

The challenges that peer educators face at Stellenbosch University

by

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Declaration

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Abstract

The aim of this research study was to look at the challenges which student peer educators face at Stellenbosch University. Semi-structured interviews were done with male and female peer educators who are involved at the Office for Institutional HIV Co-ordination (OIHC), where the peer educators have been recruited and trained. Interviews were done to determine what the peer educators' experiences are when they work on campus, go out into the community and even when they socialise with their friends.

From listening to the peer educators' experiences it was found that with safe sex messaging there are mixed responses from males and females. According to the peer educators, students would rather purchase another brand of condoms than the Choice condoms distributed on campus. It was also found that males did not have a problem with condoms being placed in their residences, while females had a problem with that. Regarding HIV testing, females are much more open and enthusiastic to go for an HIV test than males. Challenging someone's risky sexual behaviour is a huge challenge for all peer educators, since behaviour change does not happen easily. Many students also used withdrawal as a form of contraception. In the community peer educators were faced with language barriers and married people were not very enthusiastic to go for an HIV test. Behaviour change is possible, but difficult to bring about.

Opsomming

Die doel van die navorsingstudie was om te kyk na die uitdagings wat studente portuurgroep-opleiers ervaar by Stellenbosch Universiteit. Semi-gestruktureerde onderhoude is gedoen met manlike en vroulike portuurgroep-opleiers wie betrokke is by die Kantoor vir Institusionele MIV Ko-ordinering, waar die portuurgroep-opleiers opleiding ontvang het. Onderhoude is gedoen om te bepaal wat die portuurgroep-opleiers se ervarings was wanneer hulle gewerk het op kampus, in die gemeenskap, of met hulle vriende gekuier het.

Deur na die portuurgroep-opleiers se ervarings te luister is daar gevind dat deur die oordra van veilige seks boodskappe daar gemengde reaksies was by mans en vroue. Volgens die portuurgroep-opleiers sal studente liever ander kondome koop en gebruik as die Choice kondome wat op kampus versprei word. Daar is ook gevind dat mans in die koshuise nie 'n probleem gehad het as daar kondome in hulle koshuis geplaas word nie, terwyl vroue wel 'n probleem daarmee het. Wat MIV toetse betref was vroue meer entoesiasies om vir 'n MIV toets te gaan as mans. Om iemand se seksuele gedrag uit te daag is baie moeilik aangesien gedragsverandering nie so maklik gebeur nie. Baie studente gebruik ook "withdrawal" as 'n tipe voorbehoedmiddel. In die gemeenskap was daar taal probleme wat portuurgroep-opleiers ondervind het sowel as getroude mense wat nie optimisties was om vir 'n MIV toets te gaan nie. Gedragsverandering is moontlik, maar baie moeilik.

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Chapter 1: Background and Problem Statement

1.1 Working title

The challenges that student peer educators face at Stellenbosch University.

1.2 Background and Rationale

At Stellenbosch University there is a peer education programme where students are trained about HIV/AIDS issues, relationships, safe sex, and gender issues. Becoming a peer educator is an ideal opportunity for students to become part of a training programme enabling them to communicate the true facts and become involved in the community by doing The Basic HIV and Gender Facilitation short course (Office for Institutional HIV Co-ordination, 2012). The goals behind this training are that students act as an informal source of information on HIV/AIDS on campus and any other circles of influence they operate in. It also aims to influence unsupportive attitudes and promote responsible behaviour. In essence, empowering students to serve as a support structure for students in the university community. Peer educators are trained students who become educators, role models, referral agents and activists against the HIV pandemic, gender issues and other health threats to young people. The peer educators can take part in various community interaction projects in and around campus which include: mass HIV testing campaigns, marketing local HIV testing services, condom distribution, a project exploring student attitudes regarding gender, race, HIV and sexual orientation, as well as projects partnering with various NGO's, such as Legacy, Vision V, Vision K, !Khwa ttu San Cultural Centre and @heart (Office for Institutional HIV Co-ordination, 2012).

Being a peer educator can be a wonderful, informative and challenging experience. It takes a lot of courage to approach people with information on HIV/AIDS and to get them to think about positive behaviour change. There is stigma associated with the epidemic in the first place, and talking to peers about practicing safe sex, talking about HIV-related issues and being a good role model is a challenge. The knowledge gap is that we do not know the challenges that peer educators face and the experiences that they have when they go out and speak to people.

1.3 Research question

What are the challenges that peer educators face on a daily basis at Stellenbosch University?

1.4 Significance of the study

The current and new peer educators at Stellenbosch University will benefit from the study. Stellenbosch University's Office for Institutional HIV Co-ordination will also benefit from the study in sustaining and maintaining new peer educators for the programme.

1.5 Aims and Objectives

The aim of the study is to identify peer educators' experiences at Stellenbosch University.

The objectives of the study are to:

- identify challenges that the peer educators face on a daily, weekly and monthly basis.
- identify the specific needs of peer educators that would make their work better and make them more effective.
- provide guidelines on how to improve the peer education programme to prepare peer educators for their work and to prepare them for possible challenges that lie ahead.

Chapter 2: Literature Review

2.1 Introduction

Higher education institutions educate and train the most sexually active young adults who are most vulnerable to contracting HIV due to their risky social and sexual behaviour. Institutions of higher education over the past decade have become increasingly aware of the negative impact of the HIV/AIDS epidemic on their core business areas of teaching and learning, research and community engagement (AAU Competency-based training in management and leadership for the leadership of African universities, 2012).

Higher education institutions provide a special environment for HIV/AIDS because among other things they provide the stage for easy interaction among the active age group (19-24 years) thereby facilitating the spread of the disease. Vulnerability to HIV infection is associated with multiple factors, including overall HIV prevalence in the context within which one lives in combination with exposure to a number of factors, including interlinked sexual networks (HEAIDS, 2010). Student culture generally encourages adventurism which leads them into cultivating habits that render them vulnerable to contracting HIV/AIDS, for example, using drugs, drinking alcohol, engaging in casual sex (AAU Competency-based training in management and leadership for the leadership of African universities, 2012).

Peer educators are therefore effective and well-trained individuals who educate their fellow students on safe sex messaging, HIV awareness and how to be socially and sexually responsible adults. The term “peer educator” implies that the HIV prevention message being delivered to others is educational or informational in nature (Kelly, 2004). Peer educators reach peers of their same age, educational levels, ethnic group, religion, social clubs, organisations and groups. This means that first and foremost peer educators in higher education institutions will reach students (AAU Competency-based training in management and leadership for the leadership of African universities, 2012). Their aim is to reach all students.

Regarding condom use, literature indicates that factors affecting condom use are a range of situational, interpersonal and structural factors such as knowledge about

AIDS, behavioural intention, perceived susceptibility, perceived barriers, self-efficacy, and demographic factors (Peltzer, 2000). In South Africa the interplay between socio-economic factors, service costs, condom availability, condom knowledge and its access and tobacco and alcohol use, were all found to predict demand for condoms (Chandran, Berkvens, Chikobvu, Nöstlinger, Colebunders, Williams & Speybroeck, 2012). Further, gender disparities in socio-economic status were found to influence women's ability to negotiate condom use.

