank 2003:3) (cf. 2.5). This again highlights the importance of educating everyone (those with HIV and those without) about HIV and AIDS and why factors associated with HIV risk-taking behaviours amongst PLWHA should specifically be enjoying attention (cf. 2.5.1).

Category 3: Socioeconomic factors

In this theme access to health care services especially for pregnant women living with HIV situated in rural areas, were mentioned as a factor which contributes to HIV transmission. If infected expectant mothers could be identified and treated early, their chances of giving birth to an infected baby would be greatly reduced (UNICEF 2012:7). In the Lesotho National Guidelines for Prevention of Mother to Child Transmission (PMTCT) of HIV, they ensure that all pregnant women who reach antenatal clinics will be treated accordingly to limit the risk of HIV transmission (cf. 2.5.1.2). However regardless of the 62% of HIV positive pregnant women receiving treatment (cf. 2.5.1.2) and the total number of children affected with HIV having been reduced over the years (cf. 2.2.3) it is still heart-breaking that the available treatment services do not necessarily reach everyone in need in Lesotho. This probably includes a number of women who are too poor to travel to access health care. Further investigation should

be considered and discussions with government and other stakeholders in Lesotho should be informed in order to establish ways to best address this.

Category 4: Cultural factors

The participants showed the concern that women are mostly affected by the HIV; the gender inequality concept has emerged several times in previous themes in this study (cf. 2.7.1; 4.4.3.1, 4.4.3.2). In many African settings, men continue to be praised for their sexual powers and their sexual desire is often believed to be impulsive and uncontrollable, at the same time, women are often expected to be demure and restrained in their sexual experiences and desire (Ricardo & Barker 2008:3). In contrast to the perceptions of the participants in this study, generally it is found that culturally gender related factors put both men and women at risk of HIV infection (cf. 2.7.1.3). As before suggested, HIV prevention programmes should adopt a cultural approach to HIV and AIDS education, within a broader sector of the society (UNESCO 2001:89) (cf. 2.6.1, 2.7.1).

Myths about a cure for HIV were also one of the sub-categories which emerged from the participants' interviews (cf. 4.2, Table 4.3). People living with HIV are looking for a means towards a cure for HIV, and therefore they may be forced to focus on the HIV myths in their communities or in societies at large. It was emphasised in this study that it is widely men's belief that HIV can be cured when having sex with a virgin or with baby girls. These existing HIV cure misconceptions, which persist all over the world, could give rise to unorthodox sexual behaviours among PLWHA, with the belief that if they contract HIV and AIDS there is a cure (Tarkang 2013:221).

Another misconception reported in this study include older men to choose significantly younger sexual partners, as they believe they will not yet have HIV and can therefore not become infected (cf. 4.2, Table 4.3). Author Letamo (2007:193) suggested the following to address misconceptions about HIV and AIDS: "Since misconceptions may prevent people from making informed choices, intervention programmes aimed at HIV prevention, should aim to dispel misconceptions about HIV and AIDS as an important part of their strategy. Targeted HIV prevention and education programmes are needed in an effort to dispel such misconceptions and likewise to address the needs of different population sub-groups).

Category 5: Psychosocial behaviours

The study findings show that apart from the fear of being discriminated against PLWHA have many challenges, such as higher levels of stress, low self-esteem and depressions which are considered to be factors that lead people to engage in risk-taking behaviours contributing to HIV transmission (cf. 5.1, 5.2, 5.4 in Table 4.3). A study by Ownby *et al.* (2010:81) confirms that depressions and stress are increased in PLWHA especially when the diagnosis is new. According to the authors these are due to fear of the impact of the infection, fear of isolation from family and friends and concerns about infecting others. However, in other studies depression specifically were shown to be associated with increased sexual risk taking behaviour (Kelly *et al.* 1993:215) (cf. 7.2.1.4).

In order to address the psychosocial factors contributing to PLWHA practicing HIV risky behaviours programme developers should carefully consider a focus on teaching PLWHA about coping strategies, as to build on resilience and personal strengths in coping with the disease (Emlet, Tozay & Raveis 2011:10). In addition it may encourage PLWHA to make effective disclosure decisions (Kalichman *et al.* 2003:331). Most of all societies at large should be educated about HIV and AIDS since family members, friends, co-workers to name a few can contribute to effectively support PLWHA. As support from others has been shown to have a positive impact on the well-being of the person living with HIV and AIDS (Li *et al.* 2006:510) (cf. 4.4.1).

Ignorance was also identified as a sub-category. One participant used the example of men having available HIV risk reduction measures namely VMMC (cf. 2.5.1.3) but still not choosing to use it. If this is truly due to ignorance as suggested here or more associated with cultural beliefs as described in the literature (cf. 2.5.1.3) it is yet to be further investigated.

Several participants indicated that unsafe sexual practices and in turn the increased risk of transmitting HIV is commonly associated with a desire to have children (cf. 5.5 in Table 4.3). Reasons for a strong desire for a child seemed to be more socially and culturally oriented (Aska, Chompikul & Keiwkarnka 2011:200). People living with HIV are under pressure to have many children as traditionally and culturally it is expected of them (Wekesa & Coast 2014:8). Women are most commonly more affected by cultural norms associated with childbearing, in view of being pressured by their partners and if they do not procreate it could lead to separation, divorce or extramarital affairs

(Sofolahan & Airhihenbuwa 2013:7). This again deserve for culturally sensitive HIV prevention initiatives adopted for a specific community.

4.4.3.4 Theme 4: Peer influence on HIV risk-taking behaviours

This theme is divided into two categories, which highlight the role of peer pressure as well as communication in influencing HIV risk-taking behaviours. The table below (Table 4.4) shows the findings from the study on the categories and sub-categories identified.

TABLE 4.4 THEME 4: PEER INFLUENCE ON HIV RISK-TAKING BEHAVIOURS

Category 1: Peer pressure	
Sub-categories	
1.1 Key role in decision making	<ul style="list-style-type: none"> • "...sometimes friends will influence us"[3CC] • "...our friends are likely to influence sexual decision-making"[3CC] • "...they are influential"[1AA] • "And really the negative influence among peers may lead them from taking the wrong decisions"[6CC] • "Friend inform and entertains many young people listens to them"[6CC] • "...peer influence plays an important role in risky decision making during youth stage between the age 18 to 30"[7AA] • "...friends can be influential" [8BB] • "Peer influences are more influential with regards to sexual decision-making especially when a person is easily persuaded" [11BB] • "...if a person do not have right information, cannot say no sometimes friends will influence us"[3CC] • "Under this working environment peers influence their friends 'decision making, especially young people are encouraged to have pre-marital sex, and they also they attract older men"[8BB]
1.2 Encourage at-risk behaviours	<ul style="list-style-type: none"> • "All in all poverty and lower salaries are the root causes for us to listen to our friends. In order to be recognised by our friends not to avoid to be called cowards, we end up being re-infected or infecting many people? We have to hook up with older men who have money, and since they are older we cannot advise them to use condoms"[3CC] • "Some people encourage their friends to have many partners and to not use condoms"[2BB] • "I know I have been a victim many times, and people close to me have been victims, it is through friends we love to fall in the danger of getting re-infection, we always listen to them and trust the information, we do don't question where is the information from" [2BB] • "Mostly young girls learn from each other and practice dangerous sex acts in order to satisfy their partners" [5BB]

	<ul style="list-style-type: none"> • "...young women are encourages each other to have sex outside the marriage" [5BB] • "...peer pressure encourages sexual intercourse at the same time, sex, smoking and drinking are part of the transition to for them to be known as adults"[6CC] • "...attitudes and peer pressure contribute to behaviours that put young people at risk of HIV re-infection or infecting someone else" [4AA] • "peer pressure encourages people to engage in risky sexual activities"[4AA] • "...peer pressure lead to young girls to sexual abuse, rape and transactional sex, often with older men"[4AA] • "Some people encourage their friends to have many partners and to not use condoms"[7AA] • "Young people always know everything, most young people are depending too much on the trust they had on friends (because, they grew up together) peer pressure justify their practice of unprotected sex and of not using condom. Unfortunately they are not advised accordingly they end up having HIV, sexual transmitted diseases and unwanted pregnancy"[8BB] • "Because of peer pressure regardless of the fear of HIV/AIDS presence they still afraid not buy their own condoms afraid of what their friend will say"[9CC] • "...it is through friends we love to fall in the danger of getting infection and re-infection, some people encourage their friends to have many partners and to not use condoms, people listen to them and trust the information, do not want to go to peer education or support groups"[10AA]
Category 2: Communication	
Sub-categories	
2.1 Misleading information	<ul style="list-style-type: none"> • "Friends can be supportive or mislead"[3CC] • "I do not know why people are brave enough to mislead people" [2BB] • "There is a lot of misleading information from friends but we do not know where our friends get information but it seems as if we trust them"[1AA] • "...they get misleading information from peers"[1AA] • "There is a lot of information going around from friends. Some information is true while others are myths, unfortunately wrong information travel fast"[5BB] • "...forced to listen to friends who are good at providing misleading information"[6CC] • "...in most cases our friends mislead us purposely"[7AA] • "There is a growing number of PLWHA who engaged in unprotected sexual activity with HIV negative people, because they get misleading information from peers that when one has unprotected sex with a person who is not infected can cure HIV"[8BB] • "...friends can mislead u purposely"[10AA] • "Friends provide misleading information that promote transmission HIV"[11BB]

2.2 Lack of information from parents	<ul style="list-style-type: none"> • <i>"Lack of communication on sex issues"[5BB]</i> • <i>"...there is a tendency whereby parents are not having sex talk with their girls. Parents need to protect their daughters by communicating to them and ensuring they are aware of how to protect themselves if sexually active. Young girl are particularly vulnerable do not listen to their parents"[5BB]</i> • <i>"With poor communications between young people and their parents on the subject of sex create a lot of problems. They therefore forced to listen to friends"[6CC]</i> • <i>"...our parents do not talk about sex, HIV, or condoms frequently with their children because they considered these topics disrespectful, on the other side"[8BB]</i>
2.3 Need for correct information	<ul style="list-style-type: none"> • <i>"Education programmes should take place to dispel the myths. People should be educated about HIV in order to have factual knowledge, to know more about condom use that proper and consistent use of condoms prevents transmission of HIV and other sexually transmitted diseases"[5BB]</i> • <i>"There is a need for reliable sources of information. There is a need as well for education programs to improve parents' knowledge on HIV and AIDS"[6CC]</i> • <i>"People living with HIV should always get reliable social support in order to cope, support groups at work and at villages to avoid HIV myths which are common among the youth. Social supports are especially important in terms of providing correct information for dealing with the demands of daily life. Often young men and women have insufficient information and understanding of HIV/AIDS, and are usually not aware of their vulnerability to the disease or how best to prevent it"[4AA]</i> • <i>"...get information from right sources"[8BB]</i> • <i>"...people get information from unreliable sources"[10AA]</i>

Category 1: Peer pressure

Cherie and Berhane (2012:161) indicate that peers have significant influences on young people's behaviour. Peer pressure was identified by many participants as a factor with a negative influence on the practices of risky sexual behaviour. Findings showed that peers play a key role in decision making and also commonly encourage at-risk behaviours (cf. 1.1, 1.2 in Table 4.4). Negeri (2014:6) also noted peer pressure as a common factor in most young people's decision, not only in the use of substance abuse, but to engage in unsafe sex practices.

Reasons why peer pressure are accepted include: people not having enough information not to be influenced and that too much trust is invested into peers and therefore there is no need to question the information (cf. 1.1, 1.2 in Table 4.4). In addition participants explained that younger people commonly have a need to fit in and to impress their friends and as a result they may become victims of sexual abuse in addition to being

exposed to HIV (cf. 1.1, 1.2 in Table 4.4). Fortunately several initiatives are already in place to address the effects of peer pressure. Peer education makes use of peer influence in a positive way (Zielony, Kimzeke, Stacic, & De Bruyn 2003:11) (cf. 2.6.3.2). In Lesotho, peer education taking place in a variety of settings such as schools, universities, churches, workplaces is one of the key strategies in the HIV prevention programme (cf. 2.6.4). In view that peer pressure seems to still strongly affect risk-taking behaviours, as described by the participants in this study, investigation into the effects and/successes of the current programmes might be warranted. Lessons learned from those with great success rates could be used in other programmes to also increase success and contribute to individuals who are able to make informed decisions.

Category 2: Communication

The extent to which peers impact on persons' decision making, especially with reference to participating in risky sexual activities had already been established, in the category mentioned previously. In this category it became apparent that peers commonly communicate misleading information and there was some question as to whether this was due to not having the correct knowledge or if some peers mislead others on purpose (cf. 2.1 Table 4.4).

In accordance with Loosli (2004:9) the diffusion of innovation theory can be useful to address negative peer influence for it asserts people adopt new behaviours, when they are convinced by other members whom they trust. It is therefore suggested that influential and respected people should take a leading role in HIV and AIDS awareness campaigns, because risk behavioural changes encouraged by prominent people may influence others to do the same and young people can learn from them.

This study already recognised the cultural practices of men and women not communicating about sex, especially talking about HIV and negotiating safe sex practices (cf. 4.4.3.1 – 4.4.3.3). Findings from the current theme showed that parents do not tend to talk to their children about sex (cf. 2.2, Table 4.4) one participant explained that it is considered to be disrespectful to talk about it. As a result, information from unrepeatable sources (peers and other sources like television, radio etc.) are commonly the only places where children can obtain information about sex. Participants were of the view that parents have a significant role to play in communicating reliable information to their children and parents should thus be educated and encouraged to take charge of

informing and empowering their children (cf. 2.3 in Table 4.4). A study conducted in Ethiopia mainly showed that parental and peer influences are among the key drivers for positive prevention of HIV and AIDS (Negeri 2014:2). This reinforces the focus on the importance of parents to empower their children through communicating the correct information timeously.

4.4.3.5 Theme 5: Societies influence on HIV risk-taking behaviours

The main categories that arose from Theme 5 were: Category 1, Cultural norms; Category 2, Societal norms; and Category 3, Lack of correct information. These are intertwined factors that promote harmful practices that increase the risk of HIV transmission in society (cf. Table 4.5).

TABLE 4.5 THEME 5: SOCIETIES INFLUENCE ON HIV RISK-TAKING BEHAVIOURS

Category 1: Cultural norms	
Sub-categories	
1.1 Condom use beliefs	<ul style="list-style-type: none"> • "...they also admitted not to talk or hold discussion about sex or condom use with her friends and relatives as her culture does not allow her to do that"[2BB] • "Married women who want to protect themselves are suspected to be unfaithful if they ask their husbands to use condoms"[5BB] • "Cultural norms discouraging women to use condoms so this contribute significantly to transmitting HIV"[5BB] • "In our community we are facing culture of continued reluctance to use condoms in sexual relationships"[4AA] • "Women, whether single or married, are unable to negotiate the use of condoms"[4AA] • "...the myths surrounding condom use hinder the possibility of either partner successfully to enforce, sexual behaviour which might prevent the spread of HIV among women"[8BB]
1.2 Cultural norm of multiple partners	<ul style="list-style-type: none"> • "Cultural norms encourages them to having different sexual partners to proof that they is a man"[5BB] • "Increasing numbers of married women are becoming infected because their husbands have extra marital affairs"[4AA] • "Surprising enough when women can have extra sexual partner, they can be called by many names or bring shame to her family. But cultural are encouraging men to have multiple partners, while women are expected to abstain or be faithful, (laughing) this is so funny. But women in particular, the lack of power or lack of control in relationships and in most cases is associated with more unprotected sex"[8BB] • "And cultural norms are condoning men to have different sexual partners and the same men are refusing to use condoms therefore contribute significantly to spreading HIV and are especially hard to change in most [9CC]

1.3 Communication practices	<ul style="list-style-type: none"> • "Women even if they know about dangerous behavior but many fail to communicate about, how and whether to protect each other" [2BB] • "...we don't talk to our husband about sex, it's our culture"[2BB] • Besides, in our cultures discussing sex is taboo, is not acceptable, and very difficult"[2BB] • "Women in our communities are facing so many challenges, communicating about sex issues is still the problem, discussing about how protect each other themselves is not possible in our communities, discussion about sex or condom use with her friends and relatives as her culture does not allow her to do that, we don't talk to our husband about sex, it's our culture"[10AA] • "Communication about sex issues is still a norm, parents in general not explaining sex to their children, this leads young people to get information from unreliable sources or from friends with less factual knowledge" [11BB]
1.4 Gender discrepancies (female submissiveness)	<ul style="list-style-type: none"> • "Gender contributes to increased HIV risks of individuals to get re-infected and transmit HIV. Women's position within the society, should be submissive to men, greatly increases their individual risks to HIV/AIDS" [5BB] • "I am also aware that culture has a role to play especially among women to make decisions, women cannot negotiate safe sex, the culture of paying lobola, proves the women's sexual obligation, gives men the power over women that they own them and therefore women cannot negotiate or decide when and how to have sex" [6CC] • "In our society much, women are at a disadvantage, they are considered to have less power over their bodies than men. Women are therefore more likely to acquire sexually transmitted infections, including HIV than men" [4AA] • "In marriages often, women who are living with HIV have a lot of abuse in their relationship. (Pause) its fear of being divorced and lot of emotions. When you tell a partner to use a condom, they ask 'which means you don't trust me/or are you sleeping around?' [2BB] • "Women are encouraged to go for testing during antenatal care when tests are positive are blamed, men do not have such opportunities for testing HIV like women"[5BB] • "Society has accepted it as norms with women being not able than men to have control over their bodies"[8BB]
Category 2: Societal norms	
Sub-categories	
2.1 Fear of stigma and discrimination	<ul style="list-style-type: none"> • "Societal attitudes towards PLWHA is related to negative views formed as a result of ignorance and lack of awareness"[3CC] • "People still get fired from their jobs and people still get kicked out of their houses. And the fear is there even now most people are not able to disclose their HIV status to their partners. They do this to avoid rejection, refusals to have sex or of being stigmatized or discriminated against"[1AA] • "To me stigma will never end. The problem that we are facing as a person living with this virus, there's a stigma and a discrimination, because people, if you say I am HIV-positive, they are going to chase you away"[1AA]

