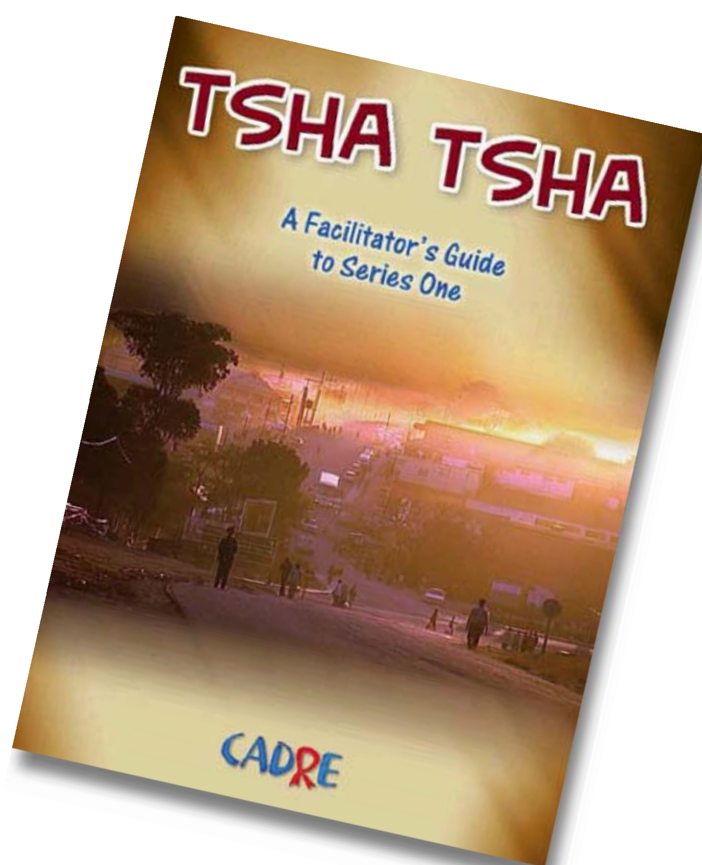
# *TSHA TSHA* IN CORRECTIONAL CENTRES

*An evaluation of pilot activities in two sites in South Africa*



correctional services

Department:
Correctional Services
REPUBLIC OF SOUTH AFRICA

JOHNS HOPKINS
Health and Education in South Africa

CADRE

## *TSHA TSHA* IN CORRECTIONAL CENTRES
## An evaluation of pilot activities in two sites in South Africa

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[1] The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

## TABLE OF CONTENTS

**TABLE OF CONTENTS** ..... **3**

**ABBREVIATIONS AND ACRONYMS** ..... **4**

**EXECUTIVE SUMMARY** ..... **5**

**INTRODUCTION** ..... **7**

THE INTERVENTION ..... 7
EVALUATION OF THE INTERVENTION ..... 8
LIMITATIONS OF THE STUDY ..... 10

**PRE-INTERVENTION FINDINGS** ..... **11**

QUANTITATIVE FINDINGS: PRE-INTERVENTION SURVEY QUESTIONNAIRE ..... 11
*Personal exposure to HIV/AIDS* ..... *11*
*Exposure to mass media, educational television and radio programmes* ..... *11*
*HIV/AIDS knowledge* ..... *12*
*Attitudes to HIV/AIDS* ..... *13*
*Risks of HIV infection* ..... *14*
*HIV testing* ..... *14*
QUALITATIVE FINDINGS: PRE-INTERVENTION FOCUS GROUPS ..... 14
*Knowledge about HIV/AIDS* ..... *14*
*Perceptions about HIV/AIDS* ..... *16*
*Perceptions of non-sexual risks of HIV infection in the correctional centre* ..... *18*
*Perceptions of sexual risks of HIV infection* ..... *19*
*Perceptions of HIV prevention methods* ..... *21*
*HIV testing* ..... *23*

**POST INTERVENTION FINDINGS** ..... **25**

QUANTITATIVE FINDINGS: POST-INTERVENTION ASSESSMENT ..... 25
*HIV/AIDS knowledge* ..... *25*
*HIV/AIDS attitudes* ..... *26*
QUALITATIVE FINDINGS: POST-INTERVENTION FOCUS GROUPS ..... 27
*Knowledge about HIV/AIDS* ..... *27*
*HIV/AIDS attitudes to prevention* ..... *29*
*Attitudes to care and support* ..... *31*
*Effects on PLHA and peer norms* ..... *31*
*Identification with circumstances in Tsha Tsha* ..... *34*
*Identification with Tsha Tsha characters* ..... *35*
*Learnings from the intervention* ..... *36*

**DISCUSSION** ..... **40**

**CONCLUSIONS AND RECOMMENDATIONS** ..... **42**

**APPENDIX ONE: *TSHA TSHA* HIV/AIDS PRE- AND POST-ASSESSMENT SURVEY QUESTIONNAIRE** ..... **44**

**APPENDIX TWO: PRE-ASSESSMENT FOCUS GROUP DISCUSSION GUIDE FOR FACILITATORS AND PARTICIPANTS** ..... **48**

**APPENDIX THREE: POST-ASSESSMENT FOCUS GROUP DISCUSSION GUIDE FOR PARTICIPANTS** ..... **50**

**APPENDIX FOUR: POST-ASSESSMENT FOCUS GROUP DISCUSSION GUIDE FOR FACILITATORS** ..... **52**

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral treatment/therapy |
| ARV | Antiretroviral (drugs) |
| CSVR | Centre for the Study of Violence and Reconciliation |
| DCS | Department of Correctional Services |
| HIV | Human immunodeficiency virus |
| JHHESA | Johns Hopkins Health and Education in South Africa |
| JHUHCP | Johns Hopkins University Health Communication Partnership |
| PEPFAR | US President's Emergency Plan for AIDS Relief |
| PLHA | Person living with HIV or AIDS |
| PMTCT | Prevention of mother-to-child transmission |
| SABC | South African Broadcasting Corporation |
| SANTA | South African National Tuberculosis Association |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| USAID | United States Agency for International Development |
| VCT | Voluntary counselling and testing |

## EXECUTIVE SUMMARY

This report presents the findings of an evaluation of the *Tsha Tsha* pilot intervention at two correctional centres in Gauteng, South Africa. *Tsha Tsha* is a youth-based television drama series that focuses on the lives of young people and the challenges they face in a world affected by HIV/AIDS. A Facilitator's Guide to series one of the programme was developed to allow material from *Tsha Tsha* to be used in discussion, reflection and debate about HIV/AIDS and related issues.

The pilot intervention at two correctional centres consisted of the provision of *Tsha Tsha* series one and two on VHS tapes; provision of Facilitator's Guides; training of peer educators in the use of the *Tsha Tsha* resources as educational materials; and conducting a pre-and post-evaluation to assess the usefulness and impact of the intervention in the context of correctional centres.

A qualitative and quantitative approach was used to evaluate the impact of the intervention. The qualitative component consisted of 14 focus groups conducted pre- and post-intervention. The quantitative component consisted of pre- and post-intervention survey questionnaires. The qualitative data was analysed using Hyperesearch 2.6; SPSS 11.0 was used to analyse the survey questionnaire data.

Findings are presented in terms of key areas focused on in the research: exposure to HIV/AIDS communication; personal relation to HIV/AIDS; and knowledge, attitudes and practices in relation to HIV prevention, care and support, and treatment. In addition, the value, relevance and usefulness of the visual material as an HIV prevention method are discussed.

The findings of the evaluation suggest that the methodology used for the intervention, as well as the actual intervention, are useful tools in engaging individuals and groups around key sexual and reproductive health issues, among others.

The findings are mainly representative of the sample and are thus not necessarily generalisable to other settings.

Key findings included:

- Exposure to HIV/AIDS communication, both within and outside correctional centres, varied. This ranged from those who had extensive biomedical knowledge to those who had little or no factual knowledge about HIV/AIDS.
- Commonly participants reported not taking HIV/AIDS seriously or personalising HIV risk of infection, despite repeated exposure to HIV/AIDS communication. Internalisation of personal risk of infection followed knowing someone who had died from HIV/AIDS or finding out one's own HIV-positive status.
- Parallel frameworks for understanding the origin and causes of HIV/AIDS existed, with accurate factual knowledge co-existing alongside other belief systems.
- Knowledge of HIV/AIDS was generally high pre-intervention, but improved post-intervention. This included individuals who had little or no knowledge of

HIV/AIDS prior to the intervention. There was a heightened fear of casual transmission of HIV/AIDS which improved post-intervention.

- Attitudes towards HIV/AIDS prevention, care and support, and treatment shifted significantly post-intervention. This was strongly evidenced in less discriminatory and stigmatising behaviour towards people living with HIV/AIDS at correctional centres.
- The concepts of faithfulness and reducing the number of concurrent sexual partners emerged as key concepts for HIV prevention post-intervention. In addition, common related themes included open parent-child communication; the importance of relationships and getting to know one's sexual partner; and disclosure of HIV status as a way of living openly and positively.
- Facilitators and participants in the pilot intervention identified with the *Tsha Tsha* characters, events and circumstances and attributed this to the realism of the storylines, characters, their depth and their humaneness.
- The risk of HIV infection at correctional centres remains an issue to be further investigated and preventative measures need to be put in place. These include addressing the transmission of HIV/AIDS through contact with infected blood (fighting, stabbing, biting) and through unprotected consensual and non-consensual sexual relations between offenders, offenders and DCS personnel, and offenders and maintenance workers.
- Participation in the pilot intervention gave participants an opportunity to work and learn as a group, to develop communication and interpersonal skills, and to develop confidence and self-esteem. It also provided an important opportunity for participants to reflect on their attitudes and behaviours, not only in relation to HIV/AIDS, but also in relation to crime and the concepts of choice and change.

It is recommended that the *Tsha Tsha* intervention be rolled out nationally at correctional centres in South Africa as a key HIV/AIDS prevention intervention. It would be beneficial for selected DCS personnel to trained as trainers in the methodology, as well as to be exposed to the intervention as participants.

## INTRODUCTION

*Tsha Tsha* is a Xhosa-language television drama, subtitled in English, that focuses on the lives of young people dealing with love, sexuality and relationships in a world affected by HIV/AIDS. A total of 78 episodes of the programme have been broadcast on the SABC1 channel during primetime viewing periods from 2003 to 2007.

*Tsha Tsha* is a collaboration between the Centre for AIDS Development, Research and Evaluation (CADRE), Curious Pictures, and the South African Broadcasting Corporation, Education (SABC Education). Additional support is provided by Johns Hopkins Health and Education in South Africa (JHHESA) and Johns Hopkins University Bloomberg School of Public Health, Centre for Communications Programs. Financial support for the series has been provided by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID).

The success and demonstrable impacts of the *Tsha Tsha* television drama series[2] led to the development of a Facilitator's Guide for use of *Tsha Tsha* to stimulate discussion, debate, reflection and learning about HIV/AIDS and related topics in non-broadcast settings. Since 2005, various series of *Tsha Tsha* have been distributed in video/DVD format and a training manual to support episodes 1-13 has been made available.

In 2005, CADRE and the South African Department of Correctional Services (DCS) concluded an Operational Agreement to pilot the use of *Tsha Tsha* resources in correctional centres in South Africa. The pilot project was in line with the Department's comprehensive HIV/AIDS programme as well as the White Paper on Corrections, which relates to the rehabilitation of offenders. *Tsha Tsha* materials were endorsed by the DCS Quality Assurance Committee and CADRE was recognised as a service provider.

## THE INTERVENTION

In November 2005, CADRE supplied the Directorate: HIV and AIDS (Offender Programme) at head office, Pretoria, with sets of *Tsha Tsha* resources. These comprised VHS video copies of *Tsha Tsha* episodes 1-26 and a training manual designed to complement episodes 1-13. These were distributed to 239 correctional centres throughout South Africa.

The intervention specific to this evaluation was the piloting of an educational intervention in two correctional centres – Leeuwkop Correctional Centre (Male Juvenile Section) and Johannesburg Correctional Centre (Female Section). Both are located in Gauteng.

[2] Kelly, K., Parker, W., Hajiyiannis, H., Ntlabati, P., & Kincaid, L. (2005). *Tsha Tsha*: *Key findings of the evaluation of episodes 1-26*. Johannesburg: CADRE.

DCS runs HIV/AIDS educational activities in correctional centres with the assistance of trained peer educators who are sentenced offenders who have received training in HIV/AIDS from DCS, working in partnership with two AIDS organisations.

