Changing the Course of AIDS

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Published by Cornell University Press

Deutsch, Charles and David Dickinson.
Changing the Course of AIDS: Peer Education in South Africa and Its Lessons for the Global Crisis.


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Robert Mokwena is a forty-five-year-old African miner who works for Mineco—a fictitious name for a large South African mining company. Over the past decade he has watched family and friends die. His best friend of many years, Benny Modise, died shortly after telling Mokwena that he was HIV-positive. At the time of his friend’s death, antiretroviral treatment was unavailable. As he became more and more debilitated, Modise was unable to work and was put on medical disability. Admitted to hospital he grew increasingly despondent. Finally, Modise hung himself from a tree in the hospital grounds. Soon after this tragedy, Mokwena’s niece died of AIDS and her infant daughter soon followed. Mokwena could do nothing for them but stand by helplessly and watch them die.

At work, after over twenty years underground, Mokwena had been promoted to a surface job as a training instructor for new recruits to the company. Part of his orientation program included a module on HIV/AIDS. People asked questions. Questions he couldn’t answer.

So when the opportunity arose to enhance his knowledge of this epidemic, he took it. He became what is known as a peer educator—a commonly
promoted communication channel that, in the context of AIDS means a lay person who helps educate coworkers, community members, and family and friends about HIV/AIDS, how to prevent infection and how to deal with the disease. “I became a workplace peer educator because I wanted to help my brothers and sisters,” Mokwena explains. “Most of my colleagues cannot read and write. They need someone who knows their language and culture, someone with good communication skills.” He wants to give his coworkers, family, and community not only education but also hope. There was no hope for his best friend, and that’s why he believes Modise took his own life. “I think I would have convinced him to live if I was trained as a peer educator by then.” On the death of his niece and her child he explains, “All the family was affected by this. I still believe I could have done something as a peer educator.”

Becoming a peer educator was Mokwena’s way of responding to the AIDS epidemic. “Fortunately I was chosen to be among the first volunteers to be trained [by the company] as a peer educator in the year 2000. I received a four-day course and a certificate. Empowered with information I have influenced a lot of people.”

This book is about what happens when people like Mokwena decide to help those around them to deal with a catastrophic disease. It tells the story of South African peer educators and their quest to encourage behavioral change. The subject of this story—how to help other human beings change dangerous and destructive behaviors—is a very old one that has existed as long as there has been concern for others. Today, it is particularly urgent, acute, and pressing: a matter of life and death for millions of South Africans as well as for many millions more across the globe at risk or already infected with HIV.

In its sub-Saharan African epicenter, the AIDS pandemic presents a socially debilitating loss of life and a seemingly bottomless well of human suffering. Perhaps one in five adult South Africans is infected with HIV, and there is little evidence to show that the rate of new infections is slowing (Rehle et al. 2007). Only a fraction of those infected with the virus are aware that they are HIV-positive, and only a fraction of this fraction openly comes to terms with their status. Treatment, while increasingly available in South Africa, remains underutilized. Many people who are infected access treatment only when desperate and it is too late. To stem the epidemic, individuals at risk need to take steps to prevent infection, get tested for HIV,
and, if infected, live openly with the virus and access available treatment. These are matters of individual behavior. Given the record so far, it is clear that, despite vast sums spent in combating the epidemic, there has been little progress. In the absence of a decisive medical response to AIDS, the quest to change individual behavior remains.

Although AIDS is an African tragedy, Africa is only one chapter of the pandemic. Beginning in San Francisco, its discovery in the early 1980s among the gay populations of world cities is well known. As are its transmission to hemophiliacs via contaminated blood and its spread into a range of vulnerable groups in developed countries: intravenous drug users, sex workers, and the inner-city poor. The pandemic continues. There are chapters still being written: on how the virus is entering into the vast populations of India and China and on how infection among drug users in the former socialist countries of Eastern Europe threatens the wider population. Given this, the quest for behavioral change in the era of AIDS is a matter of importance not only in South Africa, not only in Africa, but also globally.

Out of Africa, this book argues, comes something new. Something needed by all of us. The lessons we can draw from South African peer educators is relevant to stemming the AIDS pandemic beyond Africa. Preventing infection requires individuals to address and change the least manageable of human behaviors. For HIV infection is, for most, a question of sex: sexual behaviors that infection starkly exposes. Sexual behavior is embedded within beliefs about gender, faith, status, morality, identity, and more. Preventing infection, or coming to terms with being HIV-positive, requires individuals to take responsibility for themselves. Yet, this is not straightforward. Their actions and the actions of others with whom they coexist are enmeshed within a web of social understandings and responsibilities that can neither be ignored nor thrown out wholesale. The social worlds that we inhabit are shaped by the past as well as our own actions. In the story this book tells, a history of colonialism and apartheid have molded the life of individuals in South Africa, but many other institutions—such as churches, unions, and government—also play a role in shaping and reshaping the terrain of everyday life, and everyday sex. This book has lessons for regions as diverse as Asia and Eastern Europe where the epidemic is unfolding with, it would seem, little cognizance of what has happened elsewhere. Even in the advanced countries with their
low rates of infection, there is much to learn from what peer educators are doing. For it may well be that the limits of managing this disease from above have been reached, and it is time to learn from below—where the parameters of risk are determined.

South African lessons are also relevant to other health-related problems, not just to HIV/AIDS. The quest for behavioral change is not, after all, confined to the AIDS pandemic. We are all acutely aware, from our own experiences, just how difficult it is to change what we do. Seemingly small decisions—what we eat, how much we drink, whether we light up a cigarette, how much exercise we get, or how fast we drive—make for big problems. Many of us manage, with only the occasional regret, miscalculation, or sense of guilt, lives not as well lived as we would like. For others, behaviors result in obesity, addiction, abuse, broken lives, illness, and premature death. We know all this, but we often stand powerless. Telling people what they should do to help themselves does not stop unhealthy eating, smoking, drinking, or reckless driving. Nor is it stopping AIDS.

In exasperation at our own stubbornness, we may resort to legal penalties. We may try to force people to change. That may moderate some behavior, perhaps speeding, but many choices lie beyond what we feel comfortable about legislating, are not amenable to legislation, can be legislated only at the margins, or will be driven underground by legal penalties. We remain with the problem of what to do after we admit that, for all the logic of our messages, individuals seem to be chained to behaviors that detract from their own and others’ well-being.

This problem confronts us when we try to do something as seemingly innocuous as getting people to cut down on fat and salt in their diet—things that we know may add years to their lives and enhance their quality of life. If this is true, then the problem of getting people to change their behavior when it comes to AIDS is clearly enormous. Which is why the subject of this book—what has happened when HIV/AIDS peer educators try to get people to change their behavior—has much to teach us about getting people to change behaviors that have little to do with the HIV/AIDS epidemic. Even the slightest advances around AIDS can help us make progress in influencing the choices that have an impact on peoples’ health and well-being and, by extension, escalating health care and social costs.

The choices people make are not simply individual ones. They exist in a web of social, workplace, family, and community relationships. Their
individual choices are constrained by contexts in which they live and work. Typically, in thinking about the context of people’s lives, we often focus on material conditions. There is a good reason for this. We know that many social and health problems are concentrated among the poor, and that their choices are restricted by difficult material conditions. Nonetheless, poor people can and do make choices. What we need to understand are the social factors that make it hard to enact these choices. A lack of resources is part of any answer, but not the only one. Consider, for example, the issue of alcohol abuse; we know that alcoholism is a major problem in many poor communities, but not all poor people are alcoholics and not all alcoholics are poor. This book looks at the psychological terrain that people inhabit and how the ordering of this psychological space can hamper attempts to change behavior. By this I do not mean probing the id, ego, and superego of South Africans but instead looking at the web of social relationships that influence behavior. Through an analysis of peer educator activity, we examine the texture of the social spaces of South African workers, their families, and their communities and how this constrains individuals’ ability to respond to the epidemic. We will also see how peer educators, under the most difficult of contexts and with the most difficult of issues, labor to bring about behavioral change.

**HIV/AIDS and Behavioral Change**

Changes in sexual behavior could prevent most HIV infection and dramatically undercut the potency of the pandemic. Change in beliefs and behavior also play an important part in the effectiveness of providing antiretroviral treatment and in mitigating the impact of the disease, including the stigmatization of those who are infected or affected.

Early responses to AIDS assumed that knowledge about HIV/AIDS would be sufficient to change beliefs and bring about behavioral change (UNFPA 2002). This assumption promoted *top-down* or *vertical communication programs* that disseminate information from centers of expertise to target audiences. In short, the assumption was that information = knowledge = belief = behavior. Enough lectures, charts, illustrations, and graphs would change peoples’ beliefs about the disease, which would, in turn, lead to lasting changes in their behavior. The general failure of such
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programs, evidenced by continued HIV infection and persistent stigmatization of those with the disease, has prompted a rethinking of such communication strategies (UNFPA 2002). Where success in changing sexual behavior and lowering infection rates has been observed, a number of authors have pointed to the contribution of horizontal, rather than vertical, communication processes (Low-Beer and Stoneburner 2003, 2004; Parker 2004; USAID 2002). A number of features characterize horizontal communication processes, including: embeddedness in local cultural contexts; dialogue, especially among similar individuals, rather than information delivered by experts; individuals as change agents, rather than as targets for change; and the importance of face-to-face, personal communication channels (Low-Beer and Stoneburner 2003; Panford et al. 2001; Parker 2004; USAID 2002).

Despite the potential of horizontal communication processes in changing beliefs and behavior around HIV and AIDS, Daniel Low-Beer and Rand Stoneburner (2003) point out that their value is rarely recognized. One important consequence of this neglect is that, beyond broad principles, we understand relatively little about horizontal communication processes around HIV/AIDS. This is not surprising. Apart from the vested interests of AIDS experts, who dominate vertical programs and are unlikely to voluntarily relinquish their role, horizontal communication throws up barriers to external observation because it is framed within local cultures and consists of face-to-face interaction between peers. Thus, even if the value of horizontal communication in changing beliefs and behaviors is acknowledged, how such communication takes place and why it works, if it works, remains opaque.