	<ul style="list-style-type: none"> • <i>"Some of the people in the community don't want to get involved too much, or associated with HIV and AIDS, because there's still very much stigma and ignorance"[1AA]</i> • <i>"Stigma, discrimination, denial and silence hinders most people decision making seek HIV related services such as testing, treatment and status disclosure"[6CC]</i> • <i>"Fear of stigma and discrimination..."[7AA]</i> • <i>"The fear of discrimination is a major constraint and still a hindrance in the fight against the disease"[9CC]</i> • <i>"Community members may not seek testing because of the fear of discovering that they are HIV positive and fearing of the resulting stigma and discrimination. Further family members may encourage relatives with HIV/AIDS to remain silent about their HIV status to prevent gossip, social rejection and HIV-related stigma"[9CC]</i> • <i>"The stigma and discrimination is still high among the communities, there is the fear for family members. Most people are not able to disclose their HIV status to their partners to avoid rejection. And people are afraid to know their status and disclosed their HIV status"[10AA]</i> • <i>"People are afraid of humiliation. High levels of stress and stigma attached to their HIV status, lead to lower self-esteem and depression"[11BB]</i>
2.2 Poverty	<ul style="list-style-type: none"> • <i>"...transactional sexual relationships is encouraged somehow in our community because of the state of poverty because of insufficient income in the family this leads to high rates of migration, now women left their homes and villages to care for families. These in most cases one having sex partner relationship (transactional sexual relationship) in order to receive additional support for food, transport"[6CC]</i> • <i>"...financial stress"[9CC]</i> • <i>"...women are depressed and stressed, they have to take care of their families, we are forced to leave out homes to look for the jobs in the factories, while we are in town we are facing so many challenges like having extramarital in exchange of money when we are still searching for the job even when we are employed the salaries are low" [10AA]</i>
Category 3: Lack of correct information	
	<ul style="list-style-type: none"> • <i>"Lack correct information about HIV in our communities creates so many problems to PLWHA"[3CC]</i> • <i>"The lack of HIV facts information in our community results in people not to disclosed their HIV status and those who are not tested not go for voluntary testing"[3CC]</i> • <i>"The society believe that HIV/AIDS is a curse, there is not enough education even after a long time"[7AA]</i> • <i>"There is still lack of correct information about HIV issues in our society" [10AA]</i> • <i>"Lack of knowledge and understanding about HIV, especially among youth 18 to 35 years still feel that HIV/AIDS is a "death sentence" but still cannot not buy their condoms" [11BB]</i>

It was found that HIV and AIDS incidence among PLWHA continues to increase despite several behavioural-changing interventions addressing the whole Lesotho population (cf.

2.2.3, 2.6.4). Possible reasons for this could be contributed to specific cultural and societal norms within the Lesotho population (cf. 1.1, 1.2 in Table 4.5).

Category 1: Cultural norms

Most of the factors underpinning HIV risk-taking behaviour across communities are largely related cultural norms, including condom use beliefs, cultural norm of multiple partners, communication practices and gender discrepancies (female submissiveness) (cf. 2.7.1).

In this study it was clear that unprotected sex (specifically related to condom use) was a definite contributing factor to both transmitting HIV and being re-infected with HIV (cf. 4.4.3.1 – 4.4.3.3). In investigating cultural norms associated with condom use the findings showed that culturally, condom use is associated with myths surrounding its use. Bogart, Skinner, Weinhardt, Glasman, Sitzler, Toefy and Kalichman (2011:181-182) report on several studies that investigated cultural beliefs surrounding illness (especially HIV) and use this to explain sexual risk behaviours. In terms of cultural beliefs which affect condom use, some cultures in Sub-Saharan Africa seem to believe that HIV was developed and is spread by governments through condoms, and that the quality of free condoms is low (Bogart *et al.* 2011:182 referencing Mufane 2005 and Rödlach 2006). It is not known exactly what PLWHA in Lesotho believe and there were calls for further research in order to effectively address these beliefs.

It was revealed that some men refused to use condoms because they claimed it was not in their culture to do so. Whereas women in the interviews mentioned that cultural norms hindered them from practising safe sex, because of the men's dislike of condoms and their denial of HIV and AIDS played a strong part in addition to the misconception that women were unfaithful if they requested a male partner to use a condom (cf. 1.1, Table 4.5). This was seen in many studies conducted in Sub-Saharan Africa as summarised by Loosli (2004:1-37) and Scott (2009:83-93). One means to address this was through the making of a documentary film called "Protection: Masculinity and Condom Use in Sub-Saharan Africa", which if not yet used during educational interventions in Lesotho may be an option.

Communities often revere men who are in relationships with more than one partner, but condemn women who do the same. This suggests that cultural norms support and

maintain multiple partnerships which may constitute important obstacles for the achievement of the 'Zero new infection' vision promoted by behaviour (UNAIDS 2011:2). This echoes that HIV prevention programmes must include counselling and skills-building practices addressing specifically PLWHA in terms of beliefs and norms with regards to having multiple sexual partners. In addition attention should be given to a cultural sensitive approach when addressing HIV and AIDS in preventive measures (Rose *et al.* 2010:38).

Cultural norms further require that women submit to men's authority as also mentioned in previous themes and supported in the literature (cf. 4.4.3.1 – 4.4.3.3, 2.7.1). The findings from this theme highlights that from a cultural perspective women is expected to be subservient to men and not express their own feelings and desires, women may not tell their husbands that they are not satisfied sexually nor may they disclose what will satisfy them. These practices hinder prevention efforts since communication about sex is observed as a key strategy in consistent sexual practices of any kind (cf. 2.7.3). The Behaviour Change Communication (BCC) strategy is an "interactive process with communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individuals, communities and societal behaviour change; and maintain appropriate behaviours" (Loosli 2004:9). If not yet focussed on the BCC strategy could be used in Lesotho population in order to try to address several of the cultural norms contributing to negative HIV risk-taking behaviours.

Category 2: Societal norms

With reference to societal norms associated with HIV risk-taking behaviours, there were similarities in the findings from this study and the understandings of UNESCO (2002:89) in which discrimination and stigmatisation of PLWHA remains one of the most prominent factors that have wide effects on society and continues to impact the successful management of HIV and AIDS (cf. 2.1, Table 4.5 and 2.7.1). Therefore HIV related stigma is considered a barrier to effectively prevent and treat HIV (Mahajan, Sayles, Patel, Remien, Sawires, Ortiz, Szekeres & Coates 2008:572).

In addition to/ or as a result of stigma and discrimination the findings in this theme show that PLWHA specifically fear to be socially rejected (being rejected by partners, family, friends and even colleagues at work), losing their jobs and being humiliated. This

highlights the need for continued work to be done in Lesotho to address HIV discrimination and stigmatisation. In conformity with the findings from previous themes (cf. 4.4.3.1 – 4.4.3.3) another societal factor to consider and to address when looking at HIV prevention in Lesotho is the effects that poverty have.

Category 3: Lack of correct information

Findings from this theme highlighted that there is still a need for correct information about all aspects of HIV and AIDS to be made available to, not only PLWHA but also to everyone living in Lesotho. Reliable information may allow PLWHA to make more informed decisions. As per the discussion in Chapter 2 (cf. 2.7.1.3), one of the UNESCO aims for HIV programme designers is to pay close attention to the provision of culturally appropriate education, utilising accurate information within using well adapted methods and contents about HIV transmission, safe sex practices and drug abuse (UNESCO 2001:20). The current study serves as directive to start identifying some beliefs in the Lesotho population which should ideally be further researched and considered in future HIV prevention initiatives.

4.4.3.6 Theme 6: Beliefs about HIV treatment

All mentioned factors identified in Theme 6 were informed by the following interview question: Would you say that if a person living with HIV is taking HIV treatment that it makes their chances less likely to be re-infected or to transmit HIV? Only one category was identified namely: Correct understanding of treatment.

TABLE 4.6 THEME 6: BELIEFS ABOUT HIV TREATMENT

Categories and sub-categories	Verbatim text
Category 1: Correct understanding of HIV treatment	
Sub-category	
1.1 Beliefs about HIV treatment	<ul style="list-style-type: none"> • <i>"Treatment makes us healthy and live long"</i>[6CC] • <i>"...medication only helps to one to live long life"</i>[4AA] • <i>"The HIV treatment only put the virus the body in control"</i>[4AA] • <i>"Treatment only boosts our immune system (soldiers). Treatment makes us live well they must always continue to take my treatment because if not or go and take treatment, they going to die and buried"</i>[3CC] • <i>"...medication only helps to boost the immune system"</i>[2BB]

	<ul style="list-style-type: none"> • <i>"We are always told at the clinic that we have to be responsible and be faithful in our medications. It is that we can survive for long time"</i>[1AA] • <i>"Treatment only boosts our immune system, increased success in the treatment of HIV infection has prolonged our lives there is increasing beliefs that the disease is not as severe as previously considered, and most people are no more taking care of themself. Protect yourself adhere to medication and avoid substance abuse, otherwise you will die"</i>[8BB] • <i>"...the treatment do not cure AIDS. It can only be controlled"</i>[9CC]
1.2 Health and re-infection	<ul style="list-style-type: none"> • <i>"No, one can still be re-infected and you can still infect other people medication only helps to one to live long life, it doesn't cure the virus or stop it from spreading" [4AA]</i> • <i>"There is a belief concerning HIV treatment that when one feel and looks healthy HIV is cured, no it is not true, HIV can still be transmitted and one can be re-infected, The HIV treatment only put the virus the body in control, currently it clear that there is no cure for HIV" [4AA]</i> • <i>"I do not belief that people living with HIV taking HIV the treatment make their chances of getting to be re-infected or to transmit HIV less"</i>[5BB] • <i>"according to information we get from support groups HIV re-infection can occur even when are healthy because of the use of ARVS"</i>[5BB] • <i>"Treatment makes us healthy and live long, however having unprotected sex with multiple partners are greatest risk for HIV re-infection to PLWHA"</i>[6CC] • <i>"Treatment only boost our immune system (soldiers) but if we continue to misbehave or do silly things there is a big chance to be re-infected or to transmit HIV to other people we love"</i>[3CC] • <i>"No, even if you are under HIV medication you can still be re-infected and you can still infect other people. Because medication only helps to boost the immune system, it doesn't cure the virus or stop it from spreading"</i>[2BB] • <i>"It is not true that people living with HIV taking HIV the treatment make their chances of getting to be re-infected or to transmit HIV are slim"</i>[1AA] • <i>"it does not mean that under HIV treatment one cannot still be re-infected and can still infect other people"</i>[7AA] • <i>"One has the responsibility for protecting self and partner from being re-infected and infecting other people. It is not true that people living with HIV taking HIV the treatment make their chances of getting to be re-infected or to transmit HIV are slim"</i>[9CC] • <i>"The people are spreading wrong information, it is not true that people living with HIV taking HIV the treatment make their chances of getting to be re-infected or to transmit HIV are low, there should be education programmes" [10AA]</i> • <i>"Since we have treatment for HIV, most people on HIV treatment believes that they are less likely to pass HIV on to an HIV-negative sexual partner through unprotected anal sex"</i>[11BB] • <i>"People living with HIV receiving treatment are too at a higher risk for HIV re-infection or transmit HIV to other people"</i>[11BB]

Category 1: Correct understanding of HIV treatment.

As previously discussed in Chapter 2 (cf.2.5) the scaling up of ART has also contributed significantly to the decline of annual new HIV infections around the world, including among children (WHO, UNICEF & UNAIDS 2013:9). Furthermore ART has been shown to reduce HIV-related morbidity and mortality (WHO, UNICEF & UNAIDS 2013:7) (cf. 2.4). In this study the personal experience from participants confirmed that ARV treatment have positive aspects. According to them the treatment has played an important role for they live longer with healthier lives due to the availability of ARV (cf. 1.1, 1.2 in Table 4.6). It was expected that the participants in this study would have a good understanding of HIV treatment, considering the inclusion criteria of the sample population (cf. 3.3.2.2, 3.3.2.3).

Many participants were critical towards people who were still engaging in risk-taking behaviours while they were still on treatment, it was mentioned that when PLWHA felt healthy, because of HIV treatment there were increasing beliefs that the disease was not severe and that they were not taking care of themselves anymore (cf. 2.4). In this study the participants emphasised that ARV treatment is only beneficial when people adhere to their treatment on a daily basis for the rest of their lives, but regardless of taking medication religiously, these people can still be re-infected if engaged in, at risk behaviours. If this is the case barriers to adherence (whether structural, psychological, or social) must be addressed and people need the resources and opportunity to become knowledgeable about the available treatment options so that they can make fully informed decisions (US PLWHA CAUCUS 2011:20) (cf. 2.4).

4.4.3.7 Theme 7: Beliefs about a cure/vaccine for HIV

There is only one category identified in Theme 7, namely: Correct understanding of an HIV cure/vaccine; in Table 4.7 two sub-categories identified in this category are shown.

TABLE 4.7 THEME 7: BELIEFS ABOUT A CURE/VACCINE FOR HIV

Category 1: Correct understanding of an HIV cure/vaccine	
Sub-categories	
1.1 Current situation and options	<ul style="list-style-type: none"> • <i>"No, I don't think there will be vaccine to cure HIV, we are always advised to protect ourselves, being HIV positive should not mean we should sleep around"</i> [3CC] • <i>"No, what I know is that HIV, it is not curable, so everyone is aware of it because HIV has been there for a very long time now there is still no cure for it. There will not be a cure in the future as doctors have worked on it for years with no progress, doctors have tried but failed. In order to avoid HIV you must wear condom to have sex with your partner"</i> [2BB] • <i>"No, there is still no vaccine to cure HIV, so since we are not sure when there will be cure, ten to twenty years, there should be continuing education"</i> [6CC] • <i>"HIV is treatable with the use of ARVs, no progress made till now not curable at all"</i> [4AA] • <i>"No, HIV, it is not curable, there is still no cure for it, as long as I am taking my treatment I am ok, I am faithful to my medication so I look healthy. In order to avoid HIV re-infection please wear condom to have sex with your partner"</i> [7AA] • <i>"No, I know that there is no vaccine to cure HIV, we have been waiting it have been years, so we do not have hope, the treatment that we are taking real helped us a lot especially while we are faithful let's hope for at least for 20 years so because there is neither a cure for HIV/AIDS, nor a vaccine"</i> [8BB] • <i>"Really there is currently no cure for HIV. Let's wait for 20-50 years, according to me as long as treatment is available we are fine especially when we are being faithful to the treatment we take. It is only through treatment that having this opportunity to have access to drugs enhances long and quality of life for HIV-positive people. Because there is neither a cure for HIV/AIDS, nor a vaccine to prevent infection, safe sex practices provide the only protection against sexual transmission"</i> [9CC] • <i>"The cure for HIV let's forget, treatment works may expect that the cure is not coming soon but twenty to fifty years to come, the treatment is available and free it is wise for people living with HIV to adhere to treatment while there is no cure. That all nothing else because it has helped so many people to live longer"</i> [10AA]
1.2 Hope for a future cure	<ul style="list-style-type: none"> • <i>"It has been long years having ARVs over the world and the doctors having discussions about curing AIDS but still no cure, This will take fifty years, so we have to be faithful to our treatment, it has been working for years"</i> [3CC] • <i>"...maybe if we pray hard it will take maybe 30 to 50 years"</i> [2BB] • <i>"Yes think cure for HIV is coming but twenty years to come, as much as we did not have treatment long time ago, but now the treatment is available in almost every clinics or hospitals so it is good to people living with HIV to adhere to treatment while there is no cure"</i> [1AA] • <i>"...we have learnt that the cure for HIV will come, not soon maybe hundred years I guess"</i> [5BB] • <i>"...ten to twenty years"</i> [6CC]

	<ul style="list-style-type: none"> • "...maybe 30 years"[4AA] • "No, HIV, it is not curable, there is still no cure for it and there will not be a cure in the near future, it will take maybe 30 years maybe really I do not know"[7AA] • "Let's wait for 20-50 years"[9CC] • "The cure for HIV maybe the within 20 years to come, I encourage people to use protection on every sexual activity and maybe the vaccine will be expensive so people like as with low income cannot afford to pay for it"[11BB]
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Category 1: Correct understanding of an HIV cure/vaccine

There was a common understanding among the participants that HIV is treatable with the use of ART, but that there is still no vaccine to cure HIV (cf. 1.1, 1.2 in Table 4.7). The lack of an effective HIV vaccine means prevention through behavioural change is the most important available strategy to reduce new infections (Bonell & Imrie 2001:155).

