

**A Contextual Assessment of a Workplace HIV/AIDS Peer Education Programme
in the South African Mining Sector**

Roslyn Anderson

Student Number: 203500936

Supervisor: Anil Bhagwanjee

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DECLARATION

Submitted in partial fulfillment of the requirements for the degree of Masters in Industrial Psychology, in the Graduate Programme in the School of Psychology in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, South Africa.

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

Roslyn Anderson

Date

ACKNOWLEDGEMENTS

To my Heavenly Father, Jesus Christ

To my Husband Simon, Parents Mark and Kerry, Family and Friends

To Anil Bhagwanjee

Thank You

PERSONAL MOTIVATION FOR STUDY

When driving through the streets of Durban I saw a child begging for money on the side of the road. I asked God what I could do to help this child and millions of other children like him, the simple answer that came: 'Help keep his parents healthy and employed.'

ABSTRACT

Set in the mining sector, the aim of this study was to explore the experiences, insights and reflections of a particular group of peer educator's with regard to their organisation's peer education programme. Using the PRECEDE-PROCEED Model (Green & Kreuter, 1991) as an organising framework, this study explored the pre-disposing, enabling and reinforcing factors that had an impact on this HIV/AIDS peer education programme.

The specific objectives to be assessed in this study were the peer educator's perceived impact on attitude and behaviour change amongst employees; the perceived organisational barriers and supports that peer educators encountered in programme delivery as well as further training needs of the peer educators. Using an interpretivist paradigm, the study was concerned with describing and interpreting people's feelings and experiences with qualitative depth. Interviewees comprised of a non-probability saturation sample of five current adult peer educators and one adult ex-peer educator, employed in the Eastern Region of the Organisation (KwaZulu-Natal). In addition the regional manager and the human resource manager were interviewed.

Semi-structured tape recorded interviews were used to collect data from the peer educators, and the data was transcribed verbatim from the digital recording. Themes were induced and coded by looking for reoccurring peer educator views, following which the researcher was able to induce potential predisposing, enabling and reinforcing factors that the peer educators faced in programme delivery. Based on the findings of the study, appropriate recommendations are

offered with a view to improving programme delivery and quality. Finally, the main constraints which limited the study findings are considered.

ACRONYMS USED IN THE TREATISE

AIDS Acquired Immune Deficiency Syndrome

ART Anti-Retroviral Therapy

HIV Human Immunodeficiency Virus

STI Sexually Transmitted Infection

VCT Voluntary Counseling and Testing

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CHAPTER ONE: INTRODUCTION

Sub-Saharan Africa is home to 60% of the world's 33 million people living with HIV/AIDS, of which 5,6 million are South African adults (ASSA, 2008; UNAIDS, 2008). This high infection rate of the economically active population means that HIV/AIDS is a significant threat to the South African business sector. The HIV/AIDS epidemic has already had a large impact on labour productivity and worker absenteeism and employee benefit costs. In addition, many businesses experience high labour turnover and hence high recruitment and training costs, lost experience and skills, lowered workplace morale and cohesion, poor use of managerial time and decreased reliability of supply chain and distribution channels as a result of HIV/AIDS (Rosen, Feeley, Connelly & Simon, 2007; Rosen et al. 2004; Veenstra & Whiteside, 2005; Whiteside, 2001). It is thus crucial that business responds decisively to the HIV/AIDS epidemic.

In responding to the threat of HIV/AIDS, one particular South African organisation, a corporate entity in the mining sector, implemented a comprehensive HIV/AIDS programme in their business over the past eight years. This study investigated a specific component of this organisation's HIV/AIDS programme, viz., the peer education programme. Peer educators were introduced as part of the HIV/AIDS prevention programme with a view to bringing about positive change in the area of sexual risk behaviours. The rationale underlying peer education is that group representatives are empowered, through specific training, to effect positive change among individuals from their peer group (Dickinson, 2006). Peer education is said to be one of the most effective educational intervention methods available (Hope, 2003), primarily because of

the similarity between message giver and message receiver, which is critical to message impact (Wolf & Bond, 2002).

The aim of this exploratory qualitative study was to explore the peer educator's experiences, insights and reflections with regard to the company's peer education programme. Semi-structured interviews were used to explore peer educator's perceptions of the organisational and contextual barriers and supports for the programme, the perceived impact of peer education on employee's attitudes and behaviours and further training needs of the peer educators.

Given the limited scope and resources available for this research treatise, the study was designed as the first phase in a more complex longitudinal investigation into programme efficacy, which should include process, outcome and impact measures. In addition to direct measures involving all programme stakeholders, such a study could, following Wolf and Bond (2002), incorporate indirect indicators such as the number of condoms being taken by employees, employees talking more openly about HIV/AIDS and disclosing their status as well as more employees participating in VCT.

In confining this study to peer educator's experiences, insights and reflections on the programme and its impact on employees', an interpretivist paradigm was adopted, which was concerned with describing and interpreting people's feelings and experiences by using in-depth qualitative methods. In addition, the PRECEDE- PROCEED Model (Green & Kreuter, 1991) was used as a planning framework in order to situate this study as the first phase of the large-scale investigation to follow. This model is a framework for planning and evaluating health promotion

programmes and views health behaviour as influenced by individual, organisational and environmental forces. It is an ideal planning framework for large scale research investigations, and will be elaborated on in the next chapter.

CHAPTER TWO: LITERATURE REVIEW

2.1 HIV/AIDS: Epidemiology and Impact

It is estimated that 33 million people are living with HIV/AIDS globally, with an estimated 2.7 million people being newly infected with the HI virus annually (UNAIDS, 2008). Over 60% of people living with HIV live in sub-Saharan Africa, including 5,6 million South African adults (UNAIDS, 2008). 20% of South African adults aged between 20-64 years (i.e. the economically active) are infected, including 1.6 million of the KwaZulu-Natal population (ASSA, 2008).

AIDS is said to be raising labour costs and diminishing the competitiveness of Southern Africa in the global market by “limiting the ability of African countries to attract industries that depend on low-cost labour and makes investments in African business less desirable. It therefore threatens the foundations of economic development in Africa” (Rosen et al. 2004, p. 324). Whiteside (2001) recognises that private businesses do not operate in isolation from the macro-economic trends of HIV/AIDS.

The direct costs of HIV/AIDS to business include recruitment, benefits and training. An indirect cost associated with HIV/AIDS is loss of productivity due to absenteeism of employees who care for the ill at home, attend funerals or due to their own illnesses. Further indirect costs include low performing ill employees, diminishing employee morale, loss of skills and experience and

the increased use of managerial time (Rosen et al. 2007; Rosen et al. 2004 ; Veenstra & Whiteside, 2005; Whiteside, 2001). Notwithstanding the complexities involved in measuring the actual costs of HIV to the business (Nattrass, Neilson, Bery, Mistry & Sievers, 2004), Rosen et al. (2004) reported that HIV/AIDS adds 0.4 - 5.9% to the company's annual wage and salary bill, and estimated that the cost of a new HIV infection ranged from 0.5 to 3.6 times the annual salary of the infected employee. Provincially, it is reported that KwaZulu-Natal businesses appear to be the worst affected by the epidemic (ASSA, 2008; Ellis & Terwin, 2004).

2.2 Men as the Target for Intervention

Due to biological, social and cultural factors, men play a crucial role in HIV transmission, with male behaviour classically placing women at increased risk of sexually transmitted infections (STI's), including HIV (Booyesen & Summerton, 2002; Elwy, Hart, Hawkes & Petticrew, 2002). This justifies a call to identify strategies and interventions that target heterosexual men and their female partners (Elwy et al. 2002). From a biological standpoint, interventions with heterosexual men are vital in controlling the spread of HIV, given that HIV is more easily transmitted from men to women than the other way around (Elwy et al. 2002). In some cultures women are not permitted to decline sexual intercourse with their partners or to insist on condom usage (Campbell & MacPhail, 2002; Colvin, 2000; Greene & Biddlecom, 1997; Gregson, Zhuwau, Anderson & Chandiwana 1998; Molassiotis, Saralis-Avis, Nyirenda & Atkins, 2004). Confounding this problem are social and cultural norms that allows men to have multiple partners outside of the home, thus increasing the risk of contracting and spreading HIV (Moses, Muia & Bradley, 1994). In a Zimbabwean study, for example, Gregson, Zhuwau, Anderson &

Chandiwana (1998) found that 57% of female respondents reported that their husbands had had other sexual partners.

Given that migration is an independent risk factor for HIV among men, due to a high risk of multiple partners and concurrent sexual relations, prevention interventions in the mining sector are urgently indicated in order to stop further infections (Colvin, 2000; Gregson et al. 1998; Lurie et al. 2003; Quinn, 1996). Migrant workers are amongst the groups of people that have been recognised as being at the highest risk of contracting HIV (Lampthey, 2002) and migrant men remain at high risk of infection even as they get older, as a result of a lack of social support (Quinn 1996; Williams et al. 2000). Since workforces in the mining sector comprise primarily of men, these workplaces offer a strategic setting for HIV intervention programmes aimed at the adult male target population.

2.3 Business's Response and Commitment to dealing with HIV/AIDS

Mervyn Davies, the group chief executive of Standard Chartered Bank had the following to say regarding business's response to HIV/AIDS: “The impact of AIDS on business and economic prosperity cannot be ignored. Our customers in many parts of the world and our own staff are threatened by the epidemic. For companies operating in regions where HIV/AIDS is having its greatest impact, the day to day operations of business could be compromised by diminishing productivity. We have to help solve the problem” (Davies, M in Nattrass et al. 2004, p. 3).

Rosen et al. (2004) supports Davies when she argues that AIDS will raise labour costs, reduce consumer numbers and create poverty amongst those who are left behind. Reduced productivity and increased HIV related costs are a threat to business (Whiteside, 2001). Business therefore needs to take on the vital role of mitigating the risk of HIV/ AIDS on business profitability (Nattrass et al. 2004; Rosen et al. 2003). Companies need to be aware of both direct and indirect costs if they are to have an incentive to invest in HIV/AIDS prevention and treatment initiatives. The average period between infection and HIV/AIDS related symptoms of 5-10 years, offers the opportunity to offset infection costs (Rosen et al. 2004). Thus, the net benefits of an HIV prevention programme can be determined by the 'avoided costs' of an infection less the cost of a prevention programme (Rosen et al. 2007).