Workplace peer educators in South Africa operate within programs set up by companies that have become concerned about the impact of the AIDS epidemic on their public image and their ability to maintain a healthy workforce. Largely pushed by grassroots concern and activism—as well as frustration with the South African government’s failure to come to grips with the epidemic—these companies have initiated workplace behavioral change programs in an attempt to stem the epidemic. Although workplace peer educators formally operate within vertically oriented company AIDS programs, they are best understood as grassroots change agents who operate within the specific cultures of their peer groups and utilize personal communication channels. Workplace HIV/AIDS peer educators are, thus,
attempting, through horizontal communication processes, to change be-
liefs and behaviors around HIV/AIDS. Studying their activity provides in-
sight into the process of peer-to-peer communication around HIV/AIDS
and the challenges that this entails. This is important: There is much to
learn about AIDS beliefs and behaviors from what is unfolding on the
ground. This is perhaps especially so in South Africa where a colossal fail-
ure of leadership—across state, business, unions, and academia—in the
face of AIDS has contrasted with responses from below.

HIV/AIDS in South Africa

AIDS presents a major challenge to South Africa. The primary means of
HIV transmission in sub-Saharan Africa is unprotected heterosexual sex
(UNAIDS 2003). Unless treated with antiretroviral drugs, the virus’s de-
struction of the immune system results in increased illness and eventual
death within nine to eleven years of infection (UNAIDS and WHO 2007).
Antiretroviral drug treatment can control but not eliminate the virus for
periods not yet established. The continuing incidence of HIV infection
draws attention to the difficulties of responding to this disease. Stigma-
tization, fear, and discrimination—linked to sexual transmission and the
disease’s incurability—hamper efforts to promote prevention, testing, and
treatment.

South Africa’s antenatal HIV sero-prevalence surveys, measuring
whether the person’s immune system has “sero-converted” (i.e., produced
antibodies) in response to the HIV virus, at public sector clinics have shown
a rise in HIV prevalence among pregnant women from 0.7 percent in 1990
to 28.0 percent in 2007 (Department of Health 2008). A national sero-
prevalence survey (Human Sciences Research Council [HSRC] 2005) indi-
cated a wide difference in infection rates between the four racial categories
used in South Africa: Africans, colo reds, Indians, and whites. These four
racial categories were inherited from apartheid. They continue to be used
in South Africa both for official purposes, notably Employment Equity
legislation, and, with some variation, in popular discourse. Employment
Equity legislation additionally groups Africans (indigenous people), col-
oreds (people of mixed origins), and Indians (people originally from the
Indian subcontinent) as “black.” All black people are regarded as being
“previously disadvantaged” in comparison to whites, though it is recognized that the apartheid racial hierarchy resulted in greater discrimination against Africans than coloreds or Indians.

Among those two years and older, 13.3 percent of Africans, 0.6 percent of whites, 1.9 percent of colored, and 1.6 percent of Indians were found to be infected. While there is room to doubt the precise levels found in this survey, it is clear that HIV prevalence is much higher among Africans than other racial groups. Magnifying this racial dimension of the disease’s distribution is the overwhelming numerical domination of Africans within the country’s population. Statistics South Africa (2008a) estimated that of a population of 48.7 million, 79.2 percent were African, just over 9 percent white, 9 percent colored, and 2.6 percent Indian. Given the close correlation between race and socioeconomic status in South Africa, high prevalence rates among Africans equates to high HIV prevalence rates among the poor and poorly educated. The racial distribution of the disease, its causes, and its consequences are important issues that this book returns to a number of times.

There are also marked differences in the burden of the epidemic by gender. The HSRC survey found that while 8.2 percent of males (of two years and over) were HIV-positive, the rate among females was 13.3 percent. The intersection of race and gender leads to the highest infection rates among African women estimated at 24.4 percent of those between fifteen and forty-nine years of age. Perhaps the most frightening statistic, and the one that gives the best insight into how HIV/AIDS is affecting South Africa, is looking at the distribution by age. Since HIV is transmitted primarily by sex, prevalence peaks among people of working age: 33 percent among women aged twenty-five to twenty-nine and 23 percent among men aged thirty to thirty-nine (for all races). Among African women between twenty-five and twenty-nine, this peak spikes to 38 percent. Such peaks are disguised by much lower rates of infection among children, who are at little risk of infection until they become sexually active and older people whose most active sexual periods were before HIV was widespread. In the absence of behavioral change to reduce infection, over time the disease will be infecting approximately one in three women and one in four men in their twenties and thirties.

A plateauing of prevalence rates, which may now be occurring, does not indicate a slowing of the epidemic but rather that the number of new
infections is offset by the deaths of those infected earlier. Demographic models predict that average life expectancy will drop to forty-six years in 2010, twenty-two years lower than it would have been in the absence of AIDS (Rehle and Shisana 2003). The effective provision and uptake of antiretroviral treatment will mitigate this drop in life expectancy. It will also increase the percentages infected with the virus because HIV-positive people will be living longer. Along with this will be the need for individuals and society to deal with the implications of a large proportion of the population relying on expensive, chronic antiretroviral medication.

The South African Context

An epidemic needs to be understood within the context that shapes the terrain on which the pathogen, and its host, exists. South Africa’s HIV prevalence rates are not unique. However, it stands out as the most industrialized and most highly developed country with such high levels of infection.

It is impossible to tell the story of HIV/AIDS in South Africa without understanding the history and impact of apartheid—a legalized system of racial discrimination—and the transition to democracy that took place in 1994. In South Africa, Dutch and British settled the territory they occupied and thus the country was not, unlike many other imperial territories, governed only by means of a small colonial administration. These settler colonialists divided the country into a rich, white minority and an impoverished black majority. The story of South Africa’s political miracle—the avoidance of an all-out race war—speaks to the eventual pragmatism of the white elite in stepping down from political power before the country descended into chaos. It also captures the agreement from leaders on both sides of the racial divide as to the desired future direction of the country: a modern, prosperous African state with legal equality for all and a transformation process designed to redress past discrimination.

This narrative of South Africa’s apartheid era and democratic transition, however, misses important historical stages pertinent to understanding the country and its peoples today. Prior to European conquest, South Africa was populated by several Bantu-speaking societies. The term Bantu has picked up negative connotations in popular use. However, as a linguistic categorization of the majority of Africans in southern Africa, it remains
a valid and useful category. These groups, as well as smaller populations of Khoe-San or Bushmen, were organized along family, clan, and tribal lines that in some cases solidified into larger nation polities. These indigenous societies had distinct political, military, economic, and social structures. The long process of colonization, which is usually dated with the arrival of Dutch settlers in 1652, subjugated these political entities. Thus, the construction of apartheid following the electoral victory of the Afrikaner (settlers of Dutch origin) National Party in 1948 was not the introduction of racial domination in South Africa but its brutal and open codification as an ideology subscribed to by the majority of whites and its systematic implementation through racist laws.

Yet despite centuries of colonialism and decades of apartheid, much of pre-colonial society remains—albeit often fragmented, devalued, and hidden. Belief in traditional African values often oscillates between pride and embarrassment. The truth is that these legacies are complex. In presenting itself as a modern organization, the African National Congress (ANC) has consistently striven to overcome tribalism as a division of black unity and a danger to its founding vision of a diverse but harmonious society. In part this was because of the apartheid government’s deliberate policy of highlighting and supporting ethnic differences as a strategy of divide and rule. Precisely mapping ethnic groups is not possible (as the apartheid ethnographers found out). The fact that there are eleven official languages (two of European origin and nine indigenous), and that each of these are associated with a particular group that may itself be subdivided, highlights the complexity of ethnicity in South Africa. For all the ANC’s ideal of racial unity, the question of ethnicity is of great significance to individuals’ identities and loyalties, to social networks, and to the political need to craft not only a racial but also an ethnic balance of political power. However, beyond a public celebration of linguistic diversity, the legacy of the old within the modern is played out furtively.

To understand the context of the AIDS epidemic, we need to recognize how South Africa’s difficult historical legacy shapes every facet of life. Given the subject of this book, we will need to bear in mind not only why the country’s population has been particularly vulnerable to the transmission of the HIV virus but also how health care systems and access to those systems has been shaped by the broader processes that have constructed South Africa.
Pre-colonial Africa had extensive systems of indigenous healing. These attempted to address individual’s health problems and were also responsible for public health and social stability though their influence on rights of passage to new social status and for maintenance of public health through prescribing and maintaining social and sexual relationships. These roles were (and remain) deeply linked to an African cosmology in which ancestors play a significant role for the living. Offending the ancestors—by failing to adhere to appropriate standards of behavior—brings problems to individuals and society. But these ancestors can also be used by traditional African healers to restore balance through processes of divination. Most commonly this is done by means of “throwing the bones” (tossing a collection of objects, including small animal bones, which are then interpreted). Mediating between the living and the ancestors, traditional healers seek to identify the root cause of problems and prescribe necessary corrective action. Typically, this combines paying attention to the ancestors and restoring, at least for a period, strained social relationships. Ceremonies in which an animal is slaughtered and eaten and traditional beer consumed are the most common way of rectifying ancestral neglect.

