USING PEER EDUCATIONAPPROACH TO PREVENT HIV/AIDS ON YOUNGPEOPLE IN SUB SAHARA AFRICA: EXAMPLE THE PROJECT “YELLOW REGLO A” CAMEROON.

SALOME CLEMENCE NGO IBOM

Assignment submitted in partial fulfilment of the requirement for the degree of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University

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Declaration

I certify that the assignment entitled: submitted for the degree of: Master of Philosophy (HIV/AID Management) is the result of my own research, except where otherwise acknowledged, and that this assignment in whole or in part has not been submitted for an award, including a higher degree, to any other university or institution.

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Abstract

"I know my body, HIV/AIDS will never happen to me."
Many people especially young-adults (15-39) have a low risk perception, information and knowledge when it comes to sexual activity and STIs. They think that they are infallible and that misfortune – like contracting HIV-only happens to someone else. In many countries and cultures where secrecy and shame surround the subject, sex is a social taboo. In Cameroon, for example, traditionally the uncle gives sex education for boys and by the aunt for girls. However, in current times extended families do not often live together, so the traditional way of giving sex education become more difficult.

The government has tried to solve this vacuum by designing an AIDS education programme, which should be implemented in primary and secondary schools. However, most teachers are too ashamed to talk with their pupils about these sensitive matters and the pupils are too afraid to ask sensitive questions. Preventing HIV/AIDS among young-adults in Sub Sahara Africa especially in Cameroon is critical as many are at significant risk for HIV infection.

Peer education actually stands to be one strategy for both HIV/AIDS prevention and sexual health promotion for this population. It builds on the strong ties between age-mates fostered during socialization and bypasses adults who are reluctant to talk to youth about sexual matters. Therefore, this research paper will focus specially on the HIV prevention programme; the peer education approach set up on young-adults people in Cameroon; when trying to ascertain whether it can play a significant and constructive role in the fight against HIV/AIDS in the Douala community and in the large extend the whole country.

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To you all my sincere thanks and love.

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LIST OF ACRONYMS USED IN THE STUDY

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
UNAIDS	United Nations Programs on HIV/AIDS
WHO	World Health Organization
FHI	Family Health International
MSM	Men who have sex with men
NGO'S	Non-governmental organizations
AIDSCAP	AIDS Control and Prevention Program
BCC	Behaviour change communication
CSW	Commercial sex worker
FHI	Family Health International
IEC	Information, education and communication
IMPACT	Implementing AIDS Prevention and Care Project
KAP	Knowledge, attitude and practice
STD/STI	Sexually transmitted disease/Sexually transmitted infection
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Chapter1- A research question regarding HIV/AIDS in Sub Saharan Africa

Introduction

Research is a systematic approach to finding a question to its observable components and testing possible answers to the questions. From the behavioural scientist's point of view, research methodology is a tool that can be used to unravel the mysteries of data collected in research. Substantive issues are the questions behavioural scientists are studying. Therefore, in the phenomena of HIV/AIDS we are interested in the causes of the fatal acquired immune deficiency syndrome; the specific immunologic profile that typifies AIDS, the toxic side effects of antiretroviral drug like AZT, the impact of HIV/AIDS to name but a few. More especially, we are interested in this research in Peer Education approach as both agent and recipient in the prevention of HIV/AIDS on young people in Sub-Saharan Africa namely in Cameroon.

Aids are a moral and economic test but more than this, it is a social challenge. HIV/AIDS touches the core of every person's life. In 1990, Osborne said that 'the Achilles heel of HIV is its dependence on behaviour; that is voluntary. Our best attack is that which enlist people in his or her own defence'.
To enlist and train a whole (and diverse) community in its own defence is not small task. In this thesis, after defining the HIV/AIDS impact of HIV/AIDS epidemic in Sub Saharan Africa, I will examine the most important component of HIV/AIDS prevention programme (peer education) set up in Cameroon thereafter the feasible methodology that can be used to evaluate HIV/AIDS peer education programme.

1- A RESEARCH QUESTION REGARDING HIV/AIDS in Sub Saharan Africa.

1.1 A brief history of HIV/AIDS

In 1981, unusual lung infection was seen in men who have sex with men in United States. The centre for disease control in Atlanta USA first report, the 5 June 1981, in its morbidity and mortality report that few men had died of a deadly form of pneumonia. Therefore, the medical fraternity became aware that something was wrong. In 1982 after various manifestations that are indicative of a suppressed immune system, it was named acquired immunodeficiency syndrome (AIDS).

It consists of two types of HIV:
The causative agent named human immunodeficiency virus type1, found today world widely, was first isolated in a French laboratory in 1983. It is closely related of the virus SIV CPZ that infected chimpanzees. It could have been transferred to human in the 1940's through the butchering of chimpanzees for food.

The second type of the virus is predominantly in west Africa HIV-Z; it was discovered in 1986 and was probably transmitted to humans by monkey that is hunted in West Africa.
Human immunodeficiency virus (HIV) is one of many viruses that can infect human. It cannot live on their own, but have to use cells to reproduce their component and genetic code in order to survive. When a virus infects an uninfected cell, this code is transferred.

HIV is retroviruses that infect the most important cells of the immune system (CD4) by binding to receptors. Then the viruses fuse to the cell membrane and release their contents into the cells.
It belongs to a particular family of viruses called retroviruses. Retroviruses such as HIV contain a special enzyme
called reverse transcriptase which catalyses a reaction going in the opposite direction converting RNA to DNA.HIV infects a variety of cells of the immune system, the most important being CD4 through :

Table.1 HIV Routes of transmission

Route of transmission	Description
Sexual transmission	Heterosexual and homosexual: infected secretions in contact with mucous membranes
Blood borne	Infected blood transferred to individual: blood transfusion and blood products; needle sticks and sharp objects; splashes of blood into the eyes;

	intravenous drug users
Vertical transmission	Mother to child: in utero (in the womb); during the birth process; after birth through breastfeeding.

The body fights a constant battle to try to overcome HIV infection. However, the ability of HIV to mutate enables it to overcome the body's defence in the long run. This is a gradual and progressive process leading to a weakening of the immune system usually over the course of about eight to ten years. The weakened immune system manifests as a susceptibility to unusual (opportunistic) infections and rare cancerous growths (malignancies). HIV harms a significant number of cells, the result is HIV disease: AIDS.

Aids are an acronym name for acquired immune deficiency syndrome. It is the clinical definition given to the onset of certain life threatening infections in persons whose immune systems have ceased to function properly.

The condition is acquired in sense that it is not hereditary. Aids, generally accepted is caused by the human immunodeficiency virus (HIV) which, over a period of years (five to twelve or more) inhibits the cells that usually fight infection.
HIV attacks and destroys the body's immune system (the body's natural defence mechanism) consequently; it cannot offer resistance to conditions that usually do not involve danger to healthy people.
Aids are a syndrome of symptoms. It is not a specific disease. It is a collection of several conditions that occur because of damage the virus causes to the immune system.

Although Aids was first recognized as a disease more than twenty years ago, many people still wrongly, confuse HIV with Aids when in act they are two related but different medical conditions.
HIV stands for human immunodeficiency virus, a virus that weakens the body's immune system.
HIV, in the absence of treatment, usually progresses to AIDS. A person infected with HIV may look and feel perfectly well for many years.

HIV disease has different stages: during the initial infection, a person can have a flu-like disease. This is followed by a period of recovery and clinical latency when people appear healthy (although

there is an ongoing immunological battle). This is followed by a symptomatic HIV infection with the final phase being full-blown AIDS. This is characterized by a set of specific infections and conditions that indicate a much-weakened immune system. Although people usually develop symptomatic HIV or AIDS eight to ten years after infection, there is a lot of individual variation. Some people develop AIDS within two years, while others stay healthy for more that twelve years. AIDS is a low walking ailment that can linger for year before it starts to destroy. People who have been diagnosed with advanced HIV infection can often improve and become asymptomatic again.

The FDA approved the first HIV test in 1985, since then there has been various methods for HIV diagnostic. One can test either for the virus towards HIV or for the antibodies itself. Detecting HIV antibodies is usually a reliable method of diagnosis. It is also less costly and technically less complicated than testing for the virus. Therefore, the norm of HIV testing is detecting antibodies.

However, antibody test cannot be used to diagnose HIV infection in children less than 15 months (of age of infected mothers); sometimes, people acutely infected with HIV may not have developed antibodies yet despite already having infectious viruses in their blood (the widow period).

Although there is no treatment available that can cure HIV, currently available therapy is very effective in controlling the disease and allowing the immune system to recover. Antiretroviral therapy can thus prevent the progression of HIV to AIDS and restore the immune system of patients with AIDS to such an extent that they can return to relatively normal health. A successful therapy became a reality with the strategy of HAART (highly active antiretroviral therapy) which is based on particular combinations of a least three different antiretroviral drugs was developed.

Unfortunately, some of these drugs are not yet affordable to the sub-Saharan African public sector. Therefore preventing HIV infection is much more cost effective than treating established infection. Prevention is however complicated by the complexities sexuality and human behaviour; moreover, Prevention strategies failure can probably be attributed to factors outlined in the table below.

Table 2. Factors that hamper HIV prevention

Regimen	Combination
Perception of risk	It is human nature to underestimate long-term risk and overestimate short-

	term risk. Especially young people often do not perceive something that may only kill them after 10 years as dangerous enough to prevent taking sexual risks.
Stigmatization and denial	The fear of stigmatization and denial cause many people to refrain from being tested for HIV or to continue having unprotected sex even after the diagnosis of HIV.
Social taboos	The lack of appropriate sexual education makes young people very vulnerable.
Lack of political will	The absence of strong message by prominent political figures that HIV is a sexually transmitted infection encourages denial
Migrant labour	Migrant labourers (usually men) commonly have sexual partners in many places.
Women who are not empowered	Women who are socially and economically dependent on men without the protection and care of a strong social fabric are vulnerable and can easily resort to informal commercial sex in an attempt to survive and care for children.

Although they are many strategies of HIV prevention in sub Saharan Africa, studies show that people do not know, especially young adult, therefore the best way of preventing the spread of HIV is through awareness.

There is a serious paucity of good quality information about the sexual behaviour of young-adults in Sub-Saharan Africa. However due to the growing prevalence of the pandemic, there is broad agreement among school management teams, teachers, students, religions leaders, communities leaders, stakeholders, workers as well as among well-informed outsiders that peer education approach build on "know to react" of HIV/AIDS topic into community curriculum can produce the desired changes in sexual behaviour.

"We know that mobilizing a wide range of actors, from business, religious groups, to teachers and people living with HIV/AIDS, will indeed make a difference in successfully tackling the epidemic," said Madami M. Tall, representative of the World Bank and chair of the UN theme group on HIV/AIDS Cameroon.

Cameroon's government has taken positive steps to address HIV care and prevention in the country. According to its strategic HIV/AIDS plan (2000-2005) the government aims to increase condom use among high risk groups, make voluntary HIV counselling and testing services more widely available nationwide, expand the antiretroviral programme for people living with HIV/AIDS; but moreover build awareness among young adult through peer education approach.

1.2 The scale of HIV/AIDS in Sub Saharan Africa

According to the United Nations, the past two decades have seen 60 million people infected by HIV/AIDS and 20 million deaths; ninety-five percent of the infected population countries.
Today, HIV/AIDS is a global catastrophe. According to the Joint United Nations Program on HIV/AIDS UNAIDS, approximately 38.6 million people worldwide are living with HIV/AIDS, and more than 4 million people were newly infected in 2005(about 11.000 each day). In the Unites States, more than 1 million people are unaware of their status, and approximately 40.000 new infections occurring each year. Worldwide, more than 25 million people with HIV died since the pandemic began, including more than 520.000 in the United States in 2005.

The Human Immunodeficiency Virus (HIV), which causes acquired immune deficiency syndrome(AIDS) has lead to great concern in the world but moreover in Sub Saharan Africa in recent years, the majority of people infected with HIV/AIDS are between the ages of 20 and 45 and are employed, many by small and mid-sized businesses. HIV/AIDS affects economies and communities at all levels from the individual to the macro economy.

HIV/AIDS pandemic has affected virtually every segment of the population in nearly every country around the world and poses a major threat to sub Saharan countries.
A study carried out using deaths notices from the inter newspaper, when analyzed by age shows that the majority of deaths are in the 20-to 40- year olds .This is also the age group with the longest increase. While this method of analysis has biases, it has the advantage of being consistent and illustrating the magnitude of an existing problem.

Most African businesses that have more than 10 employees have already seen at least one employee die of HIV/AIDS or currently employ infected workers. In some countries, the number of HIV

infected employees has been devastating, for example, in a sugar mill in South Africa, 26 percent of all tested workers were infected with HIV. Infected workers incurred, on average 55 additional days of sick leave during the last two years of their life (Morris. D.R. Burdge and E.J. Cheevers. 2001. Economic Impact of HIV Infection on a cohort of Male Sugar Mill Workers in South Africa from the Perspective of Industry.)

The social and economic impact of the disease is intensified by the fact that Aids kills primarily young and middle aged adults during their peak productive and reproductive years. In Botswana, it has been estimated that 35 to 40 percent of all teachers are infected with HIV ("Education in Africa threatened by AIDS" 2001. allAfrica.com 7-27-0001.).

At the macro level, an effect of this nature on the workforce can influence the economies of entire countries by reducing the labour supply and disposable incomes. One study in Kenya on sugar estate found that 25 percent of the estate's workforce was infected with HIV. (Forsythe, s. and B. Rau. 1996 AIDS in Kenya; Socio-economic Impact and Policy implications. Arlington, VA: Family Health International).

Another study said that even in countries such as Ghana, which has a more moderate prevalence of HIV, businesses report significant members of both AIDS deaths and known HIV infections. (Nabila, J.S., P. Antwi, K. Yeboah, and S.O Kwankye. 2001). A Study of the Economic Impact of HIV/AIDS on Selected Business Organizations in Ghana Accra). AIDS impacts, markets, saving rates, investment and consumer spending.

While assessing the economic impact of AIDS is very difficult, studies suggest that some of the hardest- hit countries may forfeit 2% or more of GDP growth per year because of the epidemic.
A Kenyan analysis indicated that HIV/AIDS would produce a significant impact with predictions that HIV/AIDS would leave the Kenyan economy one sixth smaller than it would have been in the absence of HIV/AIDS (Forsythe, S. and B. Rau. 1996). The immediate effects are of course, experienced by the person who becomes sick and then by his or her family or house hold. Between the extreme of productivity and profitability, they are also effects on cost expenditures.

1.3 The impact of HIV/AIDS in Sub Saharan Africa.

The lethal nature of the HIV/AIDS pandemic, its causal connection with sexual activity, its non-respect for geographical or cultural boundaries, and its implications for human reproduction, clearly conjure the spectre of the annihilation of the human species. However, while HIV/AIDS has the poise and posture of global pandemic, there is no doubt that it is particularly an African problem.

According to recent statistics, of the 5.3 million people infected with HIV/AIDS worldwide, about two-thirds are in sub-Saharan Africa. some of the latest estimates from UNAIDS sourcing may put the number of new HIV infection in 2000 at 5.3 million; of which 45000 occurred in North America, 6000 in Australia, 500 in New Zealand and 3.8 million in Sub-Saharan (Kenya Times,vol.2 No 32732, Tuesday 5th December 2000).

In my own country, Cameroon the rate of HIV infection amongst the sexually active population has rapidly progressed from 0.5 percent in 1987 to 11 percent in 2000. in may 2001 nearly a million Cameroonians, including 5000 infants, out of a populations of about 15 million, are HIV positive; 52000 persons died of AIDS in 1999 alone,5168 cases of new infection were recorded in 2000 and 91000 AIDS orphans are on record.

After malaria, the HIV/AIDS epidemic has overtaken every other disease as the top killer in Cameroon; where it has been responsible for an estimated 53000 deaths in 1999. And as Johanna Mc Geary has so aptly remarked, AIDS in Africa bears little resemblance to the epidemic elsewhere which is usually limited to specific high-risk groups and brought under control through intensive education, vigorous political action and expensive drug therapy'(Mc Geary 2001:45). In Africa, by contrast, the disease has bred a Darwin perversion. Societies fittest not it is frailest are the ones who die-adults spirited away, leaving the old and the children behind. You cannot define risk groups: everyone who is sexually active is at risk.

HIV/AIDS continues to pose a major threat to people in Africa. Although the number of new infections across the continent was 5 percent less in 2000 than it had been in 1999, the number who died of AIDS was 9 percent more than in the preceding year. The overall infection rate for Africa at the end of 1999 was 8.7 percent, with 23.5 million out of an adult population of 268.9 million being

infected; over two million AIDS-related deaths. These countries confront the demanding challenge to the needs of a burgeoning number of orphans.

HIV/AIDS is unravelling hard-won development gains in Africa and will have a crippling effect on its future prospects. For this reason, more and more African businesses find that they must operate in a worsening socio-economic environment. Areas of concern are the way the disease affects on households, on the demographic structure of society, on the various sectors with which they have traditionally interacted, and on the economy in general.

HIV/AIDS continues to poses a major threat to Africa. During the year 2000, an estimated 2.4 million Africans died of HIV-related illnesses, while a further 3.8 million adults and children became infected with HIV (UNAIDS December 2000). About 80 percent of the global total of AIDS deaths during 2000 occurred in Africa and almost 72 percent of the new HIV infections. However, although the number, who died of AIDS in Africa in 2000 was 9 percent more than in 1999; the number of new infections was 5 percent less. UNAIDS tentatively attributes the decline in new infections to two factors:

1-infection rates have stabilized or even fallen in some countries;

2- the epidemic has gone on for so long that it has already affected many people in the sexually active population, leaving a smaller pool of people still able to acquire the infection (UNAIDS December 2000:4). However, the agency warms that if the number of new infections in a heavily populated country such as Nigeria expands rapidly, the slight improvement of 2000 will be quickly erased.

The highest rates of HIV infection occur in the countries of Eastern and Southern Africa. Nevertheless, the threat from the disease is not confined to these sub-regions. More than half of the countries in Sub-Sahara Africa (24 out of 43 for which data are available) are experiencing a generalized epidemic, with the adult HIV infection rates (i.e., the rates for those aged 15-49) exceeding 5 percent at the end of 1999. These countries experiencing a generalized epidemic include countries with large populations, such as Nigeria, Ethiopia, South Africa, and the Democratic Republic of Congo. Taken all together, the heavily infected countries account for 80 percent of the adults in the sub-continent -215 million out of a total adult population of 214.9 being HIV-positive at the end of 1999. table3

On the other hand, 19 countries with lower infection rates tend to be less populous- only four have populations above 10 million and none has a population that exceeds 20 million. The average infection rate for these countries is 2.2 percent, with 1.2 million adults out of 54 million being HIV positive at the end of 1999. For Africa as a whole, the average infection rate at the end of 1999 was 8.74 percents, with 23.5 million out of an adult population of 268.9 million being infected.

In 1999, over two million AIDS –related deaths occurred in the countries of Africa with infection rates of 5 percent or more (table3) this was about three-quarters of global total. Because of so many deaths, these countries confront the demanding challenge of responding to the needs of a burgeoning number of orphans. In each of four of these countries- Ethiopia, Uganda, Tanzania, Kenya, Zambia and the Democratic Republic of Congo- it exceeds half a million (other estimates give much higher figures for all countries with orphan numbers standing close to or in excess of million in each of (Ethiopia, Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe).

The social and economic implications of deaths on this scale from just one disease, the prolonged periods of extensive illness that precede them, the intractable challenge posed by the huge number of orphans, and the disruptions that the disease and its consequences are bringing to household, employment, heath, education and other system, constitute a disaster of overwhelming proportions.

Table 3 HIV Estimates, Sub-Saharan Afica.1999

Adults (15-49) (UNAIDS; 2005)

	number	HIV infected	Infection rate	Aids orphans	Aids Deaths
Countries with infection rate abone5% (24 countries)	214.944m	22.312m	10.385	11,424.200	2,091.800
Countries with infection rate below 5% (19 countries(	54.003m	1.194m	2.21%	619.760	113,000

All countries (43)	268.967m	23.506m	8.74%	12.043.960	2.204.800

It has almost become a truism that HIV/AIDS is unravelling hard-won development gains and exerting a crippling effect on future development prospects. The repercussions of the epidemic are such that the worst affected countries are already experiencing major development reversals. If the epidemic goes into a more rapid expansion phase in less severely affected countries, the trend will be the same. This means that already many African businesses find that they must operate in a substantially changed (and worsened) socio-economic environment. In the future, others may face similar prospects.