The *Tsha Tsha* intervention was structured as follows:

- A subset of existing peer educators volunteered to participate in the *Tsha Tsha* pilot training activity. This group comprised 56 peer educators (42 females and 14 males).
- The volunteers were trained by CADRE and JHHESA staff in the use of *Tsha Tsha* educational resources to facilitate group discussions on HIV/AIDS and related topics. This included the use of the training manual.
- Training was conducted at Johannesburg Correctional Centre on 14-15 February 2006 and at Leeuwkop Correctional Centre on 18-19 February 2006.
- A subset of volunteers comprising eight female and four male peer educators was then selected to facilitate the use of *Tsha Tsha* materials in their respective centres over a period of four months using the methods they had learned.
- Activities comprised approximately 13 two-hour sessions taking place weekly or on alternate weeks.
- A total of 81 offenders – 55 females and 26 males – volunteered to take part in the sessions. Participation criteria included an agreement to attend at least eight sessions and to participate in the pre- and post-intervention evaluation activities.
- By the end of the intervention, a total of 68 offenders had attended eight or more sessions. Reduced or non-attendance was linked to factors including diminished interest in participation, having other duties or tasks, and being transferred or released.
- The pilot intervention was completed at the end of June 2006.

## EVALUATION OF THE INTERVENTION

The evaluation was designed to collect relevant and appropriate baseline and post-intervention data that would determine the relevance of *Tsha Tsha* as an HIV/AIDS intervention at two correctional centres in South Africa.

The objectives of the research evaluation were:

- To explore the usefulness of participatory approaches in initiating dialogue about HIV/AIDS and related themes;
- To test for potential changes in knowledge, attitudes and behaviours in relation to key intervention themes (most of which are HIV-related);
- To explore the relevance of *Tsha Tsha* as an HIV/AIDS intervention within correctional centres; and
- To make recommendations regarding further use of *Tsha Tsha* at the same or other correctional centres, including how *Tsha Tsha* might be integrated into existing HIV/AIDS programmes at correctional centres.

The evaluation included a mix of quantitative and qualitative components.

### *Survey questionnaires*

A pre- and post-assessment group-administered survey questionnaire was used to assess participants' knowledge and attitudes to HIV/AIDS, exposure to HIV/AIDS mass media campaigns, personal experience with HIV/AIDS, perceptions of risk, and orientation to Voluntary Counselling and Testing (VCT).

Questionnaires were administered in English, Zulu, Xhosa, and in some instances Sotho and Afrikaans, by a consultant with extensive experience working at correctional centres. At Leeuwkop Juvenile Correctional Centre, the consultant was assisted by a male colleague from the Centre for the Study of Violence and Reconciliation (CSVR) who had experience working with young male offenders. The survey administrators assisted those who required translation or help in understanding and/or completing the questionnaire.[3]

A total of 81 participants completed the baseline questionnaire, while 52 completed the post-intervention questionnaire.

The baseline survey was completed by 26 male (32%) and 55 female (68%) participants. The group was predominantly African (85%), with smaller proportions of Coloured (10%) and White (5%) participants. Participants ranged in age from 17 to 50, but the majority was younger and the average age was 24.

Around two fifths (43%) had attended an HIV/AIDS workshop in the past year, and around one in five (19%) had previous training in HIV/AIDS as peer educators.

At follow-up, the survey questionnaire was completed by 20 males (38%) and 32 (62%) females who were respondents in the pre-intervention assessment. The racial breakdown was 92% African, 6% Coloured and 2% White. The age range was 18 to 50, and the average age was 24.

The lower rate of response at the post-intervention phase was due to a range of factors, including participants attending other courses, having to fulfill other obligations within the correctional centres, attending school, writing examinations, or illness at the time of the assessments. Some participants had been released or transferred to other correctional centres by the time of the post-assessment.[4]

Survey responses were analysed in SPSS 11.0 for Mac.

### *Focus group discussions*

Focus groups were used to explore and deepen the evaluators' understanding of offenders' knowledge of HIV/AIDS, as well as exploring other perspectives and

[3] Some offenders that participated in the programme are illiterate.
[4] Despite the relatively low return rate of survey completion at the post-assessment phase, there were high levels of participation in the other post-assessment activity – focus groups – which was reflective of the original offenders at almost a hundred percent.

attitudes. The focus groups were also an opportunity to develop a more detailed understanding of the context of the project – correctional centres – and perceptions of HIV risk within that context.

Focus groups were conducted with male and female offenders at the two pilot sites prior to and following the intervention. All those who responded to the survey questionnaire were required to participate in the focus group discussions. Two consultants were retained to conduct the focus groups with participants in their home language(s).

Focus group discussion guides included semi-structured questions and were designed to elicit participants' views on a range of issues. Topics that were explored during the pre-intervention phase included: when participants first had heard about HIV/AIDS and what they understood from the experience or exchange; subsequent knowledge of HIV/AIDS and its meaning; personal experiences of HIV/AIDS; understandings about the transmission of HIV; care and support of people living with HIV/AIDS; AIDS treatment literacy; and HIV prevention.

During the post-intervention focus groups, discussion centred upon the applicability of the *Tsha Tsha* intervention to offenders' lives – whether they felt able to take the lessons and content from *Tsha Tsha* and apply these in their own contexts. This was followed by discussions about choices *Tsha Tsha* characters make in the drama, and how, if at all, these might impact on participants' choices in the future.

Focus group discussions were conducted with the facilitators of the groups to gain insights into their experiences as peer educators and their impressions of the intervention from their perspective as facilitators.

Focus group discussions were tape-recorded, translated into English and transcribed.

### Limitations of the study

The findings are mainly representative of the sample – female offenders at the Johannesburg Female Correctional Centre and male juvenile offenders at Leeuwkop Correctional Centre – and are thus not necessarily generalisable to other settings.

The quantitative baseline survey involved 81 respondents and the follow-up survey involved 52 respondents, giving a response rate of 64%. Although the post-intervention sample was similar to the pre-intervention sample in terms of age composition, there were changes in terms of sex, race and overall numbers of respondents and thus the comparative findings can not be used to provide reliable measures of change. Additionally, it was not possible to assess the extent to which respondents had been exposed to other interventions apart from the *Tsha Tsha* intervention. These would include exposure to other formal interventions that might have been accessed through television, radio, or print media. There might also have been exposure to interpersonal discussion and other forms of interaction or

information. These factors make statistical comparisons with baseline data unreliable. The qualitative data do, however, provide direct insights into baseline knowledge and awareness.

The post-intervention evaluation took place soon after the intervention, and it is thus not possible to draw conclusions about long-term impacts.

This is also an internal evaluation in the sense that the researchers have been closely involved in the development of the *Tsha Tsha* television series and the intervention design. It should therefore be recognised that there may be an inclination towards over-elaborating positive impacts and under-elaborating negative impacts. This possibility has been drawn into the data interpretation process, and there has been particular attention to ensuring that conclusions are demonstrably linked to findings.

## PRE-INTERVENTION FINDINGS

### Quantitative findings: Pre-intervention survey questionnaire

#### *Personal exposure to HIV/AIDS*

Prior to the intervention, the participants in the pilot programme had relatively high levels of personal experience with HIV/AIDS and high levels of knowledge about many aspects of HIV infection risk. This included perspectives and perceptions of risks in their present context.

More than 80% of participants personally knew someone who had died of AIDS in the past year.

#### *Exposure to mass media, educational television and radio programmes*

Nearly two thirds (61%) listened to the radio daily, with 20% listening 2-6 days a week, and 11% never listening to the radio. Television was much less likely to be accessed, with nearly two thirds (65%) never watching television, only 7% watching television 2-6 times a week, and 17% watching television daily.

Over a quarter (29%) read a magazine daily, 30% read a magazine 2-6 days a week, 22% one day a week, and 19% never read a magazine. Similar rates were found for newspapers – 22% read a newspaper every day, 23% read a newspaper 2-6 days a week, 37% once a week, and 19% never.

Table 1: Exposure to mass media

| | Never | 1 day a week | 2 to 6 days a week | Every day of the week |
|---|---|---|---|---|
| Listen to radio | 11% | 9% | 20% | 61% |
| Listen to community radio | 36% | 11% | 27% | 26% |
| Watch TV | 64% | 11% | 7% | 17% |

| Read a magazine | 19% | 22% | 30% | 29% |
|---|---|---|---|---|
| Read a newspaper | 19% | 37% | 23% | 22% |

Table 2 shows the proportion of participants who had been exposed to various HIV/AIDS communication programmes during the past year. *Tsha Tsha* is the television series that has been viewed by most respondents (69%), followed by Khomanani radio programmes and adverts (63%) and Soul City on television (56%), with lower proportions for other programmes.

Table 2: Exposure to HIV/AIDS communication programmes

| **Programme *(n=81)*** | **Percent** |
|---|---|
| Watched *Tsha Tsha* on television | 69% |
| Heard a Khomanani radio programme or advert | 63% |
| Watched *Soul City* on television | 56% |
| Seen a Khomanani television programme or advert | 53% |
| Listened to *Soul City* on the radio | 47% |
| Watched *Takalani Sesame* on television | 46% |
| Watched *Beat it – Siyanqoba* on television | 24% |

More than two fifths (43%) of participants had attended a workshop on HIV/AIDS in the past year.

One in five participants (20%) reported having called the national tollfree AIDS helpline, followed by 15% who had called the Stop Women Abuse Helpline, 11% who had called Childline, and 8% who had called Life Line and Thetha Junction.

### *HIV/AIDS knowledge*

HIV/AIDS knowledge was assessed through a series of questions. Overall respondents were knowledgeable about HIV/AIDS, with more than three quarters (78%) of respondents answering the knowledge questions correctly (see Table 3). High scores were achieved on knowledge that HIV is not transmitted by touch (91%), that condoms have to be used consistently to prevent HIV (94%), and that HIV is not transmitted through sharing a meal (90%). Less likely to be answered correctly were questions about traditional healers being able to cure AIDS (64%), and knowledge that having fewer sexual partners reduces HIV risk (36%).

Table 3: HIV/AIDS knowledge

| **True or False**[5] *(n=81)* | **Percent correct** |
|---|---|
| If you use condoms every time you have sex you can prevent HIV infection [true] | 94% |

[5] Questions were asked in such a way that they involved both disagree and agree responses. For purposes of summarizing in this table, we have turned all statements into a positive direction and indicated this through inserting “not” in brackets.

| | |
|---|---|
| You can be infected with HIV by touching a person with HIV/AIDS [false] | 91% |
| A person with HIV can look healthy [true] | 91% |
| HIV can be transmitted by sharing a meal with someone who is infected with HIV [false] | 90% |
| To prevent HIV infection, a condom must be used for every round of sex [true] | 84% |
| You can reduce the risk of HIV by being faithful to your sexual partner [true] | 82% |
| It is against the law for a girl of 15 to have sex with a much older man, even if she agrees to it [true] | 82% |
| Sexually transmitted infections increase the risk of HIV infection [true] | 81% |
| A mother can pass HIV on to her baby during pregnancy and childbirth [true] | 78% |
| A woman can transmit HIV to her baby through breastfeeding [true] | 78% |
| Traditional healers can cure AIDS [false] | 64% |
| If a person is raped, there are drugs that can prevent HIV infection [true] | 60% |
| If you have fewer sexual partners, you are less likely to get infected with HIV [true] | 36% |
| **Average** | **78%** |

### *Attitudes to HIV/AIDS*

Overall participants held positive attitudes in relation to HIV/AIDS and to people living with the disease (see Table 4). However, the notion that getting AIDS is the result of sinning was held by about a third of respondents. Similar proportions of respondents felt that HIV-positive people should not have sex; that family members would not support them if they had HIV; and that they would be embarrassed to be seen with someone with HIV/AIDS. Perceptions of social norms discriminating against people with HIV/AIDS were seen as being high, with half of respondents believing that people with HIV would soon lose their friends.

Table 4: Attitudes to HIV/AIDS

| **How much do you agree with the following statements?**[6] *(n=81)* | **Agree / Strongly agree** |
|---|---|
| A woman has a right to say no to sex if she does not want it | 91% |
| Young people should not start having sex before the age of 18 | 85% |
| It is [not] a waste of money to train/educate someone who is HIV-positive | 82% |
| It is [not] acceptable for a man to have more than one girlfriend at the same time | 80% |
| It is [not] okay for older men to have sex with girls younger than 18 | 80% |
| When you learn that you have HIV, your life is [not] over | 80% |
| AIDS should be talked about openly at funerals of people who have died of the disease | 76% |
| I would [not] be embarrassed to be seen with someone who everyone knows has HIV/AIDS | 66% |
| If I told members of my family I had HIV, most of them would support me | 65% |
| People who know they are HIV-positive should [be able to] have sex | 63% |

[6] See footnote 5 above.

| | |
|---|---|
| Getting AIDS is [not] the result of sinning | 63% |
| People with HIV will [not] soon lose their friends | 51% |

### *Risks of HIV infection*

In the pre-intervention survey questionnaire, participants were asked an open-ended question about their perceptions of HIV infection risk in correctional centres.

Male participants identified four main categories of risk:

- Sharing of needles and razors;
- Contact with blood spread through fights;
- Sharing eating utensils; and
- Sexual intercourse between offenders (including rape).

