AN EVALUATION OF THE INFLUENCE OF AN HIV/AIDS PEER EDUCATION PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

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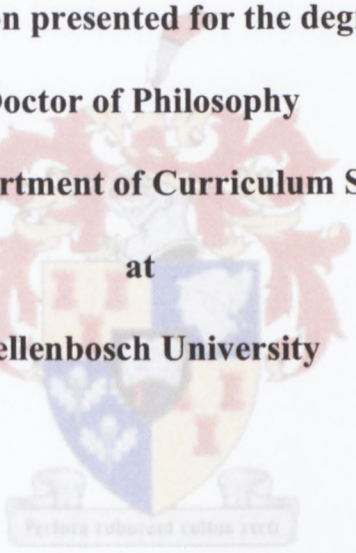

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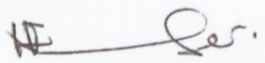

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Signature Date

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ABSTRACT

South Africa is now in its eighteenth year of democracy. However, a major problem that we are facing is the scourge of the HIV/AIDS pandemic throughout Africa, with the most seriously affected areas being in Sub-Saharan Africa. Despite a National Strategic Plan (NSP) for HIV/AIDS, government authorities have been unable to stem the tide of daily HIV infections amongst all people.

Education seems to be one of the most powerful weapons to fight this pandemic; hence it is expected of HEIs to respond to this problem in a meaningful manner in order to stem the tide of the HIV/AIDS pandemic on all university campuses. HEAIDS took the initiative to bring all role players in HEIs together to devise plans for how to deal with the pandemic at HEIs.

Despite the fact that 22 out of the 23 higher education institutions surveyed by HEAIDS in 2008 were engaged in peer education training programmes, none of them monitored or evaluated these programmes. The aim of this study is to evaluate and establish the influence of a peer education programme amongst students at a selected HEI in the Western Cape. An evaluation research design was employed, using a mixed methods approach to collect data. A Logic Model was developed which assisted me with the evaluation design. I used Bandura's social cognitive theory (SCT) to assist me with the analysis and interpretation of the data. The study attempted to understand the key issues involved in the peer education programme, challenges faced by staff in the implementation of these programmes, how peer educators experienced the training programmes, as well as the experiences of other students who interacted with the peer educators.

The quantitative data revealed that more work needs to be done with regard to behaviour change amongst peer educators. However, in this study, the qualitative data showed that peer educators need to develop more skills to empower themselves to facilitate workshops and to enhance their communication skills.

OPSOMMING

Suid-Afrika is tans in sy agtiende jaar van demokrasie. Die probleem wat nog hierdie bedeling in die gesig staar, bly nog steeds die MIV en VIGS pandemie, waarvan die grootste problem in Sub-Sahara Afrika, is. Ten spyte van 'n omvattende nasionale plan teen MIV en VIGS kan die owerhede nog nie hierdie aaklige pandemie stuit nie, en word mense nog op 'n daaglikse basis daardeur geaffekteer. Opvoeding bly nog die grootste wapen waarmee hierdie pandemie beveg kan word, daarom word dit van die opvoedkundige instansies, veral universiteite, verwag om die voortou te neem met die bevegting van hierdie pandemie. "HEAIDS" het die inisiatief geneem om alle rolspelers by hoër opvoedkundige instansies bymekaar te bring om sodoende planne te beraam, hoe om te werk te gaan om die pandemie te bekamp.

Ten spyte van die feit dat 22 uit 23 hoër opvoedkundige instansies deel was van die opnames wat in 2008 op hul kampusse, onder sekere portuurgroepe gedoen was, was geen analiese of evaluering gedoen nie. Die doel van hierdie navorsings projek is om portuurgroep opleidings programme te evalueer by n universiteit in die Wes-Kaap en om vas te stel wat die invloed van hierdie programme onder sekere portuurgroepe by hierdie hoër opvoedkundige instansie, het. Daar was van 'n evaluerings navorsing metode gebruik gemaak met gemengde maniere om die data in te vorder. 'n Logiese model was ontwikkel wat my gehelp het met die evaluerings ontwerp. Die Teoretiese raamwerk wat gebruik was om die data te intepreteer was Bandura se Sosiale Kognitiewe Teorie. Die studie het gepoog om die belangrike aspekte wat betrokke is by portuurgroep opleidings programme uit te beeld en om vas te stel watter uitdagings die personeel ondervind het met die implimentering van die opleidings programme. Ek wou ook vasstel hoe die portuurgroepe en die ander studente op kampus, hierdie programme ondervind het.

Kwantitatiewe data het bewys dat meer gedoen moet word met betrekking tot die gedragsveranderinge van portuurgroepe.

Kwalitatiewe data het bewys dat daar meer opleiding nodig is vir die portuurgroepe ten opsigte van vaardigheidsontwikkeling. Daar moet gefokus word op die ontwikkeling van kommunikasie metodes en die fasilitering van werkswinkels.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASSA	Actuarial Society of South Africa
BASE	Be Active in Self Education
BCC	Behaviour change communication
CBO	Community Based Organizations
CDC	Centre for Disease Control
CTP	Committee of Technikon Principals
DHS	Demographic and Health Surveys
DoE	Department of Education
FAO	Federal Agricultural Organization
HCT	HIV Counseling and Testing services
HE	Higher Education
HEAIDS	Higher Education HIV/AIDS Programme
HEARD	Health Economics and AIDS Research Division
HEI	Higher Education Institution
HESA	Higher Education South Africa
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HSRC	Human Science research Council
ICT	Information Communication Technology
IIEP	International Institute for Education Planning
IO	Institutional Officer
MDGs	Millennium Development Goals MDGs
NGO	Non Governmental Organization
NQF	National Qualifications Framework
NSP	National Strategic Plan
NWG	National Working Group
PEO	Peer education training officer
PLWHA	People living with HIV and AIDS
PO	Project officer
SADEC	Southern African Development Countries
SANAC	South African National Aids Council
SAQA	The South African Qualifications Authority

SAUVCA	South African Universities Vice-Chancellors Association
SCT	Social Cognitive theory
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	United Nations Program on AIDS
UNICEF	United Nations Children Fund
WCED	Western Cape Education Department
WHO	World Health Organization
YRBS	Youth Risk Behavior survey

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CHAPTER 1

CONTEXUALISATION AND ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Human immune deficiency and acquired immune deficiency syndrome (HIV/AIDS) poses a major threat to development and poverty alleviation, particularly in Sub-Saharan Africa. While there are some positive signs in South Africa's national response to HIV/AIDS, a turning point has not yet been reached where the country can safely say that it is rolling back the pandemic. For this to happen, renewed commitments by government, civil society and the private sector will be important to ensure the implementation of the HIV and AIDS and Sexually Transmitted Infection (STI) National Strategic Plan (NSP) 2012-2016. Education has been declared an effective preventative approach and the single most powerful weapon against HIV transmission.

However, there is a paucity of research on the type of education required and the appropriate teaching/learning methods. Generally one hopes that education will influence a change of attitudes and behaviour on the part of the students (Sukati, Vilakati & Esampally, 2010). This study attempts to evaluate the influence of peer education programmes at a higher education institution (HEI) in the Western Cape. As programmes dealing with social problems are often complex, it is critical that evaluators understand as much as possible about the programmes. This research project will strive to evaluate the HIV/AIDS and Sexually Transmitted Infection (STI) peer education training programmes. A good understanding of these programmes will mean that the researcher needs to focus on the following elements:

- Understanding the key issues involved in the peer education programme;
- Challenges faced by staff in the implementation of these programmes;
- The experiences of other students who interact with the peer educators.

There is a dire need to understand the challenges faced by students and staff who are involved with peer education training programmes at HEIs and to know how effective these programmes are. Funnel and Rogers (2011) recommend two evaluation activities that can assist evaluators in developing a clear understanding of the programme, namely develop a programme theory of the

programme and developing a Logic Model of the programme (Refer to 3.2.1 and 3.4). Both these activities involve aligning the implicit and explicit, often undocumented assumptions, that would allow for a deeper understanding of the programmes (Funnel & Rogers, 2011). Implicit implies that the structure and activities of the programme is not very clearly spelt out. Explicit are those activities that are not visible. The project leader or researcher has a major role to play in creating activities that could make the theory more understandable or explicit (Weiss, 1999:8). Throughout the study, I made an attempt to get to know all the structures and activities of the various peer education programmes to be evaluated.

My personal interest in this study stems from my involvement with the HIV/AIDS activities at this HEI since 2002. I was appointed as HIV/AIDS institutional representative to what was then called the Peninsula Technikon.[1] This stemmed from a meeting that was held by the Minister of Education, Prof. Kader Asmal, with all the vice-chancellors of higher education institutions (HEIs) in South Africa. Nationally, the South African Universities' Vice-Chancellors Association (SAUVCA) and the Committee of Technikon Principals (CTP) were charged with making HIV/AIDS a priority on their respective campuses. SAUVCA and CTP have held four national meetings with all institutional representatives annually since 2002. During the above meetings it was decided that institutions would be assisted in the following areas with regard to dealing with HIV/AIDS on all campuses:

- Peer education programmes;
- Voluntary counselling and testing;
- Workplace policy and procedures;
- Curriculum development.

I was involved in the first two audits that were done on HEIs. Since the merger in 2005, the HEI where I was doing my research has formed its own HIV/AIDS Unit. An HOD is in charge and the coordinator of all the functions of this Unit. During a recent feedback from the director of Higher Education HIV/AIDS Programme (HEAIDS), the report stated clearly that no monitoring and evaluation of peer education activities are being done thus far. However, out of the 23 HEIs which were audited, 22 are involved with peer education training on their respective campuses. I have also been a member since 2000 of the university's HIV/AIDS institutional

[1] In January 2005 the Peninsula Technikon in Bellville merged with the Cape Town Technikon in Cape Town to form the Cape Peninsula University of Technology.

committee. I am passionate about HIV/AIDS and sexuality education, particularly for young people. Hence my interest in pursuing this study.

Wolcott (2009:61) recommends that qualitative research should be written up in the first person. He claims that the writer should own the research and therefore make it his or her own.

1.2 BACKGROUND

HIV/AIDS is one of the main challenges facing South Africa today. The latest statistics on the global HIV/AIDS pandemic were published by UNAIDS, WHO and UNICEF in November 2011, and refer to the end of 2010. People living with HIV/AIDS in 2010 were estimated at 34 million. 50% of the proportions of adults living with HIV/AIDS in 2010 were women. Children living with HIV/AIDS in 2010 accounted for 3.4 million. New infections in 2010 numbered 2.7 million for adults and 390,000 for children. People, who died of HIV/AIDS numbered 1.8 million in 2010. The largest proportion of adults living with HIV/AIDS is in the age group 15-49 (WHO and UNICEF, November, 2011).

The figures and tables that follow give an indication of numbers of people globally, nationally and provincially who are infected with HIV and AIDS. Tables 1.2 and 1.3 refer to statistics in South Africa. Table 1.4 indicates infection rates in the Western Cape, as the HEI where the study is conducted is situated within this province.

Figure 1.1 below refers to global statistics for HIV/AIDS at the end of 2010.

Figure 1.1: Global number of people living with HIV by year (UNAIDS Report, 2010)

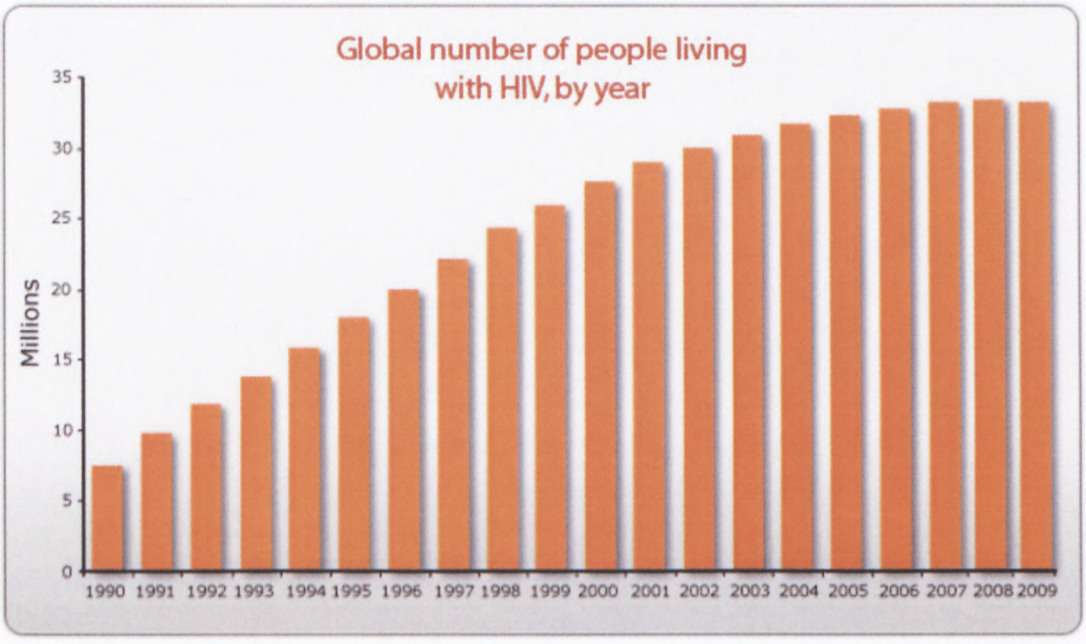


Table 1.1 below refers to regional HIV/AIDS statistics

Table 1.1: Regional statistics for HIV/AIDS end of 2010 (UNAIDS Report, 2010)

Region	Adults and children living with HIV/AIDS	Adults and children newly infected	Adult prevalence*	AIDS-related deaths in adults & children
Sub-Saharan Africa	22.9 million	1.9 million	5.0%	1.2 million
North Africa & Middle East	470,000	59,000	0.2%	35,000
South and South-East Asia	4 million	270,000	0.3%	250,000
East Asia	790,000	88,000	0.1%	56,000
Oceania	54,000	3,300	0.3%	1,600
Latin America	1.5 million	100,000	0.4%	67,000
Caribbean	200,000	12,000	0.9%	9,000
Eastern Europe & Central Asia	1.5 million	160,000	0.9%	90,000
North America	1.3 million	58,000	0.6%	20,000
Western & Central Europe	840,000	30,000	0.2%	9,900
Global Total	**34 million**	**2.7 million**	**0.8%**	**1.8 million**

Table 1.2: HIV prevalence (%) by province 2002-2008 (Statistics South Africa-Mid-year Population Estimates, 2010)

Province	2002	2005	2008
KwaZulu-Natal	11.7	16.5	15.8
Mpumalanga	14.1	15.2	15.4
Free State	14.9	2.6	12.6
North West	10.3	10.9	11.3
Gauteng	14.7	10.8	10.3
Eastern Cape	6.6	8.9	9.0
Limpopo	9.8	8.0	8.8
Northern Cape	8.4	5.4	5.9
Western Cape	10.7	1.9	3.8
National	**11.4**	**10.8**	

It is estimated that of the 34.5 million people living with HIV worldwide at the end of 2010, more than 68% were living in Sub-Saharan Africa (UNAIDS HIV Epidemic Update, 2010). About 5.54 million people were estimated to be living with HIV in South Africa in 2010 (HIV and AIDS Strategic Plan for South Africa, 2012-2016). Together with the strategic plan, the South African National AIDS Council (SANAC) mandated the health department to operationalise a plan for comprehensive HIV/AIDS care, management and treatment. This plan would represent the country's multisectoral response to the challenge from HIV infections and the wide-ranging impact of HIV and AIDS (Strategic Plan for South Africa, 2012-2016). Some key recommendations to put this plan into practice were as follows:

- Universal testing for HIV/AIDS and screening for tuberculosis (TB);
- To consolidate existing partnerships;
- Strengthening coordination, monitoring and evaluation at the level of SANAC;
- To ensure the dignity and safety of all citizens, particularly with regard to stigma and discrimination;
- To ensure access to quality treatment and care and support services for all people.

Table 1.3 shows the prevalence estimates and the total number of people living with HIV/AIDS from 2001 to 2010. The total number of persons living with HIV in South Africa increased from an estimated 4.10 million in 2001 to 5.24 million in 2010 (Statistics South Africa-Mid-year Population Estimates, 2010).

Table 1.3: HIV prevalence estimates and the number of people living with HIV, 2001-2010 (Statistics South Africa-Mid-year Population Estimates, 2010)

Year	Population Percentage of women	15-49 years Percentage of men	Percentage of the total population	Total number of people living with HIV (in millions)
2001	18.7	15.4	9.4	4.10
2002	19.2	15.8	9.6	4.38
2003	19.4	16.1	9.8	4.53
2004	19.6	16.3	9.9	4.64
2005	19.7	16.5	10.0	4.74
2006	19.7	16.6	10.1	4.85
2007	19.7	16.7	10.2	4.93
2008	19.7	16.9	10.3	5.02
2009	19.6	17.0	10.3	5.11
2010	19.7	17.3	10.5	5.24

Provinces that recorded the highest HIV prevalence were KwaZulu-Natal (39.5%), Mpumalanga (35.1%), Free State (30.6%) and Gauteng (30.4%). The Northern Cape and Western Cape recorded the lowest prevalence at 18.4% and 18.5% respectively.

Because infection rates vary between different groups of people, the findings from antenatal clinics cannot be applied directly to men, newborn babies and children. This is why South Africa has sought also to survey the general population.

This strategic plan also recognises geographic variations, with some provinces in South Africa more severely affected. These differences also reflect background socioeconomic conditions. This was clearly demonstrated by the HIV surveillance data that were gathered per district in the Western Cape Province. It is in this province where I will be conducting the research. During 2005 the average infection rate in this province was the lowest in the country at 15.7%. However, two metropole health districts registered prevalence rates of 33.0% and 29.0%

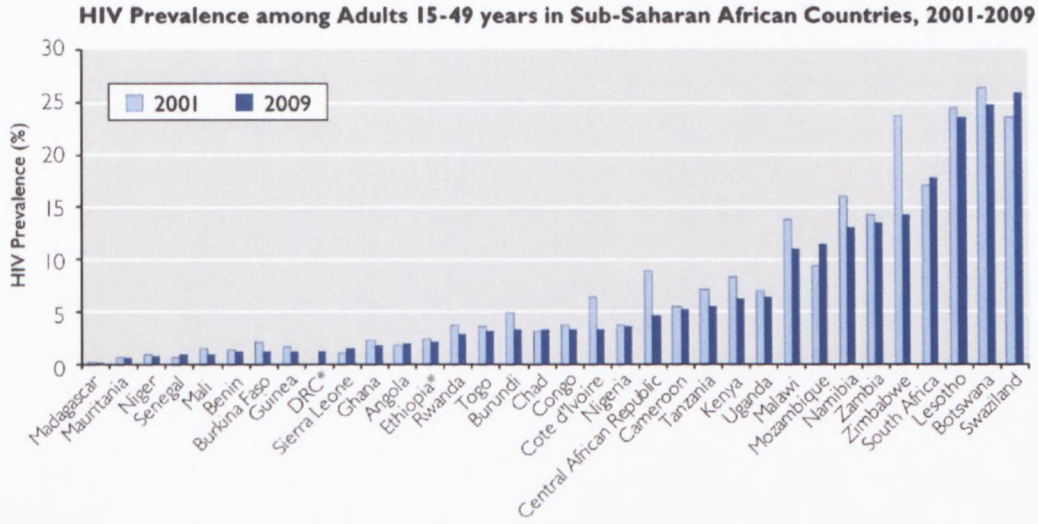
respectively. This was higher than the national average. According to the Human Sciences Research Council (HSRC) (2005), a household survey revealed people that live in rural and urban settlements seem to be at a higher risk of HIV/AIDS infection (HIV/AIDS Strategic Plan for South Africa, 2012-2016).

Sub-Saharan Africa has a heterogeneous epidemic with differing patterns in the three regions. In Southern Africa prevalence has stabilised at high levels in most countries, while prevalence in East Africa has declined since 2000 and stabilised at lower levels than in Southern Africa. In West Africa prevalence rates are markedly lower than on the rest of the subcontinent, at under 2% across the region, except in Cameroon (5.3%), Côte d'Ivoire (3.4%), Gabon (5.2%), and Nigeria (3.6%). Within countries, the impact of HIV/AIDS also varies a great deal, with urban centres often being the most affected. Across all three regions heterosexual sex is the primary form of transmission, though in countries with more concentrated epidemics, other forms of transmission can play a significant role, including sex work, migration, men having sex with men, and mother-to-child transmission (Keizer Family Foundation Fact Sheet, 2009).

With 11.3 million people living with HIV/AIDS (PLWHA) in 2009, Southern Africa continues to be the most severely affected region in the world, accounting for nearly half of all PLWHA on the subcontinent. UNAIDS estimates 40% of all HIV-positive women in the world live in the sub-region. Globally more than one in five PLWHA live in Botswana, South Africa and Zimbabwe; 5.6 million PLWHA live in South Africa alone. Swaziland has the highest prevalence of any country in the world: approximately one in every four citizens is HIV positive. Prevalence rates in most countries in the region have stabilised, though Zimbabwe experienced a recent surge in new infections – possibly related to its ongoing civil and political unrest. Further decreasing the number of new HIV infections in Southern Africa is a continuing challenge. Compared to other countries in the sub-region, Angola has a remarkably low HIV prevalence (2%), in part due to the limited cross-country travel during its protracted civil war (1975–2002), which impeded the spread of the virus (UNAIDS, 2010).

In this region the epidemic affects individuals at all levels of society, education, income and migration strata (Refer to Figure 1.2).

Figure 1.2: HIV Prevalence amongst adults 15-49 years in Sub-Saharan countries, 2001-2009 (UNAIDS Report, 2010)



All data from UNAIDS 2010 Report on the Global HIV Epidemic
*DRC and Ethiopia from UNAIDS 2008 Epidemic Update, data for 2001 and 2007.

Comprehensive knowledge of HIV/AIDS remains low in Sub-Saharan Africa and is an obstacle to reducing incidence rates. For example, approximately 2 million PLWHA in South Africa do not know they are infected, believe they are not in danger of becoming infected, and are unaware they can transmit the virus to others. A review of Demographic and Health Surveys (DHS) from countries across West Africa from 2003–2008 estimated less than 50% of the population between the ages of 15 and 49 had adequate correct knowledge about HIV/AIDS (identified two major ways of preventing the sexual transmission of HIV, rejected the two most common local misconceptions about HIV transmission, and knew a healthy-looking person could have HIV (UNAIDS, 2008).

The recently released results of HEAIDS survey of HEIs show that the prevalence rate amongst administrative staff that were surveyed stands at 4.4%. The survey also concluded that 9.9% of service workers are HIV positive. This HEAIDS survey included 21 HEIs out of a possible 23 HEIs in the country. Prevalence rate amongst students is 3.4% (HEAIDS Survey, 2009). The highest prevalence rate emerged from the Eastern Cape and Kwazulu-Natal. The Western Cape has the lowest figures, and the provinces of Gauteng, Free State and Limpopo occupied the middle ground as far as prevalence rates are concerned.

Dorrington (2000) predicted, that by the end of 2000, 13% of South Africa's residents will be HIV infected, with the number of new infections increasing by about 2,000 to 2,500 per day – that is, between one and two each minute. Dorrington (2000) predicted that life expectancy will be 41 years in 2010. ASSA (2010) predicted life expectancy to be 50 years until 2015. In 2008 the Western Cape had just less than 300,000 HIV-positive people. This accounted for about 6% of the overall rate in South Africa. It is the province with the least infections and the lowest prevalence rate. In this province it is estimated that I in every 10 adults are HIV positive.

Table 1.4 gives an indication of the prevalence rate of HIV/AIDS in the Western Cape. Nicolai (2008) discusses the whole population, antenatal clinics, adults between 20-64 years old, new infections over a 12-month period, AIDS deaths over the same period and the number of people requiring antiretroviral treatment (ARV).

Table 1.4: Western Cape HIV/AIDS statistics (Nicolai, 2008)

	Western Cape
Whole Population	6%
Antenatal clinic estimate	16%
Adults (ages 20-64)	9%
People living with HIV	298,000
New HIV infections (over the year)	27,000
AIDS death (over the year)	14,000
Total people in need of ART (mid-year)	55,000
Total people accessing ART (mid-year)	41,000
Accumulated AIDS deaths	79,000
New infections per day	73
New deaths per day	39

Currently HIV/AIDS has reached epidemic proportions in South Africa and has serious consequences, particularly for our youth (Van Wyk, 2005). The definition of youth various considerably globally and in South Africa, and it is also dependent on the context in which it is used. The United Nations refers to the 1.2 billion young people between the ages of 15-24 as "youths". They constitute 18% of the world's population (South African Youth Risk Behaviour Survey, 2008). According to Jogunosimi (2004), about half a million African youths between

the ages of 15 and 24 will die from AIDS and related diseases by the year 2005. In the light of the epidemic proportions of HIV/AIDS in our country, it is important that HEIs play a major role in combating this disease (Aiello & Bisgard, 2003).

One of the strategies that could be used on an HEI campus is the implementation of peer education programmes that focus on HIV/AIDS, STIs and tuberculosis (TB). However, Campbell (2004) argues that a positive environment that supports peer education is essential in order for training programmes to be successful. In her opinion, peer education was developed to replace the traditional didactic approach to health education that was adopted with most students. Campbell (2004) identifies two processes for the successful implementation of peer education. Firstly, peer education should provide a platform for a group of young people to collectively re-negotiate their identities. This is based on the assumption that sexual behaviour is determined by peer norms as much as by individual decisions. Secondly, peer education should empower young people to take ownership of their sexuality, as well as help them to develop sexual negotiation skills. Young people who are empowered will gain confidence and will strive to seek health interventions; for example, they might see that they themselves have a key role to play in HIV prevention, rather than seeing it as the responsibility of other medical experts (Campbell, 2004:1). Bandura (1996) states that it is a combination of self-confidence and self-empowerment that makes young people feel that they are in control of their sexual health.

Carter and Carter (1993:1) suggested that sexuality education should be given a high priority in high school curricula in order to prepare students for all the challenges they may have to face in HEIs. It is clear that young people are the "at risk" population when we look at STIs and HIV/AIDS statistics. Sexuality and family life education help to prepare students for the transition to adulthood and to face the challenges of HEIs (Carter & Carter, 1993:1).

In March 2001 the then Minister of Education, Prof. Kader Asmal, announced the National Plan on Higher Education (HE), which was set to change the HE landscape. A National Working Group (NWG) was tasked to make recommendations to the minister on the future of HEIs. Each institution had to make submissions to the NWG on their programmes, qualification mixes and niche areas (HESA, 2008), hence the National Audit that was spearheaded by Higher Education HIV/AIDS Programme (HEAIDS). Academics at HEIs should link HIV/AIDS policies to formal teaching structures and, where possible, be assisted by a formal committee. Integrated training and education on how to infuse HIV/AIDS policy into the curriculum should be provided, including the utilisation of staff members in the Teaching Development Department,

to train lecturers on how to infuse HIV and AIDS and broader sexuality issues into their course material (Aiello & Bisgard, 2003:15).

Core courses and service learning are the most common means of infusing HIV/AIDS information and sexuality content, while short courses are the least common approach used. More staff members at universities (60%), than at Technikons (51%) have established an institutional policy for including HIV and AIDS content in the curriculum (Aiello & Bisgard, 2003:15).

By 2005 most of the universities in the Western Cape and nationally had established an HIV/AIDS department to oversee sexuality and HIV/AIDS activities on their respective campuses. This greatly facilitates the training of peer educators on our campuses. Deutsch and Swartz (2002:4) describe peer education "as the process whereby trained supervisors assist a group of suitable learners to educate their peers in a structured manner; informally role model healthy behaviour; recognise youth in need of additional help and refer them for assistance; and to advocate for resources and services for themselves and their peers".

In conducting this research project I hope to make a meaningful contribution to the peer education training programmes in HEIs. These training programmes could enhance the knowledge of peer educators with regard to HIV/AIDS, STIs and TB. They could also be identified as optimally effective programmes for best practice for HEIs. These research results could be disseminated amongst various stakeholders in HEIs, which will help to promote a more comprehensive approach to peer education training, particularly with regard to sexuality, HIV/AIDS, STIs and TB. It will also assist in the growing field of research on youth sexuality and peer education.

1.3 STATEMENT OF THE PROBLEM

Each university in South Africa has an HIV/AIDS department (Aiello & Bisgard, 2003:15-16). Kelly (2003) states that universities have a special responsibility for the development of human resources, they are crucial agents of change and providers of leadership that they should be at the forefront in developing deeper understandings of HIV/AIDS and programmes to mitigate the impact of the epidemic. On HEI campuses students are involved in talking, listening, thinking, communicating about and learning pertaining to sexuality issues with their peers related to HIV/AIDS, STIs and TB. Peer education, therefore, is about harnessing young people's

creativity and credibility to promote healthy lifestyles. Worldwide, as well as in South Africa peer education is one of the most widely used strategies to address HIV/AIDS (Dalrymple & Durden, 2004; Deutsch & Swartz, 2002).

Higher education institutions have unique ways of doing peer education on their respective campuses. However, Aggleton and Crewe (2005), in a review of education related to sexuality, discuss the two main arguments that have emerged with regard to sexuality education. On the one hand, the view is that training about sexuality could lead to "experimentation" amongst peers. On the other hand, but most importantly, the learning of sexuality issues is important for the development of all youths in the context of HIV/AIDS and STIs.

Kirby (2005), in an evaluation of the impact of sex and HIV education programmes on sexual behaviour on youths in both developed and developing countries, found them to be effective. Visser (2005) did an evaluation in South Africa on the implementation of life skills and HIV/AIDS education, and found that the programme failed, because of trainers' non-commitment, negative attitudes and poor relationship with students. Tijuana, Finger, Ruland and Savariaud (2004) believe that in order for a training programme to be effective, the trainers need to be trained adequately and that sexuality education has to first impact on the trainers. Currently, there is no evidence to prove the commitment of trainers or that they do have an impact on peer educators. To date very little has been done in HEIs in this regard. Students are introduced to various disciplines through texts and lectures (CSUMB'S Monterey Bay's Service Learning Prism, 2008:2), but they lack the skills to utilise their own life experiences to deal with issues of sexuality and HIV/AIDS.

However, the literature search to date could not bring to the fore any information on scientific evidence that programme evaluation on peer educator training in HEI's were researched.

The study will explore the effectiveness and challenges of peer educator training programmes at an HEI in the Western Cape with a possible view to identifying best practices, as well as developing a model for peer education programmes that are optimally effective. In doing so, I will attempt to answer the following research questions: How effective are peer education programmes for HIV education in HEIs? How can peer education have an impact on the lives of these young peer educators and other students, with regard to the acquisition of knowledge and behaviour change?

1.4 RESEARCH OBJECTIVES

1.4.1 Purpose

The purpose of this research is to evaluate and establish the influence of a peer education programme amongst students at a selected HEI in the Western Cape. The purpose would be to identify various best practices and challenges of these peer education training programmes at an HEI in the Western Cape.

1.4.2 Objectives

1.4.2.1 To describe the formation of the HIV/AIDS Unit at an HEI in the Western Cape in relation to its mission and vision statement.

The first objective of this research project is **to establish** how this HIV/AIDS Unit **was established** and how **its operations are linked to its mission and vision** statement to make a profound difference in the lives of young people, particular the peer educators attached to this Unit.

1.4.2.2 To evaluate the effectiveness and influence of peer education and related training programmes in the HIV/AIDS Unit amongst the peer educators at a HEI in the Western Cape.

The second objective of this research is to **evaluate** the effectiveness and influence of the peer education and related training programmes in the HIV/AIDS unit, with specific reference to their experiences and how this would influence them.

1.4.2.3 To evaluate staff's experiences and challenges in the implementation of the training programmes in the HIV/AIDS Unit.

The third objective is to **evaluate the experiences and challenges of all the staff** involved in the training programmes. This will include all the staff, administrative staff in the HIV/AIDS unit as well as everyone who plays a role in the execution of these training programmes.

1.4.2.4 To illustrate the experiences and influences of students who have attended various activities hosted by the peer educators and the HIV/AIDS Unit.

The fourth objective will **evaluate the experiences of students** who have attended a training session facilitated by the peer educators. It will attempt to establish how these students experienced these training sessions.

1.5 THE THEORETICAL FRAMEWORK

Every programme is based on some conception or set of beliefs about what must be done to bring about the intended social benefits (Funnel & Rogers, 2011:3-8). That set of beliefs is referred to as the programme theory. It may be expressed in a detailed programme plan and rationale, or be implicit in the programme's structure and activities. When the programme theory is not articulated or documented in any way, the theory is regarded as "tacit" or "implicit" (Weiss, 1999). Implicit implies that the structure and activities of the programme are not explicitly spelt out. The project leader or researcher has a major role to play in creating activities that could make the theory more understandable or explicit (Weiss, 1999:8).

For this project Social Cognitive Theory (SCT) (Bandura, 1986) will be used as the theoretical framework. SCT is largely based upon the work of the psychologist Albert Bandura. By means of SCT I aim to evaluate how the peer educators experience the influence of peer education training programmes at this HEI. SCT elaborates on the interplay between the individuals (in this project the peer educators), their behaviour and the environment in which they find themselves (Bandura, 1998:5). Pjares (2002) agrees with Bandura, but he adds other factors that young adults react to that play an important role in their response to their environment and the way in which they behave. One of the most important factors is the social life of young adults (Pjares, 2002). In terms of SCT, Bandura (1998) and Pjares (2002) agree that cognitive thinking is an important determinant, but at the same time a very complex element in young adults' social life. Hence agency and structure are fundamental issues in the study of young adults' lives. In this project I will explore issues of agency and structure, credibility and role-modelling in relation to peer education training programmes.

A research or evaluation design is presented as an overall plan or strategic framework. This framework will guide the activities that I will employ to ensure that the research problem is addressed appropriately (Babbie & Mouton, 2001:74-75; Durheim, 2002:29; Ledy, 1997:93; Merriam, 1998:6). The theoretical framework would also enable me to understand different aspects of the various phenomena that are being studied in this project, even those that are not part of the theory (Anfara & Mertz, 2006) However, included in the SCT I will draw on aspects

of an interpretive framework, where the experiences of people count. This research aims to understand and interpret the meaning that peer educators, the trainers involved in the training programmes, as well as the unit's administrative staff give to their explanations of the peer education training programme that they experienced. This will enable me to evaluate the conceptualisation, the implementation process and the outcomes of this specific programme in order to improve it (Dane, 2011:299). This framework acknowledges that knowledge is socially constructed; thus this research adopts Clives (2002) ideology that it is essential in the study of people to just recognise how people define the situation in which they find themselves: "if people define situations as real, they are real in their consequences" (2002:789).

It is important to study the intervention in its natural setting and preferably through its entire cycle. Thus this research depicts what De Vos *et al.* (2005) would term, an 'interpretive phenomenological epistemology'. This means that I would like to explore the interaction of peer educators with the trainers as well as with their own peers and how they experience their role as peer educators. It is also important to get to understand their perceptions of life and their world (life world) as well as their knowledge base and how they apply their knowledge as peer educators. SCT would assist me to interpret the life world of these peer educators and trainers within the peer education training environment. I hope to explore how they do or do not apply their acquired knowledge and skills when dealing with their own behaviour, or in trying to influence the behaviour of their peers.

Bandura (1998) states that people learn through direct experience, indirectly by observing and modelling the behaviour of others, and through training that leads to confidence in being able to carry out behaviour. Consequently, it is extremely important to note that Bandura's theory is incorporated into the interactive experimental learning activities in the context of peer education. Peer educators can thus be influential teachers and role models (Zieloni, Kimzeke, Stakic, De Bruyn & Bodiroza, 2003) In this regard, Turner and Shepherd (1999) claim that there seems to be a limited theoretical understanding of how peer-based programmes work. They claim that programmes continually revolve around assumptions that are not always articulated clearly. Turner and Shepherd (1999) are also of the opinion that it is difficult to develop a theoretical model for peer education, because definitions and terminology are not applied consistently. These inconsistencies do not allow for comparisons and generalisations across various programmes (Turner & Shepherd, 1999).

SCT underlines the influence of social modelling, credibility and personal agency in human behaviour (Bandura 1998). The development of SCT by Bandura (1986) brought about a means of moving away from previous behaviourist models that focused purely on learning through the effects of one's actions and whether they were met with rewards, reinforcement or even negative consequences. In dealing with peer educators, it seems that the reinforcement of positive behaviour is very important. For instance, it seems that peer educators need to be reminded constantly of the consequences of negative behaviours, for example, unsafe sexual practices. Bandura (1986) describes the importance of peers having competent role models whose behaviour they can assess and hopefully build on. Other important ingredients of SCT include the chance to learn and practise new skills and to receive constructive feedback in a very safe environment. This process of observational learning described by SCT is particularly relevant for peer education programmes, since young adults are thereby given the opportunity to observe how others behave and how these behaviours are accepted or rejected by the peer group, staff or others, e.g. volunteers.

The theoretical assumption that expectations and value judgments are created in relation to the perceived benefits of behaving in ways that are acceptable to the group is crucial to this study. I draw from Bandura's (1986) assertion that during this process a young adult's self-esteem and confidence are being built and they develop the ability to adopt new behaviours and ultimately create a sense of personal agency. Derived from the work of Bandura (1986) and colleagues, SCT claims that modelling forms part of the learning process. Bandura (1986) believes that participants need to practise and experience this modelled behaviour in a very positive way before they would adopt it. Individuals will only be influenced by modelled behaviour of adults if the models have exemplary characteristics. Only if participants are able to observe these good attributes of models, will they decide whether or not to adopt these behaviours. Important elements in the learning process for participants are role modelling, credibility and reinforcement of learned behaviour (Bandura, 1977).

In terms of the claims for peer education, SCT seems to be relevant in terms of credibility, empowerment, role modelling and reinforcement. Peer educators would have to have credibility with others in order to be influential. In order to act as role models, according to the tenets of the theory, peers would need to be able to observe peer role models practising healthy behaviours. Peer educators would then need the scope to practise this themselves. In order to facilitate this process, they would need positive reinforcement from their role models. The process of

applying socially learned behaviour successfully could be very inspirational and empowering for peer educators (Bandura, 1977).

Together with the empowerment aspect, peer educators should acquire a great deal of personal agency. Personal agency refers to one's capability to originate and direct actions for given purposes (Zimmerman & Cleary, 2006). This is an important aspect that will influence the way peer educators will go about their tasks effectively and efficiently. This aspect is also influenced by self-belief and how confident individuals are to perform specific tasks (Zimmerman & Cleary, 2006). It is important for peer educators to have this characteristic in order for them to perform their tasks efficiently and influence each other effectively.

The concept of agency implies a young adult who is active in making his/her own decisions and plans, and who desires to carry out these plans (Lewis, 1990). These are characteristics that are expected of well-trained peer educators. Gallagher (2000) implies that the sense of agency has an important role to play in thinking abilities, including self-awareness of individuals, about their critical thinking and mental capacity. Indeed, the ability to recognise oneself as the agent of behaviour is the way the self builds itself up as an entity independent of the external world. This is particularly true for young adults. The sense of agency and the scientific study of it have important implications in social cognition, moral reasoning, and psychopathology (Gallagher, 2000). Different levels of personal agency may occur amongst people. Some young adults think they can do big things, e.g. they set out to write a book or to make a fortune within a short period of time. There are others who may have the same ideas, set them out on paper, but never get down to performing the tasks they set out (Gallagher, 2000). This is so applicable to peer educators, since they receive the same training at a specific time, but not everyone will execute instructions or follow up on training requirements, or go out and put what they have learnt into practice. Bandura (1986) stresses the importance of personal agency in SCT. Khan (1992) believes that morality is closely linked to agency. He claims that individuals can be held responsible for their actions. In order for peer educators to be recognised, they have to achieve a high status as role models among their peers. The peer educators therefore have to have the characteristic of personal agency in order to be recognised as credible leaders amongst their peers (Bandura, 1986).

Another claim for peer education is that peer educators automatically have credibility within their peer group (HEA, 1993). However, SCT asserts that to be a credible role model, one needs to have a high status within the peer group (Bandura, 1977). It is therefore important to make

considerable attempts to attract those young adults with high status, specifically amongst their peers, to undertake peer education training. Kelly (1991), Grosberg (1993) and Wiist and Snider (1991) found some exceptions in community peer education projects. During these projects they discovered that their projects were successful, because of the participation of prominent opinion leaders within these communities in the peer education projects. The evidence suggested that these participants' status within their respective communities was a factor in the effectiveness of the projects. In the context of peer education, this means that peer educators should be trustworthy and credible opinion leaders within the target group. This is particularly important when peer educators are fulfilling their roles informally among their peers. This happens on a continual basis, where they reach their peers through everyday contact and activities. It is through this everyday contact and the passing on of information to each other that peer educators also act as role models.