The debate and research on HIV vaccine is on-going, Bill Gates predicted that a vaccine and a cure for HIV will become a reality within the next 15 years by 2030 (Johnston & Agencies 2015:online), therefore, at the moment it is vital to prevent HIV infection through other mechanisms, such as preventive interventions that include condom use and HIV testing, which is often coupled with behavioural change, counselling and treatment to reduce viral load.

The participants in this study indicated that while researchers are still discovering a cure for HIV and AIDS, presently HIV treatment is the only hope since it prolongs their lives and make them look healthy. There was also a great awareness among the participants that the cure is not coming any sooner (cf. 1.1, 1.2 in Table 4.7). UNICEF, UNAIDS and WHO (2002:5) advise that, since there is no cure or vaccine for HIV and AIDS, prevention of new infections must be the corner stone for combating HIV and AIDS, preventive measures should be through educating people that these are the only vaccine available for this disease (cf. 2.5).

4.4.3.8 Theme 8: HIV risk-taking behaviours to inform PLWHA about

Theme 8 has three associated categories that emerged, namely: Category 1, Risk-taking behaviours; Category 2, Adherence to medicine; and Category 3, Correct information.

The sub-categories identified under each category are illustrated in Table 4.8 and will be discussed.

Previous themes already highlighted several risk-taking behaviours identified in PLWHA in Lesotho. The final question in the interview was asked to establish which of the risk-taking behaviours (that the sample population identified) deserve attention.

TABLE 4.8 THEME 8: HIV RISK-TAKING BEHAVIOURS TO INFORM PLWHA ABOUT

Category 1: Risk-taking behaviours	
Sub-categories	
1.1 Safe sex practices	<ul style="list-style-type: none"> • "...what it means for something to be safe, even when you're just talking about a kiss, there should be a condom in front of you in order to have safe sex"[3CC] • "To prevent reinfection, safer sex should always happen in every sexual activity...the couple should use condoms whether they like it or not"[3CC] • "They should always protect themselves from HIV, use condoms at all times"[1AA] • "...always use condoms at all times" [5BB] • "...should know how to protect themselves, safer sex always, abstain or use condom"[6CC] • "To prevent re-infection, safer sex should always happen in every sexual activity as educators have recommended. The couple should use condoms whether they like it or not and continue to. Risk behaviours such as unprotected sex, should be avoided"[8BB] • "Having protection in all sexual acts"[9CC] • "People should always protect themselves when having sex to protect them from HIV, (pause) use condoms at all times"[10AA] • "Use condoms at all times avoid unprotected sex please"[11BB]
1.2 Destructive behaviours	<ul style="list-style-type: none"> • "My last advise is, people should avoid alcohol and drugs, these cannot solve problems"[2BB] • "...not mix medication with alcohol"[1AA] • "I also discourage sexual abuse, rape and transactional sex, often with older men, and multiple partners to proof manhood"[5BB] • "...avoid negative destroying norms such as encouraging men to have many multiple sex partners" [6CC] • "...no transactional sex for women" [6CC] • "Use of substance abuse which is a fashion..." [7AA] • "Risk behaviours such as unprotected sex, multiple sex partners, substance use, and sex exchange for money should be avoided" [8BB] • "Let's avoid using drugs and alcohol"[9CC] • "Having multiple sexual partners should be avoided by all means especially it is influenced much under the influence of substance abuse"[11BB]

Category 2: Adherence to medicine	
2.1	<ul style="list-style-type: none"> • <i>"People living with HIV and AIDS should understand that living with HIV and AIDS is similar to living with any other disease and therefore they need to take their medication"</i>[3CC] • <i>"Continue to take the medications to remain healthy and in reducing risks of reinfection"</i>[3CC] • <i>"Most people when they recover they do not take their medication. They should be informed about sticking to HIV treatment even though there are so many challenges we are facing which in most cases discourage ART treatment. Some of the religions and our communities give advice to pray or use herbal medication I think this is a bad teaching to discouraging us from taking medicines"</i> [2BB] • <i>"...not skipping medication"</i>[1AA] • <i>"Should at all times use treatment well to prevent transmission to HIV-negative partners"</i>[1AA] • <i>"...adhere to medication"</i>[5BB] • <i>"...adhere to your medications"</i>[6CC] • <i>"...adhere to treatment"</i>[6CC] • <i>"They should be informed about sticking to HIV treatment even though there are so many challenges we are facing which in most cases discourage ART treatment"</i>[7AA] • <i>"...be faithful to medications in order to remain healthy and in reducing risks of re-infection"</i>[8BB] • <i>"...adhering to our medication is important to all of us"</i>[9CC] • <i>"...be faithful to our medication, not skip medication"</i>[10AA] • <i>"They should be informed about sticking to HIV treatment"</i>[2BB]
Category 3: Correct information	
Sub-categories	
3.1 Informed about prevention	<ul style="list-style-type: none"> • <i>"Medical male circumcision"</i>[6CC] • <i>"...the prevention of virus of transmission to the unborn child"</i> [7AA] • <i>"The prevention of unintended pregnancies among HIV-infected women"</i>[7AA]
3.2 Reliable information sources	<ul style="list-style-type: none"> • <i>"...people should avoid misleading friends who pressurise us to do risky behaviours"</i>[10AA] • <i>"People should go away from negative people, because they provide wrong information"</i>[11BB] • <i>"...stick to factual information"</i>[5BB] • <i>"...always find information to reliable sources"</i>[5BB] • <i>"...stop spreading wrong information purposely"</i>[5BB]
3.3 Support groups	<ul style="list-style-type: none"> • <i>"...go support groups where we get right information"</i> [5BB] • <i>"...go to support groups and our clinic sessions to get useful education"</i>[6CC] • <i>"...high levels of stress and stress place demands especially on women's ability to attend to the tasks associated and concerns regarding basic daily needs e.g., finances, food, rent, child care, and their general health care my advice is take steps over protecting oneself from HIV re- infection and infecting other people"</i>[8BB]

	<ul style="list-style-type: none"> • "Avoid taking information...unreliable sources. Let's go to the clinics nearby and attend support groups it is the only reason we cannot get misled"[9CC] • "...people should visit to the clinic or attend peer education session in the factory"[11BB]
3.4 Know and disclose your status	<ul style="list-style-type: none"> • "...knowing ones status is important"[5BB] • "...free to disclose their status"[6CC] • "...non-disclosure among people living with HIV and AIDS can lead to HIV transmission" [7AA] • "People should be free to disclose their status; this will help us even more to get the support to our family and friends"[10AA] • "...what is more painful is most of people living with HIV and AIDS are not able to disclose their HIV status to their sexual partners" [11BB]

These findings in Theme 8 are found to be consistent with HIV risk-taking behaviours that have been mentioned in previous themes outlined in this chapter (cf. 4.4.3.1 – 4.4.3.8). A summary of the factors associated with HIV risk-taking behaviours is presented in Figure 4.5.



Figure 4.1: FACTORS ASSOCIATED WITH HIV RISK-TAKING BEHAVIOURS
Mabathoana 2016.

Category 1: Risk-taking behaviours

Unprotected sex was one of the HIV risk-taking behaviours which seemed to dominate a lot of discussions in this study (cf. 4.4.3.1 – 4.4.3.8). Findings in this theme revealed that there is a need to inform PLWHA about safer sex practices. Safer sex are choices adopted by individuals to reduce the chances of re-infection and HIV transmission, mostly by correct and consistent condom use and reducing the number of sexual partners (UNAIDS 2011:25). Preventive programmes addressing this issue should especially address the myths and misconceptions about HIV and AIDS infection as well as transmission with relation to perceptions about condom use (cf. 4.4.3.5). In addition the sample population requested to inform PLWHA about various destructive behaviours as practiced by many (cf. 1.2, Table 4.8).

Category 2: Adherence to medicine

Based on previous explanations from Chapter 2 (cf. 2.6.1.2; 4.6, 4.7) adherence to HIV medicine is a key factor in HIV treatment. In one study strict adherence to HIV medication was found to be essential for maintaining therapeutic levels of antiretroviral and avoiding the development of drug-resistant HIV strains (Kelly & Kalichman 2002:631). Participants in this study indicated that the importance of HIV treatment adherence should also be communicated to PLWHA. This is probably due to the cohort having had first-hand experience about being informed about HIV treatment and taking treatment themselves. Several successful HIV treatment interventions is already in place in Lesotho.

Category 3: Correct information

Several components of the findings in this study indicated that a lack of knowledge especially of one's own HIV status and disclosing one's status to partners are critical elements contributing to PLWHA practising HIV risk-taking behaviours (cf. 4.1; 4.2; 4.5). Concerning was the fact that PLWHA seem to commonly obtain wrong information from unreliable sources and there was a need for correct information to be distributed amongst everyone living in Lesotho regardless of their HIV status. Communities should be informed about reputable sources from which HIV and AIDS information can be obtained and these resources should be available throughout the whole of Lesotho to ensure that it reaches those in rural areas too.

In terms of HIV prevention three aspects were highlighted which PLWHA should be informed about including: Voluntary Medical Male Circumcision (VMMC), PMTCT and the prevention of unintended pregnancies amongst HIV.

In terms of PMTCT and the prevention of unintended pregnancies amongst HIV positive women, HIV prevention initiatives in Lesotho seem to be successful (cf. 2.5.1.2) but more work is still required since only 62% of HIV positive pregnant women received treatment (in 2015) (Makamure & Glenwright 2015:online). Educational initiatives in schools and workplaces could therefore continue to inform girls and young women about HIV and pregnancy (cf. 2.6).

The majority of participants perceived a support group as an important strategy for acquiring correct HIV related knowledge and having a platform to interact and share ideas in how to cope with their HIV concerns (cf. 3.3, in Table 4.8). In addition PLWHA can gain a better understanding of side effects and other negative consequences but at the same time improve their ability to confront adverse situations about HIV treatment in participating in support groups (WHO 2005:3). This justifies the strengthening of support groups, as one of the strategies for providing reliable information and promoting social support among PLWHA.

4.5 CONCLUSION

The findings of the semi-structured interviews were presented in this chapter. The demographic details of the participants were discussed with the illustration of displayed figures and tables. The last section discussed the themes and sub-categories that emerged from the data.

In the next chapter, Chapter 5, the concluding thoughts on the findings are presented, followed by a conclusion of the study with some recommendations, a short discussion on the limitations of the study, and ends with a concluding remark.

CHAPTER 5

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

A detailed study was done with the intention to identify factors related to HIV risk taking behaviours amongst PLWHA in Lesotho.

The aim of Chapter 5 is to provide a brief overview of the study and to present some concluding thoughts on the findings. This chapter commences with an overview, followed by a conclusion of the study with some recommendations, a short discussion on the limitations of the study, and ends with concluding remarks

5.2 OVERVIEW OF THE STUDY

The research was conducted and based on two research questions. The questions were designed to address a gap identified in the body of knowledge regarding information on factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho (cf. 1.2; 1.3).

5.2.1 Research question 1

The research question was stated as: How can the factors associated with HIV risk-taking behaviours amongst PLWHA be conceptualised and contextualised as a theoretical framework?

In order to address this question the following objective was pursued: To conceptualise and contextualise the factors associated with HIV risk-taking behaviours amongst PLWHA as a theoretical framework a detailed literature study was completed. The main findings are summarised as follows:

- In spite of the success of prevention and treatment made worldwide there are still a number of new HIV infections as well as HIV related deaths occurring. Sub-Saharan

African countries are still mostly affected by this epidemic with Lesotho having the second highest prevalence rate at 23.2% (cf. 2.3).

- PLWHA now live longer and healthier lives due to the greater availability of ARTs however a major challenge in the health management of PLWHA is vulnerability to re-infection, risk in accordance with other diseases and the chance of transmitting the infection (cf. 2.4).
- Currently there is no cure for HIV and AIDS however, HIV therapy has been successful to slow down the viral replication in PLWHA. There have been several HIV and AIDS preventive programmes developed to address the epidemic. Even though many of these programmes have had varying degrees of success worldwide, there is evidence that some have failed to reach highly vulnerable populations (cf. 2.5).
- According to literature factors related to HIV risk-taking behaviours that could lead to HIV and AIDS re-infection and HIV transmission can be summarised as follows:
 - Underlying determinants: (a) demographic factors such as sex, age, marital status, mobility and residence;(b) socioeconomic for example income, education and occupation; (c) sociocultural including culture, ethnicity, gender and religion; and (d) Psychosocial implications resulting from HIV (cf. 2.7.1); and
 - Proximate determinants: risky sexual behaviour and practices (including multiple sex partners, type of sex partners, condom use, STI history, substance abuse and treatment optimism) (cf. 2.7.2).
- Many researchers have called for increased attention to three theories explaining HIV and AIDS risk taking behaviours; they include Social Cognitive Theory (SCT), Health Belief Model (HBM) as well as the Risk Reduction Model (ARRM) (cf. 2.6).

5.2.2 Research question 2

The research question was stated as: What are the factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho?

In order to address this question the following objective was pursued to identify and describe factors associated with HIV risk-taking behaviours amongst PLWHA in Lesotho semi-structured interviews were conducted. The interviews were conducted with factory workers (cf. 3.3.3.2; 3.3.3.3) in the Maseru district of Lesotho. The findings were detailed and discussed in Chapter 4. The main findings are summarised as follows:

- The demographic information of the participants showed that there were more females than males who participated in the interviews. This correlates well with the female to male ratio of factory workers who forms part of the ALAFA support groups. The majority of participants were married and had one partner only, and of those not married some wanted children in the future. Only one participant studied up to a tertiary level. Participants mostly grew up in small towns but resided in bigger cities in view of work availability (cf. 4.4.1).

To identify the factors associated with HIV risk-taking behaviours eight themes were recognised, namely: (1) Theme 1: Meaning of HIV risk taking behaviour, (2) Theme 2: Risk for HIV re- infection (3); Theme 3: HIV transmission risk behaviours (4); Theme 4: Peer influence HIV risk behaviours (5); Theme 5: Society influence HIV risk behaviours (6) Theme 6: Beliefs about HIV treatment (7); Theme 7: Beliefs about HIV cure/vaccine; (8) Theme 8: Healthy HIV behaviours to be taken into consideration.

The risk-taking behaviours identified were categorised into the following broad factors:

- (a) Socioeconomic factors included ignorance about HIV transmission, treatment access, substance abuse, poverty, transactional sex, *etc.* (cf. 4.2; 4.3; 4.5).
- (b) Sociocultural factors covered aspects such as lack of communication about sex issues, high rate of multiple concurrent partners, HIV non-disclosure, gender discrepancies as well as stigma and discrimination, beliefs about HIV treatment, peer pressure *etc.* (cf. 4.2; 4.3; 4.4; 4.5).
- (c) Psychosocial behavioural factors comprised of stress and depression, desire to have children, HIV treatment non-adherence, HIV non-disclosure, stigma and discrimination *etc.* (cf. 4.3).

The participants reported a need to address the following HIV-risk-taking behaviours: education about safe sex practices, how to manage destructive behaviours associated with risk-taking behaviours, and the importance of adherence to HIV treatment. Furthermore there was a request for correct information from reliable sources to be more readily available to everyone in Lesotho (not only PLWHA) as well as for support groups to address HIV risk-taking behaviours (cf. 4.4.3.8).

5.3 CONCLUSION OF THE STUDY

The researcher first conducted a literature study to form the theoretical basis of the study in order to provide scientific evidence, while semi-structured interviews were used to gain insight about factors associated with the HIV risk-taking behaviours among PLWHA in Lesotho.

The factors associated with the HIV risk-taking behaviours which were found in this research study were consistent with the HIV risk-taking behaviours found in the literature (cf. Chanter 4).

Whilst acknowledging the contribution made by current HIV prevention and treatment services provided in Lesotho there was a perception that:

- PLWHA still practise risky sexual behaviours such as:
 - having unprotected sex;
 - abusing various substances which leads to practicing risky sexual behaviours;
 - having multiple sex partners;
 - participating in transactional sex;
 - not having HIV testing;
 - not disclosing their HIV status;
 - not participating in HIV risk reduction measures such as VMMC;
 - HIV positive females not seeking medical attention during pregnancy; and
 - HIV treatment optimism.
- Reasons as to why PLWHA are still engaging in risky sexual behaviours include:
 - lack of knowledge about HIV (prevention, treatment, management, re-infection, transmission etc.);
 - poverty;
 - peer pressure;
 - cultural beliefs and practices;
 - stigma and discrimination;
 - gender inequality;
 - misperceptions about HIV and AIDS;
 - fear of losing their partners, friends and jobs; and
 - obtaining wrong information from unrepeatable sources.