Qualitative data from Stellenbosch University's KABP Study of 2008-2009, strongly supports that there is a campus culture of excessive drinking, particularly on weekends, and that this is reinforced by university-sponsored activities and campus 'bashes' (HEAIDS, 2010). The consumption of spirit liquor is common even among the youngest and 'getting drunk' is something that students commonly set out to do (HEAIDS 2010). Stellenbosch University respondents reported in this study that excessive drinking often leads to unplanned and unprotected sex which would in many instances probably not occur outside of the context of drunkenness. It was found that HIV is a concern, but this concern is easier for students to overlook than the concern of avoiding pregnancy.

2.2 Peer Education

Peer education involves training and supporting members of a given group to effect change among members of the same group (Population Council, 2012). Peer education is used to effect changes in knowledge, attitudes, beliefs and behaviours at the individual level. However peer education may also create change at the group or societal level by modifying norms and stimulating collective action that contribute to changes in policies and programmes. Worldwide peer education is one of the most widely used strategies to address the HIV/AIDS pandemic. Peer education programmes need to set realistic behaviour-change goals that reflect the challenges faced by the intended audience and where they are along the behaviour-change continuum i.e. pre-contemplation, contemplation, preparation, action, maintenance. The cost of implementing high quality peer education can be high, due to the ongoing need for funds to adequately train, support and supervise peer educators, and equip them with resource material. Compensation for peer educators is also crucial.

According to Walker & Avis (1999) peer education programmes fail for the following reasons:

- when there is a lack of clear aims and objectives for the project;
- an inconsistency between the project design and the external environment or constraints which should dictate the project;
- a lack of appreciation that peer education is a complex process to manage

and requires highly skilled staff;

- inadequate training and support for peer educators; and
- a failure to secure multi-agency support.

One of the criticisms of peer education is that it is not a long-term investment as young people may be involved for a certain time and then move on to other interests (Hill in Backett-Milburn & Wilson, 2000). Frankham (2006) found that young people are volunteering to become peer educators for reasons quite extraneous to the project's aims. They also become peer educators for reasons which signal they have priorities which are unlikely to accord with everyone else in their same-age peer group. Some of the challenges that peer educators face are that in some contexts, relationships and familiarity between peers and their groups might act as barriers to communication, for example a peer-led HIV intervention in the UK reported that gay men were often unwilling to discuss sex with peer educators they already knew (Alcock, More, Patil, Porel, Vaidya, & Osrin, 2009). Programme managers should reflect on the nature of relationships between peer educators and their groups and how these may enhance or hinder the implementation of programme strategies.

Clarification of misconceptions especially in situations of changing peer group membership, may lead to greater acceptance and participation by target groups, that is the conceptual frameworks for community-based programmes should be based on empirical evidence as well as theory; organisers of peer training programmes should emphasise rapport-building, communication and negotiation skills; programme managers should consider the ways in which credibility may be constructed, in the

recruitment, training and supervision of peer educators (Alcock et al., 2009).

Retaining young people as HIV/AIDS peer educators is challenging since peer educators must buy into HIV/AIDS prevention, champion HIV/AIDS prevention messages to adolescent and young adult audiences, and apply HIV/AIDS prevention in their own daily lives despite social pressures and other barriers that often inhibit condom use (Pearlman, Camberg, Wallace, Symons, & Finison, 2002). According to Walker & Avis (1999) peer education alone cannot maintain long-term behaviour change, this will only occur within a broad range of initiatives aimed at young people including appropriate services, health promotion in schools, colleges and informal settings such as nightclubs and youth clubs and other community-based initiatives.

2.3 Safe sex messaging

According to Philpott, Kerr & Boydell (2006) most sexual health education programmes use fear and risk of disease to motivate people to practise safer sex, giving the impression that safer sex and pleasurable sex are mutually exclusive. Research has proven that promoting pleasure alongside safer sex messaging can increase the consistent use of condoms and other forms of safer sex. A study of sex and relationship education found that in STI/HIV prevention public health outcomes may benefit from a greater acceptance of positive sexual experiences (Philpott et al., 2006). Other studies show that denying the possibility of pleasure in sexual relations, especially for women, has a negative impact on their active negotiation of safer sex. Philpott et al. (2006) found that the power of pleasure lies in promoting of the use of male and female condoms, in conjunction with safe sex messaging, which could increase the consistent use of condoms and the practice of safer sex. When promoting condoms it is important for public health campaigns to address how to increase sexual pleasure, since condoms are normally perceived as reducing sexual pleasure. Philpott et al. (2006) also found that there are a number of reasons why people do not use condoms and practice riskier sex instead. They are a sense of not being at risk, due to ignorance or myths about HIV/AIDS; the belief that condoms are not effective in preventing HIV; requesting condoms means a lack of trust for your partner; and in general condoms appear to be an awkward and unnecessary necessity. The reasons why female condoms are not used are limited supplies and access, relatively higher cost, lack of understanding of how to use them and general

discomfort on the part of both men and women with touching the woman's body to insert the condom, and in general they are perceived as awkward, uncomfortable and not sexy. Philpott et al. (2006) also found that pleasure and sexiness are often culturally specific, so it is vital to tailor pleasure-focused HIV prevention to the needs and desires of target communities. Efforts to eroticise condoms require detailed discussions about how to make condoms feel better. With safe sex messaging keep your focus on pleasure and sex rather than disease, but it is also important to strike a balance between promoting pleasure and promoting health. When doing safe sex messaging, eliminate messages and attitudes that promote shame or fear about sex, sexual preference or pleasure.

Qualitative research is starting to show that strong social and cultural forces shape sexual behaviour and is helping to explain why providing information and condoms are often not enough to change this behaviour (Marston & King, 2006). In Marston & King's (2006) study they found that young people would use condoms with long-term partners to avoid pregnancy which is more of a concern than disease prevention. The nature of the partner and the partnership influences not just whether a young person uses a condom but sexual behaviour in general. Individuals might see sex as something that could strengthen a relationship, or as a way to please a partner.

2.4 Condoms

Condom use is one of the most difficult issues to address in designing programmes to reduce the sexual transmission of HIV in Africa (Peltzer, 2001). According to Winskell, Obyerodhyambo, & Stephenson (2011) condoms are an important part of comprehensive efforts to control the HIV epidemic for those who know their HIV status and for those who don't. Although young people account for almost half of all new HIV infections, reported condom use among them remains low in many sub-Saharan African countries. Winskell et al. (2011) found that social representations of condoms may include imagery (e.g. condom as raincoat), associations (e.g. condoms equal immorality), or cultural scripts (e.g. female-initiated condom negotiation). Social representations are dynamic systems of social knowledge and may reflect existing understandings and help to shape future developments.

Peltzer (2001) found that the most common reasons for not using condoms were “I do not have the AIDS virus”, “I thought I was safe”, and “I was with my steady sex partner” which indicates a low perceived susceptibility. Peltzer (2001) also found a significant relationship between the reasons for not using a condom, which is “I didn’t think of using a condom”, “I find condoms painful”, and “I was using alcohol or drugs” and condom use intentions. Another barrier to condom purchase and use is social acceptability since there is a social stigma attached to this (Winskell et al., 2011).

Opt, Loffredo, Knowles, Fletcher (2007) found that relationship status, rather than concern for HIV infection, may influence condom use because single, non-traditional students were more likely to report using latex condoms than were those in monogamous relationships. Marston & King (2006) found that young people also worry that asking their partner to use a condom implies that they think their partner is diseased, so condom-free intercourse can be seen as a sign of trust. Despite the stigmatising effect for women in carrying condoms or using other contraception, women, not men, are generally considered responsible for pregnancy prevention.