Female participants identified six categories of risk:

- Exposure to needles in the correctional centre hospital/clinic;
- Exposure to blood through fights and helping bleeding or sick people (no gloves);
- Exposure to blood through assisting women who gave birth in correctional centres;
- Sharing utensils and other personal effects;
- Overcrowding and sleeping in the same bed (as well as sharing showers, cells); and
- Sexual intercourse between offenders (including rape).

### *HIV testing*

Respondents were asked if they had ever been tested for HIV. There was a high rate of ever having been tested amongst female participants (82%), while the rate for males was considerably lower (19%). The main reasons for testing among females were: *'I wanted to know my status'*; *'I was pregnant'*; and *'I was feeling sick'*. For males, the main reasons were: *'I wanted to know my status'* and *'I engaged in risky sex'*.

The main reason for not having been tested for females was: *'I was scared'* (60%). For males, the reasons included: *'I'm not ready to be tested'*; *'I do not think I am HIV-positive'*; and *'I trust my partner'*.

## Qualitative findings: Pre-intervention focus groups

### *Knowledge about HIV/AIDS*

Participants at both correctional centres generally had high levels of knowledge about HIV transmission, prevention, care and support, and treatment. They were able to describe accurately the difference between HIV and AIDS, modes of HIV transmission, HIV prevention methods and treatment options. This included detailed biomedical knowledge:

*HIV is a sickness that allows many diseases to come easily to you and you cannot be cured. When you have AIDS it is when many diseases are already in you... You will be coughing, have cancer and all the other diseases. (Male participant)*[7]

*If your CD4 count is low, less than 200, you have AIDS. You are not HIV-positive but you are full-blown. (Female participant)*

Some participants mentioned hearing about HIV/AIDS for the first time when they entered the correctional centre as a product of encountering offenders who were living with HIV or who had AIDS.

A subset of participants recognised that anyone, including themselves, could be potentially infected with HIV:

*Everybody, everyone. I no longer think it's for homosexuals – it's for me too. I can get it. And anyone - it doesn't matter what's your status, what's your level of education, if you are rich or you are poor - you will get it, you might get it, you just have to be on guard. (Female facilitator)*

HIV transmission pathways were well known, with participants naming unprotected sex, exposure to infected blood, and mother-to-child transmission as the main means of transmission. There were clearly different levels of knowledge among participants, with most of the peer educators and some group members displaying better than average levels of knowledge.

While male participants rarely mentioned mother-to child transmission, female participants' knowledge about HIV transmission from mother-to-child was well-developed. Several women who are living with HIV have children and most seemed to have knowledge of the potential to transmit the virus to the child.

Although infidelity and having unprotected sex were identified as risk factors by male and female participants alike, only male participants talked about the role of peer pressure in having multiple and concurrent sexual partners.

*Participant 1: Pressure. Peer pressure because you'll find that he [my peer] is with so many girls and me I'm with one. And then they say, 'Haai you, you are only with one girl. You are weak, weak, weak'.*

*Facilitator: So what do you have to do to prove that you're a 'real' man?*

*Participant 1: You must have many girls.*

*Participant 2: I must maybe have about four to five girlfriends.*

*Facilitator: At the same time?*

*Participant 2: At the same time... (Male facilitators)*[8]

---

[7] Pre-Ass LWKOP Gp1 Male 23Feb06 (37466-37799)
[8] Pre-Ass LWKOP Fac Male 23Feb06 (58585-59823)

With regard to HIV treatment, participants were generally well-informed, with most knowing about the existence of antiretroviral treatment/therapy (ART), as well as when antiretroviral drugs (ARVs) are indicated, and that treatment is life-long. Participants described positive living and healthy lifestyle as ways of living with HIV, including exercise, healthy eating, reducing levels of stress, and having social support.

> *There is medication to help… ARVs and I think the positive attitude also counts a lot. I saw people having AIDS – they just decide it's finished and they died very quickly because they gave up on life. Then you get people who remain with positive attitudes, who are positive about life – they eat healthy, they exercise and they live for years. (Female participant)*[9]

Some of the issues that participants were not clear about included the length of ARV treatment (with some confusing it with the length of treatment for tuberculosis - TB) and whether government-supplied ARVs were as effective as those bought privately. Despite the generally high level of knowledge, there were individuals who had little or no knowledge about HIV treatment and some who believed that HIV or AIDS could be cured.

### Perceptions about HIV/AIDS

Participants were asked about their perceptions of the origin of AIDS. In response, many common myths were mentioned including that HIV was created to destroy black people, that AIDS was a punishment from God, and that it was caused by witchcraft.

In further discussion, it was observed that HIV was linked to sexual behaviours that were seen as immoral, including promiscuity, sex with prostitutes and sex between homosexuals.

Overall, there was a sense that HIV/AIDS affected others. Knowing someone who was living with HIV or who had died of AIDS was the reason given most often by participants for understanding that HIV/AIDS was 'real'.

> *First time I heard about AIDS, I did not take it serious, I only realised here in prison that AIDS kills. I was working at the hospital so I saw a HIV-positive person die in front of me…. That's when I took it serious. (Male participant)*[10]

Participants were asked whether their understanding of HIV/AIDS had changed from the first time they had heard about the disease to the present, and if so, what this could be attributed to. The greatest indicator of positive change was personal experience of HIV/AIDS. The vast majority of participants described that HIV/AIDS became a reality for them after someone close to them (partner, family member, friend,

[9] Pre-Ass JHB Female Gp1 21Feb06 (54491-54880)
[10] Pre-Ass LWKOP Gp2 Male 23Feb06 (6076-7614)

colleague etc.) had died of AIDS. There were also reflections on personal risks which, for some, were linked to understandings gleaned in the correctional centre context.

> *This place makes you think... about your life outside, the unprotected sex you had and now I know how AIDS kills, how it affects you and that you can live with AIDS for 10 or 15 years as long as you treat it. This place [the correctional centre] opens our minds... I started to realise when people came with small books to teach us about AIDS, when you opened it, you see people infected with AIDS and you realise that this thing is serious, that's when I start to realise. (Male participant)*[11]

> *I started hearing about HIV/AIDS when my boyfriend passed away last year, so I heard that he is HIV-positive and then I did not go to test… I was afraid... Now I'm thinking of going to test because we did not use condoms. (Female participant)*[12]

> *When I started to know about HIV/AIDS it was in 2004. My mother passed away, she had HIV... You know it was terrible, but from then I started to learn about it. Now I know if someone is talking about AIDS what she will be talking about because I have got experience… I was the one who was nursing her doing all that stuff. (Female participant)*[13]

Among females finding out that one is HIV-positive resulted in a closer engagement with HIV. Being HIV-positive was typically discovered through being tested during pregnancy or as a product of the death of a partner, with psychological impacts being compounded as a product of incarceration.

> *It was the worst day of my life when I found out that I was HIV-positive and there already I was nine months pregnant…. I gave birth... Then I came to prison... During those two months I had to deal with this thing alone and I almost committed suicide. But it's funny because I got sentenced to five years imprisonment and I got 'growth' here. Here I found a lot of people who are like me that are living healthy, are living nice, they are not dead. I think if I didn't get sentenced in July I would have killed myself and that baby. (Female facilitator)*[14]

A range of experiences characterised the continuum of beliefs from the perception that AIDS is a disease that affects others to increasing perceptions of personal risk of HIV infection.

> *The first time I heard about AIDS, I did not take it seriously because I was on drugs. The drugs were telling me ugh, AIDS is nothing, it won't get to me and when I had sex I would have it without a condom... When I came*

[11] Pre-Ass LWKOP Gp2 Male 23Feb06 (6076-7614)
[12] Pre-Ass JHB Female Gp1 21Feb06 (4915-5668)
[13] Pre-Ass JHB Female Gp1 21Feb06 (6795-7295)
[14] Pre-Ass JHB Fac Fem 21Feb06 (60656-64255)

*to jail I learned about AIDS and I took a test and tested negative. That's when I realised AIDS is serious, I must take it serious. I must not play because AIDS is killing people. (Male participant)*[15]

### *Perceptions of non-sexual risks of HIV infection in the correctional centre*

Participants identified similar categories of non-sexual risk to those found in the questionnaire component. Participants identified exposure to blood – through physical fights, biting, and accidents – as an HIV infection risk. There is a widespread sense that many participants may be HIV-positive, but because of low disclosure rates it is not known for certain who is or is not living with HIV.

*Like when we fight we bite each other. Others scratch with the fingers, others cut with objects. Then if I cut and you cut and we hold each other in that struggle transmission is possible. (Female facilitator)*[16]

*Here in prison we fight over a lot of things, it can be money or cigarettes. At times you don't know if he has it and you fight with him and you stab him or he stabs me. So through that one can get it... So there is fear now because you don't know who has it. (Male participant)*[17]

Female participants identified the lack of easy access to protective measures such as gloves as problematic in instances where they are exposed to blood.

*If someone gets hurt it's not always possible to say, 'Okay, you must bleed. I'm just gonna go get gloves from the hospital.' (Female participant)*[18]

Female participants perceived a risk of exposure to HIV while assisting fellow offenders to give birth in correctional centres where gloves were not available.

*Here in prison… sometimes a pregnant woman just gives birth in the middle of nowhere and people that are not trained to help deliver the baby then [are also] without gloves. And no one knows whether they have a cut or they don't, and if that person is HIV-positive everyone is at risk. (Female facilitator)*[19]

Reference was made to overcrowding as a factor perceived to be related to the risk of HIV infection. This was only mentioned by female participants. Amongst females there were also fears of exposure to menstrual blood in bathtubs and on toilet seats.

*For now we are overcrowded, we are starting to share beds like we are sleeping two-two. If we are sleeping together and one has a wound, and*

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[15] Pre-Ass LWKOP Gp2 Male 23 Feb06 (4644-5520)
[16] Pre-Ass JHB Fac Fem 21Feb06 (67223-68172)
[17] Pre-Ass LWKOP Gp1 Male 23Feb06 (18007-9002)
[18] Pre-Ass JHB Female Gp1 21Feb06 (18071-18452)
[19] Pre-Ass JHB Fac Fem 21Feb06 (34901-35541)

*there is blood coming out and maybe I've got a wound somewhere. If we are touching each other, I can get HIV. (Female participant)*[20]

*For us in my section, we only have two tubs, some of us don't clean and just leave their mess like that. We don't know that if that person is infected or something because us women, we have our monthly periods, some they just leave it like that. (Female participant)*[21]

Participants also mentioned fear of HIV infection if razor blades, needles and earrings are shared.

Among male participants the perception was that there is a risk of HIV infection through sharing eating utensils with people living with HIV/AIDS. For some young men, there was an intense focus on the cleanliness of eating and drinking utensils, with the belief that HIV could be spread in water being used to soak and wash cups and plates. There were also some beliefs that food could be infected with HIV if the person cooking it is HIV-positive.

*The plates that we eat from are not properly washed. They take them and put them in the water and take them out just like that since we are many, close to 600. Even mugs are not properly washed... You find that somebody is dripping blood and the water they use to wash utensils is not changed regularly. As they put the plates and mugs inside the water there is already blood with AIDS in the water. They will continue dipping all 600 plates in that water. When I take my plate and mug to get my food I will be getting HIV in a plate and mug that has AIDS. I will be eating and drinking AIDS. (Male participant)*[22]

### *Perceptions of sexual risks of HIV infection*

Apart from the sexual risks identified in the questionnaire component, male prisoners added sexual intercourse with correctional centre personnel, whilst females mentioned sexual intercourse with maintenance workers, as additional risks.[23]

Male and female participants described rape or sexual coercion as an HIV infection risk in correctional centres. At both correctional centres there were participants who described incidents of non-consensual sex, either between offenders or between offenders and correctional centre personnel. Non-consensual sex was accompanied by open or veiled threats about non-compliance or the suggestion that events would be reported to higher authorities. Female participants also reported that sex occurred with male maintenance workers.

[20] Pre-Ass JHB F Gp2 21Feb06 (23905-24406)
[21] Pre-Ass JHB Female Gp1 21Feb06 (17316-17648)
[22] Pre-Ass LWKOP Gp1 Male 23Feb06 (26987-27600)
[23] The aim of the pilot intervention was not the exploration of sexual practices within correctional centres, and thus emerging findings in relation to this area need to be seen as anecdotal and requiring further in-depth study.

Sex in exchange for money or goods between offenders and correctional services personnel was talked about by male and female offenders.

Among male and female focus group participants there were concerns raised about their sexual partners outside the correctional centre.

> *Even us here, the women, some of us we are married outside and we don't even know what our husbands are doing, so I think it's very difficult to...to control AIDS. You can tell yourself, 'Oh, me I'm here, I'm safe', but my husband is not safe outside, I don't know what he's doing out there, so you go out and you just get infected, just like that. (Female participant)*[24]

In the correctional centres, participants described a range of sexual behaviours that are perceived to carry HIV risk, including consensual sex between offenders. The lack of access to condoms was identified as central to perceptions of risk, as unprotected sexual intercourse is taking place primarily between same-sex offenders. Participants described that, although condoms were available at correctional centres, correctional services personnel did not readily provide condoms to offenders.

