AN EVALUATION OF HEALTH PROMOTERS' PEER EDUCATION PROGRAMME ADMINISTERED AT THE DURBAN UNIVERSITY OF TECHNOLOGY

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Abstract:

This study evaluated the efficacy of DramAidE's Health Promoter's Peer Education Programme administered at the Durban University of Technology. The study was conducted to determine how peer educators address HIV/AIDS issues and whether participants of their workshops are able to personalise their risk of HIV/AIDS. The study also sought to determine the extent to which the programme adopted communication for social change and participatory education methods. Data was collected through interviews with health promoters, project co-ordinators, peer educators and focus group discussions with participants attending workshops. Participant observation was also conducted in order to gain first hand experience. The key findings suggest that HIV/AIDS and related issues were effectively addressed by peer educators in workshops but that they were ineffective at allowing participants to personalise their risk of HIV/AIDS. Communication for Social Change as well as Participatory Education approaches were found to have been administered. However the study also located room for improvement with regard to both approaches. The study suggests that the programme needs to broaden its target market by including all DUT students and that peer educators needed more training workshops. The subject matter of workshops should also be more inclusive of participant's content and peer educators need to share more personal experiences with their participants.

Keywords: Peer Education; HIV/AIDS; Participatory Education; Communication for Social Change and DUT

Chapter 1:

i) Introduction and Background

Peer education is neither a new nor an untested approach to learning and development. Published reports of studies being conducted on peer education can be recorded from as early as 1996 if not earlier (Kerrigan, 2000). Kerrigan's findings acknowledged peer education as a strategy which could be used in HIV/AIDS prevention. As an approach which is most widely used to address HIV/AIDS, peer education involves empowering people with skills to affect change among a group of their peers mostly with regard to behavioural change or change of attitudes, beliefs and knowledge at an individual and sometimes even societal level (Kerrigan, 2000).

A document called *Rutanang*, which means learning from one another, provided the first set of guidelines in 2003 where peer education could be implemented in South African higher education institutions (Chetty and Michel, 2005). This supported peer education as a mechanism of social change to be integrated into higher learning institutions. The South African Department of Health in an effort to prevent HIV/AIDS, met with 25 of the nation's leaders in health and education during December 2000 with a special interest in using peer education (Rutanang, n.d). By acknowledging the need for peers to work with students and formalising an agreement to incorporate into tertiary institutions, South Africa allowed for peer education to be a recognised strategy in combating the HIV/AIDS epidemic.

Drama in AIDS Education (DramAidE) is a Non-Government Organisation which integrates peer education in many of their programmes. The Health Promoter programme is a project run by DramAidE which is supplemented by their own peer education programme targeting tertiary education students and focuses on HIV/AIDS and related issues. The peer education programme was launched in 2001 with the realisation that young people prefer or are at least more free and relaxed when they share sensitive issues with their peers. Research has shown that there is a greater likelihood for people to listen and personalise messages coming from their peers who are perceived to be similar to them (Mason, 2003).

This study was conducted at the Durban University of Technology (DUT), reviewing the Peer education is a programme, managed by DramAidE through the university's

student counselling department. This project specifically targets HIV/AIDS issues on campuses. According to the DramAidE website[1] , health promoters are meant to: "Form support groups for those infected and affected by AIDS, sustain the new support groups using DramAidE methodologies, promote the concept of voluntary counselling and testing (VCT), engage in face-to-face dialogue with students to break the stigma and promote positive living which enhances or adds value to existing peer education and HIV/AIDS projects on campuses". They do so through participatory methods emphasising dialogue and use this to "effectively help students to personalise the risk of HIV infection, break the stigma and deal more effectively with their personal health and relationship problems"[2].

The Health Promoters in their capacity as co-ordinators also train tertiary education students to be peer educators. The programme employs strategies inclusive of campaigns and workshops which involve active participation from their participants in HIV/AIDS prevention and empowerment. Peers are meant to conduct workshops within these residences to students, facilitating discussion and addressing misconceptions about HIV/AIDS and related issues. Peer educators are students trained to listen and be supportive of their fellow participants regarding HIV/AIDS issues.

An evaluation of the peer education workshops within four DUT residences in the Durban region was carried out to determine the strategies implemented and the efficacy of their workshops. With the knowledge acquired from Health Promoters, this study analysed the strategies of Peer Educators with frameworks derived from participatory education (*Theory of Participatory Education* by Paulo Freire 1970) and communication for social change (*Communication for Social Change Theory* by Figueroa, Kincaid et al. 2002).

The aim of this study was to determine the efficacy of Health Promoters' Peer Education programme within DUT, using this institution as a case study to assess the programme. The main objective of this study was to determine the extent to which participatory and communication for social change approaches have been utilised by

[1] (http://www.dramaide.co.za/contentpage.aspx?pageid=2209)
[2] As above

the Peer Education programme in DUT. By conducting research into the programme's structure, content and reception, an overview of the issues which the peer educators tackle were analysed as well as their relationship to their audience.

The study aimed to answer the following questions:

1) How does the Health Promoters' Peer Education Programme address key issues surrounding HIV/AIDS at the Durban University of Technology?
2) To what extent do Peer Educators administer Communication for Social Change and Participatory approaches?
3) To what extent does the peer education programme enable students to personalise their experiences with HIV/AIDS?

ii) Literature Review

To date AIDS has 27 years of existence since it was first recognized in 1981,. Despite massive interventions, AIDS remains one of the diseases that affect the whole world. Over 65 million people have been infected and 25 million died as a result of it[3].Africa is the most severely affected Sub-Saharan region in the world (Katjavivi and Otaala, 2004). UNAIDS and WHO (2007) add that, in the Sub-Saharan Africa, more than two out of three (68%) adults and nearly 90% of children infected with HIV live in this region.

