'*Whatever I was saying, he came up with his opinions as well*.' Interaction Between HIV/AIDS Peer Educators and Peers: A Grounded Perspective on Horizontal and Vertical Health Communication

David Dickinson
Department of Sociology
Wits University
South Africa

david.dickinson@wits.ac.za

Draft: November 3rd 2010
Presented at: APHA Session 4117.0 Health Communication for International Sexual Health

Abstract

A critical debate within heath communication is the importance of horizontal and vertical components. In South Africa tens of thousands of peer educators have been trained on HIV and AIDS. Typically, such peer educators are utilised within vertical communication programs as transmitters and translators of health messages. Twenty-eight workplace HIV/AIDS peer educators from a South African company participated in a five-month action research project. Using dictaphones they documented their communication with peers. Focus group discussions and in-depth interviews further explored these interactions. In contrast to the company programme's emphasis on delivering simple messages to peers and avoiding entanglement in complex discussions, many peer educators reported frustrations when peers responded with their own ideas and theories about HIV/AIDS. These alternative theories frequently had different implications for behaviour than the messages that peer educators had been trained to deliver. Viewed from below, communication between peer educators and peers over HIV/AIDS sheds light on the relative merits of vertical and horizontal communication. The paper argues that greater attention needs to be paid to the nature of peer educator-to-peer communication. This has implication for health communication and suggests a need to re-engineer peer educator training to allow engagement with the beliefs of peers and not only the communication of medical knowledge.

Introduction: Horizontal and Vertical Communication and Behavioral Change

Health promotion programs frequently conceptualize peer education as providing simple, easily understood, messages to peers in a shared idiom. The assumption is that such expert-designed message, made comprehensible, will be welcomed. Programs based on such assumptions form a vertical model of peer education in which the peer educators are little more than conduits of allopathic medical knowledge. However, as this article illustrates, away from formal talks or lessons peer educators have to engage in complex and contested dialogue with peers. These discussions, which move away from the careful scripting conceived by experts, constitute horizontal communication. Such communication may well be messy. Indeed, peers may 'talk back' and counter the health promotion messages communicated by peer educators. The following example, recorded by an African female peer educator, illustrates how horizontal communication can move away from the straightforward idea of peer educators as conduits of expert messages.

> During an informal discussion, a male peer contradicted the peer educator's account of AIDS being the result of a sexually transmitted virus. Rather, he contended that the problem was a traditional

> disease, *uGunsula,* resulting from the mixing of different blood/semen;[1] the outcome of promiscuous behaviour. The peer went on to back up his explanation by reference to the need to match blood types before giving a blood transfusion. White people [i.e. those with scientific medical knowledge], mistakenly thought that this was a new disease and called it AIDS. The peer educator tried to respond to the point about blood groups by saying that she and her partner have different blood groups but they have had a baby without any sickness involved. However, the peer has a response to this. "When you are in love, over time, your blood group becomes one."[2] At this point the peer educator was stumped; "I didn't say to him that I was confused, but I was confused on what to answer him, because whatever I was saying, he came up with his opinions as well."

In this interaction, the peer educator faced a difficult choice. She could have gone along with the peer's belief, which had preventive value, but would have been acknowledging the ability of traditional healers to cure *uGunsula*/AIDS. Her attempts to counter the peer's arguments quickly took her away from what her training had equipped her for. It also went beyond what any expert could realistically have anticipated might happen.

Peer education is used extensively to educate and assist behavioral change (Horizons/Population Council, 2005). The key advantage of peer education, its peer rather than expert protagonist, stems 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 may change beliefs and bring about behavioral change remains inadequately understood (Turner and Shepherd 1999). One important dimension in which we can evaluate peer education, in theory and practice, is how they communicate with peers. This article argues that while the public accounts (Cornwell 1984) given by peer educators of their activity often corresponds with their formal location within a horizontal communication system, more probing analysis reveals a more complex, and contested, process of horizontal communication with peers. This has important consequences for the design and management of peer education programs.

This article draws on accounts by South African workplace HIV/AIDS peer educators. Most large South African workplaces have peer educators operating within their HIV/AIDS programs. The South African Department of Labour (2003) recommends a ratio of one peer educator to every 50 workers. 'Deco,' the mining company researched had a similar ratio, with approximately 150 peer education in a workforce of some 7,000 employees.