The concept of role modelling seems most central to SCT. Klepp (1986:64) argues that the role of the peer educator "is to serve as a positive role model and to provide social information rather than merely providing facts ... peer leaders enhance the program's applicability by modelling appropriate behaviours". However, the theory seems to have limitations due to the requirement for observation of modelled behaviour. It is debatable whether all health behaviours are susceptible to modelling. Many advocates of peer education, such as Klepp (1986), believe that the process of peers talking among themselves and determining a course of action is a strong indication of the success of peer education projects. It is very interesting to note, particularly in the field of sexual health, that there are limited opportunities to observe modelled behaviour such as safer sexual practices. However, the health promotion literature supports claims that peers can function as effective health promotion models. Perry and Sieving (1993) conclude this from various studies conducted across the globe. They cite the above study above by Kelly (1991), which demonstrated that opinion leaders were effective in reducing HIV risk-taking behaviour amongst gay men in three American cities. These opinion leaders were more mature men, with similar sexual orientation and interests. Younger adults tend to listen and follow advice from these more mature adults. Grossberg (1993) applied this to opinion leaders in an American college programme, with very similar results. Above all, changes in behaviour are not attributed to modelling influences, but rather to the conversations that opinion leaders held with their peers. In the conclusions of the Perry, Kelly and Sieving (in a 1993 study), it remains debatable whether the opinion leaders demonstrated safer sexual practices. Before the intervention 39% of the opinion leaders were having unprotected sex, while after the

intervention this figure dropped to 24 %. This demonstrates that as many as a quarter of the role models were not practising safer sex behaviour, yet they were supposed to be role models! This is of great significance, when one takes into account Bandura's argument that to be a role model one needs to demonstrate the desired behaviour at all times (Turner & Shepherd, 1993).

Another study indicated that peer norms were a factor in the effectiveness of substance abuse prevention programmes (Hansen & Graham, 1991). However, peer norms can also be promoted without role modelling of desired behaviour. Kelly (1991) has clearly demonstrated that peers do not always "practise what they preach". McKeganey and Barnard (1992), and Klee and Reid (1995) demonstrated in the study with former drug users that some of them return to their habits of drug abuse, despite having peer educators dealing with the issues within the communities they lived in. This is further evidence that models may fail to maintain the desired health behaviours. Peers (1993), in a review on drug users, is of the opinion that modelling effects in peer education have not been clearly demonstrated.

Bandura (1991) emphasises that by using the principles of SCT, modelling can teach us behaviours, such as how to respect each other, and how to change from bad to good practices. He also believes that it can teach us judgment and morality, and develop the cognitive abilities of individuals. The development of cognitive abilities is of particular interest, because it shows that modelling can be seen in two fundamentally different yet relevant and applicable ways. On the one hand, responses to modelling are concrete where individuals mimic the behaviour very closely, as in the case of aggressive behaviour. On the other hand, individuals can transpose information they have gained from one modelled scenario and apply it in many different areas. These ideas are very important. This means that we do not necessarily have to experience something to know how to respond or to behave. It is hoped that in this study peer educators training programmes will encourage them to become role models amongst their peers. These peer educators can become role models, if socially accepted behaviour can be reinforced through these training programmes.

The way in which reinforcement operates in peer education is in the numerous opportunities peer educators may have to exercise influence or peer pressure. Young people often socialise in a group with their own peers. This can be seen as a great advantage for the reinforcement of current behaviour amongst peers. Reinforcing a message through ongoing contact is likely to be far more effective than trying to do it in a more formal way through a lesson or a once-off talk by a parent or educator. Evidence of this is once again found in Kelly's (1991) study of safer

sexual practices. The method was effective because of the frequent prompting about safe sexual practices by credible peers (Refer to 3.2.1.2). This could be perceived as external reinforcement for behaviour change. Jay (1994) also claims that regular reinforcement by peers is a factor in the effectiveness of a health promotion programme for contraceptive use. Successful reinforcement means that the peer educators have continued contact with the targeted group. However, Tudifer (1992) and Phelps (1994) say that many peer education projects have relied too much on specific input from a once-off session, which is completely inadequate. They claim that with that type of project the reinforcement effect could not be claimed. Once peer educators are confident in performing in a particular way, they will become empowered. This will lead to greater expectations of themselves to become more successful. These characteristics are referred to by Bandura (1989) as empowerment and self-efficacy.

Empowerment and self-efficacy are essential elements in SCT (Bandura, 1989). In this regard, individuals will most likely put socially learned behaviour into practice, if they think it will be effective. Therefore, it is no use providing peers merely with loads of information, if in a social and interactive situation; for example, they cannot resist taking drugs if they are in a situation where drugs are freely available or indulging in unsafe sexual practices, because they do not have access to condoms easily. The content of peer education programmes should include social skills such as assertiveness training to empower peers to cope with these various pressures (Valdeserri, 1989).

However, this concept has implications for peer education as an "empowering process" (Howard & McCabe, 1990; Bingham, 1993). Whilst some peer education programmes have demonstrated that it is possible to provide individuals with the skills to say no to peer pressures to engage in sexual activity or to participate in taking drugs, it is difficult to class such responses as evidence of empowerment (Howard & McCabe, 1990; Bingham, 1993). Jay (1984) suggests that resistance to engage in sexual practices or not to participate in drugs could rather be seen as compliance with programme goals, which inevitably was the key objective of the study, rather than empowerment of these young people. As noted, empowerment is a very difficult concept to evaluate.

It is evident that self-efficacy and empowerment are more readily applied to the claim that peer education is beneficial to those who are providing it. Peer educators who provide a service to their peers are expected to have a very high level of self-efficacy. Young adults who volunteer to become peer educators have a belief in their capacity and are self-confident that they can do

the job. Klein (1994) illustrates that volunteers normally have past experience of effectiveness in social situations and are therefore confident in carrying out the tasks at hand. This suggests that those who become peer educators already possess the necessary skills and qualities. However, other reviews (Peers, 1993; Wilton, 1995) demonstrate that peer educators generally benefit from peer education training programmes in terms of skills and personal development. There is still insufficient research evidence that the acquiring of skills and personal development can be equated to "empowerment".

Self-efficacy is not just a simple "believe in yourself and you will succeed". It also requires skills and experiences in order to achieve success (Pajares, 2002). It also assists individuals to make choices, it motivates young adults and it also assists them to deal with failures and setbacks in life (Bandura, 1994). Bandura (1994) also claims that people's self-efficacy and their actual skills or abilities do not always match or combine in productive ways. Someone might be extremely skilful or knowledgeable, but may have low self-efficacy, thus hindering their ability to become great achievers. Having varied levels of self-efficacy amongst peer educators can explain why two individuals, with similar skills and knowledge, that have undergone similar training programmes, end up displaying extremely different behaviours.

Bandura (1994) identifies four sources of self-efficacy and says that it could be developed over a period of time. Firstly, experiences in which the individual can experience success will help to build self-efficacy. However, success should not come too easily. This is very true with young adults. If they do not succeed, they cannot deal with failure! Peer educators have a harder time recovering from failure, hence they relinquish participation in a project or peer education training programme. Secondly, self-efficacy can be built by the observation of models similar to the individuals who are achieving success. The strength of the self-efficacy is more strongly influenced if the individual associates closely with the model. Applied to peer educators, this is so true. If they have a good role model whom they can identify with in the training group or project, they strive to be like that person or acquire some of the model's attributes and good qualities. Encouragement and persuasion by others are the third source of self-efficacy. While not usually totally effective on its own, persuasion, accompanied by the identification of key elements, which may enhance the likelihood of success, are more likely to improve self-efficacy. Lastly, self-efficacy is also built on the physical and mental state of a person. Peer educators who can balance academic and social life on campus normally display great personal strength, as well as a well-balanced emotional state. They persevere until they reach success in

whatever they strive to achieve. They are also committed to peer education training programmes and projects and are keen to make a difference in the lives of others as well as in their own lives (Bandura, 1994).

Bandura's (1994) theory also holds several implications. One of these is "controlling the environment". It is not always easy to control the environment, as work, school or HEIs and home environments are not always static, particularly for young people. Their mobility seems to vary considerably, as they leave home and school to enter HEIs. He stresses the importance of an "environment conducive to learning". This positive environment is important for peer educators to build self-efficacy and to gain credibility. This kind of setting will also allow individuals to grow and succeed. This environment will also adequately challenge and stimulate individuals in order for them to develop skills and gain more knowledge. It is therefore important that trainers should use a multidimensional approach to dissemination of knowledge to peer educators, thus assisting them in developing different cognitive capabilities and skills. Persons involved in peer education training should be role models in order for young people to have good examples to copy from. It is important to create an educational environment and to equip young adults with the necessary tools in order for them to take an active role in their education or role as peer educator. Bandura (1999) states that if educators/trainers succeed in developing high self-efficacy in students, they will empower students with the skills to cope with difficulties that they might encounter along their way. The following proverb from Bandura illustrates this beautifully: "You cannot prevent the bird of worry and care from flying over your head, but you can stop it from building a nest in your hair" (Bandura, 1999).

If young adults acquire a high level of self-efficacy, it will prevent them from taking risk and chances. However, a positive environment and good cognitive skills are not enough to predict how individual's lives would end up. Bandura admits that we cannot predict accurately how individuals will deal with chance encounters. However, people who have low self-efficacy are less likely to take risk and chances. These are the people who will remain stuck in their stagnant lifestyles (Bandura, 1982). Applied to peer education, we as trainers could make a difference in the lives of these young adults. Educators/trainers could assist peer educators not to be the slaves of their environment. Educators/trainers could assist these peer educators to escape from the traditional confines of elements such as poverty and gender constructs. The fact that these peer educators have access to an HEI is a major milestone that they have achieved. They should

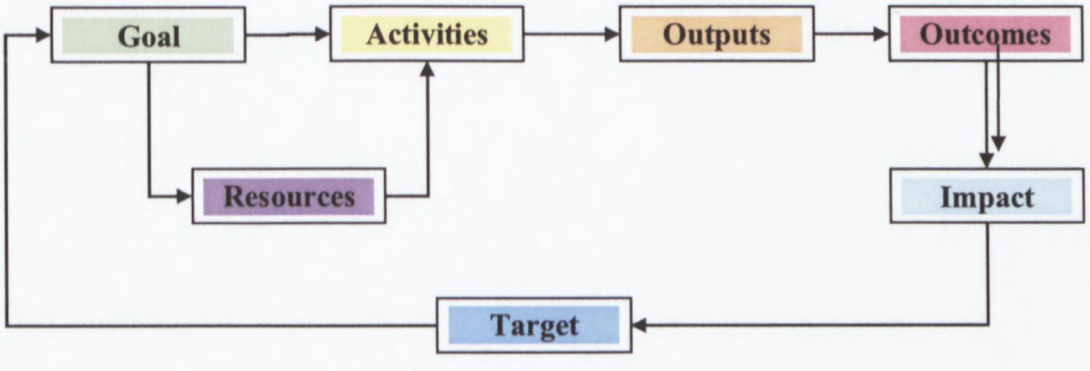
be taught to take control and responsibility of their lives. This will allow them to make the most of the chances given to them (Bandura, 1989).

Bandura emphasises that in SCT people are neither driven by inner forces nor automatically shaped and controlled by the environment (Bandura, 1986). People function as contributors to their own motivation, behaviour and development within a network of reciprocally interacting influences. For peer educators, this network may include various stakeholders, for example, administrative and academic staff at HEIs, staff in HIV/AIDS units at HEIs, parents, guardians, fellow students and peers, and the communities they come from. These societal systems provide meaningful assistance and resources that might increase opportunities for these young adults to add value to their lives and, above all, to influence the course of their lives (Bandura, 1989).

1.6 RESEARCH PARADIGM, DESIGN AND METHODOLOGY

This study will employ mixed methods as defined by Creswell and Plano Clark (2011:2) as follows: "those methods that include at least one quantitative (designed to collect numbers) and one qualitative method (designed to collect words), where neither type of method is inherently linked to any particular inquiry paradigm". A descriptive design will be employed. The Logic Model will be applied as a framework to assist me with the design of the project. The Logic Model is a flow diagram or picture of how a programme or project works according to the underlying theory and assumptions. Similar to a flowchart, it lays out programme activities and outcomes using boxes and, using arrows to connect the boxes, shows how the activities and outcomes connect with one another as indicated below (Refer to Figure 1.3) (Patton, 1997).

Figure 1.3: Steps of the Logic Model (Patton, 1997)



1.7 METHODS OF DATA COLLECTION

Evaluation is a systematic assessment and therefore should follow a systematically and mutually agreed on plan (Blom, 2008). Bertrand and Solis (2008) describe evaluation research as "the systematic application of quantitative and qualitative research techniques to determine the appropriateness and effectiveness of the design and implementation of social programmes". Evaluation research may be performed at programme or population level. This research study is aimed at programme level. Bertram and Solis (2008) define programme evaluation as the collection of information about a programme or a certain aspect of the programme in order to make decisions about the programme. They identify three main types of evaluation research, classified according to the questions the evaluation study needs to answer. Bertrand and Solis (2008) and Blom (2008) describe the main processes as process evaluation, results (outcomes) evaluation and impact assessment (measuring cause and effect).

Results-based evaluation thus assesses the effectiveness of the programme for producing the desired changes in behaviour, knowledge and attitudes of the target group – in this study the peer educators. The fundamental assumption, according to Babbie and Mouton (2001), is that the outcomes observed can be directly attributed to the programme.

I made use of questionnaires to collect my quantitative data. In order to collect the qualitative data, as I am using a mixed method approach. I will utilise the following methods of data collection:

- Peer educators' portfolios;
- Selected documentation of the Unit;
- Observation;
- Focus group interviews with the peer educators;
- Focus group interviews with other students in residences who attended group discussions with these peer educators;
- Personal interviews with all staff members of the Unit;
- The two visiting International students to the Unit preferred to be interviewed together.

1.7.1 Questionnaires

"A questionnaire is a totally structured instrument" (Polit, Beck & Hungler, 2001).

Respondents are all requested to respond to the same set of questions in exactly the same order. The same set of options is assigned to all the responses. Questionnaires are less costly and require less time and effort to administer. Questionnaires also offer the possibility of complete anonymity, which may be crucial if more sensitive information is being collected. For this research purpose, issues on sexuality and HIV and AIDS could be very sensitive for young people (Polit *et al.,* 2001). In the light of this sensitivity around sexuality and HIV/AIDS, I made arrangements with both the Student Counselling departments on this HEI should referral have become necessary (Refer to Appendix 16).

Participants were the peer educators at a selected HEI. A questionnaire which focused on assessing participants' knowledge and attitudes on sexuality issues, e.g. dating, relationships, STI's, HIV/AIDS and at risk behaviour, was designed for completion by the research participants. The questionnaire that was used was adapted for this research from the CDC's Youth Risk Behaviour survey (YRBS) that had been implemented nationally in secondary schools in Texas. The revised university version is known as the YRBS-C and consist of 84 dichotomous (yes-no) and multiple-choice items. The survey would also ask for demographic data and personal behaviours in the areas of alcohol and other drug use, violence, sexuality, nutrition and exercise (CDC's Youth Risk Behaviour Survey (YRBS-C) 2011). The analysis of questionnaire data served to refine the interview guide which framed the semi-structured focus group interviews.

1.7.2 Focus group interviews with peer educators and students interacting with peer educators

De Vos, Strydom, Fouche and Delport (2005) explain that focus groups are meaningful when trying to take a new topic to a population and if one want to explore thoughts and feelings and not just behaviour. Personal interviews were conducted with the staff of the HIV/AIDS unit of the HEI and focus group interviews were conducted with the peer educators involved in all training programmes as well as students who attended group discussions facilitated by these peer educators. The peer educators and other students therefore will have the opportunity to reflect on their own attitudes towards sexuality and HIV/AIDS. It will also allow participants to develop skills, e.g. communication, counselling and other life skills by active participation. The

group dynamics came to a fore as participants shared and compared perceptions, positions, experiences, desires and concerns. Focus group interviews also allowed for a deeper exploration and understanding of the objectives as listed in 1.4.2. This implies that interviews would be framed around particular areas of interest, but will allow for flexibility in scope and depth. Data obtained will be comprehensive and comparable. The interview schedule will be finalised once the analysis of the questionnaires has been completed. The focus groups were recorded and fully transcribed, after which content analysis would be employed to interpret the data.

I did focus group interviews with all the peer educators (students) in the various training groups. The size of the group ranged between 5 and 10 participants. Focus group interviews were also held with students who have participated in the peer educators' programmes. This was done to determine how they experienced the training groups that were facilitated by the peer educators.

1.7.3 Personal interviews with staff of the HIV/AIDS Unit

Personal interviews (one-on-one) will be conducted with all the staff of the HIV/AIDS unit. This will allow me to obtain more information and deeper insight in the operations of the unit as a whole. However, the two visiting international students indicated that they would like to be interviewed together.

1.7.4 Portfolios of peer educators

Spaulding and Straut (2006:69) describe portfolios as a cornerstone in education. Wiggens (1998) agrees with them as he felt that portfolios played a major role in teacher training colleges, where portfolios were examined to assess the effects on students' learning.

Peer educators are encouraged to compile portfolios throughout the year of all the activities that they participate in. These portfolios are assessed as part of my data collection. These portfolios will also contribute to the final assessment of the peer educators' performance throughout the year, as they have to provide evidence of their interaction and events that they participated in. All of them come into contention for awards in the different categories at their annual award ceremony. During 2010, 2011 AND 2012, I was one of three assessors of these portfolios. This will be discussed further in the analyses (Refer to 4.2).

1.7.5 Observation of the HIV/AIDS Unit activities

Sapsford and Jupp (2006:57) describe all human beings as observers in everyday life. Data collection by means of observation could be described as a main research tool or as a preliminary method or supplement to other methods. Observational research also distinguishes between more formal or structured methods, whereby the researcher has a specific agenda regarding what he/she wants to observe. This is particularly useful when a researcher wants to test a hypothesis or correlate different variables (Sapsford & Jupp, 2006:57).

For this study, I have chosen a less structured or qualitative method for the observation. This will allow me to observe peer educators and staff activities in a much more holistic and natural manner (Sapsford & Jupp, 2006:57). Further discussion will be found in Chapter 4 (Refer to 4.3).

1.7.6 Document review

Henning (2011:98-99) states that the collection of documents and other artefacts that might be important in a research project is often neglected in qualitative research. These include any handwritten, computerised or in printed documents. Documents may be hard copies or electronic and may include reports, performance ratings, funding proposals, minutes of meetings, newsletters and marketing materials (Evaluations Briefs: CDC, 2009). Various documents of the HIV/AIDS Unit will be reviewed:

- Evaluations of training programmes, workshops, any other event, done by peer educators;
- Reports;
- Photographs;
- Minutes of meeting;
- Strategic Plan of the peer educators.

1.7.7 Population sample

The study population was different groups of peer educators from three different satellite campuses as well as the trainers on the particular campuses and all other staff of the HIV/AIDS unit. This HEI consist of various satellite campuses. Although the study was designed to incorporate a quantitative aspect, it is largely a qualitative study which encompassed an in-depth

critical analysis of various forms of data in order to construct a rich and meaningful picture of sexuality, STIs and HIV/AIDS peer education training programmes at the HEI. The study was designed to explore various dimensions of the aim as mentioned in 1.3.1. In so doing, this study intends to highlight the issues in all their complexity, as Leedy and Omrod (2005) argue that qualitative research does.

1.7.8 Data Analysis

De Vos *et al.* (2005) explain that analysis transforms data into findings; it is a process that involves reducing the volume of raw information, ordering and structuring a mass of data, identifying significant patterns and thereby constructing a framework for communicating the essence of what the data reveal. Focus groups were transcribed and analysed in content analysis. Group interviews were recorded, with all participants' written permission, and thereafter grouped into themes and then analysed and transcribed as required in the implementation of qualitative methods. Coding was done by an independent coder.

Quantitative data was analysed with the help of an SPSS data analysis computer programme. Statistical procedures therefore were applied in the analysis of the questionnaires. Appropriate statistical analysis was performed on frequencies or percentages obtained to determine significant findings that were relevant to the research aims. Data analysis is discussed in broader detail in Chapter 4.

1.8 ETHICAL CONSIDERATIONS

Ethical guidelines in research are needed to guard against the possible harmful effects of research (Mertens, 1998). I undertake to ensure that the anticipated ethical guidelines will be followed throughout the study. Ethical principles should be upheld throughout the research process in order to enhance the credibility and trustworthiness of data and to demonstrate the researcher's integrity.

> The interactive nature of qualitative research raises ethical questions that non-qualitative researchers ask less frequently. Informed consent either curbs the abuse of research findings or creates a balanced relationship between the researcher and informants. Though, it does contribute to empowering the researched (Glesne *et al.*, 1992:109–111).

The right to self-determination and confidentiality could be viewed as synonymous with the preservation of privacy (De Vos *et al.*, 2004:67). This is regarded as a very serious aspect of this

research, since personal interaction with students and staff is vital. The participants within the field of study, the research design and methodology raised their own unique ethical issues.

It will be important to protect and safeguard every individual's privacy. It is every individual's right to decide when, where, to whom and to what extent his or her attitudes, beliefs and behaviour will be revealed. Therefore it is imperative that all researchers are adequately skilled to undertake the proposed investigations. All researchers are ethically obliged to ensure this. Ethical guidelines should be honoured at all times.

Similar ethical principles apply in both traditional and action research approaches. These include respect for research participants, prevention of harm, assurances of confidentiality and/or anonymity and maintenance of privacy. However, these principles may have differing implications for each approach.

Permission to conduct the research was sought from Stellenbosch University, where I am a registered student, as well as the HEI where the research will be conducted (Refer to Appendix 1). Confidentiality will at all times be maintained. Transcriptions will be locked in a safe for at least five years. Access to any documentation will be controlled by me as the researcher in this project. The ethical concerns for this study will be elaborated on further in Chapter 4.

1.9 VALIDITY AND RELIABILITY

Validity and reliability in the field of social science research are very contentious issues. This is particularly true for mixed methods research. There is also a close relationship between these two concepts. These two concepts are usually complementary, but they can also be conflicting because, although a measure may be reliable, there is no guarantee that what it measures will be valid (Neuman, 2003:186). The questionnaire used was a modified version based on the Youth and Risk questionnaire, which has been implemented nationally in secondary schools in Texas and revised for universities. Validity and reliability has been repeatedly validated (CDC's Youth Risk Behaviour Survey, 2011) (YRBS-Y).

1.10 CHAPTER DIVISION

1.10.1 Chapter 2: Literature review

Relevant literature from the Internet, training manuals, conference reports and curricula, journals, research reports and programme reports were reviewed. An extensive literature review was done on the influences and challenges of the peer education training programmes with regard to HIV/AIDS, STI's and TB in HEIs. HEAIDS material, policy documentation and the various methods of peer education evaluation methods will be reviewed.

1.10.2 Chapter 3: Design and methodology

In this chapter the various methods of data collection was discussed and an explanation was given of the research design, i.e. evaluation research and design and mixed methods. In addition, this chapter will present the methodology of how questionnaires and focus groups were used. The Logic Model was used as a framework, to guide the development of the project.

1.10.3 Chapter 4: Data presentation/analysis

Quantitative data was analysed, using the latest version of SPSS. Qualitative data was analysed and interpreted using thematic analysis. Other issues such as ethical principles and validity were addressed. An independent coder was utilised to assist with the coding of the qualitative data and the development of themes. The researcher was very mindful of "bracketing" and "intuition" when the data was analysed (Polit & Hungler, 1996:328).

Data was analysed and presented in appropriate formats.

1.10.4 Chapter 5: Conclusions and recommendations

In this chapter the researcher summarised her findings and made appropriate suggestions and recommendations for the dissemination of results.

1.11 SUMMARY

In Chapter 1 I attempted to introduce the research project. I gave some background to the HIV/AIDS epidemic, globally, nationally and provincially, and will elaborate further on these issues in my literature review. The research aims to evaluate and establish the influence of a peer education programme amongst students at a selected HEI in the Western Cape. The

purpose would be to identify the various best practices and challenges faced by these peer education training programmes at an HEI in the Western Cape.

The following objectives would be explored.

- The first objective of this research project is to establish how this HIV/AIDS Unit was established and how its operations are linked to its mission and vision statement.
- The second objective of this research is to evaluate the effectiveness and influence of the peer education and related training programmes in the HIV/AIDS unit, with specific reference to experiences of the peer educators and how this would influence them.
- The third objective is to evaluate the experiences and challenges of all the staff involved in the training programmes. This will include all the staff, administrative staff in the HIV/AIDS Unit as well as everyone else who plays a role in the execution of these training programmes.

The fourth objective will evaluate the experiences of students who have attended a training session facilitated by the peer educators. It will attempt to establish how these students experienced these training sessions.

Bandura's SCT was explained as the theoretical framework for this study.

Furthermore, this chapter describes the division of the various chapters. Chapter 2 gave a brief overview of the Literature review of relevant materials from the Internet, training manuals, conference reports and curricula, journals, research reports and programme reports that was consulted to support the research project.

In Chapter 3 the Design and methodology was discussed. The various methods of data collection were discussed and an explanation was given of the research design.

Chapter 4 covered the data presentation, analysis and discussion. Quantitative data was analysed, using the latest version of SPSS. Qualitative data was analysed and interpreted using thematic analysis. Other issues such as ethical principles and validity were addressed. An independent coder was utilised to assist with the coding of the qualitative data and the development of themes. Data was analysed and presented in appropriate formats.

Chapter 5 presented the conclusions and recommendations. In this chapter all the findings were summarised and appropriate suggestions and recommendations for the dissemination of results were made.

The following chapter will present the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

As the fastest-growing region in the world, Sub-Saharan Africa is confronting many of the greatest global health and development challenges. With a population of more than 840 million, and growing at the rate of 2.4% per year, Sub-Saharan Africa will double in size in just 30 years (HIV and AIDS and STI National Strategic Plan (NSP) 2012-2016). Half the population in African countries is younger than 18. It is widely accepted that the future of Sub-Saharan Africa rests to a great extent on the investments made in the education, health and employment opportunities of its youth and on how successfully its youth transition to a healthy and productive adulthood.

Youth is defined by the United Nations as referring to young people between the ages of 15 and 24 years (UNAIDS, 2012). This age is a time of transition from childhood to adulthood, a time of increased responsibility and independence, as well as of increased health risks. During this period youths of both genders generally complete or leave school and become sexually active; many girls marry and begin childbearing. As youths make these transitions, national investments in Achieving the Millennium Development Goals (MDGs) can help to ensure that they are able to maximise their potential for healthy, productive lives that contribute to alleviating the high levels of poverty that impede development. This is the age group that higher education institutions (HEIs) particularly deal with as students enter an HEI for the first time. Reaching the MDGs depends to a great extent on improving the health, education and economic and social well-being of young people.

This literature review will attempt to explore the importance and the role of peer education programmes in the context of HIV/AIDS and STIs at HEIs across Sub-Saharan Africa.

2.1.1 Achieving the Millennium Development Goals (MDGs)

The MDGs were endorsed by 189 countries at the September 2000 United Nations Millennium General Assembly in New York (The World Bank, 2002). Each goal has specific targets and indicators to be achieved by 2015, many of which relate to the youth. With just five years

remaining in this 20-year plan, far greater attention to the educational and health needs of the world's giant generation of youth is needed, especially in Sub-Saharan Africa, which is facing some of the highest hurdles in meeting the MDGs.

Although youths around the world share many similarities, the experience of being a young woman or man is as diverse as the cultures from which young people come. In the West African country of Mali a young woman is very likely to have experienced female genital cutting by the age of 5. She may never attend school. She is likely to be married and have a child by age 16 and to believe that her husband is justified in beating her for certain "transgressions." In southern Africa a young Zambian woman is more likely to have gone to school, but has few job opportunities and is among the world's highest at-risk people of becoming infected with HIV. By contrast, a young woman in the East African country of Rwanda is the most likely of the three girls to be educated and the least likely to be sexually active, married or have a child. She may have a boyfriend, but she is less likely to have a pregnancy during adolescence than is a girl in the United States. She is only one tenth as likely to be HIV positive as a girl in Zambia. These three young women have very different experiences, but they share common dreams and ambitions about health, family and work. With government investments in health, education and job opportunities, and political commitments to the aspirations of the Millennium Development Goals, these young women – a part of the more than 1.2 billion young people around the world – have a chance to realise their personal goals and help their nations achieve higher levels of economic and social development (www.prb.org).

These efforts will spur on progress on the many MDG outcomes that directly or indirectly impacts on these developments. The MDGs call on all countries to achieve universal primary education and for girls and boys to have equal school enrolment at all levels by 2015. Nothing is more critical for the youth of Sub-Saharan Africa than an education that prepares them for a healthy life and the ability to support themselves and their families. The relationship between a mother's education and the timing of her marriage and first birth is well established, as is the relationship between a mother's education and the health of her children. Keeping girls in school delays marriage and the start of childbearing, and reduces health risks associated with pregnancy at a young age for young mothers and their offspring. With growing evidence of these relationships has come greater attention to investing in girls as part of a comprehensive development strategy (www.prb.org).

Halting and reversing the spread of HIV/AIDS is the primary aim of MDG 6. In Sub-Saharan Africa, where two-thirds of the 33 million people living with HIV reside, the AIDS epidemic has altered virtually every aspect of life: Nearly three-quarters of all deaths due to HIV in 2008 occurred in Sub-Saharan Africa. Throughout the region, 60% of all those infected are women, and new HIV infections are occurring most frequently among youths, especially young women.

Youths in Sub-Saharan Africa, especially women, face the greatest risk of HIV infection through cross-generational sex between an unmarried adolescent girl and a man 10 or more years older, which is not unusual in the region.

DHS surveys showed that as many as 20% of 15- to 19-year-old girls in Uganda and 25% in Nigeria had such an older partner in the last year. These relationships are often driven by economic need and they expose young women to grave health risks, including HIV. The countries profiled in this chart book include some of those most deeply affected by HIV, such as Malawi, Mozambique and Zambia, as well as countries where HIV prevalence among the population ages 15 to 49 remains below 1%, including Madagascar and Senegal. HIV prevalence among the population ages 15 to 24 is an indicator used to track progress on MDG 6. Figure 11 shows the midpoint of the estimated prevalence among young women and young men across the region. Across the region young women are generally three times as likely as men of the same age to be infected with HIV (3.2% vs. 1.1%). This ratio is fairly consistent regardless of HIV prevalence within the country. In the five countries profiled with the highest prevalence (Uganda, Kenya, Mozambique, Malawi and Zambia), more than 2% of all youths are HIV positive. These five countries are located in East Africa – one of the two regions, along with Southern Africa, that has been hardest hit by the epidemic.

UNAIDS reported in 2009 that the epidemic is stabilising in most countries in the region, although at a high level of infection. Zambia and Tanzania are among the few countries where a drop in incidence has been reported in the last several years. Ringheim and Gribble (2010:45) say that "using condoms is critical in reducing the epidemic amongst youth". Safer sex practices are important, particularly in youths who engage with multiple partners.

2.2 HIV AND AIDS AND STI STRATEGIC PLAN FOR SOUTH AFRICA, 2012-2016 (NSP)

The HIV and AIDS and STI strategic plan for South Africa 2012-2016 (NSP) was developed based on the findings of the National Strategic Plan of 2000-2005 and 2007 to 2011, as well as the Operational Plan for Comprehensive HIV and AIDS Care Management and Treatment. This document is representative of the country's multisectoral response to the challenge of HIV infection and the wide-ranging impacts of AIDS. The primary aims of the NSP are as follows:

- To be led by a long-term focus and vision. All initiatives should be clearly linkable to the vision of the NSP;
- To be innovative, without diminishing the importance of evidence-based initiatives. Innovative ways should be sought to face new challenges;
- Monitoring and protecting of human rights would be a top priority in this plan, as it was seriously lacking in the NSP2005-2007 (NSP2012-2016).

Priority Area 1: Prevention

The target was to reduce national HIV incidence by 50% by 2011. This did not happen as yet, hence the revised plan. Particular emphasis is laid on the training of all educators in life skills and HIV/AIDS. However, the emphasis was on primary and secondary school teachers (NSP2012-2016).

Priority area 2: Treatment, care and mitigation

The target was to provide access to 80% of HIV-positive people to treatment, care and support by 2011 in order to reduce morbidity and mortality as well as other impacts of HIV/AIDS (NSP2012-2016).

Priority 3: Research, monitoring and surveillance

The goal here is to implement the monitoring and evaluation framework of the NSP. Regular surveillance has to be conducted, as well as policy and operational research (NSP2012-2016).

Priority 4: Human and legal rights

HIV/AIDS is a human rights issue. A major objective of the NSP is to create a social environment that encourages many more people to test voluntary for HIV and to seek medical attention and support. This objective has to be aligned with the progressive Constitution of South Africa (NSP2012-2016).

The NSP 2012-2016 builds on the successes of the previous NSP of 2007-2011. However, it also aims to address and improve of some of the challenges faced with the previous NSP in the successful implementation of this NSP (National Strategic Plan for HIV and AIDS, STI's and TB, 2012-2016).

Another important stakeholder in combating HIV/AIDS is the South African National Council on HIV/AIDS (SANAC).

2.3 THE SOUTH AFRICAN NATIONAL COUNCIL ON HIV/AIDS (SANAC)

The Inter-Ministerial Committee (IMC) on AIDS was the first high-level political body that was established to oversee the national response to HIV/AIDS. This IMC was established in 1997. The main objectives of the IMC were to provide leadership, political oversight and guidance to the HIV/AIDS programme. The HIV/AIDS epidemic presents all South Africans with huge challenges. Too many people are infected and get infected on a daily basis. SANAC realised that if the impact of HIV/AIDS is to be mitigated, different role-players and stakeholders will have to combine their efforts to combat the epidemic. SANAC was established to fulfil the role of collaboration and to ensure the implementation of the NSP. The objectives of SANAC are as follows:

- To advise the government on HIV/AIDS and STIs;
- To create and strengthen partnerships for an expanded national response to HIV and AIDS in South Africa;
- To receive and disseminate reports on all sectoral interventions to HIV/AIDS in South Africa;
- To oversee all monitoring and evaluation of all aspects of the NSP (2011-2016).

One of the very important partners that SADEC had to link with is South African higher education.

2.4 THE NATIONAL PLAN ON HIGHER EDUCATION

In March 2001 the then Minister of Education, Professor Kader Asmal, announced the National Plan on Higher Education (HE), which was set to change the HE landscape. A National Working Group (NWG) on HE was tasked to make recommendations to the Minister on the future of higher education. Each institution had to make submissions to the NWG on their programmes, qualification mix and niche areas. At educational institutions all educators were to attempt to bring about behavioural changes in students. Educators should also be updated and informed with regard to students' backgrounds and cultural belief systems in order to have a better understanding of students' behaviour. The fundamental principle is that HIV and AIDS should be treated in all relevant respects like any other life-threatening conditions. However, HIV/AIDS is still surrounded with ignorance, prejudice and stigma. In view of this, students, employees, their families and communities should be assisting in limiting HIV transmission by embarking on responsible education programmes (Chetty, 2000:56). Although the above statement was made a few years ago, it seems as if little progress has been made since then. In this regard Ramphela (2005:8) has stated:

> Education and training programmes for all public officials are of key importance, and public education programmes, including school-based ones, should be vigorously promoted too. Men need to be educated about the difference between manhood and male dominance. Real men do not need to violate the rights of women and children to assert their manhood. Women need to be part of the teaching and learning of husbands, sons, brothers and significant others about gender relationships in a human rights culture. It is only when a critical mass of citizens is confident enough to demand their rights that culture will flourish. In such a flourishing human rights culture, accountability of public officials will be better enforced. Comparatively, the Republic of South Africa is quite a large country, covering 1,221,042 square kilometres, and the population is estimated at around 40 million.

At the HIV/AIDS conference hosted by HEAIDS (2010), Dr Blade Nzimandi, Minister of Higher Education and Training, in his opening address acknowledged the HEAIDS secretariat for all their efforts and initiatives in trying to combat the spread of HIV/AIDS at HEIs. He was heartened by the fact that HEAIDS were initiating strong programmes on HEIs and that this was supported by many international partners and our own universities. He mentioned that the HIV/AIDS pandemic is the greatest public health crisis that the world is facing today. Despite the sustained efforts directed at containing the disease, the rate of infection continues to grow in

many parts of the world, especially in the developing countries. This growth has potentially damaging consequences for households, communities, businesses and national economies.

The United Nations Programme on AIDS (UNAIDS) 2010 Report estimates that in 2008 there were 33.4 million people living with HIV worldwide. This is more than 20% t higher than in 2000, and roughly three times higher than in 1990. In the same year (2008) about 2.7 million people became infected and approximately two million died of AIDS-related illnesses, the report states.

Sub-Saharan Africa bears the brunt of this and it remains a challenge that we cannot ignore. According to the UNAIDS Report, it was estimated that of the 2.7 million global infections in 2008, 1.9 million or 70% occurred in Sub-Saharan Africa. In the same year the region accounted for 68% of new HIV infections among adults and 91% of new HIV infections among children. The region also accounted for 72% of the world's AIDS-related deaths in 2008.

The consequences of this is that the natural age distribution in many national populations in Sub-Saharan Africa has been dramatically skewed because of HIV, with potentially perilous consequences for the transfer of knowledge and values from one generation to the next.

Minister Nzimande (HEAIDS Conference proceedings, 2010) posed the following key questions to the HE sector:

> The greatest conundrum facing us is that people are dying younger, poverty is growing and we are in the midst of a slowing economy. How does higher education respond to this? What is the leadership role that our institutions must play and how do we contribute to this war against HIV and AIDS?

Within Sub-Saharan Africa, Southern Africa, with 35% of the overall global HIV infections, remains the area most heavily affected by the pandemic. The nine countries with the highest HIV prevalence worldwide are all located in the Sub-Saharan region. In this context South Africa is reported to be a home to the world's largest population of people living with HIV, about 5.7 million people, according to the 2011 UNAIDS Report.

However, the country has one of the largest antiretroviral programmes in the world. Substantial public health benefits ensue from this improved access to treatment. In many parts of the country mortality among patients is reported to have declined significantly as a result of these ART provisions (Nzimande, 2010).

A 2008 survey by the Human Sciences Research Council (HSRC) on HIV prevalence in South Africa shows that the prevalence of the virus in the total population of South Africa has stabilised at a level of about 11%. By way of comparison, the HEAIDS zero-prevalence study shows a prevalence of almost 10% among service staff (9.9%), 4.4% among administrative staff, 1.5% among academic staff and 3.4% among students in the higher education sector.

The decline in the infection rate in South Africa's total population and the drop in infection rate at HEIs seems to be a positive indication of the stabilisation of the disease (HSRC, 2008; HEAIDS, 2010). However, HIV/AIDS remains a major threat. It is of concern that the rate of infection is higher among women, Africans and service staff at the institutions. The HEAIDS study (2010) clearly shows that no institution can afford to relax its efforts to prevent the spread of HIV and to offer care, support and treatment to students and staff living with HIV. In some instances our efforts need to be intensified. HIV prevalence among students and staff varies quite considerably from region to region and university to university. Table 2.1 illustrates HIV activities at the four universities in the Western Cape.