South Africa (SA) is the country with the largest number of infections in the world (UNAIDS and WHO, 2007). Ironically, SA had a number of misappropriation cases in some interventions/ programmes geared to curb the spread of HIV/AIDS. In 1996, the then Health Minister Nkosazana Dlamini-Zuma was reprimanded for a R14 million project to create a play about HIV/AIDS known as Sarafina II (Phila Legislative Update, 2000). In 2003, President Thabo Mbeki in an interview at the Plaza Hotel in New York said he knew of no person who had succumbed to the disease[4]. After he acknowledged that there is a disease like AIDS, his denialism continued when he claimed that antiretroviral drugs are ineffective and lethally toxic in the face of scientific evidence to the contrary (Mbali, 2004).

[3] (http://www.sauvca.org.za/resources/0000000036/0000000064/0000000066/%20Strategic%20Framework%20Final.pdf)
[4] (http://www.guardian.co.uk/world/2003/sep/28/southafrica.aids)

His denialism ballooned after a speech he delivered at the 2000 International AIDS Conference where he restated that not everything could be “blamed on a single virus” and that poverty claims more lives around the world than AIDS (Mbeki, 2008:4). Mbeki also stressed that everybody had the right to turn to the remedies of traditional healers if that was their choice. He takes the position of denialism while South Africans are succumbing to a serious disease like AIDS every day.

Universities are hard-hit by the Aids pandemic. South Africa's only survey of HIV prevalence among college students conducted at the University of Durban-Westville (now a campus of University of KwaZulu Natal) revealed infection rates of 26 percent in women and 12 percent in men aged 20 to 24 in 2000 (Stremlau and Nkosi, 2001). Even Dube and Ocholla (2005) show in their study that the principal clientele (students) of South African universities and Technikons have the highest concentration of HIV/AIDS infection because infections are most severe in the 16-30 age groups. Higher learning institutions have a responsibility to come up with whatever they can to fight against the AIDS pandemic. The youth at these institutions are the victims of HIV/AIDS. Either they have lost their loved ones or they themselves are infected by this disease.

The disease has the greatest impact on youth because they are sexually active. According to Bogdanovich, (2006), nearly nine million youth in the world are living with HIV/AIDS, and 67 percent of these youth are young women in sub-Saharan Africa. UNAIDS and WHO (2007) revealed that adults who lived with HIV in the globe in 2007 was 30.8 million, newly infected was 2.1 million and AIDS deaths was 1.7 million.

A report by Professor Michael Kelly confirmed that HIV is having a serious impact on the fiscal situation of the universities in much the same way as it does on other institutions (Katjavivi and Otaala, 2004: 579).Therefore, these finding show that HIV/AIDS is a serious and a fast spreading disease and institutions like universities should act accordingly to this epidemic.

Institutions such as universities are vulnerable to many adverse effects of HIV/AIDS; sugar-daddy’s practices, sexual experimentation, prostitution on campus, multiple partners and similar high-risk activities are all manifested to a high or lesser degree (Katjavivi and Otaala (2004: 579). The issue of sugar-daddies is also echoed by Lovell

(2002:3) who states, “Young (women’s) lives are being cut short through sex which is too often forced, coerced, or ‘bought’ with sugar-daddy gifts.” The study by Raijmakers and Pretorius (2006) on university students revealed cultural roles assigned to females and females’ lack of power to negotiate safe sex as some of the factors that increase vulnerability of women to HIV infection. A study in Witwatersrand showed that South African young women are bearing the brunt of the HIV/AIDS epidemic with nearly one in four women aged 20 to 24 testing HIV positive compared to one in 14 men of the same age (Dalrymple and Durden 2006). Since there is no cure for AIDS, the South African government’s strategy focuses on prevention by promoting public awareness and delivering life skills and HIV/AIDS education. Katjavivi and Otaala (2004: 578) argue, “As long as there is no cure for HIV/AIDS, one of the most important lines of battle against the epidemic is effective HIV/AIDS education.”

The strategies to curb the spread of AIDS needs to be as comprehensive as the virus itself (Katjavivi and Otaala, 2004), thus DramAidE and the Centre for HIV/AIDS Networking (HIVAN) are some HIV/AIDS units that have been established on campuses to deal with AIDS. These units are bearing fruits because there is now a high level of awareness among youth on AIDS[5]. However, the challenge still remains on changing behaviour. These organisations have to ensure that the awareness is translated into behaviour change[6].

However, efforts to promote various forms of sexual behaviour, such as the increasing use of condoms have also been singularly unsuccessful, often because they draw on individualised psychological, as opposed to more holistic, models of behaviour change (Ellison, et al, 2003:5). The control of HIV/AIDS is sometimes hindered by the beliefs and the attitudes of associated religious organisations (Ellison, et al, 2003). Some religious people infected with HIV/AIDS do not visit clinics because they believe a prayer alone can keep them alive and healthy.

In March 2007, a speech given by Naledi Pandor during the launch of Higher Education HIV/AIDS programmes, pointed out that African universities must renew their commitment to help Africa find effective solutions to its perennial problems including the disease like AIDS (Department of Education, 2007). This statement supports that

[5] (http://www.southafrica.info/ess_info/sa_glance/health/aids.htm)
[6] (http://www.southafrica.info/ess_info/sa_glance/health/aids.htm)

there must be a viable solution to the AIDS problem when the cure is still not available. Therefore, peer education programmes are one of the strategies that are thought to be appropriate in the fight against AIDS. Peer education is a programme whereby well-trained and motivated individuals educate or facilitate informal, organised educational activities with peers. These trained individuals are mostly of the same age, background and sometimes have the same interests as those facilitated.

Worldwide, peer education is one of the most widely used strategies to address the HIV/AIDS pandemic mostly in schools (Adamchak, 2006). Of the peer education programmes initiated in Cameroon in 1993, 60 peer health educators were trained to work with university students, many of whom later applied to become peer educators themselves (Aggleton and Rivers, 1999: 231). Students viewed the peer education programme as a useful programme that would help to reduce the number of students contracting HIV/AIDS. At the University of Cape Town, the Student HIV/AIDS Resistance Programme (SHARP) was the first peer education programme at the South African higher education institution launched in 1994 (University of Pretoria Centre for the Study of AIDS, 2004).