Findings suggest that prevention efforts to promote condom use must be gender as well as culture-specific if they are to be effective (Peltzer, 2000). At an intrapersonal level, educational aspirations and students’ performance, ability to plan and prepare for condom-use, personal coping strategies including alcohol use, personality traits such as sensation seeking and impulsivity have been found to be related to condom use (Chandran et al., 2012).

2.5 Risky sexual behaviour

According to Anastasi, Sawyer, & Pinciaro in Opt & Loffredo (2004), even though students are knowledgeable about how HIV is transmitted and protection methods this does not stop them from engaging in risky sexual practices or influences them to increase their condom use. College students believe they have minimal personal risk for contracting HIV (Lewis & Malow in Opt & Loffredo, 2004). One major risk factor for HIV infection is the number of sexual partners a person has, especially if they are in concurrent relationships (HEAIDS, 2010). Alcohol consumption, particularly at venues such as bars and clubs, is linked to a higher likelihood of casual sex in

combination with diminished judgment including disinhibition in relation to the use of condoms for HIV prevention.

Results from Opt & Loffredo's (2004) study show that female students view HIV/AIDS as a larger problem for their age group than male students. Although HIV infection rates in college populations may be low compared to other high-risk populations, college students engage in risky behaviours which could increase the spread of HIV (Opt, Loffredo, Knowles, Fletcher, 2007). Netting & Burnett in Opt et al. (2007) stated that with the long incubation period of AIDS, the serial nature of monogamy, and the lack of objective knowledge regarding HIV status, monogamous couples are still at risk for HIV. Marston & King (2006) found that social expectations, especially ideas about how men and women should behave, are a powerful influence on behaviour; the influence of sexual partners is also considerable, as are young people's ideas about stigma and risk; and social pressures make it difficult to communicate clearly with partners, which makes safer sex less likely. Some of the risk factors for engaging in unsafe sexual activities among the college students are use of alcohol, partner characteristics such as steady versus non-steady partner, and substance abuse (Kanekar & Sharma, 2010).

Several studies have found that pregnancy prevention rather than disease prevention was the reason for condom use (Kanekar & Sharma, 2010). Nesidai, Ng'ang'a, Mwangi, & Wanzala (2011) found that knowledge about the effectiveness of condom use and concern about being at risk for HIV infection, was reported to be unrelated to safe sex. The importance of condom stigma for condom refusal may be explained by its association with HIV stigma (Chandran et al., 2012). A body of literature shows that HIV-related stigma acts as a strong barrier to actual condom use, clearly demonstrating the influence of cultural values and social norms in adopting safer sex behaviours. Chandran et al. (2012) found that the social norms and cultural values expressed as shame associated with condom use that may link using condoms to taboo behaviours such as promiscuous sex may lead to condom refusal even in the presence of other factors facilitating condom use (e.g. knowledge of HIV and condoms, its availability and affordability and belief that condoms can prevent HIV). Additionally, the in-depth exploration of 'condom refusal' identified sexual relationships where condom use may be perceived as less important because

partners know their HIV status and live in stable relationships (Chandran et al., 2012). In Stellenbosch University's KABP study it was found that casual sex is affirmed and supported by some, particularly male students (HEAIDS, 2010).

An AIDS-prevention programme should stress that anyone can get AIDS, regardless of sex, age, race, wealth, health, or sexual orientation (Poureslami, Roberts, & Tavakoli, 2001). Ideas must be generated to help students to translate their beliefs and attitudes about AIDS into safe and responsible sexual activity. An AIDS-prevention programme should establish a link between AIDS knowledge, the negative consequences of getting AIDS and other STIs and condom use.

2.6 HIV Testing

In Opt et al's (2007) study they found that non-tested non-traditional students reported that they might be motivated to get tested if they thought they might have been exposed to HIV or if the testing were part of another medical procedure or care. They also found that a larger percentage of non-traditional students who reported knowing someone with HIV/AIDS were more likely to have been tested than were traditional students. In addition to risk perception and knowledge of HIV, self-efficacy plays an important role in HIV testing (Basen-Engquist in Norwood, 2011). Having the confidence to get tested as well as ask a partner to get tested for HIV is an important tool for prevention (Norwood, 2011). Worldwide, AIDS stigma manifests itself in the form of ostracism, rejection, discrimination and avoidance of HIV infected people, compulsory HIV testing without prior consent or protection of confidentiality, violence against HIV infected individuals or people who are perceived to be infected with HIV, and the quarantine of HIV infected individuals (UNAIDS, in White, Dutta, Kundu, Puckett, Hayes, & Johnson, 2011). Research has shown that people who choose to test for HIV are motivated by several factors, such as having recently engaged in risky sex, being pregnant, having recently used drugs with needles, having had multiple sexual partners, having had a sexually transmitted disease (STD), or knowing someone who is infected with HIV or AIDS (Kakoko, Astrom, Lugoe, & Lie in Norwood, 2011). Deterrents of getting tested for HIV are low perception of risk, fear of receiving positive results, concerns about confidentiality and test affordability, lack of transportation to a testing facility and simply not being offered a test.

2.7 Withdrawal

A Kaiser Family Foundation national survey of sexually active 18–24 year old men and women showed that 43% have ever used withdrawal (also known as coitus interruptus), 20% consider it a safer-sex behaviour and 12% use it regularly (Whittaker, Merkh, Henry-Moss, Hock-Long, 2010). Research indicates that 15% of sexually active males aged 15–19 used withdrawal at last sex, as did 10% of those aged 20–25. The main benefits of withdrawal are that it is more convenient and allows greater intimacy than condoms, while the main drawbacks are concerns about males' lack of self-control and reduced sexual pleasure, mainly for males. In Whittaker et al.'s (2010) study it was found that many of the positive reasons participants gave for using withdrawal is its convenience, lack of side effects, connotations of trust and being more pleasurable than condoms.

They also found that withdrawal is also used as an alternative to and in conjunction with hormonal contraception. Withdrawal was occasionally used in lieu of a condom when one was not available or desired. Relationship development and establishment of trust also played a role in the decision to use withdrawal instead of condoms or hormonal methods. Whittaker et al.'s (2010) study also found that participants occasionally used withdrawal when they had intended to use condoms but condoms had been unavailable, they had gotten caught up in the heat of the moment or they had been intoxicated. The study also found that many participants viewed withdrawal as a popular and accepted part of sexual behaviour and some believed that a man should not ejaculate inside a woman unless she specifically gives him permission to do so.

Chapter 3: Research Methodology

3.1 Research design and methods

The paradigm is qualitative infused in this study. Qualitative research is research based on non-numerical data to answer a research question (Christensen, Johnson & Turner, 2011). During and after data collection the researcher continually attempts to understand the data from the participants' subjective perspectives. The most important task of the qualitative researcher is to understand the insiders' views. Qualitative research is most useful for understanding and describing local situations and for theory generation (Christensen et al., 2011). The research design is content analysis since the peer educators were interviewed. Interviews are good for measuring attitudes and most other content of interest. They allow probing and posing of follow-up questions by the interviewer and they can provide in-depth information. Interviews can provide information about participants' subjective perspectives and ways of thinking. They have relatively high response rates which are often attainable.