Steven Feierman (1985) describes the suppression of these indigenous systems of health care by colonial authorities across Africa who stripped away any serious roles of political or social control from subjugated populations. Witchcraft acts promulgated throughout the nineteenth and twentieth centuries in most African colonies eliminated the role of traditional healers in any form of social regulation. This change had public health implications. For example, traditions such as a cleansing period after the death of a spouse before resuming sex became a practice that relied on family subscription rather than a necessity backed by traditional healers forming part of the polity. This reduced the role of traditional healer to the provider of individual healing services—typically out of view (Chavunduka 1986). Alongside this suppression of traditional medicine, colonialists, notably in the form of missionaries, introduced Western medical practices. This kind of medicine has been of limited value across Africa for several reasons. Whether under colonial rule or after independence, insufficient resources have been available for doctors, nurses, hospitals, and clinics. Moreover, the narrow scope of Western medicine, even when available, largely ignores spiritual and social aspects of health. One result is that plural medical systems now exist in most African countries (MacCormack
1986) including South Africa. In such plural systems, people use different healing systems—such as Western, traditional, faith, and patent medicine—depending on accessibility, respectability, sympathy, cost, and perceived efficacy. Often, given doubt over efficacy and the multiple dimensions of health, more than one system is simultaneously consulted.

As the South African network of Western-based medical care extended, it did so in an uneven way. Health resources tend to be biased toward urban areas and to provide better service to richer sections of the populations. In South Africa, racial segregation reinforced this inequality with modern health care available, through public and private systems, for whites and limited poor-quality care available for blacks. Where health care was available for Africans, this was often based on economic expediency, as in the mining industry where an extensive system of health screening and interventions aimed at maintaining healthy workers was introduced with little regard for their families or, indeed, for workers beyond their period of service. Packard (1990) provides a detailed account of such a response in South Africa to tuberculosis among black migrant mine workers.

After the end of apartheid in 1994, the new government had to integrate a fragmented health service that had been divided both on racial and national (i.e., notionally independent, ethnically defined, black “homeland” states) lines—much of it squalid and underresourced. What it also inherited was a private health care system to which the richest 15 percent of the population had access via private insurance. While spending on health has been a priority for the ANC government, the public health care system remains distinctly second-class in relation to private care with limited facilities and poor services. Not surprisingly, despite the existence of extensive Western health care facilities, accessing plural health care options remains common in South Africa. While accessing what services are available from public-sector hospitals and clinics, Africans, in particular, consult traditional and spiritual healers or buy patent, often quack, medicines based on herbal formulas, which are available almost anywhere from street corners to large pharmacies.

The AIDS epidemic as a new health concern entered into this complex set of health systems operating in South Africa. Understanding the South African government’s response to the epidemic, which we review shortly, requires placing the arrival of the disease within the wider tensions held within this complex system. The aspiration that all should have access to
health services is undermined by the reality of limited and unequally distributed resources. Any hope that Africans, freed from colonial bondage, could draw on their own indigenous healing knowledge has not been fulfilled because of a fragmented and chaotic traditional health care system.

The story of AIDS in South Africa is, as this book emphasizes, much more than one of the state’s response. It is also about how individuals, families, and communities have responded to the epidemic. In this regard, it is a question of understanding not only the legacy of publicly devalued traditional healing systems of Africans but also other dimensions of the African population. This is not to downplay the presence of other racial groups in South Africa. But the overwhelming majority of South Africans are Africans, and it is among this population that the epidemic is, at least currently, disproportionately concentrated. In South Africa there has been a long and deeply harmful process dehumanizing Africans. In response, Africans have, as oppressed people do everywhere (Scott 1990), learned to hide their true feelings, to dissemble, to steal advantage by stealth, and to undermine by petty, calibrated acts of sabotage what they dare not openly challenge. The need to overcome this public subservience to domination was the key to Steve Biko’s call for black consciousness. To the extent that this project remains unfulfilled, it feeds into typical responses to HIV/AIDS in which mostly white experts tell black Africans what they should be doing to protect themselves from AIDS, make sure they know their HIV-status, and, if infected, live healthfully and, when appropriate, start antiretroviral therapy. Many in the assembled audiences display a polite public reception, learn the correct responses, but do little more once the lecture is over. Away from such public performance, many rely on the alternatives explanations of HIV/AIDS that draw on African experience of their dehumanization with expert pronouncements commonly contradicted by a range of AIDS myths involving racial conspiracies that reflect a colonialized past as well as continued underdevelopment.

1. Steven Biko (1946–1977) founded the Black Consciousness Movement in South Africa. This movement stressed the need for blacks to take pride in themselves. Although black consciousness never rivaled the ANC as an organized opposition to apartheid, its influence in reshaping the cultural landscape of racial oppression and resistance was enormous. Biko was killed by police while in custody.
This book will explore not only the gulf between a handful of educated experts and an underdeveloped and undervalued African population but also the divisions within this population—divisions that have significant implications for any response to HIV/AIDS. Race dominates any evaluation of what divides South Africans, but within the four racial categories—Africans coloreds, Indians, and whites—there are further subdivisions. The African majority is divided by ethnic differences the salience of which depends on the situation, but which are readily available to justify actions or explain grievances that race alone cannot explain.

The gendered culture of South Africans, black and white, sets up another tension. While the South African Constitution is not infrequently referred to with pride, this coexists with widespread resentment among African men (and often women) of the rights that it gives to women and children. Religion further exacerbates divisions within the country. Although an overwhelming Christian country, South Africa has minorities of Muslims (among Indians and coloreds), Jews (among whites and the Lemba—a small African Jewish community found in South Africa and number of neighboring states [Le Roux 2003]), and Hindus (among Indians). Christians in South Africa are divided among a host of denominations, some linked closely to race. While almost 80 percent of South Africans describe themselves as Christians, they attend a range of mainline churches (e.g., Dutch Reformed, Catholic, Anglican, Methodist), as well as African Initiated, or Zionist, and Pentecostal churches. While very few Africans report that they subscribe to African traditional beliefs, in reality such beliefs coexist alongside Christian teachings and practice in most Zionist churches and, frequently, among the congregations of mainline and even Pentecostal churches despite hostile official stances.

Despite these differences within the African population, which the more public tensions of race conceal, there is a strong social ideology of unity—often expressed in the concept of *ubuntu* or the idea that people can only be people (that is fulfill their potential) with the help of other people. But while this ideal of unity is frequently espoused, any close observer sees what everybody knows: It is largely absent. While African children may grow up with the entire neighborhood acting as surrogate parents, the adult world of Africans, and South Africans generally, is a much harsher and individualistic competition for advantage and control. High levels of rape and child sexual abuse highlight the disregard for the welfare and dignity of others in South Africa. Africans often express nostalgia for what they claim to be the
authentic social norms that prevailed in a pre-colonial golden age. At that
time, neighbors supposedly rallied to help and care for one another. Today,
the reality is that—with exceptions—below a pervasive culture of po-
lite cheerfulness, there is frequent mistrust of neighbors’ and even family
members’ real intentions. All this is, as we shall see, highly pertinent for
how peer educators work in South Africa.

Poverty aggravates all these tensions and reduces opportunities for
generosity or even reciprocity. It is hard to care for others when you are
hungry. In post-apartheid South Africa hunger is not unknown, but the
widespread provision of social security means that most families can put
food, even if it is only pap (maize porridge) on the table. What constantly
corrodes social fabric in South Africa is less absolute poverty than inequal-
ity, within families, within communities, and within the country. Despite
a widened social security net, inequality is increasing (South African Insti-
tute of Race Relations [SAIRR] 2008). Using the internationally used Gini
coefficient measure of inequality in which a score of zero reflects perfect
income equality (everybody has the same level of income) and one com-
plete inequality (one person receives the country’s entire income), South
Africa is one of the world’s most unequal countries. South Africa’s Gini
coefficient of 0.7 reflects the reality of the top 10 percent of households en-
joying 50 percent of national income while the bottom 40 percent of house-
holds received just 7 percent of income (Statistics South Africa 2008b). By
comparison, Scandinavian countries (some of the world’s most equal)
have Gini coefficients at around 0.25, while the United States (one of the
most unequal developed societies) has a Gini coefficient of 0.4. Inequal-
ity in South Africa stems in large part from a distorted labor market that
has an intense shortage of skills, allowing a minority to earn high sala-
ries, while a vast army of poorly educated, mainly African and colored,
adults search unsuccessfully for employment. Although mitigated by ex-
tensive but largely unrecorded informal activity, South Africa’s employ-
ment rate stands, depending on how it is measured, at between 20 and
40 percent.

**Five Companies**

Macroeconomic variables help us understand the broad terrain on which
AIDS operates, but local conditions also shape the epidemic and responses.
This book focuses on workplace peer education. As well as having their own internal cultures, companies help shape the context of peoples’ lives in many ways. In this book, we draw on the work of peer educators in five large South African companies: a mining company, two automobile manufacturers, a retail group, and a financial institution.

Above all other industries, the mining sector has shaped South African economic development and the country’s social structure. Extracting the countries vast mineral wealth—gold, platinum, diamonds, and coal—has been the country’s economic backbone. Much of this mining continues to use labor-intensive methods with profitability maintained by cheap labor. To achieve this, the mining industry has relied on migrant workers, both from neighboring states and within the country’s borders. The flow of migrant workers set in motion by South Africa’s mines endures to this day. Mining remains a high profile component of labor migration, but is now only the tip of the iceberg. Many apparently urbanized workers retain strong links with rural areas, or, looked at another way, many young men and women growing up in rural areas or small towns have little choice but to migrate to the urban areas if they are to find work. Approximately 55 percent of South Africa’s population lives in urban areas. However, given widespread mobility, this is a gross simplification of where people live and work beyond providing a snapshot on census day.

