# AGENTS OF CHANGE: THE IMPLEMENTATION AND EVALUATION OF A PEER EDUCATION PROGRAMME ON SEXUALITY IN THE ANGLICAN CHURCH OF THE WESTERN CAPE

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**This thesis is presented for a Doctor of Philosophy at the University of Stellenbosch**

**“Declaration**

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

**Signature:** ..... **Date:** .....”

**“Verklaring**

Ek, die ondergetekende, verklaar hiermee dat the werk in hierdie proefskrif vervat my eie oorspronklike werk is en dat ek dit nie vantevore in die geheel of gedeeltelik by enige universiteit ter verkryging van ’n graad voorgelê het nie.

**Handtekening:** ..... **Datum**: .....”

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# ABSTRACT


## INTRODUCTION

Religion is important in Africa and many churches are involved in HIV ministry. Prevention programmes, however, are less frequent in the church setting and there is little evaluation of them. If an effective model is found, it can contribute to HIV prevention efforts in Sub-Saharan Africa.

This study was conducted in the Cape Town Diocese of the Anglican Church. Fikelela, an HIV/AIDS project of the Diocese, developed a 20-session peer education programme (Agents of Change) aimed at changing the risky sexual behaviour of youth. Workshops were also aimed at parents.

A literature review was conducted looking at three areas: 'theories of behaviour change', 'adolescent sexual relationships', and 'religion and HIV'. A conceptual framework for the programme was developed by integrating findings from the literature review.
The aim of this research was to evaluate the effectiveness and functioning of the programme, to develop a best practice model and to make recommendations for the use of the programme in the wider church.

## METHODS

Outcome mapping was used to integrate an approach to the design, monitoring and evaluation of the programme. Changes in project partners, key project strategies and organisational practices were all monitored. Project partners were defined as peer educators, facilitators, young people, clergy and parents. Monitoring allowed an in-depth understanding of which aspects of the programme worked.

Evaluation was designed as a quasi-experimental study that compared non-randomly chosen intervention and control groups. 1352 participants took part at base-line, 176 returned matched questionnaires in the intervention groups and 92 in the control groups. Reported changes in attitudes, knowledge and sexual behaviour were compared between the two groups.

## RESULTS

The main factors leading to the success of the programme were: a well developed curriculum and programme, effective training camps, the support given by facilitators to peer educators, ongoing mentoring and training, role modelling by peer educators, a participatory style of education and positive peer pressure within a strong church based social network. Challenging the church's negative attitude to condoms was also important. The weakest areas of the programme were amongst clergy and parents and in challenging media messages and norms on gender.

The project impact evaluation showed significant differences at baseline between genders in terms of sexual beliefs and behaviour. There was no significant impact of religiosity on sexual activity.

The programme was successful at increasing condom usage (Condom use score 3.5 vs. 2.1; p=0.02) and reduced sexual debut (9.6% vs. 22.6%; p=0.04). There was increased abstinence amongst the intervention group, but it did not reach statistical significance (22.5% vs. 12,5%; p=0.25). There was no effect on the number of partners (Mean 1.7 vs. 1.4; p=0.67).

**CONCLUSIONS**

Implementation: The programme should be promoted as a youth development programme rather than an HIV prevention programme. Priority should be given to churches in communities with the highest HIV rates. The target group should include younger teens. Peer educators should be selected by peers not by adults.

Strategies: The strategies of training camp and quarterly gatherings are effective, but a new strategy needs to be devised to impact the parents.

Content: The programme should build self-efficacy amongst the youth, develop a critical consciousness about sexual health, provide positive messages rather than fear-inducing ones, address sexual coercion and persuasion, explore the linking of condom use with trust, address inter-generational sex and promote community outreach and advocacy activities.

The programme is effective and meets the threshold of evidence required to be rolled out. It should be rolled out through the Anglican Church with its estimated membership of two million and could be adapted for other denominations as well.

# Uittreksel


## INLEIDING

Godsdiens is belangrik in Afrika en talle kerke is betrokke by HIV-bediening. Voorkomingsprogramme is egter ongewoon in die kerkomgewing en die evaluering daarvan vind selde plaas. Indien ‘n effektiewe voorkomingsprogram model gevind kan word, behoort dit ‘n belangrike bydrae te lewer tot HIV infeksie voorkomingspogings in Sub-Sahara Afrika.

Hierdie studie is gedoen onder die lidmate van die Kaapstadse Biskoplike gebied van die Anglikaanse Kerk. ‘n Bestaande HIV/VIGS projek van die Biskoplike gebied, genaamd Fikelela, het ‘n 20-sessie portuurgroepopvoedingsprogram (Agente van Verandering) ontwikkel wat gemik is op die verandering van riskante seksuele gedrag onder die jeug. Daar was ook werkswinkels gemik op ouers.

‘n Voorstellingsraamwerk vir die program is ontwikkel deur die integrasie van gedragsveranderingsteorieë met bewyse ten opsigte van verandering van seksuele gedrag onder adolossente en die invloed van godsdiens op adolossente seksualiteit.

Die doelwit van hierdie navorsing was om die doeltreffendheid en funksionering van die program te evalueer, ‘n optimale praktiese model te ontwikkel en aanbevelings vir die gebruik van die program aan ‘n wyer sirkel van kerke te maak.

## METODES

Uitkomskartering is gebruik om ‘n benadering tot die ontwerp, waarneming en evaluering van die program te integreer. Alle veranderinge in projekvennote, sleutelprojekstrategieë en organisatoriese handelinge is waargeneem. Projekvennote is gedefinieër as portuurgroepopvoeders, fasiliteerders, jongmense, leraars en ouers. ‘n Diepgaande begrip van watter aspekte van die program gewerk het, is bewerkstellig.

Die evaluasie was ontwerp as ‘n prospektiewe bykans-eksperimentele studie wat nie-lukraak gekose intervensiegroepe en kontrolegroepe vergelyk het. Daar was1352 deelnemers by aanvang, 176 afgepaarde vraelyste is teruggestuur in die intervensiegroepe en 92 in die kontrolegroepe. Veranderings in houdings, kennis en seksuele gedrag wat gerapporteer is, is tussen die twee groepe vergelyk.

## RESULTATE

Die hooffaktore wat tot die sukses van die program gelei het, was: ‘n goed ontwikkelde kurrikulum en program, effektiewe opleidingskampe, ondersteuning aan portuurgroepopvoeders deur die fasiliteerders, deurlopende raadgewing en opleiding, portuurgroepopvoeders as rolmodelle, ‘n deelnemende styl van opvoeding en positiewe

groepsdruk binne ‘n sterk kerkgebaseerde sosiale netwerk. Die uitdaging van die kerk se negatiewe houding teenoor kondome was ook belangrik. Die swakste areas van die program was onder die leraars en ouers en in die uitdaging van media boodskappe en norme aangaande geslagskwessies.

Die evaluering van die projekimpak het betekenisvolle verskille op grondslag tussen geslagte in terme van seksuele geloof en gedrag getoon. Daar was geen betekenisvolle impak van godsienstigheid op seksuele aktiwiteit nie.

Die program was wel suksesvol in die toename van kondoomgebruik (p=0.02) en verhoging in ouderdom van eerste seksuele optrede (p =0.04), maar het geen impak in toename van geheelonthouding onder dié wie alreeds seksueel aktief is (p=0.25) of op die aantal seksmaats (p=0.67) gewys nie.

**GEVOLGTREKKING**

Implementering: Die program moet eerder as ‘n jeug-ontwikkelingsprogram, as ‘n HIV-voorkomingsprogram bemark word. Kerke in gemeenskappe met die hoogste HIV-koers moet voorkeur geniet. Die teikengroep moet jonger tieners insluit. Portuurgroepopvoeders moet deur portuurgroepe self aangewys word en nie deur volwassenes nie.

Strategieë: Die strategieë van opleidingskampe en kwartaalikse byeenkomste is effektief, maar nuwe strategieë word benodig om ‘n impak op ouers te maak.

Inhoud: Die program behoort self-doeltreffendheid onder die jeug te bou, ‘n kritiese bewustheid oor seksuele gesondheid te ontwikkel, eerder positiewe as vrees-gebaseerde boodskappe aan te bied, seksuele dwang en oorreding aan te spreek, die verband tussen kondoomgebruik en vertroue te verken, intergenerasie-seks aan te spreek en gemeenskapsuitreik- en aanbevelingsprogramme te bevorder.

Die program is effektief en voldoen aan die verlangde bewyse ten einde aangewend te kan word.Met sy geskatte lidmaatskap van twee miljoen behoort die Anglikaanse Kerk dit aan te wend en kan dit ook vir ander denominasies aangepas word.

# ACKNOWLEDGMENTS


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# DEDICATION

I dedicate this thesis to Professors Steve de Gruchy and Alan Flisher.

*'Because we stand on the shoulders of giants'*

## Table of Contents

## Table of Tables

## Table of figures

# ABBREVIATIONS

| | |
|---|---|
| ACSA | Anglican Church of Southern Africa |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANARELA | African Network of Religious Leaders living with or affected by AIDS |
| AOC | Agents of change |
| ARHAP | African Religious Assets Programme |
| ARV | Anti-retroviral |
| ASRH | Adolescent Sexual and Reproductive Health |
| FBO | Faith based organisation |
| FGD | Focus Group Discussion |
| GOLD | Generation of Leaders Discovered (Peer education) |
| HBM | Health Belief Model |
| HIV | Human Immunodeficiency Virus |
| KAP | Knowledge, attitudes and practices |
| LFA | Logical Framework Analysis |
| MI | Motivational Interviewing |
| OM | Outcome mapping |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| SCT | Social Cognitive Theory |
| SLT | Social Learning Theory |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TRA | Theory of Reasoned Action |
| WHO | World Health Organisation |
| YRBS | Youth Risk Behaviour Survey |

# CHAPTER ONE: INTRODUCTION AND OVERVIEW OF THE THESIS

This thesis explores the impact of an HIV prevention programme which is being run in the Anglican Church in Cape Town. The programme, known as Agents of Change, is a peer education programme geared for adolescents between the ages of 12 and19. The aim of this introductory chapter is to set the programme in context, by first of all examining the challenge of HIV and AIDS. Secondly the response of the Church to HIV and AIDS is considered. Thus the scene is set for an overview of the thesis to be presented.

## 1.1. THE CHALLENGE OF HIV AND AIDS

*'Please don't hurt us anymore, we are wounded already.'* [1]

### 1.1.1. THE EFFECT OF AIDS ON SUB-SAHARAN AFRICA

Since the beginning of the pandemic, more than 15 million Africans have died from AIDS. Two thirds of all people living with HIV are found in Sub-Saharan Africa, although less than 10% of the world's population live here (22.5 million out of 33.3 million) (292). During 2009 alone an estimated 1.3 million people died of AIDS and an additional 1.8 million became infected (292). AIDS has caused immense human suffering on this continent and it has impacted many areas of people's lives.

#### 1.1.1.1. The effect on households

The consequences of HIV are often most severe in the poorest sectors of society. A poor family that is coping with a member who is sick with HIV may not cope with the medical costs. Household income is reduced at the same time as expenses increase, for instance for medical treatment or transport. The death of the bread winner can lead to destitution for the family. This is made worse by the crippling costs of the funeral, which may leave nothing for the children (2,3). Children may be forced to abandon their education and girls may be forced into sex work. AIDS is increasing the percentage of people living in desperate poverty (1).

#### 1.1.1.2. The effect on children

In 2008 more than 14.1 million children were estimated to have lost one or both parents to AIDS in Sub-Saharan Africa (1). Children affected by HIV and AIDS are forced to bear great hardship and trauma. They lose their parents and often their childhood too. The combination of illness and reduced family income may have negative outcomes for children

[1] HIV+ woman, infected at the age of 32 through her first sexual encounter.
World AIDS Day service St Georges Cathedral, Cape Town.

in terms of their nutrition, their health, education and emotional support (2,3). As the parents become ill, children may take on more responsibility to earn an income, produce food and care for family members. Often both the parents are HIV+, which means that the children may become orphans. Many are now raised by their grandparents or live in child-headed households (4). Orphaned children are at higher risk of living in poverty, suffering from depression and being exposed to HIV infection (290).

#### 1.1.1.3. The effect on education:

A decline in school enrolment is one of the most visible signs of the pandemic. Children may be taken out of school to care for sick parents. Many are unable to afford school fees or uniforms. Studies suggest that children who drop out of school are twice as likely to contract HIV as those who complete primary school (5). In Swaziland it is estimated that school enrolment has fallen by 25-30% as a result of the pandemic (6). HIV is having a devastating effect on the already inadequate supply of teachers in some African countries. One study in South Africa found that 21% of teachers aged 25-34 are living with HIV (7,4). Teachers who are affected by HIV are likely to take increasing periods of time off work, to care for sick relatives and to attend funerals (8). Skilled teachers are not easily replaced. Tanzania has estimated it needs an additional 45,000 teachers to make up for those who have died or left work because of HIV (9,4).

#### 1.1.1.4. The effect on the economy:

The vast majority of people living with HIV in Africa are aged between 15 and 49 years and are in the prime of their working lives. AIDS damages the economy by depleting skills. The costs to companies for health care and funeral benefits continue to spiral and reduce profits. Absenteeism hits productivity. Studies of East African businesses have shown that absenteeism, which is increased by the pandemic can count for up to 50% of company costs (10). By making labour more expensive and limiting profits, AIDS makes investment in African businesses less desirable (4).

## 1.1.2. HIV/AIDS IN SOUTH AFRICA

South Africa is home to the world's largest population of people living with HIV (5.6 million) (292). According to the national demographic survey, just over ten percent of the population (10.9%) is living with HIV, the distribution by age and gender is indicated in Figure 1.1:

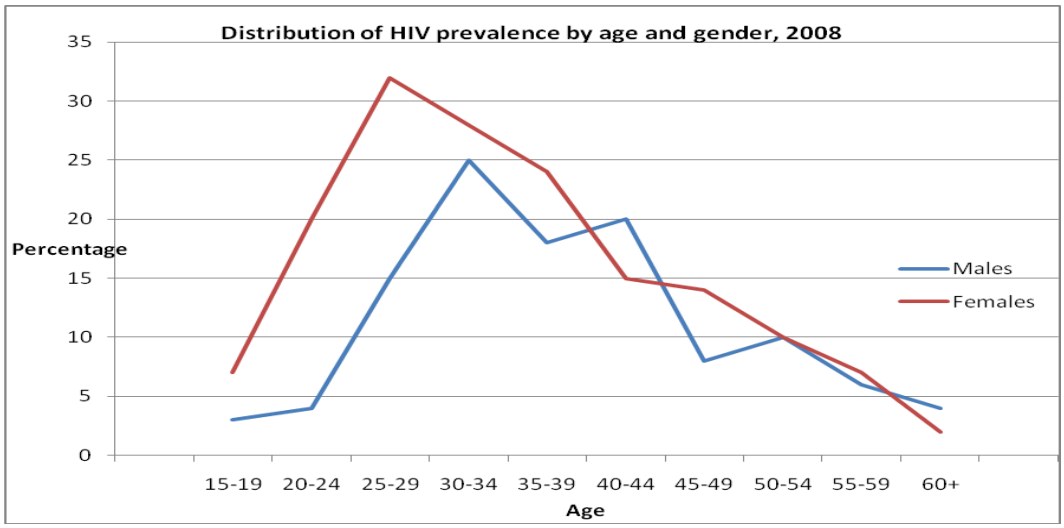


***Figure 1.1: HIV prevalence by age and gender (11).***

In females, prevalence peaks at 32.7% amongst those aged between 25 and 29 years, and in males the peak is 25.8% amongst those ages 30-34 years (11)**.**

## 1.1.3. HIV/AIDS AND THE WESTERN CAPE

The Western Cape shows a lower prevalence than other provinces; in 2008 KwaZulu-Natal had a prevalence of 15.8%, Gauteng 10.3% and the Western Cape was 3.8% (11). However, whereas in KwaZulu-Natal prevalence rates fell between 2005 and 2008 (KZN from 16.5 to 15.8%, and Gauteng from 10.8 to 10.3%) in the Western Cape there has been an increase from 1.9 to 3.8% (11). In certain communities in the Western Cape there are 'pockets' of high prevalence. Between the years 2001 and 2004 the prevalence in certain communities increased rapidly:

- Cape Town central: 3.7% to 13.7% (increase of 10%)
- Khayelitsha: 22.0% to 33.0% (increase of 11%)
- Mitchells Plain: 0.7% to 12.9% (increase of 12.2%)
- Gugulethu/ Nyanga: 16.1% to 29.1% (increase of 13%) (12)

According to the results of the 2008 HIV and Syphilis Antenatal Survey (13) the HIV rates amongst pregnant women have continued to rise in the Western Cape; from 15.1% in 2006 to 16.1% in 2008.

In some of the communities served by the peer education programme 'Agents of Change' which is evaluated in this thesis, the HIV prevalence amongst pregnant women is high as shown in Table 1.1 below:

**Table 1.1: HIV prevalence amongst pregnant women in selected communities**

| Area | 2007 | 2008 |
|---|---|---|
| Khayelitsha | 31.4% | 33.4% |
| Klipfontein | 23.2% | 23.4% |
| Mitchells Plain | 11.7% | 13.9% |
| Northern | 22.7% | 21.4% |

Source: 2008 HIV and Syphilis Antenatal Survey (13)

These figures indicate that the HIV rates are still continuing to rise in the Western Cape.

## 1.1.4. HIV/AIDS AND YOUTH

Today's youth generation is the largest in history. Nearly half of the global population is under 25 years (14). On a global level, roughly half of all new infections occur in young people aged between 15 and 24 years (9). Globally, unsafe sex is one of the main risk factor associated with disease in 15-24 year olds (293) Sub-Saharan Africa contains almost two thirds of all young people living with HIV, approximately 6.2 million people of whom 75% are female (14). Youth are also the greatest hope for turning the tide of HIV. The few countries that have successfully decreased national HIV prevalence have achieved these gains mostly by encouraging behaviour change amongst youth (15). There are many countries in Africa that have reported decreases in HIV transmission related to changes in sexual behaviour such as Uganda, Senegal, Cote d'Ivoire, Kenya, Malawi, Tanzania, Zimbabwe, rural parts of Botswana, Burkina Faso, Namibia, Swaziland, urban parts of Burundi and Rwanda (294). In South African young people (25-29 years) the prevalence in 2008 was 15.7% amongst males and an alarming 32.7% amongst females (11).However there are some signs for optimism amongst adolescents when the National surveys from 2002 (16), 2003 (17) 2005 (18) and 2008 (11) are compared. It appears that prevalence amongst young males has been steadily decreasing, as indicated in Figure 1.2:

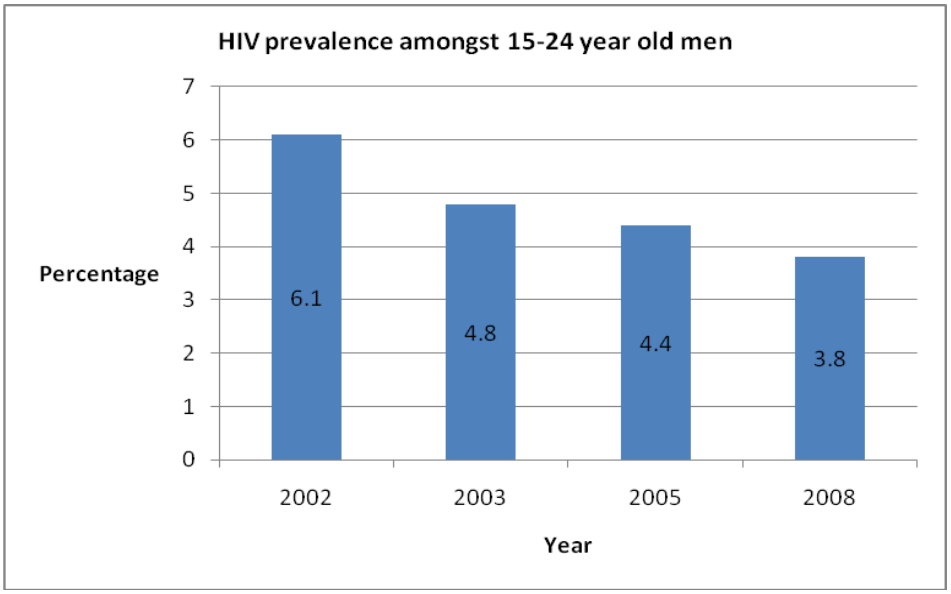


***Figure 1.2: HIV prevalence amongst 15-24 year old men***

Now it appears that prevalence amongst young women may also be dropping, as indicated in Figure 1.3:

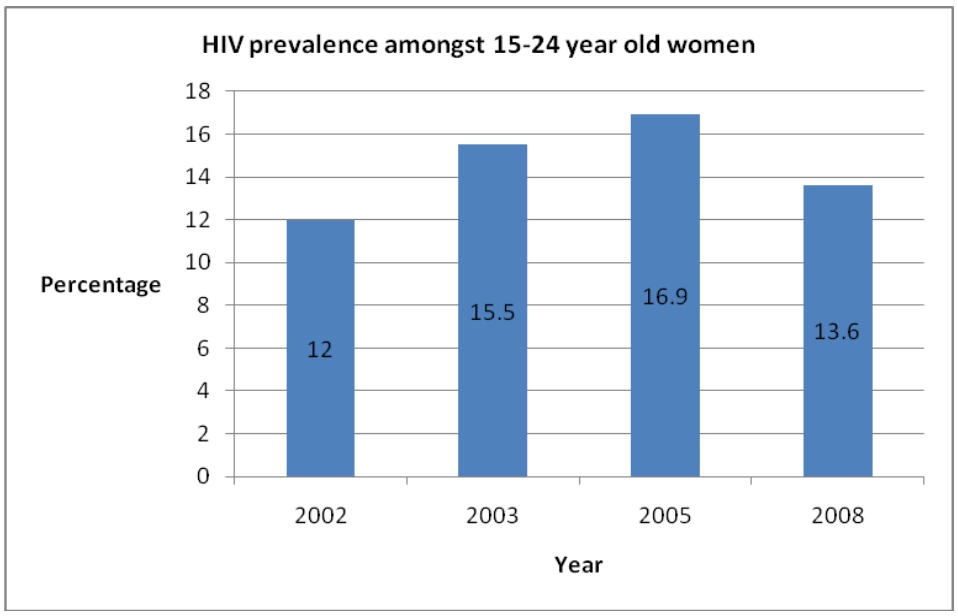


***Figure 1.3: HIV prevalence amongst 15-24 year old women***

There has been an increase in condom use amongst both males and females as indicated in Figures 1.4 and 1.5:

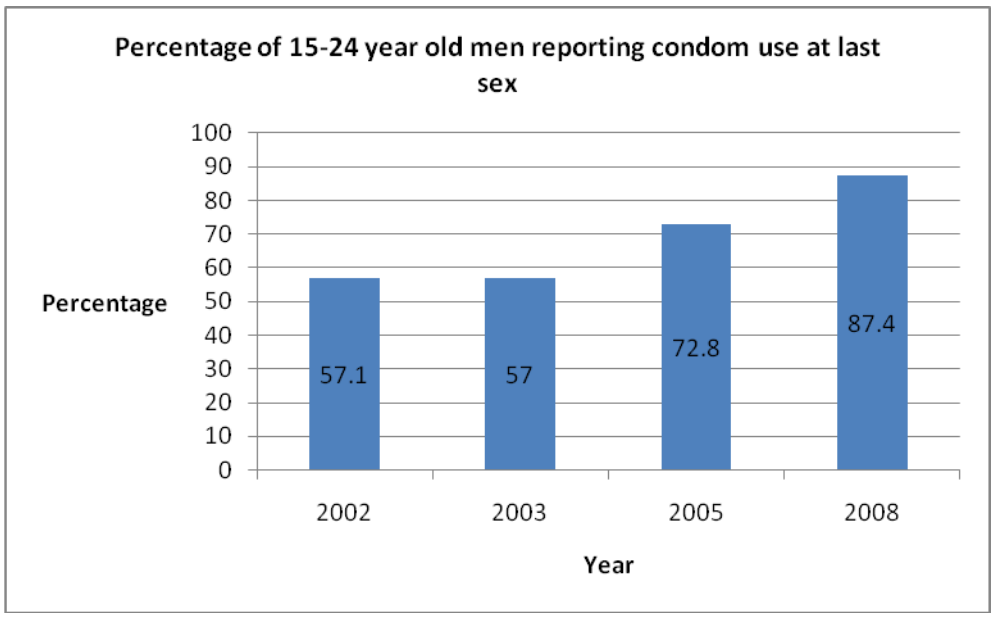


***Figure 1.4: Condom use amongst 15-24 year old males***

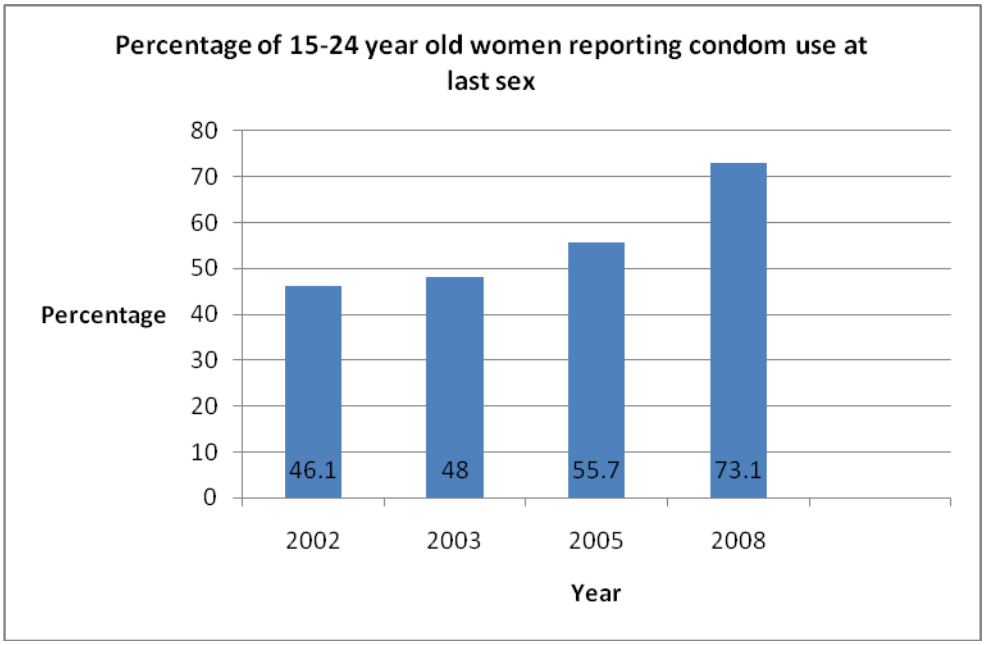


***Figure 1.5: Condom use amongst females aged 15-24***

However, there has been no significant drop in the number of partners for either males or females, as indicated in Figure 1.6:

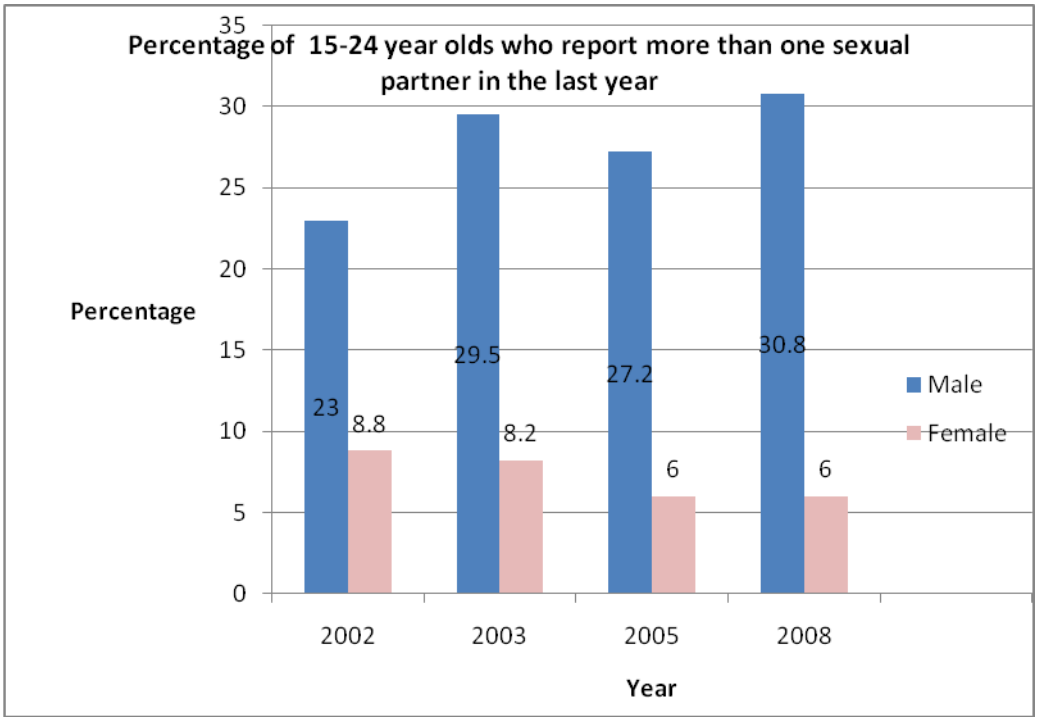


***Figure 1.6: Percentage of 15-24 year olds who report more than one sexual partner***

There has been a rise in the age of sexual debut amongst males, but not amongst females, as indicated in Figures 1.7 and 1.8:

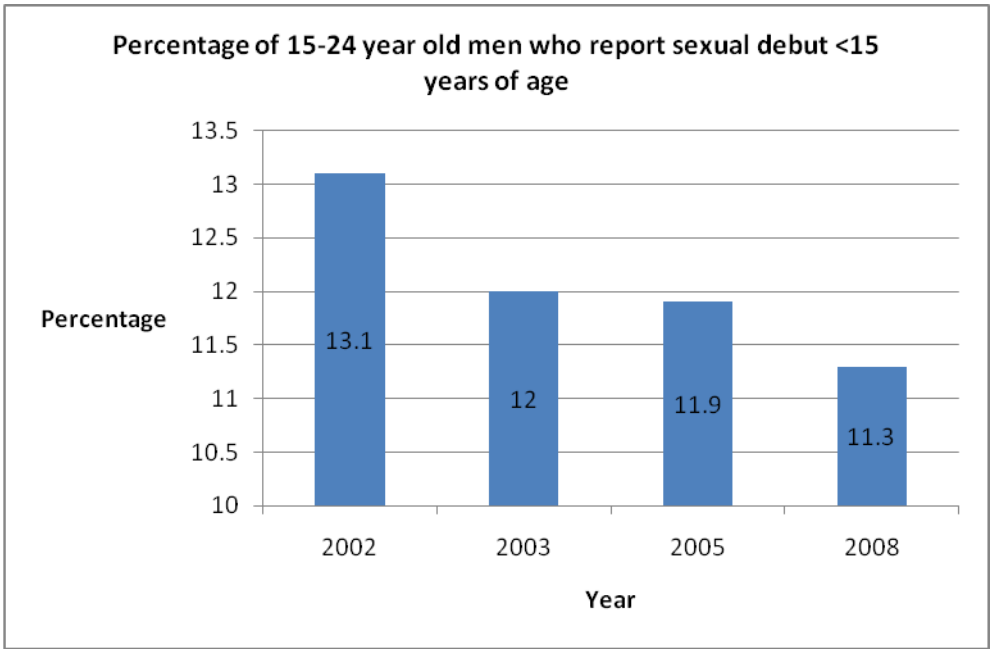


***Figure 1.7: Age of reported sexual debut, males aged 15-24***

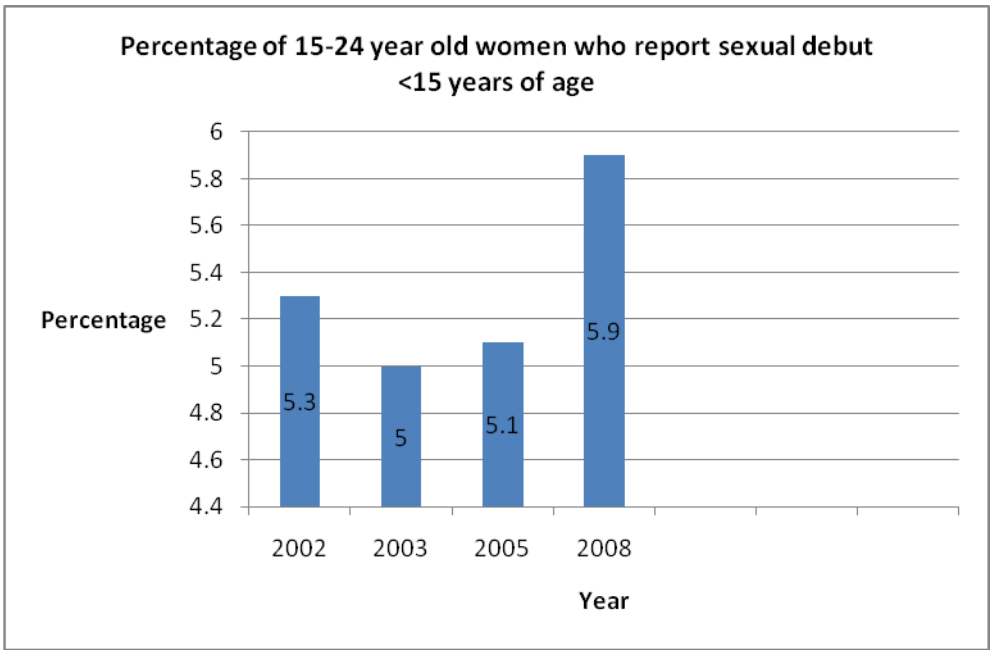


***Figure 1.8: Age of reported sexual debut, females aged 15-24***

Thus it would appear that the drop in prevalence amongst young people is primarily due to an increase in condom use.

# 1.2. THE RESPONSE OF THE CHURCH

Africans have a deeply religious and spiritual orientation, and most people's lives are touched by religion (19). Churches are growing rapidly in Africa, whereas in many parts of the developed world the numbers of church-goers are dropping (20). In South Africa, according to the 2001 census, the majority of South Africans (79.8%) identify themselves as being members of the Christian churches (21). Many churches are involved in HIV ministry in the areas of care and orphan support. UNAIDS estimates that one in five organisations engaged in HIV programmes are faith based (22). However, prevention programmes are much less frequent in the church setting. In the following section the development of a prevention programme in the Anglican Church is discussed.

## 1.2.1. THE ANGLICAN CHURCH

The Anglican Church in the Western Cape is made up of three Dioceses: Cape Town, False Bay and Saldanha Bay. It forms part of the Anglican Church of Southern Africa (see map in Appendix 2). Fikelela AIDS project was established in 2001 with the vision to mobilise the Anglican Church around issues of HIV and AIDS. Fikelela works in three areas; providing support for people living with HIV, caring for orphans, and HIV prevention.

The church has the potential to become a key organisation in prevention work because of its reach into all communities, and its strong history of voluntarism. Faith communities express clearer norms against pre-marital sex than other groups such as the media or peers (23). For this reason the Agents of Change programme was developed by the Fikelela AIDS Project as an intervention to be used within the church context. The goal of the Agents of Change was to reduce the vulnerability of youth to HIV infection using peer education as a methodology. Peer educators were selected by their youth group to be trained to run a twenty session life skills programme, with the support of facilitators.

The churches that participate in the Agents of Change programme are predominantly in the previously disadvantaged communities of the Western Cape. These communities are under-developed and struggling with socio-economic issues such as crime, drugs, violence, poverty and unemployment.

Eighteen of the churches are situated in communities that have been identified as being the twenty-one most vulnerable communities in the Western Cape. These areas have the highest rates of violent crime (rape, assault and murder), gangsterism, drug and substance abuse. (Mitchells Plain, Manenberg, Hanover Park, Nyanga, Elsie's River, Bishop Lavis, Gugulethu, Paarl) (24). Seven of the churches are situated in communities with the highest HIV rates in the Western Cape. The Gugulethu/Nyanga district had a 29.1% HIV prevalence rate in 2006 (12).

The Anglican Church has a strong presence in Southern Africa, so it was important to identify if the programme was effective and which aspects of the programme were critical to success or needed to be further adapted or improved. Although there are many faith-based organisations that are running peer education programmes in schools, no other projects have been identified that work directly with church youth and peer education. It was hoped that this evaluation would lead to the formulation of a best practice model for the Anglican Church, with applicability to the whole Anglican Church of Southern Africa, as well as other denominations and even other faith-based communities.

## 1.3. OVERVIEW OF THE THESIS

Figure 1.9 gives an overview of the thesis and the logical steps involved (25). The overview begins with stating the gap in knowledge and then the research question. This is followed by the literature review which leads to the conceptual framework. After this follows the methodology, findings and discussion, which lead to the conclusion regarding the contribution to the stated gap in knowledge, and thus the circle is completed.

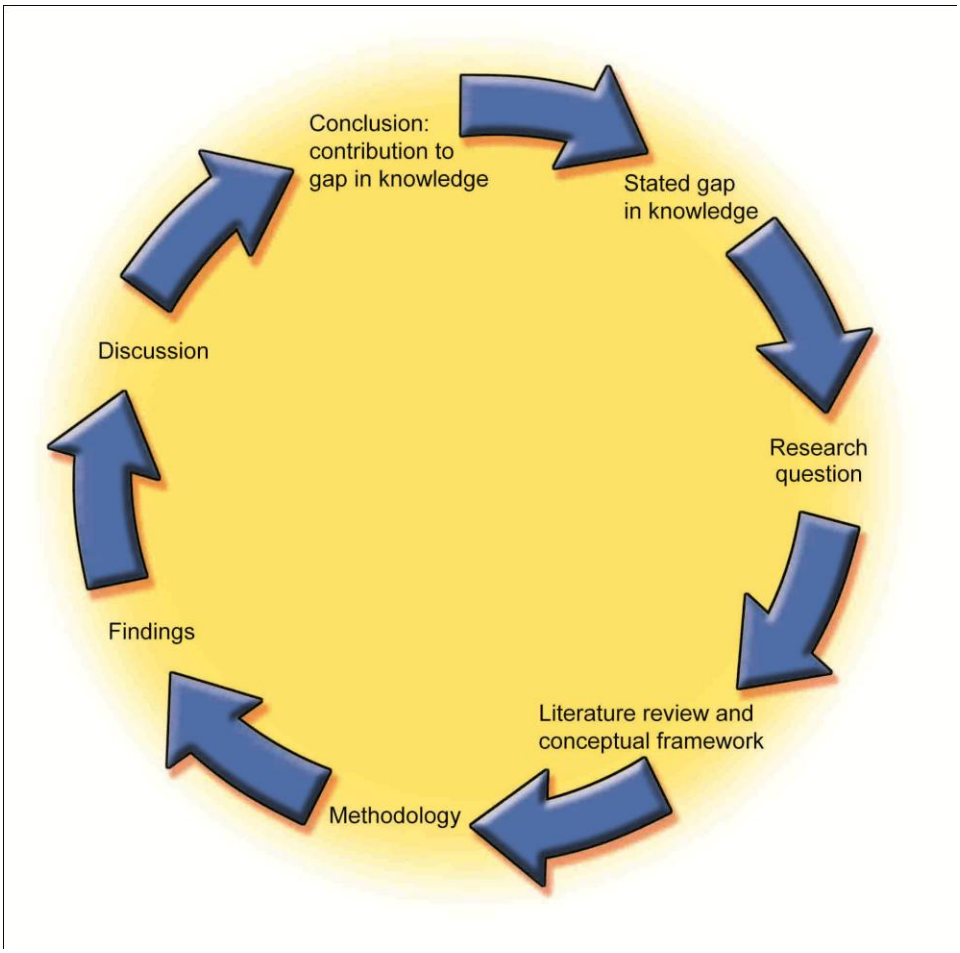


***Figure 1.9: Overview of thesis (adapted from Leshem and Trafford) (25)***

## 1.3.1. THE GAP IN KNOWLEDGE

This research seeks to fill the gap in knowledge regarding the effectiveness of a Church based peer education programme for HIV prevention in Africa. There are three levels where knowledge is lacking:

### 1.3.1.1. Scarcity of evaluations of church based HIV interventions

It has been identified that churches are of key importance in combating HIV and AIDS (26).The role of African Faith-Based Organisations (FBOs) in combating HIV and AIDS is widely recognised as having growing significance and as being underutilised, given the influence and reach of FBOs in African societies (27,28). It is remarkably difficult to access studies on religiosity and sexual activity from Africa. Most of the literature refers to the scarcity of research into this area (29,30,31,32). One of the identified problems of FBOs is in the area of monitoring and evaluation. This means that good practice models are often not identified or evaluated. '*There is a paucity of quality data available. The programmes are there but documentation is a problem'* (33). The World Health Organisation has identified that evaluations and operational research should be core elements of any interventions. Greater collaboration is needed between programme managers and researchers to facilitate effective design of monitoring and evaluation (34).This research seeks to incorporate monitoring and evaluation into the programme design.

### 1.3.1.2. Limited number of evaluations of peer education programmes in Africa

There are remarkably few studies of HIV prevention programmes in Africa, considering the magnitude of the problem (35,36,37,38). The latest systematic review was published in 2010 'Effectiveness of HIV prevention for youth in sub-Saharan Africa: systematic review and meta-analysis of randomized and non-randomized trials' (35). In this review only 28 interventions met the inclusion criteria (to have a control group and to be published after 1990, focusing on youth aged 10-25 and reporting an evaluation of interventions aimed at preventing HIV transmission by reducing sexual risk-taking). When one considers the importance of this topic, together with the large amounts of aid being spent on HIV interventions, it is sobering to realise how few high quality evaluations have taken place. Many interventions take place, but they are either not evaluated, the research design is not robust, or else the evaluation data are not analysed and disseminated.

### 1.3.1.3. Lack of evaluations of peer education programmes based in Churches in Africa

This is the only evaluation of a peer-education programme based in the Church in Africa that was identified. Thus the identified gap in knowledge is *whether or not peer education programmes are effective in changing sexual behaviour and therefore preventing HIV transmission amongst youth in a church based setting in Africa*. This research is of importance, due to the large numbers of churches in Sub-Saharan Africa. If a model can be found that is effective, it could contribute to HIV prevention efforts.

## 1.3.2. RESEARCH QUESTION

The primary aim of the research is to evaluate the effectiveness and functioning of the Agents of Change Programme and to make recommendations in order to develop a best practice model for peer education in a church context.

The objectives are:

- to assess the effect of the programme on sexual knowledge, attitudes and behaviour of participating youth;
- to identify which strategies within the programme and which organisational practices within Fikelela best enable these changes to take place;
- to identify the processes which led to behaviour change; and
- to make recommendations for the formulation of a best practice model for peer education programmes for church-based youth.

The research question is thus identified as the following:

*'What is the impact of the Agents of Change programme on the sexual beliefs and practices of participating youth, what are the factors that led to this impact, and what recommendations can be made for a best-practice model for peer education programmes on HIV infection in the church context?*

## 1.3.3. LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

### 1.3.3.1. The literature review

The goal of the literature review is to understand three areas pertaining to the research; these are process, content and context.

### 1.3.3.1(i) Chapter Two: the process

First of all the research evaluates a programme which is attempting to change the sexual beliefs and practices of young people. Therefore it is important to understand the process through which behaviour change takes place.

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Chapter Two examines the process of behaviour change; identifying the relevant theories of behaviour change in the area of youth prevention programmes, and which are most relevant to this intervention. The chapter starts with a history of how theories of behaviour change have progressed through the years. Initially programmes were based on information sharing, but it was realised that information alone did not change behaviour. Further theories were therefore developed, looking firstly at the individual's psychological process, and secondly at social relationships as well as structural and environmental factors.

The literature review examines the key theories in these two areas:

- **Individual level theories of behaviour change**

Key theories examined in this section are the Health Belief Model (39), Social Cognitive Theory (40), the Theory of Reasoned Action (41), the Stages of Change Model (42), the Aids Risk Reduction Model (43) and Motivational Interviewing (44).

Each theory is presented and then a review of HIV prevention programmes which used the model is examined. Finally the Agents of Change Programme is discussed in relationship to the model.

- **Social and structural theories of behaviour change**

In this section key theories which are discussed are the following: Freirian theories of behaviour change (45,46), the concept of social capital (47) and finally vulnerability reduction (48).The relevance of these theories to the Agents of Change programme is discussed and key learnings from these sections are used in the development of the conceptual framework.

**1.3.3.1(ii) Chapter Three: the content**

In Chapter Three the content of the programme is examined. The Agents of Change programme focuses on the issue of adolescent sexual relationships with the goal of reducing the risk of HIV infection. Those factors which place adolescents at risk of HIV infection are examined using the theory of triadic influence (49) as a framework. The theory of triadic influence identifies three clusters of factors: intrapersonal, proximal and distal.

- **Intrapersonal**

These intrapersonal factors are individual factors which lead young people to engage in risky sexual practices. They include factors such as gender-based biological differences (50), age of puberty (51), body image (52), early sexual debut (53) and poor personal self-assertiveness (54).

- **Proximal**

The proximal factors examined are those which are influenced by the social situation. These include gender norms (55), older partners (56), transactional sex (57), attitudes to pregnancy (58) and attitudes to condoms (59).

- **Distal**

Distal factors come from the community and culture that surround the individual and include issues such as violence (58), poverty (49) and the influence of the media (60).
The insights emerging from the literature review of adolescent sexual relationships are incorporated into the development of the conceptual framework.

#### 1.3.3.1 (iii) Chapter Four: the context

Finally in chapter four the context of the programme is examined; namely the Church. Four areas are examined in this section of the literature review: the role of religion in HIV work in Africa, the influence of religion on adolescent sexuality, the effect of religious affiliation on sexuality and how religion impacts sexuality.

- **The role of religion in HIV work in Africa**

In this section the importance of religion in Africa is examined (20). The potentially positive role of the Church in terms of HIV prevention is considered (22), as well as the potentially negative role the Church can play in this area (28).

- **The influence of religion on adolescent sexuality**

First of all substantial research is examined from high-income countries regarding the influence of religion on adolescent sexuality (61). Influences include a later initiation of sexual behaviour (62), lower numbers of partners (63) but a reduced level of condom use (64). Secondly the more limited research which is available from Africa is examined (29). This research indicates a smaller difference between religious and non-religious youth in terms of sexual debut than in high-income countries (32). Similar results were seen in terms of lower condom use amongst religious youth (65).

- **The effect of religious affiliation on sexual behaviour**

Firstly the impact of Christianity and Islam on sexual behaviour is examined. Risk increasing factors in Muslims include a lower incidence of condom use (66) and higher numbers of partners (67). Risk reducing factors include circumcision (31), later sexual debut for unmarried girls (68) and lower levels of alcohol use (69). When Christian denominations were compared, some of the findings include lower levels of sexual activity amongst the stricter so-called 'sects' (70), and the highest levels amongst adherents of African Traditional Religions (67).

- **How religiosity influences sexual behaviour**

In the final section the factors are examined which determine the extent to which an individual's behaviour is influenced by their religious affiliation. These include: moral and religious teaching, socialisation within the group, the individual's level of attendance and commitment as well as cultural and social issues in the community.

The insights from the literature review on Religion and HIV are incorporated into the final conceptual framework.

Therefore in Chapters Two, Three and Four the literature review examines three over-lapping areas which have a direct bearing on this programme. This is illustrated in Figure 1.10:

- Chapter Two: the process (theories of behaviour change)
- Chapter Three: the content (adolescent sexual relationships)
- Chapter Four: the faith based context (religion and HIV)

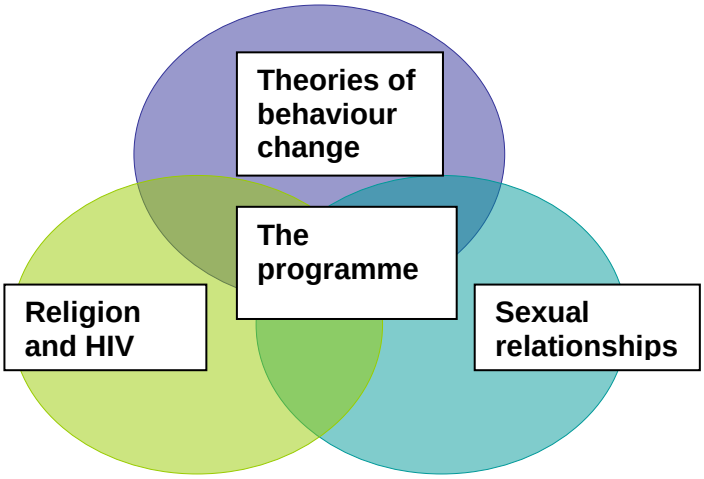


***Figure 1.10: Areas of the literature review***

### 1.3.3.2. Conceptual framework

Agents of Change is a *peer education programme, dealing with reduction in risky behaviour between adolescent sexual partners, in a church setting*.

Three factors are involved in the programme:

- The process (a reduction in risky behaviour)
- The content (dealing with sexual relationships)
- The context (a church setting)

Thus the conceptual framework is built up from these three areas with insights from the literature review.

## 1.3.4. METHODOLOGY

Chapter Five examines the methodology. First of all the development of the intervention is presented: the baseline survey, the development of the intervention and its subsequent piloting.

Secondly the methodology is explained. It is clear that behaviour change is a complex process, involving many actors and multiple potential processes. Outcome mapping (OM) was chosen as it allows for a study design that is sensitive to this complexity (71). Outcomes are defined as changes that one expects to see in people, groups or organisations that are influenced by the programme. There is a direct focus on change in the behaviour of the main actors or 'change partners'. OM can work with multiple partners and strategies, and enable ongoing monitoring of change in the partners, the strategies as well as organisational issues. Adaptation and ongoing learning is an in-built part of the monitoring process and yet there is also scope for more specific in-depth evaluation.

In Outcome Mapping three stages are involved: project planning, project monitoring and project impact evaluation (72).

### 1.3.4.1. Project planning

In this stage the vision and mission of the intervention were identified. The five change partners were chosen, these are the individuals or groups that the programme intended to influence. Outcome challenges, defined as 'changes in behaviour, relationships activities or actions' (72), were set. Progress markers, or 'stepping-stones' along the path to change were defined for each change partner.

### 1.3.4.2. Project Monitoring

In this stage tools were developed to monitor three areas:

- the achievement of progress markers by the different change partners – an outcomes journal; and
- the success of strategies to encourage change in the change partners – a strategy journal; and
- the functioning of the programme as an organisational unit – a performance journal.

### 1.3.4.3. Project Impact Evaluation

Such in-depth evaluation was designed as a quasi-experimental study design that compared non-randomly chosen intervention and control groups. Reported changes in attitudes, knowledge and sexual behaviour were compared between the two groups (73).

## 1.3.5. FINDINGS

In Chapters Six, Seven and Eight the findings of the Project Monitoring and the Project Impact Evaluation are presented.

### 1.3.5.1. Chapter Six: Monitoring of the effect of the programme on the 'change partners'

The groups that the programme intended to influence in terms of behaviour change were identified as the peer educators, the young people attending Agents of Change sessions, the facilitators, the parents and the clergy. The monitoring of the process took place using progress markers, (stepping stones along the path to change). Data was collected through camp and training evaluation forms, evaluation sheets gathered at quarterly meetings, focus group discussions, steering committee meetings and reports by facilitators. With this data, the progress of the change partners towards their outcome challenges was assessed.

### 1.3.5.2. Chapter Seven: Monitoring of Performance and Strategies

In this section aspects of organisational performance which affected the effectiveness of the programme were examined as well as the effectiveness of strategies used by the programme.

- **Performance**

During this stage of the monitoring process, the organisational practices of the programme were examined. These were examined in terms of the organisation's ability to achieve the following goals as identified by OM: 'prospecting for new ideas and opportunities', 'seeking feedback from key informants', 'obtaining support from the next highest power', 'assessing and adapting procedures and materials', 'checking on those already served', 'sharing the best vision with the world', 'experimenting to remain innovative' and 'organisational reflection' (72).

- **Strategies**

In this section the strategies of the programme are examined. There were three identified strategies: training camps, quarterly gatherings and parenting workshops.

### 1.3.5.3. Chapter Eight: Findings of the quasi-experimental evaluation

Reported changes in attitudes, knowledge and sexual behaviour were reported in this section. Changes were compared between the non-randomly chosen intervention and control groups, and the difference analysed for statistical significance.

## 1.3.6. DISCUSSION

Chapter Nine discusses the findings in relation to the literature, and is divided into the following themes: the impact of peer education on sexual behaviour, the influence of religiosity on sexuality, and insights offered by behaviour change theories, gender and the church. In the final section a critique of the research is presented.

### 1.3.6.1. The impact of peer education on sexual behaviour

In this section the findings of the impact of the Agents of Change programme are compared with other studies, both in Africa (35) and internationally (74). Then the findings are compared with school-based studies (37) and community-based interventions (75). The factors are examined which may have influenced the effect of the programme, and an assessment is made about whether the programme should be rolled out.

### 1.3.6.2. The influence of religiosity on sexuality

In this section the findings of the influence of religiosity on sexuality are compared with other studies from high-income countries (61) and African countries (32). The mechanisms through which the religious element of the programme may have influenced youth are examined

### 1.3.6.3. The link between behaviour change and theories

In this section the qualitative assessment of Agents of Change is examined in order to establish which theories of behaviour change might explain the change taking place. The results are compared with Freirian theories of learning, Social Learning Theory, Diffusion of Innovation, Theory of Reasoned Action, Motivational Communication and the Social Ecological Model.

### 1.3.6.4. Gender and the Church

In this section, the findings of the study regarding coercion and rape supportive attitudes are examined and the resulting challenge to the church is presented.

### 1.3.6.5. Critique of the research

The critique of the research follows, considering the areas of reporting bias, social desirability bias, the strength of the findings, cultural issues, religiosity and sexuality, and the selection of churches.

## 1.3.7. CONCLUSION

In the final Chapter Ten, a conclusion is formulated that demonstrates how the thesis has addressed the research question, aim and objectives. Conclusions are drawn based on the findings of the research and a best practice model is presented. Recommendations are made for future adaptations of the Agents of Change programme. An agenda for future research is drawn up and a way forward is charted for dissemination of the knowledge.

# CHAPTER TWO: LITERATURE REVIEW - THEORIES OF BEHAVIOUR CHANGE

## 2.1. INTRODUCTION

In this chapter the process of behaviour change is examined. The Agents of Change programme is an intervention which seeks to bring about behaviour change. For this reason it is important to place it within a framework of theories of behaviour change and these are reviewed in this section.

Prevention of HIV requires the apparently 'simple' task of avoiding unprotected sex. However, sexual behaviour is deeply embedded in individual feelings, physical needs, social and cultural relationships and environmental and economic processes. This makes HIV prevention very complex (76). The primary cause of HIV infection is sexual behaviour, so one of the most important strategies for preventing AIDS is to change behaviour.

It is important to examine the theories of behaviour change and the prevention programmes that have been based on them. This section of the literature review starts by examining a history of theories of behaviour change used in prevention programmes. Then various important theories are described, followed by a review of studies looking at prevention programmes, which have been based on them. The following theories are examined in this final section: the Health Belief Model, Social Cognitive Theory, the Theory of Reasoned Action, the Stages of Change model, the AIDS Risk Reduction model, Diffusion of Innovations and finally Motivational Interviewing.

## 2.2. THE HISTORY OF THEORIES OF BEHAVIOUR CHANGE

There have been several generations of prevention initiatives, which have chronologically overlapped, but show a general progression in terms of their thinking and understanding (76,77).

### 2.2.1. FIRST GENERATION

These initiatives started predominantly in the developed world. They relied on the assumption that giving correct information about transmission and prevention would lead to behaviour change. They were based on the premise that if young people had the necessary knowledge, they would rationally choose to avoid unprotected sex (78, 76). Studies in both the developed and developing world have shown that initiatives based solely on information giving have increased knowledge about HIV, but have been ineffective in leading to behaviour change (78,76,79,80,81). There is often a belief that information will automatically be internalised and this will lead to behaviour change but this often does not occur. HIV risk information is necessary, but is not sufficient to motivate behaviour change.

The difficult task is to develop interventions that influence the other factors that are more responsible for behaviour change (80).

### 2.2.2. SECOND GENERATION

These initiatives included information, but added values clarification and skills especially in the area of decision making and communication. Some of these programmes did show a slight impact, depending on which skills were taught and how they were taught (78).

### 2.2.3. THIRD GENERATION

This did not evolve out of the first two, but was in reaction to them, out of a concern that the first two generations did not emphasize morality. Emerging from a moralistic paradigm the third generation approach emphasized abstinence only. To avoid the possibility of a confusing double message, only the risks of contraception were emphasized. These interventions were carried to Africa through funding from the USA. Studies have shown that although abstinence is an important part of a prevention strategy, abstinence-only programmes are ineffective (82).

### 2.2.4. FOURTH GENERATION

These use curricula based upon theories of behaviour change that have been shown to be effective in other health areas. They are based on individual psychosocial and cognitive approaches (76). Some of these programmes have been rigorously studied, some have been found to be effective and others not (80,83).

### 2.2.5. FIFTH GENERATION

Social science researchers came to realise that because sex takes place within a specific social context, programmes cannot only concentrate on the individual, but must also take into account the socio-cultural factors (76). Beyond the individual and the immediate social relationships lie the larger issues of structural and environmental determinants that have an important role to play in sexual behaviour (76).

The fourth and fifth generation interventions were based on various types of theory:

- **Individual:** Individual level theories focus on the individual's psychological process, such as values, attitudes and beliefs.
- **Social, structural and environmental:** Social level theories emphasize social relationships, whereas structural and environmental theories focus on how structural and environmental factors influence behaviour (76).

These different levels form a continuum, which moves from the individual to the societal level. This typology will be used to structure the discussion of the various theories in the next sections.

# 2.3. INDIVIDUAL LEVEL THEORIES OF BEHAVIOUR CHANGE

These theories have been generally created using cognitive-attitudinal and affective-motivational constructs (76). Most of the psychosocial theories originated in developed countries but have been used internationally, with mixed results. These theories do not generally consider the interaction of social, cultural and environmental factors but rather focus on individual factors. Each theory has different assumptions but they all state that behaviour change occurs when some of the following are altered:

- Risk perceptions
- Attitudes
- Self-efficacy beliefs
- Intentions
- Outcome expectations.

Programmes based on these theories attempt to impact one or more of these variables. The programmes used instruction and modelling in order to teach risk reduction skills (76). There are many such models, but we shall consider those most commonly used in HIV prevention programmes:

- The Health Belief Model
- Social Cognitive Theory
- Theory of Reasoned Action
- Stages of Change Model
- Aids Risk Reduction Model

## 2.3.1. HEALTH BELIEF MODEL

Firstly a brief history of this model is described and then the components of the Health Belief Model (HBM). Then a review of intervention studies based on the HBM is presented.

### 2.3.1.1. History of the Health Belief Model

The health belief model was developed in the 1950s by a group of social psychologists in the United States (US) public health service in an effort to explain the widespread failure of people to participate in programmes to prevent or to detect disease. The development of the HBM grew out of the limited success of public health programmes. For instance, tuberculosis (TB) was known to be dangerous and screening was free, but people did not choose to screen. When researchers tried to discover why, they found that people's readiness to screen depended on two factors:

- Perceived threat: was contracting TB a possibility for them?
- Perceived personal benefits: would screening be of benefit – would early detection and treatment improve their lives? (39)

Over three decades, the model has been one of the most widely used psychosocial approaches to explaining health related behaviour (39).

### 2.3.1.2. Components of the Health Belief Model

Many studies have concluded that no significant relationship exists between sexual knowledge and safe sex (84). The HBM focuses on the stage which comes between knowledge and action, which is the perception of individual risk that mediates action based on knowledge. It identifies four inter-related elements that must be present for knowledge to be translated into preventative action (85,86):

- **Perceived susceptibility**: a person perceives that they are susceptible to HIV *("I personally am at risk")*
- **Perceived severity** : they perceive HIV to be a serious condition *("If I get HIV it is a serious problem")*
- **Perceived benefits**: they perceive there are benefits to taking preventive action *("Using condoms will help protect me")*
- **Perceived barriers**: the potential barriers to taking preventive actions are outweighed by potential benefits *("Even though my boyfriend may not like it, it is worth using condoms for safety")*

In this model, promoting action to change behaviour includes changing individual personal beliefs. Individuals weigh the benefits against the perceived cost and barriers to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions often target perception of risk, beliefs in the severity of AIDS, beliefs in the effectiveness of condom use and the benefits of condom use or delaying sex (76).

This model is based on a belief that individuals will take action to prevent ill health if they regard themselves as susceptible to the condition. They will take action if they believe that a course of action will be beneficial in reducing either their susceptibility to or the severity of the condition and if they believe that the anticipated barriers to taking action are outweighed by its benefits (39).

In order for a person to change their behaviour, they need the knowledge, but they also need to make a decision to act. The four components of the HBM interact in order to influence a person's readiness to act.

Your **perceived susceptibility**, or subjective perception of risk *("Can I catch it?")* together with the **perceived severity** of contracting the illness and possible social consequences *("If I catch it, does it matter?")* form the perceived threat. This will influence your readiness to act.

The interaction between these factors is illustrated in Figure 2.1:

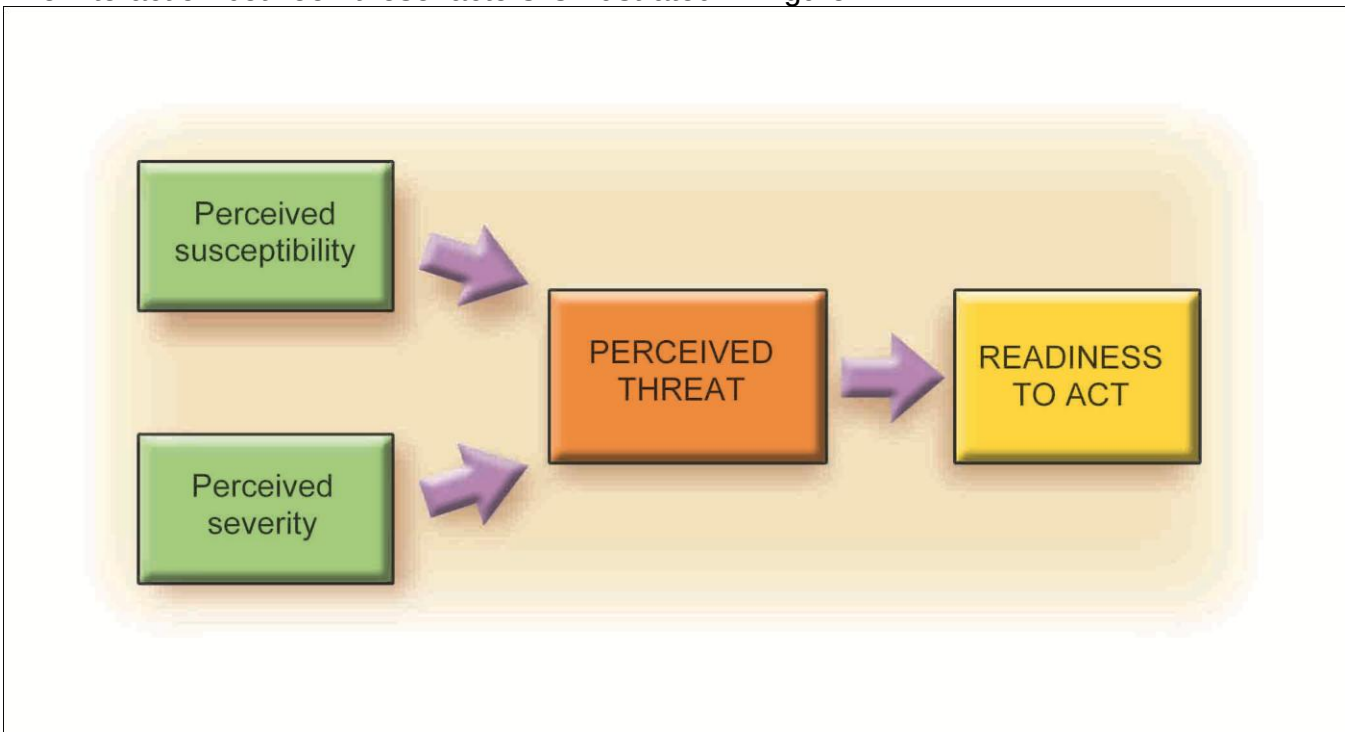


***Figure 2.1: The Health Belief Model***

Even if you think you are susceptible, the action you take depends on your beliefs regarding the effectiveness of the action. *("Using condoms might protect me, but I am not sure they work anyway")*. These are the **perceived benefits** of the action.
An individual weighs up costs and benefits: the effectiveness of the action versus perceptions regarding negative side effects. *("A condom would protect me, but my boyfriend will think I am a slut if I ask to use it")*. If the benefits are greater than the **perceived barriers**, this will lead to a preferred path of action.

Thus the energy to act comes from a combination of levels of susceptibility and severity. The perception of benefits versus barriers of specific actions leads to the selection of a preferred action:

***SUSCEPTIBILITY + SEVERITY = ENERGY TO ACT (MOTIVATION)***
***BENEFITS – BARRIERS = PREFERRED ACTION***

Apart from these four components, two further components were later noted and added into the HBM, cues to action and self-efficacy:

### 2.3.1.2(i) Cues to action

It was noted that cues may trigger action: you have the knowledge, you are aware of the severity, the benefits outweigh the barriers, but you do not start the action until something triggers you. For example, this may be a friend who discloses their status to you, or something viewed on the media.

### 2.3.1.2(ii) Self-efficacy

This concept was added to the HBM by Bandura in 1977 (40,39). Self-efficacy is defined as '*the conviction that one can successfully execute the behaviour required to produce the outcomes'* (40). It requires a good deal of confidence that one can alter lifestyle before successful change is possible. For behaviour change to succeed, people must:

- feel threatened by current behaviour (perceived susceptibility and severity);
- believe that change of a specific kind will be beneficial by resulting in a valued outcome at acceptable cost (perceived benefits outweigh perceived barriers);and
- they must also feel themselves competent (self efficacy).

### 2.3.1.3. Review of studies of programmes using the Health Belief Model

One might predict that **perceived threat** (perceptions of susceptibility and severity) would be associated largely with an intention to take action. Initial campaigns focussed on the fear factor around AIDS. If people were convinced of the severity of the disease and if therefore the benefits of action were obvious then surely the individual would take action. However, studies both in the developed and developing world have shown that **perceived barriers** were the single most powerful predictors of behaviour relative to other HBM components (39,76,86,87). This is the main problem with condoms, although the perceived threat is high, the barriers are higher than the perceived benefits. Perceived severity was actually the least powerful predictor. This may help to explain why health messages based on fear have tended not to be so successful (39).

Although fear of HIV may be high, a high risk person may say 'I don't care'. The perceived severity of rejection by a partner may exceed the perceived severity of the infection. Barriers to behaviour change are often high, in terms of relationships with one's sexual partner, or social and cultural norms. One of the most important barriers is lack of self-efficacy (39).

If perceived threat is high and perceived benefits outweigh perceived barriers, a **cue to action** can prompt action. One of the factors that have been identified in the success of the HIV prevention programmes in Uganda was the high percentage of the community that knew somebody who had died of AIDS (88).

### 2.3.1.4. Discussion of the Health Belief Model in relationship to Agents of Change

The weakness of the HBM model when dealing with adolescents is that it fails to take into account the strong influence of peer pressure, it emphasizes the knowledge and beliefs of individuals as if they exist apart from the social world (87,89). This model fails to recognise that often the locus of control is not with the individual, but may lie with an external person (90). For instance a teenage girl may want to use condoms, but her boyfriend may refuse. It also fails to show how much motivation may be needed to make health issues relevant.

One of the current challenges with HIV prevention programmes is that many adolescents suffer from 'AIDS fatigue', they have grown up hearing about AIDS, and tend to 'switch off' when the subject is raised. This tends to reduce the feeling of perceived threat. However when the programme involves Voluntary Testing and Counselling, the experience of actually going through the test seems to bring sharply into focus the fact that they also could be at risk. Despite not taking these socio-demographic factors into account, this theory was of great benefit in strengthening the Agents of Change programme in various areas (39):

- Firstly, to correct adolescents' misconceptions about the prevalence of risky and safe behaviours amongst their peers.
- Secondly to enhance self efficacy by empowering youths with the skills necessary to successfully perform risk-reducing behaviours, for example by questioning sexual partners about sexual histories, using condoms correctly and refusing offers of sex in certain high pressure social situations (89).
- Thirdly, this theory was helpful in identifying the barriers and benefits of actions amongst *specific* social and cultural groups. In this way the programme could be geared to challenge the specific perceived barriers experienced by different social groups.
- Fourthly specific cues to action could be incorporated, for instance inviting a speaker to the group who is living with HIV, or someone who was unable to fall pregnant as an adult because of STIs they caught through having unprotected sex as a teenager.

The importance of the HBM to the design of the programme in shown in Figure 2.2:

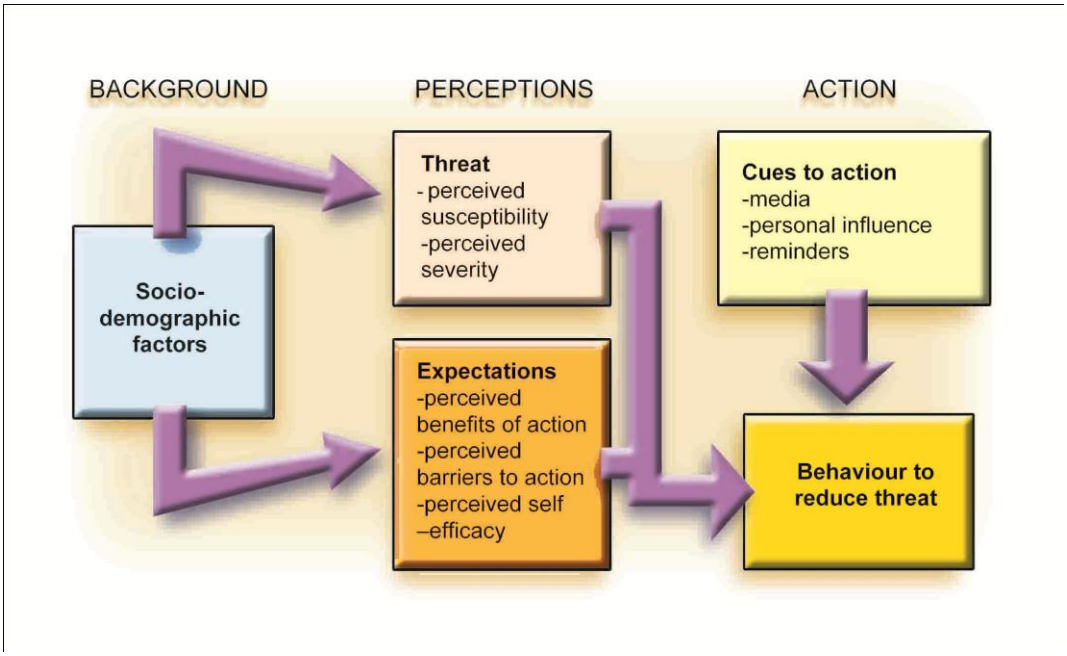


***Figure 2.2: The importance of perceived threats and expectations***

## 2.3.2. SOCIAL COGNITIVE (OR LEARNING) THEORY

*'People are neither powerless objects nor free agents' (40).*

Social Cognitive Theory was developed by Bandura in 1977 (76). The premise of Social Cognitive Theory (SCT) is that new behaviours are learnt either by modelling the behaviours of others, or through direct experience. SCT focuses on the important roles of self regulatory processes, and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants. Prevention of HIV requires people to exercise influence over their own behaviour and their social environment. People need to be given not only reasons to alter habits, but also the behavioural means, resources and social supports to do so. Effective self-regulation of behaviour is not achieved by an act of will. It requires certain skills in self-motivation and self-guidance. There is a major difference between possessing self-regulative skills and being able to use them effectively and consistently under difficult circumstances (91).

### 2.3.2.1. The central components of Social Cognitive Theory

Social Cognitive Theory has the following key components: self-efficacy, outcome expectancies, social modelling and social support for personal change. Self-efficacy is the belief in one's ability to implement the necessary behaviour. Outcome expectancies are expectations and values regarding outcomes of the behaviour. The expectation is what the consequence of a particular action will be, and the value is regarding the relative importance of that consequence. Empirical evidence suggests that self-efficacy and outcome expectations predict adolescents' sexual behaviour in both Western and non-Western contexts (92).

Social Cognitive Theory's basic tenets are that behaviour interacts with personal factors and environments. Personal behaviour is largely determined by people's expectations and values regarding the outcomes of the behaviour (outcome expectations). The theory emphasizes the importance of modelling as a learning mechanism. It has been seen to be an effective framework for HIV prevention programmes, but many have questioned it in the context of Africa because of the cultural and societal environmental factors at play (76). For example a person may have outcome expectancies that to have unprotected sex will lead to negative consequences, but be unable to change because of gender power imbalance in a relationship, or because poverty is forcing them to have unprotected sex. In this next section the concepts of self-efficacy, outcome expectancies, social modelling and social support for personal change is discussed.

#### 2.3.2.1(i) Self-efficacy

Self-efficacy is concerned with people's beliefs that they can exert control over their patterns of behaviour. Their beliefs about their capabilities affect what they choose to do, how much effort they put into it and how long they will persevere in the face of difficulties.

When people lack self-efficacy they do not manage situations effectively even though they know what to do and have the required skills.

Perceived self-efficacy can affect every phase of change:

- whether you consider changing;
- how hard you try to change; and
- how well you maintain change.

Self-efficacy is particularly important in the context of influencing sexuality. The major problem is not teaching about safer sex, it is equipping people with skills and self-beliefs that enable them to put the teaching consistently into practice. Risk reduction calls not just for increased personal efficacy but also increased efficacy in the area of interpersonal relationships. Difficulties arise because self protection often conflicts with interpersonal pressures (40). The threat of coercion, desire for social acceptance, fear of rejection and embarrassment can override the influence of judgment. Experiences of forced sex lower women's sense of efficacy to negotiate safer sex. The weaker the perceived self-efficacy, the more social and environmental factors can increase the likelihood of risky sexual behaviour. Exercise of personal control over sexual behaviours that carry risk of infection calls on skills and self-efficacy in communicating frankly about sexual matters and protective methods and ensuring their use.

Enhanced self-efficacy not only reduces anticipatory fears and inhibitions about the action to be taken, but through expectations of eventual success, it affects attempts to persevere with action once it is initiated. The degree of self-efficacy determines how much effort people will expend in the face of obstacles and adverse experiences. The degree of self-efficacy may be influenced by the following factors:

- Performance accomplishments (personal) –*"I managed last time"*
- Vicarious experience (modelling) – "*I saw my friend achieve it"*.
- Verbal persuasion (suggestions or self instructions) – "*My best friend advised me to"*
- Emotional arousal (from symbolic messages) (93) – *"I feel proud and strong"*

Self-efficacy therefore is not a fixed personality trait but can be influenced by external factors. Self-efficacy might increase during the exposure to Agents of Change, but it might also decrease after the programme ends.

### 2.3.2.1(ii) Outcome expectancies

SCT aims to increase positive outcome expectations (the perceived benefits of behaviour change), or to highlight the negative outcomes of not changing. Outcome expectancies can be divided into personal and social:

- **Personal outcome expectancies**

One may expect positive psychological outcomes (for example: *"I will feel empowered if I use a condom*:) or physical (for example: *"I will not get an STI")* (91).

- **Social outcome expectancies**

One may expect positive social outcomes such as recognition, approval, acceptance, support or friendship (94). How social outcomes are perceived may depend on the current norms and values, especially in the peer group. Often the social outcome *("I will be popular with all my friends who are having sex")* may compete with the personal outcome *("I don't feel I am ready to have sex")*. The importance of personal and social outcome expectancies is illustrated in Figure 2.3.which gives an overview of SCT:

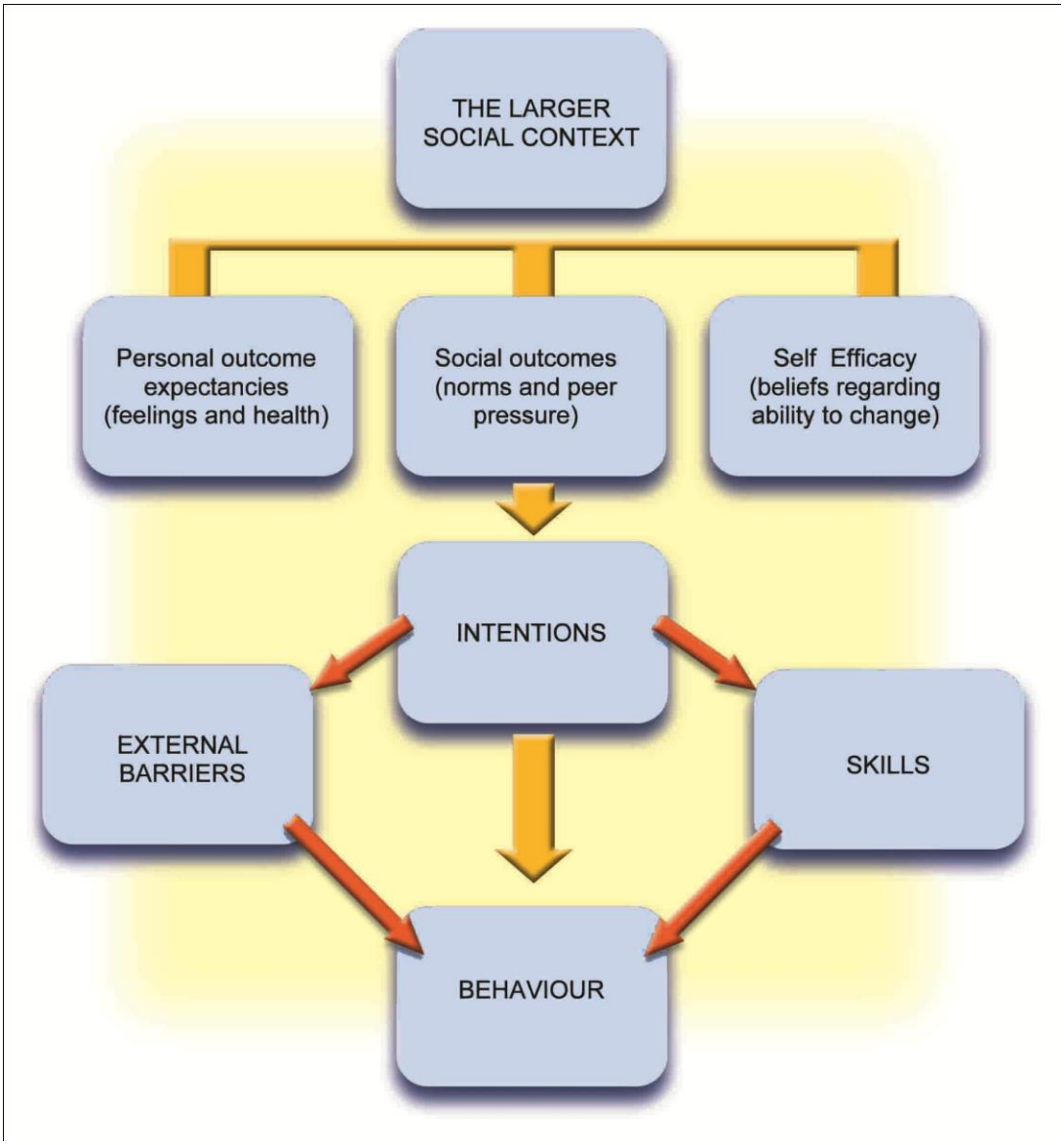


***Figure 2.3: Social Cognitive Theory***
***Adapted from Aaro (92).***

In this model, in terms of a particular behaviour change, an individual is affected firstly by the larger social environment. Then he or she has their own personal outcome expectancies of what the behaviour will lead to, as well as their social outcome expectancies. They will have a certain level of self-efficacy. All of these factors will determine the intention to change. However that intention to change will be limited by any external environmental barriers present, and any lack of skills the person has. All these may limit the likelihood of the behaviour taking place.

For instance Person A:

- would like to use condoms, she believes that they work and can protect her (personal outcome expectations);
- believes other friends use them and that her boyfriend will understand and support her (social expectations);
- believes that she is strong enough to ask her partner to use them (self-efficacy)
- however condoms are not freely available so she can only buy them sometimes (barriers);
- as a couple they don't talk about sex so it is embarrassing to talk about practically using condoms (skills);
- so they don't end up using them regularly (behaviour)

In this way the SCT explains how patterns of behaviour are acquired, and how they are regulated by self-generated and external sources of influence (40).

### 2.3.2.1(iii) Social modelling

SCT when used in programmes aims to strengthen self-efficacy by building skills primarily through social modelling**.** Social modelling occurs when an external person models certain behaviour such as a sports star or TV character, or a role model from your peer group. Modelling leads to vicarious learning, when the learning is not personally experienced, but you learn through what happens to other people (40). People judge their own capabilities in part from how well those whom they regard as similar, exercise control over situations. People develop stronger belief in their own capabilities, if they see models similar to themselves solve problems successfully, than if they see the models as very different from themselves.

Similar characteristics and situations should be used in modelling (92). Interpersonal influences operating within one's own immediate social network are stronger than general normative sanctions. The norms of general society are more distant. The reaction of outsiders carries less weight than the peer group. The more your friends do it, the stronger your own personal self-efficacy (91). This is one of the strengths of peer education programmes. Programmes need to provide models of desired behaviour that are linked to social and cultural narratives (95). In this way barriers and perceived social outcomes specific to that social grouping can be addressed. You are more likely to adopt modelled

behaviour if it results in outcomes you value than if it has unrewarding or punishing effects. Modelling can strengthen or weaken inhibitions over behaviour. Behavioural restraints are most strongly developed by observing the consequences experienced through modelling; for example, meeting a pregnant teenager or an HIV positive person from a similar background to your own. 'Exposure to models performing feared activities without any harmful effects creates favourable changes in attitudes' (40).

Diversified modelling is more effective than one single model (several role models rather than one). Verbal persuasion has weak and short lived effects and the most effective approach is a combination of modelling with guided participation. Models who have high status, competence and power are more effective in prompting behaviour than those of lower standing. People most responsive to modelling influences are those with a low confidence and self-efficacy (40).

### 2.3.2.1(iv) Social support for personal change

According to SCT, human behaviour is defined in terms of 'a continuous reciprocal interaction between cognitive, behavioural and environmental determinants' (40,91).

These determinants are

- personal (cognitive, affective and biological) factors;
- environmental (social and external) factors; and
- behavioural (skills)

The interaction between these three determinants is illustrated in Figure 2.4. below:

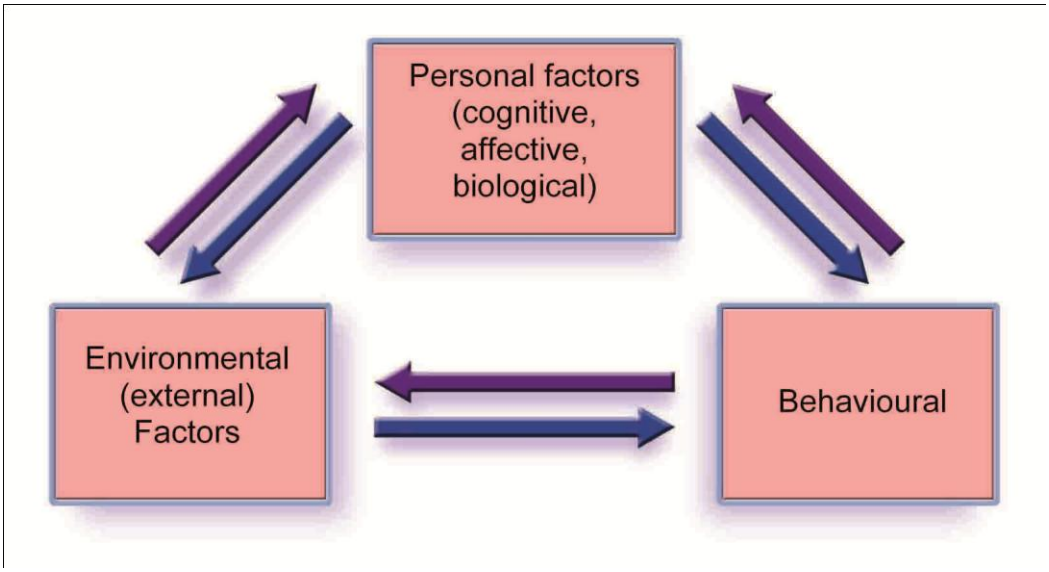


***Figure 2.4: The interaction between determinants in Social Cognitive Theory***

They all operate as interacting determinants of each other. An effective programme of change includes four major components aimed at altering each of the three types of interacting determinants:

- informational – increase awareness of risk (personal);
- development of social and self regulative skills (behavioural);
- skill enhancements and building self-efficacy (personal); and
- enlisting and creating social support (environmental).

This interaction is important for two reasons:

- Firstly, programmes need to impact both the individual (personal and behavioural) as well as the environment. Without the simultaneous strengthening of social support, the person is much less likely to change.
- Secondly, change is an ongoing process, so programmes need to promote continuing adherence rather that a once-off campaign. It is important that those who are trying to change be encouraged to stay away from detrimental social environments, in order to prevent relapse (40).

### 2.3.2.2. A review of studies of programmes using the social cognitive model

SCT has been successfully utilised by programmes in developed countries to obtain positive changes in risk behaviour (41). Programmes built on SCT integrate information and attitudinal change to enhance motivation, reinforce risk reduction skills and self-efficacy (41). King's meta-analysis of HIV interventions found twelve published interventions using SCT that all obtained positive changes (76). Several of the programmes listed by the Centre for Disease Control as programmes which have shown effectiveness have used SCT successfully for risk reduction (96). Kirby's review of effective school-based programmes found that one of the factors in effectiveness was the use of SCT (78). SCT appears to be successful in its simultaneous attention to the three areas of personal outcomes, social outcomes and self-efficacy.

### 2.3.2.2(i) Personal outcomes

In programmes using SCT, participants who expressed more favourable personal outcomes for not having sex were less likely to have initiated sexual intercourse than those who held less favourable personal outcome expectancies. Adolescents who believed that abstaining from sex would benefit them personally were more likely to report never having had sex (94). People interpret information in terms of potential gain and potential loss. There is evidence that communication is more persuasive when discussing health benefits as opposed to health losses (91).

### 2.3.2.2(ii) Social outcomes:

Participants who perceived peers to be less favourable to sex were more likely to report never having had sex. This could be interpreted in two different ways– they are influenced by friends not having sex, or their choice not to have sex influences what they think others are doing! It is also possible that they choose friends who share similar views or have a

similar social background (94). In terms of condom use, social outcome expectancies were more important than personal outcome expectancies.

#### 2.3.2.2(iii) Self-efficacy

Perceived self-efficacy was a good predictor of whether preventive practices would be adopted (40). In a national survey of South African youth, Sayles found that high self-efficacy was strongly associated with condom use (97). In this study he found the following:

- Females – 42% of females with low self-efficacy used condoms during their last sexual encounter vs. 65% of females with high self-efficacy.
- Males – 54% of males with low self efficacy used condoms at their last sexual encounter vs. 75% of males with high self-efficacy.

Sayles identified factors associated with self-efficacy. Many of these are modifiable and can potentially be used in programmes to improve self-efficacy. Self-efficacy may be shaped by social norms, outcome expectations, and communication with family or community members, which shows the complexity of the interactions. According to this study self-efficacy and its effects on condom use are influenced by the individual's knowledge of HIV (does he/she take HIV seriously, has he/she been tested), prior sexual experiences (early sexual debut, use of condoms, or history of unwanted sex), outcome expectations (risk of HIV, or condom use is a sign of distrust), socio-demographic characteristics, socio-structural facilitators, ability to talk with partner, access to condoms, or socio-structural barriers (partner makes decisions about condom use, would not be friends with someone with HIV, peer pressure) (97). These factors show the complexity of the factors included in the SCT model.

### 2.3.2.3. Discussion of Social Cognitive Theory in relation to the Agents of Change Programme

The strongest part of this theory in relation to Agents of Change is the emphasis on modelling, which is the basic tenet of peer education, that peers should '*live the message not just give the message'.* It shows how modelling leads to vicarious learning and that the role models should be as close as possible to participants in terms of background, age and gender. These are important aspects to bear in mind in the selection of peer educators.

When designing an intervention for a specific group of people it is important to assess the relative importance of the components (personal outcomes, social outcomes or lack of self-efficacy) in this model for a change in intention in this specific group. Thus the intervention must decide whether to mainly focus on changing personal attitudes, perceived social norms or on building self-efficacy (41). This can also help in the preparation and adaptation of materials.

One critique of this model is that it can be quite mechanistic and assume a fairly linear cause-effect. In reality these components are networked in a much more complex system.

## 2.3.3. THEORY OF REASONED ACTION

Interventions which have a traditional educational focus have often been criticised as ineffectual. However, the Theory of Reasoned Action sees that the problem of changing behaviour is not one of converting knowledge to behaviour, but rather one of identifying the kinds of knowledge that need to be provided, or the structural changes that must be made in order to influence the particular behaviour.

The Theory of Reasoned Action can be used to identify the factors which underlie any given behaviour. Once these factors have been identified, information about them can be used to develop interventions to influence behaviours. 'The key to successful behavioural interventions is to identify the determinants of the specific behaviours one wants to maintain or change' (41).

The Theory of Reasoned Action (TRA) is a general theory of human behaviour that deals with the relations between beliefs, attitudes, intentions and behaviours. Each variable has been defined and standardised procedures for assessing these variables have been developed. The theory assumes a causal chain that links beliefs to behaviour (41). It provides a cognitive model of the decision-making process to engage in a certain behaviour. It takes a linear cause-effect perspective and rests on the assumption that the decision to engage in a behaviour is based on the anticipated positive or negative outcomes that the individual expects to result from the behaviour (98). The individual assessment of anticipated outcomes can be measured and combined into a causal model that links these beliefs to intention and behaviour.

The TRA focuses on the organisation of cognitive components that directly predict intention and behaviour. It does not encompass the external socio-cultural or environmental predictors of beliefs (99). It can assume a very rational decision making process, which does not take adequate account of the emotions and feelings involved in interpersonal relationships. Figure 2.5 below illustrates these cognitive components.

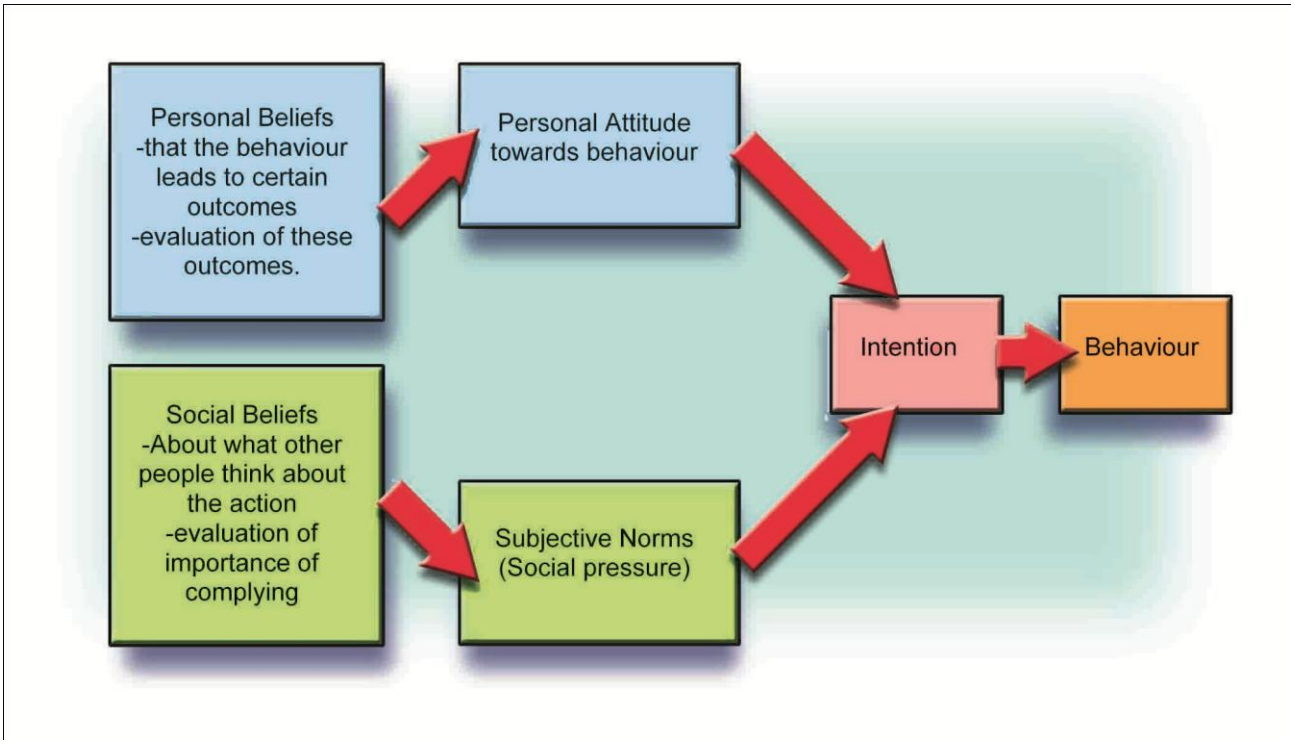


***Figure 2.5: The Theory of Reasoned Action***

### 2.3.3.1. The central components of the Theory of Reasoned Action

The central components of the Theory of Reasoned Action are beliefs, which lead to either personal attitudes or subjective norms. These beliefs affect the intentions, which impact on behaviour.

### 2.3.3.1(i).Beliefs

Beliefs are underlying cognitive structures. They may be:

- Beliefs about the outcomes produced by the behaviour *("if I use a condom, I won't fall pregnant")*, with an evaluation of those outcomes *("if I fall pregnant I really don't mind, I would like a baby")*. These beliefs lead to **Personal Attitudes.**
- Beliefs about what other people think about the behaviour ('my friends think only sluts carry condoms'), with an evaluation of how important it is to comply with what those people think ('my health is more important than what those stupid people think'). These beliefs lead to **Subjective Norms.** These subjective norms create social pressure in terms of an individual's own cognitive construction.

### 2.3.3.1. (ii) Intention

A person's intention is seen as a balancing of the relative importance of these personal attitudes and subjective norms. These factors are similar to the personal and social outcomes of Social Cognitive Theory. However in the TRA, behaviour is ultimately determined by a cognitive structure composed of underlying personal attitudes and normative beliefs, the environmental factors are not emphasized as in SCT.

In order to change behaviour the intervention must influence the beliefs that underlie the decision to perform the action or not.

### 2.3.3.1(iii) Behaviour

It is necessary to define the specific behaviour, by examining four elements:

- Action;
- target;
- context; and
- time.

