Recipient Experiences of a Peer-Led Abstinence Programme at the University of the Western Cape

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ABSTRACT

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In this minithesis the researcher explores the experiences of recipients of the HIV/AIDS peer education abstinence programme at the University of the Western Cape (UWC), with a particular focus on their perceptions of the extent to which, and the manner in which, the programme influenced their knowledge, attitudes and beliefs regarding sexual risk behaviour, HIV and abstinence.

The study begins with an exploration of the effect of HIV/AIDS on South African youth. It discusses mediating risk factors as well as developmental factors which make youth susceptible to high-risk sexual behaviour, particularly in tertiary institutions where students are exposed to further factors enhancing this susceptibility. The study continues with a discussion of the strengths and weaknesses of a variety of HIV interventions, with a particular focus on peer education.

The researcher considered the responses of the recipients of the UWC peer-led programme to determine perceived strengths and weaknesses of this programme. Responses were regarded in light of the degree to which recipients perceived the programme to have incorporated the components deemed necessary (in the literature) for successful interventions. The findings include a reflection on the extent to which the recipients experienced shifts in knowledge, attitudes and beliefs, as well as actual behaviour change and the presence of barriers and medicating factors affecting safe

sexual behaviour. Furthermore, recipients' views on the format of the peer education approach were considered.

The researcher discovered that most recipients felt they had benefited from the UWC HIV peer-led programme in that, due to the informal nature of the workshops they were able to discuss their views and hear the perspectives of others. Consequently, recipients felt they grew in their ability to communicate, negotiate and assert themselves. Furthermore, many recipients reported experiencing a positive shift in attitude and perspective, becoming more tolerant and respectful of others and themselves, as well as experiencing a greater sense of susceptibility to HIV/AIDS. Further, due to heightened awareness and self-esteem, recipients mentioned a desire to protect themselves and others as well as possessing the self-efficacy to do so.

Recipients reported primarily the desire to consistently utilise condoms and to remain faithful to partners, with few choosing the option of abstinence. Despite these intentions there were few reports of actual sexual behavior change, beyond changes in everyday life such as increased assertiveness, and ability to make decisions, communicate and negotiate. Reported barriers to safe sexual behaviour included chiefly fear of rejection and embarrassment, amongst others. The researcher is unsure whether the positive changes that occurred are sufficient to enable recipients to overcome these barriers.

It was generally felt that the peer-education approach was beneficial, particularly due to the informal, discussion format as well as role-plays. However, many recipients stated they did not feel it was crucial for the facilitator to be a peer as long as he/she demonstrated certain qualities.

The researcher concluded the study with a number of recommendations for the UWC HIV peer-led programme and for further research.

April 2008

DECLARATION

I declare that *Recipient Experiences of a Peer-Led Abstinence Programme at the University of the Western Cape* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Kerry Buchan April 2008

Signed: _____

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CHAPTER ONE

Introduction

1.1 Introduction

This chapter introduces the area of study by providing relevant background information and outlines the aims of this research. It concludes by outlining the remainder of this mini-thesis.

1.2 Background and motivation

Until fairly recently Acquired Immune Deficiency Syndrome (AIDS) was a largely unknown disease. At present, the Human Immunodeficiency Virus (HIV) poses a serious threat to South Africa, with high numbers of people infected and affected and the impact being felt across all sectors of society. In a study by Karim & Karim, completed in 2005, South Africa was estimated to be the country with the largest number of people living with HIV/AIDS.

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Young people are at the hub of the global HIV and AIDS pandemic, with the age group between 15-24 having the fastest-growing infection rates, closely followed by the age group of 25-35 (van der Merwe & Gouws, 2005; Hartell, 2005). Youth are more susceptible due to the experimentation that occurs during this development stage resulting in risk-taking behaviour, and due to factors such as low perception of vulnerability (Hartell, 2005; Mathews, 2005).

A large proportion of this high-risk youth group attends tertiary education institutions. The experience of students is such that they generally become less inhibited in their sexual and other behavior as they are exposed to more freedom (van der Merwe & Gouws, 2005). For this reason, along with the fact that these are often formative patterns of behaviour, and that the main role of tertiary institutions is education, these institutions are prime settings for the implementation of HIV prevention programmes. Furthermore, young people are key resources for the wellbeing of their future. The very energy, charisma and creativity, as well as desire to learn and adopt new ways that make them

more susceptible to high-risk behaviour, also enable them to bring insight and inspiration to intervention programmes involving others like themselves (Campbell, 2004). All people, regardless of age, have the right of reproductive choice and the opportunity and ability to make safe and informed choices, making it even more critical that the more susceptible youth be empowered in this respect.

Curriculum-based peer education programmes have become increasingly popular as a means of intervention in tertiary education institutions. These programmes are facilitated by students from these institutions who are given training and supervision, resulting in the provision of knowledge and skills by educators at the same level as the recipients. It is thought that this type of education leads to information being received as more credible and accessible and the impact in general being more effective. Furthermore, it is believed that peer education increases the possibility of new skills and behaviour being extended to other peers following the programmes (Ergene, Cok, Tümer & Ünal, 2005; Maritz, 2001).

The University of the Western Cape is an illustration of a tertiary education institution that conducts one of these peer-led, curriculum based interventions as part of a larger HIV/AIDS programme. A number of volunteer students are trained in order to conduct a series of workshops or sessions with fellow students. The target behaviour that is the focus of this programme is the incorporation of safer sexual practices by students, in particular emphasizing abstinence, but also focusing on delay of sexual debut, mutual faithfulness; partner reduction; and the use of condoms as effective strategies to prevent sexually transmitted infections (STIs), including HIV, and unwanted pregnancies. Given the critical status of HIV and AIDS in our country, and particularly amongst our youth, such an intervention is of great significance. Of greater import is to ensure that the interventions that are carried out, such as the UWC HIV peer-led abstinence programme, have an effective impact on the recipients who participate in such endeavors.

Although peer education is widely used there has been relatively little research based on this type of intervention (Deutch & Swarts, 2002; Ergene et al., 2005; Green, 2001). In addition, the research that has been conducted has focussed primarily on the experiences

of the peer educators, rather than the programme recipients. A paper by Kirby, Laris & Rolleri (2006), following a review of a number of HIV intervention programmes, declared the need for more evaluations of curriculum-based programmes (which include peer education programmes), especially those in developing countries and with youth at highest risk, due to gaps in these areas. Additional research of South African peer education programmes in general and recipients' experiences in particular will be valuable for the future implementation of peer education programmes.

1.3 Aims of the present study

This study aims to explore the experiences of recipients of the HIV peer-led abstinence programme offered by the HIV/AIDS Programme of the University of the Western Cape. This exploration should enable the researcher to determine recipients' perceptions of the strengths and weaknesses of the programme on the basis of self-reported changes in HIV-related knowledge and normative beliefs regarding abstinence and personal risk perceptions of acquiring HIV. Recommendations will be made for the UWC programme on the basis of the findings.

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1.4 Significance of the study

It is anticipated that the information gained in this study will be utilised to make recommendations for the current HIV peer-led programme at UWC and for future peer-led HIV intervention programmes in tertiary institutions. In addition, it is hoped that this study may provide a foundation for further research.

1.5 Outline of the remainder of the mini-thesis

In Chapter two literature and theoretical perspectives considered to be relevant to this study will be reviewed.

Chapter three focusses on the methodology employed in this study. It includes a description of the research design, the participants, the procedure of data collection and analysis, as well as indicating self-reflexive issues of the researcher and ethical considerations relevant to the research.

Chapter four outlines the results of the data analysis. The results are presented in the form of seven themes, focusing on the perceived experiences of the peer-led programme, as well as particular changes that were experienced as a result of the programme, and any perceived barriers to change. The results include recipient quotes provided in verbatim to better illuminate the findings.

Chapter five is a discussion of the results. The findings of the study are considered in light of the relevant literature and theory. The researcher has also included subjective interpretations and judgments, particularly regarding the strengths and limitations of the UWC peer-led programme on the basis of the recipients' experiences.

Chapter six presents conclusions based on the discussion and findings, as well as the study in general. The chapter includes a list of recommendations for further research as well as recommendations for the UWC programme that evolved from the study.

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CHAPTER TWO

Literature Review

2.1 Introduction

Chapter two discusses literature of relevance to the current study. The chapter begins by reporting on the state of HIV and AIDS in South Africa. Thereafter, HIV and AIDS will be discussed in relation to youth specifically, with a particular focus on youth in tertiary institutions. Further literature will be covered with reference to factors that are thought to play a role in the sexual risk-taking behaviour of youth, followed by a discussion of the theory that has been considered in relation to various risk-taking behaviours and to inform interventions. Finally, there will be a consideration of literature pertaining to interventions for HIV/AIDS, in particular looking at peer education and the role of peer education at the University of the Western Cape (UWC).

2.2 HIV/AIDS in South Africa

At present HIV and AIDS is one of the major challenges facing South Africa, with high numbers of people infected and affected, impacting on individuals and society as a whole. UNAIDS estimated that the total number of South Africans living with the virus at the end of 2005 was approximately 5.5 million and, according to the UNAIDS 2006 Global Report (cited in AIDS Foundation, 2006), South Africa is considered to have the most severe HIV epidemic in the world.

In 2006 the prevalence in the Western Cape (where UWC is located) was the lowest in the country at 15.7%, yet the two metropole health areas of Khayelitsha and Gugulethu/Nyanga registered prevalence rates of 33.0% and 29% respectively (HIV & AIDS and STI Strategic Plan for South Africa (2007-2011), 2007). These prevalence rates point towards the disproportionate effect of HIV and AIDS on particular sectors of the society and the complexity of factors involved in the epidemic i.e. socio-economic status, culture, age, ethnicity and gender, all of which need to be considered in the implementation and design of interventions for HIV/AIDS.

Despite the disproportionate prevalence rates, it cannot be denied that the HIV/ AIDS pandemic affects South Africa as a whole in a variety of ways. It is for this reason that the South African government responded by means of the HIV/AIDS and STD Strategic Plan for South Africa (2007-2011) (2007), which focuses specifically on four priority areas: prevention; treatment, care and support; research, monitoring and evaluation; and human and legal rights. This particular study is related to the area of prevention and for this reason it is important to understand the factors involved in the transmission of HIV, as well as those who are affected, to ensure that interventions are designed accordingly.

HIV is transmitted by a variety of means including mother to child transmission; blood transfusion, intravenous drug use; exposure to blood in healthcare and other settings; as well as sexual intercourse. In South Africa HIV is transmitted primarily by sexual behaviours with the reported age of initiation of penetrative sexual intercourse indicated by various studies to be between 14 to 17 for both males and females (Asamoah, 2003; Harrison, 2005). Therefore, when considering means of tackling the epidemic, it is imperative that the youth be the focus of interventions. Furthermore, these interventions should specifically aim to change sexual risk behaviour amongst the youth, this remaining one of the biggest challenges in the attempts to curb the infection rate of HIV/AIDS.

2.3 HIV/AIDS and youth

HIV/AIDS is particularly devastating amongst the youth of South Africa, with the age group between 15-24 exhibiting the fastest-growing infection rates, closely followed by the age group of 25-29. Harrison (2005) states that young people between the ages 15-24 comprise more than half of all South Africans infected with HIV. Reported prevalence rates of HIV infections within this group fall between 15.64% and 20.1%, with woman being three to four times more likely to be HIV positive than males (van der Merwe & Gouws, 2005; Hartell, 2005; Mathews, 2005). A fairly recent nationwide survey of youth found that the HIV prevalence rate was 15.5% in women in the age group 15-24 years, while for men in this group the rate was 4.8%. Furthermore, within this age group it is women aged 20-24 that constitute the highest prevalence rate at 24.5% (Harrison, 2005).

The terms 'youth' and 'adolescence' are used interchangeably in the literature. According to the World Health Organisation (WHO) (cited in Harrison, 2005 and Mba, 2003) the age range of 10-19 years is identified as 'adolescence' while the term 'youth' indicates the age group 15-24. This study will refer to 'youth' and concentrates mostly on the age group 18 – 24 years.

Regardless of the ages delineating the period in question it can be conceived of as the stage between puberty and mature adulthood. This is a time of many physical, cognitive, normative and social changes which have been recognized as influential in the shaping of future health, as well as making it a particularly vulnerable period of life (Hoberg, 2002; Mba, 2003). The patterns of behaviour that develop during these significant years either protect or place young people at risk later in life (James, Reddy, Taylor & Jinabhai, 2004). Following is a consideration of the unique experiences of youth, an understanding of which is necessary to develop effective intervention plans aimed at reducing their risk.

The period of youth is characterized by, amongst others, the breaking of parental bonds; the development of a unique identity alongside the evolution of independence and decision-making, sexuality, and the formation of morals and values; and the establishment of a position within a peer group with associated social and peer norms (Hoberg, 2002). These developments make youth more susceptible to a higher prevalence of experimentation and exploration, resulting in greater risk-taking behaviour. In particular, the emergent sexual drive and consequent physical urges coincides with a time of conflicting feelings, attitudes and societal practices related to sexuality, leading to many young people becoming involved in high-risk sexual behaviour (Asamoah, 2003; Harrison, 2005; Mba, 2003; Simbayi, Chauveau, & Shisana, 2004; Zwane, Mngadi & Nxumalo, 2004). Youth are even more susceptible due to a low perception of vulnerability (Harrison, 2005; Hartell, 2005).

In addition, the global trend has been towards greater opportunities for the youth in terms of education, employment and travel, resulting in young people leaving home to live on their own and a delay in settling down and marriage. Consequently, youth are sexually

active at a younger age than previous generations, resulting in them engaging in sex more frequently and having a longer period of sexual activity before getting married. This younger age at which sexual debut occurs and the delay in marriages places young people at risk of unintended pregnancies and sexually transmitted diseases (STIs), of which HIV is common (Harrison, 2005; Zwane et al., 2004).

With young people leaving home earlier and living alone before entering adulthood and marriage, as well as the fact that they constitute the most vulnerable group who concurrently play a substantial role in the future of our country, the need for youth-focused programmes has become more obvious. In addition, various studies have shown that positive behaviour change is more likely in this group than in older ages due to the very same developmental and experimerimental tendencies that place them at risk (HIV and AIDS and STI Strategic Plan, 2007). A survey conducted by the Kaiser Family Foundation in conjunction with the South African Broadcasting Corporation (SABC) in 2007 indicated that South African youth are generally optimistic about their futures and place a high level of import on living a healthy lifestyle and achieving a variety of goals. These findings further designate youth as the most suitable group to be targeted for HIV interventions to achieve the most extensive impact.

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2.4 Sexual Behaviour and tertiary institutions

A large proportion of the aforementioned high-risk youth group (which in this study encompasses 18-24 years of age) enroll at, and form the life-blood of, institutions of higher learning on an annual basis. Besides the changes that usually occur during adolescence, making youth more likely to participate in risk-taking behaviour, attending tertiary institutions is a further transition and augments the possibility of high-risk behaviour. When attending tertiary institutions youth often become less inhibited in their sexual and other behavior as they are exposed to more freedom (van der Merwe & Gouws, 2005). These institutions are prime settings for the implementation of youth-focussed HIV prevention programmes.

There are approximately 564,000 students, mostly in the 18-30 age range enrolled in South African public higher education institutions (Deutch & Swarts, 2002). These are the nation's leaders, yet the prevalence rates as indicated by a 2001 SAUVCA report (cited in van der Merwe & Gouws, 2005, p. 47) were approximately 22% amongst university undergraduates and 11% of university postgraduates.

HIV/AIDS can potentially affect every aspect of an institution, with a loss of staff and students and the depletion of the pool of skills and knowledge that sustain an organisation (van der Merwe & Gouws, 2005). This is only one of the reasons why the implementation of HIV prevention programmes is so important in institutions of higher education. In addition, the role of tertiary institutions is education and these institutions shape the attitudes and practices of future decision-makers (Deutch & Swarts, 2002). Aside from the accountability of tertiary institutions to society, these institutions also offer many advantages in terms of contending with HIV/AIDS (Deutch & Swarts, 2002; Ergene et al., 2005). These include the fact that the youth are so accessible, as well as the availability of resources, such as campus health services, which are more suited to the needs of this group. Finally, students tend to be more approachable and open to learning in general, as well as more optimistic and future-orientated.

Although some students become infected before their studies, most students become infected while enrolled at tertiary institutions, especially at residential institutions. Tertiary institutions like UWC are concentrations of young people who find themselves presented with a wide variety of opportunities and experiences for meeting other young people with the same developmental interest in sex. This can be particularly so for students who come from rural areas to tertiary institutions in urban areas (such as Cape Town) (Deutch & Swarts, 2002; Ergene et al., 2005).

These students experience freedom from adult supervision and rules, often for the first time. This new-found freedom and a need for release from pressures, which often leads to substance use, can result in a relaxation of social and sexual inhibitions and a suspension of good judgment (Deutch & Swarts, 2002). A study by Farrow and Arnold (2003) found

that during the transition to university young people adopted behaviours synonymous with students, including wearing more casual clothing; consuming more alcohol; and participating in social and sexual activities, often involving casual sex relationships, numerous sexual partners and unprotected sex under the influence of substances.

In a study by Ergene et al. (2005) other factors related to high-risk sexual behavior included sociocultural attitude, peer pressure, feelings of embarrassment about sexuality and a lack of opportunity to meet sexual partners privately. In addition, there is often a common misperception on campus that high-risk behaviour is the norm, which can make students highly susceptible, regardless of prior knowledge (Deutch & Swarts, 2002). A study by Barnes (2000) on sexual behaviour at UWC indicated similar factors as linked to high-risk behaviour, especially campus norms; peer pressure; cultural norms related to sexual violence and rights; poverty; and the silence around HIV/AIDS. To address risk behaviours, like sexual risk behaviour, it is imperative to have a full understanding of the factors, such as those mentioned above which underlie and maintain these behaviours.

2.5 Factors affecting risk-taking behaviour

Sexual risk behaviours are those that expose young people to a greater risk of infection by HIV and other STIs as well as unintended pregnancies. These behaviours are defined by most of the literature as high levels of sexual activity, including one-night stands; having multiple concurrent sexual partners; the behaviours that one engages in with those partners (such as non or inconsistent use of condoms); and the probability that those partners are HIV positive (Akande, 2001; Farrow & Arnold, 2003; Harrison, Xaba, Kunene & Ntuli, 2001; Peltzer, 2002).

Simbayi et al. (2004) refer to a review of 75 research papers and reports which revealed that, among other findings, a) the majority of sexually active youth reported at least one partner during the past year, with 10-25% of males consistently reported more than four partners per year compared to 1-5% among females; and b) between 50-60% of sexually active youths reported never having used condoms before and, in addition, those who reported using condoms only did so inconsistently. A more recent survey conducted by

the Kaiser Family Foundation and the SABC (2007) found that the incidence of multiple sexual partners is one of the main behaviours fuelling the HIV epidemic (Keeton, 2007). The survey also reported that 67% of young South Africans (age 15-24) have ever had sexual intercourse and that more than six in ten of these participants reported that they used a condom the last time they had sex, while 45% said they always used condoms during sexual intercourse, and 17% reported that they never used a condom. In addition, more than 53% of those who had had sex in the last 12 months stated that they suspected that, or they were unsure whether, their partner was having sex with other people.

A number of studies have been conducted to understand, and consequently predict, the factors that cause youths to participate in sexual risk behaviours and the findings add insight into why a large percentage of the youth do not practice safe sexual practices involving the ABC approach (Abstain, Be faithful and Condomise). According to Eaton, Flisher & Aarø (2003); Mathews (2005); and Simbayi et al. (2004) to understand the various factors underlying risk behaviour it is necessary to understand the interactive effects of factors at three levels: personal factors (within the person); the proximal context (interpersonal) and distal context (structural and cultural). For the purpose of simplifying the reporting of the literature regarding risk factors it will be divided according to these afore-mentioned levels.

2.5.1 Personal factors

The majority of studies on HIV and sexual risk behaviour focus on the level of the individual. Personal/individual factors are those that reside within the individual person such as knowledge, cognitions (beliefs), and attitudes. A discussion of the impact of these factors on HIV and sexual risk behaviour follows.

Knowledge: According to Akande (2001) a fundamental change that has occurred amongst African youth is that they have become more knowledgeable about HIV and AIDS. However, various authors state that although young South Africans have an acceptable understanding and knowledge of the general scope of HIV/AIDS, they display substantial ignorance on specific points, such as the mode of transmission and whether or

not a vaccine exists, as well as hold a number of misconceptions (Eaton et al., 2003; Kaiser Family Foundation & SABC, 2007; Lagerberg, 2004; Mba, 2003). James et al. (2004) also refer to a superficial knowledge, stating as an example that only half of the students they interviewed could name a sexually transmitted disease.

Greatly evident in the literature is the discrepancy between awareness and behaviour. Many studies have found that, while young people are very much aware of HIV/AIDS, many have not adopted safe sexual behaviours in response (Akande, 2001; Harrison et al., 2001; James et al, 2004; Lagerberg, 2004; Opt & Loffredo, 2004; Zwane et al., 2004). Most authors conclude that knowledge alone is insufficient to change behaviour and that intentions and actual behaviour change are influenced by additional factors.

