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FACULTY OF SOCIAL SCIENCES AND HUMANITIES

Department of Social Work

The Efficacy Of The Peer Led Model In The Provision Of A Comprehensive HIV Package For Informal Traders In Chitungwiza

BY

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A DISSERTATION REPORT SUBMITTED TO THE DEPARTMENT OF SOCIAL WORK, BINDURA UNIVERSITY OF SCIENCE EDUCATION, FACULTY OF SOCIAL SCIENCES AND HUMANITIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE SOCIAL WORK HONOURS DEGREE

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ABSTRACT

Peer education has gained widespread recognition and stands as a crucial approach in enhancing the availability of HIV/AIDS services to high-risk populations of contracting HIV. Thus the study aimed at assessing the efficacy of the peer-led model in the provision of a comprehensive HIV package for informal traders in Chitungwiza. The sample size for the research was 20 participants. The study followed a qualitative approach which encompassed of focus group discussions, in-depth interviews and face to face interviews which were conducted with 14 peer led mentees, 4 peer led mentors and 2 NAC programmes officers respectively. The collected data was thematically analysed and presented three major themes which were subsequently curtailed into subthemes. The major findings were on the efficacy of the peer led model in promoting HIV/AIDS service accessibility to informal traders, the challenges inhibiting the traders from effectively accessing these services and the solutions to help counter the problems. The efficacy part displayed factors like increased condom uptake, improved knowledge levels, behaviour change, friendly service provision, increased awareness of HIV services and improved access to health services. Challenges discovered included unaffordability, stigma and discrimination, highly demanding nature of informal trading, ignorance and transportation difficulties. Hence the proposed solutions were mobile clinic system, stakeholder collaboration, HIV/AIDS education, stigma reduction and provision of financial support. The researcher also proposed recommendations to the implementing agency, government and social workers. These included a robust M&E system, stakeholder collaboration, capacity building and training, strong referral system, continuous advocacy and others.

APPROVAL FORM

Supervisor

I certify that I have supervised **KUFA BERTHA VIMBAI** in conducting an explorative research titled: **The efficacy of the peer led model in the provision of a comprehensive HIV package for informal traders in Chitungwiza**, in partial fulfilment of a Bachelor of Science (Honours) Degree in Social Work and I hereby recommend it for acceptance by Bindura University of Science Education.

Name……Signature……...….Date……..

Chairperson of the Department Board of Examiners

The undersigned certify that the Departmental Board of Examiners is satisfied that this project report entitled: **The efficacy of the peer led model in the provision of a comprehensive HIV package for informal traders in Chitungwiza** by Kufa Bertha Vimbai meets the examination requirements. I therefore recommend the dissertation report for acceptance by Bindura University of Science Education in partial fulfilment of the requirements of a Bachelor of Science (Honours) Degree in Social Work

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DECLARATION AND RELEASE FORM

I **KUFA BERTHA VIMBAI** studying for a Bachelor of Science (Honours) Degree in Social Work, cognizant of the fact that plagiarism is a serious academic offence and that falsifying information is a breach of ethics in Social Work truthfully declare that:

1. The project report titled '**The efficacy of the peer led model in the provision of a comprehensive HIV package for informal traders in Chitungwiza"** is a result of my own work and has not been plagiarized.
2. I have followed research ethics required in pursuit of Social Work research.
3. Permission is hereby granted to Bindura University of Science Education to use this dissertation report for academic purposes only.

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DEDICATION

This dissertation is dedicated to those who have played a crucial role in my research journey, providing unwavering support and inspiration. Your love, encouragement, and belief in my abilities have been the driving force behind my success and made this journey meaningful and enjoyable.

In light of this, my heartfelt dedication goes to my mother (Mary Kufa) who has extended boundless love and support during my research journey. Her resilience, endless sacrifices and strong belief in my dreams continued to inspire me each day. I also dedicate this dissertation to my late father (Patson Kufa) who despite not being with us, his memories still live in my heart. His determination and wisdom have shaped and motivated me. I dedicate this work to my father, knowing that he would be proud. I dedicate this dissertation to my siblings, Faura and Tiriwashe for being supportive and understanding. My sincerest dedication also goes to my friends, Mathew, Patience and Tania whose encouragements have been my pillar of strength.

This dissertation is a testament to the collective effort and belief of my friends and family. Thank you all for being my guiding lights during the darkest hours and my cheerleaders during the brightest moments. This accomplishment is as much yours as it is mine.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CSE	Comprehensive Sexuality Education
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HTS	HIV Testing and Counselling
NAC	National AIDS Council
NGOs	Non-Governmental Organizations
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PSH	Population Solutions for Health
PSZ	Population Services Zimbabwe
PZAT	Pangea Zimbabwe AIDS Trust
SAYWHAT	Students and Youth Working on Health Action Team
SRHR	Sexual Reproductive Health and Rights

STI	Sexually Transmitted Infections
VMMC	Voluntary Medical Male Circumcision

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CHAPTER 1: INTRODUCTION & BACKGROUND OF THE STUDY

1.0 Introduction

This first chapter of the study was focused on giving the introduction and background of the study. This encompassed of the introduction, background of study, statement of the problem, aim of the study, objectives, research questions, assumptions, significance of the study, limitations, delimitations, definition of key terms, chapter outline and the chapter conclusion. The global, regional and local background of the study was presented to provide an appreciation of the situation at hand from greater lens. The aim and objectives informed the methodology used for the study whilst the significance highlighted the gaps covered by the research which makes it an important one. Key terms were defined to develop greater understanding of the topic and for clarity purposes. Therefore this chapter was essential in providing a roadmap and laying a basic foundation for the study.

1.1 Background of Study

Since the 19th century, HIV/AIDS epidemic has been a very topical issue worldwide. With the first identification of HIV being discovered four decades ago, the epidemic has led to high morbidity and mortality, serious illness, stigma and discrimination and affected various sectors of human life like education and the economy (Sharp and Hahn, 2011). The Global AIDS Strategy recognized the nexus between ignorance, lack of HIV prevention, poor treatment, care and support services and stigma and discrimination of HIV positive people and therefore proposed measures to combat this (UNAIDS, 1998). Interventions in the form of Anti-Retroviral Treatment, HIV/AIDS education, condom promotion, support groups, adherence and monitoring services were introduced globally so as to try and mitigate the impacts of the virus. The Global AIDS Strategy

also presents how developing countries are the mostly affected by the epidemic due to their impoverished state, lack of adequate education and their poor economies which force individuals to become informal traders in order to make ends meet. Thus it recognizes the large contribution of informal traders in spreading the virus and hence this group requires differentiated service delivery models.

In the region of Africa, a majority of the countries are developing countries with unstable economies, poor living conditions and poverty which cause many individuals to engage in informal trade for income purposes (Salia, Sidat, Dias, Martins and Craveiro, 2020). This group is not to be spared as key drivers of HIV spread as the nature of their jobs makes them susceptible or prone to HIV contraction and spread (International Labour Organization, 2005). The types of informal trading in Africa include vending, cross boarder trading, sex work, mining and many others. These are highly-demanding and therefore leaves the informal traders with no time to access desired health services including HIV/AIDS services. Other factors leading to the proneness of informal traders to the virus include factors like unstable or irregular income, lack of education or attaining only low level education like primary school, lack of social protection services like medical and funeral aid services. Salia, Sidat, Dias, Martins and Craveiro (2020) present how the South-Mozambican boarder has become a hotspot are for HIV spread. This is caused by risky sexual behaviour which also leads to transmission of other forms of STIs. In South Africa, informal trading and migrant labour is argued to be a key driver of the AIDS epidemic (International Organization for Migration, 2005). A majority of these are migrants from many countries in Southern Africa who seek greener pastures in South Africa. In Botswana, Tanzania, East and Sub-Saharan Africa, the issue is the same and economic hardships are the precipitating factor of informal trade.

Risky sexual behaviour by informal traders is usually caused by family separation due to work. Many leave their partners at home and thus sex as a basic need under Maslow's first tier of the hierarchy of needs is not attained (Montag, Sindermann, Lester and Kenneth 2020). People will hence resort to other ways to fulfil this quest. Sense of freedom or having no one to monitor them also causes informal traders to engage in promiscuity, stigmatization of female informal traders also shuns them from accessing services and delays and corruption at boarders also cause them to offer free sex so as to bribe officers. This act of having multiple concurrent partners fuels HIV spread amongst informal traders. High mobility also affects adherence to drugs by traders living with HIV. HIV/AIDS interventions introduced in Africa include behaviour change, combination prevention, peer education, research and ART (Coates, Ritcher and Caceres, 2008).

Informal trading also fuels HIV spread in Zimbabwe specifically. Due to economic hardships, unstable economy, hyper-inflation, unemployment and poor living standards majority of the employees (80%) are informal traders (ZIMSTAT, 2023). These include miners, vendors, bus touts etc. In high density suburbs like Chitungwiza, the economy is highly informal with a majority being vendors, bus touts, money changers and sex workers. This group indulges in reckless sexual behaviour due to lack of education or low level education, negative peer influence, lack of time to access health services, ignorance, drug and substance abuse, stigmatization and many more. This leads to increased HIV incidence, poor positive living and thus interventions like the peer led programme are being launched by organizations as they aim at addressing HIV spread and control.

1.2 Statement of Problem

The peer led model aims at closing the tap of new infections in the country and is in line with the UNAIDS 95-95-95 global targets. It seeks to reduce HIV incidence amongst sex workers and other subgroups like market traders, money changers, bus touts and artisanal miners through addressing

the HIV/AIDS and Sexual Reproductive Health needs of these vulnerable groups (Gwarisa, 2022). In Chitungwiza, the economy is highly informal and this is why the model was adopted in the district. Jobs in the informal economy are characterized by unregulated contractual arrangements and poor working conditions. In addition, there is no social protection mechanisms in place and the informal economy is highly vulnerable to the HIV/AIDS pandemic (Zimbabwe HIV&AIDS Strategy for the Informal Economy, 2020). This sector also had limited targeted and integrated HIV, TB, STI, Cancer and SRHR services. In Chitungwiza, most informal traders are vendors, sex workers, money changers and bus touts. These groups are also prone to drug and substance abuse and this increases their vulnerability to HIV/AIDS. Under the influence of drugs, these groups indulge in reckless sexual behaviour leading to HIV transmission. Their behaviours of friendships 'sahwira' also precipitates reckless sexual behaviour which leads to HIV spread. These friendships also informs their knowledge levels, attitudes, behaviours and practices. Thus negative peer influence as a common practice also causes them to shun away from seeking health services including HIV/AIDS services. The peer led review in Chitungwiza revealed that most vendors rely on local herbs and traditional medicines due to stigma and discrimination at health facilities (Zimbabwe HIV/AIDS Strategy for the Informal Economy, 2020).

The job of being an informal trader is also highly demanding and thus this group does not have ample time to visit health facilities and access different health services. This is because health service providers are usually far away from them and they cannot leave their workplace in pursuit of health services. This makes the informal economy extremely vulnerable to HIV/AIDS as they can neither access health facilities nor social protection programmes. More to this, health services are usually provided during normal daily operating hours and therefore inaccessible to them and thus further exposing them to HIV. Zimbabwe HIV/AIDS Strategy for Informal Traders (2020)

also reveals that most women in informal trading indulge in sex work as a way of supplementing their small incomes, thus their vulnerability to HIV/AIDS. It is also paramount to note that the major religious activity in Chitungwiza is the apostolic sect. Other schools of thought like Chowdhury, Bershteyn, Milali, Citron, Nyimbili, Musuka and Cuadros (2023) propounds that this group has led to many defaulters as prophets and church leaders claim to cleanse people of HIV. Amongst the informal traders, there are some who believe in these religious practices and therefore their health-seeking behaviour is very low. This is because in some white garment churches, believers are not allowed to be formally employed, rather they become informal traders for income generation purposes.

The peer led programme was adopted by National AIDS Council in 2020 and it seeks to reach out to informal traders during their working hours, at their workplaces, with a comprehensive HIV/AIDS package. Under peer education, well capacitated peers are trained on HIV prevention, treatment, care and support. These recruit fellow peers and deliver wide-ranged HIV/AIDS services. Therefore this research sought to explore the efficacy of the peer led model in provision of HIV/AIDS services, challenges faced in accessing them and to come up with measures that can be put in place to improve the peer led model in reaching informal traders with a comprehensive HIV package in Chitungwiza

1.3 Aim

The main aim of the research was to analyse the efficacy of the peer led model in reaching informal traders with a comprehensive HIV package in Chitungwiza.

1.4 Research Objectives

The study was guided by the following objectives;

1. To analyze the efficacy of the peer led model in provision of HIV/AIDS services for informal traders in Chitungwiza.
2. To identify the challenges encountered by informal traders in accessing these services in Chitungwiza.
3. To determine measures to improve the delivery of HIV services for informal traders in the district.

1.5 Research Questions

The research questions were as follows;

1. How efficient are the services offered to informal traders through the peer led model?
2. What are some of the challenges faced by informal traders in accessing these services?
3. Which are the most possible solutions to the challenges faced by informal traders in accessing HIV/AIDS services.

1.6 Assumptions

The assumptions of the study included facts that the peer educators and the peer mentees would give honest and truthful responses. The researcher also expected to get solid assistance from National AIDS Council Chitungwiza District through information and linking the researcher with the peer led mentors and mentees. The mentors were also assumed to freely give information without expecting much in return as this programme is voluntary. However, there was a possibility that the peer led mentees could give inadequate information due to the nature of their busy jobs so that they can quickly resume their work.

1.7 Justification of study

It was very essential to carry out this study as it monitors and evaluates the work of the peer led model in delivering HIV/AIDS services for informal traders in Chitungwiza. This study critically evaluated the accessibility, affordability, appropriateness and efficiency of HIV prevention services offered and thus improving HIV/AIDS service delivery. This study benefited the agency implementing the model, National AIDS Council through monitoring and evaluation feedback and success story documentation. It revealed the successes of the model which can be documented as significant stories by the agency. The study scouted for the challenges encountered by informal traders in accessing HIV/AIDS services under the peer led model. The study also provided solutions effective for modification of the model and this informs future programming and modification of the model to best achieve its desired targets and aims. The study also benefited peer led mentors through identifying and exploring the challenges they face during their voluntary work and also the peer led mentees through analysing the efficacy of the HIV/AIDS services extended to them. This brings about positive change and modification in the model which improves HIV/AIDS service delivery and makes their work easier. The study was also advantageous to other informal traders yet to be enrolled in the programme and the Chitungwiza community as the area for the project and research. This is because they will get a modified version of the peer led model and the community benefits through social development respectively. Therefore it was worth giving the researcher the resources necessary to carry out this study so as to promote a variety of perspectives on the results and to fill in the gaps left out by other scholars who carried out similar research.