In line with other company HIV/AIDS programs, Deco's peer educators were expected to conduct a range of activities. Key among these was the giving of formal talks to co-workers and holding informal discussion both in and outside the workplace on HIV/AIDS and related issues. While giving formal talks corresponds to 'outreach activity' typical of NGO organized peer education projects, informal activity is often a much more embedded, and therefore less forced process of interaction. Such activity often takes more intimate forms and included providing advice, support, and practical help. Though such activity may have been set up in advance, it is characteristically different from formal presentations in its responsive (rather than scripted), confidential, and individualized format (Dickinson 2009).

[1] Traditional African understandings of body fluids typically group blood and semen together as 'blood' (e.g. *madi* in Sesotho) that can take different forms.

[2] A widespread belief that leads to the need for the cleansing of blood if a sexual partner dies and the danger of pollution should this not be done.

Of 28 African peer educators who participated in the action research project[3] on which this paper is based, 27 reported conducting formal talks with peers at work. The same number reported having informal talks. Of those who provided estimates, there was an average of 6.3 informal discussions at work per month (n=19) and 4.8 in the community (n=23), giving a reported average of just over 11 informal discussion per month in total.[4] This paper focuses on these informal discussions and what these tell us about the way the peer educators communicate with their peers.

Inagaki (2007) outlines three models of communication aimed at bringing about behavioural change. First, the modernization paradigm that is top-down, relies on mass communication, and assumes the superiority of its messages. Second the diffusion model, which is also top-down and assuming of the superiority of its messages, but focuses on the importance of interpersonal communication, including peer education. Rogers' (2003) diffusion of innovation 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" (28). Third, the participatory model which aims to be horizontal, interpersonal, and which seeks, not to provide knowledge or solutions, but to generate these as the result of discourse. The value of drawing on peoples' knowledge of their own situation, through participatory development appraisal, is now widely recognized (Chambers 1994) and forms a standard tool for organizations such as the World Bank (1996).

Peer education can be placed within either of the latter two models. Indeed opinions as to whether it should comprise part of a vertical transmission of information as in the diffusion model or be part of a horizontal process as in the participatory model is contested. Singhal and Rogers 2003, Kelly *et al* 1997 and Wohlfeiler 1997 draw on diffusion theory to explain the success of peer education programs among gay men in American cities. By contrast, Low-Beer and Stoneburner (2003, 2004) and Parker (2004) argue that vertical communication was of limited value in bringing down prevalence rates in Uganda and we need to understand how horizontal processes of communication brought this about.

While this paper looks at what horizontal communication entails, it should be recognized that peer education, at least within the context of the South African AIDS epidemic, is embedded within wider programs that utilize a range of vertical communication methods (such as mass media) in addition to horizontal elements. Moreover, any peer educator *program* involves two sets of relationships which can be conceptualized and designed as either vertical or horizontal. That is, first the relationship between the peer educators and their coordinators (often occupational nurses, as in the case of Digco), managers, and trainers, and, second, the relationship between peer educators and their peers.[5]

The first set of relationships tends, especially within companies, to be vertically organised with reporting lines and some attempt to monitor peer educator activity. Although there is room for participatory communication in training this tends to be limited, with a focus on providing peer educators with the correct information on HIV/AIDS. This generally translates into an assumption that the relationship between peer educators and peers will, despite their peer status, have a significant vertical component;

[3] An additional Afrikaans peer educator participated. His contributions are excluded from the analysis which focuses on the horizontal discourse within African working class communities.

[4] This compares to a study of 600 South African workplace peer educators (Dickinson 2006) in which the peer educators reported a monthly average of 26 informal interactions (in all locations). More in-depth research (Dickinson 2007) in which the peer educators kept diaries of their activities, found levels of informal activity closer to the median of the larger study; 14 informal interactions per month.

[5] A third set of relationships, among peer educators themselves, is not discussed in this article.

the transmission of scientifically correct medical information. In this conception of peer education, peers are valued for their socio-cultural access and ability to use the language of peers, not for the co-production of knowledge.