Attitudes, beliefs and perceptions: Intentions are to a large degree shaped not only by knowledge but also by attitudes, beliefs and perceptions. Individuals tend to weigh up the costs and benefits of safe sexual behaviours (abstinence, being faithful or using condoms) according to their beliefs, attitudes and perception (which are often erroneous). To consider beliefs only on a personal level is complex due to the fact that personal beliefs are shaped by external influences to varying extents and, for that reason, this section overlaps with the other levels.

Many youths do not like to use condoms or to abstain due to a number of beliefs and attitudes (Kaiser Family Foundation & SABC, 2007). One such belief/attitude discussed in the literature is that of responsibility, since many individuals believe that the responsibility for taking precautions lies with the female in the relationship, an excuse often used by men who do not initiate discussions regarding precautions (Akande, 2001; MacPhail & Campbell, 2001). However, in addition to this belief is the belief held by females and males alike that if females carry condoms or initiate discussions regarding precautions they are deemed to be promiscuous (Farrow & Arnold, 2003; MacPhail & Campbell, 2001; Simbayi et al., 2004).

Other beliefs and attitudes which influence the choice to reject condom use or abstinence include the belief that the suppression of sexual desire leads to ill health; that having sex with a condom causes a loss of pleasure; and that condoms are awkward, annoying, unromantic, uncomfortable or cause a loss of erection (Akande, 2001; Chitamun & Finchilescu, 2003; Farrow & Arnold, 2003; Peltzer, Oladimeji & Morakinyo, 2001).

With regard to beliefs pertaining to abstinence and monogamy in particular it appears that the beliefs and attitudes that result in abstinence include conservative or religious beliefs regarding sex; followed by fears of unwanted pregnancy and HIV/AIDS (Blinn-Pike, 1999; Chitamun & Finchilescu, 2003; Eaton et al., 2003; MacPhail & Campbell, 2001). In terms of monogamy, a dominant belief held by many men is that being a 'normal' man is associated with multiple partners and power over women (Eaton et al., 2003; MacPhail & Campbell, 2001). A further perception is that males have a more highly charged sex drive and therefore have the right to assert this by seeking sex within relationships (Eaton et al., 2003; Harrison, et al., 2001).

Beliefs regarding trust result in the inconsistent or lack of use of condoms. It seems that many youths believe that once trust and commitment have been established in a relationship it becomes less necessary to use condoms, and the assumption is made that long-term relationships involve less risk. However, the basis for trust and the level of commitment does not appear to take into account whether or not the partner has been tested and is rather based on appearance and reputation. Some young women feel that to insist on condom use in a steady relationship indicates a lack of trust and respect which can lead to the destruction of one's relationship and/or reputation (Eaton et al., 2003; Farrow & Arnold, 2003; MacPhail & Campbell, 2001).

It has been found that most females engage in sex in a stable relationship rather than opting for abstinence in the belief that sex is important for expressing love and will make their partners happy, as well as to feel loved and needed (Chitamun & Finchilescu, 2003). Unfortunately, these beliefs are not wholly incorrect as studies have shown that some men believe they are entitled to insist on sex from their girlfriends as proof of their love

(MacPhail & Campbell, 2001). Also, many females believe they will face rejection by sexual partners and emotional distress if they insist on sexual precautions or abstinence.

Self-efficacy: Self-beliefs affect self-efficacy, a factor discussed by many authors in relation to sexual behaviour. Youth with low self-esteem may engage in high-risk behaviour to feel accepted and more confident, or due to the fact that they are unable to make decisions or negotiate safer alternatives for the behaviour (Eaton et al, 2003; Harrison, 2005; Hartell, 2005). Many females in particular define themselves and their self esteem by their relationships, thereby reducing their ability to exercise self-efficacy for fear of rejection. Self-efficacy is imperative in following through with condom use. Condom use is more likely to occur if one has the self-confidence to insist upon the use of a condom and to correctly use a condom (Akande, 2001; Chitamun & Finchilescu, 2003).

Unfortunately, when people begin their studies at tertiary institutions they often struggle to adjust to forming new relationships; increased academic pressures; and the social opportunities and expectations, causing them to experience high levels of self-criticism and low efficacy. This appears to arise from individuals struggling to find the right balance between personal relationships and academic success. Feelings of isolation and a lack of self-efficacy can result in students being more susceptible to risky sexual relationships and being unable to insist on safe sexual practices (Farrow & Arnold, 2003).

Perception of risk: Finally, and of great significance when considering why youths continue to partake in sexual risk behaviour is the perception of vulnerability. Related to self efficacy is the aspect of fatalism, which appears to be present to a large degree among the youth and comprises beliefs such as the belief that they have little control over what happens so there is no point in taking precautions; that they are unable to control their sexual urges, to take initiative in condom use or to use condoms correctly; and that they could ‘as easily be knocked over by a car’ (Akande, 2001; Keeton, 2007; Peltzer, 2002). On the other hand, there is the optimistically biased belief that HIV happens to other people and not themselves (James et al, 2004; Keeton, 2007; MacPhail & Campbell, 2001). Hartell (2005) reports that the majority of youths believe they are not susceptible

to HIV infection and Eaton et al. (2003) report that many people are still in denial about HIV/AIDS as well as personal risk and responsibility.

2.5.2 Proximal factors

The proximal context involves interpersonal relationships and their effect on sexual behaviour. HIV interventions that focus on the proximal context go beyond individual behaviour change goals and take into consideration the immediate interpersonal and community level, including factors such as peer interactions (norms and pressure); interactions with adults in the community; negotiation skills in relationships; and gender-based violence and coercion, as influenced by norms and perception. Below is a brief discussion regarding how these aspects affect sexual behaviour.

Communication and peer pressure play an important role in high-risk sexual behaviour. Adolescents often receive conflicting messages about sex and sexuality and lack the knowledge, confidence and skills to discuss sexual issues, including contraception and prevention of infection (Hartell, 2005). Unfortunately, despite the acknowledged desire by youth to communicate more openly with parents regarding sexual matters on the basis that they trust their parents' advice, most youth do not feel they are able to do so (Chitamun & Finchilescu, 2003; Keeton, 2007). Harrison et al. (2001) mention the absence of inter-generational communication on sexuality due to a practice rooted in tradition where parents did not discuss sexual matters with their children. Certain parents fear that by discussing sexual behaviour, or even precautions that can be taken, their children will be encouraged to partake in sex. Furthermore, there are some parents who punish their children for even raising the subject (Eaton et al., 2003; Kirby et al., 2006).

Staff at public health clinics play an important role because they too can provide youth with information and resources, including condoms. However, many of these staff members have been reported to scold or mock young people and to break confidentiality. As a result many young people are reluctant to make use of these services (Eaton et al., 2003; Kalichman & Simbayi, 2004). Therefore it appears that youth find they are unable to approach their parents or adult professionals for advice and information.

Consequently, youths rely instead on friends for information regarding sex, HIV, STIs and pregnancy (Hartell, 2005; James et al., 2004; Lagerberg, 2004). A study by Lefkowitz, Boone & Shearer (2004) indicates that, during emerging adulthood, relationships with close friends can be particularly important and influential and communication about sex-related topics can be vital in terms of self-esteem and -efficacy, knowledge and motivation. However, the survey by the Kaiser Family Foundation and the SABC (2007) also found that participants trusted most other sources as more knowledgeable in comparison with friends, indicating that at times youths will accept whatever advice or information they can acquire, even if they do not fully trust their friends' knowledge.

Peer norms: As discussed in the previous section there is evidence that the youth do not always trust the information they gain from friends but depend on it nonetheless. This caution surrounding their peers' advice/information may stem from the fact that the influence of peers can be negative or positive, as young people may feel the need to be more like their friends even if their friends are engaging in risk-taking behaviour. MacPhail and Campbell (2001) report findings that, although discussing safe sex within friendships can be a strong predictor of practicing safer sex, in the majority of cases peer norms encourage risks. Nonetheless, the positive influence of peer pressure and communication is an important principle behind peer-education programmes (Deutch & Swarts, 2002). If their friends become knowledgeable sources of information youth are more likely to continue approaching them for advice while also being able to trust their information. In addition, self-esteem and self-efficacy once more come into play as youths will be more able to disregard peer pressure if they are more confident, and this confidence can be gained through association with knowledgeable peers.

Negotiation: Decision-making and communication with sexual partners remains an extremely important skill. Unfortunately, the absence of the decision-making process or communication, characterized by non-negotiation, appears to be widespread, due to a number of factors including peer influences, physiological changes of young people, self-

esteem and –efficacy, all interlinked with the level of understanding and perception of risks (Eaton et al., 2003; Harrison, 2005).

Sexual coercion and gender-based violence also undermine the ability of many females, in particular, to participate in negotiation or communication regarding safer sexual practices. Many studies in South Africa indicate the presence of gender inequalities, violence or coercion within relationships (Eaton et al., 2003; Harrison, 2005; Harrison et al., 2001). In these relationships the men are often abusive and controlling of sexual activity and women desist from insisting on sexual precautions or abstinence due to the threat of violence and rejection (MacPhail & Campbell, 2001). Chitamun and Finchilescu (2003) report that domestic violence and sexual abuse result in many women not having a choice whether or not to engage in sexual activity. Many of the reasons behind this violence and coercion can be understood at a structural/cultural level. Thus, the following section deals with more distal factors involved in sexual risk behaviour.

2.5.3 Distal context

Other effective interventions go beyond specifically focusing on individual behaviours and community/interpersonal aspects and instead focus on the broader social context or distal context. The distal context involves environmental and structural factors which impact on the individual and the community. Such aspects include, amongst others, culture and socioeconomic status, as discussed below.

Culture: Key to some cultures is the issue of patriarchy and unequal power relations, often resulting in the subordination of women. Females are expected to be submissive and young women have little or no control over decision-making, the sexual behaviour of their male partners, or the use of condoms. In addition, there is often a generational gap present in coerced relationships, with the demand of sexual services from younger unmarried women who are particularly powerless in these circumstances (Eaton et al., 2003; Harrison, 2005, Mba, 2003). Further, in society as a whole and regardless of culture, there still remains an implicit societal norm positioning men as more powerful

than women, often resulting in women lacking the self-efficacy to negotiate sexual behaviour or avoidance thereof.

Traditional beliefs often undermine HIV prevention efforts and campaigns. In particular, certain cultural groups hold distinct beliefs that view pregnancy as an achievement and teenage mothers are becoming increasingly acceptable in these communities (Farrow & Arnold, 2003; Netswera, 2002; Peltzer et al., 2001). This view can, of course, influence decisions to abstain or use condoms.

Many myths regarding sexuality as held by various cultures undermine the desire of individuals to adhere to safer sexual practices. For instance a study by Kalichman and Simbayi (2004) found that one in three participants either believed that HIV/AIDS is caused by spirits and supernatural forces or indicated that they were not sure whether this belief is true. Kalichman and Simbayi also refer to the fact that these myths most likely arise from misinformation, which appears to be the source of stigmatizing beliefs. These beliefs further erode the attempts to prevent the spread of HIV as people are forced to hide their condition and continue engaging in high-risk behaviour (HIV and AIDS and STI Strategic Plan, 2007). Silence and denial prevent young people from accurately assessing their own personal infection risk.

Harrison et al. (2001) found that many young women believe evil spirits will haunt them if they do not have sex close to the age of puberty and that if boys do not have sex when they are young they will experience pain and cry when they eventually do. In addition, these boys who do not have sex are thought to have more sperm and therefore be more likely to impregnate females. Further, it is commonly accepted that HIV infection is believed to occur due to particular traditional health practices requiring the use of unsterilised blades, knives, and thorns and due to traditional healers recommending sex with a virgin as part of a treatment plan (HIV and AIDS and STI Strategic Plan, 2007).

Socioeconomic status: Many unsafe sexual practices take place as a result of poverty and the economic gain connected with sexual practices, such as prostitution and sex with

older men ('sugar daddies') in exchange for gifts and money. Unfortunately, this commodification of sex typically results in the sex taking place according to the terms of the males in the relationship, often meaning no condom (Eaton et al, 2003; Harrison et al., 2001; MacPhail & Campbell, 2001; Zwane et al., 2004). A study conducted by Barnes in 2000 indicated that there were many students at UWC who experienced financial difficulties and that prostitution and the 'sugar daddy' syndrome existed on the campus. It is unknown whether this is still the case as more current research has not been conducted.

In general poverty, overcrowding, unemployment, and low levels of education appear to be linked to higher levels of sexual activity and less knowledge about HIV and AIDS. Further, poverty is often associated with higher levels of domestic violence, and physical and sexual abuse in relationships. In South Africa poverty as a structural factor exerts a pervasive influence on young people's sexual behaviour and HIV risk (Eaton et al, 2003).

2.6 Alternative theories of risk behaviour

Understanding the theory underpinning risk behaviour enables one to facilitate a programme in such as way as to achieve maximum impact, due to theory-driven interventions being based on key constructs and processes. Some of the theories mentioned in the literature are Social Cognitive Learning Theory; Social Inoculation Theory; Differential Association Theory, Communications of Innovations Theory; Theory of Reasoned Action (revised as Theory of Planned Behaviour); Theory of Self-Regulation and Self-Control; and the Health Belief Model (Deutch & Swarts, 2002; Eaton et al., 2003; Mathews, 2005). These theories all focus primarily on the personal and interpersonal factors influencing health behaviour.

For the purposes of this study the Health Belief Model (HBM) will constitute the theoretical framework. The HBM proposes that for an individual to change behaviour in order to avoid a disease, he/she needs to believe that (a) he/she is susceptible to the disease (perceived susceptibility); (b) the disease could have at least a moderately severe impact on his/her life (perceived severity); (c) certain behaviours could be beneficial in reducing perceived susceptibility or the severity of the disease (perceived benefits); and

(d) these behaviours could be impeded by certain factors (perceived barriers) (Rosenstock, 1990). To improve its predictive ability some researchers have expanded the HBM to include the concept of self-efficacy (Lin, Simoni & Zemon, 2005).

Applied to sexual risk behaviour, youth's behaviour is expected to be influenced by informed decisions and awareness of susceptibility to sexually transmitted diseases and unwanted pregnancies. However, the likelihood of safer sexual practices is also associated with certain outcomes (e.g. fear of rejection and the inability to prove fertility) and perceived barriers, such as cost, pain and embarrassment, which inform youth's attitudes towards such behaviour.

Theory not only informs the development of programmes but also enables the evaluation of interventions to the degree that they emphasise the particular constructs and processes outlined in the theory. The HBM is suitable for the study of the UWC peer-education programme which focuses on perceptions, beliefs and values, and resulting intentions.

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2.7 HIV/AIDS intervention programmes

Numerous methodologically sound evaluations of risk reduction interventions have shown that HIV prevention interventions can reduce sexual risk behaviour (Mathews, 2005). However, these have been shown to focus on different levels of intervention i.e. some focus on the personal factors (knowledge, attitudes and behaviour) alone; others take into consideration interpersonal and proximal factors, while others go beyond individual and interpersonal behavior change and target the structural context. These all achieve varying levels of success and sustained behavioural change.

Until fairly recently, many interventions isolated the personal factors of knowledge, attitudes, behaviour and practices (KABP) as target areas for change. Many studies have shown that these interventions have an impact on knowledge and awareness, but fewer have demonstrated actual behaviour change (Harrison, 2005; Harrison, Smit & Myer, 2000; Hartell, 2005). As previously noted knowledge does not necessarily impact on intentions and behaviour and it is for this reason that interventions have focused on

interpersonal and other factors in addition to basic knowledge and awareness. Furthermore, studies have shown that students are tired of conventional approaches towards HIV/AIDS education and awareness (James, 2002; Maritz, 2001). A speech given by a young Zambian peer educator held at the 5th Annual Reproductive Health Priorities Conference illustrates this feeling:

> AIDS tomorrow, AIDS everyday on TV, AIDS. Young people don't like boring stuff. And if you use those abbreviations – ABC, KABP – I find those boring things, they don't mean anything (James, 2002, p.185).

2.7.1 Characteristics of successful programmes

Kirby et al. (2006) reviewed 83 evaluations of intervention programmes and concluded that HIV education programmes that are based on a written curriculum and that are implemented among groups of youth are a promising type of intervention to reduce adolescent sexual risk behaviours. The curriculum should not only focus on knowledge and awareness but also on the mediating factors (psychological factors) that determine whether youth become involved in sexual risk behaviour. It is recommended that the curriculum include or pay attention to the following aspects: knowledge, perceived risk, perceived severity, personal values and attitudes, perceived peer behaviour and norms, perceived partner values, self-efficacy and skills to refuse sex or use condoms, motivation and intentions to abstain from sex and limit partners, communication about past relationships and HIV risk, other behaviours (e.g. alcohol and drug use), and relationships with parents and psychological states.

The authors listed a number of characteristics they found common to successful programmes. Virtually all the programmes encouraged specific behaviours with the majority encouraging abstinence as well as discussing or promoting the use of condoms, and/or other forms of contraception in the event that young people chose to be sexually active. Eighty-three percent of successful programmes were based on at least one theory, with Social Cognitive Learning Theory being the most commonly applied theory. Twelve percent of the programmes made use of the Health Belief Model. Nearly all of the successful programmes included at least two different types of interactive activities to

involve youth and to assist in the personalization of information. Examples of such activities were role playing, simulations, or individual worksheets. Finally, at least ninety percent of the programmes trained their peer educators before the educators implemented curriculum activities. In addition, with regard to peer educator qualities the authors concluded that what is most important to young people is whether the educator can relate to youth, not the age of the educator.

2.7.2 The role of abstinence in interventions

Kirby et al. (2006) refer in their review the impact of abstinence-only programmes versus comprehensive sex and HIV education programmes (i.e. focussing on other aspects of prevention like monogamy and using condoms). This is an important topic considering the focus of the peer education programme at UWC being on abstinence in particular.

It is necessary to firstly define abstinence. Past research has tended to equate abstinence with virginity yet virginity is a not a requirement for abstinence. The *Concise Oxford Dictionary* (1964) defines abstinence as 'refraining from any pleasure or in the sense of continence, fasting, or going without alcohol' (p.6). As reported by Norris, Clark & Magnus (2003) this definition does not presume a lack of experience, but rather a choice to refrain from indulging one's sexual appetite. Harrison (2005) and Simbayi et al. (2004) use the term 'secondary abstinence' to refer to a period of time during which an individual chooses to refrain from sexual activity after having previously been sexually active. Norris et al. (2003, p.141) further define sexual abstinence as 'a specific set of behaviours used to actively avoid sexual intercourse by persons who are not married but are interested in a romantic relationship with a partner'.

Abstinence is an often-cited preventative strategy for young people given that it is the only method that is one hundred percent guaranteed to prevent infection of sexually transmitted diseases and unwanted pregnancies (Blinn-Pike, 1999; Harrison, 2005; Norris et al., 2003). Hartell (2005) states that it is therefore necessary that abstinence be made 'valuable' to adolescents. However, abstinence is not an easy option to implement and Blinn-Pike (1999) describes the choice to remain abstinent as possibly one of the most

significant challenges facing youth today. In particular, as previously noted, it requires skills and self-efficacy to negotiate and communicate the desire to abstain from sexual activity. In addition, Agha (2002) found that many youth interpret abstinence to be inhibiting and to mean they cannot have a social life involving having a boyfriend or girlfriend. It is therefore not surprising that findings indicate that abstinence is not the dominant mode of prevention amongst the youth (Simbayi et al., 2004).

Kirby et al. (2006) concluded that programmes fall along a continuum and do not actually fall neatly into abstinence-only and comprehensive programmes. However, they did find that the programmes that tended to advocate mainly abstinence were not particularly successful in delaying sexual debut, but that both these programmes as well as the more comprehensive programmes did result in some positive impact on some measure of sexual behaviour besides a delay in the initiation of sex.

Harrison et al. (2000) believe that programmes should not rely solely on the message to use condoms to the exclusion of other potentially more effective messages, such as abstinence, reducing one's partners or being faithful to one safe partner. However, programmes that focus on abstinence alone and do not include information and skills related to being faithful and condom-usage are likely to fail, specifically because when youth are not able to abstain they do not have alternative options for safe sexual practices. Lagerberg (2004) claims that total abstinence is unrealistic. Simbayi et al. (2004) recommend that youth be given the option and that when they cannot abstain condom use should be encouraged. Maritz (2001, p.3) states that several studies have shown that 'well-designed and accessible programmes that combine messages about safer sex, as well as abstinence, may delay sexual debut, as well as increase preventative behaviours among young people who are already sexually active'.

Norris et al. (2003) use the HBM to argue that for sexual abstinence to be followed youth need to perceive the consequences of sexual intercourse negatively and there should be an absence of barriers to pursuing abstinence. These authors recommend that programmes need to focus on self-efficacy related to sexual abstinence because youth who view

themselves as able to successfully practice sexual abstinence are more likely to engage in abstinence behaviour. The authors recommend in particular using role play and other simulations to practice saying no and that youth should be taught to say no in a manner that is suited to their own personality style and appropriate to the social situations that youths anticipate finding themselves in. This therefore makes it more likely that youth will succeed in their attempts to practice sexual abstinence.