Table 2.1: Summary of the 4 Universities' HIV/AIDS Units Based in the Western Cape (HESA study, 2011)

	A	B	C	D
Name of the Unit	**HIV/AIDS Unit With logo to be approved**	**HIV/AIDS Institutional Co-ordinating Unit (HAICU) with approved Logo**	**HIV/AIDS Programmes With approved logo**	**HIV/AIDS Office With approved logo**
Student Enrolment	34, 000	20,000	17,000	24,000
Rank	Head of Department (HOD)[1]	Director	Director[1] (Promoted to Prof)	Manager[1]
Highest Qualification	PhD (Public Health)	MSc (Counselling)	PhD (Psychology)	MSc (Counselling)
Line Manager	Executive Dean of Student Affairs	DVC (with HIV/AIDS Portfolio)	VC	DVC (Staff/Community Interventions)
Salary/Job Scale	7	5	5	5
Staff Component	Administrative Assistant[1]	Administrative Assistant	Administrative Assistant[1]	Administrative Assistant[1]

	A	B	C	D
Name of the Unit	**HIV/AIDS Unit With logo to be approved**	**HIV/AIDS Institutional Co-ordinating Unit (HAICU) with approved Logo**	**HIV/AIDS Programmes With approved logo**	**HIV/AIDS Office With approved logo**
	Registered Nurse[2]	Project Manager	Project Manager[2]	Co-ordinator Curriculum and Training[1]
	Projects Officer[3]	Project Officer (Peer Education)	Project Co-ordinator[3]	Co-ordinator Prevention[1]
	Peer Education Officer (CT Campus)[3]	Project Officer (Information/ Education)	Project Co-ordinator[4]	
	Admin/Driver[1]	Project Officer (Communication)	Senior Lecturer (Curriculum)[5]	
	Health Promoter (CT Campus)[4]	**Note:** All of the above posts have been institutionalised and are permanent	Health Promoter[6] Health Promoter[3]	
	Health Promoter (Blvl Campus)[4]		**1** Permanent	**1** Permanent
	2 Admin Interns (6 months basis)[5]		**2** Seconded Post	
	International HIV/AIDS Programme Intern[6]		**3** USAID Funded	
	1 Permanent		**4** Health wise Funded	
	2 From Agency		**5** Dual Post with Education Faculty	
	3 Engender Health Previously		**6** Dram Aide Funded	
	4 Dram Aide Funded		**Other Funding Source:** PEPFAR	
	5 CPUT Funded		UNAIDS and Health wise	
	6 CIDA Funded and Germany			
	EU Funded Staff Contracts will have to be institutionalised According to Signed			

	A	B	C	D
Name of the Unit	**HIV/AIDS Unit With logo to be approved**	**HIV/AIDS Institutional Co-ordinating Unit (HAICU) with approved Logo**	**HIV/AIDS Programmes With approved logo**	**HIV/AIDS Office With approved logo**
	Agreement in the EU/HEAIDS Grant Funding Proposal. Awaiting 3rd Phase of EU/HEAIDS Grant			

Table 2.2: Summary of the 4 Universities' HIV/AIDS Units Based in the Western Cape

	A	B	C	D
Name of the Unit	**HIV/AIDS Unit**	**HIV/AIDS Institutional Co-ordinating Unit (HAICU)**	**HIV/AIDS Programmes**	**HIV/AIDS Office**
Research Supervision	Yes 3 D Tech students 2 M Tech Students 3 Masters student already graduated	No	Yes 2 Masters Students	No All postgraduate studies done at African Centre of AIDS Management
Depart-mental Research	Yes	Yes Limited research	Yes	Yes: Limited research started only this year (2011)
Research Outputs (Refer to Research Outputs Document)	• Presented at local, national and international conferences • Published research in national and international journals • Published TB Screening Instrument was incorporated in National TB Policy for persons with advanced HIV • Research data from publication to be used in meta analysis study by WHO/CDC	• Presented at local, national and international conferences	• Presented at local, national and international conferences	None

	A	B	C	D
Name of the Unit	**HIV/AIDS Unit**	**HIV/AIDS Institutional Co-ordinating Unit (HAICU)**	**HIV/AIDS Programmes**	**HIV/AIDS Office**
	• 1 MA supervised graduated • 1 M Tech supervised graduated • 2 B Tech supervised graduated			
Other Programmes	• Curriculum Integration • Peer Education Programme • VCT Campus Drive/Routine VCT • Care and support • Community Outreach • Awareness • Workplace Programme • Wellness Mobile	• Curriculum Integration • Peer Education Programme • VCT Campus Drive/Routine VCT • Care and support • Community Outreach • Awareness • Wellness Mobile operated independently from HAICU	• Curriculum Integration • Peer Education Programme • VCT Campus Drive/Routine VCT • Care and support • Community Outreach • Awareness • NO Wellness Mobile	• Curriculum Integration • VCT Campus Drive/Routine VCT • Community Outreach • Awareness • NO Wellness Mobile

Among students there is almost a six-fold difference between the lowest and highest regions. This is a strong indication of how the infection rates differ from region to region and university to university.

Tables 2.3 and 2.4 highlight the HIV prevalence rate among universities in the Western Cape (HESA Study, 2011). The HEI where my study takes place is located in this province. The prevalence rate is classified according to gender in Table 2.3 and age in Table 2.4.

Table 2.3: HIV prevalence rate by gender

	University A	University B	University C	University D	National
Male	0.3%	0.7%	0.1%	2.8%	2.0%
Female	3.0%	0.0%	0.2%	2.3%	4.7%
Total	1.7%	0.3%	0.2%	2.5%	3.4%

Table 2.4: HIV prevalence rate by age group

Age Group	N	HIV Positive
18-24 year olds	816	1.7%
25-34 year olds	85	2.6%

The average HIV prevalence among service workers is 9.9%, rising to 20% in KwaZulu-Natal. One of the clearest implications of the survey is the need to strengthen workplace HIV/ AIDS programmes at institutions. Behaviour that puts students at risk of HIV infection is quite common and it occurs at all institutions. HIV prevalence among students increases sharply with age as they progress from their late teens to early 20s and even more so after the 25-year mark. Nzimande (2010) reminded HEIs that they have an obligation, as a sector, to act on these results and to be proactive in their messages on HIV and AIDS, the way in which HIV/ AIDS is dealt with in the curriculum, the comprehensiveness of our HIV services and the structuring of workplace programmes in particular (Nzimande, 2010).

What also emerged from the HEAIDS study (2010) is that class and gender once again surface as points of vulnerability. What was more disturbing is that these disparities are even prevalent in our higher education sector. There are some examples in the sector of the good practice of infusing HIV/AIDS into our academic programmes. Nzimande (HEAIDS Conference, 2010) encouraged academics to take the opportunity to share these experiences and best practices.

One of the many concerns is that HIV/AIDS stigma and discrimination towards those affected by the disease are still high and lead to environments of fear, distrust and pervasive discrimination. Another concern relates to the persistence of attitudes that perpetuate gender inequalities. Perceptions of risk amongst women on HEI campuses are too high and the study points to concerns about sexual harassment. Nzimande (HEAIDS Conference, 2010) urged all

academics and Vice-Chancellors to adopt zero tolerance of these issues and work actively towards their elimination.

2.5 INSTITUTIONAL RESPONSES TO HIV/AIDS FROM HEIs IN THE SOUTHERN AFRICAN DEVELOPMENT COMMUNITY (SADEC)

HEIs in SADEC occupy a unique position to engage in debates and action, and to develop policy on HIV/AIDS, particularly in view of the fact that there is currently no cure for HIV/AIDS. Education therefore is regarded as the best "cure" as a social response to the epidemic. It is important that every tertiary institution address the issue of an institutionalised response to the HIV/AIDS pandemic (Van Wyk & Pieterse, 2006). Van Wyk and Pieterse (2006) argue that the answer to this question is "potentially in the recognition that the history, the nature and shape of the epidemic reveals itself as an intellectual challenge". An effective institutional response thus requires the entire institution to recognise both the threat of HIV/AIDS and the possibilities for a transformed institution and society. All HEIs need to respond holistically to this epidemic. It is clear that this should be one of HEIs' core functions in addition to teaching, learning, community engagement and research. Part of this core function is to develop institutional HIV/AIDS policies, workplace and peer education programmes, HIV Counselling and Testing services (HCT). The integration of HIV/AIDS issues into curricula is very important together with other research endeavours around HIV/AIDS. The HIV/AIDS pandemic is making serious inroads into the education and training sector in the region. HIV/AIDS negatively affects the supply of skilled personnel providing educational services, as there are significant losses in teacher numbers because of HIV/AIDS. Vice-Chancellors occupy positions of responsibility. They should take the initiative in bringing about changes in implementing HIV/AIDS activities on their respective campuses. It is obvious that the SADEC region is enveloped in a full HIV/AIDS epidemic. HIV prevalence rates in this region remain the most advanced in the world. Botswana's and Swaziland's prevalence rate is above 35%. Lesotho, Namibia and South Africa are above 20%, while Mozambique, Malawi and Zambia have a prevalence rate of 10%. Angola, the Democratic Republic of Congo (DRC) and Madagascar have a prevalence rate of 5%. Looking at some countries mentioned above, it is clear that not every country in the SADEC region perceives HIV/AIDS as a serious problem (Report on the Global AIDS Epidemic, UNAIDS, 2011). The major challenge facing HEIs in SADEC is clear. All HEIs should embark on a coherent, coordinated response to HIV/AIDS. It is acknowledged, that some HEIs in this region have formulated admirable HIV/AIDS policies,

have engaged in research, and that innovation and support structures were put into place on their campuses; others have yet to embark on some of these initiatives. In order for HEIs to achieve this, excellent leadership from Vice-Chancellors and all involved in HEIs is absolutely vital (Saint, 2004:5-7).

Table 2.5: Summary of HIV/AIDS responses at HEIs in the SADEC region (UNAIDS, 2011)

Institution	On-Campus VCT	AIDS Policy	Peer Education	Workplace Programme	HIV/AIDS Co-ordinating Bodies	HIV/AIDS Research Centres
University Agostinho Neto	No	No	No	No	No	No
University of Botswana	Yes	Yes	Yes	Yes	Yes	Yes
University of Kinshasa	Yes	No			No	No
University of Lubumbashi		No			No	No
National University of Lesotho	No	Draft	Yes	Yes	Yes	No
University of Antananarivo	No	No	No	No	No	No
University of Malawi	In planning	Yes		Yes	Yes	No
Mzuzu University	Counselling only	Yes	Yes	No	Yes	No
University of Mauritius	No	No			No	No
University Eduardo Mondlane	No	No	Yes	Yes	Yes	No
University of Namibia	Yes	Yes	Yes		Yes	Yes
University of Cape Town	Yes	Yes	Yes	Yes	Yes	Yes
Cape Peninsula University of Technology	Yes	Yes	Yes	No	Yes	Yes
Central University of Technology	Yes		Yes			
University of Fort Hare	Yes		Yes	Yes		
University of Free State	Yes	Yes				

Institution	On-Campus VCT	AIDS Policy	Peer Education	Workplace Programme	HIV/AIDS Co-ordinating Bodies	HIV/AIDS Research Centres
University of Johannesburg	Yes	Yes	Yes	Yes	Yes	
University of Kwa Zulu Natal	Yes	Yes	Yes	Yes	Yes	Yes
University of Limpopo			Yes			
Mangosuthu Technikon			Yes			
Nelson Mandela Metropolitan University	Yes	Yes	Yes	Yes	Yes	
North West University	Yes	Yes	Yes	Yes	Yes	
University of Pretoria	Yes	Yes	Yes	Yes	Yes	Yes
Rhodes University	Yes	Yes	Yes	Yes	Yes	Yes
Stellenbosch University	Yes	Yes	Yes	Yes	Yes	Yes
Tshwane University of Technology	Yes		Yes	Yes	Yes	
University of South Africa	Yes	Yes	Yes	Yes	Yes	Yes
Vaal University of Technology	Yes		Yes			
University of Venda	Yes				Yes	
Walter Sisulu University	Yes		Yes			
University of the Western Cape	Yes	Yes	Yes	Yes	Yes	
University of the Witwatersrand	Yes	Yes	Yes	Yes	Yes	Yes
University of Zululand	Yes	Yes	Yes			
University of Swaziland	No	Draft	Yes		Yes	No
University of Dar Es Salaam	Yes	Draft	Yes	Yes	Yes	No
Muhimbili University College	Yes	National Policy	Yes		Yes	
Mzumbe University	No	No			No	No

Institution	On-Campus VCT	AIDS Policy	Peer Education	Workplace Programme	HIV/AIDS Co-ordinating Bodies	HIV/AIDS Research Centres
Sokoine University of Agriculture	No	Yes	Yes		Yes	No
Open University of Tanzania	No	Draft	No	No	In planning	No
University of Zambia	Yes	Yes			Yes	Resource Centre Planned
Copperbelt University	Yes	Yes	Yes	Yes		No
University of Zimbabwe		Yes	Yes		No	No
Bindura University of Science	Yes	No	Yes	Yes	Yes	No
Zimbabwe National University of Science and Technology	Counselling only				Yes	No
Chinhoyi University of Technology			Yes	Yes	Yes	No
Midlands State University	Counselling only	Yes	Yes		Yes	
Zimbabwe Open University	No	Draft	Yes		Yes	In planning

Effective coordination across all sectors is key to the successful implementation of this NSP. The South African National Aids Council (SANAC) is expected to take a leading role in coordinating the implementation of this plan. One of the important stakeholders who form part of this NSP is the Higher Education HIV/AIDS programme (HEAIDS, 2003).

2.6 THE RESPONSE OF A UNIVERSITY TO HIV/AIDS

Kelly (2002), in a paper entitled "Crafting the Response of a University to HIV/AIDS", says that every HEI should have a mandate on how to respond to the needs of an AIDS-affected society. He further says "that the heart of every university's business is knowledge" (Kelly, 2002:1). Societies invest heavily in HEIs so that they can transfer knowledge through teaching and learning and research. The epidemic of HIV/AIDS within our societies does not change this mandate. Every university should recognise that HIV/AIDS should add greater responsibilities

in the transfer of knowledge and to educate with regard to the different facets of the disease. Education for all in a world of HIV/AIDS, therefore presents an unprecedented challenge to all HEIs, as the education of all children and youths, merits the highest priority in a world afflicted by HIV/AIDS (World Bank, 2000).

It is frequently stated that in a world with HIV/AIDS, business cannot continue as usual. Equally so, this rule should apply to each HEI. The HIV/AIDS dimension has to be included in all facets of university business (Kelly, 2002:1). The core business of each HEI should be the transfer of knowledge (teaching), knowledge generation (research) and knowledge sharing (engagement with communities). Each university therefore should accept their mandate in terms of HIV/AIDS as crucial. They need to respond to the needs of an AIDS affected society through AIDS-informed knowledge, training, research and community engagement.

According to Kelly (2002), the all too frequent response to HIV/AIDS in HEI's, has been noted to be denial. Everyone involve in HEIs, including academics, administrative staff and students, should recognise and admit honestly that they are confronted with a major problem and the challenge of HIV/AIDS. No university could claim that it is not affected by this pandemic – on the contrary, no university can deny that HIV/AIDS poses a threat to it as an institution, as they form part of a society where HIV/AIDS is rampant. The Universities should fulfil a pivotal role in mitigating this pandemic, since many youths who are most vulnerable are at HEIs. However, the university might be worse off and affected as a great majority of those who form the university community are young, in their teens or early twenties. It is in this age group that the prevalence of HIV/AIDS is particularly high. The risks for a university are also heightened by the liberal atmosphere that tends to be characteristic of universities and by campus cultures which may be open to activities and lifestyles which facilitate HIV transmission with ease. Kelly (2002) suggests that universities should craft a two-way response to this epidemic. Firstly, the university should look inward and decide how it could maintain itself and its functions amidst the HIV/AIDS epidemic which it is already experiencing. It is vital that each HEI takes cognisance of the fact that they are already affected and therefore they need to strategise on how to keep the university in good working order. Secondly, each HEI should look outward and focus on its core functions of teaching, learning, research and community outreach. In executing these functions, the university should take full account of HIV/AIDS and possibly make it the fourth core value of HEIs (Kelly, 2002).

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The components of a comprehensive university response should include a well-defined HIV/AIDS policy. Each HEI should develop a comprehensive policy and ensure that it is being implemented. Every aspect of the disease must be factored into university planning, both at strategic and operational levels. Management and personnel issues should be taken care of, as the disease could be working away silently on the campus (Kelly, 2002). HIV-awareness campaigns needs to be conducted at regular intervals. A review of policies and procedures governing medical aids, sick leave, loans, benefits and pensions is vital. The entire university community should be involved in establishing partnerships and educating each other. Special provision should be made for staff and students to access treatment, care and antiretroviral drugs. Workplace education for all staff, as well as challenges to denial and stigma, should be available at all HEIs (Kelly, 2002:4).

All HEIs have an obligation to teaching and training responses to HIV/AIDS. Every university must seek to produce graduates who are competent to manage HIV/AIDS within their respective professions for which they were trained. This means that HIV/AIDS has to be included in all training programmes and curricula. The majority of Health Sciences programmes already do this, but there is a great need for other faculties and programmes to include HIV/AIDS into the curricula. All lecturing staff should be assisted and encouraged to develop a sound understanding and knowledge of HIV/AIDS. This knowledge should also be transferred to the students in the workplace. Absenteeism due to death or illness related to HIV/AIDS is a reality on our campuses. Teaching methodologies could be adjusted to foster more independent learning and make learners more self-motivated. In a case where the lecturer is off sick or away, the students are able to carry on, as they would be equipped with intellectual tools that will enable them to be more adaptable and innovative in responding to the needs of a fast-changing world of HIV/AIDS (Kelly, 2002:4-5).

Kelly and Chetty encourage universities to continuously engage in scientific research with regard to HIV/AIDS. They assert that universities should not be put off by the high financial cost of research. HEIs should collaborate and form partnerships. Cooperation efforts are rewarded and they enhance the global ability to manage the AIDS crisis. This strengthens the research capacity of university departments that suffer from a dearth of human and financial resources. It is further acknowledged that HIV/AIDS research raises multiple ethical issues, relating to prevention and care. Independent Ethic Committees play a major role in ensuring that

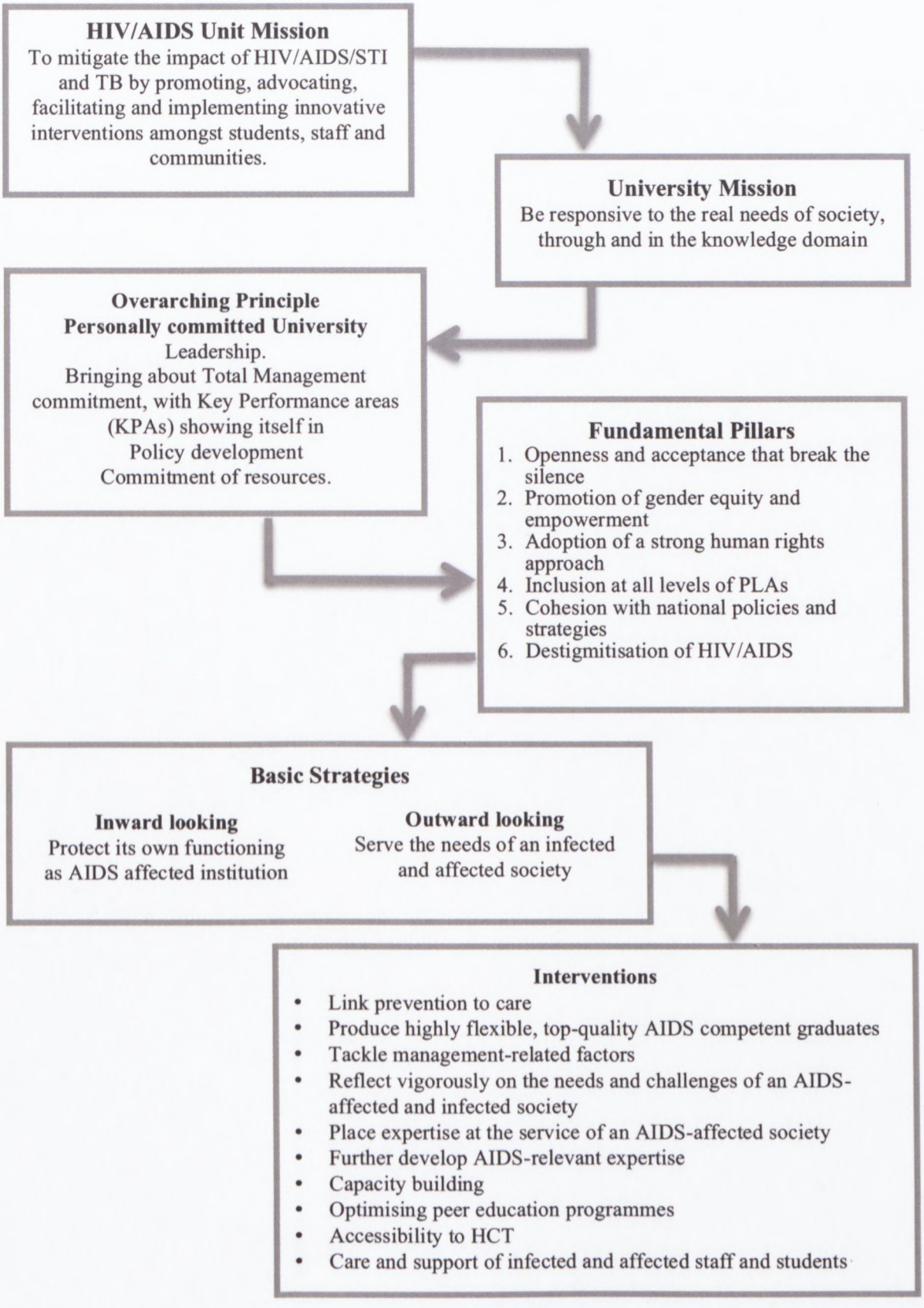
no harm would be done to any participants in HIV/AIDS research projects (Kelly, 2002; Chetty, 2000).

In a climate of heightened HIV/AIDS awareness, a university must ensure that it becomes the engine of development, progress, understanding and hope for people, institutions and society in all that relates to the disease. To accomplish this, in addition to teaching and research functions, it needs to pay adequate attention to unstinting engagement with the community. Both students and staff should be empowered to participate in community training and awareness programmes on HIV/AIDS (Kelly, 2002; Chetty, 2000; Driscoll, 2001).

The following figure (Figure 2.1) will highlight the conceptual framework for a comprehensive university response to HIV/AIDS. This framework discusses the vision and mission statement of the HEI and other overarching principals and strategies of how to deal with the challenge of HIV/AIDS on university campuses.

Figure 2.1: Conceptual framework for a comprehensive university response to HIV/AIDS

(Kelly, 2002:12-13)



2.7 HIGHER EDUCATION AND HIV AND AIDS PROGRAMMES (HEAIDS)

The HEAIDS initiative is based on a partnership between all the Vice-Chancellors of the South African Universities (SAUVCA), as well as the Department of National Education (DoE). HEIs became aware of the pandemic as early as the 1990s. HEAIDS is South Africa's nationally co-ordinated comprehensive and large-scale HIV-prevention effort. The HEAIDS programme is designed to develop and strengthen the capacity, the systems and the structures of all HEIs (HEAIDS, 2010). HEAIDS also implement its strategies as part of the multisectoral response of the NSP.

Many individual HEIs developed their institutionalised HIV-control programmes. In 2000 SAUVCA took the initiative to call for a national response in all HEIs in South Africa. The support organisations such as the Department for International Development (DIFID), Development Corporation Ireland (DCI) and Centres for Disease Control (CDC) (Atlanta, Georgia, USA) were co-opted and made programmes in South African HEIs financially possible from 2007. European funding (EU) gave a major boost to HEAIDS in 2008. This funding was given in collaboration with the Department of Health (DOE) and the Department of Education (DOE) to kick start phase two of the HEAIDS programme. Launched in November 2001, HEAIDS is the first coordinated effort aimed at improving the capacity of HEIs to address the prevention, management and mitigation of the impact of HIV/AIDS.

At national level, a small team based at SAUVCA's Pretoria office manages the HEAIDS programmes. At institutional level, each HEI has assigned a focus person (entitled the Institutional Officer) to help drive the institutional response to HIV and AIDS matters and training. Institutional Officers (IOs) were identified and nominated by the Vice-Chancellors at each institution and are mainly responsible for shaping the strategy, planning, co-ordination, reporting, capacity building and managing of their institutional grant.

Many of the above Institutional Officers are involved in a range of other HIV and AIDS-related activities aside from HEAIDS, whilst others have more conventional institutional responsibilities, for example, policy formulation, awareness programmes on-site as well as outreach programmes to communities. I was fortunate to be appointed the first Institutional Officer at the HEI where this study was conducted. I am therefore familiar with the HEAIDS activities. I was also instrumental in the first national survey (audit) that was spearheaded by HEAIDS on all HEIs in 2003.

At its inception the HEAIDS programme was focused broadly on four priority service areas (HIV counselling and testing, peer group education, workplace programmes, and curriculum integration), which were made deliberately flexible in order to accommodate the wide variations between institutions in their responses to HIV and AIDS matters and training. Such flexibility was also appropriate to the culture of HEIs in which devolved authority and institutional autonomy are key principles. In the broader context, institutions were given the freedom to define an institutional response which best reflected their needs, priorities and capabilities. However, since 2005 it has become apparent that a stronger strategic framework with clearer indicators is necessary in order to better manage the programme and its elaboration over the longer term.

Although implementing prevention programme efforts at HEIs only reaches a small proportion of the population, the importance of these programmes should not be underestimated (Berry, 2005). Students represent a population of great importance, given that they are likely to become the country's future leaders, opinion makers and policy makers. Universities are also expected to take the leading role in HIV/AIDS research activities. These research findings are to be disseminated. HEIs therefore have a dual role to fulfil. The first is to protect the health of the students and staff, and to perform research that would increase the understanding of the pandemic and how it can be controlled outside of the universities within other communities. Interventions are imperative at HEIs to mitigate the impact of HIV/AIDS (Berry, 2005).

HEAIDS (2010 Report) is South Africa's nationally coordinated, comprehensive large-scale effort aimed at developing and strengthening capacity within the structures and systems of HEIs. University students make up part of the youth population. Students at HEIs constitute a very important part of society, as they are pivotal in the development of society and the determination of future norms. HEAIDS comprises of 23 institutions, including both universities and universities of technology.

Each university is unique in its structure of cultural diversity among students and mode of teaching. Some have contact sessions and others adopt distance learning. They also differ considerably regarding location, physical structure, human resources and finances. Each institution operates with a high level of independence. HIV/AIDS programmes at all these institutions are unique and differ from one another. There is a need to research and understand current practices at HEIs with regard to the impact of HIV/AIDS in order to stem the tide of

infection at HEIs. Good practices have to be identified and shared with other institutions. Hence, this study would like to determine a best practice model for peer education at HEIs.

Berry (2005) stated that HIV/AIDS has infected 28% of people in South Africa, while 13% of the people who are living with HIV/AIDS in the world can be found in South Africa. This 28% increased to 67% according to the Kaiser Family Fact Sheet (2009). Sub-Saharan Africa remains the region of the world most affected by HIV/AIDS (Kaiser Family Fact Sheet, 2009). It is worthwhile focusing attention on the difference between the statistics of 2001 and 2004. During 2001 about 6 million South Africans were living with the disease. Statistics South Africa (Stats SA, 2010) estimated the mid-year prevalence rate for HIV/AIDS at approximately 10,5%. The total number of people living with HIV is estimated at 5, 24 million. For adults aged 15-49 years an estimated 17% of the population is HIV positive (Stats SA, 2010). Interventions such as condom usage has been accompanied by a troubling rise in prevalence among persons aged 20–34, highlighting the need for greater prevention efforts targeted at older age groups, and tailored to their realities and concerns (UNAIDS/WHO, 2001). Ramjee (2005:12) also agrees that Sub-Saharan Africa remains the region of the world most affected by HIV/AIDS and states that an estimated 25.4 million people were living with HIV in this region in 2004, and that approximately 3.1 million people would become newly infected by the end of 2015, while about two million children under the age of 15 years were living with HIV and more than 12 million children would become orphaned as a result of AIDS. The Department of Education's impact assessment done for all universities and technikons indicated that the infection levels for university undergraduates would reach 33% and for technikon undergraduates, 36% by 2005 (Kinghorn, 2000:189). AIDS has become the greatest threat to the continent's development and many affected countries are losing valuable community members to AIDS. Essential services are depleted and at the same time state institutions and resources have become strained and/or over-stretched (UNAIDS/WHO, 2001).

The then Minister of Education, Professor Kader Asmal, argued in 1999 that AIDS is everyone's concern and that the country needs to ensure that every institution responds to the needs of its internal constituency and that of its broader external community. The Minister appealed for the mobilisation and conversion of institutional resources into tangible deeds that will ensure that interventions are not viewed purely as an administrative function that is lightly delegated. Mobilisation, therefore, needs to take place at the highest level, so that the scale and the nature of the HIV/AIDS pandemic can be stemmed effectively by developing concrete and substantive

mechanisms. Vigorous prevention efforts are needed to equip young people with the knowledge and services they need to protect themselves against HIV/AIDS. Socio-economic programmes that can reduce the vulnerability of young men and women are vital (UNAIDS/WHO, 2001).

A survey (Botha, 2001) conducted by the student counselling division at a HEI revealed that the information which students have regarding HIV/AIDS prevention and living with the disease is obtained mainly from the mass media as well as awareness campaigns on campus. It seems, however, that these efforts are not sufficient, firstly, to change behaviour to prevent new infections or re-infections, or secondly, to destigmatise HIV testing, and thirdly, to destigmatise people living with the disease. Furthermore, the majority of students (76%) indicated that they are sexually active – slightly more for males (79%) than females (74%). An alarmingly high percentage of students (82%) indicated that they do not know whether they are HIV positive or HIV negative, and were very scared to determine their status. It was also clear that a minority of sexually active students (27%) consistently use condoms during intercourse, while 18,3% never use them during anal or vaginal sex, and that 29% never use condoms during oral sex. A high percentage of students (25%) had more than two sexual partners during the previous 24 months. The number of students who have had more than 10 sexual partners is nearly 3%, while 39% have known their sexual partners for less than two months before starting a sexual relationship, and that 10% have had one-night stands (Botha, 2001).

It is reported that a large number of students (32%) did not access any health care services when they experienced symptoms of other sexually transmitted diseases, e.g. trichomoniasis, candidiasis and gonorrhoea. In this regard, students indicated that they would appreciate more involvement from academic staff to facilitate their learning about HIV and AIDS in an academic curriculum. Lastly, they indicated that they experienced the following problems:

- Distribution of condoms;
- Access to health care facilities;
- Lack of opportunities and knowledge to discuss sensitive issues like safer sex;
- Lack of visibility of the impact and face of the disease, especially in the last stages;
- Lack of knowledge and skills on how to care for and support people (friends and relatives) living with the disease (Botha, 2001).

The above-mentioned survey also resulted in an increase in student counselling division's activities, and a greater awareness among students regarding HIV/AIDS, and an increasing number of students wanting to determine their HIV status. Individual blood testing with pre- and post-test counselling is currently offered via the health clinic and student counselling division. However, student counselling division personnel experience great difficulty in delivering this service as a result of logistical constraints including insufficient office space and trained staff (Botha, 2001).

In 2008 the HEI where this project was conducted received European funding (EU). This funding made it possible for the HIV/AIDS Unit to intensify its programmes, particularly with regard to reducing stigma and discrimination.

Eight-year-old Nkosi Johnson's words of wisdom are quoted to highlight the plight to reduce stigma and discrimination:

> I want people to understand about AIDS – to be careful and respect AIDS – you can't get AIDS if you touch, hug, kiss, hold hands with someone who is infected. Care for us and accept us – we are human beings. We are normal. We have hands. We have feet. We can walk, we can talk, we have needs just like everybody else – don't be afraid of us – we are all the same! (Memorial Lecture at 2nd South African AIDS Conference, June 2005).

These words from this HIV/AIDS activist highlight the need for disclosure and to decrease stigmatisation of HIV/AIDS. HEIs have a pivotal role to play in making disclosure possible and decreasing stigmatisation.

Sexually transmitted Infections (STIs) are widespread in South Africa and since the mid-20th century have reached endemic proportions. STIs facilitate the transmission of HIV/AIDS. The correct treatment of symptomatic STIs could reduce the infection rates as proved in Tanzania and Mwanza. New HIV infections in these two countries were reduced by 42% (Wilkinson, Ramjee, Sturm & Karim, 2008). In Natal 10% of young people are treated at least once a year for an STI. Repeated episodes of STIs are also very frequent. The prevalence of STIs (gonorrhoea, Chlamydia infection, trichomoniasis or recent/active syphilis) is high. Among sex workers 77% had at least one STI and 33% had multiple infections; among pregnant women the corresponding rates were 52% and 18%; and among women attending family planning clinics the rates were 27% and 10%. Prevalence of HIV infection is also high: sex workers 50%, pregnant women 16% and women attending family planning clinics 24%. Sex workers reported an average of 20 clients each week and only 10% reported using a condom in more than half of

all episodes of intercourse. Symptoms and signs associated with STIs (lower abdominal pain, burning urine, vaginal discharge, genital itch, and genital ulceration) were frequently not recognised or not acted upon. Infection was frequently asymptomatic or unrecognised: 60% of infected women in the family planning clinic were asymptomatic and 14% of sex workers had unrecognised genital ulcers. Quality of treatment was poor: only 10-40% of patients presenting with an STI to family doctors or primary care clinics were given the correct drugs. Evidence that STIs contribute to the HIV and AIDS epidemic further enhances the seriousness of the problem (Wilkinson *et al.*, 2008).

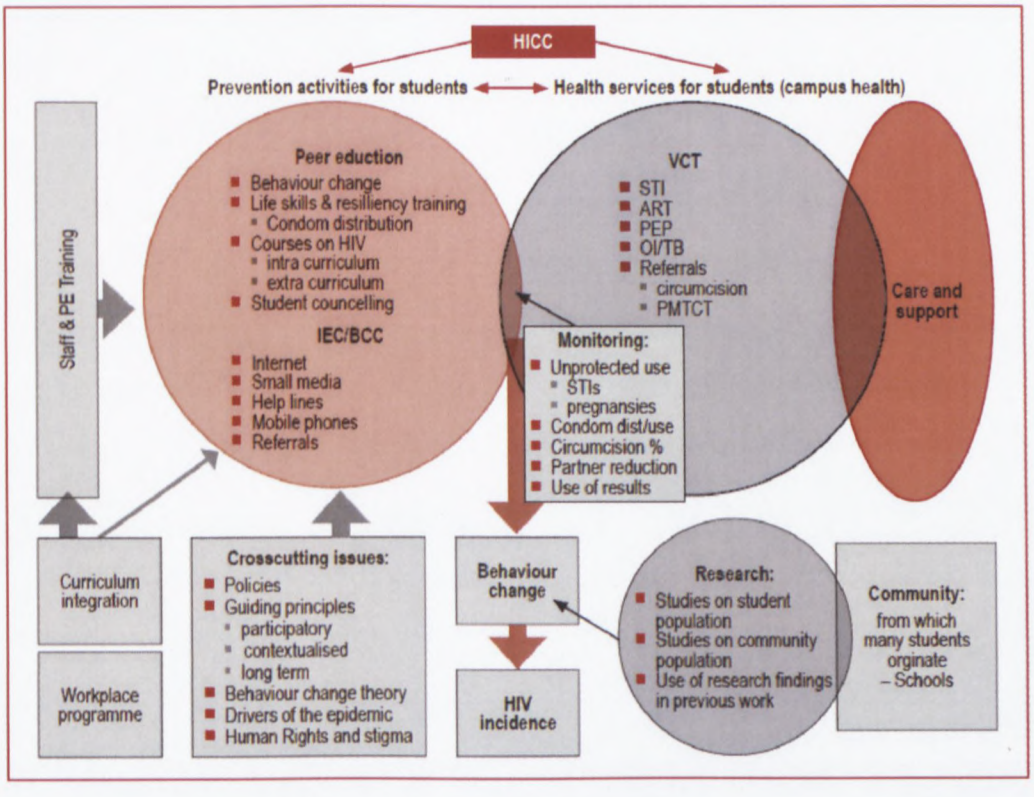
Currently there is a great deal of controversy about the use of condoms in the prevention of STDs and HIV/AIDS. A major problem is that people are not taught how to use condoms safely. Presley (2005:1) explains that while the assertion that condoms were not 100% effective is understandable, it was important to recognise that effectiveness was almost entirely a function of correct and consistent usage. Although it is known that STIs contribute to HIV infection, no specific relationship was produced (Pressly, 2005). It is imperative, however, that STIs should receive equal attention when planning and implementing prevention strategies for HIV and AIDS. It was recommended in the WHO's global programme on AIDS (2010) that AIDS and STIs programmes should not be implemented separately. Thus the prevention of STIs is a priority for the MRC National AIDS Research Programme.

From 2007-2009 HEAIDS conducted a seroprevalence study to identify good practices at HEIs. The main objective of the study was to identify the wider role of HEIs in national efforts to control HIV/AIDS. The study defined and focused on the following:

- Good practices: These are well documented and they assist programming practices that provide evidence for success, which are valuable for replication and up skilling;
- Innovative practices: These are practices that invent, or begin to apply, techniques, methods, processes and initiatives etc. that are new or novel. This also means new solutions to a particular programme aspect that is being judged interesting and potentially effective;
- Peer education programmes: This is a health promotion and intervention strategy. It refers to unleashing the potential of individuals to transform their lives and those of members in their surrounding communities. This also means empowering individuals so that they are able to make informed decisions about the various challenges that they face (Deutch & Swartz, 2004);

- Counselling: This is defined as a process that individuals embark on to sort out issues and to help them to reach decisions that affect their lives. It involves a trained individual to talk to the client in a way that assists the client to solve his or her problems (USAID, 2010);
- HIV testing and counselling (HCT): HCT is a confidential dialogue between a counsellor and a client. This dialogue supports clients to make informed decisions regarding future behaviours concerning HIV/AIDS. HCT consists of pre-test counselling, a rapid HIV test and post-test counselling (USAID, 2010);
- Behaviour change communication (BCC): This is an interactive process with individuals, communities and societies. The focus is on developing messages and approaches using a variety of communication channels. This strategy is used to encourage positive attitudes and behaviours and to promote individual and societal change (Mishya, Granwal, Alva, Gu & Wang, 2007);
- Life skills: This covers the abilities that individuals need in order to develop and use adaptive and positive behaviours. These life skills will assist individuals to deal effectively with social demands and challenges of everyday living and the rapidly changing environment (WHO, 1999).

Figure 2.2: Overview of HIV control activities at HEIs (HEAIDS, 2010)



Within the context of institutional autonomy and the role of HEIs at national level, the Minister of education has developed a strategic Framework for phase 2 of HEAIDS to be implemented (HEAIDS, 2006). Phase 2 of HEAIDS was completed in 2009. The third phase was to commence in 2010, but to date, nothing has happened.

The framework has two main strategies:

- To maintain institutional capacity;
- To grow and strengthen the teaching, training, research, community engagement and service functions.

These strategies will be implemented by formulating institutional policies, setting norms and standards for funding models and human and material resources, curriculum integration, standardised interventions-based practice in prevention, care and support and curriculum integration, improved monitoring and evaluation, and establishing workplace programmes (HEAIDS, 2006). Many of these initiatives have already been implemented, but the major objective of this phase of HEAIDS was to reduce the number of new infections in South Africa by 50% by 2011. This framework also falls within the ambit of the Strategic Plan for South Africa, 2001-2011, now extended to 2016.

2.8 EVALUATION CAPACITY FOR HIV AND AIDS PREVENTION PROGRAMMES

Educators implementing HIV/AIDS prevention programmes, even those using science-based interventions, need to conduct evaluations to support the implementation and transfer of effective interventions in order to account for services, demonstrate effectiveness and improve programmes. However, there is a lack of monitoring and evaluation because of the lack of resources in HEAIDS to evaluate any HIV/AIDS-related programmes. In particular, evaluation should be explored in the field of distance learning.

The HEAIDS programme calls upon all universities and universities of technology in South Africa to develop and build HIV/AIDS content into teaching and learning, by rewarding teaching staff for their efforts to teach HIV/AIDS and/or incorporating HIV/ AIDS content into course work for students (Report, HEAIDS, 2010).

2.9 THE IMPACT OF HIV AND AIDS ON EDUCATION

The White Paper on special needs education (2001) reports that the development of an inclusive education and training system has to take into account the incidence and spread of HIV/AIDS and STIs. The ministry therefore needs to make provision for curriculum integration of HIV/AIDS from primary to secondary school, as well as HEIs.

In planning education in the context of HIV and AIDS and related matters there are two major perspectives. The first is the role of education in reducing the spread of the disease. The second is the impact of the AIDS pandemic on the education system in Africa. In a paper entitled *Conspiracy to Silence: AIDS on African University Campuses*, Kelly (2002) reported the failure of many African universities to speak out and to confront the HIV and AIDS crisis head on. The overriding message of the paper is that the institutions studied remain in the dark concerning the HIV/AIDS situation on their campuses. This could be because of denial, lack of knowledge or simply just ignorance. Saint (2004) concurs with Kelly (2002) that many educators also cannot see the need or find the time to deal with these sensitive issues within the classroom situation. Educators do not feel equipped to deal with sexuality and HIV/AIDS issues. They also feel extremely uncomfortable about their own sexuality and therefore cannot deal with that of their students (Kelly, 2002; Saint, 2004). The seven countries Kelly included in his study were Benin, Ghana, Kenya, Namibia, South Africa and Zambia. In spite of differences in finer details, the study shows that HIV/AIDS is having a serious impact on the fiscal situation of universities. Kelly (2002) and Saint (2004) both agree that HIV/AIDS increases operating costs, reduces productivity, especially through high absenteeism, diverts resources and threatens income sources.

Evidence suggests that the university population in Africa is a high-risk sector for the transmission of HIV infection. Sexual experimentation, prostitution on campuses, unprotected casual sex, gender violence, multiple partners and similar high-risk activities are all manifested to a greater or lesser degree. Kelly and Saint suggest that the entire university community and, in particular university managements, need to face this squarely in the HIV/AIDS context of university life today. The university culture is in danger of negating risk more than safety. Hence HEIs are in danger of affirming death more than life, if they do not take drastic actions to combat this pandemic on their campuses and beyond (Kelly, 2002; Saint, 2004).

2.9.1 The impact of HIV and AIDS on staff and students in HEIs

The staff members at HEIs throughout Africa face a major and, in many instances, an escalating threat from HIV/AIDS. Prevalence levels among staff and students are not well documented, but there are reports of systems whose operations are becoming increasingly affected by absenteeism and deaths as a result of HIV/AIDS-related conditions. Student absenteeism also occurs, but these may be less noteworthy, partly because students, being mostly young, are more likely to be in the relatively early stages of infection. Evidence suggests that when they become ill, many students may withdraw altogether from their studies (Whiteside *et al.*, 2000:101).

Staff and student absenteeism also arises from attending the funerals of fellow staff members, students, members of one's family, and members of one's community. It has been estimated that for industry absenteeism as a result of HIV infection accounts for some 37% of the increased costs (to deal with AIDS and related conditions), absenteeism as a result of AIDS accounts for 15%, and funeral attendance by employees accounts for 6% (Whiteside *et al.*, 2000:101).

