HIV AND AIDS PRACTICE NEEDS OF PEER EDUCATORS IN THE DEPARTMENT OF SOCIAL DEVELOPMENT IN THE FREE STATE

by

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DECLARATION

I declare that the research study and report, entitled, HIV and AIDS practice needs of peer educators in the Department of Social Development in the Free State, is my own work and that the report has not been previously submitted for a degree at any other university or institution. I have given full acknowledgement to the sources I have used in the research.

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Harry Diamond

DEDICATION

This research study is dedicated to my wife Gina for her generous love and support, my two sons, Nkosinathi and Akhona and my little daughter Neo, particularly for their appreciation of my work and understanding when I could not sing them a cradlesong and bedtime stories during the evenings because I was chasing deadliness.

I wish to further dedicate this to my parents who laid the foundation for my academic and professional aspiration.

To God I declare the glory and everlasting power and I wish to dedicate this and other work that I should still do to His purpose.

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My most important acknowledgement is special thanks to God my Almighty for His everlasting love and forgiveness.

ABSTRACT

The Cognitive theory was utilised in an attempt to understand the HIV and AIDS practice needs of peer educators in the Department of Social Development in the Free State province. The absence of guidelines affects the utilisation of peer educators and thus leads to the under-utilisation of programmes. The practice needs were therefore identified and recommendations were submitted with a view to address existing gaps

Applied research was utilised as findings were used to make suggestions on the development of practice guidelines for programmes used by peer educators. As the researcher was interested in the rich data from peer educators' explanations about their HIV and AIDS practice needs, the most suitable research design for the study was the qualitative design with a collective case study.

Purposive sampling was selected as the most appropriate sampling method within non-probability sampling, as the researcher's own knowledge and judgment of the population, its elements and the nature and purpose of the study, guided him. Within purposive sampling the researcher implemented volunteer sampling by issuing invitations to targeted participants who met specific criteria.

Data collection was conducted through the implementation of two focus groups sessions consisting of 11 participants and eight participants respectively in each group for the duration of 90 minutes. Data collected was analysed using Creswell's analytical spiral.

The planned research was expected to address issues of gaps and practice needs, as well as guidelines necessary for the implementation of the HIV and AIDS workplace prevention programme.

LIST OF KEY CONCEPTS

The following key concepts will be discussed and highlighted:

- HIV;
- AIDS;
- Practice needs;
- Practice guidelines;
- Peer education; and
- HIV and AIDS prevention programmes.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral (treatment/therapy)
EAP	Employee Assistance Programme
EHWP	Employee Health and Wellness Programme
GEMS	Government Employees Medical Scheme
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
PEP	Post-exposure prophylaxis
UNAIDS	Joint United Nations Development Programme on HIV / AIDS

CHAPTER ONE

GENERAL ORIENTATION AND INTRODUCTION

1.1 INTRODUCTION

HIV and AIDS have reached pandemic proportions in South Africa and have serious consequences for individuals as well as for the country's health resources and economy (James & Gilliland, 2005:333; Gallant & Tyndale, 2004:1337; Visser, 2006:93). The impact of the HIV and AIDS pandemic is affecting all spheres of life and all sectors of society and, according to Visagie (2006:iii), the epidemic has reached such proportions that drastic action is needed to stop the spread of the disease.

There are attempts by various disciplines including the psycho-social professions, to mitigate the many and heterogeneous implications linked to HIV and AIDS. Inarguably AIDS is not curable and causes death, even though there is treatment in the form of antiretroviral treatment (ART). According to De Waal (2006:6) Africa's shocking life expectancy regression is overwhelmingly due to AIDS. The International Labour Organization (ILO) (2008:3) reports that "a big fruit processing company in South Africa's northern Limpopo province used to lose at least one worker a month to AIDS".

Although it is well established that AIDS is a deadly disease, it can be mitigated with a treatment programme such as ART. In recent decades there have been increased efforts to make available and facilitate access to ART. Youde (2007:8) argues that the roll-out of the ART programme has been slow citing the fact that "antiretroviral treatment remains out of reach of the vast majority of South Africans who need it". However, in spite of this, there is a realistic indication that the success in curbing the increase in the spread of the virus in South Africa including the workplace is minimal (Booysen, 2004:46).

According to Mphosi (2012), the manager of the Employee Health and Wellness Programme (EHWP) at the Free State provincial Department of Social Development, as well as Moeketsi (2013) assistant manager for the Employee Assistance Programme of the Free State provincial Department of Health, it is evident that the implementation of peer education is ineffective, due to amongst other factors, the lack of resources and guidelines to provide training to peer educators in terms of the provision of preventative interventions.

Thus, in order for the HIV prevention programmes in the Department of Social Development to achieve resounding success, it is necessary to emphasise the importance of a holistic approach where all role players such as management, peer educators, counsellors and the employee organisations are meaningfully involved in the design and implementation of programmes. As the focus of this study will be on peer educators, it is important to understand the concept of peer educators.

Dickinson (2010:27) indicates that workplace peer educators are formally positioned within vertically structured communication programmes run by HIV and AIDS managers and are expected to present talks or training sessions to co-workers on assigned topics. The researcher is of the view that, peer educators are mainly people in any setting, including a workplace, who are involved in assisting their peers or colleagues with specific educational matters such as HIV infection prevention or treatment.

It is thus essential to provide guidelines on peer education as part of the HIV and AIDS workplace programmes to improve on the effective utilisation of peer educators in mitigating the impact of HIV and AIDS in the Department of Social Development. The following key concepts will be highlighted: HIV, AIDS, practice needs, practice guidelines, peer education and HIV and AIDS prevention programmes.

- **HIV**

Singhal and Rogers (2003:391) define HIV as an organism that causes an infection that depletes white blood cells and leads to lessened immunity. HIV refers to the Human

Immunodeficiency Virus which causes AIDS (Page, Louw & Pakkiri, 2006:2; Prince, Louw, Roe & Adams 2006:8).

- **AIDS**

AIDS refers to Acquired Immunodeficiency Syndrome (Page et al., 2006:2; Prince et al., 2006:8). Visagie (2006:1) defines AIDS as "a collection of diseases resulting from the breakdown of the immune system after it has been invaded and weakened by HIV".

- **Practice needs**

The term practice needs refers to the needs of practitioners within a specific occupational or professional body. These needs are identified by the practitioners as their collective or individual needs which have an influence on the performance of their work. Practice needs may include needs such as recognition, support by high authority and autonomy (Page et al., 2006:111).

- **Practice guidelines**

Practice guidelines are a set of practical service tools such as guidelines on how to conduct interviews and on report writing which are developed to guide practitioners on the expected minimum standards of service (Page et al., 2006 104).

- **Peer education**

Peer education is a formal communication programme designed by employers and is conducted by peer educators, who are peers or co-workers in a workplace, who present talks or training sessions on HIV and AIDS related topics (Page et al., 2006:100).

- **HIV and AIDS prevention programmes**

HIV and AIDS prevention programmes are multi-option interventions which are aimed at encouraging behaviour change, and include informational support as a process through which a recipient is provided with information, advice and guidance that can help the recipient avoid HIV and AIDS infection (James & Gilliland, 2005:335).

1.2 THEORETICAL FRAMEWORK

In an attempt to understand the HIV and AIDS practice needs of peer educators in the Department of Social Development, Cognitive theory was utilised (Bergh, 2011:241). With the emphasis nowadays on technology and information processing, Cognitive perspectives are more relevant than they were in earlier days, as cognitive theorists emphasise that cognition plays a vital role in behaviour change. The fact that behaviour varies from situation to situation may not necessarily mean that behaviour is controlled by situations, but rather that the person is interpreting the situations differently. Thus the same set of stimuli, such as practice guidelines, may lead to different responses from different employees or from the same employee at different times (Social Cognitive Theory, 2012:1). According to James and Gilliland (2005:11), the goal of the cognitive model is to help people become aware of, and to change their views and beliefs about situations, because most social and behavioural dysfunction results directly from the misconceptions that people hold about themselves, other people and various life situations (Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2006:392). Misconceptions may occur due to the lack of HIV and AIDS practice guidelines for peer educators.

Hepworth et al., (2006:373) state that Cognitive theorists present a compelling case to the effect that the quality and intensity of emotions experienced in a given situation are largely determined by the perceptions and attributions of meaning associated with that situation. Removing barriers usually enables persons to move several points higher on the readiness scale. Efforts in the Cognitive theory aim to change a person's irrational or faulty thinking and behaviours by educating the person and reinforcing positive experiences that will lead to fundamental changes in the way that person copes (Bergh, 2011:241). Implementing the Cognitive theory may thus lead to the provision of practice guidelines through training that may reinforce positive experiences that may enhance the peer educators' coping skills.

Bergh (2011:241) indicates that according to Cognitive theories, people are rational in thinking and form their own personalities and destiny by using cognitive powers and knowledge to create and change cognitive constructs or plans and processes about reality. Peer educators will thus act according to their acquired thinking or knowledge of HIV and AIDS and will develop according to their cognitive constructs.

Albertyn and Bergh (2011:332) indicate that cognitive psychology explores, inter alia, why people behave differently or have different ideas on issues, for example on HIV and AIDS prevention, and how to act in a new situation. The cognitive psychologist is concerned with answering the following particular questions:

- How is knowledge acquired? Two processes are important here namely perception, the process by which events are detected and interpreted by the person, and learning, the process by which new ideas and behaviours are acquired.
- How is knowledge retained? This lead to the concept of memory.
- How is knowledge used? Some of the prominent uses are thinking, reasoning, problem-solving and decision-making.

Geldenhuys and Ngokha (2011:78) explain that in terms of the cognitive approach, learning involves the acquisition of new knowledge about the world and an ability to perceive objects in the environment as a means towards gaining desired goals. Cognitive theories are thus concerned with how and why people decide to do things. Cognition is also very important in the work environment. The person's intelligence, personality, motivation, memory, perception and attention, as well as the way he/she learns, thinks and solves problems, are all factors that determine how work is done (Albertyn & Bergh, 2011:334). The authors elaborate further that an application of the cognitive approach for training is that if the trainers ask the people to pay attention to some specific aspect of the learning situation, they will learn more quickly than if they had not received the instruction. Training can be instructed using words and symbols (Albertyn & Bergh, 2011:334).

The Cognitive theory was utilised in an attempt to understand the HIV and AIDS practice needs of peer educators in the Department of Social Development. The absence of guidelines affects the utilisation of peer educators and thus leads to the under-utilisation of programmes. The researcher is of the opinion that the utilisation of the Cognitive theory can, underpin the best practice endeavours of peer educators in most HIV and AIDS educational programmes.

1.3 RATIONALE AND PROBLEM STATEMENT

The problem investigated was to establish how the use of practice guidelines can contribute to the success of the HIV and AIDS prevention programmes, particularly regarding the utilisation of peer educators (Creswell, 2003:80). As indicated in the introduction, the impact of the problem is apparent in the success of the HIV and AIDS intervention and prevention programmes. The extent of the research problem revealed that there is limited availability of recently scientifically researched guidelines and manuals that are openly and universally usable and this result in the under-utilisation of peer educators in practice (Bless, Higson-Smith & Kagee, 2006:20).

The researcher acknowledges that, as HIV and AIDS is generally a sensitive matter for instance in terms of trust and confidentiality, employees should play a critical role in workplace-based intervention programmes. The most important motivation for this research was to establish the extent of the existing gap in terms of the availability of satisfactory and dependable information regarding the utilisation of HIV and AIDS practice guidelines in the Department of Social Development.

The problems experienced in practice are that these gaps could have a negative impact on the implementation of HIV and AIDS intervention and prevention programmes. Although the peer educators are generally regarded as semi-professionals, the quality of the service they are expected to render is supposed to meet acceptable standards. Therefore, the quality of the services rendered by peer educators is likely to improve

through this study given the fact that the peer educators will be in a position to identify practice needs in terms of the utilisation of practice guidelines. This will also facilitate the increase of the utilisation rate of the programme within the workplace.

The use of the Cognitive theory, increased both qualitative and quantitative utilisation rates of the programmes in question (Bergh, 2011:241), because the researcher used the Cognitive theory in the context of cognitive learning. Cognitive learning entails obtaining knowledge and understanding and emphasises the changes that take place during the learning process. The utilisation of peer education, which forms part of the HIV and AIDS prevention programme, is likely to improve through this study, as practice needs will be identified and proper plans to address existing gaps in the practice guidelines, will be developed. The study further investigated the specific problems and challenges encountered by peer educators in terms of the implementation of peer education and also provided insight on the practice needs of peer educators.

To address the problem, the study focused on the following research question. What are the HIV and AIDS practice needs of peer educators in the Department of Social Development?

1.4 GOAL AND OBJECTIVES

The goal of the study was to determine the HIV and AIDS practice needs of peer educators in the Department of Social Development. The study seeks as its objectives to:

- conceptualise HIV and AIDS peer education;
- determine the views of peer educators on how they perceive their role in the design and implementation of HIV and AIDS workplace programmes;
- determine what the HIV and AIDS practice needs of peer educators are; and
- make suggestions to the Free State Department of the Premier on the enhancement of HIV and AIDS practice guidelines for peer educators.

1.5 TYPE OF RESEARCH

Applied research was utilised as the findings will be used to develop practice guidelines for programmes used by peer educators (Bless & Higson-Smith, 2005:38; Neuman, 2006:25). The end result of the study will be to improve the utilisation of practice guidelines and manuals to achieve the desired results of peer education in the Department of Social Development. It is therefore relevant to use developmental research as a sub-type of the applied research (De Vos, 2005a:392).

1.6 FEASIBILITY OF THE STUDY

The researcher was granted permission by the Department of Social Development, and after receiving the permission letter, he circulated it to the district managers where the participants are stationed and followed up with telephone calls. Furthermore, the researcher solicited the assistance of the manager of the Employee Health and Wellness Programme (EHWP) to identify the study population and give their contact details. The following matters added value to the feasibility of the study.

- The researcher is also an employee of the Department of Social Development and entry and access to the participants was easy to attain.
- The researcher did not have to travel long and costly distances and was granted leave of absence for the first focus group session and few hours of time off from duty for the second session.
- Although the researcher had to postpone the second focus group session due to poor attendance, he was able to arrange a follow-up appointment in order to ensure that the research process would not be compromised.
- The researcher had access to his employer's computer and email service, however, he purchased a new computer and printer as a back-up to ensure the accuracy of the data capturing and analysis as well as report writing would not be compromised.

- The researcher purchased a voice recorder to aid in the process of data collection.

The researcher contacted the district managers of both Lejweleputswa and Fezile Dabi districts to further confirm the permission to contact the study as well as to finalise the logistical arrangement. Both district managers identified contact persons to help the researcher with the arrangements of the sessions. The process was smooth and practical to execute. The researcher travelled to the workplaces in which the participants are stationed in both districts.

1.7 ETHICAL CONSIDERATIONS

Strict fundamental ethics both in relation to professional codes of practice and basic respect for human life were applied in the study (Bless et al., 2006:140; Neuman, 2000:6; Strydom, 2011:115). Ethical aspects play a critical role in any research project, and even if the project is successful and is conducted in the highest professional manner, the ethical aspects must not be compromised at all. The ethical aspects discussed below were taken into consideration.

- **Avoidance of harm**

Due to the sensitivity around the subject of HIV and AIDS associated with issues such as stigma, discrimination or marginalisation, special care was taken to ensure participants' protection from these and other issues (Babbie, 2005:63). The researcher avoided harm by ensuring that the research questions were tested through pilot testing before the commencement of the main study (Bless et al., 2006:141). It was evident that the questions involved discussing sensitive issues especially on the subject of HIV and AIDS and in addition, the researcher ensured that participants had sufficient chance to ask questions. At the end of each session, the participants were given the opportunity of having a debriefing session where necessary. The researcher explained the reasons for the use of a voice recorder and the participants indicated that they were comfortable in this regard and acceptance in this fact.

- **Voluntary participation**

Participation would not be compulsory or obligatory and participants would thus not be coerced to take part in the research project as forced participation would be violating their fundamental rights of making choices. Central to ensuring 'free-will participation' is to allow the participants to decline to participate if they choose to do so (Bless et al., 2006:142). All participants took part in the study voluntarily.