1.8 Delimitations of Study

Delimitations of a study refers to the shortfalls or weaknesses of a research consciously set by the researcher themself (Theofanidis and Fountouki, 2018). The delimitations of this study included facts that the research was limited to informal traders enrolled under the peer led model implemented by National AIDS Council in Chitungwiza and that the researcher resorted to purposive sampling due to insufficient funds. Hence the sample size was restricted to only 20 research participants.

1.9 Limitations of Study

Study limitations are the shortcomings or weaknesses of a research design which may impact the results or outcomes of the research. These are outside the researcher's control (Theofanidis and Fountouki, 2018). The limitations of this study included lack of funding as there was no procurement of refreshments for the participants. Lack of funding also hindered swift movement of the researcher. The research also had a limitation of a smaller geographical area due to lack of ample time.

1.10 Definition of Key Terms

- **Efficacy** is the ability to produce positive and desired effects or benefits after proper application (Cartwright, 2009). It refers to the proper utilization of time and resources to produce favourable effects.
- **Peer-led or peer education model** is an education model which is implemented in order to foster behavioural and attitudinal change and to improve knowledge levels of individuals and groups within the same age, occupation, status or educational levels. (Sakru, Aldi and Afyoncu, 2023)

- **Informal traders** are defined by Mafukata and Kancheya (2015) as the "non-registered, non-accounting and non-tax paying grassroots based individuals or group of household members whose business practices are based on street vending or hawking but not limited to selling or providing small quantities of goods and services to an undefined market to earn a living". These include informal cross boarder traders, artisanal miners, vendors, money changes, bus touts and sex workers.
- **HIV package** refers to the wide-ranged services extended to people pertaining to HIV/AIDS. These include HIV prevention, treatment, care and support services including stigma reduction. This is because no single intervention is sufficient to control the epidemic, hence these complement each other (Kurth, Celum, Baeten, Vermund and Wasserheit, 2011).

1.11 Chapters Outline

Chapter 1: Introduction and Background

This chapter seeks to introduce the research topic, with specific emphasis on the background of study, statement of problem, aim of study, research objectives, research questions, significance of study, limitations, delimitations, definition of terms and conclusion of the chapter.

Chapter 2: Literature Review

The second chapter seeks to review literature in relation to the study. This will be the global, regional and national literature review. It will also emphasize on the theoretical frameworks applicable to the study, how they link with the research objectives and their relevance to the study.

Chapter 3: Research Methodology

The third chapter will outline the research methodology to be used in data collection, analysis and compilation by the research. It will mirror the research approach, research design, target population, sample size, sampling techniques, data collection methods, data collection tools, data analysis, ethical considerations, validity and reliability of the study.

Chapter 4: Data Presentation, Analysis and Discussion of Findings

This chapter will present the data, the data analysis and well a discussion on the findings. The data will be presented through both the narrative and tabular format.

Chapter 5: Chapter Summary, Conclusions and Recommendations

The final chapter of the research will give a summary, conclusions and provide recommendations to the study conducted.

1.12 Chapter Conclusion

In conclusion, the first chapter of this dissertation highlighted on the global, regional and national background of the study. It also revealed the statement of the problem, aims of the study, objectives, research questions, assumptions, justification of study, definition of key terms and the chapter outline of the study. These were paramount in order to understand why the student chose the research topic and they pave way for the coming chapters.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

This chapter was focused on the literature review and theoretical framework for the study. The first section of this chapter presented key issues under Albert Bandura's social learning theory as the theoretical framework for the study. It also revealed the relevance of the theory's key concepts namely, observational learning, imitation, modelling, reinforcement, self-efficacy and empowerment and retention and context to the study. The literature review of this study explored what other researchers have put forward concerning the research topic, revealed the gap they left and the essence of this study. This sector assisted in reviewing scholars' perceptions on the efficacy of HIV/AIDS services delivered to informal traders under the peer-led model, assessment of the challenges faced in accessing these services and solutions to help counter the challenges hence improving the delivery of these HIV/AIDS services.

2.1 Theoretical Framework

Theoretical framework refers to the lens or theories that can be used to explain and present a research topic. The peer-led model can best be understood using Albert Bandura's social learning theory.

2.1.1 Albert Bandura's Social Learning Theory

This theory is based on the belief that human behaviour is shaped by social interactions in the society (Nabavi and Bijandi, 2012). It presents the role of the social environment in influencing human behaviour, which can have either positive or negative effects. The theory suggests that through social interactions, individuals observe the behaviours of others, process the information, and imitate those behaviours. Consequently, individuals who are close or spend a significant

amount of time together tend to exhibit similar behaviours. The social learning theory also encompasses several key concepts that are parallel to the traditional theory. These include observation, imitation, and modelling. These concepts are interconnected with the elements of observational learning, retention and context, motivation and reward, and the individual's state of mind.

The first key concept of Albert Bandura's social learning theory is observation or observational learning. This was deduced from his famous Bobo doll experiment which he conducted in 1961 so as to study behavioural patterns. For this experiment, the theorist used 36 boys and 36 girls at Stanford University Nursery School. 24 children were exposed to aggressive behaviour whereby aggressive models punched the bobo doll and said mean words to the doll, the other 24 were exposed to non-aggressive behaviour and 24 to none (Cherry, 2022). Each group had boys and girls and this was to test the influence of children on each other. The children were allowed to play in a room afterwards and those exposed to aggressive behaviour displayed the exact behaviour which they were exposed too and they became aggressive, tossing, kicking and saying mean words to the bobo doll. Those exposed to non-aggressive behaviour were less aggressive. From this study, Albert Bandura concluded that children replicate the behaviour which they frequently and also that boys might exhibit more aggression than girls (Cherry, 2022).

The second key concept of the social learning theory by Albert Bandura is imitation. This is whereby individuals copy the behaviour of other people which they usually consider as their role models. It is closely related to the concept of observational learning whereby individuals imitate the specific behaviours they have observed. The Bobo doll experiment exemplifies this second key aspect of the social learning theory. This concept is interconnected with the idea of "motivation and reward" or "reinforcement," whereby behaviours that are rewarded are more likely to be

imitated, while behaviours that are punished are abandoned (PulseLearning, 2023). This mechanism enables individuals to distinguish between desirable and undesirable behaviours, thereby fostering a desire to compete in exhibiting positive behaviour.

Modelling is the third key concept of the social learning theory (Bandura, 1977). This happens after a person has observed positive behaviour and the positive outcomes it bore forth (Nabavi and Bijandi, 2012). They attempt to imitate the positive behaviour learned from their role models. The modelling process follows 4 specific steps namely, attention, retention, reproduction and motivation, as well explained by Nabavi and Bijandi (2012). At 'attention' stage, the person pays particular attention to the model's actions. At 'retention' the observer remembers the observed actions and behaviour, they can even rehearse it. The third stage is 'reproduction', which is the ability to reproduce or replicate the observed behaviour. 'Motivation' is the last stage whereby the person develops the desire to want to demonstrate the learned behaviour.

Another key issue of the social learning theory by Albert Bandura is that of retention and context. This subscribes to the idea that human beings learn through internalization of information in their memories. Now when a similar situation occurs, they become aware of how to handle it exactly the same way like the memorized one (PulseLearning, 2023). State of mind is also another concept of pertinence. It proposes that external reinforcement is not the sole factor influencing behaviour and learning. Rather, intrinsic reinforcement, that is an internal feeling of accomplishment, increased self-confidence and being proud after one has exhibited positive behaviour also plays a role in learning and motivating individuals to imitate such behaviour in the future (PulseLearning, 2023). Bandura also proposes 'self-efficacy and empowerment as another crucial element of the social learning theory. Self-efficacy suggests that individuals are more likely to engage in learned behaviour if they believe it will be effective or beneficial to them (Bandura, 1977). Empowerment

involves equipping peer educators with knowledge, skills, and resources, which builds trust among their peers that these educators can effectively impact their lives.

2.1.2 Relevance of theory to the study

The social learning theory is highly relevant to the study of the peer led model. It aligns with the key principles of the theory, demonstrating its applicability in this context. The peer-led model emphasizes the role of modelling in the behaviour learning process. Peer educators or mentors are equipped with knowledge about HIV/AIDS and awareness of where to access HIV services, which transforms their behaviours and lives. As a result, their peers perceive them as role models and try to learn from them. The peer education approach also incorporates observational learning by recruiting peers to influence the behaviour of their peers. This is because peers spend significant time together and thus increasing the likelihood of observing positive behavioural patterns of peer mentors. Subsequently, imitation occurs as peers attempt to replicate the observed positive behaviours, leading to improved health-seeking behaviour.

'Retention and context' is relevant whereby peers memorize how their role models respond to health situations, allowing them to recall and apply that information in their own health situations even after the program concludes. Peer led mentors can share their personal survival stories whilst working with their peer mentees so as to foster retention and context.

Reinforcement, which aligns with Skinner's behavioural theory, is another significant element of the social learning theory that is relevant to peer education. This is because peers often interact more with individuals similar to themselves, and through reinforcement peer mentees can easily accept HIV/AIDS information from their peer mentors leading to improved health-seeking behaviour, particularly regarding HIV/AIDS services. Empowerment and self-efficacy, as outlined

in Albert Bandura's social learning theory, play a crucial role in the peer-led model. Peer mentors educate their mentees about the benefits of adopting a positive health attitude to increase the likelihood of its practice. Bandura (1977) suggests that individuals are more likely to engage in learned behaviour if they believe it will be effective or beneficial to them. The peer-led model utilizes stories of significant change or success stories to motivate other peers to seek health services. Preference is given to peer mentors who have experienced similar challenges. Empowerment is also fostered through the training of peer mentors, instilling trust in the information they share. Therefore, through reinforcement, empowerment, self-efficacy, and retention and context, the social learning theory informs the implementation of the peer-led model in HIV/AIDS interventions.

To sum up, Albert Bandura's social learning theory proves to be of much relevance to the study of the peer led model. Its crucial elements like modelling, observational learning, imitation, reinforcement, empowerment and self-efficacy, retention and context speaks to the operations of the peer led model. These include improved health seeking behaviour, peer influence, improved HIV/AIDS knowledge levels and many more.

2.2 Literature Review

According to Winchester and Salji (2016), literature review refers to an "in-depth and evidence based analysis of a subject". It is what other researchers and scholars have published and said concerning the issue a research topic is going to focus on.

2.2.1 The efficacy of the peer led model in provision of HIV/AIDS services for informal traders

Scholars present on how the peer led or peer education model is a paramount strategy of improving the health and well-being of people especially pertaining their Sexual Reproductive Health. Globally, the peer led model is argued to be efficient in fostering friendly-service provision. This is presented by Dodd, Widnall, Russell, Curtin, Simmonds, Limmer and Kidger (2022) to be a very effective way of improving people's health-seeking behaviour as people are most likely to seek health services from their peers or friends or people similar them. Additionally, people develop strong relationships with their peers, which makes them more likely to open up about their health conditions and issues. This in turn, improves the referral pathway to ensure that they receive the necessary health services. Siddiqui, Kataria, Watson, and Chandra-Mouli (2020) also argue that peer education is essential for improving knowledge, attitudes, and intentions of people. Since the model involves capacitated peers imparting health education to their peers, the point is thus justified. These reveal how this education is mostly about Sexual Reproductive Health like condom use, Sexually Transmitted Infections, HIV/AIDS and Family Planning amongst many others. Dodd, Widnall, Russell, Curtin, Simmonds, Limmer and Kidger (2022) also further support this idea highlighting how peer education enhances awareness of available service providers and the services which they offer. This improves the accessibility of health services to peers and improves the uptake of diverse health services.

Another importance of the peer led model across the globe is in promoting positive attitude and behaviour. This aligns with the social learning theory (Dodd et al, 2022). These scholars reveal the essence of role modelling in impacting human behaviour and attitude. They argue that peers can easily learn from people they see as role models, making it easier to take their advice and

knowledge seriously. They emphasize that this method has been mostly used in fostering HIV prevention amongst teenagers in schools in the US, Canada, United Kingdom, Africa, Greece and Turkey through sex education programmes. Thus indeed the peer education model is argued to promote behaviour change amongst peers across the globe.

Regionally, the peer-led model is also propounded to be beneficial to the health systems of different countries. Mitchell (2023) supports this idea by arguing that the model is crucial for knowledge acquisition, particularly in schools in Sub-Saharan Africa. The model facilitates learning through modelling and social interaction. This perspective is further supported by Faust and Yaya (2018), who highlight how peer education has been a significant HIV educational intervention in Sub-Saharan Africa for a considerable period. Medley, Kennedy, O'Reilly, and Sweat (2009) also endorse the idea of HIV/AIDS education, further justifying the effectiveness of the model in knowledge acquisition.

Medley et al (2009) also present that the peer education model is significant in fostering behaviour change. They argue that the model fosters positive behaviour change which is essential for promoting health-seeking behaviour amongst peers. This improves the uptake of health services related to HIV/AIDS, thereby reducing HIV incidence in Sub-Saharan Africa. The scholars also highlight that this is why peer education focused on HIV prevention has been widely implemented in developing countries. Einstein, Zamperoni, Humphrey, and Deighton (2019) also support this notion by demonstrating how peer education has promoted behaviour change in developing countries, particularly relating to safer sexual practices among high-risk groups. This resulted in a decline in cases of Sexually Transmitted Infections.

Medley et al (2009) further reveal how the peer education model has been essential in increasing condom use in developing countries in Africa. They explain that peer educators are key in

distributing condoms to their peers to promote safer sexual practices. This has contributed to a decline in cases of STIs including HIV/AIDS in Africa. Faust and Yaya (2018) add to this by presenting how the peer education intervention has promoted condom use, improved knowledge levels regarding HIV/AIDS and reduced new cases of HIV in Sub-Saharan Africa. Hence the peer education model is beneficial for HIV programming in Africa.