HEIs may well be experiencing similar costs, but almost none are equipped with HIV/AIDS-sensitive management information systems that allow these to be quantified. The extensive HIV/AIDS-related absenteeism, the loss of human resources and the largely invisible costs to which HIV/AIDS give rise are hampering HEIs in the achievement of their educational, research and social goals. Staff members functioning in these institutions are finding it more difficult to carry on (Whiteside *et al.*, 2000:101).

At the same time it becomes more and more difficult to respond to society's needs for highly skilled and appropriately qualified personnel. To put these problems in perspective, one might note that the University of Nairobi believes that an average of two members of the immediate university community die from AIDS each week (Kelly, 2001:47-49). The crude death rate for staff at the University of Zambia is higher than the national rate (even when this takes account of AIDS deaths in the national population), and more than half of those who have died at the University of Nairobi in the past decade have been in the age range 20-34, the age range in which AIDS deaths very frequently occur (Kelly, 2001:49-50). In the period 1994-2000 18 out of 146 academic and 72 out of 406 non-academic staff died at the Copperbelt University in Zambia, giving an annual death rate of approximately 2% for academics and 3% for non-academics (Lungu *et al.*, 2001:78).

One in every six students drops out of the universities in the Western Cape each year for financial or personal reasons that are very likely HIV-related (Kelly, 2001:56). 30% of the nurses graduating from the University of Natal die within three years of completing their study programme (Jones, 2001:34-35). Estimates for South Africa were that by 2008 more than 30% of undergraduate students in the 25 public universities and more than 35% of those in the technikons or polytechnics would be infected with HIV (Kinghorn, 2000:89-90).

Faced with this actual and potential loss, universities tend to be fragmented and un-coordinated in their response to the challenge of HIV/AIDS and, until recently, few responses were institutionalised. Instead, most tended to depend heavily on the generous initiatives of individual members of staff who, through genuine concern or insight into the pandemic, attempted to get involved in stemming the tide of this pandemic. They embarked on strategies such as awareness campaigns, HCT drives and peer education programmes on their respective campuses to highlight the plight of those caught up in the HIV/AIDS pandemic (Kinghorn, 2000:89-90).

Moreover, university life frequently creates high-risk social situations for students. The potential danger of these situations for leading to HIV infection may be aggravated by prevailing attitudes of denial, secrecy, fatalism and a sense of invulnerability. Students also perceive the availability of treatment or the participation in treatment trials positively (Chetty, 2000).

At the same time universities and universities of technology show a strong tendency to regard HIV/AIDS as principally a student issue, which would be dealt with by the institutions' student health facilities. Student health medical staff bears the brunt of doing pre- and post -test counselling for HIV testing on both staff and students. It is the medical staff on the on-site clinics that take the responsibility to refer students to the appropriate hospitals and health facilities where antiretroviral (ARV) treatment could be accessed (Chetty, 2000).

Against this background, which has been extensively surveyed, HEIs have two major responsibilities in relation to HIV/AIDS.

1. They must protect themselves so that they can continue to function efficiently and effectively in their circumstances as a community (staff members and student population) which is HIV and AIDS infected.

2. They must gear themselves to respond more dynamically to the needs of an HIV-positive and AIDS-infected society. Self-protection is therefore crucial as without it, they will not be able to provide the training, research and knowledge needs of society (Chetty, 2000:67-69).

2.10 THE USE OF INFORMATION COMMUNICATION TECHNOLOGY (ICT) TO RESPOND TO THE CHALLENGE OF HIV AND AIDS IN HEIs

As noted above, AIDS-affected communities in HEIs have two major HIV/AIDS responsibilities. Firstly, irrespective of the extent to which HIV/AIDS already affects them, they must protect their continued functioning by continuously striving towards putting mechanisms in place to deal with this pandemic in a positive manner. Secondly, they must respond dynamically to the needs of an AIDS-affected society (Kelly, 2002). Driscoll concurs with Kelly that in view of the enormity of the HIV/AIDS pandemic, all resources and tools that are available should be utilised to respond to the pandemic. ICTs are seen as one of the major potential tools to respond, as they could provide access to information and knowledge for those working on the problem, those who are HIV positive and to others who need to take preventative action. ICT allows for different people and networks in various parts of the world to be connected (Driscoll, 2001).

UNIADS field staff and many other people who are working in Africa and other developing countries with inadequate resources agree and suggest that focused applications of ICT could assist communities and health care providers to improve the lives of those poor and vulnerable people who are living with HIV/AIDS. In order to ensure effective country coordination, UNIADS field staff need to have access to high-quality and up-to-date advice and support. Here ICT plays a major role in providing this support and information by developing regional technical resource networks and making programmes available on selected cross-border issues relevant to the region (Driscoll, 2001).

HEIs are best placed to respond to the needs of society with regard to ICT. They are able to prepare and provide large numbers of persons who are knowledgeable and skilled in areas of specialisation and with the flexibility that is required in an HE environment to provide the necessary ICT support for HIV/AIDS activities. HEIs could be dynamic with inter-disciplinary collaborative research on every aspect of HIV/AIDS and its impact on communities. This would also mean forming partnerships and engaging with society at all levels, both the public and the private sector (Kelly, 2002). An example of a successful partnership with regard to the use of

ICT is the one between the University of Manitoba and the University of Nairobi. They utilised CD-ROMs very successfully in their distance-learning programmes. These CD-ROMs included advocacy skills, counselling, community care and communication, and behaviour. These topics were all discussed in relation to HIV/AIDS (Driscoll, 2001).

Informed and imaginative use of ICTs can facilitate appropriate responses from university executives, academics and administrators to HIV/AIDS. Modalities that could be utilised more optimally for supporting HEIs with ICT are e-mail, websites and CD–ROMs, databases, documentation and library access, list-servers and on-line discussions, web-based discussion groups, workshops and symposia, networking with other partners, information sources, question and answer sites (e-mail and/or web), chat rooms for personal support and information, on-line publications, distance education, video-conferencing and involvement and participation with appropriate community organisations (Kelly, 2002).

HEIs should create a supportive environment for people living with HIV/AIDS and at the same time should also play an appropriate role in the battle against HIV/AIDS in the surrounding communities. As with policy and management issues, ICTs' potential to contribute to staff and student welfare is only beginning to be tapped (Driscoll, 2001).

All the above can be geared towards enhancing personal support for staff and students. In many cases the provision of one or more of these services could quite literally provide a lifeline for a member of the university (or other) community weighed down with ignorance, anxiety and an all-encompassing sense of isolation. The above services could be supported by making available online reports and documentation that show up the link between HIV/AIDS and the fields of professional interest, packaged according to the specific professional area. One could ask, for instance, whether those teaching all-important agriculture disciplines at universities or agricultural colleges have access to the Federal Agricultural Organisation (FAO). This is very informative information that everyone that is involve with agriculture and food, should have access to in order to equip themselves in the light of dealing with food security and HIV/AIDS (FAO, 2001). Likewise, there are the excellent AIDS Briefs for professionals and for sectoral planners and managers, produced by the Health Economics and AIDS Research Division of the University of Natal which also provides excellent information in this regard (Kelly, 2002; Driscoll, 2001).

The above sources of information make provision for professionals as well as managers in the media, the legal professions, social sectors, construction, manufacturing, commercial agriculture, the civil service and natural sciences.

This information reveals the way HIV/AIDS manifests itself significantly in every area of public and private enterprise and also highlights the necessity to take account of the disease in all management operations. Academic staff in HEIs needs to group themselves around such documents in their own professional area and decide just how they can modify their curriculum to take account of the realities that documents such as the above depict (Driscoll, 2001).

ICT can contribute to this through the promotion of networking, professional databases, bibliographic databases, documentation, discussion forums, interactive workshops, tele-conferencing and the establishment of formal links.

An important aspect of the above development is the need to establish different channels for different professional groups. While there are undoubtedly some commonalities, mainstreaming HIV/AIDS content into the curriculum of a professional discipline requires a sharper focus – a focus that can see the interaction between the disease and the professional area, how to manage this interaction and how to ensure that this advancement of professional interests or activities does not contribute to the spread of HIV infection, whether for the professionals themselves, for their workers or for the communities in which they serve (Kelly, 2004; Driscoll, 2001).

The HEI where this project is being conducted is making use of the following ICT in their peer education training programme: e-mail, Facebook, SMS, Cell Life and online group discussions. They also utilise CD-ROMs and videos.

Globally all youths have a responsibility to respond to the HIV/AIDS pandemic. Sidibe (2012) indicated on the eve of the UNAIDS HIV/AIDS conference that young people are the most vulnerable to new infections of HIV. In this technological age young people are also more open to change and will therefore adjust to the use of ICT with more ease. He added that their calls for support and assistance often fall on deaf ears. The latest statistic in 2011 for young people aged 15-24 years living with HIV is 900,000. This UNAIDS report indicated that young people lack information on HIV prevention and transmission. The UNIGASS declaration (2007:20) echoes this sentiment. They formulated a declaration that calls upon all countries to:

> By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV/AIDS education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers (*Article 53, Declaration of Commitment on HIV/AIDS, UNIGASS, June 2007*. Youth Position Paper on the 2001 United Nations General Assembly Special Session on HIV/AIDS).

Hence the education of all youths has become the chief approach.

2.11 WHY PEER EDUCATION?

In 2008 South Africa's population between the age of 18 and 24 years numbered 77 100. Growing up in a stable family is an impossible dream for many young people in South Africa. This is because of factors such as poverty, family breakdown, lack of education, unemployment, teenage pregnancy and the impact of HIV/AIDS on our youth (Holburn & Eddy, 2011:1) In the light of these factors young people rely a great deal on their peers for information on issues that are especially sensitive or culturally unacceptable.

Peer education makes use of peer influence in a positive way. It is therefore important that peer educators have credibility amongst their peers. This would form an important base upon which peer education could be built. Peer education is also a way to empower young people. It offers them the opportunities to participate in activities that affect them and to access the information and services they need to protect their health.

Backett-Milburn and Wilson (2000) and Bament (2001) state that peer education is very popular and widely used. It seemed to be very appealing to most trainers involved with young people. Ward (1997), Bailey and Elvin (1999) and Turner and Shepherd (1999) concur with the views of these authors, as they are of the opinion that young people have a natural influence on each other's knowledge, attitude and behaviour.

However, this general conceptualisation leaves many questions unanswered. Some of these questions are:

1. Who is a peer?
    - What are the characteristics of peers?
    - What is a peer group?

2. What is a peer educator?

   - How does a peer educator differ from a peer?
   - What are the roles of peer educators?
   - What type of peer educator can exert influence?

3. What are the aims of peer education?

   - What is underlying ideology?
   - What does peer education aim to achieve? (McDonald, Roche, Unbridge & Skinner, 2003:9).

At the HEI where the study will be taking place the peer educators' training programme includes the following:

- An HIV Module
- Men as Partners Module
- HIV/AIDS Stigma and Discrimination
- Facilitation Skills
- Communication Skills
- A workshop on Diversity
- Event planning
- Time management.

They also attend four seminars, which include debates, film shows and colloquiums on HIV/AIDS and related issues. All peer educators are required to participate in awareness campaigns, community outreach programmes, group discussions at residences with other students and HCT drives. Peer educators are also responsible for the distribution of condoms across all campuses and for filling up all condom dispensers across all campuses. In addition to these functions, peer educators from each main campus work as a team to initiate a Self-Initiative Project (SIP). They have to submit quarterly reports at the end of each term. The peer educators have joint monthly meetings on the last Friday of every month.

It is very difficult to define peer education, as there is evidence of a lack of clarity within the literature (Gray, 1996; Shiner, 1999; Bament, 2001). Shiner (1999), however, says that peer education is best understood as an umbrella term that refers to a range of activities. Finn (1981:123) defines peer education as follows:

> *"The sharing of information, attitudes or behaviours by people who are not professionally trained educators, but whose goal is to educate."*

The following definition is in line with what my study aims to focus on, namely HIV/AIDS peer education training programmes.

> *Youth educate their peers or younger children on personal/life skills or on pertinent societal issues such as drug abuse, HIV/AIDS or prejudice. Youth learn important skills related to designing and delivering effective presentations or workshops, ranging from one-time presentations to intensive, semester-long programmes* (Goldsmith & Reynolds, 1997 cited in Lezin, n.d.:3).

McDonald *et al.* (2003) defines a peer educator *"as a young person who possesses the necessary characteristics to be considered a peer, is credible and influential and has received peer education training"*. Training is very important for these peer educators. They need training in important issues that will assist them with the tasks at hand. McDonald *et al.* (2003) focused on alcohol and drug-related issues in their training programme for peer educators. In my project I focus on HIV/AIDS and sexuality issues and will evaluate the training programmes accordingly.

McDonald *et al.* (2003) included skills development, facilitation skills, delivering education and/or influencing social norms in their training programmes. In these training programmes peer educators may adopt various roles. They could be a facilitator, a counsellor or a source of support for their peers. Peer educators are also good at sharing information or a good referral source. These roles can be categorised as either peer support or peer leadership. During the peer support role, the peer educator and the other young people are regarded as equals. In this role the peer educator engages in organising activities, for example health promotion initiatives, such as open days and condom awareness days. It is in this role and these types of activities where they may act as role models (Bandura, 2000). This then leads to discussions on various topics related to drugs and alcohol use, or any other everyday issues that young people enjoy chatting about (Gore, 1999).

However, the peer leadership role is more direct. When they assume this role, they are regarded as the ones who need to take the lead or are experts (McDonald *et al.*, 2003:14-15). The peer

leadership approach is the more commonly used approach. This also allows peer educators to be with an adult or teacher when they exercise their duties. This will strengthen their confidence and will enhance their leadership abilities (Klepp, 1986).

Peer educators are also expected to exert an influence on other young people. Effective peer educators are young persons who are able to naturally exert an influence on their target group. Young people, who display a natural ability to lead and help are normally good candidates to be trained as peer educators. It is important to utilise existing leaders amongst the group, as they will be able to capitalise on the influence they already have among their peers. Young people will turn to those in their circle who tend to give advice easily and who are readily willing to assist and to refer (Wiist & Snider, 1991). Gore (1999) refers to such a young person as a "true peer". This is the peer educator who is considered to be a member of a particular group and who is respected by all in this group. True peers are identical in terms of the characteristics of the specific group. In contrast, near peers share many characteristics of the true peers but differ in some ways. They might be slightly older or possessing greater power or status to communicate messages (Gore, 1999).

The literature suggests that young people find peers more effective and credible. Young people might feel threatened with slightly older and more powerful peers. McDonald *et al.* (2003) found this to be the case with their alcohol and drug project. Slightly older peers were seen as having more experience of life in general, but particularly with drug-related experiences. Young people also felt that near peers are better integrated into the wider youth culture than they themselves are, particularly if the recipients still attended school and the peer educator has already left school (Force & Jarvis, 1995; Cripps, 1997). Similarly, young people who have had some relevant drug experience are seen as credible information sources. Near peers who are known to have received appropriate training may also have enhanced credibility. In contrast, young people may believe true peers do not possess sufficient knowledge. Cripps (1997) found in his study that young people believed their true peers to be untrustworthy, because they lack knowledge. They could be seen as having limited life experiences. They were found to lack real-life knowledge of drugs and alcohol, regardless of whether they were trained to deliver education in drugs and alcohol abuse.

2.12 COMMON APPROACHES TO PEER EDUCATION

The literature has essentially identified five approaches to peer education.

2.12.1 Information based

The information-based approach can also be referred to as a "knowledge only" approach. It was particularly used in drug education and was very much abstinence based. This approach was based on arousal of fear, assuming that young people would be so frightened by the possible negative consequences of using drugs that they would decide to quit (Coggans, 1997). Later on information-based approaches became more factual and unbiased, but still assumed that if young people had all the facts and knowledge at their disposal, they would decide not to use drugs (Coggans, 1997). Midford (2000) found these approaches to be ineffective in preventing alcohol and drug abuse.

2.12.2 Affective

Wragg (1991) and Milford (2000) developed this approach in the late 1970s following the lack of success with the information-based approaches. They based this approach on psychological factors: lack of self esteem and of interpersonal and communication skills. In this approach issues of drug abuse were often omitted, as it emphasised the development of communication and interpersonal skills as well as self-esteem. Midford (2000) says that the success of affective programmes has been equivocal at best and do not support the notion that effective living is a key to preventing young people from resorting to drug abuse.

2.12.3 Information-based plus affective

The above two approaches were combined. This led to information being given and the psychological aspects addressed. However, even with the combined approach only limited impacts were measured on drug use (Schaps, 1981; Glyn, 1983; Hawkins, 1985).

2.12.4 Psychosocial

Wragg (1991) introduced psychosocial approaches in the 1980s. In this training he included peer resistance and refusal skills training, social inoculation, life skills or social skills training. These approaches were based on the assumption that young people used drugs as a result of the influences of the media and their peers (Midford, 2000). Unlike the other approaches, this

approach is also based on a number of psychosocial theories (Wragg, 1991). In general these approaches have been much more successful in meeting aims and objectives than other approaches (Wragg, 1991). Midford (2000) suggested that some well designed and implemented psychosocial training programmes have been able to prevent or delay the onset of drug use.

2.12.5 Alternatives

Tobler (1992) describes two key components as alternative initiatives. The first is the provision of drug-free activities and the second is the development of personal competence. Tobler (1992) argues that young people will be less likely to use drugs if they have alternatives forms of satisfaction. Young people should not be allowed to get bored or frustrated. Drug education initiatives based on the alternatives have been proved to increase self-esteem and community participation. However, they did not seem to have an impact on drug abuse. However, high-intensity and well-financed initiatives appear to be effective with current drug users (Tobler, 1992). It is entirely up to the organisation or institution to decide which initiative to use for their peer education training programmes. McDonald *et al.* (2003) suggest that the most powerful approach to use is the psychosocial approach. In some programmes it is common for trainers to adopt the less effective information-based approach that substitutes a peer educator for an adult teacher (Baklien, 1993; Mellanby, 2001).

2.13 THE DELIVERY OF PEER EDUCATION

Peer education can be done in an informal or formal manner. When peer education is done in a formal way, it is similar to traditional classroom teaching. All activities are structured and well planned. In the formal setting there is a transfer of information and knowledge from teacher to student. Teaching takes place in a didactical way and it is very structured. Here the teacher is placed in the role of "expert" (Prendergast & Miller, 1996; Gore, 1999). Such formal education often occurs in schools (Bament, 2001).

In contrast, informal peer education involves a range of activities. These activities also differ somewhat from the traditional classroom model. These informal activities are as follows:

1. informal, unstructured discussions;
2. dissemination of resources;
3. activities that draw on popular culture, such as drama, music and art (Ryan, 1999);

4. spontaneous, everyday conversations with friends, acquaintances, family or even strangers (Gore, 1999).

The dichotomous relationship between formal and informal methods of delivering peer education may not be the most appropriate methods of executing peer education activities. Instead, peer education can in a number of different dimensions, which could include planned/unplanned (spontaneous, opportunistic), structured/unstructured, and the use of existing social networks and other group structures. Traditional learning methods/innovative learning methods together with didactic/interactive methods could also be employed. It is important to integrate the theory with the practical applications when trainers deliver peer education training programmes. The activities of peer educators may rely on processes such as information transfer (e.g. didactics, lecture presentation), interaction (discussions), practical activities (role plays), modelling (observation of others), popular culture (music events, drama, artwork) and opportunistic intervention (e.g. spontaneous conversation) (McDonald *et al.*, 2003:19-20).

2.14 PEER EDUCATION SETTINGS

Bleeker (2001) confirms that peer education for young people can take place in a variety of settings. However, he states that the most appropriate setting for a given peer education initiative is determined by the needs and characteristics of the target group (Bleeker, 2001). Educational settings, such as schools and HEIs, may be more ideal for peer education, as a large number of young people could be reached at a given time. In contrast, community settings such as shelters and youth centres may be more appropriate for the marginalised and socially excluded or at-risk youths. Shiner (2000) claims that it is easier to contact young people who are indigenous, and culturally and linguistically diverse, in community settings. An outreach form of peer education may occur through formal networks, with the peer educators accessing people where they tend to congregate. Settings may include educational institutions, for example, schools and HEIs such as colleges and universities. Community settings include, for example, youth centres, drug agencies, health agencies, outreach services and clinics. Clubs are also regarded as community centres, according to Weiss and Nicholson (1998). Fors and Jarvis (1995) mention shelters for homeless or runaway youths as part of community structures. Miller (1996) recommends peer education to be done at juvenile justice centres, as well as in the workplace. Social settings include entertainment events, sports and recreation venues, as well as coffee shops. Other locations where particularly drug users congregate, are clubs, raves, pubs, parks and public toilets (Bleeker, 2001; Hunter, 1997; Todts, 1996; Turner & Shepherd, 1999).

2.15 THE AIMS OF PEER EDUCATION

Peer education aims to target the young people's knowledge, attitudes, values, beliefs, skills and behaviour. Initiatives may also differ in what they aim to change about a particular variable. Peer educators may aim to enhance their knowledge about the social and physical effects of various drugs, legal and ethical issues, prevalence of drug abuse, prevalence of drug-related sources of harm, etc. When they want to enhance certain skills, they would aim to recognise and respond to drug- related problems among family, friends and acquaintances, respond to an overdose, make informed decisions, resist peer pressure, and avoid drug-using situations. Once the focus is on behaviour change, peer educators would aim to prevent or stop drug abuse, delay the onset of drug use, prevent an increase in drug use, minimise risky behaviour and harmful practices and increase the frequency of looking out for and helping friends experiencing drug-related harm (McDonald *et al.*, 2003:23).

All of the abovementioned aims may be valid. However, they need to be matched with the circumstances and scope of the given peer education initiative. McDonald *et al.* (2003) suggest that the following issues have to be considered before embarking on any peer education initiative. Trainers have to ensure that the planned aims are achievable and measurable, and that the appropriate strategies are employed to meet the aims. They have to ensure that sufficient time and resources are available to implement appropriately. Finally, the aims have to be appropriate for the target group (McDonald *et al.*, 2003:23).

The aim of my project is to evaluate peer education training programmes at a HEI. HIV/AIDS has a major impact on all role players at HEIs.

2.16 PEER EDUCATION AND HIV

In reviewing the literature Mellenby, Newcombe, Rees and Trip (2001) found that peer educators are more effective in reaching out to their peers who may be at risk. However, they argue that peer educators were less effective in communicating factual knowledge with regards to sexual education than the adult peer educators. Sex education in schools is common, but the content of these programmes is questionable and does not address all issues relevant to sexuality. An example of this is found by Landry, Kaeser and Richards (1999), who found that nearly 35% of the school districts in the United States have set policies regarding sex education based on an abstinence-only format; only in limited cases was contraception discussed or

recommended. Kirby (2002) concurs that many HIV education programmes are implemented in schools, but that they do not cover the subject adequately. The importance of HIV education is unquestionable. However, it needs to be combined with a variety of content, which could also ensure a reduction in risky behaviours.

Peer education and counselling is one modality that has received some attention in the literature. This may be one effective method of facilitating positive health behaviours. An example of this is illustrated by Jay, Du Randt, Shoffit, Linder and Lit (1984), who found that adolescent girls who received information on oral contraception from their peers showed better compliance than those who went to consult with a nurse. Within the area of HIV prevention Borgia, Marinacci, Schifano and Perucci (2005) found that a peer-led HIV prevention programme resulted in much greater improvement of knowledge amongst high school learners than a teacher led programme. Peer education therefore offers a promising mechanism for delivering information about HIV/AIDS, because it utilises the energy of young people to create a social environment where they could interact with each other. This also tends to be a very inexpensive exercise for them. Peer education also gives adolescents access to different models that are familiar to them and they would in most likelihood enact these models of behaviour (Ozer *et al.*, 1997).

Klein and Sondag (1994) claim that universities and colleges have increasingly used the method of peer education to promote health. It has been a popular approach amongst health promotion professionals, because it takes advantage of the positive aspects of peer influence. An assumption of peer education is that students are more receptive to the influence of their peers. This is so because they share similar values interests. It is further assumed that because peers share similar values and interest, discussions with trained peer educators will facilitate understanding of health information. This will encourage them to change behaviour (Klein & Sondag, 1994).

2.17 THE BASE PROGRAMME (BE ACTIVE IN SELF-EDUCATION)

The BASE Programme (Be Active in Self-Education) is a programme that was founded in 1991 in New York City. This programme was developed in public schools to assist young high school learners to educate themselves on sexuality and particularly on HIV/AIDS issues (Cole, Nelson & Steele, 2008). Freudenberg and Radosh (1998) argue that schools provide the ideal and logical setting for HIV-prevention programmes, because they can reach a large number of adolescents simultaneously. The major aim of this programme is to help high school learners to

teach their peers about HIV/AIDS prevention in a manner that is youth orientated and easy to replicate. According to AIDS Action (2001), the BASE programme is guided by the assumption that young people are inherently smart and creative. Given the proper resources and supervision, young people will come up with effective solutions to the challenges they face. However, merely providing information about HIV/AIDS is not sufficient to inspire behavioural change. Young people must be involved in the learning process. Anyone who has lived through adolescence will know that young people have a tremendous influence on each other, lending strength to the principle of peer education for the group. HIV/AIDS education must be repeated over a considerable stretch of time. One-shot information sessions are not effective (AIDS Action, 2001:8).

The BASE programme is unique amongst HIV education efforts, as it attempted to include learners at all levels of the programme (BASE City Public Schools *et al.*, 1993). Learners were selected to serve on learner councils, some were chosen to be AIDS Ambassadors and others were co-opted to write grant proposals to implement new projects. All these learners played a major role in these various constituencies to reduce risky sexual behaviour and to encourage their peers to make healthy decisions with regard to sexual health (AIDS Action, 2001). Since the implementation of this programme, more than 10,000 learners have designed peer education projects, which were presented to over a million learners in the New York Public Schools (AIDS Action, 2001). Between 1995 and 1997 this BASE programme was replicated in seven other cities in the United States of America (AIDS Action, 2001; National Community AIDS partnership, 1994).

2.18 PEER EDUCATION AT HIGHER EDUCATION INSTITUTIONS (HEIs)

There are currently approximately 754,000 students enrolled at public universities in South Africa. These students' ages range from 18 to 30 years. There are also 300,000 students enrolled at Further Education and Training Colleges (FET) and approximately 50,000 students in private higher education institutions throughout South Africa (HEAIDS Report, 2010).

Many of these students are in the prime of their lives. Sexual activity is part of their experimentation and this often goes hand in hand with high rates of HIV infection and other sexually transmitted infections (STIs). This often is a result of new found freedom at university and being away from home with no adult supervision. University campuses therefore are ideally situated to offer peer education. HEIs present structured and informal opportunities for all these

students to meet and socialise in the absence of adult and community constraints. These opportunities often lend themselves to substance abuse and alcohol abuse, which might lead to irresponsible sexual activity and unsafe sexual practices. This quite often leads to engagement with multiple sexual partners, which places these young people at risk of contracting STIs and HIV/AIDS (HEAIDS Report, 2010).

On the other hand, students who decide to further their education become more receptive and open to different kinds of health education and health-promotion messages. They develop inquisitive minds and become more aware of a healthy body and mind. Students realise that in order to fulfil a lifelong dream to become educated, it is important to remain healthy, physically as well as psychologically. Being a student includes preparing oneself for a future. Very often this future goes hand in hand with a professional career, hence avoiding high-risk behaviour is part of preparing for this healthy future and a profession (Deutsch & Swartz, 2003).

2.18.1 The current model of peer education at HEIs

Currently the literature shows that peer education programmes on HEIs focus on the following:

1. Preventing the spread of HIV/AIDS and other STIs on HEI campuses;
2. Promoting social norms and providing support for developing healthy attitudes and behaviour on campus;
3. Reducing the stigma attached to living with HIV/AIDS;
4. Providing role models for healthy sexual behaviour on campus;
5. Providing education about human rights with special reference to issues of gender;
6. Encouraging participation in voluntary counselling and testing (VCT);
7. Encouraging participation in the care and support of people infected with HIV and sick with AIDS (Deutsch & Swartz, 2003).

These topics are extensively focused on, and are aligned with, the four roles that Rutanang (Refer to 2.18.2) proposes for peer educators. All HEIs in South Africa adopted this model (Deutsch & Swartz, 2003).

One of the main outcomes for the first phase of HEAIDS was a model for the establishment of peer education. This model has been used extensively by HEIs. It is called Rutanang (meaning "learning from one another" in Sotho) (Deutsch & Swartz, 2003).

2.18.2 The Rutanang model

The Rutanang model, "learning from one another", is a collaborative project of the South African Departments of Health, Education and Social Development, the South African Vice-Chancellors' Association (SAUVCA), numerous non-governmental organisations (NGOs) and selected United States (US) partners. The following sponsors made the materials available: the Harvard School of Public Health; the Association of Schools of Public Health through a cooperative agreement with the Centres for Disease Control and Prevention (CDC) and USAID. This project is intended to support life skills and HIV/AIDS activities within HEIs. It includes a set of documents that has been developed over a period of eighteen months. At least 300 people were involved in developing this material throughout nine provinces in South Africa. Three national consultative meetings were held to verify materials that were developed. At the national consultative workshops the sustainability of the series was also discussed and ensured. The major aim of the Rutanang process is to provide facilitators and participants an opportunity to reflect and evaluate the contents of the series. This will allow for programme improvement by both the facilitators and participants. Rutanang consists of a series of five books. The books include standards of practice for peer education in South Africa, a peer education implementation guide for NGOs, for schools and for HEIs in South Africa, as well as extensive lesson plans (Deutsch & Swartz, 2003).

2.18.3 Book 4: A peer education implementation guide for higher education in South Africa

In the executive summary of this series Dr Simela, Chief Director HIV/AIDS, STIs and Tuberculosis (TB), National Department of Health (2003:111) describes young people as the most vulnerable group to contract these diseases. She believes young peoples' discussions are mostly about sexuality with their peers. They talk, listen and learn about sexuality from one another. Adults therefore are not regarded as credible messengers to teach about abstinence and other responsible sexual behaviours. She said the following:

> *The necessary outcomes of HIV/AIDS education, including reinforcing accurate and consistent information, helping young people examine and change how they think and behave sexually, building their decision making skills, facilitating violence, require face to face discussion with people who are trusted, knowledgeable, accessible and relatively comfortable talking about sexual matters* (Deutsch & Swartz, 2003:111).

This is also the rationale behind peer education in schools, NGOs, CBOs and in HEIs in South Africa.

Another tool that was developed by HEAIDS is a CD-ROM, which was widely distributed to all HEIs for use in peer education programmes. A discussion on this tool will now follow.

2.18.4 "YOURE MOVES: A game of love and life" – CD-ROM

This educational CD-ROM was developed in 2003 by HEAIDS. All institutional officers responsible at the time for HIV/AIDS activities on their respective campuses were issued with a hundred copies. At the time of the development of this tool I was the institutional officer at my HEI. I distributed the CD to all faculties and departments and put some in the library. My copy I still use for educational purposes when I do HIV/AIDS education with youths at school or church level. This CD-ROM consists of games, which could be played by both male and females. It includes topics such as dating and relationships, hetero-, bi- and homosexual. It also speaks extensively to the abuse of alcohol and drugs. Lastly it spells out the dangers of contracting STIs and eventually HIV/AIDS. It also allows young people to test their own knowledge with regard to STIs and HIV/AIDS by doing the various quizzes on the CD-ROM. The CD-ROM ends with an extensive resources list, where these young people could access more information when required.

Examples of Quiz Questions are:

"Young people between the ages of 15-24 are particularly at risk of contracting HIV

True

False" (Your Moves – CD-ROM, HEAIDS, 2003).

At the end of each question the correct answer is given with an extensive explanation. These young people also get a chance to score themselves. By doing the quiz and the scoring, they are able to assess their own level of knowledge.

This CD-ROM is utilised in the HEI where the project is being done. It is used with the integration of the HIV/AIDS module into the curriculum (Your Moves-CD-ROM, HEAIDS, 2003).

This initiative from HEAIDS seems to have been very popular on HEI campuses Some libraries installed booths where students could access the CD-ROM in their own time and in this way expand their knowledge on sexuality, STIs and HIV/AIDS issues.

Story telling became another means of allowing young people to gain more knowledge and to deal with so many issues that they might have to cope with regarding to their own sexuality and HIV/AIDS.

2.18.5 Story telling

Story telling could be used by peer educators to relate stories about themselves, family and friends who are all affected by or infected with HIV/AIDS. One of the HEIs also used story telling as a means for young people to express themselves and to gain knowledge. This was particularly helpful in the child-headed households where the parents had died of HIV/AIDS. Some children also are left to grow up with elderly grandparents. By the time they reach HEIs they have so much "baggage" to deal with, particularly as they become more knowledgeable about HIV/AIDS and realise that's what their parents died of (Digital Story telling Project: Voices of the Youth-Soweto, 2006).

Many non-governmental organisations (NGOs) emerged that also contributed to HIV and tuberculosis education, not only in the communities, but also in HEIs. One of these NGOs is Mindset.

2.18.6 Mindset outreach programme

Mindset Health provides free digital health education. This content is presented in video, multimedia and print formats. It is also produced in various local languages, including Zulu, Xhosa, Sotho, English and Afrikaans. The major goal of Mindset is to promote health through the empowerment of health care providers and health workers. Together with Johns Hopkins University and USIAD, they produced eight 10-minute video case studies with facilitation guides for pre- or in-service training of health care providers in HIV/AIDS and tuberculosis. I was very fortunate to have the team come and do training on our campus. These facilitation

guides and videos are extremely educational and are also used in peer education training programmes.

This training material consists of different modules. Examples of modules are:

Module 1: Introducing Mindset network

Module 2: Overview of the Mindset health technology and content

Module 3: Facilitation skills and your role as facilitator

Module 4: Various HIV/AIDS-related topics, e.g. How to adhere to ARV treatment; Women and violence etc.

Mindset Health also has an extensive focus on outreach programmes, with a particular emphasis on peer education. The facilitators do peer education programmes at schools and amongst sports communities. Case studies consist of various topics on STIs and HIV/AIDS as well as tuberculosis (Mindset Health Facilitation Guide, Series 1, 2007).

2.19 UNIVERSITY OF WESTERN CAPE (UWC) AND UNIVERSITY OF ZAMBIA (UNZA) (ZAWECA HIV/AIDS PEER EDUCATION PROJECT)

Two HEIs, one in the Western Cape and one in Zambia, embarked on a combined effort to institute a peer education programme on their respective campuses. The collaborative project was referred to as ZAWECA. This was also part of forming partnerships and linking their academic work to extracurricular activities. Both these institutions believe in creating a caring and compassionate environment that would address the needs of students who are infected with or affected by HIV/AIDS. This project started in 2003.

The core aim of the project was to develop peer education programmes. The aim was to develop best practice models. Each institution developed its own model peer education programme in order to address its own needs. However, the team members on both HEIs constantly exchanged ideas and experiences. At the one institution all first-year students were exposed to basic information about HIV/AIDS and they were made aware of the availability of HCT and condoms. Students were also taught to address stigma and discrimination. The programme was also used to develop student leadership. This gave rise to students participating in peer education outreach programmes.

Peer educators were selected using a two-step selection procedure, comprising of a paper selection followed by individual interviews. The selected students then received intensive training for their new roles. The first two days of the training programme were conducted by an external facilitator. The training commenced with basic facts on HIV/AIDS. During these sessions peer educators were encouraged to reflect critically on their personal attitudes towards the disease. They are also expected to raise any questions or concerns. After the two days of introduction, the intensive four-day training commenced. This included life skills and growth, as well as the legal aspects of HIV/AIDS, diversity, facilitation skills, gender issues and group dynamics. Peer educators were also taken off campus. This allowed for team building. They had regular supervision session every two weeks. A total of 55 peer educators were trained at the end of the two-year period at UWC (ZAWECA HIV/AIDS Project Close Out Report, 2005).

The University of Zambia (UNZA) had a similar target group as the UWC programme, namely first-year students. However, UNZA also attempted to include senior students in the HIV/AIDS prevention and positive living programme. This programme focused on raising awareness on issues related to reproductive health, HIV/AIDS, and very specifically HCT. In contrast to the UWC programme, the UNZA programme placed a strong emphasis on one-to-one counselling. This was a strategy that has proved to be very effective in the University of Zambia's context. After selection the peer educators undertook an initial five day in-house training session on the main campus. Topics included HIV/AIDS, facilitation skills, risk management, self-awareness and communication skills. During the second year of the collaborative project portfolio building was included in the training sessions. UNZA students also started community outreach programmes to the surrounding communities. These included VCT drives, talk shows, discussion forums and panel discussions with commercial sex workers, and people living with AIDS. Senior students were used as guest speakers. At the end of the two-year pilot UNZA had trained 66 peer educators (ZAWECA HIV/AIDS Project Close Out Report, 2005). This project also led to an exchange programme between the two HEIs and it provided an excellent opportunity to experiment with regional collaboration in the context of HIV/AIDS peer education. Despite some project challenges, for example, communicating across two countries, the pilot could be regarded as a resounding success. It strengthened relationships and fostered many new relationships amongst staff and students (ZAWECA HIV/AIDS Project Close Out Report, 2005).

2.20 SUMMARY

To conclude this literature review a number of arguments are presented in the literature to support the use of peer education. These include the credibility of peer education as well as peer educators feeling less threatened and more empowered to fulfil their roles. Other factors that play a role in the success of peer education initiatives are ongoing contact between peer educators and target groups, and the potential for peer education to access marginalised populations. It is also cost effective and has numerous benefits for peer educators. A number of studies, reviews and meta-analyses have found peer education to be more effective than adult education (McDonald *et al.*, 2003:42). The literature review also highlights the attempts of HEAIDS to assist HEIs in South Africa in combating the HIV/AIDS pandemic. It also gives a clear indication of the statistics of HIV/AIDS globally, nationally and provincially.

The following chapter will outline the methodology and design that I will employ in my study.

CHAPTER 3

DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter will focus on the research design and methodology. I will discuss the research design used in this study to evaluate HIV/AIDS and STI training programmes for peer educators at an HEI. A description of the essential elements of the programme will follow, after which the chapter concludes with details of the methodology that was considered most appropriate to address the research objectives within the broader and local constraints of the study. Together with Social Cognitive Theory (SCT) and an interpretive framework, the Logic Model will be developed in the planning and implementation of the research. The research aims to evaluate and establish the influence of a peer education programme amongst students at a selected HEI in the Western Cape. The purpose would be to identify various best practices in, and the challenges facing, these peer education training programmes at an HEI in the Western Cape.

3.2 RESEARCH DESIGN

Babbie (2004:72) describes a research design as the plan of how the research enquiry would be undertaken. I will be using a formative evaluation research design. In formative evaluation the processes of the peer education training programmes will be assessed (Dane, 2011:299). With this evaluation design, I hope to explore how peer education training is being done at this particular HEI. In order to do this, I will evaluate all the programme administrators (the trainers and all staff involved) and the recipients (the peer educators and other students) who are involved in the programme and have a keen interest in it (Dane, 2011:300). In process evaluation I will be able to "see" and understand certain aspects of the phenomenon being studied, while other aspects might be concealed (Anfara & Mertz, 2006).

The design of this study was carefully planned in order to incorporate the following objectives of this study. The first objective of this research project is to explore how the HIV/AIDS Unit was establish and how its operations are linked to its mission and vision statement. The second objective is to evaluate the effectiveness and influence of the peer education and related training programmes in the HIV/AIDS unit, with specific reference to the peer educators experiences and how this would influence them. The third objective is to evaluate the experiences and

challenges of all the staff involved in the training programmes. This will include all the staff, administrative staff in the HIV/AIDS unit, as well as everyone who plays a role in the execution of these training programmes. Fourthly, I will evaluate the experiences of students who have attended a training session facilitated by the peer educators.

3.3 RESEARCH METHOD

For this study I will use an evaluation research design, applying a mixed methods approach to collect data. I will use a questionnaire to collect quantitative data. Qualitative data will be collected by means of focus group interviews, personal interviews, observation, document analysis and the assessment of student portfolios.

3.3.1 Programme evaluation

Programme evaluation is as old as social science research and has always been used for a specific purpose in such fields as education and public health. Examples of this are the provision of literacy and occupational training by the most effective and economical means and reducing mortality and morbidity rates from infectious diseases (Rossi, 1987:21). Immediately after World War II large-scale evaluation programmes were implemented for urban development and housing. By the end of 1960 large-scale evaluation programmes were commonplace and social scientists were engaged in evaluations of delinquency prevention programmes, rehabilitation programmes, etc.

The history of programme evaluation is quite interesting. Since the inception of social sciences, researchers focused on factors contributing to social problems in various communities. This research gave rise to other studies, which led to interventions on how to address these problems (Babbie & Mouton, 2001). Shadish, Cook and Leviton (1991) name Tyler in the educational field and Lewin in the social sciences as early forerunners of programme evaluation. According to Shaddish, Cook and Leviton (1991), Patton (1997), Pawson and Tilley (1997) and Babbie and Mouton (2001), programme evaluation only came to light as recently as the 1960s. This development of programme evaluation since the 1960s could be attributed to the American presidents Kennedy, Johnson and Nixon. They took a keen interest in the administration of education, finance and housing as well as health. This was particularly aimed at the alleviation of poverty among Americans. These presidents used terms such as "The War on Poverty" and "the establishment of a Great Society" to give real impetus to the institution of programme

evaluation (Shaddish, Cook & Leviton, 1991; Patton, 1997; Pawson & Tilley, 1997; Babbie & Mouton, 2001). Every year these presidents made substantial financial investments in education, finance and housing congresses. They expected a detailed account from the administrators on how this money was spent. Congress was also interested in how effective the programmes were as well as what the disadvantages were. Media reporting on these Congresses was extensive, highlighting any fraud or mismanagement of funds. The government at the time became increasingly aware of its financial obligations and spending of funds, and therefore insisted on thorough feedback and taking responsibility for the administration of government funding (Wholey, 2003).