- **Informed consent**

In order to ensure that the researcher's actions are deemed ethical, participants must provide informed consent to participate in the study (Henning, 2004:73; McLaughlin, 2007:59). The researcher addressed the following aspects in the consent form: the purpose of the study and the procedure to be used in data collection; the use of a tape recorder; the right of the participant to withdraw voluntary from the study at any time; the participant's right to confidentiality; no direct benefits to accrue to the participants in the study; and the signature of both the participant as well as the researcher (Horrocks & King, 2010:110; Creswell, 2009:89). The consent form also informed the participants that information collected from the study would be stored at the Department of Social Work and Criminology for 15 years, according to the policy of the University of Pretoria.

The participants all completed and signed the informed consent form. The consent forms were also used as confirmation of presence and participation of the participants in the study.

- **Deception of participants**

Any uncertainties regarding the research project in terms of the purpose or the questions to be asked were dealt with effectively prior to the research activity (Babbie, 2005:67; Neuman, 2000:229). The researcher withheld no information regarding the study or the researcher from the participants, and made sure to give out information in an honest and transparent manner (Strydom, 2011:119).

- **Violation of privacy, anonymity and confidentiality**

The researcher understood the importance of the participants' privacy and did not in any way violate it. To ensure that violation of the participants' privacy was avoided, the researcher took care to allow the participants to decide when, where, to whom and to what extent their beliefs and behaviour would be revealed (Bless et al., 2006:143; Strydom, 2011:119). It was however, not possible for participants to remain anonymous as they were all involved in focus groups. The researcher also avoided breaching confidentiality as he obtained the participants' consent to share their responses, without sharing any identifiable information (Strydom, 2011:119). The researcher also emphasised that as a social worker, he conforms to the Code of Ethics of the South African Council for Social Service Professions for good practice.

- **Debriefing of participants**

Although there was no harm done to the participants during the study, the subject of HIV and AIDS was sensitive to some of the participants. The researcher arranged a debriefing session for the participants immediately after the focus group session by making use of the services of an expert (Strydom, 2011:122).

- **Publication of the findings**

The research findings will be published without falsification, plagiarism or suppression in the form of a mini-dissertation handed primarily to the University of Pretoria, Faculty of Humanities. The researcher also explained to the participants that the research findings will be incorporated in a scientific article, and may possibly be published in peer-reviewed scholarly journals (Nkadimeng-Malata, 2009:28).

The researcher assured the participants that the process of analysing the data collected would be handled with stringent confidentiality and that the results and findings would be made available to the Free State Provincial government and could be accessed by participants who may be interested.

- **Acknowledgment of participation in the research project**

The researcher compiled a letter of appreciation to each focus group participant including the pilot test participants in appreciation for their participation and sharing of information during the data collection process.

1.8 LIMITATIONS OF THE STUDY

The researcher is of the view that the failure of five participants to arrive was a mood damper even though it did not have probable impact on the validity of the data collected.

It was evident that some of the participants had a small but significant degree of speculative ideas and expectations about the study, as some of the participants wanted to solicit the support of the researcher to assist them with advice on how to deal with the gaps in their programme. The researcher repeatedly indicated that findings of the study will be shared with the Free State Department of the Premier and the recommendations in this regard will be accessible to the management of their programmes.

As the researcher is a member of middle management, some of the participants were inclined to treat him as a senior person and not as a researcher and to some extent this led to some of them feeling overwhelmed and too cautious. The researcher was able to encourage those participants to feel free and respond to the discussion in a relaxed manner.

1.9 OUTLINE OF THE REPORT

The outline of the dissertation is set out below.

CHAPTER ONE: GENERAL ORIENTATION AND INTRODUCTION

Chapter One consists of the general introduction and orientation of the study in terms of the definition of concepts, the rationale and problem statement, the goal and objectives and ethical considerations of the study.

CHAPTER TWO: HIV AND AIDS WORKPLACE INTERVENTION PROGRAMMES

This chapter presents an in-depth literature discussion on HIV and AIDS workplace intervention programmes, with specific reference to peer education.

CHAPTER THREE: RESEARCH METHODOLOGY

Chapter Three describes the research approach, the type of research, the research design and research method, as well as the validity and reliability regarding the study.

CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION

In Chapter Four, the results will be presented after data analysis and interpretation on the HIV and AIDS practice needs of peer educators.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

In the last chapter, conclusions will be drawn and suggestions made to the Free State provincial Department of Social Development on HIV and AIDS practice needs of peer educators.

1.10 SUMMARY

In Chapter One, the researcher presented the background on the HIV and AIDS epidemic which includes statistics regarding the prevalence of the HIV and AIDS epidemic and as well as the opinions of professionals and managers of the Wellness Programmes.

During this chapter an introductory background was also provided in relation to the theoretical framework and the rationale and problem statement relating to the study as well as the goals and objectives of the study.

The researcher also stated that applied research will be used as the type of research and further gave details regarding the feasibility of the study which includes its cost effectiveness of study and confirmation that the researcher was granted permission by the department of Social Development to conduct the study in the department including access to the participants.

In the next chapter, the researcher provided a literature review related to the HIV and AIDS epidemic and will also discuss its historical background with an overview of critical aspects in this regard, which includes the transmission and prevention of the spread of HIV. Furthermore, attention will also be given to the details on how the various sectors of society responded to HIV and AIDS with particular reference to the workplace.

CHAPTER TWO

HIV AND AIDS WORKPLACE INTERVENTION PROGRAMMES

2.1 INTRODUCTION

The chapter intends to provide an in-depth review of literature in terms of the following: an overview of the global HIV and AIDS epidemic in terms of its historic emergence, manifestation and how the world responded to this epidemic. Furthermore, Chapter Two will provide a South African perspective with greater emphasis on the responses of both government and the private sector in terms of policy and strategy development and implementation. The chapter will also describe practice needs and the necessity of peer education.

2.2 HISTORICAL OVERVIEW OF HIV AND AIDS

Scientists discovered the Human Immunodeficiency Virus (HIV) in September 1983 to be the cause of the disease called AIDS (Evian, 2006:3). Walker, Reid and Cornel (2004:12) assert that “the first AIDS cases in South Africa were reported in 1993 and further indicate that at first the epidemic had its greatest impact among minority groups – intravenous drug users, prostitutes and gay men.”

The researcher is in agreement with the observations made and contentions held by the above authors regarding the fact that AIDS was discovered during the 1980’s; however, AIDS might have existed earlier as demonstrated by Fourie (2006:1) who indicates that “in 1982 AIDS claimed its first two South African victims” and Gallant (2012:14) who asserts that “unusual cases of rare infections and cancers began to be seen in gay and bisexual men between 1979 and 1981, and the AIDS epidemic is said to have begun in 1981.”

The researcher is of the view that in recent times AIDS rapidly affected other members of society. Blaming AIDS on men having sex with other men (MSM) can be regarded as homophobia. In relation to the history of the discovery of AIDS in the early 1980's Lawson (2008:22) indicates that, "in the general population, growing fear about AIDS was immediately bound up with homophobic sentiments."

Modise (2005:2) mentions that: "in working with individuals, families and communities, it is important to note that HIV and AIDS have an impact on both the social functioning of the infected and affected." The researcher is of the view that the main general concern for humanity in this regard is that the pandemic is affecting people who are economically active, which could include employees between the ages of 18 and 40 years.

The HIV and AIDS epidemic affects far broader groups of people including women, children and heterosexual members of the society. Kalichman (2009:124) states that "the major mode of HIV transmission in Africa remains vaginal intercourse and asks the question; why has HIV spread through the general heterosexual population in Africa is not a mystery."

2.3 OVERVIEW OF THE GLOBAL HIV AND AIDS EPIDEMIC

There is evidence of a slight decrease in HIV infection in Sub-Saharan Africa in the last decade. According to the Joint United Nations Development Programme on HIV / AIDS (UNAIDS) World AIDS Day Report (2011:7), the total number of new HIV infections in sub-Saharan Africa has dropped by more than 26%, down to 1.9 million (1.7million – 2.1 million) from the estimated 2.6 million (2.4 million – 2.8 million) at the height of the epidemic in 1997. In 22 sub-Saharan countries, research shows HIV incidence declined by more than 25% between 2001 and 2009. This includes some of the world's largest epidemics in Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe. The annual HIV incidence in South Africa, though still high, dropped by a third between 2001 and 2009 from 2.4% (2.1%–2.6%) to 1.5% (1.3%–1.8%). Although these declines bring about a

slight relief, the HIV prevalence is still high as Van Dyk (2012:7, 8) indicates that Southern Africa remains an area most heavily affected by the epidemic in the world.

In terms of the age dimensions and related demographics, it is evident that females who are economically active are still highly vulnerable to HIV infection and prevalence. The estimated 2011 national HIV prevalence was 29.5% (95% CI 28.7-30.2%) showing a slight drop of 0.7% from the 2010 national HIV prevalence. The 2011 confidence interval includes the 2010 point estimate of 30.2% and the 2011 estimate is also in line with estimates from 2007 – 2009. This indicates a stable prevalence of HIV infections among pregnant women aged 15 – 49 years and attending their first antenatal care during their current pregnancy in public health clinics in South Africa over the past five years (National Antenatal Sentinel HIV and Syphilis Prevalence Survey, 2011:iii).

In relation to both gender and age, the researcher sees the HIV prevalence statistics as a reflection and an indication that HIV infection appears to be higher in females than particularly males in the economically active ages. Green and Ruark (2011:187) indicates that “young women in particular have much higher rates of infection than do young men, although HIV prevalence among men often surpasses that among women for adults in their 40s and 50s. Prince et al. (2006:31), concur in this regard and state that “the epidemic is spreading at a faster rate among women than among men.”

2.4 HIV AND AIDS IN SOUTH AFRICA

According to the South African 2010 National Antenatal Sentinel HIV and Syphilis Prevalence Survey Report (Department of Health, 2010a:8), the WHO/UNAIDS model estimated that for the general population, HIV prevalence was about 17.9%. The UNAIDS model also calculated that there were 332,512 new infections for adults above the age of 15 years.

The 2005 National HIV and Syphilis Prevalence Survey Report of South Africa (2005:3) noted that the magnitude and progression of HIV and AIDS was still an important public

health challenge and that there was no significant decline in this regard, in comparison to the 2004 study. In addition to the comparison, the findings of the above-mentioned survey further revealed that there was a distressing proportional increase in the prevalence of both HIV and Syphilis in women aged between 30 to 39 years. Furthermore, it noted that as part of the total research population, there was a relative decline of 0.4% of the female population sample. The reality is that this age group certainly forms part of the reproductive and economically active population and most importantly, the working age category. Despite the decline in the number of participants in the 2005 National HIV and Syphilis Prevalence Survey (2005:12), there is evidence that there is still an increase in the rate of HIV infection amongst women of the age between 30 and 39 years in comparison to the previous surveys.

2.5 THE TRANSMISSION OF HIV

Historically, the highly regarded mode of HIV transmission was perceived to be sexually intercourse by gay or bisexual men; however, other common risk categories were later expanded to include injection drug users, hemophiliacs and Haitians (Gallant, 2012:14). Although the above contention has historical importance regarding transmission, the researcher is of the view that critical and relevant points for discussion include the mode of transmission and prognosis or manifestation of HIV and AIDS post infection.

There is general consensus from the literature regarding the different ways in which HIV is transmitted. Gallant (2012:18) and Van Dyk (2012:38, 42, 46, 48) provide a broad complementary discussion regarding different ways in which HIV can be transmitted as set out below.

- **Sexual transmission**

This can occur during or as a result of sexual activity such as intercourse in which semen, vaginal fluids or blood of an infected person enters the body of an uninfected person.

- **Blood exposure**

HIV can be transmitted when an uninfected person with a cut or open wound is exposed to infected blood; or as a result of blood transfusion and sharing of needles or syringes with positive or infected users.

- **Childbirth and breastfeeding**

An infection can occur when a pregnant HIV positive mother gives birth or during breastfeeding. Similarly, Fan, Conner, and Villarreal (2011:127) also table the same common modes of HIV transmission and expand their explanations as follows.

- **Birth**

Peri-natal transmission from an infected mother to her gestating infant: Essentially this explanation contributes richly to the understanding of the biological nature of transmission. In this regard, Fan et al. (2011:127-133) demonstrate the relationship between the source and target which is the bloodstreams of HIV infected woman and developing fetus respectively, particularly in relation to the birth process in which the child is likely to swallow or come into contact with the cervical fluids or blood due to bleeding linked to delivery. This risk is heightened by lack of proper treatment during pregnancy especially in the form of antiretroviral or antiviral medication.

- **Blood**

Transmission from an HIV infected source to the bloodstream: Two common sources include firstly, receiving a transfusion of HIV infected blood as well as organ transplant, secondly, injecting oneself with HIV infected blood which commonly happens during sharing of needles between individuals or accidentally between HIV infected blood of a patient and a health care worker. The researcher agrees with this assertion, particularly with reference to presence of a syringe as it draws blood and serves as container that provides an isolation of blood from exposure to the external elements. As Fan et al. (2011:129) put it, when blood is kept in a container and is transmitted in the shortest possible time, the blood cells remain alive.

- **Sex**

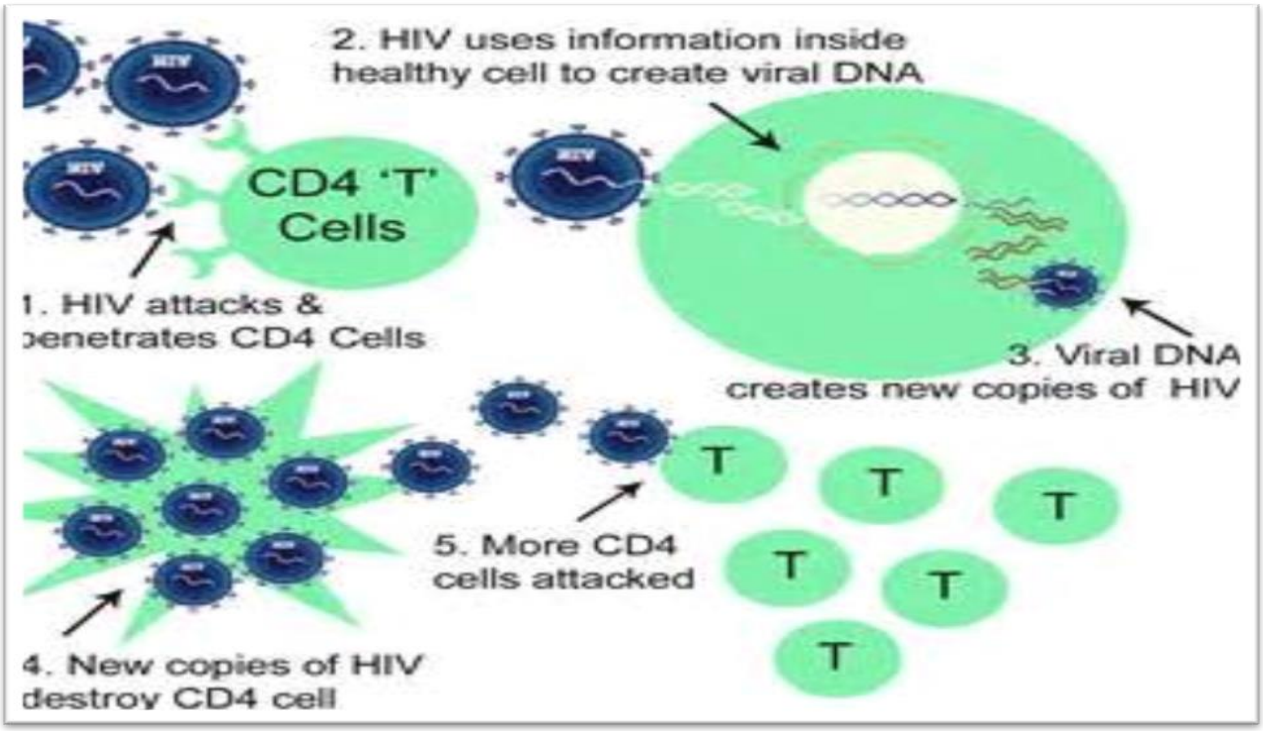
Intimate sexual contact with an HIV infected person: Fan et al. (2011:130-133) emphasise a separation of the theoretical and epidemiological perspectives of this risk. Theoretically, transmission can take place when HIV infected bodily fluid which includes blood, semen and or vaginal secretions make direct contact with an exposed bloodstream of the target site or another person during sexual contact. In epidemiological terms, reference is made to practices such as where oral sex or wet kissing is performed and saliva is exchanged. Although the risks are generally low in this regard, infection may still be possible if HIV infected semen or bodily fluids enters bloodstreams via small tears and or cuts in the lips, mouth or throat during sex.