> *[Sex] happens in prison you see, but now… they're acting like it doesn't happen and a lot of people, this thing, it's spreading in prison.… Some of the care workers … take it as if it doesn't exist, you understand.… They pretend it doesn't exist because maybe she feels or he feels a bit embarrassed to give the inmate a condom knowing that there are no women this side. So obviously what is he going to do with it, you know that type of a thing. (Male facilitator)*[25]

> *There are [condoms] but you can't get them.… While I was doing HIV/AIDS peer education, one of my group members asked: "Hey man, where can I access condoms here?" Then we referred that person to the…health care worker…So when that guy he went there…he said, "I'm asking for condoms." Then they asked him, "What for?" Because here, there's this thing that should they find you sodomising another person, they take it as a rape, they do not take that thing of consent, you see. So they ask you, "What are you going to do with that condom?" Then obviously you're not going to tell that person, "Hey no, what, what I'm going to do one, two, three, one, two, three." Then obviously you've got no other choice, you have to leave. You cannot break into the hospital and steal condoms. But you know they are there…And they are given by the health department for the very same things because they know things they happen in prison. (Male facilitator)*[26]

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[24] Pre-Ass JHB Female Gp1 21Feb06 (13141-14267)
[25] Pre-Ass LWKOP Fac Male 23Feb06 (69004-69952)
[26] Pre-Ass LWKOP Fac Male 23Feb06 (67672-69001)

Female participants also described the risk of HIV and other sexually transmitted infections (STIs) through having unprotected sex with women, including where ‘sex aids’ are used and shared between people.

> *Here in prison, you end up having an affair with another woman and then…there are no condoms. You can end up infecting each other. (Female participant)*[27]

> *There are no female condoms available and even normal condoms, because in some instances, other objects other than the parts of the body are used [in sexual relations] and infections can be a high risk. (Female participant)*[28]

### Perceptions of HIV prevention methods

Attitudes towards the prevention of HIV and sexually transmitted infections varied, with some participants likening their attitude to HIV to the fatalism they associated with crime. Some participants described having the same thought patterns regarding the potential risk of HIV infection as they had about being caught in criminal activity: an attitude characterised by risk-taking and fatalism. On a similar level, responsibility for HIV infection was perceived as resting on others and not the self, in the same way that criminal activities were seen to result from a perception of not having choice and feeling pressurised to act in a particular way.

> *It depends on the situation…. There are people who realise that you know what, my life is coming together. Maybe I'm finished with school, I'm getting a job, you know, things are okay now. I love life, you see. That person, he will think differently from me. I carry a gun, first of all, and I know I'm going to die anytime.*

> *Facilitator: So what does that mean?*

> *That means I'm reckless, you see. For me it means I was living a reckless life, you see. That's why like for me I knew about HIV.... [but] I didn't care. It's just like going to rob a shop or to rob a Spar or something. You know there are security guards there, you know there are policemen and you know you are going to get shot…. There's a chance that I might get shot. (Male facilitator)*[29]

Several participants described having a history of multiple and/or concurrent sexual partners and saw little or no risk for HIV infection, as a result of the belief that using a condom eliminates such risk.

[27] Pre-Ass JHB Gp2 21Feb06 (24447-24680)
[28] Pre-Ass JHB Fac Fem 21Feb06 (69208-69557)
[29] Pre-Ass LWKOP Fac Male 23Feb06 (48380-54514)

> *The main issue here is to play safe. Play safe always, at all costs, just use a condom. Because you can dump a guy this month, next month get a new guy. (Female facilitator)*[30]

> *I can sleep with a hundred partners because maybe this one does not satisfy me I will try the next one. I don't think my life is [in] danger while using a condom; I can sleep with a hundred. (Female participant)*[31]

Among some female participants the concept of polygamy was viewed as 'acceptable' and normative with a few believing that it was a lifestyle choice that protected against HIV infection. For example: '*It happens to have been proven in real life situations that people in polygamy don't get this [HIV].' (Female facilitator)*[32]

> *It depends from which perspective you are looking at it…remember that… good morals to you might be bad morals to me. Morals are influenced by very many values and very many systems. As a polygamist myself I don't have a problem of having many, many partners. (Female facilitator)*[33]

> *The participants made it clear that women don't bring it [HIV] to the family because in a polygamous situation women look after each other. The first wife is the boss. If you're going out, you'll come to the fist wife and say, "Today I want to go to town." And the first wife will say, "Go with so-and-so, or I am coming with you." (Female facilitator)*[34]

Attitudes towards condom use varied, with some participants expressing that condoms should be used during every sexual encounter and others stating that condom use was linked to perceptions of love and trust. However, most participants noted situations where condoms are not likely to be used, such as with a long-term partner, because of social and cultural pressures (such as peer pressure), or when wanting to conceive a child: *'There are no plastic children. You can't use latex and hope to increase your progenity.' (Female participant)*[35]

The notion that condom use is viewed as an indication of being less of a 'man' emerged as a factor that influenced male participants in their attitudes towards condom use. Alcohol and drug use were also noted as influencing attitudes and decisions to use condoms.

> *You must take into context the life that you are living…Alcohol and drugs they have an influence. Somewhere somehow, they affect these decisions. Especially now, I'm drunk, I'm high and there's a mentality around the guys, to say, eish….if you're using protection you are weak…. And like how can you eat the sweet with the cover on, you know these things they*

[30] Pre-Ass JHB Fac Fem 21Feb06 (96511-97074)
[31] Pre-Ass JHB F Gp2 21Feb06 (46804-47953)
[32] Post-Ass JHB Fac F Gp1 23Jun06 (23836-28604)
[33] Pre-Ass JHB Fac Fem 21Feb06 (96069-96479)
[34] Post-Ass JHB Fac F Gp1 (29193-30923)
[35] Pre-Ass JHB Fac Fem 21Feb06 (41220-41625)

*are happening, it's tough, we guys, we are taking it serious. (Male facilitator)*[36]

Female participants described situations of feeling powerless to insist that a sexual partner use condoms, which was exacerbated by being socio-economically and/or emotionally dependant on a partner, fearing accusations of infidelity, or of being infected with HIV.

> *Participant 1: It's a very difficult situation, especially for a woman, you are out there, you don't have education, you don't have a degree at university, you cannot get a job and this guy is giving you a house, he is giving you money, he is giving your children food to eat and he says, "There is no way that I'm going to have sex with a condom – you either take your things and go." Where are you going to go, being a woman with children without a dad? You gonna take that risk.*
>
> *Participant 2: I agree with what she is saying, because I stay with the father of my child, he does not allow me to even go to the shop or do anything else. If I tell him about the condom, he says to me is there anyone I'm sleeping with during the day? (Female participants)*[37]

### *HIV testing*

In focus groups, participants identified similar reasons as in the questionnaire for having tested or not having tested for HIV.

Females expressed a fear of HIV testing and finding out their results, particularly in cases where they had witnessed a family member or a person close to them die from AIDS.

> *I'm afraid, scared to test. I'm scared to test because I have a reason …of seeing my own mother dying of that disease. It affected me a lot, that now...if I think about going to test, I get so scared about my result. I will tell myself, what if I go and they tell me I've got this thing? So I'm so scared, I can't lie. I'm scared because of what I went through, of what I experienced through my own mother.*[38]

There was also mistrust about the reliability of HIV tests.

> *I have a question, let me say you go for HIV test at the clinic and they test you and find you are positive. Then you go back again because you want to make sure, then it says negative. Then you go again for the third time and it says positive. Which one is right? …This is something that*

[36] Pre-Ass LWKOP Fac Male 23Feb06 (43796-46069)
[37] Pre-Ass JHB F Gp1 21Feb06 (26567-27974)
[38] Pre-Ass JHB Female Gp1 21Feb06 (28554-29989)

*happened to a friend of mine. What I am trying to find out is if there is no mistake somewhere. (Male participant)*[39]

Female participants spoke about their personal experiences of VCT, whereas few males did so. In addition, females were more likely to have been for an HIV test than males, and to believe that it was in their best interests to know their status. In the words of one participant: *'I think it's better to know your status so as to get the treatment sooner, even if it's difficult.' (Female participant)*[40]

There was a perceived lack of confidentiality regarding individuals' HIV test results, and long delays in communicating results to offenders. These were seen as contributing towards the relatively low uptake of VCT services at the two correctional centres visited. There were also reports of results being unavailable as a product of being misplaced.

> *I don't mind to go there to [the] sisters and take a blood test because I want to know my status.... So last time I did go there, when I have to get my results they tell me they are missing, I have to take another one again. So I'm still waiting for my results because I [took] it again.... It takes two weeks…but when you go there there's no result. You can go three months. I go there for three months and then they tell me my result is missing, then I take another one again. Even now I'm still waiting.*[41]

The lack of discreetness when relaying test results to offenders, as well as the way results are communicated, was identified as problematic by participants who talked about their VCT experiences at correctional centres.

> *I went to take [a] blood test…with my friend… I could see that in prison there's no secret because the way they reacted towards us, they cancel us and then they said we must go and take the blood and then they said they will call us when the results are back. And then maybe after three weeks or four weeks the sister came to call both of us and said, "Your results are back, let's go." And then we go there and I went in first and they tell me, "Okay, fine, for now we are still negative." Just like that – "For now we are still negative." And then they talk to me and say, "Just be like that, don't do wrong things as we know in prison what's happening", and then I went out. Then this girl came in, you know, they didn't even wait for me maybe to go out, they just show it in her face that she's positive.... You know, she could see, she couldn't even wait for them to tell her because she could see the way the sisters were looking at her. Immediately when they started to want to talk they said "Okay, go, go, move this side, the doctor will see you, you are not right." Imagine that, I didn't even wait for*

[39] Pre-Ass LWKOP Gp1 Male 23Feb06 (24638-25589)
[40] Pre-Ass JHB Female Gp1 21Feb06 (29992-30101)
[41]Post-Ass JHB Fac F Gp2 27Jun06 (26465-28147)

*her because I could see that this girl she can maybe collapse or what and I can't face it. (Female facilitator)*[42]

*Participant 1: Say I'm waiting for my result. When I can go there and ask them they'll just bring a file [with the] results of people. We are checking, I'm checking with the sister, we are opening [the file], so I'm looking at everything, everyone's result....*

*Facilitator: You can see everybody's results?*

*Participant 1: Ja, maybe mine is there down or it's not there, then we'll take the book, me and sister, we just open the book, we look - I'm looking at other people's things now.*

*Facilitator: So would you say that that puts people off from testing?*

*Participant 2: Ja, definitely. In prison, definitely. I'm sorry I won't take it like you. I will tell them straight: "We need to be alone. I don't want other people around me." But if you don't do it they don't care. If you can't stand up for yourself, they don't care in this prison.... But we've got the right, we have the right to stand up and say, "Listen, I want to be alone when you look through the results." (Female facilitator)*[43]

## POST INTERVENTION FINDINGS

### Quantitative findings: Post-intervention assessment

As has been noted in the limitations section of this survey, the response rate of the post-assessment questionnaire, in conjunction with possible exposure of participants to a wide range of other influences, makes it impossible to measure changes quantitatively. The pre-assessment findings do, however, provide insight into various aspects of respondents' knowledge, awareness, perspectives and practices, and are thus useful in relation to assessing the impact of HIV/AIDS interventions.

Noting the limitations, pre- and post-intervention assessments were compared to provide insight into possible areas of change. The main marked change was noted in relation to helpline access. Increases in respondents who reported calling helplines were noted as follows: AIDS Helpline, 20% at baseline to 30% post intervention; Stop Woman Abuse Helpline, 11% to 30%; Childline, 8% to 31%; Life Line, 8% to 26% and ThethaJunction, 8% to 23%.

#### *HIV/AIDS knowledge*

Existing HIV/AIDS knowledge levels were high, and therefore were not expected to change to a large degree. Overall, and on average, there was a small positive increase.

[42] Post-Ass JHB Fac F Gp2 27Jun06 (28149-29941)

[43] Post- Ass JHB Fac F Gp2 27Jun06 (29944-31391)

However, knowledge about the risks of having fewer sexual partners was more likely to be incorrect post-intervention.