In order to appreciate the turbulent ambience that HIV/AIDS is creating for African businesses, it is necessary to understand some of the social and economic consequences of the epidemic. The areas of greatest concern are the way the disease impacts on households, on the demographic structure of society, on the various sectors with which businesses have traditionally interacted, and on the economy in general.

The immediate effects of HIV/AIDS are experienced at the individual and household levels. The effects have many facets: illness, physical and psychological pain and suffering, health care and cost, income loss, reduced household productivity, death, funeral costs, mourning and grief, increased poverty, increased vulnerability of women, growth in the number of orphans, the social dislocation of those who survive, and the ultimate disappearance of households to illustrate , consider the following:

Following an AIDS death, household consumption in Cote D'ivoire falls 44 percent on the previous year and households with an AIDS patient spend twice as much on medical expenses as those without such a patient (Bechu 1998).

In Ethiopia, AIDS-affected households were found to spend between 11.6 and 16.4 hours per week in agriculture, compared with a mean of 33.6 hours for non-AIDS affected households (UNAIDS-UNECA 2000).

In Tanzania, a case study survey found that in households where one person was sick because of AIDS, 29 percent of labour was spent on AIDS- related matters; if two household members were devoted to nursing duties, the average household loss from agricultural activities was 43 percent (UNAIDS-UNECA 2000).

In Zimbabwe, a bed-ridden AIDS patient was estimated to cost the affected household an additional US$23-34 per month. In a survey carried out in 2000 to assess the impact of adult female mortality in two districts, it was found that 65 percent of the households where the deceased female had lived were no longer in existence (UNAIDS-UNECA 2000).

The reduction in household income, the increase in privately borne medical expenditure, and the reduction in time devoted to agricultural activities signals a dramatic deepening of poverty for affected households. Given the largely rural background from which the majority of African workplaces draw their employees, it is probable that the epidemic is reducing potential future employee's intakes. It is also clear that employees must take cognizance in their workplace research and service activities of the way the disease is changing the structure of households and their ability to produce what they require to meet their own needs.

Data on orphans has already been presented in table 3. The challenge posed by the increase in orphans is already being encountered on massive scale across the continent. Equality, the problem seems set to expand almost without limit, with no end in sight. As with AIDS itself, nothing of such all-encompassing magnitude has ever before been experience by humanity. No well-elaborated paradigms exist for guidance in coping with it. There is no real understanding of how best to support children who have no caregivers in their households, or how to enable extended families and communities respond to the care, nutrition, health, education and other needs of children who have lost one or both parents to AIDS.

Concerns are expressed that the increase in the number of orphaned juveniles as a proportion of the general population will lead to sustained increase in crime levels in the short to medium term (Schonteich 2000).

Questions are asked about how orphans in rural areas can learn to be productive when there is nobody to pass the relevant knowledge on to them (UNAIDS,December 2000:13-14). Questions are also raised about how today's orphans will become tomorrow's parents when they will never have known the formative years of a normal childhood, being parented in a normal family with father , mother, brother and sisters (Kelly 2000).

Business throughout Africa exists in a milieu where AIDS has magnified the orphans question beyond previously imaginable boundaries. Apart from the impact on potential future employee's numbers and quality, this area urgently cries out for concentrated and concerted workplace and communities' action. It might be necessary for some workplace, at least to think about developing centres for orphan studies or incorporating such studies more expressly into the other research activities that are being conducted. Responding to a problem as large as that posed by orphans will require skills and understandings that yet can scarcely be identified, but which will surely entail imaginative, innovative responses from the best minds that workplace and communities possess.

The most significant demographic impacts of HIV/AIDS are on population growth rates (and in consequence, on size) and structure. The United States census Bureau estimates that in 26 countries the population growth rate in 2000 is already lower than it would have been in a no AIDS scenario, with the difference being very substantial for some countries will continue to decline during the coming decade. For the first time, it is now being projected that AIDS will lead to negative population growth, with Botswana, South Africa, and Zimbabwe experiencing population decline by 2003. Other countries, such as Lesotho, Mozambique, Namibia and Swaziland, will be experiencing a growth rate of nearly zero, whereas in the absence of AIDS they would have been growing at the rate of two percent or more (Stanecki 2000).

One outcome of this AIDS mortality will be a reduction in the numbers of persons to be employed. Recent World Bank projections for four countries document, the kind of reduction in employee's numbers that AIDS is expected to cause the smaller number of low-level candidates will work its way through the system to generate an even smaller number of candidates for all staff. This could have two effects: a potentially smaller number of applicants would reduce pressures for recruitment and/or expansions; at the same time, the smaller pool of applicant might also display a smaller range of high qualify employees**.**

A further effect of the AIDS mortality will be the emergence of population structures that have never been experienced before. Because AIDS influences most severely on those in the productive age group (women aged 20-30 and man aged 30-40), dependency ratios will increase, with larger number of young and elder persons depending on the productive capacity of a smaller proportion of those in their economically (and biologically most productive years. For biological and socio-cultural reasons, significantly more African women than men are HIV-positive and women are infected at younger ages than men are. This trend is producing more men than women in the various age-cohorts, a factor that "may push men to seek partners in younger age cohorts" (Stanecki, 2000, p.2).

Since sexual "age-mixing", typically between older men and younger women, is one of the many factors, that play a role in kick starting and maintaining a sexually transmitted HIV epidemic (UNAIDS December 2000). The changing population structure could lead to older men infecting younger women; who then transmit the disease to their partners or children, thereby establishing a vicious cycle of infection and disease. As will be seen in many setting, sexual age mixing is a phenomenon that is regularly encountered in African communities.

The effect of the epidemic on life expectancy is devastating. In each of the countries of southern African life expectancy is lower in the AIDS situation than if there had been no AIDS. While 19 of 26 countries have seen the indicators lose ten years or more. In all countries, apart from Ghana, life expectancy is currently estimated as being below 55 year, while by the year 2010 it will have fallen to 50 or less- in some countries as Angola Botswana, Cameroon, Cote d'ivoire, Kenya, Rwanda, South Africa, Zambia and Zimbabwe (UNICEF 2001).

Fuelling this decline in life expectancy will be an increase in death rates. In Botswana and Zimbabwe, these are already more than 3 percent higher than they would have in the absence of AIDS. However, in all countries affected by AIDS the death rate is higher than in a no AIDS situation. These death rates will continue to increase, even though mortality due to non-AIDS causes will continue to decline. Contributing to these expanded death rates are increases in infant and child mortality. The latter sensitive index of development showed a downturn during the 1990s largely because of AIDS, in such countries as Angola Botswana, Cameroon, Cote d'ivoire Kenya, Rwanda, South Africa, Zambia and Zimbabwe (UNICEF 2001).

One further perspective is relevant for community administrators. According to models developed for UNAIDS, in any country where 15 percent or more of adults are currently infected, at least 35 percent of boys now aged 15 will die of AIDS (UNAIDS, June 2000:25). Even bleaker is the prospect for young people in more heavily infected countries. In 1997, half of the 15-year-old boys in Zimbabwe could expect to die before the age of 50, while the likelihood of a 15-year-old girl dying before the end of her reproductive years increased from 11 percent in the early 1980s to over 40 percent in 1997. Where such circumstance obtain, they raise serious issues relating to training employment and replacement policies for community and workplace own staff. They also raise major questions about the design and analysis of job as well as the number of employees that should be recruits in response to currently estimated needs.

Not only is Africa the worst HIV/AIDS affected region, it is also the world's poorest region with the lowest access to and quality of health care(Botchwey 2000:9) although HIV/AIDS is more than a health problem, it makes one of its most significant impacts on the health sector. This sector must deal with an increasing number of AIDS-related illnesses, diverting its already scarce resources to caring for such illnesses. Studies repeatedly return to three issues in this area:

-the way hospital beds and services are being increasingly given over to AIDS patients;
-the way high levels of morbidity and mortality among health-care staff are reducing capacities to provide care and treatment; and
-the prohibitive costs of scaling up HIV/AIDS health programmes to adequate levels of acceptability.
In response to these pressures community are finding themselves faced with difficult choices. In particular they are finding it necessary to make trade-offs between treating AIDS as against preventing new HIV infections; between treating AIDS as against treating illnesses; and between spending on health as against spending on other sectors (Botchwey, 2000).

A further consideration is that the growth of AIDS-related illnesses is expanding the demand for health care and consequently the demand for health-service individual. One estimate for South Africa is that the demand for health services in 2010 could be more than 11 percent higher than in a no AIDS scenario (Quattek, 200:41).

In addition to ensuring, that their health-care employees will have the flexibility to cope with the ever-increasing demands of the AIDS epidemic, community and workplace must be prepared to adjust so that they can also respond to demands for an increase in the number of such employees.

The impact of HIV/AIDS on the education sector is not altogether straightforward. At one level, evidence is emerging that education remains virtually the only "vaccine" currently available for warding off HIV infection. Beyond the early stages of the AIDS pandemic, education reduces the risk of HIV, with better-educated persons exposing themselves less to the risk of infection. The positive side of this is that providing more extensive and better quality education-even if not dealing directly with reproductive health and AIDS education-is likely to make a population less vulnerable to HIV infection. The negative side is that "new HIV infections will gradually become concentrated among illiterate and poor people as the epidemic spreads among the population" (Vandemootele and Delamonica, 2000).

Both aspects, positive and negative, highlight the importance of universalizing education of good quality so that this "social vaccine" is available to all persons. The relevance for Sub Saharan African community is that they must see the preventions strategies in its totality, with themselves as one of its parts, with peer education having tools that may need to be subordinated to the good of the whole.

At another level, AIDS is playing havoc with education systems. It is reducing the number of children in school, not merely, because it leads to fewer children in need of education, but also because sick parents are taking their children (especially girls) out of school, orphans are not attending school. Households are becoming more reliant on children's labour and the economic contribution they can make, and AIDS-costs are reducing family ability to provide educational services, with high levels of morbidity and mortality among teachers. UNICEF has estimated that in 1999 alone 860.000 children in Sub-Saharan Africa lost their teachers to AIDS (UNICEF 2000:8).

In addition, the quality of education is also being eroded by such factors as frequent teacher absenteeism; intermittent student attendance; low teacher morale; considerable student and teacher trauma; repeated occasions for grief and mourning in the school. In families and in the community there is a widespread sense of insecurity and anxiety among young learners, especially orphans;

unhappiness and fear of stigmatization and ostracisation on the part of both teachers and students who have been affected by HIV/AIDS; and teacher uncertainly about personal HIV status (UNECA 2000).

Compounding these problems are those of reduced resources, rather generalized poverty, a sense of unreality about the curriculum's relationship to real life, a disconnect between the world of the school and the world of work, and a pervasive doubt about the need for school education when it seems certain that many will die young because of AIDS.

HIV/AIDS impacts on the private and industrial sector by reducing productivity, increasing costs, diverting productive resources, and affecting the market for business products.

Many effects arise from the various consequences that follow when the disease is present in the workforce such as: increased absenteeism, reduced performance levels of infected workers, additional burdens on healthy workers, inexperience of replacement workers, increased medical and insurance costs, extensive recruitment and training costs,. Increased size of workforce to cover for possible sickness, absenteeism and death, payment of funeral and other benefits. The extensive household impacts of the disease, and the increasing private costs of medical care, reduce the market demand for products of all types. There is also a market effect when individuals die before they have finished paying for goods they have purchased (WHITESIDE and Sunter, 2000).

Most of these factors affect workplace, since they are expected to organize their affairs according to sound business principles. Therefore, workplace need to learn from what AIDS is doing to the business world and how the business community is responding to the disease. Although data are limited, the following examples are illustrative.

-in three firms in Abidjan, the average annual costs per employee due to HIV ranged from 0.8 to 3.2 percent of the 1997 wage bill (UNIDS-UNECA, 2000).

-on a tea and coffee estate in Malawi, production loss in 1995/96 to illness was 3.4 percent of gross profit (UNAIDS-UNECA, 2000).

-Swaziland estimates that it will have to train more than twice as many teachers as usual over the next 17 years just to keep services at their 1997 level (Swaziland Ministry of Education, 1999).

-Between 1993 and 1997, medical costs per employee for 6 firms in Dar es Salaam increased five-fold and funeral costs increased six-fold (UNAIDS-UNECA, 2000).

In a study carried out across a number of countries, it was found that absenteeism, funeral attendance and employee burial costs, taken collectively, accounted for almost three-quarters of the increased labour costs due to HIV/AIDS; with labour turnover, health care, recruitment and training costs accounting for the balance of 26 percent. It is clear that absenteeism, due at first to illnesses during the period of HIV infection and subsequently to the full-blown AIDS condition, is responsible for the greater part of the increased costs. As will be seen, small business in Africa generally, does not maintain good records on such absenteeism or other HIV/AIDS-related costs. However, big business companies find it necessary to do so therefore they should provide the small business with a lesson.

HIV/AIDS influences operational situation of a small business in much the same way as on any other enterprise. It tends to increase operating costs, reduce productivity, divert resources from planned activities, and threaten sources of income. Although the case studies have been able to provide little hard evidence in these areas, they make it clear that four effects are being experienced by small business in Africa, with the first three making their greatest impact through the way they affect the small business workforce.

Whiteside and Sunter (2000:109 ff.) provide useful schemas for analyzing the financial impact of HIV/AIDS on a company's workforce. The analysis can be applied equally well to small workplace and can guide them in collecting data that would enable them to monitor one of the principal ways through which HIV/AIDS would affect their costs (see below)

Cost area	Percent of total increased costs
Absenteeism due to HIV	37
Absenteeism due to AIDS	15
Burial & funeral benefits of an employee	16
Funeral attendance by employee	6
Health care	5
Labour turnover	5
recruitment	9
training	7

Direct costs	Indirect costs	Systemic costs
Benefits package	Absenteeism	Loss of workplace cohesion
Recruitment	Morbidity o the job	Loss of productivity
Training	Management resources	Loss of skills and experience
HIV/AIDS programmes		

Table 4-The economic impacts of HIV/AIDS on an institution's workforce.
Source: Derived from Whiteside and Sunter 2000:112

Essentially, they propose that the costs involved be analyzed as direct costs (those that involve increased financial outlay), indirect costs (those that reflect reduced workforce productivity, whether by the infected worker or by others whom HIV/AIDS concerns deflect to other activities), and systemic costs (those arising from the way the disease reduces the overall skills and experience in the workforce, affects morale, etc.).

-Direct costs

The case studies indicate that the factory is already bearing increased costs for the maintenance of regular medical services through their clinic and health centres. These must be kept supplied with rising amounts of materials for testing and treating an increasing number of STD cases, with drugs for tuberculosis and other AIDS-related illnesses, and with disposable materials and special equipment that will protect health workers against possible infection. Additional calls, and therefore costs, are involved in providing some form of hospital care for staff or employees who may become severely ill.

As is the case with other large companies, small factories are called upon to make terminal benefits available to employees earlier than expected. Further, some companies contract with private medical insurance companies to provide medical coverage for their employees. The tendency has been for the premiums of these schemes, and for pension and life benefits, to increase rapidly as HIV/AIDS spreads. For South Africa, Metropolitan Life has estimated that the costs of an average set of insurance benefits could double for many scheme by 5005 and triple by 2010 (Quattek 2000:38).Few companies will be able to avoid similar cost increases.

Companies also face ever larger and more frequent expenses for funerals. The conditions of service at almost all institutions oblige business to provide a funeral grant when a member of staff, spouse, or child passes away. They also require the company to provide funeral transportation (or cash in lieu) for the carrying of the dead to their place of origin. These payments place a heavy burden on workplace budgets. In mid 1999 for example, the AES factory Douala, estimated that it was spending close to US$1,500 each month on funeral grants and expenses. At AES Yaoundé, funeral-related vehicle use jumped from 7 percent of total transport request in 1991 to 22 percent in 1999.

Many companies have not yet begun to deal with the replacement and training cost of those who have died or left active company service because of HIV/AIDS. This is largely because the majority of staff severances have occurred among the cadre of general workers, where replacement is not costly (or may not take place, because of pressures on the company to retrench workers). But increasingly, companies are coming to recognize that considerable costs are involved in the recruitment and training of replacement administrative and technical staff. Particularly costly are the losses that many of the workplace has experienced of trainee members of staff working abroad. The death of such individuals represents a three-fold loss for a company: the loss of well-qualified and carefully selected individuals, the loss of professional development investments, and the costs of repatriating the remains of the deceased.

-Indirect costs.

As shown in table 4 above, absenteeism accounts for the largest share of the costs arising from HIV/AIDS. Employee absenteeism stemming from HIV/AIDS has two aspects: the absences that occur as the immune system progressively breaks down during the almost invisible HIV stage of the disease, and the absence that occur when the disease has progressed to full-blown AIDS. The former end to be of short duration, but increase in frequency and duration as time progresses. The latter may be quite extended and almost inevitably lead to permanent absence from duties.

The immune system can be breaking down for a long period, and the infected person can be set by a series of illnesses long before diagnosis of full-blown AIDS. A conservative assumption might be

that, on average, each infected employee loses six months of professional time before developing full-blown AIDS and then 12 months thereafter (World Bank, 2000:23).

While both forms of absenteeism lead to loss of productivity, the costs of sporadic absences caused by intermittent illness during the HIV stage can be more trouble some to manage because they are so unpredictable and because the situation is at too early to justify a replacement for the individual in question. These unscheduled absences can be very disruptive of working and general administrative activities, with individuals having to cover for colleagues at short notice or with the work being left undone. Repeated experiences of this type tend to lower the morale even of healthy staff, leading to further declines in productivity.

A further aspect of absenteeism is the way this has increased in order to facilitate funeral attendance. In some countries, funerals occur mostly at weekends so that they cause minimal disruption of normal operations. But in others, they occur throughout the week. In such circumstance, production and other departments may be deprived of a member of staff for several days at a time. In the case of death of a staff member, the impact is even more severe because of the company tradition that other members of staff, and representatives of the company management, participate in the funeral. The increase in the number of funerals is also becoming burdensome to the members of some workplace communities where there is a strong expectation that they will contribute financially to the costs associated with the period of mourning and burial.

Workplace provisions for sick leave tend to be generous. A person infected with HIV will normally continue to receive full benefits throughout the series of comparatively short illness that precede the diagnosis of full-blown AIDS. when a more extended period of leave is required because of the progression of the disease, this may cover several months, a year or more, humanitarian considerations frequently deter block workplace administrators from adhering to the strict contractual provisions regarding sick leave and terminating the benefits of an employees who will clearly pass away in the very near future. Moreover, as one of the studies noted, responsible officers may not report absence due to prolonged illness, precisely so that the affected individual may not lose salary or other benefits that have assumed greater importance than ever because of the illness.

-Systemic costs

Because much of their concern is with the impact of HIV/AIDS on employees and workplace core operations, the case studies make only glancing references to issues such as staff morale, the ability of skilled or unskilled employees to continue to work together as a team, AIDS-occasioned breakdown in routines, or reduced experience in the workforce. The AES factory refers to the possibility of HIV/AIDS "wiping out the reservoir of knowledge and expertise created over time" more over the company stakeholder think that "the virus could decimate the human resources of the institution" or worst " unskilled and semiskilled having to stand for their sick or incapacitated skilled colleague in both production and research areas. More frequently, however, the skilled staffs cover for job or research undertakings that, because of morbidity or mortality, can no longer be undertaken by unskilled and semiskilled.

In most companies, morale and motivation are at low ebb. This is more for finance-related than for HIV/AIDS-related reasons (i.e., dissatisfaction with conditions of service, inadequate resources for production and research, insufficient medical supplies, poor state of facilities.
In workplaces, a larger incidence of morbidity and mortality occurs among the unskilled employees and semi-skilled; this reflects the pattern across companies. In Cameroon for instance, it is forecast that the HIV/AIDS infection rate will peak 5% for highly skilled workers, compared with 15% of the skilled , 25 % for semi-skilled and 55% for unskilled , annul AIDS –death are forecast to peak at 1.2 per 100 highly skilled workers at 2.0 per skilled 3.4 per semi-skilled and unskilled workers. (Cameroon Tribune).

Because of this pattern, one might think that HIV/AIDS is not disrupting actual workplace operation to the same extent as it is disrupting other areas of workplace operations. However it must be remembered that replacement of highly skilled staff with skilled is much more difficult and protracted than replacement of staff in semi and unskilled employees.

In addition, workplace operations involve many highly specialized areas. It may be possible for other staff to move over and cover for sick or deceased colleague in some general field. But they cannot easily do so when the loss is in an area where the affected member of staff is the only specialist. Such a loss affects present and future generations of employees, because of the lengthy academic training that a replacement may need.