Table 1: Conceptual framework for HIV infection and transmission

According to Page et al. (2006:29), transmission is the action of causing something to pass from one to another. The researcher submits and describes the transmission process of HIV as follows.

Stages	Process	Description
Contact phase	Exposure and contact with a source	The virus containing bodily fluids gets into contact with the uninfected host or human tissue or organ.
	Entry into the bloodstream	
Asymptomatic phase	Immune system response	Although the bloodstream of human tissues is infected, there are no symptoms of HIV infection.
	Attachment to a bodily or host tissues	The HIV precipitated encoding into immune cells
	Sero-conversion	This is when antibodies (which are generated when the immune system identifies an attack and begins to destroy it) are produced and during this process a person is considered antibody-positive or HIV positive.
HIV symptomatic phase	Symptoms of HIV infection have manifested such as weight loss,	CD4 count less than 499 and above 200. Certain symptoms emerge such as thrush of mouth or vagina necessitating inception of treatment of opportunistic diseases.
Later phase	Progressive stage of HIV infection leading to vulnerability to opportunistic infections	CD4 count is less than 200 and AIDS related opportunistic infections emerge such as cancer. ART is required

Figure 1: Transmission of HIV (AIDSmeds, 2012)



In terms of Figure 1, the researcher is of the understanding that HIV hides its DNA in the DNA of the cell and when the cell tries to make new proteins, it accidentally makes new viruses as well. Page et al. (2006:17) indicate that once the HIV nucleic acid has become part of the host cell nucleic acid, it has gained control over the cell. From this moment on, instead of carrying out its normal activities, the host cell is used to make more copies of the HI virus.

2.6 DIAGNOSING HIV INFECTION AND AIDS

According to Strand, Matlosa, Strode and Chirambo (2005:24-26), there are three different methods of testing HIV infection. The most commonly cited estimate on HIV prevalence is generated through blood tests on a sample of the women who visit antenatal clinics provided by the public health care system, so-called antenatal clinic tests. The second method is the household survey where nationally representative samples of households are visited and individuals are asked to answer a set of questions, as well as to do an HIV test. The third method mentioned involves a more theoretically complex and methodologically demanding statistical modelling. In their explanation Strand et al. (2005:26) indicate that in essence, there are various models which process data on the basis of a set of epidemiological and demographic assumptions, all of which generate projections of, for instance, past, present and future levels of HIV prevalence, numbers of people sick with AIDS related illness and mortality statistics due to AIDS.

Gallant (2012:24) indicates that tests to diagnose HIV infection are highly accurate and demonstrate that with standard blood test (serology), the laboratory first does the enzyme-linked immunoassay (ELISA or EIA). A negative ELISA generally means a person is not infected, though it can be negative if he or she has been infected very recently. If positive, the laboratory automatically runs a second test called a Western blot (WB) (Van Dyk, 2012:98). If both tests are positive, the person is infected. Viral load testing (HIV RNA) and rapid test are also used to detect and test infection although the former is not a perfect diagnostic test whereas the latter is accurate almost instant (Gallant, 2012:24, 25). Van Dyk (2012:97) adds that, “the diagnosis of HIV infection should be based on a combination of the following: assessment of the clinical history of the patient, identification of risk factors, clinical assessment of signs and symptoms and testing for HIV. The researcher has observed that both Gallant (2012) and (Van Dyk, 2012) agree on the same methods of HIV infection diagnosis.

2.7 PREVENTION OF HIV INFECTION AND ITS SPREAD

Over the past three decades, although HIV has proven to be a significant issue affecting amongst others aspects the health, social, economic and political global agenda, it can still be prevented from spreading. It is against this backdrop that the researcher is of the opinion that no simplistic and singular approach would help with the prevention of HIV infection and spread. Green and Ruark (2011:37) share the same view and elaborate further that several decades into the AIDS pandemic, as prevention interventions have seemed to produce so few results, there has been a move away from individual-centric understandings of the epidemic towards an understanding of AIDS as fuelled by structural factors such as poverty, lack of education, gender inequality and other forms of discrimination, and broad-level political and economic forces.

Gallant (2012:20) suggests that, on the basis of the established means of infection or transmission, the following measures can help to prevent HIV infection and its spread.

- **Sexual transmission**

This refers to HIV negative and HIV positive people. In terms of HIV negative people, abstinence is encouraged. However where sexual activity takes place, there is a need to limit the number of sexual partners, engaging in sexual activities other than anal or vaginal intercourse, unless a condom is used and also to avoid semen or bodily fluids such as vaginal fluids into the mouth or eyes. In terms of HIV positive people, condom use is recommended as the most effective means especially if used correctly and regularly.

Although the researcher is in agreement with the sentiments cited above, the following factors are seen as limitations; firstly the source does not explain and emphasise whether it is important or not for sexual partners to know each other's HIV status. Secondly, does not provide a clear understanding as to how HIV infection will be prevented, especially with reference a married HIV negative person especially on having vaginal intercourse and lastly, the concept of limiting number sexual partners is

not explained in this regard in terms of how is this will help with the prevention of the HIV infection in light of the varying complexity of cultural beliefs.

Green and Ruark (2011:79, 81) assert that focusing on changing fundamental risk behaviours such as risky sex or drug use will not only reduce the harm or risk but will also avoid the risk. Furthermore, decreases in risky behaviours (fewer partners) and increases in risk avoidance strategies (abstinence and faithfulness) have been linked to reduced HIV infection rates.

- **Drug use**

Sharing of needles and syringes is discouraged and where sharing is unavoidable decontamination is encouraged. Van Dyk (2012:179) asserts that there is need to emphasise the implementation of primary prevention programmes which includes anti-drug campaigns and rehabilitation, harm reduction and needle exchange and bleach distribution for purpose of sterilising and decontamination.

The researcher agrees with the discouragement of sharing needles and syringes but is not in agreement with the decontamination thereof as it is unclear how this would be done effectively and safely or how often it could be done. According to the researcher this however, does not guarantee safety and low level of risk.

- **Transmission to infants**

The researcher is of the opinion that HIV testing of all pregnant women and not only targeting breastfeeding or exclusive breastfeeding HIV positive mothers should be encouraged. According to Heymann, Sherr and Kidman (2012:173), HIV infection immediately or prior to or during pregnancy can be particularly risky. The researcher is in agreement with the importance of testing all pregnant women only if it is intended to ensure that if the pregnant woman is HIV infected, commencement of effective mother to child prevention treatment will all be done. In this manner, the spread of the disease to the unborn child is limited.

In terms of childbirth, the risk will still be high unless precautionary measures are taken into account. This includes but is not limited to the provision of ART to the mother during labour and to the baby post-delivery and during breastfeeding as a mother is likely to pass the HIV to her baby when the viral load in her blood or breast milk is very high (Van Dyk, 2012:47, 56).

2.8 THE SOUTH AFRICAN AND AFRICAN RESPONSES TO THE HIV AND AIDS EPIDEMIC

2.8.1 Public Health and government policy response

2.8.1.1 Pre-1994 era

The HIV and AIDS epidemic in South Africa emerged during the apartheid era during the 1980s. This was the time in which the country was deeply divided by factors including amongst others: racial, religious, gender and cultural divisions. In 1982 South Africa was governed by a political party bent on racial separation and discrimination (Fourie, 2006:51). Furthermore, there was widespread poverty, an unequal distribution of resource, political instability and widespread ignorance about HIV and AIDS.

The researcher is of the view that the prevailing political tension further nurtured negative and destructive responses towards the HIV and AIDS epidemic. Walker et al. (2004:13) state that unsurprisingly during the apartheid era in South Africa, racial and political attitudes strongly influenced people's attitudes to AIDS. Furthermore, some blacks argued that whites had deliberately spread the disease and that the promotion of condom use was a racist device to curb the growth of the African population. Walker et al. (2004:14) assert that while these debates continued, the region faced the largest and fastest-growing epidemic in the world.

The immensity of discrimination was based not only on racial lines but on sexual orientation as well. Lawson (2008:24) indicates that the apartheid government

considered AIDS to be associated with homosexuality and that the government was not planning to provide any assistance to those affected, as it was the homosexual community's 'own affairs'. In support of this view, Van Dyk (2012:9) indicates that in the 1980s AIDS was seen by the apartheid government as a 'gay' disease that would 'sort itself out' and a general atmosphere of distrust, disinterest and blame prevailed.

Fourie (2006:52) further asserts that during 1982 South Africa had an absence of social cohesion and there was decaying social fabric, great female vulnerability while the economy relied on migrant labour practice. There was much more suspicion that HIV and AIDS had originated from outside the borders of the country especially the central parts of the African continent. Walker et al. (2004:13-14) indicate that several theories stated that the AIDS disease existed for centuries in central Africa and remained undetected due to lack of diagnostic facilities. The country's mining industry bosses were among the most concerned. By now, South Africa's mines were employing nearly three quarters of a million migrant workers (Lawson, 2008:34).

2.8.1.2 Post-1994 era

In the year 1994, the South African political landscape achieved a historic transformational landmark with the election of an inclusive democratic government. A new administration was established for the five year period and undoubtedly this was also a period which the epidemic took its toll on the health care system with rapid increase of infections across the country. Van Dyk (2012:9-10) indicates that HIV infection in pregnant women increased to an estimated 19% in 1998 from 4% in 1994. The researcher identifies three critical factors which manifested during the post 1994 era which are set out below.

- **Denialism and AIDS scandals**

A new form of resisting the reality of AIDS emerged when the government began to debate the question; Does HIV cause AIDS? This did not help in curbing the ravaging deaths caused by AIDS and in soothing the desperation of those affected and infected.

Kalichman (2009:16) indicates that the internet played an important influence to the rise of denialism and states that the best known figure was South Africa's former President Thabo Mbeki who became involved in denialism by surfing the internet. His actions not only contributed to the denial that AIDS was caused by HIV (infection) but also, to the prolonged lack of meaningful policy direction in response to the epidemic. Fourie (2006:154) states that in the year 2000 President Mbeki reiterated his doubts about the South African epidemic and said that poverty and not HIV is the main contributing factor to AIDS. The Mbeki era was characterised by a president who linked up with AIDS dissidents who believed that HIV does not cause AIDS (Van Dyk, 2012:10).

- **Resistance and hesitance to provide lifesaving treatment**

Although a cure for AIDS is still not available, ARVs were available especially for pregnant mothers as amongst others, prevention of mother to child HIV transmission. In the early years of the democratic dispensation, the state was reluctant to provide these treatments through its public health care system. Furthermore, on the reverse of denialism, the state contested that the ARVs were toxic and unsafe.

Van Dyk (2012:10) states that Minister Manto Tshabalala Msimang chose to support intake of untested and unlicensed of vitamin supplements and promoted the consumption of vegetables as an alternative to ARVs. The same views are expressed by Lawson (2008:215) who says that during the year 2000, two drugs namely Azidothymidine (AZT) and nevirapine both appeared to reduce transmission by 50%, however, the minister had rejected the Medicine Control Council's reports confirming that these were safe.

In the recent years post 2008, the state made strides in ensuring that treatment in the form of antiretroviral drugs was made available through the public health care system. Van Dyk (2012:17) reports that in 2009 President Zuma committed to implement the new National Strategic HIV Plan in 2011 and this plan estimated that about 1.3 million South Africans were on ARVs.

2.8.2 Public service and corporate sector workplace response

The HIV and AIDS epidemic had a significant impact on both the public service and the private sectors. The researcher is of the view that some of the areas impacted by the HIV and AIDS epidemic include the recruitment policies, human resource management practices and the most importantly, employee and employer relations. Dickinson (2010:44) suggests that since HIV/AIDS primarily affects those of working age, it makes business sense to prevent HIV infection of workers and ensure, through the use of antiretroviral drugs, so that those already infected can continue working "so that companies don't lose labor, accumulated skills, and experience".

Fourie (2006:78) indicates that the HIV and AIDS epidemic has had an impact in the workplace and mentions that increased absenteeism, low productivity and the general risk of infection are some of the aspects to be considered in the workplace. Van Dyk (2012:464) concurs in this regard and further indicates that there is probably not one single workplace in South Africa that has not been affected by AIDS.

Dickinson (2010:52,66) states that both government departments and the corporate HIV and AIDS workplace response continue to grow in scale and scope, as in many of these employers appoint managers, specialising in HIV and AIDS. Furthermore are policy and legislative frameworks in place such as Code of Good Practice on Key Aspects of HIV/AIDS and Employment issued in the year 2000. The researcher is of the opinion that each workplace needs to develop a policy and strategy to deal with issues of prevention, support and care and the employees should take an active part in the process. Van Dyk (2012:464) urges that effective management of AIDS in the workplace requires an integrated strategy that is based on an understanding and assessment of the impact of AIDS on the specific workplace. According to Van Dyk (2012:464-465), the following six tasks can be considered in developing such a strategy.

Task One – establish a representative AIDS management team.

Task Two – assess the risk and impact of AIDS on the specific workplace.

Task Three – assess the current preparedness, needs and resources of the workplace.

Task Four – develop and implement an AIDS policy.

Task Five – develop and implement an integrated AIDS programme.

Task Six – monitor, evaluate and review workplace policies and programmes.

The researcher agrees with the six tasks as presented above by Van Dyk (2012) but is of the view that task five should emphasise the development of an integrated implementation plan which is critical in the management of HIV and AIDS in the workplace. The researcher designed the following table to make a distinctive and clearer presentation of the six tasks mentioned by Van Dyk (2012).

Table 2: Six tasks for developing an integrated AIDS strategy

Task	Descriptive details
Task One – establish a representative AIDS management team.	• Management team • Steering committee • HIV and AIDS coordinator • Peer educators
Task Two – assess the risk and impact of AIDS on the specific workplace	• Risk and assessment
Task Three – assess the current preparedness, needs and resources of the workplace.	• Needs and resources assessment
Task Four – develop and implement an AIDS policy.	• AIDS policy
Task Five – develop and implement an integrated. AIDS programme.	AIDS Programme to focus on the following activities • Condoms distribution • Training and information sessions • HCT (HIV Counselling and Testing) • Safety (awareness and avoidance of harm) • Wellness programme • ART • Tuberculosis (TB)/STIs – awareness and communication • Community outreach • Awareness campaigns (including commemoration of important calendar of events such as World AIDS day

Task Six – monitor, evaluate and review workplace policies and programmes.	• Ensure monitoring, evaluation and review of the policies and programmes on annual basis

2.9 THE IMPACT OF HIV AND AIDS ON EMPLOYEES

HIV and AIDS is not only a disease or illness but it is also associated with a myriad of social and emotional issues such as, but not limited to, stigmatisation, discrimination, depression and stress. The researcher is of the view that in most cases, employees develop a negative sense of self such as low morale, decreased productivity and there is also an increase in absenteeism. According to Strand et al. (2005:86-88), HIV and AIDS has a negative impact on staff in terms of the increase in levels of morbidity, mortality or early retirement, increased absenteeism and lower staff morale.

Dickinson (2010:25) states that a workplace HIV and AIDS response programme should include education and communication, minimising stigma and discrimination, distribution of condoms, voluntary testing and counselling, wellness programmes, access to treatment and assistance to families and communities.

2.10 COMPONENTS OF AN HIV AND AIDS WORKPLACE PROGRAMME

Dickinson (2005:11) asserts that there is a growing body of literature on issues surrounding HIV and AIDS in the workplace that acknowledges the challenges of responding to HIV and AIDS, but the subject of workplace order, or how the workplace actually operates, is less commonly addressed. The author continues that it is problematic to attribute the breakdown in treatment programmes simply to the fact that they are not the best practice prototypes. It is rather that best-practice policies are not yet fully developed and that managers may sometimes deliberately select which aspects of best practice they wish to implement.