In the Zimbabwean context, the peer-led model is also presented to be key in health programming including HIV programming. Peer education is firstly argued to promote health education in the country. Mabaya, Ncube, Tweya, Timire, Edwards, Ameyan, Zwangobani, Makoni, Mangombe, Xaba and Samuelson (2022) present that peer education enhances adolescents' Sexual Reproductive Health and links of Voluntary Medical Male Circumcision. Campbell, Scott, Nhamo, Nyamukapa, Skovdal and Gregson (2014) also further elaborate on how peer educators work on community-organized educational events to promote community literacy on HIV/AIDS through condom education and broader SRH education. Mabaya et al (2022) also expounds that peer education promotes health service provision. After gaining knowledge and awareness of available service providers, there is improved uptake of HIV services like HIV Testing and Counselling, VMMC, STI screening and treatment and many others. Mabaya et al (2022) justifies this view using statistics collected from Bulawayo and Mount Darwin in 2022. Other statistics from Zimbabwe National Family Planning Clinic also reveals an increase in people seeking clinical adolescent sexual reproductive health services after peer educators' intervention through referrals.

Scholars also present how the peer education model is efficient in promoting positive behaviour change in Zimbabwe. The education provided by peer educators is instrumental in fostering changes in sexual behaviour, making peers more responsible for their health and engage in safe sex. Behaviour change is also enhanced through role modelling which provides motivation and

encouragement to other peers when they observe their educated and well-trained peer educators (Medley et al, 2009). Mabaya et al. (2022) also argue that the model is effective in condom distribution in the country, as peers distribute condoms to their peers, reducing the spread of STIs and HIV incidence. Therefore the peer-led model is essential for HIV programming in Zimbabwe.

2.2.2 Challenges encountered by informal traders in accessing HIV/ADS services.

Informal traders face a plethora of challenges in accessing different HIV services. Global scholars reveal financial problems as a notable challenge hindering informal traders from accessing diverse health services. Jafaari, McFarland and Sharifi (2022) present this highlighting how the informal trading business usually have low economic outcomes. This hinders informal traders from affording differentiated desired health services. Oladosu, Khai and Asaduzzaman (2023) also subscribe to the same idea stating that informal traders are 'lower earners' who usually lack health or medical insurance. In some cases, absenteeism from informal work can lead to pay cuts or job loss leading to unaffordability of services. Fear of losing customers also discourages them from seeking health services in order to maintain financial stability.

Distance and transportation problems also restrict informal traders from seeking their desired health services including those related to HIV/AIDS (Jafaari et al, 2022). Distance from market stalls to health facilities can be so long that informal traders fail to visit health services to access HIV/AIDS services. This challenge is more prevalent among informal traders in rural areas (Oladosu et al., 2023). High mobility as a nature of the informal trading business also cause informal traders to incur additional transportation costs and makes it more difficult to frequently visit health centres whilst they are in another town.

Informal traders also fail to access HIV services due to ignorance about health systems. Oladosu, Khai and Asaduzzaman (2023) argue that informal traders typically have low levels of education, which hinders their understanding of health proceses and discourages them from visiting health centres and hospitals. Unsuitable operating hours of health facilities further complicate the issue, as informal traders often resume work very early in the morning and finish late at night when hospitals have already closed. Consequently, they miss out on health services that are usually offered during the day.

Jafaari, McFarland and Sharifi (2022) also present fear of stigma and discrimination as another factor inhibiting informal traders from accessing HIV/AIDS services. These three present that the medical personnel, including nurses and doctors, may hold negative attitudes towards informal traders, perceiving them as impoverished, carefree, talkative and rebellious due to the often illegal nature of street vending. Sex workers, who may also be informal traders, can face pre-judgment and discrimination, further affecting service delivery. This stigma and discrimination contribute to their reluctance to seek HIV/AIDS services such as testing, STI screening, and treatment. This is one of the major reasons why the peer-to-peer approach was introduced. Hence global studies reveal how financial problems, transportation and distance issues, fear of stigma and ignorance hinder informal traders from accessing health services.

Scholars also present other challenges faced by informal traders in accessing HIV/AIDS services in Africa. The nature of their jobs, characterized by busyness and high demands, leaves them with limited time to seek healthcare services, including those related to HIV/AIDS (International Office of Migration, 2005). The fear of losing customers whilst away at health facilities also deters informal traders from visiting health centres. As informal trading is often a low-paying occupation, lack of affordability becomes a significant barrier to accessing HIV/AIDS services.

Immigration laws and processes at border posts can also impede informal traders from accessing timely HIV/AIDS services. This idea is presented by Kurebwa (2015) who present that the long processes at boarder posts cause informal traders to spend more days seeking clearance at boarders and this hinders them from accessing HIV/AIDS services on time. This is a common barrier for informal cross boarder traders at Limpopo boarder post.Cross-border traders also face challenges due to the lack of adequate interventions targeting their specific needs (International Office of Migration, 2005). (Kurebwa, 2015). It is presented that the criminalization of sex work in Africa has led to few HIV interventions targeting informal traders like sex workers (International Office of Migration, 2005). This also links with social exclusion which is presented by Kurebwa (2015).

Poor infrastructural development, especially in developing countries like those in Africa, further restricts informal traders' access to HIV/AIDS services. Inadequate resources for constructing necessary infrastructure, such as roads and buildings, lead to limited availability and poor funding of health facilities, particularly in urban and rural areas (Ahmed, 2016). This restricts the accessibility of HIV/AIDS services for these informal traders thus increasing their susceptibility to HIV/AIDS. In Zimbabwe, the issue of poor infrastructure and poor service delivery at hospitals and clinics is common especially in high density suburbs (Mupedziswa and Gumbo, 2001).

In line with the vulnerability of informal traders to HIV/AIDS, scholars like Ahmed (2016) argue that women are even more vulnerable than men. This is due to socio-cultural beliefs of patriarchy and their status in the society which hinders them from being financially able to access different HIV/AIDS services. Thus when a woman becomes an informal traders, there is intersectionality of her vulnerability. One vulnerability triggers another up until the case is serious. However, other would like to argue that men are actually more vulnerable than women due to the socio-cultural belief of men being strong and 'men don't cry' practice. This has triggered toxic masculinity

whereby men view seeking health services as a sign of being weak. This is the reason why men's health-seeking behaviour is lower than that of women.

Literature in Zimbabwe also reveals the various challenges faced by informal traders in accessing HIV/AIDS services. The first issue is that of the busy and highly-demanding nature of informal trading. The Zimbabwe HIV&AIDS Strategy for the Informal Economy (2020) posits that informal trading is a very busy and demanding occupation which leaves the traders with no ample time to access different health services. This hinders informal traders from accessing different HIV/AIDS services especially because most health centres operate during normal daily hours. The occupation also brings fast money but in very small amounts and thus informal traders are engulfed with the feeling of losing customers whilst away seeking health services. Because of this, they chose to stay at work rather than to seek health services.

The Zimbabwe HIV&AIDS Strategy for the Informal Economy (2020) further moves on to propound that informal trading is also a lowly-paying occupation and this worsens the situation of informal traders accessing HIV/AIDS services. Low wages in the informal sector, exacerbated by harsh economic conditions, further limit their ability to afford healthcare services through the lack of social protection programmes like medical aids. This view is also presented by Mupedziswa and Gumbo (2001) and thus peer educators help in linking people to free HIV/AIDS service providers.

Geographical distance between marketplaces and health centres, coupled with the fear of losing customers, hinders informal traders from seeking HIV/AIDS services. Lack of knowledge and awareness about available service providers also contributes to their reluctance to access HIV/AIDS services, despite some organizations offering free services (Zimbabwe HIV&AIDS Strategy for the Informal Economy, 2020).

Social isolation is another challenge faced by informal traders, particularly mobile vendors and cross-border traders, while they are away from home (Shoghli, Maleki, & Khodaei, 2023). Being away from family and community support negatively impacts their health-seeking behaviour and adherence to HIV/AIDS treatment, especially for those living with HIV. Peer education programs play a crucial role in addressing these challenges by providing information, linking informal traders with service providers, and increasing health literacy knowledge (Shoghli et al., 2023).

2.2.3 Measures to improve the delivery of HIV services for informal traders.

Scholarly discussions also reveal several measures which are paramount to improve the delivery of HIV/AIDS services for informal traders across the globe, in Africa and in Zimbabwe. A research carried out in India by Hart (2010) reflects on the importance of stigma reduction as a way of promoting the uptake of HIV/AIDS services by high risk groups like sex workers and reducing HIV incidence. Hart (2010) also argues that a multifaceted approach, inclusive of behavioural, structural and biomedical strategies is fundamental so as to promote universal access of HIV/AIDS services. Global scholars like Sundaranjan, Ponticiello, Nansera, Jeremiah and Muyindike (2022) present on the necessity of mobile outreach programmes as a way of reaching out to hard-to-reach groups like sex workers and cross boarder traders in terms of HIV programming. These programs address transportation challenges and contribute to reducing ignorance through community outreach efforts. Sundaranjan et al (2022) also highlight on the issue of community engagement with local leaders so as to enable effective programming and to scale up uptake of HIV services, specifically HIV testing.

African scholars like Mhlangeni, Du Preez and Zungu (2021) present on the provision of workplace HIV and TB services so as to curb the challenge of transportation costs and lack of time to access HIV services by informal traders. They state this arguing that informal trading has

conditions which make informal traders largely susceptible to HIV and Tuberculosis. This workplace provisions of HIV/AIDS services promotes timely accessibility of services to informal traders. This idea is supported by other scholars like Jere and Nyondo-Mipando (2022), who conducted qualitative research on market traders' preferences regarding HIV service provision in Lilongwe, Malawi. They concluded that providing HIV/AIDS services at the marketplace is an essential solution in HIV programming.

Other African scholars like Oladosu, Khai and Asaduzzaman (2021) also present on the importance of strengthening the social network system so as to improve the uptake of HIV services by informal traders in Africa. This is mainly the role of families, relatives, neighbours, co-workers in supporting and motivating each other to access different HIV/AIDS services like HIV testing and counselling. Oladosu et al (2021) also emphasize on the role of the social network system in overcoming financial constraints limiting informal traders from accessing HIV services. This solves the issue of unaffordability and thus promoting the health and wellbeing of informal traders.

Condom distribution is also presented to be a paramount way of reaching informal traders with HIV services so as to promote their accessibility to the traders in Africa. Condom distribution is also argued to promote safer sexual practices and to close the tap of new HIV infections. This approach is part of peer navigation whereby peer educators provide knowledge and distribute condoms to high-risk groups aiming to reduce HIV incidence and STI transmission (Akuiyibo, Anyanti, Idogho, Piot, Amoo, Nwankwo, and Anosike, 2021). It promotes behavioural change and increases uptake of HIV services by informal traders in the region.

Kurebwa (2015) emphasizes on the need to promote HIV/AIDS education. This will improve awareness and knowledge levels on different HIV/AIDS services available, the stakeholders providing them and how to access them. It will also sensitize the communities on the importance

of accessing different HIV services on time like HIV testing and thus promote behaviour change amongst informal traders in Zimbabwe. Kurebwa (2015) further elaborated on this idea presenting on the importance of gender mainstreaming in delivering this HIV education and also the importance of life skills education at lower levels of education so as to promote positive behaviour at a tender age. Awareness campaigns are also part and parcel of promoting HIV education.

Kurebwa (2015) also puts forward that it is important for Zimbabwe to collaborate with neighbouring countries like South Africa in terms of HIV programming. This is because most cross boarder traders at Beitbridge boarder post, operate in South Africa. He presents on the necessity of implementing Cross Boarder HIV and AIDS initiatives so as to promote accessibility of services to cross boarder traders in the country.

Peer navigation is also argued to be an effective method of promoting accessibility of HIV/AIDS services to informal traders in Zimbabwe This idea is presented by Hlongwa, Moyo and Dzinamira (2023) illustrating how peers are an effective way of promoting behavioural change through role modelling. This solves the problem of peer influence which is also argued by scholars to be another reason why informal traders shun away from seeking HIV/AIDS services. Peer education directly challenges these negative tendencies through introducing peers who are knowledgeable about HIV/AIDS and are responsible champions of Sexual Reproductive Health. This makes it easy to influence their thoughts and actions because it is coming from a fellow peer. Shoghli, Maleki and Khodaei (2023) present that peer educators or mentors follow a healthy lifestyle which will pose as an example to peers and members of the society thus fostering maximum behaviour change. This means that they increase positivity towards seeking health services in the society. According to these three, this is the reason why World Health Organization recognized peer education as an effective method for evoking behaviour change.

Community mobilization and engagement is also presented to be another way of promoting the uptake of HIV/AIDS services by informal traders in Zimbabwe. This is argued to promote awareness, reduce stigma and discrimination of informal traders like sex workers and promote behavioural change (Hlongwa, Moyo and Dzinamira, 2023). Training of medical personnel is also essential to promote friendly service provision which will increase the uptake of services and thus improving health and wellbeing. Hlongwa et al (2023) further argues that there is need for a multidisciplinary approach in community mobilization and engagement. This is the involvement of community leaders, religious and faith-based leaders and traditional leaders so as to increase effectiveness and collective effort in demystifying myths, and stigma towards sex workers.

2.3 Chapter Summary

Chapter 2 of this study presented key issues under Albert Bandura's social learning theory as the theoretical framework for the study. It also revealed the relevance of its key concepts namely, observational learning, imitation, modelling, reinforcement, self-efficacy and empowerment and retention and context to the study. The literature review of this study displayed that peer education is efficient in fostering behaviour change, linking people to HIV service providers, educating the community on HIV/AIDS, facilitating condom distribution, promoting accessibility of HIV services, and promoting friendly service provision. Challenges of transportation, busy schedules, lack of finances, poor infrastructure, ignorance and stigma and discrimination are also argued to be stumbling blocks hindering informal traders from accessing different HIV/AIDS services. Henceforth community engagement and outreach programmes, stigma reduction, peer navigation, collaboration, provision of workplace HIV services, education and strengthening of social systems are the key solutions to addressing these problems and thus promoting increased uptake of HIV/ADS services. This will reduce HIV incidence and promote health and wellbeing of societies.