As shocking as these impacts are, they do not begin to adequately reflect the physical and emotional devastation to individuals, families, communities and businesses coping with HIV/AIDS and of the terrible impact of HIV/AIDS on company and global economy. Despite advances in HIV/AIDS research, there is no cure for AIDS or a vaccine to prevent infection, the pandemic continues to undermine lives, communities and businesses.

While Africa continues to be the region most severely impacted by the pandemic, infections rates in other region (notably Eastern, central Europe and Asia) are climbing rapidly. They unpredicted 68 million more deaths over the next twenty years unless efforts at treatment and prevention are increased. Looking at the current HIV/AIDS situation in the world and the emerging trends especially in Sub Saharan Africa, it is clear that if businesses and communities do not act together now the cost of inaction will be far greater.

According to Dr Peter Piot, Executive Director of the joint United Nations Programme on HIV/AIDS (UNAIDS) "the strong political will and social mobilization are realities which should lead to the scaling up of HIV care and prevention programmes and avoid a worsening epidemic in the country" there is a rising trend in Cameroon prevalence rate posing serious threat to the country's economic recovery and development.

The epidemic grew slowly between the late 1980s and 1996, with average prevalence among pregnant women in urban areas rising from below 2% to fewer than 5%; however the latest surveillance data indicates an HIV prevalence of around 11%. Furthermore, statistics showed a concentration of deaths in the younger age groups (86 percent of deaths were below 46 years). Cameroon's experience, demonstrates that countries with low to moderate HIV prevalence are not necessarily immune from a more severe epidemic more over it show how suddenly an epidemic can surge, points to the need for increased prevention efforts.

Giving the gravity of the AIDS crisis, the key question is therefore, what cost effective preventive efforts can be use to fight the increase of HIV/AIDS in Sub Saharan communities? Does peer education approach can prevent young people from this tragedy in Douala community?

Chapter 2 - Peer Education as HIV/AIDS prevention approach.

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2.1- introduction

2.2 -What is peer education approach?

2.3-peer education: behaviour theory and behaviour change

2.4-peer education as both agents and recipients of HIV prevention

2.5 -advantages and disadvantages of peer education approach

2.6suggestion to improve peer education approach

2.1 introductions

First in North America and Western Europe, and now in Africa, where the HIV/AIDS fiercest toll is being exacted, the world have grappled for 25 long years, with humankind's worst pandemic since the plague cut down one-third of Europe's population nearly seven centuries ago. We have struggled to grasp the virology of AIDS, its demography, its impact on human physiology, its social and economic consequences, its responsiveness to medical treatment. But most of all we are struggling to implement effective strategies approach in the prevention of HIV/AIDS on young-adults people.

More than half of people newly infected with the human immunodeficiency virus (HIV) worldwide are aged 15-24 years (United Nations Children's Fund (UNICEF) et al 2002). Empowering young people with the basic human right of reproductive choice is, therefore, critically important. Over the past decade, there has been a growing interest in involving young people as peer educators in health education in Cameroon, particularly in the area of sexual health.

Peer education approaches offer the possibility of changing behaviour and increasing knowledge to prevent HIV. This research explains what a peer education is and gives guidance on how to develop a project focused on young people.

Young people are at the centre of the global HIV and acquired immunodeficiency syndrome AIDS pandemic. They are also a key human resource for the future wellbeing to communities. Each day nearly 6.000 young people aged from 15-24 years become infected with HIV (UNICEF et al 2002). Educating young people about HIV, and teaching them skills in negotiation, conflict resolution,

critical thinking, decision-making and communication, improve their self-confidence and ability to make informed choices; for example, postponing sex until they are mature enough to protect themselves from HIV and other sexually transmitted infections (STIs) and unwanted pregnancies (UNICEF et al 2002). In 2003, an estimated 11 per cent of adults in Cameroon were living with HIV/AIDS (Joint AUNAIDS 1999, UNAIDS/UNICEF/WORLD Health Organisation (WHO) 2004.

In Cameroon, one third of the people who become infected with HIV do so during adolescence. Since HIV is mainly transmitted through unprotected sex, the obvious conclusion is that young people are sexually active. Therefore, it is very important that young people are involved in AIDS prevention programmes especially because young can more easily adopt new, safer behaviour patterns than adults can since they form their attitudes and behaviour patterns during adolescence. So, the 'profit' is higher when young people are involved.

However, it is important that young people are targeted and involved in the right way. Prevention programmes should not only focus on the transfer of knowledge. Research has shown that only transferring knowledge is not enough to bring about a behaviour change. Therefore, prevention programmes should also address the prevalent attitudes and norms among young people and should use negotiation.

In addition, it is important that youth are reactively involved in the programmes, in designing, implementation and evaluation. They know best which subjects are important to bring up and how this can be done best to involve other young people. This will increase the impact of the prevention programmes. (It will often work the opposite way: if adults tell young people how they should behave themselves, they will resist that and might think that adults want to keep them from experiencing the pleasures of sex.)

Many adolescents have a low risk perception when it comes to sexual activity and STIs. They think that they are infallible and that misfortune – like contracting HIV-only happens to someone else. This type of thinking can result in high-risk sexual behaviour.

In many countries and cultures, secrecy and shame surround the subject of sex. It is a social taboo. In Cameroon, for example, traditionally the uncle gives sex education for boys and by the aunt for girls.

However, in current times extended families do not often live together, so the traditional way of giving sex education becomes more difficult.

In many developing countries, government has tried to solve this vacuum by designing an AIDS education programme, which should be implemented in primary and secondary schools. But most teachers are too ashamed to talk with their pupils about these sensitive matters and the pupils are too afraid to ask sensitive questions.

Much different kind of issues cause young people practice high-risk sexual behaviour, which can lead to contracting HIV. Young people are the most important source of nation. Therefore, it is important that they remain free of HIV/AIDS.

In Cameroon, the "Reglo A" runs a peer education programme. Young people can sign up for peer education training which lasts for one week. During the training, they learn the technical facts about STDs and HIV/AIDS, but also about how to communicate with peers about these sensitive subjects and they receive a life skills training. The training is presented by different people, by for example a nurse who explains the technical facts and by other trainers about the role of peer educators, etc. After the training, the peer educators are supposed to disseminate the information they have learned. This can be done by informal talks or by organising activities in the community or in schools.

Peer education is a good method to disseminate the right information among young people. The peer educators can also give advice to their friends on sexual matters. Instead of negative peer pressure, peer education can lead to positive peer pressure among young people, which can lead to safer sexual behaviour. The peer educators also plan, implement and evaluate their own activities. This increases 'ownership' and will increase the effect of the programme. However, this alone will not be enough. If young people have the knowledge and adopted a safe attitude, then they should also be able to carry out safe sex. Therefore, it is important that there are also youth friendly clinics where they can get treatment and counselling.

Prevention works best, and it is most cost effective, when started early. One good example of prevention programme is peer education. Peer education has been used in many areas of public health. As the effects of HIV/AIDS become more and more apparent in Cameroon, MTN ACMS and

the government have developed a comprehensive service incorporating HIV/AIDS advocates (peer educators) for educating young people about HIV/AIDS prevention, counselling and support. Through various HIV/AIDS workshop, they managed to facilitate education maintenance and behaviour change to curb the HIV/AIDS pandemic in schools, and the communities surrounded. What is peer education and how does the Cameroonian "Reglo A" use peer education approach to prevent HIV/AIDS on young people

2.2 What is peer education approach?

Peer education is a popular, often ubiquitous concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy. The English term 'peer' refers to:
-One that is equal standing with another; one belonging to the same societal group especially based on age, grade or status.
-an equal in civil standing or rank; equal in any respect. (The concise oxford Dictionary).
-One belonging to the same societal group especially based on age, grade or status. (Merriam Webster's Dictionary).

The term 'education' (v. educate) on the other hand refers to:
-the development," training,", or "persuasion" of a given person or thing or the "knowledge" resulting from the educational process (Merriam Webster's Dictionary, 1985).
-bringing up (of the young); systematic instruction; development of character or mental powers; training. (The concise Oxford Dictionary).

In practice, peer education has taken on a range of definitions and interpretations of who is peer and what is education(e.g., advocacy, counselling, facilitating discussions, drama, lecturing ,distributing materials, making referrals to services, providing support, etc.; Shoemaker,et al, 1998; Flanagan, et al, 1996).

Gary Svensen defines peer education as Peer-to-peer communication and as an approach whereby a minority of peer representatives from a group or population actively attempt to inform or influence the majority (European Guidelines for Peer Education). Peer education typically involves the use of members of a given group to effect change among members of the same group. This education is

often used to effect change at the individual level, attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. However, peer education may also effect change at the group or societal level by modify norms and stimulating collective action that leads to changes in programs and policies.

2.3. Peer education: behavioural theory and behaviour change

Peer education as a behaviour change strategy draws on several well-known behavioural theories. Some of these theories are:

-Social Learning Theory that asserts that people serve as models of human behaviour and that some people (significant others) are capable of eliciting behaviour change in certain individuals, based on the individual's value and interpretation system (Bandura, 1986).

-The Theory of Reasoned Action which asserts that one of the influential elements for behaviour change is a person's perception of social norms or beliefs about what is important to the individual to do or think about a particular behaviour (Fishbein and Ajzen, 1986).

-The diffusion of innovation Theory that posits that certain individuals (opinion leaders) from a given population act as agents of behaviour change by disseminating information and influencing groups norms among their community (Rogers, 1983).

-Theory of diffusion of innovation underpins the larger part of the proposed peer education strategy. (Rogers, 1983) This theory's approach uses peer educators who belong socially to the target group. It depends on informal peer-to-peer communication and social influences that occur outside the formal training environment to create the right conditions for spontaneous discussions amongst young people to take place.

The Theory of participatory Education has also been important in the development of peer education (Freine, 1970). "participatory or empowerment models of education posit that powerlessness at the community or group level, and the economic and social conditions inherent to the lack of power are major risk factor for poor health" (Amaro,1995).

Empowerment in the freirian sense of the word results through the full participation of the people affected by a given problem or health condition; through such dialogue the affected community collectively plans and implements a response to the problem or health condition in question. Many advocates of peer education claim that this horizontal process of peers (equals) talking among them and determining a course of action is key to peer education's influence on behaviour change.

Peer education draws from elements of each of these behavioural theories as it implicitly asserts that certain members of a given peer group (peer educators) can be influential in eliciting behaviour change among their peers. Research shows that just providing information about HIV is not enough to promote behaviour change

People do not change with information, they change when other friends around them change.

According to Advocates for youth, peer education draws on the credibility young people have with their peers. It uses the power of role modelling and provides flexibility in meeting the many needs for today's young people. Along with the explosive infection rates of HIV/AIDS, other STIs, and unplanned pregnancies among adolescents, young people are facing many social and cultural pressures. They are searching for hope, identify, and answer to their numerous questions.

Not only can per education create positive group norms of behaviours , decreasing risk for HIV/AIDS, STIs, and unplanned pregnancies, but also, peer education applied within a community development framework, can stimulate lifestyle change. This can encourage personal vision and modify an adolescent's knowledge, attitudes, beliefs, and behaviour. This change at an individual level can result in change at the group level. Change at group level can result in change at a community level.

Eventually, the peer education process in one community can serve as a model for other communities and lead to collective action causing transformation of programs and policies at a national level. The challenge in hosting peer-education prevention work is to understand this behaviour change process and to establish appropriate relationships, training and tools to reach the adolescent target group on their level. This means recognizing adolescent participation as an essential approach to effective HIV

prevention by enabling adolescents, with support and supervising of adults, to design and implement their own peer education intervention.

Peer education has been used in many areas of public health, including nutrition, education, family planning, substance use, and violence prevention. However, HIV/AIDS peer education stands out owing to the number of examples of its use in the recent international public health literature. Because of this popularity, global efforts to further understand and improve the process and impact of peer education in the area of HIV/AIDS prevention, care, and support have also increased.

Preventing HIV/AIDS among young people is critical as many are at significant risk for HIV infection. Peer education is one strategy for both HIV/AIDS prevention and sexual health promotion for this group. It builds on the strong ties between age mates fostered during socialization and bypasses adults who are reluctant to talk about sexual matters.

2.4. Peer education as both agents and recipients of HIV prevention.

How to implement a peer educator program?

Case study for example “Y’ello Reglo Cameroon”

Close to 1 million adults and children are currently livings with HIV/AIDS in Cameroon. An estimated 210.000 children under 14 have lost one or both parents to HIV/AIDS in the country in that effect, Mr Urbain Olanguena Awono, Minister of public health and chairperson of the National Aids control committee in Cameroon said:

“The Aids pandemic is an overwhelming challenge against humanity, fast depleting our human resources with an upper effect on our economic and social systems. Together we must consolidate and intensify our efforts to stop the expanding epidemic from ravaging our youths leaving our homes fatherless and motherless. We must build a strong protective fortress for Cameroon and Cameroonian now, because tomorrow might be too late and history will hold us accountable,”

Formalized in March 2007 by the signing of an “M toU” between all three parties (UNAIDS, MTN and ACMS) “Y’ello Reglo” is a project of interpersonal communication contributing to HIV prevention among young-adult aged 15-39 attending school, out of school or working. The strategy is to strengthen the capacity of young-adult who are roles models in their community and who are grouped within the “club Reglo”. The project “Y’ello Reglo” stems from the 100% young project launched by ACMS in 2000 with the aim to raise awareness about STI/AIDS among young-adult people. The originality of this peer awareness approach lies in the fact that with little financial means, young adult people are able to fight stigma and discrimination faced by people living with HIV and to influence the immediate environment by using their own communication channels.

The ACMS has been running their peer education program since 2000. Each year approximately 50 Peer educators are recruited through schools, teachers, guidance counsellors, newspapers and word of mouth. The young people are asked to complete an application and come in for an interview. After hiring, the peer educators receive 60 hours of training, meeting three hours a day, everyday for four week. They are asked to volunteer their time for the first 10 hours of training to ensure that they are committed to the program and they received minimum wage for the next 50.

They are paid CFA 15000 for completing the training. The program encourages communication, life planning, decision-making, and conflict management, setting goals and designing personal plans.
The peer educators conduct their education through one –on-one contacts and organized group presentations. Each peer educator agrees to make at least 50 contacts and complete a service-learning project in community.

The projects use a bimonthly newspaper (French and English), 5 weekly radios shows produced by the young and broadcasted in 5 provincial capitals.
The project currently includes 110 Reglo Clubs (with amount 3000 young members who are “role models” in their communities. All over those clubs the project Y’ello have many affiliates doing peer education programs all over the country:

- a little help from your friends
- the how to say no program
- chit-chat peer education

The program is designed to use existing peer networks among young people, to provide accurate, honest information about sexuality in one-on-one conversations. Formal groups of 10-15 peer educators are recruited for every district through newspaper ads, fliers, and world of mouth.

Peer educators conduct education through various techniques including individual contacts, workshops, questions boxes, posted in schools, information tables at events, and a call-in youth radio show. After training is completed, peer educators continue to meet weekly, and most of them are eventually hired after making their 50 contact to continue delivering individual and group sexuality education.

Founders have evaluated the program three years in row and have found that peer educators had a statistically significant increase in knowledge and that the majority of participants had improved communication skills. Pre-and post-tests have consistently indicated an increase in knowledge among peer educators, I in the areas of anatomy and physiology, puberty issues, STIs and condom use.

Trainers use lectures, art therapy, small groups, videos, games speakers, discussions, and theatre-type activities. To qualify as peer educators, young people must receive at least 80 out of 100 on a test at the end of training. Those who do not pas the test receive one-on-one tutoring until they are able to pass. School performance is also monitored, and peer educators must remain in good academic standing to continue the program.

After training is completed, the young people meet weekly for two hours, and the conduct their education through one –on-one contact, a resource centre, group presentations and a hotline. Peer educators also perform some clerical duties for the clinic.

Before implementing the program, it is worthy:
- To be sure there is enough resource to continually train, supervise, and pay peer educators (paying peer educators will increase their attendance and accountability).

-Script presentations so that they are standardized and you can be sure what information peer educators are presenting.

-Recruit and hire a diverse group of peer educators so that they are representative of the overall population they will be speaking to. Young people will not be likely to see the educators as “peer” if they are very different from them in terms of ethnicity, socioeconomic status, gender, etc.

-Be aware of the time restrictions and scheduling problems associated. While working with young people (time away from school, sports practice, studying, etc.). Try to schedule meetings and presentations at times/locations that will be most convenient for peer educators.

-Expect that the peer educators will have their own problems, and be sure that your staffs are prepared and available to address those problems. Establish strong relations with schools, teachers, counsellors, parents, and other youth-serving agencies and professionals before implementing the program. This will ensure that they stay committed to the program, even if you hit some bumps along the way.

-If possible, use volunteers to help coordinate the peer education program, as the workload involved in coordinating such a program are not only capable, but are also dedicated to , and likely to enjoy working with young .

-identify your expected outcomes before starting the program so that you know what you hope to achieve and so you can evaluate the progress of your program periodically. If possible, get parents involved in the program. Doing so will help to integrate the program more fully into the community and will provide opportunity to offer young people not only accurate and comprehensive information about sexual health, but also caring, support, skills, role models, and understanding.

Peer education stand for a comprehensive service offering incorporating various HIV/AIDS advocates (peer educators) to facilitate education maintenance and behaviour change to curb the HIV/AIDS pandemic.
Peer education programmes are effective in modifying knowledge, attitudes, communication and risk behaviours related to HIV/AIDS, STI and or reducing the incidence of HIV /STI.
It draws on several well-known behavioural theories such as social learning theory, the theory of reasoned action and the diffusion of innovation theory. Peer education draws on elements of each of

these behavioural theories to produce changes among their peer; how is the process of selection and recruitment of peer educators?

Recruiting and selecting peer educators

In general, the process of selecting the peer educators is an element that is critical to programme success. They must be acceptable to the target group and their personality must be both conductive to training and suited to the work they will be doing. One way to identify candidates for peer educators is to observe a group's behaviour and then identify its natural opinion leaders.
There are certain qualities necessary for when selecting peer educators such as:

-Ability to communicate clearly and persuasively with peers.
-Good interpersonal skills, including listening skills.
-A socio-cultural background similar to that of the target audience-may include age, sex and social class.
-Accepted and respected by their peers.
-A non-judgmental attitude.
-Strong motivation to work towards human immunodeficiency virus (HIV) risk reduction.
-Care, compassion and respect for people affected by HIV and acquired immunodeficiency syndrome (AIDS).
-Self-confidence and potential for leadership.
-Pass a practical, knowledge-based exam at the end of training.
-Time and energy to devote to this work.
-Potential to be a safer-sex role model for their peers.
-Able to get to the location of the target audience.
-Able to work irregular hours.

In the Douala Urban community in Cameroon, social network interviews and nomination techniques were use to identify and select key informants. Interviews were conducted with program manager from the community regarding the use of peer education in HIV /AIDS prevention, care, and support intervention. 70 key informants (30 men and 40 women), made up of stakeholders, parents, staff

managements, and peers educators themselves were obtained using a nomination method of recruitment.

The recruitment and selection of peer education in “Y’ello Reglo” project was not the responsibility of project managers only. The selection was a collaborative effort between the trainers and the target audience. More over the selection process involved the relevant stakeholders in the community (staff management, the school union, parenthood, and the medical personnel, teachers and religions leaders.) to increase the acceptability of peer educators in the community.

Nominated informants were contacted by e-mail, phone, fax, word of mouth, sharps magazine, newsletter, and community news. Those who agreed to participate were asking to respond to a brief questionnaire that asked them about:

-Selection of peer education as a programme strategy.
-Challenges faced in the implementation of peer education.
-Resources needed to strengthen peer education programme.
-Changes they would like to make to peer education programme.
-Suggested agenda topics for the awareness.
-Research questions to be addressed in order to improve peer education programme.

Then they are notified their key role and responsibilities:

-Promote behaviour change by educating peers on safer sex options.
-Be HIV/AIDS role models in the communities.
-Educate youth on risk reduction methods to prevent further spread of HIV/AIDS STI and TB during communities organized education sessions and during Health Days.
-Increase VCT uptake on-site.
-Promote utilization of condoms by fellow peers.
-Encourage enrolment in Disease Management Programme for HIV infected peers.
-Promote counselling services through utilization of the EAP and medical services counselling programme.

Keys informants are people selected for their leadership potential to impart knowledge and skills with
Their co-peers, they need to learn the necessary skills in order to fulfil this role.

Training of peer educators

“Y’elllo Reglo” project peer educators in HIV/AIDS prevention were equipped with essential skills in order to facilitate and initiate awareness interventions. The training programme for peer education consists of five separate workshops.