Table 5: HIV/AIDS knowledge

| True or False | % at baseline | % post-intervention |
|---|---|---|
| A person with HIV can look healthy (true) | 91.3% | 98.0% |
| If you use condoms every time you have sex you can prevent HIV infection (true) | 93.6% | 96.0% |
| HIV can be transmitted by sharing a meal with someone who is infected with HIV (false) | 90.1% | 92.2% |
| You can be infected with HIV by touching a person with HIV/AIDS (false) | 91.4% | 94.1% |
| To prevent HIV infection, a condom must be used for every round of sex (true) | 84.0% | 90.2% |
| A mother can pass HIV on to her baby during pregnancy and childbirth (true) | 77.5% | 88.2% |
| You can reduce the risk of HIV by being faithful to your sexual partner (true) | 81.5% | 88.2% |
| Sexually transmitted infections increase the risk of HIV infection (true) | 81.0% | 86.0% |
| A woman can transmit HIV to her baby through breastfeeding (true) | 77.8% | 84.3% |
| It is against the law for a girl of 15 to have sex with a much older man, even if she agrees to it (true) | 81.5% | 84.0% |
| If a person is raped, there are drugs that can prevent HIV infection (true) | 60.0% | 68.6% |
| Traditional healers can cure AIDS (false) | 64.2% | 66.7% |
| If you have fewer sexual partners, you are less likely to get infected with HIV (true) | 36.3% | 24.5% |
| **Average** | **77.7%** | **81.6%** |

### *HIV/AIDS attitudes*

The intervention appears to have led to changes in attitudes of participants, with changes of more than 10% being noted for most indicators. Changes were particularly notable in the areas where *Tsha Tsha* has strong emphasis – for example, in portraying the humanity and potentials of people living with HIV/AIDS. Although there was some shift in the notion that AIDS was the result of sinning, this did not change markedly.

## Table 6: Attitudes to HIV/AIDS

| **How much do you agree with the following statements?**[44] | **Baseline: Agree / Strongly agree** | **Post-intervention Agree / Strongly agree** |
|---|---|---|
| Its [not] okay for older men to have sex with girls younger than 18 | 79.5% | 94.1% |
| A woman has a right to say no to sex if she does not want it | 91.1% | 92.2% |
| AIDS should be talked about openly at funerals of people who have died of the disease | 75.9% | 92.2% |
| When you learn that you have HIV, your life is [not] over | 79.5% | 90.0% |
| It is [not] a waste of money to train/educate someone who is HIV-positive | 82.2% | 90.2% |
| It is [not] acceptable for a man to have more than one girlfriend at the same time | 80.2% | 86.3% |
| Young people should not start having sex before the age of 18 | 85.0% | 82.4% |
| I would [not] be embarrassed to be seen with someone who everyone knows has HIV/AIDS | 65.8% | 80.4% |
| If I told members of my family I had HIV, most of them would support me | 65.0% | 76.0% |
| People who know they are HIV-positive should [be able to] have sex | 63.1% | 72.5% |
| Getting AIDS is [not] the result of sinning | 63.0% | 66.0% |
| People with HIV will [not] soon lose their friends | 50.6% | 64.0% |
| **Average** | **73.4%** | **82.2%** |

## Qualitative findings: Post-intervention focus groups

### *Knowledge about HIV/AIDS*

Despite the generally high levels of knowledge there were some participants from both correctional centres who had little or no knowledge about HIV and AIDS at the pre-intervention phase. The *Tsha Tsha* intervention provided them with information that was perceived to be helpful and educative.

> *Before coming to prison I had no information about HIV, but due to this programme I have information now. (Female participant)*[45]

> *I enjoyed it because I have learned many things. Before I did not have right information about HIV, but now I have and it's clear. (Female participant)*[46]

[44] Questions were asked in such a way that they involved both disagree and agree responses. For purposes of summarising in this table, we have turned all statements into a positive direction and indicated this through inserting "not" in brackets.
[45] Post-Ass JHB F Gp1 26May06 (48873-48993)
[46] Post-Ass JHB F Gp2 26May06 (1326-1552)

Participants who did not previously know the difference between HIV and AIDS described learning this after exposure to the intervention. For several participants, HIV and AIDS had been synonymous with death, a particular understanding of symptoms, and strong ideas about physical appearance in relation to health and HIV status. For many participants, one of the main lessons taken from the intervention sessions was the idea that HIV status can only be confirmed through a blood test and cannot be assessed based on assumptions or physical appearance.

> *What I have learnt is not to judge people by their appearance. Like myself, when I see a person with shingles, I had a belief that it was AIDS. In my mind I was thinking that symptoms of HIV are shingles, TB, swollen glands, but now I have realised that you can have all those things being negative. It does not mean that you only find those things in the HIV-positive people. (Female participant)*[47]

Modes of HIV transmission were readily identified by most participants, with unprotected sexual intercourse and contact with infected blood being described as the primary means of HIV infection. There were, however, participants at the pre-intervention phase of the programme who did not know the main pathways of HIV transmission and who believed that casual transmission was possible. This knowledge changed as a product of the intervention.

> *Before I did not know how one gets HIV. I was telling myself even the mosquito bite gives you HIV, or sitting where an HIV-positive person was sitting, but now I know how one gets HIV and I also know how to prevent yourself getting HIV. (Female participant)*[48]

An increase in knowledge about HIV and how it is transmitted led to fundamental changes in attitudes towards people perceived to be living with HIV or AIDS.

> *I liked the part of Viwe's father, because I don't think he hated people who are HIV-positive on purpose. He was not knowledgeable about the virus. Like myself, I hated people who are HIV-positive. I have learnt something from that programme. My sister's child was positive. I did not like it when my kids were playing with him, so this programme has taught me how HIV is contracted. Even when the children were sharing a sucker I did not like it, but now I know that you cannot get AIDS by sharing food, clothes. (Female participant)*[49]

> *We must give a sick person love, like we have seen how Andile was caring for his mother. Before we had even feared touching a cup which was*

[47] Post-Ass JHB F Gp1 26May06 (34111-34516)
[48] Post-Ass JHB F Gp2 26May06 (3101-3458)
[49] Post-Ass JHB F Gp2 26 May06 (14968-15670)

*touched by a person with HIV. In this programme we have learned how HIV is contracted. (Female participant)*[50]

Knowledge of HIV prevention methods was high overall, and most participants cited methods including abstinence, use of condoms, and being faithful. Avoiding direct contact with blood was another commonly cited method of prevention. There was evidence that some concepts, such as being faithful, had developed at fairly sophisticated levels, with participants talking about the need for both partners to be faithful to each in order to prevent HIV infection, or debating the usefulness of people living with HIV/AIDS using condoms.

*I've learned a lot of things about HIV/AIDS that I didn't know before. I didn't know about all those things before…like you must use protection and you must have one partner and you must be faithful. (Female participant)*[51]

In terms of knowledge about the care and support of people living with HIV/AIDS, there was a good understanding about the interrelatedness of psychosocial aspects, including that emotional and psychological support are as important as providing assistance at a physical level. In the following example the participant reflected on how her behaviour would have been different towards her mother – who died of AIDS – had she had knowledge and information about care and support.

*I even think things would have been better if I did this course before my mother died because, to tell the truth, my mother passed away due to HIV. During that time I had no information. If I had this information I would have been able to give her support. But I still thank this group because now I have information, anyone can come to me, or anyone in my family who can be infected with this disease - I know that it's very important to give that person love and counselling. (Female participant)*[52]

Participants described learning key concepts of living positively and healthily with HIV or AIDS after exposure to the *Tsha Tsha* intervention. This included learning about the importance of incorporating exercise, healthy nutrition and reducing stress as key factors that work in combination with ARVs to improve the quality and length of life of people living with HIV/AIDS.

### HIV/AIDS attitudes to prevention

Following the intervention, attitudes towards HIV prevention appeared to be more personalised, with participants reflecting on the importance of limiting exposure to multiple sexual partners.

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[50] Post-Ass JHB F Gp3 8Jun06 (1681-1892)
[51] Post-Ass JHB F Gp4 28Jun06 (15233-17671)
[52] Post-Ass JHB F Gp2 26May06 (29262-29882)

*Participant 1: For me it's just not right to sleep around because if you do that you are degrading yourself.*

*Facilitator: Were you always holding this belief or did the programme make you think this way?*

*Participant 1: It's this programme. Myself, I was doing what my brother was doing, so this programme has changed me. I'm just wondering if this programme hasn't changed my dear brother too. (Male Participant)*[53]

It appears that exposure to and participation in the *Tsha Tsha* intervention made a particular impact on the concept of being faithful, with many citing the importance of being faithful to one's partner as a primary learning they had got from the programme.

*It has taught me that you need to be faithful to your partner and your partner must know about what you are doing. But one part which left me confused is when DJ came from the mountain and he 'tested his equipment' with another girl, leaving his girlfriend. What if that girl was positive and maybe 'tested' by other guys as well? Tsha Tsha really taught me that we need to be faithful. (Female participant)*[54]

Although being incarcerated changed relationship dynamics, there were examples where participants' behaviour was inspired or informed by the intervention. For example, a female participant described that she had mailed condoms to her teenage son from the correctional centre. This had led to them having a conversation about the dangers of unprotected sex for the first time.

*Tsha Tsha means a lot to my personal life. It opened my eyes in a lot of ways. You know, it's through Tsha Tsha that I went to my son and said: "Listen, you have to start using condoms now." And he was so cross with me because I sent him a pack of condoms. He said: "How dare you do it?" I said: "Well, I'm still your mum. You don't have a dad and I'm here to tell you what's right and what's wrong"... I came to prison when he was six... and then he went to live with my mother. He stays with her but she's not going to talk to him about these kinds of things, about sex and about HIV/AIDS... I've been thinking of myself as a 29-year old woman that came to prison...[yet] I'm 39-years old and I realise I can talk to my kid like this. I am allowed to do it. (Female facilitator)*[55]

Some female participants spoke openly about changes in attitude which they linked to the intervention. For example: *'I learnt that AIDS is not a sin. Before I got this education I thought maybe a person who's got AIDS is promiscuous.' (Female*

[53] Post-Ass LWKOP M Gp1 17May06 (17570-19010)
[54] Post-Ass JHB F Gp1 26May06 (27839-28239)
55 Post-Ass JHB Fac F Gp1 23Jun06 (99842-102193)

*participant)*[56] In some cases, women living with HIV/AIDS spoke about being able to forgive themselves for being HIV-positive after reflecting and debating the issue in the groups.

> *[What stood out for me] is when the pastor said AIDS is not a sin because even me, before, I used to say it's God's punishment… that maybe I've sinned, that is why God is punishing me with AIDS. Now I know AIDS is not a sin. It's just a disease that we don't know where it comes from and we just have to live positively. (Female participant)*[57]

### *Attitudes to care and support*

Following the intervention, participants said they felt empowered and in positions to offer care and support to people living with HIV/AIDS (PLHA). Many participants referred to Andile caring for his mother and supporting Viwe as behaviour that had influenced their attitudes towards people living with HIV/AIDS.

> *The scene which touched me is the one where you find that Andile's mother is sick with AIDS and Andile and his sister need to find proper food for their mother… The mother needs to go for special treatment and also get some pills, only to find that they are not in a position to afford all those things for her because they are not employed… I have seen that having AIDS makes people stigmatise the family. For example, Viwe's father did not like that family and was only saying bad things about that family. That part touched me a great deal. I came to realise that HIV/AIDS affects and infects many people, even families, and I think we need to take steps to support those affected by the disease. (Male participant)*[58]

A number of male participants referred to the gender dynamics of males taking care of sick people, saying that it was not typical of a male like Andile to take care of his sick mother. However, this depiction had influenced them to the extent that many expressed the desire and openness to do what they perceived as traditionally female tasks.

### *Effects on PLHA and peer norms*

Most participants spoke about the perceived importance of disclosure and living openly with HIV/AIDS. For many, this was seen as a change from the attitude of thinking that disclosure of HIV status should be avoided.

56 Post-Ass JHB F Gp2 26May06 (36852-37087)
57 Post-Ass JHB F Gp4 28Jun06 (20714-21837)
58 Post-Ass LWKOP M Gp1 17May06 (1206-2008)

*Through the episodes that I have watched I have learned about honesty and that we need to disclose to other people in order to get support from them. (Female participant)*[59]

*Before this Tsha Tsha course I had that feeling you didn't have to tell others if you had this disease…. But now I know that if you tell others, you are safe. They know you, they talk to you…. It's helped me a lot. (Female participant)*[60]

Participants referred to scenes of disclosure from *Tsha Tsha* – and spoke about how they had been touched by the honesty and courage of individual characters.

*Another part which touched me is when Viwe attended the funeral of Andile's mother wearing a red ribbon and her father was not impressed. He even told her to 'remove this rubbish' because she was embarrassing the family. At the graveside Viwe removed this ribbon and threw it in the grave. At that moment everybody who was there started folding ribbons. This taught me a lesson that if you have HIV you do not need to be in denial. (Male participant)*[61]

Participants who were living with HIV noted a number of beneficial outcomes as a product of the intervention. These included a perceived decrease in stigmatisation and discriminatory practices:

*I'm HIV-positive, and the way people used to treat us, those who were in the course, they changed. Their behaviour towards us has changed a lot... Sometimes we use the same toilets and the same shower. If you go to the toilet and they know that you are positive, some people would go to the toilet with Dettol, stuff like that you know, not knowing the toilet cannot make you get HIV infected... When they attended this course, they did understand better what's going on with this virus. (Female participant)*[62]

*No one would sit in the same cell... No one wanted to be next to me. No one wanted to bath where I bathed. No one wanted to sit on the same toilet seat I sat on, but now since there's knowledge about it, everybody has changed. (Female participant)*[63]

*Sometimes when I get out of the shower someone will come with Jik and scrubbing brush and scrub the shower before she showers…. But it has changed a lot. (Female participant)*[64]

Effects of the intervention included perceptions that it was possible to live productively with HIV.