2.7.3 Skills training and self-efficacy

A study by Harrison et al. (2000) reviewed various behavioural change programmes and recommend that behaviour interventions which normally include raising awareness, educating people, promoting condoms and reducing high risk behaviours need to include a skills development component in order to achieve actual behaviour change, as well as be informed by theory. The authors concluded that many prevention programmes have limited impact due to the emphasis on knowledge and prevention without information regarding the skills to achieve these changes.

This emphasis on skills training forming part of intervention programmes has been emphasized by a number of other authors including Hartell (2005); James (2002); and Mba (2003). Harrison (2005) emphasizes in particular negotiation skills, assertiveness training, and a focus on self-esteem. Rosenstock (1990) also stresses skills training and self-efficacy in terms of his Health Belief Model when applied to intervention programmes. He states specifically that the target behaviour should be broken into components that are relatively easy to manage and training be provided on achieving these. He mentions in particular role play and relaxation training. Simbayi et al. (2004) also refer to the inclusion of negotiation skills in intervention programmes.

As can be noted skills training is often linked with self-efficacy and, indeed, a large percentage of the literature referred to a focus on self –efficacy (which tends to result from having the necessary skills) for intervention programmes to be successful (Akande, 2001; Harrison, 2005; James, 2002; Kirby et al., 2006; Simbayi et al., 2004). Also in relation to self-esteem, a number of authors refer to the importance of the involvement of

youth in the implementation of intervention programmes. Kirby et al. (2006) were proponents of this and so is James (2002) who recommends that involvement in the programmes provides youth with self-worth and skills. Hartell (2005) recommends that health educators should invite young people to assist in the planning, implementation, and evaluation of HIV/AIDS programmes.

2.7.4 Context-specific interventions

In addition to skills and self-efficacy a few authors stated that it is necessary to consider not only the personal factors but also interpersonal and structural factors that are involved in sexual risk behaviour. James et al. (2004); Mba (2003); Netswera (2002); and Simbayi, et al. (2004) all refer to the importance of interventions taking into consideration context, culture and socio-economic factors. James et al. (2004) refer specifically to a sound understanding of cultural differences and gender discrepancies pertinent to the group the intervention is intended for. Netswera (2002) also places an emphasis on culture, in particular cultural beliefs that feed into sexual risk behaviours. Simbayi et al. (2004) found that certain HIV interventions may be more suitable for targeting some sub-populations and not others due to a variety of differences between groups. They recommend that integrated and generic as well as targeted HIV/AIDS intervention programmes be implemented. Mba (2003) states that intervention programmes must be based on a full understanding of the individual as well as the broader socio-economic factors that influence behaviour.

2.7.5 The re-negotiation of norms

A final point given considerable weight in the literature is that of shifting existing norms and creating new peer and social norms that are more conducive to safe sexual practices. The review by Harrison et al. (2000) concluded that instead of attempting to convince individuals to change their behaviour on the basis of external norms, new collective norms of behaviour be developed within the group that is being targeted, as recipients are more likely to adhere to self-created versus imposed norms. MacPhail and Campbell (2001) believe that the context should be provided in which young people can renegotiate dominant high-risk norms. Zwane et al. (2004) stress that it is necessary to work outside

of the purely individualistic and cognitive paradigm and focus also on social norms and perceptions which impact individual decision-making.

2.7.6 Peer education programmes

Taking the above-mentioned findings and recommendations regarding successful HIV interventions into consideration, as well as the fact that youth rely on friends to communicate about issues concerning STIs/HIV (James et al., 2004; Lefkowitz et al., 2004) and the association of peer pressure with sexual behaviour, many programmes have focused on peer-led education approaches to change sexual behaviour.

The definition of peer education is not a straightforward one as it has taken on a range of interpretations and definitions. Maritz (2001, p.2) defines "peer" as "one that is of equal standing with another; or belonging to the same societal group especially based on age, grade or status". "Education" refers to the "development", "training", or "persuasion" of a given person or thing or the "knowledge" resulting from the educational process". Peer education is the process whereby peer educators are trained to facilitate small groups of their peers in the process of social-learning, skills training and discovery (Deutch & Swarts, 2002). The ultimate goal of HIV-focussed peer education is to promote responsible sexual behaviour among peers so that they are less inclined to place themselves at risk of HIV infection.

Despite the variety of definitions for peer education a key characteristic of the approach has to do with the educators being of the same societal group or social standing, whether relating to age, ethnicity, gender, cultural or sub-cultural membership (Parkin & Mckeganey, 2000). The assumption is that peer educators will be perceived as more credible, resulting in more effective interaction (Green, 2001).

2.7.7 Benefits of peer education

Peer education is said to have a range of benefits over other interventions. Harrison et al. (2000) claim that peer education approaches empower youth as well as educating them, through the transfer of the control of knowledge from experts to lay members, making the

process more accessible and less intimidating, as well as through teaching skills to use in the context of relationships in general. A Global Programme on AIDS reporting on peer approaches among youth (in Wolf, Bond, & Tawfik, 2000) noted that the rationale of using such approaches is a) they give consideration to the social and cultural context, b) they promote alternative safer social norms and provide support for the adoption of positive attitudes and behaviours, and c) they increase the possibility of youth involvement in both participation in and development of programmes.

Much of the literature refers to the suitability of peer education approaches for providing the environment necessary to shift social norms. Agha (2002) refers to the fact that because peer education involves sharing attitudes, beliefs and knowledge about abstinence and condom use, many youth can model these attitudes and beliefs and re-create their own in order to increase their beliefs in the efficacy of abstinence, monogamy and condom use. Simply put, the belief becomes that "if others can do it (and are doing it), then so can I". According to Harrison et al. (2000) the group debate and negotiation of messages and behaviours allowed by means of peer education interventions leads to the establishment of new collective norms and behaviour.

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Hunter (2004) refers to peer education in the setting of tertiary institutions in particular and claims that these interventions allow for the sharing of accurate information about prevailing social norms on campus, especially in reminding students that extreme behaviour (e.g. excessive alcohol and many different sexual partners) is not 'normal'. In addition, these interventions are thought to provide a setting that gives students permission to care for themselves – emphasizing that it is acceptable for them to set sexual boundaries, and teaching assertiveness and refusal skills.

As summarised by Hartell (2005) peer education approaches appear to be the most effective due to offering accurate information in a manner that is accessible, less intimidating and relevant to youth due to the control of the knowledge being transferred from the hands of experts to lay members. Peer education allows room for debate and negotiation regarding messages and behaviours, and the formation of adapted norms.

Further, the component of skills training in peer education approaches is an aspect that sets peer education programmes apart from other behavioural change programmes. Skills training is therefore a vital component of peer education approaches (Agha, 2002; Deutch & Swarts, 2002; Hunter, 2004; Zwane et al., 2004) Lefkowitz et al. (2004) claim that the skills learnt through these interactions, especially communication skills, will be carried over to sexual relationships, thus increasing the chance of change in behaviour. In a similar vein youth who have learnt skills and information through peer education interventions are more able to informally educate their own peers and teach, demonstrate or model the skills they have learnt.

This last point feeds into another benefit of peer education programmes, being the fact that peer educators are able to reinforce learning through ongoing contact (Green, 2001); and the fact that peer education utilises established channels of communication (Green, 2001; Parkin & McKeganey, 2000). Hunter (2004, p.42) refers to 'teachable moments' that occur informally as peer educators talk to roommates, teammates and classmates.

2.7.8 Criticisms and limitations of peer education

Peer education has received some criticism and limitations have been noted. One of these is the fact that many people overlook the importance of training and the fact that without adequate training of peer educators, peer education programmes will not be successful. In addition, due to the fact that peer educators are volunteers they move on and are replaced by new peer educators who then need training, making it an intensive process. Hunter (2004) indicates that the minimum training required should include social norming theory, listening skills, communication skills, confrontation skills, referral skills, programming strategies, information on role modelling and ethics, stress and time management and marketing skills. In addition, he stresses that with training should go adequate support and funding. Harrison et al. (2000) reiterate the sentiment that essential elements, such as building skills and increasing competence, may be neglected if thorough training and ongoing support are not provided to volunteer peer educators.

A further criticism is that youth actually do not always trust the information of their peers over that of health professionals, a point that was made earlier in this chapter. Ergene et al. (2005) report findings that young people did not trust the information they received from peer educators, preferring to seek additional information from health professionals. James (2002) stresses that many peer relationships lack the egalitarian quality which the term implies, in that aspects like gender, age and culture can result in power dynamics and other dynamics (such as female recipients being attracted to male peer educators). She found that many recipients of peer education claimed they would prefer to receive advice in an anonymous youth centre from adults versus their peers.

Kelly (2004) believes that the notion that health messages may have greater credibility when they come from someone who is seen as similar to the recipient is logical and attractive but requires further examination to determine whether it is likely to have an impact on members of the target population. He suggests an alternative being that of the 'popular opinion leader' (POL) approach i.e. using popular and socially influential members of the target population to be recruited and trained in how to communicate HIV risk reduction messages.

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A point made by many of the authors is the need for additional evaluation of these peer education programmes (Deutch & Swarts, 2002; Ergene et al., 2005; James, 2002; Kelly, 2004). In addition, it is important to remember that results will to a certain extent be unique to the settings and circumstances in which peer education programmes are implemented and should not be generalized across all peer education programmes.

2.8 The HIV peer-led (AB) programme at the University of the Western Cape (UWC)

An HIV/AIDS programme was established in 2001 in response to the recognized, increasing need for UWC to prevent, manage and lessen the impact of HIV/AIDS on the university. An aspect of the programme involved building partnerships with other universities, organizations and communities. It was through the ZAWECA HIV/AIDS Peer Education Project, a collaborative project between UWC and the University of

Zambia (UNZA), that the UWC-based HIV/AIDS peer education programme was developed and implemented (2003-2005) (The ZAWECA HIV/AIDS Peer Education Project, Project close-out report, July 2005).

The aim of the programme was to change student attitudes and perceptions and assist in the development of appropriate lifeskills; disseminating information; and continued evaluation of the progress of the peer education programme. Over the two year period in which the Peer Education programme was implemented at UWC fifty-five HIV/AIDS peer educators were recruited and trained. Prospective trainees were required to undergo a selection process comprising a paper selection followed by an individual interview. The selected peer educators then received intensive training, commencing at the beginning of the academic year (2005). This involved basic information regarding HIV/AIDS, encouragement to reflect on their own personal attitudes relating to HIV, and addressing their questions and concerns. In addition, a four day skills development and growth training programme was conducted, which focused on biomedical, psychosocial, and legal aspects of HIV/AIDS; diversity; facilitation skills; group dynamics; and gender. All trainees were also required to attend a portfolio development workshop as well as fortnightly follow-up training and supervision sessions. Since this period more peer-educators have been trained and conduct a variety of activities and projects at UWC. One of the peer-led initiatives at UWC is the peer-led HIV/AIDS programme.

The peer-led (AB) Programme uses 25 senior students on a voluntary basis who are trained in the manner described above in order to perform duties as peer educators. Each peer educator facilitates a 60 to 90 minute discussion group of students across different year levels on a weekly basis. This takes place over a course of seven weeks. The peer-led abstinence programme is based on a structured curriculum which guides recipients through a process of self-discovery, looking at their values, beliefs and past experiences to come to an understanding of how these influence current behaviour. Themes covered in the workshops include self esteem, values, gender-related issues, and decision-making and negotiation skills. Discussion and debate are encouraged and regular use is made of role-play scenarios in order to integrate newly acquired skills.

The peer educators are trained and facilitate workshops within an 'AB' framework which denotes *Abstain* and *Be faithful*. This approach places a particular focus on abstinence, including delay of sexual debut, mutual faithfulness and partner reduction for sexually active young adults, with a lesser focus on condom-use in the event that the abstinence is unachievable (hence the label of the 'AB' programme versus utilizing the usual 'ABC' framework). The programme is aimed at promoting abstinence and being faithful as effective and achievable strategies to prevent sexually transmitted infections (STIs), including HIV, and unintended pregnancy. It is hoped that recipients who are not sexually active will obtain the negotiating skills to delay sexual debut and that those who are sexually active will choose to reduce their number of sexual partners.

2.9 Chapter summary

The chapter began with a discussion regarding HIV and AIDS in South Africa, referring in particular to the fact that the epidemic poses a major challenge to the country as a whole, making it vital to understand the disease and intervene accordingly. The primary method of transmission is sexual intercourse and young South Africans constitute the most vulnerable risk group in relation to sexual behaviour and HIV transmission, in particular the age group from 15-24. During this period youth undergo a variety of developmental changes, involving the formation of a unique identity, including sexual identity. These changes, as well as a low perception of risk and the fact that youth marry later and live alone without adult supervision, result in increased sexual risk behaviour.

A large percentage of youth can be found in tertiary institutions where the environment is such that it often augments the possibility of sexual risk behaviour. However, on the other hand tertiary institutions are the ideal setting for youth-focussed interventions due to accessibility to the youth and the roles that institutions play in education.

To develop appropriate intervention programmes it is necessary to understand what factors lie behind the sexual risk behaviours of youth, which include, amongst others, having multiple partners and not using condoms. The literature discusses the risk factors in terms of three categories, being personal, proximal and distal factors. Personal factors

include knowledge, attitudes and beliefs regarding HIV and sexual behaviours, as well as perceptions of vulnerability. Of particular significance is the role of self-efficacy in sexual relationships. Proximal factors referred to in the literature revolve around communication. Reference is made to communication with adults and peers, and the role of peer norms, as well as negotiation and decision-making with sexual partners, including an emphasis on sexual coercion and gender-based violence having a significant influence on sexual risk behaviour. Finally, distal factors involve culture and socioeconomic beliefs in particular. Cultural beliefs and stigma can interfere with safe sexual practices. In terms of socioeconomic status poverty can lead to high-risk sexual encounters for economic gain or due to a lack of ability to negotiate safe sexual behaviour.

HIV and AIDS intervention programmes focus on a variety of the afore-mentioned factors. The literature indicates that intervention programmes that focus only on personal factors, in particular knowledge, attitudes and beliefs do not necessarily impact on behaviour. The literature indicates that successful programmes include some or all of the following aspects: a focus on self-efficacy; a foundation based on a particular theory; the involvement of youth in the programmes; attention to context-specific factors; the provision of an environment in which norms can be re-negotiated; skills training; and a focus on abstinence in combination with other practices. The literature indicates that peer education programmes are considered to be effective as a result of including most of these aspects as well as being led by peer educators, leading to the establishment of greater credibility with the recipients. The literature also refers to criticisms and limitations of peer education programmes, namely the fact that youth do not trust the information provided by peers as much as information provided by experts, and the necessity for continuous training and support.

Finally, the chapter ends off with an overview of the UWC peer education programme, based on the ABC principles, with a specific focus on abstinence and being faithful.

CHAPTER THREE

Methodology

3.1 Aims

The aim of this study was to explore and describe the experiences of recipients of the HIV peer education programme offered by the University of the Western Cape (UWC). The researcher hoped to examine the recipients' subjective experiences in terms of perceived strengths and weaknesses of the programme, with regard to how they felt the programme impacted on them and, by extension, impacted on others. The study specifically attempted to explore changes in HIV-related knowledge, attitudes, and to a lesser extent behaviour, with a focus on abstinence in particular.

3.2 Research design

This exploratory study was conducted within a qualitative paradigm, which was felt to be most suited to the exploration of individual, subjective experiences. While many HIV-related studies measure concepts such as knowledge, attitudes and behaviour as quantities this study aims to explore recipients' subjective understandings and perceptions as tied to such concepts, and not constrained to only these concepts, within their lived experience of the HIV peer-education programme. As stated by Hayes (2000) qualitative research and analysis provides us with richer information about the topics under investigation, enabling an understanding of the complexities of human experiences more accurately, rather than regarding humans as simplistic, robotic and uniform.

Due to its emphasis on developing a true understanding of issues at hand qualitative research does not produce results which can be easily replicated (Hayes, 2000). It is acknowledged that the uniqueness of human beings results in research findings that will have validity but not reliability. The focus is on achieving information-rich data rather than replicable data.

It was felt that for the researcher to be able to explore and describe the experiences of the recipients it would be most beneficial to connect with these experiences as fully as

possible. Denzin and Lincoln (2000) describe qualitative research as 'a situated activity that locates the observer in the world.' 'This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them' (p.3). Thus, the data collection and analysis employed assisted the researcher to immerse herself in the experience of the recipients to attempt to elicit the meanings and sense they ascribed to their experience of the programme as a whole, as well as aspects of the programme such as knowledge, attitudes, and perceptions.

However, the experience of the other is not transparent and thus for the researcher to describe it requires the help of the other whose experience is under study (Leong & Austin, 2006). Thus, the researcher is required to take a respectful stance toward the participants, or in this case recipients, who are the real experts. Participant selection and the manner in which data was collected was vital for the trustworthiness of the research.

3.3 Participants

Staff members in the HIV/AIDS programme facilitated access to the participants. These participants were selected from the attendance register for the programme, with a focus on homogeneity and availability, making it a purposive sample. The primary goal of purposive samples is not generaliseabilty but choosing participants who are likely to be knowledgeable and informative about the topic to provide useful and rich information (Vaughn, Schumm & Sinagub, 1996). Morgan (1997) states that such 'bias' (sample bias) is only a problem if it is ignored, whereas it was taken into consideration that the results of this study are limited in the extent to which they can be generalized and this was considered when interpreting and reporting on the data.

One specific criterion had to be met in order for recipients to be authentic candidates for the data collection processes. Besides having been recipients of the AB programme they must have attended at least seventy five percent of the sessions. Once the programme recipients had been approached participation in this study was entered upon on a voluntary basis and no incentives were provided. In total there were 24 recipients of the

programme who participated in this research and either participated in focus groups or interviews.

3.4 Data collection

Due to working in a qualitative paradigm and the exploratory nature of the study the researcher felt that two appropriate techniques for gathering data would be via focus groups and interviews, and that the utilization of both would result in more authentic and comprehensive data.

3.4.1 Focus groups

Focus groups are group discussions, with ideally between six and nine participants, with the aim of eliciting an understanding of participants' points of view on certain pre-determined topics. Smaller focus groups with four to six participants may also be conducted (Krueger & Casey, 1994). Focus groups are compatible with the views of the qualitative paradigm. Firstly, the nature of reality is viewed as constructed by the subjective meanings and interpretations of others and, secondly multiple views of reality are believed to exist. One of the main strengths of focus groups is that individuals are invited to participate in an environment where their varied viewpoints are encouraged and desired (Vaughn et al, 1996).

Focus groups are likely to offer a variety of advantages for data collection. Firstly, Stewart and Shamdasani (1990) propose that focus groups produce a vast amount of data expressed in the respondents' own words and context. They refer to the synergistic effect of focus groups in that the combined effort of group members is likely to promote greater disclosure of ideas than via individual interviews. Secondly, focus groups are expected to provide a sense of security for participants who may be intimidated by the moderator. This security was felt to be particularly useful for this study, considering the topic of sexual behaviour and HIV/AIDS being one which students may feel more comfortable sharing with peers rather than a researcher/moderator. Thirdly, individual participants may be prompted to respond to the opinions and experiences of others which would produce data that might not have been uncovered in individual interviews. Fourthly, the

level of enthusiasm about a topic often increases after a while, encouraging increased expression from group members. Finally, an additional benefit of using focus groups is the ability to obtain direct evidence on similarities and differences in the participants' opinions and experiences versus having to reach such conclusion from later analysis of individual interviews (Morgan, 1997).

The use of focus groups was an ideal data collection technique for this research given that the data collection procedure, in the form of focus groups, reconstructed the group atmosphere in which the workshops were conducted i.e. where recipients were encouraged to become involved in discussions and to voice their opinions and perspectives. It was hoped that the workshop-scenario could be re-experienced more fully by both the recipients and the researcher, in order to provide a more accurate and rich understanding of their experiences in the programme groups. The interview guide (see Appendix A) was used to provide probes to direct the discussion when necessary.

Stewart and Shamdasani (1990) state that focus groups should be structured in such a way as to facilitate the goals of the researcher. Thus, as far as possible, pre-existing groups (from the peer-education programme) came together to form focus groups. The use of pre-existing groups resulted in already-established dynamics and, to some degree, acquaintance and ease, leading to the researcher being able to explore more 'naturally occurring' data as may have been collected by participant observation at the workshops (Kitzinger, 1994). In addition, it was thought the pre-established acquaintances in the groups may lead to less anxiety and more candidness in the data collection process.

However, it was also felt that some groups should comprise various recipients of the programme who were not necessarily in the same workshop groups, in order to constitute single- versus mixed-gender groups. Stewart and Shamdasani (1990, p. 36) refer to the fact that men and women behave differently in group situations and that 'the ability to create rapport and maximize scope and depth of focus group discussion is influenced heavily by the gender composition of the group'. Aspects such as males dominating the conversation, the desire to impress the opposite sex, and females being too intimated by

male presence to voice their true opinions were possible consequences of conducting mixed-gender groups. As much as the researcher, as moderator, attempted to encourage an acceptable and equal level of interaction in the mixed-gender groups it was felt a single-gender group would elicit interesting and beneficial results, especially considering the interaction in the group most likely paralleled the interaction of the recipients with same-sex peers, an element being explored in the study.