On the other hand, George (2006:179) states that there are companies that implement HIV treatment programmes, but although there is evidence of substantial investment in these programmes, the lack of utilisation of services seems to be evident. The gross results thus fall short of the anticipated returns desired by management, as some companies are experiencing low uptake of voluntary counselling and testing (VCT) coupled with low ART uptake, which suggests a gap through which a large proportion of HIV positive employees are slipping. George (2006:179) also explains that a fair amount of research has been conducted on the impact of HIV and AIDS in the private sector, but much of it remains out of the public domain, as anonymous workplace surveys can generate prevalence estimates for demographic groups that are not represented in antenatal surveys.

As emphasised by Dickinson (2005:11), problems of access and socio-cultural differences will be minimal when peer educators take centre stage in HIV and AIDS awareness activities because their peers accept them more easily compared to the way they accept strangers. Dickinson (2010.27) indicates that workplace peer educators are formally positioned within vertically structured communication programmes run by HIV and AIDS managers and are expected to present talks or training sessions to co-workers on assigned topics. James and Gilliland (2005:52) describe the function of the peer educators as being that of swiftly determining the previous coping skills and environmental resources available to use as a stopgap measure to gain time and provide a modicum of stability in an out-of-control situation.

It is critical to note that in the workplace including the public sector, there is only a limited supply of recent scientifically developed and most importantly, openly shared guidelines and training manuals on peer education. In relation to this statement, a critical gap that exists is the area of the lack of satisfactory and dependable information regarding the prevalence of HIV in the workplace to enable proper planning. James and Gilliland (2005:377) are adamant that planning is of little consequence if no training follows. James and Gilliland (2005:52) warn that without training, guessing may be used, based on previous experience with what does and does not work with a particular

problem. Staff members who have been trained in the appropriate methods, techniques and procedures have increased confidence in their ability. Training should include both knowledge and skill building and should be on-going, with immediate training for new members of the treatment team and continuous education for veterans (James & Gilliland, 2005:377).

The persistently disproportionate distribution of information or guidelines and training manuals on peer education is regrettable taking into account other advancements and developments inter alia, the provision of antiretroviral therapy as part of attempts to deal with HIV and AIDS in South Africa. James and Gilliland (2005:334) explain that a person with AIDS may have many terrifying, uncontrollable physical problems and psychological issues and therefore, the peer educator must be prepared to consider a variety of the person's secondary losses, such as stigmatisation, personal rejection, prejudice, religious rejection, job loss, economic deprivation, discrimination, legal oppression, fear of contagion, guilt, shame and loss of self-esteem.

James and Gilliland (2005:335) are adamant that there is no other outreach more important, challenging or necessary than that done with the HIV and AIDS-positive clientele. Thus, special knowledge, training and attitudes of peer educators who help people in this underserved population deserve special consideration and commendation.

The researcher has however, established that there are no guidelines in certain Free State departments, for instance those of, Health, Social Development and Education. Thus, the findings in the research will largely assist government departments in the Free State that have already implemented HIV and AIDS workplace programmes, to illustrate that all stakeholders are essential in the implementation of successful and robust workplace HIV and AIDS responses. Furthermore, the study intends to add to the knowledge base in practice in the form of the development of a user-friendly guideline that can be customised to address the HIV and AIDS practice needs of peer educators

in the Departments of Health and Social Development. The researcher has identified the following elements and components of the HIV and AIDS Workplace programme.

2.10.1 Voluntary counselling and testing

According to Granich, Gilks, Dye, De Kock and Williams (2009:55), universal voluntary testing and treatment could reduce the incidence of AIDS related stigma and could substantially reduce the incidence of AIDS related disease and death, including from tuberculosis. The researcher is of the view that HIV voluntary counselling and testing should be done with greater professional care and should not only be conducted to gather statistics on the number of persons who are tested HIV positive or negative but should be used as a programme to educate employees and to mitigate against stigma related to HIV and AIDS. Such an HIV and AIDS Workplace Programme should also provide activities related to health screening such as HIV voluntary counselling and testing (HVCT). In the Department of Social Development, this programme is referred to as HIV counseling and testing (HCT) and is conducted by the department's EHWP.

Counselling and testing for HIV should not be separate from the development of relationships and intimacy (Rhodes, McCoy, Omli, Cohen, Champion & Du Rant, 2006:23). The researcher is in agreement with the opinion that a common object of HVCT should be to, amongst others, diagnose the HIV status, to indirectly provide information for prevention and to provide support to the infected. However, the researcher is of the opinion that HVCT should also serve as an educational programme that also improves healthy and relationships and lifestyle. According to the HIV Counselling and Testing Policy Guidelines (Department of Health, 2010b:15), there is a range of circumstances under which HIV testing occurs and this includes the following:

- Among individuals or couples wanting to know their status.
- Among pregnant women participating in the prevention of mother-to-child transmission (PMTCT) programme.
- Clinical diagnosis as part of basic patient care.
- Research and other screening purposes.

- Domestic violence and sexual assault.
- Prior to providing post-exposure prophylaxis (PEP) after a needle stick injury, sexual assault and rape (Acts of sexual penetration - Criminal Law (Sexual Offences & Related Matters) Amendment Act 32 of 2007).
- Per court order of the accused in sexual offence cases.
- Abandoned babies/children to facilitate PEP or placement of the child.
- As a pre requisite for Medical Male Circumcision (MMC)

The researcher is of the opinion that all peer educators need to understand these and other circumstances in order for them to educate their co-workers and peers about issues of HVCT in the workplace.

2.10.2 Condom distribution

According to Rhodes et al. (2006:23), understanding condom use is crucial for the development and evaluation of targeted and or tailored strategies to prevent the risk of disease exposure and transmission. The distribution of condoms in the workplace particularly in the public sector has become a common feature especially in private or secluded areas such as office toilets, corridors and near the office escalators and elevators. The researcher is of the opinion that greater emphasis should be put on education on the use of condoms and this can take various forms such as posters, information leaflets placed in the condoms packages and routine sessions and talks that are conducted by peer educators or external expects. The use of condoms during sex can be regarded as one form of protected sexual intercourse and it is proven to be effective on condition that it is used properly and correctly. Rhodes et al. (2006:11) indicate that although condoms are effective at preventing the transmission of HIV and STDs, their overall rates of use remain low.

There are various myths such as that condoms are unsafe, condoms cause discomfort or interference during sexual activities and general ignorance and misuse of condoms which includes amongst others using one condom with multiple sex partners. Common examples of condom misuse include storing condoms in wallets, using sharp instruments to open condom packages, applying condoms after sex has begun, not

using a new condom when switching from one form of sex to another, and removing condoms before sex is concluded (Rhodes et al., 2006:18).

2.10.3 Peer education

Peer education can play a pivotal role in information sharing and co-worker education due to existing effective communication patterns and sometimes, shared experiences amongst co-workers. Peer education is a formal communication programme designed by employers and is conducted by peer educators who are peers or co-workers in a workplace who present talks or training sessions on HIV and AIDS related topics. Dickinson (2010:26) indicates that peer education is not confined to workplace HIV and AIDS programmes and has been used extensively over a range of issues to educate and assist behavioral change across the globe.

Page et al. (2006:100) describe peer educators as fellow employees who are trusted and respected. Peer education in the context of HIV and AIDS refers to education, learning and awareness of HIV and AIDS related matters in a workplace. To support this assertion, “HIV and AIDS education should not just be a one-way transfer of information but should give workers the chance to discuss their fears and concerns” (Page et al., 2006:105).

Vass and Phakathi (2006:84) in their research on small and medium enterprises found that the apparent disjuncture between levels of knowledge and information about HIV and AIDS in the community and the workplace was raised as one of the key challenge facing workforces. They further state that internal pressure from key employees who have had some exposure to the impact of HIV and AIDS in their personal lives and or communities may be an important factor in galvanising action. Peer education thus forms part of HIV and AIDS infection prevention and also the support effort for affected employees in a workplace.

2.10.4 Practice needs

Practice needs refer to the needs such as handbook, guidelines for practitioners within a specific occupational or professional body that are identified by the practitioners as their collective or individual needs which have an influence on the performance of their work. To select just a few explanatory examples from Page et al. (2006:111) who identifies that a tool needed by an establishment to manage HIV and AIDS in the workplace and indicate that a "toolkit consists of suggestion for managing a company's HIV and AIDS strategy, preventing the spread of HIV and AIDS and communicating HIV and AIDS issues". These practice needs, for example, how to conduct interviews or write a report, can be addressed by practice guidelines. Vass and Phakathi (2006:89) suggest that, "whereas the initial introduction and training of peer educators were successful, maintaining their commitment, upgrading their skills and facilitating access to the workforce were fraught with problems".

Clearly practice guidelines include support, capacity building and the availability of practical service tools which are developed to guide practitioners on the expected minimum standards of service. In the opinion of the researcher HIV and AIDS prevention programmes can be seen as multi-option interventions which are aimed at encouraging behaviour change and include informational support by peer educators, which is a process through which a recipient is provided with information, advice and guidance that can help the recipient to address his or her own problems and potentially change his or her behaviour. In terms of the ILO (2008:26), "Behaviour change is a form of participatory education that encourages people to understand their own attitudes to HIV, assess their own risk, and motivate them to change their behaviour. The programme uses targeted messages and approaches and is implemented through a system of peer education".

2.11 SUMMARY

The in-depth literature review provided sound and meaningful understanding of the historical discovery of the HIV pandemic and the disparities in the way in which how

countries of the world responded to the pandemic particularly in South Africa in terms of the lines of various government regimes. The researcher was also able to source information gainfully on HIV and AIDS as a disease in terms of the process of infection, how it is transmitted and to provide meaningful ways of preventing its spread.

In terms of peer education, the researcher was able to gain a better understanding of the utilisation of peer education as part of the various HIV and AIDS workplace programmes. This part further presented the benefits of peer education and the perceivable shortcoming and challenges experienced by peer educators in certain section of employment.

The next chapter will present the research methodology covering aspects such as the approach and design, how data were collected and presented during the study. the data management processes which includes population sampling, data recording and analysis and pilot testing.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In Chapter Three a detailed demonstration of the method that was used to carry out the research will be provided. Specific attention was given to the approach, the design, sampling method, how data were collected and analysed and the writing of the final report. The researcher also discussed the process by which data was analysed, taking into account the similarities and differences in order to derive themes and sub-themes out of the raw data collected from the participants.

3.2 RESEARCH APPROACH

A qualitative approach was utilised as the researcher intends to understand how the social world of professional practices and intervention programmes are interpreted, understood and experienced (Creswell, 2003:18). The researcher had furthermore, relied on expressions from the participants in the form of words, experiences, language and descriptions to formulate a meaningful understanding from the data gathered (Neuman, 2000:16). As the researcher is not interested in numbers (Babbie, 2005:487) he needed to be flexible and sensitive to the social context or the subject to be studied (Blaikie, 2001:243). Exploratory research was relevant (Babbie, 2005:89; Fouché & De Vos, 2005:106) as the researcher wanted to acquire a better understanding of the gaps in practice relating to guidelines on HIV and AIDS peer education in the Department of Social Development.

3.3 RESEARCH DESIGN AND METHODS

The most suitable research design used for the study was the qualitative design with a collective case study (Fouché, 2005:272; Creswell, 2007:244), as it furthered the understanding of the HIV and AIDS practice needs of peer educators. As any interest in individuals is secondary to the group of peer educators (Fouché, 2005:272), the collective case study further gave a comprehensive and in-depth insight into any existing gaps and how to improve on HIV and AIDS educational programmes for future utilisation or application (Mouton, 2001:150). The choice of a qualitative design was in line with the view of Fouché (2005:272) stating that the case being studied may refer to a process, activity, event, programme or individual, or multiple individuals.

The population, sample and sampling method, methods of data collection, analysis and pilot study will all be discussed below (Creswell, 2009:15). The various aspects that were addressed were set out as follows.

3.3.1 Study population and sampling

The population and subsequently the sampled participants, were members of EHWP employed by the Department of Social Development of Free State provincial government. The government's Employee Health and Wellness Strategic Framework covers a range of programmes such as HIV and AIDS in the workplace which addresses peer education (EH&WSF, 2008:23). The sample of the population targeted 24 male and female peer educators.

There are two basic methods of sampling: probability and non-probability sampling. Non-probability sampling was selected where the probability of each member being drawn into a sample is not known (Strydom & Delport, 2011:392). The researcher used the purposive sampling as the most appropriate sampling method within non-probability sampling, as the researcher's own knowledge and judgment of the population, its

elements, and the nature and purpose of the study guided him (Fouché & Delport 2005:74; Strydom & Delport, 2005:329).. The researcher was also interested in key information gained by targeting individuals knowledgeable about peer education and willing to share information to enrich the quality of the research project (Grinnell & Unrau, 2011:237; Strydom & Delport, 2011:392). The following criteria were encouraged and guided the selection of the participants (Neuman, 2000:196, 198).

- **Above the age of 25 years**

  According to the information that the researcher received from the personnel section about where the participants are employed, the youngest workers are from the age of 25 years. Therefore, the purpose for this criterion is to ensure that these individuals are also selected taking into account that they form part of the most active members of the EHWP in their respective workplaces.

- **Any race group is acceptable**

  The researcher was interested at ensuring that there is no unjustifiable discrimination especially along racial line in as far as recruitment of participants. This was also informed by the fact that health issues such as HIV and AIDS generally affect all racial groups. However, there are misconceptions that tend to influence the behaviour of people and racial classification and perhaps consideration of racial lines is one of them. Walker et al. (2004:13) state that unsurprisingly during the apartheid era in South Africa, racial and political attitudes strongly influenced people's attitudes to AIDS. Furthermore, some blacks argued that whites had deliberately spread the disease and that the promotion of condom use was a racist device to curb the growth of the African population.

- **More than three years in the employment of the specified department**

  The researcher considered the fact that it would add more value to target employees with more experience and stay in an organisation who are likely to be more knowledgeable about their organisation.

- **Involvement in wellness or EAP committees in their respective workplaces**
  The researcher included this criterion because it enabled him to have participants who are exposed to the workplace activities such as EAP committees because of the likelihood that EAP deals with the HIV and AIDS subject. In the main, members of the EAP committees take part in HIV and AIDS activities such as World AIDS day, HIV VCT campaigns and condom distribution and general distribution of information pamphlets and posters.

- **An ability to communicate in English, Afrikaans or Sesotho**
  The researcher was of the opinion that ideally, the participants should be able to communicate in one of the predominant languages spoken in the Free State province and this had encouraged sound communication within the focus groups. According to the Free State Provincial Government website, the following percentage indicates the proficiency of languages in the province namely; Sesotho 64.2%, isiXhosa 7.5% and Afrikaans 12.7%.

Within purposive sampling the researcher implemented volunteer sampling by issuing invitations to targeted participants who met the above criteria (Strydom & Delport, 2005:328). The invitation was sent through coordinators of the EHW committees. The volunteer sampling gave the participants the confidence that they have not been coerced into being part of the study and that their right to privacy has not being violated. The researcher ensured that participants did not pursue any hidden agendas that might have motivated participants to volunteer to be partaking in the study (Strydom & Delport, 2011:394).

3.3.2 Data collection

The researcher utilised focus groups for data collection because they provide a sense of security which eventually contributed to the sharing and collection of rich data (Kumar, 2011:129). The group interviews were facilitated by the researcher to encourage

participants to communicate amongst themselves, ask each other questions, exchange views and comment on the responses of others regarding the topic at hand (Kumar, 2011:128). The researcher perceived that the topic on HIV and AIDS is sensitive in many sectors of the South African society (Burton, 2000:187-188; Bloor, Frankland, Thomas & Robson, 2001:5), but relied on the true feelings of the participants. While collecting data, the researcher was interested in the detailed, rich and holistic information as well as the contextual data that reflect the social reality being studied (Creswell, 2003:18).