Programmes often fail because they fail to define the specific action. For instance they promote 'safer sex'. The behaviour needs to be more closely defined: for example to use a condom (action) with all partners (target), casual and regular (context), every single time (time). Or 'use condoms every time for oral sex with long term partners'. The information necessary to increase condom use with your spouse may be different from that needed to increase condom use with a casual partner.

Sometimes interventions target behaviours without defining them specifically enough. They may have a goal, for instance *avoiding HIV* or *promoting safe sex.* It is more effective to target a specific defined behaviour in a particular context (for example to increase condom usage with faithful and casual partners of adolescents (41).

It is important to remember that although condom use is a behaviour for men, it is a *goal* for women. The behaviour for a woman should rather be specifically defined – for instance – put a condom on my partner during sex, or talk to my partner about condoms, or refuse to have sex if he does not use a condom.

### 2.3.3.1(iv) The importance of intentions in the theory of reasoned action

The TRA assumes that most social behaviours are under volitional control. The most important determinant is the intention to perform the action. In order to change a specific behaviour you must change the intentions. Intentions are formed from personal attitudes and subjective norms. The more one believes that performing a behaviour will lead to positive outcomes (or prevent negative ones) the more favourable the persons attitude. A person who believes that most referents (individuals or groups) think he/she should perform the behaviour will feel internalised social pressure to do so. Therefore, in order to impact intentions, the intervention should impact the **beliefs** that lead to attitudes and internalised social norms.

Any given communication can be viewed as a **belief statement,** for example, *"it is risky to date older guys because they have been sexually active for more years than your peers, so are more likely to have HIV".* The listener can accept or reject the information.

If accepted, it can change their beliefs *("now I realise it is not wise to date older guys")*, and thus intentions *("if an older guy hits on me, even though I feel flattered, and he has money to spend, I shall stay clear").* If one's intentions have changed, then the behaviour is much more likely to change.

When attempting to influence intentions it is important to determine whether the intention is primarily under attitudinal control or normative control, or both. It is important to identify:

- Significant outcomes: these are identified by examining the costs and benefits of performing a particular action. This intention can be said to be under attitudinal control for one is influenced by your attitude to that particular action.
- Significant referents: these are identified by considering the people who approve or disapprove. This intention can be said to be under normative control, for one is acting according to norms defined by significant others.

Significant outcomes and referents will vary from group to group. For instance in one group it may be difficult to use condoms because they are too expensive. For another group the belief is that condoms can get stuck inside you. Thus different beliefs need to be addressed and very different interventions may be needed to change the same behaviour in different populations.

Once important outcomes and referents have been identified, it is necessary to decide which attitudes and normative beliefs to target in the intervention. In terms of attitudes the following can be assessed:

- the strength of the belief; and
- how the outcomes are evaluated (for example: serious or *"I don't care"*)

In terms of important referents the following can be assessed:

- the strength of the belief (for example: "*all my friends are doing it");*and
- the motivation to comply with the referents (for example: *"I really want to fit in")*

One of the main reasons interventions fail is that they do not address relevant beliefs. Messages are rarely directed at attitudes or normative beliefs. Messages often only give factual information, which is already known (for example: condoms protect against STIs) or which is assumed to be useful by the educator. The information will be more effective if it addresses the actual attitudinal or normative beliefs underlying the behaviour.

### 2.3.3.2. A review of studies of programmes using the Theory of Reasoned Action

The Centre for Disease Control found evidence of success in several programmes in the USA that used the TRA. These programmes used interactive sessions to change perceived norms and attitudes. They evidenced an increase in condom use as well as a reduction in STIs (96).

Gillmore's study of teenage sexual behaviour in the USA found that paths from intentions to behaviour and from norms and attitudes to intentions were significant, as were paths from personal and social beliefs to attitude and norm respectively. The study then attempted to understand the proximal factors influencing youth's decisions to have sex (98).

Sexual intercourse among teens is often characterised as unplanned and impulsive, but there are factors such as educational aspirations and acceptance of premarital childbearing that are mediated by individual cognitive processes. The study found that condom use among teens was more highly related to attitudes than to norms, and that the most predictive personal beliefs were not beliefs about the efficacy of condoms to prevent pregnancy and disease, but rather beliefs about their potential negative effects on intimacy. Boys hold different norms around sexual activity than girls do. The factors that influence a virgin's decision to have sex will be different to a sexually active person's decision to have sex again. These are reflected in differences in beliefs, norms, attitudes and intentions.

The study found firstly that personal attitudes were more influenced by positive outcomes than by negative ones. This shows the importance of programmes focussing on positive rather than on negative messages. It also found that social norms had a stronger effect on intentions to have sex than personal attitudes. This reflects the power of peer pressure in an adolescent's life, where social pressure may over-rule personal attitudes.

In this study, for the sexually active, intentions were more strongly related to personal attitudes than to norms (for instance, *"I would like to have sex"*) whereas for virgins norms were more strongly related to intentions than attitudes (for instance *"people think I am too young to have sex"*) (98). However, Fishbein found the opposite, that those who were inexperienced placed more emphasis on attitude *("I want to stay a virgin")* than the sexually experienced, who placed more emphasis on norms *("everyone is doing it").* This could be because of the difference between adult norms and teenage norms. Adult norms tend to prohibit teenage sex; teenage norms would encourage it (41).

### 2.3.3.3. Discussion of the Theory of Reasoned Action in relation to the Agents of Change Programme

One of the weaknesses of the TRA is that it assumes that most social behaviours are under volitional control. The most important determinant is the intention to perform the action. In the context in which Agents of Change is run it appears that the most important

determinants are often peer pressure - the perceived social norms, or outside influences, such as gender imbalances of power or poverty.

However, one of the areas where the TRA is helpful to the programme is in the insight that significant outcomes and referents vary from group to group. Belief statements that are relevant to a specific group can be addressed and in some cases changed by giving further education. For instance a belief that it is better to date an older guy because he will give better gifts could be challenged with information regarding his higher risk of HIV. A belief that there is nowhere in the community to access affordable condoms could be counteracted with the necessary information. The need to define the behaviour very clearly was also important, as well as the need to work out which were more influential, personal or social beliefs. This theory is also helpful in understanding the importance of peer pressure: an individual's perception of what people who are important to them think about a particular action can be very influential. For instance if their peers think that using condoms is 'cool' or 'not cool' this will influence their decision making (90).

## 2.3.4. STAGES OF CHANGE MODEL

Behavioural research suggests that adopting a new behaviour or eliminating a bad habit is a process and occurs in small steps as a person slowly progresses through a series of cognitive and behavioural changes. The Stages of Change Model identifies various steps (42):

- Pre-contemplation: there is no intention to change behaviour in the foreseeable future
- Contemplation: intention to change at some point, but not in the near future
- Preparation: there is a firm intention to change in the near future and some preliminary attempts to do so.
- Action: the new behaviour is being implemented
- Maintenance: the behaviour is being practiced and maintained
- Relapse: one can relapse in terms of stopping the new behaviour or reverting to the previous behaviour and re-entering the cycle at an earlier stage such as contemplation.

These stages are illustrated in Figure 2.6 below:

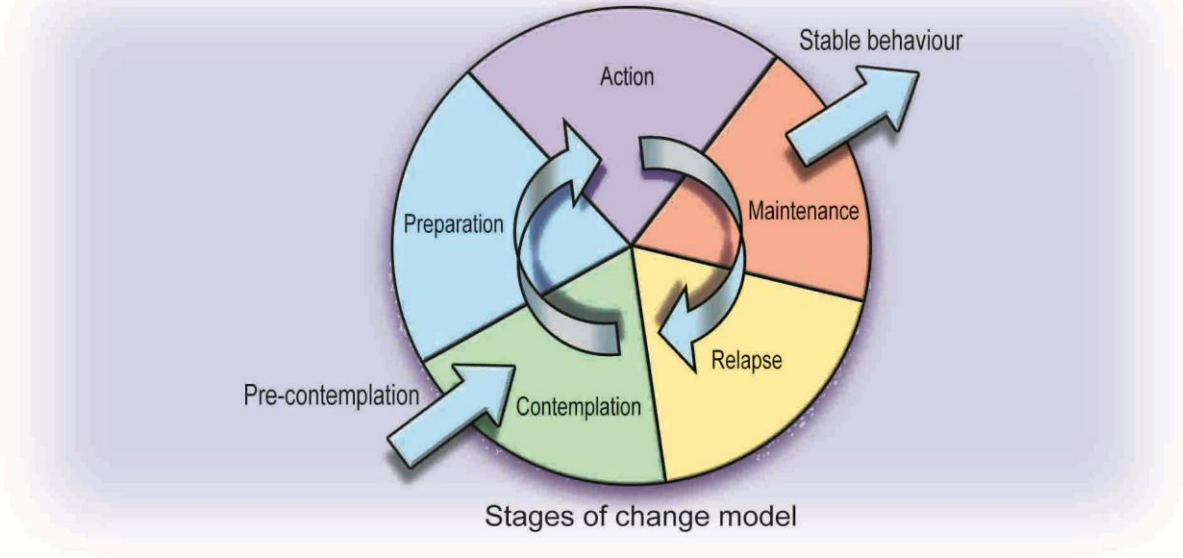


***Figure 2.6: The stages of change model (100)***

One of the important insights of the Stages of Change Model is that there are different strategies for people who are at different stages.

- For those not yet sexually active, one could consider them to be in the maintenance stage, and the goal would be to maintain and promote continued sexual abstinence.
- For the sexually active, the prevention programme would attempt to move them through the Stages of Change. For some, the intervention might lead towards a return to abstinence, for others towards the action and maintenance of partner reduction and condom usage (43).
- For those already using condoms, the focus might be on moving from occasional condom use to consistent usage.

Key stages in the model are the maintenance and relapse stages. Much of the focus in an intervention should be on coping behaviours and strategies once a successful change has been made and not just on the initial change. It is important that change is seen as an ongoing process, not a once off event and that relapse is a normal part of the cycle.

### 2.3.4.1. A review of studies of programmes using the stages of change model

The Center for Disease Control lists several studies of programmes that used the Stages of Change Model successfully. All these studies had both intervention and control groups and showed positive results for behavioural and health outcomes. They all included stories of real life experiences of local community members who had moved through different stages of change and therefore could be seen as role models (96).

One HIV prevention programme focussing on condom usage in the USA defined the stages as follows (42):

- Pre-contemplative: lacks the intention to use condoms
- Contemplative: has a positive intention to use condoms
- Ready for action: uses a condom sometimes
- Action stage: has been using condoms consistently for less than six months
- Maintenance stage: has been using condoms consistently for more than six months.

In order to measure the stage of change at which a person was, they measured four variables: frequency and duration of condom usage and future and immediate intentions with respect to condom use:

- Frequency - when you have sex how often do you use a condom?
- Duration – how long have you been using condoms every time you have sex?
- Future intentions - in the next 6 months how likely is it that you will continue using condoms every time you have sex?
- Immediate intentions - how likely is it that from now you will use a condom every time you have sex?

The study found that the person's stage of change provided proscriptive and prescriptive information on the correct message to give, and how to give the message. A message which is effective with someone in the action stage may be ineffective or detrimental with individuals in pre-contemplation or contemplation stages.

In a study of STI clinic attendees in South Africa, there was also a need for different messages for people at different stages (101):

- Pre-contemplation ("*I don't see the need"*) – People at this stage were against condoms: interventions were needed to improve knowledge about sexual behaviour and encourage them to examine their personal risk.
- Contemplators ("*I want to but can't"*) - Interventions need to help contemplators to assess the outcomes of not using a condom, diminished physical pleasure versus the risk of HIV. They need to try to use a condom and gain self-efficacy.
- Action ("*I want to and can, but not consistently"*) – A focus on improving communication between sexual partners is very important.
- To maintain condom use ("*I want to – and do!"*) - The interventions need to focus on acquiring skills to circumvent obstacles to condom use, to cope with setbacks and to improve social support.

#### 2.3.4.2. AIDS risk reduction model

An adaptation of the Stages of Change Model has been developed particularly for work in the HIV prevention area. The AIDS Risk Reduction Model has three stages (43):

- Labelling: to label one's specific sexual behaviour as risky (pre-contemplation and contemplation).
- Commitment: to commit to a reduction in high risk activities (ready).
- Action: enacting the strategies to reduce high risk behaviour (action and maintenance).

In order to reduce risky behaviour it is important that an individual's self description is 'at risk'. The labelling by an external person may merely lead to resistance, whereas if a person labels their own behaviour, it may lead to a commitment to change (99). A commitment to change should be demonstrated through increasingly protective actions and the acquisition of skills which can lead to risk reduction, such as communication with partner, or condom negotiation.

#### 2.3.4.3. Discussion of the Stages of Change Model in relation to the Agents of Change programme

The Stages of Change model has significant importance in terms of the Agents of Change Programme. One of the weaknesses of the Church's response to behaviour change is that it tends to take a moral view. Young people are divided into virgins, or the 'pure' and those who have lost their virginity, the 'sinners'. The danger is that once young people have lost their virginity, in terms of morals, they have 'fallen', so it doesn't make a difference if they have many partners or use condoms. Thus an introduction of concepts from the Stages of Change model is very helpful, to show that a person can move from one stage to another.

The Stages of Change is also helpful in defining the goal. The goal is not action (use a condom) but rather maintenance (use a condom consistently). In this programme the goal of 'stable behaviour' could be defined as either abstaining or having protected sex with one partner. A reduction in numbers of partners or an increase in condom use is a step (action) on the way to that behaviour. Change may be incremental; it does not have to be all or nothing.

The other insight which is helpful when dealing with issues of sexuality in a Church context is the idea of 'relapse'. Because sexuality is often linked with feelings of guilt, to know that relapses are part of a normal cycle and that one can start again, is an empowering concept.

## 2.3.5. DIFFUSION OF INNOVATIONS

### 2.3.5.1. The Theory of Diffusion of Innovations

Diffusion of Innovations is a theory that explains how new ideas spread through social systems. Based on the book 'Diffusion of Innovations' first published by Everett Rogers in 1962 (102) this theory proposes that there are four elements which affect the spread of a new innovation:

- the innovation itself;
- communication channels;
- time; and
- a social system.

The innovation is the new idea or concept which is being introduced. The communication channels may be a social network or the media. The time taken for the new idea to be accepted is influenced by many factors, amongst them the credibility of the communication channel and the amount of exposure to the new idea. The social system may be friendship groups or broader social groupings (103,76). The speed at which the innovation will spread is affected by the strength of social norms within the group as well as the connectedness between the members of the social system.

### 2.3.5.2. The role of the opinion leader

Central to the theory of diffusion of innovations is the concept of the opinion leader or innovator. Within this theory the role of innovators or 'early adopters' is important as they are the first people to initiate the new behaviour or endorse the new idea. They become change agents in their social system. They adopt the new idea first and then influence others to accept it. They both disseminate the information and influence the norms in their community. In the case of peer educators, they become both educators (communication channels) and innovators (influencing behaviour) (103,76). Young people are more likely to adopt new behaviours if they are communicated to them by people whom they see as opinion leaders. This is the argument for using peer educators rather than adults as educators. An adult may give the message but is less likely to be an opinion leader within the peer group (76). Thus peer educators should be selected who are part of the social structure of the target group. In this way the formal training in sessions is strengthened by the role modelling in social situations as well as spontaneous discussions taking place between peers (104). As stated by Susanna George, founder of GOLD peer education programme:

*"The message giver is the strongest message" (104).*

#### 2.3.5.3. The importance of Diffusion of Innovation for the Agents of Change Programme

#### 2.3.5.3(i) Peer educators

According to the diffusion of innovation theory, the role of the peer educator is of crucial importance. When applied to HIV prevention the theory would propose that behaviour can be influenced when key opinion leaders both endorse and adopt certain behaviours. By doing so they influence others and eventually the new behaviour is diffused throughout the social network as an acceptable norm. It is then much easier for an individual to adopt this behaviour. This is a key belief of peer education programmes, as George says 'People don't change with information, they change when those around them change' (104).

The challenge for HIV prevention programmes is to choose as peer educators young people who have the most influence on their peers. If selected by clergy or youth leaders, peer educators may be chosen who are perceived to be living the desired behaviours, but they may not be influential in the peer group (105). This is why in the Agents of Change programme it is recommended that peer educators are **elected** by their peers and not **selected** by clergy or youth leaders.

The peer educator is both educator and role model; they must live the message as well as give the message (76). If they teach one thing and live in a different way, then the message loses any credibility, therefore peer educators are encouraged to be role models within their peer groups.

#### 2.3.5.3(ii) Communication

Communication of the desired norms or behaviours can take place through the sessions. These are interactive and give a chance for young people to see how the behaviours can be used in different situations through the use of role plays. But the teaching will only be accepted into the social system if it is also communicated by the peer educators in real life situations, if the peer educators live the message as well as give the message.

## 2.3.6. MOTIVATIONAL INTERVIEWING

Many of the above theories see the issue in a mechanistic way, where you need to pull the right lever by having the right message or targeted content, in order to influence behaviour. They do not deal with the issue of how the interaction around this message or content can best take place. Motivational interviewing (MI) is a theory of communication that helps to answer a different challenge – instead of focussing on what to communicate it focuses on **how** to communicate.

### 2.3.6.1. The background of Motivational Interviewing

MI was originally started in the field of drug and alcohol addiction. In the last 25 years, this approach has been used in the field of behaviour change around alcoholism, drug abuse, marriage counselling, and recidivism for convicts, sexual behaviour change, smoking, and in the context of many diseases such as diabetes, obesity, HIV/AIDS and sexually transmitted diseases (44).

MI is based on understanding the factors that facilitate or impede change. It recognises that behaviour change is a complex and difficult process that involves ambivalence; it is not a simple decision whether to change or not. It is a style of communication that is not confrontational or instructional, but rather collaborative and guiding. One of the founders of MI, Rollnick elaborates on this further:

*"Motivational interviewing is a directive, client-centered counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence" (106).*

MI also recognises the importance of 'change talk'. Change talk refers to the person's own articulation of their desire, ability, reasons or need to change behaviour. When people talk about change themselves they are more likely to change than if someone else, such as parent, priest or youth leader talks about it. Change talk becomes self advocacy (107).

### 2.3.6.2. The principles of Motivational Interviewing

MI is based on the following principles defined by the founders: rolling with resistance, expressing empathy, developing discrepancy and support for self-efficacy (106).

### 2.3.6.2.(i) Express empathy

MI is based on a principle of expressing empathy with the client without judging or necessarily agreeing (108).

'Acceptance is not the same thing as agreement or approval. It is possible to accept and understand a person's perspective without agreeing with or endorsing it' (44).

Empathy is defined as all attempts to understand how the client thinks or feels about the topic. Empathy requires skills in listening and reflecting back to the client a deep understanding of their situation. The paradox is that acceptance of people as they are frees them to change. Non acceptance, the message that 'you are not alright' immobilises the change process because it throws them into a defensive mode.

### 2.3.6.2(ii) Roll with resistance

This principle recognises that when resistance is present, it is often helpful for the communicator to change their interaction, rather than labelling the client as 'non-compliant'

or 'difficult'. In many interactions by adults with adolescents, they are deemed to be difficult or unresponsive, whereas this may be as much due to the nature of the interaction as to the intrinsic resistance within the teenager.

*"You slut, how could you act like that?"* may well elicit the response *"I'm the normal one, everyone else is doing it, you are just so old fashioned".* By pushing harder, we are actually getting the person to argue their position not to change more strongly.

If you feel that your personal freedom is being infringed or challenged, you will hold more strongly to your views. There are certain communication styles that have been shown to increase resistance. The following communication styles will trigger resistance to change:

- Arguing for change: when someone is arguing for change, the natural response is to argue for the opposing view. When one argues for change, for example by saying *'Why don't you.'* the response is *'Yes, but…'*
- Assuming the expert role. A particularly unhelpful stance in abstinence only teaching is to state opinions about contraceptives that are contradicted in other circles. For instance some churches will teach that condoms don't work, because they have small holes in them. When questioned, the expert role is taken, that this is the view of the Vatican, or some important authority figure. Adopting an authoritarian stance as the unquestioned expert who should be obeyed tends to lead to resistance that is often expressed as passive agreement rather than overt disagreement.
- Shaming/blaming. Sexuality has very strong moral connotations. In fact in the Victorian age, 'immorality' became almost exclusively associated with sexual sin. The other 'seven deadly sins' such as greed are often ignored. People guilty of these are not stigmatised. People guilty of sexual sin are shamed, or made to feel guilty. The Church talks about 'fallen women'. Within the Anglican Church the organisation called St Mary Magdalene was created for fallen women who had babies, because they were not able to join the Mothers Union.

MI is supportive of the person's autonomy and is respectful of the person's control over their own lifestyle and choices. The responsibility for change lies with the client

### 2.3.6.2(iii) Develop discrepancy

This in some senses is the heart of communication for behaviour change. A person will change when they feel that their actions are not in line with their own goals or values. If a young person can see that casual sex is going to compromise their chances of an educational future, or will give them a bad name as being promiscuous, they are more likely to change. In MI the interviewer seeks to develop motivation for change by reflecting discrepancy between the client's behaviour and his or her personal values and goals (not the interviewer's values and goals).

In order to create this discrepancy, it is important to understand that most people are in a state of ambivalence regarding their behaviour. There are gains, and there are losses. First of all it is necessary to recognise that this ambivalence does exist. Very often people try to encourage behaviour change by pointing out all the negatives of sex *'sex is something dirty and unpleasant, save it for the one you love!'* (109). At this point the attention of the young people may be lost. In this research the young people said that the main reason for having sex was because they enjoyed it. They become involved in sex because it is fun and makes them feel loved. If communication with young people ignores the reasons why they have decided NOT to abstain, the battle has been lost.

The role of mentors is to help the young people make responsible choices. They do this by looking at the positive and negative consequences of their behaviour and resolving their ambivalence in the light of their own values and goals. Figure 2.7 shows the ambivalence which is in the minds of many young people in terms of choices they make regarding sexual behaviour.

| **Reasons for not abstaining or changing sexual practices** | **Reasons for abstaining or changing sexual practices** |
|---|---|
| *BENEFITS OF MAINTAINING STATUS QUO*<br>Pleasure continues<br>Keep same friends<br>Feel loved<br>Feel sexy<br>Forget troubles | *COSTS OF CHANGE*<br>Less physical pleasure<br>Delayed gratification<br>Not feeling loved<br>Troubles not buried<br>Lose your friends |
| *COSTS OF MAINTAINING STATUS QUO*<br>Loss of self esteem (called a slut)<br>Possible STIs/HIV<br>Possible pregnancy<br>Feel far from God<br>Emptiness<br>Loss of self respect | *BENEFITS OF CHANGE*<br><br>Self esteem<br>Safe from STIs/AIDS<br>Safe from pregnancy<br>Strong relationship with God<br>My family feel proud of me<br>Better education chances in the future |

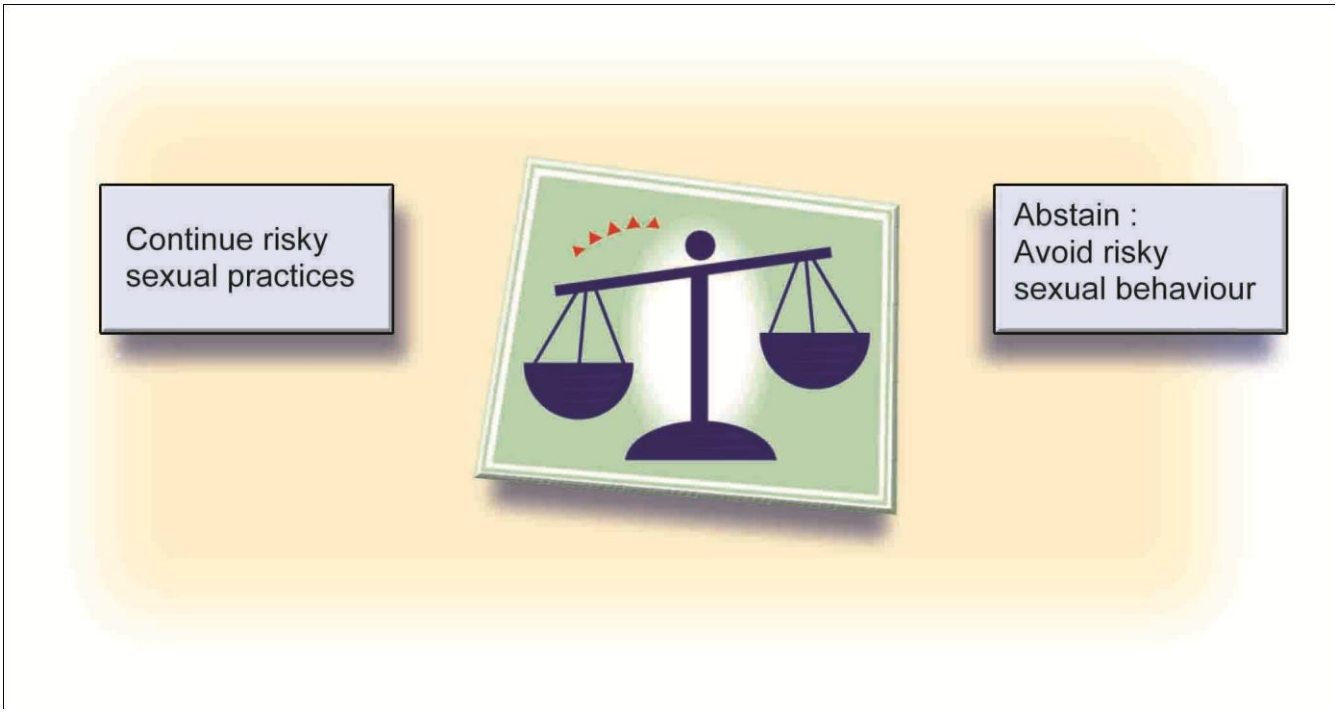


***Figure 2.7. The ambivalence of changing sexual behaviour.***

Thus developing discrepancy involves recognising this ambivalence, and then helping the young person resolve it. The task is to increasingly place weights on one side of the balance (106). Young people of faith engaging in casual sex are often in a situation of discrepancy between their belief in fidelity (even if not in marriage) and their actual behaviour. The mentor can help them become aware of this discrepancy. This often leads to an increase in the perceived importance of change.

### 2.3.6.2(iv) Build self-efficacy

Self-efficacy or the belief that you can change is crucial for change. Here the role of faith and hope become very important. This can be because of an internal sense of faith *"if God gives me strength, I can abstain",* or from the external faith that the mentor has in you. This belief in the importance of building self-efficacy to support change is exemplified in the words of Johan Wolfgang von Goethe:

'If you treat a person as he is, he will stay as he is. But if you treat him as if he were what he ought to be, and could be, he will become what he ought to be and could be.' Johan Wolfgang von Goethe (1749-1832)[2]

Thus the mentor's belief in the person's ability becomes a self-fulfilling prophecy. It becomes part of their self identity. This can be particularly important for teenagers who may be receiving a lot of criticism or lack of affirmation in their home situations. Each person possesses a powerful potential for change. Your task as mentor is to release the potential and facilitate the change processes already inherent in the individual (44).

[2] Adapted from www.quotationspage.com

MI focuses on evoking or eliciting ideas about change and how to change from the client. Change talk may express the desire, ability, reasons or need to change or speak of actual commitment and change itself. Helping people to articulate what is possible for them or to develop their own solutions is more likely to build self-efficacy and lead to change. Self-efficacy essentially speaks to the person's confidence in their ability to change.

MI does not focus on the giving of information but recognises that this may also be an important aspect of developing discrepancy or building self-efficacy. Information is shared with permission and in terms of the person's expressed needs or interests. Clients are asked to work with and process the implications of new information for themselves.

#### 2.3.6.3. Discussion of the relevance of Motivational Interviewing for the Agents of Change Programme

The Agents of Change programme involves several players with interest in supporting the young people in their behaviour change: peer educators, facilitators, parents and clergy. The key insight of MI for this programme is the fact that the *way* you communicate can either increase or decrease the motivation for change. This is particularly important in a Church setting where communication often involves an expert preaching or external judging of one's behaviour.

Another important insight is that there is ambivalence within each person. The Church tends to make clear moral statements, that a certain behaviour is wrong, and this does not allow space for people to explore their own ambivalence or to develop discrepancy. People are confronted with religious rules to be obeyed, rather than helped to explore their own values in relation to their own behaviour.

## 2.4. COMMUNITY LEVEL THEORIES OF BEHAVIOUR CHANGE

In this section Freirian theories of behaviour change are examined as well as the concept of social capital and the social ecological model for health promotion.

### 2.4.1. FREIRIAN THEORIES OF BEHAVIOUR CHANGE

#### 2.4.1.1. Introduction to Paolo Freire

Paolo Freire was born in Brazil in 1921. He was born into a poor family and this experience shaped his understanding of education. He studied philosophy and the psychology of language at law school. In Brazil at that time, literacy was a requirement for voting, and so he worked with poor and illiterate sugarcane workers and taught 300 of them to read in just 45 days using his new insights.

He believed that education can never be neutral, it can be the means to keep people conforming to society or it can become the 'practice of freedom' by which people develop a critical consciousness of society and participate in transforming it. He was critical of the 'banking' concept of education where a learner is seen as an empty vessel and the teacher as the source of all knowledge. In 1968 Freire published Pedagogy of the Oppressed which became a seminal work in terms of his philosophy of education (110).

Freirian theory proposes a problem-based approach in which teacher and learner undertake to investigate problems together through a process of dialogue. This flexibility must be built into the programme and is very different to the normal didactic model that is generally used in schools (111, 92). There is a danger that teachers easily slip back into the traditional didactic methods that they are used to. It is important that a dialogue between learner and educator is achieved. In his theory of participatory education Freire proposes that the full participation and empowerment of the people who are affected by a problem is essential in order to enact change (103). Thus in his view the success of a peer education programme would be related to the effectiveness of this participatory dialogue (112).

Two concepts from Freirian theory have particular relevance to peer education, namely empowerment and critical consciousness. Paulo Freire conceptualises empowerment as requiring a more cognitive dimension, which focuses on people's analysis of their circumstances (46,45). His argument is that group behaviour change must be preceded by the development of a critical consciousness. This requires an intellectual understanding of the way in which social conditions have led to a situation of disadvantage (for example an understanding of the way in which factors such as gender and poverty shape poor sexual health for youth).

Powerlessness undermines the ability of young people to choose health enhancing behaviour. Theories of behaviour change conceptualise empowerment in terms of an individualised and subjective sense of confidence (self-efficacy) and believe that through training young people can be empowered at the individual level. This understanding of empowerment tends to focus on the emotional or motivational dimensions of empowerment. However given the structural constraints, the individual may not have the ability to act or be constrained. For example, a girl may have learnt the skills to negotiate condom use and feel confident to do so in a role play, but given the gender imbalance, when the moment arrives, she gives in to sex without a condom or finds that condoms are not accessible or affordable. Thus a Freirian understanding of empowerment is not limited to the individual, rather groups must work together to develop a sense of personal and collective confidence in their ability to change behaviour. The group may also actively challenge the structural constraints and processes which place their health at risk. Therefore one of the roles of peer educators may be to develop the group's confidence to act together on collective decisions.

Freire suggests that people are initially in a stage of 'naïve consciousness' where they lack insight into the way in which social norms and the social environment undermine their health. They do not see that their own actions can change these norms or conditions. The goal is to move people towards a stage of 'critical consciousness' where there is a dynamic interaction between critical thought and critical action. By reflecting critically in a group on the conditions that shape their lives young people are empowered to change these conditions The transition from naive to critical consciousness involves an '*active, dialogical educational program'*(45); where learners are actively involved in critically analysing social norms and conditions and generating scenarios of alternative ways of being.

#### 2.4.1.2. Relevance of Freirian Theories for Agents of Change

An important goal of peer education is to provide safe spaces for young people to develop a critical consciousness about their sexual health. It should promote a context within which youth can collectively develop the belief and confidence in their power to resist dominant gender norms. The potential exists for Agents of Change to use the existing active, dialogical programme, with further training for facilitators and peer educators, to move to this level of interaction. For example a group of young women may discuss the gender norm that a request by a girl to use a condom puts her in the category of a 'slut'. If they discuss it critically, they may realise that the gender norm that 'girls are either pure or sluts' puts their health at risk. From this starting point, young women could develop a critical consciousness of this construction of femininity and collectively work towards redefining it (for example, we believe that a strong capable woman who cares about her future would not be involved in risky sex).

## 2.4.2. SOCIAL CAPITAL

In this section three inter-connected themes are discussed; social capital, social networks and social support.

#### 2.4.2.1. Social capital

The church is a potential place where social capital can be built within a community. Internationally it has been found that church attendance improves psychological health across multiple religions and populations (113). There are several explanations for this, including the positive effect of social networks and social support provided by church members (113).

The concept of social capital was introduced by Bourdieu. Starting from the role of economic capital, he pioneered the concept of social capital (295). In 1988 James Coleman further defined social capital as the aspects of social structure such as personal relationships and networks of relations that benefit the development and wellbeing of individuals (114). Among other variable such as: having both parents in the home, fewer siblings, fewer changes of school, and a mother's expectations for their child's educational

achievement, he identified regular attendance at religious services as a factor which confers social capital (114).

Several studies have looked at these factors including that of religious attendance. Runyan conducted a study in the USA of pre-schoolers who had been identified as being 'at-risk' of abuse or neglect. Only thirteen percent of the children were identified as 'doing well'. The interesting finding was that 'doing well' was not affected significantly by the race or gender of the child, or by the education level of the mother. Two factors were statistically significant – regular church attendance (OR 1.71) and 'personal social support' (OR 1.69) (115). This indicates that church attendance and forming part of a church community can help to build social capital which can be beneficial in the raising of children.

Gregson argues that an important determinant of the success of prevention interventions is the extent to which they are able to mobilise sources of social capital (116). Social capital can be described as a 'health-enabling community'. According to the social capital approach people are most likely to undergo health-enhancing behaviour change if they live in communities characterised by trust, reciprocal help and support, a positive community identity as well as high levels of involvement in local organisations and networks, Campbell argues that the most important dimension of health-enhancing social capital is perceived citizen power, a characteristic of communities where people feel that their needs and views are respected and valued, and where they have channels to participate in making decisions (117).

#### 2.4.2.2. Social networks

Gregson uses the network dimensions of social capital, defining social capital in terms of participation or 'civic engagement' in local community networks (116). Within a social network, social capital may play a key role by promoting two psychosocial processes which play a key role in facilitating safe sexual behaviour:

- Collective negotiation of identities at the peer level (group norms),
- Empowerment or self efficacy associated with skills building and confidence

A group of studies provide preliminary evidence that membership of certain groups can play a role in how members respond to HIV:

- Camlin and Snow found that participation in clubs and community groups can be associated with safer behaviours (118)
- Campbell found that membership in certain social groups led to a reduction in risk: youth groups and sports clubs (117).

The reason for lower rates of risky behaviour is linked to issues such as a shared value system, as well as the fact of being involved in positive activities, which leaves less time for

risky behaviour. Community networks can also provide the contexts for the diffusion of health related information.

#### 2.4.2.3. Social support

Adoption of safe sexual behaviour is assumed to be predicated on a number of psychosocial attributes including HIV knowledge, perceived personal vulnerability, peer influence, self-efficacy (given that people who feel they are in control of their lives are more likely to feel that they can take control of their sexual health). Group memberships may help to facilitate these attributes:

- Development of a sense of solidarity which may boost member confidence, social skills and perceived self efficacy.
- Supportive contexts within which peers can make collectively negotiated decisions to change their behaviour. Campbell and Macphail (119) suggest that in ideal situations social groups can provide contexts for young people to develop insight into how gender relations can undermine sexual health. The presence of adult mentors in the church can also help to provide this supportive context for young people from dysfunctional backgrounds.
- Intra- and inter-group dynamics may play an important part in this process, providing 'bridging social capital' in that they put young people in touch with diverse and more powerful social grouping, whose support might increase the likelihood of programme success (120).

#### 2.4.2.4. Relevance of social capital for the Agents of Change Programme

These studies indicate that perhaps the Agents of Change program could be strengthened by the conscious building and enhancing of social capital. Through socialisation, social networking can be increased by full youth programmes involving stay-awakes, hikes, fund-raising activities and community outreach. Social support can be enhanced by more involvement of adult mentors in the lives of the young people, and the affirmation of clergy as they consciously involve young people more thoroughly in the life of the church, rather than just as a separate youth group. Bridging social capital can be enhanced by linking of churches with better resourced churches as well as partner organisations who can offer opportunities for training or recreational activities.

### 2.4.3. THE SOCIAL ECOLOGICAL MODEL FOR HEALTH PROMOTION

Social ecology is the study of people in a particular environment and how they interact with and influence each another. Thus the social ecological model for health promotion sees that influencing the individual is only one part of the process. There are influences and interactions within a hierarchy of systems that determine the behaviour of the individual (103,112,121):

- **Individual level.**

At the individual level behaviour is influenced by intrapersonal factors. These include the personal characteristics of the individual such as knowledge, attitudes, self-concept and skills.

- **Interpersonal (micro-system) level**

At this level behaviour is influenced by interaction with primary groups such as family, friendship groups or other social networks such as sports clubs or church youth groups. An individual is shaped by encounters with others and will also have influence over other members. These primary networks provide a social identity, and an individual may play different roles in different networks for instance one individual may be a daughter, a learner and a youth group leader.

- **Organisational factors (meso-system)**

At this level the individual is influenced by the norms and structures of the institutions and organizations they are a part of. The meso-system is the network of rules, policies and informal structures of the organisations the individual belongs to such as school, church or sports club. The individual is an active part of such organizations.

- **Community factors (exo-system)**

At this level the individual is influenced by the community, which is made up of many organisations and networks of relationships. The norms and standards of these social networks affect the individual, but he or she is not an active participant. The role of the media is very important at this level.

- **Social structure (macro-system)**

At the macro-system level the behaviour of the individual is influenced by public policy and systems. At this level laws and regulations, such as the age of consent, or guidelines regarding school sexual education affect the individual. These policies are influenced by the cultural context of the state, for instance the State may be Western capitalist, Islamic and so on.

This theory recognises the importance of the interplay between the individual and the environment and considers multi-level systemic influences on risky behaviour. The importance of the individual is emphasized less than the other levels in the process of behaviour change. The social ecological model is essentially a systems theory which understands that there are influences which come from within and between different systems. In approaches which focus on the individual the intervention is primarily about building skills, providing education and developing self-efficacy, so that the individual is empowered to change their behaviour. From an ecological perspective it is important to understand the potential sources of social influence. It is also crucial to understand how to impact social norms, so that it becomes more socially acceptable to change behaviour (122).

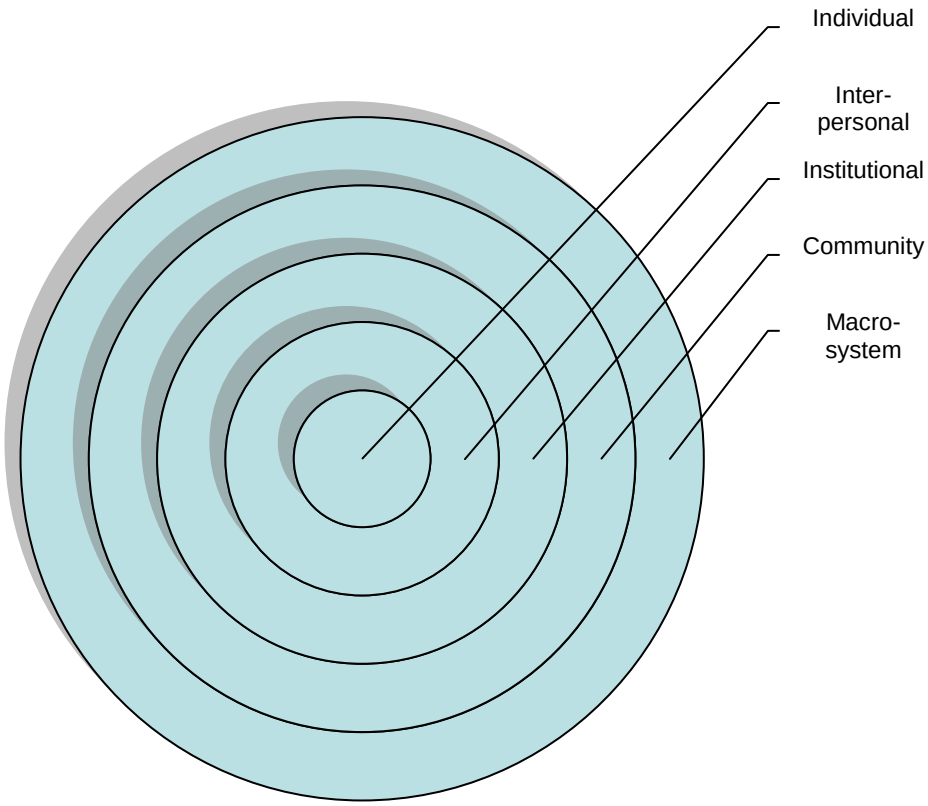


***Figure 2.8: A social-ecological model (121)***

## 2.5. ENVIRONMENTAL LEVEL THEORIES OF BEHAVIOUR CHANGE

Prevention strategies have often been reduced to an understanding of prevention which focuses entirely on the sexual transmission of the virus, and with promoting free choices by empowered, autonomous individuals (48). The 'problem tree' gives a good framework for a more comprehensive understanding of HIV prevention. The 'problem tree' approach identifies the roots of vulnerability such as poverty, sexual violence or ignorance, which lead to the final impact HIV, such as sickness, orphans and stigma. This approach is illustrated in Figure 2.9:

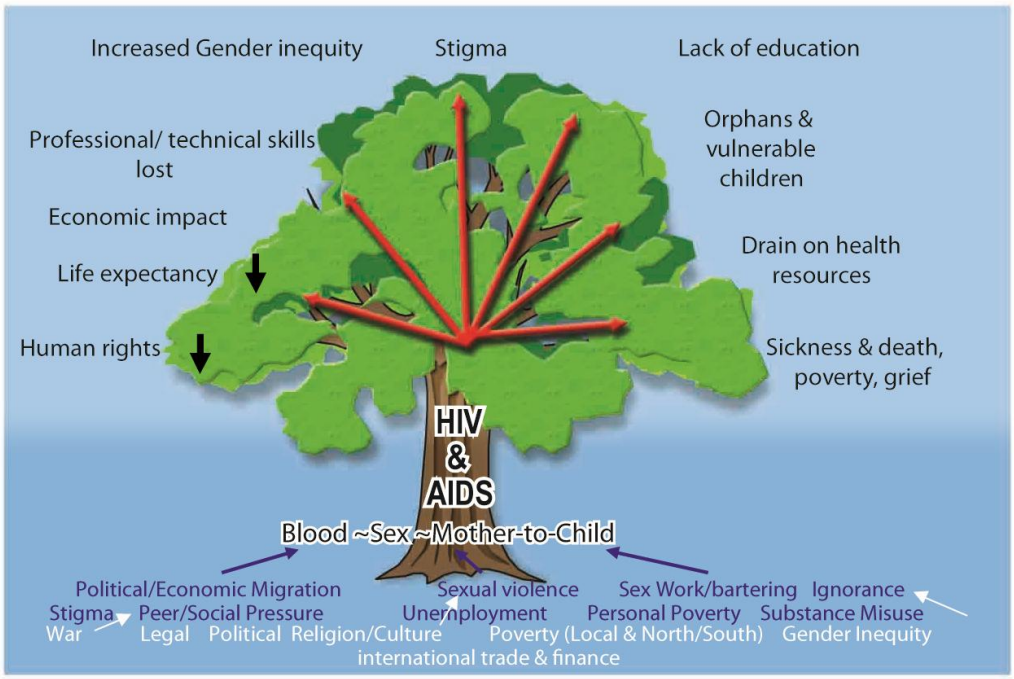


***Figure 2.9: The problem tree framework (48)***

According to this framework, there are three levels to be considered: the impact, the problem and the causes, as illustrated in Table 2.1:

**Table 2.1: The three levels of the problem tree framework**

| | |
|---|---|
| **Leaves and branches- impact** | Sickness, stigma, death, orphans and vulnerable children, economic impact, increased gender inequality etc. |
| **Trunk – the problem** | The HIV pandemic |
| **Roots – the causes** | • Superficial roots – body fluids that act as vectors (blood, milk, genital fluids)<br>• Deeper roots – personal factors that increase your risk: sexual violence, sex work, unemployment, ignorance, peer pressure, sexuality and sexual drive.<br>• Deepest roots – poverty , gender inequality, cultural issues, war, religion |

HIV prevention should not just focus on the impact, but also needs to respond the three levels. Efforts need to be put into mitigating the impact of the virus and the risk of HIV should be reduced through comprehensive HIV prevention strategies. But the causes of HIV should also be tackled through efforts to decrease the vulnerability of young people, as illustrated in Table 2.2:

**Table 2.2: The three levels of prevention**

| | |
|---|---|
| **Mitigate the impact** | Orphans and vulnerable children, health care, pastoral care. |
| **Reduce the risk** | Comprehensive HIV prevention strategies. |
| **Decrease vulnerability** | Gender, poverty, culture. |

Source: (48) Smith A, Maher J, Simmons J, Dolan M. CAFOD: Just one world: an understanding of HIV prevention from the perspective of a faith-based development agency. London, CAFOD; 2004.

## 2.5.1. MITIGATING THE IMPACT

There is a crucial link between prevention and care. Treatment and support are all part of prevention. They reduce the risk of people living with HIV declining into poverty and ill health. Orphans, who are already at risk, are supported.

## 2.5.2. REDUCING THE RISK

Often HIV prevention is used to refer to one or two limited risk reduction strategies such as abstinence or ABC. There are however many potential strategies. There is a need for a broad and multi-faceted response if HIV prevention is to be effective.

Reducing risk involves many different strategies which deal with immediate protection:

- abstinence;
- delaying the first sexual encounter;
- mutually faithful monogamous long-term relationships;
- reduction in the number of sexual partners;
- reduction in instances of casual sex;
- condom use;
- non-penetrative sex;
- Voluntary Counselling and Testing; and
- prompt treatment for STIs.

There is a spectrum of risk reduction strategies which forms a continuum running from high-risk to low-risk activities. An individual needs to identify their actual levels of risk and what changes they can make given their circumstances. Individuals can be supported in choosing a strategy which assists them to move from a higher risk activity to a lower risk one as illustrated in Figure 2.10:

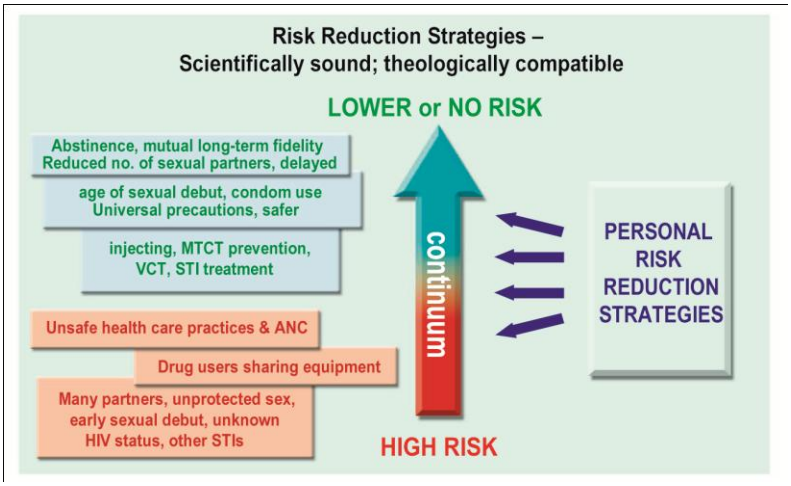


***Figure 2.10: The spectrum of risk behaviour (48)***

Behaviour change is often believed to be a matter of personal choice made by autonomous individuals. Within this framework, behaviour change is about an individual's capacity to identify and take up risk-reduction strategies which are sustainable given their varying circumstances. Each individual needs to identify where they are on the spectrum and make changes according to their personal risk. The advantage of this approach is that it can set more realistic goals for behaviour change as well as being less judgmental, for instance one is not expecting a high-risk individual with multiple partners having unprotected sex to abstain immediately, but rather one is setting a goal which is achievable for that person.

## 2.5.3. DECREASING VULNERABILITY

An individual's ability to adopt a strategy is conditioned by their social context. Although individual level interventions are helpful, they are not sufficiently efficacious to reduce HIV transmission.(294) The roots of the problem tree need to be tackled, which are those social factors that affect and limit the behaviours of individuals as well as communities. These roots are caused by power imbalances and affect the risk reduction choices of those who are disempowered. Therefore an overall HIV prevention strategy must aim to address these imbalances of power. These 'roots' are deeper causative factors, and may be economic, gender-based, religious, social or cultural. By addressing these issues, a prevention cycle is created as illustrated in Figure 2.11:

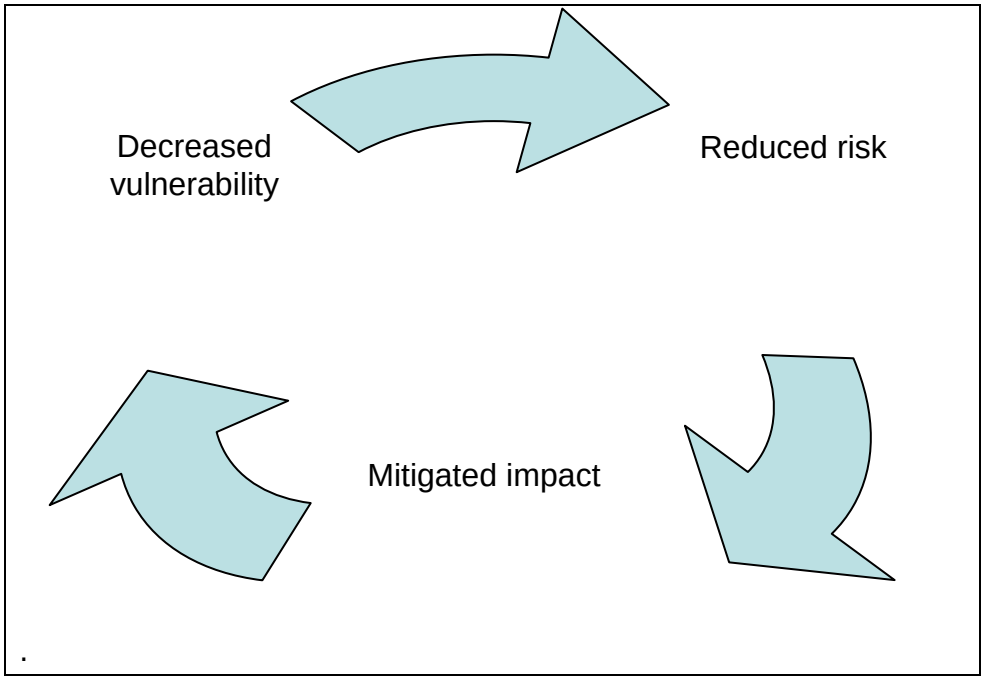


***Figure 2.11: The prevention cycle***

It is important for an HIV prevention programme to identify which part of the cycle they are focussing on, whether aiming to decrease vulnerability, reduce risk or mitigating the impact of the virus. Smith clarifies the importance of focuses on various levels:

*'Behaviour change programmes must seek to remove the contextual blocks as well as supporting a person's chosen risk reduction/behaviour change strategy. Thus behaviour change programmes must be directed at two layers, risk reduction and vulnerability (48)'.*

## 2.6. SUMMARY

Key insights from all these theories of behaviour change were identified and incorporated into the conceptual framework of the Agents of Change programme. The following are the key insights:

- **Communication**

The style of communication has influence by either increasing or decreasing motivation for change. This is important for various levels of the programme, how peer educators present their sessions, how facilitators relate to the youth and how the parents relate to their children. The concept of empathy is also very important, since more judgemental forms of communication may increase resistance to change rather than enabling it.

- **The need to be specific**

It is important to tailor the programme to the needs in the particular community where it is being run. Social beliefs vary from group to group. The barriers and benefits of actions vary amongst specific social and cultural groups. These should be defined by participants in that particular community.

- **Perceived susceptibility**

Many young people suffer from 'AIDS fatigue' which means that they have heard so much about AIDS at school and through the media that they 'switch off' when the subject is raised. The concept of perceived susceptibility is thus important in order to reduce 'AIDS fatigue'. Firstly there is a need to correct adolescents' misconceptions about the prevalence of risky and safe behaviours amongst their peers. Secondly it is possible to increase perceived susceptibility for instance by inviting a speaker living with HIV from that specific community.

- **Importance of modelling**

Peer educators should 'live the message not just give the message'. Modelling can lead to vicarious learning. It is also important that the selection of peer educators should be as close as possible to participants in terms of background, age and gender.

- **Positive messaging**

Positive messages have more power for change than negative messages. For example prevention programmes that focus on the risk of acquiring genital herpes from unprotected sex, rather than the possibility of experiencing love and closeness through other behaviours, may be less successful. Thus one should focus on perceived benefits more than feared consequences.

- **Self-efficacy**

Change comes through affirmation, rather than information. Through teaching skills and increasing self-efficacy you can release the potential locked within.

- **Social norms**

Social norms often have more influence than personal attitudes. Peer pressure appears to be more influential than personal attitudes. Therefore interventions that focus on changing peer norms are likely to have more impact than ones that attempt to change individual value systems.

- **Ambivalence**

The various theories recognise that sometimes there is a conflict between personal attitudes and social norms. A person may simultaneously hold contradictory personal attitudes and be stuck in ambivalence. Motivational Interviewing is helpful in this area, as it recognises this ambivalence inside the client. Motivational Interviewing attempts to develop discrepancy, so that the client can be motivated to consider change. It also recognises that this type of ambivalence may not be resolved and if contradictory the two sides may cancel each other out and lead to paralysis rather than change.

- **Stages of change**

This is a very helpful concept for dealing with mixed groups of adolescents, some of whom are sexually active and some of whom are not yet active. The message and the strategies can be altered depending on where a person is in the stages of change model. Typically prevention programmes have one message for all. The goal is not action but maintenance. Behaviour change is on a spectrum and people should be encouraged to move from higher risk behaviour to lower risk behaviour.

- **Decreasing vulnerability**

The challenge is to identify those factors which increase vulnerability and to work towards decreasing them. This can happen at the micro level, for instance through churches setting up after-school clubs or at the macro level through advocacy.

## 2.7. DEVELOPING A CONCEPTUAL FRAMEWORK

The conceptual framework had two roles; firstly it was used in the development of the intervention, to assist in deciding which factors were important to be included in the programme. Secondly it had the role of serving as a framework for the interpretation of the findings of the evaluation of the intervention. Within the conceptual framework, two themes emerged; the importance of peer education and the strategy for reducing risky behaviour.

### 2.7.1. PEER EDUCATION

Peer education is based on behaviour change theories. Peer educators have several roles; as role models, as educators and as members of the same peer group.

#### 2.7.1.1. Role models

According to the theory of diffusion of innovation, peer educators should be selected to represent the social structure of the target group. It has been shown that adolescents will be more likely to follow the behaviour of role models if they perceive the role models are similar to themselves (123). Opinion leaders act as agents of behavioural change by disseminating information and influencing group norms in their peer group (90). The time taken for an idea to diffuse through a social network depends on how members of the network perceive the advantages and compatibility of the innovation.

#### 2.7.1.2. Educators

According to Freirian theories of education, the full participation and empowerment of the people who are affected by a problem is essential in order to enact change (103). Thus peer education is based on participatory education through discussion and role plays, not through traditional didactic methods. The success of a peer education programme is related to the effectiveness of this participatory dialogue (112, 111, 92).

#### 2.7.1.3. Peer group members

At the heart of peer education is the belief that people do not change through providing information, they change when those around them change (104). Adolescents are particularly concerned with social acceptability within their peer group (124).

### 2.7.2. REDUCTION IN RISKY BEHAVIOUR

Various theories of behaviour change underpin the process of reduction in risky behaviour. Risky behaviour is defined as early sexual debut, unprotected sex and multiple partners, as well as sex under the influence of drugs or alcohol. Behaviour change is a complex and difficult process that involves ambivalence; it is not a simple decision whether to change or not (108). Change can be supported through the following processes:

#### 2.7.2.1. Developing a futures-orientated thinking

Risky behaviour reflects a lack of futures-oriented thinking. Adolescents are generally concerned with immediate risks and benefits rather than the future. If they can understand the consequences of their actions they may be more likely to change (124).

#### 2.7.2.2. Building self-efficacy

According to Bandura's social learning theory, an increase in self confidence, and a belief that they can effectively use the skills needed for a particular action, will increase the likelihood that a young person will take that action (103). Self-efficacy, the belief that you can change is crucial for change. Change does not take place through information but through affirmation and inspiration. Here the affirmation or encouragement of a mentor can build self-efficacy.

#### 2.7.2.3. Role of parents

Parenting input has been proven to be effective in the context of a relationship which is characterised by 'supervision, support and open communication' (125). Parental disapproval of early sexual activity is also associated with a later onset of intercourse (126).

#### 2.7.2.4. A collaborative and guiding style of communication

Motivational communication is based on understanding the factors that facilitate or impede change. It is a style of communication that is not confrontational or instructional, but rather collaborative and guiding. Motivational interviewing is based on principles of empathy, developing discrepancy and of supporting self efficacy (106, 44,108).

#### 2.7.2.5. Developing normative beliefs around sexual behaviour

According to the theory of reasoned action, the intention of a person to adopt a recommended behaviour is determined by their normative beliefs (views which are shaped by the norms and standards of society and whether people important to them approve of the behaviour) (112). These normative beliefs can be impacted in the case of this programme, by the influence of those around the young people, the peer educators, facilitators, clergy and parents.

#### 2.7.2.6. Strengthening interpersonal processes

According to the Social Ecological Model, the change in an individual is only one part of the process. Behaviour is determined by individual factors, interpersonal processes, institutional factors, community factors and public policy (103,112). Peer education can have the greatest effect at personal and interpersonal levels. On the interpersonal level it can impact on relationships between sexual partners, between parents and children, between peers, and between youth and adult mentors (facilitators).

#### 2.7.2.7. Building social capital

Through socialisation between peers, and relationship building with adult mentors, social capital is increased which can form a protective 'shield' for young people.

#### 2.7.2.8. Reducing vulnerability

Prevention is not just about encouraging individual behaviour change, but about identifying the causes of vulnerability and attempting to address them.

## 2.8. CONCLUSION

In this chapter several theories of behaviour change that are relevant to HIV prevention were presented. Their key components were examined and key studies of programmes

that were based on these theories were discussed. The importance of the theories was discussed in relation to the Agents of Change programme. Based on these findings the first stage of the conceptual framework was developed and centred around the two themes of peer education and reduction of risky behaviour. This emerging conceptual framework is further developed in the following chapter which examines adolescent sexual relationships.

# CHAPTER THREE: A LITERATURE REVIEW OF ADOLESCENT SEXUAL RELATIONSHIPS

## 3.1. INTRODUCTION

'Agents of Change' is a programme that is dealing with behaviour change in sexual relationships. Therefore it is important to understand the context of sexual relationships in Sub-Saharan Africa. The content of Agents of Change is a 20 session life skills programme which aims to positively influence sexual relationships between adolescents. Chapter Three therefore deals with this issue of adolescent sexual relationships**.**

Globally 15 to 24 year olds account for half of all new cases of HIV (7).Young people between the ages of 15 and 24 years are the age group most threatened by HIV and yet also the greatest hope for turning the tide of the epidemic. The few countries that have successfully decreased HIV prevalence have mostly done so by encouraging behaviour change amongst young people (7).

Most young people become sexually active in their teens; adolescence is a time of experimentation, curiosity and emancipation. Factors such as increasing urbanisation, poverty, exposure to conflicting sexual values and behaviour, and the breakdown of traditional sexuality are encouraging premarital sexual activity amongst adolescents (7).

The South African National HIV Survey of 2008 indicated that 8.7% of South African between the ages of 15-24 were HIV positive. Amongst males, 3.7% tested positive and 13.9% of females were HIV positive. Therefore this section attempts to understand the factors that lead to young people engaging in risky sexual behaviour in spite of all the efforts which have been put into education and prevention in this country (11).

## 3.2. THEORY OF TRIADIC INFLUENCE

The literature on sexuality and the reasons why so many young people are at risk for unsafe sexual practices is extensive. In order to examine the reasons for such high levels of risk, the theory of triadic influence is used as a framework (49). The theory of triadic influence is used to describe the various factors that influence sexual relationships in terms of whether they are intrapersonal, proximal or distal to the individual. The theory of triadic influence seeks to understand risk behaviour as a product of multiple streams of influence.

The first stream or cluster of influences is known as **intrapersonal.** These are individual factors, such as adolescent stages of development, biological factors that increase vulnerability, self esteem and early sexual debut.

The second stream or cluster is known as **proximal**; these are social or situational influences which contribute to the development of social norms. For instance a girl may have sex because of certain gender norms that indicate that women should give in to the desires of their male partner. The proximal cluster of factors includes gender norms, intergenerational sex, transactional sex, attitudes to pregnancy and attitudes to condoms.

The third cluster is known as **distal**; these are environmental issues from the broader society. For instance violence has become endemic in South Africa, which increases the incidence of rape and the likelihood of an adolescent becoming a victim of coercive sexual practices. The distal cluster includes poverty, violence and the media.

These clusters of influences are illustrated in Figure 3.1 below:

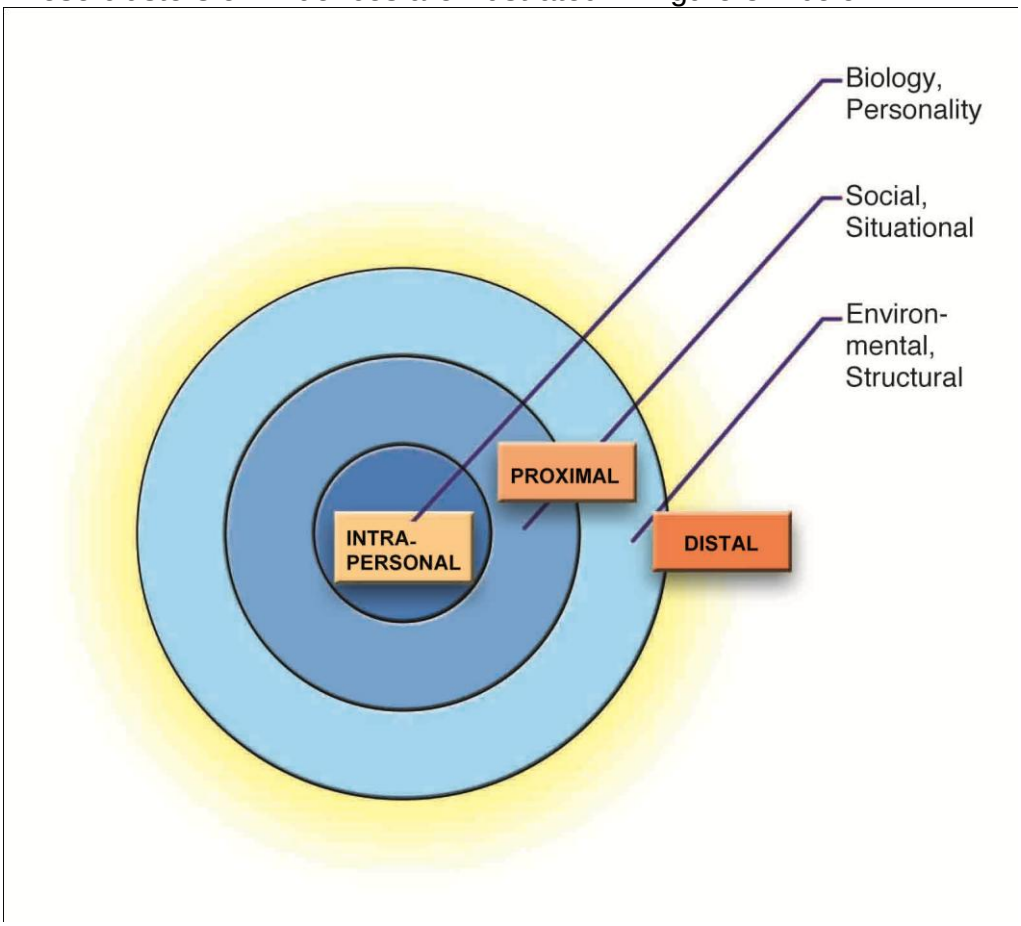


***Figure 3.1: Triadic influences on sexual relationships (49)***

In this matrix of influences, three levels are therefore identified in Table 3.1:

**Table 3.1: Levels of influence**

| Levels of influence | Factors | Leading to |
|---|---|---|
| Intrapersonal | Biology, personality | Self determination and control |
| Proximal | Social , situational | Normative beliefs |
| Distal | Environmental, structural | Cultural beliefs, availability of resources and physical aspects of the environment |

Source:(49) Petersen I, Bhana A, McKay M. Sexual violence and youth in South Africa: The need for community based prevention interventions. Child Abuse and Neglect 2005;29:1233-1248.

The three clusters are inter-related and there will be some cross over, however this matrix provides a useful framework for examining the influences on risk behaviour.

## 3.2.1. INTRA-PERSONAL

The first cluster of influences that lead young people to engage in risky sexual practices are the intrapersonal influences. These are influences relating to the individual person such as sex-based biological factors, age of puberty, body image, early sexual debut and poor personal self-assertiveness.

### 3.2.1.1. Biological factors relating to gender

When one examines HIV prevalence amongst young people globally, one is struck by the disparity between girls and boys. As Kofi Annan, former Secretary General of the United Nations said in his address to the XVth AIDS conference in Bangkok:

*'Adolescent girls are six times more likely to be infected than adolescent boys' (127).*

### 3.2.1.1(i) Sub-Saharan Africa

When one considers Sub-Saharan Africa, the differences between males and females are very marked. In a review of community-based studies of HIV infection in East and Southern Africa it was confirmed that young women are infected in large numbers compared with their male counterparts. In 11 countries with nationally representative surveys of HIV prevalence, young women aged 15-24 years were between 1.3 times and 12 times more likely to be infected than young men (53). Some of these figures are indicated in Table 3.2 below:

**Table 3.2: Percentage of 15-24 year olds infected with HIV in selected African countries; 2001-2003**

| **Place** | Zimbabwe | Tanzania | Zambia | Kenya | Burundi |
|---|---|---|---|---|---|
| **Female** | 18 | 4 | 11 | 6 | 4 |
| **Male** | 5 | 3 | 3 | 1 | 2 |

Source: Demographic and Health Surveys and WHO Regional Office for Africa (53)

### 3.2.1.1 (ii) South Africa

The same pattern emerges when data from South Africa is considered. The gender gap is at its widest in the age group 20-24 years, with 21.1% of females infected and only 5.1% of males (11). In MacPhail's study of Carletonville (Johannesburg), the following rates of infection were shown as illustrated in Table 3.3:

**Table 3.3: Prevalence of HIV infection at different ages in Carletonville, 1998**

| **Age** | 15 | 25 | 35 | 45 | 55 |
|---|---|---|---|---|---|
| **Female %** | 8 | 57 | 40 | 22 | 12 |
| **Male %** | 0.2 | 25 | 40 | 21 | 10 |

(128) MacPhail C, Williams B, Campbell C. Relative risk of HIV infection among young men and women in a South African Township. International Journal of STDs and AIDS 2002;13(5):331-341.

These disturbing figures reveal 57% prevalence amongst 25 year old women as compared to 25% prevalence amongst males. Men reach their peak of infection by the age of 35 years (40%).

The difference does not appear to be explained by age of sexual debut. It appears that boys in fact often initiate sex at an earlier age than girls, which would place them at greater risk. In Varga's study in Kwa-Zulu Natal, boys initiated sex at an average age of 14.8 years and girls at 16.2 years (129).

Nor does the difference appear to be explained by numbers of sexual partners. In almost all surveys carried out by the World Health Organisation's Global Programme on AIDS in Eastern and Southern Africa, boys report a higher turnover of partners before marriage than women. It appears that boys are having more sex than girls, from an earlier age, but fewer of them are becoming infected (130). In MacPhail's study, people with more sexual partners are indeed more likely to be infected; however among women who report having had one sexual partner, 24% are infected; compared to only eight percent of men. For women with two partners, 45% are infected, whereas men with more than eight partners still have a lower rate of only 27%. It appears that the rate of infection per partnership is about three times greater for women than for men (128).

### 3.2.1.1(iii) Biological factors

From a biological point of view, there are marked differences between women and men that make women more susceptible to HIV transmission. In studies of discordant couples in Uganda, Italy and South Africa it was shown that men are two to three times more likely to transmit HIV to women than vice versa (128,130-133). There are two main reasons, differences in male and female genital physiology and sexually transmitted infections:

- **Differences in male and female genital physiology**

These physiological differences affect susceptibility to infection. Women are more susceptible to sexually transmitted infections (STIs) because of the greater mucosal surface exposed to pathogens during sexual intercourse, particularly in young girls whose genital tracts are not fully mature (50). Differences in the genital contact surfaces mean that coital tearing and injury are more common in women. Semen contains more HIV than vaginal or cervical secretions (132). Since the vagina serves as a receptacle for male genital excretions, this area can be exposed to HIV for long periods of time. In contrast the exposure of a susceptible male to an infected female involves a smaller vulnerable area and briefer contact (134).

- **Sexually Transmitted Infections**

There are higher levels of STIs among women as compared to men. In the Carletonville study the most striking and strongest independent risk factor for HIV was herpes simplex virus (HSV) type two. Herpetic genital ulcers are co-factors in HIV transmission (through increasing both susceptibility and infectiousness). The two epidemics are mutually reinforcing each other. Young women with HSV-2 were eight times more likely to be infected with HIV (53). Because STIs are very often hidden in women, they are more difficult to identify than in men and they often go untreated, which leads to chronic infections and long term complications. Similarly, the risk of contracting HIV during a single coital act was less than one percent if no other STI was present, but the risk increased 8-10 times in the presence of a genital ulcer and 4-5 times if there was a urethral or vaginal discharge (135).

### 3.2.1.2. Age of puberty

The adolescent years are challenging because young people reach sexual maturity before society endorses the fact that they are sexually active. The stage of reaching sexual maturity is termed puberty. Adolescents reach puberty at different ages. There are standardised measures, such as the Tanner scale, which measures physical signs of development based on external sex characteristics, such as the size of the breasts, genitalia or development of pubic hair. Puberty generally occurs in boys from ages thirteen to sixteen and in girls between the ages of twelve and fifteen. The age at which a young person reaches puberty will affect their likelihood of becoming sexually active. Early maturers are often sexually active at an earlier age and more sexually risky than those who mature later. This may be partially attributable to the fact that young people who mature early may socialise with an older social group (51).

### 3.2.1.3. Psychological factors

### 3.2.1.3(i) Poor self-esteem and assertiveness

Relationships where there is a more equal power balance appear to be protective against unsafe or unwanted sex (54). In Jewkes' study of pregnant teenagers (58) the most common response to discovering a boyfriend's infidelity was to do nothing. This would obviously put a girl at risk if the boyfriend has multiple partners. If a girl is empowered enough to confront her partner, this is an indication of greater equality of power distribution within the relationship. For girls who have low esteem, acquiring and keeping a boyfriend may be one of the ways to increase self-esteem.

### 3.2.1.3(ii) Body image

We live in a society that objectifies women's physical appearance. Adolescent girls are growing up in a society that objectifies and commodifies women's physical appearance. Girls internalise messages that their looks are their greatest commodity.

Body objectification is the process of relating to one's own body as an object of another's gaze and desire, that is 'internalising the male gaze' (136). The meaning of being in one's own body changes as girls undergo puberty. Adolescent girls often feel a particular sense of body shame due to the changes they are undergoing at puberty (52,136).

Body self consciousness has been negatively associated with sexual self-esteem and sexual assertiveness (137). Body shame has been linked to increased sexual risk taking. Shame leads one to feel worthless. Once in sexual situations, a woman who fears negative evaluation may focus more on her partner's judgments of her than on her own desires, safety and pleasure. This makes it difficult for women to enact safer sex. In distancing herself from her own interests, she may find it difficult to protect herself from infection and pregnancy. A poor body image may lead to higher levels of risky behaviour and lower condom use.

Girls who are less satisfied with their body image use condoms less because they fear abandonment by their partners. Thus they are more at risk for unsafe sexual activity. Girls who internalise messages that their real thoughts and feelings are not valued and their looks are their greatest commodity may be doubly at risk. The following quotes by young women from the USA illustrate feelings about body image:

*'I feel I'm less than equal...cause I really have low self-esteem...like I find myself ugly, really ugly sometimes I ask my boyfriends, how could you be with such an ugly person?'(Teenage girl) (137).*
*'A bad thing about guys is sometimes they like don't want to talk to you on the phone, or if they do want to talk to you, they don't want to talk in front of their guy friends because they say, like, I have a girlfriend, girlfriend's there to look nice, shut up don't say anything, girls should be seen, not heard, you know' (Teenage girl) (137).*

### 3.2.1.4. Early sexual debut

Young people become sexually active at a young age for many reasons. Some are due to early sexual maturity, some to personality type, some due to peer pressure or sexual coercion. There are potentially harmful effects on young people of initiating coitus at a young age. Studies indicate that young people with early sexual debut were more likely to:

- have had more sexual partners in the previous year;
- have had sex with risky partners;
- have had STIs; and
- have not used condoms(53,138,128)

In Sub-Saharan Africa it is common for girls to experience an early sexual debut as indicated in Table 3.4 below:

**Table 3.4: Percentage of girls who became sexually active before 15 years age: 2009**

| Kenya | Malawi | Angola | Lesotho | South Africa |
|---|---|---|---|---|
| 11 | 21 | 23 | 17 | 6 |

UNAIDS Global Report for 2010 :Annex 2: Country progress indicators and data, 2004 to 2010 (296)

## 3.2.2. PROXIMAL INFLUENCES

This is the cluster that is defined as social or situational and which relates to social norms. These are norms which shape the way that decisions are made regarding sexual activity. In order to develop better educational interventions, emphasis needs to be given to the way in which young people understand their social and physical worlds, and to the social and cultural processes that help them to make sense of sexual desires and feelings and interests. A central theoretical assumption is that sexual activity is to a large extent, socially constructed (139). This cluster involves gender norms and attitudes to pregnancy and condoms. Other key influences which are included in this section are inter-personal relationships; in particular focussing on relationships with older partners and relationships which include transactional sex.

### 3.2.2.1. Gender norms

Prevention efforts show disappointing results even when condoms are freely available and awareness is high. It appears that providing information and access to condoms – while important – are often not enough to change behaviour (55). One of the factors that limit the success of these efforts is gender norms.

There is a growing literature on gender norms which can be defined as values and beliefs that guide people's actions. These norms and values are constructed by society and culture. The gendered differences between men's and women's risk behaviours that are reflected in HIV prevalence statistics reflect deep social differences in the construction of gender roles (140). 'Gender' refers to the norms that are shared within society about what is appropriate behaviour for women and men. Gender based power is derived from these social meanings (141). These normative beliefs about one's gender roles guide interactions between men and women at both the individual and social levels.

Marston conducted a systematic review of 268 qualitative studies of young people's sexual behaviour, from a range of countries (Mexico, UK, South Africa, Thailand, Nigeria, China, US, Holland, Uganda, Tanzania, Taiwan, Nepal, Puerto Rico, Canada, Ghana, Nicaragua, Columbia, Eastern Indonesia, India, Sweden, Brazil, Philippines, Cambodia) and found that there are similar social and cultural forces which shape young people's sexual behaviour. These gender norms can help to explain why information campaigns and condom distribution programmes alone are usually not enough to change behaviour (55). They appeared to be present in varying degrees in all the countries assessed.

First of all gender roles regarding masculinity will be examined and then gender roles around femininity in order to assess their impact in putting young people at risk.

### 3.2.2.1(i) Masculinity

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The tradition of polygamy holds that men need frequent sexual gratification and multiple partners (57). In sexual relationships outside of polygamy, this masculinity may be negatively expressed through the pursuit of multiple risky partnerships (140). To attract multiple partners is a mark of status for a man (142). In polygamy, sexual encounters are mostly controlled by men with little concern for women's desires (143). Women had to accept being one of several partners, and often being in an inferior position. With urbanisation there has been a decline in traditional polygamy in South Africa, but the practice of multiple partners has continued, with men's sexual networks broadening to include casual girlfriends or 'town wives'. These concurrent relationships are not completely public, but they are accepted as a norm (56).

In South Africa, in certain communities, the understanding of masculinity has been impacted by the long term social processes of colonialism and apartheid. Family institutions were broken down through migrant labour. African men were dispossessed in society, but retained their rural homes, with their patriarchal system of authority including the subordination of women. The strength of these historical social norms has made it hard to incorporate more recent social changes, such as a move towards more gender equality. In the next section certain aspects of masculinity will be discussed which put women at risk, such as sexual prowess, power and peer pressure.

- **Sexual Prowess**

Systematic reviews throughout many cultures reveal a concept of traditional masculinity that expects men to be sexually active and to have multiple partners (55). A study in KwaZulu-Natal showed that 41% of male and 20% of female respondents agreed that it is natural for a man to have more than one partner (144). Harrison's study of secondary school students in the same province showed the following differences between males and females as illustrated in Table 3.5:

**Table 3.5: Differences between males and females regarding sexual activity, KwaZulu-Natal secondary school students 2006**

| | Male | Female |
|---|---|---|
| Age of first sex | 15.8 | 16.5 |
| Sexual partners lifetime | 5.3 | 2.2 |
| Current secondary partner | 51.3% | 34.3% |
| Length of primary relation | 22.3 months | 30.4 months |

(140) Harrison A, O'Sullivan L, Hoffman S, Dolezal C, Morrell R. Gender role and relationship norms among young adults in South Africa: Measuring the context of masculinity and HIV risk. Journal of Urban Health 2006;83(4):709-722.

The results of Harrison's study reflect the gender norms that boys are more active sexually, with more concurrent partners who are changed more frequently (140).

Social norms prescribe that men should have sex as a marker of masculinity. These social norms are underpinned by peer pressure. This peer pressure is illustrated by the following quote from a youth from KwaZulu-Natal:

*'Others laugh at me saying that I have never tasted where I come from (had sex). I want to have a taste and tell them that I have also tasted that' (Male, KwaZulu-Natal) (49).*

Marston's study shows that in many countries social norms dictate that boys should initiate sex. If a girl wants to initiate sex it is believed that she is 'loose' or might be a prostitute (55).

People in many cultures believe that men have a natural or biological need for sex. In Varga's study in KwaZulu-Natal 53% of respondents thought that sex is more important to men than women and only four percent felt it was more important to women. Most boys agreed that sexual conquests and repeated STIs were vital elements of a strong masculine image; to have an STI was seen to be proof of success in gaining multiple partners. Boys are given a lot more latitude socially and are encouraged to engage in sexual practices that would be considered inappropriate for girls. They gain their respectability by being sexually active. The importance of Zulu masculinity is embodied in the concept of 'isoka', which denotes a man who is socially successful, popular with women and with strong sexual connotations, as a 'player' (129). Such attitudes are illustrated in the following comments by a 24 year old male:

*'I am a man. I cannot have one affair. For a man to have three girl friends is very reasonable' (142).*

- **Power**

Key to an understanding of masculinity is that the male should be the dominant and decision making partner. The quotes in this section, taken from focus group discussions with adolescents in KwaZulu-Natal illustrate the expectations that men should dominate women:

*'The belief is created in society. You know that you do not question a man's word'.*
*'A man knows everything, and he can make better decisions than a woman' (129).*

Boys are socialised to traditional patriarchal notions of masculinity, which promote and legitimise unequal gendered power relations as illustrated in the following quotes from the focus group discussions:

*'Boys grow up thinking that he should get whatever he wants from a girl. She is supposed to respect him without any refusal. If he wants sex, a woman has to agree. Just because he thinks of controlling his own sister, he gets an idea that he can control every girl' (Girl) (49).*
*'We need girls to give us. That's what the Bible says. We need to be given when we ask…what we want' (Boy) (49).*

In many cases men use their decision making power to justify sexual coercion as illustrated in these quotes from Kwa-Zulu Natal:

*'When a girl resists, if he is a real man, he must not allow the girl to stop him, he must win and get what he wants' (Male) (129).*
*'It happens that I force her. Because I cannot control myself. In our tradition, it is the man who makes such decisions and a woman must follow' (Male) (129).*
*'Sex is a symbol of power in the affair, once you have sex with a woman, you have a strong say in the running of the relationship' (Male) (142).*

Because of the imbalance of power, many male and female participants appear to accept the normality of some degree of sexual coercion. These norms are linked to rape myths, which are used to legitimate sexual abuse. For example, there is a strong belief that boys/men are unable to control their sexual urges and that women are responsible for controlling them. It follows that if a girl wears clothing that shows off her body or walks about at night, she is asking to be raped. This attitude is seen in the following quotes from focus group discussions:

*'When boys see those buttocks, they cannot control themselves. The way they dress is wrong.' (Boy)*
*'The girls should not go about at night, they cause trouble.' (Boy)*
*'The girls who go about at night are the ones who are the cause of their rape, trouble for themselves. You cannot let the girl pass at night (without raping her)… laughter.' (Boys) (49)*

This attitude towards women who wear revealing clothing is shown clearly in the following case study:

**Case study:**
*Attacked for miniskirt : stripped and sexually abused (18 February 2008, The Sowetan)*

Nwabisa Ngcukana, 25, had to parade butt naked at the Noord Taxi Rank after a mob of taxi drivers stripped and tore her clothes. Her crime was wearing a short skirt. "I have never been so traumatised in my life. I thought these taxi drivers were going to rape me," Ngcukana said. "As they stripped me they kept shouting that this is what I wanted. Some were sticking their finger in my vagina while others poured alcohol over my head and called me all sorts of names (145)."

Patriarchal ideology also understands sexual violence as a strategy used by boys and men to put women in their place if they become too independent and assertive as illustrated in the following quotes from a focus group discussion:

*'When they are together they say "that girl is sociable and outgoing as she can speak her mind and that will only stop once she gets 'to know boys' ('to have sex') then she will know her place and become humbler." (Boy)*
*'It's a way to show the girl that she is still under their control. Boys like to punish girls.' (Girl)*
*'In other cases when the sister is behaving well and the family seem to treat her better…the guy will rape the girl in order to have her lose her pride'(Boy) (49).*

- **Peer pressure**

Whereas girls traditionally receive some sexual education from mothers, particularly around the time of first menstruation, there is often an almost complete absence of sexual education of adolescent boys. By the time of traditional circumcision rites, which incorporate some teaching on sexuality, most young men have been sexually active for several years. They experience the physical effects of puberty with little information except for that received from peers. The encouragement of boys to become sexually active is also linked with a quest for knowledge and information in the face of silence about their sexuality. Thus the only way to learn is through experience (139). If a young man is not seen to be sexually active, he may be looked down on by his peers. Boys often report sexual experiences to one another in exaggerated terms to gain status. Taking part in penetrative sex is seen as a sign of manhood (55). The following quotes from youth from Mitchell's Plain, Cape Town and KwaZulu-Natal illustrate this pressure to gain status with your peers by having sex:

*'They can do anything as long as they get liked by their friends' (Boy, focus group discussion) (49).*
*'It is called 'The League'; the guys say how many girls they have slept with. Everyone wants to get to the top of The League'* [3] *(Male peer educator)*
*'It's not enough to get her to fall in love with you. To show that you control the relationship, you must be able to show your friends that you have slept with her.'(Male, KwaZulu-Natal) (142)*

There is also strong peer pressure to prove that you are not homosexual, by becoming sexually active with a girl. Being branded queer or gay can lead to social exclusion as illustrated in the following quote (55):

*'This thing of calling a boy names (gay) puts him in a bad category, after being called by those names, he will propose sex'(Male, focus group discussion) (49).*

[3] Anglican Youth Group meeting , Mitchells Plain, 2007

### 3.2.2.1(ii) Femininity

Traditional gender roles around femininity are similar in many cultures; the girl should be chaste, passive and give in to the male partner's needs. In this section we will look at the double standards around femininity, passivity and disempowerment. We shall also consider the desire for love and issues of communication that are affected by gender roles.

- **Double standards**

This is a surprisingly universal theme. In most cultures it is acceptable for young men to be sexually active and to have multiple partners, whereas women are expected to remain chaste or to be in monogamous relationships. Women's sexual freedom is universally restricted in comparison with men's. The exact nature of what is seen to be inappropriate and the penalties for transgression vary from society to society, from verbal censure to honour killings (55).This double standard is illustrated in a quote by a youth from KwaZulu-Natal:

*'You are being a isoka (player) if you are sleeping around. If you are a girl and do that ungcolile (you are dirty). There has never been any praise for a woman who was sleeping with many different men' (Male, KwaZulu-Natal) (129).*

Women find themselves in a double bind; virginity is seen as a proof of the character and worthiness of a young woman by a potential partner, family and community. However women are at the same time expected to meet the sexual needs of their partner (139). In cultures where virginity is highly valued, young women may be coerced by older men into having sex, or they use practices such as anal sex which preserve their virginity but put them at increased risk of infection (141). If they are seen to be sexually active, their reputations may suffer (55). There is a perception that young men are sexual beings and young women ought not to be. Sexually active young women or those who are assumed to be so, are called sluts, whores, cheap, or loose (139).

- **Passivity**

Gender norms dictate that just as men should be dominating, women should be passive in the sexual arena. The emphasis on men's pleasure can lead to a use of other practices like vaginal drying agents that increase women's risk of contracting HIV. Women are expected to be ignorant about sex and passive in sexual interactions, so it is difficult to be informed about risk reduction strategies (141).

Traditional theories of adolescent development state the key tasks are to achieve separation and autonomy (146). However for girls, the development of a sense of self is intimately bound to relationships and to her ability to maintain them. Young women are encouraged to attach themselves to young men in order to succeed as a conventional 'feminine' women, otherwise they are 'on the shelf' or a 'spinster'. Their sexual identity is then constructed in a context that defines sex in terms of men's needs and drives. Women tend to be seen and to consider themselves as passive recipients of men's passions. Most

women understand sex as penetration of the vagina by the penis, defined in terms of men's natural sex drive (147). In order to maintain relationships, women may silence their own needs and desires such as the need for protection against STIs. Girls are particularly vulnerable to making their own needs secondary to the desires of their partners (137). This vulnerability is illustrated in the following quote from a young woman from KwaZulu-Natal:

*'I don't refuse because I know that he is the only one for me. I don't want to lose him, so I must satisfy him' (142).*

Expectations of women's passivity are in conflict with the need for her to be assertive in order to ensure personal safety (147). Female gender norms of passivity may primarily inhibit girls sexual self-efficacy, a girl's conviction that she can act upon her own sexual needs, such as enjoying sex, refusing unwanted sex and insisting on the use of protection. Research has shown that sexual self-efficacy is associated with safer sex (137).

- **Disempowerment**

Unequal power in sexual relations reduces women's ability to negotiate condom usage, to express their concerns about infidelity and to refuse sex (141). If we are to understand young people's sexual relationships, we need to understand the power relations within which sexual identities and practices are embedded. The emphasis on condoms has reinforced a dominant male understanding of sex as the penetrative act (147).

Gender affects the ability to act, with women generally having less power than men. This power imbalance varies at an individual level because of the characteristics of the relationship – marriage, "sugar daddy"[4], or casual. It may also be affected by family dynamics; for example whether the man or woman is the bread winner and relationships of the extended family for instance if you are living in a household with in-laws (141).

Studies have shown that women with more egalitarian relationships are more likely to use condoms. In Pettifor's national household survey of women aged 15-24, sexually experienced women with low relationship control were 2.1 times more likely to use condoms inconsistently (17).

Studies in the USA, Zimbabwe, Ethiopia, Nigeria and Botswana all linked disempowerment in the relationship to poor condom use (148). By contrast, studies of Yoruba women in Nigeria show that they have considerable power to refuse sex. This is explained by their economic independence. These women were compared with Bagandan women who felt powerless to change culturally sanctioned high risk behaviour such as concurrent sexual partners for men (142).

[4] A 'sugar daddy' relationship refers to a young girl who has a sexual relationship with an older man for material benefit.

- **Looking for love**

Girls often are looking for love and concede to sex in order to find love. Men however often see sex as an expression of pleasure, not necessarily commitment. The following quotes from adolescents in KwaZulu-Natal illustrate this confusion between love and sex:

*'Sex is something you do in order to enjoy each other. It is about love and pleasure, but you can get pleasure without having to be deeply in love with your partner' (Girl, KwaZulu-Natal) (142).*

They will often then have sex in order to please their partner or to keep him. Intercourse is seen as a way of demonstrating love and commitment as illustrated in the following quote:

*'It is my procedure to have sex with the girl in the first two weeks of the affair. To prove if she is really committed to me and prepared to do anything to make me happy' (Male, KwaZulu-Natal) (142).*

The emotional aspects of sexual relationships are often more important to young women than they are to young men and the physical sensation of sex is more dominant in many young men's minds. The global influence of youth culture, despite an emphasis on romantic love, has increasingly moved from waiting until marriage, to a validation of 'surrender to love'; as an expectation of sexual activity (139). There is a sense that sex is morally acceptable if love is involved. If sex is linked with romantic love, then a girl should be swept off her feet and would not plan to use condoms.

- **Communication**

Communication is very important in terms of risk reduction. The strongest risk factor for not always using condoms was not having talked to the partner about condom use. Communication with partners about condoms has been shown to be associated with consistent condom use (148).

For both males and females, social expectations hamper communication about sex (129). For girls to discuss sex or condom use would brand them as cheap or loose. Women may avoid saying "yes" directly to sexual activity in case they seem inappropriately willing as illustrated in the following quote:

*'When women say no, they mean yes. A woman can never come out clearly and say let's do it. You need to read her facial expressions. If she keeps on saying no and closes her eyes she wants it' (Male, KwaZulu-Natal) (129).*

This sexual coyness may sometimes lead to an increase in coercion as illustrated below:

*'When we say no, we mean something else. Women often test a man just to see what he is going to do. Not that we do not want to have sex, but we have to show that we have dignity. In the end, men lose patience and react violently' (Female, KwaZulu-Natal) (129).*

Research on sexual communication has shown that women who do not communicate with their sexual partners about sexual issues use condoms less consistently than women who feel comfortable communicating (137). Discussion about STIs may raise questions about sexual faithfulness. Women are not supposed to be knowledgeable about sex and may be uncomfortable speaking about sexual matters. If they raise the topic they may be perceived to be promiscuous. Another barrier is that both men and women may lack the language to describe their desires and fears. Men may be reluctant to acknowledge their ignorance of sexual matters (141).

### 3.2.2.1(iii) The impact of traditional gender roles on HIV risk

In this section gender roles are considered in terms of their impact on increasing HIV risk, firstly in males and then in females.

- **Males**

Traditional masculine gender roles place men and boys at risk because of the encouragement of early sexual debut and multiple partners. Traditional roles of masculinity also discourage condom usage since it is seen as limiting virility as illustrated in the following quote (55):

*'If I ask him to use a condom, he won't feel like a man' (Girl, KwaZulu-Natal) (142).*

Research found that masculine ideology, defined in terms of social gender roles, was associated with using condoms less consistently and with viewing condoms as reducing male sexual pleasure. Some worry they will be unable to achieve penetration and may even avoid condom use for fear of loss of erection. Men are also encouraged to be self reliant, which discourages them from seeking information about sex and encourages them to deny that they are at risk (141).

- **Females**

Traditional feminine gender roles put women at risk in many ways. Because they are supposed to be 'chaste' they often are not able to communicate about sex, or to request condom usage. They are supposed to meet the male partner's needs, and are often too disempowered to either refuse sex or ask for condoms. The focus on the body means that a woman's value is seen through her body and ability to keep a sexual partner. Thus she may be willing to engage in risky sexual behaviour in order to keep him.

The importance of challenging some of these traditional gender roles that place both young men and women at risk is illustrated in the following quote by Kofi Annan, former Secretary General of the United Nations in his address to the XVth AIDS conference in Bangkok:
'*What is needed is positive change that will give more power and confidence to women and girls. Change that will transform relationships between women and men at all levels of society' (127).*

### 3.2.2.2. Older partners

Luke's review of Sub Saharan Africa looked at 45 quantitative and qualitative studies and found that it is the norm for adolescent girls to engage in sexual relations with older partners. Sizeable proportions of girls' partners' are more than six to ten years older (56). Table 3.6 below lists some of these findings:

**Table 3.6: Age difference between sexual partners**

| Country location | Study citation | |
|---|---|---|
| Guinea | Gorgen 1998 | Girls aged 15-25: partner averaged 5.5 years older |
| Kenya | Kekovole 1997 | Girls aged 15-19: partner 3 years older |
| Zimbabwe | Gregson 2002 | Girls aged 15-24: partner averaged 6 years older |
| Uganda | Kelly 2001 | Girls aged 15-29:17% reported partners 10+ years older<br>HIV+ females: partners averaged 6.3 years older<br>HIV- females : partners averaged 5.7 years older |
| Zimbabwe | Sherman 1999 | Girls aged 14-19: most partners 3-4 years older |
| Tanzania | Komba 1994 | Girls aged 14-19: 66% had a partner 2 or more years older; 33% 10 or more years older. |
| South Africa (Carletonville) | MacPhail 2002 | Girls aged 20: partner averaged 5 years older. |

Source:(56) Luke N, Kurz K. Cross generational and transactional sexual relations in Sub-Saharan Africa: Prevalence of behavior and implications for negotiating safer sexual practices. Population Services International (PSI) and International Centre for Research on Women (ICRW) Washington. 2002; (128) MacPhail C, Williams B, Campbell C. Relative risk of HIV infection among young men and women in a South African Township. International Journal of STDs and AIDS 2002;13(5):331-341.

It is considerably more common in South Africa for girls to be involved in relationships with a large age gap than for boys, as indicated in Figure 3.2:

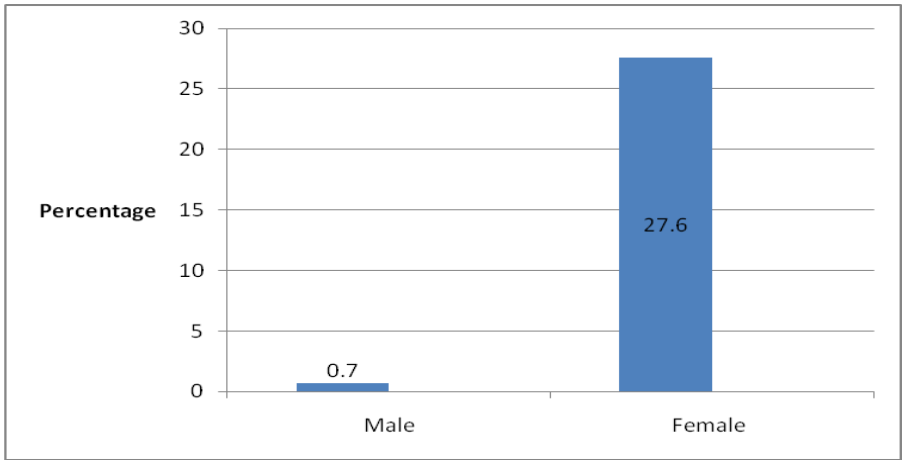


***Figure 3.2: Proportion of South African youth aged 15 and older who are involved in relationships with partners five years older or more. (11)***

Certain groups of girls, such as those who have become pregnant, have much older partners on average. Men may often choose an adolescent girl as a non-marital sexual partner. Several studies reveal significant associations between unsafe sexual behaviour, HIV risk and cross-generational sex. Three of the studies reviewed found that greater age differences between partners indicated a significant increase in adolescent girls' risk of HIV. Two additional studies found that unsafe behaviours, including non use of condoms and no discussion of HIV are significantly linked to greater age differences between sexual partners (56).