A focus group study usually consists of a minimum of three focus groups. After the third group the researcher typically evaluates the information received and, if necessary, additional groups may be held to elicit any further themes or ideas, until saturation is achieved (Krueger & Casey, 1994). For this study a mixed-gender pilot focus group was carried out following which three focus groups were conducted. It was felt that the information acquired from the one female-only and two mixed-gender groups was sufficient and that saturation had been achieved.

All methods of data collection have limitations. The disadvantages of focus groups which apply to this study include the following: the issue of generalisability has already been mentioned but it is worth noting that information from focus groups should be generalized with caution due to the fact that it is not necessarily representative of individuals within the group and can be effected by the selection and recruitment of participants. Secondly, as much as focus groups can be positively affected by the ordinary properties of group interaction, they can also be negatively affected. Dominant participants usually monopolise the conversation while more shy participants do not contribute. It is important to consider what information may be censored as a result of group compositions. 'Minority' (female/black/gay) voices are often muted by 'majority' voices (Kitzinger, 1994; Leong & Austin, 2006). These limitations were taken into consideration when the decision was made to conduct mixed-gender focus groups and also contributed to the decision to conduct interviews in conjunction with focus groups. Kitzinger (1994, p. 112) points out that 'knowing what is (and is not) expressed in a group context may be as important as knowing what is expressed in a confidential, one-to-one interview', thereafter suggesting the use of a combination of such methods.

3.4.2 Interviews

Five one-on-one, individual interviews were conducted (three female and two male) in order to ascertain, if possible, information that may not necessarily have surfaced from the focus groups, as well as to elaborate on certain aspects of the information that did transpire from the groups. The interviewees were also all recipients of the 'AB' programme who had attended at least seventy five percent of the sessions. They were selected purposively on the basis of availability and the fact that they were likely to provide information-rich data.

To more fully explore the recipients' experiences the researcher made use of semi-structured interviews, allowing for more flexibility for participants to express their own views. The semi-structured approach is one in which the interviewer has an outline of topics or issues to be covered but does not employ a standard set of questions to be asked in the interview (Patton, 1990). The interview guide (see Appendix A) served as a list of questions or issues to be explored in the course of the interview. It merely served as a basic checklist to ensure that the researcher had covered all topics, and the conversation did not strictly adhere to the order or content of the interview guide. The same interview guide was used while conducting the focus groups – it enabled the researcher/moderator to keep the discussion focused but allowed for individual perspectives and experiences to be disclosed.

Benefits of the interviews (besides the one-to-one, confidential format) included the increased ability for the researcher to attend to non-verbal elements of conversation and certain nuances, as well as experiencing a more in-depth, directed and reflective process.

3.5 Procedure

Permission to undertake this study was sought from the UWC HIV/AIDS programme. After the participants had been contacted by administrative staff in the HIV/AIDS programme the researcher was notified and arrangements were made to meet with the participant/s. The venues for the data collection included an unoccupied room at the HIV/AIDS progamme offices and facilities at the Institute for Counselling.

Focus groups were between 60 and 90 minutes in duration and the interviews were between 40 to 60 minutes in duration. The researcher spent a short time establishing rapport with the participant/s before beginning the data collection process. The procedure to be followed was explained, as well as the purpose of the study. Following this the participants were asked to complete and sign a consent form (see Appendix B for the Participant Information and Consent Document). The interviews and the focus groups began with an open-ended question to participants to share with the researcher their experience/s of the Peer-Led 'AB' Programme. Thereafter the discussion or interview was allowed to flow in a natural manner, with the interview guide being used to occasionally focus the direction of the discussion or interviews. At times, probes were used in order to encourage contributions or to expand upon or clarify information. The researcher found it necessary to refer to the third person i.e. 'people' or 'one' when making particular queries, as direct and personal questions tended to result in discomfort and restricted information.

The researcher played the role of moderator and interviewer without an assistant, which did result in less extensive notes and less ability (in focus groups) to attend to the non-verbal behaviour and other dynamics of participants.

All interviews and the focus groups were audio recorded to ensure accuracy. While the researcher did compile basic notes during data collection, the audio recording captured the participants' experiences as articulated in their own words. Field notes (regarding the group dynamics, non-verbal behavior of interviewees, note-worthy points, reflections etc) were compiled following the completion of focus groups and interviews. All audio-recorded conversations were transcribed verbatim by an external transcriber. There were sections of the transcripts where the transcriber could not clearly hear the conversation and attempted as best as possible to capture the essence of the meaning.

3.6 Data analysis

The data from the focus groups and interviews was analysed by means of thematic analysis. The emphasis was placed on unearthing meaningful, shared themes in the

different groups and individuals' descriptions of their experiences of the Peer-Led 'AB' Programme. Ryan and Bernard (2005) describe themes as abstract concepts that investigators identify before, during, and after data collection. Patterns and themes that emerge from the data are analysed to understand what is of importance to the participants (recipients). The information that resulted from transcribed interviews and focus groups, as well as field notes from during and after the data collection, was subjected to thematic analysis according to a model suggested by Vaughn et al. (1996). Data analysis consisted of the following steps: firstly, *identifying the big ideas,* secondly, *unitizing the data,* thirdly, *categorizing the units,* fourthly, *negotiating categories,* and, finally, *identifying themes.* The researcher combined steps three and four in that the categorizing of units lead to the negotiation of the categories that evolved.

3.6.1 Identifying the big ideas

The big ideas emerged during and immediately after the focus groups and interviews, through consideration of words, ideas, themes, intensity of responses, and non-verbal communication, as well as following careful reading of the transcripts. According to Krueger and Casey (1994, p. 109) this process is like 'detective work' in that it involves looking for clues across the data which in this case are the trends and patterns that reappear in the focus groups and interviews. The big ideas or themes that transpired were identified as impressions or hypotheses that provided an initial orientation or framework for the development of definite and major findings. As much as the big ideas emerge following re-reading, careful consideration of and immersion in the data, the process does involve subjective judgment in the selection and interpretation.

Theory also played a role in the identification of big ideas. The theoretical underpinning of this study, namely the Health Belief Model in particular and literature review in general, provided a variety of presuppositions which supplemented the framework for developing data analysis after step one.

3.6.2 Unitising the data

This step involved identifying units of information that would form the basis of later categories. The size of a unit of information could vary from a phrase to a paragraph, so long as it was informative by itself and better informed the research question. Codes and notes were made in the margins of the transcripts to relate to each identified theme. At this stage the transcripts were re-read and the units of information were cut out using a pair of scissors. It was then possible to continue to the next stage of sorting the data.

3.6.3 Categorising the units and negotiating categories

This step entailed sorting the units of data into relevant piles to eventually represent categories or themes. The categories consisted of information units of the same content. Categories served as headings, providing an organizational theme for the units of information. During this process the researcher defined rules describing category properties and criteria and all units of data were measured against these rules in order to determine inclusion in appropriate categories. Once all the units of data had been categorized the categories and their rules were reviewed for overlap or completeness and certain categories were merged and the rules redefined. Furthermore, it was considered whether any miscellaneous data units could not fit into any of the categories.

3.6.4 Identifying themes

Step four involves a re-examination of the big ideas produced in step one in order to determine if any of these were supported by the categories that had been created. Once again theory was noted to assist in the final interpretation of categories and findings. Taking the units of information and categories into consideration it was explored how the big ideas could be reframed or restated. The researcher then used these refined ideas to identify themes and the categories and units of information were explored regarding the extent to which they supported the themes. The final themes and sub-themes constitute the findings of this study (as presented in Chapter 4).

3.7 Reflexivity

Qualitative analysis usually involves the researcher interacting quite strongly with the data. The researcher selects the form of analysis, decides on themes, and identifies what is considered important and insignificant in the data (Hayes, 2000). Thus, the research is open to problems such as self-fulfilling prophecies, bias and distortion. Marecek (2003) states that social identities and value commitments of researchers inevitably influence their research in terms of choices regarding topics, theoretical frameworks, and interpretation of data. She continues by observing that many qualitative researchers disregard the convention of the discipline and acknowledge the importance of reflexivity.

For this purpose I had to be aware of my perceptions, values and attitudes, as well as think about my own experience during the research process and consider how I may have unwittingly, or wittingly, influenced the outcomes of this study.

It was important for me to bear in mind that although during the research process I thought of myself as a student and, as such, sharing some common ground with the participants, I was older, pursuing a Masters degree versus undergraduate degree and had experience in a committed relationship of six years versus still dating and having to worry about the related difficulties. All of these factors, including the fact that I am white while 23 of the 24 participants were black, set me apart in the process. These distinctions cannot be ignored as they may have resulted in the participants not feeling comfortable to open up to me fully, lest I should judge them or not understand them, and the fact that I may have made assumptions about the topic on the basis of my experience which at the time of the data collection was different from the majority of the participants.

Thus, I was forced to ensure that I phrased all my queries in a way in which I could learn from my participants versus assuming that I already had some insight into their possible answers. It is of course possible that my values and worldview impacted on the research process despite trying to maintain a respectful stance towards the process. I did become aware during the process that I had assumed the programme would be largely successful

and had to be aware of this positive bias in order to avoid distortions in the collection and interpretation of data.

In terms of demographic differences the fact that I was a female may have had an impact on the responses of males and females in the groups and interviews in different ways. It is possible that certain male participants may have been less likely to be fully honest about their sexual behaviour and instead attempted to convey a "socially acceptable" picture should they have worried that, as a female, I may not have understood their perspective. With regard to female participants it is likely that my being a fellow female may have influenced their responses due to the fact that there was often a feminist undercurrent (which was directly discussed in one of the groups), which I was aware of relating to.

Furthermore, the fact that I was white also impacted on my ability to relate to cultural differences and beliefs, such as polygamy, which was mentioned on a few occasions during the data collection process. Again, I ensured that to the best of my ability I maintained a respectful and open stance to learning from the participants and relating their experiences back to the research in question. In addition, the fact that I am English-speaking may have resulted in language differences playing a role and there may have been misunderstandings from both my side and that of the participants.

Finally, I was heavily involved in the emergence of themes from that data since, besides using the literature and theory as a basis for discerning possible themes, others emerged due to my own study and interpretation of the data, resulting in a subjective influence.

3.8 Ethical considerations

Due to the nature of the topic the researcher at all times remained sensitive to the boundaries and experiences of participants during the collection, analysis and reporting of data. The researcher aimed to ensure that the participants felt safe and comfortable in order to facilitate the exploration of their experiences. Consent was obtained from participants following a clear explanation of the procedure and purpose of the study.

Participants were advised that they could refuse to participate or volunteer particular information and that they could withdraw from the study at any time.

Permission was obtained to tape-record the focus group discussions and interviews. Confidentiality was ensured at all times during the research process and anonymity was preserved with regards to data transcription and the final report. (See Appendix B for the Participant Information and Consent Document).

3.9 Chapter summary

This chapter outlined the methodology employed in this study. It began with a description of the aims of the study as well as the research design that was used to achieve the aims. This was followed by a description of the participants and continued with a discussion regarding the data collection tools, being both focus groups and interviews. Included in this discussion was a section regarding the advantages and disadvantages of both methods of data collection in the context of this study. Thereafter, the chapter focused on the procedure adhered to during the data collection process. This was followed by a step-by-step account of the researcher's approach to and use of thematic analysis in order to analyse the data. Finally the chapter concluded with the consideration of various self-reflexive issues relating to the researcher as well as an examination of ethical issues associated with the study.

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CHAPTER FOUR

Findings

4.1 Introduction

The themes which emerged from the focus groups and interviews are presented in this chapter. Seven themes will be considered, incorporating recipients' perceptions of the peer-led programme, as well as particular changes that were experienced due to the programme, and any perceived barriers to possible changes. Each of these themes and their sub-themes will be discussed in turn and will relate to findings across all the data.

4.2 The experience of peer education as a format for the workshops

Each focus group/interview was commenced with a broad question concerning how recipients experienced the HIV/AIDS peer-led programme. Responses were positive in that all recipients stated that they had benefited in some way from the programme and they had much to say about how effective the informal sessions were. Recipient responses regarding the manner in which the workshops were conducted i.e. according to a peer-led format, will be discussed across five themes: interaction, informal format, peer educators as facilitators, the effect of programme workshops, and composition of groups.

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4.2.1 Interaction

Most of the participants remarked with enthusiasm that the format of the workshops, being informal discussions around specific topics, allowed for valuable interaction. This was experienced as positive by the recipients in a variety of ways.

Firstly, the interaction allowed recipients to get to know each other and feel comfortable with and accepted by the others in the group. This provided them with a safe environment in which they were able to open up to one another. Furthermore, individuals in the group came to see that although they may have felt different from others and perhaps alone in their worries and fears many people in the group thought or felt the same way. Thus, the experience led to group members believing that others understood and related to them,

which contributed to a growing sense of confidence, self-esteem and belonging. The following quotes capture the above-mentioned sentiments:

> *I liked the idea that I was…my peers, people I could relate to…to our peers that you got to related to each other in a way that you in the same level, so you open up easy.*
>
> *It was wonderful because I get to know people more.*
>
> *Most of the time you think you're the only person with these kinds of views and then you're like, "Wow, I'm not a freak…somebody thinks like me". It's a safe environment to talk about what you usually don't talk about. People accept you for who you are and you can put your views out there and they won't judge you.*

Secondly, in opening up to each other and sharing their personal perspectives and opinions amongst themselves, recipients not only learned what was held in common with others but also learned new information and viewpoints from fellow group participants, resulting in broadened outlooks. Many views which before had remained unquestioned were challenged by direct and indirect confrontation i.e. by simply observing or hearing about incidences contrary to previously-held beliefs. Recipients explained these differences and shifts in perspective as follows:

> *It was interesting to see how people's perspectives and stuff around issues changed so dramatically from the backgrounds of religion and culture.*
>
> *We learnt a lot from each other…each others' views and their mistakes and sort of how they dealt with and like even if…like your views when people support that it really changes you.*

Finally, the interaction amongst group members resulted in the more extroverted participants encouraging the shy participants to open up and contribute to discussions, facilitating the increase in confidence that occurred in the group. Finally, the interaction in the groups assisted in the discovery of the intricacies of co-operating and interacting in a group, including the ability to both communicate and listen effectively. The following two quotations indicate the recipients' thoughts in this regard:

> *… she is very shy but I always motivated her "come say something, I see you are here but you hardly speak unless you are given a chance"…*
>
> *…yeah, cause you could debate and you could argue about it and you could listen to each others opinions and agree or disagree you know.*

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4.2.2. Informal format (open discussion versus lecture format)

The informal nature of the workshops resulted in recipients experiencing sessions as more interesting and effective. The sessions were described as open discussions rather than lectures. The lack of hierarchy resulted in a sense of equality so that all group participants felt appreciated, respected and that what they had to add was relevant. In addition, while lecture formats often result in content being experienced as more general and possibly irrelevant to certain individuals, the smaller groups and the informal discussion format resulted in the content being personally relevant to most participants and it could be shared in a manner in which it was experienced as more entertaining and appealing. Consequently, it seems that the more informal format resulted in the content being conveyed more effectively due to it being received more positively in general as well as co-created by group members. These reflections are captured in the following quotations:

> *You get to be free somehow and think that I won't be irrelevant and I won't be out of line and, yeah, it makes it quite easy to interact.*
>
> *It was mostly like a discussion session, where we talk our minds, everyday we just had a topic on the table and then everybody just speaks their minds, no one is wrong.*
>
> *We as individuals found solutions and then we put our ideas together as to how to deal with that particular situation.*
>
> *…it just was presented in a different way that it actually made more sense or that it is more, you know sometimes you have the same boring old talks or lectures, it just goes over your head, it was presented in a way that maybe made it more fun for you...*

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4.2.3 Peer educators as facilitators

Recipients expressed the following as benefits of having a peer (fellow student) as facilitator, rather than an older person or a professional: recipients felt less inhibited; they did not feel they were being judged; they felt the facilitators were better able to relate to their experiences in the context of campus and relationships; and they experienced peer facilitators as more approachable. It is worth noting that many of the group recipients felt anxious about being accepted and understood and for these individuals having a peer facilitator reduced their anxiety in this respect. The sense of equality made it easier for individuals to open up to as well as approach facilitators, as they had less fear of being judged or feeling inadequate. A number of recipients' views on peer facilitators follow:

But if you get someone who is young and understands, you tend to think that maybe they understand the situations that we have…

…there was no like… 'ag, I'm your superior here and you guys must just listen to me', everybody was on one level.
…better for me to be facilitated by my peer because we kinda like experience the same thing, you know, our everyday life whereas an adult who may approach it in a, that level of adulthood…he's not aware of things that happen around campus"

I think that for an adult they maybe judge you…and we'll be more reserved.

However, a few recipients shared their views on the qualities possessed by successful peer educators and age was not always included. Comments included the fact that peer educators need to be well-informed; properly equipped and prepared; not strict; and the fact that, regardless of age, it is the personality of the facilitator that matters – they should have a more open, caring personality rather than being reserved and unapproachable.

I'm not sure I agree with that…if you find an adult who is more open or willing to accept whatever…

…maybe have your own inhibitions about talking to older people about sex and yeah, but then I also say, it all depends on how the person comes forward…I like it if they don't have their own reserved judgment.

I think it was (peer educator's name)…he is like so mellow and so nice to everyone. He puts everyone at ease.

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You must be well equipped, you must be informed, you can't just go and stand there.

It wasn't really nice to have them standing there and reading from the manual…I think maybe they should develop some skill of reading it and making it more personal because they're dealing with people, not scenarios.

It seemed that the quality perceived to be the most important for a successful facilitator was that he/she be accepting and non-judgmental, and many recipients came to realize that age does not necessarily determine this quality.

4.2.4 Effect of programme workshops on recipients

There were mixed views regarding whether or not the manner in which the workshops had been conducted would result in having a more lasting impression on recipients. Many recipients stated that because the information was personally relevant and because of the way it was discussed it would not be forgotten. Others stated that they forgot the newly

acquired knowledge fairly quickly following the termination of the workshops, as revealed in the following verbalizations:

> *...after that workshop, I forgot everything, I didn't even bother talking about it unless it came up in conversation.*
>
> *You could share it probably for the first two days or three days or a week, yeah, you've been back you know, but then afterwards, hey you forget like…*

However, it is worth noting that even the people who stated they had forgotten information tended to fairly easily recall aspects of the workshops during the data collection process. Furthermore, the researcher observed that the majority of participants spoke of their experiences of the programme with enthusiasm. It also became clear that while they did not necessarily recall specific aspects of the workshops many recipients described and demonstrated an increased sense of confidence, self-esteem and self-worth. These less observable or measurable qualities were indeed lasting for many of the recipients and will be discussed further in this chapter.

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4.2.5 Composition of groups

There were a variety of opinions regarding the strengths and weaknesses of the composition of the groups that participated in the workshops. Many recipients felt that the more diverse the groups were the more participants were able to learn empathy and open-mindedness, as well as challenge various stereotypes. Certain assumptions held by recipients were contested when faced with direct opposing evidence due to the diverse nature of the groups. Recipients explained their experiences of the diversity as follows:

> *If a 22-year old guy can say that, you know… it was really inspiring to me. It made me see that not all guys are idiots. Not all guys are dogs. (Female participant)*
>
> *I discovered the way that some other cultures they been taught about HIV, not necessarily HIV and AIDS, about their sexual behaviour, about their beliefs, their norms and everything, its different from one culture to another culture. (Male participant)*

In groups with greater homogeneity it was observed that thinking regarding aspects common to the group members became more resolute and led to collective and strengthened opinions. For instance, it became clear that there was a tendency towards

feminism in an all-female group, which was positive in that it nurtured assertiveness and women's rights and allowed a space for females to feel more comfortable to express and stand up for themselves. However, this could be detrimental in that the narrowed focus on the feminine perspective prevented acknowledgement of opposing views.

