HIV prevention in the workplace

A proposed framework (Kevin Joubert and Pierre Brouard)

Background to the Process

‘The microbe is nothing, the terrain everything’

- Louis Pasteur on transmission of infectious diseases

The process so far

- Sabcoha Breakfast
  - Debbie Muirhead and Andrew van Zyl (Aurum)
- Sabcoha seminar
  - Thinking out of the box
  - Development of analytical model
- Presentation at Wits conference

Today's Session

- We want to discuss our thinking thus far to get further input and ideas
- Discussion
  - Is the model valid and useful?
  - How can it be improved?
  - Are there other useful approaches which should be explored

Today's Session

- Two major approaches (ideally they should be integrated):
  - Interventions which focus on individual behaviour change
  - Interventions which focus on a higher systems level

Background

- This framework is a joint effort
- Result of working with SABCOHA
- Is not a definitive model but a work in progress
- Needs the feedback and input of others
- Is located in a view that HIV prevention has to happen at multiple levels

Lessons learned so far

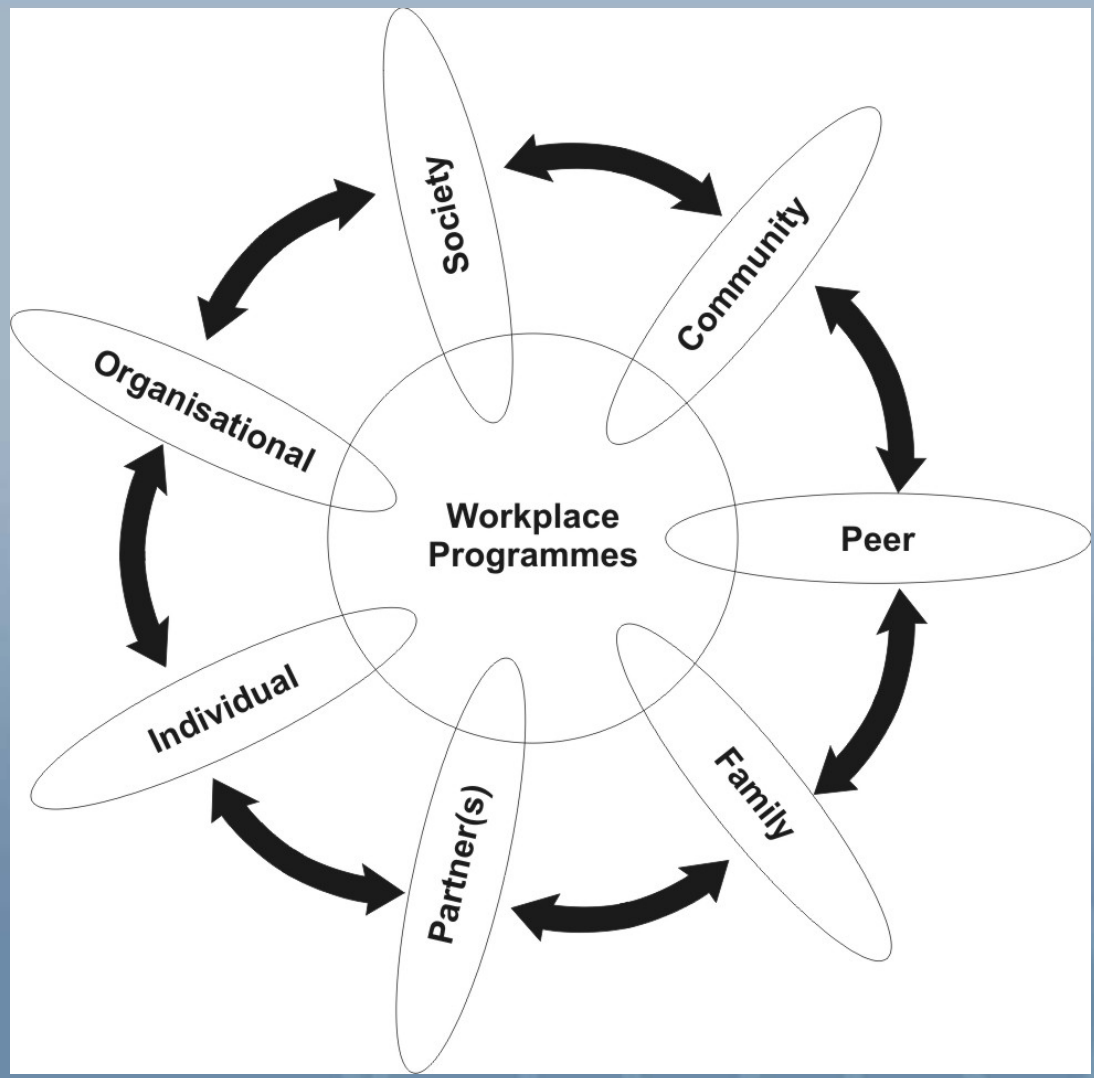
- Leadership is crucial
- General awareness needs to be complemented by targeted programmes
- Social mobilisation is key
- Stigma must be specifically targeted
- Integrate medical interventions into whole programme (VCT, ART)
- Social cohesion and social capital strengthen interventions