3.2 Target population

The target population is the peer educators of the Office for Institutional HIV Co-ordination (OIHC) at Stellenbosch University. The list of peer educators were randomly selected from OIHC's database with the permission of the HIV Prevention Co-ordinator. An electronic invitation was sent to 72 student peer educators during the 2012 academic year at Stellenbosch University. A representative sample of males and females from the diversity groups responded to the electronic invitation and 12 respondents agreed to do an interview of 30 minutes.

3.3 Data collection method

The data collection method was semi-structured interviews. The interviews were done in a closed conference room in the JS Gericke Library at Stellenbosch University from September–November 2012. Appointments were made with the peer educators who responded to the electronic invitation to do an interview. The measuring instrument was the list of interview questions (See Appendix 1). Each peer educator who agreed to do an interview received a letter of informed consent which they signed and they had the option to opt-out of the interview at any time.

Confidentiality during every interview was maintained and in no way could any peer educator be identified.

3.4 Data analysis

Semi-structured interviews with open-ended questions were used. Open-ended questions allowed the participants to freely express their views on the research questions. The interviews were taped on a digital recorder and the interviews were transcribed verbatim by the researcher. Codes were developed from the interview schedule questions and themes emerged during the data analysis.

3.5 Ethical clearance

Ethical clearance was obtained from Stellenbosch University's Research Ethics Committee. After ethical approval was received a list of peer educators' names at Stellenbosch University, were obtained from the Office for Institutional HIV Co-ordination's (OIHC) database, with the permission of the OIHC Manager and the HIV Prevention Manager.

Chapter 4: Data Analysis and Findings

4.1 Participants

An electronic invitation was sent by the researcher to 72 peer educators requesting their voluntary participation in the study. After numerous requests to participate in the study, semi-structured interviews were done with only 12 peer educators, i.e. 3 Coloured males, 2 Black males, 4 White females, 1 Coloured female, 2 Black females. Despite numerous invitations, no White male participants responded to the invitation.

4.2 Reasons for doing the peer education course

The main reasons for doing the peer education course were:

- **Share knowledge with friends**

Two participants wanted to share their peer education knowledge with friends because they don't want anyone to be infected further with HIV. The one participant stated that "*Friends still believe that if the guy doesn't go inside you, you won't be infected*". She aims to go far with the knowledge that she has. Another peer educator's friends kept coming to her for advice on various issues, which is why she did the peer education course. Through the course she became a source of knowledge and support for her friends. Another participant believes that there is a gap between the "textbook stuff" and real life. She intends filling this gap of knowledge as a peer educator.

- **Educating the community**

One of the participants indicated to use his peer education skills and knowledge in the community, especially with the youth. Another participant wanted to make a difference in people's lives, especially in the HIV field.

- **Use information in the workplace**

One participant intends using his peer education skills in the workplace once he has completed his degree and enters the world of work.

- **Informing the church**

After completing the peer education course a participant spoke to everyone about HIV awareness including her church group. Three participants found that the church was not receptive to safe sex messaging.

- **Peer education: A life-changing experience**

One of the participants said that before the peer education course she knew a lot about HIV and AIDS and after completing the course she now has a title, a role, which is more symbolic. One participant felt empowered after completing the peer education course and he aims to have a significant influence over a small group of people in his immediate environment. Another participant did the peer education course in order to gather skills for the work that she wanted to do later in Psychology. For another participant the peer education course led to behaviour change for herself, since she felt that she had to practice what she preaches to fellow students. In general the course became a life-changing experience for everyone who completed it.

4.3 Safe sex messaging experiences

- **Safe sex messaging with females**

One participant found that safe sex messaging was much more challenging with females than with males. Females become more defensive “*They are like: You don’t tell me what to do! This is how I do my thing.*” When her friend asked her to get a pregnancy test and she wanted to know why they did not use condoms the friend responded “*We don’t use condoms. You don’t tell me what to do! He pulls out all the time!*” One participant found that at community outreaches females were more responsive to safe sex messaging. Another participant found that safe sex messaging with females was easier than with males but she discovered that females did not want to openly admit that they were sexually active. A male participant found that females had a problem asking a man to wear a condom.

- **Safe sex messaging with males**

The majority of participants found that on campus males are more receptive to safe sex messaging than females. At community outreaches the response of males to safe sex messaging varied. Males were sometimes much more reserved than females. They would listen to what was being said but that they were set in their ways and were not willing to change their behaviour. At other community outreaches some males were much more receptive to safe sex messaging than females. Males' biggest fear is getting a woman pregnant and not sexually transmitted infections (STIs). They were more concerned about "withdrawal". The majority of female peer educators indicated that safe sex messaging with males was always "weird", since they could not understand how they knew so much about their male sexuality. Males ended up joking about sex and the Choice condoms distributed on campus. If they decided to use condoms they would rather choose any other brand than Choice condoms.

4.4 Condom distribution

- **Condom distribution in the community**

The participants found that when doing condom distribution outside campus that the general public are more resistant to condoms. Some participants provide friends who are sexually active with condoms distributed on campus. The rest of the peer educators did not do condom distribution since only a limited number of them are chosen and receive remuneration to do condom distribution on campus.

- **Condom distribution at men's residences**

The majority of male participants found that men's residences at the university do not have a problem with condoms being placed in their condocans. They joked when a male participant filled their condocans with condoms "*Oh are you the one who puts in the condoms?*" Female participants found that in the male residences the men seemed to be uncomfortable when they filled their condocans with condoms and they started joking and made negative comments about the Choice condoms.

- **Condom distribution at female residences**

The majority of male participants found that female residences have a problem with condoms being placed in their condocans. The women were shocked when the peer educators brought condoms into their residences.

4.5 Persuading people to go for an HIV test

One of the participants experienced difficulty getting people to go for an HIV test, especially in the black community. She found that an HIV test instils fear in people since they believe that they are going to die if they were to test HIV positive. Some students were enthusiastic about going for an HIV test especially if they needed to be persuaded to go for an HIV test. Other people refused to go for an HIV test. It is more difficult persuading males to get an HIV test. They say *“Right now I’m feeling okay. Until something goes wrong with me I don’t feel the need to go and get tested.”* Some males are surprized when female peer educators ask them whether they would consider going for an HIV test. Responses are *“No, no, no, I haven’t been sleeping around!”* or *“There were those who looked at me funny like, What do you think I am?”*

Females are more responsive to go for an HIV test. First-year students are more enthusiastic to go for an HIV test. For them it is fun and a new experience. A problem arises when one of them tests HIV-positive, especially when they arrive at the testing site in a group.

A participant said *“It’s the people that are actually at risk that you struggle with. They have a genuine fear and you can even see how uncomfortable they become when talking to them. Maybe they are at risk and you don’t want to push them. Maybe it’s a sensitive topic for reasons you don’t know and you don’t want to intrude”*.

Some people become defensive when persuading them to go for an HIV test *“I know I’m good, I’m fine. What are you implying?”* People responded in fear and ignorance when asked to go for an HIV test *“I don’t have AIDS, I don’t have HIV, I don’t need to get tested.”* Another person responded that she won’t get HIV because she’s American. The responses from some students were *“White people think HIV is a*

Black thing. Foreigners think it's an African thing." This indicates that some people think HIV is race or culture-specific.