As Inagaki (2007) points out, health promotion aims at behaviour change in line with Western medicine. This limits scope for participatory communication. A medical emphasis on responding to AIDS leaves little room for negotiation over factual messages on, for example, whether the HIV virus exists or not. While there might be more scope over behavioural options, the general adoption (with the noticeable exceptions of many religious organizations) of the ABC (Abstain, Be faithful, Condomise) message however pre-determine these options.

Given that peers do not always agree or welcome the messages that peer educators are asked to transmit, peer educators find themselves in the middle of what is supposed to be a vertical communication line: expert to peer educator to peer, but which in fact, as this article demonstrates is often, in reality, contested with *de facto* horizontal communication occurring at the peer educator-to-peer node.

Frankham (1998:11) notes how student peer educators expressed anxiety over how to maintain control within the interactions they had with peers. A common strategy in this regard was to "set about trying to set themselves up as experts," though this appeared not to dampen their expressed anxiety that peers might resist this authority. Frankham (1998:13) goes on to point out that, "peer education seems to sit (often uneasily) at the intersection of two cultural domains – the professional cultures of health educators and the peer cultures of [in this case] young people."

The holding of formal education sessions limits the degree to which peers can object to the messages given to them by peer educators. Typically, they are held in company time and, while such activity is often in competition with demands for production, the peer educator is able to assume a position of authority. Informal interactions can be a very different matter. Obviously, where a peer educator is approached by a peer for information or advice over HIV/AIDS then there is likely to be a co-operative engagement. Such interactions are likely to involve vertical transmission of information and quite possible additional horizontal communication around how behavioural change might be best integrated into the peers particular context (Dickinson 2009). Where, however, peer educators seek to go beyond this and, for example take advantage of 'teachable moments' within ongoing peer interaction, or indeed of attempting to creat such moments, then it is possible that their attempts will be contested by peers.

After a description of the methodology used to collect data, the article outlines why horizontal communication between peers can be difficult. It then looks at how peer educators can engage with peers in ways that maintain a vertical communication structure, but which have limited effect in engaging peers who do not share the peer educators' commitment to an allopathic understanding of HIV/AIDS. Some of the particular challenges of peer educator-to-peer horizontal communication are then explored. This provides the foundation for the discussion and conclusion, which argues that peer education programs need to be designed and operated with an understanding of the realities of horizontal communication within specific contexts. It is also suggested that these messy realities should not be seen as undermining the value of peer education. Rather, that other medium of health communication would do well to learn from them in order to strengthen their own impact.

Methodology

The data reported in this article comes primarily from African HIV/AIDS peer educators working in 'Digco' a South African mining company with over 7,000 employees most of whom are low skilled. The peer educators were participants in an action research project that explored 'AIDS myths'[6] circulating within their peer groups over a five month period. Of the 146 peer educators in Digco, 36 were initially recruited into the project by nurses who co-ordinate peer educators at different mine shafts. Of these 36 peer educators, 29 peer educators provided recordings on their interactions with peers and 23 were interviewed at the end of the project.

The project involved the peer educators using dictaphones to report on what they believed to be AIDS myths encountered between the beginning October 2008 and the end of February 2009. Recordings were made in English, Afrikaans, IsiXhosa, IsiZulu, Sepedi, and Sesotho. These were translated and transcribed into English. I was struck by how recordings sometimes illustrated that peers would fight back when peer educators attempted to challenge what they believed to be to be erroneous beliefs. Six workshops, each of between four and six hours provided a structure to the project and allowed for recordings to be collected and discussed.

By the time interviews were conducted I had worked with the peer educators for six months and there was a strong relationship of trust. The interviews, which lasted between one and three hours, were remarkably frank and interviews went beyond providing only 'public accounts' (Cornwell 1984) of peer education allowing frank discussion of the difficulties they encountered when in discussion with peers.

I took notes during the interviews and reviewed these as soon as possible afterwards. Interviews were also taped and transcribed. At the completion of the project, I wrote a research report which I presented to the peer educators at a final feedback workshop in November 2009. Comments and discussion at this event helped to further clarify issues.