In this respect mixed-gender groups allowed for the acknowledgement of different perspectives and increased empathy and tolerance. In addition, understanding and awareness of the opposite gender was at times empowering and enlightening. Recipients particularly mentioned having learnt and discussed how men perceive women in terms of body language and dress code. The females asserted their right to wear a short skirt to look and feel good without it being perceived as a message that they are open to sex and males complained that women must communicate clearly what they want rather than providing confusing, mixed messages. In the mixed-gender groups the ratio of males to females was important as it appeared that male participants in groups in which females constituted the majority were better able to make themselves heard versus females in groups constituting mainly male recipients. The benefits and limitations of single-gender versus mixed–gender groups were expressed by a number of participants as follows:

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> *It makes them three males and then majority was then mostly women, but he was a strong talker… (Female participant)*
>
> *So in that programme they sort of like, we got to understand the side of the woman like when they saying no, it's not easy for them to say no (Male participant)*
>
> *Also, I think we learnt, like in the role plays…all their smooth talk…Ja, how to go against the smooth talkers. (Female participant)*
>
> *…guys speaking their mind and girls were speaking their mind…that you got a neutral understanding how we each understand what we say to one another or react in certain ways to one another. (Female participant)*
>
> *If they were speaking nonsense we would stand up but you find some ladies if you didn't point at them they would be happy to kinda fall back into the background. (Female participant)*
>
> *The guys in our group were aggressive. Not in a bad way but if they wanted to get something off their chest they, you know, fought to get it out, whereas the girls were kinda like…put up your hand…nobody sees it…kinda….they just had a "Ok, it's fine. Let's just leave it at that (Female participant)*

As mentioned the actual mix of the groups sometimes resulted in the presence of minorities who at times experienced themselves as being unheard and unable to voice their opinions. However, in some groups the minorities forced others to change their assumptions, such as a homosexual participant who challenged the thinking of her group. This phenomenon was expressed as follows by a male recipient in a largely female group:

> *…you find that that role is opposing the man, it's most of the guys that are a bad apple…the whole um session is always guys which I really didn't feel comfortable about that…I spoke out and I stood my ground but I learned how women felt and they also learnt from me..*

Finally, with regard to group composition, a few recipients who were in intimate relationships during the programme stated that it would be beneficial if partners could participate in the groups with them, in order to initiate communication in their relationships. It was particularly expressed by female recipients that, while what they had learnt had empowered them, it would have helped if their partners had directly experienced the programme rather than the females attempting to implement the changes alone in the relationship. Two recipients verbalized their thoughts on the subject of couples participating in groups as follows:

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> *Definitely I think it would be beneficial to us as a couple…I think my boyfriend would have been more understanding because he is back home and our relationship would have been better now you know, in terms of communication.*

> *So if he was there and we were talking neutral ground at that stage and we were talking to each other…We get a chance to let it out.*

Recipient experiences of change: During the data collection and analysis process it became clear that the major changes and shifts that the recipients experienced in the programme could be categorized according to the following five themes: attitudes and beliefs; knowledge and information; communication; skills and self-empowerment; and behaviour change in line with the ABC principles.

4.3 Attitudes and beliefs

4.3.1 Empathy and tolerance

Frequent mention was made of the fact that the HIV/AIDS peer-led programme resulted in major shifts in recipients' mindsets by exposing them to alternative opinions, beliefs and views. This consequently led to an increase in tolerance, empathy and respect particularly towards fellow recipients, the opposite sex, other cultures, and HIV-positive individuals. Many recipients mentioned how they had learnt as a result of the workshops not to make assumptions and to refrain from judging others, due to having had their assumptions challenged and learning the importance of feeling understood and accepted. The researcher also observed that, with the increased empathy and tolerance group recipients fostered, they also gained a greater desire to empower and protect others as well as themselves. This was verbalised by both male interviewees who reported having learnt how difficult it can be for females to assert themselves and thus wanting to empower future partners. The following quotations capture the thoughts of the recipients with regard to shifts in attitudes that occurred:

> *…what we as individuals, like we have different values, what … the other person might not value the way you do so, its sort of like taught me to acknowledge my values and … the next person …*

> *…the more you talk to people the more you realize that there are some stuff that you thought you knew, but it's not the way, it's not how its supposed to be.*

> *So it changed your whole perspective on how I look at other people and we should never underestimate the people that we have in our life and the more you value them the more you feel the need to protect them in every way.*

> *It changed me you know…and then I saw you know, a positive mind of seeing people who are…are infected and yeah it changed me.*

4.3.2 Beliefs as expressed by recipients

A number of shared and individual beliefs that were expressed during the workshops were challenged due to others recipients' disagreeing and/or holding dissimilar beliefs. Consequently, recipients were forced to think differently when hearing diverse perspectives. These beliefs provided insight into some of the more common norms and thinking amongst the youth, as well as some of the thoughts which are held by most but generally not shared unless a conducive and safe environment is provided. These shared beliefs were valuable due to their potential impact on sexual behaviour.

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One belief reported, was that women feel that to be acceptable and adequate it is necessary to have a boyfriend. This idea of a boyfriend being required to bolster self-esteem was mentioned by a number of females in the group as a belief held by other females on campus. A male participant expressed the belief that women are only interested in men who have status, money and power, regardless of their personalities, resulting in many men feeling inadequate. Two males referred to the fact that it is not only women who are scared of rejection and these revelations contributed to the females realising that they are not always the powerless victims in relationships and that males can be hurt. In line with this, a number of male recipients referred to the belief held by many people in society that women are victims and men are perpetrators, expressing their anger that women should take responsibility for their actions and not always blame males. The following quotations elaborate on a number of the above beliefs:

> *Because everybody has a boyfriend and you must be in, you must have a boyfriend. (Female participant)*
>
> *…guys are scared of rejection…I mean, I'm scared to approach girls because of I'm scared of rejection. (Male participant)*
>
> *…they see themselves as victims. I would love them to take charge of the situation. (Male participant)*

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A number of culturally-related beliefs were shared during the workshops. One such belief expressed by a recipient was that certain cultures are unable to express themselves effectively due to cultural norms, making them more susceptible to unsafe sexual behaviours. Similarly, it was verbalized that certain cultures enforce gender roles that can result in females being more vulnerable and unable to assert themselves. The above sentiments are more clearly expressed in the following three quotations.

> *We do things more differently than what you (African people) do. We can be more outspoken…but you guys are not supposed to say um, how you feel, you must suppress your feelings. (Female Participant)*
>
> *For the African man it is important that the woman must show affection through sex…and it is a must, and if you don't have then you go to a next person, a next women, which means now you as the woman feel responsible for, you chase your husband away. (Female Participant)*

…she is the woman, he's the man um, she had to obey or go by that law of the husband is superior. (Female Participant)

Elaborating further on the role that cultural beliefs play with regard to gender norms two male participants expressed the belief that having multiple girlfriends is not so much a cultural norm as a social norm and the 'accepted' behaviour among many of the young males i.e. males have multiple girlfriends because they do not want to be viewed as inadequate by their peers. Finally, a few male recipients expressed their belief that women provide mixed messages, making it difficult for men to understand what they really want. The above beliefs were verbalized as follows:

I would say it's male, it's male behaviour (referring to polygamy)...if you focus on one, uh, 'now man, come on, you're boring'. (Male Participant)

Let's say (she) has been persuaded by her partner let's say to commit into sexual intercourse, then like they don't really say no, you know, it's just kind of a yes… (Male Participant)

4.3.3 "HIV as real"

A change in attitude that became apparent through the data collection process was an increased sense of vulnerability to becoming HIV positive and, consequently, the desire to take more responsibility for one's life and choices. It appears that there were two prevailing attitudes regarding vulnerability to HIV/AIDS as experienced by recipients before attending the workshops, being firstly, 'it's going to happen anyway so there's no point in doing anything about it' and, secondly, 'it doesn't affect me'. However, it seems that the workshops made HIV real to the recipients, with many of them referring to HIV as something that affects them personally versus being something 'out there', thus resulting in the need to be conscious of the choices made which could lead to infection and the consequences of being HIV positive. Recipients described this change as follows:

So when I attended the sessions and get to talk about it, it made me realize that, as much as I seen in the media, it is real.

I use to think, okay face it, all the billboards, let's face it, HIV is real, but hey, if I die, I die, so what about it, but when you go to (the) session you get to learn more

….helping me to look at it in a different way as much as I…like looking at it like AIDS is real…

It's your problem, people must deal with their own problems. Keep it to yourselves…but since then it has become my problem. It's my reality. It's what I'm dealing with.

It also appeared that recipients became aware that they were not helpless and that they could personally take action to prevent themselves from being as vulnerable to contracting HIV. Furthermore, they expressed the belief that they not only have the right, but also a responsibility, to take care of themselves. This was expressed as follows:

…so it's not worth it you know, and as a person I have a, I have my own um right and responsibilities you know and I have the right to take care of myself.

…so it's more about making the right choices which is going to be good for you and so that you don't have like any regrets.

I've been provided with the skill, so it's about me taking the initiative ensuring that I live that positive lifestyle.

This is my life and nobody else…I cannot give another person such a huge responsibility to make me happy. I cannot give another person such a responsibility to make my life complete, to make decisions for me.

4.4 Communication

Communication was discussed in a variety of contexts, with recipient responses being best summarized as communication in terms of sharing in the groups (interaction) and communication as sharing with peers and others outside of the groups, including communication within intimate relationships.

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4.4.1 Communication within the groups

Communication in groups has been discussed in terms of the format of the workshops making interaction and discussion possible amongst the group participants. The manner in which these workshops were conducted was experienced by recipients as encouraging and taught them to both share and listen as part of the process. More extroverted participants enjoyed being provided an accepting forum to express their views, while the more introverted participants, who generally preferred to sit on the periphery of discussions, found that they gained confidence in expressing themselves and had an increased desire to do so. Often this confidence was gained indirectly through a process of modeling by observing others communicating in the group and being well-received, as well as being gained directly when encouraged by group members to share an opinion.

Once they had expressed themselves the experience of being listened to and having their opinions viewed as valuable encouraged these more introverted members to continue participating in discussions. These shifts in ability and confidence to communicate are expressed in the verbalizations that follow:

> *... programme would encourage me, because speak to my next fellow person about it you know, encourage him also to share with what I've got.*

> *It helped me to communicate more with people. In the lectures I didn't participate like when they ask questions and stuff but now I can.*

Most recipient responses regarding communication related to having gained communication skills through a process of doing rather than in a more direct manner, such as being taught specific skills. Only a few recipients mentioned practical communication skills being imparted during workshops, mentioning learning about types of communication and how to communicate effectively.

Interestingly, it became clear that most programme recipients reported minimal communication amongst themselves when outside of the group context. Furthermore, any communication that did take place outside of the workshops was most often of a more superficial nature. It seemed that the experience of the group as a safe and accepting forum did not carry to outside the workshop context, as indicated by these verbalizations:

> *There's a connection but when you're outside you just greet people, you know, you don't stand and like discuss what you guys talk about (in the workshops).*

> *As a group when it's over it's over.*

> *We do, not talk in depth but kinda laugh at some of the things that were said in the group kinda…it's passing most of the time.*

4.4.2 Communicating with peers/others outside of the group

When asked how the increased confidence and ability to communicate and listen, as gained through the workshops, would benefit recipients in interpersonal relationships many of them referred to feeling more capable negotiating and making joint-decisions. Specifically, it was mentioned that, when negotiating and reaching agreements, recipients were able to express their opinions as well as listen to and attempt to better understand the

views of the other. A few of the recipients referred to this specifically in relation to sexual/intimate partners, as verbalized below:

> *…if you communicate more with your partner you'll be able to overcome a lot of things and there wouldn't be misunderstandings and you like, you avoid getting into problems.*

> *You have to make a decision for the both of us and then we have to talk about the decision, you can't just think, 'Okay today I'm gonna buy a house'.*

While the above refers to communication in general, when the topic was raised regarding the sharing particularly of what had been learnt in the workshops with others who had not participated in the workshops, opinions were mixed. Some recipients expressed the desire to share with peers what they had gained or learned during workshops, due to having found the programme to be personally beneficial. This desire to share with others outside of the groups appeared to draw on the afore-mentioned increased sense of responsibility, as well as the confidence gained through the interaction in groups. The quotations that follow capture these feelings:

> *I would love that, because it is not, it's not actually that difficult, you just need to get, yeah you just need to get all your facts straight, just to get the materials involved and then you get the people.*

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> *…it's something for me that I must go and practice outside the workshop and then I can share it with other people and then must recruit more people to come and join the programme so that we can be, so that the society in large can become more aware of themselves and the issues of HIV and AIDS.*

While a number of recipients expressed the desire to share what they had learned as a result of the programme only a few of the recipients reported that they had actually shared the experience and knowledge gained. The sharing took place by means of direct communication of the knowledge that was gained; teaching and practicing of the skills that were learned; as well as sharing in a more indirect fashion through behaviour and teaching by example, as described in the following verbalisations:

> *I shared…used to share the sessions with my Mom…You know, obviously she's from a different generation and she's had limited information or access to information on these things.*

> *…the 'I' statements…I talked about it to one girl and we actually tried it the whole day…But it's hard to go up to someone and say 'do you know your ABC's?' or something like that but to maybe share the lifeskills.*

The thing is we don't teach it but you kind of put into your everyday life. We don't tell them…Ja, we teach by example…

However, as alluded to even in the above quotations, many recipients found it difficult to share their knowledge and experience of the programme with others. Thus, while the few recipients as reported above expressed the desire to, or even actually did communicate what they had learned, the majority did not. Their reasons for not sharing included feeling embarrassed; forgetting the information; fearing rejection; and not being provided with an opportunity to do so (further discussed in section 4.8 – barriers to behaviour change).

…if the situation presents itself, but generally you wouldn't talk about it.

…after that workshop, I forgot everything, I didn't even bother talking about it unless it came up in a conversation.

Therefore, it seems that programme recipients learnt a great deal about communicating and listening as a result of the actual interaction that took place within groups. This enabled them to feel more confident in their ability to communicate and contributed to decision-making, negotiation and listening within interpersonal relationships. However, while a few recipients would have liked to share with others specifically what they had learnt in the groups, few actually did.

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4.5 Knowledge

The topic of information and knowledge was mentioned in a few contexts, being the relevance of the information; the fact that while many recipients already possessed knowledge about HIV/AIDS they learnt more about it; and awareness and self-discovery.

4.5.1 Relevance of information

The majority of the recipients found that the information shared was relevant due to the fact that they all received the opportunity to share their own opinions and views and to thereby provide direct input. Thus, it was not as in lectures when the information is imposed on the attendees but rather it was information generated by and for the participants in the group, making HIV/AIDS personally relevant and relating to the lives and circumstances of the participants. The following quotations further illustrate this:

Okay most of the topics we covered I think they touched my life in almost all aspects.

…the programme itself, it was very interesting because I personally feel that I've benefited a lot in terms of getting knowledge, getting more knowledge on HIV and AIDS and stuff yeah…

"wait a minute, this might be relevant", cause probably maybe before the session a lot of things, we, we never thought that they were relevant until we actually talk about them and discover they were, they are relevant.

However, as previously mentioned in section 4.2.5, in groups which constituted minority parties – whether being the minority in terms of gender, race, culture or sexual orientation – the information discussed was often more relevant to the majority within the group, due to their dominance and the possibility that minority parties had different experiences or views they were unable to share. Thus, the more homogenous and alike members were the more similar their experiences and fears appeared to be, resulting in discussions being relevant to most of the participants in these more homogenous groups. In this respect the fact that all recipients were students of similar ages already resulted in a greater chance that they would share some experiences and views, leading to more personally appropriate workshops. The following recipient described being able to learn from others:

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… you see I saw that okay, my mistakes actually uh, were because of this and because of that you see, then I was like ghee, this is very good session for myself

Due to the fact that the programme revolved around the topic of HIV/AIDS it could be assumed that the information would have been particularly relevant to recipients who were infected or personally affected by HIV. Interestingly, only one recipient mentioned the personal experience of HIV in her life, due to her sister being HIV positive. She stated that she therefore found the workshops extremely relevant as well as empowering:

It was relevant in every sense…like my sister and my family and my whole life and my approach to my life…and not just in relationships and stuff but even school work because I learnt to prioritize and not to be so selfish.

4.5.2 'Old knowledge' versus 'new knowledge'

In general it is worth noting that most recipients held negative views about having to learn the straight facts of HIV/AIDS but were interested in more detailed aspects and

more practical and personally relevant information. There were a few recipients who did not feel they learnt anything new with regard to HIV/AIDS from the workshops:

> *…it wasn't like really any new material that you would encounter for the first time. Nothing that was said or taught in the group I had never not been exposed to before.*

However, while the majority of recipients spoke about having existing knowledge about HIV/AIDS there were a few who mentioned being surprised to still learn more from the workshops, and having benefited from having their existing knowledge confirmed:

> *I knew what's the dangers and everything but now I know more.*
>
> *I had heard of it before but a different version of what I heard there so in that sense I learnt something new.*
>
> *You kind of heard about it but you wasn't like 100% sure and then afterwards you're like 'Oh, OK, so it's definitely true'.*

All knowledge that was reported to have been experienced as newly acquired knowledge tended to be more specific versus the general knowledge most recipients already held. Examples of more specific knowledge learnt by recipients follow:

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> *I didn't know that if you were raped the day before that you be actually given ARVs the following morning.*
>
> *…New, yes, new in the sense of uh, the pictures (of genitalia affected by STIs) that she had shown to us, um because we never, you only hear about the stuff we are never exposed in person to…*
>
> *…now it's more in detail, that the kind of sex you would do, the oral sex…I didn't know oral sex had diseases.*
>
> *And I also learnt about contraceptives and that stuff. Things I didn't know about.*
>
> *What is that window thing again (the window period)…I didn't know what that was.*

Moreover, the new knowledge, particularly practical skills, was experienced as more personal and empowering. It seems that as recipients gained more knowledge HIV/AIDS became increasingly real, and consequently something more concrete. This shift led to many recipients feeling they were more capable to do something practical to empower themselves. Furthermore, it became clear that the excess of theory received in everyday forms made HIV/AIDS lose its personal relevance and become 'something out there'

rather than a known, concrete disease which one is able to face in one's own life. Recipient thoughts were as follows:

> *HIV is not about dying. It's not about getting AIDS then you get sick, then you die, it helps you to, um, understand something and when you understand it, that's when the fear is gone, now develop an interest on knowing everything about it.*
> *I know this AIDS, read about it, but the minute you get to a place where they talk about it, personally you there, the presence is there, that's where you start to be more open-minded.*
>
> *…that wasn't more of like teaching us about HIV and AIDS, it was about you as an individual on how we can live a protected lifestyle…*
>
> *I believe information is power and stuff and when you're informed you know how to make a decision.*

4.5.3 Awareness and self-discovery

Many recipients spoke about how the information and knowledge they gained assisted them to develop a deeper awareness around certain issues, as well as encouraged them to become more aware of HIV/AIDS in general. In addition, this awareness included personal awareness as part of a process of self-discovery. The interaction and sharing within groups resulted in a reflection on personal values and attitudes, leading to a process of self-discovery and increased self-awareness. Furthermore, recipients became aware of how their self-awareness interacted with their general awareness regarding HIV/AIDS in terms of their values, beliefs and attitudes affecting their behaviour. A few relevant recipient quotations follow:

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> *…it has made me discover myself more like actually it was about self discovering. So discover yourself more and then you understand yourself better.*
>
> *This programme sort of build that consciousness, make you aware, open your eyes that this really there…*
>
> *…we aware of the HIV and AIDS, how it is contracted and everything and then…it makes you become aware of how your values and beliefs and everything can influence your choices in life so that you cannot end up contracting HIV and AIDS and things like that.*

Nonetheless, the frequently- mentioned gap between knowledge and behaviour was made obvious in some of the responses of the recipients. While they indicated they had developed increased awareness regarding the dangers of unsafe sexual behaviour, as well as increased awareness regarding themselves and what makes them vulnerable to unsafe

sexual behaviour, many of them had not yet implemented changes in their lives or put their new-found awareness to practice, as indicated by the following recipients:

> *I will say I have the awareness now that, this key is for me to actually implement, for me to implement…*
>
> *Wow, we're all going to practice safe sex and we gonna talk to our girlfriends and boyfriends and we are gonna discuss A,B,C,D in the bedroom before the A,B,C,D happens but when we get there it doesn't really happen…and are you willing to listen to your girlfriend and are you willing to tell your boyfriend that you're uncomfortable and that's what's supposed to happen so…*
>
> *…well I do enjoy, I love sex. I don't think much will change, I still love sex, but now I much aware now of dangers and stuff like that so I … to the programme, now I wanna equip myself with awareness … preventing myself from diseases*

4.6 Skills and self-empowerment

The majority of recipients reported that that they learnt various new skills as a result of the HIV peer-led programme, leading to a sense of empowerment, and increased self-esteem and self-efficacy. Many recipients had felt that HIV/AIDS would not personally affect them or that they were helpless against the disease. However, during the course of the programme, as their general awareness and knowledge increased, including self-awareness and knowledge of relevant skills, recipients began to experience their relationship to HIV/AIDS in a different way, in terms of their own capacity and efficacy.