CHAPTER 3: RESEARCH METHODOLOGY

3.0 Introduction

This chapter focused on the research methodology used by the research for the purposes of this qualitative study. This chapter highlighted on the research approach chosen for the study, the research design, targeted population, sample size, sampling techniques, data collection methods, the data collection tools, data analysis method used for the study. It also shaded more light on the ethical considerations applied, validity and reliability of the study as well as the chapter conclusion. This sector was essential in proving that the used methodology was the best for the study.

3.1 Research Approach

According to Sileyew (2019), research methodology refers to the method or way through which a research is done. The qualitative methodology of research was used for the purpose of this study. This was essential in giving room for asking open ended questions and allowing deeper understanding of the peer led model according to the participants' views. These enabled the researcher to gather in-depth and solid information about the peer led model and thus promoting solid analysis of the model's efficacy in reaching informal traders with a comprehensive HIV package in Chitungwiza necessary for their health and wellbeing. The research tools used for the study were focus group discussion guide, in-depth interview schedule guide and face to face interview guides.

3.2 Research Design

Research design refers to the specific method used in a certain type of research (Sileyew, 2019). An exploratory research design was used for the purpose of this study. This type of research

consists of literature search, focus group discussions, interviews or case studies. It entails looking for information from knowledgeable people for hypothesis creation. Therefore for this research the researcher employed the explorative research design through focus group discussions and interviews so as to gain comprehensive information about the peer led model from NAC district officers, peer-led mentors and mentees. This was enabled through the open ended and interactive nature of the research design.

3.3 Target Population

Akman (2023) defines target population as a group of people with distinct characteristics which separates them from the general population and qualifies them to be research participants in a certain study. These have to be linked with a study's aim and objectives. For this study, the targeted population were informal traders in Chitungwiza, specifically those enrolled or formally enrolled under the peer led model as mentees or mentors and the programmes officers at National AIDS Council Chitungwiza district office.

3.4 Sample Size

Sample size refers to the actual specific number of participants in a research (Institute for Work and Health, 2008). The sample size for this study was 20 participants. (2 NAC programme officers, 4 peer led mentors and 14 peer led mentees).

3.5 Sampling Technique

Sampling technique refers to the method through which a sample is selected. For this study, the informal traders and the district officers were picked using purposive sampling. Purposive sampling is the use of experience and expertise by a researcher to select a research sample that is most relevant for the aim or purposes of the study (McCombes, 2019). This enabled the researcher

to gain detailed information about the peer led model from an effective group of participants who are directly affected by the model. The peer led mentors and mentees are the drivers of the peer led programme and the district officers control, monitors and evaluates it. Thus they were pertinent for the research.

3.6 Data Collection Methods

For this study, the researcher used focus group discussions, face to face interviews and in-depth interviews to collect data from research participants.

3.6.1 Focus group discussions

Focus group discussions are discussions facilitated with a small group of people on a specific topic which they are knowledgeable about (INTRAC for Civil Society, 2017). These are paramount in discovering the views, thoughts and behaviours of that small group of people in line with the programme or project at hand. This was essential in providing the researcher with quality data on the peer led model. Focus group discussions were facilitated using focus group discussion guides with 2 groups of peer led mentees (7 for each) to constitute a total number of 14 informal traders enrolled under the programme as peer led mentees. The researcher utilized in-session monitoring visits done by the agency at the mentors' workplaces to conduct these discussions. Each discussion lasted for an hour and the researcher was writing notes.

3.6.2 In-depth interviews

These involve intensive interviews with few respondents so as to explore their opinions on a certain research topic (Knott, 2022). In- depth interviews are argued to be goal-driven and very useful in directly collecting data from research participants. (Showkat and Parveen, 2017). This was the participants' views, opinions, thoughts and experiences on the peer led model. In-depth interviews

also gave the opportunity to collect quality and comprehensive data as they gave the participants room to share more about the topic in discussion. In-depth interviews were conducted using in-depth interview guides with open ended questions for 4 peer led mentors in the district. The researcher utilized the 4th quarter and annual peer led review meeting done by NAC at Utano centre as well as the monitoring visits done for mentors at their workplaces. Each interview lasted for 30 minutes and the researcher was writing notes.

3.6.3 Face to face interviews

Face to face interviews were done on one on one basis. One on one interviews are the opposite of focus group discussions as they entail speaking to only one research participant at a time. These were applied in interviewing the key informants which are the 2 programmes officers at National Aids Council Chitungwiza district office. The duration of each interview was 45 minutes and these were conducted at the district office using the face to face interview guide. The researcher was writing notes on the responses of the participants. These interviews enabled the researcher to collect ample data about the peer led model without any distractions.

3.7 Data Analysis & Presentation

Thematic data analysis

Data analysis and presentation is presented by Babajide (2022) as the process of assessing, cleansing and inspecting collected data with an aim of coming up with comprehensive conclusions and understandings. For this research, qualitative data was analysed through the thematic data analysis.

The thematic method of qualitative data analysis consists of 6 stages.

- The first stage is “Data familiarization” and it entails gaining more insight on the collected data. The researcher utilized this stage through reading and re-reading her findings from the interviews and focus group discussions.
- The second stage is called “Generating codes” and it entails coming up with phrases or sentences (codes) which describes the collected data (Caulfield, 2023). This is more like substitution of words from interviews and the focus group discussions conducted by the researcher. The researcher applied this stage through denoting and interpreting interesting facts from their findings and jotting them down as phrases.
- The third stage is called “Generating themes” and it involves combination of codes to come up with a stronger and common idea. Irrelevant codes are hereby discarded. The researcher creatively analyzed her findings and merged common ideas or facts into one strong point.
- The fourth stage is “Reviewing themes” and it encompasses weighing the generated themes to see if they are important and accurate representations of the collected data. The researcher utilized this stage in evaluating and analyzing the developed themes.
- The fifth stage is called “Defining and naming themes”. This is whereby the reviewed themes are defined and there is understanding how they make understanding the collected data easier. It might include renaming themes to a more understandable phrase. At this stage, the researcher formulated meanings for each theme and explained its relevance to the research. The researcher also provided understandable names for each theme.
- The last stage is called “Writing up” and this is now when the researcher provides a written report on the analyzed data or findings. The researcher made use of this stage to prepare a research report of her findings.

3.8 Ethical Considerations

Ethics involves segregation between the right and the wrong, providing a guideline for responsible and acceptable code of conduct. Ethical considerations are meant to protect the rights and interests of research participants as well as that of the researcher (Drolet, Derouin, Leblanc, Ruest and William Jones, 2023). In this research, the following ethics were taken into consideration;

- **Informed Consent**

According to Kadam (2017), informed consent means that the participants are well aware of the risks and benefits of participating in the study. The participants have to adequately understand everything with regards to participating in the research and hence the information given should be clear and understandable. The researcher observed this ethic by informing the participants about the research pros and cons.

- **Confidentiality**

Confidentiality refers to privacy in the process of information gathering or data collection and storage. According to Strydom (2011), the concept of confidentiality is similar to anonymity and protection of participants' privacy. Anonymity is the process through which the identity of the participant is kept in secret or hidden to avoid identification (Hollway and Jefferson, 2013). Bourke (2008) highlights that confidentiality preserves human dignity. The researcher ensured confidentiality to the participants by keeping safe the information shared.

- **Voluntary participation**

Voluntary participation refers to freedom to choose whether or not to become a participant in the research (Peer Connect, 2023). It involve free responses from the participant without force or coercion and also the freedom to withdraw at any time. The researcher upholded voluntary

participation through informing participants that they are free to participate in the research and can withdraw any time they want to.

- **No harm**

No harm means assessing and making sure that the research and its analysis does not pose any harm to the vulnerable research participants either unintendedly or otherwise (Buchanan and Warwick, 2020). The researcher applied this ethic through careful study design and maintaining confidentiality.

3.9 Assumptions

The assumptions of the study included facts that the peer educators and the peer mentees would give honest and truthful responses. The researcher also expected to get solid assistance from National AIDS Council Chitungwiza District through information and linking the researcher with the peer led mentors and mentees. The mentors were also assumed to freely give information without expecting much in return as this programme is voluntary. However, there was a possibility that the peer led mentees could give inadequate information due to the nature of their busy jobs so that they can quickly resume their work.

3.10 Delimitations of Study

Delimitations of a study refers to the shortfalls or weaknesses of a research consciously set by the researcher themself (Theofanidis and Fountouki, 2018). The delimitations of this study included facts that the research was limited to informal traders enrolled under the peer led model implemented by National AIDS Council in Chitungwiza and that the researcher resorted to purposive sampling due to insufficient funds. Hence the sample size was restricted to only 20 research participants.

3.11 Limitations of Study

Study limitations are the shortcomings or weaknesses of a research design which may impact the results or outcomes of the research. These are outside the researcher's control (Theofanidis and Fountouki, 2018). The limitations of this study included lack of funding as there was no procurement of refreshments for the participants. Lack of funding also hindered swift movement of the researcher. The research also had a limitation of a smaller geographical area due to lack of ample time.

3.12 Validity and Reliability

Validity and reliability are both about how apt or appropriate a research method is for a specific study. Validity refers to the accuracy of a method in measuring something whist reliability is more of the belief in the data a researcher has collected (Fullerton, 1993). The researcher believed that the qualitative method was valid for the study due to its nature of allowing room for gaining more and deeper information.

3.13 Chapter Conclusion

Chapter 3 of this study presented on the research methodology of study. It revealed that this study used the qualitative research approach through focus group discussions, in-depth interviews and face to face interviews. This chapter also showed informal traders enrolled under the peer led model as mentees or mentors and the programmes officers at National AIDS Council Chitungwiza district office as the targeted population for the study. Purposive sampling was also revealed to be the sampling technique for the study. The chapter also highlighted on the thematic data analysis method used for the study, ethical considerations, assumptions, limitations, delimitations and the validity and reliability section of the study. All these were necessary to prove that the methodology used was appropriate for the study.

CHAPTER 4: DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter focused on data presentation and analysis of the study. This entails of the chapter introduction, biographical information of research participants, qualitative data presentation, discussion of findings and the conclusion of the chapter. The researcher utilized the thematic method of data analysis to analyse the collected data and came up with themes on the efficacy of the peer led model in provision of HIV/AIDS services for informal traders in Chitungwiza. The research was guided by three objectives on the efficacy of the peer led model in provision of HIV/AIDS services for informal traders in Chitungwiza, identification of challenges encountered by informal traders in accessing these services and determination of measures to improve the delivery of HIV services for informal traders in the district. These 3 objectives informed the discussion of findings section in this chapter. The chapter ended with a conclusion and this whole chapter is essential for understanding the results of the study.

4.1 Demographic Information of Participants

This section presents the demographic information of the participants which will be displayed in tabular form. The profile is of great significance as it assists in contextualising the concepts under study. Table 4.1.1 indicates the number of the participants.

4.1.1 Table

Total Response Rate

Participant	**Intended**	**Actual**
Face to face interviewees	2	2

In-depth Interviewees	4	4
Focus group discussion participants	14	14
Total	**20**	**20**

From the table above, a total of 20 people participated in the subject under investigation. The face to face interviewees were the 2 NAC programmes officers, 4 in-depth interviewees were peer led mentors and the 14 focus group participants were peer led mentees. This translates to 100% response percentage from the participation and it was due to effective compliance of the informal traders and the assistance of NAC programmes officers in mobilizing the peer led mentors and mentees.

4.1.2 Table

Biographical information of face to face participants

	F2F Interviewee 1	**F2F Interviewee 2**
Sex	Female	Female
Age	36	29
Job Title	District AIDS Coordinator	Graduate Trainee
Work Experience at NAC	12	4
Educational Background	• Bachelor's degree in Development Studies • Master's degree in Development Studies	• Bachelor's degree in Development Studies • Master's degree in Gender and Policy Studies

Key Qualifications	• Coordination skills • Project planning, management, organizing and directing • Monitoring and evaluation • Research skills • Community development skills • Computer skills • Problem solving skills • Social and environmental impact analysis	• Project planning, management, organization and direction • Change management • Gender and development expert • Monitoring and evaluation • Research skills • Computer skills • Social and environmental impact analysis

Table 2 shows the biographical and pertinent information of 2 face to face interviewees

The table above illustrates the biographical information of face to face interviewees who were interviewed by the researcher. The table shows that the interviewees were 2 females who have worked as programmes officers under National AIDS Council for 12 and 4 years respectively. This shows that the research participants are well experienced in the programming field and hence making them suitable participants for the research. Both the participants are also holders of a Bachelor's and Master's degrees in the Social Sciences and Humanities Department. This shows that they are well-educated and suitable to provide key information for the study. Their key competencies and skills like monitoring and evaluation and project planning, management, organizing and directing demonstrates their understanding in management of projects like the peer led model in the organization. This also means that they were capable of providing rich information

about the model to the researcher. Therefore, the biographical information of face to face interviewees denotes apt selection of research participants.

4.1.3 Table

Biographical Information of in-depth interviewees

	Mentor 1	Mentor 2	Mentor 3	Mentor 4
Sex	**Male**	**Male**	**Female**	**Female**
Age	**46**	**56**	**59**	**43**
Time one has worked as a NAC peer led mentor	**2**	**2**	**2**	**2**
Time as a peer educator before	**8**	**8**	**8**	**8**

Table 3 shows the biographical information of in-depth interviewees

The table above shows the biographical information of peer led mentors who were interviewed by the researcher using in-depth interviews. It can be denoted that the interviewees were 2 males and 2 females to constitute a total of 4 participants. This shows that there was gender balance in the selection of research participants. The ages of all participants is above 40 and this indicates that they have been in informal trading for a long time. This validates the information they provided. The table also depicts that all peer led mentors have been NAC peer led mentors for 2 years because this is when the condom promotion model was modified into peer led model so as to provide multi-dimensional services to informal traders rather than just distribution of condoms. Henceforth the table justifies the selection of the peer led mentors as in-depth interviewees for the study.

4.2 Qualitative Data Presentation

For the purposes of this study, the researcher collected data from peer led mentors, peer led mentees and the programmes officers respectively. This section outlines the direct quotations from

the participants in line with the study objectives and data collection tools used. The study sought to analyse the efficacy of the peer led model in provision of HIV/AIDS services for informal traders in Chitungwiza, to identify the challenges encountered by informal traders in accessing these services and to determine the measures to improve the delivery of HIV services for informal traders in the district. These became the three major themes of the research and they will supplementary curtail into sub-themes thereby making the data presentation comprehensive and coherent.