According to Shadish, Cook and Leviton (1991), programme evaluation was made compulsory by instituting and applying relevant legislation. This legislation was promulgated in 1962. This also led to the professionalisation of programme evaluation. In 1993 the American Senate promulgated the "Governance Performance and Results Act", which further pressurised the public and private sector to focus on results-orientated programmes (Wholey, 2003).

Babbie and Mouton (2001) also give their reason why programme evaluation has become so important since the 1960s. They state that during the 1950s and 1960s the study of social science methodologies has developed in such a way that it became an acceptable scientific practice. All the technical support made programme evaluation possible.

The need for programme evaluation was identified. New job opportunities were created. This led to the implementation of many courses in programme evaluation at American HEIs. This gave rise to the establishment of the first professional society for HEIs which developed the first journal in the field of Social Science, called the *Evaluation Review* in 1976 (Shadish, Cook & Leviton, 1991).

Evaluation research was introduced very recently in South Africa. This research was mainly conducted in the education sector, e.g. the Department of Education, Joint Education Trust and the Bishop Tutu Educational trust. International agencies such as USAID and the Ford Foundation also employ huge amounts of money in projects here in South Africa. This requires continuous programme evaluation and monitoring (Babbie & Mouton, 1992:337). Today there is a very young and vibrant culture of research on programme evaluation in South Africa, particularly in higher education institutions, and various programmes and projects are being

monitored and evaluated as it is important to measure the success or the outcomes of these projects or programmes.

In South Africa programme evaluation only really came into its own in the late 1980s (Babbie & Mouton, 2001). This was especially so with regard to educational programmes. Many of the overseas funders insisted that programmes be evaluated and that audited feedback be given. Various government departments, for example, the Department of Health and Social Welfare, appointed different departments for the monitoring and evaluation of programmes. This was particularly done with the focus on the evaluation of the Reconstruction and Development Plan after 1994 to alleviate poverty.

Babbie (2004) describes a social intervention "as an action taken within a social context for the purpose of producing some intended results". Herbert Spencer (in Babbie & Mouton, 2004), a Social Darwinist, believed that the world is plagued by all kinds of social ills such as crime, poverty, unemployment, illiteracy and injustice. He reasoned that it is only by devising various interventions on all levels in society that we are able to improve the lives of human beings who are poor, illiterate and unemployed. The first programme evaluation studies were conducted as far back as the eighteen-century in the fields of education and public health. But greater emphasis was placed on these evaluation studies during the 1930s with the outbreak of the Great Depression in the United States of America (Babbie & Mouton, 1992:336-337). It was only during the 1960s, when Lyndon Johnson declared "war on poverty" and various governments started to pay attention to different kinds of interventions, that programme evaluation became an accepted research enterprise (Babbie & Mouton, 1992:336).

The purpose of programme evaluation is to improve and refine existing programmes, meet accreditation requirements and to ensure proper management of programmes. Michael Patton (1997) describes the purposes of evaluation studies by classifying them under uses or purposes – for example, audits, quality control and accreditation or licensing; improvement of programmes, for example, formative evaluation, identifying strengths and weaknesses and managing more effectively; and lastly, to generate knowledge through building new theories and models to inform policy (Patton, 1997:76). Pattern (1997) argues that improvement-orientated or developmental evaluations use more inductive strategies. In these strategies criteria are less formal as the researcher searches for different strengths and weaknesses that may emerge from the study of the programme. In this project the researcher hopes to combine these strategies in

order to make recommendations to address the challenges, strengths and weaknesses faced in the peer education training programmes for both trainers and peer educators.

Examples of improvement-orientated evaluations are formative evaluation, quality improvement, responsive evaluation and empowerment evaluation. These types of evaluations all pose different types of questions, such as "Has the programme been properly implemented? What are the constraints preventing proper implementation and what are the strengths and weaknesses?" (Babbie & Mouton, 2001:338-340). Participants' responsiveness to the programme is also being closely monitored and evaluated.

During improvement-orientated evaluations it is important to collect data for specific periods of time at the beginning of an intervention or very early in the implementation phase. This will allow the researcher to make suggestions about improvement early on in the implementation phase. The participants will also be allowed to make the necessary adjustments to progress towards the desired outcomes. Information systems could also be employed adequately to monitor programmes, to track implementation and to provide regular feedback to the programme managers.

Some people might just seek to gain knowledge by trying to understand the programme better as well as to reduce the risk of failure and uncertainty. Others may only seek to satisfy funders and major stakeholders (Babbie & Mouton, 2001:339). Babbie and Mouton (2001) refer to this as knowledge-orientated evaluations. The challenge in using this type of evaluation is concerns about people being too judgmental and how they apply the application. In both cases a decision has to be taken whether to continue with a certain programme, particularly if it depends on funding (Babbie & Mouton, 2001:339). The other option is to decide to continue with the programme, but to make major improvements. This will often depend on how willing trainers and participants are to change their attitudes and what their understanding of the programme is. Only then will the generation of new knowledge take place. This new knowledge could be identifying a new model or an underlying theory, which might be able to highlight the differences between types of interventions. This could also enforce policy options and decision-making (Babbie & Mouton, 2001:339).

When evaluators aim to establish the intrinsic value, merit and worth of a programme, then it is called judgment-orientated evaluation (Babbie & Mouton, 2001:337). This could be cited as the main reason why evaluations are undertaken. The following questions are most frequently asked

when these types of evaluations are being done:" Was the programme successful; did it achieve its goals? Was the intended target group reached?" Babbie and Mouton (2001) also refers to the degree of "accountability", "compliance" and "audits" as an indication that some form of judgment call is being made. Formulating specific criteria against which the judgment call could be made is crucial. Funders of programmes will normally stipulate the criteria related to "economics", for example, efficiency and cost effectiveness. Political stakeholders might be more concerned with accountability, whereas programme managers might be more goal orientated. Other stakeholders, for example, SAQA, might be more interested in quality assurance (Babbie & Mouton, 2001).

Patton (1997) describes judgment-orientated evaluations following a four-stage pattern as follows: first, selecting criteria of merit and worth; second, the setting of standards of performance for measuring outcomes, for example; third, measuring performance quantitatively; and fourth, synthesising results into a judgment of value (Babbie & Mouton, 2001:338).

Rutman (1984) refers to theoretically based programme evaluation as "the use of scientific methods to measure the implementation and outcomes of programmes for decision-making purposes" (Rutman, 1984:10). Rutman also refers to "programme as any intervention or set of activities mounted to achieve external objectives" (Rutman, 1984:11). In doing evaluation research, the researcher aims to have a specific purpose and will utilise a specific research method (Babbie, 1992:348). Programme evaluation is as old as social science research and has always been used for a specific purpose. With this research, the researcher wishes to evaluate peer education programmes at an HEI as spelled out in the objectives indicated in Chapter 1 (Refer to 1.4.2). Fundamentally, evaluation research is appropriate whenever some social intervention occurs or when it is planned. Students are social beings and interact with each other on a regular basis, more so in peer education programmes in HEIs. In these programmes students interact within a social context with the purpose of producing some intended results. In doing evaluation research, the researcher is able to determine whether the intended result was produced (Babbie, 1992:346-348).

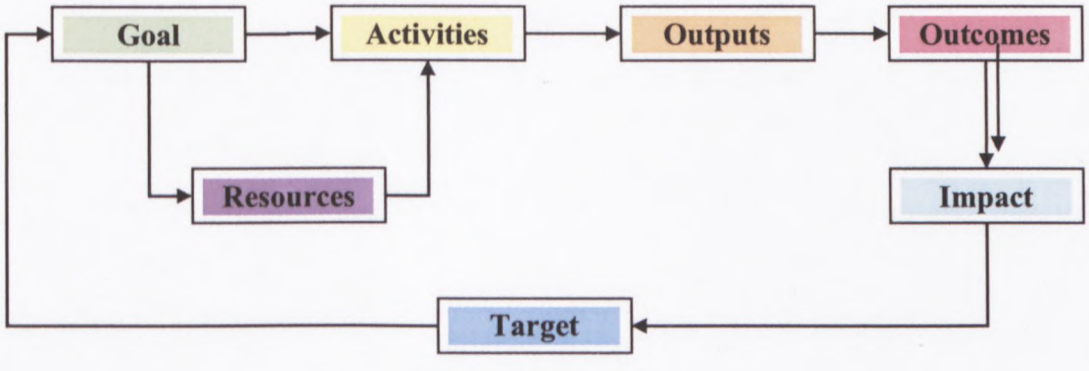
Cronbach (1980), Pawson and Tilley (1997) recognises the tension between theory and practice, particularly when experiential methods are being employed in the field. In this project I will apply the SCT framework combined with an interpretive framework in order to attain the objectives of this study. Weiss (1998:55) says that there is no right or wrong method in applying a specific theory. Hence I will apply SCT included in an interpretative framework to construct

peer education training programmes using a Logic Model. This theory may allow me to express a detailed programme plan and rationale in the programme structure and activities for peer education training programmes (Taylor, 2008). As part of this structure and theory construction, I will adapt the Logic Model as part of my methodology.

3.4 LOGIC MODELLING

A logic model is a visual representation of a plausible and sensible method of how a programme will work under certain conditions to solve identified problems and is fundamental to programme evaluation (Funnel & Rogers, 2011:278). It is an essential tool for programme evaluators to use during the process of evaluation (Bickman, 1987). It is a picture of why and how you believe a programme will work. It provides a good framework, which I could revisit throughout the planning, implementation and the evaluation phase of my study (Evaluation Briefs: CDC, 2009; Taylor-Powell & Hennert, 2008). Similar to a flowchart, it lays out programme activities and outcomes using boxes and, using arrows to connect the boxes, it shows how the activities and outcomes are linked with one another as indicated in Figure 3.1 below.

Figure 3.1: Steps of the Logic Model (Patton, 1997)



There are many terms used to refer to causal models, which describe how a programme is understood or intended to contribute to its specified outcomes. The choice of term used is often based on local responses to the words "theory" and "logic" (Rogers, 2004:4) and can range from Logic Model to Programme/ Results/ Theoretical/ Logical framework or even Programme Theory. The terms "Programme Theory" and "Logic Model" are often used interchangeably, but neither of the terms is clearly defined in the literature. In this project I will use SCT as the theoretical framework, but will develop a Logic Model to illustrate the programme objectives,

activities and outcomes as described by (Rossi, Lipsey & Freeman, 2004; Taylor-Powell & Hennert, 2008; CDC, 2009). Programme characteristics may include the population to be reached (target group), the resources to be used, and identification of the types and levels of service elements (Rossi, Lipsey & Freeman, 2004; Taylor-Powell & Hennert, 2008; CDC, 2009). In this project the target group will be the peer educators and the staff of the HIV/AIDS Unit at a specific HEI. I would attempt to communicate the underlying "theory" or set of assumptions or hypothesis that the peer educators and the HIV/AIDS Unit's staff at a specific HEI have about the peer education training programmes, why the programme will work, or why it is a good solution to an identified problem, or note challenges that they face within the Unit (Rossi, Lipsey & Freeman, 2004; CDC, 2009).

Logic Models can be applied to different types of evaluations ((Rossi, Lipsey & Freeman, 2004).

- In **Clarificatory Evaluation** the Logic Model is used to understand the programme – exactly how the activities link to objectives and outcomes, and how this will all lead to sustainable change in the target group.

- In **Process Evaluation** the Logic Model is used to identify expectations about how the programme should work; an "ideal type" – which can then be used to assess the deviations in practice, why these deviations have occurred, and how the deviations may affect programme outputs. This assists programme managers (and evaluators) to identify differences (including positive and negative unintended consequences), and to consider possible mechanisms for fine-tuning programme operations to align the actual programme with the planned approach, or re-visit programme strategies to consider alternatives.

- In **Performance Monitoring** the Logic Model is used to focus on which kinds of output and outcome indicators are appropriate for specific target populations, communities, or time periods. For example, among indicators of learner improvement in school, one might expect attendance to improve in the first semester of a programme, but academic test score improvement only after a significant period of programme participation, with the timing possibly varying by the age and developmental stage of the children.

- In **Impact Evaluations** the Logic Model is used to spell out how, and for whom, certain services are expected to create specific changes/benefits. For example, if the programme includes parenting classes, the Logic Model will identify this activity as a key programme

component and show the types of changes in parenting that will be used to measure programme outcomes (e.g. by improving parental assistance with homework or helping parents communicate more effectively with adolescents).

There are many benefits to developing a Logic Model – both for evaluators and programme managers. Logic Models could be very useful to programme managers and evaluators. They improve the understanding and conceptualisation of the programme. They also enhance shared understandings by all stakeholders of the programme and allow for participants to monitor their own progress within the programme. They encourage increasing engagement by participants, which will lead to ownership and self-determination by all stakeholders (Patton, 1999).

3.4.1 The development of the Logic Model for this project

If you are developing a Logic Model for the first time, a very simple graphical representation of the programme will suffice. I would start this model at a strategic point that is easily understandable. Afterwards I would construct the model further, as the research unfolds. Through out the construction of the Logic Model, I would keep the aim of my study in mind (Rossi, Lipsey & Freeman, 2004).

The following Logic Model **(Step 1)** is how I started to think about the construction of the Logic Model for this project. I asked myself the following question; "What is it that the HEI wants to change and how are they going to do it with regard to peer education training programmes?" The peer education programme consists of different strands of activities. Each of these strands needs to be developed separately with its own outcomes and clearly show linkages where they occur.

In the planning phase I attended a meeting with the institutional HIV/AIDS committee, where I sought permission to do the research. I was given an opportunity to explain my project in detail. A month later I subsequently met with the peer educators, where I was introduced by the trainer in charge of the programme. The HOD of the Unit was also in attendance and reiterated the importance of this research project. I was given some time to explain my role for the next 18 months within the HIV/AIDS Unit. I then explained my research project in detail. On this occasion I made all attempts to receive verbal approval from the peer educators to be my research subjects. At a follow-up meeting I discussed dates and venues to begin data collection.

In **Step 2** it is possible to develop a slightly more complex version of the planning. The next version of the Logic Model identifies the following basic components in all interventions:

- Goals and objectives;
- Inputs and resources;
- Programme activities;
- Outputs;
- Target group definition;
- Outcomes (immediate/ intermediate/ long-term or "impact").

A good understanding of the programme means that I am in a position to

- understand the key issues involved in the peer education training programmes;
- formulate appropriate evaluation questions;
- collect and analyse appropriate data;
- come to appropriate conclusions;
- make useful recommendations.

In **Step 3** a report in a useful format to stakeholders involved should be written (Taylor-Powell & Henert, 2008; Funnel & Rogers).

In applying the SCT, assisted by an interpretive framework, I was able to develop a clear understanding of the peer education training programme, followed by the developing of a Logic Model. Within this Logic Model the project's goals and objectives, inputs and resources, programme activities and intended outputs could be clearly defined and expressed (Taylor-Powell & Henert, 2008; Funnel & Rogers). It is often time consuming and becomes quite intriguing when you try and draw all these lines and arrows (Refer to Figure 3.1), but it is an essential step as It helps you to make all the logical connections. Some researchers depict a Logic Model as a circle, which indicates a connection between the beginning and the end. The reality of any project is that it rarely remains the same right to the end, as situations and environments change as the project unfolds (Taylor-Powell & Henert, 2008).

In structuring the Logic Model clearly and logically, as illustrated in Table 3.1 below, it provoked my thoughts and it allowed me to engage with the construction of ideas appropriately. This allowed me to apply the Logic Model to my project more effectively (Patton, 1999; Wider Foundation, 2009).

Table 3.1: The construction of the Logic Model for this project (modified from Patton, 1999)

CLARIFYING PROGRAMME THEORY:

1. **Problem or Issue Statement**:

   Challenges faced by trainers and peer educators in the peer education training programmes

2. **Target Group:**

   Peer educators and trainers

3. **Influential Factors**:

   Peer pressure, time management, punctuality, absenteeism, workload of trainers

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DEMONSTRATING YOUR PROGRAMME'S PROGRESS:

1. **Outputs:**

   Developing training material for both peer educators and trainers; organise group discussions and workshops for both peer educators and other students

2. **Outcomes:**

   Trained and committed peer educators who could reach out to other students across the campus

3. **Impact:**

   Peer educators to influence their peers to change their behaviour towards sexuality, HIV/AIDS and related issues; to draw more students to the HIV/AIDS peer educator programme

4. **Activities:**

   Conducting of various workshops related to sexuality, HIV/AIDS and STIs for peer educators; plan various events on campus where peer educators are involved e.g. HCT drives, distribution of condoms

5. **Resources:**

   Well trained staff; financial resources to provide materials, transport and refreshments to conduct the training workshops and to do outreach activities in the community

↓

PROGRAMME EVALUATION QUESTIONS AND INDICATORS

1. **Focus area:**

   Peer educators HIV/AIDS and STI training programmes

2. **Audience:**

   Trainers involved in the peer education programmes; peer educators

3. **Questions:**

   Do the programme and its peer educators address issues related to sexual behaviours, HIV/AIDS, STIs and similar issues on the campus and in the community effectively? How knowledgeable are the peer educators about subjects with which they work? How motivated are the peer educators in carrying out their activities?

4. **Indicators:**

   Peer educators will be selected according to specific criteria by the HIV/AIDS Unit's staff; the willingness and commitment from each peer educator.

3.4.2 The Logic Model applied to this project

Objective	Activities	Outputs	Outcomes	Data to be collected	Data Source
1. To describe the formation of the HIV/AIDS Unit and how it is linked to its mission and vision statement	1. To review all documentation related to mission and vision statement and strategic goal and objectives	1. Staff are reminded in strategic planning with regard to the mission and vision statement of the Unit	1. Dedicated staff who live up to the mission and vision statement of the Unit	1. Personal interviews with all Unit staff	1. Transcribed interviews 1.2 Documentation on vision, mission statement and strategic goals and objectives
2. To evaluate the effectiveness and influence of peer education and related training programmes in the HIV/AIDS unit amongst the peer educators	2.1 Develop training material for every training session for the peer educators 2.2 To conduct various workshops on sexuality, STIs and HIV/AIDS Issues	2.1 All peer educators selected should commit to the training programmes and various events related to their training 2.2 Attendance register of peer educators 2.3 Trained and orientated peer educators who understand the benefits of the peer educator training programme	2.1 Peer educators will have improved knowledge on HIV/AIDS and STIs and facilitation skills 2.2 Improved understanding amongst all peer educators of all the topics discussed 2.3 Improving networking and peer support	2.1 Focus group interviews with all peer educators participating in the training programmes 2.2 A questionnaire to be completed by each peer educator in the peer education training programme 2.3 Assessment of students portfolios	2.1. Transcribed interviews that will be coded and put into themes 2.2 Completed and captured survey data, using SPSS 2.3 Assessment of students portfolios
3. To evaluate staff's experiences and challenges in the implementation of the training programmes in the HIV/AIDS Unit	3.1 Train the trainer workshops to update trainers on various aspects of sexuality, STIs and HIV/AIDS	3.2 Staff ready to be trained within the HIV/AIDS Unit 3.3 Attendance register of all staff attending training sessions	3.3 Comprehensive trainers manual for each staff member involved in training peer educators	3.4 Documentation analysis of primary and secondary documentation related to the training programmes and events. 3. Personal interviews with all staff involved in the training programmes	3.5 Observation of various events and training sessions 3.6. Documentation analysis of primary and secondary documentation related to the training programmes and events. 3. Transcribed interviews, coded and put into themes
4. To illustrate the experiences and influences of students who attended various activities hosted by the peer educators and the HIV/AIDS Unit	4.1 Organise workshops and discussions by the peer educators themselves for other students on campus 4.2 Providing resources for peer educators in order to make discussion groups and workshops possible with their peers, e.g. materials such as pamphlets, posters, transport and refreshments	4.2 Attendance register of peer educators, as well as the attendees	4.3 Organise workshops and discussions to discuss results of project with all other HIV Directorate staff across the country	4.4 Focus group interviews with the other students who attend these workshops and discussion groups	4.5 Transcribed interviews, coded and put into themes

I could keep track of the development of the Logic Model by keeping a checklist. The following checklist was modified according to the example of the Wider Foundation (2009), so that I could continuously keep track of how the Logic Model for this project was developing.

Table 3.2: Logic Model checklist adapted from Wider Foundation, August, 2009

	YES	UNSURE	NO
Do the outcomes represent meaningful benefits or changes for participants?	X		
Will the outcomes help you communicate the benefits of your programme?	X		
Are your outcome goals clear and understandable?	X		
Are your outcome goals realistic?	X		
Does your model include the outcomes of greatest importance to your key stakeholders?	X		
Is it reasonable, based on research, theory, or common sense, to assume that the programme can influence outcomes in a substantial way?	X		
Does the model include all important programme activities that participants receive?	X		
Does the model make appropriate connections between inputs, activities, outputs and outcomes?	X		

3.4.3 Critique of programme evaluation

Rossi and Freeman (1987) argue that evaluations are undertaken for various reasons, for example, to judge the worth of ongoing programmes and to estimate the usefulness of the attempts to improve them; to assess the utility of innovative programmes and initiatives; to increase the effectiveness of programme management and administration. Evaluations may also contribute to substantive and methodological social science knowledge. Scholars like Schriven (1998) and Stufflebeam (2001 as cited by Huey-Tsyh Chen, 2005) claim to have identified flaws in theory-driven programme evaluations. Scriven (1998) separates the merit of a programme from evaluating a programme. Scriven totally ignores the fact that evaluators can have their own bias, particularly if they use a theory that was developed by themselves. Like Scriven, Stufflebeam (2001) also does not recommend theory-driven outcome evaluation. He suggests that a conflict of interest might arise, if evaluators develop their own theory and then decide to evaluate the theory. He further argues that theory driven outcome evaluation depends on a base of sound theories, which few programmes could point to as their foundation. He is also of the

opinion that theory-based outcome evaluation is too difficult to do correctly (Stufflebeam, 2001 in Huey-Tsyh Chen, 2005:233-234). However Huey-Tsyh Chen (2005:233-235) claims that Stufflebeam's stance on the difficulty of conducting evaluation research has not yet been substantiated with any evidence-based research. Huey-Tsyh Chen (2005) is convinced that through the correct application of programme theory, procedures could be carried out with minimal difficulties, which could result in useful conclusions. In this project an attempt has been made to describe the programme theory in such a way that it will appropriately differentiate among objectives, activities, outputs, outcomes and resources (Funnel & Rogers, 2011:297).

3.5 METHODS OF DATA COLLECTION

This project used a mixed method for data collection. Tashakkori and Cresswell (2007) describe mixed methods research as research *"in which the investigator collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative approaches and methods in a single study or a program of inquiry".*

However, several definitions of mixed methods have emerged over the years that incorporate various elements of methods, research processes, philosophy and research design. Greene, Caracelli and Graham (1989) and Cresswell and Plano-Clark (2010) in their definition of mixed methods focused on methods and philosophy, whilst Johnson, Onwuegbuzie and Turner (2007) focused on qualitative and quantitative research methods. It is evident from these definitions that some authors include various elements of methods, research processes and philosophy and research design when dealing with mix methods research.

Mixed method research provides strengths that offset the weaknesses of both quantitative and qualitative research. Jick (1979) argues that this has been the historical argument for mixed methods for the last thirty years. He argues that quantitative research does not understand the context and setting in which people talk. In contrast, qualitative research is very aware of the kinds of settings that people talk in. With quantitative research, the researcher is in the background and seldom discusses his or her own personal biases or interpretations. In qualitative research the researchers make their own interpretations and their own biases come into play. Researchers are able to use all the tools available rather than being restricted to one of the two methods. A mixed method also addresses questions that cannot be answered by a single method alone and it provides a bridge across the sometimes adversarial divide between qualitative and quantitative researchers. This method also encourages the use of multiple

worldviews or paradigms (for example, beliefs and values), rather than the typical association of certain paradigms with quantitative and qualitative research. This method is also very practical, as it allows the researcher to solve a problem by using both numbers and words. Understanding the essential issues of rigour in quantitative research as well as reliability, validity, experiential control and generalizability is very important for anyone who embarks on a mixed method approach (Creswell & Plano Clark, 2011:5-14).

A mixed methods approach is a research design that allows the researcher to search for a general understanding of values, the most basic beliefs, concepts and attitudes of an individual or group. In this project the specific group would be peer educators at a HEI. I hope that engaging in a mixed method approach allowed me a better understanding of the research problems in this study in order for me to analyse and interpret my data within an interpretative framework and through the lens of SCT (Cresswell & Plano Clark, 2011:5).

3.5.1 Selection of participants for my research

I will be using convenient sampling for this study. Mertens (2010:145) defines sampling as "the method used to select a given number of people or objects from a population". Since I will be evaluating peer education programmes, my target group would be all the peer educators that would be selected for the programme by the HIV/AIDS Unit's staff. This would give as many students a chance to be selected to participate in the research. Hence, every member of the peer education population actually has a possibility of being in this sample group (Denscombe, 2011). I will start with identification of the peer educators in order to select the participants. The setting will be a HEI. Convenience sampling means that the persons participating in the study were chosen because they were readily available (Mertens, 2010). In February, 2010, forty peer educators who met the entry criteria were selected and were part of the peer education training programmes at this particular HEI.

3.6 DATA COLLECTION TECHNIQUES

I utilised a self administered questionnaire to collect quantitative data for this study.

3.6.1 Questionnaires

Questionnaires are a means to elicit information from subjects through written responses (Burns & Grove, 2009:406). The questionnaire that was used in this study was adapted from the CDC's

Youth Risk Behaviour survey (YRBS) that had been implemented nationally in secondary schools in Texas. The revised university version is known as the YRBS-C and consists of 84 dichotomous (yes-no) and multiple-choice items. The survey also asked for demographic data and personal behaviours in the areas of alcohol and other drug use, violence, sexuality, nutrition and exercise. This questionnaire is thirteen (13) pages long (CDC's Youth Risk Behaviour survey (YRBS, 2011) (Refer to Appendix 2).

The analysis of the questionnaire data will serve to refine the interview guide that will frame the semi-structured focus group interviews, which would follow at a later stage in the study. Denscombe (2011:157) describes questionnaires as a very good way to gain information on both facts and opinions in practice. The following types of questionnaires could be used for data collection; mailed or telephonic; on a website and self-administered (Burns & Grove, 2009:406). I made use of the self-administered questionnaire, which was given to peer educators at the same time. This helped to ensure that the return rate was higher. As far as possible, I used examples before any item that might be confusing. This is especially important if the item involves ranking responses. Respondents were shown exactly what they needed to do. An attempt was made to organise the questions into a logical sequence. The questionnaire started off with a few interesting and non-threatening items. The questionnaire was administered in a lecture hall at this HEI.

3.6.2 Focus group interviews

Berg (2009) claims that focus group interviews give the researcher an opportunity to observe how the participants socially construct knowledge in their attitudes, opinions and experiences in much detail. Burns and Grove (2009) say that focus groups were designed to ascertain the participants' perceptions in a focused area in a setting that is non-threatening. The effective use of focus groups needs careful planning. It is important to be clear on what the aims of the focus groups are and how one would recruit for the focus groups. I did focus groups with all the peer educators, as well as other students in residences who participated in group discussions, which were facilitated by these peer educators. I discussed venues with the trainers as well as the dates and times when the interviews would take place. The trainers were instrumental in assisting me to organise the focus groups with the peer educators. Both the trainers and peer educators assisted me with the arrangements for the focus groups with other students in the residences on the three different campuses of this HEI. All participants signed a written consent form, prior to the focus group interviews (Refer to Appendix 20 and Appendix 21). During the focus groups,

the subjects were valuable resources of information, and they were able to report and articulate their feelings. I was able to observe some of the group dynamics that existed among participants. All focus groups were recorded with a digital hand recorder and transcribed.

3.6.3 Personal interviews

Personal interviews would be conducted with all the staff in the HIV/AIDS unit. I attended two staff meetings with the HIV/AIDS Unit to discuss the research during the initial planning phase of the study. Staff in the HIV/AIDS Unit consists of the HOD, the receptionist, the two office management interns, the two health promoters and the two staff members who head the peer education training programmes. The unit also facilitates international students on an annual basis. These students come to work voluntarily in the unit. At the time of data collection the HIV/AIDS Unit was hosting two students from Germany. They willingly volunteered to be interviewed. However, they requested to be interviewed together. I granted this request. I recorded all interviews with a digital hand recorder. Each participant signed a written consent form prior to the interview. A moderator was present during all the interviews (Burns & Grove, 2009:513) (Refer to 3.6.2). All the interviews took place in the meeting room in the HIV/AIDS Unit, so that the staff could return to their work stations at completion of the interviews.

3.6.4 The Moderator Role

Appointing a moderator is important. Professional moderators bring their experience in working with people to the focus group. Krueger (1996: 38). I had arranged for a moderator to be present during all the focus group interviews (Burns & Grove, 2009:513). This also enhanced the validity and the ethicalness of this research project, as the moderator ensured that all participants were dealt with in a respectful and fair manner. After moderating a few focus groups, the moderator might feel that he had heard the topic being discussed in various ways and by now the information is regarded as old "stuff". However, it still deserves the utmost respect and listening that was present the first time he heard the information. Lack of respect will quickly be passed on to participants. This might essentially lead to the shutdown of meaningful communication(Krueger,1996;3-4).The moderator should be a knowledgeable person and should be up to date with research methodology, as well as the topic to be discussed. The moderator will be able to have a powerful influence on the process of interaction that will take place within the group. The way in which the moderator behaves, plus the verbal and non-verbal cues that he or she gives to the group, are crucial elements for a focus group to be successful.

Extreme dominance or extreme passivity from the moderator, may lead to problems (Burns and Grove, 2009). Empathy and positive regard for all people are critical qualities for an effective moderator. The moderator should also be ready to hear unpleasant views. In order to do this, the moderator has to be self disciplined. Focus groups could be jeopardised if moderators cannot hold back their personal opinions. The moderator should be professional and therefore will be able to stay emotionally unattached to the topic and stay neutral at all times (Krueger, 1996, 5- The moderator that attended all the focus groups and personal interviews, is indeed a credible person who has many years of not only lecturing research, but are hands on currently with many high profile research projects. He possesses unique talents and skills which make him an accredited and experienced moderator as described by Krueger (1996: 7) (refer to Appendix 3).

3.6.5 Overview of portfolios

Spaulding and Straut (2006:69) describe portfolios as a cornerstone in education as they felt that portfolios played a major role in the authentic assessment movement in studies which examined portfolios for their effects on students' learning. Portfolios are known to be used in subjects like Science, Mathematics, Literacy and Social Studies (Roth, 1994 cited in Spaulding & Straut, 2006:69). A substantial portion of the literature on portfolios focused on the training of student-teachers. Portfolios are regarded as one of the most important assessment tools in the training of teachers. They also assist new teachers to find employment, as well as to determine whether the student has successfully completed his/her training and whether the student is ready to graduate from teachers training college (Barton & Collins, 1997; Klekker, 2000; Morgan, Shannon & Ball, 1996). Mertens (2010:355-358) discusses performance assessment in tandem with the compilation of a portfolio. He claims that a portfolio might include collections of the participants' work on which the participant's performance could be assessed. This work might be written assignments, video recordings, or solutions or recommendations for problems. As times are changing and HEIs are moving with technology and the integration of technology into classroom instruction, portfolios used in teacher preparation programmes have also begun to use technology. However, a review of the literature on the electronic use of portfolios is more opinion based than empirical. Those persons lobbying for e-portfolios reported innovation and creativity from those who used them. They also encourage interactivity amongst all stakeholders. These stakeholders include both the trainers and the student teachers at HEIs (Spaulding, Straut, Wright & Cakar, 2006:69).

In this project portfolios were used as part of the training of peer educators. Therefore, stakeholders were both the trainers as well as the peer educators. During the training programmes the peer educators are taught how to compile the portfolio. They are also taught how to make a power-point presentation. These students are expected to make use of power-point presentation when they have to facilitate a group or do a presentation. Each peer educator had to compile a portfolio of all their training sessions, community outreach and proof of leadership, while they were executing their duties as peer educators. These portfolios are marked and peer educators are given an equal chance to be rewarded in the different categories at their annual awards ceremony.

There are challenges that researchers face when using portfolios as part of their data collection, particularly in evaluation studies. This is basically because of the subjective nature of the collection process and the scoring of the data assessed in the portfolio (Mertens, 2010:357). The two co-assessors were extremely subjective, as they knew the peer educators on a more personal level and interacted with them more frequently than I did. They tend to be more lenient towards the peer educators, because they were close friends. They also did not want to severe their relationship with the peer educators, as these peer educators were the people that they socialise with outside of working hours as well. The two markers therefore made themselves guilty of favouritism. Here the subjective nature of the assessment, as described by Mertens (2010), is very relevant as it could lead to bias, which was the case in this project. I discussed this afterwards with the HOD and training officers and make some recommendations for the assessment of portfolios in Chapter 4 (Refer to Appendix 17). This could also influence the peer educator's chance of coming into consideration for an award. Most of the peer educators completed their stint in this training programme and did not necessarily enter into the programme the following year again.

I made use of a rubric to develop new portfolio guidelines, for future use in this Unit for the assessment of the peer educators' portfolios (Refer to Appendix 17). A rubric presents a "gradation of performance from poor to excellent or above standard, at standard or below standard. A scale value is assigned to each gradation (1 = poor, 5 = excellent)" (Mertens, 2010:357). Portfolios could provide a wealth of information, as was proved by the teachers training programmes. This will also be relevant for my study, as peer educators had to provide evidence in the portfolios of their involvement, leadership and acquired skills, as well as how they transferred those skills to their peers.

3.6.6 Observation

Data collection by means of observation is often described as the main research tool or as a supplement to other methods (Sapsford & Jupp, 2006:57). I used the less structured or qualitative method of observation, where I observed and witnessed first hand the experiences of the events as they were happening around me (Descombe, 2011; Sapsford & Jupp, 2006:57). Through this I directly gained valuable knowledge and information. This assisted me in my understanding of the operations of the peer education training programmes (Sapsford & Jupp, 2006:57-58). Without any observation, participation or interacting with the peer educators and trainers, it would not have been possible to gain in-depth insight into the peer educators' activities. Here I remain an observer from the outside. This also happens in a much less formal and unstructured manner (Babbie & Mouton, 2004:293; Sapsford & Jupp, 2006:57). In contrast, I could have been part of the observational research in a much more structured and systematic way. In this way the researcher is a member of the group that he/she is studying, while doing the study herself (Babbie & Mouton, 2004:293; Sapsford & Jupp, 2006:57).

During observation I observed the frequency of events and how long they lasted. At all times the peer educators' behaviour and body language, as well as their interaction with the trainer, were noted. During the observation process I made field notes and I gained an insight into how peer educators and trainers responded to each other in a given situation and in particular circumstances while they were involved in training (Denscombe, 2011:200-208).

It is hoped that through acquiring this knowledge and these skills, students will be influenced to change their attitudes and behaviour with regard to sexuality, HIV/AIDS and STIs.

3.7 DOCUMENT REVIEW

Henning (2011:98-99) states that the collection of documents and other artefacts that might be important in a research project is often neglected in qualitative research. These documents include any handwritten, computerised or printed format work. Documents may be hard copies or electronic, and may include reports, performance ratings, funding proposals, meeting minutes, newsletters and marketing materials (Evaluation Briefs: CDC, 2009). Plat (1981) and Scot (1990 cited in Descombe, 2011) argue that documents need to be evaluated in relation to certain criteria.

I will review the following documentation of the HIV/AIDS Unit: peer education meeting minutes, reports and evaluations on some workshops, different training programmes, for example, HIV/AIDS module (Refer to Appendix 11) and Men as Partners (MAP) (Refer to Appendix 10) training programme. Document review is very useful to gather background information. In order to accomplish this, I will review the Mission and Vision statements and the strategic goals of the HIV/AIDS Unit (Refer to Appendix 23). This will enable me to understand and gain an insight into the history, philosophy and operation of the programme I will be evaluating. While reviewing the documents, it may become clear what the actual purpose of the programme was and whether implementation took place according to the initial programme plans. Basic evaluation questions related to the number and type of participants, number and type of programme personnel and what the programme would cost, was included in the programme plans, which were made available to me (Evaluation Briefs: CDC, 2009).

It is most important that researchers check in advance whether they would have access to documentary resources (Descombe, 2011:220). Plat (1981) and Scot (1990 cited in Descombe, 2011) state that documents need to be authentic and representative. The documents were meaningful, as they were written in simple language and could be understood by all the trainers/staff as well as the peer educators. They clarified the course content and contributed to the outcomes of the programme. They should also be credible. Denscombe (2011:226) argues that the credibility of minutes as records is part of public accountability. It is the researcher's responsibility to establish whether the documents are real or whether they are faked or forged.

I discussed and verified with the HOD the type of documents in this unit. I then determined which ones would be valuable in answering my evaluation questions. I was granted permission from the HOD and secured the documents that were identified for this research project prior to my data collection. Simultaneously, I ensured that I had the permission of other stakeholders involved before the project's analysis and results were released. Ensuring confidentiality throughout this process is very important in order to secure access to sensitive or confidential documents. The advantages of document review are that it is relatively inexpensive and may highlight issues not noted by other means. On the other hand, information may be inapplicable, disorganised, unavailable or outdated. It could also be time consuming to collect, review and analyse many documents. These could be regarded as some of the disadvantages of document review (Evaluation Briefs: CDC, 2009; Descombe, 2011).

3.8 ANALYSIS OF DATA

We use statistics almost daily. The invention of statistical methods is one of the most important developments of modern times (Utts, 1996, 4). Statistics is defined as follows: "Statistics is a collection of procedures and principles for gaining and processing information in order to make decisions when faced with uncertainty" (Utt, 1996: 4). For this project the Statistical Package for the Social Sciences (SPSS) was applied to do the statistical analysis of the questionnaires as part of the quantitative data analysis. According to Shell and Shell (2011), the use of SPSS is very important in social science disciplines, just as a farmer that cannot do his job without a tractor! The SPSS is updated on a regular basis and is therefore commonly used by many researchers (Shell & Shell, 2011:73).

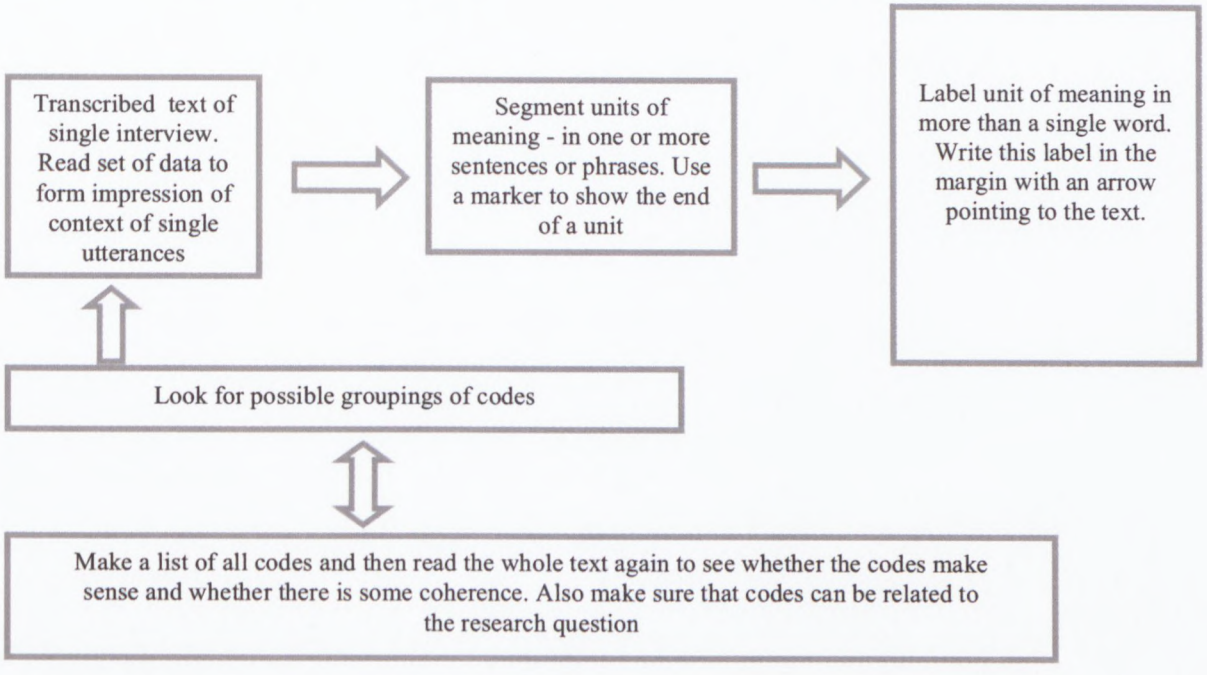
The data editor of SPSS has two interconnected, toggled windows. These two windows allow for data screening, which is important to exclude errors that might occur during data collection, data entry and/or correction. Data could be presented in different forms, for example, graphs, histograms, stem and leave diagrams, box and whisker plots, etc. This makes SPSS very attractive to use, as errors could be corrected and changes to the data set could be easily facilitated (Shell & Shell, 2011:77).