Another initiative called, Higher Education Aids Programme (HEAIDS) was also launched in 2000/2001 as a partnership between the Department of Education, the South African Universities Vice-Chancellors Association (SAUVCA) and the Committee of Technikons (CTP)[7]. The mission of this partnership is to "identify, contextualize and replicate 'Best Practice' with respect to prevention, behavioural change, care and support, gender and curriculum integration"[8] .

The usefulness of peer education programmes was recognised just after this partnership had been formed. The peer education programme was introduced to higher education institutions on the realisation that students prefer to socialise and talk more about health related issues with their peers and seemed to adopt advices from them. The impact of peer pressure on young, often vulnerable students, who may be away from parental guidance for the first time, is well established. These students are at higher risks of being

[7] (http://www.sauvca.org.za/resources/0000000036/0000000064/0000000066/HEAIDS%20Strategic%20Framework%20Final.pdf)

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influenced into unhealthy living lifestyle practices such as alcohol abuse and having unprotected sex. The opportunity to bring change to the university students is possible because it is easy to access them (students) since they are always there on campuses. According to Aggleton and Rivers (1999:231), “High levels of education and literacy mean that it is possible to use a wide range of materials and methods in order to communicate messages about HIV infection.” The study by Ocholla and Onyancha (2004) found that most publications for AIDS awareness are produced in English. Ocholla (2000) attributes the production in English to increasing recognition of English as a medium of scientific communication and indeed an international language that publishing houses prefer. University students present an older adolescent population with whom it is possible to talk more frankly about HIV-related issues (Aggleton and Rivers (1999: 231).

Peer education has over the years become a popular tool in health promotion deployed in the fight against health issues that confront us. However, advocates of peer education rarely make reference to theories in their rationale for particular projects (Turner and Shepherd. 1999: 238). The work of peer education is diverse and often lacking in theoretical justification for which one can just draw inferences. For example, there is an assumption that one of the needs for peer education to be successful is that peer educators are often perceived to be credible to their fellow peers. However, the social learning theory states that for one to be a credible role model, they would need to have a high standing in the peer group, and yet “many projects make no attempt to ensure that those with high status are specifically recruited to undertake peer education” (Turner and Shepherd. 1999: 238). This is one example which demonstrates that though theories are present, in practice some are not followed and rather just implied.

Zierch et al, (2000) found that while peers were considered suitable to discuss some aspects of the industry, many preferred to consult "professionals" about health related matters. This problem of peer educators not having expert knowledge is understandable because most of the peer educators are people who are studying for their own careers in life, and so it would be inappropriate for them to devote most of their time to learning more about health issues and not on their own fields of study (Mellanby, Rees, and Tripp. 2000: 543). So, although peer education is effective, it is difficult to investigate that assumption.

A number of studies have been taken throughout the United States, South America, West Africa and certain parts of South Africa to name a few places but none has been focused within DUT as a representative of the Durban tertiary monitoring. For example, the study by Dube and Ocholla (2005) did not focus on the effectiveness of peer education but on the impact of the disease on institutional mandates such as staff performance, recruitment and hiring, research, student intake, student performance and drop-out-rate.

Although considerable information can be found on Peer Education as a programme, not many studies show the specific issues which are being targeted and how individuals go about doing this. However, a report by Dalrymple and Durden (2006) about Higher Education HIV and AIDS Programme (peer education) show that most respondents found all of the sessions of the programme interesting and accessible and felt that the information was useful for their particular campus. Although it is not clearly stated how the programme was useful for the campus, this study wanted to find out whether peer educators represent other racial groups who are also part of DUT population. The impact of racial representation or lack of representation in the peer education programme would be the crucial point to tackle in our report. For other universities, the merger of campuses had caused some problems and tensions that need to be addressed, (Dalrymple and Durden, 2006). DUT has remained the institution that has never been affected by the merger programme, thus this research will evaluate the effectiveness of the programme.
The study by Dalrymple and Durden (2006) also found that a number of institutions lack resources to develop fully-fledged peer education programmes. Therefore, the evaluation of peer education at DUT gives a direction whether their resources or lack thereof, impact on the outcome of their peer education programme.

Chapter 2:

iii) Theoretical Framework:

DramAidE uses participatory and community dialogue approaches thus providing the motivation to use the *Theory of Communication for Social Change* (Figueroa, Kincaid et al. 2002) and the *Theory of Participatory Education* (Freire, 1970).

The *Theory of Communication for Social Change* was developed in 1997 by the Rockefeller Foundation which saw a need for communication strategies to be revitalised. A conceptual model was created for communication for social change with strategic proposals developed (Figueroa, Kincaid at al. 2002). These include the

idea of having a shift in power from governments and organisations to instead, the people who are being targeted. Proactive and personal communication is used that empower people through horizontal rather than vertical communication. Figueroa, Kincaid et al. (2002) created an integrated model in their research which exposes the full potential and reach of communication for social change. This model integrates context, content, access, participation and feedback.

According to Figueroa et al (2002), there are five basic elements which come forward in their theory. These are the 'catalyst'; 'community dialogue'; 'collective action'; 'individual change' and 'social change' which all affect one another. What this research was interested in was the 'catalyst' and 'community dialogue' which were elements that lead to change. The catalyst/stimulus can be either an internal or external agent which brings about dialogue (Figueroa et al., 2002). The study used this concept to determine what motivated people to attend the workshops in the first place thus determining how successful the Peer Educators' catalyst was. The second and slightly more significant concept is 'community dialogue' which is thought to lead to collective action (Figueroa et al. 2002). Community dialogue implies a substantial interaction leading to resolution through meaningful conversation. It therefore also emphasises equal participation and community empowerment by horizontal interaction. The concept was broken down into 10 elements which were used in this study. These are 'Recognition of a problem'; 'Identification and involvement of leaders and stakeholders'; 'Clarification of perceptions'; 'Expression of individual and shared needs'; 'Vision of the future'; 'Assessment of current status'; 'Setting objectives'; 'Options for action'; 'Consensus on action' and an 'Action plan'.