4.2.1 The efficacy of the peer led model in provision of HIV/AIDS services for informal traders

The research indicated that the peer led model has been very comprehensive in improving the provision of HIV/AIDS services to informal traders in the district of Chitungwiza. Following this main theme, six sub themes emerged from the chief theme. These include increased condom uptake, improved knowledge levels, behaviour change, friendly service provision, increased awareness of available services and improved access to health services.

4.2.1.1 Increased condom uptake

The study found out that the peer led model has been very efficient in increasing the uptake of condoms amongst informal traders in Chitungwiza. All of the four peer led mentors indicated that the peer led model has brought in a more diversified way of reaching out to informal traders with even more HIV/AIDS services. This has been beneficial in increasing the uptake of both male and female condoms. One of the respondents indicated that:

> "*There was a drastic change from condom promotion whereby as condom promoters we just distributed condoms in hotspot areas, now with the peer led model, as mentors now,*

we get the chance to educate our peers on correct and consistent condom use and its significance. This promotes acceptability and awareness of both male and female condoms in the district."

All of the focus group participants highlighted that continuous reminders and education on HIV/AIDS has helped in neutralizing negative tendencies towards condom use. It has helped to demystify the myths and misconceptions surrounding condom use and sexual pleasure. Thus through peer education, many informal traders proudly use condoms. One focus group respondent echoed that:

"*Vanhu taikurudzirana kusangana pasina protection tichiti sweet haridyirwe mubepa asi nekuti taane ruzivo rwekuti condom rinotora body warmth and harikanganise taste yebonde, tavakushandisa protection nguva dzose"* (As informal traders, we encouraged each other to refrain from protected sexual intercourse due to fear that condoms hinder sexual pleasure, but now because we are educated enough to know that female condoms specifically take body temperature if worn on time, we now accept and use condoms effectively).

However, one face to face interviewee indicated the prevailing gap in the uptake of female condoms in the district as it continues to be relatively lower than that of male condoms in the district. This amounted to culture, religion and tradition as the major causes of low female condom uptake. She noted that:

"*Despite the undisputable positive impact of the peer led model in increasing condom use amongst informal traders, there is a notable variation between male and female condom*

uptake. Female condom uptake continues to be relatively lower than that of male condoms due to patriarchy and religious beliefs in the Zimbabwean society."

4.2.1.2 Improved knowledge levels

All four in-depth interviewees presented that the peer led model has been essential in improving knowledge levels of informal traders on HIV/AIDS. They said that they conduct four sessions with their peer groups every month at their marketplaces and conduct follow up sessions for those who will have missed the sessions so as to ensure that no one is left out. One peer led mentor illustrated that:

"I conduct peer led sessions every Friday with my peer group. We are obliged to conduct four sessions every month with our mentees and track this with an attendance register. We also follow up on the absent mentees through follow up individual sessions."

All fourteen focus group discussion participants highlighted that the peer led sessions sensitize them on HIV/AIDS and other health topics. This has been essential in arming them enough to make informed decisions about their health and lives. The participants also indicated that HIV/AIDS education eye-opened them about the importance of HIV testing and knowing their statuses. One focus group discussion participant presented that:

"*The peer led model has helped me understand the importance of knowing my HIV status. It exposed me to different HIV/AIDS services which I wasn't aware of. It boosted my self-esteem, knowledge and understanding of HIV/AIDS education."*

One in-depth interviewee indicated that the peer led model has been very essential in improving knowledge levels on HIV/AIDS especially in spelling out the difference between HIV and

AIDS. This is because a majority in the community are ignorant and this causes them to stigmatize and discriminate HIV positive individuals through speech. The peer led mentor said that:

> *"Uchitoconducter session ndopaunoona kuti vanhu havasikutomboziva nezveHIV/AIDS sesu hedu takagumira grade 7. Nezuro chaiye during session, patone vamwe mother vaitoti Edzi kureva HIV positive people. Ndakatozodzokorodza kudzidzisa on HIV/AIDS introduction kuti vanzwisise nekuti patakaiita vaive vasipo"* (Whilst conducting sessions that is when you realize that a majority lack information on HIV/AIDS especially informal traders as a less educated group. Just yesterday during my peer led session, a woman was saying "Edzi" meaning HIV positive people. I had to re-teach on HIV/AIDS introduction for her to understand because on the first day she wasn't around)

4.2.1.3 Behaviour change

According to the study findings, the peer led model has also been pertinent in fostering positive behaviour change amongst informal traders. One informal trader from the focus group discussion mentioned that:

> *"Seboys munenge muchivhura hombe muchisimbisana kuramba HIV testing muchiti ukatsvaga makudo mugomo unomawana. Ndakazoita imwe risk zvekuti ndakanonetsa mentor vangu vakandibatsira ndikanotestwa. Ndopandakadzidza kuti munhu unofanira kugara uchizva status yako nekushandisa protection nguva dzese. Ndakatojoinisa boys dzangu kuno kuti vadzidzewo vapfeke protection nguva dzese"* (As boys we often indulge in reckless sexual behaviour and refrain from HIV testing due to fear of the

uncertainty. I once indulged in unprotected intercourse and the fear was so overwhelming that I asked my mentor for help and I was tested for HIV. That is when I learnt about protected intercourse and the importance of knowing your HIV status. I recruited my friends here so that they can also learn and have a changed sexual behaviour.

To further strengthen this idea, one peer led mentor highlighted that:

"*Whilst working with informal traders under the model you can easily note the change in health-seeking behaviour of mentees. Now mentees can open up freely about their problems which makes it easier to refer them for services."*

4.2.1.4 Friendly service provision

Friendly service provision is another notable importance of the peer led model to informal traders. All mentors, mentees and the programmes officers attested that the peer led model builds a friendly relationship between mentors and mentees thereby making it easy for the mentors to open up to their mentors about anything and any service they require. One face to face interviewee mentioned that:

"The mentor-mentee relationship has cultivated trust and engagement, leading to increased awareness, behaviour change, and utilization of HIV/AIDS services."

One focus group participant adds on to this indicating that the peer led model gives the informal traders an opportunity to receive services from one who is like them. This means that there will be less judgment but rather more support. Peers also often face the same problems so the mentors might be knowledgeable about the best solutions to their peer's problems. One focus group participant mentioned that:

"In my experience, the peer-led model has been highly effective in providing HIV/AIDS services to us informal traders. The peer mentors understand the unique challenges we face and they create a supportive and non-judgmental environment, which encourages open discussions about HIV/AIDS."

4.2.1.5 Awareness of available services

Under this sub theme, participants indicated that the peer led model is efficient in improving awareness of available services. One in-depth interviewee said that:

"During education sessions, we continuously tell our mentees about the available services and their benefits. This promotes awareness of the different services available"

One focus group participant attested to how the peer led model has assisted her in accessing PrEP. Before the model, she did not know where to access it. She indicated that:

"I couldn't use PrEP because I didn't know any clinics which offer it. The peer led model has equipped me with knowledge of multiple service providers in my district where I can freely access different HIV/AIDS services."

4.2.1.6 Accessibility of health services

All research participants mentioned the importance of the model in improving access to HIV/AIDS services. They mentioned the importance of the referral pathway in improving access to services. One face to face interviewee said that:

"The peer-led model offers a comprehensive range of services for informal traders, including HIV testing, counselling, education on prevention strategies, treatment

referrals, and support services. This ensures that informal traders have access to the necessary resources for HIV/AIDS prevention, detection, and management."

Two research participants also highlighted on how the referral books have been essential in ensuring that mentees get the required HIV/AIDS services on time and also to track for progress in accessing them. One in-depth interviewee stated that:

"*We applaud NAC for assisting with referral books which we use to refer our mentees for different services. These have wide-varied services which benefit the mentees."*

In support of this, one face to face interviewee mentioned that:

"There has been a significant improvement in accessibility, with a 40% increase in the number of informal traders accessing HIV testing and counselling since the introduction of referral books."

Hence the findings prove that the model is efficient in improving accessibility of HIV/AIDS services.

4.2.2 Challenges encountered by informal traders in accessing HIV/AIDS services.

Despite the peer led model being significant in the provision of HIV/AIDS services for informal traders, it is also embedded with different challenges which may affect the uptake of services by informal traders in the district. These include demanding profession, unaffordability, stigma and discrimination, ignorance and transportation difficulties.

4.2.2.1 Demanding nature of informal trading

Under this sub theme, participants indicated the demanding nature of informal trading as a barrier to them in accessing HIV/AIDS services. One face to face interviewee mentioned that although

the model tries to counter this problem, its effects are still evident. The programmes officer said that:

> *"From our monitoring and evaluation sessions, we discovered that irregular working hours and busy schedules hinder the informal traders from accessing health services like HIV/AIDS education delivered to them by their peer led mentors. One will be excusing themselves during session if a customer comes, what more when they have to leave the marketplace in pursuit of HIV/AIDS services at hospital facilities."*

One focus group participant echoed that fear of losing customers while at the clinic restricts the movements of informal traders. Though the model brings them HIV/AIDS education at their workplaces, other services are still missing. The vendor stated that:

> "*You will be afraid of missing customers whilst away. So the model has been really helpful in equipping us with HIV/AIDS knowledge at our workplaces. However, we still wish for the other HIV/AIDS services to be that much accessible as well."*

4.2.2.2 Unaffordability

Eleven of the focus group discussion participants attested that unaffordability is a significant challenge when trying to access HIV/AIDS services. They highlighted that their informal trading business is low income-giving and therefore they fail to afford basic health services. One of them elaborated that:

> *"Basa redu rinounza fast money but iri ishoma and painouyira inenge yakawandirwa saka zvekumboishandisa zvechipatara haaa panenge pasitorina mari yacho." (*Our informal trading business brings fast money but in very short amounts, when it comes there will be multiple responsibilities to cover such that none is left for health purposes)

Another focus group participant brought to light that HIV/AIDS services like STI screening and treatment are very expensive for the informal traders:

> "*Local organizational clinics like Population Services Zimbabwe and PZAT offer STI screening and treatment services but you have to pay. Due to lack of money, we then fail to access such services."*

Another female from the focus group discussion indicated that unaffordability of contraceptive services as well as the lack of adequate information about the contraceptive pill affects its use by informal traders. Administration costs emanating from $5 to $15 also makes it hard for informal traders to visit health facilities and access different services like STI screening and treatment and cancer screening. The participant suggested awareness raising on available free services as a strategy to address the problem of unaffordability. She said that:

> "*Morning after pills are very expensive, ranging from $2 to $5."Administration costs also range from $5 to $15 and this is very unaffordable. Continuous awareness raising on free service delivery by local organizations like New Start Centre is therefore necessary to solve the problem of unaffordability."*

4.2.2.3 Stigma and discrimination

Seven of the focus group participants mentioned that stigma and discrimination from the medical personnel restricts them from visiting health facilities to seek health services. This is further worsened by poor salaries leading to extreme stigmatization and prejudgment of informal traders in health service delivery. One focus group participant elaborated that:

> "*Ana mbuya vekuchipatara vagara vatone kaattitude kekuti mainformal traders vane 'I don't care attitude' pakuchengetedza hutano saka vanotibatsira nemuono iwoyo. Worse*

mazuvaano nekusabhadharwa, vanenge vakatoshatirwa." (Nurses at the medical facilities usually have a negative attitude towards informal traders because they say we have an 'I don't care' attitude when it comes to our health. Especially these days due to poor wages, the situation becomes very serious.)

Another focus group participant highlighted that free HIV/AIDS services also attract negative attitude from health workers. It adds on to the already existing prejudice and hatred towards informal traders as a carefree, rebellious and talkative group. She echoed that:

"*Munenge magara makamakirwa kutaurisa nehundurani mozouya kuzotora mushonga wemahara haa munoitwa party"* (You will already be hated for being talkative and rebellious then you try to access free HIV/AIDS services, they will party on you.)

One in-depth interviewee put forward that the community as a whole still lacks adequate information on HIV/AIDS. This results in stigma and discrimination of many people seeking HIV/AIDS services. The peer led mentor presented that:

"When it comes to accessing HIV/AIDS services, mentees face challenges due to stigma and discrimination surrounding the disease. Many people in our community have misconceptions and fears about HIV/AIDS, which leads to discrimination against those seeking services."

4.2.2.4 Ignorance

The participants also mentioned lack of knowledge as another factor inhibiting informal traders from effectively accessing HIV/AIDS services. One face to face interviewee and focus group participant respectively pointed out that:

"Mentees also have limited awareness and knowledge about HIV/AIDS, prevention methods and available services which hinders their ability to access appropriate healthcare."

"One of the challenges I encountered while accessing HIV/AIDS services was the lack of awareness about available services. As an informal trader, I have a busy schedule and limited access to information."

4.2.2.5 Transportation difficulties

The research participants also highlighted that transportation difficulties restrict them from visiting health centres to access different HIV/AIDS services, have regular check-ups and to access necessary medications. One peer led mentor and mentee respectively indicated that:

"*Factors like distance, transportation difficulties, and work schedules make it difficult for us to attend regular check-ups or access necessary medications."*

"Financial constraints, unaffordability and transportation issues also mak.e it difficult to reach healthcare facilities."

4.2.3 Measures to improve the delivery of HIV services for informal traders

The researcher managed to ask the participants for solutions to solve the challenges mentioned in the second objective. Strategies and coping mechanisms which can improve the delivery of

+HIV/AIDS services to informal traders are presented below. These sub themes include mobile clinic system, financial support, stigma reduction, HIV/AIDS education and stakeholder collaboration.