The advantages of using the focus group interview include a better understanding of how people feel or think about their HIV and AIDS practice needs. Participants have certain characteristics in common as stated above. The ability to produce concentrated amounts of data on precisely the same topic of guidelines and the synergy of the group both have the potential to uncover important constructs, which may be lost with individually generated data (Greeff, 2011:373; Greeff, 2005:312).

As a disadvantage, Greeff (2011:374) mentions that focus groups can be costly, that they require researchers who are skilled in group processes, and that personal bias can also be a problem. Due to years of experience in practice, the researcher is skilled in group processes (Bless et al., 2006:183), and he tried to avoid bias by involving the passive members and not focusing on the active members alone (Bless et al., 2006:123). By stressing the importance of confidentiality, showing interest in all the participants unconditionally, being friendly to them, having a sense of humour, being a good listener and being open to new ideas and careful planning, the researcher tried to avoid social posturing to be polite and also endeavoured to avoid forced compliance.

The target for the focus groups was twenty four (24) male and female peer educators older than 25 years, divided into two equal groups. During the study 19 participants were reached. The researcher conducted two separate focus groups and had one session per focus group for the duration of 90 minutes (Kumar, 2011:128). The first group consisted of 11 participants and the second group had eight group members

(Greeff, 2011:366). There were two valid reasons for not having reached the targeted 24 participants namely that in the first group, one participant fell ill on the date of the session, and in group two several participants could not attend the group session because they did not have transport on the morning of the session and they communicated their apology in this regard.

Before the commencement of the group session it was necessary to utilise self-introduction approach and the researcher completed an attendance register to acquire the basic details such as age, gender, language and years employed for the purpose of recording the demographic information of each participant (Bloor et al., 2001:39). Although the most recent information usually comes in the first two group meetings with considerable repetition after that, reaching saturation on the discussion or not being able to, will determine whether interviews should be terminated, or more group interviews should be scheduled with participants (Babbie, 2005:317; Babbie & Mouton, 2006:292; Greeff, 2005:306; Kumar, 2011:128).

During the sessions, the researcher made use of questions for the focus groups as a guide to ensure that the data collection process was smooth and seamless (Greeff, 2011:369). In developing the questions for the interview guide, the researcher reviewed the literature and consulted with experts (Greeff, 2005:308). The distinctive feature of the questions was to be open-ended (Bless et al., 2006:124) to avoid a simple yes or no answer. There were no leading questions, and the researcher avoided directing the interviewees' stories in a certain direction (Hennik, Hutter & Bailey, 2011:118) and avoided asking "why" or giving examples (Greeff, 2011:370). He made sure his questions began with simple wording and moved from general to specific questions in a sequence (Greeff, 2005:308). The researcher conducted the focus groups after hours and used his study leave which was available.

Apart from the questions, the researcher structured both sessions in the following manner.

- There were introductions at the beginning of the session.

- The purpose of the research project was explained and the ethical issues were clarified, including permission to conduct the research project.
- The researcher allowed participants to complete the consent forms and ask questions where needed.
- At the end of the sessions, the researcher conducted a brief evaluation of the session which included the questions which had been asked, the professional conduct of the researcher and the use of the data collection tools. All participants indicated that they were happy with all the three areas of the evaluation.

The researcher made use of a voice recorder as the main instrument to collect audio data which was timed with the field notes. The researcher made use of his cellphone to capture the responses and this was only used as a back-up to the voice recorder of the researcher.

3.3.3 Data analysis

The researcher was cautious in making sense of the data captured. He thus moved from raw data to evidence-based interpretations that were the foundation for his report (Creswell, 1998:201). Through data analysis, order, structure and meaning to the mass of collected data were accomplished (De Vos, 2005b:333). Data collected were analysed using Creswell's (1998:142) analytical spiral. However, the guidelines were not followed rigidly, as some steps overlapped, whilst others were done before other steps (De Vos, 2005b:334), bearing in mind that the main activities also moved in circles (Schurink, Fouché & De Vos, 2011:403). The steps are discussed below according to three stages, namely: preparing and organising, reducing, visualising, representing and displaying of data (Schurink et al., 2011:404). During the preparation and organising of data, the researcher attended to the following steps below.

- **Planning for recording of data**

Recording of data took place by means of note taking and the use of a tape recorder, with the consent of the participants. Audio tapes and field notes were used to record all

data. The researcher planned for the recoding of data in a systematic manner that is appropriate to the setting, and to the participants, or both, and that will facilitate analysis (De Vos, 2005b:334).

- **Data collection and preliminary analysis as a two-fold approach**

Both data capturing and analysis occurred simultaneously as the two go hand in hand and have an inseparable relationship that builds a coherent interpretation of data (De Vos, 2005b:335). Thus, data analysis commenced during group interviews on site, as well as away from the site after the focus group interviews (Babbie, 2005:320).

- **Managing the data**

In managing data, the notes and tape-recorded data were organised into file folders, which were converted into text units using a key word or a sentence to make it easy to analyse (Creswell 1998:143).

- **Reading and writing memos**

After the organisation and conversion of the data, transcripts in their entirety were read several times, in order to gain a sense of the focus group interview and to became completely familiar with the data before breaking it into parts (De Vos, 2005b:337). During the reducing of the data (Schurink et al., 2011:410) the researcher attended to the steps listed below.

- **Generating categories and coding the data**

Notes of phrases, key concepts and ideas that emerged were made. Thereafter the classification and generating of categories and identification of themes and patterns, took place (Creswell, 2009:186; Neuman, 2000:424-425). An interpretation was created by making sense of the data, and then the researcher formed a broader picture relating to meanings attached to HIV and AIDS practice needs of peer educators. The researcher reduced the information into smaller parts to simplify the management of the data.

Coding data is the hard work of reducing mountains of raw data into manageable piles by assigning code labels for themes (De Vos, 2005b:338; Neuman, 2003:444). The researcher used specific coding keys to simplify the process by using abbreviations of key words during the focus group sessions (De Vos, 2005b:338).

- **Testing the emergent understandings and searching for alternative explanations**

Following the coding, data was evaluated for usefulness and centrality. The researcher determined how useful the data at his disposal was in illuminating the research question and how central the data was to the story that is unfolding about the HIV and AIDS practice needs of peer educators (De Vos, 2005b:338). As categories and patterns were discovered, the very patterns that had seemed so apparent were challenged. Other plausible explanations for the data were investigated and also the linkages between them, to demonstrate why the explanations offered were the most plausible of all (De Vos, 2005b:339).

- **Interpreting and developing typologies**

The researcher stepped back and formed broader opinions of what was going on with the data (Schurink et al., 2011:416). Data was interpreted by giving meaning or making it understandable. While visualising, representing and displaying the data (Schurink et al., 2011:418) the researcher followed the steps described below.

- **Presenting the data**

Presentation of data was the final phase of data analysis, in which the findings were presented in a written report and the chapters to be included in the final document were outlined (De Vos, 2005b:339).

Kumar (2011:184) states that the four indicators to reflect validity and reliability in qualitative research are credibility, transferability, dependability and conformability. As the purpose of the qualitative study is to explore the experiences, feelings and beliefs of peer educators, they are the best judges to determine whether or not the research

findings have been able to reflect their opinions and feelings accurately. Hence, credibility is synonymous with validity in qualitative research (Kumar, 2011:185) and will therefore, be possible to achieve. Transferability according to Kumar (2011:185), refers to the degree to which the results of the qualitative study can be generalised to other settings. Transferability will be possible to establish due to the extensive and thorough description of the process that the researcher will follow and others can replicate the same process. Dependability, according to Kumar (2011:185) is concerned with whether a researcher would obtain the same results if they observed the same thing twice. Although flexibility and freedom are both advocated in the qualitative study, dependability was possible as the researcher kept extensive and detailed record of the process undertaken, to allow others to replicate to ascertain the level of dependability. Confirmability is similar to reliability in qualitative research and may be difficult to establish as it refers to the degree to which the results could be confirmed by others. For confirmability to be established, it is necessity for researchers to follow the process in an identical manner for the results to be compared (Kumar, 2011:185).

3.4 PILOT TESTING

Although pilot testing is crucial in research (Bless et al., 2006:60; Brown & Dowling 1998:67; Strydom, 2005:206), the pilot testing of focus group questions is difficult and presents special problems, as the questions used in focus groups interviews are hard to separate from the environment of the focus group. Therefore, the true pilot test will be the first focus group to ascertain the level of sensitivity in terms of the impact of the questions and the length of the session (Greeff, 2011:370).

The researcher did pilot testing with team members, experts in the education field and potential participants. These participants were excluded from participating in the main study (Greeff, 2011:370; Greeff, 2005:209). The researcher also familiarised himself with all the necessary operating or technical aspects of the audio recorder (Kumar, 2011:161).

The researcher conducted a pilot test and selected a group of six participants which included the manager and members of the EHWP unit as well as members of the EHWP committees from two child and youth care centers. The group members fulfilled the criteria as stipulated for the participants in the main study. The researcher conducted semi-structured interviews to test the following:

- the relevance of the research questions and the line of questioning;
- the suitable duration of the focus group session;
- the use of the recording apparatus and documentation;

The pilot test provided the researcher with confidence in terms of the line of questioning and facilitation of the session. The researcher identified the following factors as the key benefits of the pilot test.

- The focus group interviews would be conducted satisfactorily within the 90 minutes
- Those who participated in the pilot test indicated that the questions were insightful and relevant to the research topic.
- The researcher was able to identify areas which could be improved such as taking field notes by making use of abbreviations, shortening some of the sentences and identifying respondents by way of codes or numbers and names.
- The voice recorder performed better audio sound when used as a roving microphone in line with the respondents. In addition, the researcher used a cellphone as back-up to the voice recorder.

3.5 SUMMARY

Chapter Three dealt in detail with the research approach, design and methods. An in-depth discussion followed on the scientific data collection process, an analysis of the population and sample and the pilot testing. The next chapter will deal with the

presentation of the data, an in-depth analysis of the data collected and will also provide an interpretation of the results.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

Chapter Four focuses on the presentation, analysis and interpretation of the empirical data based on themes and sub-themes identified from participants' responses. The goal of the study was to determine the HIV and AIDS practice needs of peer educators in the Department of Social Development in the Free State province.

The study used focus groups interviews to collect the empirical data. The focus groups consisted of employees of the Department of Social Development who are participating in the various forms of peer education and support activities which forms part of their workplace's EHWP. Two focus group sessions were conducted separately at different dates and venues.

4.2 PRESENTATION OF DATA

The demographic information of the participants is presented in the form of figures followed by discussions and an analysis of the information presented.

SECTION A

- **AGE DISTRIBUTION**

During the process of identifying and recruiting the participants, the researcher observed that members of the EHWP committees are in the main, chosen by the staff members or fellow co-workers and this implies that the majority of the workforce in the respective workplaces is made up of younger workers. This means that their choices or election of committee members would certainly favour peers in terms of age and other related influences.

Figure 2: Doughnut of age distribution (in years)

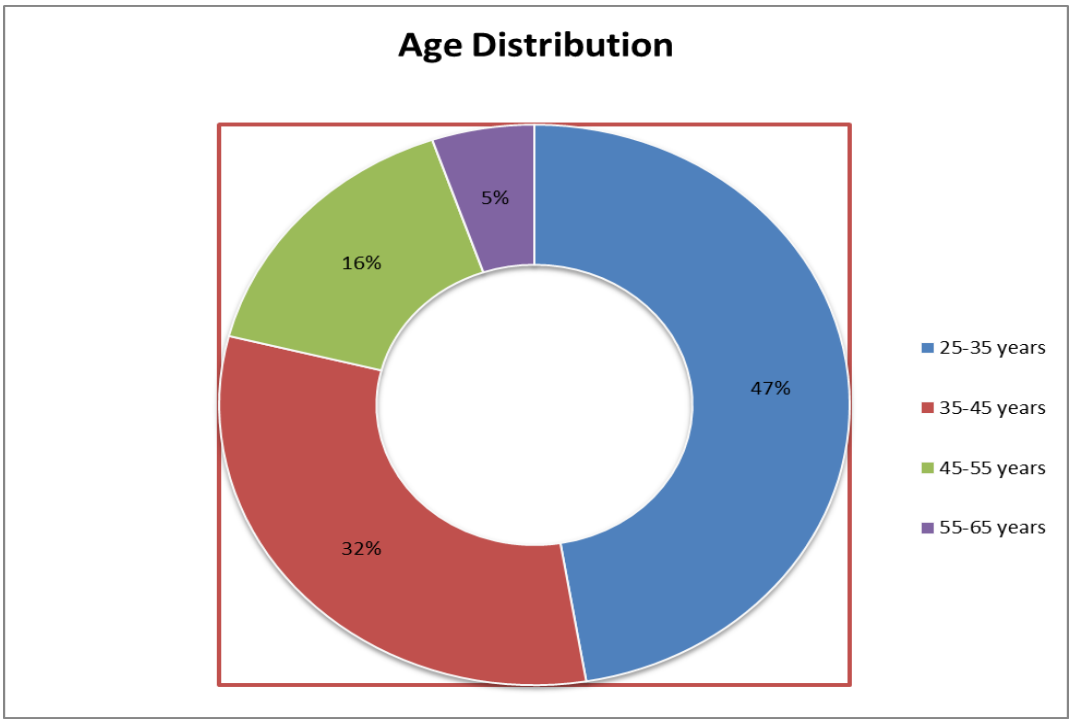
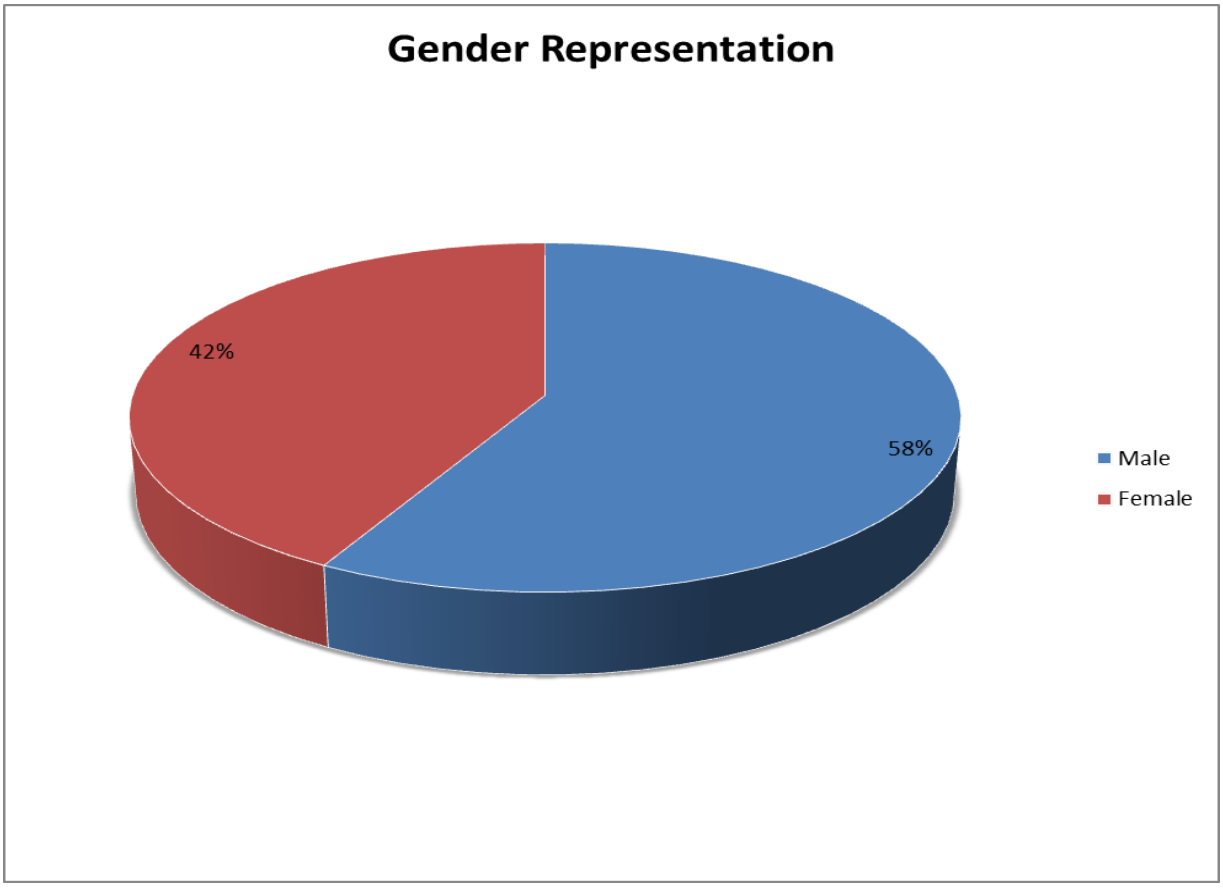


Figure 2 indicated that the majority of the participants (79%) were between the ages of 25 and 45 years. The researcher is of the opinion that peer refers to people of the same age or equals and this is the reason why age distribution was important in this regard. In a study to determine the effectiveness of peer education related to adolescents, Mahat and Scoloveno (2010:373) identified that adolescents feel comfortable when they receive information and relate to information provided by people of the same age group.