It was found that if people are not sexually active they do not feel the need for an HIV test. They feel they are not at risk. Some people feel that if they don't go for an HIV test then they don't have a problem to deal with. Students have busy schedules. The HIV Campaign takes place in the Neelsie Student Centre and students normally pass through the student centre on their way to class, on the way to another appointment or to have lunch and are not always open to stop and have an HIV test. So students' busy schedules may also be a barrier to students not going for an HIV test.

In the community people do not want to go for an HIV test because they know they have risky behaviour and are afraid of the test result. Some people assume that because they are married they are safe and that they do not need to go for an HIV test.

4.6 The effect of becoming a peer educator on the participants' friendships

The majority of participants become the ones who provide condoms for friends who are sexually active. Some of a participant's friends were pleased that he is a peer educator. A few of his friends would speak to him about their problems, others said that he is doing "the devil's work" because of the condom distribution and were not really responsive to his peer education work. The majority of participants found:

- that the peer education course was beneficial and discovered that friends came to them more often with relationship questions;
- the peer education course gave them more confidence to speak to everyone about HIV issues;
- friends see them as a reliable source of HIV information, relationship information, sexual health and reproductive information and understanding gender dynamics;

- some friends responded to them being peer educators at first with suspicion and ignorance “*You’re doing what? Do you know someone who has AIDS? Do you think you can catch it?*” After a while they were supportive;
- some friends only saw them as being condom distributors.
- becoming a peer educator made no difference to their friendships;
- some friends came to double-check information that they had.

4.7 Challenges in community outreaches

Some participants found that the church had the most protest about their HIV awareness messages and that there was a lot of resistance from the community regarding HIV awareness information. For a few participants there were language barriers and there is a possibility that the HIV information could have been lost in translation. People in the community are not enthusiastic to take condoms. They will stay for a demonstration on how to use a female condom but none of them will take a female condom.

One participant indicated that the community outreaches were more rewarding and more real and more honest. She wanted to know “*Where does HIV live and why am I here?*” since she never had a client test HIV positive on campus. Regarding language the Afrikaans accent was different in the community. A man who was being counselled by a female peer educator was offended that she as a young woman was counselling him on his sexual health. There were many myths about sex, HIV, pregnancies, breastfeeding and tuberculosis in the community. The community was not responsive to peer education information and it was really difficult getting through to people. The youth used “withdrawal” as a form of contraception. The church and the parents left sex education of their children as a responsibility of the school teachers. In the community females were more outspoken than males. Males held on to traditional roles and did not believe that a woman should earn more than a man.

4.8 Risky sexual behaviour

Interview questions 8, 9, 10 & 12 in Appendix 1 were all related to risky sexual behaviour and how the participants would encourage someone to change the risky

sexual behaviour pattern. When challenging someone with risky sexual behaviour all the participants had a non-judgmental attitude. One participant found that when enquiring about risky sexual behaviour some women felt that they were being judged and that their boyfriends were being judged. When asking friends whether they used condoms the response was *“What do you know? You don’t know everything. Do you know him?”* *“Like they are protective of their boyfriends. And I’m like “No”.* It is also really difficult to change people’s attitudes. Responses from friends are *“What do you know about my sex life? I enjoy it. This is how I’m going to do it.”*

All participants agreed that it is difficult challenging someone’s risky sexual behaviour. A participant was aware that a friend has multiple sexual partners and is not using condoms. Despite providing the friend with information on the dangers of risky sexual behaviour there is no attempt to change behaviour. Challenging someone’s risky sexual behaviour is a frustrating experience. Women assume that because they are on oral contraceptives such as the pill they are fine, so they don’t use condoms. They forget about sexually transmitted infections. Behaviour change is difficult.

One participant said *“Often it is so much more than risky behaviour. It’s not the behaviour. The behaviour is just a symptom and my approach, if I know the person well enough, is to find out what the cause is.”* *“And then eventually what happened was we spoke about the reasons she was doing it. And you ask the person and you come to the conclusion you know they are trying to prove a point, what, why? And the behaviour changed.”*

The participants found that alcohol abuse and risky sexual behaviour are linked. *“Students keep saying they were intoxicated because they think that is an excuse for all sorts of unacceptable behaviour.”*

“It’s difficult to change someone who is looking for that kind of pleasure to think why that is not acceptable behaviour.” Too many people are having oral sex without a condom. The person does not realize that he/she is involved in risky sexual behaviour. With men it is about how many sexual partners they can have and they boast about it. With women having a boyfriend is important to be accepted by the

peer group. Women use the morning after pill as a form of contraception since they don't use condoms. They don't insist on condoms in order to keep their boyfriends. People refuse to realize that everyone has a sexual network. One participant also came across the following misconception, *“And another thing that bothers me is that people look at statistics in the wrong way. Someone said that “So few White people have HIV, what are the chances of me getting it from a White person?”*

4.9 The many roles of a peer educator

Juggling the roles of student, role model, a mentor, a mentee, a health promoter, and behaviour-change agent is difficult for one participant and she rather keeps the HIV information with friends informal. For some participants all the different roles have been an adjustment. For other participants all the roles come naturally. All the roles have become part of their everyday life and that the role as peer educator and the way that they have been living their life go hand-in-hand. One participant found that since she knew the facts about HIV, her own behaviour had to change. She found that it's no use telling others to change their behaviour when her own behaviour does not change. Some participants take on a parental-authoritative role with friends since they have become a reliable source of information for them since becoming peer educators. The majority of participants see themselves as a role model for friends. Another participant found that the peer education course has not made a difference to his already exemplary life.

4.10 Support from the peer education supervisor

Most of the participants felt that their peer education supervisor has been very supportive and that the Office for Institutional HIV Co-ordination (OIHC) in general is a welcoming group of people who are non-judgmental and offer guidance. Only one participant felt that if she had a problem she would confide in her friends who are the same age and who experience the same problems that she does. Another peer educator felt that she still has a connection and support from the OIHC since she distributes condoms on campus for them. Other peer educators felt that the OIHC employees are accessible, understanding, approachable and that they are doing good work. Some peer educators, through working together, have built good relationships with other peer educators.

Chapter 5: Recommendations and Conclusion

5.1 Recommendations

HIV education should be integrated into the curriculum since students are the most vulnerable age group to HIV infection. They are in the age group where they experiment with sex, alcohol and drugs without thinking about the consequences of their actions. They are influenced by peer pressure and do whatever their peer group wants them to do. HIV education will help students, especially female students to make informed decisions when it comes to sex. Most of all HIV education is a way of encouraging all students to practice safe sex so that eventually there will be an HIV-free society.

The best way to integrate HIV/AIDS into teaching and learning is to:

- integrate HIV/AIDS into different parts of the curriculum (e.g., foundation year, core courses, specialized modules, extra curricula activity, etc.);
- assess student needs and review where HIV/AIDS knowledge is lacking;
- distinguish between short and long term goals for integration;
- consider the cost implications to ensure that adequate financial resources are provided;
- be more practical to minimize AIDS fatigue among students (AAU Competency-based training in management and leadership for the leadership of African universities, 2012).

HIV prevention efforts must focus on the areas of highest risk for HIV infection. A key emphasis needs to be on disrupting sexual networks by continuously emphasising the importance of not having overlapping sexual relationships and consistently using condoms. This coupled with the need to know the status of one's partner before commencing a sexual relationship would ensure that the university retains its status as a low HIV-infection environment (HEAIDS, 2010).