4.2.3.1 Mobile clinic system

Mobile clinic system improves the accessibility of HIV/AIDS services to informal traders at their market places. All in-depth interviewees subscribed to this view mentioning how mobile clinic system reduces transport costs, saves time and reduces mobility of traders. One peer led mentor illustrated that:

> "*When we conduct sessions, it is important to have a tent set up aside where our mentees can access different HIV/AIDS services. This will cut transport costs."*

Another female peer led mentee further supports this idea mentioning that:

> *"In order to help us to easily access HIV/AIDS services, there should be establishment of drop-in centres near marketplaces where we can access information, counselling, testing, and support services."*

The programmes officers at NAC district office also suggested this solution as it addresses most of the problems as indicated by the mentees during monitoring and evaluation sessions and meetings. They acknowledged the need for collaboration with local stakeholders in executing this strategy. One programmes officer elaborated that:

> *"From the quarterly meetings we have with our mentees, transport challenges and the highly demanding nature of informal trading have been significant challenges hindering our mentees from effectively accessing HIV/AIDS services. The peer led model only bring HIV/AIDS education and condom distribution to their work places. Hence we realized that there is need to invite local partners during combined sessions so that our mentees can access other services like HITS, PrEP, PEP, VMMC and family planning."*

Thus the findings under this subtheme indicated that mobile clinic system will cut transport costs, save time, reduce mobility and improve accessibility of services as well as its uptake by the mentees.

4.2.3.2 Financial support

One of the peer led mentors proposed provision of financial support from governmental and non-governmental institutions as a key way of addressing unaffordability. She said that:

> *"Financial support is necessary for mentees. Collaborating with governmental or non-governmental organizations to provide financial assistance or subsidies for HIV/AIDS treatment and care can alleviate the financial burden. Subsidies for medications, transportation allowances, or tailored health insurance options for informal traders would be beneficial."*

Whilst proposing other solutions, one face to face interviewee indicated that:

> *"Seeking help from local health departments, NGOs specializing in HIV/AIDS, or community-based organizations can provide valuable support in addressing the challenges faced by informal traders. Collaboration with these entities can help develop tailored interventions and secure resources necessary for better training and support for mentors and mentees*."

Hence the participant suggests stakeholder collaboration as a way of gaining financial assistance necessary to improve acceptability and accessibility of HIV/AIDS services to informal traders.

4.2.3.3 Stigma reduction

The participants also established stigma reduction as a strategy of solving stigma and discrimination. They highlighted that awareness campaigns and training of medical personnel can be helpful in reducing stigma and promoting friendly medical service provision. One face to face interviewee alluded that:

> *"To overcome the challenges mentioned, extensive community engagement and awareness campaigns are key to address misconceptions and build trust amongst informal traders. Utilization of peer mentors in establishing connections and providing accurate information is necessary as well as training of medical personnel improve service delivery."*

This idea was further strengthened by an in-depth interviewee who postulated that:

> *"Addressing stigma and discrimination is a priority. Community dialogues and sensitization programs can help challenge and reduce the stigma associated with HIV/AIDS. Engaging influential community leaders is essential to promote acceptance and support for those seeking services."*

4.2.3.4 HIV/AIDS education

The research findings also indicated HIV/AIDS education as another measure. This can be enabled through community outreach programmes and it promotes community sensitization. One in-depth interviewee accredited that:

> *"To overcome the challenges hindering informal traders from effectively accessing services, education and awareness campaigns within informal trading communities are crucial. There is need for accurate and comprehensive information about HIV/AIDS,*

prevention methods, and available services. These campaigns can be conducted through community meetings, local radio stations, or distributing pamphlets in markets."

Other peer led mentors and mentees mentioned this as a solution which actually helped them when they faced problems in accessing HIV/AIDS services. They mentioned that lack of education amongst themselves as traders can prevent them from accessing available services. One peer led mentee testified that:

"To overcome these challenges, I sought help from my mentor who provided me with information about available services, including testing locations and support groups. He also addressed my concerns about stigma and discrimination, assuring me of confidentiality. His help was extremely helpful and made accessing HIV/AIDS services much easier for me."

4.2.3.5 Stakeholder collaboration

All of the research participants indicated the necessity of stakeholder collaboration in improving the accessibility of HIV/AIDS services to informal traders in the district. The participants pointed out that collaboration with local stakeholders improve service delivery and addressing the challenges faced by the informal traders at health facilities. One face to face interviewee echoed that:

"*To improve the accessibility of HIV/AIDS services for informal traders, partnerships between local healthcare facilities and market associations should be strengthened. This would ensure that healthcare providers understand the specific needs and challenges faced by informal traders and can provide culturally sensitive services."*

This solution was further supported by another face to face interviewee who provided a wide package of solutions to address the problems mentioned above. Amongst these, she highlighted the importance of stakeholder collaboration in sourcing out for funding, resources and providing the HIV/AIDS services to the mentees. She proposed that:

> *"Measures to improve accessibility for peer-led mentees include establishing convenient service delivery points like mobile clinics, utilizing technology such as telemedicine for remote consultations, providing online resources and educational materials, and strengthening referral systems and collaboration with healthcare facilities. Collaborating with local community organizations, NGOs, and government agencies helps in securing additional funding and resources necessary for better training and support for mentors and improves logistical arrangements. Other stakeholders like PSH, PSZ, PZAT and SAYWHAT can also assist in providing the HIV/AIDS services for free"*

4.3 Discussion of Findings

This section of discussion of findings expounds on the different key issues denoted from the research findings as themes of the study. The study managed to assess the efficacy of the peer led model in the provision of HIV/AIDS services for informal traders using Chitungwiza as the case study. The research was carried out with fourteen peer led mentees as focus group participants, four peer led mentors as in-depth interviewees and two programmes officers at National AIDS Council Chitungwiza district as face to face interviewees to constitute a total of twenty research participants. All programmes officers are holders of undergraduate and master's degrees, have technical skills and are well-experienced in working with the model. All mentors have been informal traders for a long time and have worked under NAC since the beginning of the peer led

model. This made them suitable participants for the research. It is also paramount to note that the research findings are in line with the literature review and theoretical framework of the study.

The first objective was focusing on the efficacy of the peer led model in the provision of HIV/AIDS services for informal traders in Chitungwiza. The research confirmed increased condom uptake as the first efficiency of the peer led model. The research discovered that HIV/AIDS education promoted acceptability and awareness of both male and female condoms. This idea of increased condom uptake concurs with Medley, Kennedy, O'Reilly and Sweat (2009) and Faust and Yaya (2018) who argue that peer education has been very essential in increasing condom use in developing countries in Africa. These explain how peer educators are key in distributing condoms to their peers with an aim of reducing HIV incidence and promoting safer sexual practices. This is also in line with Albert Bandura's element of "self-efficacy" in his social learning theory which asserts that a person is most likely to practice learnt behaviour if they think that it will be effective or benefit them. Thus when educated about condom use and its benefits in HIV/AIDS prevention, informal traders practice safer sex. However, the study also indicated that female condom uptake continues to be relatively lower than that of male condoms in the district therefore the need for demystification of myths and misconceptions surrounding female condom. Henceforth, the researcher concluded that the peer led model is an effective way of increasing condom uptake through education and self-efficacy.

The researcher also learnt that the peer led model plays a significant role in improving knowledge levels of informal traders. This is through the educative sessions conducted by peer led mentors four times every month with their groups of mentees on Comprehensive Sexuality Education. This concurs with Mabaya, Ncube, Tweya, Timire, Edwards, Ameyan, Zwangobani, Makoni, Mangombe, Xaba and Samuelson (2022) who present that peer education enhances adolescents'

Sexual Reproductive Health and links of Voluntary Medical Male Circumcision. Campbell, Scott, Nhamo, Nyamukapa, Skovdal and Gregson (2014) also further elaborate on how peer educators work on community organized educational events to promote community literacy on HIV/AIDS. Faust and Yaya (2018) also present on how peer education has been paramount as an HIV educational intervention in Sub-Saharan Africa for quite some time now. All this reveals the role of the peer led model in fostering HIV/AIDS education. This role is also explained by Albert Bandura's element of 'empowerment' in his social learning theory. This entails the issue of equipping peer educators with knowledge, skills and resources which make the other peers trust that the peer educators can effectively impact their lives with the education they provide. Hence the researcher judged that the model enables the mentors to be educated so that they can disseminate that HIV/AIDS education to their peers.

Fostering behaviour change is another crucial impact of the peer led model. Equipping informal traders with information on HIV/AIDS enables them to make informed decisions about their sexual reproductive health. It promotes a good health behaviour which may include safe sexual practices and development of a health seeking behaviour. Albert Bandura's social learning theory agrees with this concept of behaviour change. According to Bandura, behaviour change is enhanced through 'role modelling' which provides motivation and encouragement to other peers when they look at the attitude and behaviours of their educated and well-trained peer educators. This also leads to the concept of 'imitation'. Under this element, peers try and copy observed positive behaviour. Bandura argues that friends usually copy and imitate each other. Thus mentees copy and imitate the good health behaviour they see from their mentors. Scholarly reviews also concurs with this idea. Medley, Kennedy, O'Reilly and Sweat (2009) present that the peer education model is significant in promoting health-seeking behaviour amongst peers which improves the uptake of

health services especially those related to HIV/AIDS and reduces HIV incidence in Sub-Saharan Africa. Dodd, Widnall, Russell, Curtin, Simmonds, Limmer and Kidger (2022) also reveal the essence of role modelling in impacting human behaviour and attitude. These scholars argue that peers can easily learn from people they see as role models and it is easier to take advice and knowledge which they give seriously. The researcher therefore finalized that the model is a crucial way of changing human behaviour for the better.

The study also brought out that the peer led model is very efficient in fostering friendly HIV/AIDS services. This promotes rapport building, development of trust, comfort and increases the acceptance of HIV/AIDS information disseminated by the mentor to the mentees. Friendly service provision also creates a conducive platform to ask questions, seek advice and seek different HIV/AIDS services like PMTCT, HIV Testing and Counselling and STI Screening and Treatment freely. Dodd et al (2022) supports the idea of friendly service provision highlighting that peer education boosts the confidence and esteem of mentees as they feel that they are not judged. This allows them to open up about their health conditions, accept SRH information disseminated to them and to seek their desired HIV/AIDS services without fear of stigma and discrimination. This also improves the referral pathway used to ensure that informal traders get their desired health services. This also assents with Albert Bandura's element of 'reinforcement' in his social learning theory which puts forward that people usually interact more with people similar to them as they are more comfortable around them. This leads to acceptance of information and also improved health seeking tendencies. Therefore the researcher rounded off that the peer led model is efficient in improving health seeking behaviour through friendly service provision.

The study unearthed that the peer led model is paramount in raising awareness on different HIV/AIDS services available. This is because people lack adequate information about HIV/AIDS

services available and where to access them. It is then the role of peer led mentors to equip their mentees with information about different stakeholders who offer HIV/AIDS services in their diversity. This improves the accessibility of HIV/AIDS services to informal traders in the district. This idea is expounded by Dodd, Widnall, Russell, Curtin, Simmonds, Limmer and Kidger (2022) who state that peer education improves awareness of available service providers and the services which they offer. This improves the accessibility of health services to peers and also the uptake of diverse health services. Mabaya et al (2022) also expounds that peer education raises awareness on available service providers thereby leading to improved uptake of HIV/AIDS services. The theoretical framework for this study also agrees with this idea through its concept of internalization of information in people's memories. When equipped with information of different HIV/AIDS service providers, mentees memorize this and can use this information in the future when they need services. Henceforth the researcher finalized that the peer led model is important in raising awareness on diverse HIV/AIDS services available and their service providers.

The study also brought out that the peer led model is beneficial through improving access to health services. Besides accessibility being enhanced through awareness of the services available and knowing where to access them, the referral pathway also plays a pivotal role in improving access to health services. One peer led mentor stated that the newly introduced referral books have been very helpful in improving access to health services. The books make it easier for mentees to get their desired HIV/AIDS services because of the relationship that NAC has with its stakeholders. It triggers seriousness and good service delivery even from the medical personnel at the health facility rather than informal traders going there as mere individuals from the community. Referral books also allows tracking for progress in referred cases, future reference and documentation. This idea is in congruency with Mabaya et al (2022) who indicates that peer education improves

accessibility and uptake of HIV services like HIV Testing and Counselling, VMMC, STI screening and treatment and many others. Mabaya et al (2022) justifies this view using statistics collected from Bulawayo and Mount Darwin in 2022. Other statistics from Zimbabwe National Family Planning Clinic also reveals an increase in people seeking clinical adolescent sexual reproductive health services after peer educators' intervention through referrals. Thus the model has been efficient in promoting health service provision.

The second objective was to identify the challenges encountered by informal traders in accessing these services in Chitungwiza. The study revealed the highly demanding nature of informal trading as the first challenge affecting the accessibility of HIV/AIDS services to informal traders The research puts to light that irregular and unpredictable work schedules, busy and highly-demanding nature, lack of formal employment benefits like sick leave or health insurance and the transient nature of trading activities leaves informal traders with no ample time to visit health facilities and seek HIV/AIDS services. More to this idea, the Zimbabwe HIV&AIDS Strategy for the Informal Economy (2020) posits that the demanding nature of informal trading, that is lack of social protection, low-paying and highly-demanding nature affects accessibility of HIV/AIDS services. Thus the nature of informal trading itself can also restrict traders from accessing HIV/AIDS services.

Unaffordability is another significant challenge faced by most informal traders when trying to access HIV/AIDS services. This is because informal trading is a low income-giving profession and so they sometimes cannot afford services. One participant highlighted on the unaffordable prices for STI treatment and more interestingly the recurring shortages of drugs such as PrEP, PEP and STI treatment medicine from other facilities they will be referred to. Jafaari, McFarland and Sharifi (2022) agrees with this view highlighting how the informal trading business usually have

low economic outcomes which hinders informal traders from affording differentiated desired health services. Oladosu, Khai and Asaduzzaman (2023) also subscribe to the same idea stating that informal traders are 'lower earners' who usually lack health or medical insurance. In some cases, absenteeism from informal work can lead to pay cuts or job loss leading to unaffordability of services to them. Thus the quest for financial stability causes them to shun away from seeking health services.

The study brought out that stigma and discrimination is hindering informal traders from effectively accessing HIV/AIDS services. This stigma mainly comes from the medical personnel who have prejudice towards informal traders due to the nature of their jobs. This can lead to harsh treatment which cause informal traders to shun away from seeking HIV/AIDS services. In line with this view, Jafaari, McFarland and Sharifi (2022) present that nurses and doctors usually have an attitude towards informal traders as an impoverished, carefree, talkative and rebellious group. This affects service delivery and can cause informal traders to shun away from seeking HIV/AIDS services. Henceforth the researcher noted stigma and discrimination as a stumbling block to the healthiness of informal traders.