The findings of the semi-structured interviews, combined with those of the literature study assisted the researcher by providing an understanding about factors associated with the HIV risk-taking behaviours among PLWHA in Lesotho. This work already serve as a basis for further investigation in the field.

It is recommended that further investigations is done to establish if the HIV risk-taking behaviours as identified in this study is present in the greater Basotho population. This should be done before recommendations for decision-makers in health departments and community-based organisations as well other stakeholders in the prevention of HIV and AIDS in Lesotho can be proposed.

5.4 LIMITATIONS OF THE STUDY

The following limitations were recognised in this study:

In view that some of the interviews had to be conducted during a lunch hour or after work hours it could have been possible that some of the interviewees responses to each question were shorter as they might have been in a rush to get back to work or to get home. This was not perceived by the researcher to have an impact on the findings since the available discussions offered enough information.

The researcher was of the opinion that due to the fact that the topic discussed was of a sensitive nature, some participants had additional personal and/or emotional concerns which they wished to discuss at length. The researcher then had to, on occasion, bring the discussions back to the question at hand in order to obtain the required information to address the research questions. These participants were debriefed at the end of the interview and also referred for counselling.

The study was conducted in Lesotho; in the Maseru district, in three textile and clothing factories and did not cover all the districts nor PLWHA in Lesotho. Therefore the findings of this study were limited to PLWHA in these three textile and clothing factories and the Maseru district. In order to generalise the findings of this study to the larger Lesotho population, further research into the PLWHA in the greater Lesotho is proposed.

5.5 RECOMMENDATIONS

That the findings of this research be made available to the decision-makers in health departments and community-based organisations as well as other role-players. Dissemination of the research findings will be aimed at providing an understanding of factors associated with the HIV risk-taking behaviours among PLWHA in Lesotho. These findings could already be used to make recommendations for HIV positive preventive programmes for PLWHA working in the textile industry, in the Maseru district. Further research is however recommended to generalise the findings of this study to all PLWHA in Lesotho. This will be beneficial as it could assist all stakeholders' country wide to intensify HIV positive preventive programmes for PLWHA.

5.7 CONCLUSIVE REMARK

Research in this field of HIV prevention is on-going and HIV preventive programmes are constantly evolving as new HIV issues are emerging. The lack of an effective HIV vaccine or a cure for HIV and AIDS demonstrates a need to understand factors associated with the HIV risk-taking behaviours among PLWHA. The findings of this study supported the need for continued research to identify HIV risk-taking behaviours among PLWHA country wide in order to decrease their risk of transmitting HIV to others and to protect themselves from being re-infected or contracting other sexually transmitted diseases.

REFERENCES

Adebiyi, I. & Ajuwon, A. J. (2015). Sexual Behaviour and Serostatus Disclosure among Persons Living With HIV in Ibadan, Nigeria. *Afr. J. Biomed. Res* 18(2):69-80.

AED (Academy for Educational Development) Centre on AIDS & Community Health. (2004). Best Practices in Prevention Services for Persons Living with HIV. United States of America: Washington DC.

ALAFA (Apparel Lesotho Alliance to fight AIDS). (2006). Peer Educator's Guide revised in 2013. The ALAFA team. Maseru Lesotho.

ALAFA (Apparel Lesotho Alliance to fight AIDS). (2009). Follow-up HIV Zero-Prevalence Study Report. The ALAFA team. Maseru: Lesotho.

Ansell, N. (2009). Embodied learning: responding to AIDS in Lesotho's education sector. *Children's Geographies*. 7(1):21–36. DOI:10.1080/14733280802630981.

Apanga, P. (2014). HIV and AIDS-related stigma and discrimination in Sub-Saharan Africa: A Review. *Journal of Natural Sciences Research* 4(21):41-49.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2919838/>

Retrieved on 2 February 2016.

Aska, M., Chompikul, J., Keiwkarnka, B. (2011). Determinants of fertility desires among HIV positive women living in the Western Highlands Province of Papua New Guinea. *World Journal of AIDS* 1:198-207. doi:10.4236/wja.2011.14029.

<http://dx.doi.org/10.4236/wja.2011.14029>

Retrieved 5 February 2016.

Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R. & Puren, A. (2005). Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk. The ANRS 1265 Trial. *PLoS Med.* 2(11):e298.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1262556/pdf/pmed.0020298.pdf>

Retrieved on 14 February 2016.

AVERTing HIV and AIDS. (2015a). HIV and AIDS in Lesotho.

<http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/lesotho>

Retrieved on 14 February 2016.

AVERTing HIV and AIDS. (2015b). HIV and AIDS in Swaziland.

<http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/swaziland>

Retrieved on 14 February 2016.

Babbie, E. (2007). *The practice of social research*. (11th Ed.). Belmont: Thompson.

Babbie, E. & Mouton, J. (2001). *The practice of social research*. Cape Town: Oxford University Press.

Baidoobonso, S.M. (2013). An Exploration Of The Relationships Between Markers Of Social Status And Position And HIV Risk Behaviours In African, Caribbean, And Other Black Populations (Unpublished Ph.D. thesis.). The University of Western Ontario.

Bandura, A. (1990). Selective Activation and Disengagement of Moral Control. *Journal of Social Issues* 46(I):27-46.

<https://web.stanford.edu/dept/psychology/bandura/pajares/Bandura1990JSI.pdf>

Retrieved on 4 January 2016.

Bauermeister, J.A., Carballo-Diéquez, A., Ventuneac, A. & Dolezal, C. (2010). Assessing motivations to engage in intentional condomless anal intercourse in HIV-risk contexts ("bareback sex") among men who have sex with men. *AIDS Educ Prev* 21(2):156-168.

doi: [10.1521/aeap.2009.21.2.156](https://doi.org/10.1521/aeap.2009.21.2.156)

Bennell, P. Hyde, K. & Swainson, N. (2002). The impact of the HIV/AIDS epidemic on the education sector in Sub-Saharan Africa: A synthesis of the findings and recommendations of three country studies. Centre for International Education University of Sussex Institute of Education.

http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/1127_644%20Synthesis.pdf

Retrieved on 4 January 2016.

Blackwell-Hardie, V.K.D. (2009). A thesis submitted in conformity with the requirements for the degree of Master of Arts Department of Adult Education and Counselling Psychology. (Unpublished MA Thesis). University of Toronto Canada.

Boerma, J. T. & Weir, S.S. (2005). Integrating Demographic and Epidemiological Approaches to Research on HIV/AIDS: The Proximate-Determinants Framework. *The Journal of Infectious Diseases* 1(191):Suppl 1:S61–67.

Bogart, L.M., Skinner, D., Weinhardt, L.S., Glasman, L., Sitzler, C., Toefy, Y. & Kalichman, C. K. (2011). HIV misconceptions associated with condom use among black South Africans: An exploratory study. *Afr J AIDS Res* 10(2):181–187. doi:10.2989/16085906.2011.593384.

Boler, T. (2003). The sound of silence: difficulties in communicating on HIV/AIDS in schools.

<http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/HIV%20AIDS%20187.pdf>

Retrieved on 10 January 2015.

Bonell, C. & Imrie, J. (2001). Behavioural interventions to prevent HIV infection: rapid evolution, increasing rigour, moderate success. *Br Med Bull* 58(1):155-170. doi: 10.1093/bmb/58.1.155.

Bowen, G.A. (2005). From Qualitative Dissertation to Quality Articles: Seven Lessons Learned. *The Qualitative Report* 15(4):864-879.

Bulled, N.L. (2015). Hesitance towards voluntary medical male circumcision in Lesotho: Reconfiguring global health governance. *Global Public Health: An International Journal for Research, Policy and Practice* 10(5-6):757-772.

DOI:10.1080/17441692.2014.962559.

Bunnell, R., Mermin, J., & De Cock, K.M. (2006). HIV prevention for a threatened continent: Implementing positive prevention in Africa. *Journal of the American Medical Association* 296(7):855-858.

Burns, N. & Grove, S.K. (2005). *The Practice of Nursing Research: Appraisal, synthesis and generation of evidence*. (6th Ed.). St. Louis, Missouri: Saunders Elsevier.

Cambiano, V.O., Connor, J., Phillips, A.N., Rodger, A., Lodwick, R., Pharris, A., Lampe, F., Nakagawa, F., Smith, C. & van de Laar, M.J. (2013). Antiretroviral therapy for prevention of HIV transmission: Implications for Europe. *Eurosurveillance* 18(48):1-23. <http://www.eurosurveillance.org/images/dynamic/EE/V18N48/art20647.pdf>
Retrieved on 10 January 2015.

Catania, J.A., Kegeles, S.M. & Coates, T.J. (1990). Towards an understanding of risk behavior: an AIDS risk reduction model (ARRM). *Health Educ Q* 17(1):53-72.

CDC (Centres for Disease Control and Prevention). (2010) Fact Sheet: The Role of STD Prevention and Treatment in HIV Prevention. <http://www.cdc.gov/std/hiv/stds-and-hiv-fact-sheet.pdf>
Retrieved on 10 January 2015.

CDC (Centres for Disease Control and Prevention). (2006). Multidrug-Resistant Organisms in Healthcare Settings. <http://www.cdc.gov/mmwr>.

Cherie, C. & Berhane, Y. (2012). Peer pressure is the prime driver of risky sexual behaviours among school adolescents in Addis Ababa, Ethiopia. *World Journal of AIDS* 2:159-164. <http://dx.doi.org/10.4236/wja.2012.23021>.

Chinyama, E.P. (2013). Living with HIV and AIDS in King Williams Town, Eastern Cape. *Journal of Academic Research in Business and Social Sciences* 3(11):16-43. DOI: 10.6007/IJARBSS/v3-i11/317.

Choudhry, V., Ambresin, A.E., Nyakato, V.N. & Agardh, A. (2015). Transactional sex and HIV risks evidence from a cross-sectional national survey among young people in Uganda. *Glob Health Action* 21(8):27249. Doi: 10.3402/gha.v8.27249. <http://www.ncbi.nlm.nih.gov/pubmed/26001780>
Retrieved on 28 February 2016.

Cheli, P.M. (2015) Lesotho circumcises more than 100,000 males. Public Eye online. <http://www.publiceyenews.com/site/2015/08/31/lesotho-circumcises-more-than-100000-males/>

Chipatiso, L.M., Machisa, M., Nyambo, V. & Chiramba, K. (2014). *The gender-based violence indicators Study Lesotho*. Gender Links Lesotho. GBV Indicators Research in Lesotho. Gender Links. Cyrildene, Johannesburg: South Africa. <http://www.genderlinks.org.za/article/gender-based-violence-indicators-study-lesotho-2015-02-27>

Chun, H.M., Carpenter, R.J., Macalino, G.E. & Crum-Cianflone, N.F. (2013). The Role of Sexually Transmitted Infections in HIV-1 Progression: A Comprehensive Review of the Literature. *J Sex Transm Dis* 2013:1-15. Doi: 10.1155/2013/176459.

Clarke, D. J. & Aggleton, P. (2012). Skills-Based HIV Education and Education for All. Background paper prepared for the Education for All Global Monitoring Report 2012 Youth and skills: Putting education to work. United Nations Educational, Scientific and Cultural Organization. <http://unesdoc.unesco.org/images/0021/002178/217866e.pdf>

Cleary, P.D., Van Devanter, N., Rogers, T., Singer, E., Shipton-Levy, R., Steilen, M., Stuart, A., Avorn, J. & Pindyck, J. (1991). Behavior changes after notification of HIV infection. *American Journal of Public Health* 81:1586–1590.

Cloete, A., Strebel, A., Simbayi, L., Van Wyk, B., Henda ,N. & Nqeketo, A. (2010). Challenges Faced by People Living with HIV/AIDS in Cape Town, South Africa: Issues for Group Risk Reduction Interventions. *AIDS Research and Treatment* 2010:1-8. <http://dx.doi.org/10.1155/2010/420270>.

Coburn, B.J., Okano, J.T. & Blower, S. (2013). Current drivers and geographic patterns of HIV in Lesotho: implications for treatment and prevention in Sub-Saharan Africa. *BMC Medicine* 11(224):1-11. DOI: 10.1186/1741-7015-11-224. <http://www.biomedcentral.com/1741-7015/11/224>

Cohen, L., Manion, L. & Morrison, K. (2007). *Research methods in education*. (6th Ed.). London: Routledge. Current drivers and geographic patterns of HIV in Lesotho: implications for treatment and prevention in Sub-Saharan Africa.

Corno, L. & De Walque, D. (2007). The determinants of HIV infection and related sexual behaviors: Evidence from Lesotho. World Bank Policy Research Working Paper Series 4421.

[http://siteresources.worldbank.org/EXTHDOFFICE/Resources/5485726-1334870720628/8597105-1334870813980/Lesotho Evaluation Report.pdf](http://siteresources.worldbank.org/EXTHDOFFICE/Resources/5485726-1334870720628/8597105-1334870813980/Lesotho_Evaluation_Report.pdf)

Retrieved on 5 February 2016.

Corno, L. & De Walque, D. (2012). Mines, migration and HIV/AIDS in Southern Africa. *Journal of African Economies* 21(3):465-498. doi: 10.1093/jae/ejs005.

<http://jae.oxfordjournals.org/content/21/3/465.full.pdf+html>

Retrieved on 5 February 2016.

Cotton, S., Puchalski, C.M., Susan, N.S., Joseph, M., Amy, H.P., Feinberg, J., Pargament, K.I., Justice, A.C., Leonard, A.C., Tsevat, J. (2006). Spirituality and Religion in Patients with HIV and AIDS. *J Gen Intern Med* 21(5):S5–13.

Crepaz, N. & Marks, G. (2002). Towards an understanding of sexual risk behaviour in people living with HIV: a review of social, psychological, and medical findings. *AIDS* 16(2):135–49.

Crepaz, N., Lyles, C.M., Wolitski, R.J., Passin, W.F., Rama, S.M., Herbst, J.H., Purcell, D.W., Malow, R.M., Stall, R. & HIV/AIDS Prevention Research Synthesis (PRS) Team. (2006). Do prevention interventions reduce HIV risk behaviours among people living with HIV? A meta-analytic review of controlled trials. *AIDS* 20(2):143–157.

Creswell, J.W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd Ed.). Los Angeles: SAGE Publications Inc.

Creswell, J.W. (2014). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. (4th Ed.). Los Angeles: SAGE Publications Inc.

CWHA (Centre for Women and HIV Advocacy). (2011). *Issues in HIV Policy: Poverty and Risk Factors for HIV*. New York

Denzin, N.K. & Lincon, Y.S. (2000). Strategies of inquiry. In Denzin, N.K. & Lincon, Y.S (Eds). *Handbook of qualitative research*. Thousand oaks, California: SAGE Publications Inc.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. (2011). *Research at grass roots: For the social sciences and human service professions*. (4th Ed.). Pretoria: Van Schaik Publishers.

Dicicco-Bloom, B. & Grabtree, B.F. (2006). The qualitative research interview. *Med Educ*40(4):314-21.

DiClemente, R.J., Wingood, G.M., Del Rio, C., & Crosby, R.A. (2002). Prevention interventions for HIV positive individuals. *Sexually Transmitted Infections* 78:393-395. doi:10.1136/sti.78.6.393.

Duffy, L. (2005). Suffering, shame, and silence: The stigma of HIV/AIDS. *Journal of the Association of Nurses in AIDS Care* 16(1):13–20. doi: 10.1016/j.jana.2004.11.002.

Emler, C.A., Tozay, S. & Raveis, V.H. (2011). "I'm not going to die from the AIDS": Resilience in aging with HIV Disease. *Gerontologist* 51(1):101-11. doi: 10.1093/geront/gnq060.

Engel, M. (2015). HIV vaccine trial opens in South Africa. Fred Hutch News Service. <https://www.fredhutch.org/en/news/center-news/2015/02/hiv-vaccine-clinical-trial-launches-in-south-africa.html>

Retrieved on 20 January 2016

Esterberg, K.G. (2002). *Qualitative methods in social research*. Boston, MA: McGraw-Hill.

Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. Sydney: Allen & Unwin.

Ezeokana, J.O., Nnedum, O.A.U. & Madu, S.N. (2009). Pervasiveness of Poverty among People Living with HIV/AIDS in South Eastern Nigeria. *J Hum Ecol* 25(3):147-159.

Family Health International. (1996). Behaviour Change – A Summary of Four Major Theories.

<https://www.k4health.org/sites/default/files/Summary%20of%20BC%20theories.pdf>

Retrieved on 6 June 2014

Fisher, A.A. & Foreit, J.R. (2002). *Designing HIV/AIDS intervention studies: An operations research handbook*. New York: The Population Council.

Fisher, J.D., & Fisher, W.A. (2000). Theoretical Approaches to Individual-Level Change in HIV Risk Behaviour. CHIP Documents, Paper 4.

http://digitalcommons.uconn.edu/cgi/viewcontent.cgi?article=1003&context=chip_docs

Retrieved on 6 June 2014

Fisher, J.D. & Smith, L. (2009). Secondary Prevention of HIV Infection: The Current State of Prevention for Positives. *Curr Opin HIV AIDS* 4(4):279–287.