Because of the limited negotiating power of adolescent girls, sexual partnerships between girls and older men are fundamentally imbalanced. Girls appear to be able to negotiate relationship formation; for example, they can choose the types and number of partners they have and can discontinue a relationship if gift-giving ceases. However, once in a sexual partnership, they are less able to control sexual practices. Men appear to control the conditions of sexual intercourse, including condom and contraceptive use and the use of violence. Girls are not likely to insist on condom use for many reasons, including social norms and lack of self perceived risk of HIV. Suggesting condom use may jeopardise their goals for the relationship, including the receipt of money and gifts (56).

It is likely that age mixing helps explain the disparity in HIV infection levels between men and women in many parts of Africa, especially in the adolescent age groups. Older men often have higher rates of HIV infection than adolescent boys (56). These relationships often involve an exchange of gifts for sexual favours, thus older age and higher economic status are resources held by men in cross-generational relationships that allow them more power in reproductive and sexual decision making. Younger age often is an indication of deference or ignorance regarding sexual matters on the part of the female. In this section firstly the risks of older partners will be examined and then the motivation for becoming involved with an older man (56).

### 3.2.2.2(i) HIV risk of older partners

A review of studies found that greater age differences were associated with increased risk of HIV as illustrated in Table 3.7:

**Table 3.7: Relative risk of HIV for girls with an older partner**

| Country | Relative risk of HIV |
|---|---|
| Rakai,Uganda | Girls with a partner 10 years older or more, the relative risk for HIV doubled. |
| Zimbabwe | A one year increase in age difference between partners is associated with a 4 percent increase in the risk of HIV. |
| Kisumi, Kenya and Ndola, Zambia | For girls with a partner less than four years older, none were infected with HIV, but if the age difference was four years or greater then between 34% and 38% were infected. |

Source:(57) Luke N. Age and economic asymmetries in the sexual relationships of adolescent girls in Sub-Saharan Africa. Studies in Family Planning 2003;34(2):67-85.

With an older partner, there is also a higher risk of falling pregnant. Studies in Tanzania showed that 73% of pregnant girls aged 15-19 had partners who were significantly older than the partners of their peers who did not fall pregnant (57).

A comparison of adolescent girls who had older partners (three years or more) when compared to those with peer partners (less than three years difference) showed the following results in a study in New York and Puerto Rico as illustrated in Table 3.8:

**Table 3.8: Risk of pregnancy with older partners**

| | Age of debut | Use condom at debut | Length of sexual activity(years) | Ever pregnant | Consist condom use |
|---|---|---|---|---|---|
| Older partner | 13.8 | 63% | 1.8 | 38% | 40% |
| Peer | 14.6 | 82% | 1.0 | 12% | 65% |

(149) Miller K, Clark L, Moore J. Sexual initiation with older male partners and subsequent HIV risk behaviour among female adolescents. Family Planning Perspectives 1997;29(5).

Girls with older partners are at higher risk of contracting HIV or falling pregnant, for the following reasons:

- Older men are more likely to be HIV positive than teenage boys. They have had more partners and may have had more varied sexual experience such as anal sex (149).
- There is a power differential created by differences in age and sexual experience. This leads to less likelihood of discussing HIV or negotiating condom use (54). Thus an adolescent girl may not be able to negotiate condom use.
- An adolescent girl may trust the older more experienced partner to take responsibility for the health consequences of the sexual interaction (149).
- Older men appear to prefer adolescent girls partly because it is believed they are HIV free. It also enhances their status to be seen with a younger girl (56).
- Men are less likely to use condoms with young female partners (130,149).
- If a young physiologically immature woman has sex with an HIV infected partner, she is more likely to become infected than a more mature woman (130).
- The non-marital partners of high risk men such as truck and taxi drivers are likely to be adolescents (56).
- Girls with an older partner have a younger age at first intercourse and are less likely to use a condom at first intercourse (63% rather than 82%) (149).
- There are higher levels of violence with older partners (54,57).

Sexual activity, like other decisions negotiated between couples, is not just an individual attribute but a behaviour negotiated between two partners within a wider social, cultural, and economic context. Behaviour depends not only on the characteristics of the two individuals, but also on the power differentials between them. Large differentials can place the weaker partner at great risk, because she has relatively less power to control sexual

encounters. The barriers to decision making include gender norms of male dominance and female obedience, female economic dependence on men, as well as a lack of knowledge about the realities of risk, the use of condoms or contraception. These contextual influences form the backdrop to all partnerships. Age and economic disparities only heighten the influence of these factors and weaken girls' negotiating power. In addition male violence negates the limited degree of power (57).

### 3.2.2.2(ii) Motivation for getting involved with older partners

Why then do adolescent girls become involved with older partners? Sometimes a girl may be looking for a potential spouse. An older man may have a job and regular income and be an attractive proposition as a potential partner. At times a girl may consciously desire to fall pregnant in order to trap him into marriage. Parents may pressurise their daughter to form a relationship that may lead to marriage. Parents will not be supportive of their daughter bearing a poor man's child (57).

However, it often seems that adolescents prefer partners closer in age to fulfil their desires for love, affection and eventual marriage. Studies report that girls have older partners for material benefit and simultaneously have peer boyfriends who represent more serious relationships (57). The possibility of financial rewards is a major incentive for girls to become involved in partnerships with older men. This often means that potential risks such as HIV or pregnancy do not pose a high enough cost to forgo a profitable relationship, even when it involves unprotected sex (57). This aspect of transactional sex is discussed in the following section.

### 3.2.2.3. Transactional sex

The concept of transactional sex or sex for material gain is widespread in Africa and is called by many different terms in different countries some of which are listed below:

*'Milking the goat'* – Tanzania
*'Taxi queens* '– South Africa
*'Sleeping with the big bellied'*- Uganda
*'Sleeping with the folded necks'* (obese with wealth) – Cameroon
*'De-toothing'* - Uganda

### 3.2.2.3(i) Introduction

Historically, economic exchange has been part of sexual relations in Africa, and is integral to traditional marriage rites, through lobola (bride wealth) payments. Males and older males in particular, hold the power of traditional authority and ownership or control over property. A natural shortage of labour encouraged men to marry numerous wives, who supplied labour. Thus an economic value was attached to women's capabilities. At marriage, bride-wealth cattle were exchanged between families to mark the transfer of the rights to a

woman's sexuality, offspring and labour from one lineage of men to another. When the meanings of lobola were explored in a study of three Provinces in South Africa, 79% of men said they understood that if a man paid lobola he owned his wife and 74% said that if he paid lobola his wife had to have sex whenever he wanted it (150). Lobola entrenched the dominance of the husband and the sense of being 'owed sex' (150).

This traditional foundation of economic asymmetries has new implications in the era of HIV. The economic situation of African women has deteriorated through the last century. Traditionally they have been restricted from owning property and denied access to wage opportunities that are increasingly important in the modern economy. Women's dependence on men's economic support throughout the region, means that women's personal resources, including their sexuality, have economic potential. This development has been labelled as the commoditisation or commercialisation of sexual relations. These transactions may range from commercial sex to informal transactions. Cash and gifts have increasingly entered into informal sexual relations, and the negotiating parties are individuals not families. The financial gift of lobola between families has increasingly given way to gifts between individuals. However, the traditional age, economic and gender asymmetries have remained, together with an underlying male expectation of being 'owed sex' (57).

### 3.2.2.3(ii) Adolescents and transactional sex

Adolescents are particularly vulnerable to becoming involved in transactional sex for the following reasons:

- They have fewer market opportunities than older people and often little access to pocket money from parents.
- Population growth has produced a partner squeeze in many contexts, where older economically secure men are in short supply and younger women in great supply. Thus girls and young women may find it harder to negotiate terms of sexual relationships with older partners because the availability of substitute female partners is so great.
- Educational opportunities and increased age at marriage have brought a distinct period of adolescence with greater independence from familial control. During this new period of independence, sexual relationships prior to marriage have become more widespread. Cultural ideals for adolescent behaviour have been replaced by peer pressure, a concern for status and material goods and the pressure to begin sexual relations and mimic adult norms of sexual behaviour. Adolescents may not fully realise the risks they are taking (57).

Both qualitative and quantitative research demonstrates that economic exchange is associated with unsafe sexual behaviour. In gathering data, it is difficult to measure transactions accurately for several reasons. Firstly, certain things may not be regarded as gifts, for instance giving someone a lift in your car or buying cool drinks. Secondly,

transactions involving sexual activities are regarded as prostitution in many setting and therefore questions about exchange may lead girls to under-report these behaviours. Thirdly, gifts are seen as expressions of love, not as payments for sex.

A review of studies showed the high prevalence of transactional relationships amongst sexually active girls(56):

- Malawi: among 10-18 year olds, 66% were in a relationship for gifts of money.
- Tanzania: among 14-19 year olds, 80% received money from boyfriends.
- Uganda: among 12-20 year olds, 85% had sexual relations for exchange of money or gifts.
- Swaziland: among girls older than 14, 20% said the reason they became sexually active was because of financial need.

The findings point to a large majority of adolescent girls who do engage in transactional sex. Due to the power imbalance of the economic asymmetry, the girl has less negotiating power over the use of condoms, which places her at risk as illustrated in the following quotes:

*'If a girl was to accept a gift before love-making or agree to one after, then she was denying herself the right to ask a man to use a condom. The evidence suggests that gifts are likely to reduce the power of girls to demand condom use' (56).*
*'Girls want something out of relationships. Therefore they don't push the condom issue much. If you want a 'lucrative' relationship, the last thing you want to say is 'use a condom' (56).*

One study in Kenya found that transactions of greater value have a significantly greater effect on non-use of condoms. Even a small increase in the monetary value of a gift led to decreased condom use (56). Girls who engage in transactional sex may also engage in high risk relationships. In a study in Kenya, 96% of those who usually engage in relations with truck drivers report they usually have a transaction (56). Here are some quotes from taxi drivers in Cape Town:

'*One year he knew of three young girls who became pregnant by drivers. Some ranks look like maternity wards'(Taxi driver, Cape Town).*
*'Some girls persuaded the men to give them drugs, or money for drugs, with tik[5] being the most popular: if she's willing and eager to pay in her own way, she'll do it' (Taxi driver, Cape Town) (151).*

The rates of transactional sex increase with age. Older girls are more likely to receive gifts and money. They have been exposed to the potential value of their sexuality and are more likely to expect gifts. Older partners are more likely than adolescent school boys to be

[5] The drug crystal methamphetamine

earning, and also more likely to be HIV positive. Older partners are often professionals, teachers, drivers, and working men with money.

### 3.2.2.3(iii) Motivations for transactional sex

The motivation for getting involved in transactional relationships includes the following:

- To assist with economic survival: Many girls need resources in times of economic crisis. Young mothers are particularly vulnerable. Parents may pressure their daughters to get assistance or 'choose to close their eyes because it relieves them of their financial responsibilities' (128).
- To enhance life chances: Numerous studies point to girl's motivation to secure life opportunities and enhance long term goals of higher economic status and security. Female secondary school students need financial support for fees and supplies. University students have relationships to pay for tuition, living expenses, and food. Educated young women have relationships with wealthy men to gain financial security and social mobility. They get established in a career and meet prestigious people (56).
- To increase status among peers: Older partners fulfil the expectations of the peer group that girls should have boyfriends and be sexually active. Secondly they provide girls with money and gifts for luxuries, which parents won't or can't pay. Girls' peers often encourage them to find wealthy older partner in order to receive nice things (57).
- Because of the pressure of materialism: University students are particularly at risk of attracting older partners who can buy them material goods they would not otherwise be able to afford as illustrated in the following quote:

'*Poor girls coming to campus for the first time from the village see the campus girls with good hair, nice clothes, mobile phones and even cars. They want to get those things and the easiest way is to get a rich older man' (152).*

### 3.2.2.4. Attitudes to pregnancy

South Africa has very high levels of teenage pregnancy. By the age of 19, 35% of South African girls have been pregnant and nearly as many have given birth at least once (129). Adolescents who fall pregnant are at high risk of HIV, since they have engaged in unsafe sex. Currently one in five pregnant teenagers is infected with the virus (58).

Teenage pregnancy can have very negative consequences in a young person's life. The young mother's schooling is severely impacted, which affects her subsequent earnings and the financial position of her family's household – maintenance from the father is rarely forthcoming. This often means that the child is born into greater poverty. These concerns

are often underpinned by the notion that teenage sexual activity is essentially immoral as illustrated in the following quote (58):

*'At home you are reminded every day ...you are so ashamed that your father knows you slept with a man. There is always this thing inside you which reminds you that you have done something wrong and you should be blamed' (Girl, 17 years old) (129).*

However, there are many reasons why a young woman decides to fall pregnant, or at least feels ambivalent and does not use regular contraceptives. These include a desire to prove fertility, a search for love and the partner's or family's desire for a child. These reasons also include a lack of education, a violent partner and the attitude of nurses towards teenagers who use contraceptives (58). Taking part in unprotected sex in order to fall pregnant clearly increases her risk of HIV.

### 3.2.2.4(i) Desire to prove fertility

There are different constructions of pregnancy. Fertility is seen as an important element of respectability and womanhood. The cultural importance of female fertility has been cited as a primary reason for non-use of contraceptives and unprotected sex and for persistent high pregnancy rates among adolescents (129,153,154,155). This desire to prove fertility but also realising the consequences is illustrated in the following quote by an 18 year old girl:

*'I am glad to know I am not sterile, but by becoming pregnant I will not be able to finish school. The baby's father will finish school, and get a job, then he will want someone like him, an educated women and not me, I just had his baby' (129).*

### 3.2.2.4(ii) Finding love

Living in a background of social destabilisation, with family relationships characterised by lack of affection, young people feel the need to establish acceptance, and intimacy. Falling pregnant becomes a way of finding love as illustrated in the quote below:

*'I just wanted someone to love and to love me.' (Teenage girl, Cape Town)*[6]

Interestingly, Jewkes' study of pregnant teenagers in Khayelitsha revealed indicators of greater intimacy within relationships of the pregnant teenagers, which may suggest that more of the pregnancies were wanted than was suggested (58).

A very candid teen in a youth group meeting made the interesting observation that she doesn't get drunk on alcohol, but gets 'drunk on love'. She explained that she wants so much to feel that she's loved that she'll do things she would not do under other circumstances as illustrated in the quote below:

[6] Youth group discussion; Anglican Church Tafelsig, Mitchells Plain.

*'If a boy knows enough to tell me that he loves me, then he's found the key to my heart and the key to my panties. I don't like it, but that's how I am' (Teenage girl) (109).*

Young women may decide to fall pregnant in order to prove their love to their partner (90).

### 3.2.2.4(iii) The partner's desire for a child

Sometimes young women fall pregnant because their partner is wanting to have a child, as illustrated in the quote below:

*'Many men my age already have children. It makes a guy feel pressure to have one. Everyone else has a child, so you must also do it to prove your fertility' (Male, 24 years old) (129).*

Many teenagers are encouraged to become pregnant by their partners to prove their love, womanhood and fertility. In many cultures, early fatherhood is an affirmation of masculine maturity and strength. By early adolescence boys have begun to view fatherhood as a marker of manhood and sexual prowess, thus they will encourage their girlfriend to fall pregnant in order to prove their manhood (129,155).

If the boyfriend is older, this may create more pressure. In Jewkes' study of teenagers in Khayelitsha, pregnant girls had a significantly greater age gap with their boyfriend than the sexually active non-pregnant teens (58).

### 3.2.2.4(iv) Lack of education

Globally, there are higher levels of teenage pregnancy amongst girls with a lower educational background (156). This is indicated in Table 3.9 below:

**Table 3.9: Percentage of adolescents who fall pregnant**

| Country | No education | Primary school completed | Secondary school completed |
|---|---|---|---|
| Niger | 7.8 | 6.7 | 4.6 |
| Guatemala | 7.1 | 5.1 | 2.6 |
| Kenya | 6.7 | 4.8 | 3.2 |

(149) Miller K, Clark L, Moore J. Sexual initiation with older male partners and subsequent HIV risk behaviour among female adolescents. Family Planning Perspectives 1997;29(5).

Studies link higher education levels with delayed sexual initiation and reduced risk of HIV. Education leads to a drop in teenage pregnancy because it leads to a psychological change in women. It gives her a new sense of responsibility for herself – an empowerment to shape her own future rather than having her future shaped first by her father and then by her partner. According to Murphy (156) education can lead to the following outcomes:

- Enhanced knowledge of and greater exposure to what is happening in the outside world.

- Greater decision making autonomy in the home.
- Greater physical autonomy in interacting with the outside world.
- Greater emotional autonomy.
- Greater economic and social autonomy and self reliance.

Amartya Sen refers to such transformation as 'women's agency', when women are no longer passive recipients, but active agents of change and makes the link between empowerment and fertility in the following quote:

*'There is much evidence now that women's empowerment (including female education, employment and property rights) has a very strong effect in reducing fertility' (156).*

### 3.2.2.4(v) Violent partner

Jewkes' study of teenagers in Khayelitsha focused on relationship dynamics and their association with the risk of pregnancy. The pregnant teenagers were significantly more likely to have experienced forced sexual initiation and were beaten more often. Both forced sexual initiation and unwillingness to confront an unfaithful partner are strongly associated with pregnancy and also related to each other. The associations are mediated through unequal power relations, which are reinforced by violence. Nine percent (9.2%) of pregnant teenagers had experienced forced initiation and 5.1% of non-pregnant teenagers (58). Nkanku's study in Limpopo also cited coercion as a factor in teenage pregnancy (155).

### 3.2.2.4(vi) Family desire for pregnancy

Grandmothers may encourage teenagers to produce a baby, so that they have company, and mothers often indicate that pregnancy is preferable to the possibility of infertility caused by contraceptive use. Adolescent childbirth has become institutionalised and is a fairly typical stage in the domestic life cycle of many families. The baby is usually accepted into the mother's family (58) as illustrated in the case study below:

**Case study**:
An 18 year old matric student was a server at an Anglican church. When I went to visit the family a couple of days after the birth, I asked if granny was getting any sleep. 'Don't call me Makhulu (granny), but Mama' she said. The granny had already taken the title of mother and the daughter would return to school as soon as possible.[7]

### 3.2.2.4(vii) Attitude of nurses

Nurses in family planning clinics often provide little information on the various options for contraception or discussion of their potential side effects and women are frequently scolded. This is particularly true for adolescent girls, who often report that the nurses try to moralise and scold them when they come for contraceptives (58).

[7] Personal observation

### 3.2.2.5. Attitude to the use of condoms

The use of condoms has been seen as one of the most important parts of a risk reduction strategy. However, the effectiveness of a programme which includes condom use must be measured against the objective of reducing the spread of HIV. Effectiveness requires acceptability and compliance, as well as efficacy. Condoms may be highly efficacious (transmission might be interrupted in as many as 99 percent of encounters) and yet be ineffective if used in few encounters. For example in a study of sex workers in Zaire, all 22 women who used condoms for every sexual episode were sero-negative, demonstrating that condom use was efficacious. However, the method was not effective as only 4% of the 568 women interviewed were regular users, so 11% of the sample became HIV positive (157). Condoms appear to be a more effective strategy with men who have sex with men than with heterosexual couples. This may be because of greater power imbalances between males and females which make it difficult for females to request condom use. (157).

A study of four Sub-Saharan African countries showed the following statistics regarding condom use amongst adolescents as illustrated in Table 3.10:

**Table 3.10: Percentage of adolescents who used condoms at last sex**

| **Country** | Burkina Faso | Ghana | Malawi | Uganda |
|---|---|---|---|---|
| **Male** | 49.3 | 48.9 | 38.7 | 50.7 |
| **Female** | 26.2 | 38.4 | 23.6 | 27 |

2004 National Adolescent Surveys (158)

Generally in South Africa males are more likely to use condoms than females: 53-57% of males use condoms and only 48% of females (97,159). The trend is slightly different amongst adolescents, although the overall condom usage is lower; more girls are using condoms than boys which may be an encouraging trend. Amongst high school learners, male condom use was 29.4% and female 32.7% according to the second South African national youth risk behaviour survey, and in the Western Cape the percentage of males using condoms consistently was 35.9% and females 41.7% (160). In the following sections the reasons for non-use of condoms are discussed.

### 3.2.2.5(i) Disempowerment

Using or not using a condom is not simply a question of safer sexual behaviour; it is the outcome of a negotiation between potentially unequal partners. Condoms are not neutral objects about which a straightforward decision can be made on health grounds. Sexual encounters may be sites of struggle between the exercise and acceptance of male power and male definitions of sexuality and of women's ambivalence and resistance (124). A key problem is that the condom message calls upon the woman to assert dominance in the sexual act. Almost everywhere such dominance is not the traditional role and imposes unfamiliar behaviour on both members of the couple (157).

- In a study held at STI clinics in Cape Town, only 51% of men and 57% of women said that it was right for a woman to refuse sex (135).
- In a study in Uganda measures of gender equity in power relations tend to be associated with increased discussion of condom use and actual use (141).
- In studies in Rwanda, Uganda and Zaire, condom use was significantly higher among couples in which the female was HIV positive and the male negative than among couples in which the male was positive and the female negative (141).
- Studies have shown that increased power among women is often associated with increased condom use. Women with higher scores on the Sexual Relationship Power Scale were five times more likely to use condoms consistently than were women with low scores (141).
- In Pettifor's study of South African women aged 15-24, women with low relationship control were 2.1 times more likely to use condoms inconsistently (148).
- Harrison's study of secondary school learners in Kwa-Zulu Natal found that the majority of girls would use a condom if this was initiated by the boy. However the feeling that condom use should be male initiated was so pervasive that they felt it would be easier for them to try to refuse sex completely than to try to negotiate condom use. At the same time, most of the girls upheld relationships in which male partners made decisions, introduced condoms, and controlled the timing of sex. Decisions to use condoms were controlled by males, with the tacit agreement of their female partners (59).
- In interviews with women in Durban, many described their long term partners as behaving more like fathers than husbands, thereby diminishing their status and decision making authority in the relationships (142).

Gender-based power inequalities generally incorporate the belief that men should control women's sexuality and their child-bearing capacity. If women practice family planning, the male partner loses this control. Concerns expressed by men in qualitative studies include the fear that they will lose their role as head of the family, that their partners will become promiscuous or adulterous, and they will be ridiculed by other people (141). Thus in a relationship of unequal power, it becomes very difficult for a woman to negotiate condom use.

### 3.2.2.5(ii) Pleasing your partner

One of the reasons that women say they do not use condoms is in order to please their partner, since many men prefer sex without a condom as illustrated in the following quote by an 18 year old woman:

*'He says that if a man uses a condom he can't taste the candy' (142).*

Men tend to be more negative towards condom usage them women. In Reddy's study the following results were found as illustrated in Table 3.11:

**Table 3.11: Percentage of males and females holding different attitudes to condoms: Xhosa speaking patients attending STI clinics. Cape Town 1999**

| | Male | Female |
|---|---|---|
| Using condom will lessen sexual pleasure | 43 | 20 |
| Using condom will diminish intimacy | 34 | 16 |
| Condom use is bad, not flesh to flesh | 45 | 22 |
| Waste of sperm, not good for clan name | 44 | 20 |
| It is bad like masturbation | 41 | 19 |
| Bad, because if men refuse sex, they lose virility | 33 | 14 |

(135) Reddy P, Meyer-Weitz A, Van den Borne B, Kok G. STD related knowledge, beliefs and attitudes of Xhosa speaking patients attending STD primary health care clinics in South Africa. International Journal of STDs and AIDS 1999;10:392-400.

In Jewkes' cross-sectional study of women from three South African provinces, the proportion of couples who had discussed HIV was 39% and in almost a third of relationships women had suggested using condoms (31%). Thirty-six percent of men said they did not like them and two percent of men accused the woman of infidelity (54).

In Varga's study of youth from Durban, amongst women who had discussed condoms, 42% said their partners usually refused condoms because it made sex less pleasurable. Because of their disempowerment, many women will not use a condom and give in to their partner's desires (142).

### 3.2.2.5(iii) Intimacy and trust

One of the most important barriers to condom usage is the issue of intimacy and trust. Use of condoms is associated with casual sex and where there is 'true love' condoms are no longer used as illustrated in the following quote:

*'At the start of the relationship we were playing, now I trust her, that is why I don't use it.' (Male KwaZulu-Natal) (59).*

HIV has made the issue of trust in sexual relationships a potential matter of life or death. In the standard progression of romantic relationships, after trust has been established, condoms are no longer needed as illustrated in the quotes below (124):

*'Depends on how 'easy' she is. If she'd sleep with me the first night, I'd wear a condom. But if I met a girl who weren't that type of girl and started seeing her regular, then I'd trust her, I don't like wearing them'(Male, 18 years old) (55).*
*'He said he uses condoms with his seven sex buddies, but not with his girlfriend because he loves her'.* [8] *(Anglican lay counsellor, Cape Town)*

[8] Quote from a participant at an Anglican Students Fellowship Conference, Bellville 2006

Condoms are associated with a lack of trust. In Reddy's study of Xhosa speaking patients at STI clinics, 43% of males and 35% of females said that using a condom meant that you don't trust your partner.

Women's self esteem and social status is often linked to a committed monogamous relationship. In such circumstances condom use would be an insult, suggesting infidelity and lack of 'true love'. Condom-less sex on the other hand helps maintain the desired image of the partner being faithful to them. So-called 'unsafe sex' actually keeps safe the desired relationship and its emotional intimacy, trust and economic stability. To acknowledge a possible infidelity and risk of HIV necessitates a confrontation, which may lead to at least embarrassment and at worst threaten the stability of the whole relationship. A woman may maintain the pretence that casual encounters are loving relationships. This means pretending to trust her partner, which may imply not using condoms or questioning their sexual history. Thus many people will make the rational choice to view themselves as 'safe' rather than face the social consequences of safer sex (142).

It is said that women seek love and men seek sex, so fundamental to a women's enjoyment of sex is the belief that this is love not just sex. Use of a condom may demote it into a sexual act rather than an act of intimate love.

### 3.2.2.5(iv) Guarding your reputation

Use of condoms for women is often associated with being loose or promiscuous as illustrated in the quote below:

*'If a woman offers me a condom, I won't take her seriously (i.e. marry her) I don't think she would be a good model for my kid' (Male adolescent) (55).*

AIDS has been presented as a disease of high risk groups, and the attendant moral panic has always caused some people to distance themselves from such groups, leaving their own behaviour and notions of risk unchallenged. This distancing from high risk groups leaves people in the general population unprepared to cope with the spread of the pandemic. Condoms have become associated with the sexually promiscuous and casual sex. Adolescents are primarily concerned with social acceptability and the opinions of their peers, so may not want to be associated with the negative connotations of condoms (124).

Girls who suggest using condoms are considered, by both male and female participants, to be 'loose' (124). A number of girls said they were not at risk for STIs so had no need for condoms. Believing that you are at risk for HIV would mean admitting that you had not been living up to the right standards. Carrying or buying condoms can imply sexual experience – undesirable for women, although sometimes desirable for men. Similarly, asking for condoms can imply inappropriate experience for women.

Women feel embarrassment about every stage of condom use. When they put their reputations first, buying condoms, carrying them and asking for their use are all difficult. Having a condom on one's person indicates a lack of sexual innocence, an unfeminine identity, that of a woman actively seeking sex. A sexual woman becomes easy, fair game and generally at men's disposal (124).

To suggest condom usage may also give the impression that you are HIV positive. Asking your partner to use a condom may imply that you think your partner is positive and thus condom-free intercourse can be seen as a sign of trust. In South Africa and Uganda, wanting to use a condom can be interpreted as a sign of carrying disease (55). In Reddy's study 14% of men and 8% of women believed that 'using a condom means that you have AIDS' (135). This belief is illustrated in the following quote:

*'I would be embarrassed and afraid. Maybe the guy would think I have AIDS then he wouldn't want to have sex with me' (Female, KwaZulu-Natal) (142).*

There is a prevalent idea that women are repositories of sexual (physical and moral) dirt. Thus condom use is not necessary with a woman who is morally clean, since she would also not be at risk of being 'dirty' with a disease (54).

### 3.2.2.5(v) Poor communication

There are often very low levels of communication between people who are involved in intimate physical and sexual acts. In Varga's study of pregnant girls and their partners, 61% of girls felt that AIDS related issues were not appropriate to discuss with partners. None of the males had discussed AIDS with mothers of their children. Females focused on lack of intimacy as a reason for avoiding the discussion as illustrated in the following quote:

*'We don't talk about things like condoms, sex or STDs. It isn't that kind of relationship' (Female, KwaZulu-Natal)(142).*

With such poor levels of communication, it becomes nearly impossible to discuss the use of condoms.

### 3.2.2.5(vi) Fear of rejection and violence

Many women are afraid of rejection or violence if they demand to use a condom as illustrated in the quote below by a girl from Kwa-Zulu Natal:

*'I would be afraid of his reaction. He might leave me' (142).*

Male opposition to contraceptives is common. One study from Soweto, Umlazi and Khayelitsha found that fear of losing a partner was the most important barrier to contraceptive use (58).

There is also the fear that rejection will lead to violence:

- In Reddy's study 8% of men and 14% of women believed that if you insist on condoms, your partner will beat you (135).
- In Pettifor's study women who experienced forced sex are 5.8 times more likely to use condoms inconsistently (148).
- In Varga's study, 58% of women said they avoided discussing condoms due to physical abuse or rejection (142).

This wide-spread fear of violence is illustrated in the following quote:

*'I would not talk to my boyfriend about contraception. If he thought I was using it, he would beat me' (Female, KwaZulu-Natal)(142).*

### 3.2.2.5(vii) Religious beliefs

In many religious communities, the condom is associated with immoral and sinful behaviour (162,163) as illustrated in the following quote:

'*We are saved by the blood of the lamb, not by a piece of rubber'.*[9]*(Pastor)*
*'How can you include this information on condoms? – You are promoting fornication*.'[10] *(Conference delegate)*

The President of the Vatican's Pontifical council for the family, Cardinal Alfonso Trujillo made the following statement on Catholic Online, suggesting that condoms should carry a government health warning as quoted below:

*'The AIDS virus is roughly 450 times smaller than the spermatozoon. The sperm can easily pass through the 'net' formed by the condom. These margins of uncertainty should represent an obligation on the part of the health ministries and all these campaigns to act in the same way as they do with regard to cigarettes which they state to be a danger' (163).*

At one PEPFAR[11] funded rally organised by a Faith Based Organisation in Uganda, the following advice was given to participants:

*'Using a condom with a person with these (sexually transmitted) diseases is like using a parachute which only opens 75% of the time' (164).*

A Catholic publication in Nairobi called HIV/AIDS: a call to action: Responding as Christians encourages youth with the following words:
*'Be wise, DON'T condomise' (165).*

[9] Sermon at a youth Congress, Anglican Church, Khayelitsha 2001
[10] Comment made at an inter-church conference organized by Fikelela AIDS Project, Cape Town 2004, when the information pack contained leaflets from the Department of Health which showed the correct way to put on condoms.
[11] PEPFAR – Presidents Emergency Fund for AIDS – a USA based fund for AIDS prevention.

Because of these teachings many young people identify the condom with sin, less than the sexual act itself. Therefore it seems less 'sinful' to have sex without a condom.

### 3.2.2.5(viii) Conclusion

Most people when faced with a behaviour change, such as using condoms, will feel ambivalent with internal arguments both for and against the change. The arguments for and against change can be likened to the weights on either end of a balance or scale. The literature on condoms, however, suggests that the arguments against change, which are largely relational and not medical, usually outweigh the arguments for using condoms. Prevention workers who only acknowledge one side of the scale may find the process of arguing for condom use a frustrating one that is met with overt opposition, covert non-adherence or only superficial agreement.

The decision to use a condom is not a simple rational or technical decision. The arguments for continuing to practice unsafe sex may be more immediate and more powerful than the potential fear of HIV. For many women, the decision to ask their partner to use condoms is a very difficult one. This ambivalence is illustrated in Figure 3.3 below:

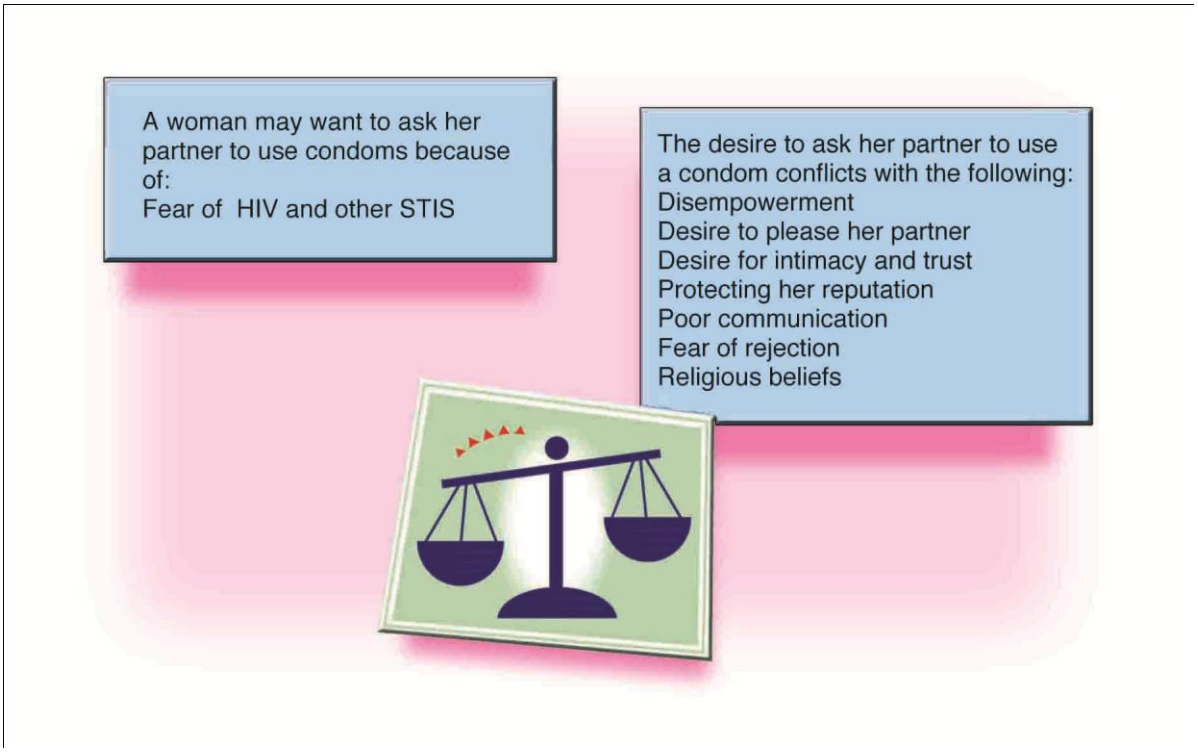


***Figure 3.3. Ambivalence in the decision making process around asking your partner to use condoms.***

For this reason many adolescents and women would choose to use other forms of contraceptives to protect themselves from unwanted pregnancy, over which they have control, and which do not affect the male's pleasure. The psycho-social benefits of unsafe sex outweigh the risks of HIV. The majority of women may choose 'unsafe love' over 'safe sex' (166).

## 3.2.3. DISTAL

The cluster of distal influences is from the community and culture that surround the individual. These include issues such as violence, poverty and the influence of the media.

### 3.2.3.1. Sexual violence

South Africa reports one of the highest rates of sexual violence in a country not at war. Estimates suggest that 120 women per 100,000 are raped every year. Girls under the age of 18 constitute approximately 40% of reported and attempted rape cases, and 12 to 17 year olds are particularly vulnerable (49). Rates of forced sex in established relationships are extremely high. In Pettifor's national study, 39% of adolescent girls report forced sex (159) and in Jewkes study of pregnant teenagers in Khayelitsha, 66% reported forced sex (58). In that study the majority of sexually active teenagers reported having sex against their will and one in ten had been raped. Two thirds of teens had been beaten by a boyfriend and pregnant teenagers report a greater frequency of beatings.

### 3.2.3.1(i) Reasons for violence against women

Since violence against women is so common, it is important to attempt to understand the reasons. There are many reasons for violence against women, such as a violent society, rape supportive attitudes, and issues of power and these are examined in this section.

- **Violent society**

South Africa has a tumultuous history. Violence was a strategy to gain power or to resolve conflict during the periods of colonialism and apartheid and it is common in the community, schools and families (58). Both micro and macro level factors in South Africa have created a context conducive to gender based violence and the sexual powerlessness of women (142).

- **Rape supportive attitudes**

Cultural beliefs and attitudes that legitimise and condone sexual violence lead to a greater tolerance of sexual coercion and rape (167). There are social scripts which often guide interpersonal interactions; for example, that men should be dominant and aggressive, and women passive and compliant or that women mean yes when they say no. Rape myths blame the woman for arousing the man and justify the act of rape. Findings show that men who self-report traditional stereotypical masculinity are more likely to hold rape supportive attitudes than those with less traditional masculinity beliefs (167).

- **Attitudes to date rape**

Another issue that can lead to high levels of violence is the belief that when you are going out with a partner, he is entitled to sex. Date rape is often not considered to be rape. In a study of 800 college students in the USA, 27% of women indicated that they had been forced to have sex in a dating situation, but when they were asked if they had been raped,

only 3% reported yes. In the same study, 15% of men indicated they had forced a woman to have sex, but only 1% responded yes when asked if they had committed a rape (167). There is often a failure to acknowledge date rape or rape between partners as a serious transgression. There is a general acceptance of the fact that once you are in a relationship sexual activity will be taking place.

- **Power**

Male violence may take place in a relationship for many reasons, such as:

- to ensure sexual availability;
- to discourage or punish infidelity;
- to assert control over the beginning and end of relationships; and
- to discourage attempts to undermine their sexual success with other women (58).

These reasons concern the underlying issue of an imbalance of power between the partners. An acceptance of the inferiority of women carries over into the sexual arena, so that men with traditional patriarchal views are more likely to think that women are to be controlled and manipulated, even to the point of sexual coercion. One partner is dominant (powerful higher status), and the other is submissive, (less powerful and with lower status). Men who devalue women or perceive them as other, an object of men's sexual desire, are more likely to feel justified in the use of interpersonal violence (167).

- **Communication issues**

Because of the low levels of communication between sexual partners, and the social expectation that women should not be the initiators of sex, this can lead to poor communication about sex. For example a girl may say no, because of this social pressure to appear chaste, when she really means yes. This is known as 'scripted refusal'. The danger is that if women say no when they mean yes, and then agree to sex, men become unable to distinguish between scripted and real refusal (124).

- **Refusal of sex**

Another common reason for sexual violence to take place is when there is refusal of sexual intercourse. In Varga's study of adolescents in Kwa-Zulu Natal, 55% of women reported having refused sex with their most recent boy friend. Of these 71% were not successful and refusal nearly always resulted in physical coercion, abuse or threats as illustrated in the following quote (142):

*'I don't refuse sex though I usually have to do it anyway. It doesn't end there. I know he is going to hit me if I don't. I am even scared to tell him I am tired of sex'(Girl, 19 years old).*

In the same study, attempts to discuss the female partner's refusal of sex with men frequently drew indirect responses, several avoided the issue completely, and a few appeared to find the question nonsensical. Many felt the statistics of rape were

exaggerated, and were generally of the opinion that women should and do anticipate sex as part of a relationship, and women want sexual satisfaction as much as men. A common comment was that it is a man's duty to satisfy a woman sexually in order to keep her from becoming bored and finding another boy friend. This belief that sex is always desired by the woman is illustrated in the following quote:

'*I do not rape anyone. All my girl friends enjoy my company' (Male, KwaZulu-Natal) (142).*

**3.2.3.1(ii) Reasons for not leaving a violent relationship**

Why then do young women remain in relationships if there are high levels of violence and sexual coercion? Some of the reasons are examined in the following section:

- **Looking for love**

Girls and women often stay in abusive relationships because they are looking for love. There are often 'islands' of love in the relationship and they keep hoping that the violence will stop. There are also broader social meanings to the relationship. Many young people have few recreational facilities or prospects of employment. To have and to hold onto a relationship becomes crucially important (58). This partnership may also bring financial benefits. The following quotes illustrate the desire of young women to hold onto their partners no matter the cost:

*'When I refused sex in the past, it led to our breaking up until I agreed to have sex again'(Girl, KwaZulu-Natal).*
*'I am afraid of losing him, since I need the money' (Girl, KwaZulu-Natal) (142).*

- **Normality of sexual violence**

Tragically, there is often a sense that violence is a normal part of sexual activities. It is seen as inevitable and many teenage women feel that they do not have much control over it (58). In Varga's study, sexual violence was discussed in a matter of fact manner, as if it was a normal part of life. Even one of the field assistants was beaten up and said the following:

*'What can I do? When he comes at me I just close the door and wait until he is finished' (Field assistant) (142).*

Violence against women in many of our communities is so common that one judge was even reported as saying:

*'Why complain? Women in the coloured community are used to being beaten up. Violence is part of their nature' (Judge) (168).*

It seems that many men did not perceive their sexual behaviour as abusive or violent; rather it was seen as a way of showing love, often through expressing jealousy. Many women described and endured such behaviour in a very matter of fact manner. This is

occurring in both traditional and modernising South African societies as illustrated in the following quote:
'*Men may beat their women when they do not observe sexual fidelity or when their own infidelity is questioned by their women' (142).*

### 3.2.3.1(iii) HIV risk of violence

There are many studies that document the ways in which violence places women at risk of HIV. Jewkes' study of women in the Eastern Cape aged between 15-26 showed a significantly increased risk of HIV infection for those with low relationship power equity and more reported incidents of intimate partner violence. The findings are reported in Table 3.12:

**Table 3.12: Effect of low relationship power and intimate partner violence on HIV acquisition**

| | | HIV acquisition per 100 person years | P value |
|---|---|---|---|
| Relationship power equity | High | 5.5 | 0.027 |
| | Low | 8.5 | |
| Reported incidents of intimate partner violence | One or none | 5.2 | 0.032 |
| | More than one | 9.6 | |

(58) Jewkes R, Vundule C, Maforah F, Jordaan E. Relationship dynamics and teenage pregnancy in South Africa. Social Science and Medicine 2001; 52:733-744.

Heise studied the global impact of gender-based violence on HIV risk, and showed that the risk can be either direct or indirect (169):

- **Direct HIV risk**

Women can be placed at risk of HIV directly through being forced to have sex. They are also limited in their ability to either refuse sex or negotiate condom use. Thus violence places them in a position of engaging in unprotected sex.

- **Indirect HIV risk**

Sexual abuse in childhood can lead to increased sexual risk taking in adolescence and adulthood (169). Sexually abused or assaulted women often turn to drugs as a coping mechanism, in addition to such unhealthy behaviour as having unprotected sex and trading sex for money or drugs.

Fear of men's reaction also hinders efforts to encourage voluntary HIV testing. This has implications for controlling the transmission of the virus between partners and also transmission from mother to child.

In a 1999 speech, Peter Piot, the Executive Director of UNAIDS, noted that violence against women has many links to HIV and AIDS.

*'Violence against women is not just a cause of the AIDS epidemic; it can also be a consequence of it' (170).*

However the links may not always be so predictable. For example in Jewkes' review, an experience of intimate partner violence influenced the likelihood of suggesting condom use, but in the opposite direction to that expected. Women who experienced violence were *more* likely to suggest condoms. It may be that women who have experienced violence in the past may find it harder to trust men and this may explain why they suggest condom use (54).

### 3.2.3.2. The impact of media

The media has a strong impact on our values and beliefs as Nicholas Johnson the former USA federal communications commissioner reminds us:

*'All television is educational, the only question is: what is it teaching?' (171)*

Whereas 50 years ago, a teenager's family, friends, school and church were probably the primary influences on his or her attitudes, values and beliefs about sexuality, today's teens have access to a fifth powerful influence, mass media (172).

A primary challenge of teenagers is self-definition. Many teens draw heavily from media images and storylines as they wrestle with who they are and where they fit in the world. When they find people or situations that resonate with their lives, they pay attention.

Social cognitive theory suggests that adolescents learn and model much from the media. At this stage of their lives, they are developing their identities, and through the influence of the media, they learn socially acceptable ways to engage in intimate relationships (60). Modelling may take place through a conscious copying of media roles or behaviours. It may also take place through a subconscious embodiment of the values embedded in the media content. The media reproduces societal norms and makes them look natural. The influence of the media is seen in this quote by an 18 year old boy:

*'Yeah, I feel like even though I disagree with a lot of things that are on TV, it still does affect me. It's kind of like what you see on TV, you kind of assume is normal, you know?' (172).*

The media are important because of the high proportion of time that young people spend under their influence. The media both create and strengthen cultural values. They have the potential to encourage the acceptance of casual sex and multiple partners, as well as sexualizing women and girls.

### 3.2.3.2(i) The impact of various types of media

The data included in this section is taken predominantly from a report of the American Psychological Association who conducted a systematic review on the sexualisation of girls

through the media. Over 400 studies were examined. Although this has limitations, because it examines US media, it is of relevance due to the high proportion of US media available in South Africa. The following statistics are taken from this report (60).

- **Television**

In a study of prime time television, 84% of shows contained at least one incident of sexual harassment, with an average of 3.4 incidents per programme. The most frequent acts were sexist comments, in which a wide variety of deprecating words were used to describe women – *broad, bimbo, dumb ass chick, fox, babe, blondie*. Thirty two percent of incidents were verbal sexual comments focusing on women's bodies, especially breasts, referred to as *boobs, knockers, hooters* and other such terms. Thirteen percent was body language, involving men leering at women or girls. Seventy eight percent of the harassment focused on demeaning terms for women and the sexualisation of their bodies.

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- **Music videos**

Between 44-81% of music videos analysed contained sexual imagery. Sexually objectifying images of women constitute a large portion of the sexual content. Women were presented more frequently than men in provocative and revealing clothing. In 57% of the videos women were portrayed exclusively as decorative sexual objects. In a study of 182 videos, 37% of women wore revealing clothing, compared to 4.2% of men. The two most frequently occurring sexual behaviours were sexual objectification and women dancing sexually.

Music videos convey information about female sexuality not only through the images and story lines of individual videos but also through the changing personas of the artists. Teen artists exploit their sexuality to establish a more mature and 'edgier' version of their former selves as they cross the threshold from teenage icon to adult musician, for example Christina Aguilera and Britney Spears. These singers are often role models to young people, and these changes as they 'grow up' drive home the point that as girls become women they should aspire to being beautiful sexual objects.

- **Music lyrics**

Some of the lyrics which teenagers listen to are very blatantly sexual, such as this song by Usher:

*I wanna make love in the club ….*
*Lets both get undressed right here*
*…I'mma give it to you non stop*
*And I don't care who's watching (Usher 2008)*

An analysis of the media diet of American adolescents demonstrated that sexual content appeared more frequently in their musical choices than in their television or magazine choices. The lyrics often sexualise women or refer to them in highly degrading ways as illustrated in these lines from songs:

*'Don't you wish your girlfriend was hot like me' (Pussycat Dolls 2005).*
*'I tell the hos all the time, Bitch get in my car' (50 cent 2005).*

Researchers coded the content of 164 songs popular with teens; 15% of songs contained sexually degrading lyrics. Most of these lyrics were concentrated in rap and R&B artists; in some individual artists, as many as 70% of their songs had degrading sexual content.

- **Movies**

There are far higher levels of female nudity when compared to males. One study found that female nudity exceeds male nudity in a four to one ratio (60). Even in children's programmes, the popular Bratz dolls are sexually and often scantily clothed. Multiple partners are frequent, and high levels of coercion of women are often portrayed.

- **Magazines**

Magazines geared at teenagers have become increasingly popular. One of the dominant themes is that a major goal for women is to present themselves as sexually desirable in order to gain the attention of men. Girls are encouraged to look and dress in certain ways in order to look sexy for men and to purchase certain products in order to be more attractive and desirable to men. Advice is given regarding hairstyle, cosmetics or diet, in order to attract the attention of boys by looking hot and sexy. Even articles on fitness, focus on the need for girls to increase their sexual desirability through exercise rather than on improving their health or well being.

*'The world of YM is a place where young women must consume and beautify themselves to achieve an almost impossible physical beauty ideal. It is a place where sexuality is both a means and an objective, where the pursuit of male is almost the sole focus of life. In fact the objective of attracting males is the only objective presented – it is an unquestioned 'good'* (60).

- **Video/Computer games**

Out of 80 teen-rated video games assessed, 27% of the games contained sexual themes. Games were significantly more likely to depict female characters partially nude or engaged in sexual behaviours than to depict male characters in this way. When the 20 top selling games were analysed, only female characters were portrayed as highly sexualised.

- **Internet**

Pornography is readily available on the Internet: 12% of all web sites are pornography sites, and 25% of all search engine requests are for pornography. Female celebrities were far more likely than male celebrities to be represented by sexualised images. There are many social network sites and good and bad sources of information. It is very difficult for young people to distinguish between them and many also portray women and girls in highly sexualised ways.

- **Advertising**

Women more often than men were shown in a state of undress and exhibited more 'sexiness'. In adverts shown on prime time television, 20.8% of women were shown in 'sexy' wear as opposed to 9.2% of men. This is particularly true of beer commercials with 75% of beer advertisements compared to 50% of non-beer advertisements labelled as 'sexist' due to the featuring of women in very limited and objectifying roles. In magazine advertisements, women are often featured as 'decorations' and their major purpose is to be looked at. They are treated as appendages to the product, rather than as active consumers or users of the product. In an analysis of men's magazines – 78% of women were depicted as suggestively dressed, partially clad or nude, and depicted as sex objects. The focus is on women's bodies as sexual objects for others viewing pleasure.

- **Clothing**

Teen magazines combine fashion and beauty in one category. Given that girls may be developing their identity in part through the clothing they choose, it is of concern when girls at increasingly younger ages are invited to try on and wear teen clothes designed to highlight female sexuality. Wearing such clothing may make it more difficult for girls to see their own worth and value in any way other than sexually. A recent phenomenon is the production of 'sexy' clothes in child and teen sizes. Focusing on the 'tween' population (aged seven to teen), sexy lingerie, camisoles and lacy panties are marketed for very young girls.

- **Cosmetics**

Advertisements for adult women's perfume overwhelmingly advertise seduction and sex appeal through the use of scent. Cosmetics and perfume are often associated specifically with the desire to be sexually attractive, a desire that seems misplaced in pre-pubescent girls, but there is a growth of products for this age group as illustrated in the following quote.

*'The message from advertisers and the mass media to girls (as eventual women) is they should always be sexually available, always have sex on their minds, be willing to be dominated and even sexually aggressed against and they will be gazed on as sexual objects' (60).*

### 3.2.3.2(ii)The impact of media on attitudes to gender

Studies have found that among children and adolescents, heavy viewers of TV have more stereotyped gender role conceptions than do light viewers (60). Peer and media influences on gender development have been found to be stronger than parental influence. Television viewing has been shown to change sex role attitudes in a way that is increasing women's vulnerability through sexualisation (171):

- **Sexualisation**

Healthy sexuality is an important component of both physical and mental health, which fosters intimacy, bonding and shared pleasure and involves mutual respect between consenting partners. Sexualisation occurs when:

- a person's value comes only from his or her sexual appeal or behaviour, to the exclusion of other characteristics;
- a person is held to a standard that equates physical attractiveness with being sexy;
- a person is sexually objectified, that is made into a 'thing' for others' sexual use, rather than seen as a person with the capacity for independent action and decision making or
- sexuality is inappropriately imposed upon a person (for instance underage).

It is evident that the influence of the media is contributing to the sexualisation of girls.
A specific and virtually unobtainable physical appearance constitutes sexiness for women and girls in our society. Sexuality is valued over other more relevant characteristics, such as a girl's personality, or athletic and academic abilities.

Sexualisation may be especially problematic when it happens to youth. Developing a sense of oneself as a sexual being is an important task of adolescence. Just at the time when girls begin to construct identity, they are more likely to suffer losses in self esteem, and perceived physical attractiveness is closely linked to self esteem. Diminishing self esteem in early adolescence may make girls particularly vulnerable to cultural messages that promise popularity, love and social acceptance through the right 'sexy' look (136).

Teenage girls are encouraged to look sexy, yet they know little about what it means to be sexual, to have sexual desires, and to make rational and responsible decisions about pleasure and risk within intimate relationships that acknowledge their own desires. Younger girls imbued with adult sexuality may seem sexually appealing and this may suggest their sexual availability and status as appropriate sexual objects (136).

The sexualisation of girls may not only reflect sexist attitudes, a societal tolerance of sexual violence and the exploitation of girls and women, but may also contribute to these phenomena (60).
The sexualisation of girls also affects boys, because if girls and women are seen exclusively as sexual beings rather than as complex human beings with many interests, talents and identities, boys and men may have difficulty relating to them on any other level than the sexual. This can limit the opportunities to interact intellectually, in sports, art or music, activism or to develop healthy friendships with women.

- **Attitudes to coercion**

Zurbriggen reports that women and men exposed to sexually objectifying images of women from mainstream media were found to be significantly more accepting of rape myths, sexual harassment, sex role stereotypes, interpersonal violence and adversarial sexual beliefs about relationships, than were those in control conditions (60). Exposure to sexist magazine adverts produced a stronger acceptance of sex role stereotyping and of rape myths among male undergraduates. This review concludes that there are reliable associations between viewing pornography and committing sexually aggressive acts (60).

- **Risk of HIV**

Impett suggests that the sexualisation of girls has negative consequences on girl's ability to develop healthy sexuality. Adolescent girls with a more objectified view of their bodies had diminished sexual health measured by decreased condom use and diminished sexual assertiveness (137). Studies have found that women who frequently watch music videos or read women's magazines, or who identify strongly with popular TV characters, were also more accepting of sexually objectifying notions of women and of other traditional gender ideologies. A woman who has learned to fear negative evaluations of her body may be more focused on her partner's judgments of her than on her own desires, safety and pleasure. A study found that greater levels of body discomfort and body self consciousness predicted lower levels of sexual assertiveness, condom use self efficacy, as well as higher levels of sexual risk taking (52).

### 3.2.3.3. Poverty

Poverty puts young people at risk for many reasons:

- Poor parenting may be a product of a poorer family having to leave children un-monitored while they go to work. This puts the children at risk of abuse or neglect. Sometimes there are low levels of trust between community members (49).
- In situations of poverty, a girl may become economically dependent on a man, because of the lack of other options open to her, so she is more likely to exchange sex for money – there is a fear of abandonment. Women who have few alternatives for economic survival will fear losing the bread winner and may hesitate to leave a risky relationship (155).
- Because of economic constraints or lack of transport, young people may not be able to access health services.
- There is a lack of recreational activities available in poor communities.
- Because of their traditional role as caretakers of children and the sick, girls may drop out of school and thus not be able to escape the cycle of poverty apart from by acquiring a sexual partner (141).

# 3.3. IMPLICATIONS FOR THE AGENTS OF CHANGE PROGRAMME

In this section the implications for the Agents of Change programme are considered, looking at the three clusters of factors discussed: intrapersonal, proximal and distal.

## 3.3.1. INTRAPERSONAL

There are three main ways in which these studies assisted with the development of the Agents of Change programme: an understanding of biological vulnerability, poor self-esteem, and body image, and support for the individual. There is a need to acknowledge both women and men as sexual beings.

### 3.3.1.1. Biological vulnerability

Many girls are not aware that they are more vulnerable to HIV infection because of biological reasons, and this is where the educational side of the Agents of Change programme can be enhanced, through inter-active dialogues around why young women may be at greater risk.

### 3.3.1.2. Poor self-esteem

The experience of being selected as a peer educator appears to be a boost to young people's self-esteem. By working with facilitators, parents and clergy so that they can comprehend the links between poor self-esteem and vulnerability, these change partners can have a role to play in boosting self-esteem.

### 3.3.1.3. Body image

The Church can have an important role in combating the strong media messages around body image. If young people can internalise that they are made in the image of God and have worth as human beings, this can help to combat the very narrow images of physical beauty that the media portray. One of the first sessions of the Agents of Change begins with an ice-breaker on the theme 'God don't make junk'.

### 3.3.1.4. Support for individuals

The church is often involved in counselling of individuals who have suffered sexual coercion or rape. This area of work would grow if the Church gave a clear message that they are on the side of the vulnerable.
In terms of prevention on the individual level it is important for the Church to understand why the rates of condom usage amongst sexually active church girls are lower than in the rest of the community, and to take action to change messages that may be going out which limit condom usage.

Another area where the Church can become involved at the level of individual prevention is in the area of education. It has been shown that education is a protective factor for HIV and teenage pregnancy (130,156). Educated women are also more resistant to patriarchal norms (173). Prevention interventions should include programmes to make sure that adolescents stay in school. This might involve after-school homework clubs, bursaries for school fees and supply of stationary and uniforms.

#### 3.3.1.5. Acknowledge both women and men as sexual beings

It is clear from every country studied that young men are sadly neglected by families and societies when it comes to their sexuality and sexual development. For all their sexual activity and the instances of sexual distress and anguish they inflict upon young women, young men pursue and are left to pursue sex and their understanding of it in almost total silence and in the absence of support. Young men's sexual health is not just about STI prevention. It is about recognising the sexual needs of young men, their search for information about their desires, experiences and bodies and the help they need in facing the impact of the larger socio-economic forces. The argument is not a claim to equal time and space it is a recognition that unless attention is paid to young men's sexuality, most efforts to help young women will be largely ineffectual. The importance of recognising young men as sexual beings is illustrated in the following quote:

*'Representing young men as 'predators' is as counterproductive as representing young women as victims' (139).*

Often there is an assumption that women are non-sexual beings. Female adolescent sexuality is represented as victimisation, as vulnerability to male predators. They are taught to defend themselves against disease, pregnancy and abuse. There are many findings that indicate that conceptualisations of young women as sexual victims and of their sexual experiences as unfortunate and inauthentic will be soundly resisted by young women themselves. If female desire to engage in sexual activity is not discussed, then there is little possibility of their developing a critique of gender or sexual arrangements (174).

### 3.3.2. PROXIMAL

In this section we consider the proximal factors discussed above and their relevance for the Agents of Change programme. There are several key areas where the programme can impact on proximal factors: gender norms, attitudes to condoms, older partner, the family, the community and men as partners.

#### 3.3.2.1. Gender norms

Gender norms are socially constructed and they do change over periods of time. This indicates that this is an important area where a programme such as Agents of Change, together with the backing of the Church, may be able to make some impact. This can take

place through interactive dialogues which encourage young people to critically assess the current gender norms, such as double standards and the acceptance of multiple partners, that put both girls and boys are risk. This process can also be assisted when priests use the powerful platform of the pulpit to challenge some of the accepted gender norms which the Church has traditionally upheld, such as the inferiority of women.

Gender role theory maintains that people behave in ways that are consistent with cultural norms and expectations of each gender as illustrated in the following quote:

*'Beliefs that promote male dominance and female sexual submissiveness and violence, therefore contribute to unsafe sexual practice' (175).*

South Africa has been classified as a 'rape-prone' society and this is the context within which prevention programmes need to be understood (176). Traditional gender roles encourage men to be violent in the name of 'masculinity' and women to be sexually passive in order to be 'feminine'.

The male-dominated structure of society is maintained by a patriarchal structure, which perpetuates sexual violence against women. Feminine gender roles do not play a causal role in perpetuating sexual aggression, but do play a supportive role in that the traditional sexual script that women are taught complements the aggressive male role. Women are taught to be the gatekeepers of 'uncontrollable' male sexuality and if they experience sexual victimisation, they are encouraged to blame themselves rather than the man (176).

One of the key institutions of this social structure is in fact the Church, both as a male-dominated hierarchical structure, and in the social roles that it endorses with its theology. Through Scriptures, traditions, sermons and teaching, religious institutions convey values and belief systems to their members (177). This theology is then worked out in the Church's practical responses to sexual violence. For example Ephesians 5:22-23 says: *'Wives submit to your husband as to the Lord. For the husband is the head of the wife as Christ is the head of the Church'.* A critical look at the history of much of our religious teaching makes clear that religious institutions have explicitly or implicitly shaped the context of values which support unequal gender roles and have tolerated violence against women (177). The research indicates that these issues are not being dealt with by the Church. In the outcomes mapping evaluation the indicator for clergy on the outcomes challenge: 'sermons on rape, violence against women and children' scored low, indicating that these issues are rarely dealt with.

In order for this programme to be more effective, issues of gender need to be addressed not only in the life-skills programme but also from the pulpit.

### 3.3.2.1(i) Silence on gender based violence

Another challenge for the church is to speak against coercion and gender based violence. The findings show that rape-supportive attitudes amongst church youth are not greatly different to the rest of the community. Coercive behaviour is also taking place amongst church-based young people. However, a study of churches in Paarl (178) looking at the support that churches give to sexually abused teenage girls indicated that only 12.5% of congregations were involved with victims of sexual abuse, only 10.3% involved in counselling and only 9.8% involved in prevention. This in then a very important area, both to be challenged through the life-skills programme, but it is also vitally important to set up adequate support and referral systems for victims of abuse.

### 3.3.2.1(ii) Developing a critical consciousness around gender issues

It is important that young women develop a critical consciousness around the double standards around gender. These dictate that a young woman should meet her partner's sexual needs but at the same time she should stay pure. This would involve encouraging young people to ask deeper questions in a Freirian style; 'but why?' (119)

- But why must I have sex when I don't want to?
- But why are the man's needs more important than mine?
- But why do I owe him sex if he buys me a drink?

Young people should be encouraged to question the norms that shape the unequal power balance in relationships(173).

### 3.3.2.1(iii) Attitudes to condoms

It often appears that the pressures on young people not to use condoms are stronger than those encouraging them to use condoms. Partners may not be keen to use them, and peer pressure may dissuade their use. The programme can assist on two levels, first of all by giving a strong message through the peer educators that consistent use of condoms is non-negotiable. The programme also needs to address local issues that limit condom usage, such as beliefs around it being a sin, or the linkage of condom use to lack of trust. These issues can be addressed in group discussion and role plays.

### 3.3.2.1(iv) Older partners

This is often an under-addressed issue in many programmes. An understanding of high risk behaviour is linked to condom use or number of partners. However, this is a very important issue that needs to be incorporated into the programme. If adolescent girls understand the risks of older partners it may be easier for them to not get swept up by the promise of gifts and prestige.

### 3.3.2.1(v)The family

Organised religious and other moral instruction often begins within the family and can offer girls important practical and psychological alternatives to the values conveyed by popular culture. When faith leaders and religious parents communicate the message that other characteristics are more important than sexuality, they help to counteract the strong message that it is only girls' sexuality that makes them valuable. By insisting that girls be allowed to remain girls and not be pushed into a precocious sexuality, they provide a haven where girls can develop at their own pace. Religion may also counteract the effects of media representation.

The Church is well placed to begin to change gender roles through the family structures. Opportunities such as marriage preparation, baptism class and Sunday school would allow more health enhancing gender norms to be encouraged. The development of gender based attitudes and beliefs amongst adolescents begins early and has implications for adult behaviour. Research with adolescent males suggest that boys begin to view women as sexual objects, see sex as a performance and use coercion to obtain sex while they are still adolescents, and such behaviour continues into adulthood. Condoning multiple partners for boys is already engrained by adolescence. Boys who observe men behaving violently towards women may come to regard this behaviour as normal and acceptable (141). Thus it is important that interventions to challenge gender norms be started at a young age.

The family often provides a positive influence in terms of values and monitoring. Interventions can help parents to improve their communication with adolescent children, as well as stressing the importance of the protective shield of the family. Studies show that strong or close family ties are one predictor of teens' ability to get through adolescence without having a child, landing in jail or developing a drug habit (172). Programmes are needed to help parents with effective discipline and not using harsh punishment (49). Strengthening trust between other concerned adults would also facilitate greater community support networks.

### 3.3.2.1(vi) A human rights approach

There is a need to move from a moralising approach, towards adopting a human rights approach to prevention
Adolescent girls have the right to the following:

- to refuse unwanted sexual behaviour;
- to the necessary knowledge and ability to protect themselves from STIs and unwanted pregnancy; and (137)
- to experience sexuality without penetration (173).

Traditionally the church has had a double message when it comes to prevention, that the burden is on the girl to say no, not expose themselves to risky places, dress conservatively and so on (179). The Church needs to adopt more of a human rights approach, where girls

are empowered to stand up for their rights, rather than a moralistic view that it is 'bad girls' who do certain things.

#### 3.3.2.1(vii) Men as partners

*"The same gender roles that leave women vulnerable to HIV also put men at risk" (180)*

Men often equate masculinity with risky behaviour, dominance over women, multiple partners and the rejection of health-seeking behaviour. It is important for the Church to elicit the support of men and boys in changing gender roles for a number of reasons:

- Men's health is also compromised by rigid gender roles.
- Men care deeply about the women in their lives: their mothers, sisters, neighbours, and friends, and are frequently shattered by violence perpetrated against them.
- Men are tired of carrying the stigma of being seen as perpetrator because of the prevalence of violence of other men.
- Relationships based on equality and mutual respect are more satisfying than those based on fear and dominance (180).

Given the fact that the Church has so many influential male leaders, if they can take a stand against sexual coercion and imbalance of power in gender roles, the Church could be very influential in this area. Clergy need to be involved in advocacy and speaking out. Most clergy play an important role in interpreting and shaping peoples understanding of the world in the context of their religion. They can help to shape expectations of acceptable family behaviour (181). The Church, rather than covering up issues of sexual abuse or harassment, which has sadly often been the case, should be at the forefront of speaking out against these issues in the Church and in the community.

A move from patriarchal relationships to partnerships will lead to reduced risk for both male and female. It is important to emphasise the advantages for men of participating in more gender equitable relationships. It can also be of benefit to explore the positive values of fatherhood with young men (141). Programmes that educate boys about parenthood may lead to stronger male parenting skills and reduced rates of pregnancy amongst their girl friends (129).

### 3.3.3. DISTAL

The importance of these studies in terms of distal factors involves violence, poverty and the media.

#### 3.3.3.1. Violence

Because of the high rate of sexual coercion amongst adolescents, this is a critical period to introduce programmes to reduce the risk of boys becoming perpetrators. While attitudes and behaviours about sex and gender are learned from an early age, adolescence is a critical age for entrenching normative sexual behaviours. Both associate with sexual and nonsexual coerciveness. Adolescence is considered a critical period in which accumulated risk factors for abusive behaviours may set in place enduring patterns of abuse in intimate relationships (169). The programme may assist in this process through interactive sessions, role plays and also through the impact of messages from the pulpit.

#### 3.3.3.1(i) Poverty

Poverty increases vulnerability on many levels, but the programme can assist with some of the consequences. One of the consequences of poverty is the fact that parents have to travel long distances on public transport and there are many unsupervised hours for their children. The Church could have a key role to play in terms of offering safe spaces for children to do home work after school, or after school care. Another of the consequences of poverty is that many children drop out of school because of there not being funds for school fees, uniforms or stationary. Through being involved in Agents of Change, the facilitators may become aware of these situations and be able to assist or refer the young person for assistance.

#### 3.3.3.1(ii) Media

The programme includes sessions on media literacy, which help the young people to develop a critical attitude to the media messages they are receiving. This could be strengthened with advocacy; both in terms of messages from youth or parents, but the voice of the Church in terms of advocacy challenging some of these media messages could also be strengthened.

## 3.3.2. CONCEPTUAL FRAMEWORK

The theory of triadic influence underpins this part of the conceptual framework, which shows the three levels of risk, intrapersonal, proximal and distal (49).

- **Intrapersonal**

Girls are more at risk because of biological issues, but also self-esteem plays a part. Here building self efficacy can be of help in reducing risky behaviour. There is a need to challenge negative body images. There must also be recognition that both males and females are sexual beings.

- **Proximal**

Gender norms and power imbalances as well as older partners place adolescent girls at risk. The programme can have an impact on changing gender norms, challenging power imbalances and educating youth about the dangers of older partners. There is a need to create a critical consciousness around gender issues. Gender–based violence and coercion must be challenged. There is a need to move from a moralising approach to a human-rights approach. It is also necessary to begin to shift from patriarchy[12] to a concept of 'men as partners'.

- **Distal**

Violence and poverty are issues which increase girls' vulnerability; the programme can have an impact in terms of challenging rape supportive attitudes, challenging attitudes in the media.

[12] **Patriarchy** is a social system where the male is seen as the primary authority figure and the female is in a position of subordination.

# CHAPTER FOUR: A LITERATURE REVIEW OF RELIGION AND HIV

## 4.1. INTRODUCTION

The Agents of Change intervention takes place within a church setting, so therefore it is important to understand the role of religion in HIV work. Religion is of great importance in Africa, and plays a key role in the lives of many people on the continent. The following quote from the African Religious Assets Programme, which is an international research collaboration working on the interface between religion and public health, emphasizes the importance of religion in the African world-view:

*'Though often hidden from Western view, religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives' (20).*

This section of the literature review is divided into the following sections:

- **The role of religion in HIV work in Africa**

Here the importance of religion in Africa is examined and the potential positive and negative roles of Faith Based Organisations in the area of HIV and AIDS.

- **The influence of religion on adolescent sexuality**

Due to the contextual differences between high income countries and low income countries in Africa, these two contexts are considered separately. Very few studies were found from other low income countries so only studies from Africa were selected.

- **The effect of religious affiliation on sexuality**

Here the effect of different religions and denominations on sexuality is examined. Due to the high prevalence of Islam and the low prevalence of other religions apart from Christianity, only Islam and Christian denominations are examined. Each country has different terminology for their denominations, and studies use different terms. A simplified nomenclature of Islam, Mainline Protestant, Catholic, Pentecostal, Zionist and African Traditional Religion is used. In some cases this terminology may differ from that used by the individual study. Affiliation and attendance are assessed to see which is more important.

- **How religion impacts sexuality**

The influence of moral teaching and socialisation are assessed.

# 4.2. THE ROLE OF RELIGION IN HIV WORK IN AFRICA

In this section the role and importance of religion in Africa is examined, and the potential positive and negative roles it can play are discussed.

## 4.2.1. THE IMPORTANCE OF RELIGION IN AFRICA

An engagement with the religiously informed health world is vital for shaping public health policy (20). Africans have a deeply religious and spiritual orientation, and most people's lives are touched by religion (19). Churches are growing rapidly in Africa, whereas in many parts of the developed world they are decreasing (20).

There is a lack of concrete data regarding the impact of religion on health care and in particular HIV work. Estimates have been made that varying from country to country between one quarter to three quarters of health care in Sub-Saharan Africa is being provided by Faith Based Organisations (FBOs) (182). UNAIDS estimates that one in five organisations engaged in HIV programmes are faith based (22). It is estimated that the Roman Catholic Church alone provides 25% of all HIV/AIDS care including home-based care and orphan support in Africa (20,183).

In South Africa, out of the 1582 entries in the National AIDS database, 162 identified themselves as faith based organisations. Of these the great majority were Christian (96%) (184). The contribution of the churches was noted by World Bank President James Wolfensohn in 2002 as quoted below:

*'Half the work in health and education in Sub-Saharan African is done by the church, but they don't talk to each other, and they don't talk to us' (20)*.

Faith Based Organisations (FBOs) operate at different levels, of which the following have been identified:

- Large international organisations such as Catholic Relief Services and World Vision.
- Local organisations such as Fikelela AIDS Project, Scripture Union, or ACVV (Afrikaanse Christelike Vroueverenigning; Afrikaans Women's Christian Organisation).
- Local congregations (28,183).

In this analysis only local FBOs, local congregations and religious leaders are looked at. Large international organisations often have different characteristics, and the impact of traditional faith healers would merit a review all of its own.

FBOs have the potential to do great good, but they can also do great harm. In the next section first of all the positive role of FBOs in HIV work is examined and then the negative role. As this quote from Lucy Keough, retired Senior Operations Officer of the World Bank notes, both roles are of critical importance:

*'The world of faith plays critical roles, both remarkably positive and highly negative'* (22)

## 4.2.2. THE POSITIVE ROLE OF FAITH BASED ORGANISATIONS IN HIV WORK

The World Health Organisation has identified the need for health related organisations to be accessible, affordable and acceptable. The role of FBOs is examined within these three categories.

### 4.2.2.1. Faith Based Organisations are accessible

FBOs and churches are accessible, able to reach out into almost every part of Africa. Canon Gideon Byamugisha, the first Anglican priest in Africa to disclose his HIV status indicates the following:

*'We have a unique presence and reach within communities. We have unique structures and programmes that are already in place. We are available. And we are sustainable. We were there long before AIDS came and we will still be there when AIDS goes away' Canon Gideon Byamugisha (Uganda) (20).*

Churches are to be found in the poorest informal settlement, in the most remote mountain village. Religious people gather in refugee camps, and in war ravaged villages. They are often present in areas that other agencies cannot reach. They are rooted in local structures and allow the widest network coverage on the continent (182). Local churches may be part of national or international denominations, allowing resources to flow from resourced to under-resourced communities (28,185). The role of FBOs in conflict zones is especially vital since social instability leads to conditions that foster the spread of HIV (19). Churches have staying power, since they are seen to be 'of the soil' (22).

### 4.2.2.2. Faith Based Organisations are affordable

Church members are often motivated by their faith and willing to volunteer their time and resources. They often initiate activities without external facilitation or support (28) as indicated by this quote from a faith leader in Zambia:

*'We are not restricted in how far we can go in helping people because we don't need the pound, we don't need the dollar, we don't need the euro' (20).*

Working within the church networks and structures means that programmes can be rolled out at minimum cost. Churches often have quite extensive infrastructure such as church buildings and halls, offices and personnel. They often have organisational and management skills, which they can utilise together with their physical infrastructure. This avoids the set up costs that an external organisation would have to spend. FBOs tend to be pro-poor and

will allocate resources towards the marginalised. They also have the capacity to raise funds both locally and internationally through denominational links (19).

#### 4.2.2.3. Faith Based Organisations are acceptable

FBOs are locally based with well understood norms and values; and they have a high level of acceptability, sometimes higher than state or foreign organisations (20). Many faith inspired organisations have a long history of involvement in health care. Many were involved in home based care and programmes for orphans and vulnerable children before the HIV pandemic (22). They are well grounded and deeply conversant with local culture (22).

FBOs are known for their spiritual values, and many religious values are important in local culture. Values such as justice, compassion, and respect for human dignity are core values of FBOs (22). Religion promotes a culture of respect for the sacredness of life, which is radically undermined by HIV. They inspire levels of trust and confidence unmatched by government or secular organisations, so they have the potential to mobilise communities into action. They deal with disease holistically (296). Grassroots mobilisation has been identified as one of the core strategies on which to build success in programmes to counter HIV (22).

One of the strengths of religion is that it can contribute in both tangible and intangible ways. It contributes in tangible ways such as compassionate care, material support, and curative interventions. It also contributes in intangible ways such as spiritual encouragement, knowledge-giving and moral formation. It is the combination of tangible and intangible contributions that give FBOs their strength and uniqueness as indicated in the following quote:

*'It is the interweaving of the intangible within the tangible which gives the tangible its specific 'religious' character and it is the expression of the intangible in tangible ways that gives the intangible its legitimacy' (20).*

FBOs can have a positive role in facilitating behaviour change. They have a large constituency and often a 'captive audience' on a weekly basis. This leads to opportunities for information and teaching. Religions uphold principles relating to family, marriage and sexuality; they promote abstinence outside of marriage and fidelity within marriage (185). Religious leaders have the potential to be powerful agents in the promotion of public health messages. They can influence critical choices around sexual practice (28). They are directly in touch with people without recourse to another intermediary. FBOs also promote a strong sense of social cohesion, which can be a protective factor. The importance of FBOs is indicated in the following quote from Peter Piot , Executive Director of UNAIDS in 2004:

*'I hope for a day when every church engages in open dialogue on issues of sexuality and gender difference. I hope for a day when every synagogue will mobilise as advocates for a*

*global response to fight AIDS, when every temple will fully welcome people living with HIV, when every mosque is a place where young people will learn about the facts of HIV and AIDS. When that will have happened, I am convinced that nothing will stop our success in fighting against AIDS' (22).*

FBOs have the potential to be key players in combating the HIV/AIDS pandemic, but they are often hindered by negative factors. These factors are looked at in the following section.

## 4.2.3. THE NEGATIVE ROLE OF FAITH BASED ORGANISATIONS

As AIDS spread throughout Africa and grew to pandemic proportions, the church especially in the early stages had a negative role to play as the Rev Dr Sam Kobia from the World Council of Churches indicates:

*'We have felt the anguish of Africa. Nearly 10,000 people are newly infected each day. We have been inspired by the courage and dignity of people living with HIV/AIDS. We have confessed our silence as the Church and to our actions that have contributed to the spread of the disease and to death' (22).*

Religion is a powerful cultural force with both a positive and negative impact on HIV prevention work (182). Religious groups hold differing positions on contentious health practices, with their views influenced by their varying theological positions. The Catholic Church for example, has been lauded as one of the largest health providers in Africa due to its theological understanding of care, whereas simultaneously it has come under fire for its stance on condoms (182). Some FBOs struggle openly with these issues, engaging in theological debates and advocating for change, while others try to work around the conflict, ignoring theological directives, in order to get the work done. The following issues are examined in this section: silence on sexuality, stigma, the marginalisation of specific groups, gender, the condom debate, poor monitoring and evaluation, a conservative worldview, and the 'generation gap'.

### 4.2.3.1. The church's silence on sexuality

Over the last three to five years there has been an increasing global interest in the role of FBOs in HIV prevention (22). The discomfort of many faith leaders in dealing with the link of HIV to sexuality partly explains the long delay in the church in coming to terms with HIV. Some clergy are still unwilling to preach about sexuality. Some church leaders have found no power in their theology to delay sexual behaviour and tacitly accept that men might have multiple partners (22).

Because of the difficulty of addressing the inter-relationships between morality, sexuality and health, these themes are often ignored from the pulpit. This silence shows itself in many ways:

- Despite heavy involvement in care and support for those affected by HIV, the churches have been slow to get involved in prevention (28).
- HIV issues are not dealt with in-depth in sermons or at religious meetings (161).
- Inadequate attention is given to issues such as domestic violence and sexual coercion (161) .
- Due to its discomfort with talking about sex, the church has failed to help young people understand their sexuality and has often ignored the needs of sexually active adolescents. The church also has enormous issues around homosexuality (28).
- Although many religious leaders and personnel are HIV positive, it is very rare for them to divulge their HIV status (161).
- Both lay leaders and clergy tend to attribute sickness or death to causes other than HIV (28).
- HIV/AIDS is not often addressed in pastoral letters, or religious position documents (161).
- Religious communities have been slow to invest resources in workplace programmes, or AIDS policies for their own organisations. Strategic plans deal with reaching out to others, but they are slow to formulate plans to deal with the epidemic within the framework of their own organisations (28).

The following quote from a Faith Based Organisation in Kwa-Zulu Natal indicates how churches can be a barrier to prevention efforts:

'*When we ask to talk about HIV in the churches they say we are encouraging the youth to sin. We recently called youth to attend a meeting on life-skills and had a very poor turnout. Later we were told by youth that the minister said if they attended the workshop they would be demoted in the church' (186).*

The roots of this weakness in church life meet around issues of sexuality, gender and disease, where AIDS makes its home. One of the challenges for the African church is that the traditional African understanding of sexuality is 'sex positive'; human sexuality is a gift from God, and sex is seen as a divine activity which brings life. This tends to contrast with more traditional Christian 'sex negative' conceptions where a link is made between sexuality and sin. These teachings were inherited from the early theologians such as Augustine of Hippo (354-430) and Thomas Aquinas (1225-74) (143). Western missionaries were heavily influenced by Western Post Enlightenment culture, and exported 'Western Christian civilisation', which did not allow for the development of indigenous culturally appropriate theologies of sexuality, gender and disease as indicated in the following quote:

*'Sexuality was not discussed because it was taboo, gender was not discussed because there was nothing to discuss (cultural definitions were largely unquestioned) and disease was not discussed because it was the province of doctors, not theologians' (187).*

Traditional cultural views were not engaged with by the churches, they were merely condemned, and the sexual behaviour of church members did not change. This left the churches vulnerable to HIV and without an adequate theology of sexuality (187).

#### 4.2.3.2. The church adds to stigma

Much of the church in Africa was slow to acknowledge AIDS. The church was uncomfortable speaking about sex and some saw AIDS as a judgement from God (28). Many churches tend to social conservatism in the area of 'family values', so they confront issues of pre-marital sexuality with difficulty. Their theological position upholds abstinence and faithfulness within marriage. The reality of the HIV pandemic forces them to acknowledge that a significant number of their members are not complying with this position as indicated in the following quote by Campbell:

*'The very public nature of the HIV epidemic brings the church face to face with the dramatic contradictions between its teaching that sex should take place only within the context of marriage and the epidemic's very public and assertive evidence of the church's failure to reinforce these teachings' (186).*

By implication, the existence of the HIV epidemic highlights the loss of the church's moral authority. The challenge that this poses to the church is illustrated in the following quote from the Archbishop of Canterbury's World AIDS Day statement in 2006:

*'No church has found it easy to confront the realities of this HIV crisis. The cultural and social context of the spread of this disease has challenged us to face some uncomfortable realities of sexual behaviour. We have struggled to balance the moral tensions inherent in preventing disease whilst maintaining sexual discipline. We are compelled to address our responsibilities to do what we can to treat the sick and to educate ourselves and others so as to avoid further spread of the infection' (22).*

One of the strategies used by representatives of many churches to regain this lost moral authority was that of linking sexual transgressions and AIDS with sin, immorality and even the end of the world. There has been an improvement in recent years, but church leaders have in the past often been promoters of stigma partly because of their difficulty in confronting aspects of human sexuality and partly because they often assume a link between AIDS and sinful activities (22). The church was the main contributor of symbolic 'ammunition' sustaining this link. Here are some quotes from a community in Kwa-Zulu Natal which illustrate this linking of AIDS with sin:

- *'If people reduce their sins, God will cure their disease. It is the devil that overpowers people, when they engage in wrongful sex' (A senior nurse) (186).*
- *'The Bible says the end of the world will come when we are struck down by incurable diseases. The Kingdom of God will come to destroy all the evil that is prevailing in the world. I always tell myself that AIDS shows us this time has come' (A parent) (186).*

When AIDS was first acknowledged in the mid 1980s, many church leaders assumed that the church, as the meeting place of God's people, was unaffected. The link with promiscuity was developed so that AIDS was viewed as a judgement from God for sinful behaviour. Only those outside the church could be infected. Gradually the church began to realise that people within it were both affected and infected. The position of the church has slowly changed over the past twenty years (28). However even though religious leaders may have spoken out against stigma at a national level, stigmatising attitudes and practices can still continue at the local level as indicated in the following quote:

*'In fact the church became the last place where churchgoers went for help, for fear of being stigmatised as sinners' (19).*

The same attitude is seen in the response of a priest to T-shirts designed by Fikelela AIDS Project for World AIDS day 2003 which said: 'Our Church has AIDS'

*'I can't wear that…..it would be like wearing a T-shirt that says – 'Our Church has prostitutes.'*

On a national level as well, churches often held theologies which made a link between AIDS and sin as indicated in this quote from Archbishop Benjamin Nzimbi of Kenya:

*'Our earlier approach in fighting AIDS was misplaced, since we likened it to a disease for sinners and a curse from God' (28).*

#### 4.2.3.3. The church's response to marginalised groups

A further stigmatisation occurs in churches due to the link of HIV with marginalised groups such as the gay community or sex workers. The church has traditionally struggled with the issue of homosexuality. This can lead to a double stigmatisation of those who are living a gay lifestyle when they contract HIV as indicated in this quote from the mother of a young man living with HIV:

*'I love my son, but I know that it is a sin to be gay. He is rejecting anti-retrovirals. What will happen to him if he dies, he doesn't deserve to go to hell' (Mother of HIV positive son).*

Working with marginalised groups such as sex workers is difficult for the church, because reaching out to them and promoting condoms is sometimes seen as opposed to working to end prostitution. Because of stigmatisation, these marginalised groups often avoid services offered by FBOs (22).

#### 4.2.3.4. The church's attitudes to gender

Churches have been criticised for their male dominance and hierarchical structures. At the organisational level the major religious faiths have a predominantly and sometimes exclusively male hierarchy. Although churches may promote the role of women in other spheres, they have not yet succeeded in making the theological equality of women a lived reality in their own organisational structures as indicated in the following quote (19,185):

*'Through its teaching, organised religion promotes the liberation of women, but through its practice contributes to maintaining their domination by men' (161).*

This makes it difficult for women to believe that they have a right to make their voices heard in decisions affecting their sexual lives. The heavy patriarchy of religious structures reduces their credibility when addressing the concerns of women. The church is seen to support traditional gender role models. This often leads to an underlying acceptance of male dominance, and a concept of masculinity that reduces sex to a physical activity, as well as a concept of femininity that expects a girl to be passive and yielding (28).

#### 4.2.3.5. The condom debate

The most highly publicised negative role of the church is that of condom use. This has been particularly intense for the Roman Catholic Church, and Evangelical Churches. For a decade the Catholic Church condemned the use of condoms, saying that condoms should:

*'Not even [be used] in marriage when one partner threatens to pass the HIV virus to another' (188).*

Up until the mid-1990s the Catholic Church refused to compromise. In 1996 the French Bishops Conference gave a qualified moral support to the use of condoms to prevent the spread of HIV/AIDS. This position helped to open the discourse on the various strategies that both the church and its laity had available to them. A Catholic priest in Kenya said:

*'There is no place in our religion for the use of condoms, whether in the regulation of fertility or in the control of the diseases. And that is the teaching of Christ' (161).*

In September 2003, Cardinal Alfonso Lopez Trujillo, president of the Vatican's Pontifical Council for the Family, continued the controversy with the statement that condoms have tiny holes through which the HIV can pass. The World Health Organisation condemned this view. Pope Benedict XV1 recently said in a new publication "Light of the World: The Pope, the Church and the Signs of the Times" that the use of condoms can be justified in some cases such as for male prostitutes seeking to prevent the spread of HIV (189). Condom use remains an issue about which people of faith continue to be ambivalent. Protestant churches are also often unhappy to include the use of condoms in their teaching, because this is seen as encouraging promiscuity or sex before marriage. This emphasis on the

condom debate has weakened the potential of organised religion to work in partnership with other organisations:

- It has tended to polarise AIDS workers into those who favour and those who oppose condoms. Sometimes this leads to intransigence on both sides.
- It has drawn attention away from the positive activities of the faith communities.
- The debate has focused almost entirely on moral perceptions, without recognising that the nearly exclusive focus on condoms has sidelined the importance of addressing the centrality of social contexts including socio-economic status, culture and gender relations.
- The debate has led to conflicting and confusing statements being placed before the public.

#### 4.2.3.6. Poor monitoring and evaluation

FBOs and churches are often weak in the area of monitoring and evaluation, since such a high percentage of their work is done by volunteers (28). Where there is documentation, it is often only shared with donors and is not disseminated in other ways within the organisation or to other organisations and denominations. There is often competition between denominations, and this extends to HIV programmes. Churches may be afraid that other denominations will 'steal their sheep', so there is a wariness to collaborate (161). This means that best practice models are infrequently shared or rolled out (182). Sometimes FBOs operate 'under the radar' of government services, which can lead to service gaps and duplication of programmes. Often the work of FBOs is initiated by visionaries, so when they leave or move on, the work may come to a halt.

#### 4.2.3.7. Conservative theology

Many churches have a conservative world view, which is often reflected in their male dominated leadership structures. This affects their positions on gender, stigma and condoms and may even lead to the church colluding with oppressive regimes (28). Faith leaders and communities have often been part of the increased stigma and gender norms that have contributed to the spread of the disease and hindered efforts to prevent HIV (22). Too often, churches see prevention as focussing on individual morality, and the entrenched structural determinants of the epidemic are ignored (190).

#### 4.2.3.8. The generation gap

Church leaders seldom approach children or young adolescents (19) as indicated in the following quote from a young person in a church in Cape Town:

*'Pastors don't normally talk to us; they only greet us' Church Youth, Cape Town.*

Another problem is that clergy often 'preach down' to their congregations. They utilise a dated educational culture of lecturing from the pulpit, rather than interactive learning, and their preaching often does not reflect the aspirations and concerns of youth (19). The sermon as a form of communication has become to some extent 'reified', and it is extremely rare for a church to consider a different way of communicating during the service. It is also difficult for young people to talk to adults about issues of sexuality. This was illustrated graphically by a young female respondent in a focus group discussion in Cape Town:

*'People in their twenties are best placed to teach young people about their sexuality. Older people are honestly gross. Who wants to hear about sex from their parents' friends?' (191).*

Thus, in Sub-Saharan Africa, religion is an important role player in terms of HIV work. Churches are accessible, with the possibility of mobilising many volunteers at affordable costs. However the church can also play a negative role because of its linking of sexuality to sin, which leads to stigma. Churches also struggle to interface with marginalised and high risk groups such as homosexual people or sex workers. In terms of prevention work the Church is often hampered by conservative theologies in dealing with issues of gender and condom use. In the next section the influence of religion on adolescent sexuality is considered.

## 4.3. THE INFLUENCE OF RELIGION ON ADOLESCENT SEXUALITY

The influence of religion on adolescent sexuality is examined in this section: firstly in high income countries and then in Africa.

### 4.3.1. THE INFLUENCE OF RELIGION ON ADOLESCENT SEXUALITY IN HIGH INCOME COUNTRIES

There is a large amount of research, particularly in the USA, on the links between religiosity and sexual behaviour. Religiosity is defined in Webster's dictionary as '*a set of beliefs concerning the cause, nature and purpose of the universe... usually involving devotional and ritual observances and often containing a moral code for conduct of human affairs: a set of beliefs and practices generally agreed upon by a number of persons' (61).*

Research and survey data generally show that religious faith and a strong moral sense play important roles in protecting young people from early sexual activity (61,192). The majority of the literature deals with Christianity alone, but some studies include other religions, although the number of such studies is quite small.

#### 4.3.1.1. The positive influence of religion

Several positive influences have been linked to adolescent religiosity:

- There is evidence that religious beliefs and practices may influence values and attitudes that affect sexual behaviour (193,62).
- Many studies of adolescent sexuality report that religious youth initiate sexual activity at a later age than non-religious youth (62,63,64,194,195).
- Adolescents with a higher religiosity score were significantly more likely to have higher self-efficacy in communication with partners about sex or HIV (194).
- Religious youth were more likely to be able to refuse an unsafe sexual encounter (194).
- Religious youth were likely to have fewer sexual partners (193,63).
- Religious beliefs have more impact on raising the age of sexual debut of girls than of boys (195).

These seem to be generalised findings throughout the literature as indicated in the following quote from Whitbeck:

*'Consistent with most research on early sexuality, adolescent religiosity had strong negative effects (delaying) on early intercourse' (196).*

#### 4.3.1.2. The negative influence of religion

Even though religious adolescents may have a later sexual debut, many studies indicate that they are less likely to use contraceptives (63,64,193,197). Thus religious identification may protect against initiating sexual activity, but fail to protect against unsafe sex once youth are sexually active. The implications are that religious youth may be just as much at risk of STIs and HIV as non-religious youth and possibly even more at risk. However their religious leaders may well consider them to be low risk. In the following section findings regarding the influence of religion on sexuality are discussed.

#### 4.3.1.3. Findings regarding the influence of religion on sexuality

In this next section the findings regarding the influence of religion on sexuality are discussed: the overall increase in sexual activity among religious youth, the limited impact of religiosity on males' sexual activity, the choice of non-vaginal sex rather than vaginal, the two-way effect of religiosity on sexuality, religion as a proxy for parental support and the dangers of limiting condom use.

#### 4.3.1.3(i) Overall increase in sexual activity among religious youth

Although sexual activity is lower among religious youth than non-religious youth, generally the levels of sexual activity among teenagers are increasing in the USA. This may reflect a weakening in the ability of organised religion to transmit teachings around sexual behaviour

to adolescents, or to effectively sanction behaviours that do not conform to these teachings (64,197). There has been a generational shift away from traditional rules and moral teaching to a more post-modern attitude towards morals (198). This attitude is reflected in the following quote:

*'Many of our participants believed in a form of religion that is inconsistent with that taught in Christian churches in the Bible belt. Our conversations with local clergy and religious leaders clearly suggested that premarital sex is a sin. Yet three quarters of the participants stated that it 'should not be' and 'is not' a sin' (199).*

#### 4.3.1.3(ii) Limited impact of religion on males' sexual activity

Some of the studies indicated that the influence of religion was less on males than females (193,195,199). In a study of religious behaviour, alcohol consumption and sexual behaviour, the effects of religion were limited to women (199). One study of religious adolescents found that the influence of religion on males was limited to Hispanic and white males, but females of all races were influenced (193). A further study found the influence of religion to be limited to adolescent girls only (64).

#### 4.3.1.3(iii) Non-vaginal sex

Many churches do not feel comfortable with discussing non-vaginal sex, such as oral or anal sex. Some church leaders believe that these subjects are too advanced for young adolescents and that teaching about such behaviours would require parental permission (200). However, several studies reveal high levels of non-vaginal sexual experience among adolescents, as technical virginity is maintained in accord with religious teaching (201).

#### 4.3.1.3(iv) Two way effect of religion on sexuality

As stated above, most studies show a substantial correlation between adolescent sexual behaviour and religious participation. Interpreters of this relationship have assumed that it was religion that affected sexual behaviour. However there is emerging literature which suggests that there is a reciprocal relationship. *'Religiosity both influences and is influenced by teenage sexuality'* (62). If the individual becomes sexually active, and feels that this is not in line with church teaching, they may then reduce their involvement in church activities. Young people who become sexually active may decrease their levels of religious involvement to reduce dissonance with religious teachings against premarital sex (193).This is particularly marked in the case of teenagers who fall pregnant, and often drop out of church because of the judgmental attitudes. Thus those still active in church will be less likely to be sexually active, not because of the effect of religion, but because the sexually active teenagers have dropped out.