Benefits of workplace interventions accrue not just to the individual, but also for the business that recognises HIV/AIDS as an urgent strategic issue that needs to be addressed. This is not only from a corporate citizenship standpoint, where maintaining work and income is vital for an HIV positive person, but also from a comprehensive understanding of costs involved. The protection of businesses most valuable resource, i.e. its employees, can be achieved by creating awareness, implementing prevention interventions and by providing treatment and support for employees (Maloon, Crous & Crafford, 2004; Ruys, A in Nattrass, et al. 2004). Given that HIV/AIDS leaves behind many orphaned children that are deprived of nutrition, education and skills transfer, problems accrue for the next generation of employees (Booyesen, 2004). Companies that offer care and treatment to their HIV positive employees allow them to be more productive and active in the workplace for longer, thus off-setting future costs. In this way, business can play a

strategically important role in containing the impact of HIV both financially and in terms of employee health and well-being and turning the tide on this epidemic.

2.4 The Settings Approach in Health Promotion

Given that the majority of the adult population spend approximately one-third of their daily lives at work, the workplace provides an excellent environment for promoting health. The workplace gives access to a target group of adults, primarily men. Employees are a captive audience whose participation can be encouraged and interventions can be easily followed up through the use of established modes of communication with continuous contact being very effective (Naidoo & Wills, 2000; Turner & Shepherd, 1999).

It is in the best interests of all stakeholders to encourage the development of healthy workers. The World Health Organisation (WHO) states that a healthy workforce is the most valuable asset for any country (WHO, 1999). By imparting knowledge and skills to employees that aims at better health management; workers and their families are due to benefit, as well as the workplace itself. Benefits of a healthy workforce include improved employee health status, increased job satisfaction, morale and worker productivity, reduced absenteeism and turnover, lower health care and insurance costs, a positive company image and market competitiveness (WHO, 1999).

Business has recognised both the adverse effects of this epidemic on the bottom line and the necessity to intervene. In particular, the workplace was identified as a niche setting for interventions targeted at men. In South Africa many large organisations have workplace

HIV/AIDS programmes in place, which include education and communication around HIV/AIDS, stigma and discrimination minimisation, condom distribution, voluntary counselling, testing and treatment, wellness programmes and family and community assistance (Dickinson, 2006). The mining sector in particular, with its predominantly male population, offered an ideal setting for these interventions and hence for this study.

2.5 The Organisation and its HIV/AIDS Programme

This South African corporate mining entity had a workforce of approximately 1600 employees and had work sites spread across all provinces in South Africa. The Organisation prioritised safety and HIV/AIDS as non-negotiable organisational priorities. It had implemented a comprehensive HIV/AIDS programme over the past eight years, including a Peer Education intervention as part of its prevention component. This study comprises a qualitative evaluation of the peer education programme conducted in the Eastern Region of the company's operations, viz., Durban.

The HIV/AIDS peer education programme was part of a strategic plan that had been systematically organised and implemented. The components of this strategic plan were as follows:

- Consultation and communication phase: this phase was aimed at acquiring the participation and buy-in of all stakeholders in the development and implementation of The Organisation's HIV/AIDS programme. A National HIV/AIDS task force with an appointed co-ordinator was

set up, with representation from the three trade unions active at the workplace as well as from management.

- Management training: this was aimed at securing management co-operation and support for the relevant stakeholders in their respective roles vis-a-vis the roll-out of the organisation's HIV/AIDS programme, and to train managers in crucial aspects related to the management of HIV/AIDS in the business.
- KAP survey (Knowledge, Attitudes and Practises Survey): This survey was conducted in 2005 and assessed employee's knowledge, attitudes and practises with regards to sexual risk behaviour and HIV/AIDS. The results of this survey were used to benchmark behavioural indices preceding the implementation of prevention and care interventions, with annual follow-up KAP surveys being used to monitor the success of the prevention interventions.
- Anonymous and voluntary HIV prevalence survey: A saturation sample of employees was tested to determine the prevalence rate of HIV in this organisation, stratified by site, gender and job grade. This served to benchmark actual disease prevalence against provincial indicators.
- Cost and impact analysis: Using the data from the prevalence survey, an economic cost and impact analysis of HIV infection was conducted. These cost projections informed a five year budget for the organisations HIV/AIDS programme.
- Peer Education: The Organisation implemented a comprehensive peer education programme as part of its prevention intervention. This programme formed the focus of this study.
- Voluntary Counselling and Testing (VCT) and treatment: These services were outsourced to an external service-provider and were provided at no cost to the employee. VCT campaigns

had been run annually and treatment for HIV positive employees was provided confidentially off-site.

- Ongoing media and communication campaigns: various campaigns (e.g. industrial theatre, World AIDS Day celebrations, high profile speakers, often people living with HIV/AIDS, had been consistently used to support these prevention and treatment interventions.

It is important to note that the timing and content of each phase of The Organisation's HIV/AIDS programme had been carefully designed to intervene at multiple levels. e.g. while peer education was a preventative intervention designed to change individual behaviour, psychological containment was offered through VCT and treatment. All this took place in the context of changes in the organisational tapestry where HIV was projected as a shared and serious organisational concern with organisational support systems being created and marketed throughout the organisation.

2.6 Rationale for Peer Education

This study focused on the peer education component of The Organisation's HIV/AIDS programme. Peer education was concerned with empowering group representatives through training or education to effect change among members in their group (Dickinson, 2006). Peer education has been used in campaigns against drug and alcohol abuse, teenage pregnancy and marital violence and has grown immensely in the area of HIV and STI prevention. Peer education is used worldwide and is thought to be one of the most effective educational intervention methods, primarily because of the similarity between message source and recipient,

which has been shown to be central to message impact (Hope, 2003; Wolf & Bond, 2002). This is especially the case where individuals are uncertain about their own opinions, and look to those in the same societal group or social standing for advice and guidance, implying that peer educators need to be seen as credible by their peers in order for them to be influential (Turner & Shepherd, 1999). Peer educators need to possess a range of competencies such as leadership and communication skills, domain knowledge, reliability and the ability to maintain confidentiality. They need to become change agents by acting as facilitators, guides and motivators (Hope, 2003).

In peer education, the control of knowledge is transferred from experts to selected lay members of a group, who are then tasked with educating their peers to bring about behavioural change. Peer educators make the information and educational process not only more accessible to their group members but also less intimidating for them. A further product of peer education is that it facilitates group negotiation of messages and appropriate behaviours, with an emergence of new collective norms (Harrison, Smit & Myer, 2000). The development of new collective norms, attitudes, beliefs and behaviours with regard to sexual health in a country stricken with HIV/AIDS are vital. Successful peer education programmes are reportedly those that are based on sound theoretical approaches (Harrison et.al. 2000).

2.7 Peer Education - Training Process and Course Content

In this organisation, peer educators were either nominated by their peers or volunteered and were selected on the basis of pre-defined criteria and qualities as described previously. Once selected,

peer educators attended a three day course where they were trained in all relevant aspects of HIV/AIDS, including:

- The epidemiology of the HIV/AIDS epidemic globally and in South Africa
- Economic and legal issues with regards to HIV/AIDS in the workplace
- Defining HIV and AIDS
- Stages of the disease (Window period, HIV well phase, HIV III phase, AIDS)
- How the virus is spread, as well as how the virus is *not* spread
- Sexually transmitted infections
- Protection and prevention
- High risk behaviour
- Condom usage and negotiation
- HIV antibody testing and treatment
- Factors affecting behaviour change
- Confidentiality issues
- Care and counselling
- The importance of HIV/AIDS education
- The roles and qualities of a peer educator
- Presentation skills

Once the peer educators had been trained they were responsible for transferring their knowledge and skills with regard to HIV/AIDS and sexual risk behaviour to their peers in the organisation through the medium of half day workshops. Peer educators were responsible for planning their

workshop/s and arranging the venue and necessary teaching aids, such as whiteboards or condoms for demonstration. The peer educators were empowered for this purpose with pedagogical skills in their training workshops, with other organisational stakeholders (management and shop stewards) being briefed to support them in their tasks.

2.8 Peer Education and Transformative Learning

The Organisation had used peer educators as a means to bring about transformative learning in employees with regards to HIV/AIDS. Transformative learning is a type of learning that aims to change one's frame of reference. "Frames of reference are the structures of assumptions through which we understand our experiences. They selectively shape and delimit expectations, perceptions, cognition, and feelings and set our 'line of action'" (Mezirow, 1997, p. 5). The peer education intervention may thus be understood as a means by which to transform people's mindsets with regards to HIV, testing, stigma, condom use and multiple sexual partnerships. A study in Zambia has shown that peer educators have been successful in transforming mindsets and have brought about changes in cultural norms and practices (Hughes-d'Aeth, 2002).

Transformative learning is concerned with four distinct learning processes (Mezirow, 1997). viz.:

- The first is where an *existing point of view is elaborated on*, to re-iterate it (for example: HIV leads to AIDS).
- The second is to *establish new points of view* (for example: hearing about Anti-Retroviral Therapy (ART) for the first time).
- The third process in transformative learning is to *transform one's point of view* (for example: the benefits of condoms make using them worthwhile).

- The forth and final way that one may transform one's frame of reference is by becoming aware and *critically reflective* of one's generalised biases (for example: one's idea that white people cannot get HIV).

The peer education programme should have ideally incorporated all four of these processes in its aim of bringing about transformative learning.

In this intervention, two parallel learning processes take place. There was the learning of the peer educators themselves which was beneficial as they learnt about HIV/AIDS and developed new skills and competencies (Molassiotis et al. 2004; Turner & Shepherd, 1999). The other learning process that took place was that of the employees who attended the peer education seminars, where they learnt about HIV/AIDS from the peer educators.

Not only were peer educators educating the workforce about HIV/AIDS and enabling a re-negotiation of peer norms through their message and behaviour (Campbell & MacPhail, 2002; Wolf & Bond, 2002), but they had also gained new competencies and skills as a consequence of the learning-and-teaching process. It would be in the interest of every organisation to have employees who are autonomous and socially responsible thinkers, who are able to identify common problems, mobilise resources and develop strategies to achieve organisational goals (Mezirow, 1997; Rimer & Glanz, 2005). If the method of transformational learning (which the HIV/AIDS peer education intervention was meant to encourage) could be transferred to other areas in a peers job description and even beyond, an organisation that embraces change would

emerge. The organisation that embraces change and values transformative learning of its employees is sure to have the cutting edge of competitive advantage in the 21st century.