Fleming, D.T. & Wasserheit, J.N. (1999). From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sex Transm Infect* 75(1):3–17.

Flick, U. 2009. An introduction to qualitative research. (4th Ed.). Thousand Oaks, California: SAGE Publications Inc.

Gerbi, G.B., Habtemariam, T., Tameru, B., Nganwa, D. & Robnett, V. 2011. A comparative study of substance use before and after establishing HIV infection status among people living with HIV/AIDS A comparative study of substance use. *Journal of Substance* 16(6):464–475. DOI: 10.3109/14659891.2010.495820

Gerbi, G.B., Habatemariam, T., Robnett, V., Nganwa, D. & Tamaru, B. (2012). The association between religious affiliation and frequency of attendance at religious services on HIV risky behaviours among people living with HIV/AIDS. *J AIDS HIV Res* 4(5):136-143.

Gilliam, P.P. & Straub, D.M. (2009). Prevention with Positives: A Review of Published Research, 1998-2008. *Journal of the Association of Nurses in AIDS Care* 20(2):92-109.

Glanz, K., Rimer, K. & Viswanath, K. (Eds.) (2008). *Health Behaviour and Health Education Theory, Research, and Practice*. (4th Ed.). San Francisco: Jossey-Bass.

http://fhc.sums.ac.ir/files/salamat/health_education.pdf

10 January 2016.

PWG (Global HIV Prevention Working Group). (2008). Behaviour Change and HIV Prevention: (Re)Considerations for the 21st Century.

https://www.malecircumcision.org/sites/default/files/document_library/PWG_behavior_report_FINAL.pdf

Retrieved 20 December 2015.

Goddard, W. & Melville, S. (2001). *Research Methodology: An Introduction*. (2nd Ed.). Landsdowne: Juta and Co Ltd.

Gordillo, V., Fekete, E.R., Platteau, T., Antoni, T.M. & Schneiderman, N., Nöstlinger C; & Eurosupport Study Group. (2009). Emotional support and gender in people living with HIV: effects on psychological well-being. *J Behav Med* 32(6):523–531. doi: 10.1007/s10865-009-9222-7.

GoL MOET (Government of Lesotho. Lesotho Ministry of Education and Training). (2005). *Education Sector Strategic Plan 2005-2015*. Maseru, Lesotho.

<http://www.unesco.org/education/edurights/media/docs/11a1cd1054eebdfd5af318634aa1307aca7fc688.pdf>

Retrieved 20 December 2015.

GoL MOHSW (Government of Lesotho. Ministry of Health and Social Welfare). (n.d.). *PHC Revitalisation Action Plan 2011-2017*. Maseru, Lesotho.

http://www.nationalplanningcycles.org/sites/default/files/country_docs/Lesotho/lesotho_phc_action_plan_2011_2017_draft_submitted_to_moh_3_2_5.pdf

Retrieved 20 December 2015.

GoL MOHSW (Government of Lesotho. Ministry of Health and Social Welfare). (2010). *Lesotho Demographic and Health Survey 2009*. Maseru, Lesotho. MOHSW.

http://dhsprogram.com/pubs/pdf/FR241/FR241%5BNEW_completeHHQst_3March2012%5D.pdf

Retrieved 20 December 2015.

GoL MOHSW (Government of Lesotho. Ministry of Health and Social Welfare). (2011). *National Strategy to Eliminate Mother to-Child Transmission of HIV*. Maseru, Lesotho: MOHSW.

http://emtct-iatt.org/wp-content/uploads/2012/11/Lesotho_National-EMTCT-Plan_2011.pdf

Retrieved 20 December 2015.

GoL MOHSW (Government of Lesotho. Ministry of Health and Social Welfare). (2012). *National HIV and AIDS Estimates for Lesotho*. Maseru, Lesotho: MOHSW.

<http://www.unaids.org/sites/default/files/country/documents//file,68395,fr..pdf>

Retrieved 20 December 2015.

GoL MOHSW (Government of Lesotho. Ministry of Health and Social Welfare). (2014). National guidelines on the use of antiretroviral therapy for HIV prevention and treatment.

http://www.emtct-iatt.org/wp-content/uploads/2015/02/National-ART-Guidelines_Final_16-June-20142.pdf

Retrieved on 14 February 2016.

GoL MOHSW (Government of Lesotho Ministry of Health). (2015). Global AIDS response progress report 2015: Follow-up to the 2011 political declaration on HIV/AIDS: intensifying efforts to eliminate HIV/AIDS.

http://www.unaids.org/sites/default/files/country/documents/LSO_narrative_report_2015.pdf

Retrieved on 14 February 2016.

GoL NAC (Government of Lesotho. National AIDS Commission). (n.d.a). Lesotho *UNGASS Country Report; Status of the National Response to the 2001 Declaration of Commitment on HIV/AIDS: 2008-2009*. (UNGASS) United Nations General Assembly Special Session. Maseru, Lesotho.

http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/lesotho_2010_country_progress_report_en.pdf

Retrieved on 14 February 2016.

GoL NAC (Government of Lesotho. National AIDS Commission). (n.d.b). National Multi-Sectorial HIV Prevention Strategy for a Multi-Sectorial Response to the HIV Epidemic in Lesotho (2011/12-2015/16) Maseru, Lesotho. MOHSW.

http://www.safaid.net/files/Lesotho_National_Prevention_Strategy_2011-2016.pdf

Retrieved on 14 February 2016.

GoL NAC (Government of Lesotho. National AIDS Commission). (2006). *National HIV and AIDS Policy*. Maseru, Lesotho.

<http://www.safaid.net/files/LesothoNational%20HIVandAIDS%20Policy2006.pdf>

Retrieved 20 December 2015.

GoL NAC (Government of Lesotho. National AIDS Commission). (2009a). *Lesotho HIV Prevention and Modes of Transmission Analysis*. Maseru, Lesotho.

<https://openknowledge.worldbank.org/handle/10986/3045>

Retrieved on 14 February 2016.

GoL NAC (Government of Lesotho. National AIDS Commission). (2009b). *Report of the Mid-Term Review of the National HIV and AIDS Strategic Plan: 2006 – 2011*. Maseru, Lesotho.

http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---

[ilo_aids/documents/legaldocument/wcms_126751.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_126751.pdf).

Retrieved on 14 February 2016.

GoL NAC (Government of Lesotho. National AIDS Commission). (2012). *Lesotho Global AIDS Response Country Progress Report Towards Zero new infections, Zero AIDS related deaths and zero discrimination. January 2010-December 2011: status of the national response to the 2011 political declaration*. Maseru, Lesotho.

http://www.nationalplanningcycles.org/sites/default/files/country_docs/Lesotho/lesotho_phc_action_plan_2011_2017_draft_submitted_to_moh_3_2_5.pdf

Retrieved on 14 February 2016.

GoL. (2014) *Kingdom of Lesotho: Millennium Development Goals Status Report*. Maseru, Lesotho.

<http://www.ls.undp.org/content/dam/lesotho/docs/Reports/MDG%20Report%20-%202013.pdf>

Retrieved on 14 February 2016.

Halkitis, P.N., Kutnick, A.H. & Slater, S. (2005). The social realities of adherence to protease inhibitor regimens: substance use, health care and psychological states. *J Health Psychol* 10(4):545–58.

Hesse-Biber, S.N. & Leavy, P.L. (2006). *The Practice of Qualitative Research*. (2nd Ed.). London: SAGE Publications Inc.

Hlalele, D. & Letsie, P.R. (2011). Gender inequality and HIV/AIDS in Lesotho: A human disease ecological perspective. *J Hum Ecol* 36(3):159-165.

IATT (Inter-Agency Task Team) on Education. (2008). *Improving the Education Response to HIV and AIDS: Lessons of partner efforts in coordination, harmonisation, alignment, information sharing and monitoring in Jamaica, Kenya, Thailand and Zambia*. Geneva: Switzerland.

<http://unesdoc.unesco.org/images/0015/001586/158683E.pdf>

Retrieved on 10 January 2016.

Indian Engender Health Society. (2006). Adherence to Treatment for HIV A Training Curriculum for Counsellors Facilitator Guide. EngenderHealth Society India.

https://www.engenderhealth.org/files/pubs/localized/india/counselor_facilitator_guide.pdf

Retrieved on 5 February 2016.

International Federation of Red Cross and Red Crescent Societies. (2009). Standards for HIV peer education programmes. Penny Bardsley and Alyson Lewis. Geneva.

http://www.ifrc.org/Global/Publications/Health/hiv_peer_education-en.pdf

Retrieved on 5 February 2016.

International HIV/AIDS Alliance. (2003). Positive Prevention: Prevention Strategies for People with HIV/AIDS. Draft Background Paper.

http://www.ahrf.org.uk/articles/postive_prevention.pdf

Retrieved on 5 February 2016.

International Labour Organisation (ILO). (2001). An ILO code of practice on HIV/AIDS and the world of work. Geneva 22, Switzerland. ILO Publications.

http://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/document_s/publication/wcms_113783.pdf

Retrieved on 16 February 2016.

IOM (International Organization for Migration). (n.d.). Briefing note on HIV and Labour Migration in Lesotho. IOM, Pretoria.

http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/events/docs/Briefing_Notes_HIV_Lesotho.pdf

Retrieved on 16 February 2016.

Ironson, G., Solomon, G.F., Balbin, E.G., O'Cleirigh, C., George, A., Kumar, M., Larson, D. & Woods, T. (2002). The Ironson–Woods Spirituality/Religiousness Index Is Associated With Long Survival, Health Behaviours, Less Distress, and Low Cortisol in People With HIV/AIDS. *Ann Behav Med* 24(1):34–48.

Israel, E., Laudari, C. & Simonetti, C. (2008). HIV Prevention among Vulnerable Populations: The Pathfinder International Approach. Pathfinder International. Technical Guidance Series Number 6.

<http://www.pathfinder.org/publications-tools/pdfs/HIV-Prevention-Among-Vulnerable-Populations-The-Pathfinder-International-Approach.pdf>

Retrieved on 14 February 2016.

Jaffe, H.W., Valdiserri, R.O. & DeCock, K.M. (2007). The reemerging HIV/AIDS epidemic in men who have sex with men. *Journal of the American Medical Association* 298(20):2412-2414.

James, S., Reddy, P., Ruiter, R.A.C., McCauley, A. & Van Den Borne, B. (2006). The impact of an HIV and AIDS life skills program on secondary school students in Kwazulu-Natal, South Africa. *AIDS Education and Prevention* 18(4):281-294.

Jarbandhan, D.B. & Schutte, D. (2006). Using the survey procedure and interview data collection technique. *Journal of Public Administration* 41(3):669-681.

Jessor, R., Turbin, M.S., and Costa, F.M. (1998). Protective factors in adolescent health behavior. *Journal of Personality and Social Psychology: Personality Processes and Individual Differences* 75(3):788-800. <http://dx.doi.org/10.1037/0022-3514.75.3.788>.

Johnston, C. & Agencies. (2015). Bill Gates predicts HIV vaccine by 2030. The Guardian United Kingdom.

<http://www.theguardian.com/society/2015/jan/24/bill-gates-hiv-vaccine-2030-intense-drugs-aids>

Retrieved 10 January 2016.

Johnson, L. & Budlender, D. (2002). HIV risk factors: a review of the demographic, socio-economic, bio-medical and behavioural determinants of HIV prevalence in South Africa. CARE Monograph No. 8. Centre for Actuarial Research, University of Cape Town.

www.commerce.uct.ac.za/care/Monographs/Monographs/mono08.pdf

Retrieved 20 January 2016.

Kachingwe, S.I., Norr, K., Kaponda, C.P.N., Norr, J., Mbweza, E., Magai, D. (2005). Preparing Teachers as HIV/AIDS Prevention Leaders in Malawi: Evidence from Focus Groups. *International Electronic Journal of Health Education* 8:193-204.

Kaiser Family Foundation. (2015). The Global HIV/AIDS Epidemic 2015.

<http://kff.org/global-health-policy/fact-sheet/the-global-hivaids-epidemic/>

Retrieved 20 January 2016.

Kalichman, S.C., Rompa, D., Cage, M., DiFonzo, K., Simpson, D. & Austin, J. Luke, W., Buckles, J., Kyomugisha, F., Benotsch, E., Pinkerton, S. & Graham, J. (2001). Effectiveness of an intervention to reduce HIV transmission risks in HIV positive persons. *American Journal of Preventive Medicine* 21(2):84-92.

Kalichman, S.C., Cherry, C., Kalichman, M.O., Amaral, C.M., White, D. Pope, H., Swetzes, C., Eaton, L., Macy, R. & Cain, D. (2011). Integrated Behavioural Intervention to Improve HIV/AIDS Treatment Adherence and Reduce HIV Transmission. *Am J Public Health* 101(3):531-538.

Kalichman, S.C., DiMarco, M., Austin, J., Luke, W., & DiFonzo, K. (2003). Stress, Social Support, and HIV-Status Disclosure to Family and Friends among HIV-Positive Men and Women. *Journal of Behavioral Medicine* 26(4):315-332.

Kalichman, C. (2000). HIV transmission risk behaviours of men and women living with HIV/AIDS: prevalence, predictors, and emerging clinical interventions. *Clinical Psychology: Science and Practice* 7(1):32-47

Kelly, J.A. (1995). *Changing HIV risk behaviour: Practical strategies*. New York: Guilford Press.

Kelly, M.J. (2000). Planning for education in the context of HIV. United Nations Education, Scientific and Cultural Organization, Paris.

<http://unesdoc.unesco.org/images/0012/001224/122405e.pdf>

Kelly, J. & Kalichman, S.C. (2002). Behavioural Research in HIV/AIDS Primary and Secondary Prevention: Recent Advances and Future Directions. *J Consult Clin Psychol* 30(3):626-639.

Kelly, J.A., Murphy, D.A., Bahr, G.R., Koob, J.J., Morgan, M.G., Kalichman, S.C., Stevenson, L.Y., Brasfield, T.L., Bernstein, B.M., St. Lawrence, J.S. (1993). Factors associated with severity of depression and high-risk sexual behavior among persons diagnosed with human immunodeficiency virus (HIV) infection. *Health Psychology* 12(3):215-219. <http://dx.doi.org/10.1037/0278-6133.12.3.215>

Kennedy, C.E., Medley, A.M., Sweat, M.D. & O'Reilly, K.R. (2010). Behavioural interventions for HIV positive prevention in developing countries: a systematic review and meta-analysis. *Bulletin of the World Health Organization* 88:615-623. Doi: 10.2471/BLT.09.068213.

Kesby, M., K. Fenton, K., Boyle, P., Power, R. (2003). An agenda for future research on HIV and sexual behaviour among African migrant communities in the UK. *Social Science Medicine* 57(9):1573-1592.

Kimaryo, S.S., Okpaku, J.O., Githuku-Shongwe, A. & Feeney, J. (2014). Turning a crisis into an Opportunity: Strategies for Scaling up the National Response to the HIV/AIDS Pandemic in Lesotho. Third Press Publishers New Rochelle, New York USA.

<http://www.undp.org/content/dam/aplaws/publication/en/publications/hiv-aids/turning-a-crisis-into-opportunity-scaling-up-lesotho-hiv-aids-pandemic-response/45.pdf>

Kirby, D. (2011). The Impact of Sex Education on The Sexual Behaviour of Young People. Population Division Expert Paper No. 2011/12. United Nations Department of Economic and Social Affairs. New York.

http://www.un.org/en/development/desa/population/publications/pdf/expert/2011-12_Kirby_Expert-Paper.pdf

Knox, J., Reddy, V., Kaighobadi, F., Nel. & Sandfort, T. (2013). Communicating HIV Status in Sexual Interactions: Assessing Social Cognitive Constructs, Situational Factors, and Individual Characteristics among South African MSM. *AIDS Behav* 17(1):350–359. Doi:10.1007/s10461-012-0337-4.

Kreuger, L.W. & Neuman, W.L. (2006). *Social work research methods: Qualitative and Quantitative applications*. Boston; Pearson Education.

Krueger, L.E., Wood, R.W., Diehr, P.H. & Maxwell, C.L. (1990). Poverty and HIV seropositivity: the poor are more likely to be infected. *AIDS* 4(8):811-814.

<http://www.ncbi.nlm.nih.gov/pubmed/2261136>

Retrieved on 31 January 2016

Lesotho Network of People Living with HIV and AIDS (LENEPWHA). (2013). Lesotho People Living with HIV Stigma Index. Maseru, Lesotho.

<http://www.stigmaindex.org/lesotho>

<http://www.stigmaindex.org/sites/default/files/reports/Lesotho%20Stigma%20Index%20draft%20report%206-%20L..pdf>

Retrieved 10 December 2015

Lesotho Joint UN Team on AIDS Newsletter. (2015). Fast Track Ending the Aids Epidemic by 2030. Lesotho.

http://www.unlesotho.org/wp-content/uploads/2015/08/JUNTA-Newsletter_July-2015-.pdf

Retrieved 10 December 2015.