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[59] Post-Ass JHB F Gp3 8Jun06 (2109-2693)
[60] Post-Ass JHB F Gp4 28Jun06 (14042-15191)
[61] Post-Ass LWKOP M Gp1 17May06 (9627-10056)
[62] Post-Ass JHB F Gp4 28Jun06 (1111-2785)
63 Post-Ass JHB F Gp4 28Jun06 (34894-41624)
64 Post-Ass JHB F Gp4 28Jun06 (26585-27993)

*The project has taught me so much. Living positively for me has been a very hard decision to accept. When I started this project I had already accepted my status, but sometimes I used to have that "Eish, I'm going to die, I can't do anything" [feeling]. But when I look at Viwe, the way she challenged life after finding out that she was positive and she was able to tell her parents that she was positive. I remember one day she said, "I'm HIV-positive and that's it and that's how I'm going to live. I'm going to live a positive life." So after she got HIV she challenged life and she did move on with her career of dancing. So it gave me another encouragement that even being HIV-positive, you still have a lot of things to do. You still have a choice to do what you want to do in life. (Female participant)*[65]

Changes in attitude extended to learning to respect the confidentiality of those who were HIV-positive. This included not gossiping or using an individual's HIV status to get back at them.

*[Describing a Tsha Tsha scene, where a person's status was revealed publicly] It touched me because it showed me that other people don't think. Instead of comforting her they did not offer her support... This part has changed me because now I know that the person who has this virus needs our support. Again, we need not go around gossiping about those who are infected. (Male participant)*[66]

Some female participants were moved to disclose their HIV status during the facilitated group discussions. Participants responded in understanding and caring ways – both during and between groups – which was different to the perceived 'typical' responses disclosure would elicit from fellow offenders at the correctional centre. In the following example, a group facilitator describes how the intervention provided an impetus for a group member to disclose her status to the group. The facilitator goes on to describe the care and support shown by group members for this person.

*Someone in my group disclosed in the class when we did the episode where Viwe disclosed to her father... [After the session] She came to me and said: "I never thought I would feel such relief by disclosing." And I can tell you, my group absolutely carries her on their hands. It's like if [she's] not there, it's "Where's she?" Or it's, "I think she's in bed. Go and fetch her".... She said she feels loved. She said everybody always thought, no, HIV, a big no, no... And that is why she was scared to disclose... And to see that change in her since she disclosed... She's more*

65 Post-Ass JHB F Gp4 28Jun06 (5080-6561)
66 Post-Ass LWKOP M Gp1 17May06 (4423-5063)

*open, more self-assured, she stands up and talks about the HIV. (Female facilitator)*[67]

### *Identification with circumstances in Tsha Tsha*

The *Tsha Tsha* drama series makes extensive use of the concept of identification, where viewers identify with characters, events and circumstances. This is related to the concept of providing role models for viewers and for promoting learning of alternative problem-solving. Additionally it relates to internalising or personalising HIV risk. Lived experience is drawn into the drama through the research processes that inform the development of *Tsha Tsha* scripts.

> *It was interesting, it was nice because I felt with most of the characters and with most of the things that's happening you feel you can relate to what's happening. So I think the way it was acted out and the way people wrote it, it does send out a message. Because personally also, some of the themes that were in the programme, I also took them to heart. And when I realised those things they've been told to me over and over but I have never really put them in memory or really took them to heart, only now because of the way they have been presented. So I think the way the programme is trying to create a type of change of attitude, I think this is the way. It's something you feel because sometimes you feel, they feel attached to the characters and then you understand what's happening and you apply it in your own life as you go on. So for me it was nice the way it was done. (Male facilitator)*[68]

Although *Tsha Tsha* is not directly related to life in a correctional centre, participants identified with a range of characters, events and circumstances in the drama series. In relation to personal circumstances, a number of participants related to portrayals of the death of a parent:

> *It was sad at the end when Andile danced his heart out, when he really needed his mother at the end to be there for him and then she died. That was sad… I really cried. My tears were rolling when I was watching that scene because I also lost my mother and I thought to myself I know exactly how he was feeling. (Female participant)*[69]

> *When Andile came back with a trophy and found his mother dead, it was a very sad time. I know that feeling because I also don't have any parent. (Female participant)*[70]

> *This programme has taught me many things because my father was sick and I was the only one who knew his status. Other members of the family*

[67] Post-Ass JHB Fac F Gp2 27Jun06 (110389-112470)
[68] Post-Ass LWKOP Fac M 17May06 (8662-9879)
69 Post-Ass JHB F Gp1 26May06 (22131-22651)
70 Post-Ass JHB F Gp1 26May06 (23289-23648)

*did not know. I could not tell them until it was too late. All along he was only taking TB treatment. [Through Tsha Tsha] I realised that I was wrong somehow, because in order for my father to live longer I was supposed to do something, like tell my family that they need to remove my father from SANTA to Baragwanath because SANTA only caters for TB sufferers… I wanted to [talk about his status] but the problem was the fear, what are people going to say about my family. (Female participant)*[71]

### Identification with Tsha Tsha characters

Among male and female participants, the characters in *Tsha Tsha* were perceived to be realistic and thus easy to identify with and to learn from. Participants were able to compare themselves and decisions they had made in their lives to characters' lives and decisions. Usually an aspect of the character or event being portrayed resulted in participants thinking about themselves and their own situations from the character's perspective. This often led to new insights and resoluteness about possibilities and change.

DJ was described by several participants as being the trigger for self-reflection, insight and self-realisation. In one example, a male participant spoke about the profound impact which DJ had on his life, in particular in relation to the storyline where DJ returns from the rural town of Lubusi to Johannesburg and is with a group of friends who are planning to rob an old man. The quotation picks up at the point where DJ decides that he does not want to live a criminal life and returns to Lubusi.

*What stood out for me was when DJ went back, the conversation he had with himself to say that, "You know what, I think I've grown up and things change and some things they don't really matter any more." And the fame and the girls and the fast life and stuff – I realise that these are not the important things in life. The important things are relationships, which were the things he had in Lubusi… In Johannesburg it's just a fast life… The fast life doesn't matter… It's just a passing phase… When I think about Tsha Tsha, I always think of that scene of DJ saying, "Hey, no man, these things don't matter anymore'… I felt like he was talking to me personally. So it was a very interesting scene for me. I'll rewind it again and again. (Male facilitator)*[72]

For others, characters such as DJ provided the means for participants to think about life from a broader and more philosophical perspective and to realise that opportunities exist for change, regardless of the situation or person.

*DJ came to Lubusi as an outcast. He was totally treated as an outcast… How many lies did he tell, but at the end he came out with the truth… I*

71 Post-Ass JHB F Gp2 26May06 (11362-13111)
72 Post-Ass LWKOP Fac M Gp1 17May06 (14539-17082)

*think in all of our lives, at one stage of our lives, we realise, listen, we have to turn around and do the right thing now. For so long I was walking the wrong path, let me take the right one now…. I think a lot of characters in this Tsha Tsha attract us because of things that went wrong in our lives. Things where I can say, "I was like that, but now I'm going to change like this." (Female facilitator)*[73]

Other participants identified with the openness of Andile's mother who died of AIDS and with Cedric's position of not knowing that he was Joy's father (hence missing out on fatherhood). These points are illustrated in the following quotations.

*Sometimes you will find that the things that are happening in the episode are the ones that were happening around your life. You didn't know which step to take, which direction to take. So like me, I really like Andile's mother because being an HIV-positive mother, I've got children, I need to tell my children that I'm HIV-positive. But before I do I need to take time and make them understand that AIDS doesn't kill… Even about sex, my children are still very young and they haven't heard yet about sex. (Female participant)*[74]

*Boniswa told Joy that Cedric is the father and he is bad… Joy bunked classes, he didn't go to school, he followed Cedric… watching what he was doing. Cedric saw the boy following him. So I think he was trying to be a good dad, but he knew that inside he was bad…. Sometimes our parents – they don't tell us the truth about our fathers, you see. Ja, so they told us our fathers are bad, things that they did, so maybe it can affect our lives. So I think that even fathers need a chance just to prove to us that they are father to us, you see. (Male facilitator)*[75]

### Learnings from the intervention

It was clear that the intervention promoted learning and dialogue – and in most instances this was a positive experience for both facilitators and participants. Discussion also spilled over into time beyond the intervention, and included discussion with offenders who were not part of the intervention.

*You know what, for me, I stress it always how important it is to know the facts about HIV and AIDS. Even in my cell I will start talking and then the next moment the whole cell is talking together. So I feel I open people's eyes to reality, to make them realise, listen, this is important to know the facts. And you won't know how many people come to me and say, "I want to be in the next course." (Female facilitator)*[76]

[73] Post-Ass JHB Fac F Gp1 23Jun06 (79159-83131)
[74] Post-Ass JHB F Gp4 28Jun06 (67364-69678)
[75] Post-Ass LWKOP Fac M 17May06 (67759-69024)
76 Post-Ass JHB Fac F Gp2 27Jun06 (82762-83385)

In some cases post-intervention discussions led to arguments which involved polarisation between facilitators and participants that was uncomfortable to deal with.

> *There was one guy who said, "You know what, let's collect all the people who are infected with HIV and AIDS, put them in one place and sort of like a gas chamber. And if we can kill all of them it means now we have a clean race." And for me that thing it was painful and I think I ended up in an argument with that person because I thought he was very insensitive – maybe he's never had people close to him who are infected with this thing. And I asked him: "Do you know if you are HIV-positive? What if you are HIV-positive? Would you agree to go to a gas chamber and to be gassed?" And then he just kept quiet, he couldn't answer me. (Male facilitator)*[77]

Some facilitators found it difficult to control discussions in the group, or to deal with participants who were interrupting the process. Such processes were difficult to handle in the context of being peer facilitators. Mention was also made of language as being a challenge that needed to be addressed, given that there were various languages used in the correctional centre context. However, this was readily addressed through translation by group members during the intervention.

There was some debate about the merits of using peer facilitators versus external facilitators. One problem that was identified was the difficulty in sharing personal issues with a fellow offender. Others noted a preference for peer facilitators, on the basis that it developed the skills of participants: '*It's better to be taught by our peers, but it can be great if you guys can come after two weeks to check whether we are in a right path.' (Male participant)*[78]

It was also recognised that participation was a valuable opportunity to discuss issues and, in particular, to engage in productive and structured debate where there was mutual respect for ideas:

> *Okay, being part of the group, it was interesting because, like I said, it is very rare where you get a chance where the guys can come together and discuss issues, especially issues like HIV and AIDS, issues like child abuse, infidelity and so forth and so forth... Actually talk in an orderly way, disciplined way, sharing ideas and opinions and respecting each other's ideas and each other's opinions... So I found that it was interesting to see that now the guys in that type of environment that we created were able to share and were able to talk – to talk about things which they couldn't normally talk about in their normal environment. (Male facilitator)*[79]

77 Post-Ass LWKOP Fac M 17May06 (90008-94680).
78 Post-Ass LWKOP M GP1 17May06 (49250-49397)
79 Post-Ass LWKOP Fac M 17May06 (82067-87907)

*This learning was a good experience. We did not have the same opinions. 'N' can come with another opinion even 'M' can come with another opinion, so as a group we did understand and at the end of the day we had some consensus about the issues. (Female participant)*[80]

There were, however, sometimes tensions related to crimes for which participants had been convicted:

*The problem with this thing is that it becomes too heated… Everyone is talking from a point of experience, from something that's happened to them or to a friend or to family. You find that there are some people who have had their sisters or girlfriends raped… and then you find some people that have raped. And then now it's two people from opposite ends of the line, and now it becomes heated. (Male facilitator)*[81]

There was considerable sharing of personal experiences in the group discussions and this was accompanied by respect for confidentiality. It was, however, recognised that it was not always productive to probe too deeply:

*I have to say our group was very, very confidential. I was keeping my ears open in the passages and in the cells and nobody came out with anything sensitive… When we talked about disclosure people came up with all sorts of experiences like when they had their first pregnancy, when they had their first sex, when they had their first day out and slept away from home, they came up with all that and then the disclosures that came there, what happened. People were willing to share their own life experiences. (Female facilitator)*[82]

*Sometimes we realise after the session that maybe today we got a bit too personal. That's why we try to say that… we appreciate everyone's honesty but we are not here to offend anyone. And we try to have a thing of confidentiality to say, "Even if you can say something here, I'm not going to point at you in the courtyard to say, hey, you know what, that guy, here at the programme he was saying he used to rape people." So we try to encourage an environment so the guys can talk freely. At the same time we also try not to get too inquisitive about someone. (Male facilitator)*[83]

Some participants expressed initial doubt about the educational nature of *Tsha Tsha*, given that it incorporated ballroom dancing, but soon understood and appreciated the complexity of the educational content.