2.9 Evaluating Peer Education Programmes

While peer education as a prevention intervention for HIV/AIDS is reportedly very popular, the underlying processes that lead to success or failure of peer education have not been well documented (Campbell & MacPhail, 2002; Wolf & Bond, 2002; Wolf, Tawfik & Bond, 2000). Evidence suggests that peer education programmes are more likely to be effective in improving knowledge rather than impacting positively on behavior change (Shen, Hong, Cai, Jin & Shi, 2008). However, Molassiotis et al. (2004) found that a workplace peer education programme reviewed in Zambia had had a positive impact on attitude and behavior change, to the extent that peers had re-evaluated the risks inherent in their own sexual behavior. Likewise, some peer education programmes conducted in Mozambique, Tanzania and Ghana have been shown to be effective in reducing the levels of HIV infection and increasing condom use (Luakamm- Josten et al. 2000; Vaz, Gloyd & Trindade, 1996; Wolf, et al. 2000).

Sloan and Myers (2005) report that the literature evaluating peer education programmes is inconsistent, and that, in their own study, the HIV/AIDS peer education programme in a South African retail group was found to be ineffective. They argue that more costly and comprehensive programmes (such as the one at this particular organisation), which include Anti-Retroviral therapy (ART), may be more effective. Coates et al. (2000) and Lamptey (2000) confirm this argument and suggest that effective programmes included: VCT, prevention of mother to child

transmission, clinical care and ART treatment. Dickinson (2006) called for further investigation aimed at understanding what peer educators bring to the company and their role in re-defining the moral fabric of the company. Lack of time, funding and technical expertise have been said to result in rigorous evaluation of peer education programmes being rare (Wolf & Bond, 2002). Rosen et al. (2004) stress the importance of information on the effectiveness of these interventions in order to determine cost-benefits. Monitoring programme successes and weaknesses over time can provide vital information to policy makers and programme planners by indicating where future efforts should be focussed (Wolf et al. 2000).

It was very difficult to determine the effects and effectiveness of the peer education programme in producing behaviour change amongst the peers trained. This left peer educators to use their own perceptions of employees' behavioural intentions to gauge whether employees were acting on their messages. Some indirect indicators that may have been used by the peer educators include: more condoms being taken home by employees, employees talked more openly about HIV/AIDS and their status, more employees went for VCT at the organisation, etc. Wolf and Bond (2002) argue that since peer education is meant to influence norms, the tracking of peer perceptions, behaviours and encounters over time could shed light on programme diffusion and impact. However, how peer educators influenced these norms is also somewhat unclear (Wolf, et al. 2000). This study was therefore concerned with assessing peer educator's perceptions of employee's behaviour change and the organisational and contextual factors that they perceived to be impacting on their programme, as well as determining their further training needs.

2.10 Theoretical Framework

The study used the PRECEDE-PROCEED Model (Green & Kreuter, 1991) as an organising framework. PRECEDE-PROCEED is a framework for planning and evaluating health promotion programmes and views health behaviour as influenced by individual, organisational and environmental forces. There are two distinct parts to this model: PRECEDE, which is concerned with programme planning, and PROCEED, which is concerned with implementation and evaluation.

PRECEDE and PROCEED work together in offering a series of nine steps for the planning, implementation and evaluation process (Green & Kreuter, 1991). The first five steps are diagnostic and address the educational and environmental issues, viz.:

Step 1: Social diagnosis

This initial step looks at social problems of concern that a particular population faced. It is a collaborative process of examining the populations' social needs together with stakeholders.

Step 2: Epidemiological diagnosis

In this stage, the social problems identified in step one are examined specifically in terms of the health problems that have contributed to the social problems that are experienced. The most deserving specific health problem is chosen as the one to be addressed further.

Step 3: Behavioural and environmental diagnosis

Here specific health related behaviours and environmental factors that may be linked to the health problem are highlighted. These are factors that the intervention would be customised to address. Environmental factors are external to the individual and can be altered to support the behaviour and the health of the individual. Environmental factors play an important role and it is crucial that cognisance is taken of specific environmental factors that individuals may be facing.

Step 4: Educational and organisational diagnosis

There are numerous factors that can influence a particular health behaviour. Within the PRECEDE part of the model, these factors are grouped according to whether they are Predisposing, Enabling or Reinforcing factors. **Predisposing factors** are those which encourage or hinder specific behaviours and motivation to change. These include knowledge, attitudes, cultural beliefs, values, perceptions and readiness to change. **Enabling factors** are the skills, resources and supports that make a desired change in behaviour or the environment possible. Enabling factors can also be factors that hinder desired behavioural and environmental changes. These supports and barriers are often created by societal forces and organisational systems. **Reinforcing factors** are those which come into being after a specific behaviour has taken place. These factors encourage repetition of the desired behaviour. These may include social support, praise and reassurance (Green & Kreuter, 1991; Rimer & Glanz, 2005).

Step 5: Administrative and policy diagnosis

Once steps 1-4 have been considered, one needs to consider the administrative capabilities and the available resources for the intervention. In addition the methods and human resources to be used also need to be determined.

The remaining four steps (steps 6-9) consist of the implementation and evaluation of the intervention. Evaluation is an important and a continuous part of the PRECEDE-PROCEDE model. The steps comprise Implementation (Step 6), Process Evaluation (Step 7), Impact Evaluation (Step 8) and Outcome Evaluation (Step 9).

In practise the PRECEDE-PROCEED model operates as a continuous cycle. The PRECEDE steps of the model provide the criteria used later in evaluating the programme, which is detailed in the PROCEED steps. These PROCEED evaluation findings then feed once again into the PRECEDE (planning) steps of the next phase of the programme. Thus the model operates in an iterative manner.

This study was located specifically in Step Four of the PRECEDE-PROCEED model (the Educational and Organisational Diagnosis), which is concerned with the Predisposing, Enabling and Reinforcing factors that influence a particular health behaviour. This phase takes into consideration the factors that Predispose, Enable and Reinforce the peer educators in their roles as change agents. In unpacking the Predisposing, Enabling and Reinforcing factors impacting on peer educators in their roles, reference is made to additional theories such as The Health Belief Model (Nutbeam & Harris, 1999) and Social Learning Theory (Bandura, 1969).

While Step Four of the PRECEDE-PROCEED model (the Educational and Organisational Diagnosis) is usually concerned with informing the planning rather than the evaluation of interventions, this exploratory study deliberately inverts this process. Given that this study

represents the first attempt and indeed the first exploratory step in evaluating the company's peer education programme, it was deemed appropriate to identify the Pre-disposing, Enabling or Reinforcing factors that will subsequently be used in re-designing the peer education programme, as per the parameters of the PRECEDE-PROCEED model. Indeed, it makes sense to evaluate the peer education programme using the same criteria that will be used in planning the next phase of the programme.

2.11 Research Problems and Objectives: Key Questions to be Answered

The aim of this study was to explore the peer educator's experiences, insights and reflections on the peer education programme within the organisation in order to gain a better understanding of the Predisposing, Enabling and Reinforcing factors that inform the programme, specifically with regard to:

1. Their perceived impact on attitude and behaviour change amongst employees.
2. The perceived organisational barriers and supports that the peer educators encountered in programme delivery.
3. Further training needs and roles of the peer educators.

These issues were assessed qualitatively through the use of individual interviews. The findings of this qualitative study, restricted to peer educators at one site in the organisation, will be used in designing a comprehensive longitudinal study, utilising qualitative and quantitative data collection methods from multiple sources, to assess the efficacy of the peer education programme and to generate recommendations for its improvement.

2.12 Significance of the Study

It would appear from the literature review that peer education is a very popular methodology in workplace HIV/AIDS prevention programmes. This case study, conducted from an interpretivist stance, sheds light on what works, what doesn't and why and in so doing enables reflection on the theoretical and epistemological underpinnings of peer education as a methodology.

Despite the non-generalisability of the findings of this qualitative study, this research project has the potential to throw up generic issues which need to be taken into account in order to inform and improve workplace peer education programmes beyond the site of the study. Building effective peer education programmes with an optimal influence on attitude and behavior change of employees, carries the potential for profound impact on the reduction of risk behavior at the workplace and beyond.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Research Paradigm

Using an interpretivist paradigm, this study explored the subjective experiences, insights and reflections of the peer educators with regard to their workplace peer education programme.

The interpretivist paradigm is concerned with describing and interpreting people's feelings and experiences with qualitative depth. The researcher aimed to listen and capture what people were saying in their everyday language and expression through direct interaction with them. The interpretive approach relies on first-hand accounts and describes emerging data in rich detail. Terre Blanche and Kelly (2002) stress the importance of using context to inform interpretation. Accordingly, the interviews in this study were scheduled in participants' workplaces in and around the Durban region, thereby enabling the researcher to understand the phenomenon in its natural setting. Thus, in keeping with the interpretivist paradigm, the researcher attempted to become a natural part of the context. To this end the researcher attended local Peer Educator meetings, joined a three-day training course for new Peer Educators and attended the organisations national peer educators' conference in Gauteng.

3.2 Research Participants

The study population comprised of adult peer educators who were employees in the Eastern Region of the Organisation (KwaZulu-Natal). The Organisation was chosen on the

basis of convenience in that it had a well established and comprehensive peer education programme. Further, the management and wellness staff were keen to support and participate in this study, and were thus likely to reflect on and implement the recommendations arising from the study. The peer education team in the Eastern Region of the Organisation was selected because of convenience for the researcher in terms of access to the sample and minimisation of study costs. A non-probability saturation sample of five current peer educators and one ex-peer educator comprised the study sample. In addition, semi-structured interviews were conducted with the Regional Manager and the Human Resource Manager (HRM) in order to validate and contextualise the findings, especially as they related to organisational barriers and supports for the peer education programme.

3.3 Research Measures and Procedure

Interviews were used for data-collection as they allowed for a natural way of interacting with people and offered a good fit with the interpretivist approach. A semi-structured interview enabled the Peer Educators to talk freely and in depth about their experiences, their perceptions regarding their roles and training needs; and the perceived barriers and supports for the Peer Education programme. The semi-structured interview schedule (Appendix One) was derived from a close review of the empirical literature on peer education and was also informed by the theoretical framework for the study.