Letamo, G. 2007. Misconceptions about HIV prevention and transmission in Botswana. *African Journal of AIDS Research* 6(2):193-198.

Lewis, J.J., Donnelly, C.A., Mare, P., Mupambireyi, Z., Garnett, G. & Gregson, S. (2007). Evaluating the proximate determinants framework for HIV infection in rural Zimbabwe. *Sex Transm Infect* 83(Suppl 1):i61–i69.

Li, K. (2009). Lesotho makes progress in prevention of mother-to-child transmission of HIV.

http://www.unicef.org/infobycountry/lesotho_51255.html

15 February 2016.

Li, L., Wu, Z., Wu, S., Jia, M., Lieber, E. & Lu, Y. (2008). Impacts of HIV/AIDS Stigma on Family Identity and Interactions in China. *Fam Syst Health* 26(4):431–442.

Little, S.J., Holte, S., Routy, J.P., Daar, E.S., Markowitz, M., Collier, A.C., Koup, R.A., Mellors, J.W., Connick, E., Conway, B., Kilby, M., Wang, L., Whitcomb, J.M., Hellmann, N.S. & Richman, D.D. (2002). Antiretroviral-drug resistance among patients recently infected with HIV. *N Engl J Med* 347(6):385–394.

Lincoln, Y. & Guba, E 1985: *Naturalistic enquiry*. California: SAGE Publications Inc.

Loosli, B.C. (2004). *Traditional practices and HIV prevention in Sub-saharan Africa*. Geneve.

http://www.gfmer.ch/GFMER_members/pdf/Traditional_HIV_Loosli.pdf

Retrieved on 6 June 2015.

Magnani, R. Macintyre, K., Karim, A.M., Brown, L., Hutchinson, P., Kaufman, C., Rutenburg, N., Hallman, K., May, J., Dallimore, A. & Transitions Study Team. (2005). The impact of life skills education on adolescent sexual risk behaviors in KwaZuluNatal South Africa. *Journal of Adolescent Health* 36(4):289-304.

Mahajana, A.P., Sayles, J.N., Patel, V.A., Remien, R.H., Ortiz, D., Szekeres, G. & Coates, T.J. (2008). Stigma in the HIV and AIDS epidemic: a review of the literature and recommendations for the way forward. *AIDS* 22(Suppl 2):S67–S79. Doi:10.1097/01.aids.0000327438.13291.62.

Mahy, M., Stover, J., Stanecki, K., Stoneburner, R. & Tassie, J. (2010). Estimating the impact of antiretroviral therapy: Regional and Global estimates of life-years gained among adults. *Sex Transm Infect* 86(2):ii67-ii71. Doi:10.1136/sti.2010.046060.

Makamure, L. & Glenwright, D. 2015. SADC (Southern African Development Community) Gender Protocol 2015 Barometer Lesotho.

file:///C:/Users/vanwykC2/Downloads/21193_baro2015_les_ch7_hiv_aids.pdf

Retrieved on 20 February 2016

Maree, K. *First Steps in Research*. Hatfield, Pretoria: Van Schaik Publishers.

Mawar, N., Paranjapea, R.S., & Khan, M.E. (2011). Social and behavioural research: Tool for intensifying fight against AIDS in India. *Eastern Journal of Medicine* 16(2):94-98.

Maykut, P. & Morehouse, R. (1994). *Beginning qualitative research: A philosophic and practical guide*. The Falmer Press teachers' library, 6. Oxford, England: Falmer Press/Taylor & Francis, Inc.

McKirnan, D.J., Ostrow, D.G. & Hope, B. (1996). Sex, drugs and escape: A psychological model of HIV-risk sexual behaviours. *AIDS Care* 8(6):655-670.

Millenium Development Goal Report on the Country. (2014). African economic outlook. [http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf)

Retrieved 2 February 2016

Miller, W.C. (2013). HIV among female sex workers and men who have sex with men in Swaziland: A combined report of quantitative and qualitative studies.

<http://www.jhsph.edu/research/centers-and-institutes/research-to-prevention/publications/Swazi-integrated-report-final.pdf>

Retrieved 28 February 2016

Mlambo, M. & Peltzer, K. (2011). HIV Sero-status disclosure and sexual behaviour among HIV positive patients who are on Antiretroviral Treatment (ART) in Mpumalanga, South Africa. *J Hum Ecol* 35(1):29-41.

Mokhothu, M.M. (2004). *The role of public service in poverty reduction strategies: challenges and solutions causes of poverty in Lesotho*. 25TH AAPAM annual roundtable conference: Kairaba Beach Hotel, Banjul 19 – 23 April 2004.

<http://unpan1.un.org/intradoc/groups/public/documents/aapam/unpan025676.pdf>

Retrieved 8 February 2016

Monette, D.R., Sullivan, T.J. & De Jong, C.R. 2008. *Applied Social Research: A Tool For The Human Science*. (7th Ed.). Belmont, California: Thompson Wadsworth.

Mosito, K.E. (2014). A Panoramic View of the Social Security and Social Protection Provisioning In Lesotho. *PER / PELJ* 17(4):1-59. <http://dx.doi.org/10.4314/pelj.v17i4.11>

National Collaborating Centre for Infectious Disease. (2010). *Interventions to prevent HIV transmission in serodiscordant couples*.

http://centreinfection.s3.amazonaws.com/wp/sites/2/2015/04/05213356/serodiscordant_couples.pdf

Retrieved on 15 October 2015.

Negeri, E.L. (2014). Assessment of risky sexual behaviours and risk perception among youths in Western Ethiopia: the influences of family and peers: a comparative cross-sectional study. *BMC Public Health* 14(301):1-12. DOI: 10.1186/1471-2458-14-301.

Nseera, E. & Bhatia, A. (2014). *Lesotho 2014. African Economic Outlook*. AfDB (African Development Bank), OECD (Organisation for Economic Co-operation and Development, UNDP (United Nations Development Programme).

http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2014/PDF/CN_Long_EN/Lesoto_EN.pdf

Retrieved 2 February 2016.

Ntaote, B. (2014). Lesotho's latest HIV figures worry US. *Lesotho Times: News without Fear or Favour*.

<http://lestimes.com/lesothos-latest-hiv-figures-worry-us/>

Retrieved 28 February 2016.

OSISA (Open Society Initiative of Southern Africa) & OSF ESP (Open society foundation Education Support Programme). (2012). *The Role of the Education Sector in Providing Care & Support for Orphans & Vulnerable Children in Lesotho & Swaziland*. Open Society Initiative of Southern Africa (OSISA).

<http://www.osisa.org/open-learning/education/swaziland/role-education-sector-providing-care-and-support-ovc-lesotho-and-s>

<http://www.refworld.org/pdfid/5242b8584.pdf>

Retrieved 28 February 2016.

Ownby, R.L., Jacobs, R.J., Waldrop-Valverde, D. & Gould. F. (2010). Depression care and prevalence in HIV-positive individuals. *Neurobehavioral HIV Medicine* 2010(2):73-83. DOI <http://dx.doi.org/10.2147/NBHIV.S7296>.

<http://www.rayownby.com/wp-content/uploads/downloads/2010/08/Ownby-et-al-Depression-prevalence-and-treatment-in-HIV-infection-PREPRINT.pdf>

Retrieved 2 February 2016.

Oxford dictionary. (2016). Definition of Behaviour.

http://www.oxforddictionaries.com/definition/american_english/behavior

Retrieved 2 February 2016.

Parker, R. & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science Medicine* 57(1):13–24.

Patton, M.Q. 2002. *Qualitative evaluation and research methods*. (3rd Ed.). Thousand Oaks, California: SAGE Publications Inc.

Pelzer, K. & Promtussananon, S. (2003). HIV/AIDS education in South Africa: teacher knowledge about HIV/AIDS: teacher attitude about and control of HIV/AIDS education. *Social Behavior and Personality: an international journal* 31(4)349-356.

Peterson, J.L., Miner, M.H., Brennan, D.J. & Rosser, B.R.S. (2012). HIV Treatment Optimism and Sexual Risk Behaviors among HIV Positive African American Men who have Sex with Men. *AIDS Educ Prev* 24(2):91-101. Doi:[10.1521/aeap.2012.24.2.91](https://doi.org/10.1521/aeap.2012.24.2.91)

Polit, D.F., Beck, C.T. & Hungler, B.P. 2001. *Essentials of nursing research*. (5th Ed.). Philadelphia: Lippincott Williams & Wilkins.

Poundstone, K.E., Strathdee, S.A. & Celentano, D.D. (2004). The Social Epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome. *Epidemiologic Reviews* 26:22–35.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proc Nutr Soc* 63(4):655-660.

Redd, A.D., Quinn, T.C., Tobian, A.A. (2013). Frequency and implications of HIV super-infection. *Lancet Infect Disease* 13(7):622–628.

Remien, R.H., Halkitis, P.N., O’Leary, A., Wolitki, R.J. & Gómez, C.A. (2005). Risk perception and sexual risk behaviours among HIV-positive men on antiretroviral therapy. *AIDS Behav* 9(2):167–76.

Ricardo, C. & Barker, G. (2008). Men, Masculinities, Sexual Exploitation and Sexual Violence: A Literature Review and Call for Action. Promundo.

https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Sooline_vordoiguslikkus/Inimkaubandus_ja_prostitusioon/homens-masculinidades-exploracao-sexual-e-violencia-sexual-ing.pdf

Retrieved 10 January 2016.

Riera, M., La Fuente, L.L., Castanyer, B., Puigventós, F., Villalonga, C., Ribas, M.A., Pareja, A., Leyes, M. & Salas, A. (2002). Adherence to antiretroviral therapy measured by pill count and drug serum concentrations: variables associated with a bad adherence. *Med Clin (Barc)* 119(8):286–92.

Robins, A.G., Dew, M.A., Davidson, S., Penkower, L., Becker, J.T. & Kingsley, L. (1994). Psychosocial factors associated with risky sexual behavior among HIV-seropositive gay men. *AIDS Educ Prev* 6(6):483–492.

Ronen, K., Richardson, B., Graham, S., Mandaliya, K., Walter Jaoko, W., McClelland, S. & Overbaugh, J. (2014). HIV-1 super infection is associated with an accelerated viral load increase but has a limited impact on disease progression. *AIDS* 28(15):2281-2286. DOI: 10. 1097/QAD.0000000000000422.

Rose, C.D., Gutin, S.A. & Reyes, M. (2010). Adapting Positive Prevention Interventions for International Settings: Applying U.S. Evidence to Epidemics in Developing Countries. *Journal of the Association of Nurses in AIDS Care* 22(1):38-52.

Rural centre for AIDS/STD prevention Facts Sheet. (2007). Behavioural Interventions for Reducing Sexual Risk Behaviour. Indiana University: Bloomington.
<http://www.indiana.edu/~aids/factsheets/factsheet21.pdf>
Retrieved 10 January 2016.

SADC (Southern African Development Community) (2009). *HIV and AIDS Strategic Framework 2010-2015*.
<http://www.sadc.int/files/4213/5435/8109/SADCHIVandAIDSStrategyFramework2010-2015.pdf>
Retrieved 10 February 2016.

Sewell, M. (2006). *The Use of Qualitative Interviews in Evaluation*. Tucson, AZ: University of Arizona.

Scott, S. (2009). HIV/AIDS: Understanding Socio-Cultural Factors and their Influence on Sexual Behaviour and Decision Making in Africa. *Journal of the Manitoba Anthropology Students' Association* 28(2009):83-93.

<http://umanitoba.ca/publications/openjournal/index.php/mb-anthro/article/viewFile/27/7>

Retrieved on 4 February 2016.

Scott-Sheldon, L.A. J., Carey, M.P., Carey, K.C., Cain, D., Harel, O., Mehlomakulu, V., Mwaba, K., Simbayi, L.C. & Kalichman, S.C. (2012). Patterns of alcohol use and sexual behaviors among current drinkers in Cape Town, South Africa. *Addict Behav* 37(4):492–497. Doi:10.1016/j.addbeh.2012.01.002.

Shapiro, K. & Ray, S. (2007). Sexual Health for People Living with HIV. *Reproductive Health Matters* 15(29 Supplement):67–92.

<http://www.who.int/reproductivehealth/publications/rtis/sexualhealth.pdf>

Retrieved 28 February 2016.

Simbayi, L.C., Kalichman, S., Strebel, C.A., Cloete, A., Henda, N. & Mqeketo, A. (2007) Disclosure of HIV status to sex partners and sexual risk behaviours among HIV-positive men and women, Cape Town, South Africa. *Sex Transm Infect* 83(1):29–34.

Singh, K., Buckner, B., Tate, J., Ndubani, P. & Kamwanga, J. (2011). Age, poverty and alcohol use as HIV risk factors for women in Mongu, Zambia. *African Health Sciences* 11(2):204-210.

Smith, C., Cambiano, V., O'Connor, J., Nakagawa, F., Lodwick, R., Rodger, A., Lampe, F., Phillips, A. (2012). *Evaluating HIV treatment as prevention in the European context*. Stockholm.

Smith, D.M., Richman, D.D. & Little, S.J. (2005). HIV Super-infection. *The Journal of Infectious Diseases* 192(3):438-444.

Sofolahan, Y., & Airhihenbuwa, C.O. (2013). Cultural expectations and reproductive desires: experiences of South African Women Living with HIV/AIDS (WLHA). *Health Care Women Int* 34(3-4):263–280.

Tameru, B., Gerbi, G., Nganwa, D., Bogale, A., Robnett, V. & Habtemariam, T. (2012). The Association between Interrelationships and Linkages of Knowledge about HIV/AIDS and its Related Risky Behaviors in People Living with HIV/AIDS. *J AIDS Clin Res* 3(7):1-7. Doi: [10.4172/2155-6113.S7-002](https://doi.org/10.4172/2155-6113.S7-002).

Tarkang, E.E. (2013). Factors associated with consistent condom use among secondary school female learners in Mbonge subdivision of rural Cameroon. *The Pan African Medical Journal*. 17:259. Doi:10.11604/pamj.2014.17.259.2772.

<http://www.panafrican-med-journal.com/content/article/17/259/pdf/259.pdf>

Retrieved 20 February 2016.

Temah, C.T. (2007). Gender inequality and HIV/AIDS epidemic in Sub-Saharan Africa, CERDI, Université d' Auvergne. Clermont-Ferrand: France.

<http://www.csae.ox.ac.uk/conferences/2007-EDiA-LaWBiDC/papers/037-Tsafack.pdf>

Retrieved 20 February 2016.

Tladi, L.S. (2006). Poverty and HIV and AIDS in South Africa: An empirical contribution. *SAHARA-J: Journal of Social Aspects of HIV/AIDS: An Open Access Journal* 3(1):369-381. DOI: 10.1080/17290376.2006.9724863.

The Centre for Women and HIV Advocacy's HIV Law Project. (2011).

<http://hivlawproject.org/wordpress-site/center-for-women-hiv-advocacy/>

<http://hivlawproject.org/wordpress-site/hiv-law-project-joins-mobilization-to-end-aids-june-2011/>

Retrieved 10 December 2015.

The World Bank (2002). Education and HIV/AIDS: A Window of Hope. The International Bank for Reconstruction and Development/ The World Bank Publications. Washington DC.

<http://siteresources.worldbank.org/EDUCATION/Resources/278200->

[1099079877269/547664-1099080042112/Edu_HIVAIDS_window_hope.pdf](http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099080042112/Edu_HIVAIDS_window_hope.pdf)

Retrieved on 27 February 2016

The World Bank. (2016). Lesotho Health Network Public-Private Partnership (PPP) brief. The World Bank Group.

<http://www.worldbank.org/en/country/lesotho/brief/lesotho-health-network-ppp>

Retrieved on 27 February 2016

Thornton, R. (2009). Sexual networks and social capital: multiple and concurrent sexual partnerships as a rational response to unstable social networks. *African Journal of AIDS Research* 8(4):xxx-xxx.

<http://www.ascleiden.nl/pdf/PaperThornton.pdf>

Retrieved 10 January 2016.

Tong, A., Sainsbury, P. & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care* 19(6):349-357.

Traube, D.E., Holloway, I.W. & Smith, L. (2011). Theory development for HIV behavioural health: Empirical Validation of Behaviour Health Models Specific to HIV Risk. *AIDS Care*. 23(6):663-670. Doi: 10.1080/09540121.2010.532532.

Tyer-Viola, L.A., Corless, I.B., Webel, A. P., Reid, P., Sullivan, K.M., Nichols, P. & International Nursing Network for HIV/AIDS Research. (2014). Exploring predictors of medication adherence among HIV positive women in North America. *J Obstet Gynecol Neonatal Nurs*. 43(2):168-178. Doi:10.1111/1552-6909.12288.

UN (United Nations). (2015). Millennium Development Goal report. New York.

[http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf)

Retrieved 20 January 2016.

UN (United Nations) Convention on the Elimination of All Forms of Discrimination against Women. (2011). Concluding observations of the Committee on the Elimination of Discrimination against Women Committee on the Elimination of Discrimination against Women Fiftieth session Geneva, 3 – 21 October 2011

<http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-LSO-CO-1-4.pdf>

Retrieved 29 February 2016.