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4.6.1 Empowerment

There were frequent comments made by recipients about having gained 'tools', 'weapons', or 'resources' to equip them to make healthier choices and avoid becoming infected by HIV. This shift was often referred to as a lifestyle shift in that their new lifestyle included a deeper and more personal awareness of the dangers of unsafe sexual behaviour and, consequently, the integration of their new-found skills, values, beliefs and attitudes in daily life to protect themselves against contracting HIV, as discussed below:

> *…you see I'm very serious, I've learned something that can save my life, which is good.*
>
> *…now I'm thinking before I'm answering or doing anything. I think that is what I learned and what is sticking and what is going to be my future weapon.*
>
> *…it was about you as an individual on how we can live a protected lifestyle so that you don't find yourself in a situation of like yeah, contracting HIV and AIDS*

With regard to the 'tools' gained a few recipients mentioned specific skills they had learned rather than stating that the programme as a whole had equipped them. Specific skills that were mentioned included communication (including listening), negotiation and decision-making skills. Communication and negotiation skills were generally learnt through the interaction and discussion that took place in the workshops and to a lesser degree through the practical teaching of these skills. Recipients did refer to a decision-making skills component that was taught and later applied in groups. The skills that recipients felt they had gained and that were beneficial were the following:

> *Ja, we learnt how to develop a strong self-esteem and how to be a good listener…an active listener and how to kind of like negotiate in a difficult situation*
>
> *…alright one I can remember is that the negotiation skills…it has also taught me how to… negotiations is one of the decision-making skills. We sort of like given steps on how to, if we got a problem we wanna make a decision, there's steps involved that can actually help you to, that can also enable you to make an informed decision on anything.*
>
> *….negotiating and how to bring across a certain point and how to…how to fail and get up and dust yourself off again, how to basically deal with life and the obstacles that life will throw at you.*
>
> *…but then at the end of the day you actually have to make up your own decision and how you would take that communication that was given to you.*

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In addition, it was mentioned by a few recipients how beneficial the role-plays were in implementing the skills. The role-plays appeared to make scenarios in which these skills would be required more real, thus resulting in recipients feeling more confident in utilising the skills. Recipients had the following to say with regard to role plays:

> *…often just talking about persuasive, how you persuade, are being persuasive and how you carry out the message. I think we had to, I think we did a role play….and then each group come up with 'remember that role play we had?'*
>
> *Those role plays put on the table what happens that nobody really wants to talk about…what most of us had experienced in our past and we got to discuss it and when you look at it with a lot of eyes apart from your own you have different opinions on how to handle it.*
>
> *Well most of the time they tell you like ABC, ABC but they don't tell you if you're in the situation how you're going to abstain….and that's what was so good about this course because they actually put you in a lot of different situations and through those situations you can learn how to apply the ABCs…your own values and what you want.*

4.6.2 Assertiveness skills

Although it was seldom stated directly or referred to as assertiveness, it became clear that many of the recipients had learnt assertiveness skills as a result of participating in the programme. This increase appeared to stem directly from discussions around the topic of assertiveness, leading to recipients becoming more aware of their rights and being able to stand up for these, as well as developing parallel to the confidence gained during the interactions. The female recipients particularly referred to having realized their right to assert themselves, regardless of the expectations of others, and many sounded confident in their ability to do so. For a few recipients who were already fairly assertive they felt secure in their right to continue. However, while this new-found assertiveness had been practiced by many recipients in everyday situations, only two of the recipients had actually practiced being assertive in sexual relationships, in terms of refusing sex. The following verbalizations were made by female recipients:

> *If you stand your ground and say like, 'look, I'm not gonna have any sexual intercourse without a condom', and you stand your ground, actually the guy tends to follow your lead.*
>
> *I can stand up for myself yeah, you see, we can change that, you can raise your voice and tell somebody that, 'no, I don't like this'.*
>
> *Now we adopted this new thing that 'I would appreciate it if you can do this and this and that for me' and it's actually working for us.*
>
> *I think it helped me be more assertive and like to stand up for myself outside of the group because I was a very passive person and it also helped me not to agree with everything that people say if it doesn't make sense to me.*
>
> *I don't have a problem speaking my mind but it was just…for…in a way that it made it OK. I used to kinda shy away from speaking my mind. It made it OK to have a strong opinion.*

4.6.3 Self-esteem

Closely related to the topic of assertiveness and empowerment is that of self esteem. During data collection it became clear that a significant number of recipients appeared to have grown in self-esteem as a result of the workshops, adding to, and closely related to their sense of empowerment and self-efficacy. It seemed that their self-esteem increased due to the environment of the workshops in which participants were able to freely express their opinions and without fearing judgement. In addition, they realized they shared many fears and anxieties with others in the groups, making them feel more 'normal' and

acceptable in comparison to peers. The accepting environment in the groups also appeared to provide recipients with a sense of belonging and identity which further added to an increase in self-esteem. Their participation in focus groups and interviews reflected this new-found self-confidence as many programme recipients expressed their enthusiasm about no longer feeling so insecure and unsure of themselves and their opinions. These sentiments were expressed as follows:

> *…let them now give everything from their point of view…It was, so that is why I am saying nobody was feeling like in um, 'I'm not good enough'.*

> *I learned how to talk in front of a lot of people like what I'm doing now and it helped me a lot. I can also raise my voice now, this was one of the things I couldn't do. I always bite my nails in front of people and at…they taught me I mustn't do that, yeah they told me a lot, that's fantastic.*

> *It made it OK to not go with the flow. It made it OK to be me. Because when you live in res it kinda forces you to move in certain cliques and in certain ways….It made me OK not to just accept drinking for the sake of drinking or chatting up guys because they want to chat me up.*

While much of this self-esteem was fostered indirectly through their involvement in the groups a few recipients mentioned having directly learnt and thought about self-esteem through practical tasks, such as discussing what constitutes self-esteem and having to complete worksheets to apply the concept to themselves. One recipient mentioned she had pasted the worksheet on her cupboard and read it daily to focus on her positive qualities. Furthermore, as recipients were encouraged to reflect on their values, beliefs and attitudes, resulting in greater self-awareness, they began to develop increased self-esteem. It seemed that as they were encouraged to learn more about themselves they came to respect themselves and care for themselves more, as illustrated by these quotations:

> *…with your values and beliefs and what each and everybody is standing for. So if you don't stand for your values and it's very easy with somebody who can just come and take you for a ride…*

> *…so discover yourself more and then you understand yourself better than you used to before…oh it has boosted myself.*

4.7 Behaviour change

From the preceding discussion of the findings it can be noted that recipients reported having experienced a variety of shifts in their lives in general following their participation

in the programme, mainly being increased ability to communicate and listen; to make decisions and negotiate; and to be assertive. Furthermore, parallel to these changes in behavior, recipients appeared to experience a greater sense of self-esteem and self-efficacy. Many recipients mentioned these changes in relation to their sexual/intimate relationships, for instance, being able to communicate more effectively with partners regarding sexual expectations and discussing previous sexual histories. A couple of recipients reported that they intended to change their selection criteria for partners to practice more control over ensuring safer sexual relationships. Most recipients stated that they had simply gained greater awareness of the dangers involved in unsafe sexual behavior and, would thus think before getting involved sexually and would take more responsibility. Recipients described the changes that had occurred or they intended to implement as follows:

> *We did and we are still communicating like nobody's business and I mean like for me communication is very important…and if there is no communication, how will the next person know how you feel…*
>
> *…where I grew up, you and your partner you don't get to have time with like talk about your sexuality and everything, things like they just happen, unplanned. So now in that programme they taught me that you and your partner should open up about almost everything in terms of like your social wellbeing and your sex life with your partner*
>
> *…but one thing I learned is I will, I wouldn't have sex with girls who sleep around or who is popular….I don't look at beauty first.*
>
> *now they are aware they think twice, wow I didn't notice the way they explain it to me now, so I must choose a way of thinking and adjust my behavior as well*
>
> *…it has changed in the sense that now I'm more aware of the consequences and the implications of not being faithful*

However, there were few recipients who reported actual sexual behaviour changes they had implemented at the time of data collection, with most participants reporting their intentions to change in the future. The changes that were reported as having already been applied included chiefly communication, negotiation and decision-making, as well as other general changes as discussed above. However, when the data collection focused on the ABC principles as presented by the programme, most recipients stated which of these they intended to implement in the future, rather than having already introduced the changes. Thus, while many of the recipients had grown in self-esteem and had chosen to

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make changes such as communicating, negotiating, listening and asserting themselves more effectively within relationships (with some having indeed done so), very few recipients had, at the time of data collection, actually applied these specifically in the context of abstinence, being faithful or condomising.

Although the UWC Peer-led AB programme has a specific focus on the components within the ABC framework of abstinence and being faithful, it was found that of the three behaviour choices most of the recipients had opted for or intended to implement monogamy and condom-usage, rather than abstaining, as illustrated by the following:

> *Realistically speaking I believe in both…abstaining…I mean not abstaining…both condomising and being faithful. It's always been that way (female participant.)*
>
> *So since the programme I really…I'm focusing on a serious relationship…to have one woman at a time. You're teaching yourself for the future, for marriage (male participant.)*
>
> *But it is important for me to get the message across to the guys that it's OK to have only one girlfriend (male participant).*
>
> *I'm not gonna have any sexual intercourse without a condom, and you stand your ground.*
>
> *Okay, I do use condoms now (male participant).*
>
> *…if you wouldn't want to use a condom, I wouldn't even debate the topic with you…(female participant).*
>
> *So if I decide to change my mind and so 'no listen it was a mistake or whatever…we didn't use a condom but from now onwards we are going to use a condom' then I'm entitled to do that (female participant).*

It was apparent that, especially for the female recipients, the increase in self esteem and the assertiveness gained through the workshops bolstered their choice to focus on condom-usage as an option for safer sexual behaviour, as they felt they would be able to insist on it. There were few female recipients who reported that they would utilize their assertiveness to insist on monogamy or abstinence. Furthermore, of interest with regard to recipient choices to initiate the regular use of condoms in their relationship, is the fact that the majority had made the choice prior to the programme or as a result of the workshops, despite the negative response to any mention of the word 'condom' as indicated below:

It's kinda leads people to switch off every time you say condomise because I look at your lips moving and you're talking about condoms and I'm playing back exactly what I've heard 101 times.

…but obviously when you go to a HIV uh session, what comes in your mind is that they want to teach you how to use a condom and that sucks.

It was reported that when abstinence was discussed within the workshops many recipients found the concept to be absurd and irrelevant. However, it seems that with further discussion a shift occurred in that many recipients were able to respect the choices of others to abstain, but would still not necessarily choose it as an option for themselves. At the time of data collection one female mentioned that she been practicing abstinence prior to the programme and that she had been thinking about having sexual intercourse with her partner but the workshops had enabled her to remain resolute in her decision to continue delaying her sexual debut. The discussions resulted in her feeling she had a right to make the choice and be respected for the choice to abstain, without feeling embarrassed. Recipients reported on abstinence as follows:

The first time the word 'abstinence' was said, everybody…most of the group cracked up. It was like 'yeah, right…which era do you live in?' you know and then more and more people were like 'it's OK to be virgins…it's something to be proud of'….I personally feel it's a good thing. I think it's something you should wear proudly like you'd wear your best garment.

And it now made it clear that people should also respect my choice and not pressurize me into doing anything because at first I did consider doing it but now have the knowledge and I'm thinking I'm not waiting to get married one day but to be ready.

Three female recipients who had been sexually active prior to the data collection process expressed the desire to practice secondary abstinence, or at the very least to delay the initiation of sex once beginning a new relationship. One female explained that she had chosen to integrate abstinence in her relationship in that she would refuse to have sexual intercourse if she was not in the mood. The following quotations illustrate these views:

My views have actually changed from not so much being faithful and condomising while having sex but actually abstaining…there's less consequences.

And since that I've realized you know what, there's nothing wrong with saying you don't want to have sex with someone.

Now I have incorporated the 'A' part to me…you know my life. I thought, my goodness, I could never sacrifice one more day of bliss and pleasure that could kill me and haunt me for the rest of my life.

…and I date them, we have sex and after that I get to know them…I'd like to get to know them for a while before anything will ever happen and to use condoms.
…if I feel for being with you tonight, then I will be with you tonight, if I'm not with you, if I don't feel for that, then you must still respect me um for that sense.

As can be noted by the recipient statement above that abstinence was going to be incorporated in terms of refusing sex when not in the mood, recipient thinking regarding what abstinence entails tended to be fairly diverse. One recipient stated that abstinence is equivalent to loving one person only i.e. that abstinence is tantamount to monogamy. Another recipient stated that she will not even make use of a sex toy, such as a vibrator, as this would mean she is not abstaining. She stated that if the body experiences sexual pleasure through any means or if one fantasizes about sexual pleasure then abstinence is not being adhered to. A further recipient shared the idea that abstinence means that penetration is not allowed, while other forms of sexual behaviour are acceptable. In one focus group it was reported that a recipient expressed the belief that a female remains a virgin if the male penetrates her anally. The following quotations illustrate this thinking:

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…it's like in, you say "no" to sex, but then you're having it in your mind…

…You're not being penetrated by a man physically…but you're thinking or you're considering it, which means it makes you just as much not being abstinence as the one that is already busy with it.

…but when you look at abstinence in terms of HIV, then it's, just as long as it's not penetration

They'd still be a virgin, even though they do have sex, but it's not like penetrating through the vagina.

Thus, in conclusion, it appears that most recipients, at the time of data collection had strong intentions towards sexual behavior change in the future, while many had implemented more general changes in relationships such as communicating effectively. One recipient felt comfortable to report that she had already chosen the route of abstinence and three others reported the decision to begin practicing secondary abstinence. All of these recipients were female. The majority of the recipients who verbalized their choices expressed that monogamy and the consistent use of condoms

were more favourable. Generally, male participants mentioned the intention to be faithful and use condoms, while females tended to assume that any relationship they would be in would be monogamous, and thus only focused on regular condom-usage.

4.8 Barriers to behaviour change

While most recipients expressed ways in which they had changed as a result of the HIV peer-led (AB) programme comments were made within focus groups and interviews about difficulties that recipients had experienced or believed they might experience in implementing and/or maintaining the knowledge and changes.

As previously mentioned in section 4.4.2 many recipients stated that they would not be able to share the information they had gained in the workshops. They reported fear of negative responses; having forgotten what they had learned; difficulty carrying messages to older people and into communities; the fact that people are often unwilling to relinquish preconceived ideas; and simply being too shy to initiate such a conversation. Recipients expressed their anxieties about sharing what they had learnt as follows:

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> *I even stand up and do it now…HIV and AIDS and then okay, then you like 'oh, not that topic again'.*
>
> *They'll tell you you stuck up you know.*
>
> *It's, it actually, you know, because we actually also um, caught up in our daily activities, you actually tend to think, forget about it.*
>
> *…most cultures you have to respect your elders, you can't just say anything you want.*
>
> *It's kind of difficult to actually erase what you have in your mind and actually try and digest other options.*

When questioned about the difficulties programme recipients had experienced or could potentially experience in implementing changes in general, and within sexual relationships in particular, they mentioned a number of actual or possible obstacles. Firstly, it was mentioned by two female recipients that one may be financially dependent on the man with whom one is involved, resulting in the sense of obligation to fulfill his needs, despite one's own needs and rights. Secondly, and closely related, was the belief

expressed by a female recipient about the fact that females often feel they need to fulfill males' expectations in order to avoid rejection and that these expectations often require behaviour that is contrary to the behaviour changes learnt due to participation in the workshops. Furthermore, it was expressed that women are often coerced into unsafe sexual relationships by violence and force, not only due to a sense of obligation. These difficulties were expressed as follows:

> *He might be the breadwinner or he might be the income and he might be the sole provider…then you feel like, okay, I have to repay him back....*
>
> *It's like in your, what you are saying don't count, because you are just there to be the cuddled.*
>
> *…so they have to conform to most of what they decide knowing that they can't do anything.*

A further obstacle, as experienced by a female participant is the mistrust experienced by male partners when a female insists on wearing a condom. Closely linked to this is the afore-mentioned sense of obligation, fear of rejection and need to fulfill the expectations of men. It was mentioned by a number of female recipients that despite their desire to make changes, such as insisting on condom-usage and abstinence, their fear of rejection and abandonment override their desire to implement these changes. Also, related to the fear of rejection and abandonment as well as the sense of obligation to fulfill the needs of men, is the sense of guilt felt by women when they do assert themselves. Finally, it was mentioned that it is difficult to assert ones' needs as a female when faced with a male who believes he has rights, by virtue of his culture, which undermine the rights of the female. It was interesting that one male mentioned a possible obstacle to implementing sexual behaviour being the fear of rejection by a female. The majority of the recipients who provided the following data were females and they often referred to the third person and what could potentially be an obstacle to behaviour change, rather than what they personally had experienced:

> *…the guy is going to think "Ok, we didn't use a condom in the first time so what have you been doing since that time? Why do you want to use a condom now?"*
>
> *…because there were comparisons made to their fathers' eras where their fathers could have five wives and all that nonsense.*

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Tomorrow she's doing the same thingy again because she's scared of losing the guy.

You really don't want to do it and you really at times…you think "Ok, I don't want to be uncool and I don't want to be outcast and I don't want people to think that I'm sort of nonsense or whatever.

I did sometimes feel guilty about and I said 'no' to someone and then my conscious or my guilty comes in and I said 'why did I say no to that one?'

4.9 Chapter summary

Seven themes emerged from the data and were further broken down into sub-themes which were reported in this chapter.

The first theme focused on how recipients experienced peer education as an approach. What emerged was that the peer education approach enabled interaction and discussion as well as a more informal format, all of which assisted in boosting the confidence of participants. There were mixed views as to whether it was more beneficial to have a peer as an educator, with some recipients feeling it depended on other qualities of the educator besides age. While many recipients did not believe the peer education approach would result in having a lasting effect (due to them being unable to recall information) their actions and words indicated otherwise. Recipients had mixed views as to the most suitable composition of groups for the peer education approach, with reported benefits to male-only and female-only as well as mixed-gender and mixed-culture groups.

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The second theme focused on was that of attitudes and beliefs. Firstly, the recipients indicated that they had gained tolerance and empathy as a result of the workshops and interaction. The findings also indicated that recipients held particular beliefs which were frequently erroneous and that these were often challenged by others in the groups. Another noticeable attitude shift that was reported was that of a desire to be more responsible. Finally, an important attitude shift that occurred was the change in the sense of vulnerability to HIV, with many recipients seeing HIV as relevant to them.

The third theme was communication and was discussed in terms of communication within and outside of groups. In general, recipients found it easier to communicate due to their experience in the groups but did not tend to share exactly what they had covered during

the workshops, mostly due to fear of judgment and criticism and not finding a suitable opportunity. However, many recipients expressed a desire to be able to do so.

The fourth theme covered in the findings section was that of knowledge. Firstly, besides a few exceptions (often due to constituting the minority in groups), most recipients found the information gained to be personally relevant. Many recipients were already aware of much of the information but stated the 'new' information was more specific versus general knowledge. It appeared the increased knowledge led to a sense of empowerment, augmented by the self-discovery that occurred with the greater awareness and knowledge.

The fifth theme, being skills and self-empowerment, focused on how recipients felt they had been empowered by the workshops. Despite only being able to recount a few specific skills, recipients were generally empowered as a result of participation in the workshops, especially in terms of negotiation skills, communication, assertiveness and self-efficacy in particular. The role-playing reportedly assisted in implementing these skills.

Behaviour change comprised the sixth theme. Recipients reported different preferences for intended behaviour change with the emphasis being on monogamy and condom usage. It was discovered that many recipients held misconceptions regarding what abstinence entails and that most recipients did not favour this as a means of sexual behaviour change they would adopt to protect themselves from HIV/AIDS.

The final theme discussed in this chapter was that of barriers to behaviour change as perceived by the recipients.

CHAPTER FIVE

Discussion of Findings

5.1 Introduction

This chapter will begin with a discussion of the themes that arose from the data/thematic analysis process, considering these in light of the literature and theory. In particular, the findings will be discussed with regards to the aspects stated in the literature (chapter two) to be necessary for an intervention to be successful, as well as those that are particularly thought to be responsible for the efficacy of peer-led interventions. The discussion will include a reflection on the findings in terms of the mediating risk factors as highlighted in the literature and the theory underpinning this study, being the Health Belief Model.

5.2 Strengths and weakness of the UWC HIV Peer-Led (AB) Programme

Based on the responses of the recipients it appears that the programme was felt to be a generally positive experience, with most recipients who participated in the study having benefited in some way. In order to determine the strengths and weaknesses of the programme and the effect thereof, as according to recipient responses, these responses will be discussed with a focus on the characteristics of successful programmes as indicated in the literature in chapter two. Considering the findings of Harrison et al. (2000); Hartell (2005); James (2002); and Kirby et al. (2006) the following were documented as features of successful programmes: the presence of a peer as facilitator; interventions based on written curricula; a focus beyond knowledge and awareness; an emphasis on mediating (risk) factors; the inclusion of a skills-training component; a focus on specific target behaviours; and an emphasis on being context-specific.

5.2.1 Structure and format of the programme

Two significant factors regarding structure and format that are necessary to make an intervention more successful are a focus on a written-curriculum and, exclusive to the peer education approach, the presence of a peer educator to facilitate the curriculum (Maritz, 2001). Theory states that students will find information provided by their peers to be more credible and accessible and that peers encourage the renegotiation of norms

due to promoting safer alternatives. (Agha, 2002; Harrison et al., 2000; James et al., 2004; Maritz, 2001). Responses from the recipients of the UWC HIV peer-led programme were mixed with regards to the benefit of a peer as an educator rather than an adult. While some recipients agreed that they were more able to relate to their peer educators and did not feel embarrassed sharing the information they did, others declared that, as long as the peer educator expressed empathy, non-judgment, and a relaxed attitude, age was irrelevant. In addition, it was mentioned that peer educators were only effective if they were well-trained, well-prepared, and presented the curriculum material in an interesting manner. This is in line with the statement by Maritz (2001) that peer educators must be acceptable to recipients and their personalities conducive to the training and suited to the work they are doing, as well as the findings by Harrison et al. (2000) and Hunter (2004) regarding the importance of facilitators being sufficiently trained. It is interesting that all recipients whose groups had been facilitated by a particular older male peer educator, as well as other recipients who had met him through their own peer educators, praised him highly, specifically mentioning his enthusiasm and accessibility, thus pointing towards the importance of personality and approachability rather than simply age.