An expert consultant entered the data for this project. The same consultant did assist me to analyse and interpret the data.

3.8.1 Qualitative data

It is important that I should be able to capture all data collected. I engaged on a continuous basis with all my data in order to understand them and to interpret them (Henning, Van Rensburg & Smit, 2011:101). I did this by developing the Logic Model systematically as my project was unfolding (Refer to 3.4.1, 3.4.2 and Table 3.1). Qualitative content analysis was employed. I started with a set of data from all the transcribed interviews. All transcriptions were done verbatim, with a wide margin left on the right-hand side of the page for margin notes and coding. See diagrammatic description of the data analysis in Figure 3.2.

Figure 3.2: Coding from text (adapted from Henning, 2011:104)



Open coding was used. Codes were literally compiled as I worked through the data. The more the researcher becomes acquainted with the data, the more he or she becomes competent in labelling the various units of meaning. Once the codes are assigned, they can now be grouped or categorised. The data should be used as a guide to decide what a category should be called. A category begins to show the themes that will be constructed from the data. This theme will be used in the discussion of the inquiry (Henning, 2011:104-106). Once the coding is completed, themes are constructed. In content analysis the data could also be categorised into themes. These themes represent a huge chunk of reality, which could be used as the basis for further categorisation and discussion around each of these themes (Henning, 2011:107-109). Raw data therefore could be put into themes. Content analysis can be regarded as a very important tool as it allows for the organisation of raw data into themes. From these themes, deductions for the subsequent discussion can be made (Henning, 2011:109).

3.9 ETHICS AND EVALUATION

Benatar (2002) in an article in the *Social Science and Medicine Journal* highlighted the importance of meeting the ethical requirements for conducting HIV/AIDS-related research, particularly in developing countries. Benatar (2002) is of the opinion that globally there is a

growing interest in conducting HIV/AIDS-related research in developing countries. He insists that research ethics be taken more seriously and that this should be closely linked to the promotion of social and economic processes that could begin reversing the huge global disparities in health care (Benatar, 2002). Benatar (2002) further suggest that problems such as the HIV/AIDS pandemic require that ethical considerations extend beyond the interpersonal level. Pera and Van Tonder (2011) agree with this view and are of the opinion that a biomedical and bioethical approach is essential when we engage in HIV/AIDS-related research. This will ensure that we honour and respect the dignity of research subjects, their integrity, privacy, safety and human rights – hence the need for informed consent.

3.9.1 Ethics: Informed consent from programme participants

The practice of programme evaluation, by its very nature, is often concerned with the positive or negative outcomes of certain organisational actions or programmes. This also has consequences for the organisation and the persons whom this organisation serves (Rubin & Babbie, 2005). One should clearly convey terms of confidentiality regarding access to evaluation results. Participants should have the right to participate or not, and all participants should review and sign an informed consent form (Kapp & Anderson, 2010). For this project, I obtained ethical approval from the university where I am registered as a student and the HEI where the research was conducted (Refer to Appendix 1). All participants also gave permission in writing by signing a consent form. A clearly delineated area for signatures of both the researcher and the participants is indicated on the consent form (Refer to Appendix 2). These consent forms are locked up in a secured safe in my department, where only academic staff has access to them. Those who responded to the questionnaires, as well as those who participated in the focus group interviews were informed that they would be under no obligation to take part in this research project. They needed to understand that their participation was completely voluntary. Despite the fact that I have obtained written permission and ethical clearance to do the research, they were entitled to withdraw at any stage, should they wish to do so. Participants were informed both verbally and in writing that the data collected will always be anonymous. They will in no way be identified. Their responses will be treated with utmost respect and confidentiality will be maintained at all times.

I strove at all times to conduct this study within an ethical context, according to the specific ethical principles indicated for evaluation research (Mertens, 2010). Issues such as systematic enquiry, competence, integrity and honesty and respect for people were upheld in this study.

Sensitivity to cultural diversity was maintained at all times. Honesty and integrity were encouraged amongst participants, which led to respect for all people in the project. Together with the ethical principles, the validity of the project had to be considered throughout the lifespan of the project (Kirkhart, 1995, 2005 in Mertens, 2010). I needed to take cognisance of all the stakeholders involved in this research project in order to ensure feasibility. When data are analysed and results are being made available, it is important to be mindful of how this would be done without violating participants' human rights. The evaluation was done by qualified people who established and maintained credibility in the evaluation context. All these elements are important and I took great care to pay attention to them. Unless these principles are maintained throughout the research process, the researcher cannot ensure validity of the data, results and their interpretation (Mertens, 2010).

3.10 VALIDITY

A central issue in qualitative research is validity (also known as credibility and/or dependability). Validity is one of the most discussed issues in qualitative research. It is based on craftsmanship, in other words, how the researcher goes about conducting the research. The researcher has to constantly be aware of his/her "moral integrity", as this is a critical aspect of ensuring that the research process and the findings of the research are trustworthy and valid and will be regarded as credible. This integrity can only be built up and earned through the skills and personal actions of the researcher (Leavy, 2011; Henning, 2011). Credibility of research findings also entails how well categories and themes have been constructed. No data should be inadvertently or systematically excluded, neither should irrelevant data be included (Henning, 2011). Plano Clark and Creswell (2011) argue that because of the complexity of mixed method research, validating findings become even more important, as the mixed methods approach involves combining complementary strengths and non-overlapping weaknesses. Trustworthiness also includes the aspect of transferability. Transferability refers to the extent to which the research findings could be transferred to other settings or groups. A vigorous presentation of findings in quantitative analysis and appropriate quotations from findings in qualitative analysis will enhance transferability (Leavy, 2011; Henning, 2011). Statistical procedures are applied or external experts are normally consulted to assist with the analysis of the quantitative data. This could also have an impact of the trustworthiness of the research, as interpretation of results might differ. Quantitative researchers also have to consider the validity of the conclusions that they are able to draw from the results (Cresswell & Plano Clark, 2011:200-201).

3.11 CONCLUSION

This chapter aimed to give details about the research design and methodological procedures which have been employed in the process of the evaluation of peer education training programmes. It gave an account of how data were collected and who all the stakeholders were in this project. It aims to give an account of the entire programme in a holistic manner. It discussed ethical guidelines and the principles which should be upheld in evaluation research.

The next chapter will discussed the implementation of the study.

CHAPTER 4

IMPLEMENTATION OF THE STUDY

4.1 INTRODUCTION

In this chapter I will discuss the implementation of the study and the analysis of the data collected via each of the different methods. I will then discuss the findings of each data-collection section as well as the findings, and provide a summary. The aim of the study is to evaluate and establish the influence of a peer education training programme amongst students at a selected HEI in the Western Cape. The purpose is to identify the various best practices and challenges of these peer education training programmes at this HEI for both staff and students.

Both quantitative and qualitative data will be analysed and discussed. Richards (2008) notes that it is difficult task for a researcher to integrate all the ideas with the selected theory. I will strive to continuously bring the integrated account of all the data into play with the findings. For the quantitative side, I administered a questionnaire to the peer educators, which was analysed and will be reported on. I will use Bandura's Social Cognitive Theory (SCT) as the lens through which I will assess and analyse all the data.

4.2 STUDY IMPLEMENTATION

The participants who participated in the personal interviews were all the HIV/AIDS Unit staff, their two Office Management and Technology student interns and two international students who did voluntary work in the Unit for a year. Some of the focus group interviews were conducted with the students who were selected in the previous year to be peer educators in the Unit. These students are part of the peer education training programmes at this HEI. The other focus group interviews were conducted with students, who attended group discussions in the residences across the three campuses of this HEI. These group discussions were facilitated by different peer educators. The peer educators and these other students are all full-time students studying at this HEI. After I met with the peer educators at one of their monthly meetings to inform them about my research study, they were requested to volunteer to participate in my study. They all agreed to participate in the questionnaire survey as well as the focus group interviews. By the time the study commenced only 28 (70%) of the initial 40 peer educators had completed the questionnaire and participated in the focus group discussions. Peer educators

divided themselves into groups of between 5 and 6 and according to the residences where they live and the campuses where they study in order to participate in the focus group discussions. All these focus groups took place in the meeting room of the HIV/AIDS Unit.

The HIV/AIDS Unit on this HEI consists of 11 staff members. I did personal interviews with all the staff members. However, the two international students preferred to be interviewed together. These interviews took place in the meeting room of the HIV/AIDS Unit.

I facilitated three focus group interviews with other students who attended the group discussions with peer educators in the various residences on three different campuses. Two of these focus groups consisted of 8 students and the third group comprised of 15 students. The PO assisted me in arranging these focus groups with the other students.

I attended workshops and strategic planning sessions with the staff and the peer educators, as well as meetings and events; hence I will report on my observations in all these sessions.

I scrutinised the following documentation of the unit: peer education meeting minutes, reports and evaluations on some workshops, different training programmes, for example, the HIV/AIDS module and the Men as Partners (MAP) training programme. Document review is very useful to gather background information. In order to accomplish this, I reviewed the Mission and Vision statement and the strategic goals of the HIV/AIDS Unit.

I was involved in the assessment of peer educator portfolios and will present an analysis of this as well.

For the quantitative aspect of the study, I will discuss the analysis of the 28 questionnaires, which all the peer educators completed.

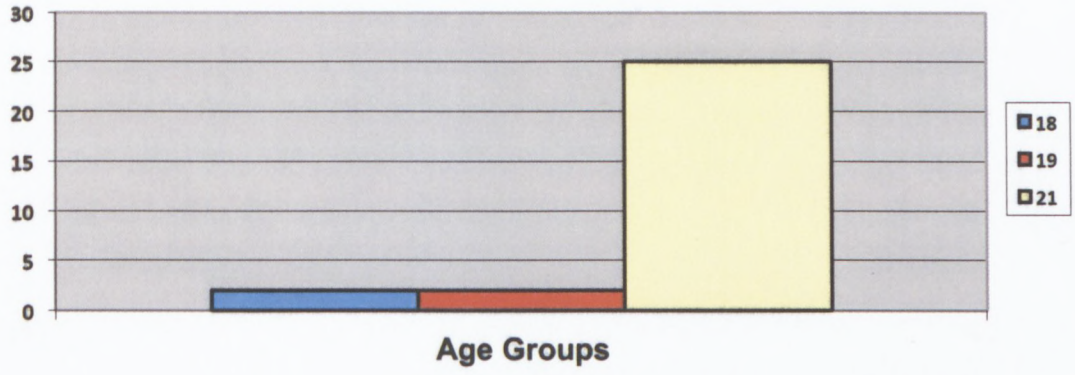
4.3 ANALYSIS OF QUESTIONNAIRES

Data were entered by means of SPSS software into nominal, ordinal and categorical variables (Refer to Appendix 5). This was done with the help of a quantitative expert, who generated a frequency table report. Discussion of the quantitative analysis of the data will now follow.

4.3.1 Age of participants

The majority of students 25 (89%) who participated in this questionnaire were 21 years and older; 2 (7.1%) were 19 years old and 1 (3.6%) was 20 years old (Refer to Figure 4.1).

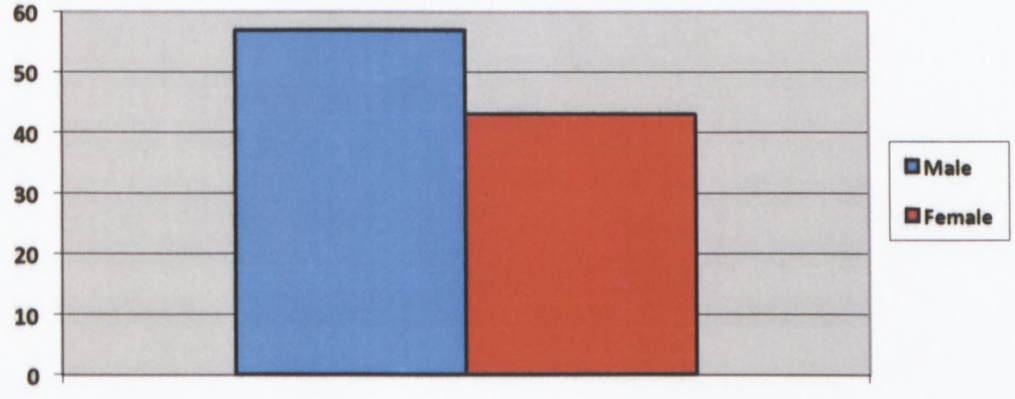
Figure 4.1: Age of participants



4.3.2 Frequency distribution of gender

16 (57%) of the participants were male and 12 (43%) were female (Refer to Figure 4.2). More males seem to participate in the peer education programmes than females.

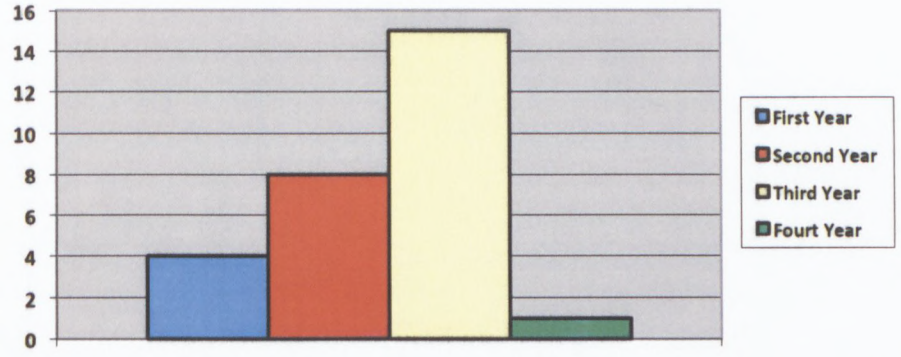
Figure 4.2: Frequency distribution of gender



4.3.3 Frequency distribution of year of study

As referred to in the discussion on my observations (Refer to 4.3), the majority of the students were Xhosa speaking. 15 (54%) were in their third year of study and 8 (28%) were second years. Only 4 students (14%) were first years and 1 (4%) was in the fourth year (Refer to Figure 4.3) as indicated in the table below.

Figure 4.3: Frequency distribution of year of study



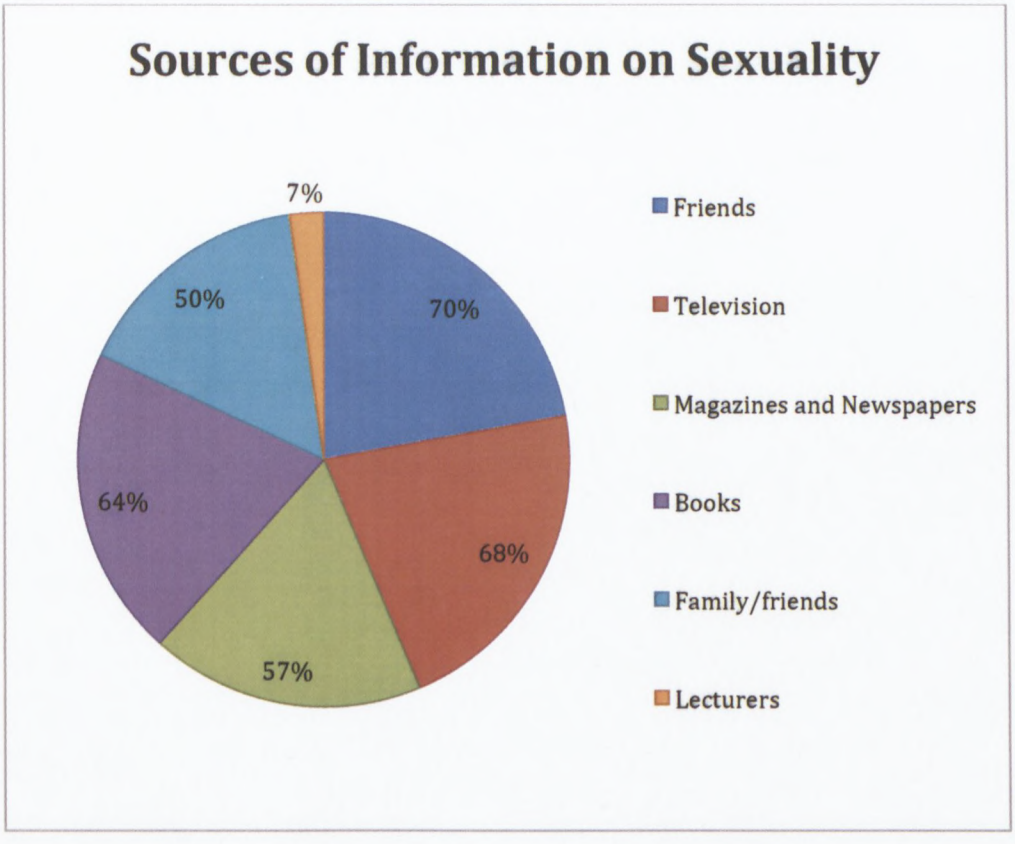
The following section will discuss the results of the rest of the topics/questions to the questionnaire. Some of the topics/questions were combined in the analysis to facilitate discussion and comparisons.

4.3.4 Prior exposure to peer education

The majority of students, 25 (89%) indicated that they have had experience in peer education; 3 (11%) had no experience with peer education. In the following question students were asked how long ago they had any training in peer education and 13 (46%) indicated that they had some training in the last six months, while 9 (32%) had had training in the last 18 months; they indicated that in those training sessions the following topics were covered: 21 (75%) had learnt about sexual orientation; 20 (90%) were made aware of safer sex; 21 (78%) received training on STIs; 23 (82%) were aware of condom usage; and 23 (82%) received training in HIV/AIDS-related issues. Overall, 21 (75%) of the topics covered in the question were addressed in the training session.

4.3.5 Sources of information on sexuality

Figure 4.4: Sources of information on sexuality



Question 7 asked about "sources of sexuality information". This was very interesting, as 20 (70%) of students reported that they receive information from their friends. The concern arises about the relevance and correctness of this information that is imparted by friends. The second highest source was the television; 19 (68%) of students relied on this medium and 15 (57%) on magazines and news papers for their information; 17 (64%) students read books to inform themselves. The family and home were fifth on the list, with 14 (50%) of the respondents indicating that they received information around sexuality issues at home from family. The lowest score was allocated to lecturers 2 (7%) as a resource for sexuality issues. This could account for the lack of integration of HIV/AIDS into all curricula across all faculties at this HEI.

4.3.6 Risk factors contributing to HIV/AIDS and STIs

The risk factors contributing to HIV/AIDS and STIs include violence-related behaviours, alcohol consumption and abuse, substance abuse, bullying, attempted suicide, sexual activity and multiple partners. These will be discussed.

4.3.6.1 Violence-related behaviours

Questions 12 to 22 asked about violence-related behaviours. 2 (7%) of participants carried a weapon such as a knife or club in the last 30 days. 1 individual carried a knife to university regularly. 19 (70%) students never felt unsafe at university, while 8 (30%) always felt unsafe. At the same time 2 (7%) students were threatened with some sort of weapon 2-3 times. 7 (25%) students were involved in a physical fight in the last 12 months. 6 individuals were involved once and others were involved 2-3 times. 3 (11%) were severely injured and had to be treated by medical personnel. 4 (4%) of physical fights happened on university property. 3 (11%) students were hit, slapped or physically injured by their boyfriends or girlfriends in the last 12 months. 4 (16%) were forced to have sexual intercourse because of violent behaviour.

4.3.6.2 Alcohol consumption and abuse

Questions 32-36 focused on alcohol and drinking habits. 4 (16%) never drank alcohol, whilst 8 (29%) are regular drinkers. 16 (59%) have been consuming alcohol since the age of 17 years. From these students, 2 (8%), 1 student started drinking alcohol between the ages of 9 and 10 years old. 24 (86%) drank alcohol in the last 3-5 days, whilst 1 (4%) drank every day for the past 30 days. 4 (16%) did not drink alcohol at all. 7 (25%) buy their liquor at a liquor store, 5 (21%) consume it at a restaurant, bar or club, 3 (11%) buy it at a sporting event or concert, 1 (4%) gets it as a present from someone else and 1 (4%) got it in some other way. 19 (68%) never drink on university property, while 8 (32%) always consume alcohol on university property.

4.3.6.3 Substance abuse

21 (75%) of students tried smoking, while 7 (25%) never smoked. 3 (12%) participants started smoking at 8 years old, while 18 (65%) of the students started smoking at the age of 17 years and above. All of these smoke on university property. However, 21 (78%) of these students attempted quitting smoking in the last 30 days. Questions 37-40 were centred on the use of marijuana (dagga). 19 (71%) of the participants never used it before, while 8 (29%) used it in some form or other. 10 (38%) used it for the first time between the ages of 17 years and above.

Questions 41-45 were about other drugs consumed. 1 (4%) of the students utilised other drugs in the form of ecstasy, cocaine, heroin or crack. 24 (86%) have never sniffed glue or aerosol sprays or paints. 3 (14%) used these forms of drugs at some stage. None of the participants has ever

injected themselves with any illegal drug. 5 (19%) of the participants were offered drugs or drugs were sold to them in the last 30 days on university property.

4.3.6.4 Bullying and attempted suicide

Questions 22 to 27 focused on bullying. 21(75%) students admitted to being bullied. 8 (29%) students felt sad and hopeless and could not get themselves to participate in any of the usual activities. 3 (11%) admitted to seriously contemplating suicide. 1 (4%) actually planned and then attempted suicide. There is no evidence from the data that this suicide attempt culminated in serious injuries.

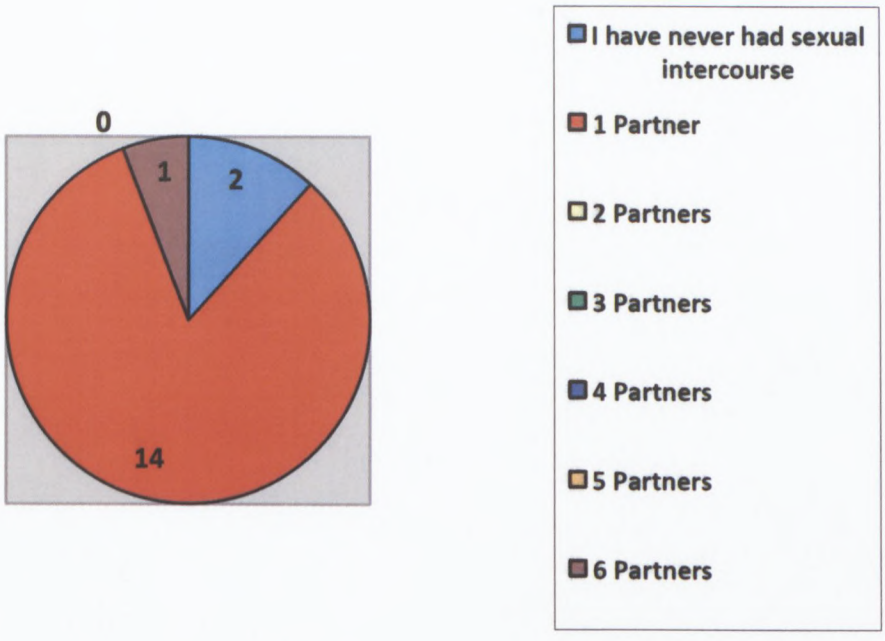
4.2.6.5 Sexual activity

Questions 46 to 53 centred on sexual activity. 93% of the participants, had already experienced sexual intercourse by the time the survey was conducted. 3 (11%) were 11 years and younger when they had their first sexual experience. 10 (36%) were 17 years and older. 12 (46%) had six or more partners during their lifetime with whom they had sexual intercourse. 5 (20%) had used alcohol or drugs prior to having sexual relations, while 22 (80%) did not indulge in alcohol or drugs prior to having sexual relations. 23 (84%) used a condom, but 4 (16%) did not use a condom during sexual intercourse. 22 (83%) also used a condom as a measure to prevent pregnancy. 3 (13%) used no method to protect themselves from pregnancy and 1 (4%) used the injectable contraceptive. All of the participants (100%) were taught about HIV/AIDS. 3 (14%) of the participants were forced to have sexual intercourse with their partners as part of violent behaviour.

4.3.6.6 Multiple partners

Within the last three months 14 (50%) had one partner and 1 (4%) had six or more partners with whom they had sex (Refer to Figure 4.5).

Figure 4.5: Multiple partners



4.4 SUMMARY OF QUANTITATIVE DATA

The majority of the peer educators who participated in the survey (89%) were 21 years and older and (54%) were in their third year of study. (89%) of these students were exposed to peer education before. This is an indication that the majority of peer educators are senior students. More males (57%) than females (43%) participated in the peer education training programmes. 70% of these peer educators relied on their friends for information regarding HIV/AIDS and other sexuality issues. This is a strong indication of peers regarding each other as credible sources of information and role models. Only 50% indicated that they received information on HIV/AIDS and sexuality from their family at home. The lowest score (7%) was allocated to lecturers for imparting this type of information. This raises a concern that academics at HEIs do not discuss these issues in the class room or it could be attributed to the lack of integrating HIV/AIDS into all curricula across all faculties at this HEI. In analysing the risk factors that contribute to HIV/AIDS and STIs, it is clear that violence-related behaviour, bullying, alcohol and substance abuse still exist (Refer to 4.3.6) among these peer educators, despite the many events and workshops that they attend where all these topics are dealt with in detail. 16% of this group still do not practise safer sex, while 4% still have multiple partners, despite various campaigns that they participate in and the distribution of condoms, which is part of the peer educator's function at this HEI.

4.5 ANALYSIS OF QUALITATIVE DATA

Focus group and personal interviews were categorised and arranged into themes. Thematic content analysis was employed to analyse the data. An independent qualitative data analysis expert was utilised to categorize, code and to divide the data into themes. This person is a professor in social work at an accredited institution and she is a renowned qualitative researcher who has published widely. I interpreted the data myself but liaised with her when I deemed it necessary. Other qualitative methods that were utilised to collect data were peer educators' portfolios and other selected documents related to my objectives and research questions; the latter were reviewed at the HIV/AIDS Unit. I also observed the order of procedure and the organisation that took place in some meetings, workshops and events. These different methods of data analysis will also be discussed.

4.5.1 Overview of portfolios

In my project portfolios were used as part of the training of peer educators; therefore both trainers and peer educators were involved.

During the training programmes the peer educators were taught how to compile a portfolio. The portfolios were also used to demonstrate their competencies as peer educators. These portfolios were examined and marks awarded for the different categories according to sixteen guidelines that were developed by the HIV/AIDS Unit staff. Percentages were assigned to each guideline; for example, cover page and layout of portfolio 10%, content page 10%, other information related to the HIV/AIDS programmes 30% (Refer to Appendix 7 and Appendix 6 for full details).

The challenges that I faced in assessing the peer educators' portfolios were as follows: the selection of the panel to assess the portfolios consisted of one international student, who had just completed matric; a full-time student who was engaged with a Masters of Technology degree at this HEI and me, a senior lecturer at the HEI where the study took place. The disparity in qualifications and experience in assessing tasks were evident in the allocation of marks to the different portfolios. This led to many disagreements that eventually ended up in a compromise situation, which could affect the validity and reliability of the assessment results of the portfolios (Mertens, 2010). Each portfolio was not marked independently. No clear-cut guidelines or instructions were provided for the assessment of the portfolios. Although scores were allocated for each category of the portfolio, scoring became subjective, as criteria for

scoring were not clearly defined, e.g. five (5) marks were allocated to philosophy, but the pertinent aspects of philosophy were not highlighted. This led to great variability of the scores, as each marker interpreted it differently. There were great variations in the curriculum vitae of peer educators and no standardisation. Certain items on the score sheet were not applicable to peer educators as they were not involved in all events and they had options regarding which ones they wanted to attend, e.g. list of events where they could be programme director – some of these events were rare. No criteria were set out for the marking of their essays (Refer to Appendix 7).

Assessing their participation in different events could contribute to relevant changes that have to be implemented in order to improve the training programmes, workshops or events. No individual level of participation in an event or any activities was measured in this study. However, the HIV/AIDS Unit staff did some evaluations of some of their training programmes (Refer to Figure 4.6 and Appendix 9).

4.5.2 Observation

As mentioned in Chapter 3, I followed Patton's (2000) criteria of observation during the implementation of the study.

In my study the physical environment differed from workshop to workshop. Sometimes the training took place in a huge lecture theatre that can seat 100 students, but the seating was not conducive to training. Tables and chairs were fixed and could not be moved around to facilitate small group discussions. It was also difficult to paste charts on the walls as they could not take sticky tape or Prestik. This made reinforcement of facts or reminding participants of pertinent issues very difficult. I also observed some students losing interest and falling asleep during the training session.

The environment and group organisation has a big influence on the young adults. This was evident in the training workshops that I attended. Peer educators formed cliques. They seemed comfortable interacting with peers from their own campus. These peer educators were combined in training sessions from the five different campuses of the HEI where the study took place. Despite the fact that the majority of peer educators came from the same ethnic group, not all of them communicated in the same language. Males seemed to dominate most of the discussions at the beginning of a training session. However, as the session progressed, the females would start giving valuable input about their experiences that contradicted those of their male counterparts.

Having a say in decision making was also very important to these peer educators. They felt that they did have some say in decision making, but most of the time the staff who facilitated would take the final decision.

The lack of communication posed a big problem to the peer educators. They complained that they do not receive information on time about upcoming outreach events. They need to prepare for these events amidst their busy academic schedules. In one workshop I observed the dissatisfaction of peer educators, as they felt that no fun was built into the training sessions. Peer educators perceived that workshops should be fun. However, fun aspects are included, but a level of seriousness and commitment should be emphasised to peer educators. The peer educator activities should not be focused on fun and eating only.

Informal interactions and unplanned activities very seldom took place. At the end of training sessions staff and students simply disappeared. I did not hear any one talking about the session. All the participants went in different directions when the session was over. It was very interesting to observe the body language and non-verbal cues of participants during and after a session. This could be attributed to either tiredness or information overload.

English was the language of choice used during training sessions, but an effort was made to attend to the native language of the programme participants. In all the programmes I attended students would communicate with each other in their own native language. Where the need arose, the staff could rely on peer educators for interpretation. They could facilitate questions or clarify queries and misunderstandings. However, the major discussions would proceed in English. This is where I observed the dominance of some peer educators, who were more fluent in English as a spoken language.

Non-verbal communication and cues are very important aspects to observe. Various aspects could be observed in many ways. Some of the females were dressed very provocatively. This led to remarks being passed, lots of laughter and distraction particularly among the male students. When students became uncomfortable with the way the workshop was conducted, they made a statement by becoming fidgety and moved about the room. They also started communicating in their own language, which not everyone understood. The facilitator had to intervene many times to bring them to order. This happened particularly when they were dissatisfied with what was said or how activities were carried out. An example of this occurred when they expressed their opinion about the "workshops not including any fun activities".

Observing what did not happen in these workshops was one of my biggest frustrations. No workshop, events or meeting of this grouping started on time. Neither trainers nor peer educators were punctual or conscious of time. One Saturday a workshop started two hours late. Everyone was running around trying to open venues and carrying equipment across to the venue. Despite the fact that we started late, peer educators still came in even much later. This was very disruptive as quite often the latecomers had to be brought up to speed with proceedings. This caused chaos as the other peer educators felt that time was being wasted. No workshop finished on time. Participants were always very disgruntled, particularly as the workshops were mostly held on a Saturday. However, all peer educators signed an agreement that workshops would be held on a Saturday. This is to prevent peer educator activities clashing with their daily academic activities. Most of the time not all the objectives set out for the day were met. This meant that many issues were left unattended to. Staff members were not always professional in the way they addressed each other in the presence of students. The project officer (PO) or the HOD would express their dissatisfaction in no uncertain terms with the peer education training officer (PEO) who failed to implement workshop plans on a number of occasions. This also happened if transport was not arranged timeously when they had to leave for a community outreach programme.

I was privileged to be involved with the HIV/AIDS Unit for at least 18 months. At all the occasions that I was involved with the staff and peer educators as well as other students I made field notes. This was very important, as they would complement my observations and assist me in being more accurate when I recorded the data and when I interpreted them. During this period I was able to observe meetings, workshops and various other events attended by both staff and peer educators of this unit. I witnessed first hand how the different groups of peer educators, other students and staff interacted with each other. It was easy to observe verbal as well as non-verbal cues of both the trainers and the peer educators. I gained a deeper insight into the multiple cultures and processes of the groups that I was investigating. Lack of communication, some hostile relationships, particularly amongst certain staff members, was clearly visible. Lack of time management and punctuality were some of the frustrations that I had to deal with during my involvement with this unit.

As an inquisitive enquirer, I could critically observe and listen attentively during meetings, events and workshops that I attended with the staff and the peer educators. I made field notes

without interacting with the group, or when it was required, I could give valuable input. This enhanced my data collected during observation.

4.5.3 Document review

I embarked on a document review to establish background information on the HIV/AIDS Unit, as well as to establish the content of the peer education training programmes.

The documentation of the unit that I reviewed included the following: training programmes for peer educators – Men as Partners (MAP) Modules 1 and 2; HIV Module 1 and 2; the Unit's Mission and Vision statement and strategic goals; and the minutes of the joint peer educators' meetings (Refer to Appendix 10, Appendix 11 and Appendix 23). I will also allude to the evaluations that the peer educators did after the training sessions. I will attach some of these as appendices. I also assessed the peer educators' portfolios, as these provided valuable evidence of their involvement in the peer education training programmes.

- ***HIV/AIDS Unit's Vision, Mission and Core Value Statements***

The Vision of this Unit is "to be the epicentre of excellence in HIV/AIDS programmes at HEIs in Africa". The Mission is "to mitigate the impact of HIV/AIDS, STI and TB by promoting, advocating, facilitating and implementing innovative interventions among students, staff and the community". The core values include "Ubuntu, compassion, empathy, caring and dignity, as well as trust, honesty, integrity and respect, as well as loyalty, dedication and commitment" (CPUT HIV/AIDS Unit, Mission and Vision Statement, 2005). During the personal interviews with staff, they referred to these mission and vision statements as well as the nine strategic objectives of the Unit.

1. Curricular integration of HIV/AIDS, STI and TB: An attempt is made to do this, but currently only a few faculties are embarking on this module. The HOD of the Unit offers the module.

2. Student and staff training: Training programmes are offered and implemented to selected students. Staff are also continuously trained and updated in HIV/AIDS and sexuality-related issues.

3. Peer education: This Unit offers peer education training programmes to selected students who commit to act as peer educators.

4. Community Outreach: 30% of training programmes within this Unit focus on community outreach.

5. Workplace programme: This is one area where this HEI is still lacking. I found no evidence of a workplace programme that is in place and implemented.

6. HIV counselling and testing: At least three campaigns per year are being conducted in this regard on all the campuses of this HEI. The Wellness Mobile Unit (Refer to Appendix 18) contributes to the success of these HCT campaigns, as the services are extended to every one, both staff and students. The peer educators play a major role in coordinating and assisting in these HCT campaigns.

7. Care and support of HIV-negative and -positive persons: The two health promoters in the Unit take care of this aspect. Peer educators also receive training from these health promoters, so that they are capable of caring for and supporting their own family and friends.

8. Internship and volunteer programmes: The Unit hosts two international volunteers on an annual basis. They contribute to the Unit by assisting with evaluations of the training programmes. They also develop posters and pamphlets for the various events. They are young adults who have just completed matric. They identify well with the peer educators and they seem to work well together. The Unit also hosts two Office Management Interns. They assist with the office administration and reception duties (Refer to Appendix 23).

9. Research: The Unit is expected to participate actively in research.

4.5.3.1 Joint peer education meeting minutes:

- ***Authenticity***

Agendas and minutes of meetings for 2011 were reviewed. They appeared authentic and were signed and dated by the Project Officer (PO) and the peer educator responsible for taking minutes on the day. I noticed that minutes were taken by a different peer educator at each meeting. This could also have been an empowering strategy (as discussed in SCT) to allow each peer facilitator to acquire the skill of minute taking.

- ***Representativeness***

Minutes were representative of who attended and apologies given. They highlighted feedback on past events. They also served as a reminder of upcoming events and the entire peer education timetable was reiterated at every meeting. This could be attributed to changes in possible schedules that were not relayed by the Project Officer timeously to all the peer educators via agreed upon methods of communication.

- ***Meaning (content and outcomes)***

Apart from multiple spelling and grammatical errors, the minutes were clear and easily understood and readable.

- ***Credibility (reflection of events and procedures)***

Minutes are filed in a specific folder. All important activities of the peer educators in the HIV/AIDS Unit are documented. They also provides a platform for feedback of past and forthcoming events. Peer educators are allowed to voice their satisfaction and dissatisfaction with regard to issues pertaining to them in the peer education programme, for example, lack of communication and lack of resources. The joint peer educators meeting produces the content, but peer facilitators rotate at each meeting to record the minutes. Minutes are signed off by the PEO responsible for the peer educators. He also chairs the meeting. Minutes are produced within a week after the meeting, but there is no indication whether they are circulated at least seven days prior to the next meeting. There is always the chance that minutes could be subtly altered and edited to exclude things which might make participants vulnerable to criticism when the minutes are publicised. However, I interviewed the person in charge of the peer educator meetings. I also attended a number of these meetings. I can therefore verify the credibility of these minutes (Refer to Appendix 8).

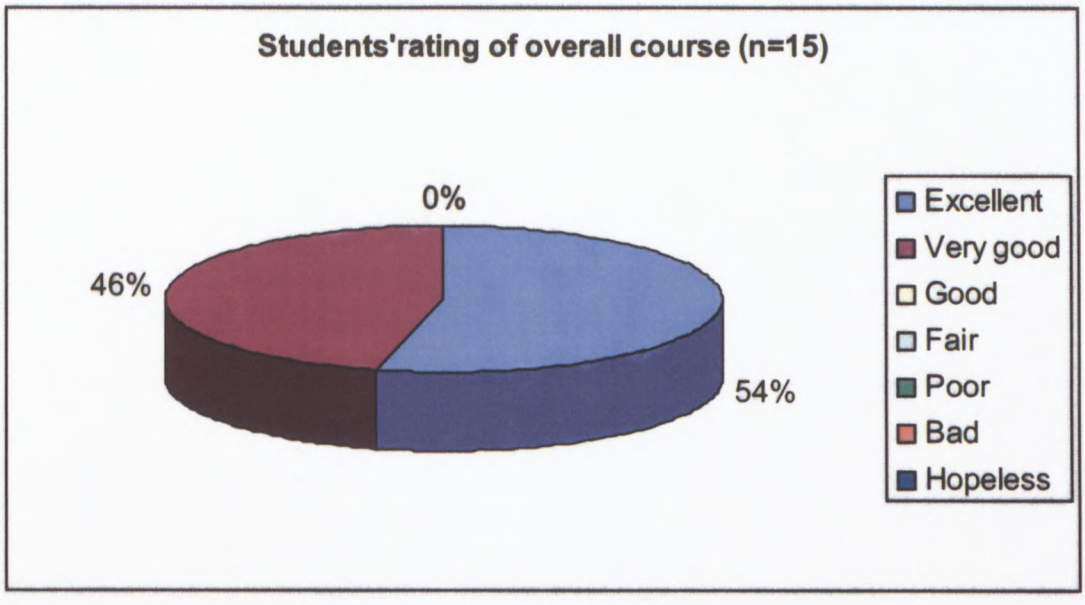
4.5.3.2 Peer education training programmes

- ***Beyond HIV/AIDS, sexually transmitted infections and tuberculosis (TB) awareness workshop***

The aim of this workshop is to change perceptions, attitudes, beliefs, opinions and practices of participants regarding HIV/AIDS, STIs and TB.

Figure 4.6 is an example of the evaluations done after the workshop. Refer to Appendix 9 for more examples of evaluations done by peer educators after training sessions.

Figure 4.6: Students' rating of overall course



The workshop material was clear and the content was structured in an orderly manner. All peer educators understood the programme and its content. The documents were complete and insightful and they were appropriately edited. This is in line with the criteria as described in the literature by Denscombe (2011) (Refer to 4.5.3). The documents were meaningful, as they were written in simple language and could be understood by all the trainers/staff as well as the peer educators. They clarified the course content and contributed to the outcomes of the programme. All the training programmes and materials were developed and produced by the HOD and the trainers of the HIV/AIDS Unit. This made them credible and they served their purpose well, as indicated by the evaluations (Refer to Appendix 9).

- ***Men as partners (MAP) training programme***

The major goals and objectives of this workshop are to provide participants with an opportunity to explore their own gender-related values and attitudes and to consider those of their peers. It also provides participants with an understanding of the relationship between contemporary gender roles, gender-based violence and HIV/AIDS. This training takes place over four days (Refer to Appendix 10).

- ***HIV communication training***

During this training session peer educators explore what communication means; the communication chain; what is facilitative and non-facilitative communication? During the training session all peer educators are expected to participate in the exercises and activities. It also allows for self-awareness to develop and exploration of one's listening skills (Refer to Appendix 11).