UNAIDS (Joint United Nations programme on HIV/AIDS). (1998). Expanding the global response to HIV/AIDS through focused action: Reducing risk and vulnerability: definitions, rationale and pathways. Geneva: Switzerland.

http://data.unaids.org/Publications/IRC-pub01/jc171-expglobresp_en.pdf

Retrieved 10 December 2015.

UNAIDS (Joint United Nations programme on HIV/AIDS). (1999). Sexual behavioural change for HIV: Where have theories taken us? Geneva: Switzerland.

http://data.unaids.org/Publications/IRC-pub04/JC159-BehavChange_en.pdf

Retrieved 10 December 2015.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2000). Opening up the HIV/AIDS Epidemic: *Guidance on encouraging beneficial disclosure, ethical partner counselling & appropriate use of HIV case reporting*. Geneva: Switzerland.

<http://www.who.int/hiv/pub/vct/en/Opening-E%5B1%5D.pdf>

Retrieved 4 January 2016.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2005). Intensifying HIV prevention UNAIDS policy position paper

Policy Position Paper for Intensifying HIV Prevention

<https://www.unodc.org/documents/hiv-aids/Intens.prevention.pdf>

Retrieved 10 January 2016.

United Nations General Assembly Special Session on HIV/AIDS. (2011).

<http://www.hivpolicy.org/biogs/HPE0320b.htm>

Retrieved 20 February 2016.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2007a) *Practical guidelines for intensifying HIV prevention: Towards Universal Access*. Geneva: Switzerland.

http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf

Retrieved 20 February 2016.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2007b) *Terminology Guidelines*. Geneva: Switzerland.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2010). UNAIDS 2011–2015 STRATEGY GETTING TO ZERO. Geneva: Switzerland.

http://www.unaids.org/sites/default/files/sub_landing/files/JC2034_UNAIDS_Strategy_en.pdf

Retrieved on 14 February 2016.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2011). Count down to zero. *Global Plan to eliminate new HIV infections among children and keeping their mothers alive 2011-2015*.

http://www.unaids.org/sites/default/files/media_asset/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en_1.pdf

Retrieved 20 February 2016.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2013). *Global Fact Sheet*. Geneva: Switzerland.

http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/20130923_FactSheet_Global_en.pdf

Retrieved on 5 December 2015.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2014). The GAP Report.

http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf

Retrieved on 14 February 2016.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2015a). UNAIDS 2016-2021 Strategy: On the fast track to end AIDS.

http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

Retrieved on 14 February 2016.

UNAIDS (Joint United Nations programme on HIV/AIDS). (2015b). On the fast track to end AIDS by 2030: Focus on location and population. Part 2a.

https://issuu.com/unaids/docs/wad2015_report_en_part02a

Retrieved on 14 February 2016

UNAIDS (Joint United Nations programme on HIV/AIDS). (2015c). *UNAIDS Fact Sheet 2015*.

<http://www.unaids.org/en/resources/campaigns/HowAIDSchangedeverything/factsheet>

Retrieved on 14 February 2016

UNAIDS (Joint United Nations programme on HIV/AIDS). (2015d). *UNAIDS How AIDS changed everything* Report.

http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf

Retrieved on 14 February 2016

UNAIDS Lesotho (Joint United Nations programme on HIV/AIDS). (2014). *Lesotho HIV Epidemic Profile*. Lesotho.

<http://www.unaidsrstes.org/wp-content/uploads/2015/05/UNAids-Profile-Lesotho.pdf>

Retrieved on 14 February 2016.

UNAIDS & OHCHR (Joint United Nations programme on HIV/AIDS & Office of the United Nations High Commissioner for Human Rights). (2007). *Handbook on HIV and Human Rights for National Human Rights Institutions*.

http://www.ohchr.org/Documents/Publications/HandbookHIV_NHRIsAug2007.pdf

Retrieved on 14 February 2016.

UNESCO (United Nations Educational, Scientific and Cultural Organization). (2000). *The Dakar Framework for Action: Education for All – meeting our collective commitments*. Adopted by the World Education Forum Dakar, Senegal, 26-28 April 2000: Including six regional frameworks for action. Paris, France. UNESCO.

http://www.unesco.at/bildung/basisdokumente/dakar_aktionsplan.pdf

Retrieved on 5 December 2015.

UNESCO (United Nations Educational, Scientific and Cultural Organization). (2001). *A Cultural Approach To HIV/AIDS Prevention And Care: Hand book 1 Methodological Handbooks, Special Series, Issue No. 1* Division of Cultural Policies UNESCO, 2001 Paris, France. UNESCO.

UNESCO (United Nations Educational, Scientific and Cultural Organization). (2003). A Cultural approach to HIV/AIDS prevention and care. HIV/AIDS Stigma and Discrimination: An Anthropological Approach. Proceedings of the round table held on 29 November 2002 at UNESCO - Paris, France. UNESCO.

<http://unesdoc.unesco.org/images/0013/001307/130756e.pdf>

Retrieved 22 January 2016.

UNESCO (United Nations Educational, Scientific and Cultural Organization). (2004). *UNESCO's strategy FOR HIV and AIDS prevention education*. Paris, France. UNESCO.

<http://unesdoc.unesco.org/images/0013/001345/134572e.pdf>

Retrieved 22 January 2016.

UNESCO (United Nations Educational, Scientific and Cultural Organization). (2008). Overview. *Good Policy and Practice in HIV & AIDS and Education* (booklet series: Booklet 1). (2nd Ed.). Paris, France. UNESCO.

<http://unesdoc.unesco.org/images/0014/001461/146121e.pdf>

Retrieved 24 January 2016.

UNESCO. (United Nations Educational, Scientific and Cultural Organization). (2011). UNESCO'S strategy for HIV AND AIDS. Paris, France. UNESCO.

<http://unesdoc.unesco.org/images/0019/001931/193118e.pdf>

Retrieved 22 January 2016.

UNICEF (United Nations Children's Emergency Fund). (2012). *Lesotho Country programme document 2013-2017*. United Nations Children Emergency Fund Lesotho

http://www.unicef.org/about/execboard/files/Lesotho-2013-2017-final_approved-English-14Sept2012.pdf

Retrieved 4 January 2016.

UNICEF (United Nations Children's Fund), UNAIDS (Joint United Nations Programme on HIV/AIDS) & WHO (World Health Organization). (2002). *Young people and HIV/AIDS: Opportunity in crisis*. Geneva: Switzerland.

http://www.unaids.org/sites/default/files/media_asset/youngpeoplehivaids_en_0.pdf

Retrieved 22 January 2016.

UN-INSTRAW (United Nations International Research and Training Institute for the Advancement of Women) & UNDP (United Nations Development Programme). (2010). *Migration, remittances and gender-responsive local development: The case of Lesotho*. UN-INSTRAW and UNDP.

US PLWHA CAUCUS (United States People Living with HIV Caucus). (2011). Positive Health, Dignity and Prevention (PHDP): A Policy Framework. United States People Living with HIV Caucus. The Global Network of People Living with HIV. Amsterdam, The Netherlands.

http://www.unaids.org/sites/default/files/media_asset/20110701_PHDP_0.pdf

Retrieved on 5 December 2015.

USAID (United States Agency for International Development). (2013). Fact Sheet. Building Local Capacity for Delivery of HIV Services in Southern Africa: Regional CSO Capacity Building. Pretoria, South Africa. BLC publications

<http://www.hivsharespace.net/system/files/MSH%20Fact%20Sheet%20Capacity%20Building%20Feb%202013%20Web.pdf>

Retrieved 4 January 2016.

Vanable, P.A., Ostrow, D.G., McKirnan, D.J., Taywaditep, K.J. & Hope, B.A. (2000). Impact of combination therapies on HIV risk perceptions and sexual risk among HIV-positive and HIV-negative gay and bisexual men. *Health Psychol* 19(2):134–145.

Van Dyk, A. (2005). *HIV/AIDS Care and Counselling a Multidisciplinary Approach*. (3rd Ed.). Cape Town. Pearson Education South Africa.

Visser, M.J. (2005). Life skills training as HIV/AIDS preventive strategy in secondary schools: evaluation of a large-scale implementation process. *Journal of Social Aspects of HIV/AIDS Research Alliance* 2(1):203-216.

Wainberg, M.A. & Jeang, K. (2008). 25 years of HIV-1 research – progress and perspectives. *BMC Medicine* 6(31):1-7. DOI: 10.1186/1741-7015-6-31.

Wagner, K.D., Unger, J.B., Bluthenthal, R.N., Andreeva, V.A. & Pentz, M.A. (2010). Cognitive Behavioural Theories Used to Explain Injection Risk Behaviour Among Injection Drug Users: A Review and Suggestions for the Integration of Cognitive and Environmental Models. *Health Educ Behav* 37(4):504–532.

Wekesa, E. & Coast, E. (2014). Fertility Desires among Men and Women Living with HIV/AIDS in Nairobi Slums: A Mixed Methods Study. *PLoS ONE* 9(8):e106292. Doi:10.1371/journal.pone.0106292.

Welman, J.C., Kruger, F. & Mitchell, B. (2010). *Research methodology*. (3rd Ed.). Cape Town, South Africa: Oxford University Press.

WHO (World Health Organisation). (2000). New data on the prevention of Mother-to-child of HIV and their Policy Implication. Geneva. World Health Organisation.

http://apps.who.int/iris/bitstream/10665/66851/1/WHO_RHR_01.28.pdf

Retrieved on 25 February 2016.

WHO (World health organisation). (2005). Mental Health and HIV/AIDS: Psychosocial Support Groups in Anti- retroviral (ARV) Therapy Programmes. Johannesburg: South Africa. World Health Organization

http://apps.who.int/iris/bitstream/10665/43199/1/9241593105_eng.pdf

Retrieved on 25 October 2015.

WHO (World Health Organisation). (2009). Priority Interventions HIV/AIDS prevention, treatment and care in the health sector. World Health Organization HIV/AIDS Department Version 1.2 – April 2009. Geneva. World Health Organisation.

http://www.who.int/hiv/pub/priority_interventions_web.pdf

Retrieved on 5 December 2015.

WHO (World Health Organisation). (2010) Priority Interventions HIV/AIDS prevention, treatment and care in the health sector. World Health Organisation

http://www.who.int/hiv/pub/guidelines/9789241500234_eng.pdf

Retrieved on 5 December 2015.

WHO (World Health Organisation), UNICEF (United Nations Children's Fund), UNAIDS (Joint United Nations Programme on HIV/AIDS). (2013). HIV treatment, Global update on HIV treatment 2013: Results, Impact and opportunities. Geneva, Switzerland. World Health Organization.

http://apps.who.int/iris/bitstream/10665/85326/1/9789241505734_eng.pdf

http://www.unaids.org/sites/default/files/sub_landing/files/20130630_treatment_report_en_3.pdf

Retrieved on 25 October 2015.

Yankah, E & Aggleton, P. (2008). Effects and Effectiveness of Life Skills Education for HIV prevention in Young People. *AIDS Education and Prevention* 20(6):465–485. Doi: 10.1521/aeap.2008.20.6.465.

Zielony, R., Kimzeke, G., Stacic, S. & De Bruyn, M. (2003). Peer Education Training of Trainers Manual. Europe and Central Asia. UN Interagency Group on Young Peoples Health Development and Protection in Europe and Central Asia. Sub-Committee on Peer Education.

<http://ift.ee/admin/upload/files/Peer%20education%20training%20materials%202003%20eng.pdf>

Retrieved on 5 November 2015.

Zizzo, S. (2011). Women and HIV and AIDS in Lesotho: Linking Social and Structural Drivers, Policy, and Human Rights. (Unpublished Dissertation). The University of North Carolina.

<https://cdr.lib.unc.edu/indexablecontent/uuid:c0cb0d70-a846-42a5-8e03-045b00e9830e>

Retrieved 10 January 2016.

APPENDICES

APPENDIX A

APPENDIX A

**ETHICS COMMITTEE OF THE FACULTY OF HEALTH
SCIENCES DOCUMENT**

Research Division
Internal Post Box G40
☎(051) 4052812
Fax (051) 4444359

E-mail address: EthicsFHS@ufs.ac.za

Ms J Du Plessis/gn

2014-10-20

REC Reference number: REC-230408-011
IRB nr 00006240

MS RS MABATHOANA
C/O MS C VAN WYK
DIVISION HEALTH SCIENCES EDUCATION
FACULTY OF HEALTH SCIENCES
UFS

Dear Ms Mabathoana

ECUFS NR 158/2014
MS RS MABATHOANA **DIVISION HEALTH SCIENCES EDUCATION**
PROJECT TITLE: INVESTIGATING FACTORS ASSOCIATED WITH HIV RISK TAKING
BEHAVIOURS AMONGST PEOPLE LIVING WITH HIV AND AIDS (PLWHA) IN LESOTHO

1. You are hereby kindly informed that the Ethics Committee approved the following and it will be condoned at the meeting scheduled for 4 November 2014:

- *The contact details of the Ethics Committee must be added to the Information document*
- *Permission from authorities*

2. **Kindly note that:**

- A progress report be presented not later than one year after approval of the project.
- Kindly refer to the ETOVS/ECUFS reference number in correspondence to the Ethics Committee secretariat.
- All relevant documents e.g. signed permission letters from the authorities, institutions; changes to the protocol, questionnaires etc. have to be submitted to the Ethics Committee before the study may be conducted (if applicable).

Yours faithfully



.....
PROF WH KRUGER
CHAIR: ETHICS COMMITTEE

APPENDIX B

APPENDIX B1	LETTER OF INVITATION TO PARTICIPATE IN THE STUDY
APPENDIX B2	CONSENT TO PARTICIPATE IN THE STUDY
APPENDIX B3	INTERVIEW SCHEDULE
APPENDIX B4	EXAMPLE OF A FULL TRANSCRIPT BEFORE DATA ANALYSIS

APPENDIX B1

**LETTER OF INVITATION TO PARTICIPATE IN THE
STUDY**

INFORMATION LETTER: SEMI-STRUCTURED INTERVIEW

Date

TO: Members of Support Group

Letter of Invitation to Participate in the Research

Masters (HPE) project titled:

INVESTIGATING FACTORS ASSOCIATED WITH HIV RISK TAKING BEHAVIOURS AMONGST PEOPLE LIVING WITH HIV AND AIDS (PLWHA) IN LESOTHO.

Principal Researcher: Ms Refiloe Stephania Mabathoana, Magister student in the Health Professions Education Programme, University of Free State.

Dear Colleague,

I am in the process of writing a mini-dissertation to obtain the M. degree in Health Professions Education in the Faculty of Health Sciences at the University of the Free State (Student number: 2011171887).

You have been selected because you have been in ALAFA programme belonging to support group with people living with HIV and AIDS (PLWHA) and we feel that your contribution in this semi-structured interview will be very valuable.

I therefore would like to request your participation in this research as a member of a panel of participants. Participation is voluntary. Your responses will be treated confidentially and you will remain anonymous. Should you feel concerned you may withdraw your consent and end your participation at any stage of the project. There will be no cost payable by any participants and it should be noted that no remuneration will be received.

Pre-selected questions will be presented and the purpose will be to stimulate discussions during the interview that will be scheduled at a specific date and time. If you indicate interest to participate you will be contacted with further arrangements.

After having addressed the research questions the findings will be written up and published. The results of this study might assist in continuing with research in the field to obtain enough information in order to develop educational programmes for PLWHA specifically for Lesotho.

If you require further information, or wish to withdraw your participation at any stage, you can contact the Faculty health coordinator or principal researcher. Thanking you in advance for your consideration to take part in this research.

Yours sincerely,

Researcher: Ms Refiloe Stephania Mabathoana
Mofuputsi Box 117767, Maseru 100
E-mail address:
rmabathoana.khetla@gmail.com
Cell phone: +266 627 61503

Study leader: Ms Chantel van Wyk
E-mail address: vanwykc2@ufs.ac.za
Contact number: +27 51 401 7773

Contact details: Secretariat (Faculty of Health Sciences Ethics Committee):
E-mail address: EthicsFHS@ufs.ac.za
Telephone: 051 401 7795

LINTLHA KHOLO TSA LENGOLO: LETHATHAMO LA LIPOTSO

Date

Ho: Litho tsa Sehlopha sa T'seetso

LENGOLO LA HO U MEMELA NKA KAROLO LIPHUPUTSONG

Sehlooho sa liphuputso Masters (HPE) :

LIPATLISISO KA MAEMO A BOITS'OARO BO BEHANG KOTSING E KHOLO EA T'SOAETSO EA HIV HO BATHO BA PHELANG LE KOKOANA-HLOKO EA HIV LE AIDS LESOTHO.

Moetelli-pele oa lipatlisiso: Ms Refiloe Stephania Mabathoana, Mofuputsi University of Free State, Division Health Sciences Education

Ho Setho se Sekhabane

Ke mothating oa ho phethela liphuputso tsaka tse boemong ba thuto e kholo (Master degree) ho Thuto ea Basebeletsi ba Bophelo lefapheng la tsa Bophelo le Mahlale University of the Free State nomoro eaka ea sekolo ke 2011171887.