Another point to note under the challenges is lack of awareness of available services. The researcher discovered that many informal traders lack information on the diverse HIV/AIDS services, where to access them and how. This hinders them from accessing these services when they need them leading to low uptake of HIV/AIDS services. This concurs with Oladosu, Khai and Asaduzzaman (2023) who posit that informal traders are usually of low level educational qualifications and this makes it difficult for them to understand health processes, thus they refrain from visiting health centres and hospitals. Their demanding occupations also makes them unaware of HIV/AIDS services available. Therefore the researcher concluded that lack of awareness about

available services remains a significant barrier hindering informal traders in accessing HIV/AIDS prevention, treatment and support services.

The researcher also learnt that transport difficulties are a stumbling block to the pursuit of HIV/AIDS services by informal traders. The research established that limited financial resources and long distances between marketplaces and health facilities result in time and transportation challenges which lead to delays in seeking HIV/AIDS services by informal traders. The nexus between long distance, transportation difficulties and work schedules makes it difficult for informal traders to attend regular check-ups or access necessary medications. This assents with Jafaari, McFarland and Sharifi, 2022) and Oladosu, Khai and Asaduzzaman (2023) who argue that distance from market stalls to health facilities can be so long that informal traders fail to visit health services to access HIV/AIDS services. Henceforth, the researcher summed up that inadequate transportation options hinders equitable access to HIV/AIDS services.

The third objective was to determine measures to improve the delivery of HIV services for informal traders in the district. Firstly, the study brought out the launching of mobile clinics during peer led sessions as an essential way of improving the accessibility of HIV/AIDS services to informal traders at their work places. This will curb transportation and high demand challenges which hinder informal traders from visiting health facilities during normal day operating hours. This concurs with Sundaranjan, Ponticiello, Nansera, Jeremiah and Muyindike (2022) who present on the necessity of mobile outreach programmes as a way of reaching out to hard-to-reach groups in terms of HIV programming like informal traders. Mhlangeni, Du Preez and Zungu (2021) also further strengthen the idea highlighting the pertinence of workplace HIV and TB services in curbing transportation costs and lack of time to access HIV services. This idea is also supported by Jere and Nyondo-Mipando (2022) who carried out a qualitative research in Lilongwe, Malawi

to prove that provision of HIV/AIDS services at the market place is the most preferred strategy by informal traders. Thus this is an essential solution to be considered in HIV programming. This solution is in line with Bandura's social learning theory as it will foster observational learning and hence encourage other traders to copy the positive behaviours of their other health-seeking peers. Therefore, mobile clinic system will increase the uptake of HIV/AIDS services.

Provision of financial support is also a necessary strategy for curbing unaffordability challenges faced by mentees as stated by the research findings. One face to face interviewee cited the importance of collaborating with governmental or non-governmental organizations for the provision of financial assistance or subsidies for HIV/AIDS treatment and care of low income workers like informal traders. Subsidies for medications, transportation allowances, or tailored health insurance options for informal traders would be beneficial in promoting accessibility of HIV/AIDS services to them. The idea of financial support is in congruency with Oladosu, Khai and Asaduzzaman (2021) who emphasize on the role of the social network system in overcoming financial constraints limiting informal traders from accessing HIV services. Therefore provision of financial aid is pertinent in mitigating the effects of unaffordability.

The researcher learnt that continuous investment in HIV/AIDS education is an essential solution in improving the accessibility of HIV/AIDS services to informal traders in the district. The participants indicated that this will be done through awareness campaigns, IEC material, galas and social media. This solution is further accentuated by Kurebwa (2015) who emphasizes on the need to promote HIV/AIDS education as a way of awareness raising, improving knowledge levels on different HIV/AIDS services available and increasing uptake of HIV/AIDS services. Kurebwa (2015) also indicated that education has promoted behaviour change amongst informal traders in

Zimbabwe. Henceforth the research and study literature justifies HIV/AIDS education as a measure to improve the delivery of HIV/AIDS services to informal traders.

Stigma reduction is also an essential strategy of solving the problem of stigma and discrimination. The research findings highlighted on the importance of training medical personnel on friendly service provision, facilitation of community dialogues and launching of sensitization programs to reduce stigma and discrimination. This idea is further justified by a research carried out in India by Hart (2010). This reflected on the importance of stigma reduction as a way of promoting the uptake of HIV/AIDS services by high risk groups like sex workers and to reduce HIV incidence. Henceforth the researcher winded up that stigma and discrimination is a challenge which requires knowledge so as to reduce its impacts on informal traders.

The study also brought out that continuous collaboration with other stakeholders is also key in promotion of support and cooperation towards achieving desired goals. The research participants indicated that stakeholders like PSH, PZAT, PSZ and SAYWHAT are paramount in HIV programming through funding, advice and in organizing community outreach programmes which improve delivery of HIV/AIDS services for informal traders in Chitungwiza. The idea of stakeholder collaboration concurs with Kurebwa (2015) who puts forward that it is important for Zimbabwe to collaborate with neighbouring countries like South Africa in terms of HIV programming. Other stakeholders like community leaders and project beneficiaries are also of paramount importance. The researcher therefore concluded that stakeholder collaboration is important in making the peer led model successful.

The study was however limited to only twenty research participants in Chitungwiza district. Future researchers should consider a larger sample size and also assessing the impact of the peer led model

in other high density suburbs of Zimbabwe like Mbare. Nonetheless though with limitations, the research was pertinent enough to bring to light key elements under each objective of the study.

4.4 Chapter Conclusion

Conclusively, the fourth chapter has managed to indicate, present and analyse the findings of the research including demographic information of the participants. The efficacy of the peer led model in the provision of HIV/AIDS services for informal traders, the challenges inhibiting the traders from accessing HIV/AIDS services and the solutions to the challenges were explored in this chapter. The next chapter will focus on summary of findings, conclusion and recommendations.

CHAPTER 5: SUMMARY OF FINDINGS, CONCLUSIONS & RECOMMENDATIONS

5.0 Introduction

This chapter summaries the study findings on assessing the efficacy of the peer led model in the provision of a comprehensive HIV package for informal traders in Chitungwiza district. It presents conclusions from the research findings namely; the efficacy of the model in HIV service provision, the challenges faced by informal traders in accessing HIV/AIDS services and the solutions to enable problem solving and improved service delivery. This chapter also presents recommendations to the implementing organization, the government and the community in trying to improve the implementation of the model, enable model diversification, to ensure project sustainability and to tackle some of the challenges affecting accessibility of HIV/AIDS services to informal traders. It also highlights study gaps and how future researches should fill them. The chapter ends with a chapter summary.

5.1 Summary of findings

The preceding chapters discussed the background of the study, reviewed the literature, methodology and the data presentation, analysis and discussion. The study sought to assess the efficacy of the peer led model in the provision of a comprehensive HIV package for informal traders in Chitungwiza. The study was guided by three objectives which were to analyse the efficacy of the peer led model in provision of HIV/AIDS services for informal traders in Chitungwiza, to identify the challenges encountered by informal traders in accessing these services and to determine the measures to improve the delivery of HIV services for informal traders. Albert Bandura's social learning theory of human behaviour was used as the theoretical framework of the study. The study followed a qualitative nature which was employed through the use of face to face interviews, in-depth interviews and focus group discussions. These were applied on two

programmes officers, four peer led mentors and 14 peer led mentees respectively to constitute a total of twenty research participants. The participants were picked using purposive sampling and thematic data analysis was then used to come with main and sub themes for the study findings.

5.1.1 Efficacy of the peer led model in provision of HIV/AIDS services

The study findings revealed that the peer led model has been very comprehensive in improving the provision of HIV/AIDS services to informal traders in the district of Chitungwiza. This is because it fostered increased condom uptake, improved knowledge levels, behaviour change, friendly service provision, increased awareness of available services and improved access to health services. These have managed to improve the health of informal traders, reduce HIV incidence and promote socio-economic development. Increased condom uptake was triggered by the HIV/AIDS education sessions and condom distributions done by the peer led mentors. Education on HIV/AIDS also promoted a good health seeking behaviour and safer sexual practices. The use of peers to educate other informal traders cultivated a relationship of trust and thus the mentees freely opened to their mentors. Education on available HIV/AIDS services raised awareness in the community and stakeholder collaboration and the referral system improved accessibility of these diverse services to the mentees. Henceforth, the findings indicated that indeed the peer led model is efficient in providing a comprehensive HIV package for informal traders in Chitungwiza district.

5.1.2 Challenges encountered by informal traders in accessing HIV/AIDS services

The research indicated that despite the peer led model being significant in the provision of HIV/AIDS services for informal traders, there are also various challenges faced by informal traders in trying to access these services. These include demanding profession, unaffordability, stigma and discrimination, ignorance and transportation difficulties. The informal trading business was revealed to be highly demanding and very busy in nature thereby leaving informal traders with no

ample time to visit health facilities and access HIV/AIDS services. The trading business was also proven to be lowly-paying and therefore other traders fail to afford other health services like STI treatment including the consultation fee. This nature also fuels transportation difficulties which restricts the movement of traders to health facilities. Other informal traders also lack information on the available services and therefore this hinders them from accessing available HIV/AIDS services. Stigma and discrimination was also discovered to be causing traders to shun away from health services due to low esteem and other emotional problems it brings forth. Therefore, the study brought out that there are many challenges inhibiting informal traders from effectively accessing HIV/AIDS services.

5.1.3 Measures to improve the delivery of HIV services for informal traders

In terms of ways of addressing the challenges hindering informal traders from effectively accessing HIV/AIDS services, the study established several ways. These measures themes include mobile clinic system, financial support, stigma reduction, HIV/AIDS education and stakeholder collaboration. These were derived from the experiences of research participants and also just as suggestions. The mobile clinic system addresses the problem of the highly demanding profession as it brings health services to the mentees at their workplaces. Stigma reduction was revealed to be fostered through capacity building and training, financial support counters unaffordability, HIV/AIDS education addresses ignorance and stakeholder collaboration improves service delivery, aids with financial assistance and curbs transportation difficulties. Hence the study showed that though many challenges are evident, these can be tackled in order to promote accessibility of HIV/AIDS services to informal traders in the district.

5.2 Conclusions

Deducing from the findings of the research, the study arrived at the following conclusions;

Indeed the peer led model has proven to be significant in improving the provision of HIV/AIDS services to informal traders in Chitungwiza district. The study concludes that the peer led model is effective because it has been promoted changed behaviours, acceptability and consistent use of condoms, fostered collaboration between HIV-focused organizations, increased seeking of HIV/AIDS services, improved knowledge levels on HIV/AIDS and raised awareness on available services and their service providers. This shows that the model is an essential tool of promoting the access to HIV/AIDS prevention, treatment, and care and support services. In spite of these important factors, the study also concludes that there are multiple challenges faced by informal traders in trying to access HIV/AIDS services. These are either caused by the nature of informal trading factors or other external issues like the economy, society and lack of education. Therefore the study concludes that there is need to foster mobile clinics, cooperation between local agencies, offer financial support, raise awareness and promote HIV/AIDS education.

Given the findings, the study concludes that the government has a pivotal role to play in enhancing the delivery of HIV/AIDS services under the peer education model. This is through capacity building and training of healthcare workers, offering financial support, policy development and support and in stigma reduction. The study highlights the need for the implementing organization to source out for external funding, launch community sensitization programmes and strengthen the referral system. Prior to the challenges and need for collaborative support, the study concludes that other local stakeholders should partner up with NAC to improve the implementation of the peer led model in the district. This will aid in diversification of the model, provision of financial support and ensure project sustainability.

5.3 Recommendations

- The implementing agency should continue partnering with many organizations and the government in order to offer more diverse HIV/AIDS services during sessions and for financial and operational support. Partnering up with local community leaders also enable implementation of culturally sensitive approaches, fosters peace, support and ensure project sustainability. By working together, they can create synergies, avoid duplication of efforts, and maximize the impact of peer led programs.
- A robust monitoring and evaluation system is also key for progress checking and making necessary adjustments. Pre and post assessments and success story documentation are necessary in order to check for improved knowledge levels and tracking behaviour change respectively. The peer led reporting template should also have a section for referrals of mentees who already knew their HIV statuses.
- There should also be incorporation of mobile technology into peer led systems and operations like mobile applications, SMS campaigns, chat boards and other response systems which provide comprehensive information on HIV/AIDS services, reminders for testing and medicine and for following up on former peer led mentees (alumni).
- The implementing agency should also develop training curricula that cover topics such as HIV/AIDS prevention, transmission, treatment, and care; communication and facilitation skills; cultural sensitivity; confidentiality; and referral mechanisms. A clear and revised peer led manual should be developed to guide peer led mentors during sessions.
- There is need to facilitate formation of peer support groups specifically for informal traders. This will create a safe space for sharing experiences, concerns and for emotional support. It will also diversify the model to offering psychosocial services by social workers

in the organization and this will increase the uptake of HIV/AIDS services through peer motivation.

- A strong referral tracking system should be launched to ensure that referred mentees visit health facilities and access the needed services.
- Capacity building and training services for medical personnel is a crucial factor in reducing stigma. The government should invest in training and capacity-building programs for government officials and healthcare workers involved in HIV/AIDS service delivery. These training programs should focus on enhancing their understanding of peer education, its principles, its role in HIV/AIDS prevention and care, stigma and discrimination, effective communication and facilitation skills. This also allows them to effectively collaborate with, and support peer educators.
- Government policies should explicitly recognize and prioritize peer education as a viable and evidence-based approach in HIV/AIDS prevention and service delivery. They should also address issues such as funding allocation, training requirements, and program integration into existing healthcare systems. By providing policy support, the government can create an enabling environment for the model's implementation and sustainability.
- Continuous learning and improvement should also be upholded through regular review and update of policies, monitoring and evaluation tools, reporting templates and training materials based on new evidence, emerging practices and feedback from stakeholders.
- There should be continuous community investment in HIV/AIDS education so as to promote continued community sensitization. This is enhanced through awareness campaigns organized by local stakeholders.

- Flexible service delivery options like extended operating hours and satellite clinics should also be considered to improve accessibility of HIV/AIDS services for informal traders.
- There should be advocacy for free HIV/AIDS services for informal traders so as to overcome financial barriers.
- The study also left out gaps in assessing how the reporting tools and monitoring and evaluation templates assist in documentation of the model's successes and failures. The study was limited to interviewees' opinions and 20 participants only. I, therefore recommend future studies to assess reporting and M&E templates, incorporate statistics on uptake of services and consider a larger sample size. These would be necessary in determining the effectiveness of the model in the district.