Whilst the *Communication for Social Change* model is highly relevant, the theoretical framework of the *Theory of Participatory Education* serves to work in conjunction with this so as to focus more deeply on the structure of content and the actual methodology or activity which enables for successful communication.

> Education represents in Freire's view both a struggle for meaning and struggle over power relations. Its dynamic is forged in the dialectical relation between individuals and the groups who live out their lives within specific historical conditions and structural constraints, on the one hand, and those cultural forms and ideologies that give rise to contradictions and struggles that define the lived realities of various societies, on the other (Giroux, 1985: xiii).

Paulo Freire's *Theory of Participatory Education* (1970) was developed in resistance to the status quo and embraced an ideology of liberation and empowerment by dissecting social structures and context. It emerged during Freire's work in Brazil and Chile in the late 1960s and early 1970s, during a plight of oppression which motivated him to find a way to help liberate the people (Taylor, 1993). By empowering people through participatory and dialogic education, he enabled them to fight against the status quo. In this sense people can resist hegemonic ideals or policies through their acquired knowledge.

Instead of affirming the idea that education brings about social change, Freire claims that social transformation is an educational process (Taylor 1993). It is this process which the study involved itself with. Three elements which form the derivates that this study used were 'Dialogue'; 'Reflective Action' and 'Active Reflection'. Dialogue according to Freire (1982: 61) is "the encounter in which the united reflection and action of the dialoguers are addressed to the world which is to be transformed and humanized." Freire uses dialogue as a concept in his opposition of banking education in the sense that he believes that its counter, dialogic education, is more liberating. Banking education refers to passive learners gaining deposits of knowledge (Taylor, 1993) whilst dialogic education enables them to be active in their learning. The other two concepts of 'active reflection' and 'reflective action' compliments the idea of critical and active learning since "the role of reflection is to react to the action and to reveal its objectives, its mean and its efficacy" (Freire 1976: 110).

In order to determine the implementation and incorporate certain aspects which were relevant to the peer education programme, certain criteria from the theories were utilised based on models of these frameworks. Firstly with the Integrated model (Figueroa et al. 2002), the 'Catalyst' of the programme was determined. The study then endeavoured to recognize who the relevant stakeholders of the programme were and determine whether participants recognized HIV/AIDS as a problem. Then, it clarified the participants' perception of HIV/AIDS and related issues. The study uncovered whether participants and peer educators were able to express their needs

and establish what the future goals are. Verification of a clear understanding of the programme in its context was necessary. An attempt to determine whether alternative actions may yield better results to be carried out as well as revealing whether the participants are able to reach a consensual agreement.

The *Theory of Participatory Education* (Friere, 1970) was operationalised for this study according to John Lyons' (2001) 8 Elements. These were the 'Theory of value'; 'Theory of knowledge'; 'Theory of human nature'; 'Theory of learning'; 'Theory of transmission'; 'Theory of society'; 'Theory of opportunity' and 'Theory of consensus'. The study evaluated how much value the participants held in the programme's content and whether they have a part in the creation of knowledge (room for reflexivity); discovered whether there is a human dimension in workshops by determining whether participant experience is inclusive in content; decided if knowledge is self and actively constructed by the participant and whether workshops allowed for participation. This study tried to uncover whether the participants' context has been considered. Another facet to explore would be the accessibility of the programme and in trying to achieve consensus, reveal whether/how peer educators facilitate understanding or agreement.

The *Theory of Participatory Education* (Freire, 1970) emphasises dialogue and critical reflexivity which this study believes to be integral for social change. The *Theory of Communication for Social Change* (Figueroa et al., 2002) furthers this argument whilst allowing those two concepts to be conceptually analysed and broken down into key elements thus creating working definitions which can be tested. The two theories were thus complementary in their use during research.

Chapter 3:

iv) Research Methodology

This study utilised qualitative methodology in a case study research design.

The Peer Education programmes are running in many higher learning institutions, therefore the focus on DUT allowed us to draw general conclusions about them through the use of a case study which "seeks to describe a unit in detail, context and holistically" (Kombo and Tromp, 2006: 72).

Target Audience

This study targeted the following three types of population groups: Health Promoters and project co-ordinators who were administering training directed at the Peer Educators; the Peer Educators themselves who received peer education training; and the students at DUT attending workshops in residences facilitated by the Peer Educators. This population was chosen to know the training, skills, approaches and methodologies which the Health Promoters or Peer Educators used. The study then endeavoured to find out how this might have equipped them in implementing Communication for Social Change and Participatory approaches. It was also used to analyse the relevance and effectiveness of Peer Education from the point of view of the recipients (DUT students).

The study through attendance in a two-day workshop conducted a participant observation of peer education training programme, facilitated by the Health promoters and project co-ordinators for the Peer Educators.[9] This allowed first-hand experience of the actual training of the Peer Educators. It also served two of our objectives. Firstly, to determine what issues surrounding HIV/AIDS were covered and secondly, to determine how the Peer Educators were equipped to use Communication for Social Change and participatory approaches.

One Health Promoter and two project co-ordinators were interviewed whom were selected through purposive sampling. A purposive sampling technique allows the researcher to decide who to include in the sample to collect focussed information (Oso, W.Y. & Onen, D. 2005:35). Health Promoters and project co-ordinators were chosen because they work for DramAidE as well as manage the peer education programme in DUT, the ones who have been training the Peer Educators. They are one of the key stakeholders in the DUT peer education programme.