- **GENDER**

During the study the researcher did not test gender as the main issue but wanted to understand availability and distribution of female and male peer educators in a workplace particularly with reference to their involvement in the peer education activities.

Figure 3: Pie chart showing gender representation

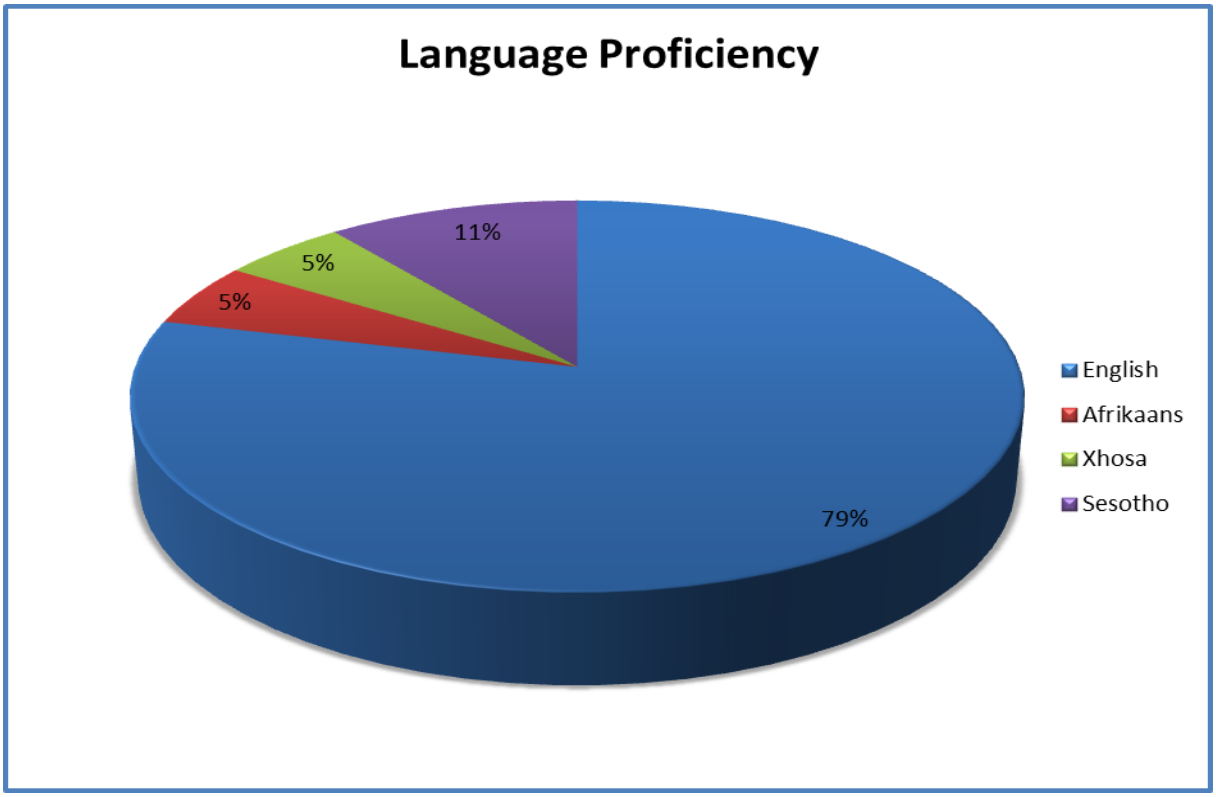


The males constituted the majority of the participants as reflected in Figure 3 and this was a balanced or equal gender representation of the population studied. Although representation of both female and males constituted a requirement for the research population, the balancing of gender representation in the research population was not of significant value and therefore, the outcome of gender representation did not impact in any way on the study.

- **LANGUAGE**

During the research project, the researcher was sensitive to communication barriers especially with regard to language proficiency during data collection. Figure 4 is intended to demostrate the distribution of the language proficiency of the participants.

Figure 4: Pie chart showing language proficiency



In terms of the analysis of the distribution of language, it was evident as depicted in Figure 4 that the majority of the participants were proficient in English (79%), followed by Sesotho (11%), with both Afrikaans and Xhosa being the least (5%). Despite the variety of the languages spoken and understood by the participants, all participants were able to understand questions asked in English; however, those who were proficient in Sesotho preferred to respond in Sesotho. The researcher was able to understand all the languages that were spoken by the participants.

- **EXPERIENCE IN THE EHWP**

The next discussion deals with the experience of participants in the EHWP as well as their years of employment in the Department of Social Development (see Figures 5 and 6 respectively).

Figure 5: Histogram of experience in the EHWP

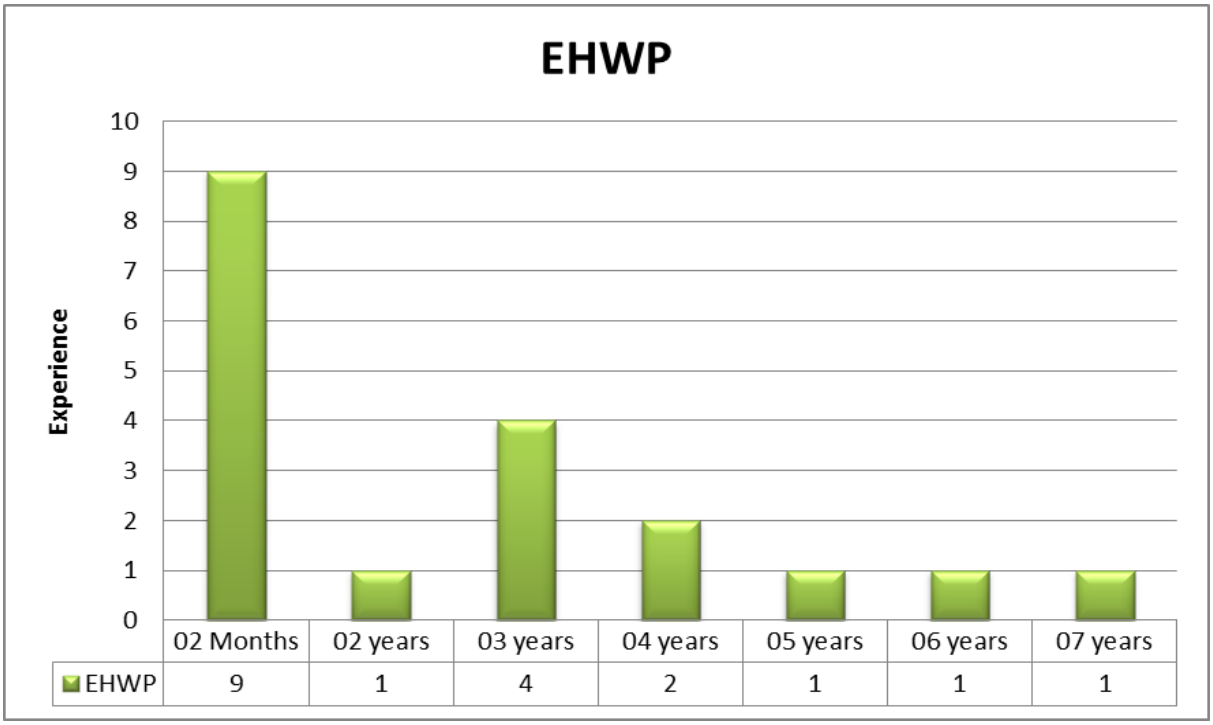


Figure 5 reveals that the majority of the participants have between two and seven years of experience. This added value in terms of the quality of the data that was collected, given the fact that participants with more experience are likely to have gained valuable exposure in the matter studied. The fact that many of the participants had experience of less than one year is indicative of the efficiency of the systems of rotation of members of various EHWP committees. However, this could also present with a negative impact on the sustainability, continuity and seamless implementation of the programme, especially if there is a lack of skills transfer and capacity building.

- **YEARS OF EMPLOYMENT**

Figure 6: Pie chart of years of employment

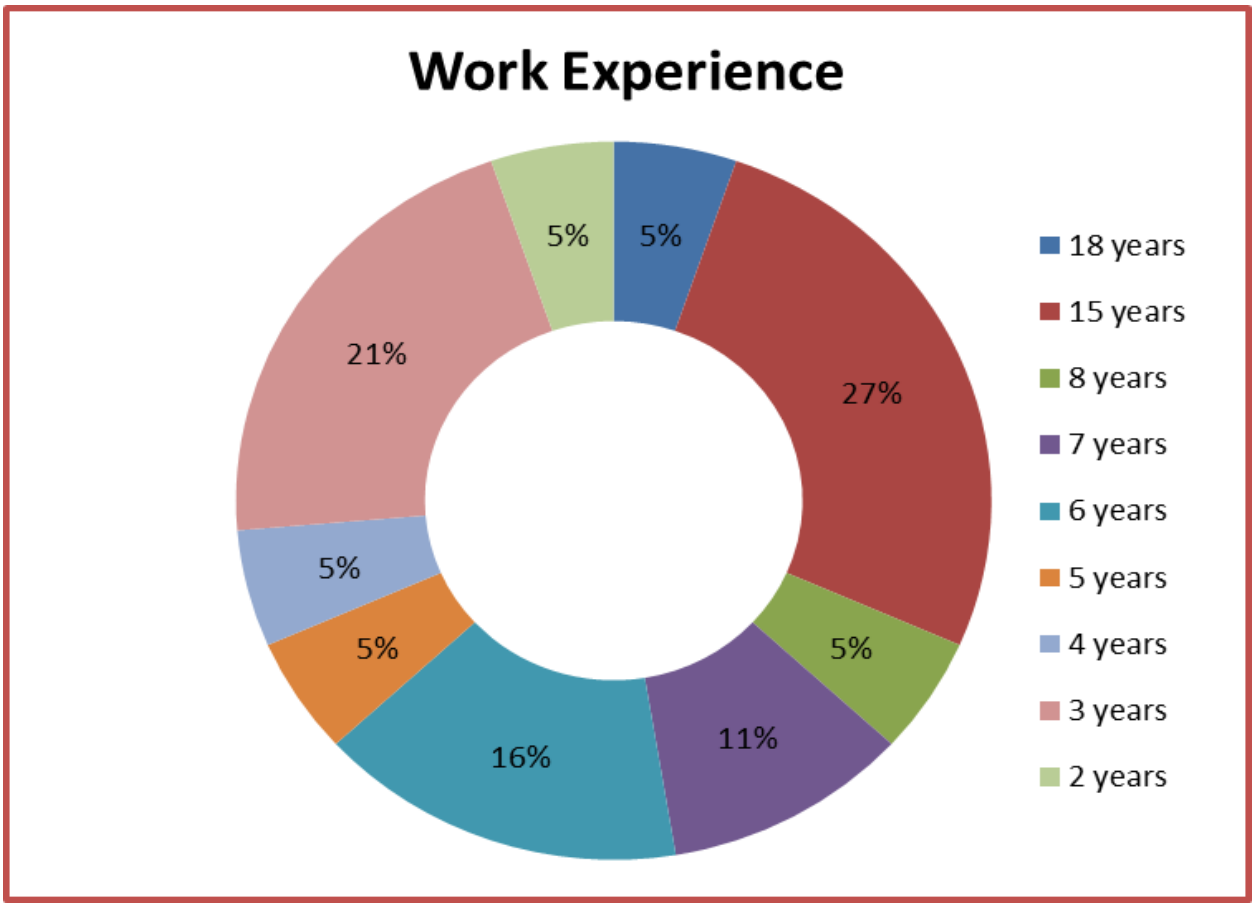


Figure 6 indicates a considerable variance in terms of the years of employment of the participants. A large portion of the participants (27%) have more than fifteen years of employment experience, followed by (21%) of participants with three years of employment experience. This aspect of more years of employment experience is significant in the study as it enriches the value of the data in terms of amongst other factors; knowledge and understanding of the organisational culture, the policies and the various aspects of labour relations within the workplace.

- **ROLE IN THE PROGRAMME**

The participants are involved in various local sub-committees of their workplaces' EHWP such as the Sports and Wellness committee, the Health and Safety committee and the Bereavement committee and they have various roles to play in terms of the activities of their respective sub-committees. This section focused on a discussion and an interpretation of the responses of the participants in this regard. The responses were revealed by the following statements:

- "As a security officer I have always taken interest in sharing information with my fellow colleagues on the importance of taking care of themselves to avoid infection."
- "My role is in terms of information sharing with workers on issues of health and initiate wellness activities."
- "Participation in information sharing with workers."
- "Participate in issues of health and arranging activities concerning calendar of events such as mental wellness."
- Participating in organising health and wellness and physical activities."
- "My role is to participate in raising awareness on HIV and AIDS."
- "My role has been to ensure that workers are aware of their health care and wellness needs."
- I am interested in talking to peers about prevention of HIV transmission and issues around risky behaviours."

The above statements indicate that in terms of the level of experience, the participants have gained a significant level of exposure to the activities of the Wellness Programme as they have taken part in the programme's activities for a period of two to seven years. It seems that the participants do not play a meaningful role in terms of taking the initiative and facilitating activities and most importantly, that they are not necessarily involved in the design and development of the programme. Page et al. (2006:114) indicate that workers should be involved in the design and running of the programme. In support of this view Dickinson (2010:74) indicates that in the workplace, peer educators

would initiate talks with co-workers on a range of issues, particularly HIV/AIDS and other sexually transmitted diseases.

SECTION B

4.2.2 Central themes

Thematic analysis is implemented as strategy for data analysis (Creswell, 2007:75). De Vos (2005:338) maintains that "identifying themes, recurring ideas or language patterns of belief that link people and settings is the most intellectually challenging phase of data analysis". Information gathered from the main study is categorised into the following themes and sub-themes presented in Table 3 below.

Table 3: Themes and sub-themes

Themes	Sub-themes
The focus and activities of the EHWP in presenting the HIV and AIDS programme	• Prevention • HIV testing • Awareness of HIV/AIDS • Distribution of condoms
Peer education and the HIV and AIDS prevention programme	
Personal capacity needs and practice guidelines	• Specific or relevant skills for HIV and AIDS Peer Education • Tools or guidelines utilised in the peer education programme
Review of the programme	• Person(s) responsible for reviews • The role of peer educators during review of the programme
The impact of the peer education activities on the effective utilisation of the HIV and AIDS prevention programme	
An effective HIV and AIDS prevention programme	• Immediate and long-term needs for effective implementation of peer education • Need for improvement in the HIV and AIDS prevention programme

THEME 1: THE FOCUS AND ACTIVITIES OF THE EHWP IN PRESENTING THE HIV AND AIDS PROGRAMME

The first theme identified was prevention, HIV testing, awareness of HIV/AIDS and the distribution of condoms as the sub-themes.

Sub-theme 1.1: Prevention

The sub-theme on prevention was intended to solicit the views of the participants on the existing activities of the EHWP that are related to HIV and AIDS programme and how these activities focus on the prevention of HIV infection. The following quotes are an indication of the responses of the participants:

- "The programme focuses on prevention and I remember there was a session for health screening including HIV testing."
- "The programme focuses on prevention as there are efforts to place posters and information sessions to raise awareness."
- "I would still suggest that an employer should make sufficient time available for workers to attend information session especially on HIV prevention."
- "The programme implementer sometimes organises professional nurses to provide information sessions to workers."
- "I am aware of activities aimed at prevention whereby nurses do come to our workplace to raise awareness on healthy lifestyles and healthy eating."