#### 4.3.1.3(v) Religion as a proxy for parental support

Studies indicate that religiosity may be a proxy for other issues such as parental support. Religiosity has been associated with improvement in marital and family stability, which has an impact on teenage risky behaviour (61,195). Greater parental monitoring, having a mother as primary caretaker, and living in a dual-parent family were all associated with having greater religious involvement (194). The effects of living in a two-parent versus single-parent house involve a number of dimensions including a higher socio-economic status, increased parental supervisory capabilities, and increased potential for communication regarding sexual or contraceptive issues (197). Many of the associations between religiosity and sexual behaviour disappear once adjustment is made for these factors (193).

#### 4.3.1.3(vi) Proxy for parent's religiosity

Parents who are more religious are more likely to involve their children in religion (193). Studies have shown that the mother's religiosity and church attendance may also have an impact on the likelihood of an adolescent becoming sexually active (196). For example an adolescent's attendance is associated with their mother's attendance, and parents who attend frequently have more conservative attitudes about sex (193). The religiosity of the adolescent, particularly in terms of church attendance, is often a reflection of the mother's religiosity. Young people are often going to church because of their parents' and not their own choice, so they may reflect a mother's conservative views (62).

#### 4.3.1.3 (vii) Raising the age of sexual debut but limiting condom use

Religion is hypothesised to influence adolescents' sexual behaviour through social control. If the religion is opposed to pre-marital sex, then the decision to engage in only one forbidden behaviour (non-marital sex) is preferable to the decision to engage in two forbidden behaviours (non-marital sex and contraception). Likewise, premeditated sex, in which an adolescent actively plans and organises a contraceptive, may create intolerable cognitive dissonance for religious youth (195).

Thus, in high income countries, it appears that religion is linked to a later sexual debut and a reduction in number of partners, particularly with girls. The impact on males is more limited. On the negative side, religious youth may exchange vaginal sex for other types of sex and are less likely to use protection when they do become sexually active.

### 4.3.2. THE INFLUENCE OF RELIGION ON ADOLESCENT SEXUALITY: STUDIES FROM AFRICA

When assessing the influence of religion on adolescent sexuality, it is noted that there are many different denominations. Within Christianity the following definitions of denominations are used in this study:

- Mainline protestant (These are Protestant churches which were originally founded from an established colonial church, such as Anglican, Dutch Reformed, or Presbyterian)
- Roman Catholic
- Pentecostal/Evangelical (These are churches which emphasise the work of the Holy Spirit , many have split away from mainline protestant churches)
- African Independent Churches (These are churches which are indigenous, such as the Zionist Church)
- New mission (this category includes groups sometimes referred to as 'sects' such as Jehovah's witnesses, Mormons)

It is remarkably difficult to access studies on religiosity and sexual activity from Africa. Most of the literature refers to the scarcity of research into this area (29,30.31.32). A search of Medline and Google scholar was conducted using key words: religion, HIV prevention, sexual activity, sexual behaviour, condoms, abstinence, Africa, Sub-Saharan Africa, to access studies looking at this issue. Although religion is a key issue in Africa, it would appear that published studies linking religion and sexuality are very limited. The eleven studies found are summarised in Table 4.1:

**4.1. Table of studies linking religion and sexual behaviour in Africa**

| Study | Location | Age sample size | Results[13] |
|---|---|---|---|
| Mash et al. (202) Survey of Anglican Youth | Cape Town, South Africa | 12-19 1306 | • 30% are sexually active (40% of males, 21% of females);<br>• only 35% used condoms at first sex;<br>• 6% forced to have sex;<br>• 33% of sexually active had more than four partners; and<br>• rates of sexual activity were similar to the general population. |
| Nweneka(32) Survey of youth in Pentecostal and mainline churches | Southern Nigeria | 12-35 341 | • by the age of 19, 42% of girls and 44% of boys were sexually active;<br>• in the past 12 months, 19% of those who had been sexually active abstained, 30% had one partner, 28% had more than one partner; and<br>• rates of sexual activity (12-35) similar to the general population (65% vs. 63%)<br>• no significant difference in number of partners or abstinence between Pentecostals and Mainline<br>• Pentecostals more likely to use a condom than mainline (p=0.007) |

[13] Odds Ratios(OR) or P value were not recorded in all cases

| Study | Location | Age sample size | Results[13] |
|---|---|---|---|
| Takyi(29) Survey of women | Ghana | 15-49 4843 | • self reported AIDS risk: Christians reported a lower level (56%-no risk) than non-Christians (49%); (p<0.001)<br>• AIDS knowledge: Christians had highest level (Roman Catholic 76%, Protestant 87%, no religion 54%);(p<0.05)<br>• higher levels of religiosity linked to lower levels of condom use (p<0.05); and<br>• the effect of religion on avoidance of multiple partners was not significant. |
| Nicholas and Durrheim (65) Survey of first year university students. | Western Cape, South Africa | 18-21 1817 | Students with high levels of religiosity:<br>• more likely to have a later age of sexual debut p<0.0001;<br>• less likely to intend to be sexually active in the year ahead p<0.0001;<br>• less likely to use safer sex practices p<0.0001; and<br>• have had fewer sexual partners in high school p<0.015. |
| Lagarde(31) Survey of rural community | Senegal | 15-59 858 | Men who cited religion as very important:<br>• less likely to cite AIDS as a major health problem (OR 0.4 (CI 0.2-0.8))<br>• less likely to intend to change behaviour (OR 0.8 (CI 0.4-1.0));<br>• had greater AIDS knowledge (OR 1.8 (CI 0.9-3.6));<br>• had similar attitudes to staying faithful to non-religious men (OR 1.0 (CI 0.5-2.2)).<br><br>Women who cited religion as very important:<br>• had similar attitudes to staying faithful to non-religious women (OR 1.1 (CI 0.6-2.2))<br>• were less likely to have discussed AIDS with others (OR 0.4 CI (0.2-0.8));<br>• were more likely to agree that condoms are forbidden by religion (OR 2.7(CI 1.1-6.5));<br>• had higher knowledge of AIDS (OR 1.5 (CI 0.7-3.1)); and<br>• feel much more at risk of AIDS (OR 9.3 (CI 4.0-2.2)). |
| Fatusi(30) National health survey | Nigeria | 15-19 2070 | Males and females:<br>• High importance of religion had no significant effect on sexual activity<br>• Frequent attenders had a close to significant difference in sexual activity (males p=0.053, females p=0.08) |

| Study | Location | Age sample size | Results[13] |
|---|---|---|---|
| Erasmus (203) Survey of Anglican Youth | South Africa, Namibia, Lesotho, Swaziland | 14-17 164 | Anglican youth aged 14-17 years:<br>• 92% consider themselves religious ;<br>• 24% sexually active;<br>• Types of sex : oral 12%, vaginal 28%, anal 2%;<br>• Been forced to have sex 12%;<br>• Agree 'people my age are too young to have sex' – 76%;<br>• Agree 'people should wait until they are married to have sex' – 80%; and<br>• Are willing to wait if they haven't yet had sex- 79%. |
| Erasmus (203) Survey of Anglican Youth | South Africa, Namibia, Lesotho, Swaziland | 18-24 174 | Anglican youth aged 18-24 years:<br>• 44% currently sexually active;<br>• 61% have been sexually active; and<br>• 84% think sex is only okay when you are married. |
| Agadjanian (162) Survey of various Religious congre-gations | Mozam-bique | Adults 731 | • Pentecostals use condoms less at the last sexual encounter (28%) than people from mainline churches (37%) (OR 0.35 (CI 0.18-0.69)) |
| Agha et al(70) National Health Survey | Zambia | 13-24 5534 | • Conservative groupings[14] more likely to delay sexual initiation (p<0.01)<br>• Conservative groups less likely to use condoms (p<0.01) |
| Allain et al (204) Survey of blood donors | Ghana | Adults 348 | No significant difference in HIV levels between those who:<br>• Believe that extra marital sex is a sin<br>• Believe that religion helps you to abstain<br><br>HIV levels were lower among:<br>• Those who had been more than 10 years in one church (OR= 0.3(CI 0.1-1.1));<br>• Those who were leaders in their church (OR 0.4 (CI 0.2-0.8)); |

### 4.3.2.1. Findings of studies from Africa

Since the studies are so few and heterogeneous, it is hard to draw firm conclusions, but a few trends do appear across the literature:

[14] Groups such as Jehovah's witnesses

#### 4.3.2.1(i) Sexual activity

There is a marked disconnect between adolescents' espoused adherence to the church's teaching around sex before marriage and their actual behaviour. Very similar results are found in Mash's study of Anglican youth in the Western Cape, Erasmus' study of the Anglican Church in Southern Africa (202,203) and Nweneka's study of Pentecostal and mainline churches in Nigeria (32). Both the Mash and the Nkweneka study compared the sexual activity of church youth with that of the local community and did not find significant differences. Indeed, Nweneka suggests that the rates of sexual activity amongst females may be greater than in the general population. These churches are in very different cultural settings and with different theologies, but these studies suggest that, unlike in high income nations where religiosity appears to have a significant effect on sexual behaviour, the effects may be less in Africa as indicated in the following quote from Nkweneka:

*'The society within which the church exists might be exerting a strong influence in determining the sexual practices of church youths' (32).*

Swartz notes that there appears to be a gap between the reported moral beliefs of young people and their actual moral behaviour. This so-called belief-behaviour gap has been noted in several studies (273).

#### 4.3.2.1(ii) Non-vaginal sex.

The two studies by Mash and Erasmus found that church youth were engaging in other forms of sexual activity such as oral and anal sex in order to maintain a technical virginity. This is in line with studies from high-income countries (202,203). Because the church often sees these subjects as 'taboo' they are giving the message that only vaginal sex is 'really sex', thus possibly exposing youth to risk through ignorance.

#### 4.3.2.1(iii) Gender

Religious boys are significantly more sexually active than religious girls (202,32). Religious women may be at higher risk than non-religious women because they are more likely to see condoms as forbidden by their religion (31). One study showed that religious women feel more at risk than religious men (31) and this may be because religious women are more likely to be submissive, lack control over their own personal risk of HIV and are less able to intervene with their partner's behaviour. On the other hand religious men reported a lower perception of HIV risk and felt more protected from HIV (29).

Two studies showed higher levels of sexual activity amongst religious girls than non-religious girls. In Fatusi's study there were lower levels of abstinence among frequent attenders than among infrequent attenders (30). The study by Nweneka showed that the rate of sexual activity among church girls was higher than in the general community (32).This finding is in sharp contrast to the studies from high income countries that show

religiosity to reduce sexual activity amongst girls. This could point to lower levels of self-efficacy amongst African women. Because of increased socialisation at church, there are more opportunities to find a partner, but because of low empowerment, they are less able to refuse sex in the way that their peers in higher income countries are able to (31).

#### 4.3.2.1(iv) Education and awareness

It appears that being involved in a religious organisation gives more opportunities for AIDS education as religious people reported higher levels of awareness and knowledge (205).

#### 4.3.2.1(v) Sexual coercion

Rates of sexual coercion are high amongst church youth (202,203). This is an area of considerable concern since few religious organisations deal with this issue openly. Religious organisations tend to be conservative and struggle to deal with issues of intimate partner violence. The hierarchy is also male-dominated which makes dealing with issues of gender more difficult.

#### 4.3.2.1(vi) Abstain, Be faithful, Condomise (ABC)

It appears that religiosity has a mixed effect on the triad of Abstinence, Being faithful and using Condoms.

**Abstinence** – some studies report a later age of sexual debut for religious youth (30,65) whereas most showed no impact (32,70,202); and one study showed an increase in sexual activity among religious females (32).

**Be faithful** – only one study showed an impact of religiosity on numbers of partners (65) whereas all the others showed no impact. One study even showed higher levels of HIV amongst those who believe extra-marital sex is a sin (204).

**Condom use** – most of the studies showed a reduction in condom use and one study showed no impact (70).

Overall these findings suggest that religious people may even be at higher risk of HIV than non-religious people, as the positive impact of a raised age of sexual debut may be cancelled out by the negative impact of reduced condom use. The positive effect of religion on girls which was noted in high-income countries does not appear to be so evident in Africa.

## 4.4. THE EFFECT OF RELIGIOUS AFFILIATION ON SEXUAL BEHAVIOUR

The impact of religion will now be examined by affiliation, looking firstly at high-income countries and then Africa.

### 4.4.1. THE IMPACT OF RELIGIOUS AFFILIATION ON SEXUAL BEHAVIOUR IN HIGH-INCOME COUNTRIES

Studies from the USA suggest that the impact of religion on sexuality may vary according to affiliation (197). This difference was particularly marked during the 1980s and 1990s when church groups were increasingly involved in high profile debates over reproductive issues. Although all churches and religions discourage non-marital sexual activity among teens, they have different attitudes to contraceptive use. Fundamentalist protestant groups, the Catholic Church and other religions such as Islam take a stricter stance against condom use than some other mainline denominations. The following table illustrates the impact of religion on sexual behaviour by affiliation.

**Table 4.2: The impact of religious affiliation on sexual behaviour in high-income countries.**

| Author | Location | Age | Results [15] |
|---|---|---|---|
| Brewster(64) Comparison of national surveys from 1982 and 1988 | USA | 11-19 | Changes between 1982 and 1988<br>Virginity amongst the white community:<br>• Roman Catholic virgins dropped from 51 to 42%;<br>• Other Protestant virgins dropped from 48% to 39%<br>• Number of fundamentalist virgins rose from 45% to 61%<br>Condom use amongst the white community:<br>• Increase in Roman Catholics 17% to 40%;<br>• Increase among Protestants 19% to 42%;and<br>• Fundamentalists stayed the same at 17%.<br><br>Virginity amongst the African American community:<br>• No change of virginity<br>Condom use amongst the African American community<br>• Increase in Roman Catholics 7% to 14%<br>• Increase amongst Protestants 12% to 22%<br>• Increase amongst Fundamentalists 7% to 16% |
| Cooksey(197) Comparison of national surveys : 1978 and 1988 | USA | 10-19 | Amongst the white community:<br>Roman Catholics – decrease in virginity $p<0.01$<br>Other Protestants – decrease in virginity $p<0.01$<br>Fundamentalists – increase in virginity $p<0.01$<br><br>African American population showed no change |

[15] P values and OR are not available in all cases

| Author | Location | Age | Results [15] |
|---|---|---|---|
| Jones(193) National Survey from 1995 | USA | Women aged 15-24 | • Sexual debut before 15 years: Roman Catholic 12%, Pentecostal 18% Mainline 13%, no religious affiliation 24% (p<0.001)<br>• No contraceptives at last sex : Roman Catholic 19%, Pentecostal 30%, Mainline 29%, none 35% (p<0.01)<br>• More than two partners; Roman Catholics 36%, Pentecostal 40%, Mainline 38%, none 40% (p<0.01)<br>• Significant difference in sexual debut by church attendance (p<0.001), no significant difference in condom use or number of partners. |

The 1980s to 1990s saw a rise to prominence in the United States of conservative Christian advocacy groups promoting a political agenda based on family values. In fundamentalist churches this appears to have led to an impact on the sexual behaviour of white adolescents. Interestingly, there were not similar changes amongst the black fundamentalist churches. It could be that the influence of poverty on sexual risk taking was stronger than the moral stance of the church. It is also true that white fundamentalist churches tend to take a strongly proscriptive stance on family issues that is in keeping with a belief that non-marital sexual behaviour is immoral. African American churches discourage sexual activity and childbearing outside of marriage, but tend to take a more forgiving line on behaviours that constitute moral transgressions. Fundamentalist believers, both black and white, are less likely to practice contraception. The changing role of fundamentalism amongst whites suggests that the transmission of religious norms may take place not only through personal interactions in formal setting such as sermons or Sunday school, but also through mass media coverage.

The conflicting values in the American mosaic present an extremely difficult challenge to teens and policymakers. For the most part those variables that led to postponement of first intercourse also tended to lower the probability of using contraceptives at this time and vice versa as indicated in the following quote by Cooksey:

*'Social factors that tend to postpone first intercourse also tend to lead to unprotected first intercourse. Conversely, variables that lead to higher proportions using some method of contraception at sexual initiation also lead to younger ages at first intercourse'(197).*

The religious environment tends to lead to a polarisation where it is difficult for sex educators to combine the two messages together. Some programmes appear to use the 'just say no' theme and then ignore the challenge of young people who are already sexually active. Other programmes promote 'safer sex', by stressing the benefits of birth control methods, but fail to emphasize the alternative of abstinence (197). An integrated message that urges teens to delay intercourse as long as possible and then use an effective contraceptive is a difficult one to present.

## 4.4.2. THE IMPACT OF RELIGIOUS AFFILIATION ON SEXUAL BEHAVIOUR IN AFRICA

Firstly the differences between Islam and Christianity on sexual behaviour are examined and then the differences between different Christian denominations.

Among 38 Sub-Saharan African countries, there appears to be a correlation between the percentage of Muslims within countries and HIV rates (66):

- Predominantly Islamic nations such as Senegal (94% Muslim), Somalia (100%) or Niger (89%) have very low rates of HIV (0.8-1.2%).
- Mixed nations such as Uganda (Christian 60% Muslim 26%), Ethiopia (Christian 40%, Muslim 50%), and Nigeria (Christian 35%, Muslim 60%) or Kenya (Christian 72%, Muslim 23%) indicate medium rates of HIV (4.1 – 6.7%).
- Predominantly Christian nations such as Malawi (Christian 69%, Muslim 28%), Namibia (Christian 85%, Muslim 2%) or South Africa (Christian 68%, Muslim 2%), or Swaziland (Christian 60%, Muslim 10%) show very high rates of HIV (14.2% - 38.8%) (69).

Although there are many demographic and cultural issues occurring in these countries, it is interesting to reflect on why HIV rates are so much higher in predominantly Christian nations. Gray conducted a survey of published articles and found that six of seven studies indicated that there is a negative correlation between the percentage of Muslims and HIV rate. (66).

### 4.4.2.1. A comparison between the impact of Christianity and Islam on sexual behaviour

The following table compares the impact of Christianity and Islam on sexual behaviour as reported in studies from various locations in Africa.

**Table 4.3: Comparison of the impact of Christianity and Islam on sexual behaviour in Sub-Saharan Africa**

| Study | Type of survey | Sample size | Findings[16] |
|---|---|---|---|
| Trinitapoli (206) Malawi . | National survey of ever married women plus their husbands | 3386 | • Muslim youth more likely to abstain ($p<0.05$)<br>• Muslim who were married were more likely to be faithful ($p<0.05$)<br>• No significant difference in condom use. |
| Gray (66) Uganda,Kenya and Tanzania | Review of various studies | n/a | • Uganda: lower HIV rates among Muslims and significantly lower rates among men aged 20-29 years.<br>• Kenyan truck drivers, Islam was associated |

[16] OR or p values are not reported in all studies

| Study | Type of survey | Sample size | Findings[16] |
|---|---|---|---|
| | | | with lower HIV rates. Muslims were significantly less likely to have engaged in sex with a prostitute.<br>• Uganda, when controlling for lifetime number of sexual partners, Muslims had lower prevalence rates.<br>• Tanzania: Wards with a larger proportion of Muslims had a higher prevalence of HIV. |
| Allain (204) Ghana | Survey of blood donors | 348 | • No significant difference in HIV levels between Christians and Muslims. |
| Kongnyuy(207) Cameroon | Survey of sexually active men aged 15-59 | | • Muslims more likely to have paid for sex (OR1.96 (CI 1.13-3.38))<br>• Muslims less likely to have early sexual debut (OR 0.45 (CI 0.39-0.54))<br>• Muslims less likely to have had at least two partners in last 12 months(OR 0.6(CI 0.59-0.82))<br>• Muslims more likely to use condoms (OR 1.96 (CI 1.6-2.4)) |
| Kagee (208) Cape Town South Africa | Survey of HIV rates | 717 | • HIV rates higher among Muslims: 2.6 % among Muslims (CI 1.2-4.8), non-Muslims 1.8% (CI 0.8-3.3) |
| Takyi(29) Ghana | National survey from 1998 | 4843 | • AIDS knowledge among women was less among Muslims 66%, than Protestant 87%, or Roman Catholic 76% ($p<0.05$)<br>• Muslims less likely to change at least one sexual behaviour; Muslims 27%, Protestants 19%, Roman Catholics 23% ($p<0.05$) |
| Lagarde (31) Senegal | Survey of men | 858 | • Men intend to be faithful: Muslim 55% vs. Christian 42% ($p<0.01$)<br>• Condoms forbidden by religion: Muslim 40% vs. Christian 37% (non significant)<br>• Casual sex in past 12 months: Muslim 22% vs. Christian 24% (non significant)<br>• Alcohol in last month: Muslim 15% vs. Christian 31% ($p<0.001$)<br>• Married and polygamous: Muslim 28% vs. Christian 15% ($p=0.06$) |

#### 4.4.2.1(i) Risk increasing factors in Muslims:

- They are less likely to use condoms (66,67).
- They were as likely or more likely to report multiple partners (66,67,68);
- Males had an earlier or similar sexual debut to Christians (66,67,209).

#### 4.4.2.1(ii)Risk reducing factors in Muslims:

- Less likely to drink alcohol (66, 69).
- Significantly more likely to have been circumcised (31, 66, 69).
- Use ritual washing after sex (66).
- Strong prohibition of homosexuality (66,69).
- Unmarried Muslim girls have a later sexual debut than Christian girls (68).
- Girls tend to marry at an earlier age (69).
- Stronger condemnation of girls being involved in extra marital relations (69).
- More likely to divorce for unfaithfulness (67,208).

Generally the rates of HIV are lower among Muslims (66,207,210), though some of the studies indicated higher HIV rates amongst Muslims (208) and one indicated no significant difference (204).

It appears that the risk factors for men in terms of multiple partners and unprotected sex may be higher. However Islamic marital codes permit four wives. Thus the multiple partners are in a closed system. This is in contrast to Christian circles where traditional polygamy has tended to give way to a tacit acceptance of multiple partners in an open system. In Islam there are strong prohibitions against sex outside of marriage. Prohibitions against homosexuality may reduce unprotected anal sex. Islam also prohibits alcohol which may lead to risky behaviour including lack of condom use. Islamic attention to ritual washing could increase penile hygiene, and lessen the risk of STIs. Muslims are circumcised as babies; whereas if Christians are circumcised this takes place in late adolescence when many are already sexually active and may already have contracted HIV.

One study of HIV prevalence in the three predominantly Muslim residential areas in Cape Town did reveal higher HIV rates among Muslims (2.6%) than Christians (1.8%) (208). This difference could be for socio-economic reasons since these areas are changing with higher income non-Muslims moving into the areas.

#### 4.4.2.2. A comparison of the different Christian denominations

When it comes to assessing the impact of Christian denominations on risk behaviour in Africa, the situation is quite complicated. Different terminology is used in different countries. Because of the small numbers of other religions the study is limited to Islam and Christianity. The following table indicates the impact of various denominations on sexual behaviour.

**Table 4.4: Comparison of the impact of different Christian denominations on sexual behaviour**.

| Study | Type of survey | Sample size | Findings[17] |
|---|---|---|---|
| Odimegwu (68) Nigeria | Survey of University students. | 1153 | Males:<br>• No difference in rates of sexual initiation (Protestant 49% vs. Pentecostal 50%)<br>• Difference in current sexual activity (Protestant 17% vs. Pentecostals 6%)<br>Females:<br>No difference in rates of current sexual activity or initiation |
| Trinitapoli (67) Malawi . | Survey of ever married women and their husbands | 500 | Males:<br>• Pentecostals have lower levels of extra marital partners (Pentecostal 4%, Catholic 15%, Protestant 6%) p<0.05 |
| Agha (70) Zambia | National survey of adolescent girls | 5534 | • Pentecostals had highest rates of sexual activity (Pentecostals 54%, Catholic 49%, Protestant 50%, Jehovah's Witness 41%) p<0.001<br>• Condom use at first sex: (Pentecostals 24%, Catholic 22%, Protestant 25%, Jehovah's witness 19%) p <0.01 |
| Allain (204) Ghana | Survey of blood donors | 348 | • Lower HIV levels with seventh day Adventists [18] |
| Gregson (211) Zimbabwe | Survey of churches in rural areas. | | African Independent Churches:<br>• Less likely to have sex before marriage (African Independent 9% vs. Mainline 30%) p<0.01<br>• More likely to be polygamous (African Independent 62% vs. Mainline10%) p<0.01<br>• Less likely to use contraceptive (African Independent 13%, Mainline 39%) p<0.01 |
| Garner (212) Kwa-Zulu , South Africa | Survey of four churches | | Support the use of condoms (Protestant 75%, Pentecostal 55%) |
| Frank (175) Kwa-Zulu, South Africa | Survey of high school students | | Adherents of African Traditional Religions more likely to be sexually active than those of other denominations p=0.02 (OR= 2.28). |
| Agadjanian(162) Mozambique | Survey of churchgoers | 731 | Protestant churches:<br>• More likely to attend information session on AIDS (Pentecostal 41%, Protestant 58%)<br>• Use condoms more frequently (Pentecostal 28%, Protestant 37%) |
| Nweneka(32) | Survey of | 341 | Pentecostals more likely to use a condom than |

[17] Not all studies included p values or odds ratios
[18] Numbers too small for significant association

| Study | Type of survey | Sample size | Findings[17] |
|---|---|---|---|
| Nigeria | church youth | | mainline churches, p =0.007. |

#### 4.4.2.2(i) Lowest rates of sexual activity among 'sects'

A consistent finding was the lower levels of sexual activity amongst groups such as the Jehovah's witnesses, Mormons and Seventh Day Adventists (70,209). This finding was supported by lower HIV rates amongst members of these groups (204). They are different from mainline Christian churches in terms of being minority groups with very strict rules. They excommunicate members who engage in premarital sex. However these same women were less likely to use condoms during first sex (70,67).

#### 4.4.2.2 (ii) Low rates of sexual activity amongst Pentecostal groups

This was a common finding, that sexual activity rates were lower amongst Pentecostal churches (68,211,212) although two studies did find higher rates or no difference amongst Pentecostals (32,70). Two studies showed an influence on adolescent males; although the rates of sexual initiation were similar between Pentecostals and mainline churches, the rates of current sexual activity were lower among Pentecostal males. This suggests that Pentecostals are being successful in encouraging males to abstain. Girls however were unaffected and perhaps are not empowered enough to be able to follow through on a choice to abstain. People often 'convert' from mainline Protestant churches to Pentecostal ones with an associated change of behaviour. Pentecostal churches are also stricter in their teachings about alcohol. Condom usage is generally lower amongst Pentecostal churches.

#### 4.4.2.2(iii) Higher rates of sexual activity amongst mainline Protestant churches

Generally rates of sexual activity were higher amongst mainline Protestant churches than sects or Pentecostal groups. However, levels of AIDS knowledge were higher. One key denominational difference is the exposure to secular messages. Education had a powerful positive effect on the likelihood of exposure to formal prevention measures, the members of mainline Protestant churches tended to be more educated. Condom usage was higher amongst members of mainline Protestant Churches. Three studies found condom usage to be lowest amongst Roman Catholic Churches (29,67,70). This should be of concern, since it appears that this church is not effectively limiting sexual activity, but is rather effectively limiting protection.

#### 4.4.2.2(iv) Highest rates of sexual activity amongst African Traditional Religions

Generally the finding is that this is the group with the highest rates of sexual activity (6,175,213). Research indicated that there was higher acceptance of multiple partners amongst followers of African Traditional Religions, due to the accepted practice of

polygamy in these denominations. Those attending mainline Protestant churches were more supportive of monogamy, which encouraged them to abstain before marriage (175).

Thus it is clear that there is a difference in HIV risk and sexual behaviour by religious affiliation. When comparing the two main religions of Africa: Islam and Christianity, Muslims are less likely to use condoms, but males may have more partners. However these risks are offset by the fact of circumcision, lower alcohol usage, later sexual debut for unmarried girls, and the fact that the polygamy allows for multiple partners within a closed and therefore safer system.

In terms of differences between Christian denominations, the differences often are blurred but a generalisation could be made that the so called 'sects' have the lowest risky behaviour, followed by Pentecostals, mainline churches and the highest levels of risky behaviour occur within the African Traditional Religions. An issue of concern is the Catholic Church's stance against condoms as it appears that they are not limiting sexual activity in the way that the more fundamentalist churches are, but they are limiting condom usage.

It appears that a small minority among African churches, those who preach about sin and at times exclude those deemed sinful, seem to hold some power to change behaviour and reduce the incidence of pre- and extra-marital sex. The power of the minority churches seems to depend on being small and set apart from the average (190). The disciplinary aspects of socialisation - monitoring behaviour and excluding group members for breaches of rules are both unpalatable and unenforceable outside of sectarian religion (70). The potential advantages of a reduction in pre- and extra-marital sex appear to be generally offset by a reduction in condom usage.

#### 4.4.2.3. Is Denomination or Commitment more important?

An important issue to discuss in terms of religiosity is whether it is the affiliation that makes the greatest difference or the level of commitment to that grouping. The table below compares levels of commitment to religion with sexual activity.

**Table 4.5: Influence on sexual activity by importance of religion**

| Study | Type of study | Sample size | Results |
|---|---|---|---|
| Fatusi (30) Nigeria | Survey of never married adolescents | 2070 | Importance of religion:<br>• Females: lower rates of sexual activity among those to whom religion is very important (very important 79%, not important 68% (OR 0.6, CI 0.4-0.9);<br>• Males – no difference.<br>Church attendance:<br>• Females: trend towards frequent attenders being more likely to initiate sex than infrequent (14% v 5%) p=0.053;<br>• Males: trend towards frequent attenders being |

| Study | Type of study | Sample size | Results |
|---|---|---|---|
| | | | more likely to abstain (82% v 71%) p=0.08. |
| Odimegwu(68) Nigeria | Survey of university students | 1153 | Importance of religion:<br>Males: lower rates of sexual activity among those to whom religion is very important (very important 14%, not very important 25%) Females: Lower rates of sexual activity among those to whom religion is very important (very important 12%, not very important 14%) Church attendance<br>• Females: frequent attenders less likely to be sexually active (9% vs 15%)<br>• Males: frequent attenders less likely to be sexually active (9% vs 17%) |
| Trinitapoli(67) Malawi | Survey of ever married women plus their husbands | 500 | Church attendance amongst adults :<br>• Infrequent: extra marital partner 17% vs. frequent 8% p<0.01<br>Teenagers abstaining:<br>• Infrequent attenders 38% vs. frequent 59% (p<0.01) |
| Allain(204) Ghana | Survey of blood donors | 348 | • Having a formal role in church activities associated with reduced odds of HIV (OR 0.41(CI 0.21-0.80)) |

A general finding seems to be that the level of commitment to the religion is more important than the affiliation in terms of impact on sexual behaviour (68,67,70). With greater levels of commitment an individual will:

- receive more frequent religious messages;
- be more likely to accept the teaching of the institution;
- be more likely to develop sexual attitudes in line with the teaching;
- be more likely to make friends with other youth with similar attitudes; and
- have increased contact with adults who may also influence their attitudes (214).

One study found that sexual activity of males was not impacted by level of importance of religion (30). Another study found that increased attendance increased sexual activity, whereas the level of importance given to religion reduced it (30). This could indicate that in certain communities attending church is one of the ways to meet possible sexual partners.

Allain indicated that HIV positive people were more likely to be frequent church attenders than HIV negative people. However this may indicate that on discovering their status they are more likely to turn to the church for spiritual support, rather than an indication that frequent church attenders have higher levels of unsafe sexually activity (204). A study of patients who had recently tested HIV positive in Kwa-Zulu Natal indicated that many of them turned to religion as a coping strategy: when scored from 1(not at all) to 4 (a lot),

clients turned to religion (2.99; CI 2.12-3.19) rather than self blame (2.37; CI 6.40 – 2.61), or substance abuse (1.93: CI 1.80-2.07) (215).

## 4.5. HOW RELIGION INFLUENCES SEXUAL BEHAVIOUR

There are several factors that determine the extent to which an individual's behaviour is influenced by their religious affiliation. These include:

- moral and religious teaching;
- socialisation within the group;
- their level of attendance and commitment to the group; and
- cultural and social issues in the community (70,209,212).

### 4.5.1. MORAL AND RELIGIOUS TEACHING

This is probably the most highly publicised of the ways in which religious institutions influence sexual behaviour. Moral teaching has an influence in the areas of extra-marital sex and attitude to condoms.

#### 4.5.1.1. Teaching on extra-marital sex

Most if not all religious groups are opposed to pre- and extra-marital sex. But the strength of the proscription varies by group. This teaching may take place in sermons and in informal lessons through which religious norms are established and adapted (67). An individual may then internalise these moral norms, which can lead to unpleasant emotions for those who violate the norms, or positive feelings for those who comply. This attitude is illustrated in the following quote from a young member of the Anglican Church in Cape Town:

*'Christian couples also have sex when they start dating, they just feel more guilty'.*

These moral teachings may also be supported by the threat of divine retribution. Garner and Van Deutekom noted quite striking differences in attitudes to pre-marital sex between the various denominations (212,216).

In Zionist and mainline Churches the *'approach seems to be that promiscuity is bad, but that abstinence is unrealistic, and that pre-marital sex with one partner is admissible' (212).* For example:
Jabulani: *'they tell us not to have more than one girlfriend, but they don't say that you can't have sex, they keep quiet about that.'*

Medium ranking church leader*: 'Yes we do tell them that sex is for marriage, but it is hard for them to keep it – and we don't want to place a heavy burden on them.'*

In contrast the Pentecostal churches gave very clear directives against pre-marital sex, and had the lowest rates of sexual activity.

Pentecostal youth: '*Sex itself is not anything bad it is that it has a time of doing it. If you are not married and you involve yourself in it, it is a sin.'*

Pentecostal sermon: 'A *Christian will not fight, a Christian will not fornicate'.*

These rules are repeated frequently during sermons and meetings. Extra- and pre-marital sex is uncompromisingly seen as displeasing to God. To stray from this rule is to imperil salvation and risk exclusion from the community of the saved. The rules are clear: no fornication, no adultery.

Membership of a mainline church tends to make promiscuous sexual behaviour less acceptable, but does not appear to eliminate it. It is possible that the clergy think they are giving clear messages, but the youth do not seem to be aware of them. Most of the young men were sexually experienced and were not bothered by anyone knowing it. Of the girls, none explicitly admitted to being sexually active, but only one or two spoke as if they believed abstinence was a worthwhile or realistic objective (216). This is illustrated in the following quote by a Pentecostal girl:

*'The abasindiswa (Pentecostals) they don't have sex at all before marriage. But we amakholwa (mainline) are more realistic, we know that we are human. So we do have our boyfriends, but just one at a time. Non-churchgoers do whatever they want – boys and girls are the same, they have as many relationships as they want.'*

#### 4.5.1.2. Teaching on condoms

Another key area of moral teaching is around the issue of condoms. Generally the Pentecostal and Catholic churches take a stronger stance against condom usage than other denominations. The Catholic Church has received the most international press regarding its opposition to condoms. The ban on condoms was laid down in 1968 in the Humanae Vitae, the encyclical that prohibited artificial contraception. In particular they have attracted a lot of criticism when they promote a limitation of condom usage for those who are not even Catholics.

In Ghana in 2001, some religious groups condemned the promotion of condoms on state television as it would encourage promiscuity. The state television campaign was stopped, which led to outrage amongst the AIDS activists. This negative role of the church is emphasized in the following quote from Deutekom:

*'They suppressed the message that would have saved lives, but failed to get their own messages of abstinence outside marriage across to their own people, let alone to those who didn't listen anyhow (216).'*

The Catholic Church has been further condemned for sending out the message that condoms are not reliable. Brazilian Cardinal Alfonzo Lopes claimed that promoting condoms was dangerous because they have tiny holes through which the HIV can pass and a high failure rate, from 5-30% (22).

Although the teaching of the Catholic hierarchy on condom usage is well known, it appears that the messages are not so strict at a grassroots level. A study of religious services in the Malawi rural districts found that although condoms were often explicitly prohibited, some religious leaders have relaxed prohibitions on condoms and encourage members especially youth who cannot abstain to use a condom. Some priests say one thing from the pulpit and another in personal counselling. One leader said:
*'I tell them this (about condoms) when we are leaving the church like if we are walking the same way just him and me (209).'*

This attitude is shown the following interview with a Catholic priest from Malawi:

'*On this question of AIDS, as a leader I get information from the people who know best about this disease. We sit down and even during prayers we tell people to abstain and protect themselves. We tell people to think of themselves and their wives and children – that if they die today, who shall take the responsibility of taking care of them' the interviewer asks the priest what he thinks about condom use for the prevention of HIV the priest laughs 'condoms? We have bales and bales of them (209).'*

A Catholic lay leader from Malawi said the following:

*'Me I am a true catholic. I think it is nice to stop the condom, but not totally. The youth wants fun and fun is dangerous. I compare it with a gun and a lion. If a lion attacks me, why should I not use a gun to prevent the danger?' (216)*

Thus there appears to be incongruence between official Catholic teaching and what is practiced at grassroots level.

In contrast the Pentecostal church appears to be strictly against condoms both in official statements and grass-roots teaching. In Van Deutekom's study almost half of the Catholics supported some condom use, but none of the Pentecostals. Many Pentecostal leaders expressed their attitude that condoms are 'satanic' and 'promoters of sin'. A deaconess from the Pentecostal church in Malawi said the following:

'*We don't teach condom use. We don't preach condom in the church, because it is not good. If you tell somebody use condom you are telling him to go and chase' (Pentecostal Church) (216).*

The same sentiment is reflected in this quote by another Pentecostal leader:

*'In this church people don't take alcohol and fornication and prostitution are not allowed, but in the Catholic Church the people are free to do as they like because there is no punishment (216).'*

Among mainline churches there is often more openness to the teaching of condoms, incorporated into an ABC message. However many leaders feel that there is a clash between what they should be teaching and the reality of high levels of sexual activity among their congregants as illustrated in this quote from a Mainline pastor:
*'I find it difficult to tell my members to use Chishango (condom) should they fail to abstain. I tell someone that doing this is sinning. Then later I again tell him, 'should you fail to abstain, use a condom.' Is this good leadership? I have disseminated two different messages at once (209).'*

The differing approaches to condom use or 'abstinence only' programmes have polarised organisations and churches. Prevention strategies have tended to be reduced to 'magic bullet' initiatives. These approaches place their protagonists in 'pro-condom or 'abstinence only' groups. Unfortunately this polarising effect has been reinforced by some of the international funders. For instance PEPFAR (President's Emergency Plan for AIDS Relief – USA), a five year plan initiated in January 2003, did not support the provision of information on safer sex strategies or condom use as part of a comprehensive programme for the general population, but only for high risk groups. PEPFAR's position is as a result of pressure from conservative Christian groups in the USA and the emphasis has been placed on A and B, while C has been heavily discouraged. In this fund, one third of the international AIDS prevention budget was targeted for abstinence until marriage programmes. The original PEPFAR five-year strategy document mentioned condom provision and promotion only for those who practice high-risk behaviours. Those who practice high-risk behaviours include "prostitutes, sexually active discordant couples [in which one partner is known to have HIV], substance abusers, and others" (217). Condom promotion was not permitted for youth generally. This policy was reviewed with the new US President Barack Obama and these provisions have been removed from the 2008 PEPFAR authorising legislation (294).However, the way the funding works is still not clear as Canon Gideon Byamugisha, an HIV positive Anglican priest says:

*"The policy is making people fearful to talk comprehensively about HIV, because they think if they do, they will miss funding. Although they know the right things to say, they don't say them, because they fear that if you talk about condoms and other safe practices, you might not get access to this money" (217).*

Programmes that focus primarily on 'abstinence only' or 'condoms only', reduce an understanding of prevention to being wholly concerned with individual sexual transmission of the virus and with promoting free choices by autonomous, empowered individuals. The complex range of issues driving the pandemic is lost as proponents of these 'one-liner' over simplistic solutions hold sway (48).

#### 4.5.1.3. Attitudes to alcohol

Religious groups tend to have more conservative attitudes to alcohol (61). This may lead to a reduction in levels of unsafe sexual behaviour (199). Those with strong religious beliefs may consume less alcohol, which may then influence the occurrence of unsafe sex.

#### 4.5.1.4. Differences between moral teachings

The main differences between mainline and Pentecostal churches are not so much the messages, but the social milieu both inside and outside the congregation. The religious teaching may not differ much, but mainline church members are more exposed to HIV information through networking within their congregations.

- Mainline congregations mix with sister parishes that are often socially different, for example, they will often receive visits by delegations from urban congregations.
- Mainline congregations are more likely to include higher status individuals who are professionally more knowledgeable, such as a nurse.
- Secular HIV organisations would rather target large mainline congregations than lots of smaller ones. Due to economies of scale, it is economically more efficient to target larger organisations.
- Mainline churches are more ideologically tolerant and accommodating. While the core of the values they officially champion may not differ from Pentecostal churches, they are typically more lenient when it comes to enforcing their members' compliance with those values. As a result mainline churches get more consistent, direct and continuous exposure to HIV prevention messages and efforts coming from outside of the churches. Even if the church leaders do not raise the controversial issues of condoms themselves, they allow for much more discussion of these issues within their congregations, for instance they may feel free to invite secular organisations to speak (162).

### 4.5.2. SOCIALISATION

A second way in which the church can influence sexual behaviour is through socialisation. This can take the form of:

- a social grouping which provides a protective influence; and
- through various forms of social control.

#### 4.5.2.1. Social groupings

The more deeply involved the religion is in daily life, the greater its ability to influence behaviour. In general, Christian Pentecostal groups and Muslim groups would fit this category. They are usually the more socially conservative groups (22).

Social groups can have a preventative effect, by modelling positive behaviour. Garner compares the Pentecostal churches with mainline churches in Kwa-Zulu. The Pentecostal youth group meets about five times a week, the group is easily the most important social reference group for its members and is a powerful influence on their attitudes and behaviour. This church like many of its theological type does not allow members to have girl or boyfriends. Members are taught to only marry other born again Christians. Some of the members of the Pentecostal church made the following comments:

*'I'm saved, I don't have boyfriends, it's irrelevant' (17 year old girl).*
*'It would be a sin to have sex, so what is there to talk about?' (16 year old boy).*

Several factors help Pentecostals abide by these strict rules. Regular and specific teaching takes place at services and summer camps. The religious experience is central to the impact of socialisation as indicated in the following quote by a University student:

*'When we are saved, we have the Holy Spirit, it changes your life. So although the pressures are there, we resist them. You must spend time with other Christians, praying with them. Even at Varsity, you can find other Christians' (212).*

In contrast few of the mainline churches had youth groups that met more than weekly, or attracted a strong following. This is illustrated in the following quote by Garner:

*'Given the muted religious experience of mainline Christianity, the absence of youth groups or choirs (socialisation) and the lack of specific teaching on sex-related matters (indoctrination) the influence of these churches on sexual praxis is limited' (212).*

In Trinitapoli's study in Malawi, the Pentecostals estimated that 95-100% of the youth were abstaining, whereas estimates in the Roman Catholic Church varied from 0-20%. Whether or not these estimates were based on reality, they create a strong peer pressure (67).

The effectiveness of social support is likely to vary depending on the extent to which members of a congregation are 'channelled' into exclusive and overlapping sets of relationships within the congregation, relationships that may augment or replace social networks based on family or clan. Social groups also reduce opportunities to pursue deviant behaviours. Without the support of a tight knit congregation, the impact of individuals' own religious commitments becomes weak (67).

#### 4.5.2.2. Social control

Different groups vary in the degree to which they exercise control over young people's sexual behaviour.

#### 4.5.2.2(i) Discipline

In Agha's study in Zambia, the 'New Mission' churches had a greater degree of social control than other denominations. This led to significantly lower levels of sexual activity. In the Jehovah's witnesses, if you are found guilty of premarital sex you are 'disfellowshipped' (removed from membership).

Seventh Day Adventists are very strict, alcohol, tobacco and premarital sex are forbidden; those found guilty have their membership withdrawn. Anyone found pregnant outside of marriage is 'deregistered 'and then not allowed to take part in any religious activities, including the Holy Communion. Compared to these two groups, other groups are more flexible. Their doctrines are based on repentance and forgiveness of sins (70).

Garner noted in Kwa-Zulu that in mainline churches *'Girls who become pregnant are usually barred from communion and they make a prayer of penitence (exclusion). But such discipline is rarely applied to the man involved, and the ethic is not reinforced by regular teaching' (212).*

Gregson found in Zimbabwe that in the majority of mainline churches*, 'avoidance of sin is largely a matter left to individual conscience and absolution can be obtained through confession and prayer. Spirit-led church leaders teach that sin can lead to sickness and often operate systems of checks and punishments for offenders'*.

Church prophets are believed to use guidance from the Holy Spirit to divine if a person has committed a sin. In cases where young women are suspected of having had pre-marital sex, older women carry out physical checks (211).

Van Deutekom noted in Ghana the difference in discipline between Pentecostal and Roman Catholic Churches. In the Catholic Church there is personal confession – if you know you are sinning you should not take communion. However, people still go for communion because they don't want to be looked at strangely. In the Pentecostal church with serious sins, like fornication or adultery, the person is called to the front, the sin is announced. They are not allowed to take part in the church activities for a number of months. They come to church and sit at the back. Leaders will lose their position and become regular members.

A Pentecostal lay preacher noted the following: 'The *church does the rebuking. When they rebuke, others also fear to go and commit sin (216).'*

#### 4.5.2.2(ii) Monitoring of behaviour

Social control also takes place through monitoring of people's behaviour. The practice of sexual surveillance is common in the rural African setting and it is one of the truly indigenous responses to the epidemic. In the African context the practice of visiting is a key aspect of both social control and social support. Many clergy make home visits to those suspected of sexual misconduct if the spouse requests it. Others take a watchful eye over the village to see what young people are up to as in indicated by a pastor from Malawi (67):

'*I do a lot of counselling. This is where I actually incorporate messages that have to do with sexual behaviour. I tell them let's change our old immoral behaviours. If you are a woman and your husband is not faithful, come talk to me as a pastor and tell me. We will agree on a date for me to come to your house and talk to both as a family about AIDS' (67).*
Van Deutekom found that social control was stronger in the Pentecostal church. The pastor does house visits to those who are absent, as well as visits for counselling. Most members attend Sundays and mid-week meetings. This social control is much less evident in the Catholic Church, where visits tended to be for the sick, rather than for social control (216).'

## 4.5.3. COMMUNITY LEVEL INFLUENCE OF RELIGION

As well as influencing individuals, religion can influence at the community level. The level of religious prevalence in the village or area will also have an impact on sexual behaviour. Living with or near a large number of religious people will affect how any given religious individuals will behave (67).

In places where particular religious rituals are widely practiced, the average participation in harmful behaviours is reduced. Religion can be understood sociologically as a group property as well as an individual one. '*What counts is not only whether a particular person is religious, but whether this religiousness is or is not ratified by the social environment' (209).*

Individuals who hold risk reductive attitudes, such as extramarital sex is a sin, should be more effective in exhibiting low risk behaviour and remaining HIV negative in villages that reflect these norms. In villages where extra-marital behaviour is more permissible, individuals own risk reductive attitude would be less effective at predicting risk behaviour and HIV status. Thus residing in a religious village lowers your chance of reporting extra marital partners, because a religious culture has been formed which makes it less socially acceptable.

Thus it would be expected that high village religiosity would lower your HIV risk behaviour. However a study by Trinitapoli shows that this is not always the case. She compared different villages with high or low religiosity. She found that for women, a high village religiosity led to lower HIV rates, but in the case of men, high village religiosity led to higher

rates of HIV. This could be because in a village of high religiosity the purchase of condoms becomes stigmatising. Another hypothesis could be that in a village with high religiosity, men will hide their affairs and possibly go and have higher risk sex with an infected woman in town (67).

Adams compared three communities in Malawi, ranked according to the levels of religiosity.

**Table 4.6: Prevalence of HIV by religious affiliation in Malawi**

| Denomination | Community | | |
|---|---|---|---|
| | Balaka | Mchinji | Rumphi |
| Catholic | 13.9 | 7.5 | 5.6 |
| Mainline | 11.5 | 7.7 | 9.1 |
| Pentecostal | 15.6 | 15.0 | 2.7 |
| AIC | 18.7 | 10.3 | 8.4 |
| Muslim | 8.8 | 0 (only 3 people) | 0 (only 6 people) |

(213) J. Adams. Religion, networks and HIV/AIDS in rural Malawi. Ohio State University; 2007.

The rates of HIV are much higher in Balaka than in the other areas. Balaka has a significantly higher number of religious people; however, it is a much poorer community. So it seems that other factors are having a greater impact than religiosity. The variations in sexual behaviour are roughly the same per denomination, but overall, Balaka has consistently and significantly higher HIV rates. For example 11% of Pentecostals report having affairs here, compared to only 2% of Pentecostals in Mchinji (213). Strong regional differences in sexual activity imply that contextual effects play a key role in HIV risk, suggesting that religious influences may be affected by local norms.

## 4.6. IMPLICATIONS FOR THE ANGLICAN CHURCH AND THE AGENTS OF CHANGE PROGRAMME

The positive and negative roles of the Anglican Church in terms of prevention are considered followed by the possible influence of the Church on sexuality.

### 4.6.1. POSITIVE AND NEGATIVE ROLES OF THE ANGLICAN CHURCH IN TERMS OF PREVENTION

#### 4.6.1.1 Positive role

The Anglican Church has a high visibility and is present in the majority of communities in the Western Cape (132 congregations). It has a history of involvement in social issues, and is known for high level advocacy, through well known figures such as the former Archbishop of Cape Town, Archbishop Emeritus Desmond Tutu and his successors, Archbishops Ndungane and Magkoba. It has strong international links with Anglican Churches around the world in particular the Episcopal Church of the USA and the Church of England. It has

a history of mobilising volunteers, and the majority of churches have either HIV task teams or social development groups.

The Anglican Church, as with other churches struggles to deal with issues of sexuality. However, the publication of the Fikelela research (191) enabled clergy to realise how many of the youth are sexually active, and resistance to discussing issues of sexuality has been greatly reduced. One of the first religious leaders in Africa to disclose his HIV status was Rev Gideon Byamugisha, an Anglican priest from Uganda, and several leaders and even priests from South Africa have joined ANARELA (African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS). In terms of condom usage, the Anglican Church has a reasonably open attitude, assisted by the strong stance that Archbishop Tutu, who took a position, which was at the time very controversial, to support the use of condoms.

#### 4.6.1.2 Negative role

The Anglican Church is battling over issues of homosexuality, in common with many denominations, and the issue is causing splits in the Anglican Communion globally. Many youth leaders are not comfortable with discussing issues of homosexuality with young people. In terms of gender, very little is being done, although statements are made at official gatherings. However, the church has begun to tackle the issue with the formation of a gender desk. Currently research is being conducted into attitudes towards gender issues in the Diocese of Cape Town. Some efforts have been made to begin to address issues of violence against women and children, but they tend to be more reactive than pro-active.
In terms of monitoring and evaluation, the Anglican Church, in common with many denominations does not have a history of documenting activities in the area of social responsibility. Certain projects do so, such as Fikelela AIDS Project, but generally monitoring and evaluation is weak.

### 4.6.2. INFLUENCE OF THE ANGLICAN CHURCH ON SEXUALITY

Both Mash's study of the Anglican Church in the Western Cape, and Erasmus' study of the Anglican Church in Southern Africa indicate high levels of sexual activity amongst Anglican Youth (202,203), and a disconnect between beliefs around 'no sex before marriage' and actual reported sexual behaviour. It appears that sexual activity is not greatly different from that in the broader community. How can the Agents of Change programme help to improve sexual practices within the framework of the Church?

#### 4.6.2.1. Teaching

It appears that the churches do address issues of sexuality from the pulpit but often in 'sex negative' and judgmental way. Young people are encouraged to stay away from sex, but are not given the skills needed to be able to do so. In order to adopt and internalise a

value, discussion and clarification are needed (218). There is very little discussion or clarification of values around sexuality in the Church, particularly in the form of communication used in sermons. Thus the Agents of Change, with its more interactive dialogical methods of teaching, should be more effective than the one-way sermon model of teaching.

The Anglican Church is a suitable site for comprehensive sexuality education that includes abstinence and condoms, because there is no objection from the hierarchy to teaching about condoms, although some individual priests and youth leaders are not so supportive.

#### 4.6.2.2. Levels of commitment

One of the challenges of the programme is that in the majority of cases, the Agents of Change programme is being run in the confirmation class. For many of these young people, they are in confirmation class because their parents want them to be confirmed, not because it is their own choice. Participating in confirmation means attending Sunday service regularly as well as a midweek class, so for many of these youth, the levels of religious commitment may not be high even though attendance is relatively high.

#### 4.6.2.3. Socialisation/social control

As well as the involvement in confirmation class or youth, where the Agents of Change programme is run, many young people are involved in other church activities such as choir or dance. In these cases there are high levels of socialisation because they have joined these groups in a voluntary capacity, and friendships may be formed as they spend time together. Most of these groups also have adult leaders, which may lead to an improvement in social control as well as mentoring taking place.

#### 4.6.2.4. Self-efficacy

One of the areas where the programme and the church may assist is in the area of self efficacy. Religion is an effective basis for self worth, since it can give meaning to human life. Religious rituals activate attachment processes that connect people to one another and to God (61). Strong associations have been found between religiosity and self-efficacy measures. In one study adolescents with high religiosity were found to be 2.3 times more likely to communicate with a new partner about sex, 2.5 times more likely to communicate about STIs and pregnancy, and 2.1 times more likely to refuse an unsafe sexual encounter (194).

### 4.6.3. CONCEPTUAL FRAMEWORK BASED ON LITERATURE REVIEW OF RELIGION

The programme takes place within a church context, so it is important to understand how the church can influence sexuality. It appears that the church can influence sexuality in the following ways:

- moral teaching (67,212,216);
- socialisation (forming a positive peer group and monitoring of behaviour) (22); and
- building self-efficacy (194).

It can have a negative effect in terms of:

- reduction of condom use (216,22); and
- silence on issues of gender and coercion (161).

## 4.6.4. FINAL CONCEPTUAL FRAMEWORK

In this section a final conceptual framework is presented. The key factors arise from peer education and from the findings of the three areas of the literature review. Chapter Two looked at the theories of behaviour change and the main factor arising from this chapter was 'Enabling behaviour change in relation to sexual behaviour'. Chapter Three examined sexual relationships and the main factor arising from this chapter was 'Changing personal, proximal and distal factors in male-female relationships'. Finally Chapter Four examined the role of religion in HIV and the main factor identified was 'Creating a supportive Church context' which covers peer education, the process of behaviour change, sexual relationships and the Church. This conceptual framework is presented in Table 4.7:

**Table 4.7: Final Conceptual Framework**

| Key factors | Actors | Actions |
|---|---|---|
| Peer education | Peer educators, peer group members | Role modelling<br>Participatory education<br>Positive peer pressure |
| Enabling behaviour change in relation to sexual behaviour | Parents, facilitators, peer educators and group members | Develop a futures orientation<br>Build self efficacy<br>Improve parental supervision and support<br>Develop a collaborative and guiding style of communication<br>Develop positive normative beliefs around sexual behaviour<br>Improve interpersonal relationships |
| Changing personal, proximal and distal factors in male-female relationships | Peer educators and peer group members | Build self esteem<br>Build social capital<br>Reduce vulnerability<br>Challenge gender norms<br>Challenge negative body images<br>Challenge power imbalances<br>Change rape-supportive attitudes<br>Challenge media messages<br>Develop an understanding of the risks of older partners<br>Challenge gender based violence and coercion |
| Creating a supportive Church | Clergy, peer group, other adults | Moral teaching: move from a moralising approach to a human-rights approach |

| | | |
|---|---|---|
| context | | Build opportunities for socialisation<br>Build self-efficacy<br>Develop a positive attitude towards sexuality<br>Shift from patriarchy towards the concept of 'men as partners'<br>Challenge Church's attitude to condom use<br>Break the silence on gender issues and coercion<br>Create a critical consciousness around gender<br>Work to decrease vulnerability caused by poverty |

# CHAPTER FIVE: METHODOLOGY

*I keep six honest serving-men*
*(They taught me all I knew);*
*Their names are What and Why and When*
*And How and Where and Who.*
(The Elephant's Child, Rudyard Kipling) (219)

## 5.1. INTRODUCTION

In this Chapter the development of the intervention is first of all presented. This is divided into four phases: the baseline survey which took place prior to the intervention, the development of the intervention, piloting of the strategy and then the roll out of the intervention.

Secondly the evaluation of the intervention is discussed, in terms of Outcome Mapping. The theoretical framework of Outcome Mapping is presented, and then the three stages are examined: project planning, project monitoring and project impact evaluation.

In the final section, limitations of the study are examined, together with ethical considerations and the final outputs of the study.

## 5.2. THE INTERVENTION

In this section the development of the intervention is presented, firstly the baseline survey, then the intervention, and finally the piloting of the intervention.

### 5.2.1. OVERVIEW OF THE INTERVENTION

In order to prepare for the intervention a baseline survey was conducted. Before intervening with the Church youth, it was important to understand their current sexual attitudes and behaviour (202). In the second phase an intervention strategy was developed based on the findings of this research. This intervention was then piloted during the third phase. The fourth phase is the current doctoral thesis – an evaluation of the roll out of the intervention. The phases of the programme are shown in Figure 5.1 below:

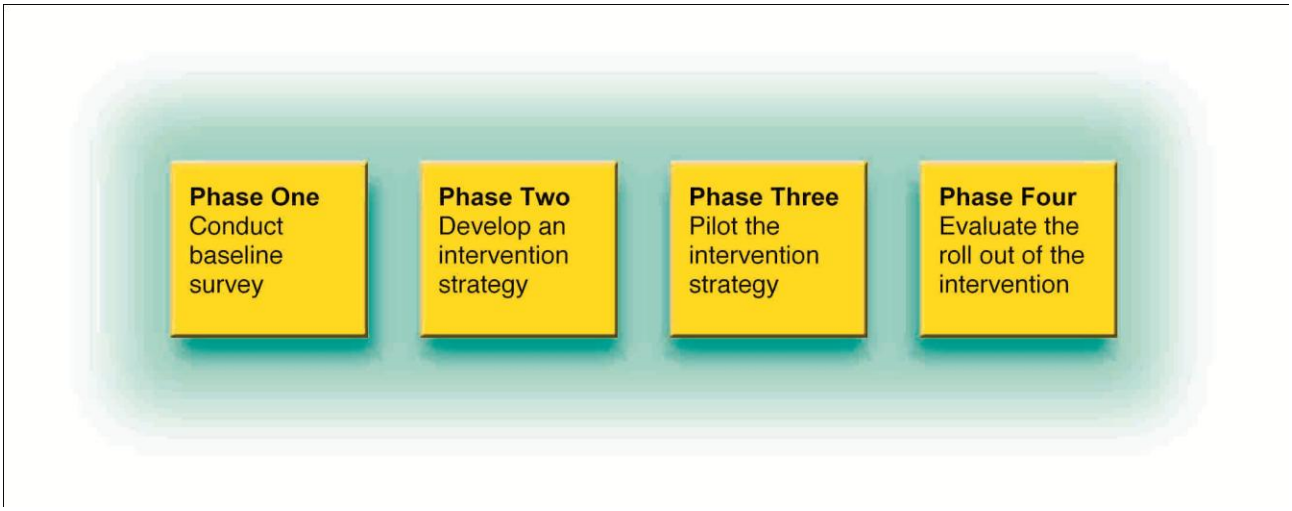


***Figure 5.1: The phases of the programme development***

### 5.2.1.1. Phase One: conducting a baseline survey of sexual activity of Anglican youth

The baseline survey was conducted prior to the doctoral thesis and was published in the South African Medical Journal (202). A brief description of this important background research is given below, and the published article is found in Appendix 8.1.

Multi-stage cluster sampling was used to select 65 out of 132 churches in the Cape Town diocese according to their location and predominant racial composition. The churches were listed first by geographical location and then by predominant race and samples taken from each cluster (for example rural coloured, urban black and so on (220).

A questionnaire was developed based on similar surveys by Lovelife (17) and Faith Matters (109) and after piloting was completed by members of either the youth group or confirmation class. The questionnaire was administered confidentially by multi-lingual research assistants with prior parental consent. Altogether 1,306 questionnaires were completed and analysed using Statistica Version 7. In addition youth were given the opportunity to attend focus group discussions (FGDs) Three FGDs were held with a total of 25 young people chosen to represent rural, urban, peri-urban areas, both genders and those who were and were not sexually active. The FGDs explored their sexual experiences and perceptions of the churches influence on their behaviour. The transcripts were analysed according to the framework method (221). Initial themes were determined from analysis of the first focus group discussion. After subsequent FGDs, the transcripts were examined according to these initial themes and additional emerging themes were also noted. On completion of all the FGDs, the analysis was completed through the use of charts that collated material together on each theme and illustrative quotes were then identified (221,222).The results of the questionnaire survey are listed in Table 5.1 and Table 5.2 below:

**Table 5.1: Demographics and sexual behaviour of Anglican youth in Cape Town Diocese (n=1306)**

| | |
|---|---|
| Sexually active (vaginal, oral and anal sex) | 31% |
| Vaginal sex | 18% |
| Oral sex | 13% |
| Anal sex | 4% |
| Think that oral sex is actually sex | 33% |
| Think that anal sex is actually sex | 50% |
| Males sexually active | 40% |
| Females sexually active | 21% |
| Have been pregnant | 3% |
| Believe that being physically forced to have sex by someone that you know is not rape | 10% |

Source: (202) Mash R, Kareithi R, Mash B. Survey of sexual behaviour among Anglican youth in the Western Cape. South African Medical Journal 2006;96(2):124-127.

**Table 5.2: Characteristics of those who were sexually active (n= 405)**

| | |
|---|---|
| No use of contraceptives during first sexual encounter | 65% |
| Sex for material gain | 6% |
| Sex because they were threatened | 10% |
| Raped | 13% |
| More than one sexual partner | 67% |
| Suspect partner of being unfaithful | 29% |
| First sexual experience in the home of one partner | 75% |
| First sexual experience with member of own peer group | 90% |
| Girls not wanting their first sexual experience (being persuaded, tricked, forced) | 50% |

(202) Mash R, Kareithi R, Mash B. Survey of sexual behaviour among Anglican youth in the Western Cape. South African Medical Journal 2006;96(2):124-127.

The baseline survey conducted on the youth of the Anglican Church of Southern Africa reported similar sexual behaviour and risks as the general population (203). This shows that there is an urgent need for effective prevention programmes to be initiated within the Church (202).

### 5.2.1.2. Phase Two: Developing an intervention strategy

Through the FGDs it was identified that the youth did want the Church to support them in behaviour change. Another section of the baseline survey asked about possible intervention strategies. Two intervention strategies were suggested by the youth, namely peer education and parenting workshops. This multi-faceted intervention was named ‘Agents of Change’.

### 5.2.1.2(i) Peer education

*‘Listening to my parents’ friends talk about sex – that is just gross’ (Female Focus Group Discussion)*

Traditionally, the elders in the church have taught about sexuality (preachers in sermons, adult youth leaders or confirmation class teachers) rather than the youth themselves.

However, programmes involving peer educators have been identified as cost-effective in terms of life years saved by the intervention (224). There is also some evidence that peer educators are more effective than adults as health promoters for adolescents (123).
There are many different definitions of peer education, but in this programme it was decided to adopt the Rutanang principles and strategies for implementing peer education (See Appendix 7)[19].In line with Rutanang principles, peer educators are defined as:

*'Selected learners chosen and trained to educate their peers in a structured manner; informally role model healthy behaviour; recognise youth in need of additional help and refer them; and advocate for resources and services for themselves and their peers'(225).*

A partnership was formed with GOLD (Generation Of Leaders Discovered) peer education, who currently run peer education programmes through non-profit organisations in 128 high schools in the Western Cape. GOLD peer education is also based on Rutanang principles. It was decided to use the GOLD materials in the Church youth groups. Eighteen sessions were adapted from their training materials and a further two sessions were added, to make a total of twenty sessions.

- **Theoretical framework of peer education**

GOLD bases its belief in the effectiveness of peer education on certain behavioural theories. According to the theory of diffusion of innovation (see 2.3.5), peer educators should be selected to represent the social structure of the target group. It has been shown that adolescents will be more likely to follow the behaviour of role models if they perceive the role models are similar to themselves (123).

It is the role modelling as well as the training environment which allows for the success of peer education (Rogers 1995). At the heart of peer education is the belief that people do not change through providing information; they change when those around them change (104). GOLD also applies a 'futures-orientated' approach to the development of the curriculum whereby risky behaviour is seen as a symptom of a lack of vision and purpose for the future. Risky behaviour reflects a lack of futures-orientated thinking. Adolescents are generally concerned with immediate risks and benefits rather than the future and they are particularly concerned with social acceptability within their peer group (124).

### 5.2.1.2(ii) Parenting workshops

A second key issue identified by the youth in the baseline survey was the role of parents as indicated in the following quote by a young man in a focus group discussion:

*'My Dad buys me Nike shoes, but posh shoes do not teach me about my sexuality or satisfy my emotional needs.'*

[19] In 2000 the Departments of Health, Education and Social Development in collaboration with the US Centres for Disease Control and Prevention, and the Harvard School of Public Health formed Rutanang, a project which has created guidelines and principles for peer education. These can be found in appendix 7.

Parenting input has been proven to be effective in the context of a relationship which is characterised by 'supervision, support and open communication' (125). Parental disapproval of early sexual activity is also associated with a later onset of intercourse (126).

Parenting workshops were developed in response to issues raised in the FGDs and in consultations with parents. Some of these issues were for example, the concern that talking about sex might lead to an increase in sexual activity, a realisation that it is important to communicate the values system of the parents and that the way the message is communicated may lead to resistance as indicated in this quote by a male from the questionnaire survey:

'*Young people have sex to rebel against their parents and to do what we are told not to.'*

The key issue identified was the need to improve communication between parents and adolescents in order to influence behaviour change. The principles of Motivational Interviewing were adapted as core strategies for the parenting workshops. These are collaboration, evocation, and respect for autonomy, empathic listening, sharing information carefully, building confidence, reducing resistance and developing discrepancy (44,126).

Three workshop sessions were developed on the themes:

- Why I should talk about sex?
- Love and sex – communicating my values
- Communication – how to talk about sex

#### 5.2.1.3. Phase Three: Piloting the intervention strategy

In the second half of 2005, a series of forums was held with clergy and youth leaders to identify churches which would form part of the pilot programme. The pilot phase of the peer education programme was launched in the Anglican Church in January 2006.

The aims of the Agents of Change programme are the following:

- To assist young people to build healthier relationships.
- To reduce their vulnerability to HIV/AIDS and teenage pregnancy.
- To enable parents to speak to their teenagers about sex.

The objectives of the Agents of Change programme are:

- To increase 'positive' peer pressure.
- To improve knowledge of the definition of sex.
- To increase the age of sexual debut.
- To reduce the number of sexual partners.
- To reduce unprotected sex.

- To reduce Sexually Transmitted Infections (STIs)

A pilot of the programme was run in 11 churches. These churches were situated in Hout Bay, Atlantis, Masiphumelele, Nyanga, Constantia, Kensington, Mitchells Plain (Rocklands and Tafelsig), Heideveld, Hawston and Paarl. The various participants in the programme are shown in Figure 5.2 below:

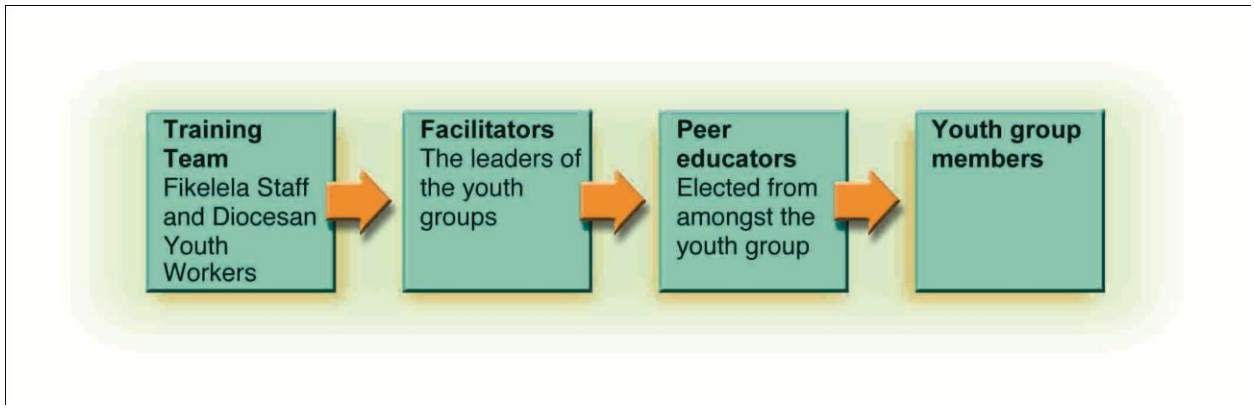


***Figure 5.2: The participants in the pilot study***

### 5.2.1.3(i) Participants

- **Facilitators**

Each church was currently running a youth group, with identified youth leaders. These youth leaders, who were mostly adults, became the facilitators of the programme. Their role was to support the peer educators in the planning of presentations, to mentor them and to function as a 'guide on the side'.

- **Peer educators**

At a youth group meeting, the members of the church youth group elected peer educators from amongst the group. Nominations were called for and peer educators elected who were perceived to show leadership potential. Their primary roles were to present the 20 life skills sessions to the youth group, and to function as role models.

### 5.2.1.3(ii) Training

The training team consisted of staff from Fikelela AIDS project, together with Diocesan Youth workers. At a three day training camp, peer educators and facilitators were trained by Fikelela staff and Diocesan Youth Workers in the following areas:

- Role of Peer Educators: the four roles of peer educators (to be role models, to be educators, to refer cases and to do community advocacy).
- Role of Facilitators: to be mentors and support the peer educators.
- Stakeholder analysis: to analyse which stakeholders are affected by the programme for instance clergy, parish council, and other youth groups in the church.

- Monitoring, Evaluation and Reporting: the facilitators were trained to use the monitoring and evaluation forms supplied by Fikelela, as well as to understand why they were needed.
- Motivational interviewing theory and practice: a simplified understanding of communicating for change, presenting which types of communication cause resistance and which types may help a person to consider change.
- Community audit: to assess which resources were available in the community (NGOs, clinic etc) as well as to identify the challenges faced (e.g. shebeens ).
- Experiential learning: to understand the importance of learning through doing.
- Lesson delivery: peer educators were trained in how to deliver a lesson and in working as a team.
- Governance: an understanding of the governance of the Anglican Church, who you must report to and ask permission from.
- Year planner: preparing the plan for the year, incorporating 20 life skills sessions into a year, taking cogniscence of other events such as holidays and Easter.

#### 5.2.1.3(iii) The programme

The peer education programme consisted of 20, ninety minute life-skills sessions run over a twelve-month period. It also consisted of a three-session parenting workshop. The following sessions were presented by the peer educators:

1. Introduction of the programme.
2. ‘Values, Self worth and Vision’: helping the young people to identify what their values are, to build self worth and a futures orientation.
3. ‘Boundaries’: how to set boundaries in relationships.
4. ‘Healthy Relationships’: identifying the qualities we look for in a relationship.
5. ‘Big Yes and Big No’: identifying the things which are major motivators and major barriers in our lives.
6. ‘Sex, Love and Reasons’: understanding the difference between sex and love and identifying reasons for waiting for sex.
7. ‘The Big Love’: understanding the different types of love;
8. ‘Sex is cool, but HIV is cold’: an understanding of HIV and its potential impact on a young person’s life.
9. ‘My sexuality’: understanding yourself as a sexual being, rights and responsibilities.
10. ‘Teen pregnancy’: understanding why teenagers fall pregnant, and the impact of teenage pregnancy on their lives.
11. ‘Sexually Transmitted Infections’: an overview of the most common sexually transmitted infections experienced by teenagers.
12. ‘Prevention and Me’: my options in terms of prevention, options and consequences of the various types of prevention.
13. ‘Light in the Darkness’: being a role model in our community.
14. ‘Drugs and Alcohol’: understanding why teenagers get involved in drugs and alcohol.
15. ‘Gender’: understanding the world view of the opposite gender.

16. 'Rape': understanding the definition of rape, what to do if it happens to you, and how to lessen your chances of it happening.
17. 'Making a difference in your community': community advocacy – planning an event.
18. 'Media': Media literacy – learning to be critical of the messages presented to us by the media.
19. 'Me as brand': identifying 'my brand' what are the values I stand for and are they in conflict with the media.
20. 'Parents': understanding what makes parents tick.

The peer educators, supported by the facilitators ran the life skills programme in their church for young people from their church and the local community. The peer educators presented these sessions to the young people using an interactive style. The facilitators assisted with preparation of the sessions, logistics and group discipline.

#### 5.2.1.3(iv) Parenting workshops

The parenting workshop had the goal of improving communication between parents and children, and helping parents to understand the challenges their children face around issues of risky behaviour. Parents of young people attending the life skills sessions were invited to attend. A broader invitation was also given in the church service to interested adults to attend. The three sessions lasted one and a half hours. The sessions were interactive, starting with the parents' own experiences of raising teenagers; the following sessions were presented by Fikelela staff as listed in Table 5.3:

**Table 5.3: Parenting workshop sessions**

| SESSION TITLE | GOAL |
|---|---|
| Teenagers and Sex | Understanding that society has changed, the role of parents has changed too, and our children need our support in new ways. |
| Sex and Love | The importance of talking about sex: if we do not talk, we are depriving our children of an important resource |
| Let's talk about sex | How to listen: what kind of communication builds resistance, what kind of communication can encourage change. |

As part of the programme, churches were encouraged to get involved in community outreach. This could involve the following activities:

- celebrating 'Big Days' (for example World AIDS Day, Women's Day, 16 days of Activism, Orphans day);
- after school care;
- voluntary counselling and testing; and
- outreach projects (for example visits to Old Age homes, orphanages, refugee camps)

#### 5.2.1.3(v) Monitoring and evaluation of the pilot study

Monthly feedback forms were received from the facilitators and quarterly monitoring and evaluation sessions held with all peer educators. Based on this feedback, the programme structure and materials were adapted and improved for the full intervention in 2007.

During the pilot study it was identified that the following changes needed to be made to the programme:

- Materials: some of the sessions were felt to be too long, and some of the language was confusing.
- Gender issues: it was important to include more sessions dealing with gender issues. We needed to look at how to help the young people gain a critical consciousness on gender issues.
- Selection of churches: the criteria for selection of churches should be related to their infrastructure and interest: There must be an existing youth group, with committed youth leaders. There must be buy-in and support from the church leadership.
- Age of peer educators: the peer educators should be at least 14 years old. It was difficult for the younger ones to cope with discipline issues.

#### 5.2.1.4. Phase four: evaluation of the roll out of the intervention

It was decided that the revised programme should then be thoroughly evaluated, once the pilot phase was completed and this doctoral thesis reports on this evaluation.

## 5.3. EVALUATION OF THE AGENTS OF CHANGE PROGRAMME

### 5.3.1. TYPE OF EVALUATION

In order to choose a study design for evaluation, it was important to understand the motivation for the research. Mouton identifies four different types of programme evaluation which answer different questions:

- **Evaluation of need:** this is a diagnostic evaluation which defines the social problem in such a way that the conceptualisation and design of appropriate interventions is maximized. This type of assessment study is a precondition to effective programmes. *'Is the programme designed in such a way that it meets the needs of the target group?'*
- **Evaluation of process:** this is a formative evaluation which involves programme monitoring. It considers the infrastructure in place, the management of the programme and tries to establish whether the necessary conditions are in place to assess outcome or impact. *'Has the programme been properly implemented and managed?'*

- **Evaluation of impact:** this is a summative evaluation which examines the intended or unintended outcomes of the programme. *'Have the intended outcomes materialised?'*
- **Evaluation of efficiency:** this type of evaluation considers the degree to which a programme produces the benefits in relation to its costs. *'Were the programme outcomes obtained in the most cost-efficient manner?'* (226,220).

The first type of evaluation, which looks at the need for the intervention, took place during the pre-intervention baseline survey where it became clear that high levels of risky sexual behaviour were taking place amongst churched youth. The chosen intervention attempts to meet the identified needs of this target group of adolescents within the Anglican churches.

The fourth type of evaluation, which looks at the efficiency of the intervention, does not form part of this study. If it can be established that this programme does indeed lead to behaviour change, further studies should take place to evaluate its efficiency.

Thus this evaluation focused on the second and third areas: a formative evaluation of the process and a summative evaluation of the impact of the intervention.

Reviews of peer education programmes have shown that such programmes do influence adolescents' attitudes and behaviour in a direction consistent with AIDS prevention. However, there is a lack of investigations that look at the mechanisms through which peers influence health related behaviour and the relationship between the intervention process and the outcome (123). The Department of Child and Adolescent Health of the World Health Organisation analysed over 1900 studies dealing with adolescent sexual and reproductive health (ASRH) and reported that very few studies explore the processes that affect health related behaviour associated with ASRH. Most research focuses on adolescent knowledge, attitudes and beliefs with little attention as to how these are derived (227).Thus it is important to evaluate both the impact of the programme and the process and to explore the relationship between them. This evaluation aims to understand the processes contributing to the impact of the programme (119). For this reason 'Outcome Mapping' was selected as the method for this research.

## 5.3.2. LINKING WITH THE CONCEPTUAL FRAMEWORK

The conceptual framework (4.6.4) shows that change is a complex process, involving many actors and multiple potential processes:

- **Peer education**

This Involves peer educators and youth group members in a process which includes role modelling, participatory education and creating positive peer pressure.

- **Enabling behaviour change to reduce risky behaviour**

This involves peer educators, facilitators and the peer youth group in the following processes **:** developing a futures orientation; building self-efficacy; improving parental supervision and support; developing a collaborative and guiding style of communication; developing positive normative beliefs around sexual behaviour and improving interpersonal relationships.

- **Changing personal, proximal and distal factors in male-female relationships**

This involves peer educators and peer group members in the following processes: building self-esteem, building social capital, reducing vulnerability, challenging gender norms, challenging negative body image, challenging power imbalances, changing rape-supportive attitudes, challenging media messages, developing an understanding of the risks of older partners, challenging gender-based violence and coercion.

- **Creating a supportive Church context**

This involves clergy, the peer group and other adults in the following processes: moral teaching: moving from a moralising approach to a human-rights approach; socialisation; building self-efficacy; developing a positive attitude towards sexuality; shifting from patriarchy towards the concept of 'men as partners'; challenging the Church's attitude to condom use; breaking the silence on gender issues and coercion; creating a critical consciousness around gender ; working to decrease vulnerability caused by poverty

- **In the context of the Church**

The clergy, the peer group and other adults are involved in processes which include moral teaching, socialisation, building self efficacy, changing attitudes to condom use and breaking the silence on gender issues.

In order to understand the complexity of these various processes, there was a need for evaluation within an interpretive, hermeneutical paradigm that could explore both the actors' experience and the processes that led to any change. Outcome mapping was chosen as the methodology because it allows for an evaluation of both outcomes and the processes that may have led to these outcomes. It is designed so that it is possible to define the outcomes of the programme as changes that one expects to see in people, groups or organisations that are influenced by the programme. There is a direct focus on change in the behaviour of the main actors or 'change partners' (72).

A second goal of the research was to also obtain quantitative data regarding the impact of the programme and this required evaluation within an empirical analytical paradigm. The study design for this goal was quasi-experimental with a non-randomised control group. The aim of the evaluation was to quantify changes in attitudes, knowledge and sexual behaviour that could be attributed to the intervention rather than to other factors (73). For this evaluation a self-reported pre- and post-intervention questionnaire was used in both control and intervention groups.

## 5.3.3. THEORETICAL FRAMEWORK OF OUTCOME MAPPING

Outcome evaluation has become a central focus of accountability driven evaluation. This type of evaluation calls for evidence that the programme leads to benefits for the people involved. Outcomes are measured to see if the programme really makes a difference in people's lives. However, the focus is often entirely on numerical indicators of outcome or impact. What such statistics cannot do is explain the *process* of change taking place in the people behind the numbers. There needs to be some way of understanding what contributed to the measured change, and what other changes may have occurred that were maybe not measured.

### 5.3.3.1. A definition of Outcome Mapping

In programme evaluation, an outcome at a lower level may be part of the process needed for an outcome at a higher level. This creates a complex system of interconnected processes and outcomes. It is often difficult to attribute specific outcomes to singular or specific components of the programme.

Outcome mapping was chosen as a method of programme evaluation, because it is able to monitor this complex process (project activities) and the outcomes (effects on change partners) and allow more in-depth evaluation of the desired impact (reduction in risky sexual behaviour). Project evaluation often focuses solely on impact, through requirements such as a logical framework analysis (LFA) for planning and reporting to donors. However, a focus on impact alone limits the potential for understanding how and why impact occurs. The singular focus on impact also ignores the many factors that may be affecting behaviour. Outcome Mapping recognises that change does not come through a simple cause-effect framework, but rather that multiple, nonlinear events lead to change. It looks at the logical links between intervention strategies and behavioural change, and how these may contribute to the desired impact (72).

'Outcome mapping' is a method which enables an organisation to plan, monitor, and evaluate the programme in an integrated way. (See Figure 5.3) This makes it possible for the organisation to document, learn from and report on their achievements. Outcome mapping is designed so that it is possible to define the outcomes of the programme as changes that one expects to see in people, groups or organisations that are influenced by the programme. Outcome mapping helps to overcome barriers to learning. In traditional outcomes evaluation, attention is focused on successes, and failures are down played. In outcome mapping, 'failures' can lead to greater learning than 'successes'. There is a direct focus on change in the behaviour of the main actors or 'change partners', rather than focusing solely on the measurement of downstream results or impact (72).

Outcome Mapping is divided into three steps (see Figure 5.3 below):

- **Project Planning**

This is a planning process that enables the programme to define its vision and mission, the groups of people that it seeks to influence and the changes in behaviour, relationships and activities that it intends to see. These changes are further elaborated in terms of concrete observable steps and linked to the strategies of the programme that are expected to enable these changes. The key organisational practices required to support these strategies are also listed.

- **Outcome and performance monitoring**

This is a monitoring process that constantly observes, documents and reflects on the changes in the participants, success of the project's strategies and organisational practices during the life of the programme.

- **Evaluation**

This allows for planning of more in-depth evaluation of key aspects of the programme – in this case a quasi-experimental study that focuses on measuring the impact of the programme on sexual behaviour.

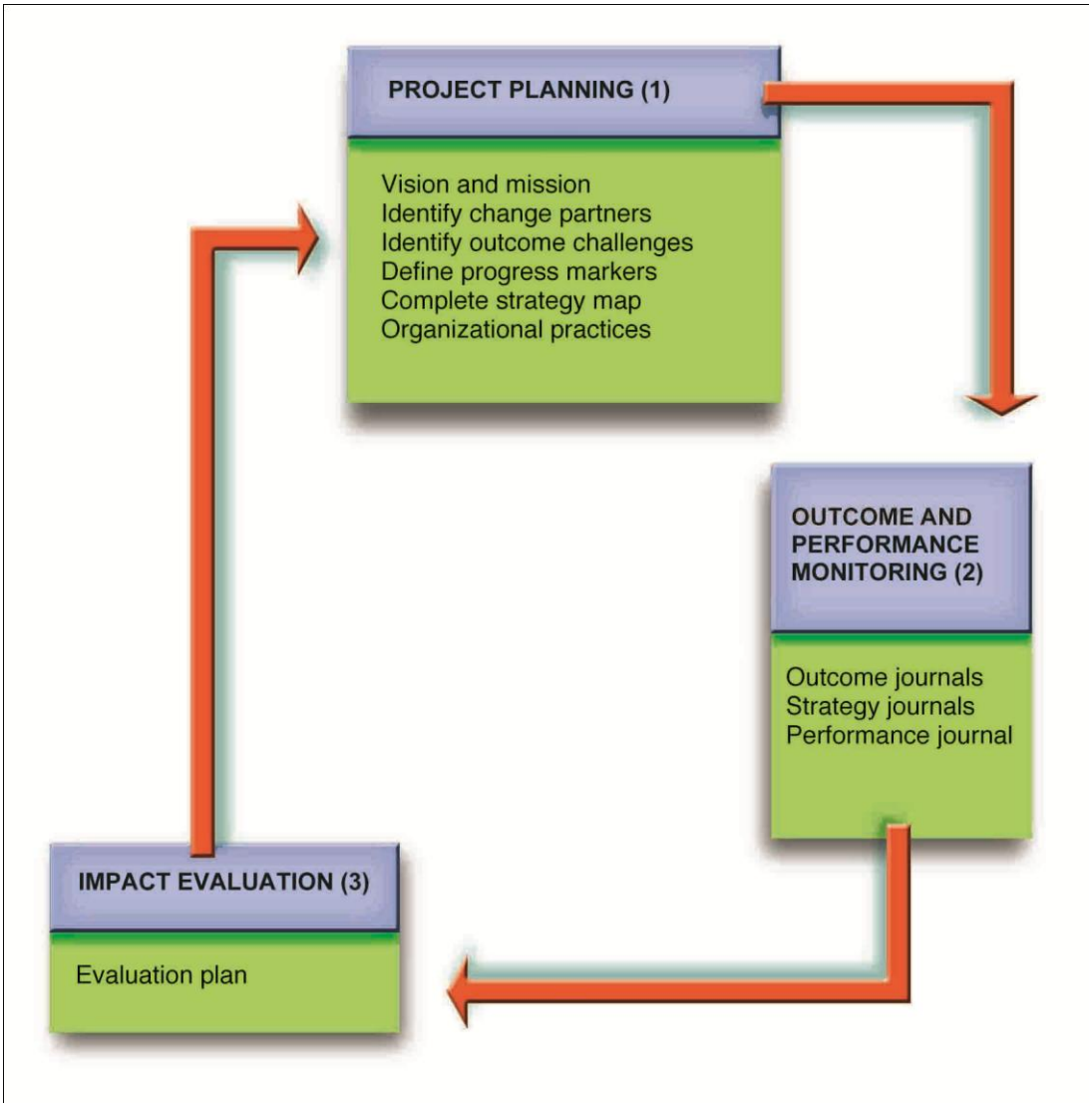


***Figure 5.3: Outcome mapping (72)***

In the following section the three steps of project planning, outcome and performance monitoring and impact evaluation are presented.

### 5.3.3.1 (i) Step One: Project Planning

In Outcome Mapping the first step of project planning involves six processes:

- Define the vision and mission: what is the goal of the project?
- Identify change partners: who are the people the project aims to influence?
- Identify outcome challenges: what are the changes in behaviour the project hopes to see in each change partner?
- Define progress markers: what are the stepping stones along the path to reach each of these outcome challenges?
- Complete strategy map: what are the strategies that will be implemented to reach each outcome challenge?

- Decide on organisational practices: which are the practices which the organisation should implement for the success of the project? (72)

In order to achieve this process for the Agents of Change programme, a participatory Outcome Mapping workshop was held with Fikelela staff, Diocesan Youth Workers and selected peer educators and facilitators. The workshop process was facilitated by Professor Bob Mash from Family Medicine and Primary Care at Stellenbosch University. These six processes that formed the project planning are presented in the following section:

- **Identifying the Vision and Mission**

The vision of Agents of Change was defined as 'to contribute to improving young people's life skills, assist young people to improve their ability to connect with their values and to create a critical mass of young people exerting 'positive' peer pressure, and thus ultimately contribute to turning the HIV/AIDS tide'. The mission of was defined as 'to assist young people in building healthier relationships through peer education and parenting workshops.'

- **Identifying the change partners**[20]

These are the individuals or groups that the programme intended to influence. Five change partners were identified as listed in Table 5.4:

**Table 5.4: Change partners**

| CHANGE PARTNERS | ROLE IN PROGRAMME |
|---|---|
| Peer educators | Conducted the 20 session life-skills sessions |
| Youth | Attended the sessions |
| Facilitators | Supported the peer educators in running the programme |
| Parents | The programme aimed to improve communication between parents and young people |
| Clergy | Provided a supportive role to the programme and addressed some of these issues in the broader church context. |

- **Identifying the outcome challenges**

Outcome challenges were identified for each change partner: Outcome challenges were defined as 'changes in the behaviour, relationships, activities, or actions of the people or groups with whom a programme works directly' (72). The following outcome challenges were identified and are listed in Table 5.5:

**Table 5.5: Outcome challenges**

| CHANGE PARTNER | OUTCOME CHALLENGE |
|---|---|
| Peer educators | Peer educators will be role-models for healthy relationships and positive lifestyle. They will be aware of and living out their personal values, goals and dreams and hold a vision of positively changing themselves and their community. They will be confident in facilitating small groups and presenting to their peers. They will show leadership and active involvement in their church and Diocese and will be growing in their |

[20] In Outcomes Mapping, these partners are called boundary partners. I have chosen to use the term change partners for clarity.

| CHANGE PARTNER | OUTCOME CHALLENGE |
|---|---|
| | relationship with God. They will be committed to their own educational achievement and to service in the community. |
| Youth | Young people will participate in and be affected by project activities, so that they will be influenced to make positive lifestyle choices. Young people within the project have a positive influence on other young people in their community who share the same issues. |
| Facilitators | Facilitators will have a strong Christ- like personal life, and be role models, mentors and advocates for peer educators and young people, through being approachable, trustworthy, available, supportive, self-giving, and with people skills - willing to learn, listen, motivate and maintain discipline. They will also be actively involved in the monitoring and evaluation of the project |
| Parents | Parents will effectively dialogue and interact with young people in an attempt to build healthy relationships. |
| Clergy | Church leaders will enable young people to develop their God-given talents and affirm young people for their contribution to life and the mission of the church. They will build healthy relationships with young people and communicate effectively through dialogue and listening to young people's creativity, concerns and feelings. They will be comfortable with addressing issues of lifestyle choices in the church. |

- **Defining the progress markers**

Progress markers illustrated the complexity of the change being sought. They represented stepping-stones along the pathway of change. Progress markers were identified for each change partner. In Outcome Mapping the progress markers are measured according the simple categories "expect to see" (the minimum to be achieved), "like to see" (satisfactory) and "love to see" (the programme had a profound effect). These simple categories are used so that the categories are readily comprehensible to all participants. The progress markers for each of the five change partners (peer educators, facilitators, youth, clergy and parents) are listed in Tables 5.6 - 5.10 below:

**Table 5.6: Progress markers for Peer educators**

| PROGRESS MARKERS FOR PEER EDUCATORS |
|---|
| **EXPECT TO SEE** |
| To be confident in sharing their personal values and goals |
| To not be using drugs, abusing alcohol or engaging in unsafe sex. |
| The message they give is the message they live |
| To facilitate the life skills sessions and make presentations |
| To attend on time for the sessions and plan appropriate times |
| To communicate practical arrangements and changes in the programme with the group |
| To regularly attend school |
| To attend the quarterly gatherings and 'sharing lessons learnt' sessions |
| **LIKE TO SEE** |
| Peer educators should continuously learn and grow in response to new challenges |
| Would like them to treat personal issues with confidentiality |
| Growing in confidence as they progress in the programme |
| To foster teamwork and participation in the group |

| |
|---|
| Should be able to impart their experience and knowledge beyond the boundaries of the church and their communities |
| **LOVE TO SEE** |
| To be enthusiastic about making a positive contribution in the lives of other people |
| Become positive leaders in the local church, diocese and their communities |
| Advocating issues affecting their communities |
| To be confident to profess their faith in Christ. |

**Table 5.7: Progress Markers for Facilitators**

| **PROGRESS MARKERS FOR FACILITATORS** |
|---|
| **EXPECT TO SEE** |
| Facilitators attend church regularly |
| Will be available to the young people |
| Attend trainings and quarterly meetings |
| Assist peer educators to facilitate the life skills programme |
| Meet weekly with peer educators |
| Demonstrate ability to listen to young people |
| Will not be authoritarian, blaming or judging |
| Will fill in monitoring report after every session and submit on time to Fikelela |
| **LIKE TO SEE** |
| Will not be using drugs, abusing alcohol or engaging in unsafe sex. |
| Have strong relationship with peer educators which is supportive and trustworthy |
| Reports reflect understanding and reflection |
| **LOVE TO SEE** |
| The facilitators are positive role models |
| Create conducive environment for young people to enjoy, influence and learn from each other |
| Have positively contributed to the growth of peer educators |
| Have collaborative and respectful communication style |
| Learn and apply learnings from Monitoring and Evaluation |

**Table 5.8. Progress markers for youth**

| **PROGRESS MARKERS FOR YOUTH** |
|---|
| **EXPECT TO SEE** |
| Young people attend the life skills sessions |
| Young people participate actively and enthusiastically in the life skills sessions |
| Young people can describe the pros and cons of different lifestyle choices |
| Young people describe what issues are important to them |
| Young people maintain their current healthy choices |
| **LIKE TO SEE** |
| Young people engage in discussions and debates on issues that affect them |
| Young people encourage their friends to attend |
| Young people use condoms if they have sex |
| Young people wait to have sex until an older age |
| Young people have a reduction in the number of sexual partners |
| Young people are not pressurising each other to have sex |
| **LOVE TO SEE** |
| Young people are not abusing alcohol or using drugs |
| Young are empowered to positively influence other young people |
| Young people wait to have sex until marriage |
| Young people get involved in lobbying and advocating and for issues that affect them |

**Table 5.9: Progress markers for clergy**

| PROGRESS MARKERS FOR CLERGY |
|---|
| **EXPECT TO SEE** |
| Take ownership of project, including it in church structures, and supporting its financial and resource needs |
| Big days celebrated – World AIDS Day, Women's day, 16 days of activism etc. |
| Youth included in year planner |
| Sermons on rape, drugs, violence against women and children |
| **LIKE TO SEE** |
| Clergy visit the agents of change programme |
| Agents share in services |
| Allow youth to develop own programmes, material and liturgies |
| **LOVE TO SEE** |
| Place youth in leadership and decision-making positions |
| Development of new styles of worship |
| Leaders give spiritual guidance and counselling |
| Promotion of youth events and training |
| Challenges the congregation to be more supportive of agents of change |

**Table 5.10: Progress markers for parents**

| PROGRESS MARKER FOR PARENTS |
|---|
| **EXPECT TO SEE** |
| Increase of listening skills |
| Respect for young people's view points |
| Trying to understand the challenges and needs of young people, especially around issues of sexuality |
| Connect with own experiences of adolescence |
| Good attendance at workshops |
| **LIKE TO SEE** |
| Understanding peer pressure |
| Less judgmental |
| Open communication |
| Increase in conversations on lifestyle choice |
| Says affirming things about young people |
| Parents get involved in lobbying and advocating on issues that affect young people |

- **Completing a strategy map for each outcome challenge**

Strategies were identified that would be implemented in order to reach each outcome challenge. The following strategies were identified as listed in Table 5.11:

**Table 5.11: Strategies**

| STRATEGY | PURPOSE |
|---|---|
| Training camps | To train peer educators and facilitators to run the 20 session life skills programme with the youth |
| Parenting workshops | To equip parents to be able to communicate more effectively with their children |
| Quarterly gatherings | To monitor the programme as well as to strengthen the programme by sharing ideas and resources. |

- **Identifying organisational practices**

Organisational practices were identified which were crucial to the programme's success. These were decided upon by the steering committee consisting of Fikelela staff together with the Diocesan Youth Workers and Diocesan HIV coordinators and are listed in Table 5.12:

**Table 5.12: Organisational practices**

| GOAL | ORGANISATIONAL PRACTICE |
|---|---|
| To connect with new ideas, opportunities and resources | Steering committee :sharing of new ideas and resources |
| To get feedback from key informants | Steering committee: sharing by Fikelela staff and Diocesan Youth workers.<br>Monthly reports by facilitators<br>Written reports from quarterly gatherings |
| To obtain support from higher level decision makers in the organisation | Reports by Fikelela Coordinator to the Board of Fikelela. Reports to Bishops of False Bay and Saldanha Bay |
| To review and revise key products, systems and procedures | Steering committee meeting<br>Yearly strategic planning held by Fikelela AIDS project |
| To share our learning with the world | Regular reports in Anglican publications: Diocesan – Good Hope magazine, Provincial – Southern Anglican. Reporting on Fikelela website and face book site.<br>Quarterly email newsletter to supporters and funders<br>Yearly report to funders |
| To create space for experimentation and personal growth | Steering committee: we always start with a time of reflection on lessons learned and growth |
| To create space for reflection as an organisation on organisational practices | Yearly strategic planning |

### 5.2.2.1 (ii) Step Two: Project Monitoring

During step two, tools were developed, incorporating the insights of the workshop participants, to monitor three areas:

- the achievement of progress markers by the different 'change partners' - an outcomes journal;
- the success of strategies to encourage change in the 'change partners' - a strategy journal; and
- the functioning of the programme as an organisational unit - a performance journal.