In my review of the documents, I found that staff/trainers and peer educators seem to accept accountability and responsibility for their activities within the HIV/AIDS Unit. All the documentation was assessed and its validity was verified according to the four criteria: authenticity, representativeness, meaning and credibility (Denscombe, 2011) as discussed in Chapter 3 (Refer to 3.6.6). Meeting minutes and agendas reflected that records are kept of transactions, for example, financial transactions and the schedules of peer educators. Peer educators felt empowered, as they rotated as minute takers in each meeting. SCT endorses this, as peer educators continuously strive to gain new knowledge and skills. Both the minutes and the training programmes contain a fairly systematic picture of activities that have happened, future activities that are being planned and decisions that were taken within the Unit. All this documentation is available on request to relevant stakeholders, which is another indication of accountability among all concerned in the Unit. The documentation is credible, because each document's purpose is clearly defined, for example, the Mission and Vision statements of the Unit as well as the peer education training programmes. The author(s) of all the documents were clear and, where necessary, their status was mentioned. All documentation was dated and signed.

Portfolios are credible, as they provide written evidence of the involvement in various activities of peer educators, for example, their involvement and participation in training sessions and community outreach programmes. Certificates of attendance at these events are in the portfolios, which is indicative of their authenticity. The peer educators also include pictures of themselves at these events in the portfolios. This is also an indication of the transferability of their acquired skills, for example, facilitation and public-speaking skills as they apply them at these events while interacting with their peers. This is a clear indication of their confidence and personal agency, as required in SCT. Peer educators thrived on being recognised and given credit by their peers. This also makes them good role models, as claimed by SCT, as their peers want to enact their good behaviour.

4.6 FOCUS GROUP INTERVIEWS WITH PEER EDUCATORS

I was much more successful in getting the participants for the focus groups. After numerous phone calls and meetings with the peer educators, I was able to do five peer educator groups and 3 groups of students who participated in a group discussion facilitated by a peer educator in a residence on campus. All the participants gave written consent prior to the interview taking place (Refer to Appendix 20 and Appendix 21). All interviews were transcribed within a week by an expert.

Peer educators as well as staff were extremely cooperative. The peer educators and the other students in the residences were not punctual, which created delays during the focus group implementations. This had financial implications for the implementation of the research, as the moderator was paid per hour. Despite these challenges, students were cooperative and participated enthusiastically in the focus groups.

According to the criteria used for the focus group discussions, as discussed in Chapter 3 (Grove 2009), the study was implemented as follows:

- The peer educators in this study were a homogeneous group who share common characteristics as young adults and peers, all studying at an HEI. In the focus groups these peer educators readily answered and discussed the questions that were posed to them. They also appeared to respect each other's views, but where necessary were also very critical of each other.
- I found the majority of these peer educators to be well informed and up to date regarding information on the latest sexuality, STI and HIV/AIDS information. Some were more informed than others, but they were always ready to share their knowledge and information. In fact, in three of the groups I had to guard against certain individuals dominating the group, because they were so enthusiastic to share their experiences.
- These peer educators reported their thoughts and feelings. This was very obvious in all the groups. Some of the peer educators utilised the opportunity to express their frustrations with some of the training programmes and trainers during these sessions.
- My experiences during these focus group interviews were that these peer educators felt at ease within the group. They appeared to complement each other well. I allowed the students to select their own groups. They did this by grouping themselves according to the campus

that they work on as peer educators. The group dynamics were very positive and allowed for the generation of valuable information.

- Although the students were at ease during the group interviews, and expressed themselves very clearly, this was different with the staff members who were interviewed individually. I needed to reassure the staff about confidentiality. They appeared apprehensive and it is my feeling that they were almost too scared to express their honest opinions for fear of victimisation. However, with the help of the moderator, I managed to alleviate their fears by reassuring them that this was a research project and that it was not a performance appraisal exercise. Some staff was much more open and vocal than others. The two international volunteers preferred to be interviewed together. They felt free to voice honest opinions, as they were of the opinion that they were visitors to the Unit for only a limited period and that they were made to work extremely hard. Their input was very useful, as they were very neutral participants who could make valuable contributions to the Unit, particularly with their technical skills, in the year that they would be attach to the HIV/AIDS Unit.
- The interviews were focused, which assisted the participants to recall forgotten information or information that they thought was less important. This was particularly true in the staff interviews, when I asked specific questions, for examples, about highlights, strengths and weakness of the programme. The peer educators' interviews were complemented by information that they compiled in a portfolio.

4.7 DISCUSSION OF THE FINDINGS IN EACH THEME IDENTIFIED

The themes were derived from the focus group interviews which were transcribed (Refer to 3.6.2, 3.6.3 and Appendix 4) and coded by an independent coder (Refer to 3.8 and Figure 3.2). Subthemes were then formulated, which will also be discussed (Refer to 3.8 and Figure 3.2). The following discussion illustrates the formulation of themes and sub-themes.

4.7.1 Formulation of themes and sub-themes

Theme 1.1: Founding

Theme 1.2: Funding

Theme 1.3: Functions and General operations of the Unit and the Peer Education programme

Sub-themes:

1.3.1 Managing and coordination of the Unit – Unit manager

1.3.2 Initiating, supervising, monitoring and evaluating – Project Officer

1.3.3 Training of peer educators and awareness campaigns – health promoters

1.3.4 Peer education – peer educators

1.3.5 Categories of staff in peer educating

- *Peer coordinator*
- *Peer educators*
- *Peer facilitators*
- *Peer assistants*

1.3.6 Categories of services:

- *Awareness campaigns*
- *Group discussions on health issues are held in residences*
- *Interaction with schools, hospices and even orphanages.*
- *HCT drive in which students and staff are encouraged to get tested*
- *Distribution of condoms*

1.3.7 Students' motivation for joining the peer educator training programme (peer educators)

1.3.8 Milestones that you have achieved with your peer education programme (mostly from staff)

Themes:

1.3.9 Behaviour change (if any) to be attributed to your peer education training programme?

4.7.2 Formation of the HIV/AIDS Unit

Interviews conducted with staff and students to find out more about the formation of the unit and its background showed that it was especially full-time staff who made a relevant informative contribution towards the development and operational procedures of the HIV/AIDS Unit (Refer to Appendix 12). This Unit also serves different satellite campuses attached to the HEI. The unit operated on an ad hoc basis before 2002 and even as far back as 1994 as a small group, until a lecturer in the applied science faculty became the HOD. He used to integrate HIV/AIDS into the curriculum and did some programmes on an ad hoc basis, while some programmes were offered by the staff of the student counselling division at this HEI.

He was eventually appointed coordinator of the activities of the HIV/AIDS unit at the HEI in 2004. Due to his multiple duties as a lecturer, he was seconded to establish the HIV/AIDS office, which subsequently became the HIV/AIDS Unit and he became the Head of the Unit. When the HIV/AIDS Unit was formally established in 2004, peer education programmes were initiated.

The coordinator's portfolio in the unit basically entails preventing, controlling and managing HIV/AIDS, STI and TB amongst students and staff at this HEI as well as in the community. More and more programmes were introduced, thus needing more permanent staff. In 2008 the Unit moved to bigger premises from where it still operates at present. Nine strategic objectives were identified, but not clearly spelled out by the interviewee. However, he referred me to access the documentation for further information. The coordinator initiated these strategic objectives and was instrumental in overseeing the implementation thereof, together with its Mission and Vision Statement (Refer to Appendix 23).

4.7.3 Funding

Funding for the various projects of the HIV/AIDS Unit was initially given by the HEI where the Unit is based. Later, funding was complemented mainly through the EU via HEAIDS, especially for curriculum integration of HIV, HCT and a few other programmes.

The peer educators' programme was initiated in 2004, when the HIV/AIDS Unit was established and it was funded by EngenderHealth and it was called the Men as Partners (MAP) peer education programme. Funding was discontinued in 2010, but the programme was continued to empower students to interact with other students both on campus and in residences. The Men as Partners programme was also financially supported by EngenderHealth. DramAidE supported the care and support programme for students. The latter is at present the only source of funding, as funding from the other sources was subsequently phased out by 2010 and the HEI where the Unit is situated currently provides the rest of the funding. Financial support by DramAidE is used for the salaries of health promoters:

> *Funding has come through EU through HEAIDS for the curriculum ... as well as from EngenderHealth ... specifically for the 'Men as Partners' education programme. We have funding from DramAide for the care and support project and for the health promoters project ...*

EU Funding, via HEAIDS, boosted the Unit with staff and a Mobile Wellness Vehicle. Parking is also provided on one of the campuses. This mobile render services to all satellite campuses (Refer to Appendix 18).

4.7.4 Functions and general operational procedures of the unit

This information is based on both peer educators and staff interviews.

The main function of the HOD is to coordinate and oversee programmes and projects, as well as the training of voluntary students as peer educators in order to operate effectively in the context of HIV/AIDS, STIs and TB in the quest to fight the HIV pandemic within its available budget. Although funding by the above donors discontinued in 2010, programmes to empower students and build their capacity after they have been recruited and selected on a voluntary basis as peer educators to participate in the HIV/AIDS activities continued.

In the case of the PO, care is taken of to initiate projects and implement them; he also plays a supervisory role over colleagues who facilitate these programmes and sees that the programmes are *"being implemented effectively."* Duties also include monitoring and evaluation of workshops and analysing data. He also assists the HOD in various managerial aspects (Refer to Appendix 9 and Appendix 12).

Training of peer educators is done mainly by the HOD and PO on an in-house basis. Other staff members contribute according to their portfolios. Trained peer educators are encouraged to interact with other students, both on campus and off campus, as well as in the residences. There are three categories of "peers"" in the peer education programme (besides the coordinator): peer educators, peer facilitators and peer assistants. Peer educators are elected and trained to be part of the peer education programmes and are responsible for basic counselling of HIV/AIDS-positive peers, staff and members of the community. They also attend and assist in the facilitation of workshops and various other peer educator activities, e.g. handing out pamphlets on related matters concerning the campaign against HIV/AIDS, STI and TB and to assist in the HCT campaign.

4.7.5 Categories of services in the programme

Basically the peer education training programme entails five portfolios. The first one is an awareness campaign whereby certain days such as Youth Day or Women's Day are chosen and during that week a campaign is run whereby students are made aware of the use of condoms.

Secondly, group discussions are held in residences regarding health issues that surround students in residences and which are related to HIV/AIDS, STI and TB. Community outreach is the third leg, which focuses on work outside of this HEI campus and which comprises at least 30% of all programmes. Other programmes include interaction with schools, hospices and even orphanages. The fourth portfolio concentrates on the HCT drive by which students and staff are encouraged to get tested, while the fifth one revolves around the distribution of condoms on the campus.

Peer educators get training on all issues relating to HIV so that they become role models to other students. According to SCT, peer educators should strive to serve as positive role models. They need to provide social information rather than just facts to their peers. They also become teachers to other students when they need information. Peer educators, if seen as credible leaders and role models, could give more impetus to, and enhance, peer education training programmes if they apply properly modelled behaviour. There is also a life skills course which, according to the PO, should become an integrated course to be presented to all first years. The training programmes cover awareness of HIV AIDS, STIs and TB, which are also presented as a workshop that is done with first years. These programmes are integrated into the curriculum of various faculties in order to reach as many students as possible. The HIV, STI and TB courses are also presented and offered to student leaders (SRC) and other organisations, peer educators and staff.

The MAP (Men as Partners) workshop is a gender-based course aimed at *"men who are looking at gender and sexuality stigma and discrimination ... and which is also facilitated to our peer educators and staff as well".*

A communication course facilitates peer educators in the basic skills of counselling and listening. This is one way where reinforcement could take place, as peer educators will have numerous opportunities during this course and afterwards to exercise an influence or apply peer pressure positively. SCT professes that reinforcing a message through ongoing contact, is likely to be far more effective than trying to do it in a formal way through a lesson or a once-off talk by a parent (Bandura, 1999). The Desmond Tutu Foundation presents these sexuality courses and staff are free to select what workshops they would like to attend. Workshops planned for 2013 include leadership and even money matters for peer educators.

Peer educators also do a portfolio management course. In this portfolio they document what they have achieved from the peer education training programmes (Refer to Appendix 6). A course is done in community outreach programmes (Refer to 4.3.1). After attending the Men as Partners workshop, they took part in a community programme involving inmates at the Malmesbury Prison. Another project at the same prison includes the project "Group of Hope", which is facilitated by inmates.

Other programmes include the phasing in of a life skill course, especially for first years, as an accredited module into the curriculum of various faculties covering the main aspects of HIV/AIDS, TB and STI. The course is also offered to student leaders (SRC), academic and residence staff and other organisations. A number of workshops are available from time to time, for example, MAP (Men As Partners), which is gender-based, a, MSM workshop (Men who have Sex with other Men) and the LGBT workshop, which concentrates on counselling and listening to lesbians, gays, bisexuals, transsexuals and 'intersexuals". The aim is to make the HIV/AIDS unit as user-friendly as possible. Other workshops concerning leadership, team building, communication and even money matters are in the pipeline for the future.

4.7.6 Motivation of students interviewed to become involved in the peer education training programmes

Interviewees seem to become involved in the peer education programme for various reasons.

- ***To become knowledgeable about HIV/AIDS***

Learning about the causes and effects, in other words acquiring more knowledge about the pandemic, seems to be an important motive. It would also help to access fellow students more easily and fight myths and ignorance around the disease. By acquiring more knowledge about HIV, participants stated over a wide range that it would enable them to reach out to fellow students and also communities in the wider sense of the word. Peer educators have to display the characteristic of personal agency in order to be recognised as credible leaders amongst their peers. Together with personal agency, peer educators also need to develop the skill of self-efficacy. This means that they need to require skills and experience to achieve success in order to deal with failures and setbacks not only in the peer education programme, but in their personal lives. Peer educators might be extremely knowledgeable and skilful, but if they have low self-efficacy, it might hinder their abilities to become great achievers or leaders. Having varied levels of self-efficacy amongst peer educators can explain why individuals, with similar

skills and knowledge, who has undergone similar training programmes, end up displaying extremely different behaviours. This was evident in these training programmes, particularly referring to sexual activity; 23 (84%) used a condom, but 4 (16%) did not use a condom during sexual intercourse: 4 (16%) of the participants were forced to have sexual intercourse with their partners, as part of violent behaviour (Refer to 4.3.6.1).

> *So I think I want to make a difference that there is HIV and we need to put it in the right perspective and know the right content and everything, not have something outside that has not been proven, but it is based on information that is factual.*

- ***To help and support others***

Being knowledgeable also helped to support peers, friends and family who tested HIV positive and also to set new moral standards. This is also evident of credibility and wanting to be seen as a role model. This is clearly so with these peer educators, as they felt empowered to assist not only their peers, but their family members as well, as demonstrated in the following quote:

> *I have family members, who are infected with HIV and AIDS, and I am infected with HIV AIDS, so I told myself let me take this part to be involved.*

In some individual cases participants and some of their family members were HIV positive themselves and by joining the campaign they found support in how to deal with the crisis.

> *For me it was personal ... I had a family member who passed away due to AIDS, so I felt like I needed to give back to the community since I wasn't there for him. I was actually one of the few family members who just turned and looked the other way when he needed us.*

- ***To help others in lifestyle, attitude and the fight against HIV/AIDS***

In some cases participants had been exposed to programmes regarding HTC at school level already and were eager to continue their involvement when they started their tertiary career. Some interviewees stated that they want to make a difference to other people's lives and by becoming a peer educator they found that it is easier for other students to relate to them as they are of the same age. Again the aspect of role modelling, which seems to be central to SCT, is being emphasised.

> *It gave me a sense of self-esteem to be able to face my problems and challenges ... introspection in my life ... and I think I should change the way I live and be able to live a different way.*

> *... you tell them why they should condomise, and then at the end of the conversation, it's like okay, cool, I'll condomise ... there's HIV.*

The sense of agency and credibility is evident in the above quotes from the peer educators as well. They also feel empowered, therefore their self-esteem is boosted, they are confident. They have acquired a sense of self-efficacy, which implies not just a simple "believe in yourself and you will succeed", but actually putting your skills and experiences, acquired in the peer education training programme into practice. It seems as if the majority of participants feel that they can make a difference in the general attitude of family, friends and peers to the pandemic by joining the campaign against it and it enables them to make a contribution in the fight against HIV/AIDS. Peer educators believe that becoming more informed by gaining knowledge means that they could dispel myths around HIV/AIDS. It also gives them a sense of empowerment and boosts their confidence. Peer educators want to acquire the skills and knowledge of the trainer. This is evidence that they are always looking for a good role model. Therefore, encouragement and persuasion by enthusiastic and motivated trainers are an important source of self-efficacy as well as role modelling for peer educators.

4.7.7 Strengths and opportunities

(As experienced by the various **students groups/peer educators** interviewed.)

Evidence coming from students with regard to strengths and opportunities clearly reflects an introspective and personal viewpoint, rather than a holistic and external judgment of the peer education work of the HIV/AIDS Unit at this HEI. The following is a summary of the personal development and gains of the peer educators while they are engaged in the peer education training programmes.

4.7.7.1 Personal gains

- ***Personal development and empowerment***

In analysing these transcripts, it became clear that all these peer educators benefited from these peer education training programmes, particularly with regard to personal gain and empowerment.

- Empowered by gaining knowledge of HIV/AIDS.

The following quote illustrates this:

So I think I want to make a difference that there is HIV and we need to put it in the right perspective and know the right content and everything, not have something outside that has not been proven, but it is based on information that is factual.

- Empowered by development of communication and counselling skills.

- Acquiring skills to facilitate group discussions and speak in public, especially play a vital role in the personal development of the participants.

There's a lot that me, myself, I have, confidence, we attend workshops and we have got skills how to deal with people ... we were taught how to counsel someone ... then you would be able to relate to them ...

I have gained confidence to approach other peers on campus.

- Empowerment by personal management skills, e.g. time management, organising and management of portfolios,

... to prepare portfolios and do a report ... I didn't see that potential in me, but being in the Unit I could produce such work.

By attending various workshops they are not only empowered by knowledge, but also in practical skills like facilitation, time management, organising, planning and managing a portfolio and handling different people from the opposite sex. This is again evident of self-efficacy and personal agency.

4.7.7.2 Developing/strengthening of self-esteem and gaining stature

Being a facilitator made them grow in stature and gave them the satisfaction of making a contribution to the wellbeing of their communities. It also became clear during the analyses of the interviews that it is especially the knowledge and skills gained from attending workshops and also the training in general, especially in counselling, that contributed to a growth in self-esteem and stature of these students.

It gave me a sense of self-esteem to be able to face my problems and challenges ... introspection in my life ... and I think I should change the way I live and be able to live a different way.

There's a lot that me, myself, I have gained public speaking being one of them, confidence being the other.

I speak freely and honestly about everything, being gay and being HIV positive, and still being a student and living on campus.

Self efficacy and confidence are again displayed in the above quotations. HIV-positive participants also displayed a strong mental capacity to disclose their status. Peer educators who

can balance academic and social life on campus normally display great personal strength, as well as a well balanced emotional state. They persevere until they reach success in whatever they strive to achieve. They are also committed to peer education training programmes and projects and are keen to make a difference in others as well as their own lives.

4.7.7.3 Acceptance of self and acceptance by peers

It is important to peer educators that they are accepted by their peers. They also want to become great achievers in their academic careers. This will ensure that they become prominent role models and leaders, not only amongst their peers on campus, but also within the communities where they live and come from.

> *When I speak with confidence to most of my peer educators, I tell them if I make a difference in one person's life, it's like I made a difference in the whole community's life...*
>
> *I am accepted by peers and have gained confidence to approach other peers on campus.*
>
> *... I find that if a peer of about same age speaks and provides correct information, it's easier to reach the student populace within the university.*

The ability for some of them to accept their own HIV-positive status as well as that of peers and family also helped them in their broader and mature outlook on the pandemic and the necessity to become involved in the fight against the spread of HIV/AIDS, STIs and TB. Closely related to that is being open about their personal status and to accept the sexual as well as the cultural diversity of their peers and friends, and also to accept the sexual orientation of gay and lesbian people.

> *I now speak freely and honestly about everything, being gay and being HIV positive, and still being a student and living on campus.*
>
> *Before, for, when I know you are HIV positive, I think that even when I touch your clothes I will be infected ...*
>
> *What I have learned is we are from different backgrounds and different communities ... we have one goal, which teaching people about HIV and AIDS ... it is a huge learning curve.*

Once again, evidence of role-modelling, credibility, empowerment and personal agency is reflected in these quotes from peer educators.

"Yes, these students know what they talking about, when they come and teach us about HIV/AIDS ... They are also our friends." This is a quote from one of the group discussions that a peer educator had with fellow students.

When peers approach them for more information about the work of the Unit and the use of condoms, it proves to them that they have won the confidence of their fellow students in their role of peer educators, that they are successful in what they are doing and that they are making a difference in their communities.

4.7.7.4 Personal moral development

Further evidence reveals that workshops especially play a vital role in the personal development of the participants, their self-confidence and a feeling of responsibility towards their communities in general. They learn to distinguish between what is right and wrong and how to deal with other students. Topics around HIV/AIDS, sex and homosexuality, which were formerly taboo at home and church, can now openly be discussed, especially in the light of the fact that they are endowed with the necessary knowledge and facilitation and communication skills gained from attending various workshops. Confidence to address these issues openly and to change the stigma around HIV/AIDS is another virtue which contributes to their personal development. Personally some of them are also obliged to engage in introspection regarding their own personal and moral life. Closely related to the introspection is to be open about their personal status and to accept the sexual as well as the cultural diversity of their peers and friends, and also to accept the sexual orientation of gay and lesbian people.

> *... what I have learned is we are from different backgrounds and different communities ... we have one goal, which teaching people about HIV and AIDS ... it is a huge learning curve.*

4.7.7.5 Weakness and threats (Staff evidence mainly)

Weaknesses and possible threats in the system of peer education training are outnumbered by the positive responses of the interviewees. However, a few points were mentioned and are relevant.

- ***Time Management***

Time management and arrangements are sometimes unsatisfactory. Despite getting an agency to conduct time management workshops with all staff, time management is still poor and does impact negatively on the programme. This I personally observed and experienced as well (Refer to 4.5.2).

> *Lack of time management affects the activities and continuity of the peer education.*

Punctuality of participants regarding the attendance of meetings and workshops seems to be a problem as well and understandingly it will disrupt the functionality of the unit. This I alluded to in my discussion on observation as my biggest frustration as a researcher (Refer to 4.5.2).

> *... one of the major things that we have as a weakness is it's always to do with punctuality ... it will delay us in terms of meetings, in terms of programmes, in terms of us leaving, let's say we want to go to a community.*

- ***Communication***

Various modes of communication are put in place in the Unit. However, miscommunication and lack of communication still seem to be a major barrier in the Unit. It could possibly be ascribed to selected cases of staff communication and relationship problems (Refer to 4.5.2).

> *... sometimes when the peer education officer has to pass information to the peer educators, sometimes there is miscommunication. You will find some educators know about an event, maybe there's a meeting that's coming, some know, some don't know.*
>
> *We are trying to bring that sense of unity within the unit ... the HIV and AIDS unit belongs to the university and not to one individual.*

- ***Commitment***

There are various incentives available for good performances and commitment of peer educators, for example, T-shirts, awards and meals. However, commitment still remains a challenge. Some peer educators are not committed enough, resulting in poor attendance of workshops and the possibility of cancelling such a workshop. Some students see this as a threat to the sustainability of the peer education programme, which in turn threatens the personal gain of peer educators (Refer to 4.5.2). Losing the knowledge they acquire from the workshops would put their personal empowerment and development in jeopardy if training programmes have to be cancelled. However, students felt in general that there are no specific threats that could not be dealt with in an amicable manner. It was important to peer educators and other students that the quality and standards of the peer education training programmes should at all times be upheld and improved.

> *Let's say there are 30 peer educators, but the ones who are really, really involved in this sort of ten are maybe 10 ... the level of dedication of peer educators ... becomes a weakness to the programme itself as a whole, because the programme is nothing without its peer educators.*

From this quote it would appear that 33% of the peer educators are very committed.

- ***Workshops***

Some of the peer educators felt that the workshops are sometimes "rhetoric" and do not adapt to new challenges and that more innovative and creative ideas should be adopted in the presentation of workshops. Peer educators should also be given more opportunities to facilitate or co-facilitate workshops, and more workshops should be presented. Again this is evidence of agency and structure, where peer educators want more autonomy and decision-making skills. They feel confident enough to facilitate workshops and are eager to transfer acquired skills and knowledge to their fellow peers and students.

> *I have found these workshops designed that way, and I have been here for almost two years now, and there haven't been updates ... statistics are old, they still haven't been revised ... So I think we 've got a lot of room to develop and improve.*
>
> *... sometimes we set ourselves too many things, too many programmes or too many tasks or too many activities ... we are rushing our activities; we don't have time, enough planning.*

- ***Lack of funding***

Lack of enough funds limits the programme functioning and outcome.

- **Counselling**

Counselling on a one-to-one basis which will be more professional and effective than the existing policy of counselling in residences

- ***Availability of enough manpower to extend service***

More staff needs to be appointed in order to extend the Unit's activities to all the other campuses equally.

- ***A lack of interest***

A lack of interest among male students in the HIV/AIDS programme as well as the lack of participation of some faculties in the activities are matters of concern at present which need to be addressed.

- ***Lack of refresher courses***

Health promoters form an important part of these training programmes. They need to have regular updates and refresher courses. Collaboration with other HEIs in the area would empower

them to perform better and enhance the training programme. Peer educators want to be associated with good role models. They should be allowed to observe. This process of observational learning described by SCT is particularly relevant for peer education programmes, since young adults are thereby given the opportunity to observe how others behave and how these behaviours are accepted or rejected by the peer group, staff or others, e.g. volunteers – in this instance, the health promoters.

> *Health promoters need to go once a year for refresher courses in counselling and also further training and should also collaborate with other universities.*

- ***Milestones***

As mentioned above, when student interviewees were questioned about milestones in the programme, responses were mainly of a personal nature, in other words personal development, a growth in self-esteem and confidence, the acquisition of personal skills such as communication and knowledge around HIV/AIDS, the ability to manage and compile a portfolio, the skill to facilitate and a comprehension of the sexual and cultural diversity of people, etc. However, it was pointed out by some peer educators that the expansion of the peer education training programme to the campuses of other universities was a highlight in their involvement in the programme, as well as the inclusion of the other four satellite campuses.

> *All satellite campuses are now included, in the programmes.*
>
> *We are now in possession of the wellness mobile which is reaching out to the satellite campuses.*

- A pledge of peer educators and all other students to adopt abstinence and tag them (a strap-on band was given to students who signed a pledge for abstinence) was implemented across the different campuses.

> *An abstinence campaign was started where students receive wristbands – "I am Proud to Wait.*

Participants suggested that there is very good interest in peer education – more than what the institution /Unit can accommodate.

> *... we have 200 interested in the programme and we can only take 30-50.*

Staff members' perceptions of milestones are to a great extent linked to campaigns launched by the Unit: e.g. staff members' contributions in publications or conferences. Examples of these highlights are as follows:

- The Candlelight Campaign and the book launched by an organisation called "Openly Positive"; The Unit held a first HIV-negative symposium for those who were tested negative and was also the first to have a, HIV/AIDS symposium for HIV positives.

- The "First Things First" campaign was held and peer education group discussions were held in campus residences around HIV/AIDS-related matters. Staff believe that a breakthrough has been made to clear the negative stigma around the AIDS disease and those are positively affected on all the campuses of this HEI.

- In 2011, this HEI's peer educators came forward and openly talked about their sexual orientation and/or HIV positivity. This resulted in an NGO, called "Oaklands" inviting them to participate in an in-house peer education training programme. This was initiated and arranged by these peer educators themselves. They wanted to transfer their knowledge and skills and empower the peer educators of Oaklands to do the same at their institution.

- The South African Business Association (SABCO) has invited peer educators to run a peer education programme at the workplace of businesses to which 5 or 10 students will be going to conduct educational programmes related to HIV (Refer to Appendix 13). Peer educators play a major role in organising these events.

Examples of staff contributions mentioned:

- A co-author of a chapter in one of the books called "Whispers not";

- A student from California did a Masters study on the work in the Malmesbury Prison, which was presented at a conference in Vienna and she received an award for the best research at a university;

- A staff member was nominated to attend the international micro-biocide meeting in Ethiopia and the participant (HOD) was awarded the Humphrey Fellowship at Emery University and he did his professional affiliation at the Centre for Disease Control (CDC) in Atlanta, contributing to a research project investigating a vaccine to combat the HIV virus.

- Another milestone for a participant was to be chosen to go to Sweden to share information on the HIV situation in South Africa. This also assisted her to be able to admit her status as HIV positive and being gay. International conferences are regularly attended.

- ***Behaviour change***

SCT claims that a large amount of learning occurs amongst people of the same age group. This could also be true for the peer educators, as they constantly seek to be recognised as role models amongst their peers. Self-efficacy is therefore enhanced and they want to be regarded as credible leaders. Hence their peers would feel comfortable about following them. Credible peer educators are very conscious of the way in which they act and behave when they are surrounded by their peers. Staff and students' perception of behaviour changes are based on anecdotal evidence and the assumption that peer educators' public declaration of abstinence might influence others. There is a perception of behaviour change among students in terms of abstinence and as far as free sex is concerned. A peer educator changed his behaviour *"of beating the women in his life and actually changed his whole 'mind-set' as far as his relation to women is concerned"*. Staff was also convinced in general that the programme caused many students to change their patterns of behaviour, especially risky behaviour in terms of alcohol abuse and the number of sexual partners (Refer to 4.3.6.1, 4.3.6.2, 4.3.6.3, 4.3.6.4 and 4.3.6.5). There are also declarations of peer educators of general behaviour changes. When they joined the peer educator programme, they were shy and had no confidence but after their training *"they are like these bubble people ... they can go out to talk to their peers"*.

There is no evidence of shared experiences of qualitative open-ended evaluations done to get feedback from participants in the programmes related to their satisfaction of the activities they attended. However, some feedback and evaluations were done on the different workshops (Refer to 4.3.3 and Appendix 9).

> *We have done an evaluation to assess whether it was effective and whether that is what they expected or not ... and we have analysed the results of that ... to ourselves within meetings ... like the HOD meetings.*

The health promoters, however, indicated that no in-depth evaluations were done on their care and support training programmes, despite the fact that, after every workshop/training session, an evaluation form was completed by the participants (Refer to Appendix 14).

The final objective refers to other students attending group discussions or events with peer educators.

From the three student groups that I have interviewed, it is evident that students benefit from these discussions. Most of the discussions are being held at the residences.

So where it took place – at our residences, namely DeBeers – the topics that were covered, as I said, they are topics that are not usually on the table, detailed from sex to contraception and just personal encounters ... so this was different.

I found the experience to be informative.

What makes it personally beneficial is that opposed to the message (methods) we received, sexual health education before ... now we get it straight from our peers.

These quotes are evidence again of most information regarding sexuality and HIV/AIDS issues are being received from peers (70%) (Refer to 4.3.5 and Figure 4.4.). Students enjoyed the different strategies that were used by peer educators to impart the different messages in the discussions.

It was the charting with the flowchart to establish what level of risk it is – the game fun factor, which is a unique method.

We did play an icebreaker kind of a game; everyone was forced to get involved.

They showed us dildos to show how to use a condom properly.

'We had this game – I can't remember the name of the game, but you get envelopes, because there is one positive and then the others are negative ... We then end up dating each other training *... But the envelopes are like having sex – so then when we exchange the envelope, it's like having sex.*

In answering the question how they perceived the peer educator, the majority of the students also saw the peer educator as a role model and a leader, as alluded to by SCT.

I would say that as much as they are young, but the fact that they are peer educators, it does stand out in social circles – that part of them will eventually always stand out when the usual crowd would be deviating from the fact that we're not peer educators.

I would say, he acted responsibility, he had to be a mentor ... he actually informs us of all risks.

Well what was outstanding is that they not necessary know all the answers, but they would say "I will go and do my research ... but I will certainly get back to you and answer your question". I respect that.

They were serious about their job ... You could see they really want to be aware of the whole HIV and AIDS thing. They were very positive.

When asked whether these discussions and events had any influence on their own behaviour, these students answered as follows:

Being more responsible ...

Yes and more cautious – when you around other people with regard to sex.

Well, I think at the end of the day it is up to the individual. The more empowered the person is, it therefore places them in a better position to make a better decision ... So now, a little bit more knowledge, which you are getting, you will benefit ... the knowledge will steer you away from the wrong act.

This was a powerful statement from the student, as SCT indicates that knowledge does empower young people, particularly to make the right decisions.

Well actually, we can't dislike anything. They came to teach us – it's like helping us about the decisions were making about our future.

The information I gained gave me more confidence to interact in discussions with other people surrounding the topic of HIV and AIDS. The fact that I was involved in these activities made me more informed and willing to share.

This is also evident of agency and credibility as discussed in SCT. Students become more confident and knowledgeable to share their experiences and knowledge with regard to HIV/AIDS and sexuality issues with their peers.

Finally, all the students seem to have benefitted from these discussions:

For me, I liked the programme. Everything was nice, because it made us to say whatever we wanted to share our views ... there were no right or wrong answers.

Their presentation, how you get infected and most of the risky ways – I learned a lot.

To that effect, us youngsters, we don't discuss most of what we should be discussing, friends or not – so now, the benefit we gain is that these peer educators, they have come in with a particular purpose."

So now, with these specific friends which are here for a purpose of educating us with something which is crucially important to our own health, I think that is what I like the most.

Once again, these quotes are evidence of the role modelling and trust in their peers.

The students also had the following suggestions to make on how to improve these group discussions at residences.

- It has to be done more frequently - at least once a month during each term.

They should visit us more often, because they only came once".

Of course, in terms of improvement, in the way that they come more often – and they may become more creative with the game factor and the humour factor and the friendship factor.

They should have more programmes.

"The discussions that they bring – they are doing a great job – they must continue with this great job, because they are teaching us a lot.

Yes and also educate us to extent whereby we actually go out and tell other people.

"There are some stuff we don't learn from our courses that we do, we have them to teach us that kind of information we need".

This is again evidence of the importance of peer teaching and gaining information from peers, as SCT recommends.

At the end of the day, we would all like to become peer educators.

And it just emphasised the fact that they care about young people out there.

- The programme should be marketed in a much more vigorous way.

Yes, so almost like marketing, but you increase awareness, because some people don't know about them.

What we agree as peer educators, we agree that they usually go to residences when they recruit first. We could be having stalls when we have a market day

It is very powerful – even take the time to actually try and get as many people to attend, and actually listen to the ways in which we can avoid it.

Another thing, market the programme at the SRC bashes. Maybe they will find out there are people from satellite campuses which we have unity again.

A Facebook page can also be made for students to join the discussion.

To improve it, they can go to Christian organisations, even other organisations, political organisations in the campus, because they will be able to attract people and send the message to a lot of people.

Marketing should also happen by word of mouth:

Another thing, I would add, or that I would request from students, if we have information, maybe they're a friend that wasn't there, tell that person, that there are such people who are at my res who are discussing such things, so that people will know about it.

- More visual presentations should be done.

I think visual presentation, like to show how the viruses are when you have one.

When we are talking, we are discussing and it is easy to forget some stuff. If you have seen, if there are videos, it will be easy for us to always remember.

We can actually have more games.

4.8 SUMMARY OF QUALITATIVE DATA

From the qualitative data themes such as communication, commitment, lack of funding, behaviour change, personal gains, motivation, relationships were common for both trainers and peer educators. Agency, role modelling, credibility and self-efficacy were evident in the peer educators. Other students who attended the group discussions in the residences, facilitated by peer educators, benefited by means of information gained and learning from their peers how to deal with HIV/AIDS and other sexuality issues. These students regarded peer educators as role models and some of them expressed the desire to join the peer education programme. Stigma and discrimination are occurring less frequently, because these students are informed and empowered by knowledge and information from the peer educators. While I was observing in various meetings, workshops and at events, I gained more insight into the operations and functioning of the trainers and peer educators. In reviewing some of the documentation of the HIV/AIDS Unit, I could verify the authenticity and credibility of these documents. I could assess whether they were representative of the training programmes and what they meant to both the trainers and the peer educators. In assessing the portfolios of the peer educators, I saw evidence of their participation and involvement in the training programmes as well as how they developed as individuals with regard to knowledge gained, leadership skills and how they were able to transfer their skills to others.

4.9 SUMMARY

This chapter described the implementation of this study. The discussion of the findings of the focus group and personal interviews was done according to the various themes identified. It was linked to Bandura's SCT. Principles and characteristics of this theory were employed to interpret the various themes and categories. Significant factors such as agency, credibility, self-efficacy and role-modelling were evident from peer educators in these peer educator training programmes. Staff and peer educators highlighted strengths and weakness in the training programmes and the Unit's activities. Portfolios, observation and documentation, were also discussed as valuable sources that contributed to the results. The questionnaire results were also discussed in the quantitative section of the study. All these discussions will be used to make positive recommendations and conclusions in the final chapter.

CHAPTER 5

INTERPRETATION OF THE FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

An audit on HIV/AIDS activities was done on all 23 HEIs in South Africa. The report clearly stated that there is no evidence to indicate how successful peer education programmes at these institutions are (HEAIDS report, 2010). Hence my interest in researching this topic. This study was undertaken in the HIV/AIDS Unit at an HEI in the Western Cape.

The aim of the research has been to evaluate and establish the influence of peer education training programmes among students at a selected HEI in the Western Cape. The research aimed to answer the following question: "Does the implementation of peer education training programmes at HEIs make a difference in the lives of peer educators and other students with regard to the acquisition of knowledge and skills to deal with HIV/AIDS and STIs and related sexuality issues?" The purpose was to identify various best practices and challenges of these peer education training programmes at an HEI in the Western Cape. The objectives were to describe the background, aim, mission and vision and the core values of the HIV/AIDS Unit at this HEI; to evaluate the effectiveness and influence of peer education and related training programmes in the HIV/AIDS Unit among the peer educators at an HEI in the Western Cape; to evaluate the staff's experiences and challenges in the implementation of the training programmes in the HIV/AIDS Unit and to illustrate the experiences of, and influences on, students who have attended various activities hosted by the peer educators and the HIV/AIDS Unit.

In 2009 I negotiated with all the relevant role-players in the HIV/AIDS Unit at this particular HEI to do the research. I made my intentions clear to all the staff members as well as the peer educators. I am also an active member of the institutional HIV/AIDS committee of this HEI. I was given the opportunity at this meeting to explain what my project would be all about. I received support letters (Refer to Appendix 16) from the HODs of the HIV/AIDS Unit as well

as the Student Counselling Units at both of the two major campuses of the HEI where the research would be conducted.

This chapter presents a summary of the preceding chapters, discusses the limitations of the research and of my findings. It then offers some recommendations and concludes with personal reflections.

5.2 BRIEF SUMMARY OF PRECEDING CHAPTERS

The first chapter begins with a brief overview of the contextualisation and orientation of the study. It outlines the purpose of the research, which understands the key issues involved in the peer education training programmes, challenges faced by staff in the implementation of these programmes and the experiences of other students who interact with the peer educators. It gives a broad background of the extent of the HIV/AIDS pandemic, globally, nationally in South Africa and provincially. It highlights the Western Cape provincial statistics, as the HEI in this study is situated in this province. A comparison of the four HEIs in the Western Cape is also discussed. The chapter then gives a synoptic view of the chapters that are to follow.

The second chapter gives an extensive account of the literature review with regard to HIV/AIDS and the effect it has particularly on the youth. The Millennium Development Goals (MDGs) are discussed in detail and linked to youth activities. There are just five years remaining in this 20-year plan to implement these MDGs. It is important to give far greater attention to the educational and health needs of the world's generation of youths, especially in sub-Saharan Africa, where government is facing the highest hurdles in meeting the MDGs.

South Africa's National Strategic Plan (NSP) for HIV/AIDS and STIs is also discussed, as well as the functions of SANEC. The HIV/AIDS seroprevalence rate in universities in the Western Cape was highlighted. Four institutional responses to HIV/AIDS from HEIs in the Southern African Development Community (SADEC) were highlighted. A conceptual framework for how HEIs could respond to the HIV/AIDS pandemic was developed. The HEAIDS initiative was explained. The HEAIDS programme is designed to develop and strengthen the capacity, the systems and the structures of all HEIs. HEAIDS also implement its strategies as part of the multisectoral response of the NSP. Evaluation capacity for HIV/AIDS prevention programmes was reviewed as well as the impact of HIV/AIDS on education. This included the impact of HIV/AIDS on both staff and students. The use of Information Communication Technology

(ICT) at HEIs in combating the pandemic was explored. Peer education and its related aims and purposes were dealt within in depth in this chapter.

The third chapter presents the procedural aspects of the research process. It explains how the methodology and the design of the research were formulated. The Social Cognitive Theory (SCT) was employed as the theoretical framework for this study.

A mixed method approach was employed to collect data. Peer educators completed a questionnaire and participated in focus group interviews. Other students who attended workshops or group discussions conducted by peer educators also participated in focus group interviews. Personal interviews were conducted with all the staff at the HIV/AIDS Unit. Data were also collected by means of observation, document analysis and portfolio assessment.