A Difficult Task

Despite the potential of health education to improve the quality of peoples' lives and reduce the costs of medical care, the limited impact of health education on behaviour is widely recognised. Despite extensive and varied health communication efforts, HIV incidence rates in South Africa continue to remain high, HIV testing remains low, and the countries, free, antiretroviral programme while growing is accessed by only approximately half the number of people estimated to require treatment. High mortality of adults in the 20 and 30s in South Africa bear testament to this continued failure to change behaviour, in line with the medical understanding of the HI virus. This section looks at some of the difficulties peer educators face when engaging with their peers over HIV/AIDS. Some of these are particular to peer education, others would apply to other forms of health promotion, such as the use of the mass media. Outlining these problems, as they apply to peer education, helps us to evaluate the relative merits not only of peer education vis-a-vis other communication formats, but also the strengths and weaknesses of different models of peer education; particularly whether it should, primarily, be part of a vertical communication channel, or a process of horizontal communication.

[6] Myths were defined as something that: is not true (scientifically or medically), but which some people believe is true; is collectively constructed, transmitted and adapted; often has a grain (small amount) of (scientific) truth; may cite an authority (usually inaccessible); and, is generally more attractive than the messages of medical science.

Within sub-Saharan Africa the medical explanation of HIV/AIDS completes with a range of other explanatory models, including traditional and religious beliefs along with racial conspiracy theories (Ashforth, 2005, Heald, 2002, Liddell, Barrett & Bydawell 2005, Macdonald 1996, Mogobe et al, 2007, Niehaus and Jonsson 2005, Ross, Essien and Torres 2006, Schneider and Fassin 2000, Stadler 2003, Steen and Mazonde, 1999). Despite the relatively urbanised and educated status of South Africans, evidence indicates that these alternative explanations of AIDS have considerable credibility. This is most clearly seen with HIV-positive individuals accessing, sequentially or concurrently, a wide range of different treatment forms, sometimes at great expense, despite antiretroviral treatment being freely available though the public health care system.

In this section of an interview, a HIV-positive peer educator describes her frustration at a neighbor, with whom she had previously attended a treatment support group, when she stopped antiretroviral treatment and turned to a herbal remedy of a traditional healer who claimed he could cure AIDS.

> **Peer Educator (PE):** We were going the same support group. But one day I was surprised. "[She told me] I don't want this ARV. Why? Because I see now my CD4 count is dropping." I say, "Look here, you know what makes your CD4 count drop? You have been suffering for a long time, your child was sick, he tested positive. And you are the one who came to me [and] said 'I'm happy now because I know what to do now. What makes my baby to be ill all along.' So what makes your CD4 count to drop is that you were stressed." She says, "No, no, no, I see those pills are not working."
>
> **David Dickinson (DD):** Then she stops taking ARVs?
>
> **PE:** [Yes, and] she stopped the baby from the ARVs.
>
> **DD:** And she's used Nyoni's [a traditional healer in a nearby township] medicine?
>
> **PE:** Yah [Yes]. The baby died on December, she follow on January, early.
>
> **DD:** And she never went back to ARVs?
>
> **PE:** Serious, I even become cross when they [her family] say "Let's go and check for her the second time [to see if she is now HIV-negative]." I say, "I can't go. Why? Because she must go back to the [ARV] treatment." Even sometimes when I'm trying to phone her, saying, "Please let's stop the traditional medicine, take the [ARV] treatment "… She dropped the phone…It's painful. To show someone the way, [then] that person turn. On the way, you see? It's like I'm working like a chicken [i.e. scratching the ground and going nowhere]. And it's painful. I help that person when she was too sick, then when she's OK she hears other people.

Thomas, Schmid, Gwele, Ngubo and Cochrane (2006:53) argue that 'strategic, pragmatic and cultural factors interlock with each other in how and why people choose to mix health systems [in South Africa]' These reasons include frustration with the Western medical system's efficiency, the therapeutic limits of Western medicine regarding HIV/AIDS, limited access to and a distrust of public institutions, and the intrinsic value of many alternative healing systems which extend beyond a response to specific illness but provide an explanation for affliction.

Beyond this difficult environment, into which health promotion messages aim to contend with, there are a number of particular difficulties that peer educators labour under when engaging with peers over HIV/AIDS. These include: the peer educators' own embeddedness within alternative understandings of

health; that a number of 'AIDS topics' are 'tricky' to explain in lay terms and which are beyond the scientific competency of peer educators; and that peer educators' character and past are generally known and any failure to correspond to delivered messages challenged.