Structured interviews were administered by researchers to the Health Promoters whom were chosen on the basis of being the managers of the peer education programme in DUT. The questions in the interviews with the health promoters ranged

[9] Peer Education Workshop. March 2008. Pietermaritzburg

from the recruitment/selection process, training, programme expectations, content and methodology.

Three Peer educators were selected through a convenience sampling for interviews. A convenience sampling was used because the study depended on voluntarism, availability and interest in the research on the part of the Peer Educators (Kombo and Tromp, 2006: 82). The study conducted structured interviews with the Peer Educators. Research targeted Peer Educators because they are actually the implementers of the peer education programme. Peer educator questions were focussed on the content, methodology, objectives and planning of the workshops they run in the residences.

Three residences were selected randomly in order to conduct one focus group in each one of them. Participants were selected from among those who attended the workshops and were approached individually. Anyone who was willing to be part of a focus group (an expectation of approximately 8 individuals) was selected.

These focus groups were also structured yet provided enough room for exploration of unexpected topics. They (focus groups) comprised of students chosen from among those who attended peer education workshops in the residences at DUT, to review their experience of the programme. We asked them questions surrounding their experience of the workshops in residences, their views on the content and methodology, and how helpful the peer education programme and the peer educators have been, and whether they have now personalised the risk of HIV/AIDS as a result of attending these workshops.

In all the four instances: training, interviews with Health Promoters, interviews with Peer Educators, and focus groups, an audio tape recorder was used for the collection of data and notes of the proceedings.

The study intended to use participant observation in the workshops conducted by the Peer Educators in all the four residencies at DUT, but only managed one, Eskombe Court Residence due to the slow pace at which the ethical clearance was issued at DUT. When the ethical clearance form was issued, it was already the end of the first

semester examination time which made it extremely difficult to pursue further research.

After data collection, the data was transcribed from the audio tapes. Thematic analysis was used to analyse the data. From the transcribed conversations (interviews and focus groups) a pattern of experiences and emphasis were listed either as direct quotes or through the paraphrasing of common ideas (Aronson, 1994). Through the thematic data analysis technique, the study sorted data according to the themes of participatory approaches, communication for social change methodology, implementation and effectiveness of Peer Education programme and key issue surrounding HIV/AIDS being addressed. "Thematic analysis focuses on identifiable themes and patterns..." (Aronson, 1994). This method allowed the study to evaluate the programme effectively under the themes that underpin and guide the peer education programme under DramAidE. Pseudonyms were used in this study so as to maintain the anonymity of the participants. [10]

Chapter 4:

v) Data Presentation and Analysis:

Most social cognitive theories which often aim to induce behavioural change, focus on having an individual first recognise that a problem exists. It is also a hallmark for successful alcohol addiction programmes. Following with this trend, the study endeavoured to determine whether participants recognised HIV/AIDS as a problem which needs to be curbed. Every participant of this study believed that those targeted in the peer education workshops together with the participants themselves, recognised HIV/AIDS as a problem. Responses to this question included, *Yes. Definitely they do (HP2);* and *Ja, its very big (Ken).*

The main objectives of this study, mentioned earlier, were subcategorised into elements drawn from the theoretical framework and based on the information acquired from the interview questions, focus group guides as well as participation

[10] HP no.s: 1-3 refer to the Health Promoters and Project Co-ordinators; PE no.s: 1-3 refer to the Peer Educators and pseudonyms for participants of focus groups are as follows (gender-specific): Anele, Banele, Carol, David, Emily, Frank, George, Harry, Ivan, James, Ken, Lucy, Mary, Ned and Oliver.

observation. Data that gave clear accounts of participants' general perceptions were interpreted according to thematic analysis, supported by their actual responses.

Communication for Social Change (CFSC) Methods:

In order to analyse how effectively and how closely the peer education programme followed CFSC methods, the elements indicated in the theoretical framework were used including defining a catalyst. Participant observation at the Pietermaritzburg training workshop displayed CFSC and participatory education approaches being used as peer educators engaged in lively debate encouraged by health promoters. Health promoters also allowed for constant interaction and active participation by throwing questions to the audience, allowing them to openly share ideas as well as ask their own questions.

The catalyst in terms of recruiting peer educators was identified by *HP1* as having them *advertise and issue posters around residences and campus*. However this study focused more on what motivated participants to attend workshops. During participant observation at one of the workshops, posters describing the topic of discussion were found throughout the residence corridors yet none on campus notice-boards. House committees were also involved in spreading notices through the residence. This suggests that the main catalyst is mass media which is not successfully targeting a larger audience i.e. the entire student body. Yet an internal stimulus was also recognised as personal experience with HIV/AIDS was also suggested as a motivator by *HP1* who felt participants …*experienced it at home.* Only one peer educator admitted to personally informing her peers, *Like if I know that you stay in the same res as I do then I'll let you know about it (PE2).* Word of mouth can be a useful catalyst yet this singular response indicates that it is not be adequately being used as a powerful communication tool.

An important element in CFSC is for those involved in the project to recognise who the major stakeholders are. It seemed quite likely that the health promoters who have been involved for quite a few years would be aware of the relevant stakeholders. The study rather focused on whether peer educators were well informed. *PE1,* mentioned: *TAC, DramAidE and DUT HIV/AIDS centre*. However the other peer educators who were interviewed failed to recognise these stakeholders instead mentioning either the

health promoter at DUT or guest speakers. This suggests that they have not been made aware of whose interests they are serving as well as which organisations they could form a beneficial relationship with.

Another aspect of CFSC is establishing future goals. As project co-ordinators, it seemed most appropriate to retrieve responses from the health promoters who would have most control over this. *HP2* wanted the programme to be integrated into DUT and have the peer educators *receive a discount from (their) student fees*. This idea could motivate more students to become peer educators and give them incentive to remain with the programme. Whilst *HP2* had institutional goals, *HP1* had more individualistic goals. He hoped for more students to become *empowered with skills of dealing with HIV/AIDS*. Although this is a relevant goal, it is also their current goal which may mean that the project isn't trying to establish future goals or create room for improvement.