5.4 Chapter Summary

The foregoing chapter gave a synopsis of research findings; it made conclusions and gave recommendations for improving the provision and accessibility of HIV/AIDS services to informal traders. The chapter also addressed study findings linking them to the research objectives. It recognized challenges like highly-demanding nature of informal trading business, stigma and discrimination, transportation difficulties, unaffordability and ignorance. These therefore led to solutions like the need for continued community sensitization, financial support, launching of mobile clinics, stigma reduction and stakeholder collaboration. The chapter also offered recommendations to the government, implementing agency and other community stakeholders in advancing the model and solving incurred problems. This chapter also highlights research gaps and how they inform future studies.

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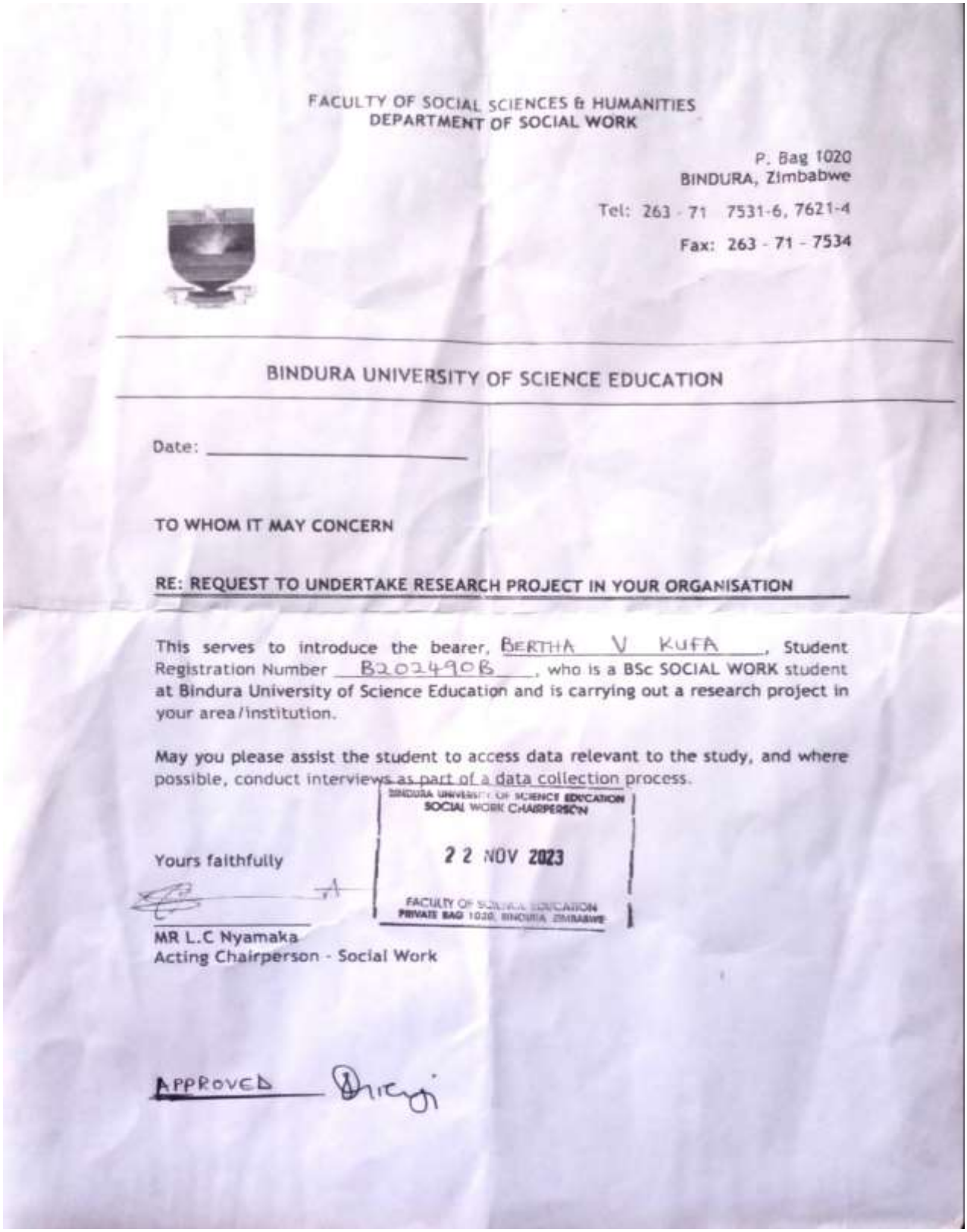
APPENDIX 1: Letter to request to conduct research



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P. Bag 1020
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BINDURA UNIVERSITY OF SCIENCE EDUCATION

Date: _____

TO WHOM IT MAY CONCERN

RE: REQUEST TO UNDERTAKE RESEARCH PROJECT IN YOUR ORGANISATION

This serves to introduce the bearer, BERTHA V KUFA, Student Registration Number B2024908, who is a BSc SOCIAL WORK student at Bindura University of Science Education and is carrying out a research project in your area/institution.

May you please assist the student to access data relevant to the study, and where possible, conduct interviews as part of a data collection process.

BINDURA UNIVERSITY OF SCIENCE EDUCATION
SOCIAL WORK CHAIRPERSON
22 NOV 2023
FACULTY OF SOCIAL SCIENCES
PRIVATE BAG 1020, BINDURA, ZIMBABWE

Yours faithfully

MR L.C Nyamaka
Acting Chairperson - Social Work

APPROVED

APPENDIX 2: Face To Face Interview Guide for 2 NAC Programmes Officers at NAC Chitungwiza District Office

Section A: Biographical Information of NAC programmes officers

1. Could you please share your age and job title?
2. How long have you been working as a programmes officer at National ADS Council?
3. Could you please state your educational background and other key qualifications you see as necessary when working with informal traders?
4. Have you worked with community members before? How was the experience?

Section B: Efficacy of the model in provision of HIV/AIDS for informal traders

1. What are the HIV/AIDS services provided for informal traders under the peer led model?
2. Determine the uptake of these services by informal traders under the peer education model?
3. How does the community respond to the impact of the model?
4. How beneficial is the peer led model in providing HIV/AIDS services to informal traders?

Section C: Challenges encountered by informal traders in accessing HIV/AIDS services

1. What challenges do you face in the implementation of the peer led model? Does any of the challenges affect the peer led mentors and mentees?
2. From your monitoring and evaluation sessions, which challenges are faced by informal traders in accessing HIV/AIDS services?
3. How do you overcome all the above mentioned problems? Did you seek any help and from where? Was their help helpful to you?

Section D: Measures to improve the delivery of HIV/AIDS services for informal traders

1. What do you think should be done in order to improve accessibility of HIV/AIDS services to peer led mentees?

Shona Translation

Section A: Biographical Information of NAC programmes officers

1. Mungataurewo here kuti makura zvakadii uye munoshanda saani?
2. Mava nenguva yakareba sei muchishanda basa iri kuNational ADS Council?
3. Mungandizivisewo here nhoroondo yedzidzo yenyu yamunoona yakakosha mukushandidzana nevatengesi vepamisika?
4. Makamboshanda here nevanhu vemunharaunda? Mungati kudii maererano nemashandiro amakaita?

Section B: Efficacy of the model in provision of HIV/AIDS for informal traders

5. Nderupi rubatsiro runopiwa vatengesi vepamisika maereano nechirwere cheshuramatongo muPeer led model?
6. Mungati kudii maererano nekugashirika kwerubatsiro urwu nevatengesi vepamisika?
7. Vanhu vemunharanda vantoambirawo zvakadii rubatsiro urwu?
8. Peer led model iri kubatsira zvakadii muhuwanikwa hwerubatsiro rweshuramatongo kuvatengesi hwepamisika?

Section C: Challenges encountered by informal traders in accessing HIV/AIDS services

1. Ndeapi matambudziko amunosangana nawo kana muchishanda nePeer led model munharaunda yenyu? Matambudziko aya anokanaganisa here vagari vemunharaunda vanokubatirai basa muPeer led model?
2. Vatengesi vepamisika varikusanganawo nematambudziko akadii mukuwana rubatsiro maererano nechirwere neshuramatongo?

3. Munokunda seyi matambudziko amareva? Makambotsvaga here rubatsiro uye kunani? Rubatsiro rwamakawana rwakakushandirai here?

Section D: Measures to improve the delivery of HIV/AIDS services for informal traders

1. Sekuona kwako, chii chingaitwe kuti rubatsiro maererano nechirwere cheshuramatongo rwuwanikwe zviri nyore kuvatengesi vepamisika?

APPENDIX 3: In-Depth Interview Schedule Guide for 4 Peer Led Mentors at NAC Peer Led Review Meeting At Utano Centre

Section A: Biographical Information of peer led mentors under the peer education model

1. Could you please share your age and gender?
2. How long have you been working as a peer led mentor with National ADS Council?
3. Have you worked under peer education before? How was the experience?

Section B: Efficacy of the model in provision of HIV/AIDS for informal traders

1. What are the HIV/AIDS services provided for informal traders under the peer led model?
2. How many mentees do you reach with HIV/AIDS services under the model?
3. How do they respond to the services being offered?
4. Can you comment overally on the effectiveness of the model?

Section C: Challenges encountered by informal traders in accessing HIV/AIDS services

1. What problems do you face in reaching out to your peer group?
2. What are the challenges faced by mentees in accessing HIV/AIDS services?
3. How do you overcome all the above mentioned problems? Did you seek any help and from where? Was their help helpful to you?

Section D: Measures to improve the delivery of HIV/AIDS services for informal traders

1. Propose any solutions which can be applied to help counter the problems you are facing in reaching out to your peer group.
2. What do you think should be done in order to improve accessibility of HIV/AIDS services to peer led mentees?

SHONA TRANSLATION

Section A: Biographical Information of peer led mentors under the peer education model

1. Mungataurewo here zita uye nechimiro chenyu?
2. Mava nenguva yakareba sei muchishanda sapeer led mentor weNational AIDS Council?
3. Makamboshanda basa rehupeer educator kare here? Mungade kuti kudii maererano nebasa iri?

Section B: Efficacy of the model in provision of HIV/AIDS for informal traders

1. Nderupi rubatsiro runopiwa vatengesi vepamisika muPeer led model?
2. Munobatsirawo vatengesi vepamisika vakawanda zvakadii kana muchishanda mu Peer led model?
3. Vatengesi vepamisika ava vanogamuchira sei rubatsiro rwavanopiwa
4. Nyatsodonongodza zvizere maererano nePeer led model?

Section C: Challenges encountered by informal traders in accessing HIV/AIDS services

1. Ndeapi matambudziko amunosangana nawo kana muchishanda nevatengesi vepamisika?
2. Ndeapi matambudziko anosanganikwa nevatengesi vepamisika mukuwana rubatsiro maererano nechirwere cheshuramatongo?
3. Unokunda seyi matambudziko awareva? Wakambotsvaga here rubatsiro uye kunani? Rubatsiro rwawakawana rwakakushandira here?

Section D: Measures to improve the delivery of HIV/AIDS services for informal traders

1. Chii chingaitwe kurerutsa matambudziko aunosangana nawo mukushanda nevatengesivepamisika?

2. Sekuona kwako, chii chingaitwe kuti rubatsiro maererano nechirwere cheshuramatongo ruwanikwe zviri nyore kuvataengesi vepamisika?

APPENDIX 4: Focus Discussion Group Guide for 14 Peer Led Mentees at NAC Monitoring and Evaluation Session at Unit L Marketplace

Section A: Efficacy of the model in provision of HIV/AIDS for informal traders

1. What HIV/AIDS services have you accessed under the peer led model?
2. How was it, accessing these services?
3. Can you comment overally on the efficacy of the Peer led model in provision of HIV/AIDS services to informal traders?

Section B: Challenges encountered by informal traders in accessing HIV/AIDS services

1. What challenges do you encounter whilst accessing HIV/AIDS services under the model?
2. How do you overcome all the above mentioned problems? Did you seek any help and from where? Was their help helpful to you?

Section C: Measures to improve the delivery of HIV/AIDS services for informal traders

1. What do you think should be done in order to improve accessibility of HIV/AIDS services to informal traders?

Shona Translation

Section A: Efficacy of the model in provision of HIV/AIDS for informal traders

1. Nderupi rubatsiro rwemaererano nechirwere cheshuramatongo rwawakambowana kupfurikidza nePeer led model?
2. Rubatsiro urwu wakaruona seyi?
3. Nyatsodonongodza zvizere maererano nePeer led model mukuwanikwa kwerubatsiro rwechirwere neshuramatongo?

Section B: Challenges encountered by informal traders in accessing HIV/AIDS services

1. Ndeapi matambudziko aunosangana nawo kana uchida kuwana rubatsiro maererano nechirwere cheshuramatongo?
2. Unokunda seyi matambudziko awareva? Wakambotsvaga here rubatsiro uye kunani? Rubatsiro rwawakawana rwakakushandira here?

Section C: Measures to improve the delivery of HIV/AIDS services for informal traders

3. Sekuona kwako, chii chingaitwe kuti rubatsiro maererano nechirwere cheshuramatongo rwuwanikwe zviri nyore kuvatengesi vepamisika?

APPENDIX 5: Informed Consent Form

Project Title: The efficacy of the Peer-led model in providing a comprehensive HIV package for informal traders in Chitungwiza district.

Consent to take part in research

I voluntarily agree to take part in this research by Bertha V Kufa, Student at Bindura University of Science Education. I understand that even if I agree to participate in this research now, I can withdraw anytime and I can refuse to answer some questions. I agree to my interview being audio-recorded and consent the student to use information from my interview in her data collection for school-related research. I have read and understood the nature of the research, its objectives, pros and cons.

I understand that I will not directly benefit from this research because it is voluntary. I understand that the information I will provide for this study will be treated with confidentiality and my identity will remain anonymous. In the case of queries, I understand that I can contact the university for further clarifications and information.

I hereby give my signature as proof of agreement between me and the researcher.

Signature of research participant…… Date……

Signature of researcher…… Date……

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