The Model

Framework for HIV prevention interventions

Individual level interventions assume that risk behaviours are due to individual, psychological needs or deficits: examples could include •biological interventions like VCT and treatment •educational interventions like peer to peer individual sessions •group training sessions •psychological interventions like individual counselling •partner and family counselling •awareness raising and exploration on the role of culture, beliefs and spirituality with individuals •provision of condoms and sexuality information	**Social interventions** assume that risk behaviours are affected by norms, values, beliefs which are socially constructed: examples could include •stigma mitigation through positive messages from leaders •shifting community norms through coalition building and mobilisation •building positive social capital and social cohesion by enhancing networks and supportive links •making safer sex sexy •working with sexual networks •working in school and faith communities
Intermediate structural level interventions target conditions outside the control of a single individual: examples could include: •setting up local testing and treatment centres •developing HIV policies and programmes in the workplace •offering social services such as grants •condom social marketing programmes •local media strategies •needle exchange programmes •programmes on sex worker rights	**Macro level structural interventions** target conditions which shape the nature of a society: examples could include: •poverty alleviation programmes •developing laws (for example on discrimination as well as laws on sale of alcohol and drugs) •developing national policies on treatment of refugees and asylum seekers •addressing gender inequity, for example through targets for educating girl children •national media laws, policies and strategies

Our model


Society
Community
Organisational
Workplace Programmes
Peer
Individual
Family
Partner(s)

The societal level

- **Key questions**
- How do we as a workplace minimise or buffer against the effects of historical and current social forces on our workplaces as a whole and employees in particular?
- How do we contribute to nation building and other national processes?

Two examples

- Endeavour to employ a diverse range of South Africans.
- Explore the imperatives of the organisation (corporate, SME, service industry, NGO) and attempt to align these with national debates and norms, e.g. constitutional values, access to justice, poverty alleviation, crime reduction, fairness and equity.

The community level

- **Key questions**
- How do we build cohesion and positive social capital in the communities from which our employees are drawn or the community in which our organisations are located?
- How do we acknowledge our links with various communities and give hope to young people?

Two examples

- Ensure that corporate social responsibility programmes meet the needs of local communities – these can be developed jointly with staff and community leaders.
- Recognise that our employees may belong to multiple “communities”, both geographic and identity based (e.g. gay communities) and acknowledge these in prevention messages.

The peer group level

- **Key questions**
- How do we develop positive peer pressure through peer programmes and assist individuals to be true to their values?
- How do we factor in age-related peer pressure?

Two examples

- Research sexual networks in communities from which staff are drawn or communities around the organisation and examine the impact of these on HIV prevalence rates.
- Examine your organisational (sub) cultures to see if they promote attitudes or behaviours which encourage risk taking or excessive alcohol use.

The family level

- **Key questions**
- To what extent do we strengthen families (in all their forms)?
- How do we build in them skills to deal with HIV and AIDS?

Two examples

- Ensure that staff members who are sent on courses or work assignments which take them away from work for long periods are able to see their families regularly.
- Ensure that staff members with family problems are able to receive counselling and support either in the workplace or through outsourced counselling options.

The relationship level

- **Key questions**
- How do we strengthen personal relationships of our workforce?
- How do we limit the stresses and strains they may experience?

Two examples

- Assist staff members who are away from home for long periods to take precautions around sex and risk taking.
- Offer opportunities for staff members to address relationship issues through counselling services.

The individual level

- **Key questions**
- How do we build an individual's capacity to make healthier decisions about their lives?
- How do we do this in relation to their partners, friends, families and communities?

Two examples

- Allow for opportunities for staff to receive counselling for a range of personal challenges and difficulties.
- Promote personal development opportunities around gender, communication, negotiation, conflict management, self esteem, assertiveness, and sexual knowledge and awareness skills.

The in-house level

- **Key questions**
- How do we create an enabling environment for people to be holistically fulfilled in their work lives?
- How do we acknowledge the internal (workplace culture) and external (social/cultural) influences which shape their lives?
- How do consult all relevant stakeholders, including people living with HIV/AIDS?