O khethuoe hobane o kile oa nka karolo moralong oa ALAFA oa sehlopha ts'eeetso sa batho ba phelang le kokoana hloko ea HIV le AIDS, 'me re bona hore ho kenya letsoho hoa hao lipatlisisong tsena ho bohlokoa haholo.

'Me ka hona ke lakatsa ho u kopa hore o kenye letsoho liphuputsong tsena o le e mong oa litho tsa lipuisano. Ho tlatsetsa ha ho qobelle, 'me ho tla bolokoa e le lekunutu. Likarabo tsa hao litla sebetsoa ka lekunutu, 'me lebitso la hao ha lena ho utulloa kapa ho tsejoa ke batho ba bang. Ha o ikutloa o sa batle ho kenya letsoho, o ka etsa joalo ho se ts'itiso ea letho maemong afe kapa afe a ts'ebetso ona.

Batho ba kentseng letsoho ha bana ho patalisoa letho, 'me ho hlokomeloe hore ha hona motho ea tlang ho lefshoa letho.

Lipotso tse khethuoeng litla fanoa lebaka e le ho ntlafatsa li puisano nakong ea lipatlisiso tseo letsatsi le nako ea tsona litlang ho fanoa. Haeba o na le thahasello ea ho kenya letsoho o tla tsebisoa le ho joetsoa lintlha ka botlalo.

Ka mora hore lipotso tsa liphuputso li arajoe li tla ngoloa le ho etsoa hore li fumanehe litsing tsa bophatlalatsi.

Litholoana tsa lipatlisiso tsena li ka thusa hore ho tsoeloe pele ka lipatlisiso tsena ho fumana litaba tse felletseng ho ntlafatsa manane a thuto ho Batho ba phelang le ts'oaetso ea kokoana-hloko ea HIV le AIDS haholo-holo ka har'a naha ea Lesotho.

Haeba o hloka litlhakisetso kapa o batla ho tlohela ho kenya letsoho boemong bofe kapa bofe, o ka kopana le rona ka ho letsetsa femeng ho Mohokahanyi oa tsa Bophelo kapa moetelli-pele oa lipatlisiso. Liteboho li isoa ho uena ka ho amohela kopo ea rona ho nka karolo lipatlisisong tsena.

Oa hao mohlanka

Researcher: Ms Refiloe Stephania Mabathoana
Mofuputsi Box 117767, Maseru 100
E-mail address: rmabathoana.khetla@gmail.com
Linomoro tsena: +266 627 61503

Study leader: Ms Chantel van Wyk
E-mail address: vanwykc2@ufs.ac.za
Linomoro tsena: +27 51 401 7773

Contact details: Secretariat (Faculty of Health Sciences Ethics Committee):
E-mail address: EthicsFHS@ufs.ac.za
Linomoro tsena: 051 405 2812

APPENDIX B2

CONSENT TO PARTICIPATE IN THE STUDY

CONSENT FORM: SEMI-STRUCTURED INTERVIEW

TO: Study participants

Consent Form

Masters (HPE) project
titled:

INVESTIGATING FACTORS ASSOCIATED WITH HIV RISK TAKING BEHAVIOURS AMONGST PEOPLE LIVING WITH HIV AND AIDS (PLWHA) IN LESOTHO.

I (title and full names)

- I have been fully informed about the research study and my participation in the study
- I agree that the interview may be voice recorded and I understand that these recordings will be kept safe and my name will not be labelled on the recording.
- I freely agree to participate in this project, and acknowledge that should I wish to withdraw my participation, due to unforeseen circumstances or personal choice, I would be required to sign a Revocation of Consent Form which will be given to me by the researcher. I understand that this will not disadvantage me in any way.
- I understand that my identity and personal details will remain confidential
- I further acknowledge that I am aware that the results from this study will be made available to the Faculty Board of the Faculty of Health Sciences, UFS. The findings will also be presented at appropriate congresses and forums and for publication purposes.
- I understand that I will be given a copy of the Consent Form to keep.
- I am aware that I can contact the researcher and/or study leader of the study at any time should I have a concern.

Signature

Date

Signature of researcher

Signature of the independent
observer

REVOCATION OF CONSENT FORM: SEMI-STRUCTURED INTERVIEW

Revocation of Consent Form

For use only for participants who initially signed consent to take part in the project but now wish to withdraw from the project.

Regarding the Masters (HPE) research study titled:

**INVESTIGATING FACTORS ASSOCIATED WITH HIV RISK TAKING
BEHAVIOURS AMONGST PEOPLE LIVING WITH HIV AND AIDS
(PLWHA) IN LESOTHO.**

I (title and full names) _____, hereby wish to WITHDRAW my consent to participate in the above research project.

I understand that such withdrawal WILL NOT jeopardise my relationship with the researcher nor with the Division of Health Sciences Education and Faculty of Health Sciences, UFS.

Signature

Date

Signature of researcher

Signature of the independent
observer

APPENDIX B3
INTERVIEW SCHEDULE

SEMI-STRUCTURED INTERVIEW SCHEDULE

TO: Principal Researcher, Assistant Researcher and participants

Participants, Interview Schedule

With regards to the Masters (HPE)
project titled:

INVESTIGATING FACTORS ASSOCIATED WITH HIV RISK TAKING
BEHAVIOURS AMONGST PEOPLE LIVING WITH HIV AND AIDS
(PLWHA) IN LESOTHO.

Researcher: _____

Participants: _____

A: INTRODUCTION:

Topic/research question	Proposed Time allocated
1. Researcher welcomes the participant	2 min
2. Researcher introduction to the research and explain the interview procedures and rules	5min
	7 minutes

B: SEMI-STRUCTURED INTERVIEW:

BIOGRAPHICAL DATA (Duration 7-10 minutes)

Q1	Sex/Gender	A: Male B: Female
Q2	How old are you now? (Lilemo tsa hao li kae hona joale?)	A: 18-21 years B: 22-25 years D: 26-30 years E: 31 + years
Q3	(Education Level O balile sehlopha sefe sekolong?)	A: None B: Primary C: Secondary D: Tertiary
Q4	Marital status (o Nyetsoe)	A: Married with only one partner B: Married with more than one partner (how many?) C: Unmarried and in a relationship with a single partner (for how long?) D: Unmarried with several partners (specify how many?) E: Other (please specify?)
Q5	Do you have children? (Na ona le bana?)	A: Yes (how many?) B: No
Q6	Would you want to have children/ to have more children?	A: Yes (how many?) B: No (elaborate briefly on your reason not to?)

Q6	Which of these best describes where you grew up as a young boy or girl?	A: Village/Rural area B: Town/semi urban area C: Big town D: Capital city
Q7	Where do you currently live?	A: Village/Rural area B: Town/semi urban area C: Big town D: Capital city
Q8	Do you believe in/belong to any particular religion?	A: Yes (specify) B: No (elaborate briefly on your reason not to?)
Q9	Apart from being supported in the support group you are currently in, do you also get support from your family or friends?	A: Yes B: No

INTERVIEW QUESTIONS (50 minutes)

Question Number	Question	Proposed time for discussion
Q1	What do you think HIV risk-taking behaviour is/means?	5 minutes
Q2	Would you say people who are living with HIV can be re-infected/ super infected? (Yes/No) Then what do you think people living with HIV do to get re-infected or super infected?	10 minutes
Q3	What do you think people living with HIV and AIDS (PLWHA) do to transmit the disease?	5 minutes
Q4	What influences do you believe peers have on people's life choices and behaviours which may then put them at risk of HIV re-infection or infecting someone else?	5 minutes
Q5	What influences do you believe society has on people's life choices and behaviours which may then put them at risk of HIV re-infection or infecting someone else?	5 minutes
Q6	Would you say that if a person living with HIV is taking HIV treatment that it makes their chances less likely to be re-infected or to transmit HIV? (explore this question with asking – tell me more and what makes you think so)	5 minutes
Q7	In your opinion, do you think there will be a vaccine or a cure for HIV? (explore this question with asking – tell me more and ask the participant to put a timeframe to this)	5 minutes
Q8	What HIV risk-taking behaviours should PLWHA be informed about?	5 minutes

APPENDIX B4

EXAMPLE OF A FULL TRANSCRIPT BEFORE DATA ANALYSIS

Transcript of Semi-Structured Interview on 29 January 2015 13:00-14:00

Researcher: R Mabathoana

Observer: Lineo Mahula

Participant: 5 BB

Introduction and welcoming was done by the researcher.

DEMOGRAPHIC DETAILS

Q1	Sex/Gender	A Male B Female
Q2	How old are you now?	A 18-21years B 22-25years D 26-30years E 31 + years
Q3	Education Level	A None B Primary C Secondary- Form3 D Tertiary
Q4	Marital status	A Married with only one partner B Married with more than one partner (how many?) C Not married and in a relationship with a single partner (for 6 months) D Not married but in relationship with several partners (specify how many?)
Q5	Do you have children? a ona le bana?	A Yes (3 Kids) B No
Q6	Would you want to have children/ to have more children?	A Yes B No because I already three two girls and one boy so they are enough.
Q6	Which of these best describes where you grew up as a young boy or girl?	A Village/Rural area B Semi urban area C Big town Maseru
Q7	Where do you currently live?	A Village/Rural area B Semi urban area C Big town Maseru

Transcript of Semi-Structured Interview on 29 January 2015 13:00-14:00

Q8	Do you believe in/belong to any particular religion?	A Yes Christian
Q9	Apart from being supported in the support group you are currently in, do you also get support from your family or friends?	A Yes my Brother and my work manager

INTERVIEW

Q	Time	Transcript	Field notes
Q1		What do you think HIV risk-taking behaviour is/means?	
	5 min	<p><i>"It means continued exposure to unprotected sexual practices so this act of not protecting oneself is dangerous to PLWHA and to others for example not using condom which is sex is not safe. Especially us men. "</i></p> <p><i>"Men do not want to know about HIV issues so many of them are still really ignorant do not have factual information and this put them in danger...they also do not want to do anything like testing to know the status..... This means there are men walking around re infecting themselves and infecting other people. These people do not know that they have HIV"</i></p> <p><i>"There are many reasons why people always put their lives in danger especially with unsafe sexual behaviours among PLWHA. PLWHA have many problems and trying to cope with the disease is difficult to most people, are therefore seeking other means such as drinking alcohol which in return catches HIV are infection by having unprotected sex under the influence of drugs and alcohol"</i></p>	Relaxed, comfortable from the beginning present his ideas well and highly energetic, gives relevant info. Respected and approach issues in professional way using gestures, head nodding and uses both left and right hand gestures while speaking
Q2		Would you say people who are living with HIV can be re-infected/ super infected? Then What do you think people living with HIV do to get re-infected or super infected?	
	6 min	<p><i>"Yes, it is true they can be re - infected. We have a Support Group with my friends and we usually have workshops on HIV and AIDS, that's where I learned more about the disease". We are told in our workshops on HIV and AIDS that we can get re-infected when we do not take care of self, we are always advised continue to avoid unprotected sex to protect ourselves and others against HIV/AIDS. "</i></p> <p><i>Would you explain further?</i></p> <p><i>"I encourage people use condoms to protect one self. Young men between the ages of 20 and 30, who are either married or not married or staying far away from their regular partners, are the most likely to become infected with HIV and to infect others. The fact that they are often away from home makes them more likely to use sex workers, become infected with STIs, contract HIV and, in turn, infect their wives</i></p>	Relax and happy seemed to deeply know the subject matter used. Voice clear hand gestures while still responding.

Transcript of Semi-Structured Interview on 29 January 2015 13:00-14:00

		<p><i>and girlfriends. "</i></p> <p>Do you have further examples of this?</p> <p><i>"mmm...men are confronted with challenges to control their risk of HIV infection. Poverty result on job seeking, moving from rural areas looking for work in urban town can put people at risks to HIV infection. Being away from home encourages one to drink alcohol and to have extra marital affairs because of boredom. Women especially the young ones tend to have many sex partners in exchange for money and practice unprotected sex with many different casual partners, in general, much higher STI and HIV. "</i></p>	
Q3		What do you think people living with HIV and AIDS (PLWHA) do to transmit HIV infection	
	7 min	<p><i>"HIV negative partners are at high risk of acquiring HIV infection from their HIV positive partners, people living with HIV/AIDS might be aware of the risk some partner do not care that you have HIV, but I think whenever you have that behaviour you potentially introduce other infections."</i></p> <p>Do you have further examples of this?</p> <p><i>"Yes they do, safe sex is still not practiced enough within our own community with HIV positive people especially. Unprotected sex is associated stress and emotions, stress thus lead the individual to more likely engage in high-risk behaviours...such as not using condoms and having multiple sexual partners and engaging in sex under the influence of alcohol. The use of drugs and alcohol are used as a mechanism for coping with low self-esteem and depression can lead to unsafe sexual practices"</i></p> <p><i>"The issue of disclosing HIV status to the partner is always a problem, so this lead to non - status disclosure due for fear to loss of personal relationships, self-esteem , the need to love and the desire to feel loved therefore threaten the future of the relationship. "</i></p>	<p>Paused for 3 seconds Good start, know the content. Shared some relevant information. Smiling and still speaking with hand gestures, sitting comfortably looking straight to the facilitator.</p>
Q4		What influence do you believe peer shaves on people's life choices and behaviours which may then put them at risk of HIV re-infection or infecting someone else?	
	7 min	<p><i>"Mostly young girls learn from each other and practice dangerous sex acts in order to satisfy their partners There is a lot of information going around from friends..... Some information is true while others are myths, unfortunately wrong information travel fast. "</i></p> <p><i>"Lack of communication on sex issues...there is a tendency whereby parents are not having sex talk with their girls...Parents need to protect their daughters by communicating to them and ensuring they are aware of how to protect themselves if sexually active. Young girl are particularly vulnerable s do not listen to their parents...young women are encourages each other to have sex outside the marriage...."</i></p>	<p>Seemed enthusiastic & participated a lot communicate well. Begin to get asks the facilitator to repeat the questions if is not clear. Shared some relevant information. & seemed very popular</p>

Transcript of Semi-Structured Interview on 29 January 2015 13:00-14:00

		<p>What else can you say? <i>"Education programmes should take place to dispel the myths...People should be educated about HIV in order in order to have factual knowledge, to know more about condom use that proper and consistent use of condoms prevents transmission of HIV and other sexually transmitted diseases"</i></p>	
Q5		<p>What influences do you believe society has on people's life choices and behaviours which may then put them at risk of HIV re-infection or infecting someone else?</p>	
	6 min	<p><i>"...Gender contributes to increased HIV risks of individuals to get re-infected and transmit HIV...Women's position within the society, should be submissive to men, greatly increases their individual risks to HIV/AIDS."</i></p> <p><i>"Married women who want to protect themselves are suspected to be unfaithful if they ask their husbands to use condoms, Women are encouraged to go for testing...during antenatal care when tests are positive are blamed...Health men do not have such opportunities for testing HIV like women. However cultural norms encourages them to having different sexual partners to proof that they is a man and discouraging women to use condoms so this contribute significantly to transmitting HIV "</i></p>	<p>Present herself well and confident, knowledgeable and shares a lot of information Voice clear. Paused for 3 seconds. Comfortable and keen to contribute. Speaking using hand gestures to explain the movement both hands left to right.</p>
Q6		<p>Would you say that if a person living with HIV is taking HIV treatment that it makes their chances less likely to be re-infected or to transmit HIV?</p>	
	5 min	<p><i>"I do not belief that people living with HIV taking HIV the treatment make their chances of getting to be re-infected or to transmit HIV less because we are always told that If a person has contracted an HIV, that person is up to many times more likely to become re-infected as a result of unprotected sexual intercourse with an HIV-infected person. According to information we get from support groups HIV re-infection can occur even when are healthy because of the use of ARVS."</i></p>	<p>While speaking looking at the facilitator and the colleagues. Seemed relaxed, confident continue d smiling spoke with hands moving right and left while looking at the facilitator.</p>
Q7		<p>In your opinion, do you think there will be a vaccine or a cure for HIV?</p>	
	3 min	<p><i>"mmmmmm...we have learnt that the cure for HIV will come not soon maybe...hundred years I guess, I do advise people to protect themselves using condoms and adhering to our treatment. We have to avoid drinking alcohol while still taking our treatment...all in all, safe sex provide the ones protection against HIV transmission."</i></p>	<p>Maintained eye contact with a clear voice. Moved his leg and crossed them but still sitting comfortably. Seem to be knowledgeable with the subject matter.</p>

Transcript of Semi-Structured Interview on 29 January 2015 13:00-14:00

Q8		What HIV risk-taking behaviours should PLWHA be informed about?	
	3 min	<p><i>"They should always use condoms at all times, adhere to medication and stick to factual information as well go support groups where we get right information. Avoid misleading friends, especially young people listen parents and always find information to reliable source knowing ones status is important and people stop spreading wrong information purposely."</i></p> <p><i>"I also discourage sexual abuse, rape and transactional sex, often with older men, and multiple partners to proof manhood."</i></p>	Spoke confidently, very active as well sharing some relevant information with smile on the face, continuously looking at the facilitator.