-Unpacking the ramifications of HIV/AIDS.
-HIV/AIDS combating skills workshop.
-Counsellors to care workshop.
-Wellness wize workshops.
-HIV and AIDS information distribution.

Unpacking the ramifications of HIV/AIDS

The purpose of this workshop is to implement policies regarding HIV/AIDS in the community.
Specific Outcomes:
-describe legislation and national policies relating to HIV/AIDS in the community
-describe and analyze policies around HIV and AIDS in the community
-develop appropriate HIV/AIDS policy for the community consistent with national requirements
Workshop duration: 3 Days

HIV/AIDS combating skills workshop.

The purpose of this workshop is to enable the workplace to have his own in-house HIV/AIDS Advocates to facilitate and initiate awareness amongst the workforce.
Specific outcomes:
-describe and explain nature of HIV/AIDS
-describe transmission routes

-describe and explain practices, which reduce and prevent risk of infection
-reflect on their own attitudes toward HIV and AIDS in the community
-Outline the rights of people living with HIV and AIDS
Workshop duration: 3 Days

Counsellors to care workshop

The purpose of this workshop is to improve the ability of HIV/AIDS advocates in a variety of settings to provide psychosocial support to those infected and / or affected by HIV/AIDS to achieve optimum level of functioning and satisfactory quality of life.
Specific Outcomes:
-discuss the basic principles of counselling
-discuss the different stages in the counselling process
-identify co-peers in need of HIV/AIDS counselling
-describe the role of the HIV/AIDS counsellor in the community
-describe key issues to be covered during of pre and post-test counselling
-conduct a counselling procedure
-identify appropriate referral resources
Workshop Duration 3 Days

Wellness wize workshop

The purpose of the workshop is to promote a safe, caring, and positive working environment where HIV-positive persons can function optimally.
Specific Outcomes:
-explain wellness and why it is important
-identify factors that influence wellness and the effects on wellness over time
-investigate the effect of wellness on people in a group or team
-discuss ways to improve the wellness of a group or team
Workshop duration: 2 Days

HIV and AIDS information workshop

The purpose of this workshop is to contribute to information distribution regarding HIV/AIDS in the workplace.

Specific Outcomes:

-describe attitudes toward HIV and AIDS in the workplace

-identify factors influencing attitudes towards HIV and AIDS

-plan an information session in the workplace on HIV and AIDS

-prepare information session in the workplace on HIV and AIDS

-offer information session in the workplace on HIV and AIDS

- evaluate the information session

Workshop Duration: 4 Days.

Key informants are volunteers train to act as multiplier people passing on their knowledge; they give information, offer guidance and counselling, run educational activities and provide support to HIV-infected peers. They also challenge discrimination in the community. Among the methods used are internal newsletters, lectures, short meetings workshops, film plays and e-mails networks, radio and TV animation.

In its peer education guidelines, "Y'ello Reglo" suggests that there should be an assessment of the participant's background and experience in HIV/AIDS education before the content of the training is decided.

The developed Critical elements of peer educator training include:

-Clarification of the educator's expected roles.

- Sufficient opportunities to practice presentation on key topics such as STI, HIV/AIDS.

-Gender and sexuality.

-Care and support for people living with HIV/AIDS.

- Time to practice skills-building exercises such as correct condom use or needle hygiene.

Peer education training programmes include the following elements:

-A preparatory meeting and retreat to enable peer educators to get to know each other and start working with project staff.

- Imparting of formal knowledge on topics related to STIs, and HIV/AIDS.

-A focus on personal development, cultural issues, biases, skills trainings.

Programmes are particularly interested in participatory methods of communicating HIV/AIDS prevention and care information to their intended audiences and of fostering a critical analysis of gender and socio-cultural norms that influence sexual risk.

A “gender – based approach” to HIV/AIDS programming takes into account the ways in which gender norms influence vulnerability to HIV, the ability to adopt HIV protective behaviour and care of people living with HIV/AIDS.

Socio-cultural constructions, values and stigmas related to sexual orientation line of work or behaviour may also influence the ability of HIV/AIDS programme planners to design and implement effective HIV/AIDS peer education programmes.

Initial training of seven to ten days and focused on theoretical and practical issues, given to key informant constitutes an important element of a successful peer education programme. The initial training is important to equip them with the necessary skills, knowledge and motivation. They were aware and have answers to the many questions such as:

What are the goals of the project?

Who is the target audience?

Are there people in the target group who have the time, interest and ability to work as peer educators?

What will the peer educators need to do?

What resources will the peer educators need to conduct these activities?

Can the project provide these resources?

How large is the target group?

How many peer educators are required to reach this group?

Can the project train and support that many peer educators?

Will the peer educators need incentives and, if so, what? Can the project provide them?

Can the peer educators be supported with supervision, refresher training and incentives over the long term? Is there a budget for this?

How many staff members will be required to support the project?

What other activities will the peer education strategy complement?

Have there been or are there any other similar projects going on in the area? This is to avoid duplication and confusion.

Training of technical staff for persons involved in peer education programmes is not as simple as ensuring that they know how to teach people about knowledge, attitudes, and practices. Peer education implies a philosophical vision in terms of respects for the population and trying to see things from their cultural perspective. This process often raises issues of race gender and class.

Aids education involves raising sensitive issues such as sexuality, different sexual practices, drug use, and other risk behaviours such as:

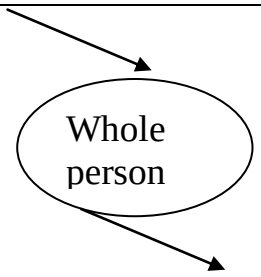
Table 5 Continuum of sexual behaviours: from low to high-risk behaviours

Low risk	Some risk	High risk
Oral sex on a man (fellation) who is wearing a condom	Oral sex(on a man or woman without a condom or barrier)	Vaginal penetrative sex without a condom
Oral sex on a woman (cunnilingus) with a latex barrier	Vaginal penetrative sex with a condom	Anal penetrative sex without a condom(very high risk)
Anilingus (oral-anal sex) with a latex barrier	Anal penetrative sex with a condom (it is safer to withdraw before ejaculation)	Swallowing semen
Contact with urine(golden showers or water sports on unbroken skin)		Sharing uncovered sex toys
		Vaginal or oral penetrative sex with a condom if using a petroleum-based lubricant
		Unprotected oral-anal contact if blood is present
		Unprotected manual-anal intercourse(fisting) without a

		latex glove
		Contact with menstrual blood
		Unprotected manual vaginal-vaginal intercourse (fisting) without a latex glove

HIV/AIDS education should never concentrate on the dissemination of information on HIV and AIDS alone. To make responsible decisions, young people must have knowledge that is firmly based on healthy values, norms and attitudes, and skills to implement these decisions. For an HIV/AIDS, education programme to be successful there should be a balance between knowledge, life skills, values and attitudes.

knowledge	Attitudes and values
Young people need to know: -how their bodies and minds works; -what problems they may experience; -how to deal with such problems; -how to prevent HIV infection.	Young people must be equipped with positive self-esteem and self-confidence in order to develop solid values that will guide their decision making



Skills to apply
Young people need to develop the assertiveness skills: -to be able to say no;

-to resist sexual abusers; -to access the health services to which they are entitled; and -to apply thinking and problem-solving skills to make positive and correct decisions in their lives,

Table 6 the building blocks for successful HIV/AIDS education (Source Adapted from Norton ET Dawson, 2000: VI)

2.5 Advantages and disadvantages of peer education approach

Advantages

The aim of the peer education approach is to develop the confidence, capacities and leadership skills of people who are trained as peer educators. This can be achieved by running project activities, training to be trainers, project planning and management training, occupying respected and responsible positions among their peers, and working as information providers on sexual and reproductive health issues. Peer education can be used with a variety of populations and age groups. People frequently turn to their peers for information and advice. These interactions tend to be more frequent, intense and diverse than those with other people, and they provide an arena for support and modelling.

The peer education has the advantage of perceived credibility of peer educators in the eyes of their target group. It is a widely utilized HIV/AIDS prevention strategy that is accepted and valued by both programme audiences and stakeholders. It can be useful and productive approach to health promotion. People exposed to peer education often praise this approach because:

-It is reached through a shared background between the educators and his or her audience.

-It was selected based on a needs assessment and /or pilot study with the target population that indicated that peer education would be an effective intervention strategy.

-It facilitates the involvement of the intended audience in programme planning, implementation and evaluation.

-It is empowering for both the educator and the beneficiary because of its horizontal and participatory approach to learning.

-It is based on behavioural theory, which asserts that people make changes not because of scientific evidence or testimony but because of the subjective judgment of close, trusted peers who act as persuasive role models for change.

-It is effective in promoting the adoption of preventive behaviour with regard to HIV/AIDS. It is also a cost- effective intervention strategy because its use of volunteers makes it inexpensive to implement and /or expand.

- It can be useful in targeting groups that are traditionally hard to reach, such as those who are alcohol and or substance misuses and street children.

-It is also useful in reaching other marginalized group, such as homosexuals or commercial sex workers.

-It can reach those who are in or out the workplace. It can work in projects to address bullying in school or assist in promoting sexual education.

-It can also be used with information and communication technologies such as internet-based counselling services or telephone help lines.

-peer educators are less likely to be seen as authority figures preaching about how others should behave. Rather, peer education is perceived more like receiving advice from a friend who is “in the know”. A successful peer as someone, who has similar concerns, is trying to help and has an understanding of what it is like to be “in”.
-they have physical and socio-cultural access to intended audiences in their natural environments without being conspicuous.

- they are effective and credible communicators who have inside knowledge of the intended audience and use appropriate language/terminology as well as non-verbal gestures to allow their peer to feel comfortable when talking about issues of sexuality and HIV/AIDS.

-Peer educators and programme beneficiaries can mutually identify with each other as individuals and as members of a specific socio-cultural reality. Because of this identification, peer educators make strong role models for promoting the adoption of HIV- preventive behaviour.

However, it is not appropriate in all situations. The main challenge of utilizing peer education with young people is the ability to make the community accept the process and foresee the advantages of peer education activities in the long run, as restrictions make it difficult for outsiders to arrange activities for them.

Disadvantages

Time limits constrained the full implementation of the project and the process of behavioural change. More time such as 5- year programme periods need, in order to promote long-lasting behavioural changes in the target group, therefore, more preparation time should be allocated for materials development so that peer educators were not sent into the field without the necessary support materials.

The nature of training that is given to peer educators is abstract. They are unable to fully put into practice what they have been taught for they do not have the teaching aids for demonstration and materials to distribute.

There is little detailed understanding of the processes involved in such interventions and a lack of evidence about their effectiveness.

When setting up a peer education programme there is no clear guidance about issues such as timing, recruitment, selection, nature of the targeted behaviour, status of peer, effects on participants, social contexts and social processes.

Evaluating this must be tailored to the realities of the time that is available, as with other health education activities, outcomes may depending on the timing of the assessment.
Peer education can include various activities and there appears to be no systematic evaluation of the effects of each of the activities. The length of each project will vary depending of its target group and the objectives but often-young people education requires long-term commitments.

As the peer educators get older, they will inevitably drop out of the project. In addition, others will have to be brought in to replace them. Often the targeted problem will not disappear and will affect the next age group of young people.
Working in an established system can also have limitations, such as having to fit your activities, into a structure setting's curriculum. A peer education project requires a dynamic staff member to work with the peers and ensure that they remain motivated.

2.6 Suggestion to improve peer education approach.

Single sessions of education are quite inadequate; education must be ongoing, allow for open discussion, and cover the wide range of issues. Employees input through focus groups, feedback questionnaires and other means is highly desirable.
To avoid burnout among peer educators, they should be treated with respect and not over loaded excessively with duties; it helps to select and train new peer educators regularly, to allow long-serving ones a rest.

It is essential to make enquiries about the profile of the intended health education audience before deciding whether to deploy peer educators.

Information alone does not lead to a change in behaviour and increasingly .There is recognition that young people should be equipped with the necessary skills to sustain behaviour change. Learning life skills, such as conflict resolution and negotiation, helps young people to relate to one another as equals, work in groups, build self- esteem, resolve disagreements peacefully and resist both peer and social pressure to take unnecessary risk. Thus, training in life skills is important in all peer education programmes.

Training should end with a written or oral examination in order to assess competency before fieldwork begins. In general, regular meeting with peer educators both individually and group are recommended, as are observations of peer educations during their work, progress reports submitted by them, and evaluations of their performance by supervisory staff.
In terms of additional support, refresher training, updated information and materials and staff retreats are also recommended. A project should also be long term because many of the attributed required such as self-esteem, take time to develop.

Frequent additional training and refresher courses in sexual and reproductive health and communication are necessary to ensure quality in peer educator's work and keep them motivated and committed. Training should use as many different participatory techniques as necessary for example, group discussions, role-play, music, dance, and drama, and puppetry to increase understanding.

True participation is a partnership in which adults have agreed responsibilities .Energetic, enthusiastic and creative young people are a tremendous resource in all areas of HIV prevention and care. Their input is invaluable to programme design and out reach, ensuring that prevention and care efforts are meaningful to people. That information is communicated through effective channels and that the messages conveyed are relevant to their everyday lives, involving co-peers in prevention.

To ensure that peer educators are doing a good job they need support include:

Regular in-service meetings, additional educational materials for own use (a handbook or manual).
Information, education and communication materials and condoms for distribution to peers. Certificates, badges, T-shirts, bags or hats to identify them as trained peer educators and acknowledge their contribution to the project.

A comprehensive evaluation of HIV/AIDS peer education programmes conducted in "REGLO A" signalled a series of programmatic recommendations including:

-Further enhancement of stakeholder's involvement and community in order to facilitate programme continuity and sustainability.

-Ongoing capacity building, such as continuing supervision and follow-up with peer educators to ensure programme quality.

-Capitalizing on and using the knowledge, creativity and energy of peer educators in programme planning extension of the reach of peer education by conducting more training in the community around.

-Provision of both non-monetary (T-shirts, materials) and financial incentives access to credit and compensation for expenses to motivate peer educators.

Generally, evaluation research aim to assess the effectiveness or impact of peer education programme on the adoption of HIV-prevention behaviours. (the effect of peer education on women's power to negotiate the use of condoms) , or the comparative studies to measure the effect of peer education in combination with or as compared to other complementary HIV-prevention strategies such as condom promotion and STI services.

On the other hand, whether a peer education/solidarity approach or a more authoritative/policy-based approach would be most effective in increasing HIV-prevention behaviours.

In addition to overall programme effectiveness strong interest in research related to programme cost-effectiveness and cost-benefit analysis. There are many challenges to organize and implement an adequate monitoring and evaluation system that could measure both programme progress and impact.

-Policy-makers/stakeholders often did not provide adequate fund for the evaluation of programmes and that asking peer educators to "keep accurate information and records is sometimes seen as an additional burden on an already underpaid/overworked employees.

-Developing clear criteria for selecting peer educators who are mutually acceptable to programme organizers and companies' members is a challenge. It is difficult to find peer educators with a minimum education requirements and skills background who were available and willing to work as volunteers.

Evaluate HIV/AIDS peer education approach refer to whether and to what extent the programme cause changes in the desired direction among a target group. Evaluation of the HIV/AIDS peer education in “Y’ello Reglo” project shows programme outputs or process indicators such as the number of peer educators trained, the number of persons in the target population contacted, and /or the number of condoms distributed by peer educators.

HIV/AIDS peer education had a positive impact on STI or intended audience including young people in and out of school, people living with HIV/AIDS, presents HIV incidence and / or risk behaviour result. Result indicate significant changes in knowledge , attitudes and self-efficacy of employees and managers significant improvement in STI clinic attendance and reductions in STI were observe in community clinic report (syphilis rates in community STI clinic fell , many young reportedly reduced their frequency of unprotected sex).

How should peer education programs are evaluate?

Like all programs, a peer education program needs to be evaluated if you want to know whether it is really working. The unique aspect of evaluating peer education programs is that there are two separate groups affected by the programs:
-the peer educators themselves
-their peer or contacts.
The effects of the program should definitely be examined on the peer educator; it is in this group that the researcher is most likely to find meaningful effects. The effects can also be assessing on the peers or contacts but more limited.

Assessing the effects of the program on the peer educators is a lot like evaluating any multi-session sexuality education program. However, a peer education program teaches some additional skills (e.g., leadership, presentation, active listening, and referral). That should be assessing as well.

Assessing the effect of the program on the contacts is more difficult. The peer educator can record his or her perception on the effect on the contact. But that assessment is somewhat biased. Another option is to have the peer educator leave the contact with a very short survey.

With a stamped envelope addressed to the program leader making this survey anonymous may encourage the contact to answer it honestly.

The peer educator might also be able to make follow-up contact three-to-six months after the initial contact. At that point, she or he could ask the contact whether they had taken any action based on the previous discussion. If peer educators make presentation to groups' audience, members may be asked to complete a short survey questions. It might focus on how participants intend to use the information they learned. If the peer education is run from a resource room or support centre, it may be possible to do some other kinds of evaluation, for example counting the number of repeat participants may be a good way to determine whether people find the peer educators helpful and interesting.

Another possibility is to have the peer educator inform contacts that they can receive an incentive of some sort (e.g. free airtime) if they call the program leader to complete a short interview about their experience with young people peer educator. Confidentiality is maintained because the contacts themselves have to initiate this process.

Chapter3- finding from prior efforts to understand and improve HIV/AIDS peer education

In the field of public health, peer education has been used in many areas including nutrition education, family planning, substance use, and violence prevention. However, HIV/AIDS peer education stands out due to the number of examples of its use in the recent international public health literature. Due to this popularity, global efforts to further understand and improve the process and impact of peer education in the area of HIV/AIDS prevention, care, and support have also increased.

During the implementation of AIDS Control and Prevention Program (AIDSCAP) of Family Health International/USAID, 116 of the 195 Behaviour Change Communication (BCC) projects employed peer education. Due to the wide use of peer education in BCC projects, AIDSCAP sponsored a study of 21 peer education and HIV/AIDS prevention and care projects in 10 countries in Africa, Asia, Latin America, and the Caribbean.

The research was conducted with 223 projects managers, peer educators, and peer beneficiaries from programs that reached a variety of population groups including factory workers, university students, commercial sex workers (CSWs), men who have sex with men (MSM), and farmers.

The objectives of the study were "to examine peer-education strategies in AIDSCAP-supported projects and clarify their definition and scope, to identify and describe factors that are essential to sustainable peer education, and to establish a set of guidelines and standards by which to design future projects using peer education." The finding of this study documented the need for:

-initial and reinforcement training;
-ongoing follow-up, support, and supervision;
-clearly understood expectations of the peer educator's role; and
-continued incentives and motivation techniques.

Findings also suggested the need for HIV/AIDS peer educators to broaden their base to other related health fields such as family planning and care for people living with HIV/AIDS. The final output of

the review was a handbook of guidelines from which future peer education programs can be designed entitled, “how to create an effective peer education project” (Flanagan and Mahler, 1996).

The purpose of the World Health Organization’s Global Programme on AIDS document entitled, “young people, AIDS and STD prevention: experiences of peer Approaches in Developing Countries” is to “ assist those involved or interested in working with young people in AIDS prevention (including nongovernmental youth organisations and National AIDS programs) to understand the basis and experience of peer approaches.”

The paper review the theoretical and practical rationales for using peer approaches, examines research and field experience of peer programs, and identifies key lessons and remaining question in the field.
Recommendations for future action found in the paper include the need to:

1- Review, document, and evaluate peer approaches in developing countries in order to identify effective program practices;

2- Provide technical support to youth organisations in project conceptualisation and design;

3- Improve coverage and intensify of peer education projects by scaling up and replicating existing projects as well as combining peer education with other approaches such as mass and small media;

4- Ensure that young people are active participants in project planning implementation, management, and assessment (Fee and Youssef, 1993).

In Europe, a joint action plan on AIDS peer education called “Europeer” was established to reach young in and outside the school system. The Europeer project conducted a literature review on HIV/AIDS peer education as well as qualitative interviews with 24 AIDS peer education projects in 11 European Union member states representing different cultures, languages, and target audiences.

Interviews were conducted with peer educators, project co-ordinators, trainers, policy makers, and evaluators. At an expert meeting, peer education policy makers, researchers, and young people from

14 European Union countries drafted a final version of the "European Guidelines for youth peer education". The guidelines are based on the literature review and the interview and are intended to provide program planners with assistance in "setting up, running and evaluating AIDS peer education project for young people".

The guidelines focus on four key areas: Policymaking and planning, project design and set up, training and implementation, monitoring and evaluation. Apart from the guidelines that have been produced in eight languages, there is also a descriptive bibliography and an interactive web site available at http://www.europeer.lu.se (Svenson, 1998).