Stigma remains a concern at Stellenbosch University and stigma reduction programmes need to be part of any programme on HIV prevention and care. Voluntary Counselling and Testing (VCT) services should continue to be promoted in the institutional context. Emphasis should be placed on couples counselling and wider communication should include emphasis on the importance of disclosure of HIV status to sexual partners in relationships where condoms are not used and/or in marital or long-term partnerships. Those undergoing VCT were given an attractive bracelet and encouraged to wear it as a sign that they have undergone VCT. This led to friends enquiring about where the bracelet was acquired, which in turn led to sharing of information about testing services and demand driven VCT. These were such good incentives and a way of getting students to get tested. Unfortunately the suppliers discontinued the manufacturing of the bracelets.

5.2 Limitations

Despite several electronic invitations to 72 peer educators only 12 responded. The small sample size of the participants is due to the peer educators preparing for their final exams so the response to the interviews was very limited. Many peer educators are trained, work for the OIHC for a year to gain work experience in the HIV field then leave, due to academic commitments or because they have completed their studies. The peer educators who continue to work for the OIHC for a longer period are mostly condom distributors or those who completed the Basic HIV Counselling course offered in the second semester. The peer educators then continue to work the following year at the HIV Voluntary Counselling and Testing Campaign in March. Every year a group of new peer educators are recruited, selected and trained.

It was also found that there are limited published reports on the effect of HIV/AIDS peer education on the peer leaders themselves (Pearlman et al., 2002). Therefore more research should be done on peer educators' experiences.

5.3 Conclusion

The work which peer educators do is often underestimated. They are individuals who are trained and go out on campus and into communities educating individuals and groups about HIV and AIDS. They are often met with resistance, ignorance and fear yet they remain enthusiastic to educate everyone. When sharing HIV awareness

information with family, friends and the community, the peer educators were not always met with enthusiasm because people do not want to talk about HIV. In the general public the topic of HIV and AIDS is still a huge stigma and people always underestimate their perception of risk. A condom is such a small mechanism of contraception but a huge form of protection against HIV and other STIs.

The literature and the researcher's findings show that students are more focused on pregnancy prevention than disease prevention. Safe sex should be discussed between couples before they have sex. In reality this does not happen. Regarding condoms, students and the general public were offended when peer educators approached them with condoms. If a woman was using oral contraceptives then people believed that condoms were not necessary. Condom promotion and use is only one of the mechanisms of HIV and STI prevention.

Peer educators were met with resistance when encouraging male students to go for an HIV test. Male students had the impression that an HIV test was for promiscuous people. However if there were incentives for getting an HIV test then the male students were willing to get tested. In the community people are also not open to go for an HIV test since they are married and they believe that they are safe from HIV.

Encouraging people to practice safe sex was not easy for peer educators, since people don't see their behaviour as risky at all. It is also difficult for peer educators to get people who have risky behaviour to go for an HIV test. These people do not see their own behaviour as being risky and they believe that if they don't go for an HIV test then they don't have to deal with the consequences of their behaviour, such as a possible HIV-positive result or an STI. Behaviour-change is a constant work in progress for each individual in the fight against HIV.

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Appendices:

Appendix 1: Interview questions

Appendix 2 : Ethical Approval

Appendix 3 : Permission letter from the OIHC

Appendix 4 : Informed consent form

Appendix 5 : Interview schedule

Appendix 1

1. On completion of your peer education training course what goals did you set for yourself for your work as peer educator?

- Share knowledge with friends.
- HIV prevention, no further infections.
- Peer education focus.
- Educating self about HIV.
- Peer education skills and knowledge to be used in the community, especially the youth.
- Intends using peer education knowledge in the workplace.
- Enthusiastic to share peer education knowledge with everyone, including the church.
- Has become a valuable source of HIV knowledge and information for friends.
- Goal is to do community work and to make a difference in people's lives, especially in the field of HIV.
- Believes there's a gap between the "textbook stuff and real life".
- Intends filling the gap (of knowledge) as a peer educator.
- Knew a lot before the peer education course, but after the course, participant has a title, a role as peer educator, which is more symbolic.
- Felt empowered after doing the peer education course.
- Before the peer education course the participant thought he knew a lot then after the course discovered he didn't know as much as he thought he did.
- Aim is to have a significant influence over a small group of people in the immediate environment.
- Wanted to gather skills for the work that the participant wanted to do later in the Psychology field.

2. As a male/female peer educator what was your experience speaking to the opposite sex about safe sex messaging compared to speaking to someone of the same sex?

- Challenges with safe sex messaging came more from females than males.
- Males more receptive to safe sex messaging.
- The church not in favour of safe sex messaging to the youth.
- Males were much more reserved than females.
- Females were more open to the safe sex messaging.

- Safe sex messaging was comfortable with males, but they were already set in their ways and did not take any new information seriously.
- Males biggest fear is getting a female pregnant than sexually transmitted infections (STIs).
- Males use “pulling out / withdrawal” ” as a form of birth control.
- Safe sex messaging with the opposite sex (males) was always "weird".
- They couldn't understand how female participants knew so much about their sexuality.
- Males joked about safe sex messaging.
- Females accepted the information yet did not openly admit that they are sexually active.
- Safe sex messaging was easier to do with men on campus than with those outside campus.
- Safe sex messaging in the community was easier with males than with females.
- Males always joke about sex.
- Conversations with males revealed that they don't like Choice condoms.
- Conversations with females were about sex, sexuality and gender.
- Found that females have a problem asking males to wear a condom.
- Males don't want to use condoms.
- Males who use condoms prefer other brands than the Choice condoms.
- Gender differences in the responses to safe sex messaging and who

takes responsibility for condoms.

3. When distributing condoms at HIV Awareness campaigns, at hostel condocans or campus condocans were there any difficulties faced or comments made from hostel staff, students, or university staff?

- The general public are more resistant to condoms.
- Male residences don't have a problem receiving condoms.
- Female residences are more resistant to condoms in their condocans.
- Females were uncomfortable when condoms were brought to the female residences.
- Negative comments were made about the Choice condoms.

4. At HIV Awareness campaigns what are the challenges that you faced when walking up to a student and persuading him/her to go for an HIV test?

- Difficult getting people to get tested, especially from the black community.
 - An HIV test instils fear in people.
 - Some people believe they are going to die.
 - Some students were enthusiastic to go for an HIV test, especially if there are incentives for testing.
 - Some people need to be persuaded to test for HIV.
 - Some people refused to go for an HIV test.
 - It is difficult for males to get tested.
 - Females are more responsive and enthusiastic to get tested.
- First-year students are always enthusiastic to go for an HIV test.
 - For them it is a new and fun experience.
 - Difficulty arises when one of them tests HIV-positive, especially if they arrive in a group.
 - It's the people that are actually at risk that you struggle with.
 - They have a genuine fear of going for an HIV test.

- There is still a stigma surrounding HIV.
 - People respond in fear and ignorance.
 - White people think HIV is a "Black" thing.
 - Foreigners think HIV is an "African" thing.
 - If people are not sexually active they don't feel the need to go for an HIV test.
 - If people don't go for an HIV test they don't have a problem to deal with.
 - Students have busy schedules and don't always have the time to stop and take an HIV test.
-
- Males are surprised if asked to go for an HIV test.
 - Men become more defensive if asked to go for an HIV test, unless there is an incentive to get tested.
 - Females are more open to go for an HIV test.