Two examples

- Through a series of qualitative and quantitative measures, develop an understanding of the needs and outlook of staff members.
- Specifically address stigma and discrimination around HIV and AIDS, and around difference and diversity in general, ensure that there are consequences of breaches, and link to diversity programmes.

Designing the Intervention

- Designing interventions at the non-individual level

- Designing the individual behaviour change process

The (Fictitious)Target Group – Call Centre

- Marital status: 82% unmarried
  - Of these 60% have a boyfriend / girlfriend
  - Of these 48% have been together for less than 1 year
- Age group
  - 20-24 yrs: 64%
  - 25-29: 28%
  - 30+: 8%
- Sex
  - Male: 52%
  - Female: 48%

The Target Group

- Music tastes:
  - 82% listen to Yfm
  - 37% listen to Metro FM
  - 25% listen to 5FM
  - 22% favour Gospel
- Number of sexual partners over the last year:
  - 0 partners 2%
  - 1 partner: 48%
  - 2 partners: 27%
  - 3-5 partners: 17%
  - 6+ partners: 6%

The Target Group

- Safer Sex:
  - (Those who are married and have 1 sexual partner have been excluded)
  - 42% use condoms all the time
  - 35% sometimes use a condom
  - 8% use non-penetrative sex or a condom
  - 12% never use a condom or safer sex
- Attitude to condoms:
  - 82% believe that condoms ‘spoil the pleasure’
  - 10% believe that government condoms are ‘no good’
  - 12% believe that condoms don’t work anyway

The Target Group

- Attitude to own risk:
  - (Those who are married and have 1 sexual partner have been excluded)
  - 66% believe that they are not at risk for HIV
  - 12% are unsure
  - 8% believe they are low risk
  - 6% believe that they are at some risk
  - 5% believe that they are at high risk
- Attitude to self-efficacy:
  - 64% indicate that they easily make changes in their life
  - 27% indicate that they are not able to make changes in their life
  - 9% are not sure

Target Group Summary

- Largely unmarried
- Relationships of short duration
- Mostly young, ‘trendy’
- Most have multiple sexual partners
- Variable use of condoms
- Generally hostile / suspicious attitude to condoms
- Generally belief of low risk for HIV
- Reasonable sense of self-efficacy

Interventions at the non-individual level

Societal level (rationale: an intervention for the call centre must start with the organisation's general modus operandi):

- Employ a range of South Africans in the team to contribute to spreading access to jobs, resources and power – this impacts more on the families and communities of the organisation than on the employees individually but it does build trust and confidence in the organisation from within.
- Ensure that debates about crime, justice, governance are reflected in company documents and processes.

Community level (rationale: the workplace is not an "island" and bringing in various notions of community will strengthen the prevention work):

- Get the group involved in an HIV-related community outreach project which they have to plan and implement together – this will help to build a common sense of purpose in the group, help them feel like they are making a contribution and will also indirectly allow them to get more informed about HIV and its impact.
- Explore the different "communities" from which the team comes and see how HIV impacts on them and feed this back to the group – this research could also inform other interventions in the organisation or interventions in communities.

Peer level (rationale: understanding peer influences and relationships is critical for an intervention's success):

- Try and research the impact of peer's – who do people socialise with and what is the relevant impact of these peers? Are peers inside the workplace more important (do they spend time together after work, are the sexual encounters between staff) than peers outside the workplace (is this where risk taking occurs?).
- Do the team respond to work stressed by going drinking together and then risk taking happens after that – are there ways of making the work less stressful or making the responses to stress more adaptive?

Family level (rationale: while it may not be possible always to address family of origin issues, all staff belong to families or create their own families – how do their dreams and aspirations impact on the choices they make – consciously and unconsciously):

- To what extent do “family” values affect the staff and are they forming family set ups of their own, are they still living at home or branching out on their own. What are these family values? Are they rebelling against mom and dad?
- Do any of the team have or want children and what do they want their children to know about HIV and AIDS?

Partner level (rationale: since the group is mostly single they may need to talk about potential partners and ideal partners – it is also likely that as single people they may not be ready to settle down and may prefer casual sexual encounters):

- To what extent do they feel their partners are acknowledged as important and do you provide opportunities for the partner/couple to receive workplace counselling benefits?
- Provide group sessions and discussions on "relationships" and the value of HIV testing involving the partner – include discussions on how to talk to your partner about sex and about having a test or being HIV positive.