A comprehensive and participatory assessment of HIV/AIDS peer education programs was recently conducted in several clusters (regional HIV/AIDS NGO networks) in Tanzania. The results of this assessment signalled a series of programmatic recommendations, including:

1-further enhancing of community involvement and ownership in order to facilitate program continuity and sustainability
2- Ongoing capacity building, such as ongoing supervision and follow-up to peer educators to ensure program quality
3-capitalising and utilising the knowledge, creativity, and energy of peer educators in program planning
4 extending the reach of peer education by conducting more training to trainers (TOTs) and peer educator trainings in other geographical areas;
5- Providing both non-monetary (e.g.' bicycles, T- shirts, materials) and financial (e.g.' access to credit and compensation for expenses) incentives to motivate peer educators;
6- Integrating reproductive health and other topical areas as identified by communities into the scope of peer educators (Hooks et al, 1998).

Each of these examples has contributed to the identification of critical discussion topics and knowledge gaps that exist in the area of HIV/AID Peer Education among distinct geographic areas and population groups. The international consultation on HIV/AIDS Peer Education sought to build on these efforts in order to strengthen and provide direction to HIV/AIDS peer education programs working with a variety of population groups from around the world.

The nature of HIV/AIDS is such that in an area with a high prevalence rate, no setting will go unaffected. Where a setting is making efforts to reduce the rate of infection within its own people it is in that setting best interest that its neighbours even its competitors do likewise.

However tragic the HIV/AIDS epidemic is for Sub Saharan Africa, there is still occasion for hope. HIV is not spread by casual contact or by mosquitoes or in the air or water. African does not have to wait for expensive vaccines to be developed at some time in the unknown future to protect themselves. Certain types of human behaviour spread HIV; therefore, it can be controlled by changes in such behaviour. What is needed is continued involvement from all sectors of society to:
-maintain a safe blood supply,
-treat and control other sexually transmitted infections
-promote interventions to reduce high-risk sexual behaviours.

Aspects that probably contributed to the rapid spread of HIV infection in Africa are the high number of migrant workers, migratory and mobile populations, the lack of empowerment (especially woman are still economically and socially vulnerable), socio-political instability and the lack of political leadership in promoting HIV prevention(informing and educating people about the facts and realities of HIV.

The importance of peer education cannot be ignored in sexual health promotion and HIV prevention. the challenge however is to find ways to train peer educators to be media through which HIV related young people knowledge , attitudes and behaviours can be moved in a positive direction these findings suggest the need for greater attention to the process for peer education as it relates to peer educators training and subsequent implementation of a peer educator programme.

Peer education can be a useful approach when working in the community with a thorough needs assessment and the participation of the intended audience; an effective project to change negative behaviour or maintain positive behaviour can be developed and implemented, provided this is integrated with other activities. Adequate monitoring and evaluation should be included from the start of the project to help avoid difficulties at later stage.

There is presently no vaccine or cure for HIV/AIDS. The most effective way to slow down the spread of HIV/AIDS is to reduce the rate of transmission from infected to uninfected people. The first step towards lowering a person's risk of becoming infected is providing knowledge and awareness of HIV. Knowing about and practising safer sex is the best way of remaining HIV negative, since the most common way of being infected with HIV through sexual intercourse.

-HIV/AIDS education can take place most effectively in Schools College and University, even through most HIV transmission occurs outside learning institutions, schools is where young people spend a large part of their time, where they are trained and where they interact with their peers.

Chapter 4- Research objective

4.1 Introduction

4.2 What is peer education?

4.3 What is the theory behind why peer education programmes should work?

4.4 what does the research tell us about peer education?

4.5 What are the pros and cons of delivering a peer education programme?

4.1 Introduction

This research thesis is designed to provide with information about peer education programs for young people. -determine if certain training methods of peer education can be utilized to help increase the acceptance of HIV prevention in public eye and convince more people especially young people to practice safer sex.

-establish whether young people opinion in Sub Saharan among respondents who sign up for peer education training are in favour of peer education training presented by different people (by for example nurse who explains the technical facts and by other).

We developed the research by asking experienced educators at school, colleges, high schools and university across the country to share their expertise and experiences with us. The research addresses the following questions.

What is peer education?

What is the theory behind why peer education programs should work?

What does the research tell us about peer education?

What are the pros and cons of delivering a peer education programs?

What do experience educators recommend for implemented a peer education program?

How should peer education programs be evalued?

It is our hope that this research paper will assist community-based organizations to determine whether a peer education program is right for their organization and or their community; to develop well-planned and effective programs and to improve already existing programs.

4.2 What is peer education?

Most peer education programs are those in which professionals train a select group of young people (the peer educators) in issues related to sexuality and other concerns for youth. The peer educators then use the knowledge and skills they have gained to educate their peers. This education may take place through formal education programs or through less structured one-on-one or small group contacts with peers.

4.3 What is the theory behind why peer education programs should work?

The premise of peer education programs is that people (particularly young) are highly influenced by their peers, and that information coming form "like individuals" will be valued more highly than information coming from adults or individuals who are not seen as part of one's peer group.

4.4 What does the research tell us about peer education?

Several evaluations have examined the effects of peer-led education programs on pregnancy- and sexuality-related outcomes. There is currently no strong evidence that peer educators are more effective than "non-peer" educators "i.e. adults" are. However, there is evidence that young people can effectively educate and influence their peers and that participation in a peer education programs may be highly beneficial to peer educators themselves. Philliber, S. (1999). "In search of Peer Power; A Review of Research on Peer- Based Interventions for Teens." In Peer Potential: Making the Most out of How Teens influence Each Other. The National Campaign to prevent Teen Pregnancy.

4.5 What are the pros and cons of delivering a peer education program?

There are many good reasons to use peer-led programs to provide young people with sexuality education. However, such programs also have some drawbacks. The following listing of pros and cons will can to determine whether the possible benefits of peer education program outweigh the potential problems.

-pros

Peer educators receive extensive sexuality-related information that they can apply to their own lives. For example, they reduce their own risky behaviours based in what they have learned. Young people

have an opportunity to play a constructive role in the community, which may increase their self-esteem and sense of accomplishment, and may help community members see young people in a positive light.

Peer educators are likely to be future supporters, advocates, and donors, volunteers, and staff members. Peer education programs provide young with work experience and substantive content for resumes and college applications. These programs give young a voice and let them be in control of something positive.

Peer educators may form supportive relationships with program staff and with other peer educators. Peer educators and their contacts receive information they may not receive in schools or elsewhere, they may learn leadership, team-building, listening, presentation, and communication skills. Some young people are more comfortable seeking information from a peer than from an adult, and because young people are typically around their peers more than adults are, the information becomes more accessible.

Peer education programs help community to build relationships with partners such as schools, teachers, parents, and other youth-serving agencies and professionals. The community commitments to youth development can be demonstrated by implementing peer education programs. Through peer education programs young people have opportunities to make new friends and to meet people they otherwise may never have met. Peer education programs may lead to increased media visibility community, which may assist with fundraising.

Interacting with peer educators can remind community employees that they are in the business of helping young people and can provide an opportunity to see the direct benefits of their hard work.
Peer education provides and opportunity to reach new audiences. For example, parents may learn from their teens' involvement, or young people who do not have other access to information may be reached.

-cons
Peer educators require intensive training and supervision and they must be replaced often, consequently, peer education programs can be expensive. There may be high costs associated with

paying the peer educators. Funding for such programs may be limited because they often involve only a small number of young people.

It can be difficult to coordinate the schedules of all the peer educators for training and formal presentations to schools groups; they may need to miss their own classes in order to do so. Transportation for peer educators to training sessions and presentations may be difficult.

As young people, peer educators often have many problems themselves, which must be addressed by the program coordinator. It may be difficult to recruit diverse peer educators, particularly male participants.
There may be limited participation by particular schools or school districts, such as those in religiously conservative areas.

It is difficult to know exactly what information the peer educators are disseminating and whether they are representing community properly. Quality control can be problematic.
It may be a challenge to ensure that peer educators will take seriously issues of confidentially and will know when they cannot keep something confidential (e.g. an abuse situation).
Young people may have a short attention span and may lack interest in the program after a short period. Young are not always completely reliable and may not show up for training sessions or scheduled presentations. There may be opposition to the idea that “young are teaching young” about sex.

Chapter 5- Research Methodology

5.1. Research design

A research design refers to the outline, plan, or strategy specifying the procedure to be used in seeking an answer to the research question. This plan has to be developed for collecting information from which the relations between the independent and dependent variables can be inferred. This plan, the design of the experiment, is presented to demonstrate how threats to internal validity operate within some studies and to show that these threats can be eliminated by incorporating control elements into the experimental design.

The experimental design is a design in which the influence of extraneous variable is controlled for, while the influence of the independent variable is tested. It enable the researcher to maintain control over the situation in terms of assignment of research participants to groups ; in terms of who gets the treatments condition, and in terms of the amount of the treatment condition that participants receive. The credibility of an estimate of programme effectiveness depends on various factors such as the evaluation research design and the validity of its outcome measures.

These factors are part of what is often referred to as the rigor of the effectiveness evaluation. In terms of research design, the "true" experimental design where the intended audience is randomly assigned to either the intervention group or the control group is often thought of as the most rigorous because it eliminates bias that could confound question of causation. In terms of HIV-related outcome measures, HIV incidence is often thought of as the most rigorous outcome measure because of its ability to predict the ultimate desired outcome (reduction of HIV).

Therefore, an experimental research approach and more especially a type of research design in this research thesis will be and experimental research design: a between-participants post test-only design and HIV risk behaviour and or HIV-related knowledge, attitudes and practices KAP as outcomes measures.
This is because either the peer education model/approach (the independent variable) or young people behaviour change communication (the dependant variable) for preventing HIV/AIDS is under the experimenter's control; and are subject to direct manipulation. They are not chosen after the fact.

Simple survey design was also use. Surveys are another way to learn about and learn from a group of people; according to the book "how to ask survey questions" (Fink, 1995) the definition of survey is " a system for collecting information to describe, compare or explain knowledge, attitudes and practices on behaviour". It represents probe into a given state of affair that exists at a given time. More often, it is defined as a method of collecting standardized information by interviewing a representative sample of some population. Therefore, direct contact must be made with the individuals whose characteristics, behaviours or attitudes are relevant to the investigation either by mail in person, or by telephone.

The researcher wished to determine if peer education approaches could play a role in preventing HIV/AIDS on young people in Cameroon and promoted behaviour change.
An experimental longitudinal approach was also considered to plan to gather the data. It is defined by Christensen 2007 as a study that repeatedly measures the same characteristics in a simple sample of individuals at selected time intervals.

5.2. Research method

A qualitative method was employed in the study. It is defined by Christensen (2007:39) as a research study that collects some type of non-numerical data to answer a research question. Non-numerical data consist of data such as the statements made by a person during an interview, written records, pictures, clothing or observed behaviour. Denzin & Lincoln; 1994 emphasized that a qualitative research is an interpretative, multi-method approach that investigates people in their natural environment. Creswell 1998 and Patton 1990 noticed that the qualitative data provides an added level of understanding; that research that collects only quantitative data often provides an incomplete analysis or picture of the phenomenon, event or situation being investigated.

5.3. Research setting

The third component of qualitative research is that it is conducted in the field or in the group natural surroundings, such as school, church, village, country community. To meet this component, of conducting the research in the natural surroundings of the research participants, the study took place at Douala urbain community centre where an affiliate of "Y'ello Reglo A" is implementing. The center run a peer education program with 35 peer educators and 350 "peer or contacts".

5.4. Population & sampling

A population refers to all the events, things, or individuals to be represented and a sample refers to any number of individuals less than the population Christensen 2007:58. Polit & Hungler (1995:243) defines population as the entire group of persons or objects that is of interest to the researcher or that meets the criteria the researcher is interested in studying. They population of the study could be defined as all the HIV/AIDS peer education team member who implement the approach at Douala urban community centre; the projects staff, peer educators, stakeholders, parent and peer or "contact". The total numbers of the target population who are expected to be included in the sample are as follow:

The site comprises of 70 key respondents (n=70). They are broken down into the following groups:

The project staff and management n=10

The stakeholders n=10

Parents n=15

Peer educators n=35.

The total numbers of workshop is n=5

The total number of peer or contact expected per workshop is n=70.

5.5. Sample size.

De Vos (2000:1910) reported that large samples enable the researchers to draw conclusions that are more accurate and make predictions that are more accurate. White (2002: 58) stated that the larger the population the smaller the percentage of that population, the smaller the percentage of that population, the smaller the percentage need to be. Stoker (1985) cited by White (2002:59) was adopted to determine the size of a sample

Population	Percentage suggested	Number of respondents
20	100%	20
30	80%	24
50	64%	32
100	45%	45
200	32%	64
500	20%	100

Table 7 determining the size of the sample Stoker (1985) cited by White (2002:59).

5.6. Sampling approach

The sampling approach of the study involves a random sampling of population: All the peer education team of the Douala urbain community. Brink defines random sampling as a sampling where population is divided into subgroup or according to some variables of importance to the study. A random sampling approach in which every member of the team has an equal change of being selected was use in the study.

5.7. Data collection

Brink (1996:148) defines data collection as the process whereby the research collect information needed to answer the research question so that the conclusion can be draw. In this research, the data collection tools include face-to-face method (interview, written record) and open question.

Face-to-face method as the name suggests is a person-to-person interview; this technique has the advantages of allowing the interviewer to clear up any ambiguities in the question asked or to probe for further clarification if the interviewee provides an inadequate answer, and it generally gives a higher completion rate and more complete information Christensen 2007 :54

The data collection team was composed of adults and youth experienced in youth peer education and in working with youth, it is made of two adults and two young people of mixed sexes. In collecting the data, more than one person was involved, training was provide to the data collectors they receive basic skills needed for such an assessment including local language fluency, interviewing skills, noted-taking ,report writing abilities and related professional experience. Also, they were trained in and adhere to ethics regarding confidentiality and special issues for interviewing youth. At the end, checks were made on the reality of the collected data by the main researcher.

The content of the interviews contain personal views and sensitive information that must remain confidential. The sharing of information gained in interviews was not only unethical but can cause damage to individuals or the programme.

At the beginning of the interview, respondents, were assured that the interview was voluntary anonymous and confidential. If the chose to proceed, they were asked to indicate their gender and specific age. The data collector's team conducts interviews with the various key informants groups, including the peer educators themselves. The team compiles the data and impressions from the interviews into notes that will constitute referenced.

5.8. Open and closed questionnaires

Questionnaires were handed out to all the target population to fill and return to the researcher or assistants. White (2002:87) defines questionnaire as instrument where the respondent writes his/her answer in response to printed questions on a document. White (2002:87) & Brink (1996:153) reported that the purpose of questions is to find out what is going on in the minds of the subjects,

their perceptions , attitudes, beliefs, feelings, motives, past events, knowledge levels and recalls as well as to gather factual information about the subjects.

5.9. Pilot study

Christensen 2004:394 noticed that pilot study is an experiment that is conducted on few participants prior to actual collection of data. The researcher employed the pilot interview to checks that skill and method needed for such assessment are accurate. This is checking the data collection method whether are they conducted properly. If there is misconduct, it can be corrected without any damage to the main study (Christensen 2004:395).

The researcher conducted pilot interviews and questionnaire a week before the actual research after three monthly workshops with three staff member on the site, two-peer educator and 50 contacts who were present to the workshops. The pilot interview respondents were excluding during the main research. The result obtained was summarized and interpreted in the findings.

5.1.1. Data analysis.

The study conducted an experimental qualitative design; therefore, the outcome data will be a bunch of observation, question answers, interviews, and record of behaviour and conversation of respondents.

5.1.2. Ethical aspects

Ethical issues need to be considered when conducting a research, while human being is the objects of study, it is important to understand the ethical and legal responsibilities of conducting research. Ethics are considered to deal with beliefs about what is right or wrong, proper or improper, good or bad (white 2002:84).

5.1.3. Consent to participate

According to Christensen (2004: 397) when the research participants arrive at the experimental site, the first task of the researcher is to obtain their consent to participate in the study. Most studies require that you obtain the research participant’s informed consent to participate in the study. Therefore every participant did fill an informed consent, as it addressed the purpose of taking part; if any uncertainties aroused, the participants were free to withdraw at any time and no risks or

discomfort may occur; parents of Peer educators was notified to obtain permission to be interviewed, depending of their age.

5.1.4. Confidentiality and privacy

Confidentiality in the context of the research study, refers to an agreement with research investigators about what may be done with the information obtained about a research participant, this means that the information obtained should not be revealed to anyone one other than the research and his/her team (Christensen 2004;163)

Privacy refers to controlling other collecting the anonymous information or ensuring that information collected is kept confidential (Christensen 2004:162). The researcher in the current study employed to obtain anonymous information and assured participants that any information gathered will be kept confidential.

Chapter 6-Analysis and Findings of the study

This research is designed for assessment teams, peers educators and peer or contacts to assess the quality of community-based youth HIV/AIDS peer education programmes; identifying ways to improve the operation of HIV/AIDS Youth Peer Education (YPE) programmes challenging. This research provides instruments and a process that can help in this task. It is designed to evaluate the influence of an YPE programme in the fight against HIV/AIDS/STI.

The tool is base on interviews, which were conducted after 5 workshops. The formative phase of the research included the development of the interview the second phase include the testing and validation of the interview. The assessment team conducts interviews with the various key informants, including the peer educators themselves. The team compiles the data and impressions from the interviews into notes that can be referenced.

This research tool includes sample interview and open questions to be used with peer educators, staff and management, parents and stakeholders. The team uses the notes and team meetings to set up the interview, as well as other information on the programme that the team gathers. An assessment team took a week to conduct interview.

Respondents were notified through community newspaper ads, fliers and word of mouth. The team members conducted the interview and distributed the question after each workshop. Respondents were randomly asked to complete it.
At the beginning of the survey, respondents were assured that they survey was voluntary, anonymous and confidential. If they chose to proceed, they were asked to indicate their gender and specific age.

The first interview tried to ascertain how respondents perceived the use of peer education approach to prevent HIV/AIDS on youth. In doing this they were assigned to one of the three groups

-those who perceived the use of peer education to have been a success.
-those who perceived the use of peer education to have been unsuccessful.
-those who were undecided about the issue.

For question 2 the following issue was under discussion: if you had to make a choice, would you prefer to use peer education or adult education to pass on information on young people or doesn't it matter who give HIV/education.

In doing so, respondents were assigned to one of three groups:
-those who prefer HIV/AIDS education given by peer
-those who prefer HIV/AIDS education given by adult
-those who feel indifferent towards the issue.

Christensen (2001) defines open questions as question that enables respondents to answer in any way they please. These type of question were applicable for and was use to test attitudes and behaviour regarding the stated research problem. Therefore, the survey was made up of open question and interview. Respondents who participate first have to be identified in order to complete the questionnaire.

As a result, all staff members that completed the survey signed up for the five workshops during 15 days. In the chosen population there was a 90% training attendance. Taking into account the high workshop participation, as well as the fact that all Douala community staff members learned about peer education during HIV/AIDS awareness care and prevention implementation, the following deduction are made:

-the majority of respondents who complete the questionnaire participate to the workshop.
-the small percentage that did not participate to the workshop but complete the questionnaire was taught about the use of peer education during the awareness sessions.

Therefore, the assumption is made that all respondents were able to form a learned opinion of these workshop irrespective, of whether they attend or not.

The Douala urban community staff member response and opinion were thus considered as pivotal to providing an answer to the stated research problem.

For question 3 a Likert scale was used this scale measures the extent to which a person agree or disagrees with a question (Kirakowski,2004) the Likert technique presents a set of attitude statements. Subjects were asked to express agreement or disagreement on three-point scale.

Chapter7- Results

7.1 survey demography background
7.2 age group
7.3strategy of selection
7.4 accesses
7.5 behavioural theories
7.6 communications
7.7 Effective
7.8 identification
7.9 needs assessment study
7.1.1 Participatory nature
7.1.2 Cost-effective
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7.1.4 Finding from workshop
7.1.5 Finding about peers educators
7.1.6 Finding about parents
7.1.7 Finding about stakeholders
7.1.8 Gender equity and equality
7.1.9 Finding about programme staff and management.
7.2.1 Finding about peer or contact
7.2.2 Improvements or upgrading of the peer education activity

The chapter reveal the results obtained from the data collected from the research field. The results are presented using tables, diagrams, through the Ms- excel spreadsheet and Epi-info analysis programme.
70 responses were gathered during the 15 days of workshops; of these, 65 were fully completed. The discussions of the findings and results of the survey questions are summarized as follows.