The monitoring took place on an ongoing basis throughout the two years of the intervention period. Information for these journals was obtained during the following activities:

- fortnightly meetings of the steering committee (Fikelela staff and Diocesan Youth workers);
- quarterly gatherings of peer educators and facilitators;
- camp evaluation (form filled in by each participant plus evaluation by steering committee);
- feedback from site visits made by Fikelela staff; and
- written reports from facilitators and Diocesan Youth Workers.

An unplanned development was that the funder CORDAID conducted an external evaluation in 2009. This consisted of the following activities:

- review of minutes, reports and written evaluations; and
- focus group discussions with peer educators, facilitators, parents, and clergy

This was very beneficial as it allowed data to be collected from an external source and this data was also included in the monitoring tools. This information was assessed by the steering committee and included in strategy journals by the Fikelela Coordinator.

- **Data collection tools**

The following data collection tools were developed: outcome journal, strategy journal and performance journal.

**Outcome Journal:** In the outcome journal the achievement of progress markers was scored as being high (actions have mostly all been achieved), medium (something has happened, but not in all change partners) and low (the change has largely been ignored or even opposed). The assessment was mostly qualitative (for example in terms of the depth of response observed) with some quantitative assessment (for example scoring by peer educators). Following this assessment and the documentation of the evidence to support it, the steering committee would reflect on what factors contributed to these changes, what unanticipated changes occurred, what lessons had been learnt and how the programme should react. This reflection formed part of the regular fortnightly meeting, however due to constraints of time; it was not covered at every meeting. Here is an example of an outcome journal for peer educators as shown in Table 5.13:

**Table 5.13: Example of an outcome journal for peer educators**

| **OUTCOME CHALLENGE**: *Peer educators will be role models for healthy relationships and positive lifestyle. They will be aware of and live out their personal values, goals and dreams and hold a vision of positively changing themselves and their community. They will be confident in facilitating small groups and presenting to their peers. They will show leadership and active involvement in their church and Diocese. They will be committed to their own educational achievements and to service in the community* | | |
|---|---|---|
| SCORE | EXPECT TO SEE | WHO? |

| | | |
|---|---|---|
| MEDIUM | To be confident in sharing their personal values, goals. | Atlantis, Hout Bay show lots of confidence. Masiphumelele are still nervous in presenting in front of others. |
| LOW | To not be using drugs, abusing alcohol or sex | There is change talk taking place amongst peer educators at quarterly gatherings. One youth member at Tafelsig has stopped taking drugs. |
| MEDIUM | The message they give is the message they live. | Facilitators report that peer educators are keen to make personal changes in their lives. |
| MEDIUM | To facilitate the life skills sessions and make presentations. | All of the sessions are going well, except for Kensington who struggle with discipline, the group is too big. |
| LOW | To attend on time for the sessions and plan appropriate times. | Some of the peer educators' time keeping is very poor. |
| LOW | To communicate practical arrangements and changes in the programme with the group. | Generally this is a problem, people send an sms to say I can't come, but don't inform us in time to make changes. |
| MEDIUM | To regularly attend school. | The peer educators are quite regular in their school attendance. |
| HIGH | To attend the quarterly training and sharing lessons learnt sessions. | Generally about 80% attend and are very enthusiastic. |
| | LIKE TO SEE | |
| HIGH | Peer educators should continuously learn and grow in response to new challenges. | Peer educators are finding the sessions very challenging. |
| HIGH | Would like them to treat personal issues with confidentiality. | Generally they take the issue of confidentiality seriously. There have been problems where peer educators are related to facilitators and tell them things. |
| HIGH | Growing in confidence as they progress in the programme. | This has been one of the reported high points. |
| MEDIUM | To foster teamwork and participation in the group | 9 out of 11 churches reported good team work. The two with problems reported issues with facilitators. |
| MEDIUM | Should be able to impart their experience and knowledge beyond the boundaries of the church and their communities. | This is beginning to happen. Tafelsig group asked to share at archdeaconry service. Hout Bay shared in Sentinel Primary. |
| | LOVE TO SEE | |
| HIGH | To be enthusiastic about making a positive contribution in the lives of other people. | First quarterly gathering showed that many feel they want to be different because the youth now look up to them. One girl mentioned splitting up from her married boyfriend. A boy mentioned that he has decided not to sleep around. |
| | Become positive leaders in the local church, Diocese and their communities. | Not yet documented. |
| | Advocating issues affecting their communities. | Not yet documented |

| |
|---|
| CONTRIBUTING FACTORS<br>Affirmation that the young people received through being elected was great. The camp bonded them together and made them feel very excited about making a difference. Where priests prayed for them in church before sending them off, they felt very encouraged. |
| SOURCES OF EVIDENCE<br>From the personal testimonies written down at quarterly gathering. From discussions with youth leaders. |
| UNANTICIPATED CHANGE<br>We saw motivation and change in action! One girl said that she didn't want to split up with her boyfriend just because her mother nagged her so much. It was when she connected with her own dreams that she realised he was messing up her life. |
| LESSONS/REQUIRED PROGRAMME CHANGE<br>The camp is a key part of the programme. It would be good to give priests and youth leaders some written suggestions regarding how to affirm the new peer educators publicly. |

**Strategy journal:** The strategy journal included the following elements:

- a description of the activities implemented;
- a judgement of their effectiveness;
- a list of outputs and; and
- a description of lessons learned and the required follow up.

An example is shown in Table 5.14 below:

**Table 5.14: Example of a strategy journal**

| |
|---|
| **Description of activities**<br>Parenting workshops consisting of three sessions were held at two churches: Hout Bay and Atlantis |
| **Effectiveness**<br>Atlantis worked very well. The group was enthusiastic and the majority attended all three sessions. Feedback from one of the peer educators indicated that there had been a shift in relationship at home as a direct result of her parents attending the workshop. The parents indicated they were keen to become peer educators themselves and share what they had learned with other parents.<br>Hout Bay was a mixed result. The first two sessions' attendance was excellent with quite a few outsiders – a Muslim mum and two Pentecostal pastors. The third session dropped to one and was cancelled and held the next week with only four. (This was partially due to Ascension day leading to a gap in the programme) The parents reported finding the sessions helpful, in particular the handouts. |
| **Outputs : Attendance**<br>Atlantis: Session one 19, session two 22, session three 24<br>Hout Bay: Session one 20, session two 18, session three 4 |
| **Lesson learned**<br>We need to find ways to get more commitment from the parents.<br>We need to find out how many of the parents are related to the youth group members.<br>Need to co-ordinate sessions with other church events. |
| **Required programme follow up**<br>'Professionalise' the course - R10 registration fee. Folder with handouts and pen to be given to participants. Certificate of completion to be handed out in church.<br>Attendance registers which notes whether their children attend the youth group, or are peer educators. |

**Performance Journal:** A performance journal was developed to record how the organisation was operating in order to perform its mission and support the programme's strategies. Information on the organisational practices was fed into ongoing work plans. This data enabled the programme to see if it was functioning optimally, and to modify its actions accordingly. Information was collected according to the following organisational practice areas:

- prospecting for new ideas , opportunities and resources;
- seeking feedback from key informants;
- obtaining support from next highest power;
- assessing and adapting products, and procedures;
- checking on those already served;
- sharing your best wisdom with the world;
- experimenting to remain innovative; and
- engaging in organisational reflection.

This is illustrated in Table 5.15 below:

**Table 5.15: Example of a performance journal**

| |
|---|
| **1. Prospecting for new ideas, opportunities and resources**<br>Materials have been sourced from Scripture Union. New icebreakers were downloaded. |
| **2. Seeking feedback from key informants**<br>Rev Gradwell and Rev Claire gave feedback on the parenting workshops. |
| **3. Obtaining support from next highest power**<br>Bishop Merwyn mentioned the programme in his Diocesan charge. |
| **4. Assessing and adapting products**<br>We must evaluate the camp training materials before next camp in January. |
| **5. Checking on those already served**<br>Kensington was visited; there were problems between peer educators and facilitators. |
| **6. Sharing your best vision with the world**<br>We need to put more stories on the website. |
| **7. Experimenting to remain innovative**<br>Add in painting t-shirts to the training camp programme. |
| **8. Engaging in organisational reflection**<br>The administration is becoming very heavy – we need to look at staffing needs for next year when we have more churches on board. |

### 5.3.3.1 (iii) Step Three: Evaluation

In this final step, an impact evaluation was conducted. This was undertaken using a quasi-experimental design, as described in section 5.4 below:

# 5.4. THE IMPACT EVALUATION

In this section the impact evaluation is presented. Firstly the introduction discusses the importance of using a control group and the necessity of triangulating data. The design for the study is presented followed by a description of the selection of intervention and control churches. The process of developing the questionnaire is described followed by the data collection and data analysis processes. In the final section the limitations of the study are explained.

## 5.4.1. INTRODUCTION

Evaluations of comprehensive school based AIDS education programmes, as well as peer education programmes, were examined from Uganda, Zambia, Cameroon, Botswana, Guinea, Kenya, USA and South Africa to decide on a methodology for impact evaluation (119,123,228,229,230). Two important components were identified:

Firstly, the importance of using a control or comparison group became clear. Without a control group, there is no reliable basis for evaluating the actual impact of these interventions (228). Participants cannot be randomly selected, since the programme works with the whole youth group and not with individuals. Thus it was decided to design the overall evaluation as quasi-experimental study with control churches matched to the intervention churches as closely as possible.

Secondly, the importance of triangulating quantitative and qualitative data was revealed. The Agents of Change programme is a complex intervention involving many factors (such as peer education, input of facilitators, attitude of clergy, and impact of training camp). Quantitative results measuring changes in sexual behaviour (impact) can be influenced by other confounding factors (due to the non-randomised study design) and also give little information about how these changes were enabled (process issues). There may also be misreporting by adolescents on their actual sexual behaviour (229). Thus the quantitative data from the questionnaire was triangulated with the more qualitative results of the monitoring process.

## 5.4.2.QUASI-EXPERIMENTAL DESIGN

The design of the quasi-experimental evaluation can be visualised in Figure 5.4 below:

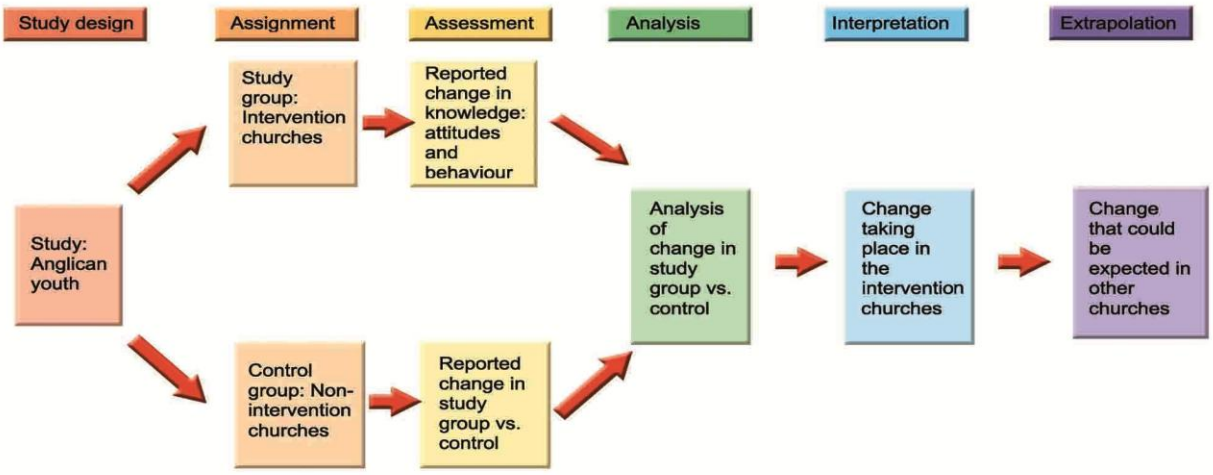


***Figure 5.4: The quasi-experimental design (231)***

## 5.4.3. SELECTION OF INTERVENTION AND CONTROL GROUPS

The Agents of Change programme was implemented throughout the three Dioceses of Cape Town, False Bay and Saldanha Bay and covered the Western Cape and parts of the Northern Cape. The impact of the Agents of Change programme was evaluated using a pre- and post-intervention questionnaire of sexual behaviour in both the control and intervention group. (See Appendix 4 for questionnaire).

In the selection of intervention and control churches, it was important to minimise selection bias and potential confounding factors. This occurs when there is something inherently different between the groups being compared that could explain differences between the groups (73). For example the control and intervention groups may exhibit different socio-economic characteristics which affect levels of sexual activity. In order to minimise selection bias the control churches were selected to be as similar as possible in terms of demographics: (race, socio-economic status), age range and gender balance.

### 5.4.3.1. Selection of intervention churches

Information was distributed to all 132 churches regarding the programme. Meetings were held with the leadership of churches that expressed interest. These churches were screened for suitability to join the programme based on criteria identified in the pilot study:

- a regular youth group meeting;

- actively involved and suitable youth leaders; and
- buy-in from the church leadership

In 2008, twenty seven churches met these criteria and were selected to join the programme, and 751 young people took part in the programme. In 2009 twenty eight churches joined the programme and 572 young people took part in the programme (Appendix 5). The reason for the drop in numbers was that in the first year, the majority of churches were the larger and more active churches, which had larger youth groups. Thus fifty seven churches took part in the programme during the two year period. Baseline data was collected from these churches participating in the programme.

#### 5.4.3.2. Selection of control churches for the study

The control churches were selected to be as similar to intervention churches as possible in order to decrease confounding. Both intervention and control churches had youth groups or confirmation classes where the research could take place. Confounding occurs when characteristics exist which create differences in the outcomes between the groups apart from those related to the intervention being assessed (232). For example confounding could occur because the young people from different churches attend schools with varying types of sex education programmes. In order to minimise confounding, as many potential confounding issues as possible were firstly identified, and secondly measured in the questionnaire. These potential confounding issues included:

- age;
- gender;
- income level;
- cultural background;
- being raised in a single parent or two parent family; and
- participating in a peer education programme at school.

One of the main potential confounding factors for the study was race. The intervention churches were categorised by urban/rural and by the predominant race. Of the fifty seven churches which took part in the baseline study forty were ‘urban coloured’, nine were ‘urban black’, six were ‘rural coloured’ and two were ‘rural black’. In the Anglican Church, churches are clustered geographically into ‘archdeaconries’, therefore control churches were selected from the same archdeaconry and in close proximity to the intervention churches. This does not always guarantee the same socio-economic status but in this way the confounding factors were reduced as much as possible. In order to further minimize confounding and because the number of Xhosa speaking churches was very small, the churches selected to be part of the study were limited to ‘urban coloured churches’ so that they would be as similar as possible.

Another potential confounding factor was the fact that the intervention churches were self-selecting , they were the ones who showed interest in taking part in the programme, whereas the control churches had not signed up, so there might be inherent differences in the churches, for instance in their willingness to deal with issues of sexuality.

The intervention and control churches are listed in Table 5.16:

**Table 5.16 Intervention and control churches**

| Intervention | Control |
|---|---|
| St Mark's Lavender Hill | St Mary's Woodstock |
| St Michael's Ottery | St Alban's Goodwood |
| Reconciliation, Manenberg | St Timothy's Factreton |
| St Mary Magdalene, Belhar | St Cyprian's Retreat |
| St Oswalds, Milnerton | St Francis, Strandfontein |
| St Faith's Plumstead | Church of the Annunciation, Woodlands |
| Holy Trinity , Kalk Bay | St Claire of Assisi, Ocean View |
| St Paul's, Faure | St John's Crawford |
| St George's, Kuilsriver | St Margaret, Parow |
| Church of the Holy Spirit, Heideveld | St Anne's, Maitland |
| Church of the Resurrection, Bonteheuwel | St Luke's Eerste River |
| St George's Silvertown | |
| Christ the Saviour, Lentegeur | |

The Centre for Statistical consultation was approached to determine the sample size. The sample size was based on an estimate of a population of 800 youth attending the youth groups. A required sample size of 260 was needed to determine the difference between the groups with 95% CI and 5% precision.

## 5.4.4. QUESTIONNAIRE DEVELOPMENT

The questionnaire was adapted from the questionnaire used in the baseline survey (202) and is listed in Appendix 4. It was designed as a KAP survey (Knowledge, Attitudes and Practice) and was based on questions used in three previous questionnaires:

- 'HIV and sexual behaviour among Young South Africans: A national survey of 15-24 year olds' (17).
- 'South African National Youth Risk Behaviour Survey' (223).
- 'Faith Matters: Teenagers, Religion and Sexuality' (109).

Certain other questions were added, in response to concerns over high levels of sexual coercion, raised by the national cross-sectional study of views on sexual violence and risk of HIV infection and AIDS among South African school pupils (233).

In the second year of the study, due to issues being raised in the ongoing literature review, additional questions were included regarding the influence of religiosity on sexual behaviour. These questions were adapted from studies by Fatusi (30) and Odimegwu (68).

#### 5.4.4.1. Validity of the questionnaire

'*A valid questionnaire measures what it claims to measure'* (234). It is important to note that a questionnaire cannot measure actual behaviour, it can only measure *reported* sexual knowledge, attitudes and behaviour. These can then be compared with reported sexual knowledge, attitudes and behaviour in the control churches. The validity of the questionnaire was tested on several levels:

Firstly, the questionnaire used is an adaptation of the original questionnaire used to collect baseline data (202). This baseline questionnaire was based on the questionnaires used in the above mentioned three surveys. Both the Pettifor and Reddy surveys have received national recognition and credibility. Although it might be expected that church youth would under-report their levels of sexual activity, the results were very similar to the rates of sexual activity in the general population as reported in the Pettifor study. This would suggest the church-based youth did not actually under-report, which speaks to the validity of the results received from the questionnaire.

Secondly, the adapted questionnaire was extensively piloted in 2007 with 337 participants in eleven churches. The young people in the pilot churches came from English, Afrikaans and Xhosa speaking backgrounds. They were representative of both urban and rural communities, and a range of private, 'Model C' and government community schools. The completion rate in the pilot study was high, since the majority of the participants filled in the questionnaire. After data cleaning, only eight questionnaires were rejected. Based on the pilot study certain questions were rephrased for clarity.

Thirdly, the questionnaire was examined by Prof Daan Nel from the Centre for Statistical Consultation at the University of Stellenbosch. Certain changes were made based on the need to separate nominal from ordinal questions.

Fourthly, there is a danger of reporting bias, where young people may under-report sexual behaviour, particularly since this is a church based programme. In order to identify reporting bias, the data received from the questionnaires was triangulated using the qualitative data from the monitoring evaluation. This enabled the detection of any major discrepancies between qualitative and quantitative findings.

### 5.4.5. DATA COLLECTION

In 2008, the pre-intervention questionnaire was administered to all participating churches at the start of the year's programme. A research co-ordinator was appointed, who also recruited several research assistants from Cornerstone Christian College. The research co-

ordinator attended the training camp and met with facilitators to explain the process and to set up appointments. She then set up appointments for the pre-intervention survey, and if she was not available she sent one of the assistants from Cornerstone College. The post-intervention questionnaire was administered once the 20 sessions of the programme had been completed. If the church had not completed all sessions in the course of the year, then the questionnaire was administered before the youth group closed in December. Thus in intervention churches the post-intervention questionnaire was administered between 9-11 months after baseline. In the control churches it was administered between 10-11 months after baseline.

At the end of 2008, insufficient post-intervention matched questionnaires had been collected to fulfil the required sample size, so the evaluation was extended for a second year.

In order to maintain confidentiality, adults were asked to leave the room during administration of the questionnaire. The young people were requested to spread out about the church or hall so that they could not see what the other person was writing. Questions were read one at a time and if necessary a translation was made of complicated terminology. The respondents filled in the questionnaires themselves. All participants were encouraged to answer each question at the same time; in order to avoid the scenario that non-sexually active youth would fill the form very quickly and sexually active would answer more questions and thus take longer. Questionnaires were folded and placed into a ballot box. They were then returned to the Fikelela office for data capturing.

#### 5.4.5.1. Challenges of data collection

Data collection was not always straightforward, sometimes because the assistants had not had personal contact with the facilitators or did not know the areas. On several occasions they did not find the venue, or came late and the participants had left already. It was later discovered that one of the assistants had been receiving her stipend and saying she was going to appointments, only to discover that she had not gone at all.

Another problem was the lack of continuity between the youth recruited to the study in the pre-intervention phase and the youth still attending the youth group in the post-intervention data collection phase. Because the survey was conducted in a youth group with very flexible membership, there were cases where very few of the same participants were present at both events. For these reasons it was necessary to continue with data collection for a second year, in order to gain the necessary number of questionnaires. This was a challenge, in some cases thirty or forty questionnaires were collected at baseline and only a couple at follow up. This negatively impacted on the strength of the study for both intervention and control groups. At baseline1352 participants took part, but only 176 returned matched questionnaires in the intervention groups and 92 in the control groups.

## 5.4.6. DATA ANALYSIS

Data on the following outcomes was available from the questionnaire (appendix 4):

- self-esteem;
- sexual behaviour;
- sexual knowledge;
- sexual coercion;
- sexual conversations;
- sexually transmitted infections;
- advocacy on sexual issues; and
- community service.

There were two databases, firstly the baseline data which included data on all the participants at base line (n=1352), and secondly the matched data, with intervention (n=176) and control participants (n=92), for both pre- and post-intervention. The databases contained three types of variables:

- Continuous variables such as age, age of first sex, number of partners.
- Ordinal variables, such as questions on self-esteem which were answered on an ordinal scale such as 1. Never, 2. Sometimes, 3 Often, 4. Always.
- Categorical (nominal) variables such as gender (male/female), type of schooling (Model C, local government, private school), did you have sex last year (yes/no).

### 5.4.6.1. Analysis of baseline data

The data was analysed by the Centre for Statistical Consultation at Stellenbosch University using Statistica Version 8. Frequency tables and percentages were presented for each variable. In the case of continuous variables the data was presented as means and histograms.

### 5.4.6.2. Analysis of males vs. females at baseline

The baseline data was then analysed by gender:

- In the case of age or age at first sex, the analysis involved comparing a categorical variable (gender) with a continuous variable (age). This analysis was done using analysis of variance (ANOVA) to investigate if there was a difference by gender. This data was presented in an ANOVA table and the p value assessed to ascertain if it was <0.05, in which case the variable differed significantly by gender.
- In the case of comparing categorical data, such as ‘has had oral sex’ (yes/no) this was analysed using a contingency table (cross tabulation). For this analysis a chi square test (Pearsons) was used. Relevant row percentages were given together with an indication of whether there was significant difference by gender ($p<0.05$).

- In the case of ordinal data such as 'never, sometimes, always', this involved comparing categorical (gender) with ordinal and was analysed using the ANOVA (analysis of variance).

#### 5.4.6.3. Analysis of religiosity at baseline

The aim of this analysis was to compare levels of religiosity with sexual activity. Categorical measures of sexual activity (not had sex, had sex last year) were compared with ordinal data measuring religiosity (for example importance of faith – very important, not very important). Therefore the data was analysed using the ANOVA (analysis of variance).

#### 5.4.6.4. Analysis of intervention vs. control at baseline

The aim of this analysis was to identify potential confounding factors. Different types of variables were analysed in the same way as described above. The only confounding factor that was just significantly different was race (p=0.049). Even though it had been decided to choose only coloured churches to avoid this possible confounding, there were in fact five white and six black participants in the intervention group and none of these groups in the control group. The statistician was approached and advised that in this case the numbers were too small and it was not necessary to re-analyse adjusting for this difference. Intervention (165 coloured, 5 white, 6 black), control (92 coloured, 0 white, 0 black)

#### 5.4.6.5. Analysis of intervention vs. control before and after the intervention

In questions with ordinal variables (such as 1.Never, 2.Sometimes, 3.Often or 4.Always) the responses were scored from 1 to 4 and a mean calculated. Then the mean scores at pre-intervention and post-intervention were compared in both the intervention and control groups to test for significance.

Categorical data was analysed using McNemar's test. This test is a non-parametric method, applied to matched pairs of subjects to determine whether the row and column marginal frequencies are equal. The probability of change in the intervention group was compared with the probability of change in the control group and tested for any significant difference.

## 5.4.7. LIMITATIONS OF THE STUDY

Firstly, in a randomised controlled trial potential confounders (for instance the influence of Lovelife, TV, knowledge of HIV positive people) are expected to be evenly distributed between the groups being compared. Because the study group was not randomly chosen, the comparison group was potentially non-equivalent. Differences in the outcomes may have resulted from some unknown set of characteristics related to the participants, but unrelated to the dependent variables (229). For example, although two churches are

situated in close proximity in the same community, the youth may attend schools with very different life skills programmes. Or the priest and youth leaders may have very different messaging in terms of condom usage. It would also have been important to assess TV viewing habits to control for access to programmes with an HIV message. However, because of the use of outcome mapping, any unknown confounding factors could potentially be identified in the monitoring process and included in interpretation of the results.

Secondly, this study seeks to assess knowledge, attitudes and behaviour. The first two are reasonably easy to assess, but behaviour is dependent on the young people giving true answers. There are two obvious limitations; firstly that this programme takes place in a church setting, where the young people are aware of the moral stance of the church against pre-marital sexual activity, so there could be a tendency for them to under-report sexual activity. However, in our previous research the statistics obtained were in line with Western Cape statistics obtained in school surveys, so it seems that the young people were being reasonably honest (202). The second potential limitation is that in the intervention churches the young people were coming into contact with youth leaders they liked and wanted to impress, so there might have been more of a danger of under-reporting (so called social desirability bias). This is a recognised problem, but our data from the questionnaires was triangulated with information from the monitoring process to detect any obvious discrepancies in behaviour change.

The greatest weakness of the study was the difficulty in obtaining sufficient numbers of matched questionnaires, which led to a weakness in the strength of the findings. This was particularly problematic when it came to sub-analyses such as ‘the sexually’ active, in terms of the matched data. The numbers were too small to be able to do further sub-analysis for instance in comparing oral sex in the intervention and control groups.

# 5.5. ETHICAL CONSIDERATIONS

## 5.5.1. ETHICAL APPROVAL AND CONSENT

In this section ethical considerations are presented, dealing with issues of approval for the research, consent and confidentiality.

### 5.5.1.1. Approval

Ethical approval was obtained from the Archbishop of Cape Town, Archbishop Njongonkulu Ndungane (Appendix 3). Permission was sought from the local priests of the participating parishes. Ethical approval to conduct the research was obtained from the Human Research Ethics Committee of the University of Stellenbosch (Appendix 6).

#### 5.5.1.2. Consent

Letters seeking informed parental consent were sent to the parishes for distribution (Appendix 1). Obtaining parental consent was difficult in many cases, particularly where the parents of the young people were not church members. The research assistant tried many strategies: forms were handed out two weeks in advance, the facilitators phoned parents asking them to send the forms back. Peer educators were also tasked with collecting parental consent forms. In some cases youth leaders filled in the forms on behalf of the parents.

Only young people who wished to participate, and had consent from parents or youth leaders, filled in the questionnaire. The assent of the youth was also sought prior to completing the questionnaire.

#### 5.5.1.3. Confidentiality

Confidentiality was preserved at all times. The questionnaires were filled in anonymously, and placed by research assistants into ballot boxes. Pre- and post- intervention questionnaires were matched by using the date of birth combined with the gender. This was an effective strategy for the majority of cases, except for one set of twins! However the questionnaires in that case were matched by comparing handwriting on the forms.

## 5.6. IMPACTS/OUTPUTS

The overall findings will be reported back to the clergy and bishops of the Diocese. A written report will be circulated to all participating churches; however data will not be linked to individual responses.

The research will generate the following outputs:

- report to the Anglican Church;
- PhD thesis;
- articles published in scientific journals; and
- conference presentations.

Following the completion of this study, findings will be incorporated into the development of a good practice model for peer education in churches. The potential impact of this model is extensive. Starting with the Anglican Church, this peer education model can be adapted and rolled out through the Anglican Church of Southern Africa (South Africa, Namibia, Lesotho, Swaziland, Mozambique and Angola – See Appendix 2). The model can also be adapted for use in other denominations and with some further adaptations for other faith communities such as mosques and synagogues. Interest has already been shown by leaders of some other denominations in the programme.

# CHAPTER SIX: MONITORING THE EFFECT OF THE AGENTS OF CHANGE PROGRAMME ON CHANGE PARTNERS

## 6.1. INTRODUCTION

The Agents of Change programme was monitored utilising Outcome Mapping as the methodology. The programme was monitored by examining the following areas:

- The effect of the programme on change partners: examining the progress made towards reaching outcome challenges.
- The effectiveness of the strategies that were used in the programme.
- The aspects of organisational performance which affected the effectiveness of the programme.

Chapter Six examines the effect of the programme on change partners. Chapter Seven considers the effectiveness of strategies and organisational performance.

The groups that the programme intended to influence in terms of behaviour change were identified as the peer educators, the youth, the facilitators, the parents and the clergy. Figure 6.1 indicates the impact of the programme on the change partners and of change partners on each other:

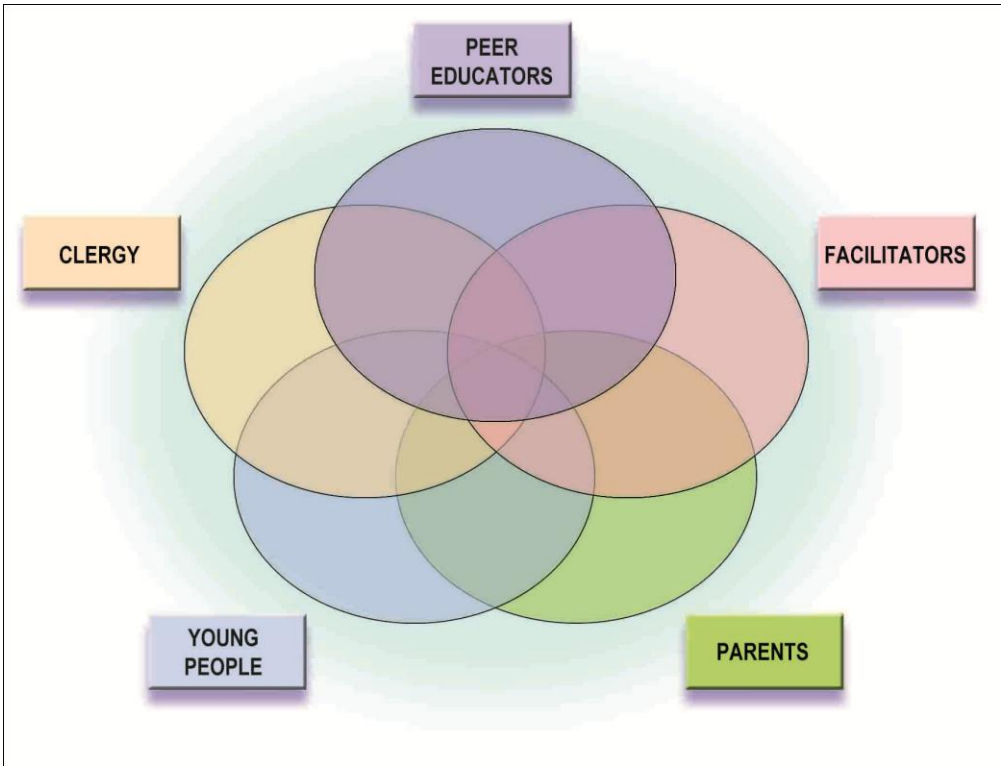


***Figure 6.1: The five change partners***

The effect of the programme on change partners was monitored by observing the progress made towards reaching the outcome challenges. Outcomes were defined as changes in the behaviour, relationships, activities, or actions of the people or groups with whom a programme works directly (72). Progress markers illustrated the depth of the change being sought, from more superficial reactive changes to deeper transformation. They represented stepping-stones along the pathway of change.

Outcome mapping uses progress markers which are in simple categories so that all participants are able to utilise and comprehend them. There were three levels of progress markers:

- “Expect to see”; which is the minimum level of involvement. If these progress marker are achieved, this indicates that the planned activity is taking place. Change is more reactive in response to the programme’s activities.
- “Like to see”; when these progress markers are reached, this indicates that some change is taking place.
- “Love to see”: if these progress markers are achieved this indicates that the programme is having a profound effect. Transformation of behaviour is deeper and likely to be more ongoing.

Data regarding the progress markers was gathered from the following sources:

- camp and training evaluations;
- quarterly gatherings – evaluation sheets;
- focus group discussions;
- steering committee meetings; and
- reports by facilitators.

In the following section the effect of the programme on the various change partners is examined, by considering how far each change partner achieved their progress markers as stepping stones towards achieving their outcome challenges. In each section the outcome challenge is presented, following by the ratings of the progress markers. The effect on peer educators is considered first, followed by the effect on facilitators, youth participating in the programme, clergy and parents.

## 6.2. EFFECT OF THE PROGRAMME ON PEER EDUCATORS

First of all the outcome challenge that was defined for peer educators is presented, and then the progress markers are examined.

### 6.2.1. OUTCOME CHALLENGE FOR PEER EDUCATORS

During the project planning, the outcome challenge for peer educators was defined as:

*Peer educators will be role-models for healthy relationships and positive lifestyle. They will be aware of and living out their personal values, goals and dreams and hold a vision of positively changing themselves and their community. They will be confident in facilitating small groups and presenting to their peers. They will show leadership and active involvement in their church and Diocese and will be growing in their relationship with God. They will be committed to their own educational achievement and to service in the community.*

## 6.2.2. PROGRESS MARKERS FOR PEER EDUCATORS

In order to move towards the achievement of the outcome challenge, it is necessary to make progress in terms of the 'progress markers'. Seventeen progress markers were developed, and both peer educators and facilitators assessed them using a simple Likert scale. If the marker was successfully achieved, they scored a three for high, if it was partially achieved, or achieved by some change partners but not all, they scored a two for medium, and if the challenge was not achieved or only achieved by a few people, they scored a one for low. These results were combined to give a mean score of low, medium or high. Table 6.1 below indicates the scores of peer educators in terms of their progress markers.

**Table 6.1 : Progress Markers for peer educators**

| **PROGRESS MARKER** | **RATING** |
|---|---|
| **EXPECT TO SEE** | |
| To be confident in sharing their personal values and goals | High |
| To not be using drugs, abusing alcohol or sex | Medium |
| The message they give is the message they live | Medium |
| To facilitate the life skills sessions and make presentations | High |
| To attend on time for the sessions and plan appropriate times | Medium |
| To communicate practical arrangements and changes in the programme with the group | Medium |
| To regularly attend school | High |
| To attend the quarterly gatherings and 'sharing lessons learnt' sessions | Low |
| **LIKE TO SEE** | |
| Peer educators should continuously learn and grow in response to new challenges | High |
| Would like them to treat personal issues with confidentiality | High |
| Growing in confidence as they progress in the programme | High |
| To foster teamwork and participation in the group | High |
| Should be able to impart their experience and knowledge beyond the boundaries of the church and their communities | Medium |
| **LOVE TO SEE** | |
| To be enthusiastic about making a positive contribution in the lives of other people | High |
| Become positive leaders in the local church, Diocese and their communities | Medium |
| Advocating issues affecting their communities | Low |
| To be confident to profess their faith in Christ. | High |

Having rated the progress markers for peer educators, these are linked with the qualitative data from evaluations, focus group discussions and reports.

### 6.2.2.1. Expect to see

Eight progress markers were defined in the category 'expect to see', which indicates the minimum level of involvement.

**6.2.2.1(i) Progress Marker One: to be confident in sharing their personal values, goals.**

This progress marker scored high – it had generally been quite successfully reached by the majority of peer educators. The peer educators seemed to have gained greatly in confidence through their involvement in the programme, both from being selected and from taking part in an 'up-front' capacity as leaders. They were challenged to formulate and share their own personal values and goals. Connecting with their own values and goals enabled them to make changes to their life choices, as well as influencing other young people as indicated by a female peer educator:

*"I started making boundaries – making the right choices – started to aim high to be the change I want to see in the world."*

They had also been empowered to share these values publically in front of other people as a male peer educator stated:

*"The vibe there is amazing, having the ability to stand up and strongly say your beliefs and how you see things and maybe, just maybe one person would have learnt something from what you said."*

As they identified with their own values, their own choices in life were impacted as indicated by a male priest:

*"What I like about this programme is that it is not just choices about sex, it is broader, they are taking charge of their lives, and it is not about us telling them what to do."*

By sharing their values with others, they were also able to influence other young people around them as stated by a male peer educator:

*"I start by myself – I look at my values, my personal values - then I express myself to help others start with their values."*

### 6.2.2.1(ii) Progress Marker Two: not to be using drugs, abusing alcohol or sex

This progress marker scored a medium. It is difficult to assess quantitatively the impact of the programme in terms of the use of drugs and alcohol. Sexual activity was monitored through the quantitative questionnaire. However there was a marked increase in the **intention** not to get involved in risky behaviour, and a number of peer educators indicated that they had reduced their risky behaviour. Generally there was significant progress towards this progress marker in terms of intention to change, and more moderate progress in terms of actual change. In this section the progress marker is examined in terms of drugs, alcohol and sex.

- **Drugs**

The programme appeared to have an influence on young people's ability to reduce their drug usage – by providing both motivation and strong peer group support for a change in behaviour. Peer educators also attempted to influence their friends to change. There was an indication of personal motivation to change as indicated by a male peer educator:

*"I am going to stop smoking weed."*

Actual change was also noted, as a male peer educator said:

*"Before I was an agent I use to be heavy on drugs, but when a friend told me to come with him to agents' camp everything changed."*

Several people indicated the importance of peer support for change as indicated in this quote by a male peer educator:

*"I was getting involved in drugs and gangs and stuff. I hit rock bottom two years back. I went to rehab and got feedback from the youth, it was a very touching letter that can motivate me. I was still being tempted by peer pressure. I needed agents of change programme desperately – the youth is a shoulder for me to lean on. Every time I come to the higher power and stick to my good circle of friends."*

A female youth member expressed how important the programme had been in her life in the following quotation:

*"This programme changed my life; I started to do drugs and ended up in jail. I was very ashamed, what will everyone think? But they did not doubt me, they supported me and helped me to get off drugs, I have been off drugs for four months now but it is very hard. You really have to choose your friends and stay in the youth and do the youth programmes. The educators have kept my mind focussed and really, really helped. I have friends and I am getting healing."*

- **Alcohol**

Similarly, with alcohol, the peer educators testified to an actual reduction in risky alcohol usage as well as a strong desire to reduce their alcohol consumption. Peer educators indicated that the support of friends was key in enabling them to change:

*"I was changed by the camp we had last time, and have stopped smoking and drinking and my life changed others lives like my friends' lives. I've stopped even standing in the street Friday nights asking for R1, R2 just for cigarette anymore." (Male peer educator)*

They indicated that being part of the church helped them to change:

*"In my life this programme did a wonderful job: I'm not smoking, not drinking and always in the church." (Male peer educator)*

Peer educators also attempted to influence friends:

*"I want to change or help to change my friends what have not changed, and to stop doing what they are doing, like look for girlfriends." (Male peer educator)*

- **Sex**

Similarly the peer educators indicated a desire to reduce their sexual activity. As well as reporting incidences where change had already taken place, some indicated a desire to abstain from sex and others had decided to be faithful. There was evidence that some of the peer educators had decided to abstain:

*"For me I like to be an agent of change coz my life is being changed. I stay away from drugs and I don't even have sex anymore!!" (Male peer educator)*

There was evidence that some peer educators had decided to be faithful:

*"I was drinking a lot of wine and I don't drink anymore. I had lots of girls before and now I only got one." (Male peer educator)*

Many noted that it was their faith in God that helped them to refrain from risky sexual relationships:

*"I am closer to God and stopped being naughty with girls." (Male peer educator)*

- **Other lifestyle issues**

Peer educators also indicated that there were improvements in their general life style. This could impact on risky behaviour on several levels – if they started to spend time with a more positive group of peers, they would be at less risk. Also if their life style became more positive, they might receive more positive feedback from parents and teachers, which could lead to an improvement in self esteem as indicated by the following male peer educator:

*"I see that I have changed my life. I used to be a real **A**hole but now I am the type of guy a person can speak to."*

- **Sometimes change did not occur**

There were also indications that some of the agents of change had not changed:

*"It saddens you when they have done agents of change and they come and tell you they are pregnant. When there is so much abuse around, it is quite difficult." (Clergy)*

**6.2.2.1(iii) Progress Marker Three: the message they give is the message they live.**

This progress marker scored a medium. Generally the churches reported that the agents of change were indeed trying to live out the message, they recognised that they cannot encourage others to change if they have not yet changed themselves. This is a progress marker that they are aspiring to, even if they have not achieved it yet! They clearly understood the importance of this progress marker:

*"It is not about practicing what you preach, it is about preaching what you practice – it is pointless if we are being hypocritical about life." (Male peer educator)*

Some indicated that they are achieving this progress marker:

*"One Friday after I had finished presenting my session, one girl came up to me and told me she would like to be like me. I was shocked, but at the same time inspired to improve and work on myself." (Female peer educator)*

Sometimes the change was short-lived and they reverted to former activity:

*"It only lasts for one week then we are back again." (Male peer educator)*

**6.2.2.1(iv) Progress Marker Four: to facilitate the life skills sessions and make presentations**

This progress marker scored a high as it was achieved successfully by the majority of the peer educators:

*"The first session was a lot of work, we had sixty people here, we prepared the whole week." (Male peer educator)*

However sometimes the peer educators did not prepare adequately and therefore they did not present well:

*"Some of the agents held onto their books for dear life as the crowd made them feel a bit unsure of their message." (Female facilitator)*

Sometimes the presentation did not go well due to nervousness:

*"It never went the way it was supposed to – I was nervous, had a facilitator who took my place when I broke down." (Male peer educator)*

At other times peer educators did not attend when expected:
*"A key person did not pitch up for session and made the team weary." (Female facilitator)*

However this progress marker was not always achieved due to other pressures.

- **Time pressure**

Many of the churches indicated that the time needed for preparation of the sessions could be too much:

*"We need to be very careful we do not overburden the P/Es with too much stuff, especially since they are still at school, some in matric." (Female facilitator)*

**6.2.2.1(v) Progress Marker Five: to attend on time for the sessions and plan appropriate times**

This progress marker scored a medium. Although many of the peer educators did achieve it, a significant number did not plan adequately.

- **Time keeping**

For many of the peer educators this was a challenge:

*"Very poor punctuality by some of the agents – hints of a lack of commitment." (Female facilitator)*

- **Attendance at planning sessions**

Some churches indicated that there was good attendance. There was a direct co-relationship between attendance at the planning sessions and the success of the sessions being presented. Churches where attendance at planning sessions was poor showed poorer results:

*"Some of us are dedicated and set an example to others we attend all meetings and projects." (Male peer educator)*

As well as planning for the upcoming sessions, these meetings were a time for peer educators to bond as a group:

**"***Lots of planning and going to each others' houses and then we eat snacks and it is a lot of fun." (Female peer educator)*

Other churches indicated that attendance was a problem, sometimes there were valid reasons, mostly school work or extra-curricular activities:

*"I am dedicated to this programme but lately my commitment has lacked because of school and the work load, I am going to try to do better." (Female peer educator)*

#### 6.2.2.1(vi) Progress Marker Six: to communicate practical arrangements and changes in the programme with the group

This progress marker scored a medium. This tended to be seen as the task of the facilitator, though the peer educators also helped to spread messages. Often changes took place at the last minute, because of other church activities taking place, and this could lead to frustration for the group as indicated by a facilitator:

*"The peer educators show low commitment and lack of organisational skills." (Male facilitator)*

#### 6.2.2.1(vii) Progress Marker Seven: to regularly attend school

This progress marker scored a high, since the majority of peer educators were regular school attenders. The sense of responsibility engendered by the programme appeared to encourage the peer educators to be more responsible in their attitude to school. Several peer educators indicated that the programme had affected their attendance in a positive way as one of the male peer educators stated:

*"I don't bunk anymore."*

#### 6.2.2.1(viii) Progress Marker Eight: to attend the quarterly training and 'sharing lessons learnt' sessions

This progress marker scored a low. This progress marker was not achieved by all the churches. The attendance at quarterly gatherings was often not as good as expected. There were many reasons for this, the most common being a clash with other activities. Since the programme was being run with churches in three Dioceses, it was very difficult to choose a date that did not clash with either an archdeaconry or Diocesan event.

There were eight progress markers in this group of 'expect to see'. Achievement of these progress markers would indicate that the programme is generally being run according to plan. Three of the eight markers scored a 'high', and four scored a 'medium', and there was one 'low'. If the markers are all scored numerically (high =3, medium= 2, low = 1), then the mean score is 2.6, which would indicate that overall the programme is being run as planned.

### 6.2.2.2. Like to see

Achievement of this group of progress markers 'like to see' indicates that some deeper change happened in the change partners.

### 6.2.2.2(i) Progress Marker Nine: Peer educators should continuously learn and grow in response to new challenges

This was one of the most successful progress markers and achieved a high. This progress marker was achieved by the majority of peer educators. Being involved in the programme for most of them meant that they were now functioning as leaders rather than as followers. The young people did appear to be growing through the challenge of being peer educators:

*"I have better leading skills. I am more punctual, I am responsible and now I can set examples to their peers. I need be to more ambitious and try to get my leading skills to higher standards." (Female peer educator)*

Peer educators also indicated other changes in terms of personal growth and attitudes as well as their choice of friends:

- **Attitudes to others**

The programme appeared to have a positive effect on peer educator's attitudes to others:

*"I stopped being negative to other people, being 'miss' whoever, and I see that people are reaching out to me and I am starting to phone some people that I never thought would talk to me." (Female peer educator)*

- **Change of friends**

Another important area highlighted by the programme was the commitment to build friendships that would build them up, rather than bring them down:

*"I must leave all my wrong friends – My friends are bringing me down." (Female peer educator)*

### 6.2.2.2(ii) Progress Marker Ten: would like them to treat personal issues with confidentiality

This progress marker was successfully reached and scored high. This appeared to be quite a positive part of the programme. The peer educators felt empowered to spend time with those having problems and to listen to their issues:

*"I have learned to listen more and give less advice. Therefore people are speaking to me about their personal issues." (Female peer educator)*

Generally both peer educators and facilitators indicated high levels of confidentiality:

*"Very NB! This is a serious point to consider guys. The matter was well handled by the team and nothing leaked out." (Female facilitator)*

It was recognised that there were certain issues that young people would not feel confident to discuss with the facilitators (adults) present, so sometimes they were asked to leave the room for reasons of confidentiality:

*"Sometimes the facilitators are asked to leave for certain discussions. We had a discussion, are you allowed to share these problems with the facilitators? Answer no, you can share it in general for instance a girl is pregnant, but not who it is. That person must give their permission." (Female peer educator)*

**6.2.2.2(iii) Progress Marker Eleven: growing in confidence as they progress in the programme**

This progress marker achieved a high for the majority of the peer educators. This appeared to be one of the strongest areas of the programme. Peer educators generally indicated that they had grown significantly in confidence. They had improved their presentation skills; they felt affirmed through being selected. Their self-esteem had grown as well as confidence and leadership, and the programme had given them a sense of hope and courage.

- **Presentation skills**

They were learning to present with less input from the facilitators:

*"What really excites me is that the peer educator team has run the programme autonomously on a few occasions without any input from us." (Male facilitator)*

Individuals indicated that they had gained confidence in presenting:

*"When I presented my first session I was shaking like a leaf and the children were really out of hand. But when I took the stand everything just flowed." (Female peer educator)*

- **Affirmation through being selected**

The programme appeared to build a sense of affirmation in the peer educators, from being selected by their peers and from being able to run the programme successfully:

*"Well the fact that I was elected by my Church made a change in my life, just to see that people exactly notice the things I do, they saw leadership qualities in me where I just thought its normal." (Male peer educator)*

- **Acceptance**

The sense of acceptance was very affirming for the peer educators:

*"People respect me more. People can rely and trust me more." (Male peer educator)*

- **Self-esteem**

Many of the peer educators indicated that their self-esteem had increased:

*"Agents of change has boosted my self-esteem and now I believe that I'm worth more than what I perceived myself to be before, I'm not waiting for people to hand out opportunities anymore, I go out and get what I want and proud to say IM A GO GETTER." (Male peer educator)*

- **Confidence and leadership**

Many of the peer educators indicated that the programme had boosted their self-confidence in a very noticeable way; they could look back at their confidence before starting the programme and compare it with marked change after having run the programme:

*"Before I started the programme I always had this stage fright. I could never look people in the eye because I felt they were judging me. Now I walk with my head held high, because through the AOC and God I have learned that it doesn't matter what other people think of me, as long as I am confident with myself and I love myself enough, no one else matters, but me and God." (Female peer educator)*

However some peer educators indicated that the programme was not building them:

*"My life is going down according to other people – I am losing my friends, I have become more quiet and withdrawn and not loud as I used to be. The sad thing is I don't really care about anyone or anything anymore." (Male peer educator)*

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- **Hope**

Some indicated that the programme gave them a sense of hope:

*"My three worlds: home, school and church had all become compact and seemed to be endless cycles of disappointment and disillusionment, this programme has provided an outlet and given me hope." (Female peer educator)*

- **Courage**

Some peer educators also indicated that they had gained courage to face other challenges in their lives:

*"At first my courage was shallow, but being in this programme made me realise that we are not alone and that there are people to help us and give us love. God always will bring us through." (Male peer educator)*

**6.2.2.2(iv) Progress Marker Twelve: to foster teamwork and participation in the group**

This progress marker was successfully achieved and scored a high. Many of the peer educators did not know each other well before starting the group and often it was challenging to have to run a programme together. In this way the programme increased the sense of teamwork and participation.

- **Teamwork**

The majority noted that through working together a strong sense of teamwork was built up. Most churches indicated that this was a very important and successful part of the programme. As the peer educators worked together, a team and support structure was formed for them as indicated by a female facilitator:

*"Young people tend to differ naturally because of finance, personality, looks and attitudes, but this programme made so much progress that they didn't care anymore. They just got befriended with one another."*

This group became an important support in difficult times:

*"This programme is what keeps me going, it's the only thing I look forward to, and it's my reason to go on with life. It made me learn to talk to someone when needed and that you don't have to keep your burdens on your shoulders alone because there are people who care." (Female peer educator)*

- **Participation in the programme**

Generally participation was good, sometimes there were too many peer educators and the group had to be divided, and not all participated in such a dedicated way as others:

*"Our team was too big, so we divided into two groups and each team leads a session every week." (Male facilitator)*

Sometimes however, things didn't work so well. Sometimes individuals did not get on well, or there were personality clashes. Sometimes the relationship between peer educators and facilitators was weak:

*"One PE had a bad temper and he did not know how to deal with it, he doesn't take criticism well, so he just left." (Male peer educator)*

**6.2.2.2(v) Progress Marker Thirteen: should be able to impart their experience and knowledge beyond the boundaries of the church and their communities**

This progress marker scored a medium because the main focus of the programme was on what took place at the church. Only some of the churches managed to share further afield, some through inviting members of other churches to the sessions, and some through being invited to present at other events.

- **People from the community coming into the sessions**

Many of the churches noted that the programme was attracting youth from other denominations and even other religions. This indicates that the programme is dealing with issues that some other churches are not looking at. It appeared that parents want their children to deal with these issues in a faith context:

*"Other religions and denominations are now involved in the youth on Friday. The mosque is willing to allow the kids to come to the life skills programme they will join the programme." (Male facilitator)*

- **Reaching out into the community**

Involvement in the Agents of Change often seemed to open up opportunities and an interest in reaching out into the community. As the church began to deal with issues such as HIV and drugs, they were invited to attend other events as well as taking on practical projects such as supporting orphanages. The Diocesan Youth worker shared the progress of the peer educators from Ceres:

*"They presented twice at schools for the grade six classes. They were invited by the police to do presentations in the farms around Ceres and were even driven around by the police bakkie!"*

Achievement of this group of progress markers "like to see" indicates that not only is the programme running as planned, but that some change is taking place in the change partners. There were five progress markers in this group, of which four scored high and one medium. When scored numerically, this group scored a mean of 2.8, which indicates that some change is indeed occurring in some of the peer educators.

### 6.2.2.3. Love to see

This group of progress markers 'love to see' indicates that more profound change has taken place.

#### 6.2.2.3(i) Progress Marker Fourteen: to be enthusiastic about making a positive contribution in the lives of other people

This progress marker was successfully achieved by the majority of the peer educators. They were enthusiastic about helping to change individuals and their communities. They recognised their influence in the lives of others in various areas, through changing themselves as individuals, through changing communities, and through creating positive peer pressure:

- **Changing individuals**

Peer educators saw that change took place at an individual level for instance in the case of a male peer educator who wanted to inspire other people for change:

*"I want to look back and say that I have made a drastic change in someone's life and that someone was inspired by what I was doing."*

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- **Changing communities**

Peer educators saw that the programme could potentially bring change into their community, a female facilitator indicated that the programme had helped her to see the broader needs of the community and how she could contribute:

*"The programme for me has not just been a lesson in drugs and sex and all those things, but it has been a lesson in what the community is lacking and how I can make a difference."*

- **Influencing others for change**

There was recognition that as the peer educators changed, they could then influence others as a male peer educator indicated:

*"My life has changed because of this programme, as my life has changed, other people's lives have changed too, I found my purpose, thank you!!"*

- **Creating positive peer pressure**

Peer educators recognised that change takes place through creating positive peer pressure, as the group changes, so the individual is enabled to change as one female peer educator shared, she felt like she was *"Becoming part of the movement."*

**6.2.2.3(ii) Progress Marker Fifteen: become positive leaders in the local church, Diocese and their communities**

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This progress marker scored a medium, as there was a lot of variation from church to church. Although this part of the programme was not consistently documented, there were significant events that took place:

*"The Agents of Change programme is helping peer educators become leaders within their community and environment." (Male facilitator)*

There was a shift in their role in church, from being merely youth who attend, to being leaders:

*"Ready, challenged, I can finally be the church, instead of just going to church." (Female peer educator)*

Several significant activities did take place:

- The Church at Ceres was asked to present sessions in two schools and out on farms in the rural areas.
- The Church in Mitchells Plain was asked to do a presentation in the Pentecost service with ten others churches present.
- The Church at Tafelsig was invited to run sessions at the Baptist Church camp.

One of the most encouraging comments was from a girl who truly has developed a vision of change in Maneberg, one of the communities facing the greatest challenges of drugs and gangsterism!

*"Because of our church is so cool, I think Manenberg is the coolest place to live and I don't want to ever leave." (Female peer educator)*

**6.2.2.3(iii) Progress Marker Sixteen: advocating for issues affecting their communities**

This progress marker only achieved a low score. Awareness of issues was increased as indicated in the following quote from a female peer educator:

*"Now I understand how a guy's mind really works, and how AIDS is affecting our community."*

However this did not generally translate into advocacy. The programme was successful in giving the peer educators a better understanding of the issues facing their community, however apart from a few churches, this did not lead to advocacy taking place.

The advocacy aspect of the programme needs to be developed further. Issues were raised at youth groups, or on a Sunday service, but this could be developed further into active advocacy. Some churches did organise marches or create posters around various issues.

**6.2.2.4(iv) Progress Marker Seventeen: to be confident to profess their faith in Christ**

This progress marker was successfully achieved by the majority of peer educators. A great number of the peer educators and facilitators indicated that the programme had strengthened their faith and increased their confidence to talk about their faith. Some indicated that they felt closer to God and others expressed that their faith in God was a spiritual resource to help with behaviour change.

- **Closeness to God**

Many of the young people indicated that they felt closer to God because of the programme as indicated by a female peer educator:

*"I have come to know God on a level that I never ever thought possible."*

- **Spiritual help with behaviour change**

Many of the young people indicated that God gave them the strength to be able to change their behaviour as shared by a male peer educator:

*"It's a start of a new beginning in my life. This programme is bringing me closer and closer to God; I want to be with God so that I can remain in this life forever. This is one of the ways to stay on the right path."*

Others indicated that their spiritual lives were not strong:

*"Terrible, I haven't been the child God wants me to be. I feel like I am a total stranger to myself right now seriously." (Female peer educator)*

Achievement of this group of outcome challenges "love to see" would indicate that something profound is taking place in the change partners. From the four outcome challenges the score there were two highs, one medium and one low. This group scored a mean of 2.2, which may indicate that some profound change is taking place, but not with all the participants.

## 6.2.3. SUMMARY: OUTCOME CHALLENGES FOR PEER EDUCATORS

### 6.2.3.1. High progress markers

The following clusters of progress markers scored high: Personal development and self-efficacy:

### 6.2.3.1(i) Personal development

Personal development included the following progress markers: "can facilitate life-skills sessions and make presentations", "to regularly attend school", "treat personal issues with confidentiality", "foster team work", "enthusiastic about making a positive contribution in the lives of others", "confident to profess their faith". The programme appeared to be very successful in terms of personal development in the peer educators' lives.

- **Presentation skills**

Through this programme, the peer educators learnt new skills in the area of preparing and presenting, being a leader 'up front'. They generally felt proud of these new skills and affirmed by the feedback from facilitators and other adults.

- **Education**

A positive impact of this programme was an improvement in attitude and attendance at school. This could lead to breaking a negative downwards spiral, as the young person began to receive positive affirmation from teachers and parents. They were also spending more time at school or on their school work, which reduced the opportunities for negative behaviour.

- **Confidentiality**

The peer educators did successfully keep confidentiality when other young people shared their problems and issues. This gained them respect amongst their peers.

- **Team work**

Through the Agents of Change programme the peer educators learned important skills of working as a team. The team also became an important support structure for them, a safe space where they could share their problems and frustrations.

- **Faith in God**

Through participation in the Agents of Change camp and by becoming more involved in church activities, many of the peer educators indicated that their faith had grown and developed. This growth in spirituality enabled them to find the internal strength to stand against negative peer pressure, as well as to align themselves with the Church's teaching on sex, drugs and alcohol.

### 6.2.3.1(ii) Self-efficacy

Another very important impact of the AOC programme was in the area of self-efficacy; 'growing in confidence', 'respond positively to new challenges', 'confident in sharing their personal values and goals':

- **Growing in confidence**

One of the most powerful impacts of this programme was in terms of an improvement in self-esteem and confidence. This started at the moment of being elected by peers as an educator. The process of preparing sessions and presenting sessions also enabled people to grow past their fears and become more confident socially.

- **Responds positively to new challenges**

As they learnt new skills and met new people, they were faced with exciting new challenges. The majority of peer educators rose to these challenges and were empowered.

- **Confident in sharing their values and goals**

Through participating in the sessions, the peer educators were able to define what their goals and values are.

### 6.2.3.2. Medium progress markers

The following clusters of progress markers scored a medium: practical skills and behaviour change:

### 6.2.3.2(i) Practical skills

This included the following cluster of progress markers: 'to attend on time and plan appropriately', 'to communicate practical arrangements and changes in programme', 'impart their experience beyond the boundaries of the church'. There appeared to be a strong relationship between the practical skills of the peer educators and the success of the

programme. In certain churches the peer educators did not attend planning meetings, arrived late for sessions and were disorganised. This meant that the programme was not well run. It could also lead to problems of discipline as the youth got bored.

### 6.2.3.2(ii) Behaviour change

This included the following cluster of progress markers: 'not to be using drugs, abusing alcohol or sex'; 'the message they live is the message they give'. The peer educators were all aware of the importance of consistency between their message and their lifestyle. It appeared that the peer educators were mostly motivated by the programme to change. This happened on various levels, the individual level, through the peer group and also at a spiritual level.

- **Individual**

Many of them indicated that they wanted to make personal changes in their own lives.

- **Peer group**

An interesting factor was that many of them were made aware of the bad influence of their friends and indicated a desire to spend more time with friends that would be a beneficial influence on their lives. This would support them to be able to follow through on any personal decision taken. Peer influence helped them want to change and peer support enabled them to go through change (especially with drugs).

- **Spiritual level**

The majority of those who either indicated a desire to change, or that they had already made changes in their lives recognised that the source of their power to change came from their faith. It appears that this was a crucial component of the programme, which differentiates it from other behaviour change programmes.

### 6.2.3.3. Low progress markers

Two progress markers scored low: 'to advocate issues affecting their community', 'to attend quarterly gatherings'.

### 6.2.3.3(i) Advocacy

Although there was quite a strong desire to see change taking place at a community level, there was very little actual advocacy. This was an area of the programmes which needed to be strengthened.

#### 6.2.3.3(ii) Attendance at quarterly gatherings

Attendance at quarterly gatherings was poor, which limited the possibility of sharing of ideas and collaboration of churches on certain community activities.

#### 6.2.3.4. Conclusion

Of the seventeen progress markers, nine scored 'high', six scored 'medium' and two scored 'low'. This gives a numerical overall mean rating of 2.4. This would indicate that the programme was moderately effective in evoking change in the peer educators. The peer educators rated their own progress as 2.3 out of a possible score of 3, whereas the facilitators rated their progress slightly higher at 2.5.

The AOC programme appears to have had an impact in the lives of the peer educators, by building assets into their lives which can enable them to withstand peer pressure and risky behaviour. Some of these key assets involved affirmation from adults, particularly the facilitators, and in some cases an improved relationship with teachers and parents. Other assets were in terms of support from peers, as the peer educators became a team they supported each other in their goals of behaviour change. The programme also gave peer educators the chance to learn new skills and to define their value systems. These aspects of the programme generally led to an improvement in self-efficacy which could help them to withstand peer pressure.

The data indicates that behaviour change did take place in certain instances, but not with all the peer educators. There was often a strong desire to change, and an understanding of the possible bad influence of current friends. The peer educators also recognised the importance of spirituality to give them the strength to change. Advocacy was a weak area of the programme.

## 6.3. THE EFFECT OF THE PROGRAMME ON FACILITATORS

In this section the effect of the programme on the second change partner, the facilitators, is examined.

### 6.3.1. OUTCOME CHALLENGE FOR FACILITATORS

The outcome challenge for the facilitators was defined as follows:

| |
|---|
| *Facilitators will have a strong Christ-like personal life, and be role models, mentors and advocates for peer educators and young people, through being approachable, trustworthy, available, supportive, self-giving, and with people skills - willing to learn, listen, motivate and maintain discipline. They will also be actively involved in the monitoring and evaluation of the project.* |

## 6.3.2. PROGRESS MARKERS FOR FACILITATORS

Sixteen progress markers were defined for facilitators as listed in Table 6.2:

**Table 6.2: Progress Markers for facilitators**

| PROGRESS MARKER | RATING |
|---|---|
| **EXPECT TO SEE** | |
| Facilitators attend church regularly | High |
| Will be available to the young people | High |
| Attend trainings and quarterly meetings | Low |
| Assist peer educators to facilitate the life skills programme | Medium |
| Meet weekly with peer educators | Medium |
| Demonstrate ability to listen to young people | High |
| Will not be authoritarian, blaming judging | Medium |
| Will fill in monitoring report after every session and submit on time to Fikelela | Low |
| **LIKE TO SEE** | |
| Will not be abusing sex, drugs or alcohol | High |
| Have strong relationship with peer educators which is supportive and trustworthy | High |
| Reports reflect understanding and reflection | Low |
| **LOVE TO SEE** | |
| The facilitators are positive role models | High |
| Create conducive environment for young people to enjoy, influence and learn from each other | High |
| Have positively contributed to the growth of peer educators | High |
| Have a collaborative and respectful communication style | Medium |
| Learn and apply learnings from Monitoring and Evaluation | Low |

The progress markers were linked with findings from the evaluations, focus groups and reports.

### 6.3.2.1. Expect to see

**6.3.2.1(i) Progress Marker One: Facilitators attend church regularly**

The facilitators were youth leaders before they became facilitators of the Agents of Change programme. They were generally selected because they were committed members of the congregation. The majority showed a strong faith and were spiritual role models to the youth. This progress marker was successfully achieved and scored high.

- **Facilitators feel a sense of calling to run this programme**

The role of facilitators in the programme was very important, but it was also interesting to see how important the programme was in the lives of the facilitators. For many of them it led to a sense of calling:

*"I feel honoured as at first I didn't understand, but now it feels like a calling from God." (Female facilitator)*

- **Facilitators grow in their own faith through being involved**

Many also indicated that their own faith had grown, both through becoming involved at a deeper level in ministry, and also because of needing to be a spiritual role model to the young people. One female facilitator indicated how her faith in God had grown through being involved in the programme:

*"I became closer to God. I have also learned that when I have problems that seem impossible to solve, that all I need is to cast it onto God and he will show me the way." (Female facilitator)*

**6.3.2.1(ii) Progress Marker Two: Facilitators will be available to the young people**

Generally the facilitators made themselves very available to the young people. Sometimes they became parent figures, filling the gap left by dysfunctional homes. This progress marker was rated high, as they functioned as mentors and were involved practically in supporting the youth.

- **Mentors**

In many cases, the facilitators became important mentors in the lives of the young people.

*"The leaders of the youth are almost like my parents because if I have a problem they help me to get through it." (Female peer educator)*

- **Practical support**

The facilitators offered practical support, often in the area of transport, taking youth home late at night. Rarely was petrol reimbursed by the church for this. Others offered their homes as a venue when the church building was not available; or supported with snacks and cool drinks, often from their own pockets.

However there were times when the facilitators did not function well, some became overcommitted to the programme and others were not able to commit fully due to other activities.

- **Sometimes facilitators became overcommitted**

Occasionally there were cases of facilitators who became too committed:

*"Yes we kept in touch with them and we saw them Thursdays, Fridays and Sundays – yes! A bit too much." (Female facilitator)*

- **Too busy**

Sometimes there was a problem of the facilitators being intrusive in other areas, and not being available in the way that the young people were hoping:

*"If we phone them we get a 'oh no not you again' feeling." (Female peer educator)*

### 6.3.2.1(iii) Progress Marker Three: attend trainings and quarterly meetings

Generally facilitators attended the initial training camp, but the attendance at quarterly meetings was poor, so this progress marker scored a low.

- **Training and quarterly gatherings have positive impact**

Those who did attend found the meetings very helpful:

"*After today's meeting we feel much more committed to finish the programme for the year." (Female facilitator)*

- **Poor attendance associated with programme failure**

The programme was impacted quite badly if the facilitators did not attend the trainings and gatherings. Those churches, which did not have a facilitator to attend the training, for whatever reason, failed to get off the ground. The young people were enthusiastic after the camp, but with no adult support they dropped out quite quickly. In a couple of cases there were older peer educators who attended even though the facilitator wasn't there, and these churches did get started**.** The suggestion was made that a separate quarterly gathering should also be held with facilitators on their own so that they could share ideas and encourage each other.

### 6.3.2.1(iv) Progress Marker Four: assist peer educators to facilitate the life skills programme

The planned strategy of the Agents of Change programme is that facilitators have the role of assisting the peer educators to run the life-skills programme. Generally it happened reasonably well, though there were several churches where the facilitator failed to take on the correct role and took over running the programme. So this progress marker scored a medium.

*"Facilitators initially struggled with agents assisting to conduct the sessions. With time and regular discussion and preparation, a healthy balance emerges." (Diocesan youth worker)*

*"A concern I had is that the facilitator that night presented almost the entire session with very little participation from the peer educators. They appeared to be just hovering in the background." (Diocesan youth worker)*

There were several areas in which the relationship was beneficial such as support on the day of presentation, assisting with issues of discipline and relating to authority figures:

- **Support on the day of presentation**

The role of the facilitator was very important when the agents presented – to back them up and be able to fill a gap if necessary, but without taking over:

*"A peer educator is someone that educates the youth group – the facilitator is there to help when they get stuck." (Female facilitator)*

- **Facilitators help with discipline on the day of the presentation**

The role of facilitators was very important in the area of discipline, often the youth were quite noisy and the facilitator stepped in to quieten the group:

*"There are certain evenings when we say nothing, do nothing. Only when there is unruly kids or a very heated debate, or we see the discussion is going off the topic, we would come in our sneaky way to get it back into track." (Female facilitator)*

- **The programme lessens the load for facilitators**

One of the positive things noted by facilitators is that this programme can lessen their load if it is being run effectively:

*"I got more time on my hands because young people are leading plus planning for young people. I have become more of a teacher mentor. Instead of planning, PE are planning programmes." (Male facilitator)*

- **The facilitator relates to authorities**

Often the facilitators were the contact with the priest and the Diocesan youth workers. It was also easier for them to negotiate with the authorities over use of the venue or access to resources such as stationary or transport costs.

In several churches this did not occur as planned, because the facilitators had low organisational abilities, or did not trust the peer educators. Sometimes the facilitators did not do the tasks expected of them, or they dropped out of the programme. On occasion there were clashes between the facilitators and peer educators.

- **Leaders have low organisational ability**

Concerns were expressed regarding the low organisational ability of facilitators. There were often confusing communications. This concern was expressed by both the Diocesan Youth Workers and those conducting the questionnaire survey.

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- **Facilitators not trusting the peer educators**

There was occasionally a problem with facilitators not trusting peer educators to be mature enough to lead the sessions. In one church the facilitator was actually a trained professional facilitator and it appeared that her standards were too high as noted by the Diocesan Youth Worker:

*"Problem as a facilitator was that agents were not trusted to do it on their own. Thought it was too early for agents to deal with these issues on their own."*

- **Facilitators not doing their work**

There were several cases where the facilitators did not fulfil the expected role. This was for various reasons such as lack of enthusiasm, other commitments or being too young for the responsibility.

**Lack of enthusiasm**: *"Our youth leaders were not supporting us at all; we had to do this on our own." (Female peer educator)*

**Other commitments**: *"I personally regret that I couldn't be part of this planning due to studies and work." (Male facilitator*)

**Age:** "*The facilitators were just too young to handle this kind of responsibility." (Male priest)*

- **Facilitator drop out**

There were several reasons for this:

**None were selected or attended the training**:*"Bonteheuwel had no facilitators – so the peer educators such as Z. became facilitators." (Diocesan Youth Worker)*

**Personal issues:** *"N came out (gay) and there were lots of problems at the parish and the programme flopped*." (*Diocesan Youth Worker)*

- **Clash between peer educators and facilitators**

Sometimes tensions arose between peer educators and facilitators:

*"I'm thinking of going back to my old church because I spend most of the time fighting and arguing with the facilitators and a few people here." (Male peer educator)*

**6.3.2.1(v) Progress Marker Five: facilitators meet weekly with peer educators**

This progress marker scored a medium; generally these regular meetings took place and led to a successful programme. But when they did not the programme struggled to run successfully.

- **Regular meetings**

If this weekly meeting took place, it tended to lead to a smooth running and successful programme. At this meeting the previous session was evaluated, the next session planned and any problems between peer educators sorted out. There were problems at several churches, so this progress marker scored a medium:

*"Yes we meet every second week and 90% of the peer educators attend – it makes my heart very glad!" (Female facilitator)*

The format for these meetings varied from church to church:

*"All churches seemed to have a specific time for meeting. Those peer educators who could make the main planning meeting get a big role on the day – the others are used for opening prayer etc." (Diocesan youth worker)*

Facilitators remarked that the preparation was necessary, not just so that the session would be led well, but also for the peer educators to prepare themselves for dealing with the topic:

*"N.B. preparation mentally is needed due to hectic issues. Giving of themselves in almost every aspect e.g. if facing an issue, they need to deal with it before actually presenting the course as to impact youth even more." (Female facilitator)*

- **Meetings not happening**

In those churches where this regular meeting did not take place, the programme tended to be less successful; generally the meetings did not take place due to a lack of time on the part of the facilitator:

*"The facilitators had to stay for 'double meetings' to try to meet with all the agents (because of no shows) so work was repeated." (Male facilitator)*

### 6.3.2.1(vi) Progress Marker Six: demonstrate ability to listen to young people

The programme appeared to improve the facilitators' understanding of the young people they are working with and the youth indicated that this relationship was very important to them, so this progress marker scored high. One of the male facilitators indicated how his perspective on the young people had changed:

*"We see situations from the perspective of peer educators and younger people." (Male facilitator)*

The programme led to a more open relationship:

*"I have been trying to help others by making time for them when it suits them and when they feel they can speak." (Female facilitator)*

The facilitators helped the young people to change:

*"One peer educator informed us that she is no longer sexually active – she has broken off her relationship with her Muslim boyfriend. Her mother tried to convince her that this relationship was not good – but her mother's words fell on deaf ears. And the young woman has been resistant to change. However this methodology of getting young people to draw out their own values and analyse their own behaviour got this young woman thinking!" (Diocesan Youth worker)*

The facilitators also gained a better understanding of the challenges faced by young people:

*"It also showed me the needs of young people in my community. The difference it made in my life is the fact that I need to seriously look at what teenagers are facing and help them. I should change the way I look at life." (Male facilitator)*

### 6.3.2.1(vii) Progress Marker Seven: will not be authoritarian, blaming, judging

Generally the peer educators indicated that the facilitators were not judgmental or authoritarian, but there were quite a number who indicated that this was an issue, so the progress marker scored medium.

- **Not judgmental**

*"The things I have learned is that I should not judge people before you know anything and I should be more open and listen more about people who are experiencing troubles. I want people to come ask me for advice." (Male facilitator).*

- **Not authoritarian**

*"Facilitators do not look over us but rather at the same level as us. We do not feel intimidated by them." (Female peer educator)*

- **Judgmental**

*"I should also change a few of my ways because I tend to break some people down and do not apologise." (Female facilitator)*

- **Authoritarian**

*"Unfortunately they are bossy, being a bit overbearing sometimes as well." (Female peer educator)*

### 6.3.2.1(viii) Progress Marker Eight: will fill in monitoring report after every session and submit on time to Fikelela

Accessing the data from the parishes was one of the greatest struggles. Initially we asked for a monthly report to be sent to us, but it became too time-consuming to be constantly chasing churches for this report. Then we asked for a quarterly report which listed the sessions completed, successes and challenges as well as the numbers attending. It was rare that forms would be returned without constant reminding. So this progress marker scored low.

*"From my point of view I feel that the programmes have been a success, but as a youth we have not filled in any forms after the programmes. So in this we won't really know if it worked or not, because they could say it worked and give all their input but then nothing really happen." (Female peer educator)*

There was some resistance, where people did not really understand or appreciate the importance of the Monitoring and Evaluation process as indicated by one male facilitator:

*"We get the impression that this programme is about numbers and not so much about the outcome."*

This group of eight progress markers was classified 'expect to see' indicating the basic requirements of the programme. Three of them were rated high, three medium, and two

low. This scored a mean of 2.1 which would indicate that not all the facilitators were performing their role in the programme as expected.

### 6.3.2.2. Like to see

#### 6.3.2.2(i) Progress Marker Nine: will not be abusing sex, drugs or alcohol

Generally the facilitators were established leaders in their churches, so there was little abuse of sex, drugs or alcohol, with a few exceptions, so this progress marker scored high. Many of those who were doing so were impacted by the programme to change their behaviour as indicated in some of the quotes below.

- **The programme challenged some of the facilitators to change**

An unintended outcome of the programme was that facilitators as well as peer educators often decided to change their behaviour, as expressed by a male facilitator:

*"I have had to stop and reflect on my own behaviour and discipline, because suddenly all these young people are looking to me for guidance and as an example. I have had to ask myself what type of role model I am, and I have had to make quite a few adjustments to my lifestyle."*

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Sometimes the peer educators even took on the role of getting the facilitators to change as in the following example where the peer educators tried to get a facilitator to stop cheating:

*"At L. one of the facilitators was cheating so the peer educators followed him and took photos on their cell phone." (Priest)*

Smoking became quite an issue when churches were together at meetings or at camp, because some of the facilitators thought it was acceptable to smoke and others felt strongly that it was a bad example to the youth as indicated by the Diocesan Youth Worker:

*"Smoking needs to be controlled, seen as risky behaviour it lessens the credibility of leaders."*

#### 6.3.2.2(ii) Progress Marker Ten: have strong relationship with peer educators which is supportive and trustworthy

Generally the relationships were extremely good. They supported the peer educators both by building their self-esteem and in practical ways. This progress marker scored a high, because of the emotional and practical support that facilitators gave to peer educators.

- **Emotional support and encouragement**

There were many cases of supportive and encouraging relationships that were formed as indicated by a female facilitator:

*"The young people are starting to trust me and are therefore open and honest with me and speak to me freely as they would speak to their parents."*

- **Practical support**

A male facilitator shared an instance of practical support that he offered to the youth:

*"Had to wake up in the middle of the night for one phone call that one of the youth are being assaulted and had to give help."*

Sometimes the peer educators complained that this relationship was not so supportive, as one female peer educator complained about lack of support from facilitators:

"*Others are not there when the peer educators are delivering the session."*
There were several churches where the facilitators were also parents, sometimes the relationships between them and their children who were peer educators was not easy as indicated by a female facilitator who is also a parent:

*"Our daughter is 19 but she also feels it is not her youth because Mummy and Daddy is there she can't express the way she would if the parents weren't there."*

**6.3.2.2(iii) Progress Marker Eleven: reports reflect understanding and reflection**

This was definitely an area of weakness in the programme. It was difficult to get even the most basic information from the facilitators. Only one or two added any sort of reflection into their written reports. However at the quarterly gatherings, when the feedback was spoken, the facilitators showed a lot of understanding and reflection around the programme. The reality is that when one is working with a group of facilitators who are volunteers, one cannot make too many demands on their time for them to do things that they do not really enjoy doing such as report writing. This progress marker scored low.

In this group of three 'like to see' progress markers, two scored a high and one scored a low. This would give an overall mean rating of 2.3, which indicates that some change is occurring in this change partner, but not in all.

### 6.3.2.3. Love to see

**6.3.2.3(i) Progress Marker Twelve: the facilitators are positive role models**

Generally the peer educators felt that the facilitators were good role models, they were youth leaders with standing in the church. So this progress marker scored high as indicated by a male peer educator:

*"Facilitators are well matured and good role models."*

However this was not always the case as in this example quoted by the Diocesan Youth Worker:

*"M. has been taken out of leadership because he had a relationship with one of the youth."*

**6.3.2.3(ii) Progress Marker Thirteen: create conducive environment for young people to enjoy, influence and learn from each other**

Generally the facilitators put a lot of effort into supporting the peer educators in preparing the sessions and to provide a supportive environment. This could be in the form of accessing additional resources to improve the session, or by creating a safe space for the youth. This progress marker scored high, since the facilitators were able to provide additional resources for the programme, as well as creating a safe space for the peer educators and providing an alternative parental figure for the young people to confide in.

- **Resources**

As adults the facilitators often had access to resources or creative ideas that peer educators did not have, as indicated in this example by a male facilitator:

*"It is all about networking, if you don't mobilise resources, it can't work. If you bring in an 18 year old girl with a baby, the kids think twice about falling pregnant – they can't go to discos and so on."*

- **Creating a safe space**

The facilitators can create an openness and safe place for sharing as indicated by a male facilitator:

*"You can see the emotional roller coaster on the night, - you can see who is struggling at home, who is affected by something you discuss. Or when somebody just says something or they are really living it. If you keep a good eye on them you can know who needs support or a phone call."*

- **Parental figures**

Since many of the young people come from dysfunctional homes, the role of the facilitator can be very important in their lives as indicated by a female facilitator:

*"I always tell my child that the person who comes to youth, the hugs and kisses they get from the group may be the only they experience."*

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They provide spiritual encouragement as this example by a female facilitator shows:

*"I have changed our youth group by means of respect, discipline and to love each other and not to make disruption. I have also asked them to always be on their knees to God and their prayers will get answered."*

Some of the facilitators however did not find the relationship to be going well:

*"Being a facilitator doesn't mean much to me, it's just I'd have to play police man and make sure everything is organised." (Male facilitator)*

### 6.3.2.3(iii) Progress Marker Fourteen: have positively contributed to the growth of peer educators

In many of the churches, growth was noted in the peer educators as the facilitators allowed them to take more of a leadership role. This progress marker scored high:

*"As a facilitator, I was concerned that a programme which focuses so much on personal and serious issues would be frowned upon, that the peer coordinators would be too shy to lead the young people in this manner. They proved me wrong. The young people have helped me to understand the full meaning of 'the change you want to see in the world'" (Male facilitator).*

They assisted them to develop conflict resolution skills as indicated by a female peer educator:

*"They do help us and support us when we are fighting."*

They helped the peer educators to grow in self-esteem as explained by a female facilitator:

*"That they realise their value and self-worth and that they grow more in faith."*

### 6.3.2.3(iv) Progress Marker Fifteen: have collaborative and respectful communication style

It appeared that most facilitators had a collaborative and respectful communication style as indicated by a male facilitator:

*"We respect the young people and love them unconditionally."*

### 6.3.2.3(v) Progress Marker Sixteen: learn and apply learnings from monitoring and evaluation

Generally this did not take place – the monitoring and evaluation was seen as a chore that Fikelela was imposing on the programme, so the progress marker scored low. However the feedback sessions at quarterly gatherings did seem to have an impact as well as the learning at camp as indicated by a male facilitator:

*"The most important thing I learned at camp was about stakeholders."*

There were five progress markers in the group 'love to see' which would indicate profound change if they were reached. Three of these scored high, one medium and one scored low. This gave an overall mean rating of 2.4 which would indicate that profound change is taking place in some of the facilitators in some areas.

## 6.3.3. SUMMARY

### 6.3.3.1. High progress markers

The following clusters of progress markers scored high: being a role model and mentor:

#### 6.3.3.1(i) Role model

This cluster included 'facilitators attend church regularly', 'will not be abusing sex, drugs or alcohol' and 'are positive role models'.

One of the strengths of this programme was that it was church-based. Therefore the facilitators were youth leaders, most of whom had been doing this work on a voluntary basis for several years. They were selected for their leadership qualities and quality of life, so the majority were positive role models in terms of life style choices. An unexpected outcome was that many of them were also impacted by the programme and made decisions to change their own life style.

#### 6.3.3.1(ii) Mentoring

This cluster included: 'will be available to the young people'; 'demonstrate ability to listen to young people', 'have strong relationship with peer educators which is supportive'; 'create a conducive learning environment for young people to enjoy'; 'influence and learn from each other'; 'have positively contributed to the growth of the peer educators'.

Generally the relationship of the facilitator with the peer educators was seen to be very supportive, and they listened and encouraged the young people. An unexpected outcome was that in many cases they began to fulfil some of the roles of parents, which is very important in some of the dysfunctional families. As they created a safe space, many of the young people began to open up and share their problems. This aspect of the programme was important for prevention, since they provided an extra parental figure in the lives of the youth. As mentors they positively contributed to the growth of the peer educators, allowing them to develop leadership skills and self-efficacy. In some of the churches the facilitators were older youth rather than young adults, and this mentoring/parenting role was much reduced.

### 6.3.3.2. Medium progress markers

The cluster of progress markers which scored medium were the collaborative ones:

#### 6.3.3.2(i) Collaborative style

The following progress markers formed this cluster: 'assist peer educators to facilitate the life skills programme'; 'will not be authoritarian, blaming or judging'; 'meet weekly with peer educators'; 'have collaborative and respectful communication style'.

This goal was only partly reached. Many of the facilitators had been youth leaders for many years, and were used to functioning in a particular way. It was difficult to move to a more egalitarian leadership style.

- **Presenting life skills**

For some it was difficult not to take over, especially when they felt unsure about the peer educators' competence to talk about issues such as sex. For others, the issues of discipline meant that they had to step in and then ended up taking over.

- **Communication style**

For some it was difficult to move to a more respectful style and they reverted to an authoritarian way of communicating, or giving orders. This was reflected in the way that some did not feel it necessary to attend the weekly planning sessions, they would rather just delegate tasks without any discussion. It was identified that the weekly planning meeting was crucial to the programme's success. In the cases where it did not take place and the peer educators did not experience the encouragement and support of the facilitators, the programme rarely went well.

#### 6.3.3.3. Low progress markers

The cluster of progress markers around monitoring and evaluation scored low:

#### 6.3.3.3(i) Monitoring and evaluation

This cluster included the following: 'attend trainings and quarterly gatherings'**:** 'will fill in monitoring report and submit on time'; 'reports show understanding and reflection'; 'learn and apply learnings from monitoring and evaluation '.

There was a general reluctance on the part of the facilitators to be involved in monitoring and evaluation. There was low attendance at the quarterly gatherings (for sharing lessons learned), and poor submission of forms. This meant that there was little learning from either of these processes.

For almost all facilitators, monitoring and evaluation was a new concept which is not used in any of the church activities and had not been used previously in the youth group. It was perceived as an external request, not a felt need by the group itself. This was a challenge to the way in which the concept was presented to the facilitators, so that they could internalise the value of the process for themselves. Given that the facilitators were volunteers, the majority of whom hold down full time jobs, the system needed to be made as simple and quick as possible. It might be better to have social gatherings of the facilitators where they are encouraged to share and learn from one another in a social setting.

#### 6.3.3.4. Conclusion

There were sixteen progress markers; eight of which scored a high, four a medium and four a low. This gave an overall mean rating of 2.3. This would indicate that the programme is having an effect on some of the facilitators. However, there was quite a marked difference between the scoring by facilitators and peer educators. The facilitators scored themselves quite low at 2.1 whereas the peer educators scored them much higher at 2.7. This may indicate that the peer educators were more appreciative of the role of the facilitators, whereas the facilitators themselves felt that they could be doing better.

It appears that the role of the facilitators in this programme was very important. They became important to the peer educators as mentors and role models. Many young people came from dysfunctional families with few role models and some without parental guidance, thus the facilitator fulfilled some of those roles in their lives.

For some of the facilitators, the change to a more 'guiding' style of leadership was a challenge, whereas others enjoyed seeing the young people develop as leaders, and for them to take a 'back seat'.

The weakness of the facilitators in the area of monitoring and evaluation was of concern because the study was often dependant on second hand reports of activities.

## 6.4. THE EFFECT OF THE PROGRAMME ON YOUNG PEOPLE

The following change partner was defined as the 'youth', which were those young people who attended the life-skills sessions.

### 6.4.1. OUTCOME CHALLENGE FOR YOUNG PEOPLE

The following outcome challenge was defined for the young people:

*Young people will participate in and be affected by project activities, so that they will be influenced to make positive lifestyle choices. Young people within the project have a positive influence on other young people in their community who share the same issues.*

### 6.4.2. PROGRESS MARKERS FOR YOUTH

Fifteen progress markers were defined for the youth**.** They were rated as indicated in Table 6.3:

**Table 6.3: Progress markers for youth**

| Progress marker | Rating |
|---|---|
| **EXPECT TO SEE** | |
| Young people attend the life-skills sessions | High |
| Young people participate actively and enthusiastically in the life-skills sessions | High |

| | |
|---|---|
| Young people can describe the consequences of different lifestyle choices | High |
| Young people describe what issues are important to them | High |
| Young people maintain their current healthy choices | Medium |
| **LIKE TO SEE** | |
| Young people engage in discussions and debates on issues that affect them | High |
| Young people encourage their friends to attend | High |
| Young people use condoms if they have sex | Medium |
| Young people wait to have sex until an older age | Medium |
| Young people have a reduction in the number of sexual partners | Medium |
| Young people are not pressurising each other to have sex | Medium |
| **LOVE TO SEE** | |
| Young people are not abusing alcohol or using drugs | Medium |
| Young are empowered to positively influence other young people | High |
| Young people wait to have sex until marriage | Not measured |
| Young people get involved in lobbying and advocating and for issues that affect them | Low |

### 6.4.2.1. Expect to see

In the following section the progress markers are presented with quotes from focus group discussions, reports and evaluations, staring with 'expect to see' which indicates a minimum level , through 'like to see', progress markers which would indicate some change taking place , through to 'love to see' which indicates some profound change taking place.

#### 6.4.2.1(i) Progress Marker One: young people attend the life-skills sessions

This progress marker scored high, due to an increase in numbers in most of the churches. This increase in numbers was not without its problems, as it often led to problems with discipline.

- **Increase in numbers**

Generally the churches indicated that there was an increase of numbers once they started the programme as indicated by a male peer educator**:**

*"The average on Friday was between 15-20 people but as soon as the peer educator programme was introduced our youth have increased up to about 40-45 and I really enjoy getting to know more people from our community."*

- **Problems of a larger group**

Sometimes the group grew too big and this caused problems of discipline as a female facilitator shared:

*"The large number of young people that attend on a given Thursday has become challenging for the peer educators to present their programme."*

There were also problems that were reported, in a few cases the numbers attending the life skills sessions did not grow, but decreased. Time-keeping was a problem in some churches, and some indicated that the youth felt forced to be there against their will.

- **Decrease in numbers**

A few churches indicated that the programme led to a drop in numbers. Sometimes this was due to resistance to the life-skills programme, particularly in churches where the youth were more used to focusing on fun activities. This appeared to be a particular problem in the middle-class churches. In poorer communities the youth group at church is one of very few social options, whereas in middle-class churches there are many social options for teenagers, so the churches tends to focus more on fun activities to attract the youth:

*"Some people find the programme boring; they only come to youth when we are going out (on an outing)." (Female peer educator)*

At other times it was due to problems of communication, so that young people were not aware that the session was taking place, as indicated by a male facilitator:
*"The sessions were not very well responded to which is a pity as the agents put effort in. I regret that I couldn't attend the sessions as I had to work."*

- **Time keeping**

Several churches mentioned time keeping as an issue*:*

*"Poor attendance and we had to wait and started late. We had to carry on with the few who attended." (Female facilitator)*

- **Forced to be there**

In churches which were running the programme with their confirmation candidates, at times their attitude was negative because they were not there of their own free will:

*"We do our programme with the confirmation candidates and we get the feeling that they are only there because they are forced to be there." (Female facilitator)*

**6.4.2.1(ii) Progress Marker Two: Young people participate actively and enthusiastically in the life skills sessions**

This progress marker scored high. On the positive side there was generally a very active participation by the young people. There was a positive attitude in the group, and the peer educators came up with lots of creative ideas to make the sessions attractive.

- **Positive attitude in the group**

Most churches indicated that there was a positive attitude in the sessions as stated by a male facilitator:

*"They didn't even want to come home; they stayed on until quarter past twelve!! There was a radical change in the youngsters."*

- **Active participation in sessions**

Generally it was reported that levels of participation were very high:

*"The impact and the material of session (values and self-worth) was a direct hit to the mind of the youth – loads of discussion and enthusiasm." (Female facilitator)*

- **Increase of participation**

Many churches indicated that there was an increase in participation. Several noted changes in individuals who had been very shy previously as indicated by a female peer educator:

*"At the beginning we didn't get a lot of comments or questions, but as they started to feel comfortable, the more outspoken people got."*

- **Creative activities**

Many of the churches were very creative in the way they presented the programme, and the additional activities they incorporated:
*"Fashion shows, attend other churches, coffee bar, youth service, had a youth band called LIFE, got the crowd started. K. ministered in dance." (Male peer educator)*

- **Lack of other activities in the community**

The programme was particularly successful in the poorer communities where there were not many activities available for the young people:

*"Normally on a Friday there is nothing to do but stand on the street corners - this is good clean fun." (Male peer educator)*

The problems that were reported included lack of discipline, lack of full participation by the young people, issues with the younger youth, youth who had other agendas when they came to youth group. There was also an embarrassment to talk about issues of sexuality reported in some groups, and full participation could be limited by gender issues. In other churches it was reported that conflict in the group was a problem.

- **Lack of discipline**

This was one of the biggest problems with the programme. The young people were not used to having other young people leading from the front; this problem was reported by a male peer educator:

*"There is one or two bad ones which tries to break down the sessions when we're busy having a session."*

- **Lack of participation**

In some cases the young people attended, but did not really participate fully as indicated by a male peer educator**:**

*"At first they didn't wanna open up, and it was difficult to get some of them to participate."*

- **Younger age group**

In churches with a younger age group in the youth, the programme tended not to function so well as reported by a female peer educator:

*"Whenever we start to talk about sex, the very young youth would find it funny/uncomfortable."*

- **Youth with other agendas**

Sometimes active participation was hindered by youth who came with other agendas such as in the case shared by a female peer educator:

*"We had a situation where youngsters would come to meet with friends that their parents would not let them see. They would take out their phones and leave in the middle of the session."*

- **Embarrassment**

For many, the subject of sex caused embarrassment as reported by a female facilitator:

*"As time went by the numbers became fewer. I think because they feel that they have to reveal themselves or what they did. All the questions that were asked – some of them felt a bit uncomfortable."*

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- **Gender**

There were a few mentions of occasions where full participation was hindered by gender issues as reported by a male peer educator:

*"When we talk about health relationships the girls over-powered the boys."*

- **Lack of interest in the topic**

Lack of interest was particularly an issue with the HIV session, where most young people are suffering from AIDS fatigue, having heard it so often at school as reported by a female peer educator:

*"HIV, AIDS session: this session was boring because it is thrown at us every day. If you come into a meeting and tell them it is about HIV they switch off, because of over exposure."*

- **Conflict in the group**

In several of the churches internal conflicts caused a problem as reported by the Diocesan Youth Worker:

*"The facilitator slapped one of the youth members and got taken out of position. That left only one facilitator and the group dropped down."*

- **Other challenges**

There were other challenges that affected the full participation of youth in the programme. Young people were often distracted by cell phones and in particular by Mxit[21]. Transport was often mentioned as an issue which kept young people away if they could not get a lift.

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### 6.4.2.1(iii) Progress Marker Three: young people can describe the consequences of different lifestyle choices

The progress marker gained a score of high – the youth were well informed about the consequences of different lifestyle choices. They learned a lot from the sessions but also from additional input by guest speakers or research the facilitators had done.