The settings for the interviews were private and uninterrupted. All interviews were recorded with the informed consent of participants. The researcher began the interviews

with a question that was easy to answer and not of a sensitive nature, such as, ‘*How long have you been a Peer Educator?*’ later moving on to more open-ended conversational questions such as, ‘*Please tell me about your experience as a Peer Educator.*’ The researcher was very familiar with the semi-structured interview probes and so did not need to refer to the interview schedule. The approach used aimed to conduct the interviews in a conversational style where participant’s experiences were privileged.

Through the process of conducting the semi-structured interviews, the researcher iteratively gained a better understanding of the peer educators experiences, insights and reflections associated with their roles, in addition to noting any new and interesting comments or perceptions (Terre Blanche & Kelly, 2002).

3.4 Data Analysis

Throughout the interview session the researcher took progress notes. Following the interviews, the researcher transcribed each interview verbatim from the digital recording. Transcripts were re-read numerous times in order to ensure the immersion of the researcher in the research material. Following the technique described by Ulin, Robinson, Tolley & Mc Neill (2002), the researcher analysed the transcripts, making notes of recurring themes or points of interest through the process of thematic analysis. Notes were made along the margins, using coloured pens to link similar ideas. The researcher made mind-maps to help make sense of the research material. Themes were induced using the bottom-up approach where the material was examined in order to determine what the “organising principles are

that ‘naturally’ underlie the material” (Terre Blanche & Kelly, 2002, p. 141). The research material was coded according to relevant themes. Once coding had taken place the researcher was able to distinguish the material into thematic groups and was able to determine sub-themes from these groups (Terre Blanche & Kelly, 2002).

3.5 Ethical Considerations

Approval for the study had been obtained from the Higher Degrees Committee of the Faculty of Humanities, Development and Social Sciences and ethical clearance was obtained from the ethics committee of the University of KwaZulu-Natal (Appendix Two). Permission for entry into the organisation had been formally obtained from management (Appendix Three), with further consultations with union shop stewards and peer educator representatives. In addition, informed consent was obtained from all interviewees (Appendix Four). All participants were briefed on the aims and objectives of the study, were fully informed of their right to withdraw from the study at any stage if they so desired and were assured of the absolute anonymity and confidentiality of their individual comments (Blaxter & Huges, 1998). Participants were interviewed in their relevant workplaces; appointments were made and clearance given by management for the employees to have time off from work in order to participate. Finally, the results of this study were reported back to management and peer educators in a dedicated workshop called for this purpose, so as to enable the Organisation to act on the findings and recommendations of this study.

CHAPTER FOUR: FINDINGS

The PRECEDE-PROCEED model was used as an a-priori organising framework to distil the peer educator's subjective experiences, insights and reflections on the peer education programme. As this study was located in Step Four of the model (the Educational and Organisational Diagnosis), this chapter presents a thematic analysis of the data, organised in terms of the predisposing, enabling and reinforcing factors that either supported or impeded programme delivery.

4.1 Predisposing Factors

Predisposing factors refer to a person's knowledge, attitudes, beliefs, values and perceptions that impact on individual and organisational behavior (Green & Kreuter, 1991). These predisposing factors are presented thematically below in terms of their negative or positive influence on programme delivery, i.e. the extent to which they supported or hindered the peer education programme.

4.1.1 Predisposing factors that hindered peer education programme delivery

HIV/AIDS constructed as a product of apartheid

Peer educators reported facing many initial obstacles to their work, arising primarily from employee's entrenched beliefs, attitudes and perceptions about the disease and its origins. In particular, peers demonstrated hardened beliefs that HIV was simply a construction of the apartheid system designed to frighten and control black people, and alternatively a view that,

even if real, HIV was deliberately transmitted by apartheid agents. In either case, this predisposed peers to be skeptical in their response to the scientific information that peer educators presented and undermined their perceptions of the severity and their personal susceptibility to HIV. Peer educators reported that this situation improved and peers became more receptive to HIV education over time.

PE 3: When I started to talk about HIV no one was ready to listen. People said that I was talking nonsense because this thing comes from the government who is trying to frighten us. So I try to explain that HIV is really killing us guys- you must listen and you can help yourself. But they understand now.

PE 5: We are trying to win people here who are so deep in dark mindsetswhen I first started talking about HIV, they said it was from someone like Basson, who gave it to the people. So I explained to them, that no it is not from Apartheid, don't worry about that, it is a disease and then when they see it is killing their closest friends that is when they realise now this is serious.

Employees negative mindsets towards HIV/AIDS

Peer educators reported some peers distorting the information that was given, in that they referred to the immune booster tablets and porridge that all peers are given, free of charge, as 'AIDS tablets' and 'AIDS porridge' respectively.

PE 1: They will sit down at lunch time and analyse my speech or lessons in a way that suits them....we get porridge from Human Resources, and you know what they call it- AIDS porridge.

PE1: We've got those bad fishes. So we must catch them. Every morning I have my porridge before I start my work, they see me eating my porridge, 'Hey you got AIDS-why you eating that porridge?' I said no, you can see how fit I am, I never been to the doctors my friend. They say, 'Ah you mean it is good porridge?' I say I run 10km in 20 mins, Have some. Now they have started asking for the porridge again.

It appears from the interviews with peer educators that these mindsets and conspiracy theories receded as peer educators ironed out misconceptions, and dealt firmly with rumors at the source.

4.1.2 Predisposing factors that supported peer education programme delivery

Peer educators reported that peers knowledge, attitudes, beliefs and emotional reactions with regard to HIV/AIDS started to change as a result of peers' personal experiences of seeing loved ones infected and dying, and employee's fears for their own children's safety.

PE 3: They see how bad this thing is, they saw someone dying because of this and they start shivering. 'I want to know about these things; especially as I was worrying about my children.'

PE 5: Employees attitudes towards peer education has changed; whereas previously I had to remind them of our session, they now ask for the session and many people now attend, because they want to hear whether we have a cure or whatever, and they want some advice as well.

4.2 Enabling Factors

Enabling factors refer to supports, resources and skills that determine the possibility of desired behavioral and environmental change (Green and Kreuter, 1991). Enabling factors also include the factors that hindered desired change.

4.2.1 Enabling factors that supported peer education programme delivery

A range of environmental cues enabled programme delivery and success. These factors are presented thematically below.

4.2.1.1 Organisational systems pertaining to the HIV/AIDS programme

Organisational systems in place pertaining to the company's HIV/AIDS programme reportedly had a positive impact on peers' attitudes and behaviours with regard to sexual risk practices. These included the peer education programme, VCT and free condom distribution. This combination of systems and resources, backed by positive environmental changes, appears to have helped to create an enabling environment in which the HIV/AIDS peer education programme operates.

HIV/AIDS knowledge derived from the peer education programme

The knowledge that peers gained from the peer education sessions facilitated a better understanding of HIV/AIDS, including transmission modes, the role of STI's, the importance of using condoms, the benefits of testing, and the mechanisms and beneficial consequences of treatment. It was clear from the interviews that much groundwork was done by the peer educators to get peers to believe that they were susceptible to HIV/AIDS, that the consequences of HIV/AIDS were serious, that the benefits of being tested were significant, and that treatment was necessary. This seems to have had a positive impact on peers.

PE 5: Before they didn't understand (about HIV) but now because of the peer education programme they know exactly so they participate in our HIV/AIDS activities and more and more of them come forward for testing and their attitudes and behaviours are different.

PE 3: They want to know, I'm sure of that because even their cross questioning of me which they used to do has stopped now, they talk nice now. It is clear that they want to know now; they want to understand everything about HIV/AIDS now.

Peer educators' support for HIV positive peers on treatment

Peer educators were positive about their impact on supporting peers to access treatment services through the external treatment service provider.

PE 5: I encourage them to just talk about the treatment, you know if you are going to get your tablets or whatever then we know how to help and try and make it easy for you.

PE 4: When he wanted to speak to the external doctor about his treatment, he asked me to translate for him on the phone, and I assisted him. It is working very well; with me backing up the external company by listening to my peer and supporting him, he goes for his treatment and takes his tablets as they prescribed, so he is very well, you can't even see that he is sick.

Building an environment conducive to disclosure of one's HIV status

Peer educators have worked hard to establish an environment where peers feel safe to disclose their HIV status. They have drawn on existing strengths such as inter-personal trust and personal vulnerability to secure close knit relationships where peers felt they were able to share their status with others.

PE 1: Now I believe some of the guys from the plant trust me because they never heard me talking about anybody else, they do not know who is infected, who is not infected. This has really helped them to talk openly to me about their concerns.

One of the peer educators is a manager and he said that this helped him as he was able to close his office door and talk in private with infected or affected peers.

PE 5: Right from the start because the guys knew me, during the day if they want to talk I close my office door. There is one guy who is telling everyone, talking about his status. He is talking about it. He is helping other people do the same because some are scared, if he is free to talk about it, then they must be also.

This peer educator's managerial position also allowed him to negotiate time off for peers who needed to go to the doctor or attend to matters at home.

PE 5: One of them came to me and said that he is all alone; he is infected; now he is all alone, there is no body at home, so I gave him some time off, just for him to look after the kids.

It appears that peers sought peer educator's advice when it came to disclosing their positive status to partners.

PE 5: 'How can I tell my family'; they ask me some things like that. So I help them go through the steps of disclosure to their partners and loved ones.

Ensuring condom availability and helping to bring about transformative learning

A further role of the peer educators was to play an active role in ensuring that there were always condoms available in the organisation for peers, drivers and sub-contractors, thereby creating an environment in which safe sex practices were promoted.

Human Resource Manager: I asked the Peer Educators at each plant firstly to monitor those condom dispenses, make sure there are always condoms there. If not go to the Managers and ask for them, if they are not around, you can phone us.

Peer educators appear to have made inroads in bringing about transformative learning in the organisation. For example one peer educator recounted his story of how he used transformative learning principles to change his peers' perceptions towards wearing condoms. The peers' existing frame of reference was that condoms broke easily.