Individual level (rationale: it is useful to adopt a behaviour change model but to contextualise it depending on social and structural factors which may hinder or help the desired change):

- Offer personal counselling opportunities to explore risks and norms around HIV and sexual risk taking.
- Explore a risk assessment and behaviour change model with staff and present the model to them – getting their buy in for the proposed model (almost as a paradoxical intervention)

The Behaviour Change Process

Behaviour Change Process

Ecosystem influence and perturbation

Intervention

Individual selection and interpretation

Acceptance that I am at risk → Intention to change behaviour → Behaviour change → New behaviour sustained

Behaviour Change Process

It is all constantly in a state of flux

Ecosystem Influence

- The individual will be influenced by other system processes such as:
  - Culture
  - Peer group
  - Communities
  - Family
  - Etc
- This influence will either support or work against our interventions at behaviour change

Perturbation

- We cannot direct the course of behaviour change, all we can do is ‘unsettle’ the individual in a way which we hope will lead to the ‘desired’ behaviour

Selection and interpretation

- We select the information to which we pay attention
- Usually we select the information which supports our existing worldview
- We interpret the information to which we pay attention according to our existing worldview

Designing the process

- Understand the target group
- Be clear on what you want to achieve in terms of behaviour change
- Design the process
- Implement using BCC approach
  - Design the messages
  - Design the communication
  - Implement
- Measure

An example

- Target:
  - Behaviour change to reduce risk of HIV infection in target group
- Of the earlier target group, what actual behaviour change should be targeted?

Target Group Summary

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Refine Target

- Behaviour change to reduce risk of HIV transmission in target group through:
  - Greater condom use
    - Address attitudes to condoms
  - Reduced number of sexual partners
  - Issue of low recognition of risk for HIV
- There may be different sub target groups

Designing the Intervention

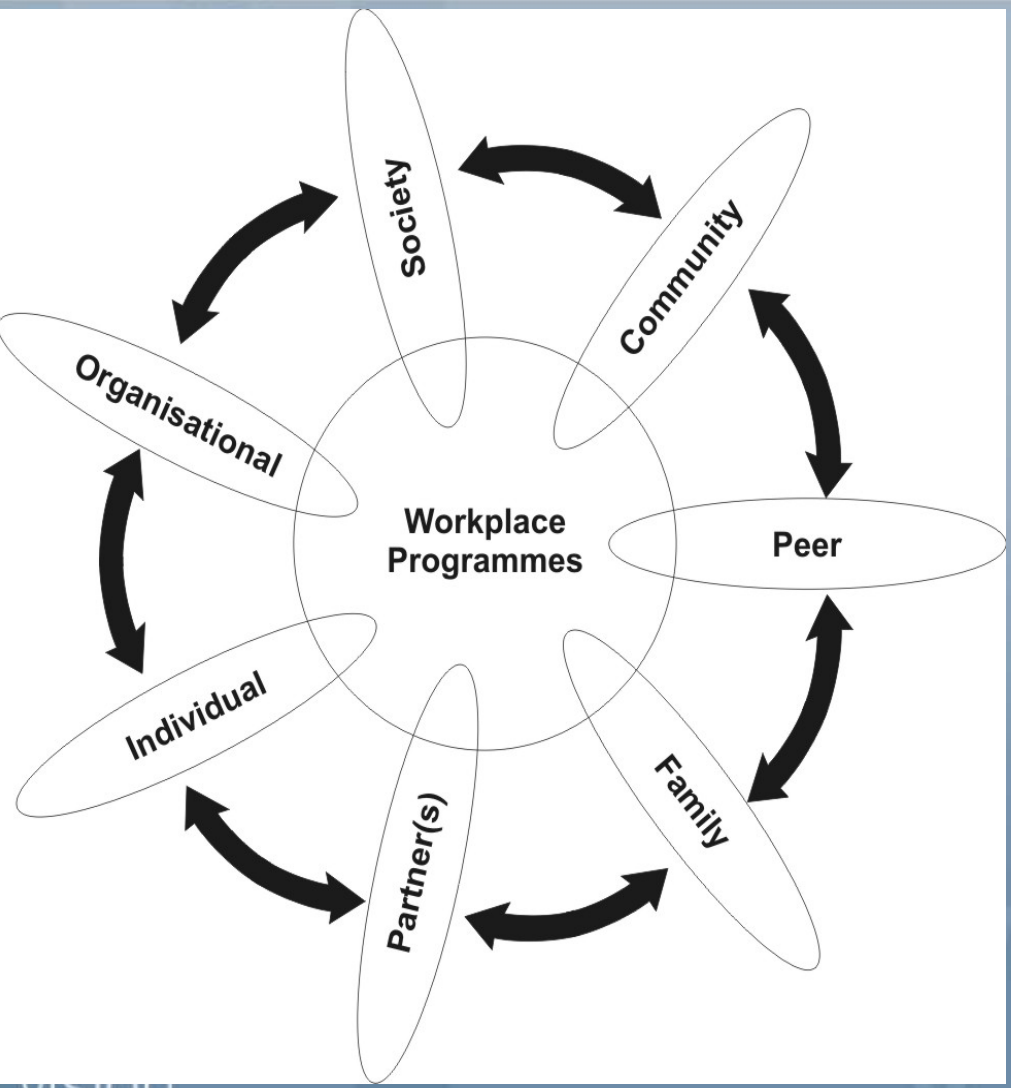
Designing the behaviour change intervention