Elsewhere (Dickinson forthcoming) I have described how most members of this group of peer educators continued to believe in non-allopathic models of health. This is not surprising given their peer status and the limited training that being a peer educator entails. The resulting 'grassroots exceptionalism' meant that while propagating an allopathic explanation of HIV/AIDS, many peer educators continued to hold a range of non-scientific explanations for other diseases and misfortunes. This separation was not always stable and their commitment to messages taught to them in their training could be undermined by arguments drawn from other paradigms of health belief.

A number of important AIDS topics, such as, for example, the existence of discordant couples, are difficult to convincingly explain in lay terms, and contradict the simple message that peer educators attempt to install; unprotected sex with somebody who is HIV positive will result in you getting infected. Attempting to encapsulate the complexity of infection risk within easy to deliver messages can end up in, apparently, contradictory communication. Thus peer educators are told that saliva is a low risk fluid and that kissing is safe, but that there is some risk should a person have sores in their mouth and therefore blood in their saliva. The message to be got across is, therefore; it's safe to kiss is there is no blood. However, an emphasis on the danger that the presence of blood entails backfires when attention shifts from mouths to genitals. In combating the circulating myth that intercourse is safe if one checks that your partner has no sores or blood on their genitals, requires a slogan to the effect that, no blood *doesn't* mean that it is safe. Within a scientific paradigm these different messages (and an additional conundrum that peer educators have to field; how can saliva be tested for HIV if it's a safe fluid?) can be accommodated within a single, coherent framework. It's another matter for peer educators who by and large don't have the scientific knowledge to do this, let alone educate their peers along these lines.

Difficulties in getting complex issues across are compounded by uncertainty, or changing opinion, within the scientific community. That HIV-positive people should use condoms even if on antiretroviral drugs was considered as an important health promotion message (Cepaz, Hart and Marks 2004). Peer educators took this to heart and attempted to rebut circulating myths that since antiretroviral drugs put HIV 'to sleep' condoms could be dispensed with (Dickinson 2007). In 2008, this medical advice was reversed (Bernard 2008) and the myth, with some caveats, became fact: an HIV-positive person with a comprehensively suppressed viral load would not, in the absence of other STIs, infect a sexual partner. Only recently, this view has again been challenged (in the case of HIV-positive women whose viral load in vaginal secretions may intermittently surge to levels capable of infecting sexual partners (Cu-Uvin et al. 2010). That messages have to be changed, and possibly re-changed, is both confusing and potentially undermining of the credibility of peer educators in the eyes of their peers.

Unlike more distant forms of communication, the disseminators of peer education are known to message recipients. This leads to direct challenges to the credibility of the messenger in a number of ways. A not infrequent assumption/accusation by peers is that peer educators must themselves be HIV-positive. This assumption can lead to accusations over their own behaviour. One of the peer educators described how she became discouraged when peers accused Digco peer educators of "attending the workshop or whatever, but you're sleeping with each other," forcing her on to the back foot by having to explain that "real peer educators" were disciplined in their behaviour. Another peer educator who was visibly pregnant explained that she had been challenged over this and felt she had to explain that she had planned her pregnancy with her partner. In other cases, peer educators acknowledged that they

had had multiple partners in the past and the fact that this was well known in their community limited their ability to convincingly represent key behavioral messages.

Beyond these challenges to character, peer educators were aware that their own competency had an effect on interactions. Thus, one male peer educator recalled how he had become confused when asked to explain why a peer, who had given oral sex to a woman who he had found out was HIV-positive, had remained negative. His first response, that the man was lucky since he had not had any open sores in his mouth that the virus could have entered, was challenged by the peer with the assertion that he had indeed had sores at the time. The peer educator reported being unsure if the man was challenging his explanation of HIV/AIDS or simply wanted to test his knowledge.

Rules of Engagement

The previous section illustrates that, for a range of reasons, peer educators face difficulties when attempting to communicate with peers about HIV/AIDS. This reality, understood by those close to the peer educators as well as the peer educators themselves, gives rise to advice as to how peer educators should operate when interacting with peers. This section looks at three ways peer educators can engage peers while remaining, largely, within a vertical model of communication; 'hit and run,' '*moruti* (preacher),' and 'call an expert.'