PE 6: The first time there was a big issue about condoms, telling me this and that, 'aish, I know how to do this', 'I use it everyday'... 'ay, this thing it breaks off', and 'sometimes when I am busy it comes off.' And I say ok, maybe you have got to tell us how you use it. And then the moment he starts explaining to us that's when I realise he is using it the wrong way, because if you look at the condom, it has got two parts, what is it you call this thing, oil, the one part has got oil, the other part it is dry, so the way he was using it, he was putting the one that was oil inside and the one that was dry outside, so then the first time when he starts to use it, it comes out. So when I started telling him how to use it most of the guys they say hey, 'that's why I have a problem like this', then they start to use the condom frequently as I'm saying now if you go to the plant you won't find full box of condoms, because they are using it now and again, because they realise.

The peer educator gave his peers a chance to explain how they were using the condoms. The moment they started explaining how they used them he realised that they were using them inside

out. He was able to get them to see that if they used the condoms the right way around that this would not be a problem. The point of view that condoms just 'break off' needed to be transformed if peers were going to start using them, and change their behavior. Through a process of the peers demonstrating the incorrect way and then later the correct way to use condoms this point of view was transformed and condoms were reportedly being used more frequently.

In addition to this particular peer educator's report of condoms being taken, there are other behavioral intention indicators that peer educators had noticed. For example: An increased uptake in VCT, a noted increase in the number of times male peers return to their rural homes, a noted decrease in the number of casual sexual partners male peers have and an increase in male peers talking to their children about HIV. Peer educators ascribed these changes to the impact of the peer education programme and these changes in turn supported and enabled the prevention programme to become more successful and operate to its optimum. Therefore further supportive enabling factors included:

Increased VCT uptake

The Peer Educators reported that there used to be much fear associated with testing and peers were reluctant to go forward for VCT. Peer educators have however reported an increase in testing numbers, which was confirmed by the company's statistical records. They felt the main reason for the increase in testing uptake was that peers had become aware of their need to be

tested and associated benefits of testing. They allegedly wanted to know their status, in order to take the relevant action steps to live longer.

PE 3: But now they are going for VCT, they want to know their status.

PE 5: They want to find out, and we show them now, if you don't know you have got HIV your CD 4 will go right down, and if it goes right down then there is no chance for you to come back so they want to find out quickly so they can catch it.

Increased visits to one's rural home and suspected decrease in casual partners

One of the peer educators reported an increase in the number of times his male peers return to their rural homes thus spending more time with their families and less time with casual partners.

PE 5: They have changed, they have changed so much now, because even the guys that never used to go home when they get paid, now they are going home to their family, because they are staying far away from their family, so when they get paid they used to just send the money, but now they are going home. They tell me they now know, I will be happy there, instead of sitting here, and then somebody else takes a chance with me.

Peer educators reported that they perceived a difference in the number of casual sexual partners their male peers had.

PE 3: The guys have many partners, casual ones. But after they saw and learnt how HIV is killing us, they changed their minds and their behaviour. They know now that when they see the ladies coming around, they need to think carefully before they act and stay away from these quick relationships- I know this because they tell me so.

One Peer Educator reported that older male peers were initially reluctant to hear about HIV and condoms - they thought themselves to be exempt from these precautions due to their age, until they were told and understood that their younger girlfriends might transmit the virus to them.

PE 5: They say, 'not me, I am old,' I say I know you are old but you are still meeting these young ladies. I said you can never satisfy the young lady because you are old. She is coming to you maybe for money but she has still got someone else so she can give you the virus also.

Peer educators worked at encouraging peers to have trusted girlfriends that they can talk to about condoms. There seemed to be consensus that it was easier to negotiate safe sex with ones girlfriend than ones wife, since girlfriends were aware of HIV/AIDS and how it is transmitted.

PE 3: That's what I told them, take her to the test, if you are ok you must protect yourself, don't get that thing (HIV), you must use condoms. But you can do that if you are both

young, the ladies of this time they know about condoms and the need for protection and testing- you must support that and give them the right message.

Reported increase in male peers talking to their children about HIV/AIDS

There were also reports of male peers who, despite finding it difficult to talk to their wives about HIV, engaged their children in discussions about HIV and encouraged them to go for testing. This indicated that the HIV prevention programme was reaching not only employees themselves but also being diffused to their children.

PE 5: Because of our culture, I will say it was surprising to hear that men are now talking to their daughters, to their kids about HIV/AIDS and safe sex. I think they feel guilty because they can not tell their wife exactly that they are having an affair with someone else. But they are telling their kids about safe sex, they are so open with them. Ja, so they are talking, although it is difficult to talk to the partner, but they are talking to the kids and that is a great thing.

4.2.1.2 Peer educator's perceived supports in their role

In examining enabling factors within the organisation it was important to look at the supports that are in place that enabled peer educators in their role as change agents. The participants reported positively on a number of interventions that had been put in place to empower the peer educators in their roles.

Peer educator's mutual support for one another

It was clear that the first line of support for the peer educators was one another. In this regard, peer educators talked to one another, shared their concerns and brainstormed how to handle difficult or sensitive issues that they were confronted with.

PE 2: We talk quite a lot, after every session, we just talk - how the session went, were people interested and what questions did she get and that. We also rely on one another to help out on advice in how to handle some questions and issues.

Human Resource Manager: We are introducing peer educator coordinators as there are certain sections in the peer education programme that you may find that the person battles to understand and you have been explaining it and you realise that you will need assistance from a senior peer educator.

Support from the HR department

Peer educators would contact the Human Resources department for anything that they needed in discharging their roles. They knew that they could rely on their support.

Human Resource Manager: If you have got a problem you can bring it to our attention and we can also go and help.

PE 1: Our HR department supports us...our managers were organised by the HR department (received HIV/AIDS training and de-briefed on the role of the peer educator).

PE 6: Sometimes I used to phone the HR manager, she is so happy to help me.

4.2.2 Enabling factors that hindered peer education programme delivery

Environmental factors which were found to dis-enable peers and hinder change are discussed in this section, with particular attention to perceived organisational and societal barriers that peer educators encountered in programme delivery.

4.2.2.1 Lack of VCT and treatment services for drivers and sub-contractors

Peer Educators reported significant concern with regard to the fact that drivers and sub-contractors at the organisation were excluded from the VCT and treatment services offered to full-time employees. This impacted negatively on the peer education programme and left some peer educators feeling helpless to assist these drivers and sub-contractors.

PE 3: The Company can not help them if they are affected. I don't know if it can help to educate them about HIV/AIDS, and then if they have problems, we can't help them with these things. I don't know what to do about this - they work with us and this is not good.

PE 4: Most of the time the drivers are the people who are asking me to assist them if they need something, like condoms, but I can't really help them with treatment if they are infected.

However there were peer educators who realised that although they could not offer VCT and treatment to drivers and sub-contractors they could still share their learnt knowledge about HIV/AIDS with them.

PE 6: I had some drivers with me at that time so I involved them in my peer education session, so it was so easy, I trained them, but I never promised them anything, the only thing I gave them was knowledge.

PE1: What I would like to do with them is organise a day or some time during the month that I can talk to the drivers about HIV/AIDS because they also have problems. They come along with other sicknesses too and they ask me about them because they are worried and have nowhere else to turn to.

4.2.2.2 Operational barriers (Time)

It was clear that the peer education training sessions were not happening in half day slots as planned, due to a lack of time.

PE3: We are working flat out so trying to fit in Peer Education is a little difficult. Also, some people start work at 6 o'clock, others at 7 o'clock, so it is difficult to train them together. I didn't even get a chance to show them that DVD we were given.

The Regional Manager was asked in an interview if he thought time was a problem for peer education and he said that the managers knew that they needed to make the time for

peer education, since HIV/AIDS was part of the organisations vision and was therefore a priority.

4.2.2.3 The racialised context of HIV/AIDS

Racial perceptions associated with HIV/AIDS in general and the HIV/AIDS programme in particular was mentioned in many of the conversations with the peer educators. For instance, when asked who attends the peer education sessions they facilitate:

PE 2: The other guys do not attend, it is just the African guys that attend. The others don't. Because the other guys feel that HIV/AIDS is only directed to Africans. .

PE 5: There are managers who said to me when I am giving HIV talks or doing peer education - 'It is a lower class thing!'

4.2.2.4 Peers fear of job loss and discrimination arising from confidentiality violations

Many fears associated with the testing process were apparent. In particular, fear of a lack of confidentiality of testing was related to concerns about possible job loss because of a fear of discrimination based on HIV status.

PE 3: When the external testing company used to come all of us in here used to run away, but I think the last time all of them they were in there for VCT, because they now all know about the need for testing because of the peer education sessions.

It appeared that most peers now trusted the confidentiality of the testing process, however there were a few who were still somewhat skeptical about confidentiality and possible job loss linked to a positive HIV status.

PE 2: Some people are still worried about confidentiality from the service provider.

PE 5: I think the fear is because of the attitude of the managers. The real fear is that he is going to be treated different after he is tested and maybe even fired from his position if he tests positive.

4.2.2.5 Fidelity, trust and patriarchy

The peer educators spoke of male peers who have girlfriends in the areas where they work, as well as wives in the rural areas where they come from. When enquiring about condom use with these two groups, the peer educators said that they felt their male peers were talking to their partners in their work areas about HIV/AIDS and condom usage. However when these male peers returned home they were unable to introduce condoms in their relationships with their wives, as this would mean having to admit to having been unfaithful.

PE 5: Most of them do use condoms with their partners near their place of work or if you have got a girlfriend in town. I know because they talk to me and also because our condom dispensers get empty over the weekend.

PE 3: You see, when you come from the farm, if you go back and tell your wife about condoms, she will ask you what you were doing there in Durban, or she will think that you don't trust her.

There was also a perception that women in the rural areas are older and do not understand HIV/AIDS.

PE 5: When they go home and then they are free, they go to their wives in the rural areas. Although the disease is hitting so much there, the older women do not want their men to use a condom, because they trust their man. The older woman has only got one man, but she doesn't know that her man has got so many girlfriends. 'That is my man, and so I do not want to use a condom with him'. That is why many guys use condoms here to protect themselves, because they do not want to take the disease to their wives.

4.2.2.6 The impact of alcohol on safe sexual practices

Based on their experiences, peer educators perceived a very direct negative relationship between alcohol and condom use, citing alcohol use as a dis-inhibiting factor with regard to engaging in risky sexual practices.