7.1. Survey demography background

N=70	female	Male
complete	45	25
percentage	64	36

Table 8 indicated the gender distribution of the respondents who complete the attitude survey.
In the survey, 64 % of respondents were female and 36 % were male

7.2. Age group

<30	30--40	>30
50%	35.71	14.29

Table 9 describes the age group distribution of the respondents who completed the attitude survey.
In term of the age group; 50% are less than 30; 35, 71 % are between 30--40; 14.29 are more than 40.
The total population to fill the questionnaires were 70 but only 65 of returned questionnaire were filled. We had 65 respondents according to stoker (1985) the researcher had 92.85% of the population.

7.3. Strategy selection

When asked the respondents if peer education is a widely utilized HIV-prevention strategy that is accepted and valued by both all the team members and the intended audience. The study revealed that 70% of respondents do agree that peer education is the widely utilized HIV-prevention strategy; 20% do not agree and 10% were undecided. See pyramid below.

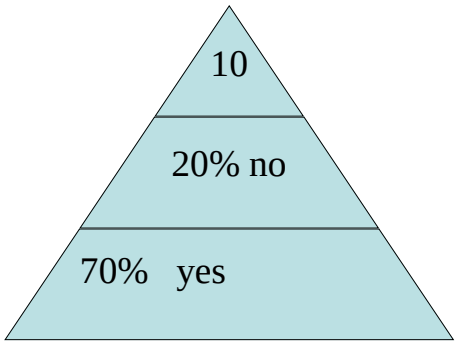


figure 1

7.4. Access.

Question was posed to the respondents if peer educators have physical and sociocultural access to intended audiences in their natural environments without being conspicuous. 80% agree that this is particularly true when working with hard-to-reach populations.15percentage were undecided; 5% do not agree. See target diagram

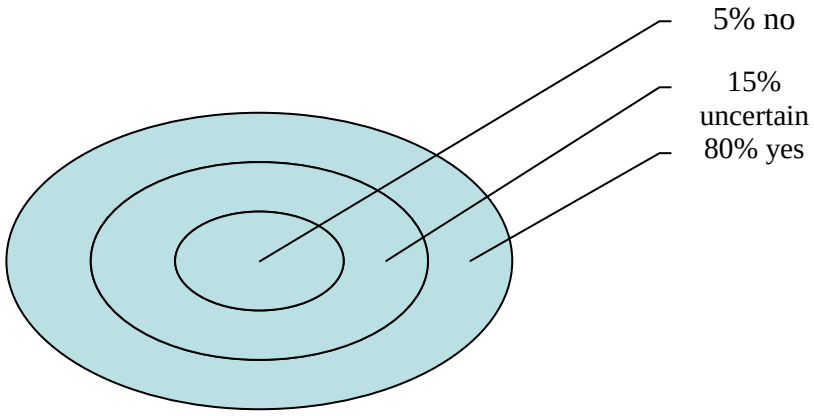


figure2

7.5. Behavioural theory.

Respondents were asked if peer education is based on behavioural theory which asserts that people make changes not because of scientific evidence or testimony but because of the subjective judgment of close, trusted peers who have adopted changes and who act as persuasive role models for change.

The study reveals that 95% think that peer education is a behavioural theory while 5% said nothing. Illustrated in the Venn diagram below

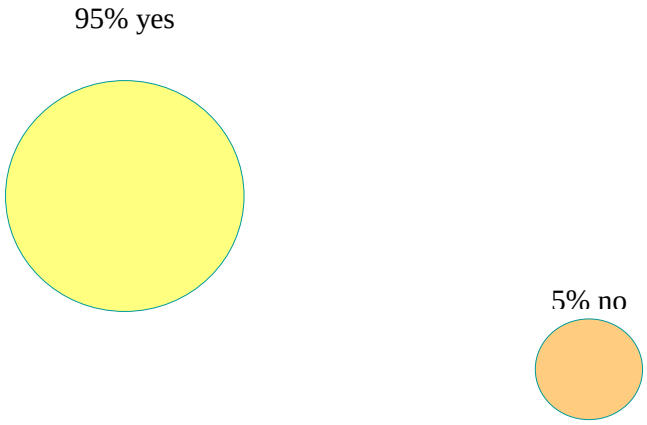


figure3

7.6 Communication

The staff members were asked if peer educators are effective and credible communicators who have inside knowledge of the intended audience and use appropriate language/terminology as well as non-verbal gestures to allow their peer to feel comfortable when talking about issues of sexuality and HIV/AIDS. 83% ascertain that peer educators are effective and credible communicators. 15% do not agree and 2% have no answer. See the Venn diagram.

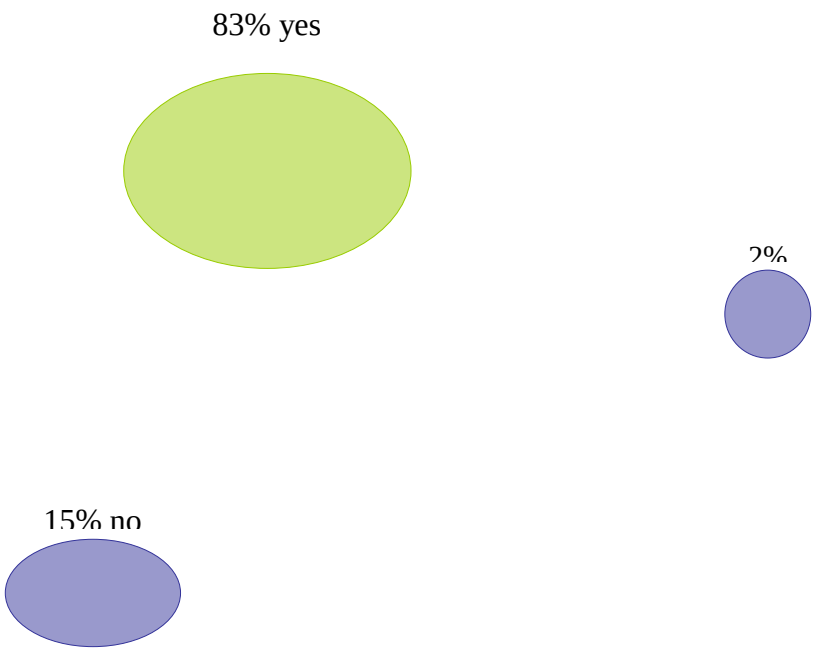


figure4

7.7. Effective.

The respondents were asked if peer education is effective in promoting the adoption of preventive behaviour with regard to HIV/AIDS. The study showed that 68% of the staff agreed that peer education is effective in promoting the adoption of preventive behaviour, 20% do not agree and 12% was undecided. See table below

Yes	68 %
No	20%
uncertain	12%

Table 11

7.8. Identification

Respondents were asked if peer educators and programme beneficiaries could mutually identify with each other as individuals and as members of a specific sociocultural reality. 90% ascertain that peer educators make strong role models for promoting the adoption of HIV-preventive behaviour 8% do not agree and 2% was uncertain.

7.9. Needs assessment study.

Respondents were asked if peer education was selected, based on a needs assessment and /or pilot study with the target population that indicated that peer education would be an effective strategy intervention. All 100% respondents reported that the approach was selected based on a needs assessment.

7.9.1 Participatory nature**.**

The respondents were asked if peer education facilitates the involvement of the intended audience in programme planning implementation and evaluation.
88% agreed that peer education is empowering for both the educator and the beneficiary because its horizontal and participatory approach to learning 10% do not agreed and 2% was uncertain. See Venn diagram

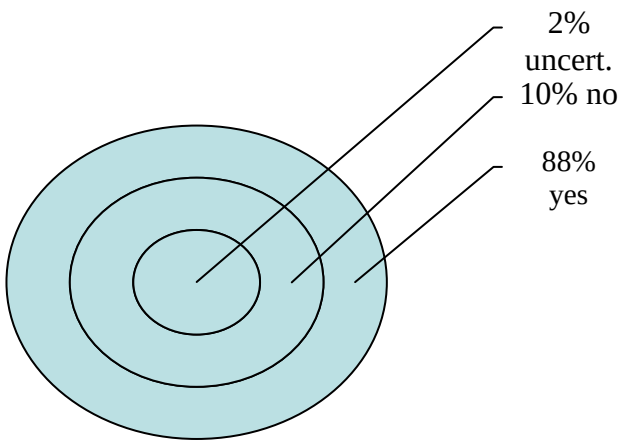


figure5

7.9.2 cost- effective.

The question was posed to the respondents to tell if peer education is a cost-effective intervention strategy. 63% of the respondents said that peer education is cost effective because of volunteers makes it inexpensive to implement and or expand. 30 % said that peer educators are granted with certain incentives that make the programme expensive and 7% did not answer.

The Douala community HIV/AIDS peer education team member were ask if peer education activities constitute a programme in and of themselves or if they are integrated into a large HIV/AIDS prevention, care and support programme within the community. 100% of respondents stated that their peer education activities were integrated with other HIV-prevention programmes strategies; to prevent HIV infection and to care for people living with HIV/AIDS.

The Douala community municipality centre has implemented complementary programme component included: condom distribution/social marketing; psychological counselling/STIs/HIV testing and services, information education and communication (IEC) campaigns and materials; drama/theatre; policy advocacy; home/hospice care; and orphan support programme etc.

7.9.3 Representatives

The aim of this survey is to evaluate the degree of representatives of the team in the entire bilingual community.

The respondents were asking to specify their first language.

The result reveals 70% French speaking and 25% English 5% unknown. See organization chart below

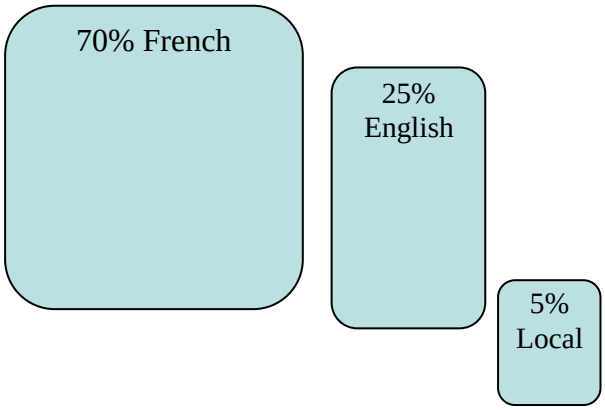


Figure6

7.9.4. Finding from workshop

The aim of this section of the survey was to evaluate the training quality and content .The assessment team ask the respondents to give a rating scale of 1 to 4 to a specific module of the workshop.

The perspectives and perception of young people and adults can be very different and even contrary. Different groups may have different views on the same issue. Therefore, the respondents may ask to scale the HIV/AIDS peer education-training programme. A low of 1 and a high of 4 should only be used in extreme case. The rating was base on 4-point:

4=very good 3= good 2= fair 1= poor.

Workshops =5	Respondents n=65	Rating average/mean
Unpacking the ramifications of HIV/AIDS(implement policies regarding HIV/AIDS in the community)	65	3
HIV/AIDS combating skills (demonstrate an understanding of HIV/AIDS and its	65	4

implications)		
Counsellors to care (conduct basic lay counselling in a structured environment)	65	2
HIV/AIDS information distribution(contribute to information distribution regarding HIV/AIDS in the workplace)	65	4
Wellness wize(explain the impact of personal wellness on activities performance)	65	3

Table 12 indicate the evaluation of training

According to the rating the situation discovered that 2 workshop are every appreciate. Of 70 respondents, 80 % thought that the training was adequate. 23% that it was inadequate and 7% are undecided.

7.9.5. Finding about peer educators.

The research expected 35 of the peer educators to filled and return back the questionnaire, but only 33 did. They were asked to identify their occupation. The study discovered that the majority of peers educators duties are occupied by 50% of volunteers out of school job seeker; 25 % are in school and 25% are new starter working see cycle diagram below.

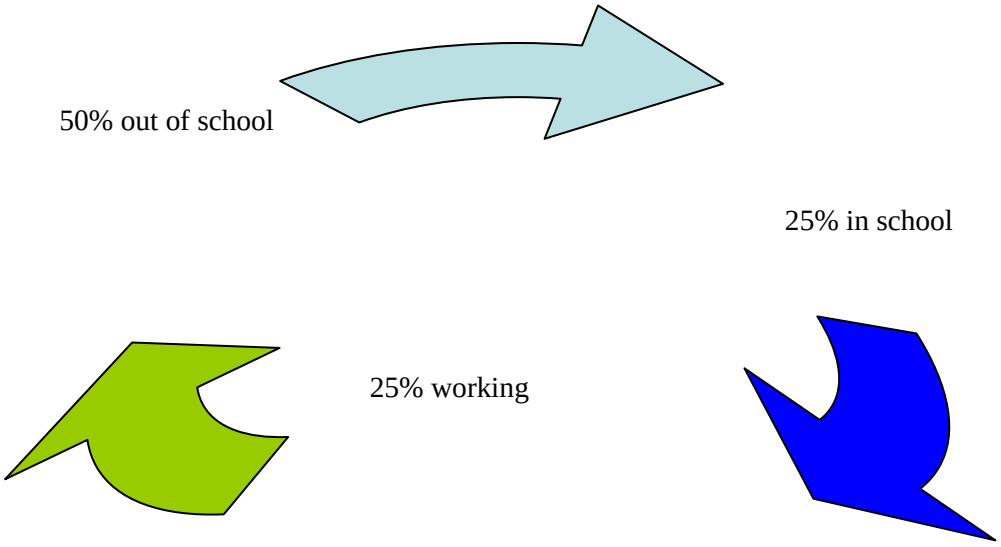


Figure7

The respondents were asked how they were selected in the programme.

35% of them said they are recruiting by presenting at local schools, 50% through world of mouth 15% by mailings. The other question that was posed was about their motivation to be and stay in the programme.

50% said they are enjoying the HIV/AIDS information the receive; 40% the status of peer educators helping and sharing with peers; 10% the incentives (non monetary-bicycles, T-shirts, materials; and financial incentives-access to credit and compensation for expenses).

Peer educators were also asked if they were active to the community before joining the programme.

The study reveal: of the 100%% only 36% were sometimes actives as volunteer in the community. 64% no

-Peer educators skills.

They respondents were ask to describe the training they received. The study showed:

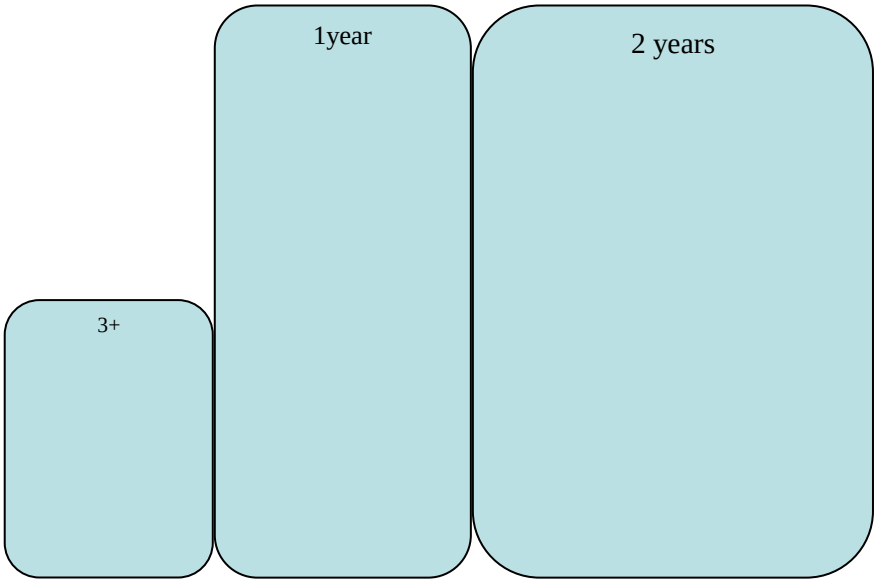
Title of training	level	N=35	percentage
Unpacking the ramification of HIV/AIDS	NQF level 5	4	11.42
HIV/AIDS combating skills	NQF level 2	16	45.71
Counsellors to care	NQF level 4	4	11.42

Wellness wise	NQF level 4	3	8.57
HIV and AIDS information distribution	NQF level 4	4	11.42

Table 13

-Year of peer educators.

The respondents were asked to identify their years of experience on peer educator's activity. The study show that 20 have 2 years; 10 have 1 year; 5 have 3 years and above.

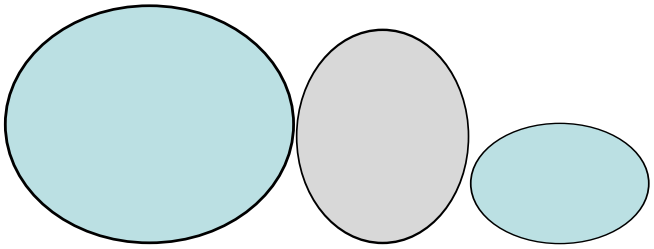


n=5; 3 years and above n=10; 1 year n=20; 2 years

figure8: organization chart illustrate the time spend in the profession of peer education

The researcher expected the15 parent to filled and return the answers back. But 10 only give back the questionnaire, they were ask if they are satisfied with the peer education approach as mean of preventing HIV/AIDS on young people. 80% agree with the programme 20% did not agree.

They were also asked if they do participate in programme activities or meetings. 50% participate in the activity 30% in the meeting and 20% not at all. See Venn diagram



50% participate 30% meeting 20% uncertain

Figure9

7.9.7. Finding about stakeholders.

Of the 10 respondents, 7 give back their questionnaire; they were asking why they became involved in the programme. 70 % stated that the programme is important for the community. 20% said it is their kind of community investment and 10% for their image. See organizational chart below

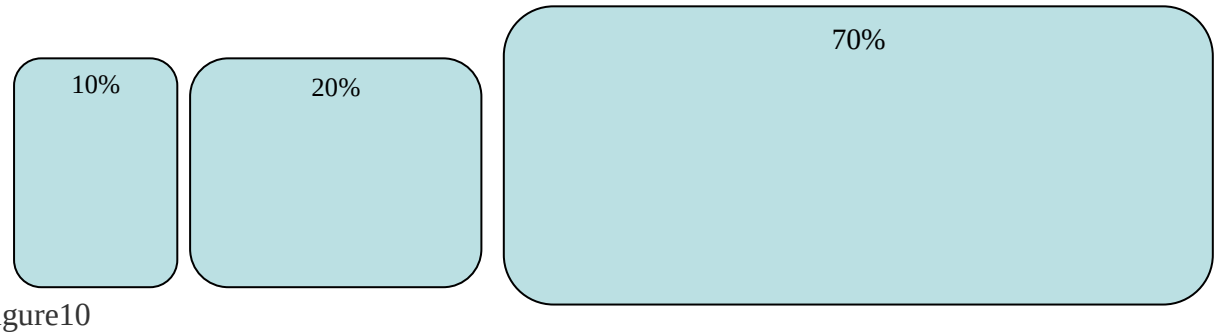


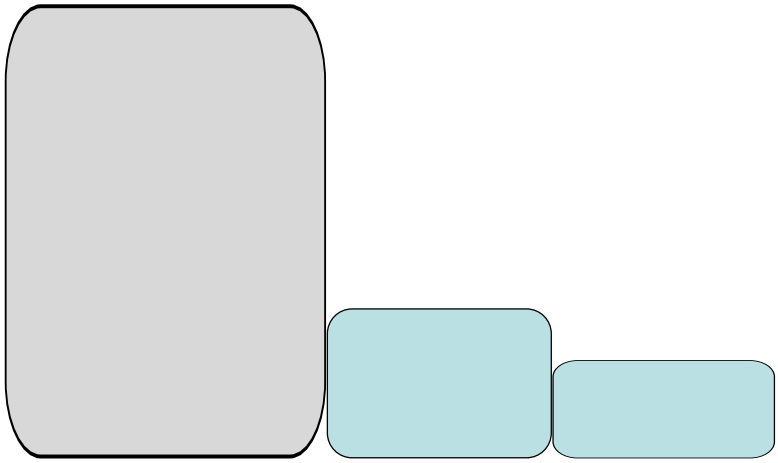
Figure10

10% sells their image; 20% CSI 70% benefit the community.

7.9.8. Gender equity and equality.

Of the 70 team member 45 was female and 35 male. The respondent was asked to tell how responsibilities are and decision-making are distributed between female and male peer educators.
The study reveal that 80% of the respondent stated that boys and girls have equal responsibility because duties are randomly assigned to every peer educators 17% do not agree and 3% are undecided.