'Hit and run' tactics were suggested (though not under this moniker) by the group's coordinator when discussions in the project workshops revealed how some peer educators struggled to cope when peers responded with counter theories. This approach, in which messages should be given as simply as possible while engagement was discouraged, represents vertical communication at its most straightforward. Some peer educators concurred in their desire to keep things simple. Thus, one peer educator, while understanding that STI sores increased the likelihood of HIV infection, though it best not to raise this, "most of the time when I educate people I just tell them to use condoms. If I start telling them that if you're making love without a condom and you don't have cuts [sores] you won't get HIV, then people would go around sleeping around without condoms." However, in general peer educators acknowledged that if a peer had a question, refusing to acknowledge it would compromise meaningful discussion.

Those peer educators who modeled their activity (often informal as well as formal) on the easily accessible model of the *moruti,* or preacher, avoided having to answer too many questions by the giving of long, often highly fluent, monologues that linked together information on HIV/AIDS and values over behaviour. As such, it provided a synthesis of the training sessions they had attended and the sermons they listen to (and often gave) in their churches.[7] This behaviour was evident in workshops and indicated that it had previously been acceptable in peer educator meetings, presumably because it was largely an extended repetition of expert-provided information and messages. When challenged, there was agreement that such an approach did little if anything to engage peers who had doubts, questions, or contrary opinions. From then on, when a peer educator started 'preaching' during a workshop, they would be challenged by others and, on occasion, would stop themselves as they started to 'warm up,' allowing discussion to return to the point under debate. In the interviews the self-reflective ability to recognize themselves as preaching and re-focus onto the peer's concern was a lesson that several peer educators highlighted as being of value.

[7] Twenty-seven of the 28 peer educators reported going to church at least two times a month. Several were lay preachers and one ran his own church.

A standard procedure suggested in training is that peer educators should not attempt to answer what they were not sure of, but rather tell the peer that they would ask a health professional and get back with the answer. This obviously, maintains the vertical nature of communication with the peer educator acting as a 'water carriers'[8] by passively transferring information. The value of 'call an expert' depends on context. Where a peer approaches a peer educator and is seeking information, this approach can be valuable (though it dependents on the relationship with a health professionals who can provide the required information). However, if there is contestation then this approach is effectively admitting defeat. Referring to a health professional was interpreted as going back for instructions from the proponents of a competing world view (allopathic medicine, in this case aligned with company management). As such their peer credibility was damaged and they could even face derision as collaborators with the cultural and class 'other.'

Peer Educator-to-peer Horizontal Communication in the Context of AIDS

Although not generally promoted by those coordinating company peer education programs whose primary focus is on the delivery (rather than reception) of key messages, active peer educators were, in practice, engaged in frequent horizontal communication. Along with the importance of face-to-face interaction, horizontal communication is characterized by its embeddedness in local contexts, dialogue, and the role of individuals as change agents (Low-Beer and Stoneburner 2003; Panford *et al* 2001; Parker 2004; USAID 2002). This section looks at some of the ways in which peer educators engaged with peers in ways that were horizontal in nature.

The degree to which actual peer educator-to-peer communication differ from the messages initiated at the head of a vertical communication channel, depends on whether this final node in the communication channel can operates within a shared allopathic understanding of health. Where a peer is open to the allopathic explanation of HIV/AIDS that the peer educator is attempting to use, then the difference between the explanation of HIV/AIDS received by the peer educator during training and that expressed to the peer is 'merely' one of idiom.[9]

However, in the face of competing explanations, peer educators faces a much more difficult task than simply finding the right ways of explaining the science of AIDS in the vernacular. Here a peer educator explains how, those who don't want to accept they are HIV-positive can draw on alternative explanations of disease.

> The person that's giving you some questions. You answer the question, then they start coming with other excuses, they've got lots of excuses. When you talk about this thing [HIV/AIDS]…[They say,] "No, it's just that I'm sick, not that I'm HIV positive. No, not HIV."…Then you hear people to say "No, I don't believe in this white [i.e. Western] medicine." …Sometimes you get confused because there are people who say they don't use it, even injection. Or tablets, they say tablets they don't use in

[8] The term is used in industrial relations to describe a negotiating partner who has no authority to make decisions, but rather takes any suggestion back to their 'principle' and returns with a response.