This study tried to determine whether any alternative actions could have yielded better results than conducting workshops in residences. Since peer educators and health promoters were most likely to notice the overall outcomes of these workshops, the questions were directed to them. There was a general consensus that workshops were the most effective action. An example of this is seen in the comment, *I don't think that at this moment, there would be something as immediate as these workshops (PE1)*. But *HP2* acknowledged that even though the workshops do seem to be effective, their target market is limited and should include *those staying at home or off campus*.

Two elements were found to be in common with CFSC approaches as well as participatory education methods. The two linking components of these theories are the concepts of consensual agreement as well as the context and background of participants included in the content. For these two concepts, responses were taken from health promoters, peer educators and participants of the workshops.

Through participant observation at one of the workshops, it was noted that the language predominately used was IsiZulu at the comfort of the participants. Language both in terms of actual language spoken and in terms of diction is highly relevant to

contextualising content by incorporating phrases, actual language and slang that appeal to and can be understood by the participants. All participants in this respect felt that peer educators successfully used age-appropriate language. *Ivan* responded *It's right for the target – I can guarantee*. Several participants related their ease at having specific phrases especially those referring to sex incorporated into the content since their backgrounds made it difficult for them to express this, which *Banele* expresses when saying,*…in our backgrounds, it's difficult to say a word 'sex' in Zulu, in that manner the language used was good.* Interaction also incorporated more than one language so as to cater for as many as they could. *Lucy listed* all the languages used when saying, *In Zulu, Xhosa, English, everything*.

All the health promoters agreed that the content was contextualised in terms of people's culture and background. Whilst some participants felt that peer educators did attempt to incorporate cultural matter, others felt that the subject matter only acknowledged the biomedical model and did not take traditional healing/alternative medicine into account, *It was all western (Harry)* (in terms of subject matter); and *Just because they won't acknowledge something of a cultural healing (Ivan).* Even if they do not endorse traditional healing, not acknowledging it as an alternative method may insult some participants or weaken their arguments with some participants. When asked if people were allowed to bring the topic up, *James* said they: *just go past it.* Ignoring someone's comments may make that person feel insecure and lose confidence in their opinions which challenges the goals of both CFSC and participatory education which tries to empower participants.

Consensual agreement is perceived as an end-product of successful dialogue. Participants who have diverse backgrounds are able to communicate with one another, giving multiple view points which through reflexive and reasonable discussion should reach a consensual agreement. In the case of peer education, it is the role of peer educators to allow for this agreement to be reached through their own skills. Peer educators were asked to describe their strategies in reaching consensus.

Peer educators at one of the workshops used a similar approach which they were taught in their training. They discuss a scenario or topic such as which gender spreads the virus and allow for debate to arise which they then resolve by affirming certain

points. Although allowing participants to air their own viewpoints, a resolution is reached. The problem is the resolution is confirmed to be true by a peer educator and thus falls into the dreaded territory of teaching instead of discussing. A discrepancy arose when asking peer educators for their strategies as it seemed their responses fell into two categories, either perceiving themselves as an expert who knows better than the participant and therefore has the power to state facts or as an equal to the participant and also learning. *To get people to agree, basically we as peer educators have been trained to know the facts, you know, it can be that people disagree about a point but its not valid. Basically what we do to solve the whole debacle is give the straight fact and give our own viewpoint as peer educators (PE1). That's what helps.* This implies that agreement is not really consensual but rather forced.

PE2 described her approach by saying, *when we don't reach an agreement, we then basically, we take into account what they have said but then we make a summary. You can have a choice between this or that. It goes either way and then we give an alternative should you need further information. These are the places to go because we not that educated ourselves. We don't know everything but this is as much as we know*. This response indicates that some peer educators don't see themselves as superior or experts in the field and understand that more than one option can exist as well. CFSC and participatory education explore the ability for participants to be included in and attach value to content. By using their responses as options, more value can be attached and there is a greater likelihood that those options are internalised.

Participatory Education Methods:

An aspect of participatory education as mentioned in the theoretical framework it that participants should have room for reflexivity and knowledge creation. During participant observation at the training workshop in Pietermaritzburg, peer educators were repeatedly reminded by the health promoters that it should not be assumed that participants are completely unaware or need to be taught. Instead they emphasised the need for peer educators to draw out participant's knowledge of certain topics which leads to ownership and personalisation. Participant observation of one of their workshops showed that peer educators were implementing this strategy as they split

participants into groups and had them present their ideas on a specific topic related to HIV/AIDS such as stigma, thus stimulating reflexivity.

Participatory education from Freire's (1970) theory, has an expectation that the content is inclusive of personal experience so as to liberate the participants. When discussing how content is created for workshops with peer educators, they did not seem to include participants experiences but instead agreed that peer educators as a group defined what should be included. A few participants at one of the residences felt that peer educators did not allow them to include their ideas or share their knowledge, *there is a lot of audience knowing more than peer educators… They should actually invite that particular person to take the platform then clarify that point to an extent where you actually acknowledge that particular person knows more than me (Ivan).* This implies that the peer educators were unwilling to acknowledge some of the audience member's views and thus fundamentally hindering an important aspect of participatory education.

Another fundamental characteristic of Participatory education is the idea that participation should not be restricted in any manner. Observation at the training workshop in Pietermaritzburg showed a restricted amount of participation allowed due to language barriers but for the most part, all peer educators were willing to partake in the activities asked of them. Participant observation at a workshop showed how the skills and strategies adopted by peer educators to motivate people to participate. They played games which involved all participants having to move around the room retrieving fellow participant's signatures as well as singing together for group cohesion. The result was quite satisfactory, however it lacked the enthusiasm which health promoters managed to stimulate. Many of the participants felt comfortable to participate like *Emily* who felt like *there are no boundaries.* Most participants agreed with her.