A permanent system of labor migration provided a mechanism for the mining companies to de-link the costs of social reproduction and economic production. Without migration, companies must pay for the education, health care, and pensions of their workforce, either directly by salary levels that allow workers to pay for these themselves or indirectly though the state and taxation. With labor migration, workers could be superexploited because the cost of social reproduction—of raising families, of old age, and of disability—were transferred onto neighboring states and black homelands within South Africa. Not surprisingly, this system was resisted. Today the National Union of Mineworkers (NUM), one of the country’s largest unions, still seeks to improve the working and conditions of black mineworkers—including campaigning for health and safety, an end to single-sex hostels that accommodate migrant workers, and the elimination of racial disparities within the workforce. White miners, long privileged by job and training reservation, are represented by separate unions that historically had been accommodated within the industry, at least from the
1930s onward. In 1922, white miners engaged in a violent insurrection on the Witwatersrand, known as the Rand Rebellion, in defense of privileges that management sought to undermine using cheaper black labor.

“Mineco,” the mining company researched for this book, has 44,500 employees (out of an industry total of some half million). Like most large mining companies in South Africa, it is a rigid bureaucracy with a vast network of operations—including hostels, hospitals, management clubs, maintenance yards, and its own security force—supporting approximately ten mines, many with multiple shafts, and processing facilities spread across three of the country’s nine provinces.

As we will see in Chapter 2, the mining industry was the first to respond to HIV/AIDS, and Mineco has a highly developed, though overstretched, HIV/AIDS program that includes a network of four hundred peer educators, testing facilities, and the provision of antiretroviral drugs for HIV-positive employees (but not their families). (Since the research for this book was conducted, Mineco has redesigned and greatly expanded its peer educator program with a target of over two thousand active peer educators.) The mining industry responded early to HIV/AIDS for a number of reasons. Given the extensive sexual networks created by the migrant labor system and single-sex hostels, there is a high level of HIV prevalence among mineworkers; this was detected relatively early as a result of annual medical checkups that all miners must, by law, undergo if they are to work underground.

Miners, whose families may live thousands of kilometers away from the mines, typically live in compounds while working. They may come from a neighboring country such as Mozambique or a former South African homeland such as the Transkei, the Xhosa-designated territory in what is now the Eastern Cape Province. Rather than living in homes or apartments, they live in single-sex hostels, where they bunk with many other miners. Previously, rigid social control limited their access to women, and homosexual relations (typically engaging in thigh sex rather than penetration) between older and younger mine workers were common (Moodie and Ndatshe 1994). Such homosexual relationships continue (Dickinson, Phillips, and Tau 2008) though almost certainly less commonly now that access to women is largely uncontrolled. In the past, miners returned home on an annual basis for perhaps six weeks between contracts. The workforce now has more permanent contracts, but frequently remains migratory.
Many miners still return only a few times a year when they have enough leave and enough money to justify the trip home. With the breakdown of apartheid’s social order, informal settlements have mushroomed outside of mine accommodation. Away from their wives for long periods, miners frequently find other sexual partners, either prostitutes or girlfriends who live in these nearby settlements. While they are away, their wives may also find other sexual partners (Lurie 2004). This creates extended sexual networks through which HIV is rapidly transmitted.

At the Mineco operation in the North West Province that I researched in 2006, there was a large hostel with capacity for 1,300 men (one of seven hostels run by the company in the area). Previously the hostel had housed 3,000 employees. Wider social developments have dramatically changed the status of the hostel. There is a clear sense that managerial authority was—in contrast to the apartheid period—weak beyond the working environment. Despite the hostel theoretically providing everything required by migrant workers, hawkers had started to operate outside the hostel in 1994. Despite a management-erected sign forbidding it, there is now widespread informal economic activity around the entrance. Hawkers sell food, beer, pirated disks, and clothes along with patent and traditional medicines and, of course, sex.

Since 2000, a large informal settlement of tin shacks (or mekhukhu) has been (illegally) erected, partly on mine-owned land that abuts the hostel perimeter. (The settlement’s nickname, Sondela, translates as “come closer.”) Many mineworkers opted to leave the hostel and live in Sondela. By doing so, they are able to take advantage of the union-negotiated option of receiving a monthly living-out allowance in lieu of accommodation and meals that the hostel offered. Many live with girlfriends—usually unemployed women who are attracted to the concentration of employed and temporarily single men. Such girlfriends are maintained while keeping a family at “home” in the rural areas, predominantly, at this operation over one thousand kilometers away in the Eastern Cape Province.

At the end of their contracts, such miners typically return home. If they are injured or fall ill while working, a medical evaluation, known in South Africa as boarding, takes place. This procedure is outlined in the Labour Relations Act (Government of South Africa 1995) and allows for the disabled or sick employee to state their case in response to medical reports, assisted by a trade union representative or other employee. This process is
conducted by a panel usually consisting of a company doctor, the employees’ manager, and a union representative. The role of the panel (or medical board) is to assess the level of disability and decide whether it is temporary or permanent. Alternative employment within the company, that the employee would be capable of doing, should be offered. The increased use of subcontractors to carry out support services (such as catering and gardening) has constrained medical boards in this regard since employment in these, less physically demanding occupations no longer falls within the payroll of mining companies. If alternatives are not available, or recovery is unlikely, disability payments, usually three years of annual salary, are issued and the employment contract ended. As we shall see, the AIDS epidemic now plays a significant role in medical boarding with implications for both rural families and shack-based girlfriends.

Like all mining operations, the working environment is difficult and can be dangerous. Underground production pressures are intense—with supervisors pushing teams to raise production and achieve monthly production bonuses. This conflicts with a high sensitivity to occupational safety and the overall objective is to “produce ore with no blood on it.” A focus on health and safety is one achievement that the NUM has helped to bring about in the industry. At this Mineco operation the NUM continued to be the dominant union among black workers, but its position was threatened by a number of splinter unions, some based on ethnic identity.

Another threat to NUM’s influence is the large number of subcontractors operating in the mine. This also reduced the ability of the mine management to ensure operational procedures and to communicate with the workforce. Productivity is lower in subcontracted areas, but remains a profitable component of overall output because of lower costs. The morning shifts drill the rock face or stope, insert roof supports, and set blasting charges. Following blasting, the stopes are left clear while the smaller afternoon shift brings in materials and prepares for the night shift, which takes out the loosened rock for processing. The language of communication between whites and Africans is Fanagolo, a simplified language using mainly English, Afrikaans, IsiZulu, and IsiXhosa vocabulary used widely for instruction in the South African mining industry. The nearly all-male environment underground is tough, and requests are responded to only when you show that you can stand up for yourself. This is as true for peer education on the surface as it is for operations underground.
The manufacturing sector in South Africa initially developed because the mining industry needed to purchase plant, parts, explosives, cables, and pipes in large quantities. Unlike mining, developments in manufacturing processes required an increasingly skilled and therefore stable workforce. The result was the creation of an urbanized African workforce close to industrial areas—though one that was kept apart from white residential areas. Manufacturing diversified from supplying the mines to meeting the needs of the growing urban population. The growing South African consumer market attracted multinational companies seeking markets across the globe.

In the manufacturing sector, I researched two auto companies “Autocircle” and “Autostar.” Both operate production lines in South Africa, and their output are integrated within the parent companies’ global production and sales strategies. Both are much smaller than Mineco, one has 3,500 employees, the other 4,000 spread over a small number of sites (two for Autocircle and three for Autostar, which operates a separate distribution warehouse). While the usual racial division of labor is present in these companies’ rank-and-file workers are noticeably better educated and skilled than in Mineco. Aware of the need for committed workers within a highly competitive global industry, Autocircle and Autostar’s production line employees formed a relatively well-paid segment of the working class.

Global companies operating in South Africa had to negotiate international public pressure during apartheid and continue to be aware of the public pressure that can be brought to bear on them. This provided a further reason for both Autocircle and Autostar to provide extensive medical care for employees, something that extended to HIV/AIDS. Between them, the two companies have approximately 130 peer educators and extensive HIV/AIDS programs linked to strong occupational health departments.

Despite the relatively privileged position of Autocircle and Autostar’s employees, these workplaces are far from models of industrial peace. Nearly every blue-collar worker in both companies belongs to the National Union of Metalworkers of South Africa (NUMSA) that dominates the engineering industry. When I interviewed production line workers in Autostar there was a clear sense of alienation and distrust of management (and sometimes the union). Even white-collar employees with whom I spoke, especially if they were black, alluded to workplace tensions. In line with the company’s global policy, Autocircle had done away with the terms
employee and employer. Reflecting a desire to have a high-involvement, high-performance workplace to which all contributed and which power relations were glossed over, now there were only leaders and associates. One African clerk whom I interviewed on her work as a peer educator maintained this jargon of leaders and associates throughout our hour-long interview. Only toward the end of our time together, when I goaded her with a question on management closing down the peer education program (a standard part of my interview schedule with peer educators, see Chapter 3) did she drop the “company speak.”

I don’t think it [cutting the peer educator program] would work. First of all, peer educators are there to sort of suss out the feeling about things. Sometimes employees would not go to a manager and vent out their problems. They would want somebody who they can feel they can relate to, you know, on the same level… There was a time when some employees were feeling that they [couldn’t] trust the medical station…. The only way that the medical station could know about that, was through us [peer educators]… Management sometimes see things from their perspective and not from the perspective of their subordinates.

Mistrust of management is widespread in South African workplaces. But given the countries racial past, this distrust is often enhanced and entrenched at what used to be known as the “color bar” that separates white managers and skilled workers from low-skilled black workers. At work, there is always the need to communicate, but real feelings can remain hidden behind a poker face or expressed only to coworkers in a vernacular that whites do not understand. If this is true for workplace instructions, it is even more so for issues of sexual behavior and HIV/AIDS.