PE 3: Even though everybody knows about HIV /AIDS, and even if you are trying to be safe, the real problem is drinking. When people get drunk they do not think, you see some places the guys and ladies are together they're drinking, dancing and all those things, and no one can think now.

PE 5: I think those guys that stay sober all the time they can be consistent (in condom use), but those guys that are drinking are running a high risk because by having too much alcohol, he won't know what hit him, and he won't use condoms.

4.3 Reinforcing Factors

Reinforcing factors refer to the feedback that the peers and peer educators received that led to either an encouragement or a discouragement in maintaining specific behaviors. Peer educators reported that peers were most likely to take up positive behaviour change because of specific reinforcements, as detailed below.

4.3.1 The need for consistent messages

There was an incident reported by one of the peer educators, where peers at the organisation received a talk by two HIV positive speakers. In particular, one of these speakers was a white, Afrikaans speaking man who is HIV positive. Hearing him talk changed peers perceptions of who may be infected and reinforced peer educators messages about the need for open dialogue about HIV/AIDS. However a peer educator reported that the message may have lost some of its

impact when the peers returned to their own place of work and saw their white manager uninvolved and not speaking about HIV/AIDS at all.

PE5: I mean there was a white guy and a black lady they gave us a show and at my session the people said that I was right, that anybody can get infected with HIV. They said 'Hey this is a big guy who is white and looks fit!' They started to see and understand what I had said, i.e. that nobody is safe from HIV.

4.3.2 VCT is encouraged, modeled and supported by peer educators

A strong emphasis of the organisations HIV/AIDS initiative and the peer education programme was to get peers to know their HIV status. It was believed that testing was the key to either help the individual to remain HIV negative or, if the individual tested positive, to provide treatment and support in order to improve the persons quality of life and keep peers productive and employed for longer than they otherwise would be. With regard to testing, peer educators led the testing campaign and presented themselves publicly for testing in order to encourage peer uptake of the testing.

PE 1: Remember that time when we were tested. People didn't want to come at first, but the minute I showed them my results, and brought it to the plant and circulated it, they started coming out for testing.

PE5: Now they are talking about it more and coming for testing, because they know that if you hide it you die quickly, because if nobody knows then nobody can help you, and most of all you cannot help yourself.

4.3.3 Visible management support

It is evident through the interviews that differences in success of the roll-out of the peer education programme, and in HIV/AIDS prevention, testing and treatment activities, pertained across the various plants/places of work in the region under study. A key factor influencing this related to the degree of managerial support, viz.:

PE 5: I think that the main issue is management support. That is why some plants have high condom usage and nearly every employee goes for testing, whereas when management does not give enough support, we do not get these same results.

Peer educators emphasised the importance of management being visible and seen to be supportive of and partaking in HIV/AIDS testing. Peer educators said management's presence would increase the number of peers who went for testing, as it would dispel many of their fears. Peer educators reported that while some managers were going for testing, others were not.

PE 2: Management needs to be on the forefront as well. Ok we are there as peer educators, but that doesn't take the responsibility away from them, they need to be seen to be supporting the programme.

PE 2: I know in the other plant they went, but here it is just me, our manager didn't even say anything about HIV/AIDS and the testing. Some of the guys they really need to hear about VCT from the manager, which will help reassure them that the testing is confidential.

There were varying perceptions among the peer educator's with regards to managerial support. Some felt that their managers supported them, allowed time for them to run their sessions and were available for peer educators to refer problems to them. Other peer educators lacked the necessary managerial support, and felt that they were seen as being the ones who dealt with HIV/AIDS in the organisation so that managers didn't have to worry about it. Some peer educators felt that they needed more than managements approval for a session but that having management at the sessions would show their concern for HIV/AIDS as an issue that the organisation was serious about.

PE 2: Sometimes you just need your senior manager to be there and to say to the guys, this is very serious, and as management we are very concerned about this.

PE5: Management's commitment is important, because if the manager is openly talking about HIV/AIDS, who is going to hide it? If he is not hiding it and he is talking about it, why must I hide it?

CHAPTER FIVE: INTEGRATION OF FINDINGS

5.1- Predisposing Factors

Predisposing factors refer to knowledge, attitudes, beliefs and values that either hindered or supported the peer education programme (Green & Kreuter, 1991). In this study, predisposing factors were found to both hinder and support the peer education programme.

With regard to predisposing factors that hindered the peer education programme, peer educators reported that some of their peers had taken the view that HIV/AIDS was a mythological social construction of the apartheid government. In particular, they believed that HIV/AIDS was construed as a myth circulated to get black people to wear condoms and thus control black population growth. Interestingly, Nicoll and Laukamm-Josten (1993) reported a similar finding in East Africa. A second and more specific nuance was that HIV/AIDS was deliberately introduced to black people by Apartheid agents, with a view to killing them and again aimed at controlling black population growth.

The existence of lay health beliefs about the causes and consequences of diseases in general (e.g. Kleinman, 1980) and HIV/AIDS specifically (e.g. Nicoll & Laukamm-Josten, 1993) is well documented. The concern, with regard to this study, is that an externalisation of attribution and cause apparently served to undermine employee's perceptions of being personally susceptible to HIV infection through their own behavior. The Health Belief Model (Nutbeam & Harris, 1999)

states that people are only likely to modify their behavior if they believe, *inter alia*, that they are personally susceptible to infection and that the consequences of the disease in question is serious.

The belief that HIV was associated with Apartheid allowed employees to believe that contracting HIV/AIDS was not related to their own behavior and was therefore out of their span of control, implying that they did not have to modify their sexual behavior. It is well established that in order for people to change their behavior they would need to believe that they are at risk for HIV infection in the first place (Lamprey, 2002; Molassiotis et al. 2004). This externalisation of cause and consequence thus appeared to serve as a barrier to the central messages transmitted via the peer education programme.

The peer educators reported playing a significant role in bringing about changes in these deeply rooted mindsets. This is similar to the findings of Wolf et al. (2000) in Ghana and Molassiotis et al. (2004) in Zambia, where peer educators were instrumental in shifting deeply rooted beliefs around HIV/AIDS. Peer education aims to educate people through giving them relevant prevention and medical information, aimed at increasing the likelihood of peers feeling as though they are in control of their health (Campbell & Mzaidume, 2002).

A second predisposing factor that hindered programme delivery was that of peer's negative mindsets towards HIV/AIDS. Peer educators reported that their peers undermined and distorted the information that they gave. Similar findings were reported by Nicoll and Laukamm-Josten (1993), where messages that contradicted and undermined that of the peer educators were

expressed by peers. In this study peers taunted the peer educators by arguing that the latter's commitment to the programme suggested that they were HIV positive themselves. Similar stigma-related obstacles with regard to peer education amongst South African youth have been documented (Campbell & MacPhail, 2002). Peer educators reportedly challenged these stigma related beliefs of their peers and reported success in this regard over the lifespan of the programme.

With regard to predisposing factors that supported programme delivery, the data suggested that the subjective experiences of seeing loved ones dying of HIV/AIDS encouraged employees to take the peer educators prevention messages seriously. This finding is echoed in the Gregson et al. (1998) Zimbabwean study where nearly a quarter of the respondents felt in danger of HIV infection after seeing friends and family dying of AIDS. Molassiotis et al. (2004) similarly reported that their Zambian participants felt the need to fight HIV/AIDS as they had lost siblings to the disease and had begun to fear for their own children's safety, turning to the peer educators for their wisdom and guidance.

5.2 Enabling Factors

The peer educators identified a number of enabling factors that either supported or hindered programme delivery and efficacy. Peer educators reported that organisational systems in place with regard to the HIV/AIDS programme were helpful. These included the peer education programme itself, supported by other interventions, including in particular the VCT service and

the distribution of condoms. Nair and Campbell (2008) confirm the importance of organisational infrastructure and systems and the impact they have on programme delivery.

Peer educators indicated that through the information that they had imparted in their workshop sessions, their peers had been empowered with factual, biological knowledge of transmission and infection and they now believed that they were personally susceptible to the disease. Basic information is a pre-requisite to a shift in attitudes and practices (Nutbeam & Harris, 1999; Dickinson, 2006) and a vital component of successful peer education programmes (Molassiotis et al. 2004). Once peers had internalised their own susceptibility to HIV, they wanted to understand more about the disease. In this regard, peer educators felt as though they were recognised as being competent and supportive. The importance of peer educators providing support for their peers is highlighted by Molassiotis et al. (2004) and Lamptey (2002), who state that in order for behavior changes to take place, people need to view their environment as being supportive of such behavioral change.

Peer educators had clearly built a setting where some peers felt safe to disclose their HIV status. Through this disclosure the peer was able to confide in the peer educator about issues such as how to disclose their positive status to their family or how to negotiate time off to go to the clinic. In instances where peer educators and their peers were friends prior to the peer education programme, communication between the two was easier. Peer education often depends on already existing channels and modes of communication such as friendships between colleagues,

with ongoing communication reinforcing learning and thereby being more effective than attending a once-off seminar (Naidoo & Wills, 2000; Turner & Shepherd, 1999).

One of the peer educators reported that her peers trusted her because she had built up a reputation for honoring the confidentiality of employee's HIV status. Turner and Shepherd (1999) found that it was important for peer educators to have credibility with their peers in order for them to be influential. A Mozambiquan study found that peer educators gained credibility by sharing aspects of their own sexual testimonies with their peers (Vaz et al.1996). Similarly, a peer educator in this study reported that she followed through with her call for HIV testing by showing her peers her own test results. She felt this role modeling encouraged her peers to take her message of VCT participation seriously.

Lampthey (2002) states that in order for changes in behavior to take place, prevention messages must be supported by ready access to condoms. With this in mind peer educators were tasked with ensuring that condoms were always available in the various plants. Condom availability is important as research has shows that safer sexual practices, including consistent correct condom use, decreases the risk of HIV transmission (Lampthey, 2002). Peer educators have thus helped transform employee's perceptions about wearing condoms. One particular peer educator used the transformative learning methods outlined by Mezirow (1999) to bring about change. His peers held the view that 'condoms always break off'. He asked his peers to demonstrate how they put a condom on and then challenged this erroneous view by demonstrating the correct way to use a condom. This particular peer educator went on to say that he was assured in his sessions that his

peers were using condoms more frequently now and he also sees that the condom dispensers are never full. Speizer, Oleko-Tambashe and Tegan (2001) reported similar findings and found contact with a peer educator to be positively correlated with increased condom use.