[9] When tasked with conducting a piece of peer educator for an assessed exercise it is not uncommon for my undergraduate health science students to refer to a medical textbook or internet source and then share this source with the peer in order to answer a question the peer has raised. Typically, they see this as providing authority to their response and, typically, this appears to be the case because their peer, usually another university student (though not one from the same class), does indeed share with the student peer educator a belief in the allopathic explanation of health as laid out in a university text book.

> their life, they've never used it. But you see that person is sick, you can see. They say, "No, I'll see my *nyanga* (traditional healer) or someone else. He'll get rid of it, he knows it." [So] I don't know [what to do next].

Recognizing the importance of alternative healing traditions among their peers, some peer educators thought about harm reduction possibilities. While harm reduction is a well understood concept in health promotion, for peer educators it frequently represents a divergence from what they have been taught; to project a single, unambiguous, message. One peer educator, recognizing that peers often trust traditional healers or church prophets argued that they should be encouraging the latter, not because they could cure AIDS, but because they used only tea, blessed water, and prayer to treat sick people. This was compatible with antiretroviral drug treatment that peer educators were promoting, whereas many of the traditional healers methods of purifying a patient's blood involved inducing diarrhea and vomiting which would further weaken somebody who was already ill.

The need for harm reduction, rather than wholesale conversion, becomes, however, less salient should a peer be genuinely seeking help from a peer educator, rather than a more causal window-shopping. As the peer educator, quoted above on how difficult it could be to engage with people who believed in traditional healing pointed out, "It's easy when a person asks for help from you…Then you start explaining to them how you must go. Now they're listening because they're asking for help."

With peers who are HIV-positive, a peer educator has to evaluate whether to engage a peer's beliefs head on, with all the problem this entails, or bide their time and wait for other options to be exhausted. Sometimes, waiting for the right moment when a dialogue can be opened up, involved a protracted processes of engagement. This was evident in the narratives given by a number of peer educators, typically when working with members of their own extended families who were clearly HIV-positive but were seeking a more palatable explanation and cure than Western medicine can offer. One of the participating peer educators explained how he was concerned with a nephew who was ill. He had accompanied this nephew to an estimated six or seven different traditional healers. Their diagnoses had focused on witchcraft; such as a jealous supervisor at work, or a women having given him *muthi* (a potion) to attract him to her. The peer educator explained that this string of consultations had made him, "tired because I see now the money is finished,[10] but the guy's still sick. I'm not a doctor, but I know many things about HIV. [11] I can see…" However, the peer educator was now optimistic that they had reached a point where the real problem was being confronted.

> I'm happy because now we need to go and make a [HIV] test…we speak about this on Saturday morning, because he came to me around about seven o'clock I the morning and we sit down there up until half past eight. He's talking about the possibility of getting HIV. I give him the assurance that if they find HIV this is not the first person in South Africa to be HIV.

When I asked the peer educator why, prior to this apparent breakthrough, he had accompanied his nephew to traditional healers and helped with the consultation fees, he responded;

> Because Prof, you have to satisfy someone. It is his opinion to go to the traditional healer. We have to walk that way until we get tired. Then I'll come up with my suggestion after that. Because I cannot

[10] Each consultation with these traditional healers had cost between R50 and R100, with the exception of one in Swaziland which had cost R500.
[11] The peer educator's brother had died of AIDS earlier in the project.

> just change him to the Western doctor while he wants to go to the traditional healer. He have to go first and satisfy himself that this is not working.

Other peer educators reported similar lengthy engagements with friends and relatives who were working though a string of alternative healers and, not infrequently, private doctors who were happy to conduct a range of tests, other than for HIV. Often these were bitter accounts; sometimes they felt humiliated at being beaten by rival explanations, others felt guilt as they speculated that they might have missed opportunities to influence events differently.

Away from such protracted engagements with sick peers, a number of peer educators felt that it was necessary to acknowledge the difficulties of prevention messages. Those who put this forward, were arguing that the messages that they were being asked to disseminate, did not correspond to the experiences of peers. This was particularly noticeable around the experience of sex, which prevention messages tend to mechanicalise. For example, the reduction of sexual pleasure with condom use is rarely addressed in health promotion messages. Peer educators defended condoms, particularly the free government ones, which are frequently accused of being inferior to retailed condoms. Rather, the point they were making was not to run down condoms, but that, if they were to explain why condoms were necessary, they needed to acknowledge that can intruded on the spontaneity, creativity and pleasure of sex. To be unwilling to do this undermined their credibility as educators. Similarly, the message of partner reduction, did not take into account than many people, especially men, found other potential partner sexually attractive. Again, while peer educators agreed that partner reduction was necessary, not to acknowledge that men were attracted to other women beyond their wife or girlfriend, was "nonsense." Delivering a message of partner reduction, however correct, would not be credible with the peers to whom it was most relevant, without acknowledging the challenges this represented.