- Analyse the company employees as regards target groups
- Understand your target group
  - What are their relevant characteristics?
  - What are the major influencing systems and processes?
- Design the process
  - What behaviour change do you want to achieve?
  - What BCC intervention do you implement?

Understand the target group

- What are the relevant characteristics of the target group
- More carefully designed
  - KAP survey
  - Focus groups

Understand the target group



1. What influences are there at the various levels and can you change these:
   - Organisational
   - Communities
   - Peer
   - Workplace
   - Partner
2. Individual level:
   What relevant influence / noise of these levels do you need to take into account

Understanding the ecosystemic influence

- It is easier to ‘piggyback’ on existing processes rather than trying to counter processes or establish new processes
- So, for example, trying to block the sexual processes existing in the group is unlikely to be effective

Understanding the ecosystemic influence

- Part of our understanding of the target group must be an analysis of the processes which influence them

- What processes support your efforts?
- What processes act against your efforts?
- What opportunities are there to develop new supportive processes?

Designing the Behaviour Change Process

Possible Process Models

- Labyrinths:
  - Lead the individual through a number of decisions to get to the desired goal
- Rituals:
  - Socially sanctioned and supported change in individual status / position

Behaviour Change Process

Ecosystem influence and perturbation

Intervention

Individual interpretation and selection

Acceptance that I am at risk → Intention to change behaviour → Behaviour change → New behaviour sustained

Behaviour Change Process

It is all constantly in a state of flux

Designing the intervention process

- Acceptance of personal risk
- Intention to change behaviour
- Changing behaviour
- Maintaining behaviour change

Acceptance that I am at Risk

- Individual:
  - Messages which personalise risk
  - (AIDS Risk Reduction Model?)
- Workplace Peer:
  - Messages regarding risk for HIV transmission
  - Generating discussions on risk
- Communities (who are they?)
  - Using or Counteract community ‘noise’

Intention to change behaviour

- Individual:
  - Messages on how to protect yourself
  - Messages to change attitude to condoms
- Workplace Peer:
  - Messages regarding risk for HIV transmission
  - Generating discussions
- Communities (who are they?)
  - Use or Counteract community ‘noise’

Behaviour change

- Behaviour change plan:
  - (Stages of Change Model?
    - Change happens in stages
    - It is a process which takes time)

Design and implement BCC

- Messages
- Communication streams
- Communication vehicles

Some possible issues

- Issues of Control
  - Do I have control?
  - How is this control achieved?
- Issues of influence
  - How strongly influenced by the group rather than by individual decision?
- Self-efficacy
- How to get selection of the message against all the competing noise
- How to ensure correct interpretation of the message intended

Summary

- To be effective our prevention interventions must:
  - Move beyond only focusing on the individual level
  - Must be designed far more carefully
  - And targeted more carefully
  - Based on evidence regarding the target group

Summary

- Interventions should try to address as many levels as possible
- Though it may be hard to know exactly what worked and why
- If you have to start small, do it well but recognise other factors
- Don’t rely too heavily on bio-medial interventions
- Be willing to make mistakes

vision

vision

Lover Boys and Girls

This high-risk group consists of (mostly) single people who are promiscuous.

The gender breakdown of this group is approximately 55% male and 45% female.

This group does not believe that Aids really exists. They believe that listening to the HIV/Aids message only spoils the fun; that HIV/Aids is not serious and that it can be cured

Lover Boys and Girls

- Members of this group are embarrassed about using condoms and believe that sex is more enjoyable without them. They do not believe that the risk of getting HIV/Aids is reduced by having fewer sexual partners and will not discontinue sexual intercourse with a partner if the partner is HIV-positive.
- A significant proportion believes that HIV/Aids can be spread by mosquitoes, and that it is mostly spread by women. They also believe that the virus is spread by "dirty blood". Some further claim that they don't know how one gets HIV/Aids and others say that it can be cured by having sex with a virgin.