With sexual behavior taking place in private, peer educators had to rely on behavioral intention indicators to give them feedback as to whether their peers were taking their messages about the severity of HIV seriously. In addition to the already mentioned increase in the number of condoms being taken from the dispensers, there are other behavior indicators that peer educators have noted. These indicators included an increase in VCT uptake, a noted increase in the number of times male peers return to their rural homes, a reported decrease in the number of casual sexual partners of male peers and finally, peer educators noted that the male peers were talking to their children about HIV/AIDS. These indicators were an encouragement to the peer educators that their messages were being taken seriously.

Peer educators felt that they had created awareness of the need to be tested and the resulting benefits of knowing one's status. It was felt that peers recognised the importance of knowing ones status, so that if positive, appropriate treatment could commence. They also noticed an increase in the number of times male peers returned to their rural homes on days off, thus spending less time with casual partners and more time with their wives. One peer educator said that the men were now talking about HIV as a 'killer disease' and thus expressed the need to stay away from the sex workers around the hostels. Older male peers felt that they did not have to wear condoms as they thought that HIV infects younger people. Peer educators worked at

correcting these erroneous mindsets by reminding these men that they had younger girlfriends who may infect them.

There were a number of dis-enabling factors that peer educators found to hinder peer education from operating optimally. These hindering factors included a lack of VCT and ART treatment for drivers and sub-contractors in the organisation; limited time in which to conduct peer education sessions; the perception that peer education was exclusively for black employees; peers fears of job loss and discrimination should they test HIV positive; broader family issues concerning condom negotiation and patriarchy; and finally the negative impact that alcohol had on consistent condom use. These hindering factors are discussed in more detail below.

One peer educator stated that truck drivers repeatedly asked her questions about HIV and had many concerns surrounding the disease. Luakmann-Josten et al. (2000) supports our peer educators concern, reporting that Transport Company Managers claimed that they were losing their most experienced drivers to AIDS. Further studies have shown that mobile populations such as long distance truck drivers are among those groups of people who are at highest risk of contracting HIV (Lamprey, 2002).

Against this backdrop, it is of concern that while truck drivers and sub-contractors were included in the peer education and prevention programme and had access to condoms, they were excluded from the company's VCT and treatment programme. Thus, while peer educators interacted with them in terms of prevention and awareness activities, they felt frustrated and somewhat helpless

that they could not help these colleagues with regard to testing or treatment interventions. VCT is considered to be an essential component of an effective HIV prevention programme (Lamprey, 2002), with evidence suggesting that the inclusion of VCT makes for a more comprehensive and successful prevention programme (Sloan & Myers, 2005). In reviewing evidence from studies conducted in Kenya, Tanzania and Trinidad, Coates et al. (2000) concludes that VCT significantly reduces risky sexual behavior and should be included as part of any HIV prevention programme in less developed countries. Peer educators who participated in this study supported these contentions. In contrast, however, Laukamm- Josten et al. (2000) found that peer education and condom provision (without VCT) had been effective in increasing knowledge and promoting behavior change among truck drivers in Tanzania.

Most peer educators struggled to find the time to get their peers together for half day peer education sessions, as this meant down time in terms of productivity. Instead of having the half day sessions as were originally planned by management, peer educators spoke informally with peers whenever there was time or when specific need or issues arose.

Even though the organisation's managers had been trained to support peer education activities and created time for the half day sessions, some peer educators found managers to be disinterested and to be making comments that implied that the HIV/AIDS programme was only directed at the black employees. These managers were also less likely to support and embrace other components of the organisations HIV/AIDS programme, including open support for VCT, and thereby appeared to attach a race stigma to HIV. This made the role of the peer educators

difficult as this lack of commitment from some managers severely undermined the central transmission, prevention and treatment messages conveyed by the peer educators.

A further stigma attached to HIV was that of job loss. Peer educators found that one of their biggest challenges in getting their peers to participate in VCT was that employees feared that management may find out their HIV status. They feared that if they were HIV positive, they may lose their job or be discriminated against. Similar fears have been reported in other studies on VCT in the mining sector (Bhagwanjee, Akintola, Petersen & George, 2008). There was no evidence to suggest that this was the case in this company and peer educators have been instrumental in assuring peers of the confidentiality of the testing process and the absolute commitment of management to non-discrimination on the basis of HIV status.

Regarding condom negotiation and patriarchy issues, peer educators felt that their peers were not using condoms on a consistent basis. They reported that even those employees who used condoms consistently with their casual 'town' partners, would not do the same with their wives when they returned home to their rural areas. Peer educators said male peers felt that older rural women did not understand much about HIV and would take offense or be suspicious if their husbands insisted on condom use. Campbell and MacPhail (2002) reported similar findings, where participants who raised the issue of condom use with their partners were seen by the partner as being insulting and questioning their faithfulness. In a study conducted in Zimbabwe, Gregson et al. (1998) reported that 45% of married female respondents felt in danger of contracting HIV, with 57% of these women attributing this to their husbands having other sexual

partners. Empirical evidence suggests that migration for work purposes, and the cultural norm of men having multiple partners outside the home, are independent risk factors for HIV infection among men (Lurie et al. 2003; Moses et al. 1994).

Peer educators were under the impression that male peers wanted to keep their wives safe and therefore used condoms with their casual 'town' partners to prevent them from contracting HIV. It is unlikely, given the proven negative correlation between alcohol and condom use (Gregson et al. 1998), that this was always the case and that condom use was consistent. The peer educators have helped peers with skills they can use to negotiate condom use and skills to disclose their positive status to family members. Research has shown that people are more likely to put the behavior they have learnt into practice if they are given appropriate social skills to do so, in particular assertiveness training (Turner & Shepherd, 1999). Greater involvement of employees' wives in an organisation's HIV/AIDS programme could lead to men being more likely to discuss their HIV status with their wives (Bhagwanjee et al. 2008).

Coates et al. (2000) argues that it is women who need negotiation skills to enable them to discuss sexual issues with their partners. The role of women in African societies, including low levels of female autonomy accruing from a patriarchal value system, has been noted as a major barrier to HIV prevention initiatives as it a primary reason for people not modifying potentially high risk sexual behaviors (Campbell & Mzaidume, 2002; Colvin, 2000; Greene & Biddlecom, 1997; Gregson et al.1998; Molassiotis et al. 2004).

Based on their interactions with their peers, peer educators made a case for a very direct negative relationship between alcohol intake and condom use, with peers being inconsistent in their use of a condom when they were intoxicated. This contention is supported by empirical findings that suggest that good intentions to be faithful and to use condoms were altered when participants were under the influence of alcohol (Gregson et al. 1998).

5.3 Reinforcing Factors

Consistent messages about HIV/AIDS acted to reinforce peers understanding of the severity of HIV and their personal susceptibility to it. One of the peer educators highlighted the importance of consistent messages to help reinforce the peer educator's teachings. He referred to the recent company road-show comprising two HIV positive speakers, one being a black woman and the other a white male who addressed employees at all sites. The peer educator said that his interactions with his peers revealed that this disclosure was crucial in supporting and entrenching the peer educators message that all people were susceptible to HIV infection, not only blacks. This must be juxtaposed against contradictory messages (such as comments or actions from some managers implying that HIV afflicts black people exclusively) which hampers peer education and the HIV/AIDS programme as a whole. Molassiotis et al. (2004) reported similar findings and cites confusing messages as a shortcoming in some HIV peer education programmes.

It appears that peer educators have been very instrumental and credible role models. This is critical, as a primary criterion for the selection of peer educators was their ability to serve as

credible role models, thereby promoting vicarious learning, in line with Social Learning Theory (Bandura, 1969). One peer educator even went as far as to bring her VCT test results to the plant for distribution and ate her immune booster porridge in full view of her peers. Turner and Shepherd (1999) state that peers need to observe their peer educators acting in a healthy manner. Numerous authors comment on role-model peer educators as being crucial to a successful peer education initiative, in that peer educators seek to bring about a change in norms and behavior, not simply through their educational messages but also through their actions, which their peers are expected to emulate (Campbell & MacPhail, 2002; Molassiotis et al. 2004; Shen et al. 2008; Turner & Shepherd, 1999; Wolf & Bond, 2002; Wolf et al. 2000). It was evident from this study that the peer educators were acutely aware of the need to serve as positive role models and did so in several ways, including leading employee participation in the annual VCT campaigns, disclosing their HIV status and speaking openly about the disease. In these ways the peer educators were able to reinforce their educational messages through their own actions.

Peer educators reported varying levels of VCT uptake at the different plants. They ascribed these different levels of VCT uptake to the varying degrees of management commitment and support at the various plants towards the HIV programme. Some peer educators felt that they received adequate support from their managers, whereas others felt that their managers shifted the burden of HIV onto the peer educators and had little to do with it. These peer educators felt that when it came time for VCT testing, managers did not participate or show any interest. Peer educators felt that it would really have helped the credibility of their message if management also took the disease seriously. They felt that it would be beneficial if managers were committed to lead by

example, participated in VCT and communicated with employees around the issue of HIV/AIDS. One peer educator on his way to conduct peer education was shocked to be asked by a manger why he was attending 'such a lower class thing'.

Perhaps for this particular population of managers to be reached, peer educators would need to be appointed and trained from this group, which is actually a fundamental motivation for peer education (Wolf et al. 2000). Nair et al. (2008) suggest that a possible way of getting people to work together on HIV may be to include it in their job description, and this recommendation might be most appropriate for managers in this company. The collaboration of diverse stakeholders is a critical for the success of peer education (Campbell and Mzaidume 2002), with a lack of commitment by any stakeholder being found to be an equally critical shortcoming in HIV peer education prevention programmes (Molassiotis et al. 2004).

CHAPTER SIX: CONCLUSIONS

6.1 Conclusions

6.1.1 Predisposing factors

- Peer educators have been instrumental in shifting peers deeply rooted mindsets with regards to HIV/AIDS. Peers who initially believed that HIV/AIDS was a construct of apartheid have come to recognise their personal susceptibility to the disease.

- Peers seeing loved ones dying have brought about an awareness of the severity of HIV/AIDS. Peers who were initially reluctant to listen to the peer educators have now turned to the peer educators for information, guidance and advice.