In addition, they were asked about the quality of teamwork between female and male peer educators. 76% stated that the teamwork is good. 14% stated that the quality of teamwork is fair 10% stated that the quality of teamwork is poor. Pre intervention and post intervention interviews with participants demonstrated increased understanding of how traditional gender roles inhibit HIV-related communication, as well as increased peer and partner communication on HIV/AIDS and sexual risk reduction. The study also found that young women were more able to express an opinion and ask question in girls-only HIV/AIDS peer education groups as compared to mixed-gender groups. See the organizational chart.



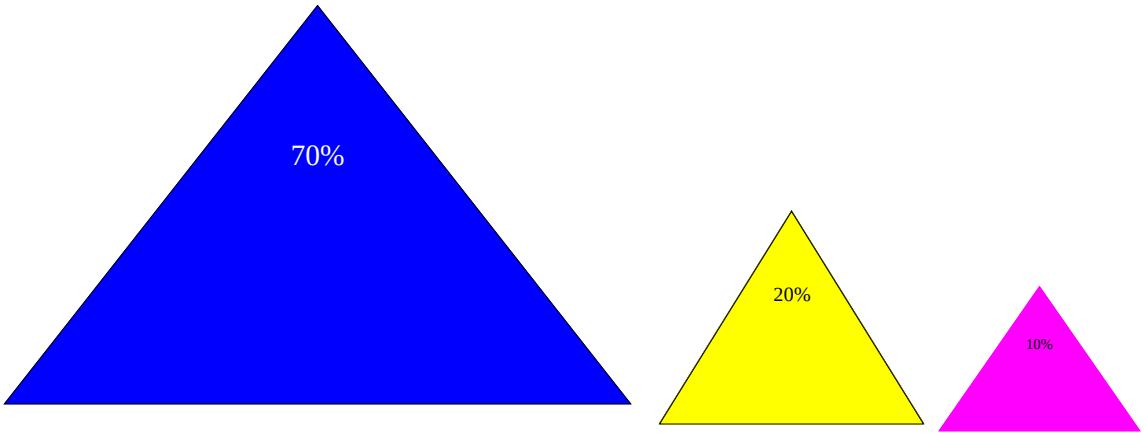
76% good 14% fair 10 % poor

Figure11

7.9.9. Finding about programme staff and management

The respondents are asked to describe how decisions are made in the programme.

70% stated that it is a collaborative approach of all teamwork includes peer educators. 20% said staff and management decide .10% is uncertain. Illustration below pyramid diagram



70% collaborative approach 20% staffs decide 10% uncertain

Figure12

7.10.1. Finding about peer or contact.

After the 5 workshops 15 days, 4 hour /day from (8to12), a week before the survey each peer educators is ask to bring at least 2 contacts. The researcher hand out questionnaire to 100 young people (peer or contact). The contacts were asked to tell how they were aware of peer education activities.

40% said their parents recommended them. 50% by their friends peer educators, 10% just curious.

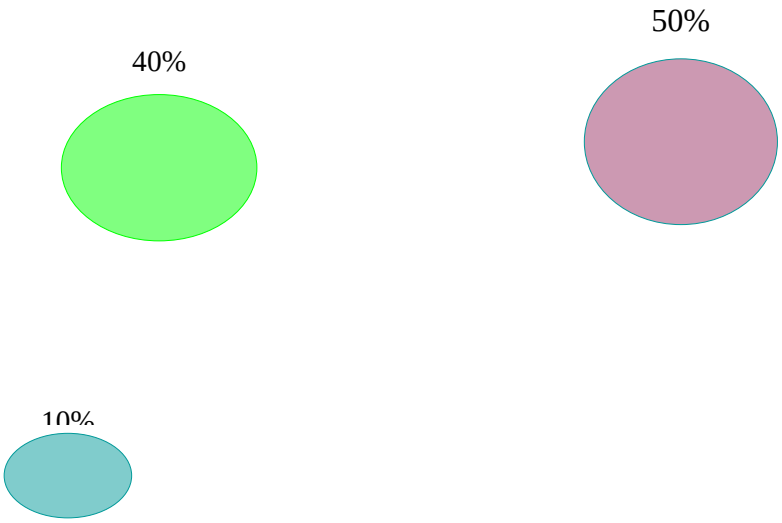


figure 13

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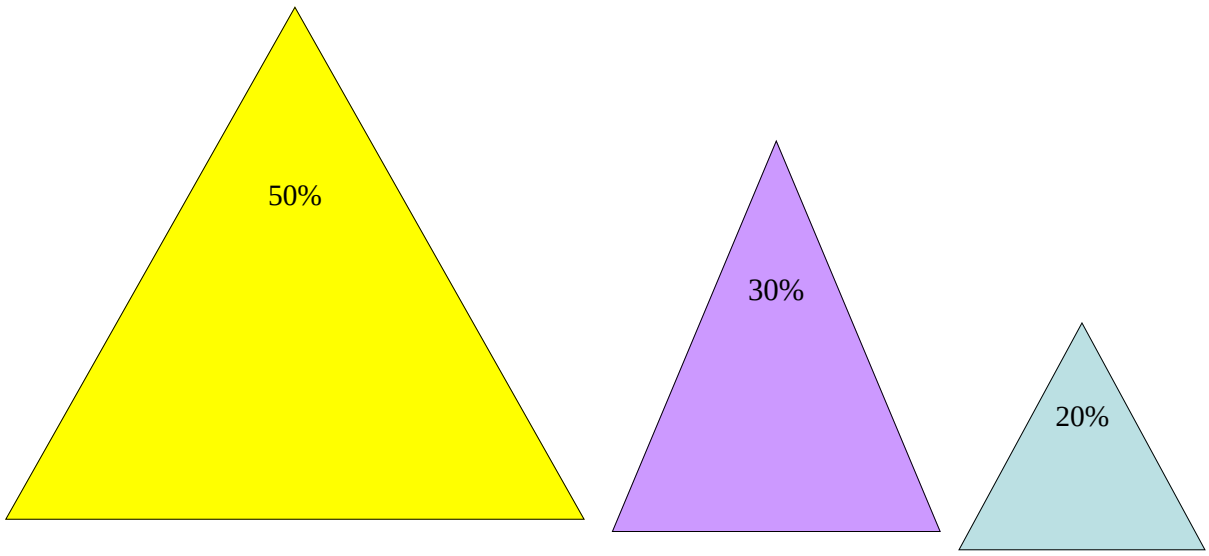
Time spend in each workshop.

Peer are ask to estimate how long they did stay at least in a workshop the result reveal that 30% stay for 4 hour ; 50 % more than 3 hour ; 20% less than 2 hours.



50% more than 3 hours 30% 4 hours 20% less than 2 hours

Figure14 pyramid diagram show time contacts attend each workshop.

-Views of the peer educators

The question was posing to peer to tell how they view their collaboration with peer educators. The result shows that 73% considered peer educators as friendly instructors; 27% rated them not fair enough.

-Belonging to the same environment (school, faith-based, district).

Contacts are asked if they preferred having local peer educators. 70% said yes 20%no 10 undecided.

-Degree of satisfaction

The respondents was asked if the enjoy being in the workshop and the youth peer education programme.

75% of the answer was positive 10% negative 5% no answer.

responses	numbers	percentage
No		20%
uncertain		5%
yes		75%

Table 14 shows the degree of satisfaction of peers.

7.10.2. Improvements or upgrading of the peer education activity**.**

Keys informants was asked if they do need the activity and programme to be improved or not.

60% said they are satisfied with the quality and content of the peer education programme whilst 36% said the programme does need improvement.

Therefore, those who answer yes provide their own views, suggestions and ideas on how to improve the programme. The following views are given:

-Reduction of formal training programme

-increase recreatives activities.

-implement local programme

-include discussions about sexual and reproductive health related to gender.

-give boy and girls equal responsibility.

-peer educators have to be active in the community before being in the programme

-peer educators have to be representative of the community.

-parents must know what the programme's goals are and how it works.

-create comics and storybooks that included male and female characters whole attitudes and behaviour reflected prevailing gender norms about communication, sex and HIV prevention.

-increase community awareness about peer education.

Chapter 8- discussion of the findings

8.1 per education programme
8.2 programme integration
8.3 stakeholders
8.4 gender sexuality and the sociocultural context

According to Brink (1996: 179), the discussion of research findings should relate to the literature review, to indicate correlations or contrast obtained in response to different research questions address to key respondents.

8.1. Peer education programme

-Cost-effectiveness

The study consisted of 92, 85% of population who responded to the questionnaire. It results in 65 respondents out of 70 staff members of the Douala community municipality HIV/AIDS peer education center. The community has set up a peer education prevention approach as mean to fight HIV/AIDS on youth people. Team member include stakeholder, programme staff and management, parents and peer educators themselves. It was found in the research that peer education can be deemed more cost- effective than counselling and testing if it cost less to implement in a given population and location ; and can produced the same or better HIV related outcomes.

Examples of costs-effectiveness analysis conducted on peer education intervention in literature review show that a study of HIV/AIDS peer education programmes among commercial sex workers in Latin America found annual programme costs ranged from US$ 17.000 to US$ 71000 to reach between 170 and 1600 commercial sex workers and to distribute condoms to value of between $ 50.000 and $ 180.000 per year. The discounted cost per primary and secondary HIV infection averted by the interventions ranged between $ 400 and $ 1000 (forsythe et al., 1992). In addition, a peer education trial among factory workers in Zimbabwe reported similar figures with an estimated cost of $100 per HIV infection averted (Katzenstein et al., 1998).

Moreover, a study from a Connecticut needle-exchange programme for injecting drug users compared the programmatic effectiveness and cost-effectiveness of a professional outreach model with a peer-driven model of needle exchange over a two-year period. While both intervention types produced significant reductions in HIV risk behaviour among the intended audience, the study found that the peer-driven model reached a larger and more diverse set of injecting drug users and did so at one-thirtieth of the cost (Broadhead et al., 1998).

The result of the cost-effectiveness analyses described above demonstrates a wide range of variation in cost per HIV infection averted for the distinct interventions. This variation in cost depends not only on the effectiveness of the intervention in terms of HIV risk behaviour, but also on other variables such as the prevalence of HIV, the rate infectivity of HIV, and the effectiveness of condoms in the given intervention area and /or population group.

-Selection of peer educators.

The survey reveals that the selection of peer educators is a critical element to programme success. Local youth-serving agencies, school, churches, and athletic teams recommended most of peer educators; using a social network interview for their selected so that the selection reflect the local environments therefore the representativeness of their community.

The selection of peer educators is documented in the literature as a significant element for the programme success. The European guidelines for youth AIDS peer education suggest that peer educators must be acceptable to the target group and that their personality must be both conductive to training and suited to the work they will be doing (Svenson 1998) .

Prior AIDSCAP research called the selection of ‘true peers’ of the intended audience one of the key principles of peer education (AIDSCAP/Zimbabwe 1997). As seen in this research a selection strategy that is becoming more popular in the published literature is the use of social network analysis and nomination technique to identify and select peer educators. For example, a peer education programme in the USA for injecting drug users selected peer educators based on nomination method through a social network interview. (Latkin et al., 1996). A similar social network/nomination technique was utilized to select popular opinion leader among gay men in an HIV/AIDS peer education programme in eight US cities. (Kelly et al., 1993).

- Training and supervision

As noticed in the survey 36% of the respondents said the peer education programme does need improvement. Programme managers as well as all the team members expressed interest in learning more about effective training methodologies as well as about how to integrate additional trainings topics such as care and support for people living with HIV/AIDS.

AIDSCAP research has document the need for comprehensive training of HIV/AIDS peer educators. AIDSCAP implementing agencies found that it was 'less expensive to implement peer education programmes if the initial training (provided to educators) was very through" (Flanagan & Mahler 1996). Therefore, in its peer education guidelines, AIDSCAP suggests that there should be an assessment of the participant's background and experience in HIV/AIDS education before the content of the training is decided.

36% of respondents who said that the programme needs improvement raised the lack of training focus on people living with HIV/AIDS. Most of them were interest in how to integrate the care and support programme in the curriculum. Many examples of peer education training programme for people living with HIV/AIDS exist in the literature. For example, a programme in Calgary Canada developed a training course to enable people living with HIV/AIDS to become peer educators in the area of HIV/AIDS counselling, support and treatment. The Tanzania AIDS support organization TASO has used peer education by people living with HIV/AIDS to promote risk reduction among those already infected to prevent further infection and to sensitive both peers and community members to the needs for stigma reduction (Nakawunde et al.,1998).

8.2. Programme integration.

The team member of the Douala community peer education municipal responds positively when the asked those if their programme constitute the only one, or are integrated into a large HIV/AIDS prevention, care and support programme in the country. 100% of respondent ascertain that the programme were integrated with other programme elements such as access to condoms, STI testing and treatment services.

The Literature reflects this shift towards multilevel prevention strategies; a growing number of papers call for the design and evaluation of interventions that address environmental and structural constraints to HIV-related preventive behaviour (Sweat & Denison, 1995; Lurie et al., Tawil et al., 1995; T. Coates& P. Collins, personal communication, 1997).

The study found that programme managers expressed particular interest in linking peer education with collective action and policy advocacy. The literature review reveal that, Sanagachi, a local NGO in Calcutta, India has facilitated the mobilization of sex workers and the formation of their own organization called the Durbar Mahila Samanwaya committee.

This organization uses conferences, outreach, and policy advocacy to fight for the right of sex worker, protection from organised violence, and the legalization of prostitution in India. The organization has also formed a cooperative society to support saving and provide loans to sex workers (all India institute of hygiene & public health 1998).

In Nigeria, the literature review reveals that the Calabar sex worker project has also documented the use of collective action to protect women from infection. Together the women from the Calabar project decided to raise their fee for sex collectively so that they could afford to refuse clients who would not agree to use condoms (Heise & Elias, 1996).

8.3. Stakeholders.

Both the result of this research and literature review highlights the importance of stakeholder involvement in HIV/AIDS peer education in order to ensure both programmatic and financial continuity. In the survey, 70% of the respondents ascertain that the involvement of stakeholder influence on young people behaviour change. Stakeholder involvement is therefore closely linked with policy advocacy in many instances.

Stakeholders such as brothel owners company supervisors, managers, police, and teachers have been documented in the literature as critical for influencing HIV-related risk behaviour in different population groups. As in this survey, the literature contains several examples of HIV/AIDS peer education programmes that integrate stakeholders into programme activities in order to increase

effectiveness. For example, sex worker peer education programmes have begun to involve the owners and managers of sex establishments in their programme strategies in order to address the power dynamics of establishments and the influence of these stakeholders on sex worker behaviour.

The 'superstar' and 'model brothel' programmes of Chiang Mai , Thailand, trained sex workers as peer educators 'superstars' and encouraged brothel owners to insist on mandatory condom use through a 'model brothel' Programme component, while the Thai government provided condoms. The proportion of sex workers refusing sex with clients who did not want to use a condom even when the client offered more money increased from 42% before the intervention to 78% one year after wards (Visrutaratna et al., 1995).

In addition, a sex worker intervention trial in the Philippines has integrated peer education and brothel owner/manager support and policies in order to decrease STI/HIV in that population (Morisky et al., 1998).

In Zimbabwe, a peer education trial conducted with factory worker documented the importance of stakeholder involvement. The study cited the commitment, support and cooperation of senior factor management as critical factors that contributed to the effectiveness of the intervention and documented the need for a government policy urging the private sector to adopt HIV-prevention programmes such as peer education. The study discovered that factory owners were willing to bear much cost of sustaining peer education one they realized the cost saving benefits of decreasing HIV in their workplaces. (Katzenstein et al., 1998).

A review of lessons learned from other worksite prevention programmes in Kenya and Tanzania discussed the need for stakeholder involvement in workplace interventions in order to ensure programme effectiveness (Hayman et al., 1996).

8.4. Gender sexuality and the sociocultural context.

The finding showed that single-sex group sessions helped young women to develop a public voice and enabled them to participate actively in subsequent group discussions with male. Interestingly, the study found that the recruitment and retention of participants in group's sessions was greater for females than for males. (45/25 survey key respondents)

The survey stated that 80% of the respondent ascertains that boys and girls (peer educators) shared responsibilities in equal, 76% stated that the teamwork is good. Obviously, in this survey a gender-based approach of HIV/AIDS programming takes into account the ways in which gender norms influence vulnerability to HIV and the ability to adopt HIV-protective behaviour. In literature review, many studies highlighted the importance of addressing gender and sexuality and found that culturally defined gender roles affect peer educator and participant recruitment, retention and ability to communicate about sex with same-sex and opposite sex peers (Weiss & Cupta 1998).

In Brazil, female peer educators helped to develop a booklet entitled the story of Maria for use with female adolescent peers groups during a series of nine weekly sessions, each facilitated by a team of two peer educators. The booklet addressed family and community pressure to maintain virginity, male pressure to have sex, and a girl's own internal pressure and desire for autonomy. By addressing these issues, the curriculum sought to help young women make informed decisions about becoming sexually active outside of marriage and to question traditional gender roles about virginity and its relationship to sexual risk (Vasconcelos et al., in Weiss & Cupta 1998).

Chapter 9- limitations recommendations and conclusion

9.1. Limitations

The research study was conduct only in one of the community setting in the country. Although Cameroon has 110 Y'ello Reglo peer education club in 5 provincials capitals, the study could not necessarily be generalize to the entire country. Palmer (2004:12) stated that doing research into issues surrounding HIV/AIDS is a highly sensitive task. The reluctance of people to attend workshop activity, to answer question and fill the questionnaire with the total number expected by the researcher did hinder the data collection. The study was highly focused on appreciating the peer education strategy to prevent HIV/AIDS on youth. However, it does reveal numerous areas that would need attention.

9.2. Recommendations

The result of this research paper indicate that there are a strong preference for peer education approach in the fight against HIV/AIDS on young people and adults; also that workshop and all IEC activities highlighting the various information that peer education offers above conventional prevention strategy because of the use of participatory approach.

According to Dr. Peter Piot, Executive Director of the joint United Nations Programme on HIV/AIDS (UNAIDS) " the strong political will and social mobilization are realities which should lead to the scaling up of HIV care and prevention programmes and avoid a worsening epidemic in the country". More over Madam M. Tall, Representative of the World Bank and Chair of the UN Theme group on HIV/AIDS in Cameroon stated, "Mobilizing a wide range of actors, from

businesses, religions groups, to teachers and people living with HIV/AIDS, would indeed make a difference in successfully tackling the epidemic".

However, despite the increase AIDS awareness amongst Cameroonians, the Cameroon's political commitment to combat the disease, the package of HIV/AIDS prevention awareness, care , treatment and services has not yet reached the vast majority of young people in Cameroon especially in the rural areas; greater challenges still lie ahead to curb the epidemic. In this, the following recommendations are made:

-give more time to implement the project such as 5 year programme time frame in order to promote long lasting behavioural changes in target populations. Imposing project time limits constrained the full implementation of the project and the process of behaviour change.

-Set up different types of programmes design and methodology so that peer education intervention might vary with demographic differences (i.e. class, ethnicity, religion and education).
-redesign the role of peer educator/facilitator to be in terms of stimulating group discussion and learning how to allow the group to come to its own conclusion and decisions, while still getting across key prevention messages.
-developed clear criteria for selecting peer educators who are mutually acceptable to programme and community members.

36% of respondents said that the training of peer educators needs improvement; Peer education due to their low educational levels necessitated additional training -made peer education training more practical and participatory in nature, structured curricula and support materials.
One respondent stated that the nature of training that is given to Peer Educators is abstract. They are train in big cities, in hotels with flip charts but when they go to the community they found a very different scenario, they are unable to fully put into practice what they have been taught for they do not have the teaching aids for demonstration and materials to distribute.

-Provide continuing education (refresher training) and updated information to peer educators after their initial training, as well as training sessions for new peer educators as old educators graduate or move away from the programme area.

-give peer educators participatory training methods (exercises, games, dynamics) and communication skills-building to sustain the motivation of peer educators. - give enough support materials to peer educators before sending them to field.

-established more open discussion to topic such as sex and sexuality that are taboo in many culture and the subsequent fears of the community, parents, and religious groups.
-organise future programming to give more importance and consideration to factors such as gender , sexuality and stigma in terms of research, programme planning and advocacy.

-integrated the intended audience in the development of education curricula and IEC materials so that these might better reflect the audience's cultural background and educational level.
- teach key informants about innovative and participatory techniques for maintaining and motivating the interest of unpaid or low-paid peer educators as well as their intended audiences.

-build awareness on lessons learn from non HIV/AIDS peer education programme in areas such as reproductive health, drug and alcohol education, violence prevention and life skills in order to incorporate them into the programme.
- make public evaluation research so that key informants assess the effectiveness or impacts of peer education programmes on the adoption of HIV prevention behaviour; specific examples included : examining the effect of peer education on the health seeking behaviour of men who have sex with men; or the effect of peer education on women's power to negotiate the use of condoms.