Health promoters who co-ordinate the peer education programme were asked to describe the methods they hoped peer educators would use in their own workshops. All responded that participatory methods and facilitation were necessary. Peer educators and participants were then asked about the levels of facilitation. All peer educators believed that they used facilitation which some of the participants echoed.

George as a participant found the facilitation skills of peer educators most appealing,…*they don't tell, they don't teach…they just facilitate* and found that it enabled him to express himself. However one of the residences did not feel that facilitation as a method was successfully achieved. *James* expresses this when referring to the peer educators as …*actually barricaded the platform.*…This statement was not disputed by his fellow participants which is obviously quite a setback in terms of facilitation. However since there are varying views of peer educators facilitation skills, one cannot generalise but rather say that some peer educators as individuals are better equipped at handling workshops than others.

Lastly, accessibility as an element of participatory education should be factored in. Access like participation should not be restricted but open to everyone. The first problem is that only students in residences are being targeted which excludes a large number of tertiary students especially since policies like *Rutanang* incorporated into tertiary institutions were created for all students and not just those in residences.

<u>HIV/AIDS and related issues:</u>

The manner in which the programme addressed HIV/AIDS and related issues was the first objective identified as two components of content and perception. Participant observation at a training session intended for peer educators as well as observation of a peer education workshop at Eskombe residence broadcast the similar issues which were conveyed to different types of audiences. Health Promoters deemed certain issues related to HIV/AIDS as important for the peer educators to cover and which they did by splitting their audience into groups whose task was to discuss a particular topic and then present it to their audience. These topics included 'positive living', 'opportunistic infections', 'stigmas and stereotypes' and 'gender issues'. In their workshop, the ABC method (Abstain, Be Faithful and Condomise), transmission and prevention were also discussed. The latter was introduced via a game drawn on from their training using a piece of paper with varying amounts of signatures as a metaphor for transmitting HIV/AIDS. These observations display a degree of imitation in their content which lacked innovation but did however support the Health Promoter's ideals of relevant and important content relating to HIV/AIDS.

The issues they addressed did suggest effectiveness, *Now they realise that HIV is like a flu anyone can get it. We got more information about STI's (Anele),* demonstrating the relevance in talking about HIV as an easily contractible disease which through their perception seemed to have not been clear before. Positive living as a topic allowed for people to understand that HIV does not mean their life is over, *Two months ago I thought when I get HIV I will kill myself but since I have attended the workshop, I've changed my mind (Banele).* The programme also motivated for one of the participant's to take an active role in their life by finding out their status. *George* re-iterated this point : *Ja, cos I've done VCT cos of peer education,* and admitted how scary the experience was for him. These changing perceptions indicate that peer education has the ability to change people's mindsets and bestowing participants with skills of empowerment.

Some individuals nevertheless found the content as repetitive of information that has already addressed the issues and which they feel is easily accessible to them, *Basically it's been done, a million times it's been done* and *…I believe we should start talking another, new language cos we open the radio – its there, we open the TV – its there…(Ivan).* Ivan also mentioned a redundancy in information which implies that the information shared is lost to the audience due to it not being stimulating, creative or new, *so what is the point of telling an individual of something they already know or is there going to be showing off how much you know and how much I know which is basically clueless at the end of the day.*

<u>Personalising experiences with HIV/AIDS:</u>

Participants being able to personalise their experiences with HIV/AIDS were found to be integral to the objectives of the Health Promotion programme as one of DramAidE's projects, supported this notion. Measuring this concept was based on the Health Promoters' as well as DramAidE's definition of the term and their expectations of how it should be incorporated into the Peer Education programme. Research was then conducted on participants' perceptions of this occurring as well as peer educators' perception regarding whether they feel they fulfil this objective. It was important to note how participants felt towards the peer educators themselves in terms of whether they felt they could trust and be supported by them as it was seen

that these dimensions would establish the type of relationship and interaction they were afforded.

Since tertiary students in residences were targeted, the study wanted to determine whether these participants understood why they were being targeted so as to explore the notion of personal risk. Most responses regarding this question showed acknowledgment of participants' belief of personal risk, *Yes, we are targeted because we are far from our homes; there are no parents to guide us (Ned).*

In order to determine what 'personalising the risk' meant, health promoters and project co-ordinators were interviewed to clarify the concept. Responses indicated that peer educators needed to practically portray or literally convey what they teach in terms of their own personal and observable behaviour, *HP3* suggested that they need *To practice what they preach*; enable participant's to recognise the problem as something that could affect anyone including them,…*hoping to achieve is that students realize that its everyone's problem. It can happen to me, it can happen to you so that way if they personalize it… (HP2)*; they should have gone through the experiences and activities which they endorse and make it possible for participants to share with them.

Ivan responded that, *If I remember correctly none of the members actually shared any of their personal stories* and felt that peer educators *themselves needed to be more personal*. He was supported by the group with this statement. If peer educators don't show how HIV/AIDS is a personal issue to them then it seems unlikely for students in turn to personalise it for themselves. Carol reinforced this point, *It is too difficult to share your personal experience with somebody but, sometimes it is helpful to somebody*. Participants therefore acknowledge how daunting it may be to reveal personal stories but feel that these personal stories may be beneficial for the group at large. When asked, two students said that they could not relate to the stories they were told. These stories were not personal but hypothetical or information based. There was a general agreement amongst the participants however to bring their own personal experiences to the workshop. This implies that peer educators might encourage participants to share or at the very least does not prevent them from sharing

their personal experiences. However, it seems as though the peer educators do not feel comfortable to share their stories in return.

When asked if they feel that peer educators practiced what they preach, there was an equal distribution of simple "*No*"s and whilst others believed that only some do, …*some do walk their talk, some don't (Anele)*; and …*sometimes they practice what they preach (Oliver)*. These statements don't deny the probability of peer educators being perceived as role models who practice what they preach. It does however undermine the images of certain peer educators as legitimate leaders who have the ability to personifying healthy behaviours to their peers.