- **They gained information from the sessions**

Generally this was true – the youth learned a lot from the sessions and understood more about the issues as reported by a female peer educator:

*"Fikelela had taught me a lot more than what I would have learnt from my family, community and friends. I understood well and was able to encourage my friends to think before they do something they regret."*

- **They learned from additional speakers and information**

In the majority of the churches effort was made to access additional speakers and information on the subjects as indicated by a female facilitator:

*"Drugs and alcohol – we have guest speakers that went through the actual experience of addiction and destruction of family household and prison/suicide."*

- **Lack of knowledge**

Generally churches indicated that the youth were well informed around these issues, but there were some gaps in knowledge as indicated by a female facilitator:

*"Youth are ill-informed as to the whereabouts of the clinics and the function of a clinic."*

### 6.4.2.1(iv) Progress Marker Four: young people describe what issues are important to them

Generally the churches reported that young people were very open to discuss issues of importance to them and this progress marker scored a high as the programme provided a safe place to open up, as a female facilitator reported:

*"To our surprise we realised that our peers are so willing to talk about themselves and open up. We ended up with an emotional meditation session where many were so moved that we could not fight tears. One of our girls had tried to commit suicide a few months ago and she of all people ended with prayers."*

[21] Internet-based cell phone communication

- . **They share their problems with someone**

Generally there were strong indications that the programme was providing a safe place for young people to either share with peer educators or with facilitators as reported by a male facilitator:

*"They have someone of their own age group (who are more knowledgeable) to come to with problems."*

**6.4.2.1(v) Progress Marker Five: young people maintain their current healthy choices**

In general the young people indicated the programme helped them to maintain healthy choices and this progress marker scored a medium. A female peer educator reports on the positive lifestyle choices that she has made:

*"I never had a boyfriend and I'm turning 18 which I'm proud of, never drank. I believe that I am that change which I want to see in the world."*

There are five progress markers rated as 'expect to see'. Of these four scored high and one medium. This is a mean score of 2.8 which suggests that the majority of young people were participating in the programme as expected.

**6.4.2.2. Like to see**

**6.4.2.2(i) Progress Marker Six: young people engage in discussions and debates on issues that affect them**

Generally this was identified as a high point of the programme; the youth participated in discussions with great enthusiasm and this progress marker scored a high. A female facilitator reported on a discussion that took place around rape:

*"We had heated debates between boys and girls at our rape session and it was extremely interesting to know how much they knew."*

However in some cases the participation was not so good:

*"You can't force children to learn from the sessions – all youth don't always give their input." (Female facilitator)*

**6.4.2.2(ii) Progress Marker Seven: young people encourage their friends to attend**

Many of the peer educators invited friends to come, and the youth also invited more young people, so this progress marker scored a high. A mother shared about her daughter's enthusiasm for inviting friends:

*"She is always bringing new members!! She brings them all no matter what denomination." (Mother)*

#### 6.4.2.2(iii) Progress Marker Eight: young people use condoms if they have sex

In focus group discussion it appeared that there was an increase in intentions to use condoms, so this progress marker scored a medium. However this progress marker is difficult to assess qualitatively and is also covered under the questionnaire survey.

#### 6.4.2.2(iv) Progress Marker Nine: young people wait to have sex until an older age

There was a desire to see this happening, and several young people committed themselves to wait, so this marker also scored a medium. This issue was also measured in the questionnaire survey. A female peer educator shared the difference that the sessions had made in the life of a friend:

*"A friend came to me and told me her boyfriend was pressurising her to have sex and I told her that she should join me in a few sessions. After session three she told me that she is not ready for this commitment in her life, coz it has consequences to face." (Female peer educator)*

#### 6.4.2.2(v) Progress Marker Ten: young people have a reduction in the number of sexual partners

There seemed to be some progress towards this marker and it scored a medium. This issue was also measured in the questionnaire survey. A male facilitator shared the difference that had been made in the lives of two members of the youth group:

*"There was two young ladies who were very promiscuous and the others would rub off on them. The others approached them and said why must other people talk about you like this and like this and you could see them physically change."*

#### 6.4.2.2(vi) Progress Marker Eleven: young people are not pressurising each other to have sex

The girls seemed to feel more confident at withstanding pressure to have sex. The debates on gender relationships were very heated and the girls definitely realised that it was their right to withstand unwanted sex. Often the girls were going out with boys who were not in the Agents of Change programme. It was difficult to quantify whether in fact the boys were pressurising the girls less. For this reason this progress marker scored a medium. A female peer educator shared about the importance of leaving someone who does not respect you:

*"What if you want to kiss but don't want sex? – How do you give the message I want to kiss but not have sex. If he doesn't listen when you tell him, then you must leave him, he doesn't respect you." (Female peer educator)*

In this group of six 'like to see' progress markers, two scored high and four medium. This gave an overall mean score of 2.3 which would indicate that there was a measure of change happening for some of the young people.

### 6.4.2.3. Love to see

#### 6.4.2.3(i) Progress Marker Twelve: young people are not abusing alcohol or using drugs

It seemed that the youth were committed to not abusing drugs and alcohol and certain individuals gave testimonies of personal change so this marker scored a medium. A male peer educator reported on the change taking place in his youth group:

*"They are starting to take control of themselves and to stop drinking and having sex."*

However, there were also cases when this did not occur as reported by a male facilitator:

*"Sometimes they can't stand against peer pressure and they take one step back. Come Friday evening they are re-energised. Last week I slipped after three days, this week I went four days without slipping."*

#### 6.4.2.3(ii) Progress Marker Thirteen: they are empowered to positively influence other young people

This progress marker scored high because this appeared to be one of the strong points of the programme. Young people were influenced both directly through the sessions, but also through interacting with the peer educators and other young people:

- **Change taking place through the sessions**

The peer educators were able to influence the youth through the sessions that they led, as a female peer educator shared in a focus group:

*"My friend wanted to have sex with her boyfriend and I told her to come to some sessions and to listen and know what she was getting herself into. After a session she told me she did not want to do it anymore because she saw things differently now and it really changed her and she kept on coming to the sessions."*

- **Change taking place through the young people's influence**

Change also took place through positive peer pressure as the young people formed new social groups and friends influenced each other. A female peer educator explained how she had been influenced by others:

*"I am changing because everyone else's behaviour changed me."*

There were also times when change did not appear to be taking place, the reasons given for this were that sometimes the peer educators were too strict on the young people and sometimes the young people had no desire to change.

- **Sometimes they are too strict**

At times the young people were actually too hard on each other and that could cause some young people to leave the programme. A male facilitator reported that the peer educators struggled to give constructive criticism:

*"When we do scold them we are trying to help them not cause destruction – I always tell them do it constructively not destructively – they still need to learn to do that – when they criticise each other there is always one with a long face."*

- **Lack of desire to change**

Sometimes the peer educators felt disappointed at the lack of change in their peers:

*"I have tried to change other people's lives but there is something going wrong, it is hard for me to do this – because you don't know how other people will trust me." (Male peer educator)*

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**6.4.2.3(iii) Progress Marker Fourteen: young people wait to have sex until marriage**

This was not a progress marker that we could measure with this age of young people. Although several said they would like to wait until marriage, we were not able to measure this since we do not track the youth until the age of marriage. This was an inappropriate marker for this type of intervention. The young people would need to be tracked for several years in order to assess this progress marker.

**6.4.2.4(iv) Progress Marker Fifteen: young people get involved in lobbying and advocating and for issues that affect them**

This happened to a small degree. There was an increase in awareness of issues and some small actions took place. For this reason it scored a low. The peer educators gave a few examples of actions that they had taken, for example:

*"Making of poster and each of them having their own theme e.g. rape, old people." (Female peer educator)*

In this group of four progress markers which are rated 'love to see', there was one high, one medium and two lows. This would give an overall score of 1.8. This may indicate that limited change is happening in some but not all of the young people.

## 6.4.3. SUMMARY

### 6.4.3.1. High progress markers

The following clusters of progress markers scored high: attendance, participation and knowledge.

### 6.4.3.1(i) Attendance

This cluster included 'young people attending sessions' and 'inviting friends to come to sessions'. On this level the programme was very successful, the great majority of churches indicated that their youth group grew, that young people invited their friends and that members of the community and even other religious groups were drawn in. So the basic format of the programme, which is youth led, interactive and creative, was successful in achieving high levels of attendance.

### 6.4.3.1(ii) Participation

This cluster included the following 'active and enthusiastic participation', 'engaging in discussions and debate'. Participation in the sessions was generally very high, but appeared to be influenced by various factors: socio-economic status, what group in the church the programme was run in and the leadership of the group.

- **Socio-economic group**

In the poorer communities, there were very few social activities taking place, the youth leaders have limited access to resources and they usually found the Agents of Change programme to be quite exciting and innovative to run. In the better resourced churches, most of the youth attended Model C or private schools and were used to quite high levels of leadership skills and good resources. Very often in those churches, the emphasis at the youth group was more on fun and building friendships, because the young people have access to so many activities over the weekends. The youth group had to work hard to keep them interested and sometimes the Agents of Change programme was not received favourably by these youth, as it was seen as too serious.

At the other end of the spectrum, the churches in informal settlements really struggled to get the programme going, due to lack of a venue outside of a Sunday, and lack of effective communication. These churches did not have offices with secretaries and there were no pew leaflets or photocopying facilities. Often there was a lack of organisation in these churches and the priest only visited from time to time, which contributed to poor communication as well.

- **Group in the church.**

In the majority of the churches, the programme took place within the regular youth group meeting. This was a voluntary group which young people choose to go to. Generally youth are there because they want to be. In some churches the sessions were run in the confirmation class. Many of these youth were there because their parents tell them that they must be. So their interaction and participation was much worse. Generally participation was better if the young people were older than 13. In churches with younger participants they were often too awkward or embarrassed to discuss the various issues.

- **Leadership**

Participation was enhanced in the churches where facilitators and clergy were actively involved in developing the programme, where creative activities took place and resources such as snacks were provided. In churches where there was conflict between leaders, the group dwindled.

### 6.4.3.1(iii) Knowledge

This cluster included the following: **'**describing issues which are important to them', 'describing the consequences of different lifestyle choices'.

This programme was generally successful at getting the necessary knowledge across to the young people, due to its youth-friendly format. One of the most challenging aspects was how to get the messages of HIV across. This was the least successful topic; due to 'AIDS fatigue' the youth have heard it too often at school. However there were still gaps in knowledge that needed to be filled. The topics which generated most participation were the gender related ones and it was very important for young people to be able to hear and understand the world view of the opposite sex.

### 6.4.3.2. Medium progress markers

### 6.4.3.2(i) Behaviour change

The cluster on behaviour change scored a medium. This cluster included the following progress markers: 'Young people maintain health life choices', 'they use condoms if they have sex', 'they wait for sex until an older age', 'there is a reduction of sexual partners', 'they are not pressurising each other to have sex', 'they are not abusing drugs or alcohol'. No sex before marriage scored a low, but is included in this cluster – it scored low because we are unable to measure this outcome.

Desire to change increased quite substantially and there were numerous reports of individuals who had also changed. However actual change was inevitably less than the desire to change, and will be measured in the questionnaire survey. In terms of how the programme influenced the youth to change, this happened at several levels:

- **Through the peer educators**

Generally the sessions were enjoyed and challenged the young people. Knowledge was gained in the sessions, but change took place from the influence of the peer educators who were giving the message and living it. This made the information given meaningful to the young people, and the messages given had value because they were lived out.

- **Through peer pressure**

The youth were also influenced by peer pressure and as a different set of values began to be seen to be 'cool' and acceptable, it became easier to stand against contradictory peer

pressure. In many cases the young people also began to socialise together outside of the youth group and create different social networks.

#### 6.4.3.3. Low progress markers

There were two progress markers which scored low. The first was 'wait to have sex before marriage' which, as indicated above was not an appropriate progress marker because of the time-frame of the evaluation. The second was 'young people get involved in lobbying and advocating.'

#### 6.4.3.3(i) Advocacy

This progress marker scored low: 'young people get involved in lobbying and advocating'. In order for young people to maintain healthy life-style choices it is important that their environment also changes. For this reason advocacy was an important part of the programme. However it appeared that the Agents of Change programme was not successful at incorporating this aspect.

#### 6.3.3.4. Conclusion

There were fifteen progress markers for the young people. One of them, number fourteen was excluded because it could not be measured (waiting for marriage). Seven of these scored high, six scored medium and one scored low. This gave an overall mean rating of 2.4. The peer educators and facilitators scored the young people fairly similarly, the peer educators scored them as a 2.4 and the facilitators scored them as 2.3.

For behaviour change to take place, young people must be reached, informed, and influenced for change. Choices of healthy lifestyle should be supported by a change in the environment. It appears that the Agents of Change programme was successful at reaching and teaching the youth, somewhat successful at influencing them for change, and not successful at influencing the environment.

## 6.5. THE EFFECT OF THE PROGRAMME ON CLERGY

The next change partner was defined as the clergy who were from the parishes participating in the programme.

### 6.5.1. OUTCOME CHALLENGE FOR THE CLERGY

The following outcome challenge was defined for clergy:

| |
|---|
| *Church leaders will enable young people to develop their God-given talents and affirm young people for their contribution to life and the mission of the church. They will build healthy relationships with young people and communicate effectively through dialogue* |

*and listening to young people's creativity concerns and feelings. They will be comfortable with addressing issues of lifestyle choices in the church.*

## 6.5.2. PROGRESS MARKERS FOR CLERGY

Twelve progress markers were defined and their rating listed in Table 6.4 below:

**Table 6.4: Progress markers for clergy**

| Progress marker | Rating |
|---|---|
| **EXPECT TO SEE** | |
| Take ownership of project, including it in church structures, and supporting its financial and resource needs. | Medium |
| Big days celebrated – World AIDS Day, Women's day, 16 days of activism and so on. | Medium |
| Youth included in year planner. | Low |
| Sermons on rape, drugs, violence against women and children. | Low |
| **LIKE TO SEE** | |
| Clergy visit the agents of change programme. | Medium |
| Agents share in services. | Medium |
| Allow youth to develop own programmes, material and liturgies. | Low |
| **LOVE TO SEE** | |
| Place youth in leadership and decision making positions. | Low |
| Development of new styles of worship . | Low |
| Leaders give spiritual guidance and counselling | Medium |
| Promotion of youth events and training | Medium |
| Challenges the congregation to be more supportive of agents of change | Medium |

### 6.5.2.1. Expect to see

There were four progress markers categorised as 'expect to see' which would indicate that they were basic requirements of the programme.

**6.5.2.1(i) Progress Marker One: take ownership of project, including it in church structures, and supporting its financial and resource needs**

This progress marker achieved a score of medium; several of the churches achieved it, but not all. The role of clergy was identified as a crucial issue. In general they were the gatekeepers to resources and support from other stakeholders in the congregation – if they were supportive of the programme, then structural support from other stakeholders was facilitated. It was also much easier for the group to access resources such as transport, stationary, and use of the church facilities. Their emotional support of the programme also gave the young people a lot of encouragement.

- **Structural support**

A female peer educator reported how the support from church leaders helped them:

*"The support from church leaders is excellent and things are going really well." (Female peer educator)*

The role of the priest could be very important in terms of empowering the facilitators to have the courage to tackle potentially difficult subjects that might get backlash from the congregation – so that they knew they had the priest's support. This was explained by a male priest:

*"There are some of the topics the facilitators feel uncomfortable with, they come with their own taboos and almost want to say this part shouldn't happen. One needs to coach them, why this is important and why it is good for the children."*

- **Finances and resources**

A female facilitator explained various ways in which the church leaders assisted them with resources:

*"They help with guidance, organising transport, raising funds and helping out with facilities."*

Sometimes additional resources were released from the church, as in one parish where the priest encouraged them to video their sessions so that they could be shared with other churches.

Often the collaboration of the priest or church warden was important in terms of communication. The facilitator may not have access to a fax or email and the access to communication was facilitated by the priest as indicated below:

*"I encouraged those involved, if there is a workshop that they are taken. I was serving as a link with the office (Fikelela) here and the youth leaders." (Priest)*

Sometimes the support was less evident, as a female peer educator explained:

*"They say we have their support, but in reality it is not that way."*

The youth in churches where the priest was not supportive, struggled quite a lot with the logistics of getting the programme going, as indicated by a female peer educator:

*"We ask for flipchart paper and it has to go to parish council, and they must check their budget and by the time we get it, the sessions are over."*

One of the priests was non-stipendiary[22], which meant that although he was supportive in theory, he was not able to be present at all, and it also led to poor communication, so his church failed to attend the training camp even though they had been selected.

- **Emotional support/endorsement**

[22] With a full time job, not employed by the Church

Apart from practical support with resources, the emotional support from the priest was seen to be very important. Resources alone were not seen to be enough as indicated by a male peer educator:

*"We need help from the clergy to give us a boost, if only they would be interested."*
The facilitators were usually selected by the priest, and this could really build the self-esteem of the facilitator as this female facilitator reported:

*"It is an honour being a facilitator; it means that my priest saw something in me." (Female facilitator)*

The priests are generally supportive of the programme if they can see growth in numbers and meaning of the youth. If those youth then start coming to church more, then they are delighted! If they are able to attend some of the sessions, it also helps them to gain a better insight into the challenges the youth face as indicated by a female facilitator:

*"He is supportive because the youth is growing as one, and the teenagers are busy with constructive work." (Female facilitator)*

A particularly supportive relationship was formed with one of the bishops. He met with the peer educators of a parish and was so impressed that he took them out for lunch at the Spur[23]. He then consistently promoted the programme, he mentioned it at the launch of the Anglican Youth Fellowship and also during his enthronement sermon.

The biggest challenge to priests is often that of being swamped with work. There are so many demands on their time and the youth group is one of many organisations that demand attention. Others feel that the Church year is so full that to try and put in additional sermons and themes is too difficult. If the priest could see a difference in the youth group, they tended to be quite supportive as indicated by a male priest who was very supportive of the programme:

*"Builds up young people so that they become more participatory in parish life, so building up the community."*

One way to increase buy-in from the congregation was when the youth as an organisation did a fund-raiser and the money went to support the church, not only the youth activities.

- **Problems regarding church leaders**

Priests and church wardens would become unsupportive of the programme when they were not given sufficient information, or when requests for money for transport were made at the last minute. A female peer educator explained the need for communication:

*"It is a two-way relationship, we must give information constantly."*

[23] Family restaurant

There were also clashes over use of and cleaning of the church hall and breakages of equipment; an example is given below by a male peer educator:

*"They never give us the resources we need like papers, and they moan if we don't pack the chairs away."*

Sometimes there were leadership issues or internal politics, particularly in the choice of facilitators. At one church there was a serious clash between facilitators and church wardens, but because the Diocesan Youth Worker worships at that church, he was able to solve the problem eventually.

However, if the relationship was difficult, the programme suffered. In one church once that relationship broke down, the priest went from seeing the programme as a good thing, to seeing it somewhat as a 'threat', the facilitator was perhaps gaining too much power and influence. He put another facilitator in place and the group folded. In another case a facilitator had a disagreement with his priest, who wanted him to use different, less 'explicit' materials. As a result of this disagreement, he left the church, and the agents programme folded. He then went on to set up a very successful programme in the next church with the full support of the priest there. At another church the priest sent the young people on camp, but when they came back and he saw such young people leading the sessions, he became uncomfortable and took them out of leadership and gave the manual to older people and told them to present the sessions. These internal politics and unsupportive attitudes towards the youth were very detrimental to the programme.

In two churches there was no priest (called an inter-regnum) and the programme did not function well at all. In one of these cases, there was a break down in relationships between peer educators and facilitators, the youth could only complain to the church wardens, who saw themselves with only a practical, and not a pastoral role. Consequently the programme folded in this church. The other church was being run by a retired priest, and when issues came up, he did not have the energy to intervene to sort them out, and perceived the programme to be a burden to him.

Sometimes the lack of financial support was a major problem, when for instance the parish council was not prepared to pay an additional rental to hire the venue used by the church in the middle of the week as well as Sunday. In one case this problem was solved by an external funder (overseas church) but that also reduced buy-in from the church and led to some conflicts over control of those funds.

Sometimes the issue was that the youth group met very separately (on a Friday night in the hall for example) and there was not much awareness or support as indicated by a female peer educator:

*"The people in our church don't really know about the programme and we should let them know the youth is learning well in these sessions".*

**6.5.2.1(ii) Progress Marker Two: 'Big days' celebrated – World AIDS Day, Women's day, 16 days of activism.**

This progress marker scored a medium, as the majority of churches did celebrate one or two of the 'big days'. In general the majority of the churches celebrated in some form the following 'big days' : orphan day (June 1st), youth day (June 16th) , women's day (August 8th) 16 days of activism (November) and World Aids Day (Dec 1st). These events were seen as opportunities for the youth to take part with prayers or in some cases a short drama.

Several churches celebrated Orphan day with visits to orphanages or collecting goods for orphans. Most of the churches gave the youth the opportunity to lead the service on the Sunday closest to youth day and the majority focused on prevention of risky behaviour. Many focused on drugs on that day. Women's day was celebrated in the majority of churches, but few agents of change participated – it was seen as more of an opportunity for the adult women to take part. Few churches participated in 16 days of activism, however three used the idea of the 'dirty washing'; where the youth wrote slogans on t-shirts which they wore in church, and then left them on a washing line outside the church during the day. World AIDS day, due to the work of Fikelela has become a fixture of most Churches. A few used the agents of change to take part, but the majority utilised their mainly adult HIV task teams.

**6.5.2.1(iii) Progress Marker Three: youth included in year planner**

This progress marker achieved a low, as the youth programme tended to be run in parallel to the church's programme, and youth events were infrequently included in the Church's official plans. The youth normally planned their own programme, and this could become a problem when their dates clashed with Church events, in which case they tended to have to take the back seat. At one church however, the youth was invited to participate in a full day year planner, which meant they were much more integrated.

It was very affirming when the peer educators were allowed to take a meaningful part in the year plan of the church. In one church they were invited to run the whole programme of the confirmation camp. At another they were given a key slot during the Lenten services. A male facilitator indicated the importance of the young people taking part in the service:

*"This programme made the priest realise that young people can also minister in the congregation."*

Several churches have now included the agents of change into their regular year programme as reported by a male peer educator:

*"Sexual programmes is going to become part of the annual youth and confirmation programme."*

#### 6.5.2.1(iv) Progress Marker Four: sermons on rape, drugs, violence against women and children

This progress marker was inadequately reached and only achieved a low score. It was very important in terms of backing up the programme, if priests could be encouraged to preach on these issues or to invite speakers to cover them. In many cases the agents of change programme was the catalyst for such sermons to take place. Some churches indicated that this was taking place fairly regularly as indicated by a male peer educator:

*"On most occasions they do preach about these issues."*

It appeared that running the programme allowed such topics to be opened up. A male priest explained how the programme made it easier for difficult topics to be tackled:

*"This is an important programme in the churches – we get stuck – and we see our children getting pregnant. This programme gives us an acceptable way in, especially with those who hold traditional views – you can't speak about this and that in church."*

At one church the priest was very supportive of the programme, due to the fact that his daughter had fallen pregnant as a teenager. So he backed up the programme with notes in the pew leaflets and sermons on the various subjects.

However the majority indicated that such sermons were not occurring, as reported by a male peer educator:

*"Hell no! They leave that to us."*

The clergy evidently do not find it easy to preach about issues of sexuality, many find it awkward and they are obviously not giving clear messages as indicated by these two quotes below:

*"Some clergy don't know how to cope; they don't want to talk about sexuality with the young people." (Priest)*
*"They think they do but they don't speak clear." (Female peer educator)*

This group of four progress markers categorised as 'expect to see', scored two mediums and two lows. This gave it an overall mean rating of only 1.5. This would indicate that in many churches the clergy were not giving adequate support to the programme.

### 6.5.2.2. Like to see

#### 6.5.2.2(i) Progress Marker Five: clergy visit the Agents of Change programme

This progress marker achieved a medium; there was a great variation from church to church in terms of support from clergy. In general the churches with good hands-on support from the priest tended to do much better. Visits from clergy meant a lot to the young people

and they found them very affirming. Some priests came with the youth to drop them at camp and stayed to support them. Others paid frequent visits to the youth group as reported by a male facilitator:

*"Fr M. comes and sits on Thu. evenings and chats and asks us what we need. Our priest helps us to keep our energy up."*

Sometimes little things could make a big impression as was explained by a male peer educator:

*"Our priest loves us – he brought us chocolates one day!"*

In two churches the priests were so committed that they functioned as additional facilitators and were very hands on – these two churches did exceptionally well. One of these priests indicated that he did not want to run the programme, but to rather function as a 'support base'.

In another church the priests or church wardens made sure one of them was present on every evening. However this was experienced by some of the peer educators to be more of a policing role as reported by a male peer educator:

*"Had to cope with us and our behaviour."*

There was also a problem in another church where instead of supporting; the priest actually took over because she felt the facilitators and peer educators were not doing a good enough job, as she explained:

*"I did some of the sessions because it was difficult for the children."*

In the case of the churches with an assistant priest, they usually received quite a lot of support – since it appears that in those churches, youth ministry was part of the assistant priest's portfolio, but where there is only one priest, youth ministry is an additional task which he or she supports only if it is a particular interest. This is explained by a male peer educator from a church with a rector and assistant priest:

*"At first the clergy were not involved but then Rev N. came (assistant priest) and gave us a lot of support. Now we get everything we need."*

A good balance seemed to occur when the priest was around, but let the young people use their own ideas as reported by a male priest:

*"I tried to allow them their own space and to do their creative work. I tried to keep them accountable, so they don't just decide to do what they want. I come to greet them before they start, then I allow the space."*

Often the priests were supportive because they really felt the youth were involved in something worthwhile. A female peer educator explained how the priest was more supportive since the programme started:

*"The priest is more into the young people now."*

Some of the youth were perhaps unrealistic in their expectations of the number of visits they might receive – bearing in mind how many organisations there are in the church and also the fact that for many priests Friday (youth night) is their day off. A female peer educator complained:

*"They do visit but not every session."*

The presence of a supportive priest was experienced as very important. In several churches thriving Agents of Change programmes lost their momentum when a supportive priest left to go to another parish, even though the facilitators did not change. In one case the new priest was not youth-friendly at all and stopped the youth services, and went back to traditional music, which led to a lot of youth leaving the church. In the other case, because he was so busy settling into a new parish, he did not have time or energy to be as hands-on as the previous priest and the youth felt somewhat abandoned. In a third case the priest actually converted to Islam, which had a huge impact on the entire church and many families left the parish.

#### 6.5.2.2(ii) Progress Marker Six: Agents of Change take part in services

This progress marker achieved a medium. Quite a few churches allowed the agents of change to take part in some form. To take part in a service seemed to be a very key moment for the peer educators. They were affirmed, felt proud and accepted by the whole congregation. This is an important way for the parents to also experience what the programme is all about. In the words of one female peer educator:

*"We used to go to church now we are church."*

Several churches invited the agents of change to take part in the service in order to present the programme to the whole congregation – at one church this took place during Education Sunday. A male peer educator explained what took place at their launch:

*"The launch in church was very important – we wore our t-shirts, we had 20 minutes and we took them nicely through the programme - got buy in."*

One church invited the agents of change to share their testimonies of attending camp, which helped the congregation to understand the programme and improved 'buy-in' from the adults. At another church both agents of change and parents mentioned the day they did a skit in church as a real turning point, the adults saw that this programme was meaningful – and many were in tears as described by a male peer educator:

*"It is a drama they do and re-enact what they are doing. The message is so clear that he doesn't even have to preach on it. The first skit they did, people were crying."*

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At another church one of the peer educators shared his testimony and had the congregation in stitches and in tears. At one church the youth had prepared a skit to perform but it was censored at the last moment which led to a lot of disappointment and disillusionment at the start of the programme.

Sometimes youth were invited to take part in leading the service as described by a male facilitator:

*"Every third Sunday we have youth service, we assign young people to lead with readings and synaxis[24] of the service."*

On a couple of occasions the peer educators were invited to take part in larger services, one at an archdeaconry level (joint service of six churches) and one with an inter-church Pentecost event. This had the dual result of making them feel extremely proud and affirmed, as well as promoting the programme. Several invitations to visit other churches followed these services.

Some of the other churches did not really give the young people the opportunity to take part in the services, as a male facilitator explained:

*"It's been a while since the young people took part in the service and the message included. However they are servers in our church."*

**6.5.2.2(iii) Progress Marker Seven: the clergy allow youth to develop own programmes, materials and liturgies**

This progress marker achieved a low, as it happened only in a handful of churches. This did occur, mainly in the form of 'skits' that were performed during the church service. They also wrote their own prayers sometimes:

*"The thing of the role plays is influenced by AOC. It inspires them to see it as a ministerial tool. (Priest)*

There were three progress markers in the group of 'like to see' markers. Two scored a medium and one scored a low. This gave an overall mean rating of 1.7. This indicates that limited change was occurring amongst a few clergy, but not all.

### 6.5.2.3. Love to see

**6.5.2.3(i) Progress Marker Eight: youth are in leadership and decision-making positions**

[24] Leading the service.

This progress marker also achieved a low. Generally churches see the youth as a parallel organisation and do not include them in decision making processes. The youth at one church made a presentation to the parish council, highlighting the importance of Agents of Change in the growth in numbers at the youth. This led to a marked increase in support from the parish council, and one of the agents was invited to become the youth representative on council.

It was seen to be very important to make regular reports to the leadership structures and to use the pew leaflet to inform people of activities coming up. Those churches that had facilitators on the parish council found accessing support for things like stationary and transport much easier.

#### 6.5.2.3(ii) Progress Marker Nine: new style of music

This progress marker achieved a low score, as it occurred in few of the churches. In churches where the priest was supportive of the work, and allowed the youth to take part in church services, there were incidences reported where new and more youth friendly styles of music were embraced. A male facilitator described some of the challenges of different churches' types of churchmanship:

*"Our church is very catholic, high mass etc, very ancient. When we go to T's church they clap hands and it was a learning environment! We told them we mustn't try to change things in an uprising type of environment. But when we are in the hall we can do new songs or spiritual dance."*

#### 6.5.2.3(iii) Progress Marker Ten: Church leaders give spiritual guidance and counselling

This progress marker achieved a medium, as most of the clergy saw this to be part of their job description. The support of the priest was considered to be very important in the area of pastoral support and spiritual guidance. When this took place, it was much appreciated and seen to be empowering. A female peer educator expressed her gratitude to her priest for his support:

*"For trusting in me and telling me over and over that I'll learn from my mistakes. Thanks a million".*

The problem is that many of the churches are large and the priest does not always have the time available for those who need him. A male priest explained the challenge:

*"My young people come to me on certain things – it is availability - if he or she (priest) has a passion for young people it is ok, but the problem is availability."*

Some struggle with the church teaching of no sex before marriage as opposed to the reality that many young people are sexually active. A male priest explained this dilemma:

*"When they come to me I ask are you sexually active – you need to use a condom, otherwise my experience is the next time they come to you, they are pregnant. If we are not facing reality we are not going anywhere. Clergy need training."*

#### 6.5.2.3(iv) Progress Marker Eleven: Clergy promote youth events and training

This achieved a medium score as the clergy were reasonably supportive of their young people attending such events. However communication was usually the problem, correspondence and information often gets 'bottled-necked' on the clergy desk and sometimes did not get fed to the relevant people in time. The clergy who were supportive of the programme were good at encouraging the youth to attend quarterly gatherings or social events. This support generally needed to be in the form of some kind of facilitation or financial support for the transport costs involved.

#### 6.5.2.3(v) Progress Marker Twelve: Clergy challenge the congregation to be more supportive of agents of change

This progress marker achieved a medium; generally the churches which had chosen to participate in the Agents of Change programme were supportive of the peer educators. Endorsement by a priest could smooth the way forward for the programme:

*"Father called the youth members up for a special blessing during Sunday service and invited the congregation to the hall afterwards for the explanation of the agents of change. It was endorsed by all." (Male facilitator)*

The group of five progress markers categorised as 'love to see' scored three mediums and two lows. This gives an overall mean rating of 1.6. As with the other progress markers, this would indicate that profound change may be happening with a few of the priests, but not with many.

## 6.5.3. SUMMARY

### 6.5.3.1. High progress markers

Unfortunately none of the progress markers scored high. This is of concern because the role of the priest is crucial to the success of this programme. Obviously it will not ever get started if the clergy do not allow it to be undertaken. The churches involved in Agents of Change are self-selecting – these are the ones where the priest recognised the importance of these issues to be dealt with by the youth. However the support from the priests was below expectations.

### 6.5.3.2. Medium progress markers

The medium progress markers formed clusters of support and inclusion.

#### 6.5.3.2(i) Support

The following progress markers scored medium under support: **'**take ownership of project', 'including it in church structures and supporting its financial and resource needs', 'clergy visit the agents of change programme', 'leaders give spiritual guidance and counselling'; 'challenges the congregation to be more supportive of agents of change'.

The support from the priest was crucial in terms of access to resources, such as space, transport and stationary. However an even more important factor appears to be that of affirmation and emotional support. Some of the issues being dealt with by the programme were not acceptable to more conservative members of the congregation, and the priests' endorsement became crucial. This was an important aspect of building self esteem in the young people, since the priest was seen as an important – if distant – figure in their lives. Small supportive actions can mean a lot to the young people and boost their confidence. This building of self-esteem could enhance self-efficacy. Many of the churches indicated that there was a growth in numbers in the youth group, and young people became more regular in church, so this made the priests feel supportive of the programme.

#### 6.5.3.2(ii) Inclusion

The progress marker which scored medium under inclusion was**:** 'agents share in services'. The churches where the programme was the most successful were all those where the priest allowed them to take part in services, and gave them positive affirmation and encouragement. An interesting and unexpected outcome of the programme was the influence of agents of change on the church. Many of the youth indicated that they had a sense of moving from the edges of the church activity to a more central role. Issues being raised at agents of change were being more frequently addressed by the church, whether in sermons, prayers or by visiting speakers. The use of drama by young people in the services appeared to have quite an impact on the adult congregants. Interestingly this is a very under-utilised form of communication in many churches, which are limited to the sermon monologue. The increased participation of young people in church services also began to have an impact in some cases on the types of music being chosen, to being more 'youth friendly', in services where youth were to take part.

### 6.5.3.3. Low progress markers

The following cluster of progress markers scored low: incorporation and internalisation.

#### 6.5.3.3(i) Incorporation

These progress markers scored low**:** 'Youth included in year planner'; 'allow youth to develop own programmes, material and liturgies'; 'place youth in leadership and decision making positions'; 'develop new styles of worship'.

This progress marker scored a low as the majority of churches did not incorporate youth into the mainstream church. Many churches included young people by having a monthly 'youth service' but the needs of youth were not incorporated into the main church service. Their programme and year planner ran parallel to the main church, and very few had young people in positions of authority. Without this happening, the youth were not able to influence the church either in the issues dealt with, or in the type of worship.

#### 6.5.3.3(ii) Internalisation

The following progress marker scored low around internalisation**: '**sermons on rape, drugs, violence against women and children'.

It was disappointing how few of the churches indicated that priests were internalising the importance of these issues to the point that they were preaching about them. This was a lost opportunity because the pulpit has great influence and reach. They were happy for the youth to present a skit on rape or to have a visiting speaker discuss teenage pregnancy, but few priests did so themselves.

A particular challenge to the church was the difficulty that many clergy face of teaching about issues of sexuality. The reality they experience in their community and congregation is that many young people are sexually active; however the official stance of the church is 'no sex before marriage'. Many of them therefore appreciated these issues being dealt with in the youth meetings, but did not feel comfortable to teach about them in sermons. In this way an important opportunity of influencing the community was lost.

#### 6.5.3.4. Conclusion

There were twelve progress markers indicated for clergy. None of them scored high, and there were seven which scored medium and five which scored low. This gave an overall mean rating of 1.6. Both facilitators and peer educators gave the clergy the same score of 1.6. Generally they felt that the clergy were allowing them space to run the programme, but were not actively supporting them as they would have liked. They were allowed to take part in the life of the church as youth members, but were not really main-streamed into the life of the church. The clergy were reasonably supportive of them tackling 'tricky' issues; however, the churches were self selecting in this instance, since the clergy who did not think that these sorts of issues should be addressed in the church would not send their young people to take part in the agents of change programme.

The role of the priest was very important in this programme as he or she functioned as the gate-keeper, whereby the programme could be implemented or not. Clergy appeared to be happy for the issues raised by the programme to be discussed with the youth at their meetings, but were not yet comfortable with raising them from the pulpit. This was unfortunate because the pulpit carries a lot of moral authority and such sermons could be very influential for adults as well. The support of the priest, in the churches where it took place was very important to the young people and to the facilitators.

## 6.6. THE EFFECT OF THE PROGRAMME ON PARENTS

### 6.6.1. OUTCOME CHALLENGE FOR PARENTS

The following outcome challenge was defined for parents:

*Parents will effectively dialogue and interact with young people in an attempt to build healthy relationships.*

### 6.6.2. PROGRESS MARKERS FOR PARENTS

The following fifteen progress markers were defined for parents, and their rating scored below in Table 6.5:

**Table 6.5: Progress Markers for parents**

| Progress marker | Rating |
|---|---|
| **EXPECT TO SEE** | |
| Increase of listening skills | Medium |
| Respect for young people's view points | Medium |
| Trying to understand the challenges and needs of young people, especially around issues of sexuality | Medium |
| Connect with own experiences of adolescence | Medium |
| Good attendance at workshops | Low |
| **LIKE TO SEE** | |
| Understanding peer pressure | High |
| Less judgmental | Low |
| Open communication | Medium |
| Increase in conversations about lifestyle choice | Medium |
| Says affirming things about young people | Medium |
| Parents get involved in lobbying and advocating on issues that affect young people | Low |
| **LOVE TO SEE** | |
| Increase in open trusting relationships | Medium |
| Allow them to make own decisions | Low |
| Improvements in positive boundary setting | Low |
| Influence other parents to have better relationships with young people | Medium |

Five of the progress markers were categorised as 'expect to see', indicating that they were basic requirements of the programme. These are examined below:

### 6.6.2.1. Expect to see

#### 6.6.2.1(i) Progress Marker One: increase of listening skills

This progress marker scored a medium, as some of the peer educators indicated that their parents were listening to them better, as indicated by a male peer educator:

*"I have grown closer to my sister and parents 'cause I feel I can speak to them about anything and they would listen."*

Some of the parents found it hard to hear about issues such as drugs or sexuality, as a mother explained:

*"A few parents that have come to youth once or twice and then they stay away – maybe it is too deep for them and maybe hitting you somewhere. The issues they deal with is daily issues and sometimes we don't want to hear these things because it is hitting on a sore place."*

#### 6.6.2.1(ii) Progress Marker Two: respect for young people's view-points

Some of the parents seemed to have gained more understanding of the young people's viewpoints so this marker scored a medium. One mother explained the following:

*"I should be more tolerant where the children's issues are concerned sometimes. What's big to them is not always big to me."*

However, this was not always the case, as a female peer educator explained:

*"It is adult ignorance – parents don't understand our point of view and refuse to broaden their mindsets."*

In a few churches the parents did not trust the young people to lead the sessions, and tried to take over, as reported by the Diocesan Youth Worker:

*"At P, the parents took over and all the kids left."*

#### 6.6.2.1(iii) Progress Marker Three: trying to understand the challenges and needs of young people especially around issue of sexuality

Society has changed a lot from when the parents were teenagers, and in many cases this programme did help parents understand these challenges, so it scored a medium. As one male facilitator explained:

*"The parents want to help their young children where sex and drinking is concerned, things is different now." (Male facilitator)*

However, many people indicated that the parents were not able or willing to address these issues, as a male peer educator reported:

*"Often parents aren't able to speak to their children. But through this programme they know that their children are made aware."*

Some did not like the focus on sex, or would have preferred the adults to do the teaching as indicated by a male peer educator:

*"The parents of the kids think we are too young to be talking about sex."*

**6.6.2.1(iv) Progress Marker Four: connect with own experience of adolescence**

There was not much documentation of this taking place; generally the parents felt that their experience was extremely different especially in terms of sexual activity. A male facilitator explained this challenge:

*"We need to realise that the youth of today cannot be compared with those who has gone before, we need to love and appreciate them in the now for who they are especially facing life today."*

**6.6.2.1(v) Progress Marker Five: good attendance at workshops**

Generally the attendance was very poor at the parenting workshops, apart from in three churches where attendance was good. In two of these churches the facilitators were parents themselves and were able to invite their own 'peer group' to the sessions. In the third church the sessions took place in the priest's house and that seemed to be attractive to parents.

Parents were quite supportive of the launch of the youth programme and other activities as reported by the Diocesan Youth Worker:

*"At W. parents stayed after launch and were very enthusiastic."*

However, in the majority of the churches, the parenting workshop either did not happen because the programme was too full or the facilitators did not get a date. In most cases when the workshop took place, the attendance was very poor indeed as indicated by the Diocesan Youth Worker:

*"Although the workshop was well advertised in pew leaflets and through the youth – only six parents came."*

There were five progress markers in the group 'expect to see'. They scored four mediums and a low. The overall mean rating was 1.8. Thus it appears that the participation of parents in the programme was not as high as anticipated.

### 6.6.2.2. Like to see

#### 6.6.2.2(i) Progress Marker Six: understanding peer pressure

This progress marker scored a high, because in several cases parents did seem to be beginning to understand peer pressure, as indicated by a male peer educator:

*"Parents did not understand the pressure youth is experiencing, but they are starting to get it".*

#### 6.6.2.2(ii) Progress Marker Seven: less judgmental

This progress marker scored low since there were only a few indications that some parents were less judgmental, as indicated by a male peer educator:

*"Parents tend to think that young people are unruly and irresponsible but this programme makes such an impression that parents actually feel that the youth are not what they think they are; they now know what they are."*

But generally the young people experienced their parents as judging them as indicated by a male peer educator:

*"They judge you by the friends you hang out with."*

#### 6.6.2.2(iii) Progress Marker Eight: communication improves between parents and children

This marker scored as medium, since generally there were indicators that communication had improved between parents and youth as reported by this mother:

*"He is more open and he is speaking now, he didn't used to speak to me now he is more open. Conversation between me and my son improved a lot."*

#### 6.6.2.2(iv) Progress Marker Nine: increase in conversations on lifestyle choices

There was a limited increase in conversations about sexuality and lifestyle choices – the parents still found this hard to talk about. For this reason this progress marker scored a medium. It seemed to be easier for youth to talk to an unrelated adult such as a facilitator**,** as reported by a female peer educator:

*"It helped me to interact more with my family about the daily challenges that we as teens go through."*

### 6.6.2.2(v) Progress Marker Ten: says affirming things about young person

This progress marker scored a medium because there were quite a few cases reported where the parents had expressed their pride in the young people both for getting involved in the programme and also for the changes they saw. A female peer educator explained the impact of this affirmation on her:

*"My mom and sister both are really proud of me; I have always been this shy quiet person who never spoke, this programme was the best thing that ever happened to me, I am totally different from who I was 3 months ago."*

Other parents were proud of their children because of the changes in their lives, as a mother explained:

*"I am a proud parent. I can thank God for the changes in my life and in my family life. Z. joined the AOC he changed everything in our lives."*

### 6.6.2.2(vi) Progress Marker Eleven: parents get involved in lobbying and advocating on issues that affect young people

There was very little evidence that this was taking place. Parents were often very supportive on a practical level with transport or snacks, but not at this deeper level of advocacy. For this reason this progress marker scored low. A few examples were given of practical support.

- **Involvement through practical support**

A father explained how they supported with transport:

*"We take them home – the three parents with cars, they take them home. Even if there is 10 in the car." (Father)*

The Diocesan Youth Worker indicated that the support of parents with food was supportive:

*"If they are there in the background or to supply snacks then they are a big help." (Diocesan Youth Worker)*

A female peer educator explained how her mother helped her prepare session:

*"When we get together to do the programme, I read it to my mother and she tells me where I can improve." (Female peer educator)*

There were six progress markers in the group of 'like to see' markers. They scored one high, three mediums and two lows. This gave an overall mean rating of 1.7. This would indicate that limited change was taking place, or else it was taking place in a limited number of parents.

### 6.6.2.3. Love to see

#### 6.6.2.3(i) Progress Marker Twelve: increase in open trusting relationships

This progress marker scored medium. There were several documented improvements in relationships and a marked desire for this. However most of the teenagers and parents found their relationships difficult.
One male peer educator indicated that some changes had already taken place:

*"I have grown closer to my mother and my sister, 'cause I feel that I can speak to them about anything and they would listen and I feel that this is the example that I want to be." (Male peer educator)*

Others indicated a desire for change:

*"I should be able to change my style of attitude towards my parents. I can't be holy on one occasion and then become devilish on the next." (Male peer educator)*

#### 6.6.2.3(ii) Progress Marker Thirteen: allow them to make decisions

There was limited evidence that parents trusted their children to make their own decisions, so this progress marker scored low:

*"It is important to start trusting your child with the choices they make." (Mother)*

#### 6.6.2.3(iii) Progress Marker Fourteen: improvement in positive boundary setting

This progress marker scored low as there was only limited evidence that positive boundary setting was taking place, as indicated by a youth member:

*"Our parents don't really know where we are most of the time."*

#### 6.6.2.3(iv) Progress Marker Fifteen: influence other parents to have better relationships with young people

Some of the parents indicated that they would like to share with others the impact of the programme and the progress marker scored a medium. A mother shared how she had encouraged other parents to send their children to the programme:

*"I told them to send their kids to AOC. It keeps them away from wrong and they will grow spiritually and improve their attitude."*

Others did not want their children to attend sessions at the Church because they were from a different denomination, as reported by a female peer educator:

*"I encouraged my friends but some of their parents do not want them to because they are from a different church."*

There were four progress markers which were categorised as 'love to see'. Two of them scored medium and two scored low. Overall the mean rating was 1.5. This indicated that profound change was not occurring in this group apart from perhaps in a few individuals.

## 6.6.3. SUMMARY

The progress markers for parents indicate that understanding peer pressure scored high, communication and relationships scored medium and participation, discipline and advocacy scored a low.

### 6.6.3.1. High progress markers

#### 6.6.3.1(i) Understanding peer pressure

It appears that through the sessions they attended, or from conversations that they had, the parents did understand that the youth of this generation are facing challenges they did not. This was the only progress marker that scored high, which reflects that the programme was not very successful in dealing with the tensions that exist between adolescents and their parents.

### 6.6.3.2. Medium progress markers

This cluster of progress markers included: communication and relationships.

#### 6.6.3.2(i) Communication

This cluster included 'increase of listening skills', 'open communication', 'increase in conversations on lifestyle choice', 'says affirming things about young people'.
In order for parents to be able to communicate their attitude to risky behaviour in an effective way, there needed to be open communication first of all. This was often very difficult during adolescence, so the small improvements in communication may be significant for improvement in prevention. Those parents who were involved with the agents of change did show an improvement in listening skills and easier conversations regarding sex, drugs and alcohol. The problem was that very few parents attended the parenting workshops, so the impact was not as great as it could have been.

Generally parents were very supportive of their child's role as a peer educator, and there appeared to be an improvement in positive communication in terms of the parents affirming and encouraging their children. This could lead to an increase of a 'cycle of positive interaction' where the parents moved from a nagging, lecturing interaction to more of an

affirming way of communicating. This could in turn lead to an increase in self-esteem on the part of the young people.

### 6.6.3.2(ii) Relationships

This cluster included the following progress markers: 'respect for young people's view-point,' 'trying to understand the challenges of young people especially around issues of sexuality' 'connect with own experiences of adolescence',' increase in trusting relationships'.

For those parents who were involved in the programme, there did appear to be an improvement in trusting relationships. They also seemed to be trying to understand the viewpoint of the youth and the challenges that they face. In understanding the gap between their experience of adolescents and current challenges, it appeared that they were more sympathetic to the struggles their children face. The role of the parent in supporting their child through these adolescent years is crucial, and bolstering the relationship with the parent is an important way to build preventive assets into the child's life.

### 6.6.3.3. Low progress markers

The following clusters of progress markers scored low: participation, discipline and advocacy.

### 6.6.3.3(i) Participation

This progress marker 'good attendance at workshops' scored low. There was very poor participation by parents in the parenting workshops. This was the least effective part of the programme. For this reason the majority of progress markers were not adequately reached. Parents of teenaged children often are working long hours, it is common for both parents to be working, and there is a limited time for extra activities, however important they are. This is in line with experiences at high school of poor attendance by parents. Another problem was that the parenting workshop was an external idea that came from Fikelela, and not something that the facilitators were committed to, so they often did not put a lot of energy into pushing the idea. Another strategy would need to be used in order to influence the parents more effectively.

### 6.6.3.3(ii) Discipline

The cluster of progress markers scored a low: **'**less judgmental', 'allow young people to make decisions',' improvement in positive boundary setting'.
The majority of tensions between parents and adolescents revolve around discipline and boundary setting. The adolescent wants to experience more freedom and the parent wants to keep them safe from risky behaviour. These three progress markers were important in

terms of putting effective discipline in place. However they scored low, which shows that the programme has not effectively assisted parents with this important part of their relationship with their adolescents. They continued to be experienced as judgmental, and struggled to allow the young people to make decisions. This is because they do not trust that the decisions their children make would keep them safe. Thus positive boundary setting was not achieved and discipline continued to lead to conflict.

#### 6.6.3.3(iii) Advocacy

This progress marker also scored a low: **'**get involved in lobbying and advocacy'.
In common with other parts of the programme, the expected goal of parents being involved in advocacy was not documented. Some parents were actively involved in the programme, but their role was on the practical side (food or transport and so on) and did not involve advocacy. This role is very important in order for issues in the community, which are putting the young people at risk to be addressed. Parents did not appear to be getting involved in advocacy: however they may have been involved in activities that their children were not aware of (for instance in their place of work).

#### 6.6.3.4. Conclusion

Only one of the 15 progress markers scored a high, nine scored a medium and five scored low. This gave an overall mean rating of 1.7. The peer educators scored their parents lower than the facilitators at 1.4, which probably indicates that communications were strained between them. On the other hand the facilitators scored the parents higher at 1.9. This could indicate that the facilitators, as adults themselves, were more aware of the efforts that parent were making in the area of communication. Many of the facilitators were themselves parents.

It appears that this was a weak part of the programme. The parental workshops were not successful due to poor attendance, so the programme was not able to influence the parents as was intended. However, there appear to have been some secondary outcomes, as the parents were involved in the youth programmes on a supportive level, they became interested in the issues which led to an improvement in communication. The parents often felt quite proud of their children's participation which could lead to affirmation on their behalf.

## 6.7. FINAL SYNTHESIS

In Outcome Mapping, the scores for progress markers are not an absolute number for 'scoring', they indicate trends. The data collected is very subjective and so they are intended to be a tool for monitoring (72). **'**Expect to see' indicates that the planned activity occurred, 'like to see' indicates that limited change took place, and 'love to see' indicates

that profound change occurred. The progress markers help to indicate whether change has taken place and on which level as indicated in Table 6.6:

**Table 6.6 Synthesis of the effect of the programme on change partners**

| Change partner | 'Expect to see': planned activity occurred | 'Like to see': limited change | 'Love to see': profound change | High progress markers | Overall rating |
|---|---|---|---|---|---|
| Peer educators | 2.6 | 2.8 | 2.2 | Personal development<br>Self-efficacy | 2.4 |
| Facilitators | 2.1 | 2.3 | 2.4 | Role model<br>Mentoring | 2.3 |
| Young people | 2.8 | 2.3 | 1.8 | Attendance<br>Participation<br>Knowledge | 2.4 |
| Clergy | 1.5 | 1.7 | 1.6 | None | 1.6 |
| Parents | 1.8 | 1.7 | 1.5 | Understanding peer pressure | 1.7 |

The programme had different levels of effect on the various change partners.

- **Peer educators**

In the case of peer educators all the planned activities took place and a level of profound change occurred. Together with the young people they scored the highest overall. This is encouraging as it indicates that the programme was successful in facilitating change in the peer educators.

- **Facilitators**

The facilitators scored lower in terms of participation which may indicate other commitments but scored the highest of all change partners in terms of profound change. This was an unexpected outcome and may indicate a shift from leader to mentor and a deeper understanding of the needs of young people.

- **Young people**

The participation by young people was one of the successes of the project but profound change did not occur amongst them to the same extent as with the peer educators. This may be reflective of the fact that they were recipients of the programme whereas the peer educators were more intimately involved and more empowered through the process.

- **Clergy**

Participation and change were both very limited in the case of the clergy. This was the weakest part of the programme. No progress markers scored high at all. This was disappointing because of the critical role of the clergy in the process. This may be indicative of the busyness of many clergy and the fact that youth ministry is often not seen as 'core business'.

- **Parents**

There was slightly more participation amongst parents, but this may be indicative of the efforts that went into adapting the programme for the parents. Very little change took place and this was one of the weakest parts of the programme.

# CHAPTER SEVEN: MONITORING OF PERFORMANCE AND STRATEGIES OF THE AGENTS OF CHANGE PROGRAMME

## 7.1. INTRODUCTION

In this chapter the performance and strategies of the programme are analysed. In this process the organisation is examined to see how it operated to fulfil its mission. First of all the organisational practices are examined and secondly the strategies that were utilised.

An analysis of the organisational practices looks at the activities undertaken, as well as the 'care and feeding' of the programme that enabled it to thrive and be sustainable (72). This analysis is a reflection on what was going on internally in the organisation, and it will highlight how the situation could be improved upon in order for it to operate more effectively.

## 7.2. MONITORING PERFORMANCE: ORGANISATIONAL PRACTICES

During this stage in the monitoring process, the organisational practices of the programme were examined. These organisational practices were important for the programme to be effective and to sustain the intervention over time. Outcome Mapping recommends that the performance of the organisation is examined in terms of its ability to achieve the following (72):

- prospecting for new ideas, opportunities and resources;
- seeking feedback from key informants;
- obtaining support from next highest power;
- assessing and adapting procedures and materials;
- checking on those already served;
- sharing your best vision with the world;
- experimenting to remain innovative; and
- organisational reflection.

The following organisational processes were identified as illustrated in Table 7.1:

**Table 7.1: Organisational practices of the Agents of Change programme**

| |
|---|
| 1.Prospecting for new ideas, opportunities, and resources<br>• Scanning of information sources, locally and globally<br>• Developing new relationships and opportunities |
| 2. Seeking feedback from key informants<br>• Seeking feedback from key boundary partners<br>• Seeking information from other actors in the field |

| |
|---|
| 3.Obtaining the support of your next highest power<br>• Presenting of ideas to higher-level decision bodies<br>• Presenting of ideas to funding partners |
| 4.Assessing and (re) designing products, services, systems and procedures<br>• Ongoing review of services and products so that they can be modified. |
| 5.Checking up on those already served to add value<br>• Programme staff obtaining feedback from change partners.<br>• Building this learning into adapting the work |
| 6. Sharing your best wisdom with the world.<br>• Putting dissemination practices into place<br>• Sharing internally within the organisation<br>• Sharing externally |
| 7. Experimenting to remain innovative<br>• Creating space for the programme to explore new directions and partnerships |
| 8. Engaging in organisational reflection<br>• Creating time for reflecting on the programme performance and direction |

In this section the eight organisational processes were described in the Agents of Change programme.

## 7.2.1. PROSPECTING FOR NEW IDEAS, OPPORTUNITIES AND RESOURCES

Two ways of prospecting for new ideas, opportunities and resources are recommended:

- Scanning of information sources, locally and globally.
- Developing new relationships and opportunities.

### 7.2.1.1. Scanning of information sources, locally and globally

Various practices were used to scan information and stay in touch with the world of HIV prevention, emerging ideas and new evidence. These included use of the internet, academic presentations and the internal network.

#### 7.2.1.1(i) Internet

The internet was the key area in which this took place, as Fikelela subscribed to several emailing lists which kept the organisation updated on recent developments, research and resources. Some of these emailing lists assisted the programme to keep up to date with research, for example:
Youth/Info Net – monthly electronic newsletter focussing on youth reproductive health and HIV prevention.
Others assisted the programme to stay in touch with new funding possibilities, such as www.fundsforngos.org.

#### 7.2.1.1(ii) University presentations

Fikelela had informal links with the University of Cape Town as Roselyn Kareithi, one of the staff members, was doing her PhD through the Department of Adolescent Health, and one of the board members, Dr Graham Bresick, is a lecturer in the Department of Family Medicine. Therefore the programme was able to keep abreast of presentations that were of interest in the field, for instance:

- Dr Douglas Kirby 'Effects of Sex and HIV prevention programmes for young people throughout the world: what works and what doesn't.' University of Cape Town, Education Building, Valkenberg - February 2010.
- Professor Ida Susser: 'The politics of gender and social movements around AIDS'. The Harold Wolpe Memorial Trust 85th Open Dialogue - February 2010, UCT.

#### 7.2.1.1(iii) Internal network

Internal reflection regarding new ideas, opportunities and resources took place on two levels:

- feedback at steering committee meetings; and
- feedback from facilitators at the churches.

Feedback was obtained from members of the steering committee, which consisted of Diocesan Youth Workers, Diocesan HIV representatives and Fikelela staff. Through this network new ideas and resources were accessed, for instance in the area of drugs. The programme was also able to access a speaker for the quarterly gathering of peer educators as well as materials to upgrade the manual.

Feedback from facilitators was extremely helpful as they were encouraged to share new ideas, and resources that they had come across, in their monthly reports and at quarterly gatherings. This enabled the programme to link into a broad network of resources, such as ice-breakers, power point presentations, and resource books, suggestions for outings and websites that could be shared with the other churches

### 7.2.1.2. Developing new relationships and opportunities

This happened in two ways, both in the formation of conscious partnerships to broaden the programme's understanding of new developments, and in reaction to problems or needs that emerged.

In order to stay in touch with new ideas and resources, partnerships with other organisations were important to the work of Fikelela; some were formal relationships and some informal, as illustrated in Table 7.2:

**Table 7.2: Partner organisations**

| NAME OF ORGANISATION | TYPE OF RELATIONSHIP |
|---|---|
| Gold Peer Education | Formal |
| Life Choices | Formal |
| Catholic Archdiocese | Informal |
| Parenting Centre | Formal |
| University of Cape Town | Informal |

The relationship with the various partner organisations is described in the following section:

### 7.2.1.2(i) Gold Peer Education

This was a formal relationship as Reverend Rachel Mash served on the board as a representative of Fikelela and attended regular quarterly meetings. Gold is operating peer education in high schools in four provinces in South Africa, Botswana and Zambia. This gave an opportunity to stay in touch with broad developments in peer education. Gold were also going through an evaluation of their own outcomes, which helped Fikelela to reflect on certain issues. It also enabled the programme to stay in touch with issues affecting peer education in a broader context than just South Africa.

A workshop was also held with peer educators from Fikelela and Gold, in order to develop and adapt the materials on gender.

### 7.2.1.2(ii) Life Choices

A partnership with Life Choices was formed in order for them to run the Voluntary Counselling and Testing (VCT) programme. Regular meetings were held for evaluation and to improve the way that VCT was run as part of the Agents of Change programme.

### 7.2.1.2(iii) Catholic Archdiocese

An informal relationship was formed with the Catholic Archdiocese who were also involved in running parenting workshops. It was helpful to reflect on the challenges that they faced in getting the parents to attend as these were similar to the challenges faced by Agents of Change

### 7.2.1.2(iv) Parenting Centre

Reverend Rachel Mash attended a training course on 'training of the trainers' in order to understand further the challenges facing parents of teenaged children. This training also enabled her to adapt the parenting workshop material that was offered for Agents of Change.

## 7.2.2. SEEKING FEEDBACK FROM KEY INFORMANTS

Feedback was sought from the following key informants:

- key change partners; and
- other actors in the field.

### 7.2.2.1. Feedback from change partners

The change partners in this programme were identified as the following:

- Peer educators.
- Facilitators.
- Clergy.
- Youth.
- Parents.

The following methods were used to seek feedback from change partners:

#### 7.2.2.1(i) Evaluation of peer educator training camp

Feedback from both peer educators and facilitators was obtained at the camp. This was a very effective way to gather information, since forms were obtained from everybody – it gave immediate feedback in terms of how the programme could be improved for the following camp, as well as evidence of change talk or intention to change amongst the peer educators.

#### 7.2.2.1(ii) Feedback at quarterly gatherings

This was another effective method of getting feedback from both peer educators and facilitators – feedback was received that enabled staff to adapt the materials in the manual, as well as feedback regarding the impact the programme was having on the youth. It was also an opportunity for youth groups to learn from one another with new ideas. The main problem was that the churches that had serious issues or had yet failed to start, did not attend the quarterly meetings.

#### 7.2.2.1(iii) Facilitators' monthly reports

This was a method with limited effectiveness in terms of gathering quantitative data on the number of sessions completed or attendance. If the facilitator did not hand in a report, a report sheet was filled in over the phone. The quantitative data obtained, with a few exceptions, was very limited. Facilitators tended to write 'one liners', which did not really help to improve the programme.

#### 7.2.2.1(iv) Focus group discussions

One of the programme's funders, a Dutch organisation called CORDAID, conducted an external evaluation. They held focus groups with the five boundary partners; peer educators, facilitators, youth, clergy and parents. This was a very important intervention as these focus groups were the main source of feedback from clergy, parents or youth. This feedback focussed on strengths and weaknesses of the programme, as well as evidence of intention to change.

#### 7.2.2.2. Feedback from other key informants

Apart from the change partners, other key informants were the following:

- Diocesan Youth Workers.
- Fikelela staff.

Feedback from key informants was received through reports to the steering committee. The steering committee, consisting of Fikelela staff and Diocesan Youth workers, received reports on the various parishes. This was useful both in terms of quantitative and qualitative data. An issue that arose was that sometimes it was discovered that Diocesan Youth workers would give reports that were discovered to be rather more 'glowing' than the actual situation This could have been because of issues of competition, one Diocese wanting to show that they were doing a better job than another.

The most effective feedback was that garnered directly by Fikelela, either at camp or quarterly gatherings, or by the external evaluators. The feedback received by interested parties such as Diocesan Youth Workers could sometimes be biased.

### 7.2.3. OBTAINING SUPPORT FROM NEXT HIGHEST POWER

The programme identified two 'next highest powers'; these were the higher level decision making bodies, and the funding bodies.

#### 7.2.3.1. Presenting of ideas to higher-level decision making bodies

Fikelela is a project of the Anglican Church, and as such reports to the Church hierarchy. It is also a registered Non- Profit Organisation and so reports to its Board.

#### 7.2.3.1(i)The Anglican Church

The methods of obtaining support from the Anglican Church were the following:

- quarterly reports;
- use of publications;
- website; and

- facebook

Quarterly reports were sent to the Archbishop and the three Bishops involved in the programme. This meant that they were informed at all times as to the progress of the programme.

Publications were used at various levels: the local Diocesan ones (Good Hope magazine – Diocese of Cape Town, The Anchor magazine – Diocese of False Bay, and the Changing Hearts and Minds magazine - Diocese of Saldanha Bay). Reports were also sent to the 'Southern Anglican' magazine which is sent to the whole province of the Anglican Church (RSA, Swaziland, Lesotho, Namibia, Angola, and Mozambique)

The Fikelela website: www.fikelela.org.za was updated on a regular basis with photographs and reports. It averaged 2745 visitors per month in 2011.

The Facebook group FIKELELA AIDS PROJECT was another way of informally communicating with people about the programme. Currently there are 625 members.

#### 7.2.3.1(ii) Fikelela Board

It was important to keep the support of the Board for this programme, and for them to understand the importance of issues such as gender. Monthly reports were sent to board members to keep them abreast of activities. The yearly strategic planning was a key time for the Board and staff to interact and discuss new ideas. Peer educators were also invited to participate in events such as the AGM so that Board members could interact with them.

#### 7.2.3.2. Presenting of ideas to funding partners

As a funded organisation reports to funders are crucial to maintain existing and develop new sources of funding. In reports to funders, a 'human face' to the programme, with photographs or personal testimonies from the peer educators, is important. A DVD was produced, which was a very helpful tool for interacting with funders. A regular email letter was developed to send out to funders and interested parties.

### 7.2.4. ASSESSING AND (RE) DESIGNING PRODUCTS AND MATERIALS

In order to assess and revise the products, services, systems and procedures, it was necessary to have an ongoing review. The following procedures were used to review services and products so that they could be adapted.

#### 7.2.4.1. Peer educator training camp evaluation

Each person attending camp filled in an evaluation form, which assessed practical issues such as venue, accommodation or catering. It also assessed to which extent the learning sessions had been successful. This enabled changes to be made in the way that presentations were made.

#### 7.2.4.2. Monthly report and quarterly gatherings

The information received through the reports and gatherings enabled the manual to be adapted to make it more user-friendly. New sessions were also incorporated as requested. Feedback shared between parishes enabled the churches to learn from each other and to adapt the programme for their particular setting. Thus power was devolved to a local level in order to contextualise the programme.

#### 7.2.4.3. Reports from field workers and Diocesan Youth workers

Information received in these reports allowed areas of weakness in the programme to be identified. Some of these areas were the parenting workshop or VCT, and the information gathered allowed for changes to be integrated or new partnerships formed to provide some of these services.

### 7.2.5. CHECKING ON THOSE ALREADY SERVED

In order to add value, it was important to check on those who had already been served by the programme. Feedback was received from change partners and these learnings were built into adapting the work**.**

#### 7.2.5.1. Programme staff obtain feedback from change partners

**I**n the design of the programme, it was intended that there would be two mechanisms for follow up of those who had been trained: regular visits and phone calls, and attendance at the quarterly meetings.

- **Visits and phone calls**

The Diocesan Youth worker conducted the follow up to parishes with support from Fikelela. This could be in the form of a visit, or by phone call, email or facebook message.

- **Attendance at quarterly gatherings**

Feedback from peer educators and facilitators was also received at the quarterly gatherings. This feedback was then discussed at steering committee level.

#### 7.2.5.2. Building of learnings into adapting the work

The feedback received was used to adapt the materials. During the two year period the manual was re-written incorporating suggestions and feedback from change partners.
Feedback was also used to adapt the services. The format and content of the training camp was adapted, as well as the content of the quarterly gatherings. The feedback was discussed at steering committee level and changes made to services and products.

## 7.2.6. SHARING YOUR BEST WISDOM WITH THE WORLD

In order to share the findings with the world, three methods were used:

- putting dissemination practices into place;
- sharing internally within the organisation; and
- sharing externally.

#### 7.2.6.1. Putting dissemination practices into place

The key practices for dissemination were identified to be the following:

- Publications: reports to funders and articles in magazines.
- Websites: Fikelela has its own website and it was decided to start a section dealing with prevention only. A facebook site was also launched.
- DVDS: A DVD was prepared on the work of Fikelela.
- Conferences: Presentations were made at various conferences.
- Visitors: All visitors to Fikelela were seen as a potential way to disseminate information and vision around the Agents of Change programme.

#### 7.2.6.2. Sharing internally within the organisation

In order to share internally within the Church, publications, website, and conferences were utilised.

- **Publications**

Magazines: The programme featured quite frequently in the monthly magazines of the three Anglican Dioceses, the Cape Town Diocese ‘Good Hope’ the False Bay Diocese ‘Anchor’ and the Saldanha Bay Magazines.

- **Websites**

There were frequent articles posted on the Fikelela website, the Diocese of Cape Town website and the False Bay Diocesan website. Saldanha Bay did not yet have a website. The facebook group became an important tool for agents of change to share with each other internally.

- **Conferences**

A presentation was also made at a conference for dissemination of best practice models hosted by the Anglican AIDS Health Care Trust for the UK Department for International Development (DFID) in June 2009. A further presentation was made at the Impumelelo Best Practice Model conference in Cape Town, International Conference Centre in 2008

### 7.2.6.3. Sharing externally

- **Publications**

An article was published in the Church Times, which is the magazine of the Anglican Church in England (Church of England). Similarly, the Southern Anglican (magazine of the Province of Southern Africa - RSA, Namibia, Angola, Mozambique, Lesotho and Swaziland) published several articles on the work of Agents of Change.

- **Websites**

The website of Anglican AIDS: www.anglicanaids.net which shows the HIV&AIDS work of the Province of Southern Africa featured several articles about Agents of Change. Cordaid, one of the Dutch funders, also featured Fikelela on its website.

- **DVD**

Fikelela produced a DVD which included the Agents of Change programme, this was sent to 200 contacts around the world. Christian AID made a DVD about the work of the Anglican Church in the area of HIV & AIDS, which included an interview with one of the agents of change and a description of the programme.

- **Conference**

A poster presentation was made at the XVI International AIDS conference in 2006 in Toronto, see Appendix 8.3.

- **Visitors**

Several visitors from overseas Dioceses visited the programme. These included the Diocese of York, Washington, Ohio, Lexington and Michigan.

One of the priests from this Diocese visited Angola. When he saw the high rates of teenage pregnancy, he presented one of the sessions from the Agents of Change manual and left it with them to use and translate into Portuguese. The exposure given to the programme increased the demand for it within local churches, and improved the programme's ability to fund-raise abroad.

### 7.2.7. EXPERIMENTING TO REMAIN INNOVATIVE

Another important organisational practice is to experiment to remain innovative. In order to do this space needs to be created for the programme to explore new directions and partnerships.

Space was created for the programme to explore new directions and partnerships, by releasing staff to attend workshops with other organisations and networks. In was in these forums that Fikelela was able to create new partnerships.

The following networking meetings were attended:

- NACOSA: The Networking Aids Community of South Africa. These are networking meetings and workshops for various Non-Profit Organisations working in the area of HIV and AIDS.
- Connect: This is a network of Christian Organisations involved in support for children.
- MSATS: These are Multi-Sectoral Action teams established by the Department of Health to enable different players in the area of HIV and AIDS to meet and network together.
- Gold Peer Education Forum Meetings: these were meetings of organisations running peer education in schools.
- Department of Health: the Department called meetings with Non-Profit Organisations in order to discuss policies around prevention.

Through these networking opportunities, relationships were formed which allowed partnerships to develop in the following areas:

- Sonke Gender Justice – Gender advocacy.
- Gold Peer Education – Use of their materials.
- Scripture Union – Use of materials and speakers.
- Treatment Action Campaign – HIV positive speakers.
- Life Choices – Voluntary Counselling and Testing.

## 7.2.8. ENGAGING IN ORGANISATIONAL REFLECTION

In order to engage in organisational reflection it is important to create time for reflecting on the programme's performance and direction.

Engaging in organisational reflection took place on the following levels:

- Steering committee meetings.
- Fikelela Board meetings.

- Fikelela Strategic planning.

At the steering committee meetings, space was made for reflecting on the organisational practices that enabled the programme to run effectively, or caused problems to occur. For example communication strategies, internal church politics, financial practices and time management were discussed.

At Board meetings, reflection occurred regarding the long term financial stability of the programme, staffing needs and financial requirements.

At Fikelela strategic planning meetings, issues, such as, the interaction between HIV prevention and care, staff development and support were reflected on.

## 7.3. STRATEGIES

Having considered the organisational practices, the strategies of the Agents of Change programme are examined. There were three main strategies: camps, quarterly gatherings and parenting workshops.

### 7.3.1. STRATEGY ONE: CAMPS

The activities are firstly described, followed by the outputs and an analysis of the effectiveness of the training camp as a strategy.

#### 7.3.1.1. Description of activities

Residential training camps were held at the beginning of the programme over three days. Three camps were held each year, one for each Diocese. They were held as close to the beginning of the year as possible. During the camp the following subjects were covered by both peer educators and facilitators:

- The role of the peer educator.
- The role of the facilitator.
- Motivational communication.
- Presentation skills.
- Experiential learning.
- Community audit.
- Year planner.

The facilitators also covered two additional subjects: stakeholder analysis and monitoring and evaluation.

Following the training input, the peer educators and facilitators were given time to prepare a session each, and then present it to the whole group. This presentation underwent peer review.

#### 7.3.1.2. Outputs

During the camps, the following people were trained: during the first year 146 peer educators and 90 facilitators were trained from 28 churches. During the second year, 148 peer educators and 42 facilitators were trained from 21 churches.

#### 7.3.1.3. Effectiveness

The camp was felt by almost all participants to be a crucial element of the programme, for the following reasons:

- **Team building**

To stay away from home was an experience that really helped the peer educators and facilitators to get to know each other in a new way. Many of them had not known each other that well before the camp. During the three days, through working together and socialising together, bonds were formed that might have taken months otherwise.

- **Vision building**

At the camp the peer educators had the chance to meet young people from many different churches. There was a great excitement and 'hype' that they were all taking on a new challenge and had been chosen to be peer educators. Many of them described how the camp inspired them to be agents of change.

- **Training**

There were positive and negative consequences of doing training at a camp. The most positive thing was that the same people were there throughout. If one was to train on consecutive Saturdays you would not get the same people right through. One is also able to start straightaway in the morning without waiting for stragglers. The negative issues were that the young people got very little sleep on camp and were often very tired on the second day.

- **Spiritual boost**

Many of the young people experienced a spiritual boost on the camp, due to being able to worship with a larger group and to have more lively worship than in their own churches. Prayer ministry also took place with many of the young people, which gave them a place to share their difficulties. Many of them mentioned how the camp had built them up spiritually.

- **Meeting new people**

For the young people this was one of the most important benefits of the camp, that there was a chance to get to know people from other areas and communities. This would not have happened to such an extent if the camp had taken place during the day time only. This finding is summed up by the following comment from the CORDAID external evaluation:

"*The camp is very important for skills, insights and motivation. It is there that the peer educators start their cooperation with the facilitators."* CORDAID Evaluation

After the camps, all peer educators and facilitators filled in a form evaluating the specific training sessions, and their feedback on effectiveness of the sessions is indicated in Table 7.3.

**Table 7.3: Effectiveness of specific sessions**

| SESSION | KEY LEARNING | EFFECTIVENESS |
|---|---|---|
| Role of peer educator | Understanding what peer education is all about. | High |
| Role of the facilitator | Understanding the difference between being a leader and a facilitator. | High to medium |
| Motivational communication | Understanding that the way you communicate can increase or decrease a person's desire to change. | Medium |
| Presentation skills | Gaining practical experience of presenting sessions and being evaluated by peers. | High |
| Community audit | Understanding the challenges and opportunities for community outreach in your geographical area. | High |
| Year planner | Incorporating the agents of change into the youth group's year plan. | High to medium |
| Stakeholder analysis | Understanding the different stakeholders affected by the agents of change programme. | Medium |
| Monitoring and evaluation | Learning how to use the M&E system and understanding its importance. | Low |

### 7.3.1.4. Lessons learned

In the following section the lessons learned are described. These were also based on the evaluations from trainings, and reports from facilitators and steering group members. Insights from the focus group discussions held with the external evaluator CORDAID are also included.

#### 7.3.1.4(i) Balance between training and fun

There was a lot to be learnt over a three day period. Because the young people stayed up so late the first night, many were very tired the next day which limited the learning opportunity. At one camp a group of girls left after the first day because the camp was too demanding. They had been expecting to only be having fun. The length of sessions was sometimes a problem because there was a lot to learn, but limited time. There was a need to prioritise what were the key goals so they could be addressed while the young people were still fresh. The events should not be publicised as a camp, but as peer education training. A problem arises when the programme is presented to the church by a youth leader and not one of the Fikelela team, because it is often presented as just a fun event.

#### 7.3.1.4(ii) Camp leaders as role models

There were a few problems that arose regarding the camp leaders as role models. Camp leaders were a mixture of Fikelela staff and Diocesan youth leaders. In particular there was a problem with camp leaders smoking in front of the youth; this caused quite a few complaints from other leaders. One leader brought alcohol to the camp, which was a big problem.

#### 7.3.1.4(iii) Budget

Since the camp was sponsored by Fikelela, it was done on a tight budget with cheap accommodation and budget food. This did affect the effectiveness of the programme as the caterers were volunteers and their time keeping was erratic. The rooms were not always ideal for the training to take place in. Sometimes there was a lack of break away rooms, and the training rooms were often crowded. The local church or Diocese involved should contribute funding to the camp in order to increase buy-in and ownership.

#### 7.3.1.4(iv) Social Interaction

In some cases it was difficult for the young people to mix. Some of the young people were happier in Afrikaans and some in Xhosa, so they tended to stick to their language groups. At one camp the youth from Xhosa speaking churches all came late so ended up in the last dormitory together. The youth from rural areas tended to be quieter, for many of them they had not been on a camp before, and they were not so used to mixing as youth from Cape Town.

#### 7.3.1.4(v) Drop out

Because the camp was free, a negative was that we had last minute cancellations by some churches, because they had not paid a deposit. The training camps were also held early in January, so some of the young people who signed up in December to attend, were not back from their holidays in January. Church offices were shut and youth were not meeting during

the holiday, so it made it difficult to contact them to confirm attendance. It was a particular problem in the case of the churches where facilitators dropped out, since there were only two per church to start off with. So in a couple of cases those churches were left with no trained facilitators at all.

#### 7.3.1.4(vi) Worship

Worship was important as part of the 'change process'. It gave the young people a sense of being part of a community, called by God to do this work. In the commissioning, they were blessed to become agents of change. The prayer ministry that took place was also an important time of healing for many of the youth, who had been touched by the issues that the camp was dealing with.

#### 7.3.1.4(vii) Discipline

It was important to have rules that were clearly understood by all. These rules needed to be agreed to by all participants at the beginning. Cell phones could become a barrier to young people bonding, for example, if they sat on Mxit all the time. Another important rule was regarding other sexes coming into dormitories. Time keeping was often a problem and led to sessions starting or finishing late – which led to a loss of productivity in the training.

#### 7.3.1.4(viii) Unexpected changes

Occasionally there was a clash with other activities which meant that people had to leave early – for example the Sunday of one camp was on Mother's day. Sometimes those who had been elected as peer educators were not able to attend, and facilitators filled the gaps with other young people at the last minute. This meant that those attending did not really know what the programme was all about.

## 7.3.2. STRATEGY TWO: QUARTERLY GATHERINGS

The second strategy to be assessed is that of the quarterly gatherings. Firstly a description of the activities is given, then the outputs listed and the effectiveness evaluated, and finally the lessons learnt are listed.

### 7.3.2.1. Description of activities

A gathering was held once a quarter with the peer educators and facilitators. The primary goal of the gatherings was to share lessons learnt, and encourage the churches. It was an opportunity for monitoring and evaluation to take place. The following four activities took place as listed in Table 7.4:

**Table 7.4: Activities taking place at the quarterly gatherings**

| | |
|---|---|
| First gathering | Reunion from camp, monitoring and evaluation, voluntary counselling and testing |
| Second gathering | Team building exercise, climbing Table Mountain, monitoring and evaluation, |
| Third gathering | Monitoring and evaluation, social activities at the beach |
| Final gathering | End of year celebration, and certification for those who successfully completed the year. |

### 7.3.2.2. Outputs

The outputs of the quarterly gatherings are listed in Table 7.5:

**Table 7.5: Outputs of quarterly gatherings**

| | Session One | Session Two | Session Three | Session Four |
|---|---|---|---|---|
| YEAR ONE | 18 churches, 92 people | 14 churches, 81 people | 9 churches, 37 people | 24 churches, 140 people |
| YEAR TWO | 20 churches 87 people | 12 churches, 69 people | 10 churches, 45 people | 19 churches ,134 people |

The quarterly gatherings were reasonably well attended, as noted by the CORDAID evaluation:

"*This is attended by approximately 60% of the peer educators and facilitators"*

### 7.3.2.3. Effectiveness

The effectiveness of the quarterly gathering was assessed from evaluation forms and feedback from the steering committee meetings. The findings are listed in Table 7.6:

**Table 7.6: Effectiveness of the quarterly gatherings**

| MEETING | KEY LEARNING | EFFECTIVENESS | REASONS |
|---|---|---|---|
| First | • Voluntary counselling and testing<br>• Sharing of lessons learnt<br>• Encouragement for those struggling | High<br>High<br>High | 90% tested<br>Full participation<br>Positive feedback and new ideas |
| Second | • Team building<br>• Sharing of lessons learned | High<br>Low | Positive participation<br>The focus was different |
| Third | • Sharing of lessons learned<br>• Social gathering | Low<br>High | Poor attendance<br>Those in attendance enjoyed it |
| Fourth | • Certification<br>• Social gathering | High<br>High | High attendance<br>Wonderful affirmation |

#### 7.3.2.4. Lessons learned

The following issues were identified at the quarterly gatherings as issues which affected the Agents of Change programme.

#### 7.3.2.4(i) Clashes with other activities

Because the programme was run with churches from three Dioceses, it was often difficult to find a date that did not clash with other youth activities: parish, archdeaconry or Diocesan. This led to the non-attendance of several churches. For individual peer educators, there were many reasons for not being able to attend, the most common being sport, or studies. The weather also was a problem, when activities were planned at the beach or the mountain.

#### 7.3.2.4(ii) Emphasis on monitoring and evaluation

A priority for Fikelela was the monitoring and evaluation, to receive the feedback from parishes and to also help those who were struggling. This was hampered for various reasons. Firstly the churches that were struggling with the programme tended to be the first to drop out of attending these gatherings. Secondly there was often a resistance to filling in the forms and information that was required, as this was seen to be a boring part of the day. The sharing verbally was much more enthusiastically received, but this could also be a problem due to the number of churches, since there was not enough time for all to share. Additional training on monitoring and evaluation should be included in the quarterly gatherings.

#### 7.3.2.4(iii) Adaptation of the manual

Feedback received at the quarterly gatherings enabled Fikelela to adapt the manual quite substantially, incorporating suggestions such as the need for a devotion at the start of the session, so that it was seen within the faith context, and icebreakers that were on the theme of the session, as well as the inclusion of new materials on issues such as gender and rape.

#### 7.3.2.4(iv) Church issues

It emerged very clearly at the quarterly gatherings that many of the difficulties being experienced were because of internal church issues. Some of the churches had several youth organisations, so there was confusion over where the programme would be run. Sometimes the other organisations perceived Agents of Change as a new organisation rather than a programme, so felt threatened by it. There could be jealousy if people started attended Agents of Change and left other organisations.

### 7.3.2.4(v) Socio-economic issues

This could be a serious hindrance to the programme. The communities where the need was the greatest were also the areas where it was more difficult to gather youth. This was due to various factors: some churches hired a hall for Sunday services, so had no venue for mid-week meetings. Others had issues of safety. It was difficult for youth to meet in the evenings, so they would meet after church, but by the time it came to run the programme the youth often wanted to go home because they had been in church for long already. Few members had access to transport so they were more impacted by poor weather. There was also an issue of communication with Fikelela, due to the lack of emails or fax machines in these churches. On the positive side – in these areas there were very few other activities available, so the excitement of this programme was a big draw-card and some of the poorer churches had a huge success. Another problem for the churches from a lower socio-economic background was the lack of access to emails or faxes. The recommendation was that they find someone from the church not necessarily the facilitator who could help them by receiving communication.

At the other end of the spectrum, the upper-income churches also struggled to run the programme successfully. This was due mainly to two reasons – the youth were getting very good life-skills programmes at their schools, so did not find the programme challenging. Secondly the youth in these churches were used to doing more entertaining things on a Friday such as outings. However this group was not of such a great concern since they were accessing good life-skills programmes at school.

### 7.3.2.4(vi) Cultural

Although the HIV rates are the highest in the Xhosa-speaking churches, these were the parishes where it was most difficult to get the programme running. More effort needed to be put into actively recruiting and supporting these churches. Some of the problems were cultural – the idea of 'youth' means anyone between 12-32 years of age. In other churches there was a clear sense of where Agents of Change would fit – in the teenage youth group, but in the Xhosa parishes this was difficult and sometimes a separate teenage group had to be formed. The Xhosa-speaking priests often demonstrated a non-democratic leadership style, so they would just appoint people facilitators or peer educators. They were not too keen on the youth electing their own peer educators. Often those selected in this way did not really know what they were being chosen to do. Another issue was the high priority given to funerals in the Xhosa community. Often those selected could not attend a camp or quarterly gathering because of a funeral, or agents of change sessions were cancelled frequently because of prayer meetings for the bereaved. There were also issues of time keeping and lack of attendance, when Diocesan Youth Workers or Fikelela staff set up meetings. Some training should be included in the quarterly gatherings on time management and planning.

### 7.3.2.4(vii) Church calendar

In certain churches, youth activities were suspended during Lent. Generally there was a sense in the churches that youth events were seen to have lower priority than parish events. So if there was a clash in terms of venue, the youth event would be the first to be cancelled. If another organisation was holding a fund-raising event, the expectation was that youth would be cancelled so that they could help work at the event.

### 7.3.2.4(viii) Priests

There were particular problems with certain categories of churches. If there was no priest (inter-regnum) it meant the church would only have a priest coming on a Sunday to take services. This meant that the programme was presented and the peer educators elected with no priest involvement. Once the new priest started, there was often limited buy-in because they had not been involved. It was recommended that the programme should not be run during an inter-regnum, but rather wait until the new priest was appointed.

If there was a non-stipendiary priest (self-supporting) it also could be a problem, because he or she had a fulltime job outside of the parish, so was not available for meetings or events mid-week. If there were relationship problems that arose, they would not have time to become involved at that level. It could also be an issue if the church was being run by a retired priest, because they sometimes did not have the energy to put into supporting the programme. They were often more conservative than younger priests, and did not feel too happy with youngsters presenting sessions on sex. In the case of a changeover from one priest to another there were often problems as well because the previous priest might have been very supportive and the new one had other priorities. It was important to try to set up meetings with the priest so that they really understood and supported the programme.

### 7.3.2.4(ix) Importance of being part of a bigger body

For many of the peer educators, the chance to meet up with friends from camp was important. The sense of being part of a bigger body, or a ‘movement’ was a crucial factor for many. There was also an important sense of breaking down cultural or racial barriers, which some of the young people do not have the opportunity to experience if their schools are only one culture.

### 7.3.2.4(x) Sharing of new materials

One of the most helpful things to take place at the quarterly gatherings was the sharing of information and ideas. Very creative ideas could then be incorporated on a parish level – which helped the churches to really take ownership of the programme. At one camp a church had given two youngsters dolls to look after and then proceeded to wake them every three hours 'for a feed' and disturb their meal times and not allow them to take part in

sporting activities! This was one example of a creative way of teaching the youth about the consequences of teenage pregnancy that was copied by several other churches.

#### 7.3.2.4(xi) Importance of affirmation

The best attendance was for the final certification day. This sense of achievement, and of having successful completed a programme was important for the young people. There was a high enthusiasm level to be felt on the day and agents travelled from far distances to be there. This was also a good opportunity to recruit new people for the following year. This event could be upgraded to become a real highlight for the young people in their lives.

The peer educators and facilitators also felt very encouraged by the affirmation that they had received from Bishops and other authority figures: the Bishop of False Bay mentioned the programme at his enthronement, at the blessing of the Diocesan office and at the launch of the Anglican Youth Fellowship. He also visited several churches, even inviting some of the peer educators for supper at the Spur in order to hear about the programme.

#### 7.3.2.4(xii) Voluntary counselling and testing

This session was very effective, because it was done in a big group, whereas VCT had not been very successful in the church setting. There is still a lot of stigma attached to testing (only those who feel at risk go for tests), but if the larger group is testing, then it is easier to test as part of a peer group. It was also helpful to form a partnership with Life Choices, who are geared at working with teenagers in schools, rather than encouraging the young people to go and test at clinics, where they experienced some judgmentalism. VCT was also more effective if the leaders, whether clergy or facilitators, were seen to be testing as well. This also reduced the stigma attached. It was recommended that the VCT should take place at the quarterly gathering but that the peer educators should be trained and encouraged to then run VCT as part of their programme at the local level.

#### 7.3.2.4(xiii) Use of materials

Several of the churches were very creative – for instance they changed the order of the sessions around to coincide with events: e.g. 'Love, sex and reasons' to take place close to Valentine's Day, or the HIV session to be close to the Candlelight memorial day. However sometimes the flexibility led to problems, where for instance some churches decided to do 'marathon sessions' where they did three sessions in one go on a Saturday, which did not allow the young people time to internalise their learning. So there was a need for a balance between flexibility in the use of the materials and an understanding of how people learn.

#### 7.3.2.4(xiv) Gender

It became clear that one of the key issues that were important in dating relationships was that of gender. For this reason a workshop was held with peer educators to develop and

adapt the sessions on gender. It was also important that there should be a balance of female and male peer educators.

#### 7.3.2.4(xv) After-care

It became clear that the majority of sexual activity was taking place in the afternoons, after school and before the parents come home. The importance of churches running some kind of after-school support programme became clear.

#### 7.3.2.4(xvi) Counselling

A frequent issue raised by the facilitators was the need for support in the area of counselling, when they have young people who are struggling with serious issues such as substance abuse or depression.

#### 7.3.2.4(xvii) Social outreach

The churches which were involved in social outreach indicated that this had many benefits; the young people bonded and gained a sense of pride in helping their community. They also learned first-hand about some of the issues that the community faced such as orphans or drug abuse.

#### 7.3.2.4(xviii) Selection of peer educators

It was important that the peer educators be elected by their peers and not selected by clergy or youth leaders as had occurred in some cases. The recommendation was that they should be over sixteen because younger peer educators struggled with discipline of the group. It was also decided that matric students should be avoided if possible because the work load was too high and parents often complained about them spending too much time on the programme.

#### 7.3.2.4(xix) HIV prevention

Many of the young people expressed boredom (‘AIDS fatigue’) with the topic of HIV. It was recommended that the programme should be presented as a youth development programme rather than an HIV prevention programme.

#### 7.3.2.4(xx) Younger age group

It was recognised that it would be easier to impact the younger age group in terms of abstaining. Once young people are already sexually active it is very difficult to stop.

## 7.3.3. STRATEGY THREE: PARENTING WORKSHOPS

In this section the third strategy, parenting workshops, is assessed, starting with a description of the activities, and then the outputs and effectiveness.

### 7.3.3.1. Description of activities

The parenting workshop consisted of a three-session training programme. The following areas were covered:

- Understanding the challenges faced by teenagers.
- The importance of talking about sex.
- How to listen.

The proposed strategy was that the facilitators would set up the dates for the parenting workshops, and parents would be invited by the youth attending the youth group. This was not a successful strategy because very few of the churches set up dates. Then Fikelela started to phone around the churches requesting dates from them, but the uptake was very poor. This was perceived as part of the programme which was top-down (requested from Fikelela), whereas the peer education was empowering the youth.

Because of poor attendance, the following strategies were attempted:

- Sermon in church, followed by discussion afterwards.
- Joint workshops with the Catholic Church.
- Encouraging parents to attend workshops run by the Parenting Centre.
- A lecture on parenting during Education Week.
- Presentation to parents of confirmation candidates.

### 7.3.3.2. Outputs and effectiveness

The outputs and effectiveness of the parenting workshops are assessed in Table 7.7:

**Table 7.7: Outputs and effectiveness of the parenting workshops**

| STRATEGY | YEAR ONE OUTPUTS | YEAR TWO OUTPUTS | EFFECTIVENESS |
|---|---|---|---|
| Parenting workshops | 7 churches<br>89 people | 5 churches<br>71 people | For those parents who attended, they found it a very helpful time, as well as a chance to link with other parents with similar problems. |
| Sermon followed by discussion | 9 churches<br>1200 people at sermon | 8 churches<br>1100 people at sermon | This was a very effective way to reach a large number of parents with a basic message. Those who stayed found it helpful, but |

| STRATEGY | YEAR ONE OUTPUTS | YEAR TWO OUTPUTS | EFFECTIVENESS |
|---|---|---|---|
| | 72 people at discussion | 69 people at discussion | not many stayed and the time available was short because they were tired after church. |
| Joint workshops with the Catholic church | n/a | 1 church<br><br>9 people | Since the Catholic church was running sessions any way, we hoped that several churches would attend, but only one did. The sessions were greatly appreciated. |
| Attending sessions run by the Parent centre | n/a | 2 churches<br><br>27 people | These six sessions were professionally done. Very good feedback from parents |
| Parenting lecture | n/a | 1 church<br><br>70 people | This was effective in terms of numbers, but it was one way communication and there was only space for theory not practice. |
| Presentation to parents of confirmation candidates | n/a | 1 church<br><br>80 people | Effective in terms of numbers, but it was compulsory for parents to be there, so the interaction was very poor. |

### 7.3.3.3. Lessons learned

At the steering committee meetings, reflection took place regarding the lack of effectiveness of the parenting workshops. The following lessons were learned:

### 7.3.3.3(i) Socio-economic differences

Generally there was only attendance at the parenting courses by middle-income churches. There was a good turnout at the course run by the Parenting Centre, and the majority of parents attended for the full six weeks. The Education Week was also held at a middle-income church and attendance was high. At the rest of the churches, attendance was very poor. The reasons for this are not clear, but it was also noted that parents show poor attendance at school meetings as well. It could be that middle-income parents have better access to transport, so it is easier to attend a session in the evening during the week. They also are more likely to have domestic help, so perhaps do not have to come back from work and do so many domestic chores. It is also possible that since they do not come home on public transport from work, they arrive home earlier, so it is more feasible to attend such sessions.

The only lower-income church where parenting workshops were a success was in Atlantis, where the community is small and parents stayed close to the church. So transport was not such a problem.

#### 7.3.3.3(ii) Role of facilitators

The planned strategy was that facilitators would advertise and set up the dates for parenting workshops, and generally speaking this did not happen. This could be because they were perceived to be the leaders of the youth, and this new role encroached onto other people's territory. Another possibility is that there was no buy-in for this parenting programme from the facilitators. Running Agents of Change was perceived to be incorporating a new programme into their own structure, whereas running parenting workshops seemed to be something Fikelela wanted to do. In one case where there was an extremely enthusiastic facilitator, who was also a parent, the session was well planned and enthusiastically supported.

#### 7.3.3.3(iii) Support versus training

It appeared that when parents were struggling with issues related to their adolescent children, what they were searching for was support, rather than training. A natural support system formed with parents dropping youth off at church and then discussing issues. When a parent is in a crisis situation, they look for counselling, not skills training. This programme, whose goal focuses on prevention, does not seem to fit the felt needs of parents. Overall the programme was not successful, as indicated in the CORDAID evaluation:

"*It was intended to involve parents and other adults in the programme by means of special workshops. This appeared not to be successful. In general this aim is not yet reached as it was envisioned."*

## 7.3.4. CONCLUSION AND REQUIRED PROGRAMME FOLLOW UP

In this final section conclusions are made regarding the strategies and required follow up is suggested**.**

#### 7.3.4.1. The training camp

The training camp is an indispensable part of the programme. It is where the peer educators and facilitators learn what their role is, where the team begins to bond, and where the foundational motivation for behaviour change is imparted.

The training programme covered most of the needs of the peer educators and facilitators. There was a need to pay more attention to structuring in activities that will help the members of different churches, in particular those from different cultural backgrounds, to mix and bond. There also needs to be more thorough in screening the camp leaders, so that they are people who can be real role models to the trainee peer educators. The programme also needs to be adapted; taking into account the fact that very little sleep is had the first night! Therefore the theory should all be covered as much as possible the first day, and the second and third days should be more practical.