If the expansion of a manufacturing sector required the growth of a black urban proletariat, this, in turn, helped to expand the market for consumer goods. The company I researched in the retail sector, which I call “Bestbuyco,” has some 41,500 employees and is one of the largest retail companies in South Africa. It has approximately 15 hypermarkets (superstores selling clothes, furniture, appliances, and other goods in addition to groceries and household goods) and 120 supermarkets across the country selling groceries, household goods, and kitchenware. In some ways retail companies have a similar workforce profile as mining companies; a
small, predominantly white, managerial corps and a vast workforce of low-skilled black workers (often colored as well as African in stores in the Western Cape or Gauteng provinces). However, there are also striking differences, noticeably in the smaller size of individual workplaces (though a hypermarket may have up to 1,000 employees). There is also a reversal of the gender bias with the most common jobs—shelf stackers, cashiers, and packers (who assist in bagging customers’ purchases at the till)—filled by women. Like the low-skilled, black workforce of the mines, they are strongly unionized. Most are members of the national retail union: the South African Commercial, Catering and Allied Workers Union.

As a national company, operating largely within the borders of South Africa, Bestbuyco is under no international pressure to deal with HIV/AIDS. However, as a retail company selling directly to consumers, it recognizes its vulnerability to public opinion. Should it run foul of this, people can choose, with relative ease, to shop at rival stores. As a result, the company strives to project an image of involvement and support for community projects and good causes. This is true also for HIV/AIDS. Its own company program is, however, noticeably “cheap and cheerful” in comparison with Mineco, Autostar, and Autocircle. While it has an extensive network of some 800 peer educators, more costly interventions such as testing programs are limited and vary between stores while the provision of antiretroviral drugs to employees is limited to a tiny, but highly profiled, scheme.

“Finco,” a financial institution with just under 30,000 employees in branches across the country as well as large offices in major urban centers, was the fifth company researched. While similar to other financial institutions in South Africa, Finco differs from the other four companies, notably in the higher levels of education and income, and lower level of unionization, of its employees. In contrast to the other companies, the majority of Finco’s workforce is composed of white-collar, often middle-class, workers. This occupation profile is reflected, given the gendered and racial division of labor, in a workforce that is 42 percent white and 64 percent female. Although not all the researched companies had accurate estimates of the HIV-prevalence rates among their employees, Finco had taken part in an industrywide survey that had revealed a rate of around 3 percent (the exact prevalence rates in the companies that participated in this survey have never been publicly released). Such a “good” result, in the context of
South Africa’s national prevalence rates, had not been expected and had taken the wind out of the sales of the HIV/AIDS program for a while.

Running an HIV/AIDS program with white-collar workers presents distinct opportunities and challenges. Such workers are easily able to access information for themselves. In Finco, every employee was on a medical aid scheme that gave access to antiretroviral drug treatment should they be HIV-positive. This achievement, proudly related by managers, was, however, only achieved by outsourcing lower-level jobs in the company such as canteen staff and security guards to subcontractors. Such workers remained without health insurance, but had become statistically invisible because they were no longer employees of Finco but of the subcontracting companies. Many middle-class employees assume that they are not at risk of contracting HIV. The problem for the company HIV/AIDS manager and the 450 or so peer educators in Finco was that any reduction of their activities as a result of the industrywide confirmation of low prevalence in the workforce would encourage perceptions that AIDS was not something that employees needed to think about. Peer educators in Finco worked against this perception, but it was often easier for them to promote “secondary awareness” by organizing community-based HIV/AIDS events and mobilizing staff to support AIDS projects in poor communities than directly address employees’ own vulnerability to infection.

The South African Response to HIV/AIDS

To understand why these companies initiated peer education programs, we have to take a short detour to discuss the history of HIV/AIDS in South Africa. The first cases of HIV/AIDS in South Africa were in the early 1980s among homosexual men linked into the global network of gay communities. This first wave of the epidemic was overtaken by the late 1980s and early 1990s by a heterosexual epidemic that spread south from Central and East African countries with truck drivers, migrants, and returning exiles (Iliffe 2006). The apartheid state’s early attempts to respond shared many of the mistakes of other national responses: limited action, shock tactics, and moral judgments. Additionally, messages from the apartheid government had little credibility among the majority, black population who saw this as another attack on them.
With the end of apartheid and the overwhelming electoral victory of the ANC in 1994, the opportunity to mount a comprehensive and credible response to the epidemic emerged. In 1994, HIV prevalence among pregnant women at state hospitals was around 7 to 8 percent. Despite the difficulties of managing the change of regime, the new government adopted a National AIDS Plan in 1994. This drew on all stakeholders in a comprehensive response to the epidemic (Leclerc-Madlala 2005). However, as Helen Schneider and Joanne Stein (2001) point out, implementation of the plan remained limited. The government’s response was characterized alternatively by foot dragging (e.g., its reluctance to provide antiretroviral drugs for HIV-positive pregnant women until forced to do so by court rulings driven by the Treatment Action Campaign) and enthusiastic support for instant solutions (e.g., the Virodene cure that turned out to be little more than an industrial solvent).

A central feature of this confused national response to HIV/AIDS in South Africa has been denial and dissent around AIDS at the very highest levels. South Africa’s first democratic president, Nelson Mandela, stated that he did not pay enough attention to AIDS during his five-year presidential term between 1994 and 1999. The dissident views of Thabo Mbeki, Mandela’s successor, on HIV/AIDS are well known, if not well understood. While not denying the existence of AIDS, he dissented from the scientific consensus that AIDS results from HIV infection. Rather, Mbeki stressed the role of poverty as the cause of AIDS (rather than it simply increasingly vulnerability to HIV infection) and toyed with theories that antiretroviral drugs are an expensive scam perpetrated by multinational pharmaceutical companies. Many observers believe that Mbeki was reacting to the link made between the epidemic and racial discourses on African sexuality (Gevisser 2007); that is, just when Africans came to power, the epidemic was blamed on black Africans’ uncontrollable sexual passions—a demeaning stereotype of Africans deeply embedded in European colonial ideology. Responding within this context, alternative explanations, especially those that promised a quick solution that would allow the new state to get on with its transformation project, were entertained while sobering mainstream explanations of the epidemic were questioned or downplayed.

Although willing to point to the failure of government, other leadership groups such as business, unions, academia, and religious organizations have been slow to fill the gap, in part because government failure has
shielded their own inaction over costly or difficult decisions (Cairns, Dickinson, and Orr 2006; Dickinson 2004a). Along with high-level pronouncements often followed by little concrete action, the South African response to the epidemic has been characterized by grassroots activity. This has taken the form of pressure groups, notably the Treatment Action Campaign (TAC); support groups of those infected with the virus; community-based groups and charities providing home-based care for the dying and support for AIDS orphans; the nongovernmental organization (NGO) sector with community programs, often utilizing peer educators; and, as this book outlines, workplace-based responses that are in large part driven by employees.

**Business, HIV/AIDS, and Workplace Peer Educators**


Considerable guidance is available to companies responding to HIV/AIDS, including codes that provide key steps and actions that should be taken (see, e.g., Department of Labour 2000, 2003; ILO 2001). These stress the need for stakeholder commitment to and involvement in drawing up a company’s HIV/AIDS policy and implementation plan. Elements of workplace programs that are now standard in larger companies include education and communication, minimizing stigma and discrimination, distribution of condoms, voluntary testing and counseling, wellness programs, access to treatment, and assistance to families and communities.

In reality, while aspiring to conform to “best practice,” company programs have often evolved in an ad hoc manner driven by the energy of
lower-level champions, on the one side, and constrained by the skepticism of more senior management with a greater focus on production and profit, on the other. The uptake of recommended workplace HIV/AIDS program processes and elements is often selective and partial (Whelan, Dickinson, and Murray 2008). This reflects the very mixed set of economic and social factors pressuring companies to take action on HIV/AIDS (Dickinson and Stevens 2005). Despite this, the response of South African companies to HIV/AIDS is the most advanced internationally, given its position as the first highly industrialized country with high levels of HIV prevalence. Located at the forefront of global experience, the South African corporate response presents opportunities to learn about and improve company HIV/AIDS responses, including workplace peer education.

Workplace peer educators, the protagonists of this book, have become a standard component of company responses to HIV/AIDS in South Africa. Peer education is not confined to workplace HIV/AIDS programs but has been used extensively over a range of issues to educate and assist behavioral change across the globe (Kerrigan and Weiss 2000). The advantage of peer education, which uses peers rather than status-holding professionals, is thought to stem from the “similarity between message source and recipient [that] is vital to the ultimate impact of the message” (Wolf and Bond 2002, 362). However, the way in which peer educators change beliefs and bring about behavioral change remains inadequately understood (Turner and Shepherd 1999).

Large South African workplaces have peer educators operating within their HIV/AIDS programs for a number of reasons. These include enthusiasm from workers to take up this role, belief on the part of HIV/AIDS managers in their value, their availability to HIV/AIDS managers who may be otherwise resource constrained, and their inclusion in best practice guidelines. The South African Department of Labour (2003) recommends a ratio of one peer educator to every fifty workers. (See Table 1 in Appendix 1 for the actual ratio of peer educators to peers in the research companies and Dickinson [2006a] for a discussion of these ratios). If South Africa’s formal sector companies (that is companies that largely comply with employment and other regulations and standards) were to follow this guideline, there would be approximately 150,000 peer educators nationwide, probably more than the national count of union shop stewards—in a country that has a union density (including the large but only marginally
unionized agricultural and domestic sectors) of between 40 and 50 percent. This statistic alerts us to the significance of workplace peer educators as a response to HIV/AIDS in South Africa or wherever there is significant formal sector employment.