The fourth chapter gave an account of the data analysis. The quantitative data were analysed by means of SPSS, while the qualitative data were analysed using content thematic analysis for the focus and personal interviews. The recorded focus and personal interviews were transcribed by an expert, after which they were coded, and then divided into themes and sub-themes (Refer to Appendix 4 and 5).

5.3 DISCUSSION OF THE FINDINGS

5.3.1 Mission and Vision Statement

In the context of the HIV Unit's vision statement, from my observation and the scrutiny of documentation in the Unit, I have been able to establish that the Unit has gone beyond the role of being a centre of excellence for HIV/AIDS and STI programmes within the peer education training programme. It has links not only locally, but also at international level. Not only did it establish Memoranda of Understanding with developing countries, but it has also introduced an excellent internship with collaborated research programmes, both nationally and internationally (Refer to Appendix 15).

With regard to the Mission statement, it has gone beyond the role of prevention, especially in its peer education programme by introducing a model for peer education. More importantly, its innovative way of training and acknowledging peer educators contributes to the Unit's application of its mission statement to practice (Refer to Appendix 23).

5.3.2 Sustainability

From my focus group interviews, informal discussions with staff and from my observations, the sustainability of the HIV/AIDS Unit was of prime concern as it impacts on all facets of the programme. Initially funding from ENGENDA HEALTH, HEAIDS and the EU assisted with the implementation of programmes. Two years ago this funding came to an end and the Unit is now solely dependent on the HEI where it resides for financial assistance. This has an impact on the number of programmes that can be implemented. Staff morale is also affected, as they are unsure of their positions, since they get only short-term contracts of 3-6 months. They also do not qualify for all the benefits that the two permanent staff members get at this HEI, for example, a housing subsidy and medical aid.

5.3.3 The development of a Logic Model

The development of a Logic Model guided me through the assessment and evaluation process. It assisted me in reaching the following:

Target Groups

- Primary Target – peer educators at a HEI;
- Secondary Target – All the staff involve in training;
- Students who attended discussions in residences with a peer educator.

Goals

- To provide students with comprehensive information relating to the HIV/AIDS pandemic;
- To provide students with a context in which to explore their personal and collective attitude towards the HIV/AIDS pandemic;
- To provide students with an opportunity to develop their communication, professional and life skills; and
- To provide students with an opportunity to engage (collaborate with) and impact on communities around them, for example, schools, prisons etc. around the HIV/AIDS pandemic.

Outcomes

Outcomes in this project are as the actual benefits that resulted from the programme activities:

- Students have assimilated and own their (appropriate) approaches to the HIV/AIDS pandemic;
- Students have inspired the community of their choice to respond appropriately to the pandemic and may have become role models for appropriate sexual behaviour in their communities;
- Students have acquired professional skills and also vital life skills;
- (Anticipated) impact;
- Students have been empowered to claim their space around issues that affect them at the institution and in society;
- Students have taken responsibility for their own sexuality and behaviour changes.

Resources

The input in the context of the Logic Model in this project was defined as resources. These resources included funding, supplies (for example, posters, pamphlets, and condoms), staff and many ideas that were brainstormed by both staff and peer educators involved in the peer education training programme:

- Websites supporting life-skills development, for example, the *Your Moves* CD-Rom;
- Intensive continuous training sessions on various aspects of life skills, professional development and facilitation and self-empowerment skills, venues, transport and meals are provided for workshops;
- Stipends are given to committed peer educators, as well as T-shirts and flash drives;
- A peer educator award ceremony where the top achievers in the peer education programme are awarded with prizes.

Activities

The output of the project is regarded as the direct products of the programme activities. These activities are also linked to the mission of this HIV/AIDS Unit. The activities therefore illustrate the work that the Unit does in order to fulfil its mission:

- Instructor-facilitated workshops are presented on a wide range of professional skills development topics;
- Peer educators are constituted into small teams and are required to roll out an HIV/AIDS awareness project of their choice to a community in line with the principle of our students taking ownership and inspiring the community towards appropriate behaviour;
- Peer educators participate in HIV Counselling and Testing drives on campus;
- Peer educators conduct training programmes and group discussions in residences;
- Peer educators participate in training programmes at prisons and other NGOs;
- Peer educators are responsible for filling up condom dispensers around campus and in residences;
- Peer educators compile portfolios of the activities and involvement in the peer education programme.

5.3.4 Observations

Peer education training programmes are being offered on all the different campuses, as well as from a Wellness Mobile Unit (Refer to Appendix 18). Office space on the campus where the Unit is situated is extremely small. Room space is limited and the office is always overcrowded. The HOD's office is the smallest and is also used as a storeroom. The two interns and the international students share one office and the Peer Education Officer (PEO) and Projects Officer (PO) share the third office. The reception area is extremely small and cramped. There are no windows, which results in poor ventilation and could therefore be deemed an extremely dangerous occupational hazard. The roof has been leaking for the past two years and despite numerous requests by the HOD to have it repaired, nothing has been done to date. The storeroom is hopelessly inadequate and the meeting room is very small. There is virtually no space to receive visitors, despite the fact that this Unit receives visitors locally, nationally and internationally on a regular basis (Refer to Appendix 15). All visitors are received in the

meeting room. There are no kitchen facilities, with the result that staff never get a break from their offices, as it becomes their space to have lunch breaks as well. This unsafe working environment, with the lack of space and poor ventilation violates the rights of workers, according to the Occupational Health and Safety Act as it is the duty of every employer to provide a safe working environment (Occupational Health and Safety Act & Regulations, 2010:11). This could also have a negative impact on the activities of the Unit. At times the venues for the workshops were not suitable and conducive to interaction and participation, as the Unit has no designated teaching venues. Attendance numbers also dwindled and occasionally did not justify group work.

Only two permanent staff members are employed in this Unit. The rest of the staff operates on renewable contracts every 3-6 months. Despite the shortage of staff, the number of outputs and quality of programmes offered is evident of the commitment of the staff members.

Rotating these peer educators to take minutes in the meetings not only empowered them, but also enhanced their minute-taking skills. I also witnessed a few times how peer educators chair important workshops and seminars. This is a sign of great leadership and personal agency. Young people who are empowered will gain confidence and will strive to seek health interventions; for example, they might see that they themselves have a key role to play in HIV prevention, rather than seeing it being the responsibility of other medical experts (Campbell, 2004:1). This is a combination of self-confidence and self-empowerment that makes young people feel that they are in control of their sexual health, as indicated in SCT (Bandura, 1986).

Other benefits of peer education training programmes include peers being regarded as credible sources of information. This has proved to be true in my study. 70% of the participants indicated that they received their HIV/AIDS and other sexuality information from their peers (Refer to 4.2.5). Secondly, empowerment of those involved is very important. Participants indicated that they would want to be more involved in decision-making processes within the peer education training programme. Hence they should be empowered with facilitation and communication skills. They would also like to do more facilitation within the training sessions. SCT claims that peers function as contributors to their own motivation. If peer educators are motivated and committed, they will produce high-quality work, particularly if they are empowered by good role models who set good examples (Bandura, 1986).

Thirdly, the emergence of peer educators as positive role models is very important. Peer educators want to be recognised by their peers as leaders and credible role models. This was evident in the focus groups with other students, who referred to the peer educators as *"great leaders and people who are knowledgeable and that can teach us all the facts with regard to HIV/AIDS and sexuality"*. This is very much in line with Bandura's SCT, as he believes that a good role model is not only responsible for teaching good behaviours, but also plays a pivotal role in teaching peers' judgment and values. All of this will contribute to the development of the young adult's cognitive ability (Bandura, 1986). Benefits for peer educators themselves could also have a positive impact on peer educators. Peer educators enjoyed workshops and events, as they received a meal and or other rewards, for example, a T-Shirt, a flash drive, a wristband, a certificate of attendance and involvement, which will also enhance Curriculum Vitaes. They also enjoy the exposure of public speaking and the development of leadership and other interpersonal skills, which would assist them in their future careers. Each one has a chance to do minute taking in peer education meetings, which they find extremely empowering (Refer to 4.3.3.1). This HEI hosts an annual awards ceremony for the peer educators, where they are rewarded for their hard work and participation throughout the year in the peer education training programmes. This is a highlight of the peer education programme.

Despite the fact that this Unit functions on a limited budget, peer educators still disseminate knowledge to other students across the campuses. Incentivising peer educators is much more cost effective than having to remunerate a staff member. On one of the campuses a peer educator volunteered to be on duty in the HIV/AIDS office in the absence of a staff member on a daily basis. This is not the ideal, hence the critical need of staff shortages should be addressed, but at least needy students have access to someone for information, referral or to collect condoms. This is all undertaken by the peer educator on duty.

Carter and Carter (1993:1) suggested that sexuality education should be given a high priority in high school curricula, in order to prepare students for all the challenges they may have to face in HEIs. It is clear that young people are the "at-risk" population when we look at STIs and HIV/AIDS statistics (Refer to Tables 2.3 and Table 2.4). Sexuality and family life education help to prepare students for the transition to adulthood and to face the challenges of HEIs (Carter & Carter, 1993: 1). Curriculum integration on HIV/AIDS, STIs and TB is therefore very important across faculties at HEIs. At this HEI an attempt is made to integrate an HIV/AIDS

module(s) into some courses. The HOD of the HIV/AIDS Unit is responsible for offering this accredited module(s). However, this is currently happening in only four out of six faculties.

The Rutanang Module devised by HEAIDS seems to be a very valuable tool. Out of the 23 HEIs that were surveyed, 22 HEIs made use of this module as part of their peer education training on their respective campuses (HEAIDS Report, 2010).This HEI, where my study was conducted, fused the Rutanang Module with ENGENDERHEALTH and aspects of the DRUMAID training module into their current HIV/AIDS and STI peer education training programmes with great success.

Tijuana, Finger and Ruland (2004) believe that in order for a training programme to be effective the trainers needs to be trained adequately and that sexuality education has to first impact on the trainers. Currently, there is only anecdotal evidence to support the commitment of trainers and that they do have an impact on peer educators. This was highlighted in the focus group and personal interviews with staff and peer educators. In reviewing the literature to date, it was found that very little is done in HEIs in this regard. Students are introduced to various disciplines through texts and lectures (CSUMB'S Monterey Bay's Service Learning Prism: 2008: 2), but lack the skills to utilise their own life experiences to deal with issues of sexuality and HIV/AIDS. Despite the fact that commitment of staff and students was evident in this project, more efforts have to be employed to increase this level of commitment, particularly among peer educators.

The level of commitment exercised by those who train the peer educators through empowerment, self-agency and credibility, could effect change in the knowledge, attitudes, beliefs and behaviours of these peer educators (Bandura, 1986). However, peer educators themselves need to be motivated and committed to acquire the knowledge and skills to combat this pandemic. Poor attendance at some workshops and events by peer educators in this project could probably be an indication of their lack of commitment and motivation. However, the attendance register at all workshops and events was changed to an activity score sheet (Refer to Appendix 24). This is to monitor the level of participation of the peer educator at an event or workshop, as well as his/her punctuality.

An assumption of peer education is that students are more receptive to the influence of their peers. This is so because they share similar values and interests. It is further assumed that because of sharing similar values and interest, discussions with trained peer educators will

facilitate understanding of health information. This will encourage them to change behaviour. However, in applying SCT, it was clear to me that those cognitive processes, or the acquisition of knowledge, do not necessarily contribute to positive behaviour changes. This was evident in the usage of condoms and drugs, multiple partners, violent behaviour and suicide tendencies among peer educators. Yet peer educators were exposed to many workshops where these topics were dealt with in detail (Refer to 4.3.6). Despite these interventions, there was still a lack of the application of knowledge and skills.

Interviewees were also convinced in general that the programme caused many students to change their patterns of behaviour, especially risky behaviour in terms of alcohol abuse and the number of sexual partners. This was emphatically demonstrated on the video tape called *Intersections,* which is a documentary that was developed by the HOD of the Unit during auditions that was part of an HIV/AIDS awareness campaign on one of the campus. On the tape some peer educators who were interviewed during an event in 2012 stated (Refer to Appendix 25):

> *"I am using a condom correctly and always"*
>
> *"If it is not on, it is not in"*
>
> *"I have to use condoms"*

Safer sex practices are important, particularly among youths who have multiple partners. One of the functions of peer educators is the distribution of condoms (Refer to 4.2.6.5 and 4.3.6.6). Condoms are distributed across all the campuses, for example, in all ablution facilities, male and female, residences, student counselling centres, in the sport centre and recreation facilities, and the campus clinic. Despite the fact that during the focus group interviews some peer educators and students admitted to not practising safer sex, 85% of peer educators indicated during the survey that they always use a condom. This is an indication that behaviour change did take place to some extent.

During the orientation of first-year students peer educators escort students to the student health centres and counselling centres on the various campuses. All students have access to health care facilities. Here the Wellness Mobile plays a big role in taking services to all students on the satellite campuses (Refer to Appendix 18).

Peer educators have opportunities and knowledge to discuss sensitive issues such as safer sex and condom usage with their peers during group discussions held in the residences.

The Health Promoters forms an important part of the training programme. They impart knowledge and skills on how to care for and support people (friends and relatives) living with the disease.

Community outreach is a very important component of the peer education training programme on this HEI. The peer educators and their trainers are involved in a peer education training programme at one of the prisons in the Western Cape. I accompanied the group on a visit to the prison on national TB day this year. It was amazing to see the response of the prisoners and the excitement among all present for the work that is being done. All the peer educators took the TB pledge (Refer to Appendix 19). This resulted in one of the peer educators in the prison referring a positive TB inmate to the prison clinic. This HEI prides itself on its community outreach programmes. This seems to be a step in the right direction in order to empower more community members to take responsibility to fight the HIV/AIDS pandemic.

5.3.5 Portfolios

This was a true reflection of the extent to which peer educators participated in various events and workshops. They graphically displayed their involvement in the peer education programmes by means of photographs and certificates in these portfolios. Evidence of community outreach participation is also evident. Peer educators need more training in how to construct a curriculum vita (CV). All the peer educators' CVs differed. They were also unsure of how to write their own philosophy statement. Not all of them understood how to write short-, medium- and long-term goals, as they did not describe this appropriately in their portfolio. It is also evident that some peer educators are more committed than others, particularly in the way the portfolios were planned and completed. Portfolios are real credited documents, as described by Denscombe (2011) and are a valuable tool to assess peers. At this HEI marks are awarded for portfolios, which allow the peer educators to come into contention for an award at the annual prize-giving ceremony, which is a highlight for all involved in the peer education training programmes.

5.4 LIMITATIONS OF THIS STUDY

- One important limitation that all the studies pointed to in the literature search was the lack of consensus on how to measure outcomes. This lack of consensus can be attributed to the minimal documentation that exists on how information is exchanged between peer educator and the recipients, and the non-existence of a single theoretical framework that guides peer

education (Frankham, 1998; Lindsey, 1997; Turner and Shepherd, 1999). This also holds for my study, for as much as I was guided by the SCT framework to interpret my data and shed light on many issues of credibility, agency, role modelling and leadership with regard to peer education, it is clear that the acquisition of knowledge does not necessarily change behaviour. My study supports this view, because during my observations, while interacting with the peer educators and other students, it was clear to me that knowledge constitutes potential power, but that true power lies within applied knowledge, for example, when peer educators demonstrate a strong commitment to practising safer sex and not just talking to their peers about it.

- SCT seems to have limitations because of the requirement for observation of modelled behaviour; for example, opportunities to observe modelled behaviour such as safer sexual practices in my study were limited. I had to rely on anecdotal evidence from staff and students during the personal and focus group interviews. It is questionable whether all health behaviours are susceptible to modelling.

- It is difficult to assess behaviour change within a period of 18 months.

- I did not categorise the ranks of peer educators, which would be an indication of the duration of their involvement in the peer education programme.

- The process of engagement with all stakeholders was time consuming. Peer educators as well as the staff had tight schedules and I was always competing with everyone else's timetables.

- I was keen to collaborate more with the staff and peer educators of the Unit, but because of my own commitments in my department, I had to be selective about which activities I became involved in. More involvement from my side could have resulted in a much broader perspective on the functioning and activities of the Unit.

- The HOD of the Unit oversees all its activities. It was extremely tedious to get staff to respond without the HOD's permission, since they operated on very tight schedules.

- Participants in the focus group indicated there was very good interest in peer education – more than what the institution /Unit can accommodate –

"we have 200 interested in the programme and we can only take 30-50". Had more students been enrolled in the peer education programme, my sample size could have been more appropriate. As a result of staff shortages and lack of funding, the Unit could only accommodate a certain number of peer educators. The Unit has to cater for the satellite campuses with the same amount of staff and funding.

- Not all peer educators pitched up for all training sessions.
- I battled for months on end to get students together who attended the discussion groups with peer educators to do focus groups.
- Peer educators were never all punctual. This had severe financial implications, particularly when focus groups were conducted, as the moderator was paid by the hour.
- Training sessions were drawn out, and interrupted by latecomers.

5.5 RECOMMENDATIONS

- ***Portfolios***

With regard to the assessment of the peer educators' portfolios, clear-cut guidelines or criteria need to be developed. All assessors need to be well informed with regard to these criteria. More experienced assessors should be appointed to mark the portfolios. Their inexperience affected the final marks scored by the peer educators. This could be critical in the final analysis to determine who qualifies for the peer educator awards. This could be compared to the study by Morgan (1999), who claims that portfolios plays a major role in assisting new teachers to find employment, as well as serving as one of the main assessment tools to determine whether the student has successfully completed his/her training and whether the student is ready to graduate from teachers training college. Equally so, the portfolio is added adds to the final assessment of the peer educator. This could also affect whether the peer educator would be considered for an award. Another academic and/or staff member from another department should be recruited to assist with the marking of portfolios. One service staff member, for example, a staff member from student counselling, should be recruited to assist with the assessments of the portfolios to overcome barriers and biases. This will ensure that someone else's perspective will be included who is not directly involved with peer education.

Portfolios should also be assessed independently by all markers. The final mark should be discussed and consensus should be reached with regard to the final mark. Clear-cut guidelines and criteria should be developed. Refer to Appendix 17 for revised criteria and portfolio guidelines, as developed and recommended by me, based on my experience of marking these portfolios for the last two years. Examples of criteria are as follows (Refer to Appendix 17):

- Cover page and layout: Originality, no plagiarism, the goals must be smart, measurable, realistic and attainable within a reasonable timeframe;
- Curriculum Vita (CV): Give a format of a standardised CV;
- Past and present academic records;
- Evidence of transferability skills;
- Short courses completed in specific ranks.

A score system needs to be put into place in order to do a proper assessment of attendance at various events. These scores could also be utilised to assess the level of involvement of the peer educator at the event or workshop (Refer to Appendix 24).

- ***Documents***

All minutes of meetings have to be reviewed by a second person. A thorough spell and grammar check has to be done in order to eliminate the many spelling and grammatical errors, which make the minutes, look very unprofessional. All persons who attend and all those who submitted apologies should be indicated in the minutes. Minutes should also be distributed seven days prior to the next meeting. There is no indication that this is happening. Here the trainer plays an important part to educate the peer educator in this regard, as self-efficacy and empowerment are more beneficial if engendered by the trainer, who should also be a good role model (Bandura, 1986).

- ***Workshops***

Training programmes must be devised and offered in a more creative manner. This could include practical sessions to ensure that the peer educators are skilled to render an efficient programme. Reduce the amount of information given at a workshop, as this may lead to information overload, as indicated by the peer educators. Change the content and structure of

workshops and update information in every workshop to avoid repetitiveness and rhetoric, as mentioned by peer educators during the focus group interviews.

> *I have found these workshops designed that way, and I have been here for almost two years now, and there haven't been updates ... statistics are old, they still haven't been revised ... So I think we've got a lot of room to develop and improve.*

Trainers should also update themselves on a regular basis and be creative when presenting workshops. Some of the interviewees felt that the workshops are sometimes just "rhetoric" and do not adapt to new challenges and that more innovative and creative ideas should be adopted in the presentation of workshops. Peer educators should also be given more opportunities to facilitate workshops and more workshops should be presented. Staff and students involved in the peer education training programme should be held accountable for the effective and efficient running of all programmes.

Work with committed peer educators and reward them for their commitment, for example, give a certificate, give an extra T-shirt. Encourage time management and punctuality amongst the peer educators.

> *Also ... sometimes we set ourselves too many things, too many programmes or too many tasks or too many activities ... we are rushing our activities, we don't have time, enough planning.*

- ***Life skills training***

First- and second-year students often want to join the peer education training programme (Refer to 4.3.3). These students have limited life experiences. They come into the training programme with no skills and techniques. It is important to put more emphasis on life skills training and behaviour change theory. Here Student Counselling colleagues, who are registered professional psychologists, could play a big role in assisting with this type of workshop. This specific training and acquisition of skills could create confidence in being able to behave in a acceptable manner. This is referred to as self-efficacy in Bandura's SCT, which includes the ability to overcome any barriers to performing the appropriate behaviour. For example, practising the correct condom use in a condom demonstration for both males and females is an important activity leading to self-confidence when talking about safer sex practices with a partner.

- ***Information, education and communication***

Information, education and communication are important aspects that should be included in peer education training programmes. Peer educators should be taught communication skills and how to put them into practice. This has to be combined with other HIV-prevention strategies to make it more effective. This will include the focus on HCT and reducing stigma. Proper communication can also enhance adopting positive behaviours, which could ultimately lead to behaviour change.

Continuously reinforce the use of understandable language while participating in a workshop; this could enhance communication amongst participants. Different methods, for example, using drama, role plays, making use of the media to exchange information and knowledge could be employed. This will also enhance social networking and advertising of valuable training sessions.

- ***Dress code for peer educators***

The dress code for all peer educators must be spelled out, particularly when they do outreach to the various communities. One female student was asked to cover herself with a jersey when we entered Malmesbury prison for an outreach programme. Provocative clothing was also very distracting during workshops and was disruptive.

- ***A policy for marketing and public relations***

A more aggressive policy towards marketing and public relations work should be adopted in order to raise more funds to enhance the outputs and quality of programmes offered. This could also provide for more staffing. The components of a comprehensive university response should include a well-defined HIV/AIDS policy. Each HEI should develop a comprehensive policy and ensure that it is being implemented. Every aspect of the disease must be factored into university planning, both at strategic and operational levels. Management and personnel issues should be taken care of, as the disease could be working away silently on the campus (Kelly, 2002). HIV-awareness campaigns need to be done at regular intervals. A review of policies and procedures governing medical aids, sick leave, loans, benefits and pensions is vital. The entire university community should be involved in establishing partnerships and educating each other. HIV/AIDS should be factored into key performance areas (KPAs) of all staff.

Methods of communication should be improved, as this causes confusion and disruptions in the training programmes. The PEO should ensure that all schedules of events and workshops should be distributed timeously – equally so any changes to the programme. All peer educators' emails and cellular telephone numbers should be kept in one file together and should be updated on a regular basis.

- ***Remuneration***

Remuneration of peer educators could also increase the retention rate of peer educators. A small stipend could motivate them and enhance their self-esteem in making a meaningful social contribution within the peer education training programmes. In this HEI peer educators received no money, but they looked forward to the prize giving and award ceremony at the end of each year, where they come into contention for various awards.

- ***Wellness Mobile***

This mobile renders a service on all the campuses. The Mobile staff are not permanent, even though it is adequately staffed. However, the staff are agency based, which is not cost effective for the HEI. The Mobile is well equipped. However, it needs to install additional tents to combat adverse weather conditions.

- ***Community outreach***

Although a commendable effort is made by this HEI to do community outreach (at least 30% of the programmes are focused on community outreach), not many community members are involved on a long-term basis to sustain the projects. Community members need to be mobilised to play a much bigger and important role in this HEI's training programmes. By doing this, community members would be empowered to take responsibility to combat the HIV/AIDS pandemic. Communities could also be empowered and taught to take care and support their own family and friends who live with the virus. Furthermore, peer educators and trainers could introduce many other HIV/AIDS, STI and TB prevention programmes at schools within their communities around the HEI. This would assist prospective students coming to the HEI to prepare them to make the move from secondary school to HEI. Sharing the reality of being independent at the HEI will allow these students to confront many issues of living in residence, away from home, what to do with supposedly extra free time, or their new-found freedom, and

the tremendous peer pressure that exists even at HEIs with regard to sexual activity and drug and alcohol abuse.

- The four HEIs in the Western Cape could also collaborate more to ensure better intensity and dissemination of information. In this way more people can benefit from the programme.

- It is recommended that the non-governmental organisations (NGOs) with strong links to the different communities be identified as partners. This will facilitate community support for the outreach projects, including projects which are part and parcel of subject curricula, which include HIV/AIDS education.

- More men need to be included as peer educators in the programme to ensure full participation of men.

- Monitor the effectiveness of the scoring sheet of the attendance register of peer educators at workshops and events.

- The HOD submitted a proposal with regard to funding and staffing for the Unit that has been approved, based on an independent evaluation of the Unit's function and staffing issues. The recommendations made by the independent consultant were in line with the HOD's previous submissions made several years ago to the HEI management. The issues in this proposal need to be taken up seriously by the management of this HEI.

- The Unit can be made sustainable if a portion of the student health levy is allocated to the Unit. R10.00 per student would generate R350,000 annually for the operation of this Unit's peer education training programmes.

- Research subsidies generated by the Unit should also be allocated to it in order to complement its funding.

- Funds linked to the integration of the accredited HIV/AIDS module that is being offered by the HOD of the Unit should be distributed fairly amongst faculties and the HIV/AIDS Unit. Lecturing is not just time consuming for the HOD, as it takes him away from the Unit, but it includes assessments, evaluations and presentations.

- Based on the observations with regard to poor physical facilities and the shortage of staff, a new building for the Unit is of crucial importance. This could enhance the effectiveness and efficiency of the activities of the Unit.

- The restructuring of the Unit and appointing staff on more permanent contracts or on a permanent basis would lift their morale and increase their outputs. The number of training officers should also be increased. They will be able to enhance the effective and efficient delivery of the training programmes.

- ***Self-reflection***

Trainers and peer educators will have to self-reflect on their own identities and how these came to be shaped. This is important for all who are involved with HIV/AIDS education, as it has an impact on the most intimate and private component of every individual's being. Peer educators as well as trainers should be clear about their personal as well as their sexual identities, since these determine how comfortable they are in dealing with HIV/AIDS and STIs and other sexuality issues. Training programmes should therefore include activities on self-reflection, which will include the social, moral and political aspects related to HIV/AIDS. Self-reflection becomes vitally important for all trainers and peer educators who are involved with HIV/AIDS education, as the challenges of this pandemic could leave many of them physically, emotionally and spiritually drained. Peer educators need to take ownership of, and responsibility for, behaviour change.

- ***Proposed model for translating theory into practice for peer education training***

(Based on Interagency Group on Young People's Health Development and Protection in Europe and Asia (IAG), 2003).

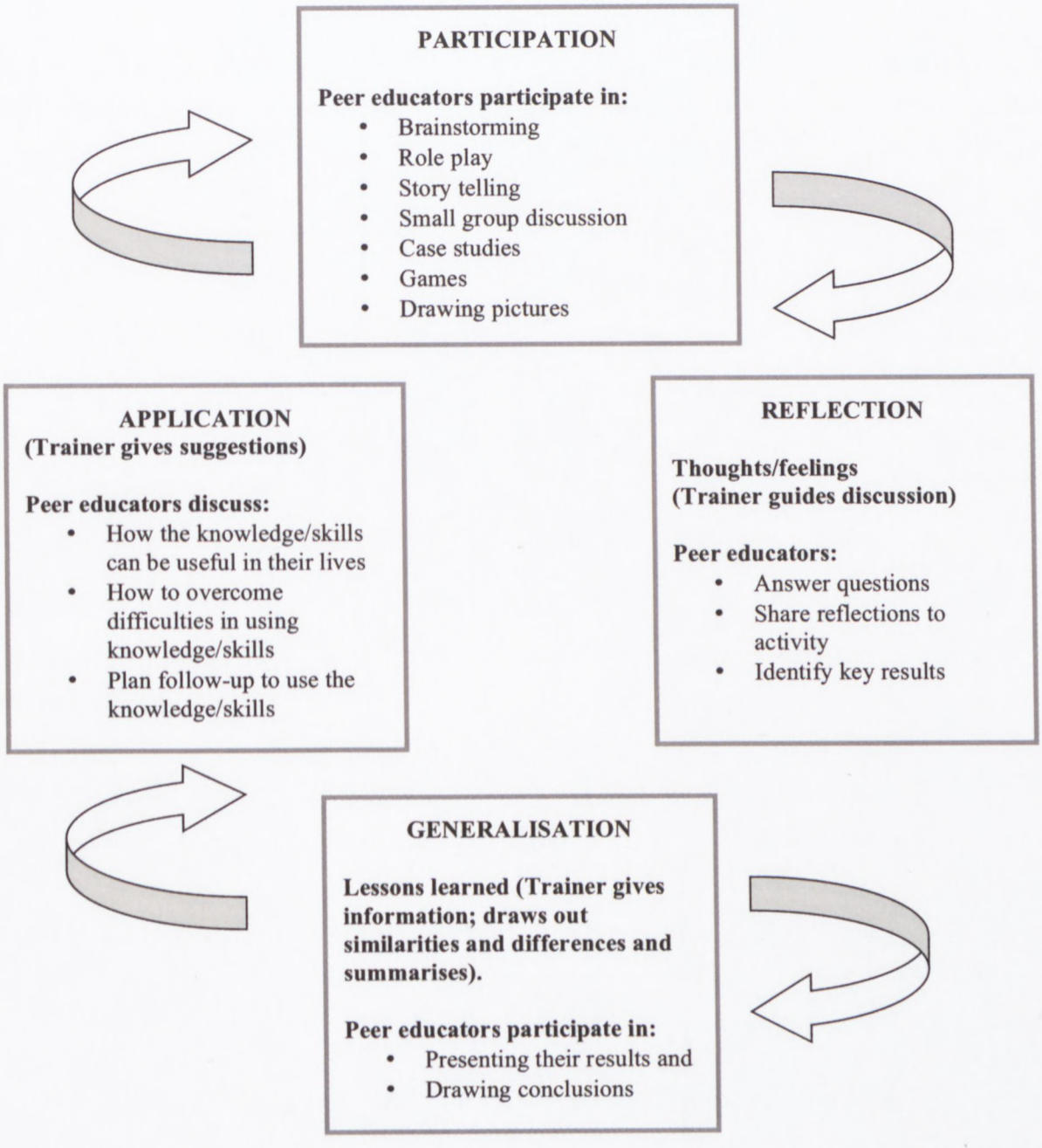
I would like to recommend the following model to be used by HEIs in order to enhance their peer education training programmes. In this model the focus is specifically on applying theory into practice. The training of peer educators is based upon an experiential learning model, using interactive techniques. However, this model could also be modified for the training the trainers, but I will focus on the training of peer educators. This model includes the following four elements:

- Direct experience (activity in which peer educators create an experience);

- Reflection on the experience;
- Generalisations (lessons learned); and
- Applying lessons learned.

The following diagram depicts these four elements.

Figure 5.1: **DIRECT EXPERIENCE** (Trainer introduces the exercise/activity and explains how to do it to the peer educators)



With regard to the participation aspect, story telling, case studies and drawing pictures could enhance peer education training at this HEI. It is important to establish how the knowledge/skills can be useful in their lives and how to overcome difficulties. SCT verifies the aspects of agency and credibility. This is particularly important when peer educators are faced with difficulties. It is only when they are able and capable of using their knowledge and skills that they would become empowered to deal with difficulties or face a crisis situation.

Peer education training programmes should include follow-up sessions to allow peer educators to use the knowledge and skills that they have acquired in the training sessions.

The one aspect that was completely absent in this peer education training programmes was reflection. This will allow students to engage at a very deep level with their own thoughts and feelings. The trainer could encourage this by doing shared reflection activities with the peer educators. Peer educators should be encouraged to ask questions and to answer questions. Key results could be identified.

In the final component, which is generalisation, the trainer gives information, draws out similarities and difference, and then summarises everything that happened during the training session. This is very important for peer educators, as they will participate in presenting their results and drawing conclusions of how they fared during participation in workshops and events. Most importantly, peer educators could focus on lessons learned in order to enhance their participation as peer educators in the Unit.

5.6 PERSONAL REFLECTIONS

Staff, peer educators and other students were interviewed to determine the impact of the programme. The evaluation of this programme clearly reflects that the study objectives were achieved. The peer educators felt honoured to provide information to their peers. The peer educators' mode of advocacy and information dissemination was through workshops and group discussions at the various residences on the different campuses. This also happened through their multiple community outreach programmes.

They mentioned that the programme was a success because people and organisations consistently invited them to do presentations to their members. Students who attended the group discussions in the residences felt enriched by the information they received from their peers. They were also empowered and felt more confident to deal with people affected by and infected

with HIV/AIDS. Students also felt they could deal more easily with personal problems. Others felt that group presentations were more effective because they reached more people in a shorter time. They also felt that there was a greater awareness about gender-specific issues. There was an increase in the number of people going for tests and more people contacted them about queries related to the topics presented. They requested more training and updates as well as more training in other sexuality-related issues. They felt strongly about programmes being offered more frequently at residences.

HCT uptake has increased tremendously on this HEI as a result of the rigorous marketing and advertising campaigns of the peer educators. Students understood the information that was provided by the peer educators. They were therefore empowered to make informed choices about their health and lifestyle. Anecdotal evidence of this was clear during the focus group interviews with both the peer educators as well as the students who attended the group discussions in residences. The fact that this programme has managed to reach men and empowered them to become health conscious and aware of the importance of seeking advice to either prevent or reduce the incidence of HIV/AIDS and STIs is significant. At the 2011 peer educator award ceremony, a male peer educator received an award for recruiting the most males to participate in the HCT campus drive. Prior to the 2011 HCT campaign, the majority of clients who came to be tested during the HCT campaign on this HEI, were females.

The findings of the evaluation prove that the peer education programme serves as an effective model to reach large numbers of students and staff, as well as communities with HIV/AIDS and STI control messages and strategies to address the pandemic. This model has proved that peer educators within HEIs have been empowered to identify the risk factors and change behaviour to being responsible for their own health and thereby not only to seek information on the HIV pandemic, but most importantly, to disseminate correct information in order to empower their peers and community members to take control of the pandemic with regard to its manifestations and treatment.

Peer educators need to explore their own creativity and take ownership of their disciplines and behaviours in order to make them worthy citizens. Not only peer educators, but all other students should be informed in such a way in the HEIs that they can see and understand the relevance of the content of HIV/AIDS in all aspects of their lives.

Accomplishment of behavioural change is complex and takes a long time, and it only happens where adequate and appropriate knowledge, with the necessary attention to the epidemiological and social aspects of the disease have been integrated appropriately into existing curricula. In educational institutions assessments (examinations and tests) compel students to a certain degree to attend classes from which they are likely to acquire the necessary knowledge to apply in assessment processes. In an attempt to avoid rote learning, students are encouraged to apply and internalise their knowledge. With HIV/AIDS education it is therefore important that arrangements be made for peer educators to participate in community projects. Projects could include the use of drama, role plays and HIV/AIDS-related campaigns, as well as working with hospitals, schools or community projects and focusing on community-based care for people living with HIV/AIDS.

This would further expose peer educators to the reality of the disease and also assist them to avoid risky situations and to work towards authentic behavioural change. Safer sex practices, together with behavioural change, should be reinforced on a continuous basis. Working through existing community-based organisations allows individuals with common social networks to be reached with HIV/AIDS prevention messages. However, some vulnerable groups may not be reached because they do not belong to any social network and are also not easily identifiable, unlike peer educators, who have the opportunity to network widely and to interact with their peers. In HEIs there is a slight advantage for academics and students, since they have a more close-knit community of students and academics. Persons who are infected and affected should be made to feel comfortable in coming forward and seeking help. It is evident that it is much easier to establish support groups on campuses than in the community. Here the health promoters play a major role in training the peer educators in how to deal with persons infected with and affected by HIV/AIDS and to participate in support groups.

Interaction between academic staff and students is likely to improve advocacy and involvement with the entire community on campus as well as around the campus. It is also important that HIV/AIDS education should take place in a non-threatening atmosphere. Peer educators, as well as other students, should feel comfortable and confident about discussing sexuality issues openly, without feeling embarrassed. Equally, the educators and trainers should feel confident and comfortable discussing these issues with their peer educators and students.

Individual behavioural change is unlikely to be sustained unless the social environment encourages healthy behaviour. SCT emphasises the fact that educators or trainers cannot control

the environment that students encounter outside of HEIs. Therefore, it is very important that trainers need to explore other means within the training sessions to build self-efficacy amongst peer educators. HIV/AIDS education is a subject that requires much time and commitment from both the trainers and the peer educators. The information taught to these peer educators should be extended to the lives of students and trainers outside the training sessions and even to the communities in which they live.

It is imperative that peer educators are aware of the referral systems when they are confronted with somebody in need of care or counselling, or if they needed help personally. Referral systems on HEI campuses should include structures such as student health services and student counselling centres. At the HEI where the research was conducted, both these services are being offered.

Peer educators should also be aware of off-campus sites. These include the local community health centres and the large secondary state hospitals. There is an HIV/AIDS directory for the Western Cape available to which needy students could be referred. Students need to be informed that treatment for all STIs, including medication, is free at these community treatment centres.

Building community ownership of intervention activities should be an important element in all the community outreach projects with which the peer educators engage. HEIs therefore need to link up with NGOs and other community organisations and health centres within their geographical boundaries. For example, the institution at which this investigation was carried out receives all its medication for treating STIs and condoms from the local community health clinic.

Potential areas of difficulty in sexuality education in primary and secondary schools could be overcome by building community ownership. Here peer educators could spread their programmes into the local primary and secondary schools. The community could also have a greater impact by pressurising government to take ownership of this pandemic that is almost certainly out of control in our country and in our province.

HEIs may be disproportionately more affected by the pandemic than any other sector, as the majority of those who form the community at HEIs are young and in the age group where they are vulnerable. This is also the age group with the highest prevalence of HIV infection. HEIs therefore have a major role to play in fighting the pandemic. Above all, HEIs have a responsibility to take a prominent leadership position in fighting the battle against HIV/AIDS.

Strong leadership will ensure that the key stakeholders remain committed, that the required resources are mobilised, that crucial policies and management structures are established, and that a strong foundation is being laid for the implementation of specific interventions (one of these should be peer education) designed to deliver on HEIs' core mandates of teaching and learning, research and knowledge generation and engagement with the community (Higher Education South Africa (HESA) 2006).

However, the intention of the National HIV/AIDS policy, as well as that of the WCED policy on HIV/AIDS, is to provide a framework for the development of provincial and schools' policies and strategic plans for their implementation. It also recommends the establishment of health advisory committees to assist all educational institutions to devise their strategic plans with regard to HIV/AIDS, including the HEIs. Education on HIV/AIDS should not be seen as an add on, but as part of an integrated curriculum (Republic of South Africa, 1996; Republic of South Africa, 1999; HESA, 2006:1).

Research is an essential function of HEIs. Academic and administrative staff in HEIs have the capacity to do ongoing monitoring and evaluation of both the peer education programmes, curricula and community outreach projects. In addition, NGOs have strengths in developing monitoring systems, but need ongoing support for the effective use of these systems. HEIs are well positioned and able to support NGOs with research projects. Data collection should take place on a continuous basis and the findings based on analyses of the data should be public and accessible so as to lead to the implementation of more effective and efficient peer education projects, both on HEIs and in the communities. Follow-up evaluation of implemented peer education programmes and outreach projects is equally important.

Most of the HIV/AIDS prevention programmes and initiatives are dependent on external support. HEIs have a major role to play in providing financial support and research expertise to these preventative programmes (Higher Education South Africa, 2006:1-2; Aiello and Bisgard, 2003:23-34). The institution should secure enough time and funding for ongoing research, as well as the monitoring and evaluation of peer education programmes. Sustainability is closely linked to student and community ownership and to institutional arrangements. Peer education training programmes could help to ensure that the prevention of HIV infection is centrally included at all stages of planning and budgeting at HEIs. It is important that all peer education training programmes and interventions on all HEI campuses become part of a coherent, well

planned and strategic process to include HIV/AIDS and STI education meaningfully across the curriculum.

Finally, if the lifespan of the peer education training programmes on HEIs is intensified and more students are engaged in these programmes, it would have the potential to develop staff and students as well as communities into advocacy-orientated communities that would eventually challenge the HIV/AIDS pandemic through united mobilised action. This is a strong recommendation and a challenge for all HEIs to take on seriously.

5.7 SUMMARY

This chapter concludes the study. It includes the interpretations of the findings of the results, the limitations of the research as well as the conclusions on all aspects of the study. It also highlights the recommendations I wish to make for future research, as well as a proposed new model for inclusion into peer education training programmes. I also recommend continuous monitoring and evaluation of peer education training programmes at all HEIs.

I trust that this research will help management at all HEIs to realise the importance of peer education training programmes and that this will form part of the continuous strategic planning processes on their campuses. I was personally and professionally enriched by this research and I hope that my investigation will make a contribution to the development of meaningful peer education training programmes with regard to HIV/AIDS and STIs content across disciplines in HEIs in South Africa and beyond.

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