### 7.3.4.2. The quarterly gatherings

The quarterly gatherings are a vital part of the programme, both for encouraging the churches that are struggling, for giving further information and resources, and for social bonding. The issue of financial support for the parishes which cannot afford transport needs to be assessed in order to improve attendance. Additional gatherings for facilitators to meet on their own need to be planned. This is in order for the facilitators to be able to support one another and also for them to be able to discuss issues of a more sensitive nature (such as church politics) without the youth present. The issues raised about gender were incorporated into the adaptation of the manual, but this issue needs to be consistently prioritised. Information and suggestions from the quarterly gatherings should be included in the adaptation of the manual on an ongoing basis.

There were other areas that needed to be followed up, in particular after-care programmes and counselling. However these issues are not dealt with by Agents of Change. The need for counselling is being dealt with at a Diocesan level, with Diocesan lay counsellors being trained, and the after-care option is being discussed and implemented at a parish level.

The final certification is an important event and as much effort as possible should be put into creating a sense of pride, for this event to be a highlight in the young people's lives.

There is a need to look at more effective strategies to convey the learnings from the quarterly gatherings to the churches that do not attend; a written description of new and creative ideas does not have as much impact as hearing it firsthand! It is also important to feedback some of the learnings from the quarterly gatherings to new peer educators and facilitators as they start the programme at the beginning of the year.

The importance of understanding the internal church politics was obvious. In the case of churches where there is no priest, or retired or non-stipendiary priest, it would be crucial to get the full support of church wardens for the programme.

The feedback from the quarterly gatherings highlighted the importance of targeting the lower socio-economic churches and Xhosa-speaking churches, to discover and overcome the barriers.

### 7.3.4.3. The parenting workshops

This was a very important part of the programme. However, Fikelela has not yet managed to find a model which the parents are willing or able to attend in numbers. For this reason, this part of the programme was the weakest. Some suggestions that are possibilities to pursue are those of support groups for parents with identified serious issues with their teenagers, such as substance abuse. A support group grows naturally out of a felt need, whereas a workshop is perceived to be giving skills rather than support.

# CHAPTER EIGHT: FINDINGS FROM THE QUASI-EXPERIMENTAL EVALUATION

This chapter consists of five sections. Firstly general information about the study population at baseline is presented, followed by a comparison of males and females. Next religiosity at baseline is presented. A comparison of intervention and control groups follows, in order to screen for potential confounding factors. The final section presents the results of the comparison between intervention and control groups before and after the intervention.

## 8.1. GENERAL INFORMATION ABOUT THE STUDY POPULATION AT BASELINE

This first section presents general information about the study population. Forty-six churches took part in the study and a total of 1352 questionnaires were completed. The denominator varies in some categories because not all respondents filled in all the questions. The questionnaires were completed by 562 (41.5%) males and 790 (58.4%) females. The majority, 1156 (88.6%), were from urban areas and only 148 (11.3%) were from rural areas. Most of the participants (1109 (88.2%)) attended sessions on life orientation at school and 546 (43.5%) of the young people had also attended some sessions at school involving peer education. In terms of demographics, the great majority of participants were coloured, which is reflective of the Anglican population in Cape Town. In terms of religion, a number of Muslims do attend youth groups at Anglican Churches. Further general information on the participants is given in Table 8.1:

**Table 8.1: General information of participants at baseline**

| Category | Sub-category | Number (%) |
|---|---|---|
| **Race (N=1348)** | Black | 97(7.2) |
| | Coloured | 1217(90.3) |
| | White | 30(2.2) |
| | Asian/Indian | 4(0.3) |
| **Parent or guardian (N=1303)** | Both parents | 823 (63.2) |
| | One parent | 400 (30.7) |
| | Another relative | 69 (5.3) |
| | A friend | 10 (0.7) |
| | Alone | 2 (0.1) |
| **School (N= 1287)** | Local government school | 857 (66.6) |
| | Former “Model C” school[25] | 332 (25.8) |
| | Independent school | 31 (2.4) |
| | College/Varsity | 44 (3.4) |
| | Working | 6 (0.7) |
| | Finished school | 20 (1.6) |
| **Religion (N= 1345)** | Anglican | 1261 (93.8) |

[25] Model C schools are formerly white schools, open to all races, which tend to have better facilities than township schools. Although they are in the public sector they charge additional tuition fees.

| | | |
|---|---|---|
| | Other Christian | 73 (5.4) |
| | Muslim | 11 (0.8) |
| | Other | 1 (0.1) |

In terms of the age range by gender, the great majority of participants were in the range 14-16 years (62.3% of males and 71.9% of females). This is the age at which young people are confirmed in the Anglican Church and there tends to be a drop-off after confirmation. The mean age of males was 15.6 years (Confidence Interval (CI) 15.4-15.6) and females 15.4 years (CI 15.3-15.5) and there was no significant difference (p=0.46). This is illustrated in Figure 8.1 below:

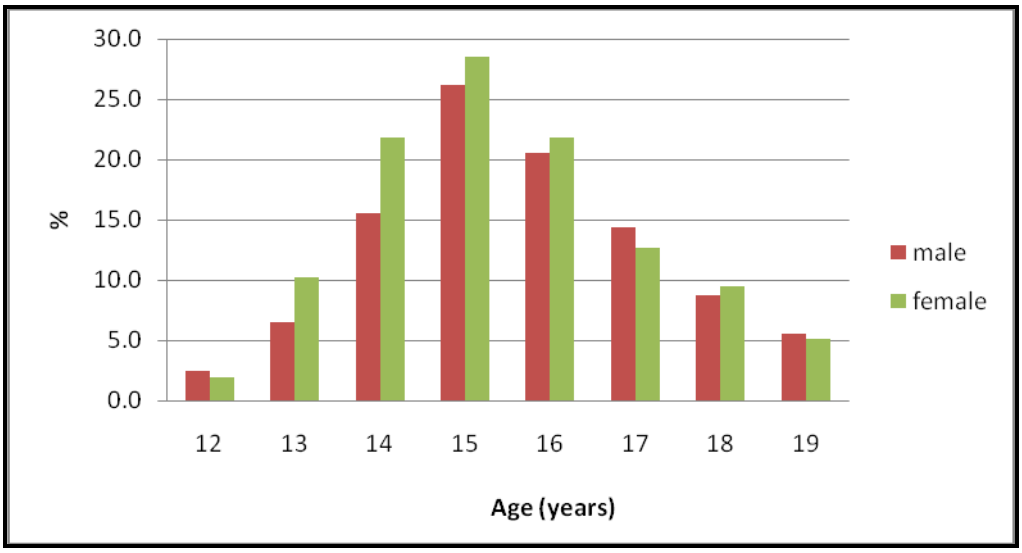


***Figure 8.1: Age range of participants by gender at baseline***

## 8.2. COMPARISON OF MALES AND FEMALES AT BASELINE

In this second section the baseline data for males and females is compared. The first three questions were posed to establish levels of self-esteem: 'Do you feel that you are as important as other people?', 'Do you have goals and believe that you can reach them?', and 'Can you stand up for your beliefs even if your friends believe something different?' The answers were recorded as 'never, sometimes, often or always'. No significant differences were recorded between male and female. However, the answer 'never' scored close to significant with each question, with the males scoring higher than females, implying a trend to lower self-esteem. The findings are recorded in Table 8.2:

**Table 8.2: Comparison of self-esteem between males and females at baseline**

| | **All N= 1342 n (%)** | **Male N= 556 n (%)** | **Female N= 786 n (%)** | **P value** |
|---|---|---|---|---|
| **Do you feel that you are as important as other people?** | | | | |
| Never | 83 (6.2) | 42 (7.6) | 40 (5.1) | 0.065 |
| Sometimes | 470 (34.9) | 188(33.8) | 280 (35.6) | 0.492 |
| Often | 243 (18.0) | 101 (18.2) | 141 (17.9) | 0.915 |
| Always | 550 (40.0) | 225 (40.5) | 325 (41.4) | 0.746 |

| | | | | |
|---|---|---|---|---|
| **Do you have goals and believe that you can reach them?** | | | | |
| Never | 27 (2.0) | 15 (2.7) | 10(1.3) | 0.059 |
| Sometimes | 275 (20.4) | 105 (18.9) | 169 (21.5) | 0.249 |
| Often | 292 (21.7) | 120(21.6) | 172 (21.8) | 0.915 |
| Always | 753 (55.9) | 316 (56.8) | 436 (55.3) | 0.584 |
| **Can you stand up for your beliefs even if your friends believe in something different?** | | | | |
| Never | 25 (1.9) | 15 (2.7) | 10 (1.3) | 0.060 |
| Sometimes | 261 (19.3) | 110 (19.7) | 150 (19.0) | 0.756 |
| Often | 270 (20.0) | 115 (20.6) | 154 (19.5) | 0.630 |
| Always | 793 (58.8) | 318 (57.0) | 474 (60.2) | 0.245 |

A comparison was made between sexual beliefs held by males and females at baseline. The majority of youth showed a good degree of knowledge and empowerment at baseline. Three of the categories (listed in Table 8.3) showed significant differences by gender: 'A person has to have sex to show love', 'Girls do not have the right to refuse sex with their boyfriends' and 'Girls mean 'yes' when they say 'no' to sex'. With all these statements the males agreed significantly more than the females ($p<0.05$). In the category 'Anal sex is really sex' there was no significant difference between those who said yes, the main difference was in those who were not sure. These findings are recorded in Table 8.3 below.

**Table 8.3: Agreement with sexual beliefs amongst males and females at baseline**

| | **All N= 1339 n(%)** | **Male N= 557 n (%)** | | **Female N=782 n (%)** | | **p value** |
|---|---|---|---|---|---|---|
| **Oral sex is really sex** | 399(29.7) | Yes | 169(30.3) | Yes | 229(29.3) | 0.085 |
| | | Not sure | 116(20.8) | Not sure | 203(26.0) | |
| | | No | 272(48.8) | No | 350(44.8) | |
| **Anal sex is really sex** | 640(47.9) | Yes | 275(49.4) | Yes | 364(46.9) | <0.01 |
| | | Not sure | 123(22.1) | Not sure | 238(30.6) | |
| | | No | 159(28.6) | No | 175(22.5) | |
| **A person has to have sex to show love** | 147(10.9) | Yes | 87(15.6) | Yes | 60 (7.6) | <0.01 |
| | | Not sure | 36(6.5) | Not sure | 40(5.1) | |
| | | No | 435(78.0) | No | 685(87.2) | |
| **It is rape if you are physically forced to have sex without consent** | 1210(90.0) | Yes | 493(88.2) | Yes | 715(91.4) | 0.109 |
| | | Not sure | 27(4.8) | Not sure | 32(4.1) | |
| | | No | 39(4.5) | No | 35(4.5) | |
| **Girls do not have the right to refuse sex with their boyfriends** | 126(9.4) | Yes | 65(11.7) | Yes | 61 (7.8) | <0.01 |
| | | Not sure | 39(7.0) | Not sure | 40(5.1) | |
| | | No | 450(81.2) | No | 682(87.1) | |
| **Girls mean 'yes' when they say 'no' to sex** | 109(8.1) | Yes | 62(11.2) | Yes | 47(6.0) | <0.01 |
| | | Not sure | 93(16.7) | Not sure | 65(8.3) | |
| | | No | 400(72.1) | No | 669(85.7) | |

When sexual behaviour was compared by gender, there were significant differences in each category: ever had sex, vaginal sex, oral sex, anal sex and sex in the preceding year

(p<0.05). In each case the males scored significantly higher than the females. The findings are recorded in Table 8.4.

**Table 8.4: Sexual behaviour by gender at baseline**

| | All N= 1346 n (%) | Male N= 559 n (%) | Female N=786 n (%) | p value |
|---|---|---|---|---|
| **Ever had sex** | 268(19.8) | 146 (26.1) | 122(15.5) | <0.01 |
| **Ever had vaginal sex** | 240 (17.8) | 130 (23.4) | 110(14.1) | <0.01 |
| **Ever had oral sex** | 155(11.5) | 91(16.4) | 64(8.2) | <0.01 |
| **Ever had anal sex** | 49(3.6) | 41(7.4) | 8(1.0) | <0.01 |
| **Had sex in preceding year** | 239(17.9) | 135(24.3) | 104(13.3) | <0.01 |

In terms of number of partners in the last year, the mean for males was 2.7 (CI 2.3-3.3) and for females 1.8 (CI 1.4-2.4), which was significantly different (p<0.01) as indicated in Figure 8.2 below.

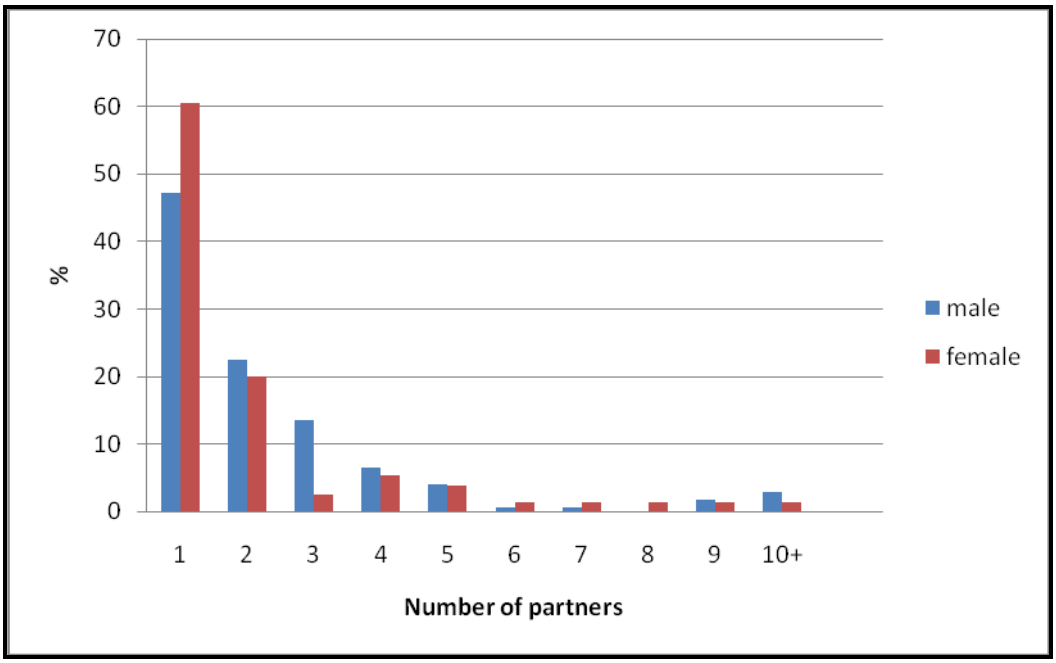


***Figure 8.2: Number of sexual partners in the past year in the sexually active at baseline (N = 246, M=138, F= 108)***

When analysing condom use, four categories of response were used (never, sometimes, frequently and always). The only category where there was a significant difference was 'always' where 17.1% of the males and only 9.1% of the females used condoms consistently (p<0.05). Significantly more males than females had sex under the influence of drugs or alcohol. Both coercive sex and 'persuasive' sex showed were significantly more likely in males. These results are shown in Table 8.5:

**Table 8.5. Sexual activity: condom use, sex under the influence, coercive and persuasive sex at baseline**

| Variable | All N =1270 n (%) | Male N=532 n(%) | Female N=738 n(%) | P value |
|---|---|---|---|---|
| **Condom use** | | | | |
| Never | 69(5.4) | 36(6.8) | 33(4.5) | 0.08 |
| Sometimes | 34(2.6) | 16(3.0) | 18(2.4) | 0.54 |
| Frequently | 23(1.8) | 13(2.4) | 10(1.4) | 0.16 |
| Always | 158(12.4) | 91(17.1) | 67(9.1) | <0.01 |
| Haven't had sex last year | 985 (77.8) | 376(71.1) | 609(82.6) | <0.01 |
| **Sex under the influence of drugs** | 22 (1.7) | 18(3.4) | 4(0.6) | <0.01 |
| **Sex under the influence of alcohol** | 84(6.6) | 54(10.1) | 30(4.1) | <0.01 |
| **Had sex to 'get something'** | 13(1) | 9(1.7) | 4(0.5) | <0.01 |
| **Forced someone to have sex** | 11(0.8) | 11(2.0) | 0(0.0) | <0.01 |
| **'Sweet talked' someone into having sex** | 126(9.6) | 109(20.0) | 17(2.2) | <0.01 |

There were significant gender differences in terms of mean age of first sexual activity (p<0.01). The mean age of debut for males was 13.8 years (CI 13.4-14.1) and females 14.8 years (CI 14.4-15.2) and the distribution is shown in Figure 8.3.

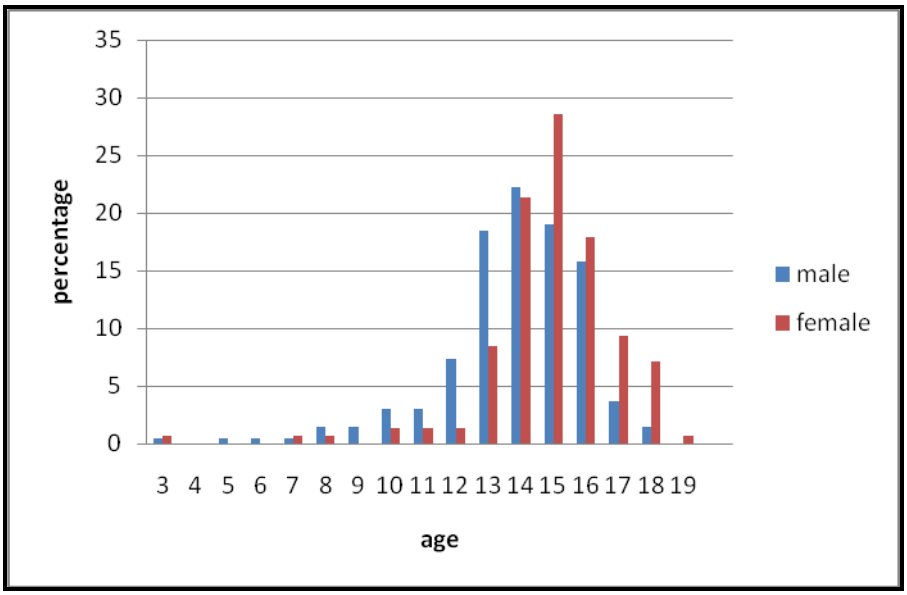


***Figure 8.3: Age of first sex at baseline (N = 330; M= 185, F= 145)***

In terms of communicating about sex, there were significant differences, with females more likely to have ever spoken to a parent (p<0.01) or a friend about sex (p<0.038) (see Table 8.6). Males are more likely to have spoken to a sibling. A much lower percentage of youth

had spoken to a church leader than to relatives or friends. Overall friends were the most likely group of people that youth would talk to about sex.

**Table 8.6. Communicating about sex at baseline**

| | All N= 1331 n(%) | Male N= 552 n(%) | Female N=779 n(%) | p value |
|---|---|---|---|---|
| **Ever spoken to your parents about sex** | 851(63.8) | 324(58.7) | 526(63.8) | <0.01 |
| **Feeling about speaking to parents** | | | | |
| Very uncomfortable | 355(27.2) | 147(27.7) | 207(26.9) | 0.760 |
| Uncomfortable | 509(39.1) | 196(36.9) | 311(40.4) | 0.199 |
| Comfortable | 439(33.7) | 188(35.4) | 251(32.7) | 0.300 |
| **Who have you spoken to?** | | | | |
| Parent | 581(45.1) | 222(42.1) | 357(47.0) | 0.076 |
| Brother/sister | 212(16.4) | 103(19.5) | 109(14.4) | 0.014 |
| Other relative | 247(19.2) | 101(19.1) | 146(19.2) | 0.962 |
| Church leader | 91(7.1) | 34(6.5) | 56(7.4) | 0.514 |
| Friend | 925(71.8) | 363(68.8) | 256(74.0) | 0.038 |

In terms of medical reponses to sexual activity, there was a significant difference between males and females who had noted a discharge from the vagina or penis ($p<0.01$). However this result (a significantly higher number amongst females) is probably misleading since not every vaginal discharge is a sexually transmitted infection. A significantly higher number of males had gone for voluntary counselling and testing for HIV than females ($p=0.025$). These figures are indicated in Table 8.7 below.

**Table 8.7: Responses to sexual activity at baseline**

| | All N= 1269 n(%) | Male N= 526 n(%) | Female N=743 n(%) | p value |
|---|---|---|---|---|
| **Reported have a genital ulcer** | 34(2.7) | 18(3.4) | 15(2.0) | 0.125 |
| **Reported a discharge from vagina or penis** | 272(21.4) | 59(11.3) | 213(28.5) | <0.01 |
| **Gone to clinic with STI** | 9(0.7) | 4(0.74) | 5(0.65) | 0.846 |
| **Gone for VCT** | 136(10.3) | 68(12.5) | 68(9.15) | 0.025 |

Under the section in the questionnaire looking at involvement in community service, a question was asked whether participants had taken any action regarding negative sexual messages in the media as well as a question concerning involvement in voluntary community projects. Over a third indicated that they had done something about these messages, which shows an awareness of the problem. There was a significant difference between males and female ($p=0.47$). Just over a quarter were involved in some kind of voluntary community service. There was no significant difference between males and females. These figures are indicated in Table 8.8 below.

**Table 8.8 Involvement in advocacy and community service at baseline**

| | All N= 1325 n(%) | Male N= 549 n(%) | Female N= 776 n(%) | p value |
|---|---|---|---|---|
| **Done anything about negative sexual messages in the media** | 461(34.7) | 184(33.5) | 275(35.4) | 0.468 |
| **Involved in community service** | 371(28.0) | 154(28.1) | 216(28.0) | 0.977 |

## 8.3. RELIGIOSITY AT BASELINE

Additional questions regarding religiosity were added to the questionnaire in year two. For this reason only 343 respondents filled in this question which looks at church attendance, importance of faith, and when it is considered acceptable to have sex (belief in 'no sex before marriage'). There were no differences in the way this sample was selected. There was no difference by gender for church attendance or importance of faith. The only significant differences by gender were in terms of when it is acceptable to have sex. Significantly more females than males felt that it was only 'ok' to have sex when you are married ($p<0.01$). Significantly more males felt that it is 'ok' when you are planning to get married ($p<0.01$). These figures are indicated in Table 8.9 below:

**Table 8.9: Religiosity and sexuality at baseline**

| Variable | All N= 343 n(%) | Male N= 130 n(%) | Female N= 213 n(%) | p value |
|---|---|---|---|---|
| **Frequency of church attendance** | | | | |
| Once a month | 14(4.1) | 6(4.6) | 8(3.8) | 0.698 |
| A few times a month | 58(16.8) | 26(20.0) | 31(14.6) | 0.192 |
| Every week | 234(67.8) | 81(62.3) | 152(71.4) | 0.082 |
| A few times a week | 43(12.5) | 18(13.9) | 25(11.7) | 0.567 |
| **How important is your faith to you?** | | | | |
| Not important | 8(2.3) | 3(2.3) | 4(1.9) | 0.801 |
| A little bit important | 42(12.0) | 21(15.9) | 21(9.9) | 0.098 |
| Very important | 298(85.9) | 108(81.8) | 189(88.7) | 0.074 |
| **When is it okay to have sex?** | | | | |
| Only when married | 228(67.1) | 73(57.5) | 153(72.5) | <0.01 |
| When you plan to marry | 72(21.2) | 37(29.1) | 35(16.6) | <0.01 |
| Going steady | 53(15.6) | 23(18.1) | 30(14.2) | 0.344 |
| When you like someone | 8(2.4) | 5(3.9) | 3(1.4) | 0.153 |

These measures of religiosity were then compared with sexual activity, where the answers were scored from 1-3 (frequency of church attendance and importance of faith) and from 1-4 (when is it ok to get married) to calculate a mean (see Table 8.10). In none of the three measures of religiosity (attendance, importance of faith or belief in no sex before marriage) was there a significant impact of religiosity on sexual activity. However the numbers of

those who were sexually active in the previous year were small and a larger sample size would have more power to detect differences.

**Table 8.10: Religiosity compared with sexual activity**

| | Not had sex last year Mean (95%CI) N=69 | Had sex last year Mean(95%C1) N=21 | P value |
|---|---|---|---|
| **Church attendance** | 2.92 (2.87-3.01) | 2.62 (2.45-2.80) | 0.09 |
| **Importance of faith** | 2.77 (2.68-2.87) | 2.86( 2.81- 2.91) | 0.68 |
| **When they think that sex is okay** | 1.45 (1.36-1.54) | 1.98(1.78-2.17) | 0.10 |

## 8.4. COMPARISON OF INTERVENTION AND CONTROL GROUPS AT BASELINE

This section compares the intervention with control group at baseline for potential confounding factors that could complicate the interpretation of the outcomes reported in section five. Only the 'matched' questionnaires were used, which had been filled in pre- and post-intervention. The list of potential confounding factors measured were age, gender, place of residence, race, who they live with, type of school, the prevention programmes that they had attended at school and religion. The mean age of the intervention group was 15.3 years and for the control group 15.0 years, which was not significantly different. The other findings are listed in Table 8.11 below. The only factor which was just significantly different was race as the intervention group included a few white and black youth (p=0.049). After consultation, the statistician indicated that the numbers were too small to necessitate re-analysis adjusting for this difference.

**Table 8.11: Comparison of control with intervention groups at baseline: possible confounding factors**

| Variable | Intervention N=176(mean) n(%) | Control N=92 (mean) N(%) | P value |
|---|---|---|---|
| **Gender** | | | |
| Male | 63(35.8) | 34(37.0) | 0.851 |
| Female | 113(64.2) | 58(63.0) | |
| **Place of residence** | | | |
| Urban | 149(87.6) | 85(94.4) | 0.082 |
| Rural | 21 (12.4) | 5(5.6) | |
| **Race** | | | |
| Coloured | 165(93.8) | 92(100) | 0.049 |
| White | 5(2.8) | 0(0) | |
| Black | 6(3.4) | 0(0) | |
| **Live with** | | | |
| One parent | 52(29.5) | 28(30.8) | 0.836 |
| Both parents | 115(65.3) | 59(64.8) | 0.934 |
| Another relative | 7(4.0) | 49(4.4) | 0.871 |
| Friend | 2(1.1) | 0(0) | 0.307 |

| | | | |
|---|---|---|---|
| **School** | | | |
| Local government | 122(71.8) | 55(61.1) | 0.053 |
| 'Model C' | 41(24.0) | 31(34.4) | 0.092 |
| Private school | 1(0.6) | 2(2.2) | 0.871 |
| Tertiary | 4(2.3) | 2(2.2) | 0.307 |
| **Prevention programmes at school** | | | |
| Peer education | 69(31.3) | 30(27.0) | 0.292 |
| Life skills | 153(68.9) | 81(73.0) | 0.686 |
| **Religion** | | | |
| Christian | 169(97.7) | 91(98.9) | 0.351 |
| Other | 4(2.3) | 1(1.1) | 0.489 |

## 8.5. COMPARISON OF INTERVENTION WITH CONTROL BEFORE AND AFTER THE INTERVENTION

In this section the intervention and control groups were compared for changes before and after the intervention. This section therefore measures the outcomes for the programme and whether it had any effect. Again, only the matched data was used with 176 in the intervention group and 92 in the control group. The numbers of matched data are much fewer than the baseline because not all the youth attend every Friday night.

In questions with ordinal or sequential categories, such as never, sometimes, often or always, the responses were scored from 1 to 4 and a mean calculated. Then the mean scores at pre-intervention and post-intervention were compared in both the intervention and control groups (p= 0.229 -0.882). Table 8.12 compares the intervention and control groups for changes in self-esteem and shows that there was no significant effect with the intervention.

**Table 8.12: Effect of the intervention on self-esteem**

| Variable | | Pre Mean (95%CI) | Post Mean (95%CI) | P value |
|---|---|---|---|---|
| **Do you feel that you are as important as other people?** | Intervention | 2.9(2.8-3.0) | 3.0(2.8-3.1) | 0.882 |
| | Control | 3.1(2.9-3.3) | 3.2(3.0-3.4) | |
| **Do you have goals and believe you can reach them?** | Intervention | 3.3(3.2-3.4) | 3.4(3.3-3.5) | 0.793 |
| | Control | 3.4(3.3-3.6) | 3.5(3.4-3.7) | |
| **Can you stand up for your beliefs even if your friends believe in something different?** | Intervention | 3.4(3.2-3.5) | 3.4(3.2-3.5) | 0.229 |
| | Control | 3.4(3.2-3.6) | 3.593.4-3.7) | |

Table 8.13 shows the effect of the intervention on beliefs about sex. Overall there was no effect of the intervention. Only the control group shifted significantly from baseline in terms of their beliefs regarding oral sex (p=0.019).

**Table 8.13 Effects of the intervention on beliefs about sex**

| Variable | | **Pre Mean (95%CI)** | **Post Mean (95%CI)** | **P value** |
|---|---|---|---|---|
| **Is oral sex really sex?** | Intervention | 2.0(1.8-2.1) | 2.0(1.9-2.1) | 0.019 |
| | Control | 1.7(1.5-1.9) | 2.0(1.8-2.2) | |
| **Is anal sex really sex?** | Intervention | 2.3(2.2-2.4) | 2.3(2.2-2.4) | 0.171 |
| | Control | 2.3(2.1-2.5) | 2.4(2.3-2.6) | |
| **A person has to have sex to show love** | Intervention | 2.8(2.7-2.9) | 2.9(2.8-2.9) | 0.769 |
| | Control | 2.8(2.7-2.9) | 2.9 (2.8-2.9) | |
| **It is rape if you are physically forced to have sex without consent** | Intervention | 2.8(2.8-2.9) | 2.9(2.8-2.9) | 0.427 |
| | Control | 2.9(2.8-3.0) | 3.0(2.9-3.0) | |
| **Girls do not have the right to refuse sex with their boyfriends** | Intervention | 2.7(2.6-2.8) | 2.8(2.7-2.8) | 0.245 |
| | Control | 2.9(2.8-3.0) | 2.9(2.8-3.0) | |
| **Girls mean 'yes' when they say 'no'** | Intervention | 2.8(2.7-2.9) | 2.8(2.7-2.9) | 0.196 |
| | Control | 2.8(2.7-2.9) | 2.8(2.7-2.9) | |

Categorical data was analysed by comparing the probability of change in the intervention group with that in the control group and testing for any significant difference using McNemar's test.[26]

Table 8.14 shows the effect of the intervention on sexual behaviour. The number of youth who started having sex during the year was significantly less in the intervention group indicating a shift in the age of sexual debut (p=0.04). There was no significant effect on youth who stopped having sex (secondary abstinence) during the year although the percentage was higher in the intervention and a larger sample size may have had more power to detect a significant effect. Numbers were too small to justify analysis in terms of different types of sex (vaginal, oral and anal).

**Table 8.14: Effect of intervention on sexual behaviour**

| **Variable** | **Intervention N=175 Number (%)** | **Control n=92 Number (%)** | **P value** |
|---|---|---|---|
| **Youth who had sex in the last year** | | | |
| Youth who stopped having sex | 6/41 (22.5) | 1/8 (12.5) | 0.25 |
| Youth who started having sex | 16/134 (9.6) | 18/84(22.6) | 0.04 |

A comparison was made of the effect of the intervention on number of sexual partners, comparing intervention and control. There was no significant difference between intervention and control groups (p=0.67). The results are listed in Table 8.15.

[26] McNemar's test is a non-parametric method used in statistics on nominal data. It is applied to 2 × 2 with matched pairs of subjects, to determine whether the row and column marginal frequencies are equal

**Table 8.15: Effect of intervention on number of sexual partners**

| Variable | Intervention (n=33) | | Control (n=7) | | |
|---|---|---|---|---|---|
| | Pre Mean (95%CI) | Post Mean (95%CI) | Pre Mean (95%CI) | Post Mean (95%CI) | P value |
| No of partners | 1.7(1.4-2.1) | 1.7(1.3-2.0) | 1.7(0.9-2.5) | 1.4(0.6-2.2) | 0.67 |

Table 8.16 shows the effect of the intervention on condom use, which was significantly increased amongst the intervention group (p=0.02). The mean score was calculated on a scale of never (1), sometimes (2), often (3) and always (4).

**Table 8.16: Effect of the intervention on condom use.**

| Variable | Intervention (n=33) | | Control (n=7) | | |
|---|---|---|---|---|---|
| | Pre Mean (95%CI) | Post Mean (95%CI) | Pre Mean (95%CI) | Post Mean (95%CI) | P value |
| **Condom use** | 2.2(1.7-2.6) | 3.5 (3.2-3.8) | 2.3(1.7-3.0) | 2.1(1.5-2.9) | 0.02 |

## 8.6 CONCLUSION

The key findings from the quasi-experimental evaluation were the following. At baseline there were significant differences by gender. These differences included sexual beliefs, sexual behaviour, including condom use and number of partners.

In terms of religiosity at baseline, there was no significant impact of religiosity on sexual activity.

When the intervention and control groups were compared before and after the intervention there were significant differences in terms of abstinence for youth who were not yet sexually active, and condom usage. There were no significant differences between youth who were already sexually active. This indicates that the programme, Agents of Change was successful at increasing condom usage and raising the age of sexual debut but did not have an impact on increasing abstinence amongst those who were already sexually active.

# CHAPTER NINE: DISCUSSION OF THE FINDINGS

In this chapter the findings from the evaluation of the Agents of Change (AOC) programme are examined and the following areas are discussed:

- The impact of peer education on sexual behaviour.
- The influence of religiosity on sexuality.
- Making sense of the programme in terms of behaviour change theories.
- Gender and the church.

The chapter ends with a critique of the research.

## 9.1. THE IMPACT OF PEER EDUCATION ON SEXUAL BEHAVIOUR

In this section the findings of the AOC programme are compared with other studies. These include studies from Sub-Saharan Africa and international studies as well as school- and community-based programmes. The factors are identified that led to the impact of the programme, and the programme is compared with identified characteristics of effective programmes. The question is then posed as to whether the programme should be rolled out, and issues concerning peer education programmes are raised.

### 9.1.1. FINDINGS OF THE AGENTS OF CHANGE PROGRAMME

In terms of the impact of AOC on sexual behaviour the following were recorded in Table 9.1:

**Table 9.1: Impact of Agents of Change programme on sexual behaviour**

| **EFFECT OF INTERVENTION** | | **Table** |
|---|---|---|
| Effect on abstinence | • Raising the age of sexual debut : significant change (p<0.04)<br>• Increased abstinence amongst those sexually active : no significant change (p=0.25) | Table 8.14 |
| Effect on numbers of partners | • No significant impact (p=0.67) | Table 8.15 |
| Effect on condom use | • Significant increase (p=0.02) | Table 8.16 |

### 9.1.2. COMPARISON WITH OTHER STUDIES

The results of the AOC programme are compared with Sub-Saharan African studies, international studies, school- and community-based interventions. Various issues are then examined – should the AOC programme be rolled out? Is peer education better than education

led by adults? Finally the question is raised as to whether programmes that make an impact on risky behaviour also have an effect on HIV rates.

### 9.1.2.1. Comparison of results with other Sub-Saharan African studies

There are remarkably few studies of HIV prevention programmes in Africa, considering the magnitude of the problem (35,36,37,38). The latest systematic review was published in 2010 'Effectiveness of HIV prevention for youth in sub-Saharan Africa: systematic review and meta-analysis of randomised and non-randomised trials' (35). In this review only 28 interventions met the inclusion criteria (to have a control group and to be published after 1990, focusing on youth aged 10-25 years and reporting an evaluation of interventions aimed at preventing HIV transmission by reducing sexual risk taking). When one considers the importance of this topic, together with the large amounts of donor funds being spent on HIV interventions, it is sobering to realise how few high quality evaluations have taken place. Many interventions take place, but they are either not evaluated, the research design is not robust, or else the evaluation data are not analysed and disseminated. A further study published in 2010 has also been included (235) in this comparison, thus giving a total of twenty two studies. These studies are summarised in Table 9.2:

**Table 9.2. Effects of HIV prevention for youth interventions in Sub-Saharan Africa.**

| Study | Sample size at base-line | Type of intervention | Effects of intervention | | | Comments |
|---|---|---|---|---|---|---|
| | | | Absti-nence | Part-ners | Con-doms | |
| Agha 2004 Zambia (230) | 481 | Single 1.45 hr session delivered by peer educators in schools | Yes | Yes | No | Abstinence: OR 0.33 (0.14-0.78) Partners : 0.24(0.10-0.59) |
| Doyle 2010 Tanzania (235) | 13,814 | Teacher led and peer assisted | Not repor-ted | Yes | Yes | Partners: Impact on males aPR[27] =0.81(0.78-0.97) Condoms: impact on females and condoms aPR 1.34 (1.07-1.69) |
| Erulkar Kenya (229) | 1544 | Health workers and youth friendly services (3 years) | No | Yes | Yes | Abstinence: females OR 0.10(0.03-0.35) Condom use at last sex; Males OR 3.74(1.71-8.18) |
| Fawole 1999 Nigeria (236) | 450 | Health workers, teachers (one month) | No | Yes | No | Partners: intervention decreased from 1.51 to 1.06, control increased from 1.3-1.39 P<0.05 |
| Harvey 2000 South Africa (237) | 1080 | Dramas – first presented by teachers/nurses then peer educators, (three days ) | No | No | Yes | Consistent condom use: OR 1.31 (1.04 -1.65) |
| James | 936 | Teachers (20 weeks) | Yes | No | No | Abstinence: recent sexual |

[27] Adjusted prevalence ratio

| Study | Sample size at base-line | Type of intervention | Effects of intervention | | | Comments |
|---|---|---|---|---|---|---|
| | | | Abstinence | Partners | Condoms | |
| 2006 South Africa (238) | | | | | | activity OR 0.59 (0.37-0.94) |
| Jewkes 2008 South Africa (239) | 2776 | Peer educators (6-8 weeks) | Not reported | Yes | No | Partners: decrease in males of transactional sex with casual partner OR 0.39(0.17-0.92). There was also an increase in transactional sex among females from the intervention |
| Kim 2001 Zimbabwe (240) | 1426 | Multimedia programme | Negative effect | Negative effect | No | Reduction in abstinence: baseline virgins OR 1.19 (1.04-1.37)<br>Increase in partners: non virgin pre-programme OR 26.05(3.74-181.3) |
| Klepp 1994 Tanzania (241) | 1063 | 20 hours of interactive learning led by teachers and health workers | Yes | Not reported | Not reported | Abstinence among baseline virgins : OR 0.4(0.22-0.73) |
| Magnani South Africa (242) | 3052 | Teachers (2 years) | Yes | Yes | Yes | Abstinence: females OR 0.89 (0.88-0.91)<br>Partners: OR 0.70 (0.65-0.76)<br>Condoms OR 1.45(1.38-1.51) |
| Maticka-Tyndale (243) | 7392 | Peer educators , teachers 18 months | Yes | Not reported | Yes | Abstinence: females abstaining at baseline OR 0.59 (0.47-0.73),<br>Condoms: impact on males who were sexually active at baseline OR1.56(1.01-2.41) |
| Meekers 2005 Cameroon (244) | 1956 | Media, peer educators, (12 months ) | No | Not reported | Yes | Condoms: consistent use with males<br>OR 1.43(1.12-1.82) |
| Meekers 1998 RSA (245) | 226 | Media, peer educators (35 months) | Not reported | Not reported | Yes | Condoms at last sex: females<br>OR 2.94(1.37-6.32) |
| Okonofua Nigeria (246) | 1896 | Peer educators, youth friendly services (11 months) | Not reported | Not reported | Yes | Condom : consistent condoms use :females<br>OR 6.06(2.72-13.53) |
| Plautz Madagas | 1785 | Health workers, media, peer educators | No | Yes | No | Partners: males OR 0.69 (0.5-0.96) |

| Study | Sample size at base-line | Type of intervention | Effects of intervention | | | Comments |
|---|---|---|---|---|---|---|
| | | | Abstinence | Partners | Condoms | |
| car (247) | | (23 months) | | | | |
| Ross Tanzania (248) | 9219 | Peer educators, teachers (3 years) | No | Yes | Yes | Partners: male OR 0.69 (0.5-0.96) Condom at last sex: males OR 1.47(1.12-1.93) |
| Shuey 1999 Uganda (249) | 800 | Teachers run school health clubs where peer health education takes place (2 years) | Yes | Yes | Not reported | Abstinence: OR 0.34 (0.19-0.61) |
| Speizer 2001 Cameroon (36) | 802 | Peer educators (18 months) | Not reported | Not reported | Yes | Condom use at last sex OR 7.92(3.69-17.02) |
| Stanton 1998 Namibia (250) Fitzgerald 1999 (251) | 515 | 14 sessions run after school by teacher or peer educators | No | No | Yes | Condom use pre-programme virgins: OR 1.62(1.05-2.51) |
| Underwood (252) | 921 | Media, (7) months) | No | Not reported | Yes | Consistent condom use OR 2.27(1.21-4.25) |
| Van Rossem 2000 Cameroon (253) | 1606 | Media, peers, youth friendly services (13 months) | No | Yes | Yes | Partners: males OR 0.54 (0.21-0.56) Consistent condom use males OR 1.58(1.04-2.42), females OR 3.13(2.03-4.82) |
| Van Rossem 1999 Guinea (254) | 2016 | Media, peer educators , youth friendly services (8 months) | No | No | Yes | Condoms at last use females 2.29 (1.09-4.83) Consistent males 1.20 (1.02- 1.40) |
| | | **Percentage of studies which reported a positive significant impact** | **6/17 35%** | **10/15 67%** | **14/20 70%** | |

When comparing the impact of those reporting on the three areas, it is evident that all the programmes, except for one, made an impact in at least one area, seven in two areas, and only one in all three areas. Since the AOC made an impact in two areas, it could be classified in the middle range of interventions. Generally it appears that abstinence is the most difficult to address: 35% of interventions had impact in this area, followed by reducing partners (67%)

and increasing condom use (70%). This is somewhat different to the AOC results where number of partners was not impacted. However, since the sample size was so small and the baseline mean number of partners in the matched data group was also less than two, this made it more difficult to demonstrate a decrease in partners.

Generally in these interventions the effect on condom use tended to be greater on males than on females. Due to the small sample size it was not possible to do subgroup analysis in the AOC data. In subgroup meta-analysis the impact on males was 1.46 times higher in intervention than control (35).

Most of the interventions were set in schools; twelve were in secondary schools, three in primary schools and one study included both secondary and primary learners. Four studies combined school and community, and eight were only community. None of the identified interventions was in a church or faith-based setting, so it was not possible to compare the AOC findings with other studies in a similar context.

### 9.1.2.2. Comparison of intervention with international studies

Kirby (74) reviewed 83 studies that measured the impact of curriculum based sex and HIV education among youth under 25 years anywhere in the world. Two thirds of the programmes significantly improved one or more sexual behaviours. His criteria for inclusion were: a reasonably strong experimental or quasi-experimental design with intervention and comparison groups and both pre-test and post-test data, a sample size of at least 100 and published after 1990. The results of these studies are listed in Table 9.3 below.

Several of the studies had insufficient power; this was aggravated by the fact that studies typically had to divide their samples into sub-groups such as sexually active or virgins, male or female. This was also a weakness of the AOC evaluation.

**Table 9.3: Impact of HIV interventions on sexual risk behaviour**.

| | **All countries** | | **Developing countries** | |
|---|---|---|---|---|
| | Positive impact | Negative impact | Positive impact | Negative Impact |
| Initiation of sex | 22/52(42%) | 1/56(2%) | 6/14 (43%) | 0/14(0%) |
| Frequency of sex | 9/31(29%) | 3/31(10%) | 2/5 (40%) | 0/5 (0%) |
| Number of partners | 12/35(35%) | 1/35(3%) | 3/8 (38%) | 0/8 (0%) |
| Condom use | 26/54(48%) | 0/54 (0%) | 7/12(58%) | 0/12 (0%) |

Overall the studies suggest that these programmes are far more likely to have a positive than negative effect, and in the developing countries no negative effects were reported. Across the 83 studies, 65% had a significant impact on one or more of these outcomes, while only 7% had

a negative effect on one or more. One third of the programmes had a positive impact on two or more behaviours. Generally studies indicate that it is possible to reduce sexual activity and increase condom use. It appears that programmes in developing countries may be slightly more effective than countries in general, though the number of evaluations is still too small to be able to generalise.

### 9.1.2.3. How does the intervention compare with school-based studies?

Ebhohimhen conducted a meta-analysis of school prevention programmes in Sub-Saharan Africa using the following criteria: studies had to have a control group, with baseline and post intervention assessments with participants under 19 years (37). Only 12 studies were identified which met the criteria. This again reflects the paucity of studies conducted relative to the magnitude of the epidemic. An additional study from Visser, based in South Africa is included (255). These studies are listed in Table 9.4; indicating whether they had an effect on increasing abstinence, reducing numbers of partners, or increasing condom usage

**Table 9.4: Effectiveness of school-based HIV prevention interventions**

| | Abstinence | Partners | Condoms | Comments |
|---|---|---|---|---|
| Agha 2002, Agha and Van Rossem (230) | No | Yes | No | Partners: p =0.001 |
| Fawole 1999 (236) | No | Yes | No | Partners: p <0.05<br>Condoms, non significant change |
| Harvey 2000 (237) | No | No | Yes | Condoms: p <0.01 |
| James 2005 (238) | No | No | No | |
| Klepp 1994 | Yes | Not reported | Not reported | Non significant increase in abstinence: 17% v 7% |
| Kuhn 1994 | Not reported | Not reported | Not reported | Knowledge and attitudes assessed |
| Munodawafa 1995 | Not reported | Not reported | Not reported | Knowledge and attitudes assessed |
| Stanton 1998 | Yes | No | Yes | Abstinence: only amongst baseline virgins p<0.05<br>Condom use: only amongst baseline virgins who become sexually active p<0.05 |
| Rusakaniko 1997 | Not reported | Not reported | Not reported | Only knowledge |
| Visser 2008 | Yes | Yes | No | Abstinence: significant change on 'had sex during last three months' (p<0.001) |

| | Abstinence | Partners | Condoms | Comments |
|---|---|---|---|---|
| | | | | Partners: multiple partners during last three months (p<0.01) |
| Proportion which reported a significant effect | 3/7 (43 %) | 3/6 (50%) | 2/6 (33%) | |
| **Comparison with general Sub-Saharan studies** (35) | **35%** | **67%** | **70%** | |

Generally it appears that school-based interventions are more successful at increasing rates of abstinence and partner reduction and less effective at the condom message. This may reflect the personal views of teachers as some of the studies indicated that teachers were not happy with mentioning condoms due to possible negative feedback from parents (241). In some cases the Department of Health had a policy that did not allow condom promotion (239).

Ebhohimhen also found that it was easier to effect a change on abstinence amongst those who were virgins at baseline (37). This is similar to the findings in AOC where results were significant in terms of raising the age of sexual debut, but once the youth were sexually active there was no significant difference between control and intervention. Four of the school interventions impacted on one behaviour and only two on two behaviours. Therefore AOC compares favourably with school based interventions.

### 9.1.2.4. Comparison with community-based interventions

This section compares AOC with community based interventions**.** Maticka (75) conducted a systematic review on community based interventions published between 1990 and 2004. These studies are found in Table 9.5:

**Table 9.5: Impact of community-based interventions**

| Study location | Description | Absti-nence | Number of partners | Condom use | Notes |
|---|---|---|---|---|---|
| Speizer 2001 Cameroon (36)[28] | Peer educators deliver one on one and group activities | Yes | No | Yes | Condoms : p<0.01 |
| Population control 2003 Cameroon (256) | Peer educators, talks, athletic activities | Yes | Yes | No | Abstain – females<br>Partner – females |
| Brieger | Eight youth | No | No | No | |

[28]Not all studies supply p value or OR

| Study location | Description | Abstinence | Number of partners | Condom use | Notes |
|---|---|---|---|---|---|
| 2001<br>Nigeria and Ghana<br>(257) | service organisations trained peer educators to deliver one on one and group | | | | |
| CEDPA<br>2000<br>Ghana<br>(258) | Peer educators deliver counselling workshops, and drama | Not reported | Not reported | Not reported | Only knowledge |
| Zambia (19)F<br>Hughes D'aeth<br>(259) | Peer educators – drama games and music , condom distribution, gender awareness | No | Yes | No | |
| Reijer 2002<br>Malawi<br>(260) | Youth committee guides delivery of anti-aids clubs and life skills education | Not reported | Not reported | Not reported | Only knowledge |
| Esu-williams 2004<br>Zambia<br>(261) | Health professionals train youth to care for people living with HIV | Yes | Not reported | Yes | Abstain: male and female<br>Condom: ever used male and female |
| Brady 2002<br>Kenya<br>(262) | Develop life skills through soccer | Not reported | Not reported | Not reported | Only skills and knowledge |
| Erulkar 2004<br>Kenya (229) | Young parents deliver educational activities | Yes | Not reported | Yes | Females: abstain OR 3.3<br>Females; reduction in partners OR 0.1<br>Males: use of condoms OR 3.7 |
| **Percentage of studies reporting significant impact** | | **3/6 (50%)** | **2/4 (50%)** | **3/6(50%)** | |

Bearing in mind that the inclusion criteria were less stringent than in the other meta-analysis, all of the studies apart from one demonstrated some significant changes. Changes in abstinence were generally in terms of raising the age of debut and not amongst the sexually active. This finding is in line with the AOC programme.

Having compared AOC with studies in Sub-Saharan Africa, international studies, school based and community based studies, the factors are examined that led to the impact of the programme on abstinence and condom use.

## 9.1.3. WHAT ARE THE FACTORS THAT LED TO THE IMPACT OF THE AGENTS OF CHANGE PROGRAMME?

The effect of the programme on the change partners is summarised below and helps to explain the factors leading to the measured impact on sexual behaviour. Likewise the strategies, which led to these effects on the change partners, are assessed and summarised below. Then the programme is compared with identified characteristics of an effective programme.

### 9.1.3.1. Effect on change partners

In this section the progress markers that scored 'high' in terms of the effect on change partners are listed. In the case of the clergy none of the factors scored 'high' so the 'medium' progress markers are listed.

**Table 9.6: Effect on change partners**

| CHANGE PARTNER | FACTOR | EFFECT | REFER-ENCE |
|---|---|---|---|
| Peer educators | **Personal development**<br>• Improvement in presentation skills<br>• Education: improved attendance at school<br>• Ability to keep confidentiality<br>• Team work<br>• Increase in faith in God<br>**Self-efficacy**<br>• Improvement in presentation skills<br>• Responds positively to new challenges<br>• Ability to share goals and values | High | 6.2.3.1 |
| Facilitators | **Role model**<br>• Attend church regularly<br>• Do not abuse sex , drugs or alcohol<br>• Are positive role models<br>**Mentoring of youth**<br>• Are available to young people<br>• Demonstrate ability to listen to young people<br>• Have strong relationship with peer educators<br>• Create a conducive learning environment<br>• Have contributed to the growth of the peer educators | High | 6.3.3.1 |
| Youth | **Attendance**<br>• Young people attending sessions<br>• Inviting friends to sessions | High | 6.4.3.1 |

| CHANGE PARTNER | FACTOR | EFFECT | REFER-ENCE |
|---|---|---|---|
| | **Participation**<br>• Active and enthusiastic participation<br>• Engaging in discussions and debate<br>• Are empowered to influence other young people<br>**Knowledge**<br>• Describing issues which are important to them<br>• Describing the consequences of different lifestyle choices | | |
| Clergy | **Support**<br>• Take ownership of the project<br>• 'Big days' are celebrated for instance World AIDS Day<br>• Support its financial and resource needs<br>• Clergy visit the AOC programme<br>• Leaders give spiritual guidance and counselling<br>• Challenge the congregation to be more supportive to AOC<br>**Inclusion**<br>• Agents share in services | Medium | 6.5.3.2 |
| Parents | **Understanding peer pressure** | High | 6.6.3.1 |

Thus it appears that the strongest factors which led to the change were:

- The personal development and increased self-confidence of peer educators.
- The mentoring and role modelling by facilitators.
- The active participation by young people, and the relevance of the programme to their needs.
- The practical support by clergy, even though it was limited.
- The fact that parents were beginning to understand some of the pressures faced by young people.

### 9.1.3.2. Strategies utilised

Having examined the effect of the programme on the five change partners, the next section looks at the effectiveness of the strategies used in the programme. These are summarised in Table 9.7:

**Table 9.7: Effectiveness of strategies**

| Strategy | Focus of strategy | Effectiveness | Reference |
|---|---|---|---|
| Initial training camp for peer educators and facilitators | • Team building<br>• Training<br>• Sharing the vision | High | 7.3.1.3 |

| | | | |
|---|---|---|---|
| Quarterly gatherings of peer educators and facilitators | • Training<br>• Bridging social capital<br>• Sharing new ideas and lessons learnt<br>• Encouragement | Medium | 7.3.2.3 |
| Parenting workshops | • Communication skills<br>• Affirmation | Low | 7.3.3.2 |

Thus it appears that the most effective strategy was the training camp for peer educators and facilitators. The quarterly gatherings were moderately successful and the parenting workshops were not successful.

## 9.1.4. COMPARING THE PROGRAMME WITH THE CHARACTERISTICS OF EFFECTIVE HIV PREVENTION INTERVENTIONS

### 9.1.4.1. Characteristics of effective interventions

Based on his evaluation of 83 studies, Kirby identifies seventeen characteristics of effective interventions on sex and HIV prevention for youth. The AOC intervention was assessed by the researcher according to these seventeen characteristics, using a Likert scale. One indicated that the goal was not reached; two indicated a minimal level was achieved, and three indicated that the level was successfully achieved. The results are indicated in Table 9.8 below (74):

**Table 9.8: A comparison of Agents of Change with the 17 characteristics of effective programmes**

| **The process of developing the curriculum** | Agents of Change | Comments |
|---|---|---|
| 1. Involved multiple people with different backgrounds in theory, research and sex/HIV education to develop the curriculum. | 2.5 | The curriculum was primarily based on the GOLD curriculum which was developed with a broad group of experts. |
| 2. Assessed relevant needs and assets of target group. | 3 | Baseline research conducted in 2005. |
| 3. Used a logic model approach that specified the health goals, the behaviours affecting those goals, the risk and protective factors affecting those behaviours and the activities addressing those risk and protective factors. | 2.5 | Outcome mapping was used to plan the programme. |
| 4. Designed activities consistent with community values and available resources (staff, facility space, supplies) | 3 | The GOLD curriculum was adapted for a faith based context, taking into account the resources available. |
| 5. Pilot tested the programme | 3 | Pilot testing occurred in three churches |
| Average | 2.8 | |
| **The contents of the curriculum** | | |
| CURRICULUM GOALS AND OBJECTIVES | | |

| | | |
|---|---|---|
| 1. Focused on clear health goals – prevention of STD/HIV and or pregnancy. | 3 | There is a clear focus |
| 2. Focused narrowly on specific behaviours leading to these health goals (such as abstaining from sex or using condoms) gave clear messages about these behaviours and addressed situations that might lead to them and how to avoid them. | 2 | Some of the churches did not feel comfortable with the condom message so the message might have become diluted. |
| 3. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviour (such as knowledge, perceived risks, values, attitudes, perceived norms and self efficacy). | 2.5 | These issues were covered |
| ACTIVITIES AND TEACHING METHODOLOGIES | | |
| 4. Created a safe social environment for youth to participate. | 2 | The context was the church youth group, which in most cases was safe, but some groups held judgmental attitudes towards those who were sexually active. |
| 5. Included multiple activities to change each of the targeted risk and protective factors. | 3 | The programme included a great variety of activities. |
| 6. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalise the information and that were designed to change each group of risk and protective factors. | 2 | The peer educators were trained to do so, but sometimes implementation was poor. |
| 7. Employed activities, instructional methods and behavioural messages that were appropriate to the youth's culture, developmental age and sexual experience. | 3 | The activities were suitable for the age, culture and faith based setting. |
| 8. Covered topics in a logical sequence. | 2 | Although the manual was in a logical sequence the groups often jumped to the sessions that looked more interesting. |
| Average | 2.4 | |
| **The implementation of the curriculum** | | |
| 1. Secured at least minimal support from appropriate authorities such as ministry of health, or community organisations. | 3 | Fikelela obtained permission from the Bishop and priests. |
| 2. Selected educators with desired characteristics trained them and provided monitoring, supervision and support. | 2 | Some of the peer educators became involved for the wrong reasons. Adequate training was provided but sometimes the attendance was poor. Supervision and support was provided by visits, Facebook and telephonically. |
| 3. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement, for instance publicised the programme, offered food, or obtained | 2 | Recruitment was successful, but sometimes retention was lacking. |

| | | |
|---|---|---|
| consent. | | |
| 4. Implemented virtually all activities with reasonable fidelity. | 2 | This varied very much from church to church. |
| Average | 2.2 | |
| **Total rating** | **2.5** | |

The process of developing the programme and the curriculum were the strongest characteristics, whereas the implementation at church level was often weaker. However, one can conclude that according to Kirby's list of characteristics of an effective programme, AOC held many of the characteristics of a potentially effective programme.

The process of development of the programme scored high (2.8) because of the baseline survey that was conducted and the multi-sectoral approach to its development. The curriculum contents scored reasonably high (2.4) showing they should be reasonably effective. The weakest part of the programme was the implementation (2.2). Although Fikelela developed a potentially effective intervention the problems at the grassroots level tended to limit its full implementation.

Having examined the factors that led to its impact, the question is posed whether this intervention should be rolled out beyond the Diocese of Cape Town.

## 9.1.5. SHOULD THE AGENTS OF CHANGE INTERVENTION BE ROLLED OUT?

The World Health Organisation conducted a systematic review of HIV interventions in the developing world in order to ascertain which types of intervention should be rolled out. Two types of community-based interventions targeting youth were identified (75).

- Those delivered through existing organisations (for example churches or soccer clubs).
- Those not affiliated with existing organisations (new organisations set up for the purpose of the intervention).

Seventeen youth programmes were assessed, eleven of which used existing organisations and six of which created their own system for delivery. The types of intervention were assessed, taking into consideration the feasibility of delivering the intervention on a large scale, the acceptability of the intervention to participants, the risk of adverse outcomes, the potential size of the effect and the presence of other health and social benefits associated with delivery of the intervention. The potential strengths of various types of community based interventions are listed in Table 9.9:

**Table 9.9: Potential strengths of community-based HIV interventions**

| Type of organisation | Feasibility | Lack of potential for adverse outcomes | Acceptability | Potential size of effect | Other health or social benefits | Threshold of evidence required for roll out |
|---|---|---|---|---|---|---|
| Existing organisa-tion | High | Low | High | Moderate | Moderate | Moderate |
| New organisa-tions | Low | Low | Low | Low | Low | High |

Source: (75) Maticka-Tyndale E, Brouillard-Coyle C. The effectiveness of community intervention targeting HIV and AIDS prevention at young people in developing countries in: Ross D, Dick B Ferguson J: Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries. UNAIDS inter-agency task team on young people. Geneva: UNAIDS;2006.

An intervention that is affiliated with an existing organisation requires a moderate threshold of evidence in order to justify roll out. Through this affiliation, the acceptance within the community as well as their mechanisms for reaching young people, their infrastructure and mode of sustainability become available for the intervention.

An intervention that requires the establishment of a new organisation requires a high threshold of evidence – the added effort and cost of setting up systems limits their feasibility, acceptability and potential effect size. This type of intervention must establish acceptance with gatekeepers, develop a mechanism as well as a sustainable method of delivery. A suitable location must also be found and infrastructure for delivering the intervention must be developed.

AOC is affiliated with an existing organisation and is therefore classified in the first category: Therefore when it is assessed according to this threshold of evidence it would need 'moderate' evidence of programme impact in order to justify rolling out. The potential strengths of the AOC programme are listed in Table 9.10:

**Table 9.10: Potential strengths of Agents of Change**

| Feasibility | Lack of potential for adverse outcomes | Acceptability | Potential size of effect | Other health or social benefits |
|---|---|---|---|---|
| Because it is church based the structure is already existing | Generally these are few, if the programme is badly run there is a danger that youth are not referred adequately when they have serious issues to contend with | This is acceptable since it has been endorsed by the religious leaders of the community | The Anglican Church constitutes 7% of the population, and it could be suitable for other churches as well. | Youth involved in the programme also get involved in the youth group at church and other church based activities, such as community outreach and social events. |

In the meta-analysis Maticka-Tyndale further classifies the interventions according to 'Go, ready, steady and do not go'. 'Go' indicates that an intervention should be rolled out, 'Ready' indicates that once a moderate threshold of evidence has been met the intervention is ready for roll out (with ongoing evaluation and adaptation). 'Steady' indicates that further evaluations should still take place, and 'do not go' indicates that this type of intervention should not be continued. In Table 9.11 community-based interventions are classified according to their readiness for roll-out.

**Table 9.11. Classification of community-based interventions according to readiness for roll-out.**

| Type | Characteristics | Conclusion | Comments |
|---|---|---|---|
| Targets youth using existing organisation | • Local organisations are accepted by community.<br>• HIV must have logical fit with organisation.<br>• Peer educators should be chosen using specific selection criteria, monitoring and support provided. | Ready | These interventions were most likely to have demonstrated sustainability, to have strong evaluation design and positive results. |
| Targets youth and creates own system and structures | • Successful negotiation needed into community.<br>• Needs further assessment.<br>• Gatekeeper into community needed.<br>• Sustainability needs to be addressed. | Steady or do not go | All evaluations had weak designs. Issues of sustainability. |

Source: (75) Maticka-Tyndale E, Brouillard-Coyle C. The effectiveness of community intervention targeting HIV and AIDS prevention at young people in developing countries in: Ross D, Dick B Ferguson J: Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries. UNAIDS inter-agency task team on young people. Geneva: UNAIDS;2006.

According to this classification, AOC would require a moderate threshold of evidence in order to be considered for rolling out. This moderate threshold of evidence has been met in the findings of this study and compare positively with both schools based and community based programmes. Therefore, with ongoing evaluation and further adaptation, the AOC programme could be considered for further roll out.

## 9.1.6. VARIOUS ISSUES REGARDING HIV PREVENTION PROGRAMMES

Having compared AOC with other programmes, there are several issues that are raised regarding HIV prevention programmes. Firstly are peer education programmes more effective than adult led ones? Secondly, if a programme leads to behaviour change, does it also lead to a reduction in HIV risk? Thirdly, having reviewed the findings, which changes should be made to the AOC programme to make it more effective?

### 9.1.6.1. Is peer education more effective than adult-led education?

Peer education can be defined as '*the process whereby well trained and motivated young people undertake formal or organised educational activities with their peers over a period of time, aimed at developing their knowledge, attitudes, beliefs and skills and enabling them to protect and be responsible for their own health" (263).*

It is estimated that 59% of peer education programmes take place in Sub-Saharan Africa (264). Therefore it is important to decide whether this is a more effective strategy than adult-led programmes. Kim conducted a systematic review of peer education programmes from both developed and developing countries. Studies were eligible if they had an appropriate comparison group, and provided pre-intervention and post-intervention data (264). Only thirteen studies were found that fit the criteria.

Overall she found '*no clear evidence that peer led sex education promotes condom use or reduces the odds of having a new partner'*. There was no clear evidence for a positive effect. This did not necessarily mean that the programmes were not working, but the poor showing for peer led programmes appeared to be due to the paucity of rigorous evaluations, which meant that the vast majority of interventions were excluded from the review. Kim states that results varied greatly, suggesting that there may be real differences in the effects of interventions included in the review. Her recommendation is that peer led interventions should not be abandoned, but rather should be fine-tuned.

However when one examines only the three studies (out of the thirteen) which were from Africa, the results are reasonably encouraging:

- Agha and Van Rossem (Zambia) 2004 significant impact on number of partners.
- Brieger et al (Ghana and Nigeria) 2001 no significant impact.
- Speizer (Cameroon ) 2001 significant impact on condoms.

Maticka-Tyndale also surveyed the literature on community-based peer education in lower and middle income countries (265). Twenty four peer led programmes were evaluated. The programmes appear to be successful at changing condom use, but she reports that the effects on other sexual behaviours are equivocal. However, once again, if one considers only the studies from Africa, the results are more promising. Here the results are considered only from the studies with a control group and are listed in Table 9.12.

**Table 9.12: Results of quasi-experimental community-based peer education studies from Africa[29].**

| | Abstain – never had sex | Abstain - recent sex | No of partners | Condoms |
|---|---|---|---|---|
| Askew, 2004 Kenya (266) | Not significant | Not reported | Not reported | Yes |
| Brieger 2001 Ghana, Nigeria (257) | Not significant | Not reported | Not reported | Not significant |
| Diop , 2004 Senegal (267) | Not significant | Yes | Not significant | Yes |
| Esu-Williams 2004 Zambia (261) | Yes | Not significant | Not significant | Yes |
| Frontiers 2001 Zambia (268) | Not reported | Yes | Yes | Not significant |
| Speizer , 2001 Cameroon (36) | No | No | No | Yes |
| Muyinda 2003 Uganda (269) | Not reported | Not reported | Not reported | Yes |
| **Percentage of those reporting significant impact** | **1/5 (20 %)** | **2/4 (50%)** | **1/4 (25%)** | **5/7 (71%)** |
| **Combined total** | **3/6 (50%)** | | **1/4 (25%)** | **5/7(71%)** |

In these community-based studies, the impact on partner reduction is lower than in school based programmes. This appears to be a similar finding to the AOC programme. It is useful to see whether those interventions using peers or adults alone were more effective. It is not clear from many of the evaluations what percentage of the programme was delivered by peers however in this analysis the programmes have been divided into those involving peers and those with no peer involvement at all. Table 9.13 lists the effect of interventions with peer involvement and it is followed by Table 9.14 which lists the effect of interventions with no reported peer involvement. The studies which were not reported are excluded from the final figure.

[29] Only significant results are recorded, p values or OR were not supplied in this study

**Table 9.13: Effect of interventions with peer involvement**

| | Abstain | Partners | Condoms |
|---|---|---|---|
| Agha 2004 (230) | Yes | Yes | No |
| Doyle 2010 (235) | Not reported | Yes | Yes |
| Harvey 2000 (237) | No | No | Yes |
| Jewkes 2008 (239) | Not reported | Yes | No |
| Maticka-Tyndale 2007 (243) | Yes | Not reported | Yes |
| Meekers 2005 (244) | No | Not reported | Yes |
| Meekers 1998 (245) | Not reported | Not reported | Yes |
| Okonofuwa 2003 (246) | Not reported | Not reported | Yes |
| Plautz 2003 (247) | No | Yes | No |
| Ross 2007 (248) | No | Yes | Yes |
| Shuey 1999 (249) | Yes | Yes | Not reported |
| Speizer 2001 (36) | Not reported | Not reported | Yes |
| Stanton 1998 (250) | No | No | Yes |
| Van Rossem 2000 (253) | No | Yes | Yes |
| Van Rossem 1999 (254) | No | No | Yes |
| **Proportion of studies which reported a significant effect** | **3/10 (30%)** | **7/10 (70%)** | **11/14 (79%)** |

**Table 9.14: Effects of interventions with no reported peer involvement**

| | Abstinence | Partners | Condoms |
|---|---|---|---|
| Erulkar 2004, Kenya (229) | No | Yes | Yes |
| Fawole 1999 Nigeria (236) | No | Yes | No |
| James 2006 South Africa (238) | Yes | No | No |
| Kim (240) | Yes | Yes | No |
| Klepp 1994 Tanzania | Yes | Not reported | Not assessed |

| | | | |
|---|---|---|---|
| (241) | | | |
| Magnani 2005 South Africa (242) | Yes | Yes | Yes |
| Underwood 2006 Zambia (252) | No | Not reported | Yes |
| **Proportion of studies which reported a significant effect** | **4/7 (57%)** | **4/5 (80%)** | **3/6 (50%)** |
| **Comparison with interventions involving peer involvement** | **30%** | **70%** | **79%** |

Both interventions run by peers and those run by adults appear to have a reasonable possibility of a significant effect. It seems in general terms that those with adults only are more effective at presenting the abstinence option and those with peers are more successful with condom promotion. This is similar to the finding from schools, where adults would push the abstinence message more strongly.

Generally these reviews indicate that the jury is still out. Peer education programmes can be effective, but it is not clear whether these programmes are effective because they are run by peer educators, or whether they might be more effective if the same programme was run by adults. As Charles Deutsch said at a consultation of USAID in 2006 '*Peer education has been stuck in a cycle of unseriousness for 30 years. We don't understand the inputs so there is no way to understand the outputs*.'[30]

It appears that there is not sufficient evidence to state that peer education programmes are better or worse than adult led ones. The difference between interventions may well be in terms of other aspects of the programme such as Kirby's characteristics of effective programmes. For this reason it would not be advisable to consider adapting AOC to an adult led programme, but it would be worthwhile in future research, to have some pilot churches run it as an adult-led intervention and compare the results.

### 9.1.6.2. Do HIV interventions have an impact on reducing the risk of HIV?

An important issue is to examine whether HIV prevention interventions have an impact on reducing the risk of HIV. It can be stated fairly categorically that HIV prevention interventions for youth can and generally do have an impact on at least one risky behaviour, several have an impact on two and a few have an impact on three. The evidence for the positive impact on behaviour of curriculum and group based sex and HIV education programmes is quite strong and encouraging (263). However do these impacts lead to a reduction of HIV risk? Jewkes reports on biological results from an intervention in South Africa. Ross (248) and Doyle (235)

[30] Said at an international consultation by USAID and FHI held in Washington, DC, called "Taking Stock of Youth Reproductive Health and HIV Peer Education: Progress, Process, and Programming for the Future." January 2006

both report on one intervention in Tanzania, but three years apart. The results of these studies are listed in Table 9.15:

**Table 9.15: Behaviour change and biological outcomes of HIV interventions**

| | Abstain | Partners | Condoms | HIV | Sexually transmitted infections |
|---|---|---|---|---|---|
| Jewkes 2008 RSA (239) | No | Decrease in males of OR 0.39(0.17-0.92) However an increase in transactional sex among females from the intervention | No | No | HSV incidence OR 0.67(95% CI 0.47-0.97) |
| Ross 2007 (248) | Not reported | Partners: male OR 0.69 (0.5-0.96) | Condom at last sex: males OR 1.47(1.12-1.93) | No | No |
| Doyle 2010 (235) | Not reported | Reduction in males in multiple partners (aPR[31] 0.87 95% CI 0.78-0.97) | Increase in condom use among females (aPR 1.34, 95%CI 1.07-1.69) | No | No |

Only one study found an impact on Herpes Simplex Virus (HSV) incidence and none of the three found an impact on HIV. The first question is why there would be an impact on HSV and not on HIV infection rates? One hypothesis is that the prevalence of herpes is much higher in young men than that of HIV whereas older men are more likely to be infected with HIV. It is easier for women to negotiate for condom use with younger partners (239).Therefore an increase in condom use would have more impact on the risk of HSV infection with younger partners, and less impact on HIV with older partners.

A meta-analysis of peer education from developing countries found that when data was pooled, the impact on condom usage was significant, OR 1.92 (95%CI 1.59-2.33). However the seven studies that measured STI infection found a non-significant *increase* in STI infections OR 1.22(95% CI 0.88-1.71). However, it was noted that the three studies which found an increase had very weak study designs (270). None of these interventions were directed at youth. However this finding raises a second and more difficult question: why would programmes that affect behaviour change not impact on HIV?

One limitation is that virtually all behaviour outcomes are self-reported. Most of the studies mention this as a possible weakness since it raised questions about reliability and validity. It may be particularly problematical because of the effects of social desirability bias, whereby

[31] Adjusted prevalence ratio

males may over-report and females under–report. However all the evaluations using self reported data indicated that in general if the questionnaire is well designed and well administered, then they are valid (271,248). This is supported by changes over time in the sexual behaviour of youth and pregnancy rates (272) and the consensus of researchers is that they are generally credible (38). Often the biases are similar in both intervention and control groups, though not always.

A second limitation is that measurements of behaviour change do not indicate who a person is having sex with. For instance a teenage girl may stop having sex with three teenage boys and start a relationship with one older man. In this scenario it would appear that the programme had been effective in reducing numbers of partners, but in fact she is now more at risk.

A third limitation is that interventions do not track what is happening in the community. For instance if the prevalence of HIV changes in the community, then even if a young person reduces their risky behaviour, their overall risk may rise, if their partner is more likely to be HIV+. For instance in Rakai, Uganda, between 1995 and 2002 age of first sex dropped for male and females, and from 1994 to 2003 the proportion of teenage girls having more than one partner grew significantly. Even with the earlier sexual debut and increase in partners, HIV prevalence remained stable, due to an increase of condom use and the rates of HIV mortality (271). If the prevalence of HIV is increasing in a community, even though individuals involved in an intervention reduce their risky behaviour, their overall risk may still increase. So a programme may actually be effective but not lead to a drop in HIV. A measurement of incidence in the community is more indicative of change.

A fourth limitation is that these studies had quite low odds ratios. The Tanzanian study reported a reduction in number of partners aPR[32] 0.87 (95% CI 0.78-0.97) and increase in condoms use of females of 1.34 (95%CI 1.07-1.69). So although they were statistically significant, the impact was not very large. Other programmes had greater effects, for instance Erulkar's study in Kenya, the increase of condom use was OR 3.74 (1.71-8.18) (229). Similarly Okonofuwa's study in Nigeria (246) reported an odds ratio of condoms use for females of 6.06 (2.72-13.53). If these studies had included biological indicators, perhaps the results would have been more positive.

In addition, one needs to recognise that HIV interventions will only reduce sexual risk taking by a modest amount (272) and they should be seen as components of broader, community wide interventions that address issues such as gender norms and vulnerability (272,235). Researchers also need to identify which mediating factors have the greatest impact in different cultures (272) and which educational strategies and activities are most effective at changing these factors. Many of these specific components are in themselves complex interventions. To

[32] Adjusted prevalence ratio

be effective, most would involve bringing about profound social and behavioural changes among both the adults and the youth involved (248).

Since there are biological outcomes from only two studies this once again underscores the high priority that should be placed on conducting evaluations with biological outcomes. Such studies as apart from being expensive are difficult because there are so many factors influencing the ultimate impact, which need to be controlled for. They also need to be done on a large scale to have the power to demonstrate a change in HIV incidence. Without such evaluations however large sums of money may continue to be spent on programmes which do not actually lead to a drop in HIV transmission.

## 9.2. THE INFLUENCE OF RELIGIOSITY ON SEXUALITY

In this second section, the findings on the influence of religiosity on sexuality are presented, and compared with other studies. Then the issue of how religiosity affects sexuality is discussed.

### 9.2.1. FINDINGS OF THE AGENTS OF CHANGE PROGRAMME

In this study religiosity was measured in three ways; by frequency of church attendance, importance of faith, and belief in no sex before marriage. The only significant difference between males and females was that more girls believed that sex should be saved for marriage (Table 8.9). When it came to comparing sexual activity with religiosity, there was no significant impact of religiosity on sexual activity in any of the three measures. The questions on religiosity were collected at baseline and only in the second year of the study, which meant that the total number of respondents was limited and the number of sexually active youth was very small. A larger sample size would have had more power to detect associations.

### 9.2.2. A COMPARISION WITH OTHER STUDIES

In the following section, these results are compared with other studies, firstly from high-income countries and then from Sub-Saharan Africa.

#### 9.2.2.1. High income countries

In high income countries there are many studies of young people and religiosity, and there appears to be conclusive evidence that religiosity does have an impact on sexual activity in these countries. (61-64,192,194-196). Religious youth are likely to initiate sex later and have a reduced number of sexual partners.

### 9.2.2.2. Sub-Saharan Africa

There are very few studies in Sub-Saharan Africa of religiosity and sexual activity, and the majority combine youth and adults. However the existing studies, which focus on youth, are far less conclusive than the studies from high income countries:

- A previous survey of Anglican youth (aged 15-19 years) in Cape Town by Mash and Kareithi (202) found the rate of sexual activity among Anglican youth (31%) was similar to the 38% (for grades 8 - 11 in the Western Cape) reported by the South African Youth Risk Behaviour Survey (SAYRBS) (223). This implies that church-based youth do not behave significantly differently from their larger peer group. Indeed, sexually active church-based youth appeared to have a higher rate of multiple partners (66%) than in the SAYRBS (48%).
- Similarly a study by Nweneka in Nigeria of both Pentecostal and mainline youth (aged 12-35 years) found no difference between church youth and their peers who do not attend church (32). These two studies have similar findings to the current one, in terms of religiosity not having an impact on sexuality.
- Fatusi's study of 15-19 year olds in Nigeria had mixed findings – women who attached high importance to religion had higher levels of abstinence, whereas those who attended church frequently were in fact *less* likely to be abstinent. In terms of men, those who attached high importance to religion had no difference in abstinence whereas those who attended church frequently were more likely to abstain (30). This finding is in line with the current study – that church attendance has a greater impact than faith alone.
- Nicholas and Durrheim's study of university students (aged 18-21 years) at the University of the Western Cape showed that religious youth had a later sexual debut and fewer partners (65).
- Agha's study in Zambia (aged 13-24 years) indicated that there was a delay in sexual debut with youth from Pentecostal churches, but no difference with mainline churches.

Thus this evaluation of the influence of religiosity on sexual behaviour is in line with others that point to a lack of conclusive evidence of the impact of religiosity on young people in Sub-Saharan Africa. Swartz indicates that this gap between what young people's stated moral beliefs and their reported moral behaviour known as the "belief-behaviour" gap has been noted by several authors (273).

### 9.2.2.3. Adolescents versus adults

Most of the studies combine youth and adults so it is not easy to ascertain if there is a difference between religiosity in adults and youth. However there are indications that religiosity may impact adults more than young people:

- Addai's study of religious affiliation and sexual initiation among Ghanaian women covered 15-49 year olds (274). The study found that religious affiliation was an important predictor of premarital sex for older women, but not younger.
- Trinitapoli's study of married men in Malawi showed that men who were frequent worshippers (weekly or more) were significantly less likely to report an extra-marital partner or report an STI (275).
- Allain's study of adult blood donors in Ghana showed that HIV levels were lower among those who had been more than 10 years in their church and those who were leaders in their church, which would suggest that the impact was greater on more mature members of the congregation (204).

These studies suggest that religiosity may have more of an impact on adults than on adolescents.

#### 9.2.2.4. Why the differences?

It appears that religiosity has more of an impact on sexual activity in high-income countries than in developing countries. The reasons for this could be issues of disempowerment and coercion. To abstain because of religious views supportive of 'no sex before marriage' is an individual decision. Young people in developing countries are less empowered to make individual decisions around their sexuality. Because of poverty and coercion, many young people experience a lack of personal agency around their sexual health. Another possible factor may be that in developed countries the percentage of churchgoers is lower. So to be committed to Church is to be in some senses 'counter-cultural', whereas in Africa the percentage is much higher. In Smith's study in Nigeria, only 5 out of the 863 interviewed said they were not Christians (276). According to the 2001 census the majority of South Africans (79.8%) identify themselves as being members of Christian churches (21).

It also appears that religion has more of an impact on adults than on adolescents. Disempowerment would also explain the difference between adults and young people. An adult is more empowered to take control of his or her sexual health than an adolescent, so if their religious value system supports abstinence or monogamy, they may be more able to do so. It is also possible that adolescents are more influenced by their peer group and pressure to 'fit in' whereas an adult has other ways to build their self-esteem and is not so dependent on acceptance by a peer group. It is interesting to note that in Durrheim's study of University students, religiosity did have an impact. One explanation for this could be that University students are more empowered than most young people (65). Many teenagers attend church because of family or cultural reasons rather than because it is part of their own personal commitment, so it is less likely to affect their sexual behaviour. Once a young person has left

home and is at University, if they choose to go to church they are perhaps more likely to buy in to the values of the church.

## 9.2.3. HOW DOES RELIGIOSITY AFFECT SEXUAL BEHAVIOUR?

Although there are several studies linking religiosity with sexual activity, there has been little study of the mechanisms by which religiosity affects sexual behaviour (206). Several studies though not all, indicate lower sexual activity rates in two groups of religious youth:

- Those from more conservative churches (Pentecostal, and so called 'sects' such as Jehovah's witnesses, Mormons) (68,211,212,152).
- Those with higher levels of religiosity: measured either in terms of attendance or importance of religion (30, 67, 68, 70).

The mechanisms by which religiosity leads to lower levels of risky sexual behaviour have been explained in several ways: through messages about sexuality, through social control and through socialisation. (See also 4.5.1.4- 4.5.2.2)

### 9.2.3.1. Messages

Certain churches have strong pro-abstinence and anti-condom theologies, in particular the 'sects' such as Jehovah's Witnesses, as well as the Pentecostals and Catholics. Although the Catholics and Pentecostals have similar pro-abstinence and anti- condom theologies, the abstinence levels of Catholics appear to be lower than Pentecostals, and similar to other mainline Protestants (67, 68). See 4.5.1.4.

### 9.2.3.2. Social control

One study by Kiwanuka provides the only data on actual rates of HIV, where HIV infection rates were highest amongst Catholics (19.9%), and Protestants (19.2%), and significantly lower among Pentecostals (14.6%) (291). This would appear to indicate that it is not so much what is *taught* in Pentecostal churches that makes the difference, but other factors. Pentecostal churches tend to have stronger social control that Catholic Churches. This is a form of informal 'policing' which takes place as members' sexual behaviour is under scrutiny as a University student from Kampala stated:

'*People are watching you – if you are saved you set a standard' (152).*

In Trinitapolis' study in Malawi, individuals who attend congregations in which the leader polices the sexual behaviour are over 50% more likely to report being faithful (206). See also 4.5.2.2.

### 9.2.3.3. Socialisation

A third mechanism has been pointed to which reduces sexual activity in Pentecostal churches and amongst youth of high religiosity in mainline churches. Garner points to the importance of socialisation in the process of behaviour change (212,277). Sadgrove states that it is *"the social rather than ideological aspect of the religious organisation that make it effective at mobilising its members to behaviour change" (152).*

Pentecostal churches have high levels of socialisation, and young people with high levels of religiosity would also have a much stronger relationship with their peer group within the church. This is supported by Sadgrove's study of twenty-five Pentecostal students at Makerere University Kampala, Uganda where he states:

'*It is the distinct social environments and socialising styles of born again Christians that are most likely to impact on their sexual behaviour (152).'*

By channelling members into many congregational activities, Pentecostal churches increase the density of personal networks and as a result social support and social control among their members (278).

In Burchardt's study of a faith based, life-skills programme in schools in Cape Town the following was noted:

*"Responses to abstinence training among learners suggest that it only had an effect where this choice was supported by sustained participation in religious sociality outside school." (279).*

Those young people who weren't committed members of their churches (nominal) saw abstinence to be unattainable, whereas for committed Christians in youth groups, to abstain was seen as a mark differentiating you from others. In the following section the mechanisms by which religiosity may impact on sexuality are compared with the Agents of Change programme.

### 9.2.3.4. Comparison with Agents of Change

**Table 9.16: Mechanisms for religiosity impacting on sexuality**

| | Level | Discussion |
|---|---|---|
| **Pro-abstinence message** | Medium | Abstinence is encouraged, but there is a recognition that many young people are sexually active, the role of condoms is also explained |
| **Social control** | Low | The Anglican Church has shifted from a former stance where girls who fall pregnant were ex-communicated etc. |
| **Socialisation** | High | Socialisation is high in Anglican Churches, 67.8% indicated they came to church every week, and 12.5% a few times a week. |

It appears that the impact of the AOC programme may have been not only through the messages given, but in the way in which it has encouraged the formation of peer groups at the churches, where peer educators form teams, and the youth gather not just for the sessions, but also socialise together, with stay-awakes, and fund-raisers, and community outreach. Thus behaviour change becomes a possible goal because they are surrounded by others who also aspire to be different.

## 9.3. THEORIES OF BEHAVIOUR CHANGE

In this section the qualitative assessment of the AOC programme is discussed, based on the outcome mapping process, in order to ascertain which theories of behaviour change might explain the changes that took place. The results are listed in Table 9.17:

**Table 9.17: Effect on change partners of the Agents of Change programme**

| Change partner | Level achieved | Topic | Areas of change | Reference |
|---|---|---|---|---|
| Peer educators | High | Personal development | Presentation skills, school attendance, team work, increase in faith | 6.2.3.1(i) |
| | High | Self-efficacy | Growing in confidence, responds positively to new challenges confident to share values and goals | 6.2.3.1 (ii) |
| | Medium | Practical skills | Planning and time keeping, communication skills | 6.2.3.2 (i) |
| | Medium | Behaviour change | No to abuse of drugs, alcohol or sex, the message they give is the message they live | 6.2.3.2 (ii) |
| | Low | Advocacy | Advocate for issues in community, attend quarterly gatherings | 6.2 3.3 (i) |
| | Low | Attendance at quarterly gatherings | Collaboration with other churches could lead to bonding social capital | 6.2.3.3 (ii) |
| Facilitators | High | Role model | Regular church attendance, not abusing sex, drugs or alcohol, positive role models | 6.3.3.1 (i) |
| | High | Mentoring | Available, ability to listen, strong supportive relationship with peer educators, create a conducive learning environment, contribute to growth of peer educators | 6.3.3.1 (ii) |
| | Medium | Collaborative style | Assist peer educators to facilitate, will not be authoritarian blaming or judging, have collaborative and respectful communication style | 6.3.3.2 (i) |

| Change partner | Level achieved | Topic | Areas of change | Reference |
|---|---|---|---|---|
| | Low | Monitoring and evaluation | Attend trainings, fill in monitoring report, reports show understanding and reflection | 6.3.3.3 (i) |
| Youth | High | Attendance | Attending, inviting friends | 6.4.3.1 (i) |
| | High | Participation | Active and enthusiastic participation, engaging in discussions and debate. | 6.4.3.1 (ii) |
| | High | Knowledge | Describing issues which are important for them, describing the consequences of different lifestyle choices. | 6.4.3.1 (iii) |
| | Medium | Behaviour change | Healthy life style choices, use condoms, wait for sex , reduction in partners | 6.4.3.2 (i) |
| | Low | Advocacy | Young people get involved in lobbying and advocacy | 6.4.3.3 (i) |
| Priests | High | None | | |
| | Medium | Support | Take ownership of project, including it in church structures, support its financial and resource needs, clergy visit AOC, leaders give spiritual guidance | 6.5.3.2 (i) |
| | Medium | Inclusion | Take part in services, affirmation | 6.5.3.2 (ii) |
| | Low | Incorporation | Young people included in year planner, allow youth to develop own programmes , materials and liturgy, place youth in leadership positions, develop new styles of worship | 6.5.3.3 (i) |
| | Low | Internalisa-tion | Sermons on rape, drugs, violence against women and children and so on. | 6.5.3.3 (ii) |
| Parents | High | Understand-ing peer pressure | Increase of understanding of influence of peer pressure on young people | 6.6.3.1 (i) |
| | Medium | Communica-tion | Increase of listening skills, open communication, increase in conversation on lifestyle choices, says affirming things about young people | 6.6.3.2 (i) |
| | Medium | Relationship | Respect for young people's view point, trying to understand challenges of young people around sexuality, connect with own experience of adolescence, increase in trusting relationships | 6.6.3.2 (ii) |
| | Low | Participation | Attendance at workshops. | 6.6.3.3 (i) |
| | Low | Discipline | Less judgemental, allow young people to make decisions, improve positive boundary setting | 6.6.3.3 (ii) |

| Change partner | Level achieved | Topic | Areas of change | Reference |
|---|---|---|---|---|
| | Low | Advocacy | Get involved in lobbying and advocacy | 6.6.3.3 (iii) |

## 9.3.1. COMPARISON WITH THEORIES

Having listed the behaviour change which took place as progress markers were reached, these results are compared with the following theories of behaviour change:

- Freirian theories of learning (see 2.4.1).
- Social learning theory (see 2.3.2).
- Diffusion of innovation (see 2.3.5).
- Theory of reasoned action (see 2.3.3).
- Motivational communication (see 2.3.6).
- Social ecological model (see 2.4.3).

### 9.3.1.1. Freirian theories of learning (see 2.4.1)

Freirian theories propose a problem solving approach in which teacher and learner undertake to investigate problems together through a process of dialogue. This dialogical approach must be built into the programme and is very different to the normal didactic model that is generally used in schools (111,92). In his theory of participatory education Freire proposes that the full participation and empowerment of the people who are affected by a problem is essential in order to enact change (103). Thus the success of a peer education program is related to the effectiveness of this participatory dialogue (112).

This theory is reflected in the results of the progress markers for youth:

| | | |
|---|---|---|
| Youth | High | Attending, inviting friends, active and enthusiastic participation, engaging in discussions and debate. |
| Youth | High | Describing issues which are important for them, describing the pros and cons of different lifestyle choices. |

Both of these indicators scored high, which shows that there was a positive level of participatory education taking place. This process was assisted by the attitudes of facilitators:

| | | |
|---|---|---|
| Facilitators | High | Create a conducive learning environment |

This open attitude on the part of facilitators to allow participatory dialogue, and the willingness of young people to contribute to discussions freely, could have been one of the factors that led to behaviour change, even though facilitators only scored medium on collaboration.

### 9.3.1.2. Social learning theory (see 2.3.2)

Bandura's social learning theory has two premises:

- People learn directly through experience, and indirectly by observing and **modelling** the behaviour of others with whom they identify.
- People must believe that they can effectively use the skills needed for a particular action **(self-efficacy)** (103).

If we examine the first premise, then the role of peer educators and facilitators is clear; they can support learning directly as educators and indirectly as role models (112).

This theory is reflected in the results of the progress markers for peer educators:

| | | |
|---|---|---|
| Peer educators | High | Presentation skills, school attendance, team work, increase in faith |
| Peer educators | Medium | Not to be abusing drugs alcohol or sex, the message they give is the message they live |

It appears that the peer educators were successful in presenting the sessions, however the peer educators only scored a medium on their lifestyle outcome, which would indicate that there are certain areas where they are not seen to be good role models, to be 'living the message they give'. This would weaken the impact of the message.

The outcome challenge for the facilitators is also relevant here as they also serve as role models to the young people:

| | | |
|---|---|---|
| Facilitators | High | Regular church attendance, not abusing sex, drugs alcohol, positive role models |

This high score from the facilitators is important, as young people look up to them as role models and might then want to model their behaviour on them. Thus social learning could be part of the process of change.

Bandura's second premise is that people must believe they can effectively use the skills needed for a particular action (self-efficacy). The more confident a person feels, the greater the likelihood that they will perform the behaviour. Perceptions of self-efficacy are based

mainly on personal experiences and this can be achieved through role play (111,92). Training which includes role play can lead to increased confidence in being able to carry out certain behaviours, as a person gains self-efficacy – the ability to overcome barriers to performing the behaviour. Here interactive experiential learning methods are important, dramas and role plays particularly, where young people practice the particular actions or conversations that they would need to do in real life. The peer educators showed enhanced levels of self-efficacy in their progress marker evaluation. This high score indicates a reasonable level of confidence.

| | | |
|---|---|---|
| Peer educators | High | Growing in confidence, responds positively to new challenges confident to share values and goals |

### 9.3.1.3. Diffusion of innovation (See 2.3.5)

Social influence plays an important role in behaviour change. The role of **opinion leaders** in a community who act as agents for behaviour change is a key element of this theory. The opinion leaders' influence on group norms takes place as a result of one-on-one contacts and group discussions (112,103,105). Friendship groups and social networks are important routes of communication and change. The potential impact of the programme can be understood through a simple conceptual framework of social norms and connectedness (280).
If a group has clear norms, then peers associated with this group will be more likely to follow these norms. The impact of the group's norms will be greater if peers are closely connected (norms and connectedness). Thus the impact of the programme may be affected both by the clarity of norms expressed and the closeness of the social group. Those churches that involved the youth in multiple activities such as hikes, talent shows or fundraising activities may have increased the closeness of the social group and thus strengthened the impact of the social norms.

According to this theory, opinion leaders are visible, popular members of social networks. They influence social norms among their peers through informal social contacts. This is in contrast to traditional peer educators who are often chosen by teachers or health workers. AOC, by its very name, aims to follow this route, of the peer educators being agents of behaviour change. The peer educators scored a medium on being role models.

| | | | |
|---|---|---|---|
| Peer educators | Medium | Behaviour change | No to abuse of drugs, alcohol or sex, the message they give is the message they live |

AOC is designed so that peer educators are elected by their peers based on a list of leadership criteria. When this takes place, they are truly opinion leaders. However in some churches the facilitators or clergy did not feel comfortable with this approach and preferred to select the peer educators themselves, based on their 'good qualities' rather than their influence as opinion leaders. The opinion leaders were often seen to be trouble makers in the group.

This may have limited the peer educators' influence on the groups of young people. The influence of facilitators and clergy in blocking this aspect of selection should be analysed as it could become a powerful advocacy tool.

### 9.3.1.4. Theory of reasoned action (See 2.3.3)

The premise of this theory is that the intention of a person to adopt a recommended behaviour is determined by:

- Their own **subjective beliefs** (personal attitudes towards the behaviour and their beliefs about the consequences of the behaviour).
- Their **normative beliefs** (views which are shaped by the norms and standards of society and whether people important to them approve of the behaviour) (112).

A peer education programme can impact the normative beliefs in particular .In the case of this programme, normative beliefs may have been impacted by the influence of those around the young people, the peer educators, facilitators, clergy and parents. The following indicators are relevant for this theory:

- Peer educators: presentation skills, increase in faith(high), not abusing drugs, sex or alcohol (medium).
- Facilitators: regular church attendance, not abusing drugs, sex or alcohol (high).
- Parents: increase in conversations on lifestyle choices, trying to understand challenges of young people around sexuality (medium).

The premise is that the young people in this programme encountered peer educators and facilitators who spoke from a faith perspective, which generally holds more conservative norms around sexual behaviour. They also came into contact with people who were trying (if not always succeeding!) to live the message of behaviour change. There was also an increase in conversations with parents around lifestyle choices, which may also have given parents the opportunity to influence the young people with their norms.

### 9.3.1.5. Motivational communication (See 2.3.6)

Motivational interviewing is based on understanding the factors that facilitate or impede change. It recognises that behaviour change is a complex and difficult process that involves ambivalence; it is not a simple decision whether to change or not. It is a style of communication that is not confrontational or instructional, but rather collaborative and guiding. Motivational interviewing is based on principles of empathy, developing discrepancy and of supporting self-efficacy (106, 44,108).