Workplace peer educators are formally positioned within vertically structured communication programs run by HIV/AIDS managers and are expected to give talks or training sessions to coworkers on assigned topics. Additionally, they are usually engaged in extensive horizontal-style communication with peers both inside and outside the workplace—efforts that are often categorized as “informal activity” (Dickinson 2006a). Moreover, as the “Jacks and Jills of all trades” within these programs, peer educators are expected to conduct a range of additional functions—articulated with different degrees of clarity—within company HIV/AIDS initiatives. These include assisting with companywide events, such as voluntary counseling and testing drives; condom distribution; providing a first line of support to coworkers; referring people to occupational health practitioners; and engaging in community projects, generally in the form of visits to institutions or talks to community groups. Workplace peer educators in South Africa are essentially volunteers. At best, there may be some time allocated for their activities with a token stipend provided. Initial training is usually limited, normally, to between two and five days. Previously, they were typically then left to their own devices. Increasingly, however, companies are attempting to organize refresher (or follow-up) training or workshops, set expectations on the activities peer educators should undertake, and require feedback from them.

Within companies, the industrial relations division between management and workers is recognized by the use of peer educators; messages on HIV/AIDS will be more effective if delivered by peers at all levels of the company. In practice, however, there is greater emphasis on employees in lower occupational levels, given the current distribution of the epidemic, and a greater response in taking up peer education among these employees, probably in large part because of the greater visibility of AIDS in their families and communities. This de facto allocation of communication responsibilities acknowledges the reality of differences in workplace status and social identity and means that peer educators work predominantly, from the perspective of management, on the other side of the industrial divide.
This industrial divide extends beyond the workplace. Peer educators do not limit their activity to coworkers, but are active with family, neighbors, churches, youth groups, and anywhere that opportunity for communication arises. But the horizontal division between management and workers, formally recognized by industrial relations practices such as collective bargaining, also divides communities. Workers’ families and friends are unlikely to have contact with managers and their relatives outside the workplace. Thus, the social space within which workplace peer educators operate is not limited to companies’ workforces but is bounded by the divisions of class and race that exist not only within companies but also throughout a society comprised of separate communities.

Despite this extensive arena of action, workplace peer educators have remained largely organized within their individual workplaces. This reflects both a commitment to their companies’ HIV/AIDS programs and the value of these programs to peer educators as a platform for activity. While there is a strong desire to link up with peer educators from other companies, peer educators have taken limited steps in this direction. Thus, to date and excluding networks of NGO-organized, community- and faith-based peer educators (Centre for the Support of Peer Education [CSPE] 2008), there is no workplace peer educator movement.

**Peer Educators and the AIDS Epidemic:**
**The Quest for Behavioral Change**

There are two key ways to bring about change: altering individual behavior and the wholesale transformation of social relationships through collective mobilization. This categorizing of social action in response to HIV/AIDS into individual behavioral change on the one hand and collective action on the other is, of course, a simplification. In reality, a rich spectrum of action including hybrid activities is taking place. Thus, for example, within AIDS campaigns there are often events that draw heavily on “confessional protest” (Young 2002) in which individuals make a public statement of personal responsibility for social ills. In the context of AIDS, this would include candlelit remembrance events for those who have, and who will, die of AIDS. Despite this diversity, this book focuses on the individual-change side of this key dichotomy, where peer educators are attempting to
alter the beliefs and behavior of their peers. Collective change, the other side of this dichotomy, is where individuals are mobilized to apply pressure, or collective action, on another social agent able to concede procedural or material claims (Kelly 1998; Olson 1965). This latter realm is about changing the system, in favor of those groups able to mobilize their collective power. There is an extensive literature—including industrial relations, political science, development, and social movements—that deals with the question of collective action.

Collective action has been and continues to be relevant to key areas of the epidemic in South Africa. The first area has been access to antiretroviral treatment, achieved in large part by collective mobilization and public pressure driven by the TAC. This campaign has had success in widening access to antiretroviral drugs. Collective action is also clearly appropriate in addressing underlying factors that fuel the epidemic, notably poverty, inequality, and the migrant labor system (Colvin 2000; Hunter 2007; Marks 2002; Nattrass 2004; Shisana et al. 2005). Factors that emerge from the social and economic structure of the country, and indeed the global system, require a response based on collective mobilization to bring about change. To date, responses along these lines have been limited (De Waal 2006).

If there is little sign of structural change in response to HIV/AIDS, then the limits to individual volition in avoiding HIV infection within a life shaped by want, powerlessness, and social disruption need to be recognized (Parker 2004). Nevertheless, the AIDS epidemic demands, with extraordinary clarity, that individual behavioral change is necessary for survival. Central to this is behavior that prevents HIV infection, such as practicing safe sex on a consistent basis and reducing the number of sexual partners. Changes in individual behavior are also necessary for HIV testing to take place and for the accessing of treatment. A critical point made in this book is that behavioral change requires that the epidemic be "normalized." By this I do not mean that we accept infection and premature death as the norm. Rather, I refer to the normalization of HIV and AIDS as an ordinary topic of conversation in intimate spaces. That discussion needs to be taking place in intimate, rather than public, space needs to be emphasized. All too often, there is a public discourse on AIDS that bears little if any resemblance to what goes on backstage, in people’s daily lives. Yet, such backstage normalization is central to defeating AIDS.
To argue that success against AIDS is not possible until we end poverty, inequality, and the mass disruption of personal relationships—in other words, until we change the social system—has great merit, but also significant dangers. This argument overlooks the fact that individual behavioral change will not be automatic even within a reformed system. More pressing, the response to HIV and AIDS cannot wait while utopia is built.

Collective action can have little impact on these basic behavioral practices. Neither marches nor petitions nor legal reform can ensure that people will use condoms. Testing and even treatment can be made compulsory, a collective response enforced by legislation, but the dangers of such approaches are generally deemed to outweigh the benefits. Such a decision may come from weighing human rights implications against the value of enforced public health measures. Alternatively, the same decision can be reached within a public health paradigm where there is a danger of compulsory measures increasing stigma and driving the disease underground. Attitudes are not something that can be easily legislated. Given this, there is a need for us to better understand and support individual behavioral change processes.

Our understandings of how individuals change is heavily influenced by diffusion theory. This field of study, which owes much to Everett Rogers (1962, 2003), who generalized diffusion theory from his own work in the 1950s on the adoption of agricultural technologies, such as new seed varieties, by American farmers. Rogers seeks to explain how new ideas are incorporated into people’s repertoires of action. In the first edition of his textbook (1962), Rogers draws on 500 publications reporting on the diffusion of innovations; the fifth edition (2003) draws on over 5,000. These publications cover a wide range of innovations including, but not limited to, the adoption of technologies in manufacturing, agriculture, transport and communication; new ideas about teaching; new products and services; and a range of health-promoting behaviors, including diet, drug use, vaccinations, family planning, and AIDS prevention.

Distilled from this data is a model of how “an innovation is communicated though certain channels over time among members of a social system” (Rogers 2003, 11). Four elements are analyzed: (1) the innovation, (2) its communication, (3) the social system in which it is diffused, and (4) the time it takes to do this. Rogers’ classic diffusion model is vertical in nature, with change agents or experts at the top of a hierarchy of actors who
conceive or develop new innovations and who are “usually professionals with a university degree in a technical field” (2003, 28). The observable patterns of innovation adoption within a community reveal patterns of influence, which may well be different from the community’s formal political or social structures. On this basis, individuals can be categorized along a scale of innovation adoption from the early to the late. Plotted on a graph, this produces an S-shaped curve that, Rogers argues, is common across the adoption of innovations. Initially, only a few bold and more far-sighted individuals experiment with the innovation. When its success is demonstrated—the threshold level—there is an acceleration of adoption within the community and, finally, the traditionalist holdouts come on board, completing the innovation’s adoption.

Turning his attention to how to expedite the process of innovation adoption, Rogers (2003, 369) puts forward the following seven steps: (1) developing a need for change among community members, (2) exchanging information, (3) getting community members to understand the problem (of not adopting), (4) creating the intent to change, (5) translating intent into action by adopting the innovation, (6) stabilizing the new behavior, and (7) with mission accomplished, exiting the relationship.

A key challenge to successfully and rapidly achieving diffusion is a lack of similarity between the initiating expert and the intended beneficiaries of the innovation, affecting the second, third, and fourth step in particular. Rogers (2003, 302) states that “the exchange of ideas occurs most frequently between individuals who are alike.” Consequently, it is necessary to overcome barriers of difference. This can be achieved either by experts winning over opinion leaders within the target community or by recruiting “change agent aides” who are similar to members of the target community and whose role is to “spread the word.” Rogers argues that such agents—in this case, peer educators—are able to bridge the gap between otherwise very different innovator and potential beneficiaries.

HIV/AIDS campaigns have drawn on diffusion theory. Notable examples have included the STOP AIDS project among gay men in San Francisco (Singhal and Rogers 2003; Wohlfeiler 1997) and its extension as a randomized controlled intervention in a number of U.S. cities (Kelly et al. 1997). Despite measured success (in decreasing unprotected anal intercourse and the increased use of condoms), little is known about why it worked. What is clear is what the opinion leaders (peer educators) recruited into the
Changing the Course of AIDS

intervention were asked to do. What is less clear is what actually took place to bring about the recorded changes. This reflects the emphasis, within diffusion theory, on mapping the path, rather than process, of diffusion. Glenn Turner and Johnathan Shepherd’s (1999) attempt to link claims for peer education to theory comes, in part, from their own research that initiated and ran a peer-led HIV prevention project with young gay and bisexual men in the United Kingdom (Shepherd, Weare, and Turner 1997). They noted that “studies…in which peer educators ‘seek out’ people and conduct conversations on safer sex with them, have tended to place greater emphasis on the measurement of outcomes and have failed to identify the effective processes associated with these interventions” (205).

Thus, what remains largely unknown is exactly how people change their beliefs and behaviors. This is not because we do not have theories that outline how this process should happen. We do. And Roger’s seven-step process is only one of many variations. These theories are generally rooted in transferring of information that will, via some internal algorithm, tip the balance in an individual’s decision-making process so that that individual will follow through with behavioral change. The problem with such theories, demonstrated again in the failure to stem HIV infections in southern Africa, is that they don’t work in practice. Which does not stop them being trotted out on a regular basis. Many peer educator manuals have a section comprised of potted accounts of theories of behavioral change. Rarely do they attempt to link these theories to how peer educators should work. Instead, the more thoughtful ones focus on how peer educators can improve formal educational activity. Less thoughtfully, some simply lay out the content that they expect peer educators to communicate.