5. Once your peers know that you are a peer educator did they bombard you with questions and advice or did they avoid talking to you about their relationships?

- Had to buy condoms for friends.
- Had to get a pregnancy test for a friend.
- In general friends were happy that a participant is a peer educator and would go to him with their problems.
- Other friends said that he is doing "the devil's work" when referring to the condom distribution.
- Had a few conservative friends who were not really responsive to the peer education work.
- After the peer education course friends are coming with more questions and talking more about their problems.
- After the peer education course the participant is talking more to friends about HIV and sexual health issues.
- Participant has become a reliable source of HIV information, sexual and reproductive health information and gender dynamics.

- Friends were first suspicious of the peer education course but now they are supportive.
- Becoming a peer educator has not made a difference in a peer educator's friendships.
- In general a peer educator's friends came to her to double-check or confirm information which they knew.

6. When doing community outreaches what challenges did you face when going out into the community and talking about HIV issues?

7. How did you deal with language barriers when doing community outreaches in the community?

- Church people were more judgmental about the peer education.
 - They assumed the participant was involved in pornography.
 - Experienced a lot of resistance in the community when talking about HIV issues.
 - People are not enthusiastic about HIV Awareness messages.
 - People in the community are not open to condom distribution.
 - People take the HIV Awareness pamphlets and then throw them away.
 - There were language barriers.
 - Possibility that the HIV message could have been lost in translation.
 - Males were much more reserved than females.
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- Females were more open to the information.
 - People did not want to take condoms.
 - They say they are married and don't need condoms.
 - Females stay for a demonstration on how to use a female condom but none of them take a female condom home.
 - In the community people do not want to go for an HIV test because they know they have risky behaviour.
 - They are afraid of the HIV test result.
 - Some people assume that because they are married they are safe from

HIV and they don't need to be tested.

- Community outreaches were a lot more real and a lot more rewarding.
- Afrikaans dialect in the community was difficult to understand.
- In the community people are honest about how they feel.
- A male client felt that the female participant was too young to counsel him.
- It was difficult to respond to the youth in the community.
- In general the youth were open to HIV Awareness messages.

- In general people were very accommodating.
- People know why you're there.
- People come and collect their airtime and condoms.
- Been doing community work in the same place a few times.
- Discovered that there are so many myths in the community about HIV, sex, pregnancies, breastfeeding, tuberculosis.
- People in the community were not responsive to the HIV Awareness information.

- The youth used "pulling out / retract" as a form of birth control.
- The church and the parents leave the responsibility of sex education to the school teachers.
- There were gender differences when it came to responding to the HIV message.
- Females were more outspoken than males.

- Males held on to traditional gender roles.
- Males did not believe that a woman should be earning more than a man.

8. Being a peer educator can be exciting and challenging. How did you go about challenging someone's risky sexual behaviour?

9. How did you motivate someone to move from a negative to a positive

behaviour change?

10. What was it like for you to go about motivating people to make good decisions about their sexual health?

12. What are the difficulties that you faced when challenging someone's perception about their perceived personal vulnerability about contracting HIV?

- Most females think that you are judging them and their boyfriends.
- It is really difficult to change people's attitudes.
- Participant has a non-judgmental approach to risky behaviour.
- Spoke to someone about the dangers of alcohol and sex, which could lead to risky sexual behaviour.
- Difficult challenging someone's risky sexual behaviour.
- Friend is sexually active but not using condoms, while having multiple partners.
- Provides friend with information on the dangers of risky sexual behaviour yet there is no attempt to change the behaviour.
- Challenging someone's risky sexual behaviour is a very frustrating experience.
- The person did not want to go for an HIV test.
- Females assume that because they are on the pill they do not need to insist on condom use.
- People forget about sexually transmitted infections (STIs).
- Found that it is often so much more than risky sexual behaviour.
- Risky sexual behaviour is just the symptom.
- There is only so much you can do to help someone.
- You can't tell people how to live their life.
- Has a non-judgmental attitude to risky sexual behaviour.
- Found that a sexually active friend does not use condoms.
- People tend to forget about STIs.
- It is difficult to change someone's risky sexual behaviour.
- "Withdrawal" is used as a form of contraception.

- Found that too many people are having oral sex without a condom.
- The person does not realize that they are engaging in risky sexual behaviour.
- Risky sexual behaviour goes together with alcohol misuse.
- With males they want to see how many sexual partners they can have.
- With females it's about having a boyfriend to be accepted by her peers.
- Condoms are not used since sex is not discussed before the time.
- Females use the morning after pill as a form of contraception.
- Some people don't like their risky sexual behaviour being challenged.
- Despite giving someone the facts about HIV they still do not want to go for an HIV test.
- They refuse to realise that everyone has a sexual network.

11. As a peer educator how did you manage your role as a student, a role model, a mentor, a mentee, a health promoter and a behaviour-change agent?

- Juggling the roles is difficult.
- She keeps the HIV education very informal.
- All the roles have been an adjustment.
- Participant has many jobs and roles to juggle but manages to make time for everything.
- The different roles come naturally.
- The roles have become part of the participant's everyday life.
- The role of peer educator and the way that the participant has been living his life go hand in hand.
- The participant felt that since she knew the facts, her own behaviour had to change.
- No use telling others to change their behaviour when your own behaviour does not change.
- The participant takes more of a parental-authoritative role with friends.

- The participant sees herself as a role model who has to remain humble.
- The peer education course has not made a difference to the way the participant has lived an already exemplary life.
- The participant has become more self-aware of the jokes that he used to make before completing the Peer Education course.
- The participant is a role model who is in a committed monogamous relationship for the past few years and always uses condoms.

13. As a peer educator do you feel you received too little or enough support from your peer education supervisor?

14. When you've had a difficult situation or experience any kind of difficulty regarding your peer education duties did you find that you could go to your peer education supervisor for guidance and support?

- Has received support and believes will receive further support from the peer education supervisor.
- Very supportive relationship with peer education supervisor.
- The Office for Institutional HIV Co-ordination (OIHC) offers valuable information and guidance.
- The participant feels that the peer education supervisor is supportive and the OIHC is a very "open" office.
- The OIHC is a welcoming group of people.
- There is a non-judgmental attitude and mutual understanding from the OIHC.
- The participant felt that there is a good support system from the OIHC.
- The participant would prefer to go to fellow peer educators or friends of the same age for support and understanding.
- The participant still has a connection and support from the OIHC because she distributes condoms on campus.
- The participant feels that the OIHC are accessible, understanding and always provides guidance.

- The participant feels that the OIHC is doing good work and they are always approachable.

Appendix 2



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STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

[*The challenges which peer educators face at Stellenbosch University.*]

You are asked to participate in a research study conducted by *Janine Roussouw*, from the *Research Development Department* at Stellenbosch University. *The results will be contributed to a mini thesis.* You were selected as a possible participant in this study because I would like to look at the challenges faced by peer educators at Stellenbosch University.