These three aspects are examined with respect to the outcomes of the AOC programme:

**Empathy** This is the ability to understand the other person without judging or necessarily agreeing is seen in the following indicators:

| | | |
|---|---|---|
| Facilitators | Medium | Assist peer educators to facilitate, will not be authoritarian blaming or judging, have collaborative and respectful communication style |
| Parents | Medium | Respect for young people's viewpoint, trying to understand challenges of young people around sexuality, connect with own experience of adolescence, increase in trusting relationships |
| Parents | Low | Less judgemental, allow young people to make decisions, improve positive boundary setting |

Although the facilitators showed a reasonable level of empathy, the parents still tended to be in a judgemental mode, which will tend to increase resistance to behaviour change.

**Developing discrepancy**: in this process there is an attempt to develop motivation for change by highlighting discrepancy between the client's behaviour and his or her personal values and goals, recognising that the responsibility for change lies with the client. This took place during the participatory learning, where possible actions were compared to value and possible consequences**.**

**Support self-efficacy:** Motivational communication recognises that a person will only change when they are ready, willing and able to change. Self-efficacy or the belief that you can change is crucial for change. Here the role of faith and hope become very important. This can be because of an internal sense of faith 'if God gives me strength, I can abstain', or from the external faith that a mentor has in you.

Thus the mentor's belief in the person's ability becomes a self-fulfilling prophecy. It becomes part of their self-identity. For teenagers, the role of adults in their lives is very important. These adults have the ability to release the potential and facilitate the change processes already inherent in the young person (44). Here the supportive role of the facilitator, clergy and parents is very important:

| | | |
|---|---|---|
| Facilitator | High | Available, ability to listen, strong supportive relationship with peer educators, create a conducive learning environment, contribute to growth of peer educators |
| Clergy | Medium | Take part in services, affirmation |
| Parents | Medium | Increase of listening skills, open communication, says affirming things about young people |

The very supportive role of facilitators may have been one of the key factors in helping the young people to consider changes of behaviour as well as the fact that parents also increased in their affirmation and open communication with young people

### 9.3.1.6. Social ecological model for health promotion

The Social Ecological model for health promotion includes multiple influences on behaviour with the individual seen to be only one part of the process.
According to this model, behaviour is viewed as being determined by the following:

- Intrapersonal factors: characteristics of the individual such as knowledge, attitudes, behaviour, self-concept , skills
- Interpersonal processes and primary groups (families, friendships, social networks)
- Institutional factors
- Community factors
- Public policy (103,112,121).

This theory recognises the importance of the interplay between the individual and the environment and considers multi-level influences on risky behaviour. The importance of the individual is emphasized less than the other levels in the process of behaviour change.

It is important to realise that peer education can only impact at some levels of this process. It can be an important intervention in terms of intrapersonal and interpersonal change, where it was successful in terms of interpersonal relations between peer educators, youth and facilitators. However the weak area was the area of parents:

| | | |
|---|---|---|
| Parents | Low | Attendance at workshops. |

According to the ecological model, the parenting workshops were a very important part of the programme. However, Fikelela has not yet managed to find a model which the parents are willing or able to attend in numbers. For this reason, this part of the programme was the weakest. Some suggestions to pursue are support groups for parents with identified serious issues with their teenagers, such as substance abuse. A support group grows naturally out of a felt need, whereas a workshop is perceived to be giving skills rather than support. It also may be considered stigmatising to ‘need’ to attend a workshop, does that mean I am a poor parent?

When one moves from the interpersonal to the other levels of influence, peer education activities need to be coordinated with other efforts designed to influence institutions, communities and public policies. In these areas, the programme scored poorly:

| | | | |
|---|---|---|---|
| Peer educators | Low | Advocacy | Advocate for issues in community , attend quarterly gatherings |
| Youth | Low | Advocacy | Young people get involved in lobbying and advocacy |

| | | | |
|---|---|---|---|
| Clergy | Low | Internalisa-tion | Sermons on rape, drugs, violence against women and children and so on. |
| Parents | Low | Advocacy | Get involved in lobbying and advocacy |

For behaviour change to take place, young people must be reached, taught, and influenced for change. Choices of healthy lifestyle should be supported by a change in the environment. It appears that the AOC programme is successful at reaching and teaching the youth, somewhat successful at influencing them for change, and not successful at influencing the environment.

How then could the programme be adapted in order to have more influence on the environment and the broader social norms? This is discussed in the next section.

## 9.3.2. STRENGTHENING THE AGENTS OF CHANGE

The AOC programme could be strengthened by two additional concepts:

- Empowerment through developing a critical consciousness.
- Building social capital (119).

### 9.3.2.1. Empowerment and critical consciousness

Powerlessness undermines the ability of young people to choose health-enhancing behaviour. One of the roles of peer education is to develop the group's confidence to act on collective decisions. Individual theories of behaviour change conceptualise empowerment in terms of a subjective sense of confidence (self-efficacy). Through training, young people can be empowered at the individual level. This understanding of empowerment tends to focus on the emotional or motivational dimensions of empowerment. However given the structural constraints, the individual may not have the ability to act and be constrained. For example, a girl may have learnt the skills to negotiate condom use and feel confident to do so in a role play, but given the gender imbalance, when the moment arrives, she gives in to sex without a condom or finds that condoms are not accessible or affordable.

Albertyn presents three levels of empowerment; personal, interface and macro-level empowerment. The first, personal empowerment refers to the way a person feels about themselves and includes self-esteem, coping skills and self-confidence. Interface level empowerment refers to the proximal relationships around the individual such as family, peer group, church and school. Interface empowerment refers to a preparedness to take action with the group, and to participate in terms of mutual support within the group. Macro level empowerment refers to the greater society and includes an awareness of rights, participation in order to bring about change in the broader society as well as critical reflection (281). The Agents of change programme has been successful at empowering peer educators at a

personal level, for example by increasing self-efficacy, although the self-efficacy of the participating youth generally was not impacted. It has also been able to increase the interface level of empowerment through the building of supportive peer groups and to a lesser extent improving parental support. However it has not been successful at the macro-level of empowerment in terms of advocacy and critical reflection on the issues of society and culture.

Paulo Freire(46,45) conceptualises empowerment with a cognitive dimension , focusing on people's analysis of their circumstances. His argument is that group behaviour change must be preceded by the development of a critical consciousness. There are two key dimensions, firstly an intellectual understanding of the way in which social conditions have led to a situation of disadvantage (for example an understanding of the way in which factors such as gender and poverty shape poor sexual health for youth).

Secondly, groups must work together to develop a sense of personal and collective confidence in their ability to change behaviour. This is done through actively working to challenge some of the processes which place their health at risk. For example a group of young women may discuss the gender norm that a request by a girl to use a condom puts her in the category of a 'slut'. If they discuss it critically, they may realise that the gender norm that 'girls are either pure or sluts' puts their health at risk. From this starting point, young women could develop a critical consciousness of this construction of femininity and collectively work towards redefining it (for example, we believe that a strong capable woman who cares about her future will ask for a condom to be used).

Freire suggests that people are initially in a stage of 'naïve consciousnesses' where they lack insight into the way in which social norms and the social environment undermine their health. They do not see that their own actions can change these norms or conditions. The goal is to move people towards a stage of 'critical consciousnesses' where there is a dynamic interaction between critical thought and critical action. By reflecting critically in a group on the conditions that shape their lives, young people are empowered to change these conditions. The transition from naive to critical consciousness involves an '*active, dialogical educational programme'*(45); where learners are actively involved in critically analysing social norms and conditions and generating scenarios of alternative ways of being. Thus an important goal of peer education is to provide safe spaces for young people to develop a critical consciousness about their sexual health. It should promote a context within which youth can collectively develop the belief and confidence in their power to resist dominant gender norms. The potential exists for AOC to use the existing active, dialogical programme, with further training for facilitators and peer educators, to move to this level of reflection.

### 9.3.2.2. Social capital (See 2.4.2)

It has been argued that an important determinant of the success of prevention interventions is the extent to which they are able to mobilise sources of social capital (116). Social capital can be described as a 'health enabling community'. According to the social capital approach people are most likely to undergo health enhancing behaviour change if they live in communities characterised by trust, reciprocal help and support, a positive community identity as well as high levels of involvement in local organisations and networks. Campbell argues that the most important dimension of health enhancing social capital is perceived citizen power, a characteristic of communities where people feel that their needs and views are respected and valued, and where they have channels to participate in making decisions (117).

Gregson uses the network dimensions of social capital, defining social capital in terms of participation or 'civic engagement' in local community networks (116). Within a social network, social capital may play a key role by promoting three psychosocial processes which play a key role in facilitating safer sexual behaviour:

- Collective negotiation of identities at the peer level (group norms).
- Empowerment or self efficacy associated with skills building and confidence.
- Sense of belonging (identity and safety within the local community) (282).

A group of studies provide preliminary evidence that membership of certain groups can play a role in how members respond to HIV:

- Camlin found that participation in clubs and community groups can be associated with safer behaviours (118).
- Campbell found that membership in certain social groups, such as youth groups and sports clubs, led to a reduction in risk (117).

The reason for lower rates of risky behaviour is linked to issues such as a shared value system, as well as the fact of being involved in positive activities, which leaves less time for risky behaviour. Community networks can also provide the contexts for the diffusion of health related information.

### 9.3.2.3. Social support

Adoption of safer sexual behaviour is assumed to be predicated on a number of psychosocial attributes including HIV knowledge, perceived personal vulnerability, peer influence, self-efficacy (given that people who feel they are in control of their lives are more likely to feel that

they can take control of their sexual health). Group memberships may help to facilitate these attributes:

- Development of a sense of solidarity which may boost member confidence, social skills and perceived self-efficacy.
- Supportive contexts within which peers can make collectively negotiated decisions to change their behaviour. Campbell suggests that in ideal situations social groups can provide contexts for young people to develop insight into how gender relations can undermine sexual health (119). The presence of adult mentors in the church can also help to provide this supportive context for young people from dysfunctional backgrounds.
- Intra- and inter-group dynamics may play an important part in this process, providing 'bridging social capital' in that they put young people in touch with diverse and more powerful social grouping, whose support might increase the likelihood of programme success (120).

These studies indicate that perhaps the AOC programme could be strengthened by the conscious building and enhancing of social capital. Through socialisation, social networking can be increased by full youth programmes involving stay-awakes, hikes, fund-raising activities and community outreach. Social support can be enhanced by more involvement of adult mentors in the lives of the young people, and the affirmation of clergy as they consciously involve young people more thoroughly in the life of the church, rather than just as a separate youth group. Bridging social capital can be enhanced by linking of churches with better resourced churches as well as partner organisations who can offer opportunities for training or recreational activities.

# 9.4. GENDER AND THE CHURCH

In this final section the key findings regarding gender are considered. These findings regarding church based youth are compared with youth of the general community. Then the response of the church to these issues is considered, taking into account the challenges that face the church in this area, and some of the potential strengths.

## 9.4.1. KEY FINDINGS AROUND GENDER

Significant differences were found between males and females in the following areas (all $p<0.01$).

### 9.4.1.1. Risky behaviour

Males were significantly more at risk due to their behaviour (see Table 8.4)

- Ever had sex (males 26.1%, females 15.5%)
- Ever had vaginal sex (males 23.4%, females 14.1%)
- Ever had oral sex (males 16.4%, females 8.2%)
- Ever had anal sex (males 7.4%, females 1.0%)
- Mean number of partners (males 2.7, females 1.8) (see Figure 8.2)
- Mean age of sexual debut (males 13.8 years, females 14.8) (see Figure 8.3)

However females were more at risk because of using less protection

- Always use condoms (males 17.1%, females 9.1%) (see Table 8.5)

#### 9.4.1.2. Coercion

Males were significantly more likely to have coerced or persuaded someone to have sex (see Table 8.5):

- Forced someone to have sex (males 2.0%, females 0.0%)
- Sweet- talked someone into having sex (males 20.0%, females 2.2%)

#### 9.4.1.3. Beliefs

Males were significantly more likely to hold rape-supportive beliefs (see Table 8.3):

- A person has to have sex to show love (males 15.6% and females 7.6 %).
- Girls do not have the right to refuse sex with their boyfriends (males 11.7%, females 7.8%).
- Girls mean ‘yes’ when they say ‘no’ to sex (males 11.8%, females 6.0%).

### 9.4.2. COMPARISON WITH OTHER STUDIES

In this next section sexual behaviour and beliefs are compared with other studies from the general community.

#### 9.4.2.1. Sexual risk

Other studies also show higher levels of sexual activity, numbers of partners and lower age of sexual debut amongst males. The Second South African National Youth Risk Behaviour Survey (YRBS) indicates that in high school learners in the Western Cape:

- 22.0% of males and 5.2% of females had initiated sex before the age of 14.
- 42.9% of males and 31.3% of females had ever had sex.
- 54.1% of males and 41.8% of females had two or more partners in their lifetime (160).

In terms of condom use, the Second YRBS indicates that more females than males always use condoms. 35.9% of males and 41.7% of females report always using condoms. In this study of Anglican youth only 17.1% of males and 9.1% of females report always using condoms.

This indicates that whereas in the general population more young women are using condoms than males, in the Church community this is not the case. It appears that girls in the Church are much less likely to use condoms than girls in the general society.

Studies indicate conclusively that although young males tend to have more partners and be sexually active from a younger age, young women's risk of contracting HIV is higher. Rehle reports that the prevalence of HIV in females aged 20-29 years is 5.6%, more than six times the prevalence in 20-29 year old males (0.9%) (283). Sexually active young women in the Church, therefore, may be particularly at risk due to low condom usage.

#### 9.4.2.2. Coercion

The YRBS reports that in the Western Cape 9.2% of males and 8.4% of females were forced to have sex. 8.4% of males forced someone to have sex and 3.7% of females forced someone to have sex. In this study of Anglican youth the reported rates were lower: 2% of males and 0% of females forced someone to have sex. It appears that levels of coercion may be lower amongst church based youth, which is an encouraging trend.
However young women are in contact with males from all sectors of society and their risk of sexual coercion is high. In a national survey Frank indicates that 1.5% of adult females report being raped before the age of 15 years (175,284). A study in Cape Town showed that 72% of pregnant teenagers had experienced coercive sex (58). Gang rape is relatively common in the Western Cape, referred to as 'istimela' (train) or 'streamlining' (285).

#### 9.4.2.3. Beliefs about sex

In Andersson's national cross-sectional study of views of school pupils on sexual violence, very similar results were found:

- National survey: 'one has to have sex to show love' (males 15.0%, females 7.4%).
- Anglican youth: 'one has to have sex to show love' (males 15.6% and females 7.6%).
- National survey: 'girls mean yes when they say no' (males 12.5%, females 5.1%).
- Anglican Youth: 'girls mean yes when they say no' (males 11.8%, females 6.0%).

Thus it is clear that misconceptions about sexual violence are common (233). Similar misconceptions are held by Church youth as those held by youth in the general society.

## 9.4.3. THE CHURCH AND GENDER

The church faces many challenges when running prevention programmes, given the fact that gender issues are some of the key factors fuelling the pandemic. In this section two areas: patriarchy and gender roles, and silence around gender-based violence are examined.

### 9.4.3.1. Patriarchy/gender roles in society

Gender role theory maintains that people behave in ways that are consistent with cultural norms and expectations of each gender. Frank states that *'Beliefs that promote male dominance and female sexual submissiveness and violence; therefore contribute to unsafe sexual practice'* (175). South Africa has been classified as a 'rape prone' society and this is the context within which prevention programmes need to be understood (176). Traditional gender roles encourage men to be violent in the name of 'masculinity' and women to be sexually passive in order to be 'feminine'.

The male-dominated structure of society is maintained by a patriarchal structure, which perpetuates sexual violence against women. Feminine gender roles do not play a causal role in perpetuating sexual aggression, but do play a supportive role in that the traditional sexual script that women are taught, complements the aggressive male role. Women are taught to be the gatekeepers of 'uncontrollable' male sexuality and if they experience sexual victimisation, they are encouraged to blame themselves rather than the man. (176).

One of the key institutions of society is the Church. It also often supports patriarchy, both through its male- dominated hierarchical structure, and through the social roles that it endorses with its theology. Through Scriptures, traditions, sermons and teaching, religious institutions convey values and belief systems to their members (177). This theology is then worked out in the Church's practical responses to sexual violence. For example Ephesians 5:22-23 says: *'Wives submit to your husband as to the Lord. For the husband is the head of the wife as Christ is the head of the Church'.* A critical look at the history of much of our religious teaching makes clear that religious institutions have explicitly or implicitly shaped the context of values which support unequal gender roles and have tolerated violence against women (177). Often these issues are not being dealt with by the church. In the outcomes mapping evaluation the indicator for clergy on the outcomes challenge: 'sermons on rape, violence against women and children' scored low, indicating that these issues are rarely dealt with.

In order for this programme to be more effective, issues of gender need to be addressed not only in the life-skills programme, but also from the pulpit.

#### 9.4.3.2. Silence on gender-based violence.

Another challenge for the church is to speak against coercion and gender-based violence. The findings show that rape supportive attitudes amongst church youth are not greatly different to the rest of the community. Coercive behaviour is also taking place amongst church-based young people. However, a study of churches in Paarl (178) looking at the support that churches give to sexually abused teenage girls indicated that only 12.5% of congregations were involved with victims of sexual abuse, only 10.3% involved in counselling and only 9.8% involved in prevention. This in then a very important area that should be challenged through the life-skills programme and addressed by setting up adequate support and referral systems for victims of abuse.

## 9.5. CRITIQUE OF THE RESEARCH

- **Reporting bias**

The strongest critique of the research is that it was based on self-reported behaviour. There is therefore the possibility for reporting bias, where young people may under report sexual behaviour, particularly since this is a church based programme. However the same type of data collection was used in the previous baseline study, where the results from Anglican youth were similar to Western Cape statistics obtained in school surveys, so it seems that the young people were being reasonably honest (202). It is also noted that this type of self-declaration is often used in other scientific surveys (11).

- **Social desirability bias**

The second potential limitation is that in the intervention churches the young people were coming into contact with peer educators or facilitators that they liked and wanted to impress, so there might have been a danger of under-reporting (so called social desirability bias). This is a recognised problem, but the data from the questionnaires was triangulated with information from the monitoring process to detect any obvious discrepancies between qualitative and quantitative findings. It was also collected anonymously so that neither the facilitators nor peer educators knew what was written.

- **Strength of findings**

A great weakness of the study was the difficulty in obtaining sufficient numbers of matched questionnaires, which led to a reduction in the power of the study. Although reasonable numbers were achieved at baseline, the matched questionnaires were often few. This is because, unlike in the school setting, the young people do not attend youth every week, so there were different participants at different times. This was particularly problematic when it came to sub-analyses such as ‘the sexually active’, in terms of the matched data. The

numbers were too small to be able to do further sub-analysis for instance in comparing oral sex in the intervention and control groups.

- **Culture**

A further critique is that the research mainly included churches in predominantly coloured communities, which are the majority in the Cape Town Diocese. In terms of the burden of HIV, the few Xhosa speaking churches are in communities with higher levels of HIV and therefore a higher priority in terms of HIV prevention. When it came to matched questionnaires the numbers were very small so the intervention/control comparison was only done between coloured churches from similar geographical areas. This also affects generalisability as the Western Cape has a much greater coloured community than other parts of South Africa.

- **Religiosity and sexuality**

Another critique is that the questions around religiosity and sexuality were added in at a later stage, which meant that the numbers answering these questions were smaller. This was an important issue that should have been included in the original baseline questionnaire.

- **Selection of churches**

The churches were self-selecting, since the clergy who did not think that these sorts of issues should be addressed in the church would not send their young people to take part in the agents of change programme. This may mean that the selected churches were more open to the discussion of sexual behaviour.

- **Non-random selection of participants**

The participants who took part in the questionnaire were not randomly selected. They were members of the church who were attending youth or confirmation class and who showed interest in taking part in the agents of change programme. Those who were not interested dropped out. There was also the possibility of the influence of confounding factors between the groups, as youth groups often attended joint functions with other church-based youth(such as fund-raising or social activities).

- **Lack of analysis of those lost to follow-up**

There was a lack of analysis of the characteristics of those who completed the follow up questionnaire with those lost to follow-up, in order to establish the risk of bias resulting from attrition.

- **Failure to address the issue of the female condom**

The issue of the female condom was not addressed in either the literature review or the research. Female condoms are one way in which sexually active young women can take control of their sexual health and this would have been an important issue to cover.

# 9.6. CONCLUSION

In this chapter the findings from the evaluation of the Agents of Change programme were examined and the following areas discussed:

- The impact of peer education on sexual behaviour.
- The influence of religiosity on sexuality.
- Making sense of the programme in terms of behaviour change theories.
- Gender and the church.
- A critique of the research

## 9.6.1 IMPACT OF PEER EDUCATION

The agents of change programme had an impact in terms of raising the age of sexual activity on base-line virgins and in terms of condom usage for the sexually active. When compared with other programmes of peer education in Sub-Saharan Africa, both in schools and the community, to have an impact in two areas compared favourably with other studies.

The strongest factors which led to this change were

- The personal development and increased self-confidence of peer educators.
- The mentoring and role modelling by facilitators.
- The active participation by young people, and the relevance of the programme to their needs.
- The practical support by clergy, even though it was limited.
- The fact that parents were beginning to understand some of the pressures faced by young people.

The most effective strategy was the training camp for peer educators and facilitators. The quarterly gatherings were moderately successful and the parenting workshops were not successful.

When the programme is compared with the characteristics of an effective programme (286), the process of developing the programme and the curriculum were the strongest characteristics, whereas the implementation at church level was often weaker. However, according to Kirby's list of characteristics of an effective programme, AOC held many of the characteristics of a potentially effective programme.

According to the classification developed by Maticka-Tyndale (75) this type of programme requires a moderate threshold of evidence to be considered for roll out. The Agents of Change

programme has reached this required threshold of evidence and, with ongoing evaluation and further adaptation, it should be considered for further roll out.

## 9.6.2. THE INFLUENCE OF RELIGIOSITY ON SEXUALITY

When it came to comparing sexual activity with religiosity, there was no significant impact of religiosity on sexual activity in any of the three measures. In high income countries there are many studies of young people and religiosity, and there appears to be conclusive evidence that religiosity does have an impact on sexual activity in these countries. However in Sub-Saharan Africa there is a lack of conclusive evidence of the impact of religiosity on young people. Thus this study is in line with others, in confirming the gap between what young people's stated moral beliefs and their reported moral behaviour or "belief-behaviour" gap (273).

Religiosity affects sexual behaviour through three mechanisms amongst others: messages, social control and socialisation. Of these three factors the strongest in the Agents of Change programme was in terms of socialisation.

## 9.6.3. THEORIES OF BEHAVIOUR CHANGE

The factors which led to the change of behaviour as evidenced in the Agents of Change programme are underpinned by the following theories of behaviour change:

- Freirian theories of learning explain the importance of the participatory dialogue which was created in the discussions between young people and peer educators.
- Social learning theory points to the important modelling role of the peer educators and the increased self-efficacy in the peer educators.
- Diffusion of innovation theory explains the importance of the peer educators as opinion leaders and that change could take place through their social networks.
- The theory of reasoned action indicates how the change partners could influence the young people in terms of their normative beliefs.
- Motivational interviewing points to the importance of the collaborative and guiding styles that facilitators developed in their mentoring of the peer educators.
- The Social ecological model shows that the programme was relatively strong in terms of change for the individual but was weaker in terms of interpersonal change (the role of parents) and public policy (advocacy).

The programme could be strengthened by empowering the youth through the development of a critical consciousness and building social capital.

## 9.6.4. GENDER AND THE CHURCH

The study indicated that whereas in the general population more young women are using condoms than males, in the Church community this is not the case. It appears that girls in the Church are much less likely to use condoms than girls in the general society.

It appears that levels of coercion may be lower amongst church based youth, which is an encouraging trend. However misconceptions about sexual violence are common and are similar to those held by youth in the general society. The challenges of these findings to the church are in terms of condom use, patriarchy and to challenge the silence around gender-based violence.

# CHAPTER TEN: CONCLUSION AND RECOMMENDATIONS

This final chapter summarises the answers to the research question and conclusions are drawn based on the findings of the research. Recommendations are made concerning the future roll out of the Agents of Change programme as well as for youth groups and the Church. The generalisability of the findings is considered and the need for further research discussed. Finally a way forward is charted for dissemination of the findings.

## 10.1. INTRODUCTION

### 10.1.1. IMPORTANCE OF THE TOPIC

South Africa is the country with the largest number of people living with HIV in the world. It is also a country where the majority (79.8%) identify themselves as being members of the Christian churches (21). This research explored an HIV prevention intervention being run in the Anglican Church in the Western Cape of South Africa.

The results are relevant to Anglican Churches throughout the Province of Southern Africa (consisting of South Africa, Angola, Mozambique, Swaziland, Lesotho and Namibia) although cultural and contextual differences should be kept in mind. The research also has relevance to other denominations although consideration should be taken of the differing positions on the use of condoms. The Agents of Change is a comprehensive sexuality programme and promotion of the use of condoms may not be acceptable in some churches.

### 10.1.2. PURPOSE OF THE RESEARCH

The literature review identified that there is a scarcity of evaluations of faith-based HIV interventions and a limited number of evaluations of peer education programmes in Africa. Thus the identified gap in knowledge was *whether or not peer education programmes are effective for HIV prevention in a church-based setting in Africa*.

The research question was identified as:

*What is the impact of the Agents of Change HIV prevention programme on the sexual beliefs and practices of participating youth, what are the factors that led to this impact , and what recommendations can be made for a best practice model for peer education programmes on HIV infection in the church context?*

Outcome Mapping enabled a comprehensive approach to monitoring the actors and factors involved in the programme and to the evaluation of the impact in terms of the effect on sexual behaviour.

## 10.2. SYNTHESIS OF THE LITERATURE REVIEW

The purpose of the literature review was to develop a conceptual framework which was used in the evaluation of the programme. The literature review consisted of three sections; ‘theories of behaviour change’, ‘sexual relationships’ and ‘the Church and HIV’.

### 10.2.1. THEORIES OF BEHAVIOUR CHANGE

Two main themes emerged from the section of the literature review dealing with theories of behaviour change: the importance of peer education and strategies for reducing risky behaviour.

#### 10.2.1.1. Peer education

Peer education can be understood in terms of behaviour change theories. Peer educators have several roles; as role models, as educators and as members of the same peer group.

- **Role models**

According to the theory of diffusion of innovation, peer educators will be more effective if they represent the social structure of the target group (123). Opinion leaders act as agents of behavioural change by disseminating information and influencing group norms in their peer group (90).

- **Educators**

According to Freirian theories of education, the full participation and empowerment of the people who are affected by a problem is essential in order to enact change (103). The success of a peer education programme is related to the effectiveness of this participatory dialogue (112,111, 92).

- **Peer group members**

Peer education is based on a belief in positive peer pressure. People do not change through providing information, they change when those around them change (104,124).

### 10.2.1.2. Reducing risky behaviour

Change can be supported through several processes: developing a futures-orientated thinking, building self efficacy, parental influence, a guiding style of communication, developing normative beliefs around sexual behaviour, strengthening inter-personal processes, building social capital and reducing vulnerability.

- **Developing a futures-orientated thinking**

Adolescents are generally concerned with immediate risks and benefits rather than the future. If they can understand the personal consequences of their actions they may be more likely to change (124).

- **Building self-efficacy**

Bandura's social learning theory indicates that an increase in self confidence, and a belief that one can effectively use the skills needed for a particular action, will increase the likelihood that a young person will take that action (103). Self-efficacy, which is the belief that you can change, is crucial for change.

- **Role of parents**

Both parental supervision and support, as well as parental disapproval of early sexual activity have been associated with later sexual debut (125,126).

- **A collaborative and guiding style of communication**

According to motivational interviewing, behaviour change can be supported by a communication style which is collaborative and guiding. It is based on principles of empathy, developing discrepancy and of supporting self efficacy (106,44 ,108).

- **Developing normative beliefs around sexual behaviour**

According to the theory of reasoned action, the intention of a person to adopt a recommended behaviour is determined by their normative beliefs which can be impacted by those around them, peers and adults (112).

- **Strengthening interpersonal processes**

According to the social ecological model, behaviour is determined by individual factors, interpersonal processes, institutional factors, community factors and public policy (103,112). Peer education can have the greatest effect at personal and interpersonal levels.

- **Building social capital**

Social capital can form a 'protective shield' for young people and can be enhanced through socialisation between peers, and relationship building with adult mentors.

- **Reducing vulnerability**

To reduce risk it is also important to identify the causes of vulnerability, and not just focus on individual behaviour change.

## 10.2.2. SEXUAL RELATIONSHIPS

The second part of the literature review dealt with sexual relationships. The theory of triadic influence underpinned this part of the literature review and discussed the issues in terms of the three levels of risk: intrapersonal, proximal and distal (49).

- **Intrapersonal**

Building self-esteem and challenging negative body images are important particularly for girls.

- **Proximal**

Gender norms and power imbalances as well as older partners place adolescent girls at risk. The programme can have an impact on changing gender norms, challenging power imbalances and educating youth about the dangers of older partners. There is a need to create a critical consciousness around gender issues.

- **Distal**

Violence and poverty are issues which increase girls' vulnerability; the programme can have an impact in terms of challenging rape-supportive attitudes as well as media messages which support the sexualisation of girls.

## 10.2.3. RELIGION AND HIV

The section of the literature review which dealt with religion and HIV looked at how the church can influence sexuality. Some of these influences are positive and some are negative.

### 10.2.3.1. Positive influences on sexuality

These positive influences are in terms of moral teaching, socialisation, and building self-efficacy:

- **Moral teaching**

The church teaching on abstaining from sex before marriage and faithfulness once you are married can influence sexuality positively (212,67,216).The church is often criticised for having a negative attitude towards sexuality.

- **Socialisation**

Socialisation may involve the formation of a positive peer group and monitoring of behaviour (22).

- **Building self-efficacy**

Self-efficacy may be enhanced by spiritual beliefs which can build self confidence and belief that one is loved by God and supported by other members of the faith community (194).

### 10.2.3.2. Negative influences on sexuality

The church can have a negative effect in terms of a reduction in condom use and through its silence on issues of gender and coercion. Studies have shown that the church's negative attitude to condoms can reduce condom use amongst young church-going people (22,216). The church also needs to move towards a less hierarchical attitude to gender and towards the concept of 'men as partners' (161).

The findings from these three sections of the literature review were combined to form the conceptual framework as indicated in Table 10:1:

**Table 10.1: Conceptual Framework**

| Key factors | Actors | Actions |
|---|---|---|
| Peer education | Peer educators, peer group members | Role modelling<br>Participatory education<br>Positive peer pressure |
| Enabling behaviour change in relation to sexual behaviour | Parents, facilitators, peer educators and group members | Develop a futures orientation<br>Build self efficacy<br>Improve parental supervision and support<br>Develop a collaborative and guiding style of communication<br>Develop positive normative beliefs around sexual behaviour<br>Improve interpersonal relationships |
| Changing personal, proximal and distal factors in male-female relationships | Peer educators and peer group members | Build self esteem<br>Build social capital<br>Reduce vulnerability<br>Challenge gender norms<br>Challenge negative body images<br>Challenge power imbalances<br>Change rape supportive attitudes<br>Challenge media messages<br>Develop an understanding of the risks of older partners<br>Challenge gender based violence and coercion |

| Key factors | Actors | Actions |
|---|---|---|
| Creating a supportive Church context | Clergy, peer group, other adults | Moral teaching: move from a moralising approach to a human-rights approach<br>Build opportunities for socialisation<br>Build self efficacy<br>Develop a positive attitude towards sexuality<br>Shift from patriarchy towards the concept of 'men as partners'<br>Challenge Church's attitude to condom use<br>Break the silence on gender issues and coercion<br>Create a critical consciousness around gender<br>Work to decrease vulnerability caused by poverty |

# 10.3. CONCLUSIONS FROM THE RESEARCH FINDINGS

The research question posed the following three questions:

- *What is the impact of the Agents of Change programme on participating youth?*
- *What are the factors that led to this impact; and*
- *What recommendations can be made for a best-practice model for peer education programmes in church?*

The conclusions in regard to each of these three questions are addressed in the following section. This is followed by consideration of whether the programme should be rolled out.

## 10.3.1. IMPACT OF THE PROGRAMME ON PARTICIPATING YOUTH

The conclusion is that the programme had a significant effect on raising the age of sexual debut and showed a significant improvement in condom use amongst those who were sexually active. It did not significantly increase abstinence amongst those already sexually active and had no significant impact on the numbers of partners. When compared with other programmes in Sub-Saharan Africa, these results show moderate success.

## 10.3.2. FACTORS THAT LED TO THIS IMPACT

The actors and factors within the programme which were thought to be responsible for the effect on the youth are considered in terms of the underlying conceptual framework in Table 10.2**:**

**Table 10.2: Evaluation of factors according to the conceptual framework**

| Area | Actors | Factors | Effectiveness |
|---|---|---|---|
| Peer education | Peer educators, peer group members | Role modelling | High |
| | | Participatory education | High |
| | | Peer pressure | High |
| Reduction in risky behaviour (process) | Parents, facilitators, sexual partners | Develop a futures orientation | Medium |
| | | Build self-efficacy | Medium |
| | | Improve communication | Medium |
| | | Develop normative beliefs | Medium |
| | | Improve interpersonal relationships | High |
| Sexual relation-ships (content) | Sexual partners, peer group members | Build self-esteem | Medium |
| | | Challenge media messages | Low |
| | | Change rape supportive attitudes | Low |
| | | Challenge gender norms | Low |
| | | Challenge power imbalances | Low |
| The Church (context) | Clergy, peer group members, other adults | Moral teaching | Medium |
| | | Socialisation | High |
| | | Building self-efficacy | Medium |
| | | Challenge church's attitude to condoms | High |
| | | Break the silence on gender issues and coercion | Low |

The strongest aspect of the conceptual framework that was realised in practice was therefore the peer education itself. This was rated as effective in the areas of role modelling, participatory education and creating positive peer pressure. In the area of reduction of risky behaviour there was an improvement in interpersonal relationships, particularly in the relationship with facilitators as mentors. In the area of sexual relationships there was no factor that scored high, but the highest factor was building self-esteem. In the area of the church the strongest element was socialisation between peer group members and improved attitudes towards use of condoms.

In conclusion therefore it appears that the main factors that led to the impact on sexual behaviour were first of all a well developed curriculum and programme. The effective training camps were also a crucial part of the programme. The ongoing mentoring and training of peer educators and facilitators was important since it encouraged the churches to continue. The aspects of peer education which were identified as most important were the areas of role

modelling, participatory education and creating positive peer pressure. The reduction of risky behaviour through building self-esteem was also identified as an important factor. The relationships with the facilitators and their mentoring of the peer educators were key in the programme. The strong socialisation taking place within the Church between peer group members was also identified as a key factor. Finally, the fact that the programme was able to challenge the church's negative attitude to condoms was identified as an important aspect of the programme.

The weakest areas of the programme were in the area of advocacy as well as challenging media messages and norms on gender.

## 10.3.3. A BEST-PRACTICE MODEL FOR PEER EDUCATION IN THE CHURCH

In this section a best practice model is identified for peer education in the Anglican Church. Three areas are considered, the implementation of the programme, the strategies to be implemented and the content of the programme as listed in Table 10.3 below. Each recommendation is linked to the underlying evidence from the thesis in the last column.

**Table 10.3: Recommendations for a best-practice model**

| **IMPLEMENTATION** | | **Reference** |
|---|---|---|
| **Type of programme** | It is recommended that this programme be promoted as a youth development programme rather than an HIV prevention programme. | 7.3.2.4 (xix) |
| **Criteria for the selection of churches** | Priority should be given to churches in communities with the highest HIV rates. | 7.3.2.4 (vi) |
| | The church should have an existing youth group, which prioritises teenagers | 7.3.2.4 (vi) |
| | A method of communication should be identified with a member of the congregation (access to fax or email) | 7.3.2.3 (v) |
| **Target group** | It is important to also focus on younger teens, from 12 to 15 years. | 7.3.2.4(xx) |
| | Focus on youth in Bible class or youth group rather than on confirmation candidates | 4.6.2.2 |
| **Selection of peer educators** | Peer educators should be elected by their peers and not selected by adults. | 7.3.2.4 (vi)<br>7.3.2.4 (xviii) |
| | Peer educators should be over sixteen but not in matric. | 7.3.2.4 (xviii) |
| | A gender balance should be maintained. | 7.3.2.4 (xiv) |
| **Choice of facilitators** | Facilitators should be adult youth leaders who have been working with the group for some time. Younger people can assist as co-facilitators. | 6.3.2.1(i) |
| | Quarterly meetings should be held with facilitators on their own. | 6.3.2.1(iii) |
| **Clergy** | Adequate buy-in needs to be received from the clergy | 7.3.2.4 (viii) |

| IMPLEMENTATION | | Reference |
|---|---|---|
| | The programme should not be run where there is an inter-regnum. | 7.3.2.4 (viii) |
| **STRATEGIES** | | |
| **Training camp** | The three day training camp is an effective strategy which should be funded and run by the local church/Diocese with assistance from outside trainers. The finances should be generated by the Diocese involved. | 7.3.1,3<br>7.3.4.1<br>7.3.1.4 (v) |
| | The training of facilitators on the importance of Monitoring and Evaluation needs to be strengthened | Table 7.3 |
| **Quarterly gatherings** | Quarterly gatherings should be strengthened with additional training on Motivational Interviewing. | 7.3.2.4 (ii) |
| | Monitoring and evaluation data should be collected in small groups orally and transcribed. | 7.3.2.4 (ii) |
| | Training should be given on issues such as time management and planning. | 7.3.2.4 (iv) |
| | The final certification should be upgraded to be a highlight in the young people's lives. | 7.3.2.4 (xi)<br>7.3.4.2 |
| | Voluntary Counselling and Testing should be incorporated into the first quarterly gathering with a session indicating how to run it at your own church. | 7.3.2.4(xii) |
| **Parenting workshops** | It is recommended that parenting workshops be removed from this programme, but that the issues be addressed in a different way by the broader church. This could be in the form of a support group. | 7.3.4.3<br>7.3.3.3(iii) |
| **Social outreach** | It is recommended that regular social outreach activities be incorporated into the programme on a local level. | 7.3.2.4 (xii)<br>6.2.2.2(v)<br>6.2.3.3(i) |
| **CONTENT** | | |
| **Condoms** | Beliefs that are limiting condom use among church-based youth need to be identified and challenged. | 9.4.2.1 |
| | The linking of condoms and lack of trust needs to be challenged. A positive message linking condom use with respect for your partner and taking responsibility for your future needs to be encouraged. | 3.3.2.1(iii) |
| **Partners** | More attention needs to be paid to the dangers of multiple partners. | 8.2 |
| | The beliefs and practices that lead to inter-generational sex need to be identified and challenged | 3.3.2.1(iv) |
| **Coercion** | The attitudes and beliefs of the specific community around sexual coercion need to be identified and challenged. | 9.4.1.2<br>9.4.1.3<br>9.4.2.3 |
| | A stronger emphasis should be placed on helping youth to challenge gender imbalance in relationships. | 3.3.2.1(ii) |
| **Peer pressure** | The values that the group aspires to should be consciously identified. The programme should focus on strengthening health enhancing social norms | 3.3.2.1 (v) |
| **Positive** | The focus should be on positive messages rather than | 4.6.2.1 |

| IMPLEMENTATION | | Reference |
|---|---|---|
| **messaging** | negative, fear-based or moralising messages. | |
| **Build self-efficacy** | The programme should seek to build self efficacy amongst the peer educators and youth by giving them as many opportunities as possible for participation. | 4.6.4.2 |
| **Recognise different stages** | This is a comprehensive programme which recognises that some of the youth are sexually active and some not, so messages of abstinence or condom use are given at different stages. | 4.3.2.1 |
| **Develop a critical consciousness** | The programme provides safe spaces for young people to develop a critical consciousness about their sexual health. | 9.3.2.1 |

Having answered the research question, indicating the impact of the programme on participating youth, the factors that may have led to this impact and describing a best-practice model for church-based peer education, the question is asked whether the Agents of Change programme should be rolled out.

## 10.3.4. SHOULD AGENTS OF CHANGE BE ROLLED OUT?

According to the World Health Organisation, the threshold of evidence required for this type of intervention to be rolled out is moderate, and this threshold can be considered to have been met (75). The characteristics identified by the World Health Organisation as required for roll-out are feasibility, lack of potential for adverse outcomes, acceptability, potential size of effect, and other health or social benefits (75).

In terms of feasibility: the structure of the church is in existence already and no additional structure needs to be set up, the programme can be run by existing youth groups. The potential for adverse outcomes is small, since the programme is being facilitated by leaders who are already running the youth groups. There is a large potential size of effect, since the Anglican Church is one of the larger denominations with 815 congregations and an estimated membership of 2,000,000 (287). The programme could readily be adapted for other denominations as well. Finally there are numerous other additional potential health or social benefits: the youth become involved in many health-enhancing and developmental activities as the programme is rolled out.

Thus it can be concluded that Agents of Change has the necessary characteristics and should be rolled out.

## 10.4. FURTHER RECOMMENDATIONS

There are three key questions to be answered in this section:

- What recommendations are there for youth groups?
- What are the recommendations for the Anglican Church?
- What is the generalisability of this study?

The recommendations for youth groups are listed in Table 10.4:

**Table 10.4: Recommendations for youth groups**

| Topic | | Reference |
|---|---|---|
| **After-school homework clubs** | Much sexual activity takes place after school when young people are not monitored and the recommendation is that churches provide after school study time at their premises, which has the dual function of improving education and also reducing opportunity and vulnerability to risky behaviour. | 7.3.2.4 (xv) |
| **Sexualisation of girls** | The negative impact of sexualisation of girls needs to be recognised. Many youth groups continue to do 'Miss' contests which may have a negative impact on some of the girls, emphasizing that your value is in your body. It is also important that the importance of sport for girls is emphasized. For example many churches have soccer competitions for boys, but few sporting opportunities for girls. | 3.2.3.2(ii) |
| **Faith in God** | Often there is a disconnect between spirituality and lifestyle. More efforts need to be made to make clear the connection between the two, through debate or role plays. | 4.3.2.1(i) |
| **Socialisation** | Socialisation is important for strengthening social norms, for forming social capital and its importance should not be underestimated. Resources should be allocated for 'fun' activities as well as serious ones. | 4.5.2<br>4.6.2.3 |
| **Homosexuality** | This is often a taboo subject in many churches, but it is important that youth leaders and facilitators be trained to support the many young people who are struggling with their sexuality. | 4.6.1.2 |

Following these recommendations to youth groups, we consider recommendations to the Anglican Church as in indicated in Table 10.5:

**Table 10.5: Recommendations for the Anglican Church**

| Topic | | Reference |
|---|---|---|
| **Counselling** | There is a need for effective support systems to be set up in the area of counselling. Priests are often unable because of time restraints to offer several sessions of in depth counselling and these referrals systems need to be in place. Partnerships with substance addiction programmes need to be formed | 7.3.2.3 (xvi)<br><br>7.3.1.4(ii) |
| **Messages around sexuality** | These messages can also lead to feelings of shame, guilt and unworthiness. It is important that the church considers the messages that are being portrayed and the impact on young people who are often very vulnerable. Religion is an effective basis for self worth, since it can give meaning to human life. | 3.3.1.2 |
| **Address sexuality in a positive way** | It appears that Churches rarely address issues of sexuality from the pulpit and often do so in 'sex negative' and judgmental way. Young people are encouraged to stay away from sex but often values around sexuality are not addressed in church. | 4.6.2.1 |
| **Advocacy** | The role of the Church in advocacy needs to be strengthened. Issues such as rape or domestic violence need to be addressed more strongly by the Church at a local and national level. | 3.3.2.1(i) |
| **Build social capital** | Young people are most likely to undergo health enhancing behaviour change if they live in communities characterised by trust, reciprocal help and support, a positive community identity as well as high levels of involvement in local organisations and networks. The Church can provide much of this social capital even if it is lacking in the broader community. | 9.3.2.2<br>9.3.2.3 |
| **Reduce vulnerability** | The Church can monitor school attendance of at risk youth and help where possible with access to school fees or stationary. | 3.3.3.1 (i) |
| **Adopt a human rights approach to sexuality** | Move from a moralising approach to a human rights approach. Young people have the right to the following:<br>• to refuse unwanted sexual behaviour;<br>• to the necessary knowledge and ability to protect themselves from STIs and unwanted pregnancy | 3.3.2.1(vi) |
| **Men as partners** | A move from patriarchal relationships to partnerships will lead to reduced risk for both male and female. It is important to emphasize the advantages for men of participating in more gender equitable relationships | 3.3.2.1(vii) |

## 10.5. GENERALISABILITY OF FINDINGS

The Anglican Church in Southern Africa is made up of 23 Dioceses in South Africa, Namibia, Swaziland, Angola and Mozambique and Lesotho. There is a reasonable cohesion between

the Dioceses, with regular meetings of Bishops. If the programme was accepted by the Archbishop for roll out, it would be reasonably easy to roll out in the South African Dioceses. There may be cultural and contextual differences in the other countries which would require adaptation. In terms of other denominations, the programme could work as well in other mainline churches such as the Methodist or Presbyterian Church. It is likely that the Catholic Church as well as the Pentecostal churches would be less supportive of a comprehensive programme that includes the role of condoms.

## 10.6. IMPLICATIONS FOR FUTURE RESEARCH

Given the importance of religion in Africa, there is a need for further research into the Church and issues such as HIV prevention and sexual coercion.

If this programme is rolled out further it will be important to research how effective it is in different settings and cultures and to adapt it for those settings. It could also be important to compare the impact of a peer education programme run in a church with an adult led prevention programme.

Given the weakness of the parenting workshops, it would be important to research other methods of involving parents, for instance parental support groups.

One aspect of the evaluation which was not undertaken was an evaluation of efficiency. This type of evaluation considers the degree to which a programme produces the benefits in relation to its costs. It would be important to consider whether this is a cost-effective programme when compared with other possible programmes (226,220).

## 10.7. DISSEMINATION OF FINDINGS

The findings will be disseminated in several ways. First of all a report will be made to the clergy of the Diocese of Cape Town. This will be followed by a report to the Bishops of the Anglican Church of Southern Africa. The problem of 'AIDS' fatigue should be communicated to the Department of Education in order to help them to improve their life-skills programmes.

The e-thesis will be made available at the University of Stellenbosch library. Following this, articles will be prepared for publication in scientific journals. One article has already been published, namely:

> Mash, R.; Mash, R.; De Villiers, P.; 'Why don't you just use a condom? Understanding the motivational tension in the minds of South African women.' 2010 African Journal of Primary Health Care and Family Medicine Volume 2, No.1. Available from http://www.phcfm.org (See Appendix 8.2)

## 10.8. SUMMARY

Given the scarcity of research into the role of the Church in HIV prevention in Africa, this research is of cutting-edge importance. Using a quasi-experimental design a church based HIV prevention programme was evaluated. The results showed a rise in the age of sexual debut amongst base-line virgins and an increase in condom use amongst those who were sexually active. The factors which led to these results were identified using Outcome Mapping as a methodology. On an organisational level they were shown to be a well developed curriculum and programme, effective training camps and ongoing mentoring and training. Factors which led to change at the church level were identified amongst the 'change partners'. The peer educators were effective at role modelling, and creating positive peer pressure. The programme led to participatory education taking place and risky behaviour was reduced through building self esteem. The facilitators had an important role in building supportive relationships with peer educators and mentoring them. The strong socialisation taking place between young people formed a positive peer pressure. The fact that this programme was taking place in the church with the support of clergy enabled the negative attitude of the church towards condoms to be challenged and led to an increase in condom use. A best practice model for peer education and HIV prevention via the Agents of Change programme in the church was created. The research shows that a church based peer education programme can yield results and should be rolled out.

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# APPENDICES

**This section contains the following appendices:**

Appendix 1: Parental consent
Appendix 2: Map of the Anglican Church of Southern Africa
Appendix 3: Letter of authorisation from Archbishop Ndungane
Appendix 4: Questionnaire
Appendix 5: List of participating churches
Appendix 6: Letter from the Ethics committee
Appendix 7: Rutanang principles
Appendix 8: Publications

- 8.1 Mash R, Kareithi R, Mash B. Survey of sexual behaviour among Anglican youth in the Western Cape. SAMJ 2006;96(2):124-127.
- 8.2 Mash R, Mash B, de Villiers P. 'Why don't you just use a condom?': Understanding the motivational tensions in the minds of South African women. African Journal of Primary Health Care & Family Medicine 2010;2(1):4.
- 8.3 Mash R, Kareithi R, Mash B. Agents of Change: a peer education programme fighting AIDS in Africa: survey of sexual behaviour amongst Anglican youth in the Western Cape, South Africa. Poster presentation at the XVI International AIDS conference, Toronto 2006

**TITLE OF THE RESEARCH PROJECT: AN EVALUATION OF THE 'AGENTS OF CHANGE' PEER EDUCATION PROGRAMME IN THE ANGLICAN CHURCH OF THE WESTERN CAPE**

**REFERENCE NUMBER:**

**PRINCIPAL INVESTIGATOR: Rev Rachel Mash**

**ADDRESS: Fikelela AIDS Project, POBOX 1932, Cape Town 800o**

**CONTACT NUMBER: 021 4651557**

Your child is being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is all about and how your child could be involved. Also, your child's participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you or your child negatively in any way whatsoever. You are also free to withdraw him/her from the study at any point, even if you do initially agree to let him/her take part.

This study has been approved by the **Committee for Human Research at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

## *What is this research study all about?*

- The youth of the Anglican Church are at risk of HIV and teenage pregnancies. Fikelela AIDS project has started a programme called Agents of Change which is a peer education project (this means that young people are taught by young people). We really want to make a difference to help our young people. This programme will involve young people teaching the youth group about sexuality, teenage pregnancy, HIV&AIDS etc. In order to see if the programme is making a difference we would like to ask the young people to fill in a questionnaire which asks questions about their beliefs, and knowledge and sexual practices. Other young people will be invited to join a small group to discuss some of the issues that arise from the questionnaire. Once we have finished the research we will be able to make the programme better so that we can roll it out to other churches.

## *What will happen?*

- After church, or in the youth group, someone will come from Fikelela. They will ask the young people if they are willing to fill in a questionnaire. They will explain what it is all about. The questions will be read out one at a time and translated where necessary. The questionnaires are completely confidential. Once they have been filled in, they will be folded, placed into a ballot box and taken away. The young people must not put their

names on the questionnaire. The questionnaires will not be seen by any of the church members. They will go straight to Fikelela and the information loaded on the computer for further analysis. .

## *Why has your child been invited to participate?*

- The young people who will fill in the questionnaires are firstly the young people from churches that are taking part in the agents of change programme. Secondly they are young people from churches where the agent of change is not taking place. The reason for this is that we need to compare the two churches to see if the programme does make a difference.

## *What will your responsibilities be?*

- You may find that your child comes home with questions about what was asked in the questionnaire. If there is anything that you find difficult to answer, please contact Fikelela. .

## *Will your child benefit from taking part in this research?*

- The benefit of this research is that we want to find a programme that can make a difference. Your child's participation in this study is very important. If we can make this programme successful we may be able to help young people from becoming infected with HIV or falling pregnant. Your child may in this way also be protected as well.

## *Are there any risks involved in your child taking part in this research?*

- By filling in this questionnaire, your child may start asking difficult questions to do with sex. It is important that you answer them honestly.

## *If you do not agree to allow your child to take part, what alternatives does your child have?*

- If you do not want your child to fill in the questionnaire, then that is not a problem at all, it is your free choice.

## *Who will have access to the information?*

- The questionnaires are filled in confidentially. All the information collected will be keyed into the computer at Fikelela, and no one else will have access to it. Once the data has all been collected, the results will be made available, but individuals will never be identified.

## *What will my child receive from taking part in this study and are there any costs involved?*

If your child takes place in the study he or she will receive a pen as a small gift to say thankyou for taking the time to fill in the questionnaire. The results of this survey will benefit many young people, because we would be able to develop a more effective programme to help others.

## *Is there any thing else that you should know or do?*

- You can contact Rev Rachel Mash on 4651557 if you have any further queries or encounter any problems.
- You can contact the Committee for Human Research at 021-938 9207 if you have any concerns or complaints that have not been adequately answered.
- You will receive a copy of this information and consent form for your own records.

**Assent of child**

I (*Name of Child/*)……. have been invited to take part in the above research project.

- My youth leader and/or my parents have explained the details of the study to me and I understand what they have said to me.
- I also know that I do not have to fill in the questionnaire if I do not want to and that I do not have to answer any question I feel uncomfortable with.
- By writing my name below, I voluntary agree to take part in this research project. I confirm that I have not been forced by anyone to take part.

..... .....

**Name of child** **Independent witness**

(To be written by the child if possible)

**Declaration by parent/legal guardian**

By signing below, I *(name of parent/legal guardian)* ……..…… agree to allow my child (name of child) ……..… who is ……. years old, to take part in a research study entitled AN EVALUATION OF THE AGENTS OF CHANGE PROGRAMME

**I declare that:**

- I have read or had read to me this information and consent form and that it is written in a language with which I am fluent and comfortable.
- If my child is older than 7 years, he/she must agree to take part in the study and his/her ASSENT must be recorded on this form.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurized to let my child take part.
- I may choose to withdraw my child from the study at any time and my child will not be penalized or prejudiced in any way.

Signed at (*place*) .....…….. on (*date*) ……..…….. 2005.

..... .....

**Signature of parent/legal guardian** **Signature of witness**

**Declaration by investigator**

I *(name)* ……..…… declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understand all aspects of the research, as discussed above
- I did/did not use a translator (i*f a translator is used, then the translator must sign the declaration below).*

Signed at (*place*) .....…….. on (*date*) ……..…….. 2005.

..... .....

**Signature of investigator** **Signature of witness**

## *Declaration by translator*

I *(name)* ……..…… declare that:

- I assisted the investigator (*name*) ……..……. to explain the information in this document to (*name of parent/legal guardian*) ……..……... using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the parent/legal guardian fully understands the content of this informed consent document and has had all his/her questions satisfactorily answered.

Signed at (*place*) .....….....…….. on (*date*) ……...…….. 2005.

..... .....

## APPENDIX TWO: MAP OF THE ANGLICAN CHURCH OF SOUTHERN AFRICA

FROM THE ANGLICAN ARCHBISHOP OF CAPE TOWN
The Most Reverend Njongonkulu Winston Hugh Ndungane DD FKC

BISHOPSCOURT CLAREMONT CAPE 7708
SOUTH AFRICA

TELEPHONE: (021) 761-2531
FAX: ([redacted]) [redacted]/761-4193
e-mail: archbish@bishopscourt-cpsa.org.za

28th June 2006

To Whom it May Concern
University of Stellenbosch
Western Cape

I hereby give permission for an evaluation of the 'Agents of Change' peer education programme to take place in my diocese, the Diocese of Cape Town, by Revd Rachel Mash.

I am aware that parental consent will be sought before any minor fills in a questionnaire, and that all replies will be treated with confidentiality. At no time will individual replies be linked to individuals.

Yours faithfully

NJONGONKULU NDUNGANE
Archbishop of Cape Town

# Fikelela : Agents of Change Programme
# 2008 Post-Implementation Survey Questionnaire

**Confidentiality**
The information you provide shall be used for the purposes of the Agent of Change Programme. It will not be identified to you in any way, and shall be treated with extreme confidentiality. No personalized information shall be given to your parents, priests, or youth leaders. **Please do not write your name in any section of this questionnaire**

.

**Explanations**
Find a space where you will feel free to fill in this questionnaire. Someone from Fikelela will read out the questions, so that everyone can answer the questions at the same time, and any necessary translation can be made.

Where there are options, please circle you answer.
You can provide more information if you so wish, or if your answer is not one of the options. Please give us your honest opinion and feelings. At the end of this exercise, kindly put your own questionnaire into the box provided. This will helps us maintain **confidentiality.**
Thank you!

**Part 1: General**

| | Questions | Response |
|---|---|---|
| 1.1 | What is your date of birth? | *DD / MM/ YEAR* |
| 1.2 | What sex are you? | 1. Male (boy)<br>2. Female (girl) |
| 1.3 | Where do you live? | 1. Urban area<br>2. Rural area |
| 1.4 | What is your race? | 1. Black<br>2. White<br>3. Coloured<br>4. Indian / Asian |
| 1.5 | Who do you live with? | 1. Both parents<br>2. One parent<br>3. Another relative<br>4. A friend |
| 1.6 | What school do you attend? | 1. Local government school<br>2 Model C school<br>3. Independent school<br>4. Not sure |
| 1.7 | What is the name of your school? | |
| 1.8 | What HIV/AIDS programmes have you attended at school? | 1. LoveLife<br>2. Peer education<br>3. Life-skills programme ( in Life Orientation class)<br>4. Other(please say what it was called) |

| | | |
|---|---|---|
| 1.9 | What is your religion/faith? | 1. Christian: Anglican<br>2. Christian: Other<br>3. Muslim<br>4. Other (please state which) |

**Part 2: Self esteem**

| | Questions | Response |
|---|---|---|
| 2.1 | Do you feel that you are as important as other people? | 1. Never<br>2. Sometimes<br>3. Often<br>4. Always |
| 2.2 | Do you have goals and believe you can reach them? | 1. Never<br>2. Sometimes<br>3. Often<br>4. Always |
| 2.3 | Can you stand up for your beliefs even if your friends believe in something different? | 1. Never<br>2. Sometimes<br>3. Often<br>4. Always |

Before you fill in the next session, let us define a few terms. There are different types of sex, for example vaginal, oral and anal.
**Vaginal sex** with someone is when the penis is in the vagina.
**Oral sex** with a man or a woman is when either you or your partner's mouth was on the penis / vagina.
**Anal sex** with someone is when the penis was in the anus.
THIS CAN HAVE BEEN DONE TO YOU OR YOU COULD HAVE DONE IT TO SOMEONE.
Therefore, someone who is sexually active has any type of sex (vaginal, oral or anal sex) with someone else.

**Part 3: Knowledge**

| | Questions | Response |
|---|---|---|
| 3.1 | Is oral sex really sex? | 1. Yes<br>2. No<br>3. Not sure |
| 3.2 | Is anal sex really sex? | 1. Yes<br>2. No<br>3. Not sure |
| 3.3 | A person has to have sex to show love. | 1. Agree<br>2. Disagree<br>3. Not sure |
| 3.4 | It is rape if you are physically forced to have sex without your consent. | 1. Agree<br>2. Disagree<br>3. Not sure |
| 3.5 | Girls do not have the right to refuse sex with their boyfriends. | 1. Agree<br>2. Disagree<br>3. Not sure |

| | | |
|---|---|---|
| 3.6 | Girls mean 'yes' when they say 'no' to sex. | 1. Agree<br>2. Disagree<br>3. Not sure |

**Part 4: Sexual behaviour**

| | **Questions** | **Response** |
|---|---|---|
| 4.1 | Have you ever had sex? | 1. Yes<br>2. No |
| 4.1.1 | Have you ever had vaginal sex? | 1. Yes<br>2. No |
| 4.1.2 | Have you ever had oral sex? | 1. Yes<br>2. No |
| 4.1.3 | Have you ever had anal sex? | 1. Yes<br>2. No |
| 4.2 | At what age did you first do any of the above? | *Write age* |
| 4.3 | In 2008, did you have sex (vaginal, oral or anal)? | 1. Yes<br>2. No |
| 4.3.1 | How many sexual partners did you have in 2008? | *Write number* |
| 4.3.2 | In 2008, how often did you or your partner(s) use a condom? | 1. Never<br>2. Sometimes<br>3. Frequently<br>4. Always<br>5. I have not had sex in 2008 |
| 4.3.3 | In 2008, have you had sex under the influence of drugs? | 1. Yes<br>2. No<br>3. I have not had sex in 2008 |
| 4.3.4 | In 2008, have you had sex under the influence of alcohol? | 1. Yes<br>2. No<br>3. I have not had sex in 2008 |
| 4.4 | In 2008, have you had sex with someone in order to get something from them (e.g. clothes, food, and cell phone)? | 1. Yes<br>2. No<br>3. I have not had sex in 2008 |
| 4.5 | Did you force someone to have sex with you in 2008? | 1. Yes<br>2. No<br>3. I have not had sex in 2008 |
| 4.6 | Have you tried to persuade (sweet talk) a girl or boy to have sex with you in 2008? | 1. Yes<br>2. No |
| 4.7 | If you have tried to sweet talk someone, did the girl or boy agree to have sex with you in 2008? | 1. Yes<br>2. No<br>3. I have not had sex in 2008 |

**Part 5: Talking about sex**

| | **Questions** | **Response** |
|---|---|---|
| 5.1 | Have you ever had a conversation about sex | 1. Yes |

| | | |
|---|---|---|
| | with your parent(s) / guardian(s)? | 2. No |
| 5.2 | How comfortable do you feel speaking about sex with your parent(s) / guardian(s)? | 1. Very uncomfortable<br>2. Uncomfortable<br>3. Comfortable |
| 5.3 | In 2008, who did you speak to about sex? | 1. Parent(s) / guardian(s)<br>2. Brother(s) / sister(s)<br>3. Other relatives<br>4. Church leader(s) / worker(s)<br>5. Agent(s) of Change<br>6. Friend(s) |

**Part 6: Clinic**

| | **Questions** | **Response** |
|---|---|---|
| 6.1 | In 2008, have you had a genital ulcer? | 1. Yes<br>2. No |
| 6.2 | In 2008, have you had a discharge from the vagina or penis? | 1. Yes<br>2. No |
| 6.3 | Have you gone to the clinic with a Sexually Transmitted Infection (STI) in 2008? | 1. Yes<br>2. No |
| 6.4 | In 2008, have you gone for HIV/AIDS Voluntary Counselling and Testing (VCT or HIV test)? | 1. Yes<br>2. No |

**Part 7: Advocacy (opposing negative messages)**

| | **Questions** | **Response** |
|---|---|---|
| 7.1 | There are lots of negative messages that we see in the media about sex. Have you ever done anything about them? | 1. Yes<br>2. No |
| 7.2 | If you have done something, what did you do? | 1. Sent an SMS<br>2. Wrote an email or letter<br>3. Made a phone call<br>4. Told my friends and/or family what is wrong with it<br>5. Other (please state) |

**Part 8: Community service/development**

| | **Questions** | **Response** |
|---|---|---|
| 8.1 | In 2008, have you volunteered in any community project? | 1. Yes<br>2. No |
| 8.1.1 | If yes, what did you do? For instance, working with children, helping old people, in a soup kitchen etc. | |

**Part 9: Your role and participation in the project**

| | | |
|---|---|---|
| 9.1 | What are you in this project? | 1. Young person attending the sessions<br>2. Agent of Change |

**Part 10: Church**

| | | |
|---|---|---|
| **10.1** | How often do you attend church (service or other activity) | 1. Once a month or less<br>2. A few times a month<br>3. Every week<br>4. Several times a week |
| **10.2** | How important is your faith to your life? | 1. Not important at all<br>2. A little bit important<br>3. Very important indeed |
| **10.3** | When do you think it is ok to have sex? | 1. Only when you are married<br>2. If you love someone and plan to marry them, or you are living with them.<br>3. If you love someone and are going steady.<br>4. If you like someone |

**List of parishes 2008**

| | Name of Area and Church |
|---|---|
| | **SALDANHA DIOCESE** |
| 1 | Maitland, St Anne's |
| 2 | Goodwood, St Alban's |
| 3 | Matroosfontein, St Nicholas |
| 4 | Bishop Lavis, St Joseph |
| 5 | Valhalla, St Joseph |
| 6 | Epping, St Faiths |
| 7 | Bothasig, Holy Trinity |
| | |
| | **CAPETOWN DIOCESE** |
| 8 | Heideveld, Holy Spirit |
| 9 | Langa, St Cyprian's |
| 10 | Gugulethu, St Mary Magdalene |
| 11 | Bonteheuwel, Church of the Resurrection |
| 12 | Gugulethu, St Columba's |
| 13 | Silvertown, St George's |
| 14 | Nyanga, Holy Cross |
| 15 | Cross roads, Eluvukweni |
| 16 | Woodstock, St Mary's |
| | |
| | **FALSE BAY DIOCESE** |
| 17 | Tafelsig, Christ the Reconciler |
| 18 | Grassy Park, Good Shepherd |
| 19 | Faure,St Paul's |
| 20 | Lentegeur, Christ the Saviour |
| 21 | Portlands, Christ the Mediator |
| 22 | Ocean View, St Claire |
| 23 | Masiphumelele, St Matthews |
| 24 | Macassar, St Joseph the Worker |
| 25 | Blackheath, Church of the Nativity |
| 26 | Eersterivier ,St Luke's |
| 27 | Kuilsriver, St George |
| 28 | Westridge, Christ the Redeemer |
| 29 | Woodlands, Church of the Annunciation |

## List of parishes 2009

| | Name of Area and Church |
|---|---|
| | **SALDANHA DIOCESE** |
| 1 | Paarl, St. Bernard Mizeki |
| 2 | Kraaifontein, St. Mary |
| 3 | Bishop Lavis, St. Joseph the Worker |
| 4 | Dunoon, St. Luke |
| 5 | Joe Slovo, St. Laurence |
| 6 | Paarl, Church of Ascension |
| 7 | Milnerton, St. Oswald's |
| 8 | Eureka, St. Andrew's |
| 9 | Wellington, St. Alban's |
| 10 | Epping, St. Faith |
| 11 | Bloekombos, St. Mark's |
| 12 | St. Augustine, O'Kiep |
| 13 | Wallacedene, St. Monica |
| | |
| | **CAPETOWN DIOCESE** |
| 14 | Bonteheuwel, Resurrection |
| 15 | Plumstead, All Saints |
| 16 | Woodstock, St. Mary |
| 17 | Plumstead, St. Faith's |
| 18 | Silvertown, St. George |
| 19 | Manenberg, Reconciliation |
| 20 | Gugulethu, St. Columba |
| 21 | Nyanga, Holy Cross |
| 22 | Heideveld, Church of the Holy Spirit |
| 23 | Salt River , St Luke's |
| | |
| | **FALSE BAY DIOCESE** |
| 23 | Belhar , All Saints |
| 24 | Ceres, St. Andrew's |
| 25 | Robertson, All Saints |
| 26 | Delft, St. Matthew's |
| 27 | Lentegeur, Christ the Redeemer |
| 28 | Nkqubela, St. Manche Masemola |

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24 October 2006

Reverend RA Mash
Discipline of Family Medicine and Primary Care
Dept of Interdisciplinary Health Sciences

Dear Reverend Mash

**RESEARCH PROJECT:** **"AGENTS OF CHANGE: THE IMPLEMENTATION AND EVALUATION OF A PEER EDUCATION PROGRAMME ON SEXUALITY IN THE ANGLICAN CHURCH OF THE WESTERN CAPE "**
**PROJECT NUMBER : N06/08/170**

At a meeting of the Committee for Human Research that was held on 6 September 2006 the above project was approved on condition that further information that was required, be submitted.

This information was supplied and the project was finally approved on 21 October 2006 **for a period of one year from this date**. This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in all further correspondence.

**Please note that a progress report (obtainable on the website of our Division) should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary).**

Patients participating in a research project in Tygerberg Hospital will not be treated free of charge as the Provincial Government of the Western Cape does not support research financially.

Due to heavy workload the nursing corps of the Tygerberg Hospital cannot offer comprehensive nursing care in research projects. It may therefore be expected of a research worker to arrange for private nursing care.

Yours faithfully

**CJ VAN TONDER**
**RESEARCH DEVELOPMENT AND SUPPORT (TYGERBERG)**
Tel: +27 21 938 9207 / E-mail: cjvt@sun.ac.za

CJVT/pm

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*Rutanang*, a multiyear collaborative effort produced guidelines for peer education agreed upon as the standard for peer education in South Africa by a wide range of stakeholder groups. *Rutanang* is a framework of what peer education might be and the programme structures and mechanisms it requires to be effective.

Fundamental to successful implementation of any peer education program is consensus about goals, essential elements and guidelines of peer education, including the roles expected of peer educators. According to *Rutanang*, peer education is the process whereby trained supervisors assist a diverse group of youth to:

1. Educate their peers in a structured manner.
2. Recognise youth in need of additional help and refer them for assistance.
3. Informally influence by modelling serious thinking, healthy behaviour.
4. Advocate for gender equity, resources and services for themselves and their peers.

In addition *Rutanang* advocates ten standards that should characterise programs:

1. *Planning*: Is there a detailed plan of action, based on actual needs with clear, measurable goals?
2. *Mobilising*: Is there commitment, understanding and support from the leadership of the school/higher education institution/community in which you are working? Are there shared vision, structure and resources?
3. *Supervisor infrastructure*: Have supervisors been carefully selected, trained and contracted?
4. *Linkages*: Have you included the partners and support structures you need for your program?
5. *Learning program*: Is your learning program an effective, tested, 'beyond awareness' program, delivering adequate dosage in an appropriate sequence, making use of interactive methodologies?
6. *Peer educator infrastructure*: Have peer educators been carefully selected, trained and contracted, with clearly defined roles, performance standards and graduated responsibilities?
7. *Management*: Are peer educators and supervisors well managed and is the delivery of all four roles of peer education quantifiable and happening effectively?
8. *Recognition and credentialing*: Are there credentialing and reward mechanisms in place to ensure growth, development and advancement opportunities for peer educators and for supervisors?
9. *Monitoring and evaluation*: Do you have a realistic monitoring and evaluation plan that includes documentation and information management?
10. *Sustainability*: Do you have a practical and operative sustainability plan dealing with compliance, public relations, staffing, funding and peer ownership?

(288,289)

# Survey of sexual behaviour among Anglican youth in the Western Cape

**Rachel Mash, Roselyn Kareithi, Bob Mash**

**To the Editor:** The sexual behaviour of young people in South Africa is clearly important with regard to their risk of acquiring HIV/AIDS and other sexually transmitted infections (STIs). As many young people are exposed to the teaching of the church on this issue, church organisations, which reach into almost every community, can make a significant contribution towards the reduction of risky sexual behaviour. This study explored the sexual behaviour of youth (aged 12 - 19 years) within the Anglican church in the Western Cape and the relevance of messages such as 'no sex before marriage'. The study makes recommendations on the design of more effective church-based interventions.

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## Method

Multistage cluster sampling was used to select 65 out of 131 churches in the Cape Town Diocese according to their location and predominant racial composition. A questionnaire was developed with reference to similar surveys commissioned by the loveLife consortium[1] and the Christian Community

February 2006, Vol. 96, No. 2 **SAMJ**

SCIENTIFIC LETTERS

organisation[2] in the USA and after piloting was completed by members of either the youth group or confirmation class. The questionnaire was administered confidentially by multilingual research assistants, and prior parental consent was obtained. Altogether 1 306 questionnaires were completed and analysed using Statistica version 7. In addition youth were given the opportunity to attend focus group discussions (FGDs). Three FGDs were held, with a total of 25 young people chosen to represent rural, urban and peri-urban areas, both genders, and those who were and were not sexually active. Youth in the FGDs explored their sexual experiences and perceptions of the church's influence on their behaviour. The transcripts were analysed according to the framework method.[3]

## Results

The female/male ratio among respondents was 59:41%, the urban/rural ratio was 64:36%, and the ethnic breakdown was 78% coloured, 12% black and 10% white. Key results are shown in Tables I and II.

In the FGDs parents were seen as an important source of information, but were often perceived to be uncomfortable answering questions about sex. Schools were also perceived as an important source of information, but the sex education messages were not individually targeted and dealt primarily with biological information on sex and HIV. Little attention was given to skills in relationships, communication and considering the personal consequences of sexual activity. Although 72% of the respondents had received teaching on sex in their church, this did not appear to impact on their sexual behaviour. The church's message on sex was perceived to be ineffective because it was delivered by elders, had a negative content and upheld marriage as the ultimate goal. Many participants did not aspire to get married and therefore the message 'no sex before marriage' appeared irrelevant.

**Table I. Demographics and sexual behaviour of Anglican youth ($N$ = 1 306)**

| | % |
|---|---|
| Sexually active (vaginal, oral and anal) | 31 |
| Vaginal sex | 18 |
| Oral sex | 13 |
| Anal sex | 4 |
| Belief that oral sex is actually sex | 33 |
| Belief that anal sex is actually sex | 50 |
| Males sexually active | 40 |
| Females sexually active | 21 |
| Pregnant | 3 |
| Belief that being physically forced to have sex by someone you know is not rape | 10 |
| Have seen other people having sex in real life | 45 |

**Table II. Characteristics of sexually active youth ($N$ = 405)**

| | % |
|---|---|
| No use of contraceptives during first sexual encounter | 65 |
| Sex for material gain | 6 |
| Threatened into having sex | 10 |
| Raped | 13 |
| More than one sexual partner | 66 |
| Suspect partner of being unfaithful | 29 |
| First sexual experience in the home of one partner | 75 |
| First sexual experience with member of own peer group | 90 |
| Girls not wanting their first sexual experience (persuaded, tricked, forced) | 50 |
| Have seen other people having sex in real life | 66 |

Engaging in sexual activity was perceived to be due to peer pressure (being accepted within the group's norms and values), the need to give and receive love, seeing other people having sex, threats, material gain, positive media images and boredom. Some also mentioned financial incentives such as receiving the child-support grant. Abstaining from sexual activity was perceived to be supported by peer pressure, parental influence and sharing of experience, girls understanding the world view of boys through having a mixed peer group and the confidence to 'say no', as well as access to a variety of other extracurricular activities. Fear of HIV/AIDS, religious guilt and incentives for remaining a virgin were mentioned infrequently.

## Discussion

The rate of sexual activity among Anglican youth is similar to the 38% (for grades 8 - 11 in the Western Cape) reported by the South African Youth Risk Behaviour Survey (SAYRBS).[4] This implies that church-based youth do not behave significantly differently from their larger peer group. However only 3% reported a pregnancy compared with 13% in the SAYRBS, which could imply that church-based youth who fall pregnant drop out of the church community. Indeed, sexually active church-based youth appeared to have a higher rate of multiple partners (66%) than in the SAYRBS (48%). Although outside the church health interventions are aimed at reducing the incidence of HIV, primarily through promoting condom use, it was interesting that fear of contracting HIV and use of condoms were not major issues among youth in this study.

## Conclusion

Based on the findings of this study a number of recommendations can be made to try to improve the impact of church interventions. All communities should be included because sexual activity among churchgoing youth involves both genders and takes place in every geographical location or community.

The first recommendation is to have peer educators who are closer in age to the youth than at present and who can act as opinion leaders and role models for change. This finding is supported by the findings of Christian Aid.[5] In this way peer pressure can be harnessed to support postponement of sexual debut and abstinence. Training courses should initially focus

SCIENTIFIC LETTERS

on equipping these peer educators. In particular the confidence of teenage girls to negotiate around sex and express their choice should be strengthened. Secondly, the church should emphasise building of healthy relationships as a goal and not focus only on marriage. In addition churches should assist with the provision of other activities for youth to engage in. Thirdly, parents should be equipped to be more open about their own mistakes and to speak more freely about sexual matters, using an age-appropriate approach. Parents should not delegate responsibility for sexual education to schools as personal values, relational issues and consequences of sex may not be addressed there. While sexuality programmes may aim to prevent the transmission of HIV/AIDS, the focus of the intervention should not be on HIV itself but on the broader issues of healthy relationships and growth of the whole person as sexuality involves the physical, emotional and spiritual wellbeing of an individual. The message should promote a positive vision of faithful, respectful and loving relationships rather than a negative one of 'not doing' or avoiding sex. Youth should be encouraged to explore the discrepancies between their behaviour and their personal goals and values as a motivator for change, rather than simply receiving instruction in the required behaviour. In addition, loss of virginity or even becoming pregnant should not lead to a permanent sense of failure or religious stigmatisation, but should be reframed as a lapse in sexual behaviour from which the person can learn and regain a 'secondary virginity'. Lastly the church can provide information to correct many of the common misunderstandings revealed in this research such as that 'forcing someone you know to have sex is not rape' or that 'anal and oral sex are not real sex'.

The full research report can be accessed on **www.fikelela.org.za**


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Review Article

# 'WHY DON'T YOU JUST USE A CONDOM?': UNDERSTANDING THE MOTIVATIONAL TENSIONS IN THE MINDS OF SOUTH AFRICAN WOMEN

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**This article is available at:**
**http://www.phcfm.org**



## ABSTRACT

**Background:** HIV/AIDS makes the largest contribution to the burden of disease in South Africa and consistent condom use is considered a key component of HIV-prevention efforts. Health workers see condoms as a straightforward technical solution to prevent transmission of the disease and are often frustrated when their simple advice is not followed.

**Objectives:** To better understand the complexity of the decision that women must make when they are asked to negotiate condom use with their partner.

**Method:** A literature review.

**Results:** A key theme that emerged included unequal power in sexual decision making, with men dominating and women being disempowered. Women may want to please their partner, who might believe that condoms will reduce sexual pleasure. The use of condoms was associated with a perceived lack of 'real' love, intimacy and trust. Other factors included the fear of losing one's reputation, being seen as 'loose' and of violence or rejection by one's partner. For many women, condom usage was forbidden by their religious beliefs. The article presents a conceptual framework to make sense of the motivational dilemma in the mind of a woman who is asked to use a condom.

**Conclusion:** Understanding this ambivalence, respecting it and helping women to resolve it may be more helpful than simply telling women to use a condom. A prevention worker who fails to recognise this dilemma and instructs women to 'simply' use a condom, may well encounter resistance.

## INTRODUCTION

Sub-Saharan Africa has the highest number of people infected with HIV. Women in Africa are becoming infected in higher numbers than men and it is widely acknowledged that young women, aged 15–24 years, constitute a particularly important group for targeting HIV prevention.[1]

The use of male condoms is seen as one of the most important components of a risk-reduction strategy for HIV. However, although condoms may be highly efficacious and HIV transmission interrupted in as many as 99% of encounters, they cannot be effective as a strategy if they are not utilised.

According to the first South African national youth risk-behaviour survey, only 40% of male and 31% of female adolescents always use a condom.[2] These figures are similar to national surveys in Burkina Faso, Ghana, Malawi and Uganda, which show male adolescent condoms use during the last sexual encounter to be between 39% and 51%, while females' use was between 24% and 38%.[3] It therefore appears that there is a tendency for women to use condoms less consistently than men.

Educating patients on the use of condoms can be a frustrating experience for health workers. On the one hand, condoms have the attraction of being a relatively straightforward, efficacious and technical solution to the problem of HIV transmission. On the other hand, patients are often passively disinterested or non-compliant with the message that they should use a condom. Evidently, the knowledge that condoms prevent HIV transmission does not in itself always lead to action and the decision to use a condom is more complex than the simple health education message implies.

Women are often the recipients of this educational message when they go for family planning, antenatal care or seek treatment for sexually transmitted infections (STIs). However, unless they intend using female condoms, which are difficult to obtain, they can only use condoms if they first negotiate condom use with their partner.

This article explores this scenario and attempts to understand the motivational dilemma in the mind of a woman who is asked to use a condom. Understanding the likely ambivalence and helping women to resolve it may be more helpful than simply telling women to use a condom.

A literature search was conducted on Medline and Google Scholar using the key words AIDS, Africa, gender and condom use. The following themes emerged from the literature and are later summarised in a conceptual framework illustrating the motivational dilemma.

## DISEMPOWERMENT

Using or not using a condom is not simply a question of safer sexual behaviour; it is the outcome of a negotiation between potentially unequal partners. Condoms are not neutral objects about which a straightforward decision can be made on health grounds. Sexual encounters may be sites of struggle between the exercise and acceptance of male power, male definitions of sexuality and women's ambivalence and resistance.[4] A key problem is that the condom message calls upon the woman to assert dominance in the sexual act. Almost everywhere such dominance is not their traditional role and imposes unfamiliar behaviour on both members of the couple.[5] Condom use increases when power is shared more

African Journal of Primary Health Care & Family Medicine
Article #79

equitably in the relationship and decreases when women have little power or control.[6] Adolescent girls in KwaZulu–Natal used a condom when this was initiated by a man but felt it would be easier to refuse sex completely than to negotiate condom use themselves. Decisions to use condoms were controlled by males, with the tacit agreement of their female partners.[7]

Gender-based power inequalities generally incorporate the belief that men should control women's sexuality and childbearing capacity. If women practice family planning then the male partner loses this control. Concerns expressed by men include the fear that they will lose their role as head of the family, that their partners will become promiscuous or adulterous and that they will be ridiculed by other people.[6] Therefore, in a relationship of unequal power, it becomes very difficult for a woman to negotiate the use of condoms.

## PLEASING YOUR PARTNER

Men are more likely to believe that using a condom will lessen sexual pleasure, diminish intimacy, waste sperm, be like masturbation or be associated with a loss of virility.[8] In Jewkes' study of women from three South African provinces, although 39% of couples had discussed HIV and in almost one-third of relationships women had suggested using condoms, 36% of men said they did not like them and 2% of men accused the woman of infidelity.[9] In Varga's study of youth from Durban, among women who had discussed condoms, 42% said their partners usually refused condoms because they made sex less pleasurable. Because of their disempowerment, many women therefore will not insist on a condom and give in to their partner's desire to 'taste the candy'.[10]

## INTIMACY AND TRUST

*'At the start of the relationship we were playing, now I trust her, that is why I don't use it.'*[7]

(Zulu man)

One of the most important barriers to condom usage for women is the issue of intimacy and trust. The use of condoms is perceived to be associated with casual sex, and where there is 'true love' condoms are no longer used. In the standard progression of romantic relationships, after trust has been established, condoms are no longer perceived to be needed.[4]

*'He said he uses condoms with his seven sex buddies, but not with his girlfriend because he loves her.'*

(Lay HIV counsellor, quoted from an Anglican Students Fellowship Conference, Bellville, 2006)

In Reddy's study of patients at STI clinics, 43% of men and 35% of women said that using a condom meant you do not trust your partner. People therefore associate condoms with casual sex and a lack of trust.

Women's self esteem and social status is often linked to a committed, monogamous relationship. In such circumstances suggesting condom use would be an insult – suggesting infidelity and a lack of 'true love'. Condomless sex, on the other hand, helps maintain the desired image of the partner being faithful to them. So-called 'unsafe sex' is actually seen as keeping 'safe' the desired relationship and its intimacy, trust and economic stability. To acknowledge a possible infidelity and risk of HIV necessitates a confrontation, which may destabilise the relationship. A woman may also want to maintain the pretence that a casual encounter is actually a meaningful relationship. This means pretending to trust her partner, which may imply not using condoms and not questioning their sexual history. In this way, many people will make the choice to view themselves as 'safe' rather than face the social consequences of safer sex.[10]

## REPUTATION

*'My boyfriend says that if a man does not trust a woman, that is the only time to use condoms.'*[11]

(Zulu woman)

AIDS has been presented as a disease with a high-risk of infection and condoms have become associated with the sexually promiscuous and with casual sex. Adolescents are primarily concerned with social acceptability and the opinions of their peers, so do not want to be associated with the negative connotations of condoms.[4]

Girls who suggest the use of condoms are considered, by both male and female participants, to be 'loose'.[4] A number of girls said they were not at risk for STIs and so had no need of condoms. Believing that you are at risk for AIDS would mean admitting that you have not been living up to certain standards.

Women feel embarrassment over every stage of condom use. When they are concerned for their reputation, then the act of buying condoms, carrying them and asking for their use is difficult. Having a condom on one's person indicates a lack of sexual innocence, an unfeminine identity – that of a woman seeking sex too actively. A sexual woman becomes easy, fair game and generally at a man's disposal.[4]

To suggest condom usage may also give the impression that you are HIV positive. In South Africa and Uganda, wanting to use a condom can be interpreted as a sign that you are carrying disease.[12] In Reddy's study, 14% of men and 8% of women believed that 'using a condom means that you have AIDS.'[8]

*'I would be embarrassed and afraid. Maybe the guy would think I have AIDS then he wouldn't want to have sex with me.'*

(Zulu woman)[10]

## POOR COMMUNICATION

There are often very low levels of communication between people who are involved in intimate physical and sexual acts. In Varga's study of pregnant girls and their partners, 61% of girls felt that AIDS-related issues were not appropriate to discuss with their partners. None of the males had discussed AIDS with the mothers of their children. Females focused on lack of intimacy as a reason for avoiding the discussion.

*'We don't talk about things like condoms, sex or STDs [sexually transmitted diseases]. It isn't that kind of relationship.'*[10]

(Zulu woman)

With such poor levels of communication, it becomes nearly impossible to discuss condoms.

## FEAR OF REJECTION AND VIOLENCE

*'I would be afraid of his reaction. He might leave me.'*[10]

(Zulu woman)

Male opposition to contraceptives is common. A study from Soweto, Umlazi and Khayelitsha found that fear of losing a partner was the most important barrier to women's contraceptive use.[13] There is also the fear that rejection will lead to violence.[8,14] In Pettifor's study, women who experienced forced sex are 5.8 times more likely to use condoms inconsistently.[14]

*'I would not talk to my boyfriend about contraception. If he thought I was using it, he would beat me.'*[10]

(Zulu woman)

## RELIGIOUS BELIEFS

In many religious communities, the condom is associated with immoral and sinful behaviour.

*'We are saved by the blood of the lamb, not by a piece of rubber.'*

(Sermon at a Youth Congress, Anglican Church, Khayelitsha, 2001)

*'How can you include this information on condoms? You are promoting fornication.'*

(Inter-church Conference, Cape Town, 2004, when the information pack contained leaflets from the Department of Health indicating the correct way to put on condoms)

The President of the Vatican's Pontifical Council for the Family made the following statement on *Catholic online*, suggesting that condoms should carry a government health warning:

> *'The AIDS virus is roughly 450 times smaller than the spermatozoon. The sperm can easily pass through the 'net' formed by the condom. These margins of uncertainty should represent an obligation on the part of the health ministries and all these campaigns to act in the same way as they do with regard to cigarettes, which they state to be a danger.'*[15]

At one rally organised by a faith-based organisation in Uganda, participants were told that 'using a condom with a person with these [sexually transmitted] diseases is like using a parachute which only opens 75% of the time.'[16] 'be wise, don't condomise,' was the message from a Catholic Publication in Nairobi called HIV/AIDS: A call to action: Responding as christians.'[17]

## CONCLUSION

It is clear from this discussion that when a health worker advises a woman to use a condom, the decision for the woman is more complex than the health worker's desire to prevent transmission of HIV. Most people, when faced with a behaviour change, such as using condoms, will feel ambivalent with internal arguments both for and against the change. The arguments for and against change can be likened to the weights on either end of a balance or scale. The literature on condoms, however, suggests that the arguments against change, which are largely relational and not medical, often outweigh the arguments for using condoms (Figure 1). Prevention workers who only acknowledge one side of the scale may find the process of arguing for condom use a frustrating one that is met with overt opposition, covert non-adherence or only superficial agreement. Arguing forcefully for condom use (one side of the balance) may perversely encourage the woman to argue the case for not using condoms (the other side of the balance) and even increase resistance to change. A more helpful approach may be to explore the pros and cons with the client and to enable her to find the solutions to overcome potential barriers, rather than to presume that the decision is simple and clear-cut. This implies that a guiding style rather than a directing style may be more effective and that health workers may need more effective communication skills when recommending the use of a condom.[18]

One resource could be Motivational Interviewing, which has been characterised as a refined form of a guiding communication style. This style of communication is primarily a way of interacting with patients that is at once collaborative, curious, respectful of their autonomy and evocative of the patients' own perspectives and solutions. Key principles include the use of empathic active listening, reflection of discrepancy between the patients' behaviour and personal values or goals, amplification of 'change talk' and reduction of 'sustain talk', information exchange and strengthening of self-efficacy. Health workers are sensitive in their approach to patients' agenda and readiness to change, while focusing on a specific behaviour. Health workers aim to help the patients resolve their own ambivalence. Specific communication skills that can be learnt within this framework are, for example, the use of a variety of reflective listening statements, summaries and open questions.[18]

## FURTHER RESOURCES

MISA (Motivational Interviewing in Southern Africa) offers training in a guiding style and communication skills: http://www.sahealthinfo.org/motivational/index.htm.

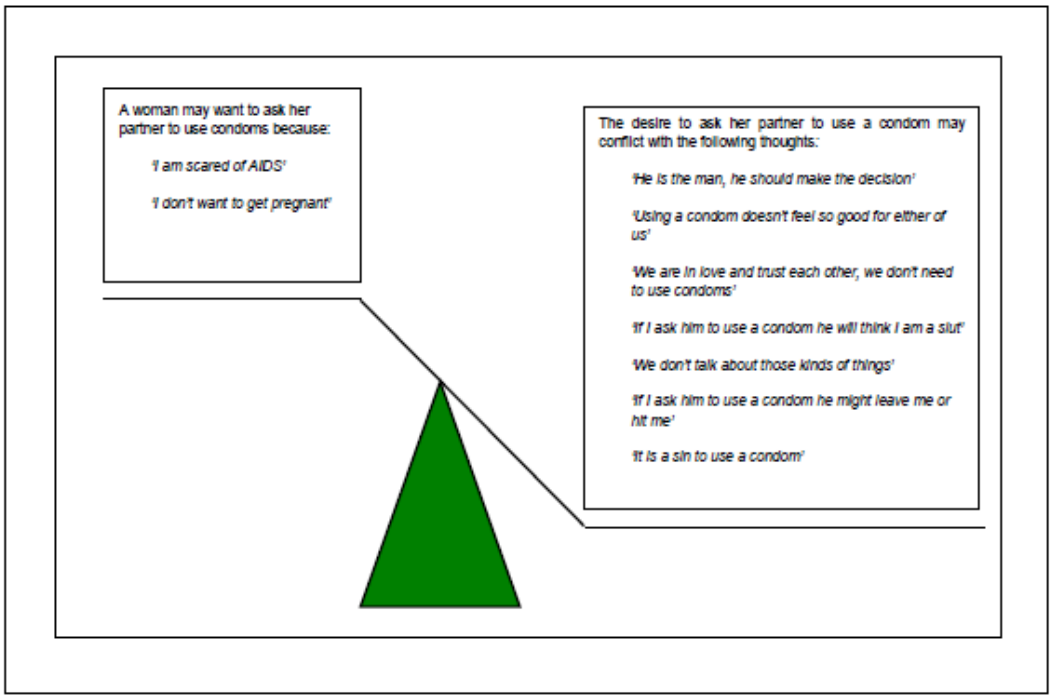


**FIGURE 1**
Motivational tensions in the minds of South African women when asked to use a condom

African Journal of Primary Health Care & Family Medicine Article #79

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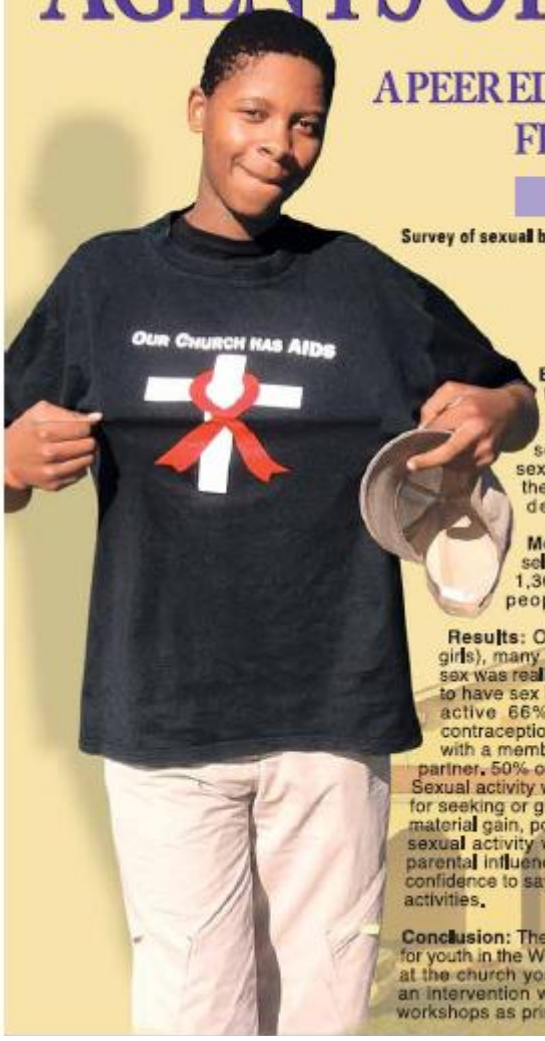
# AGENTS OF CHANGE

## A PEER EDUCATION PROGRAMME FIGHTING AIDS IN AFRICA




**PHASE ONE: RESEARCH**

**Survey of sexual behaviour amongst Anglican youth in the Western Cape, South Africa.**

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**Background:** Many young people are exposed to the teaching of the church and since it reaches into almost every community, the church can make a significant contribution towards the reduction of risky sexual behaviour. This study explored the actual sexual behaviours of youth (aged 12-19 years) within the Anglican church of the Western Cape, in order to design an effective intervention strategy.

**Methods:** Multistage cluster sampling was used to select 65 out of 13 churches in the Cape Town diocese, 1,306 questionnaires were completed and 25 young people participated in focus group interviews.

**Results:** Overall 31% were sexually active (40% boys, 32% girls), many youth did not believe that oral (33%) or anal (50%) sex was really sex. 10% did not think that 'being physically forced to have sex by someone you know' was rape, of those sexually active 66% had more than one partner, 65% used no contraception during their first sexual experience, 90% had sex with a member of their peer group and 75% in the home of one partner. 50% of girls had not wanted their first sexual experience. Sexual activity was perceived to be due to peer pressure, the need for seeking or giving love, seeing other people having sex, threats, material gain, positive media images and boredom. Abstaining from sexual activity was perceived to be supported by peer pressure, parental influence, girls understanding the world view of boys, the confidence to say no as well as access to a variety of extra curricular activities.

**Conclusion:** The rate of sexual activity is similar to the 38% reported for youth in the Western Cape in general. Thus an intervention directed at the church youth is relevant. Based on the results of this study an intervention was designed using peer education and parenting workshops as primary strategies.

## PHASE TWO: THE INTERVENTION

**The goal:**

- To reduce the incidence of unsafe sex
- To decrease the number of sexual partners
- To raise the age of sexual debut
- To combat sexual coercion

***Peer educators***
Peer educators are chosen by the youth group members
They have four roles
- Educator
- Role model
- Referrals
- Community upliftment

**The peer education programme 'agents of change' is currently being run in 11 churches in three Dioceses. It will be rolled out to 20 new churches in 2007.**

***Youth Group***
The peer educators run a twenty session life skills programme in the youth group, supported by the facilitators.
Antiboredom goals are also be devised in each church
Community service is also undertaken

***Facilitators***
The youth group leaders become the facilitators of the programme
They are trained in the following
Stakeholder analysis
Mentoring
Monitoring and Evaluation

***Parents***
Three workshops are run for parents in each church.
Why I should talk about sex?
Love and sex – communicating my values
Communication – how to talk about sex

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- Samaritan's Purse, Canada
- CORDAID
- Mpilo Ministries (Archbishop Tutu)

PARTNER ORGANISATION:
- Gold Peer Education

**www.fikelela.org.za**

Anglicans reaching out