There is an important point here. Daniel Low-Beer and Rand Stoneburner (2003, 2004) and Warren Parker (2004) among others argue that vertical communication is of limited value and we need to understand how horizontal processes of communication can bring about behavioral change. If they are right, then we are currently doing peer educators a disservice. First, we do not have a clear theory as to how behavior is changed. Second, while failing to fully acknowledge this, we do our best to make peer educators better at formal teaching in classroom situations or just ply them with reams of information. That is, we ask them to participate in and to replicate vertical communication methods. Third, despite only weak links among what might bring about behavioral change, their training, and
their prescribed activities, we then evaluate their effectiveness and pass judgment.

Those explicitly or implicitly arguing for and implementing vertical communication strategies believe that peer educators are valuable because they are able to transmit messages conceived by experts. Those operating such interventions also surmise that the chosen target audience will then make appropriate decisions based purely on the logic of the messages, as understood by these experts, that the peer educators have introduced on their behalf.

Largely outside the field of health, there has been increasing interest in participatory, rather than top-down, development processes. The value of drawing on peoples’ knowledge of their own situation, through “participatory rural [development] appraisal” is now widely recognized (Chambers 1994) and forms a standard tool for organizations such as the World Bank (1996). Tapping the knowledge of those whom we seek to work with should be a “no-brainer,” though as Robert Chambers (1994) outlines, each generation of [university-trained] researchers seem to need to rediscover this for themselves. This book draws heavily on what participants, in this case peer educators, know about their own situation.

Beyond tapping the locals for knowledge, there is the question as to how participation can empower communities (Mayo and Craig 1995), since “participatory approaches [to development] do not necessarily seek emancipation or empowerment” (Laverack and Wallerstein 2001, 182). While those concerned with empowering communities recognized the importance of both individuals and collectives, the emphasis on individual empowerment is as a stepping-stone to community mobilization and collective action (Laverack and Wallerstein 2001; Labonte 1994). Thus, the UNDP’s Human Development Report People’s Participation (United Nations Development Programme 1993, 21) argues that, “the important thing is that people have constant access to decision-making power… People can participate as individuals or as groups… Often, however, they participate more effectively through group action—as members of a community organization, perhaps, or a trade union or a political party.” Not infrequently, community empowerment is rendered down solely to its “ability to take collective action” (Williams, Labonte, and O’Brien 2003, 35). Falling back on the certainties of collective action as a means of empowerment occurs even when addressing intimate questions of sexual health (see Gordon 1995).
This book avoids gliding over the importance of individuals’ behavior, how this is constructed and constrained, and how it can be changed. Collective action, alone, is inappropriate for the problem. Rather, what is explored in this book concerns horizontal communication processes and the argument that the value of peer educators lies not in their ability to take collective action (which is limited), nor in their activity as translators of expert messages within vertical communication programs. Rather, the value of peer educators is as protagonists in a struggle over the construction of belief in their communities. Success in this enterprise will be achieved by a reconfiguration of beliefs not predetermined by expert opinion but rather through an embedded process of interaction that provides a genuine platform for behavioral change. This book describes and theorizes these processes undertaken by HIV/AIDS workplace peer educators in South Africa.

**Background to the Research**

This book draws on six years of research into workplace response to HIV/AIDS in South Africa. In addition to a survey of twenty-eight large companies, I conducted a number of case-based research projects involving a total of eleven companies. The companies represent a wide range of economic sectors and were mainly large operations (see Table 2 in Appendix 1). The principle methodologies used in the research were questionnaires, interviews, participatory observation, and research diaries kept by peer educators. The research began broadly, by pursuing wide-ranging questions across the scope of existing (but often new) company HIV/AIDS programs. At the time, there was little independent analysis of these programs, and one key objective was to map out company programs and assess how these operated. This often produced a different picture from those optimistically put forward by managers. While doing this, it was also possible to capture the processes by which programs were emerging within companies. This earlier phase of the research underpins key sections of Chapter 2, which describes the company context within which workplace peer education typically operates.

Later my research increasingly focused on peer educators. I first interviewed rank-and-file peer educators during research projects conducted
during 2003 and 2004. Only in 2005 and 2006 did I focus exclusively on peer education in Mineco, Autocircle, Autostar, Bestbuyco, and Finco. I focused on one component of workplaces responses to HIV/AIDS—peer education—for several reasons. Reviewing company responses to HIV/AIDS was becoming repetitive, and it was frustrating not to be able to go deeper into some of the issues that constituted these responses. There were, however, many choices for specialization. These included (and remain) the uptake of testing, treatment programs, stigma, extension into communities, migrant labor, occupational health practitioners, and union responses. Of course, none of these areas of specialization can be studied or understood properly in isolation from the others. While focusing on peer educators, this book necessarily touches on and refers to many of these other aspects of workplace responses. In this regard, the earlier, more holistic research is of value beyond being able to paint a realistic background to workplace peer education. Appendix 2 gives more detail on fieldwork methods used for the research that this book is based on.

My decision to study peer educators, rather than other equally interesting options, was driven by my admiration for what peer educators were trying to achieve. I had begun to appreciate just how important—and complex—their labor of love, for that is what it is, might be. It was also driven by a continued desire to know “what was really happening.” The clearest signs pointed down the company hierarchy, and I headed in that direction. When it comes to peer education, peer educators themselves are the most obvious source of knowledge and understanding. This book seeks, though evidence-based or phenomenological research, to explain the actual practice of workplace peer education in South Africa.

An Outline of the Book: The Key Arguments

Following this introduction, Chapter 2 examines why companies are responding to the AIDS epidemic. Given that AIDS forms a core business issue only for specialized industries, primarily those involved in health and death, the fact that South African companies across the economic spectrum are responding to HIV/AIDS requires explanation. Of course, one can explain this response simply by pointing to the magnitude of the epidemic and its impact among people of working age. One view of company HIV/AIDS
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programs is that they are rational economic responses that seek to protect and prolong the lives of employees. While this understanding has some validity, high levels of unemployment and the current concentration of the epidemic among lower-skilled sections of the workforce means that company-level, cost-benefit calculations rarely propel AIDS programs into the boardroom. Despite this, wider implications—including market growth, expenditure shifting, social stability, and the country’s international image—along with pressure from internal and external stakeholders exposed to the human rather than economic impact of AIDS, mean that companies have had little choice but to respond, or at least be seen to do so.

The complex set of forces that has compelled companies to implement HIV/AIDS programs also helps explain the nature of these programs, which are often run with limited resources largely outside of companies’ key reporting lines. Chapter 2 illustrates this by examining how an HIV/AIDS program in a large South African company was established. As we shall see, it was initiated largely as the result of activism on the part of lower-level managers, occupational health practitioners, and rank-and-file employees.

Limited leadership and resources from senior management helps clarify why workplace peer education, while formally part of company HIV/AIDS programs, is better understood as a response from below. What drives most peer educators has little to do with concern for the company as a commercial operation; it is, as one peer educator put it, “for the love of people.” Chapter 3 looks at workplace HIV/AIDS peer educators and the activities that they undertake. As a result of motivations that are often intense and personal, such as seeing family members die of AIDS, peer educators’ activity tends to be extensive, energetic, and wide-ranging in nature. It also takes place in different settings with a high proportion of activity conducted outside the workplace, in families, churches, and other community locations. This indicates that, while peer educators may be anchored within a company setting that provides them with training and other resources, they are active in all facets of their lives rather than limiting themselves to the workplace.

One of the most fluid elements of peer educators’ work is informal activity, which, while taking a wide range of forms, is characterized by raising awareness; giving information, advice, and support; and setting an appropriate example on HIV/AIDS issues within everyday contexts. Thus, for
example, informal activity can include a quiet chat with a coworker during the lunch break, drawing attention to a television program on HIV/AIDS in conversation with friends, or providing a model of values and behavior as the coach of a boys’ football club. It is not always easy to separate formal from informal activity, as private interactions spin out from public activity. Despite this linkage between formal and informal activity, the latter can usually be distinguished from the former by its more casual, low-profile, and often intimate formats.

Informal activity by peer educators can be understood within the paradigms of both vertical and horizontal communication processes. From the perspective of a vertical HIV/AIDS communication strategy, in which experts are attempting to impart information to targeted audiences, informal activity on the part of peer educators can serve as a valuable means by which information is reinforced, clarified, or elaborated in ways that are not easy within the formal and public context of a presentation.

However, the thrust of the research findings reported in Chapter 3 indicates that informal activity is best understood as a horizontal, rather than vertical, process of communication in which peer educators are engaged in ongoing dialogues with peers. Such as when members of a workplace peer educator group responded to an encounter with a new AIDS myth—that HIV-positive people on antiretroviral treatment need not use condoms. The peer educator who initially heard the story from a coworker immediately brought in another peer educator to quickly rebut the myth. The incident was then raised at a peer educators’ meeting, where it was confirmed that this had not been an isolated incident. There and then, an easily understood parable to counter the myth was developed in the local vernacular (Setswana), and it was agreed that each peer educator would use this parable should they encounter the myth in the future. This process rested on expert-generated information (that HIV-positive individuals on antiretroviral treatment should continue to use condoms), but in its specific formulation and enactment, this response was entirely autonomous of the company’s HIV/AIDS management structures or even the occupational nurses who were based in an adjacent building.