The quotes by the respondents indicated that the HIV and AIDS prevention programme does focus on information and communication messages such as posters with a view to educating employees on the prevention of HIV infection. However, the peer educators play a less significant part in the implementation of such activities, and it is clear that it is mainly the programme managers and experts such as professional nurses who take an active leading role in this regard. According to Page et al. (2006:115), peer educators see to the daily running of the programme activities and Van Dyk (2012:473) takes this further indicating that peer educators should be used to offer the core of education and training in the workplace.

Sub-theme 1.2: HIV testing

In this sub-theme, participants were expected to provide information on the processes of HIV testing particularly with a view to understanding the practice of HIV testing in the workplace, the frequency of HIV testing and how do the participants perceive the relevance and importance of HIV testing as an integral part of the HIV and AIDS programme. The following excerpts were an indication of the responses of the participants:

- "HIV testing is done in partnership with Government Employees Medical Scheme (GEMS) and activities on HIV Counselling and Testing (HCT) done also in partnership with the SANB."
- "I feel that there is no confidentiality especially with regard to HIV testing."
- "I am not confident to make use of the programme as there is no active marketing of the services rendered by the EHWP. I am also unsure whether my personal information will be handled confidentially by my co-workers."

It is clear that the employer of the participants affords them an opportunity to have HIV testing, but only through an exclusive programme that is conducted by GEMS. It is evident that not all employees are members of GEMS and hence they cannot take part in the HIV testing activities and secondly, the programme is not always readily available as it is dependent on the schedule of GEMS. The third observation is that respondents do not have confidence in the HIV testing process as it appears not to promote confidentiality. Page et al. (2006:105) indicate that many people are aware of HIV/AIDS but there appears to be a lack of basic knowledge about the disease.

Sub-theme 1.3: Awareness of HIV/AIDS

The researcher presented the sub-theme on awareness of HIV and AIDS with a view to discovering from the participants on whether their workplace programme focuses on HIV and AIDS awareness raising activities. The following excerpts were an indication of the responses of the participants:

- "There is insufficient support from management and perhaps this is informed by lack of understanding on what the role of EAP is at the workplace."
- "The matter of HIV receives attention only on 1st December each year. I don't feel awareness on HIV and AIDS is enough."
- "The programme does provide certain activities during World AIDS day where there is commemoration of HIV and AIDS."
- "There is no serious emphasis on HIV and AIDS, except that it is only the World AIDS day where there is something done around HIV and AIDS such as a remembrance prayer and so on and it is just for one day."
- "There are no meaningful activities except commemoration of World AIDS Day."
- "Our co-workers do not know about HIV, especially our lowest level workers as there is no sufficient condom distribution."
- "There is insufficient information especially for workers who cannot read or write and I don't think there is focus. Only members of GEMS benefit from HIV Confidential Testing."
- "There is not enough awareness on HIV prevention because the condom distribution lacks an element of education and the condoms are not available on a regular basis."
- "One of the activities is to place information posters which in most cases will be used to raise awareness on the symptoms of HIV infection."

The responses from the participants indicated that there are no regular awareness raising efforts but instead, only calendar dates of events on HIV and AIDS issues, and that peer education is not central to the programme implementation. Secondly, participation of peer educators depended on programme managers and as a result there is also a lack of confidence from peer educators which results in insufficient attention being given to lower category of the workforce. These responses reiterate the view of Page et al. (2006:112) who state that the workplace programme should take the form of formal and informal education of staff members. Employees should be educated on how to deal with the pandemic, and what should be done to reduce the risks of contracting the disease. Dickinson (2005:11) also states that problems of access and

socio-cultural differences will be minimal when peer educators take centre stage in HIV and AIDS awareness activities because their peers accept them more easily compared to the way they accept strangers:

Sub-theme 1.4: Distribution of condoms

Sub-theme four focused on gaining data on the distribution of condoms, education on condom use and whether the participants find any relevance in, and relationship between, condom distribution and HIV and AIDS workplace programme. The following statements are an indication of the responses of the participants:

- "The challenge with HIV and AIDS is that because we are colleagues at the same level it becomes difficult for colleagues to approach us and disclose their HIV status, but we have been advised by our provincial office to distribute condoms and organise events relating to HIV but not focusing on HIV."
- "I really think indeed the programme does address HIV prevention since there is emphasis and awareness on condom use and faithful relationships. There is a need to improve on issues of communication media such as videos to improve information distribution."
- "I see a need for us as peer educators to organise an expert from the Department of Health to demonstrate how to use condoms, particularly female condoms."
- "I am not sure whether co-workers use the condoms and I feel that there is a need to talk and educate workers about the correct use of condoms."
- "I am unsure if my co-workers use condoms correctly or not."
- "There is a focus on the HIV and AIDS prevention because in my workplace there is distribution of condoms and the EAP provides awareness sessions where they provide advice on symptoms of HIV."
- "There is little care given to the fill-up on condom canisters and I am unsure whether the expiry dates of condoms are considered."
- "Condom distribution is part of reasons I say there is focus on HIV prevention. The role that is played by the media is also valuable in this regard."

- "The focus is on condom distribution, although there is no specific person assigned to ensure that condoms are always available in the various collection points or canisters."
- "I regard distribution of condoms as one of the activities that is taking place at my workplace."
- "I am responsible for the distribution of condoms, although I only collect and distribute these condoms without educating workers how they are used."
- "The last time we had activities at my workplace was when one of my late colleagues was active especially in condom distribution, but since his passing away there is nothing."

Participants were aware of condom distribution, and the HIV testing that is done by GEMS and that a commemoration of World AIDS day is held once a year. The participants linked condom distribution, health screening, HIV testing and displaying of posters to the focus on HIV and AIDS, however, some of the participants are of the view that there is insufficient focus on HIV and AIDS and the literacy of lower level workers is not considered during programme design and implementation. Dickinson (2010:25) indicates that a workplace HIV and AIDS response programme should include: education and communication; minimising stigma and discrimination; the distribution of condoms; voluntary testing and counseling; wellness programmes; access to treatment; and assistance to families and communities.

THEME 2: PEER EDUCATION AND THE HIV AND AIDS PREVENTION PROGRAMME

The second theme identified was intended to attain information on the activities and functions of the peer educators in terms of their HIV and AIDS prevention programme. The following excerpts were an indication of the responses of the participants:

- "Honestly speaking we have not engaged each other especially in a formal setting to talk and educate each other."

- "I have attended workshops myself and I find this unclear whether, when a group of social workers attend such workshops as peers, would this mean peer education or not."
- "We have not done peer education within the wellness programme."
- "We can indeed conduct peer education, but there is no time because of the demands related to our work."
- "I do think that the programme does involve peer education given the fact that after attending information sessions one is able to share with one's peers."
- "Sometimes we are a bit ignorant and do not make use of information from the media such as radio and TV."
- "I think as peer educators we can take time to educate our co-workers on the use of condoms including female condoms."
- "Peer education is optimal and I think our programme is making use of peer education for information sharing."
- "I have been very much involved in the process of peer education and I further regard myself as a peer educator when I share information with my peers even outside work."
- "According to me there is no peer education because I have not seen or heard peers engaging on HIV prevention."
- "There is no peer education at my workplace as in most cases only experts are involved in sharing information."
- "Peer education has been prominent in my community, but not at my workplace. We prefer to keep our issues on HIV to ourselves."
- "There is no peer education at the workplace because co-workers are scared to share private information, and are also shy to talk about HIV and AIDS because it is regarded as a taboo because HIV is still a feared and intimidating topic."
- "There is no provision for the peer educators to meet regularly and it is seldom that they meet."

Although most participants appeared not to perceive or regard their activities as part of peer education, it was evident after the researcher explained the peer education

concept to them, they began to understand and maintain that they have performed peer education at work as well as to their friends and peers by sharing information on HIV and AIDS prevention. However, some of the participants disagreed that their workplace HIV and AIDS prevention programme involves peer education, citing that experts are often used to educate workers. Other participants were of the view that there is no peer education and they were not aware that it is their mandate to have informal or formal talks with co-workers. Dickinson (2010.27) indicates that workplace peer educators are formally positioned within vertically structured communication programmes run by HIV and AIDS managers and are expected to present talks or training sessions to co-workers on assigned topics. James and Gilliland (2005:52) describe the function of the peer educators as being that of swiftly determining the previous coping skills and environmental resources available to use as a stopgap measure to gain time and provide a modicum of stability in an out-of-control situation.

THEME 3: PERSONAL CAPACITY NEEDS AND PRACTICE GUIDELINES

Theme three dealt with attaining data on the practice needs of the participants. Specific and relevant skills for HIV and AIDS peer education and tools or guidelines utilised in the peer education programme were identified as the sub-themes.

Sub-theme 3.1: Specific or relevant skills for HIV and AIDS peer education

In theme three, the researcher intended to identify the specific or relevant skills that the peer educators possess and also to establish whether the participants believe that they need to gain any skills. The following citations were an indication of the responses of the participants:

- “During 2012, I attended a training session offered by one of our colleagues and it covered basic issues such as symptoms, testing and issues around ART and PMTC transmission.”
- “I believe that there are lots of developments in HIV literature and information and what I learned in 2008 and 2013 from the draft development plan on HIV and AIDS, demonstrates that there are many changes.”

- "There is a need to read and to search information on your own. It is very helpful in gaining information on HIV and AIDS."
- "I don't have any relevant skill and I have not attended any form of training or workshop."
- "I received training and information from my union National Education Health and Allied Workers Union (NEHAWU) and I learnt about prevention of transmission and support of infected members."
- "I received training from the Employee Health and Wellness during 2012 focusing on prevention and how to support an HIV positive person. I received training from my union."
- "I received information on HIV from the Employee Health and Wellness during 2009 on issues of prevention and the most common modes of transmission and I also attained a Security Management Diploma in 2013 where I learned about myths of HIV infection."
- "I attended training from National Association of Child Care Workers during 2011, 2012 and 2013 on issue of prevention."
- "I never received training despite the duration of my involvement in the programme."

Participants were never trained as a result they do not have the necessary skills to conduct HIV and AIDS peer education, although they have received information and training on HIV and AIDS. Vass and Phakathi (2006:89) suggest that, whereas the initial introduction and training of peer educators were successful, maintaining their commitment, upgrading their skills and facilitating access to the workforce were all processes are fraught with problems.

Sub-theme 3.2: Tools or guidelines utilised in the peer education programme

Sub-theme three was about tools and guidelines that the peer educators utilise in their peer education programme. The following statements were an indication of the responses of the participants:

- "We don't have guidelines but we depend on Ms. Mphosi who is the manager for the programme at the provincial office."
- "We are guided by the information we get from other departments, what we see on the TV and what we read."
- "I have a module from the training that I have attended as a social worker and it is helpful to me, however, there have been no guidelines."
- "We make use of pamphlets and posters."
- "We issue memorandums and place them on noticeboards."
- "There are no practice guidelines."

There are no clear and readily available tools and guidelines for the implementation of peer education. Page et al. (2006:111) insist that tools are needed by an establishment to manage HIV and AIDS in the workplace and indicate that a toolkit consists of suggestions for managing a company's HIV and AIDS strategy, preventing the spread of HIV and AIDS and communicating HIV and AIDS issues.

THEME 4: REVIEW OF THE PROGRAMME

The fourth theme identified was about the review of the HIV and AIDS programme. The person(s) responsible for reviews and the role of peer educators during the review of the programme, were identified as the two sub-themes.

Sub-theme 4.1: Person(s) responsible for reviews

In sub-theme one, the researcher intended to obtain information from the respondents in terms of the process of the review of the HIV and AIDS programme and to identify persons responsible in this regard. The following excerpts were an indication of the responses of the participants:

- "The challenge is that the provincial office comes once or twice to see and check whether what we do is still relevant."
- "There is no evaluation and review on the successes, increase utilisation and improvement on skills."

- "I am not aware of any review process of the programme."
- "I am aware of the review process through meetings but we don't review the HIV prevention programme but the entire EHWP."
- "I don't think the programme undergoes review because the approach towards doing things remains the same."

The participants' responses indicated that there are no structured and programmatic review processes or formal provision and opportunities such as meetings for review sessions. Van Dyk (2012:473) suggests that Aids programmes should be monitored and evaluated to assess whether the workplace interventions is appropriate, cost effective, if it meets the set objective and if it changes behaviour.

Sub-theme 4.2: The role of peer educators during the review of the programme

Sub-theme two is related to sub-theme one as it was intended to establish the role of the peer educators during the review of the programme. The following quotes were an indication of the responses of the participants:

- "I think it is important to conduct a review of the programme to check the sustainability of the programme at least quarterly and my role should be to make input with information and evaluate activities."
- "There is no review and our role is not clear. There is no feedback."
- "I would prefer us to have regular meetings to observe our performance and even conduct review of the programme."

It is evident that participants are aware of the need for a review of the programme and that they should make inputs to the process through reports and participation in the meetings; however, they are not aware of any review process and their role is unclear in this regard. Dickson (2010:89) is of the opinion that peer education in practice is not just about ticking off the number of talks given, the number of visits to AIDS or orphanages, or the number of conversations about AIDS in the course of the day. Rather peer education should include processes and patterns that, while made up of a string of

discrete interactions, amount to more than the sum total of a completed monitoring and evaluation form.

THEME 5: THE IMPACT OF THE PEER EDUCATION ACTIVITIES ON THE EFFECTIVE UTILISATION OF THE HIV AND AIDS PREVENTION PROGRAMME

The fifth theme identified was about the impact of peer education on the effective usage of the HIV and AIDS prevention programme. The researcher intended to solicit information from the participants regarding their views on whether there is an impact by the activities of peer education have an effect on the HIV and AIDS prevention programme. The following citations were an indication of the responses of the participants:

- "The way we do our work such as showing respect and sensitivity to the workers does impact on the effective utilisation of the HIV and AIDS programme. Show firm leadership."
- "There were effective responses in this regard and one example is the gala dinner which has encouraged workers to have confidence in the programme."
- "Co-workers enjoy exciting outings and outside wellness events in general."
- "Co-workers enjoy activities such as HCT.
- "Chronic illness assessment creates a positive atmosphere, feedback and vibe amongst workers."
- "There are positive responses to the programme such as bereavement support as there are compliments from recipients and co-workers."
- "The committee has good relationships with co-workers and this is due to the positive approach and conduct of the peer educators."
- "Our positive and polite manner of approaching co-workers has a positive influence on the utilisation of the EHWP."
- "I don't think workers are effectively making use of EHWP."
- "Although we are conducting ourselves in a positive manner, our co-workers are not interested in the programme."

There is no evidence that the HIV and AIDS workplace programme has promoted the utilisation of the EHWP of the organisation that employs the participants. This view can also be substantiated by George (2006:179) who states that there are companies that implement HIV treatment programmes, but although there is evidence of substantial investment in these programmes, the lack of utilisation of such services is evident.

THEME 6: AN EFFECTIVE HIV AND AIDS PREVENTION PROGRAMME

The sixth theme was on the effectiveness of the HIV and AIDS prevention programme. The researcher identified immediate and long-term needs of peer educators and needs for improvement in the HIV and AIDS prevention programme as the sub-themes.

Sub-theme 6.1: Immediate and long term needs of peer educators

In sub-theme one information was sought from participants on their immediate and long term needs. The following excerpts were an indication of the responses of the participants:

- "I am new in the programme and have not identified immediate practice needs except that there is a need to have funds allocated to the programme and also there is a need for basic information booklets around HIV in the workplace."
- "Team building activities for the peer educators, training and budget/funds allocation."
- "Clarify the role of EAP for both workers and management."
- "Learn from other companies that there is a need for management to engage the EAP committee and this will help with the utilisation of the programme for other issues such as support for ailing workers and issues of absenteeism."
- "Debriefing and counselling of the peer educators as a form of support since they are confronted with depressing situations."
- "Assist with issues of time management skills, but also issue of late coming."
- "Support that there is need for orientation and training of peer educators to understand what their role is particularly on issues of HIV peer education."
- "I need training and workshops on peer education."