80 Post-Ass JHB F Gp1 26May06 (35169-36071)
81 Progr-Fac LWKOP Male 5Apr06 (39437-46891)
82 Post-Ass JHB Fac F Gp2 27Jun06 (79753-80391)
83 Progr-Fac LWKOP Male 5Apr06 (46894-48866)

*It looked frivolous at the beginning, the involvement of kids, the way the kids are affected… Initially when I just saw Tsha Tsha, all the dances and the jives it looked very frivolous, I thought having to watch this at my age, no, no, I'm not interested. But when I watched it with intention I realised it was a very touching type of movie and it educates a lot, it's very informative… I saw how easily everyone is susceptible to HIV and AIDS. And I saw how easily HIV creeps in when you least expect any danger at all. (Female facilitator)*[84]

There was a sense that the facilitators provided a dynamic learning experience through making concepts clear, and some facilitators reported that role-plays provided an opportunity to provide in-depth learning.

*The thing that made me come back, I must really hand it to your facilitators – they really made it exciting, all of them, and sometimes after watching and discussing the programme, the facilitators would write things down on the board to make things clear for us. This challenged us to look within ourselves. It was really a very interesting course and it was not easy because it was very long, but we stuck to it. (Female participant)*[85]

*We used a lot of role play because I saw through role play you can give them the real picture and they understand something that plays off in front of them easier. Because we have to look at the people that are illiterate as well… We absolutely have to make sure everybody that's sitting in that group knows what's going on and a role play really it gives the message over so clearly. You explain it to them, they come and do the role play, through the role play you carry it and you can see, well, they know what you were talking about. (Female facilitator)*[86]

Participants and facilitators of the groups took ownership and responsibility for the project, with 85% of the participants attending eight or more sessions. It was reported by the female group facilitators that participants who had been absent from a session would send them letters of apology and arrangements were subsequently made where facilitators would have one-on-one sessions with participants to make up missed sessions.

*What made to come back was that I was seeking knowledge. I wanted to know more everyday. (Female participant)*[87]

Facilitators were acknowledged for their determination and encouragement to see the intervention through, even with initially resistant participants.

84 Post-Ass JHB Fac F Gp1 23Jun06 (13193-15179)
85 Post-Ass JHB F Gp1 26May06 (49228-49664)
86 Post-Ass JHB Fac F Gp2 27Jun06 (101046-102022)
87 Post-Ass JHB F Gp2 26May06 (33686-33940)

*I would like to thank [the facilitator] for encouraging me. I was a very lazy cat. I did not even want to come to the class. When I would see [the facilitator] in the spiral I would run away and she would come and encourage me... So I would like to thank her very much because now I can see that I'm going far with the information. (Female participant)*[88]

Commitment to the project was further evidenced by the facilitators starting new groups on their own initiation after the pilot intervention was finished.

*It created interest among the other inmates. And also now they want to get involved. They busy asking me, "When do we get to be part of the course?" (Male facilitator)*[89]

*We're using the CADRE project now in E Section, our waiting trial section, to give them the HIV message. I wish you can see. They are so excited they can't wait. I played episodes 11, 12, 13 for them on Monday, they were crying like babies. I was giving out tissues but we enjoy it so much. (Female facilitator)*[90]

Participants and facilitators described experiences of developing self-confidence or of discovering skill and talent that they were not previously aware of as a result of participating in the intervention – for example, facilitation skills and being a good listener. This was often expressed as a desire to continue working in the HIV/AIDS field.

*I was busy searching and seeking my potential. I didn't know what I must do in the world, what I am here for. But when time goes on, maybe it is a potential of mine…Tsha Tsha it has sharpened me to such an extent whereby I can be able to talk in front of people because of this thing, eish, it goes with confidence…. This thing it goes through with your heart, that things that you love, so that's what I love and that's what I want to do when I go outside. My dream is to open a project…and the main point of the project is to encourage youth about awareness of HIV and AIDS, drugs and alcohol, teenage pregnancy, juveniles in prison, what they should do in order to be successful in life. (Male facilitator)*[91]

*At the end of the day I want to end up being a facilitator. (Female participant)*[92]

## DISCUSSION

The quantitative study of baseline knowledge and attitudes amongst offenders shows relatively high levels of awareness of key aspects of HIV/AIDS, and these are similar

88 Post-Ass JHB F Gp2 26May06 (27273-28028)
89 Post-Ass LWKOP Fac M 17 May06 (3058-3633)
90 Post-Ass JHB Fac F Gp1 23Jun06 (1764-2382)
91 Post-Ass LWKOP Fac M 18May06 (117087-120100)
92 Post-Ass JHB F Gp1 26May06 (45354-45467)

to findings of studies that are conducted on the general population. It was also clear that the correctional centre environment included exposure to HIV/AIDS information and learning prior to the introduction of the *Tsha Tsha* intervention.

Whilst this evaluation was not specifically oriented towards quantifying perceptions of HIV risks in prisons, respondents mentioned a heightened fear of HIV infection via blood and physical contact in the correctional centre that is particular to that setting.

Whilst it is difficult to determine with certainty the level of exposure, or the actual risks of potential infection via blood, it is worth noting that there are theoretical risks of infection as a product of violence where stabbing occurs – for example, if more than one person was stabbed with the same sharp instrument, or sharing of tattooing instruments – and also exposure to contact with blood when providing assistance to someone who is bleeding profusely or who is giving birth. Measures for addressing these risks would include easy access to plastic or latex gloves, as a minimum precaution.

Risks of sexual transmission within correctional facilities are recognised worldwide, and South Africa is no exception. This includes consensual sex between offenders, coerced sex or rape between offenders, sex with correctional centre personnel and also with maintenance workers. Whilst we did not set out to quantify the extent of such risk, and recognising that most of the sexual encounters described would be considered 'illegal' in the correctional facility context, it remains important to recommend that these activities be reviewed by correctional centre management in relation to HIV risk.

With regard to the *Tsha Tsha* intervention, there is much compelling evidence to illustrate a number of important changes in knowledge, attitudes, behaviours and practices in relation to HIV/AIDS. Many participants reported learning something new, and there were important shifts in knowledge about HIV not being transmitted through casual contact. In the correctional centre context, this contributed to a reduction in fear of contracting HIV from eating utensils and the like, as well as from offenders who were known to be or suspected to be HIV-positive. Many of the HIV-positive participants also pointed to changes amongst fellow offenders with regard to the fear of casual transmission, and there were clear shifts towards non-stigmatising behaviours – for example, in relation to use of the bathroom facilities.

The intervention opened up thinking about prevention and this included reflection on sexual risks outside of the correctional centre context, but also in relation to responsibilities for loved ones, as was exemplified in the discussion between an incarcerated mother and her young son around condom use.

The intervention also provided opportunities for reflection as a product of *Tsha Tsha's* resonance with life events – notably the death of a parent. There were also important reflections in relation to one's own life situation and how to deal with particular circumstances. For example, HIV-positive participants felt empowered by

the courage exemplified by HIV-positive characters in *Tsha Tsha* which included, for some, the decision to disclose their status to fellow participants. In turn, those who were either known to be HIV-positive, or who disclosed, were treated with warmth and humanity.

Identification and reflection were also interwoven with a process of taking stock of one's life, with some participants talking about how it translated into commitments to change aspects of their lives.

The intervention contributed to considerable dialogue – both amongst participants, and also amongst offenders in the centres. For example, those who had been through the intervention were a source of knowledge for others, and themes addressed in *Tsha Tsha* made their way into discussions beyond the intervention.

Whilst there were divergent ideas, peer facilitators and participants noted that conflicting ideas were addressed through processes of mutual respect, although in some instances tensions occurred that were related to the correctional centre context – for example in relation to crimes for which offenders had been convicted. There was, however, respect for differences between offenders, and in the intervention groups there was commitment to confidentiality.

The facilitators were clearly committed to the project – for example, facilitators had one-on-one sessions to make up missed sessions, facilitators supported each other and participants, facilitators diligently kept attendance registers and notes, and participants sent letters of apology when they missed sessions. There were also reports of new groups being initiated after the pilot. Facilitators developed skills in relation to peer education, and both participants and facilitators referred to creative approaches to developing learning.

## CONCLUSIONS AND RECOMMENDATIONS

This evaluation illustrates the short-term impacts of the *Tsha Tsha* intervention and provides some insight into long-term potentials. Although the *Tsha Tsha* series does not directly address correctional facility contexts, many of the educational lessons embedded in the series are readily transferred to such contexts.

Participants in the intervention provided many examples of changes in knowledge and attitudes and impacts on behaviours – in particular behaviours towards people living with HIV within correctional facilities. Fears of casual infection were also addressed and reduced.

There were changes in participants' understanding of HIV risk, and these extended to addressing responsibilities including issues to do with responsibilities as a parent.

The evaluation did not pursue assessment of any impacts or changes in relation to risks of sexual transmission of HIV within the correctional centres, but it can be concluded from the baseline data that these are not insignificant and therefore require

attention. Equally, there do appear to be risks of excessive exposure to blood, and universal precautions (access to plastic or latex gloves) should also be implemented.

The intervention was also useful in relation to self-reflection, and through this process, beneficial in terms of developing life skills, psychological coping mechanisms and problem-solving techniques. This appeared to boost self-confidence amongst participants.

Facilitators also developed confidence through discovering talents for teaching, listening, and facilitation. This included a desire to continue working in the AIDS field.

Whilst this evaluation has not assessed the logistical implications of the intervention, it is clear that *Tsha Tsha* and the related materials and methodologies are readily integrated as tools for use by existing peer educators. Transfer of correct and appropriate knowledge is, however, contingent on appropriate training, and the correctional centres would need to address the concept of training trainers and provide appropriate resources. CADRE in conjunction with JHHESA could provide such assistance.

There is also a need for responsibility for the intervention to fall to one or more correctional centre officials who have responsibilities for HIV/AIDS education.

It does appear possible for the intervention to be readily integrated into the correctional facility setting. There would, however, be a need to commit to full implementation, to appraise the intervention regularly, and to reflect on sustained intervention across multiple centres.

The possibility of negative effects cannot be excluded and mechanisms need to be incorporated to address these. Of importance are the needs for debriefing and supporting facilitators, emphasising the need for minimising conflict, providing therapeutic support where personal experiences may trigger emotional responses, and addressing and minimising effects on offenders who are openly living with HIV or who disclose during the intervention.

## APPENDIX ONE: *TSHA TSHA* HIV/AIDS PRE- AND POST-ASSESSMENT SURVEY QUESTIONNAIRE

| **PLACE** |
|---|
| **DATE** |
| **SECTION AT CORRECTIONAL FACILITY** |
| **RACE** |

The purpose of this questionnaire is to test the impact of the *Tsha Tsha* training course being implemented in correctional facilities

Please find a private space to complete the questionnaire.

The facilitator will take you through each question.

We would like you to answer every question.

The information you provide is confidential.

Your name does not does not appear on this questionnaire and your answers cannot be linked to you.