Since communication must play a role in effective prevention strategies, the informal work of peer education merits attention. This book focuses on the informal activity—of horizontal communication—between peers because this emerges as a difficult and far-from-natural process despite peer
educators’ advantages of similarity and familiarity. Almost every peer educator whom I interviewed expressed how difficult it is to change people’s behavior. Some then indicated that, having provided information on HIV/AIDS to their peers, the onus lay with each individual to make their own choices. But many peer educators were utilizing a range of lay theories and practices to reach out to peers in ways that they hoped would promote behavioral change. Sometimes these theories and practices were sophisticated. For example, some used various tactics to ensure that, despite the need to be proactive with peers, they were not labeled as the “AIDS Lady” or “Mr. Condom,” which they felt would allow peers to discount their inputs as arising from vested interests or fanaticism. Since they engaged with peers on an ongoing basis, these theories and practices are evaluated and adapted on a trial-and-error basis. What might, from a distance, appear to be a natural and easy process of horizontal communication between peers is, in fact, something that is challenging and requires considerable effort.

Chapters 4 and 5 build on this recognition to explore the environment in which peer educators operate and what informal activity tells us about horizontal communication processes that seek to change beliefs and behavior around HIV/AIDS. The environment in which peer educators work is illustrated in Chapter 4, focusing on issues of gender, race, and belief in traditional healing. Gender, race, and belief in traditional healing all make it difficult for peer educators to convince those they work with of key messages around HIV/AIDS. Age and different generational values also complicate communication, while religious belief systems make diverse claims over almost every aspect of HIV and AIDS. But gender, race, and belief in traditional healing illustrate some of the core problems faced by peer educators as they conduct horizontal communication.

Taking into account this complex ordering of social space within which horizontal communication takes place, Chapter 5 describes peer educators’ modus operandi. This is done by using and elaborating on sociologist Erving Goffman’s (1958) dramatic conceptualization of social interaction. In short, this consists of formal, front-stage interactions between different individuals and groups, and more relaxed backstage interactions between those sharing similar social positions. Many managers and other observers recognize that highly ritualized and highly charged front-stage interactions that typify industrial relations between management and workers make it difficult to convey important messages about HIV/AIDS. They
value peer educators because they can move into backstage spaces both inside the workplace and in the community. They do not, however, recognize the complexity of this backstage work. When it comes to HIV/AIDS as well as many other behavioral change initiatives, backstage social order and its social rules also present barriers to peer education—barriers that we will explore.

Gender differences that occur in all sexually mixed social spaces make peer education work difficult. Janet Bujra (2006) describes how in the smallest backstage space of all—the couple—the micro politics of sex are linked directly to the power relations of gender that are referenced to wider social values. Thus, for example, peer educators dealing with a peer’s concern over condoms bursting during intercourse with her husband may realize that this is not about the quality of the condoms but about a lack of sexual foreplay and the woman still being dry when intercourse begins. Typically in South Africa, a woman is unable to raise this, or other, sexual issues with her partner (Abdool Karim et al. 1994; Klugman 2000; Newmann et al. 2000), let alone reveal that she has discussed it, and possible solutions, with somebody else—especially if the somebody else is male. Consequently, in such situations the peer and peer educator need to work around the central issue of gender relationships and acceptable intergender communication to find a way of innocuously introducing lubrication and avoiding burst condoms, even if nothing more fundamental changes.

While gender relationships are present in the backstage spaces of both workers and management, race sharply aligns with and is often a key marker of the industrial relations and social divisions in South Africa. In this situation, it could be assumed that, in contrast to gender, the racial status of peer educators allows unproblematic access to peers given their similarity. Given the legacies of racial division and conflict, however, racial similarity allows deflection of any need to change behavior and can result in problems being externalized. Although there can be variations, the standard pattern for this externalization is for whites to see AIDS as a problem of blacks, and blacks to see AIDS as a problem to which whites are indifferent or even instigator. The limited visibility of white peer educators, an issue described in Chapter 3, is both a symptom and driver of these socially constructed explanations of the epidemic. For whites, the lack of white peer educators confirms that the epidemic does not affect them and that blacks have brought it among themselves through promiscuity. For
blacks, whites’ absence in peer education programs indicates that they are happy to see blacks die or indeed are behind the epidemic in some way. On the issue of race, front-stage social cleavages undermine the value of similarity for HIV/AIDS peer educators. Increasing the number and visibility of white peer educators is a structural response that would help. Nonetheless, for our purposes we need to accept that a backstage space without racial difference may still be a difficult space for HIV/AIDS peer educators to work. Their often-unwelcome messages of the need for personal change can be swiftly undercut, and their own credibility as peers questioned, by easy and more palatable explanations of the epidemic in which someone else is responsible. These explanations often resonate with what appears to be common sense in a racially divided country.

While race is immediately visible, a belief in traditional values, including healing, is more difficult to see. Among whites, traditional healing effectively does not exist (though the use of other alternative health systems is widespread). Among Africans, the existence of traditional healing is very real and highly controversial; there are believers, opponents, and many shades in between. There is an ongoing cultural war over traditional beliefs within the African population that divides communities, families, and, indeed, peer educators. Traditional healing is not simply an alternative to Western medicine but part of a cosmology of traditional belief. The failure of Western medicine to decisively demonstrate superiority over AIDS means that the disease has become an important front in this struggle between Western and traditional values. The peer educator, operating at least formally within the company’s HIV/AIDS program and putting forward explanations of HIV/AIDS drawn from Western medicine, steps directly into these conflicts.

Given that backstage spaces are far from relaxed when issues around HIV/AIDS are raised, peer educators must sometimes remove themselves and peers from these constraints. They do this by “slipping out of order” and creating a space that is at least temporarily insulated against social pressures. The peer educator must take into this space not only the interests of the peer but also an awareness of external constraints that the peer faces. The space must be private and there must be guaranteed confidentiality. Without these conditions, honest conversation is not possible. Slipping out of order can only be of limited duration; both peer and peer educator must return to their everyday lives. Slipping out of order, and the necessity of
returning, can take place in many different ways. One illustration comes from David Abrams, a peer educator working as a uniform clerk in a large supermarket, whose office provided confidentiality for those seeking information on HIV/AIDS. As he explained, “they say ‘yes’ they need to see me about uniforms, but [once the door is closed] it’s about this sickness. Then there is talk, then tears, then more talk.” Often the talk was about a family member; at other times, it was about the worker’s own HIV status. These confidential talks sometimes resulted in decisions by peers to test for HIV and a request that Abrams accompany them during the procedure. This Abrams did, recognizing the fear and stigma around HIV/AIDS and his own position as a peer educator, by “going to check the post box” and then meeting up with them at the local clinic.

Slipping out of order is a form of liminality (Turner 1974) in which normal social rules are relaxed. The periods of collective liminality described by Turner allow new social formulations to be reached. However, the steps out of order described in this book are individualized, filled with realism, often emotionally stressful, and must conclude with pragmatic, sometimes devious strategies that equip peers to deal with social relationships that have not been altered while they have been out of order.

Conceived within this model of social space, peer educators are bona fide members of backstage spaces to which nonpeers or experts do not have access. Yet they need to operate out of order since the backstage spaces of workmates, friends, and family do not provide an intimacy to discuss HIV and AIDS openly or honestly. The achievements originating out of order are often small. In part this is because a plurality of interests interlock to form a system of values, status, and material interests that are invested in particular ordering of backstage space. Given this, some peer educators have come to realize that they need to move beyond the limits of working out of order if they are to accelerate more widespread behavioral change.

The problem of interlocking beliefs, the constraints these place on individuals’ ability to change their behavior, and peer educators’ evolving attempts to overcome these is the subject of Chapter 6. From the perspective of some peer educators, their work needs to expand from dealing with individuals to the varied social institutions that construct belief. By “turning” these institutions so that they incorporate concerns over HIV/AIDS, they will increasingly “speak with one voice” and reduce the psychological...
escape routes for peers who would rather not confront difficult issues of personal behavioral change.

This task is illustrated by examining the relationship of South African trade unions with peer educators. Unions are primarily concerned with the central front-stage industrial relations conflict between their members and management. Given the burden of the AIDS epidemic, we might expect unions, especially those representing African workers, to be at the forefront of dealing with AIDS and closely allied, if not seeking to lead, peer education. This has not been the case, and unions’ failure to add their voice means that peer educators—fully cognizant of the importance of unions in constructing the belief of many of their peers—need to work to bring unions around. In addressing why unions have not responded as might be expected and why peer educators have to expand their work into bringing unions into an alliance, two issues are explored.

The first returns us to the issue of contested backstage order. What emerges is that unions concerned with front-stage conflicts do not welcome the backstage chaos that confronting AIDS threatens to unleash. Marshaling power is as much about suppressing internal divisions as it is about confronting an external opponent. Beyond passing pro forma resolutions, responding to AIDS means opening up suppressed divisions within trade unions’ constituencies. Issues of gender and traditional beliefs are two of the most obvious fault lines that would threaten rank-and-file unity. The second issue returns us to another central concern of this book—the question of individual behavioral change and collective action to change structural constraints. Unions are organizations based on the principles of collective action. With this in mind, it is perhaps obvious that they have struggled to understand and to work with peer educators whose focus is the individual. These two issues help illustrate the challenge facing peer educators in trying to harmonize the voices of other social institutions around AIDS, such as traditional healers and churches.

The final chapter summarizes what we have learned from the quest of workplace peer educators to change behavior. Their activities point us toward a new way of thinking about behavior and how it can be modified. For experts, looking always from the outside, the challenges peer educators are responding to are difficult to see. Grasping what peer educators are doing, and why, will assist us more than a plethora of studies conceived in centers of expertise and administered on study populations. Whatever
we can learn about changing behavior is of immense importance in efforts to bring the AIDS epidemic to heel. What HIV/AIDS peer educators in South African companies are demonstrating is of value in changing behavior in other societies grappling with HIV/AIDS and in understanding how to alter other behaviors that compromise our health and limit the full potential of our lives.