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As mentioned earlier in this study the UWC peer facilitators introduced topics based on a structured curriculum, taught over a period of seven sessions/workshops. Of note, is that recipients indicated that the informal nature of dealing with the curricula i.e. using it as a guide versus a basis for lecturing, was received very favourably. Consequently, recipients found the content more accessible, interesting and less intimidating. This is in accordance with the findings of Harrison et al. (2000) who emphasize the benefits of informal peer-led interventions. Thus, while it is important to follow a written curriculum to provide structure, the manner in which that curriculum is shared is more significant. Secondly, the success of the curriculum depends on the content. Kirby et al. (2006) stated that the curriculum should not only focus on knowledge and awareness but also on mediating factors i.e. those risk factors that could impede safe sexual behaviour. Responses indicate that the UWC programme included more than a focus on only knowledge and awareness but that the knowledge and awareness that was gained was beneficial in of itself.

5.2.2 Knowledge and awareness

Firstly, and significantly, the findings indicate that most recipients found the content personally relevant. This was most likely due to the recipients being able to participate in and contribute to informal discussions. In some instances, where recipients constituted a minority, group discussions were not always as relevant, as they tended to at times be dominated by those with majority viewpoints. However, in the event of participants not finding the information relevant, they were often able to share this with others and could thereby provide new knowledge and information, as in the case of a homosexual participant. It appears that in the sharing of knowledge and the information held by each participant they were all able to gain awareness in terms of new insights and were also challenged on misconceptions. The majority of the recipients mentioned this fact and that, due to gaining more knowledge and understanding, it lead to greater tolerance, empathy and respect of others and self-efficacy, -discovery and -esteem for themselves.

With regard to factual knowledge specifically related to HIV/AIDS the majority of the recipients felt that they had already heard much of what was discussed in the workshops. However, it emerged that many of them possessed more general knowledge but lacked specific knowledge or held misconceptions about specific aspects regarding HIV/AIDS. This is in line with the findings of Akande (2001) who noted a fundamental change in terms of the greater extent of knowledge possessed by the South African youth as well as the findings by Eaton et al. (2003); Kaiser Family Foundation & SABC (2007); Lagerberg (2004); and Mba (2003) noting an ignorance on specific points, such as not being aware of the 'window period'. It was interesting to note that the information that was shared in a manner intended to unsettle recipients did appear to have a lasting impression on them, as a number of recipients mentioned the impact of images of genitalia affected by STIs and having met an HIV-positive student.

Yet, it is worth asking how long that impact will last. The literature contains many references to the gap between knowledge and awareness and actual behaviour change (Akande, 2001; Harrison et al., 2001; James et al., 2004; Lagerberg, 2004; Opt & Loffredo, 2004; Zwane et al., 2004). There were many indications made by recipients

that they intended to change as a result of their newly gained awareness, but unfortunately, either due to the short duration of this study or possibly as the result of a certain obstacles, many had not yet had the opportunity to put these intentions into action. A couple of recipients were frank about the fact that they were unsure they would be able to implement the changes, despite the desire to do so. Many recipients also stated that they had forgotten a great deal of the information. Yet, during the data collection process they tended to remember much information which possibly indicates that, in the right context, the information was accessible.

Rather than considering the link between knowledge/awareness and sexual behaviour it is worth considering the changes that did occur, even if they did not lead directly to behavior change. The discussion format made the information personal and thus more applicable and real, appearing to have more of an impact than a formal lecture may have had. Secondly, the sharing of knowledge and information resulted in increased empathy and tolerance, as well as reflection and self-awareness which led to greater confidence and a sense of empowerment, all of these being aspects that play a part in any behaviour change. However, in line with recommendations in the literature (Eaton, Flisher & Aarø, 2003; Mathews, 2005; Simbayi et al., 2004), the UWC peer-led programme did not only focus on knowledge and awareness, but also on mediating factors which could thwart or advance the transition from intentions to actual change.

5.2.3 Personal mediating factors

Attitudes, beliefs and perceptions: According to the literature attitudes, beliefs and perceptions can either impede actual behaviour change or promote it (Akande, 2001; Chitamun & Finchilescu, 2003; Farrow & Arnold, 2003; Peltzer, et al., 2001). Most recipients experienced the UWC peer-led programme as having promoted a positive shift in attitudes, beliefs and perceptions. However, their responses indicated that many recipients held negative and/or inaccurate beliefs and perceptions prior to the programme, some of which were challenged by peers in the groups and modified.

A significant observation was that more than half of the recipients reported having been sexually active prior to the programme or at the time of data collection, and that the prevailing attitude was that premarital sex is acceptable. There was only one recipient who indicated the wish to not engage in sexual intercourse before marriage i.e. to abstain, or to at least delay the initiation of sex in her relationship. As mentioned in the literature, to carry out one's intention to abstain one needs to believe it is a viable and worthy option and, as per the Health Belief Model, perceive the consequences of abstinence to be favourable (Norris et al., 2003; Rosenstock, 1990). Thus, this prevailing attitude suggests that few recipients would consider abstinence to be a constructive form of sexual behaviour change, and this was corroborated in the findings (to be discussed further). In addition, the findings provided by the recipients indicated that many of them did not fully understand the concept of abstinence, and as stated by Norris et al. (2003) it is difficult to encourage a behavior that is not well understood. It seemed these misperceptions had not been fully corrected during the course of the workshops, as there was still evidence of confusion around the concept of abstinence when it was discussed during the data collection process. For instance, recipients appeared to believe that, when abstaining, some forms of sex are allowed while others are not, and others believed that to even fantasise about sex or experience a self-induced orgasm would mean not adhering to abstinence. A few recipients were also unclear as to what secondary abstinence entails.

It was reported during the data collection process that a number of recipients had shared certain beliefs held by students on campus which could potentially impede behaviour change, such as the belief that women must have a boyfriend to feel socially acceptable and that to maintain a relationship sex is required; that women see themselves as victims and unable to take responsibility; that communicating one's wishes could lead to rejection; and that having multiple girlfriends is the norm for men. Many of these beliefs/attitudes are similar to findings mentioned in the literature. In particular, the belief that sex is important for expressing love and that women need to have sex with partners to maintain the relationship and to feel loved and needed, is in line with the findings by Chitamun & Finchilescu (2003). However, what transpired from the findings was that, due to the informal interactive nature of the workshops many of these beliefs were

challenged by others during the course of the programme, leading to the re-evaluation of such beliefs and attitudes. Hunter (2004) refers to this when discussing peer education and the tendency for fellow students to correct misconceptions and to share more accurate information around prevailing social norms. Further, recipients appeared to accept these new collective norms as more credible due to them arising from the interaction of the group, which is consistent with the findings by Harrison et al. (2000) who refer to the value of self-created versus imposed norms.

Indeed, there was an overwhelming indication by recipients that, as a result of the workshops, they had experienced positive shifts in terms of attitudes and norms, particularly having gained greater empathy, tolerance and respect. It seems that many recipients felt that it was a safe environment in which they could share information about themselves and, in doing so, a process of reflection occurred enabling each recipient to discover more about themselves and others. This process then lead to awareness on individual needs, rights and worth. Many recipients stated that they intended to refrain from making judgments or assumptions, and to respect the needs and wishes of others, especially intimate partners. Another major change in attitude noted among many recipients was the desire to take responsibility for personal life-choices, and that one is capable of taking action to prevent the contraction of HIV. This extended to the realization of rights i.e. the right to care for one's own body. These appear to be extremely positive shifts in terms of attitudes, beliefs and perceptions which motivate intentions as per the Health Belief Model and Theory of Reasoned Action, both being theories which contribute to the Peer Education concept (Simbayi et al., 2004).

A positive change in perceptions that occurred, and appeared to be closely linked to the increase in sense of responsibility that was noted amongst many recipients, was the perception of vulnerability. Many recipients mentioned that HIV became personally relevant as a result of their workshops and this led to their desire to prevent themselves and others from becoming infected. Most recipients indicated that they had initially possessed an attitude of fatalism as found by Akande (2001); Keeton (2007) and Peltzer (2002), as well as the belief that HIV only happens to other people (James et al., 2004;

MacPhail & Campbell, 2001). However, these recipients indicated that, due to the personal interactions and nature of the discussions, HIV became 'real'. This is greatly significant considering the Health Belief Model which indicates that for change to occur a sense of vulnerability must be present (Rosenstock, 1990).

Nonetheless, an understanding of one's vulnerability as well as the intention to change does not always lead to behaviour change due a sense of powerlessness i.e. not having the ability to implement change or being able to sustain behavioural change, which is related to one's sense of self-confidence and self-efficacy (Campbell, 2005; Harrison et al., 2000; James, 2002). Thus, a successful intervention should focus on increasing the self-efficacy of the recipients and providing the relevant skills.

Self-esteem, self-efficacy and lifeskills: An aspect of the peer education approach thought to make it more successful is the emphasis on skills training, resulting in a sense of self-efficacy and empowerment (Kirby et al., 2006). Hunter (2004) refers to this specifically in terms of programmes providing a setting for recipients to begin exercising these skills and feeling that it is acceptable and permissible to do so. The UWC HIV peer-led programme appeared to encompass the concept of self esteem and self-efficacy in the content as well as the manner in which the programme was conducted. A study of the responses indicated that the majority of the recipients gained self-confidence and self – esteem merely as a result of the interaction and debate which took place in the workshops. Developmentally, during adolescence and youth many individuals feel isolated in their experiences and often misunderstood and unheard. In addition, it is a time during which identity is consolidated and social opinion carries a great deal of weight (Erikson, 1980). The workshops seemed to be very beneficial in that the recipients expressed that they had felt heard, and realized that they are normal and not alone. It seems that the majority of the recipients gained self-esteem, and in doing so, gained confidence in their rights and needs as well as their sense of self-worth. The literature refers to how often youth engage in sexual risk behaviour due to wanting to feel accepted or being unable to say no (Eaton et al., 2003; Harrison, 2005; Hartell, 2005). Thus, this shift in self-esteem may result in a

decrease of such behavior. Furthermore, a shift in self-worth and -esteem underlies an increase in self-efficacy (Farrow & Arnold, 2003).

Self-efficacy encompasses the belief that one is able to carry out the actions needed to bring about or sustain behaviour change such as abstinence, condom use or monogamy, making it more likely the behavior will be put into practice. (Akande, 2001; Chitamun & Finchilescu, 2003). In this regard, many recipients felt they had gained various skills from the programme which empowered them to live a safer lifestyle. In particular, due to the participation in debates and discussion many recipients felt that they were better able to voice their opinions, assert their needs and listen adequately. A few of the more introverted recipients related how they had become less shy, and were more able to communicate in the groups as well as other everyday contexts. Furthermore, mention was made of the role plays that had constituted part of the workshops and how these enabled the participants to practice their negotiation and communication skills in 'real' scenarios. Many recipients felt empowered by these re-enactments and others referred to how they had gained 'weapons' or 'resources' to assist them in daily life.

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Included in the characteristics of a successful intervention in not only a focus on self-efficacy, but a parallel emphasis on a skills component. As mentioned above the UWC HIV peer-led programme did include a number of role-plays as well as skills being learnt indirectly through the very doing of them, such as interacting and debating during workshops. Harrison (2005) and Rosenstock (1990) specifically stress the importance of negotiation skills, assertiveness training, and a focus on self-esteem, all of which were mentioned by the recipients, even if not learnt directly through training but rather acquired indirectly through the interaction in the workshops. Rosenstock emphasises skills in terms of the Health Belief Model in that if individuals feel able to carry out the behaviour there is more chance they will. He thus recommends breaking target behaviour down into components that are easy to manage. Thus, considering the programme's specific focus on monogamy, condom-use and abstinence, the seeming increase in assertiveness, communication ability, negotiation skills and self-esteem amongst recipients should theoretically be empowering in terms of these target behaviours.

However, it should be noted that the majority of recipients when referring to their new-found confidence and skills had not yet had much opportunity to put these into practice in high-risk sexual situations, despite feeling they would be able to do so, and instead referred to how they applied these skills in everyday life. One cannot be sure that, for instance, a woman with a new-found sense of self-esteem would have the confidence to insist on the use of a condom by her partner when facing the possibility of rejection or judgment. Nonetheless, the sense of empowerment and self-esteem is a foundation and it is hoped that this will begin a positive cycle in which the new-found self-esteem and assertiveness within friendships or social situations would result in others reacting more positively towards these recipients, contributing to an even greater sense of confidence, and that this could ultimately be carried across to a sexual arena. Blinn-Pike (1999) talks about protective factors that buffer against the mediating factors that may impede sexual behaviour change, and the positive shifts in terms of self could no doubt provide this protection. This is apparent in the responses of a number of recipients who mentioned living a more protected, safer or empowered lifestyle, which will undoubtedly be a buffer to high risk sexual behaviour.

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5.2.4 Interpersonal mediating factors

Communication: A further mediating factor to be focused on to ensure the success of interventions is communication (Hartell, 2005; Kirby et al., 2006). This was greatly emphasized during the UWC peer-led intervention, mostly due to the informal discussion format of workshops, and lead to a general improvement in the ability to interact. Farrow & Arnold (2003) argue that communication skills are vital for discussing sexual history, condom-use and perceived peer sexual norms in the practicing of safe sexual behaviour.

It does appear from the responses of the recipients that they felt particularly safe within the workshops to discuss and debate various HIV-related topics. However, they were not as capable of communicating outside of the groups, even amongst themselves, and especially with others. This is in reference to communication particularly about HIV/AIDS and sexual behaviour, not communication in general. Thus, despite the assertion that peer education interventions lead to informal 'teachable moments' (Hunter,

2004, p. 42) it did not seem that these participants would communicate directly about what they had learnt, despite many declaring the desire to do so. It was stated by many recipients that if the context were appropriate they would share with others i.e. if the topic was initiated or they were guaranteed to not be judged. Only very few recipients mentioned being able to directly share what they had learnt with friends or family during conversations regarding sexual behavior, and most of these were females. However, of significance, and in line with findings by Lefkowitz et al. (2004), is the fact that many of the recipients mentioned feeling that they teach by example rather than direct communication. It can be hypothesized that, in becoming more confident and more able to generally assert themselves and negotiate in social situations, they would be an example to others and encourage a change in established norms.

Peer Norms: A further personal mediating factor that the literature states should be focussed upon in any successful intervention is that of peer norms, and the peer education approach is felt to be particularly suited for the challenging and re-negotiation of such norms (Hunter, 2004). Harrison et al. (2000) and MacPhail and Campbell (2001) emphasize the importance of interventions aiming to develop new collective norms amongst the recipients. In the preceding section regarding attitudes and beliefs, reference was made to individual and collective norms and beliefs which were highlighted during the workshops, such as females needing to have boyfriends to feel socially accepted, and that males are considered 'boring' if they have only one girlfriend. However, recipient responses and earlier discussion include many references to how attitudes were altered due to the interaction and debate with others during the workshops. Many recipients referred to a shift in their 'perspectives' and 'mindsets', leading to the development of new norms around rights, responsibilities, tolerance and respect. Furthermore, recipients also reported being encouraged by others to think or behave differently.

In terms of norms related particularly to sexual behaviour the following were directly challenged during workshops (as indicated by recipients): the attitude that it is acceptable for men to have multiple girlfriends and frowned upon for women to be single; the norm that women are not responsibility for condom-usage and safe sexual behavior (or are

promiscuous if they do take responsibility); and the belief that men can demand sex and women should oblige. While recipients respected that others may wish to abstain, abstinence did not gain the status of an established and encouraged norm. The changes in sexual behaviour that recipients declared they intended to implement included mainly being faithful and insisting on condom use. The concept of secondary abstinence also did not appear to become deeply entrenched, with only three females considering this option.

Why abstinence has not become an encouraged and pervasive attitude amongst youth could be due to a number of hypotheses. It is possible that the experimental nature of this particular developmental stage results in the youth not wanting to abstain from something enticing and previously prohibited, especially when their peers place so much emphasis on sex. This aligns with the finding by Agha (2002) that many youths find abstinence to be inhibiting. A second possibility as to why abstinence has not become more established is that the desire to be accepted is strong enough that individuals feel it is preferable to rather continue having sex while using a condom to ensure safe sex, then to abstain completely and be judged by peers. Perhaps it is also easier for those who abstain due to religious reasons to use this as their motivation then for individuals to claim it is simply a lifestyle choice, as peers are possibly more understanding of abstinence for religious reasons. The one recipient who reported having chosen abstinence prior to the programme cited religious reasons for this choice. However, it is interesting to note that, due to the workshops, her reasons for abstaining evolved to include it being her right and a lifestyle choice. This relates to the statement by Hartell (2005) that it is required that abstinence be made 'valuable' to the youth, and it appears that for the majority of them the need to continue having sex (although now with a focus on being faithful and using condoms) is more valuable then refusing sex and having to face the possible consequences of that. Finally, as previously mentioned, it could be due to the fact that few people appear to fully understand the concept of abstinence and thus do not make this a goal.

Kirby et al. (2006) state that another aspect of successful interventions, is that they not be limited to a focus on abstinence-only. This is significant in the context of this study due to the fact that, had the UWC HIV peer-led programme only stressed abstinence, without

providing alternative sexual behaviour choices, many recipients may not have remained in the workshops due to feeling unable or unwilling to abstain.

Sexual coercion and violence: A final personal mediating factor that should be considered in any successful intervention, according to the literature, is that of sexual coercion and violence, as this undermines the ability of women, in particular, to communicate about or negotiate safer sexual practices (Eaton et al., 2003; Harrison, 2005; Harrison et al., 2001). While a few of the female recipients of the UWC peer-led programme mentioned having felt obligated at times to perform sexual acts, there were no disclosures of direct coercion to do so. However, a recipient did mention that a female in her group had admitted to being physically abused by her partner, resulting in the reporting recipient emphasizing the rights of her fellow group member to not accept this abusive treatment, placing particular focus on her worth. In this regard, one can see how interaction in the workshops resulted in norms and attitudes being challenged. Further, the fact that the recipient was able to share this information regarding her abuse indicates how safe the environment was for disclosure, growth and self-reflection.

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Besides this particular group there was no mention of the topic of sexual coercion and violence having been directly discussed during the workshops. Interestingly, the group in which the recipient had been able to talk about her abuse consisted of mainly females. Thus, it is possible that, even in the comfortable setting of the workshops, females did not feel able to discuss sexual coercion and violence in the presence of males. This is important to note given that sexual violence and coercion are so detrimental to women's rights to safe sexual relationships, and that continued silence results in the inability for fellow participants and peers to assist these females in realizing that they have rights.

5.2.5 Structural mediating factors

Cultural factors: Kirby et al. (2006) found that for intervention programmes to be successful they should include an emphasis on the effects of cultural factors on sexual behaviour, with patriarchy and unequal power relations being key factors. The literature notes particularly the prevailing norm amongst youth that men hold a more powerful

position, often resulting in women lacking the self-efficacy to negotiate safe sexual behaviour, and being expected to be submissive in relationships, contributing to the aforementioned sexual coercion and violence (Eaton et al., 2003; Harrison, 2005; Mba, 2003). It became clear that, during the course of the programme, a few female recipients mentioned a sense of obligation to fulfill the sexual wishes of their partners. Furthermore, a few females spoke about fear of rejection or judgment in the event of insisting upon safer sexual practices or abstinence. However, as was revealed during the data collection process, a number of these recipients were challenged and appeared to shift their attitudes regarding such thinking. Yet, the extent and sustainability of this shift in relation to actual sexual situations remains unknown. Furthermore, while many recipients declared that the interaction in mixed-culture and -gender groups had enabled them to become aware of cultural beliefs and differences, it was only in the majority-female groups where patriarchal and cultural norms were truly challenged. One majority-female group reportedly placed great emphasis on feminist-thinking, resulting in a significant shift in the attitudes of the female recipients regarding their rights.

Thus, while the workshops facilitated the development of tolerance for other cultures and their beliefs, these beliefs, particularly those around patriarchal rights and sexual expectations, were only really challenged in groups where females felt comfortable to do so. It is significant to recognize that the female-male interactions in the workshops were an expression of the female-male interactions outside in the 'real world'. This brings into question what constitutes the most suitable composition for groups. Kitzinger (1994) and Leong & Austin (2006) refer to the fact that minority voices tend to be muted by majority voices while Stewart and Shamdasani (1990) refer to the fact that men and women behave differently in group situations and that the rapport and level of comfort in the group is heavily influenced by the gender composition of groups.