6.1.2 Enabling factors

6.1.2.1 Supportive enabling factors

- Organisational systems in place, including access to free condoms at the workplace, VCT services and treatment provision have supported and enabled the peer education programme and helped peers to adopt a proactive stance towards HIV prevention, testing and treatment.
- Peer educators have built an enabling environment to the extent that some peers felt safe and comfortable enough to disclose their HIV status to other employees. Peer educators helped their HIV positive peers to disclose their status to their families and to seek help from the external VCT and treatment service providers.
- Peer educators reported using transformative learning to change their peer's views, for instance transforming employee's views toward wearing condoms. In this regard, peer educators felt encouraged by the increased uplifting of condoms from the workplace condom dispensers.
- Peer educators reported that their male peers were going home more regularly on weekends and had noted, through personal interaction, a decrease in the number of

casual sexual partners amongst their peers. They felt that this was due to peers having a better understanding of the severity and ones own susceptibility to the disease.

- In light of the above perceived severity of HIV, peers were also reportedly talking to their children about HIV/AIDS. This suggested a wide social impact of the peer education programme.

- It was apparent that peer educators perceptions of support from the HR department, management and their fellow peer educators was instrumental to the success of the peer education programme.

6.1.2.2 Hindering enabling factors

- The scope of VCT and treatment at the organisation was limited to permanent employees and did not extend to truck drivers and sub-contractors. Peer educators felt that this undermined their efforts to provide comprehensive support to these cohorts who were in desperate need of testing and treatment services.

- Time restraints have restricted the peer educators from conducting their planned half day peer education sessions with employees. Peer educators adapted by running education sessions at departmental and safety meetings and through interpersonal consultations with employees.

- Given that few white employees volunteered to serve as peer educators, and given the behaviour of some managers, some employees viewed the peer education programme as being aimed at black employees only. This was counter productive to the peer educator's message of HIV being a disease that anyone could contract.
- Potential job loss and discrimination by management pursuant to a positive test result served as a barrier to employee participation in the VCT campaign. This also undermined the anti-stigma assurances conveyed by peer educators.
- Peer educators reported that their male peers reported struggling to introduce condom use with their wives. This was of concern as it meant that men were not practicing safe sex consistently. This demands further attention in the peer education programme.
- Peer educators expressed concern that alcohol consumption appeared to be negatively related to condom use.

6.1.3 Reinforcing factors

- Consistent messages about HIV to peers reinforced their beliefs about the severity, personal susceptibility and the benefits of knowing ones status.

- Peer educators acted as role models for their peers by being forerunners of VCT. Peer educators have modeled the importance of attending VCT and some have disclosed their test result to employees. This was seen to have a positive influence, resulting in an increase in VCT uptake, which has in turn encouraged the peer educators and reinforced their efforts.
- The commitment of management is crucial to programme success. In this regard, it is of concern that managers have apparently demonstrated equivocal commitment to the peer education programme, which demands urgent redress.

6.2 Recommendations

6.2.1 Programme Delivery and Evaluation

- The peer education programme was designed for delivery in a half day workshop format to every employee in the organisation. Productivity demands precluded this from happening, and even though the peer educators have adapted delivery to the environment, it is of concern that this was not a programme decision and requires further review and consideration.
- Five minutes of every staff or departmental meeting should be dedicated to talking about HIV/AIDS. Peer educators could address the staff each week on a different topic, for instance, confidentiality, stigma, condom use, disclosure of HIV status, etc.

HIV/AIDS needs to become part of the organisations tapestry, it cannot be a programme attached to the side if it is to work as intended.

- A further KAP study should be conducted to benchmark and continuously assess the knowledge, attitudes, and sexual practices of employees. This will serve to point to areas that warrant specific attention from peer educators in an ongoing fashion. Monitoring of VCT and treatment statistics from the relevant external service providers also offer a useful means of monitoring programme efficacy.

6.2.2 Further training for peer educators

- Peer educators raised a number of issues which they obviously struggled with in their prevention-education role. These include: transformation of patriarchic attitudes and practices, condom use negotiation (especially with wives), counselling peers about the risks of combining alcohol use and sexual relations, strategies to reduce the number of casual partners and enabling managerial support for programme delivery. It is recommended that refresher training for peer educators be held, focusing on specific issues worthy of detailed attention.
- It is vital that stakeholder support, including in particular that of managers and shop stewards, be mobilised as part of the next phase of the peer education programme.
- Given the organic shift in the role of peer educators to one-on-one interaction with employees, training of peer educators in lay-counselling skills should be considered.

6.2.3 Transformation of the organisational climate

- It is vital that management training be repeated annually. One component of this training should focus on information on modes of transmission, prevention, testing and treatment. A second component should focus on confidentiality, stigma, legal and organisational issues, including managements role in supporting all components of the organisations HIV/AIDS programme, including in particular peer education.

- Specific strategies and actions need to be devised to include management more fully in the organisations HIV/AIDS programme. Specific issues requiring consideration include: managers roles as champions of the VCT campaign; managers role in ensuring that confidentiality of an employees HIV status is sacrosanct and that no employee will be discriminated against on the basis of her HIV status, and managers roles in supporting the peer education programme. Consideration should also be given to including agreed HIV/AIDS objectives and actions in management's performance appraisals through their Key Performance Indicators (KPI's).

6.3 Limitations of the Study

- A larger number of peer educators should have to be included in the study in order to have a more thorough understanding into the Eastern Region peer education programme. Further, it would have been beneficial to have interviewed more ex- peer educators to have a better understanding of the barriers they faced or reason/s for

leaving the programme.

- This study was not a comprehensive assessment of the organisations peer education programme, in that only the views of the peer educators were solicited. The next phase of this evaluation should therefore include the perspectives of all relevant stakeholders, including managers, shop stewards and employees themselves, rendered through multiple data channels.

6.3.1 Personal limitations

- As a believer in abstinence until marriage, I personally wrestled with the idea of promoting condom use. However, having learnt some of the medical and social side of HIV/AIDS, I have been able to recognise that condoms are crucial, even for married couples to prevent re-infection and the increasing of ones viral load.

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Appendix One: Semi-Structured Interview Schedule

Personal details:

Age: _____ years Gender: _____

How long have you been working in this organisation: _____ Years _____ Months

When did you train as a peer educator: Year _____ Month _____

Number of peer education sessions conducted by you: _____

Dates of these sessions: _____

I would like to gain a better understanding into your personal experience of being a peer educator. Inform of confidentiality, and anonymity of individual responses and who will have access to findings.

A- Training course evaluation and competencies gained.

1-How were you selected to be a peer educator? (e.g.: volunteered, nominated, persuaded, etc)

2-How did you feel about being chosen to be a peer educator?

Probe:

- anxieties
- insecurities
- excitements
- motivation
- perceived barriers
- perceived supports

- others reactions

3- What part of your training course stands out in your mind?

4-What parts of the training course did you find easy to understand?

5-What parts of the training course did you find difficult to understand?

6- Were there certain aspects of the HIV/AIDS that you felt more confident facilitating than others? What were they? Why?

7- Were there certain aspects of HIV/AIDS that you felt less confident facilitating than others? What were they? Why?

Probe:

- feelings of self efficacy
- support
- feelings of being equipped
- feelings of capability
- areas of anxiety/confusion

B- Session evaluation , barriers and support.

1-Tell me about the attendance at your sessions?

2-What was the best part of your sessions/ talking to others for you?

3-Did you encounter any frustrations in planning, organising or talking about HIV/AIDS?

4- If so what, and what did you do when this happened?

Probe:

- barriers

- support
- frustrations
- complaints
- coping techniques

5-Tell me about who supported you in being a peer educator and how?

Probe:

- Role of HR in supporting your work (venues, ensuring attendance, debrief, etc.)
- Role of Management in supporting your work

6-Tell me about your relationship with the other peer educators?

Probe:

- Groups run jointly
- Discussions
- Debrief afterwards
- Support
- Communication
- Trust
- Dynamics

C- Personal role perceptions.

1-Do you think that employee's sexual risk behavior has changed as a result of your session/s?

As a result of the peer education program as a whole?

Probe:

- Condom use:
- Number of sexual partners:
- Faithfulness
- VCT:
- Treatment:

2-Has your own personal behavior changed now that you are a peer educator? If so, in what ways has your behavior changed?

3-How do you think that your own personal behavior impacts on your role as a peer educator?

4-Do employees come to you individually with problems?

5-What types of issues or problems do these include?

6-Do you feel competent to deal with these issues/ problems/people?

7-How do you see the role of peer educators in the future?

8-How do others in the organisation view peer educators?


Probe:

- Respect
- Trust
- Seriousness

9-What has been the most rewarding part of being a peer educator for you?

Thank you for your time.

Appendix Two: Ethical Clearance Form



RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

15 NOVEMBER 2007

MS. RF DENT (203500936)
PSYCHOLOGY

Dear Ms. Dent

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0697/07M

I wish to confirm that ethical clearance has been granted for the following project:

"A contextual assessment of a workplace HIV/AIDS peer education programme in the South African Mining Sector"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully


MS. PHUMELELE XIMBA
RESEARCH OFFICE

cc: Post-Graduate Office (Lyn Marriott)
cc: Supervisor (Anil Bhagwanjee)
cc: Praveen Rajbansi

Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

Appendix Three: Company Letter of Consent for the Study

Appendix Four: Informed Consent Form

School of Psychology

University of KwaZulu-Natal

I, _____, state that I agree to participate in a research project conducted by Roslyn Dent who is an Industrial Psychology Masters student at the University of KwaZulu- Natal Durban. I understand that the research being conducted will provide insight into my experience and role as a peer educator. Such information will be used to improve the company's HIV/AIDS program. I agree to participate in an individual interview.

I acknowledge that Roslyn Dent has explained the task to me fully; has informed me that I may withdraw my participation at any time without prejudice or penalty; has offered to answer any questions that I might have concerning the research procedure; has assured me that information obtained will be reported collectively, without identifying me personally and that the results of this study will be reported to the organisation and may take the form of published outputs. I understand that I am free to call either the student or her supervisor in the event that I have any questions or concerns.

Signature of Participant

Student:

Roslyn Dent

Cell: 073 1718 028

Supervisor:

Anil Bhagwanjee

Tel: 031 260 7973 or 083 777 4973