1. PURPOSE OF THE STUDY

The purpose of the study is to look at the challenges that peer educators face when they work at HIV Awareness Campaigns on campus, when they are doing condom distribution on campus, and when they go out into the community and do safe sex messaging.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

Firstly you would sign a consent form, which means that you are agreeing to share information with me for my study. Please be aware that the information which you give will be confidential and your name or identity will not be linked to the information given. I would like you to answer a few questions for me, therefore I would be doing a face-to-face interview with you. The interview will be an hour. You will be free to opt-out of the interview at any time when you feel uncomfortable. The interview will be conducted in a closed room. Once the interview is done the information will be processed for my study and stored and locked in a cabinet at home. The information will be used for

my mini-thesis for my MPhil in HIV/AIDS. Therefore your participation will be highly valued and appreciated.

3. POTENTIAL RISKS AND DISCOMFORTS

The risk will be minimal and there could be a possibility of a bit of discomfort about sharing the challenges that you faced as peer educator.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The current and new peer educators at Stellenbosch University will benefit from the study. Stellenbosch University's Office for Institutional HIV Co-ordination will also benefit from the study in sustaining and maintaining new peer educators for the programme.

5. PAYMENT FOR PARTICIPATION

Each participant will stand the chance to win a R200 Woolworths voucher. I will randomly draw one name from the list of participant names for the Woolworths voucher.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of [The interviews will be transcribed into a format where each idea of meaning will be coded. The codes will be developed from the interview schedule questions and codes will be added and used if new themes emerge during data analysis. The information will be safe-guarded and locked in a cabinet at home where I will be the only one having access to the data].

[For the purpose of my mini-thesis the information will be released to my supervisor.]

[The interview will be *audio-taped on a digital recorder and each participant will have the right to review their interview only. Myself and my supervisor will be the only people who have access to the*

recorded interviews. After the interviews have been processed and written for my mini-thesis, the information will be erased from the digital recorder.]

[The results of the study will be published and participants names will not be mentioned or revealed in any way.]

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. *[If appropriate, describe the anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent.]*

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Ms Janine Roussouw at janiner@sun.ac.za and Telephone no. 021 8084985 or Mrs Anja Laas at aids@sun.ac.za and Telephone no. 021 8082964, at the Africa Centre for HIV/AIDS.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE
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The information above was described to *[me/the subject/the participant]* by *Janine Roussouw* in *[Afrikaans/English]* and *[I am/the subject is/the participant is]* in command of this language or it was

satisfactorily translated to *[me/him/her]*. *[I/the participant/the subject]* was given the opportunity to ask questions and these questions were answered to *[my/his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study.] I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ *[name of the subject/participant]* and/or *[his/her]* representative _____ *[name of the representative]*. *[He/she]* was encouraged and given ample time to ask me any questions. This conversation was conducted in *[Afrikaans/*English/*Xhosa/*Other]* and *[no translator was used/this conversation was translated into _____ by _____]*.

Signature of Investigator

Date

Appendix 3 : Interview Schedule

1. Interview 1 : 18 September 2012
Time : 13h00 – 13h30

2. Interview 2 : 19 September 2012
Time: 13h00 – 13h30

3. Interview 3 : 26 September 2012
Time: 13h00 – 13h30

4. Interview 4 : 27 September 2012
Time : 13h00 – 13h30

5. Interview 5 : 2 October 2012
Time: 14h00 – 14h30

6. Interview 6: 8 October 2012
Time : 13h00 – 13h30

7. Interview 7 : 10 October 2012
Time : 17h00 – 17h30

8. Interview 8: 19 October 2012
Time : 10h00 – 10h30

9. Interview 9 : 22 October 2012
Time : 13h00 – 13h30

10. Interview 10 : 2 November 2012
Time: 12h00 – 12h30

11. Interview 11 : 12 November 2012
Time : 10h00 – 10h30

12. Interview 12 : 12 November 2012

Time : 12h00 – 12h30

Appendix 4

Interview Questions/ Vrae vir Onderhoude

1. On completion of your peer education training course what goals did you set for yourself for your work as a peer educator?/ Wanneer jy jou peer education opleiding voltooi het watter doelwitte het jy vir jouself opgestel oor jou werk as nuwe peer educator?
2. As a male/female peer educator what was your experience like speaking to the opposite sex about safe sex messaging compared to speaking to someone of the same sex? / As 'n manlike/vroulike peer educator wat was jou ondervinding om met die teenoorgestelde geslag te gesels oor veilige omgang/seks boodskappe in vergelyking met dieselfde geslag?
3. When distributing condoms at HIV awareness campaigns, at hostel condocans or campus condocans were there any difficulties faced or comments made from hostel staff, students, university staff? / Wanneer jy kondome uitgegee het by 'n MIV bewusmakingveldtog, by koshuis kondoom houers, en kampus kondoom houers was daar enige probleem of kommentaar gelever deur koshuis personeel, studente, universiteits personeel?
4. At HIV awareness campaigns what are the challenges that you faced when walking up to a student and persuading him/her to go for an HIV test? / By MIV bewusmaking veldtogte wat was die uitdagings wat jy ervaar het wanneer jy na 'n student gestap het en hom/haar te oortuig om vir 'n MIV toets te gaan?
5. Once your peers knew that you are a peer educator did they bombard you with questions and advice or did they avoid talking to you about their relationships? / Wanneer jou vriende geweet het dat jy 'n peer educator is het hulle jou oorweldig met vrae en advies of het hulle vermy om met jou te gesels oor hulle verhoudings?
6. When doing community outreaches what challenges did you face when going out into the community and talking about HIV issues? / Wanneer jy gemeenskap

uitreikings gedoen het watter uitdagings was daar in die gemeenskap toe jy gesels het oor MIV kwessies?

7. How did do you deal with language barriers when doing outreaches in the community? / Hoe het jy taal hindernisse hanteer wanneer jy uitreikings gedoen het in die gemeenskap?
8. Being a new peer educator can be exciting and challenging. How did you go about challenging someone's risky sexual behaviour? / Om 'n peer educator te wees kan opwindend en uitdagend wees. Hoe het jy te werke gegaan om iemand se riskante seksuele gedrag uittedaag?
9. How did you motivate someone to move from a negative to a positive behaviour change? / Hoe het jy iemand gemotiveer om van 'n negatiewe na 'n positiewe gedrags verandering te gaan?
10. What was it like for you to go about motivating people to make good decisions about their sexual health? / Hoe was dit vir jou om mense te motiveer om goeie besluite te maak oor hulle seksuele gedrag?
11. As a peer educator how did you manage your role as a student, a role model, a mentor, a mentee, a health promoter, and behaviour-change agent? / As peer educator hoe het jy jou rol as student, rolmodel, mentor, mentee, gesondheids promoter, en gedrag veranderings agent hanteer?
12. What are the difficulties that you faced when changing someone's perception about their perceived personal vulnerability about contracting HIV? / Watter probleme het jy ervaar wanneer jy iemand se persepsie wou verander oor hulle beskoude persoonlike kwesbaarheid om die MIV virus te kry?
13. As a peer educator do you feel you received too little or enough support from your peer education supervisor? / As 'n peer educator het jy gevoel jy kry te min of genoeg ondersteuning van jou peer education toesighouer?

14. When you've had a difficult client or experience any kind of difficulty regarding your peer education duties did you find that you could go to your peer education supervisor for guidance and support? / Wanneer jy 'n moeilike klient of ervaring of enige probleem ondervind het as peer educator, kon jy na jou peer education toesighouer gaan vir leiding en ondersteuning?