Training the Peer Educators:

The training of Peer Educators for 2008 occurred in a two day workshop run in Pietermaritzburg's Cedar College, equipping them with the skills to conduct their own workshops. The researchers used participant observation at this training workshop in order to more holistically, evaluate the peer education programme. Their programmes are administered throughout DUT campuses (two in Pietermaritzburg and three in the Durban region). By observing this training session, the researchers were able to evaluate it as an emerging theme which did not initially fall directly into one of the objectives established but fed into subcategories of these objectives and gave a significant impression on the accountability of both health promoters and peer educators.

Another observation made during this training workshop was the lack of diversity being represented in terms of race. The population was constituted by solely Black students with the exception of one Indian student from the DUT Pietermaritzburg institution. When discussing this with the Health Promoters and Project co-ordinators, they too found this a challenge which drew a consensus amongst them. They suggested (although were slightly uncertain about this) that this may possibly be due to Black racial groups considering it to be more of a problem and being more involved in working against the epidemic. *HP3* said with reference to the lack of diversity: *Maybe, it's the idea that AIDS is not their problem*, whilst *HP1* claimed that: *More black students and members of staff are involved and active*. This startling discovery leads to questions of responsibility and how programmes are advertised,

where are they situated and there effective campaigns being run. These problems directly affect theories of communication for social change as well as participatory education to which the idea of equal access and participation is important.

Another challenge encountered, was the training session running over a two-day period. The Health Promoter and Project co-ordinators all agreed that two days were insufficient for such training as *HP2* felt: *Because there is a lot of information and also the way we structure the workshop*. *HP3* suggested that *we need to be consistent. Two day training this month, next month. Not two day training this semester and two day training another semester*. Poor structure or inefficient training may result negatively in workshops as peer educators would be ill-equipped to handle these workshops. However the participant observation of the training did show health promoters trying their utmost to cover all the topics and prepare the peer educators with facilitation skills.

Language used during the training sessions was predominantly in IsiZulu. One student did not speak IsiZulu and there through attendance, it was discovered that there were people who also spoke languages like Xhosa and Tswana which were not incorporated. During one of the sessions discussing CD4 Count which involved a lot of technical terms, a student asked a question in English yet had the invited speaker respond in IsiZulu. This reduced accessibility of information to some students.

Chapter 5:

vi) Implications and a Way Forward:

Although employing the same strategies and subject learnt during training, a consideration towards incorporating new material should be made. Peer educators will then be able to address the HIV/AIDS and related issues endorsed by Health Promoters as well as incorporating new, up-to-date content. They do conduct talk shows on their own but possibly introducing subject matter which includes personal experiences, sharing stories and allowing participants to choose content or topics they would like to discuss in the follow-up workshops may allow for participants to attach more value and meaning to the workshops.

A criterion for peer educators is for them to practice what they preach and in that sense, they need to firstly change their unhealthy behaviours and project unto others the image of healthy, positive living. This may possibly induce social or behavioural change amongst their peers and allow them to personalise the risk of HIV/AIDS. Many students felt that peer educators needed to share their own experiences with the participants of workshops. Some of these experiences will obviously make the peer educators uneasy to speak about but doing so will empower others in overcoming stigma in HIV/AIDS. They can also share their initial perceptions of HIV/AIDS or related issues and discuss how those views have changed. They can also discuss what motivated them to start warning others and thus make content more personal.

More peer educators should be willing to personally invite people to the workshops. This will create better correspondence between the peer educator and their fellow students as well as creating a sense of personal inclusion. During training workshops, peer educators should be clearly informed of who the relevant stakeholders are so they can seek support from these organisations as well as including them in workshops where necessary. In order to make this programme more sustainable, future goals need to be established. By including peer educators in meetings where ideas can be bounced off one another, the programme may make itself more adaptable for the future.

A major setback noticed, was that the target was limited to only residential students. Time and convenience play a part in this as the residence allow for greater convenience in terms of meetings but if forum periods were used during campus hours, more students could be reached. Although the content is ultimately dependent on peer educators, they can use their follow up workshops to incorporate subject matter which is inclusive of participant's content. Asking them what they would like to discuss in future workshops will empower participants and create a better relationship with peer educators who will then display respect for their ideas and suggestions. By addressing these issues, the programme will then also administer Communication for Social Change as well as Participatory Education approaches more effectively.

Race is by no means a simple challenge to tackle yet the training workshop in Pietermaritzburg made this a noticeable problem which needs to be addressed. DUT may be doing a satisfactory job in terms of recruitment and advertising. The problem may lie in the individuals not attending. What therefore needs to be tackled is advertising and marketing as well as the venue and times. Location and the limitation of only students in residences having workshops may restrict attendance since as *HP1*: mentioned, only maybe *0,01%* of non-black students are found in residences.

When looking at the actual training workshop, a suggestion made by a Project co-ordinator seems to be quite worthwhile. If the Health Promoters can establish more consistency and create more training sessions within the semester then the peer educators will be better supported, have a constant source of encouragement, be taught new things on a regular basis and have information fresh in their minds whilst also suggesting what they have learnt for future training sessions.

Language needs to be at the comfort of the participant and is thus appropriate to be non-English in non-English circles but when conducting a formal training session, in which students from more than one tertiary institution are attending, English should be made the standard language. However for the comfort of the participants, their responses and their questions can be spoken in whichever language they feel most comfortable with.

Although several suggestions have been made regarding the future of this programme, this study has also noted how effective the programme is in addressing HIV/AIDS and related issues. It also emphasises facilitation and the manner in which they present their workshops resembles many facets of Communication for Social Change and Participatory Education methods. Participants for the most part seemed to have enjoyed these workshops and at present, it fulfils its need by being the most immediate intervention that tertiary institutions have provided. Its success is remarkable but if it addresses its flaws, it can become an even more effective mechanism for the future.

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