There were two notable aspects regarding group composition in the UWC peer-led workshops that emerged through this research. Firstly, mixed-gender and -culture groups allowed for the sharing of different perspectives, which resulted in increased tolerance and empathy for others. In terms of gender, both female and male recipients mentioned

that they had learnt more about the opposite gender as a result. However, it seems that the creation of mixed-gender groups runs the risk of limiting the ability of women to discuss deeper issues around patriarchal beliefs and practices, especially sexual coercion and violence. It appeared that female recipients were only truly able to assert themselves in majority-female groups. In addition, in one majority-female group (with only one male present most of the time) the recipients appeared to draw on feminist-thinking and women's rights, which are seemingly hampered by the presence of men i.e. women appear to gain more from female-only or majority-female groups as they can truly discover their rights and assert themselves. The flip side is that in majority-female groups they often do not gain the opportunity in the workshops to exercise these rights and skills with men, and to hear alternative male perspectives. Yet, when establishing mixed-gender groups it may also occur that in groups consisting of members of similar cultures women may automatically submit to the men if that is the cultural expectation. Thus, it may be more suitable to ensure that mixed-gender groups consist of recipients from a variety of cultural backgrounds, as the presence of women from other cultures, who do not adhere so fully to particular cultural expectations, may expose women who submit to these expectations to alternative norms regarding female rights, and assertiveness in practice.

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Regarding cultural myths and rituals affecting the persistence of sexual risk behaviour as mentioned by Kalichman and Simbayi (2004) and Harrison et al. (2001) there was no reference of such by recipients. It is difficult to determine whether these may impede the shifts that did occur during the workshops.

Socioeconomic Status: A final structural mediating factor which may hamper the ability of individuals to practice safe sexual behaviours, and should thus be a focus in any HIV intervention programme, is socioeconomic status. Poverty and the desire for economic gain can lead to unsafe sexual practices and the commoditization of sex. (Eaton et al., 2003; Harrison et al., 2001; MacPhail & Campbell, 2001; Zwane et al., 2004). Barnes (2000) found in a study at UWC that prostitution and the 'sugar daddy' phenomenon did exist on campus. Only one recipient mentioned during data collection the possibility of sex for economic gain. Another recipient revealed that she had only been interested in

wealthier men, despite their treatment of her, and that, due to the programme, she came to realize her worth and that this was not a healthy criteria for selecting a partner. It is not possible to say to what extent economic status may impede safe sexual practices of the recipients as this did not appear to be a focus during the workshops. This limited focus could potentially diminish the impact of the UWC HIV peer-led programme.

5.2.6 Context-specific interventions

According to the review by Kirby et al. (2006) a final requirement necessary for an intervention to be successful is that it be context-specific. James et al. (2004); Mba (2003); Netswera (2002); and Simbayi, et al. (2004) all refer to the importance of interventions taking into consideration contextual, cultural and socio-economic factors, and that there be a sound understanding of cultural differences and gender discrepancies relevant to the groups. Cultural, socio-economic and gender disparities were discussed in preceding sections with regard to the UWC peer-led intervention, with the argument that there are advantages and disadvantages to both mixed and targeted groups, especially taking into consideration gender and culture. This is in line with the findings of Simbayi et al. (2004) which recommend that integrated as well as targeted HIV/AIDS intervention programmes be implemented. In terms of the UWC programme, perhaps more thought should be given as to how the composition of the groups can affect the impact and success of the workshops, and to consider targeted groups for various purposes, based on a full understanding of broader structural factors. However, the fact that the recipients were all students at UWC and that the workshops were facilitated by fellow students did appear to result in many recipients feeling that the topics were contextually-relevant in terms of sexual behaviour in a university setting.

When considering all the above factors deemed to be necessary for an intervention to be successful the literature states that, of these factors, the following are those that make the peer education approach more effective: the format and structure (peer facilitator and informal setting) result in the information being more accessible and relevant to the recipients; the discussion and space enables the re-negotiation of social norms; the skills component makes it more likely for actual behaviour change to occur due to greater self-

efficacy; and the emphasis on peers ensures a greater chance that informal 'teachable moments' will occur with peers not involved in the interventions (Agha, 2002; Hartell, 2005; Harrison et al. ,2000; Hunter, 2004). Only one of these factors appeared to be unsuccessful on the basis of recipient responses with regard to the UWC HIV peer-led intervention, being that of the informal teaching moments. As discussed, while many recipients had the desire to share what they had learnt, few of them did so directly. However, many believed that, given a conducive environment, they would possibly be able to share what they had learnt with others. In addition, there appeared to be evidence that some of the 'teaching' was by means of indirect modeling and behaviour in the lives of the recipients. Thus, in conclusion, the programme appeared to include and promote most of the factors deemed by the literature to be necessary to ensure the success of an HIV intervention. Additionally, the programme included factors particular to peer education approaches and these did appear to make the intervention effective, specifically the informal setting and peer facilitation which allowed for discussion and debate, as well as the renegotiation of norms.

5.3 The UWC HIV peer-led programme as related to the underlying theory

As previously mentioned in this study the particular theory that underpins this research is the Health Belief Model (HBM). To determine perceived strengths and weaknesses of the UWC peer-led intervention it is useful to consider the findings in light of the theory. The findings will be considered in terms of the four aspects felt by Rosenstock (1990) to be essential to behaviour change.

The HBM postulates that for behaviour change to take place an individual should, firstly perceive him- or herself to be vulnerable to the health threat in question and, secondly believe that the health threat will have at least a moderately severe impact on his/her life. The majority of the recipients of the UWC programme reported a shift in terms of viewing HIV as real and personally relevant to them, thus leading to the perception of being vulnerable, and the related desire to protect themselves. This occurred parallel to the increased self-worth that was experienced along with the related right and responsibility to care for themselves.

According to the HBM the third condition necessary for behaviour change to take place, following the intention to change, is that individuals believe that certain behaviours will be beneficial in reducing their perceived vulnerability or the severity of the disease and, that they view these behaviours as having favourable outcomes. The fourth component to behaviour change is that of perceived barriers to the required actions, and the belief that one can overcome these barriers. Considering the findings as reported by the recipients of the UWC HIV peer-led programme, it appears that there was a significant shift in self-efficacy and self-esteem amongst many of them. This shift enabled them to feel capable of pursuing a variety of behaviours which could lead to reduced vulnerability, namely communicating with partners, assertiveness, negotiating condom use, and being more discerning regarding sexual partners. A sexual practice that most recipients appeared to view as being non-beneficial was that of abstinence, with the majority rather choosing to be faithful in relationships or to insist on condom use.

However, a number of potential barriers were mentioned by recipients including fear of rejection, judgement and mistrust; cultural beliefs around women's obligations; being too shy; dependency due to poverty; and violence and coercion. Whether or not actual behaviour change will take place depends on the extent of the self-efficacy and self-esteem gained in the workshops in order to overcome some of these barriers, as well as being able to overcome strongly ingrained habits or detrimental drives associated particularly with sexual practices (Akande, 2001).

Therefore, considering the responses gained from the recipients it seems that, while many of them had not introduced actual behaviour change in their lives, they reported the intention to change and felt more confident about change, as well as empowered to overcome the aforementioned barriers. Whether or not they can overcome those barriers at the crucial moment is not possible to know. What is of concern is whether the self-esteem and self-efficacy gained due to the workshops is sufficient to overcome the more severe barriers such as cultural beliefs and expectations and other structural aspects, such as socio-economic status, especially considering there appeared to be a limited focus on these aspects during the workshops. Nonetheless, considering the recipients' experiences

of the UWC HIV peer-led programme in light of the HBM, it can definitely be said that, according to this model, they are more equipped to change their behaviour than they were prior to the workshops. The majority of the recipients reported the intent to change and placed significance on the need to change, as well as recognised the benefit of certain sexual behaviours and felt able to overcome certain barriers.

What should be mentioned is that many recipients declared the desire to make a more general lifestyle change, including communication, assertiveness, negotiation and decision-making. While this does not necessarily include the targeted behaviours of abstinence, being faithful and using condoms, it certainly does encompass change, and a pervasive change at that, which will hopefully be carried through to the sexual arena. Indeed both Hunter (2004) and Lefkowitz (2004) refer to the carry over of skills that have been learnt to the situations in which the target behaviour is prevalent, in this case being sexual relationships.

In summary, in light of the HBM and recipient responses, the programme was effective in that many shifts were made by recipients with regard to general behavior changes in their lives, and significant transformations in attitudes and perceptions, all of which will empower recipients to make the actual sexual behaviour changes that many of them intend to make, and to hopefully overcome any barriers that they may come across. In addition, due to being aware of these potential barriers as a result of the programme they may also be more equipped to cope with them.

5.4 Chapter Summary

This chapter aimed to integrate the findings from the study with the literature and theory underpinning this research. When considering the UWC HIV peer-led programme in light of the characteristics stated in the literature to be required for the success of interventions, it seemed that in general, according to the perceptions of the recipients, the UWC programme included the majority of these characteristics. In addition, when considering whether or not the UWC peer-led programme appeared to be effective it seems that most

of the recipients experienced it as such, in that they gained certain skills or experienced shifts in attitudes and beliefs as a result of their participation in the programme.

In terms of the impact of the programme when considering the specific target behaviours i.e. abstinence, delay of sexual debut, reduction of partners, faithfulness and condom use, as well as the conditions of the Health Belief Model, the UWC HIV peer-led programme was not wholly successful in promoting abstinence, including delay of sexual debut as an optional behaviour strategy. However, the changes that did occur in terms of increased sense of vulnerability and the desire to bring about some form of change in their lives, indicate that the programme was still beneficial. In addition, it is difficult to ascertain whether or not the fact that recipients intended to change their behavior will lead to actual behaviour change due to the short duration of this study.

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CHAPTER SIX

Conclusion and Recommendations

6.1 Introduction

This chapter will begin with a summary of the discussion and integration of the findings with the literature and theory, as well as a general conclusion of this study. Included will be a list of recommendations for the UWC HIV peer-led programme based on the findings of the study.

6.2 Conclusions

In the previous chapter the strengths and weaknesses of the UWC programme as perceived by the recipients of the programme were related to relevant literature. While it seems that most of the recipients found the programme to be successful in that they all benefited in a more general sense, there were aspects which appeared to be more successful than others.

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In terms of the knowledge and awareness gained by the recipients the programme was successful in that it moved beyond only a focus on knowledge and awareness. In addition the knowledge and awareness gained was felt to be relevant and the recipients felt empowered by this new-found knowledge and awareness. In particular, the recipients expressed that the informal nature of the workshops enabled the discussion and interaction that lead to increased awareness and self-reflection.

This interaction not only lead to increased knowledge but also provided the arena for the re-negotiation of norms in that various attitudes and beliefs, when brought into discussion were challenged by others, encouraging all recipients to re-think their own attitudes, norms, beliefs and values. This promoted the fostering of respect, tolerance and empathy and, together with the basic knowledge and information gained in the workshops, enabled them to make informed decisions and feel empowered to do so.

This shift in attitudes included an emphasis on self-efficacy and confidence. The very nature of the programme resulted in an increase in self-esteem through recipients being able to interact, express opinions and feel heard and understood. This increase in self-esteem also contributed to an increase in self-worth for many, resulting in a desire amongst the recipients to protect themselves and those they love. Furthermore, the introduction of skills training components, such as role-playing, as well as the very act of communicating, debating and interacting, enabled recipients to practice their new-found skills and feel more confident in their ability to use them, with many recipients stating that they had been able to use their skills, such as appropriate communication, decision-making, assertiveness and negotiation skills. However, the majority of the recipients reported only exercising these skills in the context of social and everyday scenarios while expressing the intention and desire to exercise these skills in sexual relationships.

The intentions and desire to change as mentioned by the recipients indicate the increased sense of responsibility and vulnerability that many of them felt. This shift occurred in correlation to their greater sense of self-worth, as well as due to the informal, thus more intimate and personal nature of the workshops, making HIV more relevant and real. The actual changes that occurred amongst the recipients were generally within the groups themselves and in social relationships, in terms of increased self-confidence; being able to assert themselves more effectively; taking more responsibility in daily living; feeling less powerless and having the right to care for themselves; and being able to make daily decisions more confidently. A few recipients remarked that they were better able to communicate with their intimate partners and had more empathy towards and understanding of them, as well as some recipients changing their attitudes with regard to the number and nature of partners they sought, but, within the sexual arena, very little actual change was reported. This could be due to the fact that many recipients had not yet had the opportunity to put their intentions into practice or because they were unable to due to certain barriers.

Considering normative beliefs regarding sexual risk behaviour, there did appear to be shifts in attitudes, leading to various intentions to change as reported by recipients. The

majority expressed the desire to be more assertive in negotiating condom use (particularly among women); to be faithful; to generally be more responsible sexually; and to be more conscious and aware in sexual situations. Very few recipients intended to abstain (whether they were virgins or sexually active during the course of the programme) and it seemed that the prevailing attitude still remained that sex before marriage is the norm and, by extension, unquestioned. Nonetheless, the programme did assist in endorsing the choice of a recipient who had already chosen to abstain prior to the programme, and encouraging three recipients to practice secondary abstinence. Furthermore, the workshops lead to a shift in the recipients' attitudes towards others who might consider abstinence, in that they came to respect it as an option others may choose.

Therefore, when considering the UWC peer-led programme in terms of the abstinence focus it was not wholly successfully according to recipients' experiences. What was successful was the pervasive change amongst the recipients towards increased self-esteem, self-efficacy, sense of responsibility and related vulnerability, all being necessary components for change according to the Health Belief Model. It is hoped that these shifts will not only be prevalent in the social context but will carry across to the sexual arena.

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In terms of barriers, there were a number of factors that could possibly prevent this carry-over and transformation from intention to actual behaviour change. These included, in particular, fear of rejection and a related need for acceptance; fear of judgment; and not seeing any value in abstaining. This is where the programme appeared to be lacking, in that it seemed that many recipients did not fully understand abstinence and had misconceptions around what abstinence entails. In addition, based on recipient responses, it did not seem that there had been much discussion around the advantages and disadvantages of abstinence as well as a focus on understanding what particular barriers were preventing the youth from choosing abstinence as an option. Until this is fully understood the programme will not be successful in promoting abstinence among the recipients. In addition, there appeared to be a lack of focus on deeper contextual issues such as patriarchal and cultural beliefs and practices and socio-economic factors and how these could prevent the recipients from introducing sexual behaviour change despite their

best intentions. In this respect the gender and cultural composition of groups may have influenced the ability of recipients to discuss these matters.

Due to this study being an exploration of the recipients' experiences of the UWC HIV peer-led programme it should once again be noted that the programme brought about profound and very beneficial shifts for many of them, whether it lead to social and general behaviour change or sexual behaviour change. The format of the programme appeared to play a large role in the shifts that came about, as it is the researcher's contention that the informal, discussion format, and being in the presence of a facilitator with whom recipients felt comfortable, enabled them to fully benefit from the programme and particularly gain self-esteem and self-efficacy. It is only in light of the literature regarding HIV peer-education interventions that possible limitations of the programme can be pointed out with regard specifically to sexual behaviour change and abstinence in particular. Yet, even in this respect much of these limitations are hypotheses as it is not possible to determine the full impact the programme has had on sexual behaviour change without a follow-up evaluation and long-term exploration of the recipients' experiences.

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6.3 Limitations of the study and recommendations for further research

Considering the previous chapter and the afore-mentioned conclusions, the following limitations can be noted and recommendations made:

- To conduct follow-up explorations of the recipients' experiences not only during the programme but in a follow-up session perhaps six months to a year later to determine whether recipients were able to put their intentions into practice and whether the changes that did occur were sustained or not. With the limited duration of this study this was not possible.
- To research the concept of abstinence amongst youth more comprehensively as there is currently limited research and understanding regarding youth perceptions of abstinence and factors preventing them from integrating abstinence into their lives. Such research may provide enlightenment on the limited ability of the UWC HIV peer-led programme to promote abstinence.

- The findings of this study do not take into consideration the effect of additional risk-behaviours, such as substance abuse and their effect on safer sexual behaviour. This could be an area for future research.
- A final limitation of this study is an inadequate understanding of youth sexuality in the setting of tertiary institutions. There is little research with regards to the how the experience of this transition, including increased freedom; greater insecurity during this time of development; and the introduction to a diversity of attitudes, beliefs and norms, as well as behavior and choices, impacts students' sexual behaviour and choices.

6.4 Recommendations for the UWC HIV peer-led (AB) programme

The following recommendations are based on recipients' suggestions and have also evolved from the findings of the study regarding recipients' experiences of the programme:

- To find a means to continue the interaction of the groups following termination of the programme. This could include a monthly social get-together, incorporating an hour of activities, role play etc.
- Many recipients of the UWC HIV peer-led programme stated that, given the opportunity, they would like to share their experience of the workshops and their newly gained awareness and attitudes. It was suggested that a braai or social function in the residences could be organized and dedicated to this purpose, where students be invited to discuss the issues that were covered during the workshops. This would ensure 'teachable moments' as referred to in the literature.
- In particular, many of the recipients mentioned that they would like to share what they had learnt with the first year students, whom they felt to be particularly vulnerable, and that the SRC should be involved in this endeavor.
- It was suggested that specific groups be conducted for couples, as it was felt that had partners also experienced the workshops it would have been very beneficial to their relationships and made it easier to introduce changes in these relationships.

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- It was recommended that the programme be marketed more effectively as many of the recipients only began attending the workshops from the second or third session due to having heard about the sessions from friends.
- A suggestion made by a few recipients was that a *grand finale* be held where all the groups are able to meet each other to share what they most enjoyed with programme recipients from other groups. Perhaps this could influence the composition of groups in that they could start off as male-only and female-only and after a certain number of sessions combine to form mixed-gender and mixed-culture groups, in order to benefit from both experiences.
- In line with the above recommendation was the idea that extramural activities take place, including all the groups and implementing elements of the workshops. It was also suggested that all recipients attend a weekend camp, once again incorporating elements of the programme.
- In terms of the actual content of the programme, as was mentioned, there could be more of a focus on structural issues and consideration of how to deal with these by becoming involved in communities and the broader society. In addition, there could be more of a focus on substance use and its effect on sexual behaviour. Thirdly, it is recommended that more attention be given to ensuring that students properly understand the concept of abstinence. They could spend time considering the benefits of abstinence and the reasons behind their reluctance to consider abstinence as an option, as well as how to overcome any potential barriers. This may alleviate the confusion that was evident around what constitutes abstinence and result in more interest in committing to abstinence as a practice.
- Finally, there was no mention made about requesting partners to be tested or and little mention regarding following up on partners' sexual histories. This aspect could be included in the content, along with the difficulties experienced and skills needed to do so.

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APPENDIX A – INTERVIEW GUIDE

- How did you experience the programme? What were your perceptions and feelings related to the experience?

- How has your thinking about and attitudes towards sexual behaviour and abstinence changed as a result of the curriculum?

- In what way does the programme encourage people to change their behaviour?

- What impact has this programme had with regards to the skills necessary in order to abstain from sexual relationships or to remain faithful?

- How did you experience being facilitated by one of your peers versus an adult?

- What new information/knowledge have you learnt as a result of the programme that you were not aware of before?

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- How do or don't you feel the programme was relevant to you?

- Has your experience of this programme provided you with the skills to encourage change in others?

- What could be changed in the programme to make it more effective?

APPENDIX B – PARTICIPANT INFORMATION DOCUMENT AND CONSENT FORM

Recipient experiences of a peer-led abstinence and safer sex HIV risk-reduction intervention at the University of the Western Cape

I am researching the experiences of participants of the UWC peer-led abstinence programme. This research is conducted by me in my capacity as a Psychology Masters student at the University of the Western Cape and is necessary for the fulfillment of my degree. The research will also be used for the development of similar programmes in the future and to make recommendations for the UWC peer-led programme.

To carry out this research I will conduct focus groups discussions consisting of you and six other students who participated in the programme. The groups will be divided according to gender. The focus groups will be about 90 minutes to two hours in duration, during which time I will ask a few questions related to your experience of the programme and discussions will be held within the group.

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I am aware that it can be difficult to talk about sexual behavior and HIV/AIDS and wish to emphasise that you are in no way obliged to participate and there will be no adverse consequences should you refuse to do so. If you decide to participate you can choose to disclose only the information you are comfortable to share and may choose to leave at any time during the focus group discussions.

Confidentiality will be maintained at all times which means that only my supervisor and I will have access to the original data and your identity will be protected in the reporting of the research. I will be tape-recording the focus group discussions and the recordings will not be heard by anyone other than myself and my supervisor and will be destroyed following completion of the report.

If you agree to participate in this research and to take part in the focus groups (which will be tape-recorded) please complete the form below.

NAME:_____

AGE:_____

COURSE & YEAR OF STUDY _____

HOME LANGUAGE: _____

ARE YOU PREPARED TO PARTICIPATE IN A FOCUS GROUP AND BE RECORDED AND TO ALLOW ME TO USE YOUR WORDS WHILE KEEPING YOUR IDENTITY ANONYMOUS?

YES ☐ NO ☐ SIGNATURE: _____

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DATE: _____