**1. Demographic data**

| 1.1 | **Sex** | Male<br>1 | Female<br>2 |
|---|---|---|---|

| 1.2 | **What is your age?** | |
|---|---|---|

| 1.3 | **Which of the following languages can you speak?** [READ OUT ALL. MULTIPLE responses possible] | **Language** | **Speak** |
|---|---|---|---|
| | | isiZulu | 1 |
| | | isiXhosa | 2 |
| | | isiNdebele | 3 |
| | | isiSwati | 4 |
| | | English | 5 |
| | | Afrikaans | 6 |
| | | Sesotho sa borwa | 7 |
| | | Sepedi | 8 |
| | | Setswana | 9 |
| | | Tshivenda | 10 |
| | | Xitsonga | 11 |

**2. Relation to HIV/AIDS**

| 2.1 | **In the PAST year which of the following apply to you?** [READ OUT ALL] | Yes | No or not applicable |
|---|---|---|---|
| **a.** | I have attended a workshop on HIV/AIDS (apart from *Tsha Tsha*) | 1 | 2 |
| **b.** | I personally know someone who has died of AIDS | 1 | 2 |

**3. Media Exposure**

| 3.1 | **How many days a week do you do the following?** | Never | 1 day a week | 2 to 6 days a week | Every day of the week |
|---|---|---|---|---|---|
| **a.** | Listen to the radio | 1 | 2 | 3 | 4 |
| **b.** | Listen to local community radio stations | 1 | 2 | 3 | 4 |
| **c.** | Watch television | 1 | 2 | 3 | 4 |
| **d.** | Read a magazine | 1 | 2 | 3 | 4 |
| **e.** | Read a newspaper | 1 | 2 | 3 | 4 |

| 3.2 | **In the past 12 MONTHS have you…?** | Yes | No |
|---|---|---|---|
| **a.** | Watched Soul City on television | 1 | 2 |
| **b.** | Listened to Soul City on the radio | 1 | 2 |
| **c.** | Watched Beat it – Siyanqoba on television | 1 | 2 |
| **d.** | Watched *Tsha Tsha* on television | 1 | 2 |
| **e.** | Watched Gazlam on television | 1 | 2 |
| **f.** | Watched Takalani Sesame on television | 1 | 2 |
| **g.** | Watched Choice on television | 1 | 2 |
| **h.** | Watched Soul Buddyz on television | 1 | 2 |
| **i.** | Listened to Soul Buddyz on the radio | 1 | 2 |
| **j.** | Heard a Khomanani radio programme or advert? | 1 | 2 |
| **k.** | Seen a Khomanani television programme or advert? | 1 | 2 |
| **l.** | Read a Khomanani leaflet or pamphlet | 1 | 2 |
| **m.** | Have you seen a loveLife television advertisement | 1 | 2 |
| **n.** | Have you heard a loveLife radio advertisement | 1 | 2 |
| **o.** | Have you seen a loveLife billboard | 1 | 2 |

| p. | Have you read S'camtoPrint | 1 | 2 |
|---|---|---|---|
| q. | Heard of the Treatment Action Campaign (TAC) | 1 | 2 |

| 3.3 | **Have you ever called any of these telephone helplines** | **Yes** | **If yes, have you ever called this helpline** |
|---|---|---|---|
| a. | AIDS Helpline | 1 | 2 |
| b. | ThethaJunction / loveLife | 1 | 2 |
| c. | Circles of Support Helpline | 1 | 2 |
| d. | LifeLine | 1 | 2 |
| e. | Childline (08000-55-555) | 1 | 2 |
| f. | Stop Women Abuse Helpline | 1 | 2 |
| g. | Other | 1 | 2 |

**4. Knowledge and attitudes**

| 4.1 | **Are the following statements true or false?** | True | False | Don't know |
|---|---|---|---|---|
| a. | Traditional healers can cure AIDS | 1 | 2 | 3 |
| b. | If you have fewer sexual partners, you are less likely to get infected with HIV | 1 | 2 | 3 |
| c. | You can be infected with HIV by touching a person with HIV/AIDS | 1 | 2 | 3 |
| d. | A mother can pass HIV on to her baby during pregnancy and childbirth | 1 | 2 | 3 |
| e. | A person with HIV can look healthy | 1 | 2 | 3 |
| f. | You can reduce the risk of HIV by being faithful to your sexual partner | 1 | 2 | 3 |
| g. | A woman can transmit HIV to her baby through breastfeeding | 1 | 2 | 3 |
| h. | If you use condoms every time you have sex you can prevent HIV infection | | | |
| i. | If a person is raped, there are drugs that can prevent HIV infection | 1 | 2 | 3 |
| j. | Sexually transmitted infections increase the risk of HIV infection | 1 | 2 | 3 |
| k. | HIV can be transmitted by sharing a meal with someone who is infected with HIV | 1 | 2 | 3 |
| l. | It is against the law for a girl of 15 to have sex with a much older man, even if she agrees to it | 1 | 2 | 3 |
| m. | To prevent HIV infection, a condom must be used for every round of sex | 1 | 2 | 3 |

| 4.2 | **How much do you agree with the following statements?** | Strongly agree | Agree | Disagree | Strongly disagree | Don't know / not applicable |
|---|---|---|---|---|---|---|
| a. | Getting AIDS is the result of sinning | 1 | 2 | 3 | 4 | 5 |
| b. | AIDS should be talked about openly at funerals of people who have died of the disease | 1 | 2 | 3 | 4 | 5 |
| c. | It is a waste of money to train/educate someone who is HIV positive | 1 | 2 | 3 | 4 | 5 |
| d. | People who know they are HIV positive should not have sex | 1 | 2 | 3 | 4 | 5 |
| e. | A woman has a right to say no to sex if she does not want it | 1 | 2 | 3 | 4 | 5 |
| f. | It is okay for older men to have sex with girls younger than 18 | 1 | 2 | 3 | 4 | 5 |
| g. | If I told members of my family I had HIV, most of them would support me | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| h. | I would be embarrassed to be seen with someone who everyone knows has HIV/AIDS | 1 | 2 | 3 | 4 | 5 |
| i. | Young people should not start having sex before the age of 18 | 1 | 2 | 3 | 4 | 5 |
| j. | When you learn that you have HIV, your life is over | 1 | 2 | 3 | 4 | 5 |
| k. | It is acceptable for a man to have more than one girlfriend at the same time | 1 | 2 | 3 | 4 | 5 |
| l. | People with HIV will soon lose their friends | 1 | 2 | 3 | 4 | 5 |

**5. HIV Risk**

| | | | |
|---|---|---|---|
| 5.1 | Do you feel you are at risk of getting HIV in this correctional facility? | Yes<br>1 | No<br>2 |
| 5.2 | If YES, why do you say so? | | |

**6. VCT**

| | | | |
|---|---|---|---|
| 6.1 | Have you ever been tested for HIV? | Yes<br>1 | No<br>2 |

| 6.2 | If YES, what were your reasons for having an HIV test | |
|---|---|---|
| a. | I wanted to know my HIV status | 1 |
| b. | I was pregnant | 2 |
| c. | My partner asked me to go for testing | 3 |
| d. | I applied for an insurance policy or loan | 4 |
| e. | I was feeling sick | 5 |
| f. | I engaged in risky sexual behaviour | 6 |
| g. | My employer requested it | 7 |
| h. | I wanted to start a new sexual relationship | 8 |
| i. | Other [specify]: | 9 |

| 6.3 | If NO, what were your reasons for NOT having a HIV test? | |
|---|---|---|
| a. | I am not at risk for HIV | 1 |
| b. | I do not think that I am HIV positive | 2 |
| c. | I trust my partner | 3 |
| d. | I was scared | 4 |
| e. | I am not ready to have an HIV test | 5 |
| f. | I haven't got around to it | 6 |
| g. | I do not know where to get tested | 7 |
| h. | I don't believe the test is accurate | 8 |
| i. | I was concerned about CONFIDENTIALITY | 9 |
| j. | I was concerned about STIGMA, DISCRIMINATION or REJECTION | 10 |
| k. | I was concerned about LOSING MY JOB | 11 |
| l. | I am concerned about the STANDARD OF SERVICE | 12 |
| m. | Other [specify]: | 13 |

## APPENDIX TWO: PRE-ASSESSMENT FOCUS GROUP DISCUSSION GUIDE FOR FACILITATORS AND PARTICIPANTS

### *General introduction and overview*

- Can you recall when you first heard about HIV/AIDS? How old were you? Where did you first hear about HIV/AIDS? (e.g., TV, newspaper, at school, friend diagnosed positive etc). Did anything stand out for you? What sense did you make of this 'new' thing called HIV/AIDS?
- Between first hearing about HIV/AIDS and now, have other things stood out for you? Can you give examples? Has the meaning or understanding of HIV/AIDS you had when you first heard about the illness, changed in any way? If so, how? Why do you think the change?

### *Experiences of HIV/AIDS*

- Have you had any experiences where HIV/AIDS has affected you personally? Describe the experience, tell the story.

### *How do you understand the transmission of HIV/AIDS*

- What is HIV?
- How is HIV transmitted?
- What are some of the ways to protect one's self from becoming infected? Do others in the group agree?
- What do you think of the idea that HIV positive people should not have sex?
- What are risk factors for HIV transmission?
- What are the risks of HIV transmission in prisons?
- What are your thoughts on whether being married or being in a long-term relationship protects you from contracting HIV?
- HIV is a punishment from God. What do you think about this? Explain?

### *How do you understand prevention of HIV/AIDS?*

- What are your thoughts that HIV/AIDS can affect any one, no matter age, race, and gender? Explore. Are some people more at risk than others? Are there some people who are guaranteed never to become infected with HIV/AIDS? Explore.
- It is okay to have many partners as long as you always use a condom. Discuss.

### *HIV/AIDS care and support*

- What do you understand by the concept of home-based care?
- Who do you think is responsible for looking after people living with AIDS? Why? Is it a woman's job? Explain.
- Is it acceptable for a man to physically look after his mother/wife/sister if they are bed-ridden? If yes, why? If no, why?
- What makes a man a 'real' man?' Are there roles and responsibilities specific to men and women? What are some of these?

### *People living with HIV/AIDS*

- Should people with HIV be blamed for their status? Discuss.
- How can people with HIV/AIDS be helped? Should they be helped?
- Do you think people with HIV are immoral?

### *Disclosure*

- What do you think about telling an ex-partner or a current sexual partner that you are HIV positive? Would you? Why? If not, why?
- What are some of the reasons why people do not disclose their status to others?
- Do you think parents are justified in feeling disappointed and that their children are failures if they find out that their children are HIV positive? Why? Describe?
- Would you consider it a disappointment or a sign of failure if you were HIV positive? Discuss.

### *HIV/AIDS and treatment*

- Who knows anything about the treatment of HIV/AIDS? What treatments are available? Is there a cure? Explore.
- An HIV positive pregnant woman should have an abortion. Would you agree? Why? If you disagree, on what grounds?

## APPENDIX THREE: POST-ASSESSMENT FOCUS GROUP DISCUSSION GUIDE FOR PARTICIPANTS

### *General introduction and overview: Individual level*

- What has it been like for you watching the drama? (Probes: enjoyable; entertaining; unrealistic; educational).
- Does anything stand out for you in the drama? Any thoughts that come to mind when thinking about the drama? (This refers to the overall series/to particular scenes. Ask why that particular scene, why it stands out for that person etc).
- Did you find the series meaningful to you? Explore. In which way? (For example, would you tell me a little bit more about that?)
- Has watching this series of *Tsha Tsha* made you as an individual think about certain issues? What kind of issues have you thought about? (Explore each issue. Some of the issues were: HIV/AIDS; alcohol; drugs; unfaithfulness; unprotected sex; disclosing HIV status to parents, partners etc. Note: not necessary to probe all areas but HIV/AIDS is important).
- Did any of the actors do things that have changed the way you *see* things? (Hint: Lead characters names: Viwe; Andile; DJ; Boniswa).
- Did any of the actors do things that have changed the way you *feel about* things now?
- Did any of the actors do things that have changed the way you *do* things now?
- Has the meaning or understanding of HIV/AIDS you had when you first heard about the illness, changed in any way? If so, how? Why do you think the change?

### *Group level*

Part of the programme was to have discussions after watching the videos. We are interested in hearing about your experiences of this process.

- What was it like to be part of the group? (Probes: safe space; trust; openness; confidentiality; major issues or problems).
- What kinds of issues did you discuss in the groups? (Expand. Give examples).
- How did you experience these discussions? Give examples. (Probes: debates not resolved; not enough time; group too big; too many topics; too emotional etc).
- Did you continue to talk about issues with each other, or other people after the workshops were finished? (Probes: Where - in cells, other rooms etc; with whom; about what?)
- What are the main things you have learned from this program?
- What was your motivation for joining the program? (Probe: What were you told about the program etc?).
- What made you keep coming back to the workshops?

### *Comments on the workshops*

- What did you like about the workshops? (Expand / Describe)

- What did you not like about the workshops? (Expand / Describe)
- What would you change about the workshops? (Expand / Describe)
- Do you have any comments or suggestions about the facilitators in terms of:
- How they managed the group and the discussions? (Expand / Describe).
- How they managed differences in opinion and debates?
- Is there anything that you would change about the workshops?

## APPENDIX FOUR: POST-ASSESSMENT FOCUS GROUP DISCUSSION GUIDE FOR FACILITATORS

The focus group discussion guide used with facilitators is the same as the one used with participants, with the following additional section at the end.

### *Questions in relation to the facilitation process*

- If you think of the process of facilitating can you just sum up the problems and challenges you have been through in this process? (JHB - How did it come about that you ended up facilitating a group of 48? Or a group of 20 at Leeuwkop?)
- In terms of preparation for the group, how do you go about this? Probes: Do you divide responsibilities? Who is doing what?
- What do you find problematic by running the workshops (sessions)? (Size of the group; language; the fact that you may be friends with many of the participants; seriousness of the debates and arising conflict; anger; dealing with emotional participants; etc.
- How did you find the environment? (Probes: Open; freedom to speak; tolerance of have different opinions? Your ability to handle conflicts etc).
- How did you deal with the different opinions expressed by participants, especially if you disagree with what has been said?
- Do you ever feel stressed or emotional after workshops? If so, how do you deal / cope with your own emotions or stress?