Conclusion

Low-Beer and Stoneburner (2003) argue that the value of horizontal communication in changing beliefs and behaviour around HIV and AIDS it is rarely recognized. One consequence of this is that we understand little about what horizontal communication processes around HIV/AIDS entail. This article has outlined a number of different ways in which peer educators engaged with peers, not merely, as the conduits of expert messages, but as change agents, embedded in local contexts and seeking to promote realistic dialogue with their peers. It has pointed to the limits of assuming that peer educators operate as part of the vertical transmission of simplified, but scientifically congruent, messages. Perhaps the most important consideration is whether the peer educator-to-peer node of communication is framed within a shared paradigm of understanding; that of allopathic medicine. Where this is the case, while there are considerable difficulties around how to explain particular issues, progress can be rapid. The audience is, indeed, receptive.

But within the context of multiple and competing explanations of health and illness, combined with the intense stigma and shame of being HIV-positive, this node of communication is much more complex. Working with inappropriate assumptions in such environments will have little impact. Proposing tactics of 'hit and run' is in effect, going through the motions, quite possibly satisfactorily for program monitoring and evaluation, but is little more than taunting peers. 'Preaching' often amounts to an extended version of this, while 'call an expert' is likely to undermine the peer educators credibility if an audience is already skeptical of their messages.

Any peer educator program needs to recognize that the peer educator-to-peer node of communication will have to accommodate both of these scenarios. A key skill that peer educators need therefore to develop is to evaluate the beliefs of a peer and engage with them appropriately. Working with those who are willing to accept the allopathic explanation of HIV/AIDS are 'low hanging fruit.' But with peers that don't it needs to be recognized that horizontal communication is neither straightforward nor easy. This article has explored some dimensions of what such horizontal communication, between peer educators and their peers entails. This is important if we are to understand the challenges faced within such communication processes; a necessary prerequisite to designing and implementing effective peer educator programs.

At the end of the interviews many of the peer educators expressed their appreciation of the project. This was not surprising; the workshops had been lively and enjoyable events and a break from the often monotonous and unpleasant routine of work duties. However, the appreciated was frequently focused on how they had learned to better engage with their peers. As one peer educator put it; "I learned not to preach to people. 'Do this! Do that!' [Now] I speak to people and expect feedback from them. That's not preaching, [But] it is difficult. When you stand there you want to teach them. But that's not how it goes." Such comments suggest that peer educator training needs to move beyond teaching peer educators the allopathic explanation of, and response to, HIV/AIDS and explicitly train them to effectively and appropriately communicate.

However, communicating effectively requires not only a message and communication skills, but an understanding of the context in which the communication takes place. In this regard, the peer educator-to-peer node faces intense challenges including, the character of the peer educator, the behavioural example that they provide, the competing claims to meaning over health and illness, and how these are aligned with social tensions such as race and class. The feedback to peer educators in dialogue with peers is immediate, personal, and often cutting. Acknowledging the difficult realities that these present on the ground, may mean encouraging peer educators to work flexibility, including, for example, accompanying a peer who is pursing rival treatment strategy in order to be there at a moment when the peer may be willing to consider the allopathic alternative.

It may be tempting to see the summation of these difficulties, and the medical heresies they can entail, as undermining the effectiveness of peer education as a vehicle for health promotion. Superficially, mass media communication avoids such problems. Such a perspective is of course illusory; most target audiences for health promotion don't and can't talk back to billboards or radio ads. The problems are all there, only they are not engaged with. Or if they are, it is indirect and often crude in the form of surveys. In fact, far from abandoning peer education as too difficult it would be wise for mass communication campaigns to be designed around the experiences of peer educators. This of course means a degree of horizontal communication between experts and peer educators. One which peer educators at least would sincerely welcome.

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