- "I think because we don't have practice guidelines, my immediate needs would be the provision of manuals, electronic media and information guidelines on presentation skills."
- "I think there is a need for support from management especially with regard to the availability of transport and accommodation for workers who attend the activities of the programme."
- "I need training on how to perform first aid on my co-workers."
- "There is a need for policies on the implementation and monitoring of the programme."
- "I think there is a need for the use of social media in order to communicate information on HIV and AIDS prevention and education."

Based on the responses from the participants, peer educators are not provided with the necessary skills to conduct their work and this requires attention from the employer. James and Gilliland (2005:377) are adamant that planning is of little consequence if no training follows. These authors warn that, without training, guessing may be used, based on previous experience with what does and does not work with a particular problem.

Sub-theme 6.2: Needs for improvement in the HIV and AIDS prevention programme

In sub-theme two, the researcher recorded the views of the respondents on the need to improve the HIV and AIDS prevention programme. The following statements were an indication of the responses of the participants:

- "There is a need for guidelines, ability to handle difficult situations such as disclosures, and general training on support for workers. Dealing with stigma and breaking the silence to improve on support and positive prognosis."
- "The issues on ethical conduct such as dealing with gossiping, whispering and the need for education on openness, non-discrimination and issues of

acceptance and open talking. Experience from Transnet where management support and buy-in was visible."

- "HIV needs to be handled like any other illnesses and provision of support. Fight the stigma."
- "There is a need to improve this programme to address information gap issues and awareness campaigns to inform co-workers on the HIV and AIDS."
- "There is a need to improve in the areas of communication media such as using social media and emails."
- "Supervisors and management members are not supportive and buying-in the implementation of the programme, especially with regard to the provision of permission and time-off to attend the activities."
- "The programme is not utilised effectively because management does not support the programme activities to help to engage and encourage workers to attend the programme activities."
- 'I think peer educators need ongoing capacity building through workshops and regular updates on new information and developments in the area of HIV and AIDS in the workplace."
- "There is a need for professionalism, ethical and trustworthy and corrective measures be taken to ensure that the programme in not compromised."

The participants agreed that there is a need to improve the programme by making available practice guidelines, implementation manuals, capacity building and an increase in awareness campaigns. In terms of the ILO (2008:26) behaviour change is a form of participatory education that encourages people to understand their own attitudes to HIV, assess their own risk, and motivate them to change their behaviour. The programme uses targeted messages and approaches and is implemented through a system of peer education. George (2006:179) is of the opinion that there are companies that implement HIV treatment programmes, but although there is evidence of substantial investment in these programmes, the lack of utilisation of services seems to be evident.

4.3 SUMMARY

The purpose of this chapter was to capture and interpret the responses of the participants. The participants gave sufficient and rich information and responded frankly and shared their views without fear and hesitation.

In the next chapter, the researcher further consolidated the outcomes of the analysis and the interpretation of data collected. He formulated the findings of the research project as well as making recommendations for further considerations by the consumers and readers.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The goal of the study was is to determine the HIV and AIDS practice needs of peer educators in the Department of Social Development. An empirical study of a qualitative nature was undertaken and two focus groups were conducted with 19 participants. Relevant literature was reviewed in Chapter Two, and this confirmed that peer educators have specific practice needs such as guidelines, manuals and education or training to conduct peer education in the workplace.

In Chapter Five, the researcher will be revealing the findings of the study by amongst others, making a relation between the literature and the empirical data collected. The purpose of the study is to determine the HIV and AIDS practice needs of peer educators in the Department of Social Development in the Free State province.

5.2 CONCLUSIONS

The following conclusions are made from the findings of the empirical study.

- The participants involved in the Wellness Programme as committee members are mostly black, young, experienced English speaking males, employed for a period of two months to seven years (pages 48 and 49).
- HIV and AIDS education is not done by peer educators, however, information posters and pamphlets on noticeboards are used to communicate information on HIV and AIDS. The challenge with this is that the literacy of lower level workers is not taken into account (pages 52 and 56).

- Although condoms are distributed, there is no certainty that education on the use of condoms is provided (page 57).
- The department's Wellness Programme does not make use of HIV and AIDS peer education and the members of the Wellness Committees are not aware that it is their mandate to have informal or formal talks with co-workers (page 59).
- There is a lack of basic information and knowledge about HIV testing particularly because it seems the peer educators do not take the initiative in making use of other avenues for HIV testing such as the public primary health care services which can provide an added opportunity for HIV testing for fellow workers (page 55).
- Even though some of the peer educators have received some form of training and information on HIV and AIDS prevention, the rest have not received any relevant training and do not have skills to conduct HIV and AIDS peer education (61).
- There are no standard practice guidelines, such as educational materials and manuals for peer educators to use during their engagement with co-workers. They make use of pamphlets and information manuals from external sources which are sometimes generic in nature (page 62).
- There is a need for routine review of the HIV and AIDS prevention programme, but there is no review of the programme as well as provision and opportunities for meetings for review sessions (page 63).
- The utilisation of the HIV and AIDS programme is overshadowed by other wellness activities such as sports outings for workers, and HIV and AIDS is receiving attention only during World AIDS day and seldom during HIV Counselling and Testing campaigns which are done by GEMS (pages 52 and 55).
- There is significant doubt about the utilisation of the HIV and AIDS programme due to lack of skills and capacity and the generalised lack of trust due to insecurity regarding professional conduct, especially with regard to confidentiality (page 55).
- Peer educators require capacity building, orientation on EAP, practice guidelines and manuals as well as support from management and counselling services. Some of the more practical needs include the availability of practice guidelines,

manuals and use of social and electronic media for effective communication (pages 66, 67 and 69).

5.3 RECOMMENDATIONS

The researcher submits the following recommendations in light of the findings of the study.

- The Department of Social Development of the Free State province should consider designing a comprehensive programme on the recruitment and distribution of peer educators in the workplace.
- The Department of Social Development of the Free State province should consider designing a peer education programme which takes into account the needs such as literacy and language of its employees at all levels.
- The peer educators should be taken through a comprehensive training and capacity building process to ensure that they are certain about their roles as well as their ability to provide peer education.
- There is a need to develop and design practice guidelines, manuals and educational materials specifically for the peer education programme.
- The ideal and sustainable option is to afford the peer educators more responsibility in initiating and designing programmes aimed at HIV prevention. This will not only give them the opportunity to master the programme, but it will also promote ownership and active and meaningful participation.
- The HIV and AIDS prevention programme should be mainstreamed in the EHWP and should consider placing the emphasis on electronic and social media for effective and efficient communication and education.
- HIV testing should be done for, amongst other reasons, to estimate the prevalence and produce appropriate responses for both the affected and infected individual. This should be done for all workers in a safe and confidential manner.
- The EHWP requires improvement with regard to its focus on the HIV and AIDS prevention programme. The availability of training and capacity building as well

as standardised practice guidelines will go a long way in ensuring that peer educators are confident.

5.4 RECOMMENDATIONS FOR FURTHER RESEARCH

Despite the fact that the research project has achieved its goal, the researcher is of the opinion that there is a need for further research on the subject of HIV in the workplace with particular emphasis on the capacity building of peer educators and the development of a peer education programme which focuses on the public service sector. This can still be pursued at the Master's Degree level and would be desirable in the field of Medical or Occupational Social Work or related speciality fields.

5.5 SUMMARY

The researcher has sought to determine the HIV and AIDS practice needs of peer educators in the Department of Social Development. For exploratory purposes, a qualitative design with a collective case study was used. Two focus groups were utilised to collect data. The themes that emerged from the focus groups were identified and analytically discussed. The goal was guided by the objectives which are set out below.

- The first objective was to conceptualise HIV and AIDS peer education which was accomplished in Chapter Two.
- The second objective was to determine the views of peer educators on how they perceive their role in the design and implementation of HIV and AIDS workplace programmes. The objective was accomplished in Chapter Four.
- The third objective was to determine the HIV and AIDS practice needs of peer educators. The objective was attained in Chapter Four in which the empirical findings were presented in detail. The data collected through the focus groups were clearly analysed, presented and interpreted.

- The final objective was to make suggestions to the Free State Department of the Premier on the enhancement of HIV and AIDS practice guidelines for peer educators. The objective has been achieved in Chapter Five, where the researcher presents the recommendations based on the findings.

The researcher will therefore conclude that the goal and objectives of the study have been accomplished through this investigation.

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UNIVERSITEIT VAN PRETOR
UNIVERSITY OF PRETOR
YUNIBESITHI YA PRETOR

FACULTY OF HUMANITIES
RESEARCH ETHICS COMMITTEE

Date: 2013/05/23

Ref: MSD/26409242/13

The Head of Department
Department of Social Development – Free State
Old Mutual building, 4th Floor
Bloemfontein
9301

Dear Mr. W. Linström

Subject: **Request for permission to conduct a Master Degree research project on Employee Assistance Programme (EAP) 2013.**

I refer to the above subject

I am an employee of the Department of Social Development – Free State province employed as Acting Senior Manager: Sustainable Livelihoods and currently I am a masters/postgraduate student at the University of Pretoria doing research.

The research is about HIV and AIDS peer education programmes. Therefore the purpose of the research is to identify gaps experienced in practice that might have a negative impact on the implementation of HIV and AIDS prevention programmes in the workplace and how to improve the quality of the services rendered by peer educators.

I hereby request your permission to conduct focused group interviews with at least 12 male and female employees of your department above 25 years of age who are involved in HIV and AIDS Peer Education as well as a wellness committee. I would like to emphasize that the confidentiality of the participants' identity or information will be protected and no information may used against their employer or themselves.

Hope that my request will be considered

Kind regards

Mr. D.H. Diamond

Approved
MR IMW LINSTRÖM
ACTING HOD
SOCIAL DEVELOPMENT

D.H. Diamond Cell: 0833 243 064 or 072 730 1850. Email: diamond.a@socdevfs.gov.za
P.O. Box 3164 Bloemfontein 9300

social developmer

Department of
Social Development
FREE STATE PROVINCE

Executive Managers
Senior Managers
District Managers
Centre Managers

Permission to conduct scholarly research: D.H. Diamond

I wish to confirm that permission is granted to Mr. D.H. Diamond, Acting Senior Manager Sustainable Livelihoods to conduct qualitative research in pursuance of his Masters studies in EAP with the University of Pretoria.

The research is about HIV and AIDS peer education programmes and its purpose is to identify gaps experienced in practice that might have a negative impact on the implementation of HIV and AIDS prevention programmes in the workplace and how to improve the quality of the services rendered by peer educators.

The research interview will be conducted with focused groups with at least 12 male and female employees of above 25 years of age who are involved in HIV and AIDS Peer Education as well as a wellness committee.

Your support and cooperation will be highly anticipated

Regards

.....

Mr. J.M.W. Linström
Acting Head: Department of Social Development

Date: 2013-07-05

Informed Consent Form

Researcher's Name and contact details
Name: Harry Diamond
Tel: 0514090670 or 0833243064
Email: diamond@socdev.fs.gov.za or harry28@mobileemail.vodafonesa.co.za

1. **Title of the study.**
   HIV and AIDS practice needs of peer educators in the Department of Social Development in the Free State.

2. **Purpose** of the study.
   To establish the influence that the practice guidelines do have on the successful implementation of HIV for HIV and AIDS prevention programmes. Secondly to establish the practice needs of peer educators in terms of their work on HIV and AIDS prevention programmes especially in a workplace setting.

3. **Procedures**: Participants will complete an attendance register to confirm participation during the research and will be provided with a copy of the interview schedule which will take no longer than two hours to complete. The researcher will lead the interview process and the participants will not be expected to record answers.

4. **Risks**: There are minimal risks such as participants may feel discomfort to participate in a group interview session and respond to research questions openly.

5. **Benefits**:The participants will learn more about their programme in terms of existing gaps in the HIV and AIDS prevention programme and it expected that they would also develop interest in the outcomes of the research

6. **Participants' rights**: Participation is voluntary; they may withdraw from participation in the study at any time and without negative consequences.

7. **Confidentiality**: An assurance that all information is treated as confidential; that anonymity is assured; that the data would be destroyed should the subject withdraw. All persons having access to the research data must also be identified.

The subject's (or in the case of a minor, the parent's/guardian's) **right of access to the researcher** must be established, and the means clearly delineated, in order for clarity on any issue be sought, should doubts arise.

DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY

I, _____ hereby give my voluntary and expressed consent to participate in the research project. I hereby wish to declare that I was not coerced or promised any form of benefit (where in kind or monetary value) for taking part in the research.

I understand that all the information that I will be providing will be giving will be used solely for the purpose of this academic research project and that the contents thereof shall be treated with stringent confidentially and in a professional ethical manner.

The research is about: to establish the influence that the practice guidelines do have on the successful implementation of HIV and AIDS prevention programmes in the workplace. Secondly to establish the practice needs of peer educators in terms of their work on HIV and AIDS prevention programmes especially in a workplace setting.

Name of Participant	Signature	Date

Particulars of the researcher

Name of the researcher	Signature	Date
Particulars of the academic institution		
Name and faculty University of Pretoria	Particulars of the supervisor	Contact details of the supervisor
University of Pretoria	Dr. Florinda Taute (D.Litt. et Phil.) Snr. Lecturer Dept. of Social Work and Criminology University of Pretoria Pretoria 0001 South Africa	Dept. of Social Work and Criminology University of Pretoria Pretoria 0001 South Africa Tel. +27 82 960 7271 Fax. +27 012 420 2093

DEPARTMENT OF SOCIAL WORK
AND CRIMINOLOGY

HIV AND AIDS PRACTICE NEEDS OF PEER EDUCATORS IN THE DEPARTMENT OF SOCIAL DEVELOPMENT IN THE FREE STATE: FOCUS GROUP INTERVIEW SCHEDULE

Questions

Section A: Experience of the participants in the employee wellness programme

1. How long have you been involved with the Employee Health and Wellness Programme (EHWP) and indicate your role in the programme.

Section B: Relationship between peer education and HIV and AIDS prevent programme

2. Does your EHWP focus on HIV and AIDS programme? Explain how?
3. Indicate various activities that your EHWP perform in relation to HIV and AIDS education.
4. Does the HIV and AIDS prevention programme involve peer education?

Section C: Personal capacity needs and practice guidelines

5. Have you acquired specific or relevant skills for Peer Education? If yes, indicate those skills and if NO, explain why?
6. What tools or guidelines do you utilise in peer education programme.
7. How often does the programme go through review and who is responsible for that and what role do you play if any, in this regard?
8. How does the way you conduct the peer education activities impact on the effective utilisation of the HIV and AIDS prevention programme?
9. Indicate your immediate and long term needs to ensure that you can implement the peer education effectively in your workplace.
10. Do you think that there is a need for improvement in your workplace HIV and AIDS prevention programme? Explain where and how.

BERNICE BRADE EDITING

FREELANCE WRITER, PROOF READER AND EDITOR
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19 August 2014

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To whom it may concern

This letter serves to confirm that **in August 2014** I did the proofreading and the language editing for the dissertation of

DIEKETSENG HARRY DIAMOND

Titled: ***HIV AND AIDS PRACTICE NEEDS OF PEER EDUCATORS IN THE DEPARTMENT OF SOCIAL DEVELOPMENT IN THE FREE STATE.***

This document is being submitted in fulfilment of the requirements for the degree

MASTER OF SOCIAL WORK

In the **Department of Social Work and Criminology of the Faculty of Humanities**
At the **UNIVERSITY OF PRETORIA.**

I have proofread and edited the entire dissertation but have not been given the list of references or any appendices to edit. This editing principally involves proofreading, language, style and grammar editing; and also checking the text for clarity of meaning, sequence of thought and expression and tenses. I have also noted any inconsistencies in thought, style or logic, and any ambiguities or repetitions of words and phrases, and have corrected those errors which creep into all writing. I have written the corrections on the hard copy and have returned the document to the author, who is responsible for inserting these. Please note that this confirmation refers only to editing of work done up to the date of this letter and does not include any changes which the author or the supervisor may make later.

August 2014

Bernice McNeil