-organise and implement adequate monitoring and evaluation system that could measure both programme progress and impact. Informants felt that donors often did not provide adequate funds for the evaluation of programmes and that asking peer educators to keep accurate information and records is sometimes seen as an additional burden on an already under paid/ overworked civil servant.
- establish more communication and interaction with other peer programmes in order to learn from their experiences through conferences, seminars or visit other programme sites. Key informants expressed interest to learning about best practices or success stories related to peer education methodologies used by other programmes that would enable them to impose their own programme.

-set up more networking opportunities for peer educators both within and between programmes. Key informants viewed networking for peer educators as important for facilitating the exchange of ideas and techniques for building motivation, solidarity and social support, and for ensuring mobilization and collective action among peer educators.
-Opened access to internet and e-mail, the development of an institutional website to promote exchange and help with fundraising, and access to journals and publications as the current needs of their programme.

-integrated many other programmes components for best complement peer education in order to increase programme effectiveness in preventing HIV infections such as legislative and policy advocacy, as the illegal status of target population behaviour (such as that of commercial sex workers, injecting drug users, and men who have sex with men) is significant challenge to programme implementation.
-Create future policy and advocacy work to function in tandem with traditional peer education approaches in order to create or modify the legal and social systems that influence HIV behaviour and to increase community understanding of these complicated social issues.

-teach key informant how to conduct a community needs assessment with specific attention to socio-cultural and ethnographic assessments with young people in order to better respond to target population and community needs as well as to create strategic plans based on assessment results.

-work more horizontally with the target population, locals clubs, and organizations from the beginning of the project in areas such as programme planning, materials development and evaluation. As one team members stated, "we would be less directive and more horizontal with peers or contact. This is something that we have had to learn in the process. We would allow for more participation of the girls at the level of decision making everyone talks about participation but allowing the population to sincerely make their own decisions is sometimes difficult, as the technical staff of the institutions often believes that they know what is best and are trained to make decisions about the direction of the programme or policies that will affect the programmes. If we were to start over, we should trust more in the people and their experiences and try to strengthen a more horizontal process for programmatic input and decision-making".

The focus of peer education must be on healthy behaviours rather than on the medical aspects of the disease.
Reinforce the knowledge that young people can prevent HIV/AIDS by abstaining from or postponing sex; by having sexual relations within the context of a mutual faithful relationship with an uninfected partner; Young people must be given information on where to turn for advice, help and support if they should ever need it.

-expand or scale-up peer education activities from the local to the regional or to the national level using the financial and political backing of local government in order to make such a transition more feasible.
-teach informants how to better assess per educator skills and talents so that they might better utilize peer educators in dealing with the diversity of educational levels and backgrounds within a given population.

-developed many rapport both with the community in general and with community stakeholders who can facilitate the effective implementation and acceptance of programme activities. Several respondents suggested that stakeholders could be preventing from creating obstacles to programmes implementation if they are involved in the programme from the design stage onwards. This can help to integrate their need and priorities as well as capitalize on their potential contributions to the projects, such as financial or human resources and workspace.

The lack of financial resources is cited by many respondents as a challenge; create income generation programmes to help sustain peer education programme. -Add more opportunities for recognition and compensation of peer educators.
-Settle down the issue of incentives provision to peer educators, who are generally unpaid volunteers. Key issues/questions posed by respondents on this topic included: whether or not to give incentives? What types of incentives should be given? (Monetary or non-monetary), to whom incentives should be given (peer educators, volunteers leaders, supervisors)? And whether incentives create programme sustainability and /or accountability.

As one respondents said “peer educators are found to be very helpful and cooperative, but how long can they just volunteer? They have to earn a living too. Giving time to the project means they have to take time away from their earning, studying … etc. People are poor and they need to earn a living. They cannot be expected to use their own money to travel to places or feed themselves when they have no money. If peer educators do give staff free line and are willing to help them we at least have to feed them and pay their expenses”.

10. Conclusion

Our future lies with our youth. This saying has never been as true as it is now, at a time when HIV/AIDS is destroying countless human lives, especially in Sub-Saharan Africa. If we cannot stop the current progress of the disease, we can at least try to ensure an AIDS-free future for our youth. The role of schools, religious and civic organisations is extremely important in the fight against AIDS. We should empower our youth with education and life skills, not only so that they can prevent themselves from being infected, but also so that they can learn to become compassionate, caring members of a society that will be struggling with the aftermath of HIV/AIDS for a long time to come.

Aids differ from any other epidemic disease that has ever plagued the world. Not only it is incurable, it challenges our deepest secrets and taboos about sex and death whether as individuals or as a community. People vainly try to defend themselves against this tragedy of destruction and fear by building defensive walls of myths, stigma, prejudice and blame around themselves. Although we can understand, the feelings that make people want to distance themselves from anything to do with HIV and AIDS, this denial makes us all more vulnerable to the effects of the disease.

There is only one weapon against HIV infection and AIDS and that is behaviour change. It is unfortunately the most difficult and complex weapon to use, because people find it extremely difficult to change their sexual behaviour. Connor and Kingman (1988:1) wrote: the disease that spreads with the help of sex is a formidable foe, because it is transmitted during the most intimate and compulsive of human activities –sex.

Evidence from around the world confirms that well-designed and skilfully executed peer education preventives programmes can reduce the incidence of HIV. Studies have shown that behaviour

interventions (including information, education and communication programmes, condom promotion programmes and other behaviour change initiatives) can bring about changes in high-risk sexual behaviour. Programmes encouraging abstinence from sex and postponement of the onset of sexual activity by young people (sexual initiation) have also been successful (Harrison et al., 2000; UNAIDS, 2006).

One of the main educational functions of the Peer education in any community is to encourage changes in unsafe sexual behaviour. This is very difficult because sex comprises deeply pleasurable and meaningful acts that touch the very core of what it means to be a human being. In addition, sex is also laden with symbolic, other meanings and resonances for human beings. Peer educators should therefore set themselves realistic goals: although people will never stop having sex, they can be taught to practice safer sex.

When people have good information about the cause and prevention of HIV/AIDS, they can behave more safely. This is why HIV/AIDS peer education is so important, especially for young and adults. Therefore, young people have to join groups that are participatory and creatively using music, theatre, dance, even soccer teams to educate their friends and others about how to have healthy relationships, care for their health and prevent HIV/AIDS infection.

Peer refers to person of the same age, status or ability as another specified person (Pearsall 1999).
The importance of using adolescent models and peer educators should never be underestimated. Adolescents learn best when they learn from their peers. Peer educators in entire community are therefore faced with the tremendous task of trying to break down the walls of prejudice and lack of knowledge, so that they can convince every member of the community that HIV/AIDS touches the core of every person's life. And that we should all work together to prevent the great and prolonged pain that this disease brings with it.

Young people must be willing to talk about the disease and to change their behaviour so that they will not risk their health. This is not always easy to do in some societies where young people do not fell comfortable talking about the disease or where they are not willing to change how they live. It is often difficult to communicate HIV/AIDS information, especially in counties where young people cannot read or where girls and boys are not included in discussions.

This research thesis paper discusses the use of peer education to prevent sexually transmitted infections, including human immunodeficiency virus/ acquired immunodeficiency syndrome, in young people. It describes experiences gained from a peer education project of young people in Cameroon. (The “Y’ello Reglo” project is a peer-led HIV/AIDS prevention programme for young people in or out of school in Cameroon).

The stated objectives were fulfilled through this research study. Concisely, the aim was to appreciate the peer education approach as a gun of young generation in the fight against HIV/AIDS communities.
The study revealed inadequacies in training programme, time limits constraining the implementation of the project. Lack of support material and incentives to peer educators, unclear criteria for selecting peer education, lack of networking opportunities, lack of communication and interaction with other peer programmes.

Several challenges to the design and implementation of HIV/AIDS peer education programmes were also identified, such as the selection, training supervision and motivation of peer educators as well as stakeholder/community involvement and acceptance of the programme. The current survey also underscores the need for funding technical assistance in the areas of effectiveness/ impact evaluation and programme sustainability.
The following topics were mentioned most frequently by respondents as priority areas for further exploration and analysis for further discussion in the consultation agenda. Evaluation research , stakeholder involvement, sustainability (including income generations, scaling-up, and incentives for peer educators, selection of peer educators, training and supervision, programme methodology and content(including participatory techniques) gender sexuality and the sociocultural context. Programme integration including policy advocacy and collective action.

Largely, the results of the survey paralleled the funding of prior research conducted to identify the challenges and best practices of HIV/AIDS peer education programmes. Both the survey and prior Literature research found that peer educators are perceived as credible teachers and facilitators who possess critical and unique access to their intended audiences.

Peer education is a widely used component of HIV prevention programmes across populations groups and geographical areas. The Literature indicates that peer education is seldom implemented alone rather; it is often part of a larger more comprehensive approach to HIV prevention that includes condom distribution, STI, management, counselling, drama and /or advocacy.

Very few of the evaluations of HIV/AIDS Peer Education programmes found in the literature use rigorous research designs such as randomized controlled trials or STI/HIV incidence as outcome measures. Instead, many programmes collect only proxies of outcome measures such as HIV related knowledge self-efficacy and /or attitudes and beliefs using uncontrolled pre-test/post-test or post-test only research designs.

Review of some of the studies that have evaluated HIV/AIDS peer education programmes using experimental or quasi-experimental designs with outcome indicators such as reduction of HIV-related risk behaviour and /or STI/HIV incidence, shows that peer education (in combination with other prevention strategies) is very effective in several populations and geographical areas. However, researchers and programmes planners are still faced with the task of determining what the critical elements of peer education are within the context of a comprehensive HIV-prevention strategy that will reduce HIV risk behaviour and incidence in a given population and context.

The current review of the Literature cannot definitively answer this challenge because many programmes do not explain in depth low they select, train and supervise peer educators, what incentives they provide for peer educators, how stakeholders are involved, what attention they give to gender and sexuality, and how sustainable they are. Hopefully the finding and results of this research may help in uncovering the mystery of those challenges.

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Annexure

Annexure .1 individuals' items to the success of peer education.

Annexure 2 questionnaire

Annexure.3 check-list

Annexure.4 KAP evaluations

Annexure- 1. Individual's items to the success of Peer Education.

Many individual's items involvement is crucial for Youth Programme success such as:

1. Stakeholder cooperation.

A stakeholder is a person or organization that holds an important or influential community position, and has an interest, investment, or involvement in the programme. Stakeholders include governmental agencies; donors; policy-makers; and non-governmental, community-based, and faith-based organizations. Clinics, youth centres, and schools. Stakeholders may work with programme staff or the peer educators. To facilitate cooperation and trust, programmes need to keep stakeholders informed of their strategies, work plans and activities. Cooperation can include regular meetings, joint initiatives, and a shared vision and agenda to promote the well-being of local young people.

2. Parental involvement.

Often overlooked, the attitudes of peer educators' parents and the degree of parental involvement may be crucial for YPE programme success. Programmes should reach out to parents and involve them. Parents are gatekeepers who allow their children to participate as peer educators and can motivate them by encouraging their activities. Parental involvement can increase retention and improve a programme's anchorage within the community.

3. Youth involvement.

Meaningful youth involvement is critical for peer educator retention, motivation, and productivity. Youth involvement refers to the degree of empowerment and decision-making that youth are able to assume through established organizational mechanisms. Opportunities for meaningful involvement require adequate training and supervision that can increase youths' decision-making skills and proficiency in carrying out their responsibilities.

4. Youth-adult partnerships.

Youth-adult partnerships are a step beyond youth involvement. This partnership requires work and initiative from both youth and adults, although adult staff members often need to initiate from both youth and adults, although adult staff members often need to initiate and facilitate the process within given organizational structures. A balanced youth-adult partnership includes the following components: direct youth involvement, open communication, trustworthiness, mutual respect, and mutual sharing of positive and negative responses to the actions of others and adult support.

5. Peer educator cooperation

Cooperation and teamwork among the peer educators are important for retention and productivity. The camaraderie and friendships developed in a peer educator group are strong motivators to join, be active, and remain in a programme. Peer educators need a shared vision and commitment to the programme and its goals. Staff should encourage cooperation through group activities to increase peer educators' self-esteem and social skills. Staff should also provide supervision regarding conflicts.

6. Gender equity and equality.

Peer educators need to understand how gender influences their own attitudes and behaviours. Working in mixed groups in the field allows peer educators to practice new roles under the guidance of staff and to serve as role models for other youth. Training and supervision should cover not only biological differences but also the influence societal gender roles have on reproductive health and HIV/AIDS and on their performance as peer educators.

7. Community involvement

The degree of cooperation between an YPE programme and the local community where it operates, including various stakeholders, is important. Broad community support is critical to programme

productivity and sustainability because it increase the motivation of youth peer educators and involvement of parents as well as the responsiveness of the programme to the community and its institutions.

Annexure 2 Questionnaire

Annex 2. Questionnaire.

Assessing the quality of Youth Peer Education programmes (YPE) in the Douala Community Municipality.

Before the assessment team begins its work, a briefing about the assessment was done with the programme and all of its participants, especially those individuals and groups to be interviewed. Parents were notified to obtain permission for peer educators to be interviewed. The briefing include the purpose of the assessment and how the results will be used (and by whom) the assessment procedures and the types of questions to be asked was discussed. The issue of confidentiality and anonymity was explicit. The assessment team was composed of adults and youth experienced in youth peer education and in working with youth. The assessment team conducts interviews with the various groups supporting the programme, including the peer educators themselves. The teamwork in pairs during the interviews (an interviewer and a note –taker one youth one adult.) group and individual interviews was used. Individual for programme coordinators, trainers and managements. Stakeholders and parents in a group.

Peer educators in small interactive group a both mixed-sex and simple-sex groups. A number of interviews are conducts to parents, peer educators, staff and management, and stakeholders to add depth to the findings.

1-Peer educators:

Peer educators background

How did you become peer educators?

How were you recruited? What were your reasons for joining the programme?

Describe the training you have received.

What did you think of the training?

Did it prepare you for your work?
What would you change for next time?

What are your personal goals in your peer education work?
Do you think of your work as addressing some'problem' such as sexual risk behaviours?
What do you do to address this problem?
Describe the programme's goals and activities.
What activities do you do specifically? Do you give talks? Provide materials?
What would you like to do differently?

What are the greatest challenges for your work?
Does the project include discussions about abstinence and faithfulness to one partner, as well as condom use?
What type of adult support do you receive in your work?
Do you have enough supervision? Enough technical support?
Emotional support?
How could you get more support?
Describe how decisions are made in the programme.
Who decides what activities to carry out?
Who decides the content of these activities and the information materials used/

Who decides programme planning and strategies?
How has the work affected you personally?
In what positive and what negative ways?
What have been the reactions from fiends and family?
What is it that motivates or does not motivate you in your work?
Why do you think young people remain in or leave the programme roles to make it even better?
Are budget issues that affect your responsibilities clear to you?

Programme staff and management

Describe your level of involvement in the programme?

How could it improve? Why is it so good?
Are you clear on what your responsibilities are how to do them and when to do them?
What type of support and backup do programme staff and management provide for your activities?
Describe how decisions are made in the programme?
Who finally decides and how?
Are your suggestions and ideas taken seriously what would you do to improve the decision-making process?
Describe what kind of partnership you have with programme staff and management.
Do staff and management treat you equally and fairly?

Parental involvement

Do staff and management appreciate your contributions?
Are your parents involved in programme? If yes, how did they become involved?
Do your parents know what the programme's goals are and how it works?
Do they know what you do in the programme?
How do the support your involvement? For example, do they allow you time away from family jobs to work with the programme?
How do they support the programme in the neighbourhood or community?
Stakeholder cooperation

Describe the degree of cooperation you have with other community organizations involved with the programme.
How do they support you in your activities?
How could this cooperation improve?

Peer educator cooperation

Describe the level of teamwork among the peer educators in the programme.
How is your teamwork supported and promoted by staff?
Do you participate in recreational activities together?
How do you (peer educators) resolve disagreements among yourselves?

Describe the level of trust and cooperation among the peer educators in your programme.

Gender equity and equality

How responsibility and decision-making are are distribute between female and male peer educators?

Do boys and girls have equal responsibility?

Describe the quality of teamwork between female and male peer educators.

Is it the same at programme locality and in the field? How is it different?

Describe how the programme addresses gender and gender issues in the training and during programme activities.

How does gender equity –equal responsibility for females and males-relate to cooperation between the peer educators and programme staff and management?

2- Staff and management involvement.

Programme background

Why do you select peer education as programme strategy?

Did you prefer to integrate peer education with other intervention strategies?

What challenges do you faced in the implementation of peer education?

What changes do you like to make to the peer education programme?

What resources do you need to strengthen the peer education programme?

What research question do we addressed in order to improve the peer education programme?

Describe the programme's working model and how you put it into practice.

Describe any community involvement in the peer education programme.

Describe the involvement of the other non-governmental organizations, faith organizations, and governmental services working in the target area.

How does the programme collaborate with them?

What kind of results or impact do you expect from your programme? How will you know if you achieve these results?

How has your programme contributed to changes in the target group and in the larger community?

Describe any evaluation (formative, process, or impact) that have been or are being conducted.)

Technical frameworks

Describe the process of peer educator recruitment.

How are they selected?

How representative are they of the community?

Were they active in the community before joining the programme?

Describe the training they receive.

How many male and female peer educators do you have in the programme?

How is peer educator retention? Among males and females?

What do you believe motivates the peer educators to implement and stay involved in the programme (incentives)?

How is teamwork promoted (encouraged among the peer educators in the programme?

Describe how the peer educators are involved in programme planning, training, activities, materials development, and decision-making.

Do you think there is a youth-adult partnership in the programme? How would you describe the quality of the partnerships?

How are disagreements resolved in the programme?

Describe the level of trust and cooperation among the peer educators in the programme.

Describe the type of supervision the programme provides to the educators.

Gender equity and equality

Does the programme provide training on gender and gender issues? Describe the training.

To what extent do you address gender and gender issue in supervision and in activities?

Describe how responsibilities and decision-making are distributed between female and male peer educators. How does your programme address issues of gender violence and abuse?

Describe the level of cooperation between female and male peer educators

Community involvement

Describe the quality of communication and cooperation with other community organizations and stakeholders.

What type of direct support does the community and its organizations provide to the programme?

Parental involvement

Describe how you involve the parents of peer educators in the programme.

Donors

What type of support do you receive from donors?

How do you communicate and cooperate with donors?

How would you describe your relationship with your donors?

3-Parents involvement

Programme overview

What are the goals of the programme, as you understand them?

Do you think the programme is effective at reaching its goals?

Do you think the programme is important for you neighbourhood or community?

Youth participation

What does your son or daughter do in the programme? In which activities is she/he involved?

Do you support your son or daughter's participation in the programme? Why or why not.

Do you think your son or daughter receives benefits from participating? In what ways?

Parent's participation

How are you involved in the programme?

How did you become involved and why?

Do you participate in programme activities or meetings?

How do you communicate your ideas or concerns to the programme?

What influence do you have in the programme and its decision-making?

Are you satisfied with the level of cooperation between parents and programme staff?

Do you support or promote the programme in any manner?

What would make the programme even better?

Do you give your son or daughter time away from family jobs to work as a peer educator?

4-stakeholders involvement

Program overview

Describe your relationship to the programme.

Do you understand the goals and objectives of the programmes?

Do you share the programme's goals and vision for young people?

Are you satisfied with your awareness of the programme's activities and planning?

Do you think the programme is effective at reaching its goals?

Involvement with programme

In what ways do you cooperate with the programme and its peer educators? Describe your activities.

Are you satisfied with the quality of your communication with the programme?

What influence do you have on the programme and its decision-making?

To what degree do you feel involved in the programme?

In what ways do you support the programme and its peer educators?

What benefits do you experience from working with the programme?

Perspectives about programme

Do the programme and its peer educators address issues related to sexual behaviour, HIV, and similar issues in the community effectively?

Does the programme provide accurate information?

Do the programme and its peer educators appreciate the diversity of people, values, and opinions in the community?

How knowledgeable are the peer educators in carrying out their activities?

How important are the contributions made by the programme's peer educators?

How well does the programme negotiate between the needs of its organization, young people, stakeholders and community institutions?

What is the quality of cooperation between the programme and the groups above? Do they work well together?

How well do the youth and adults work together?

Would you characterize it as a partnership with youth having substance input? Or do the adults generally tell the youth what to do?

How could your cooperation with the programme be improved?

What are your future expectations for the programme

Annexure 3 checklist

The team member after the interviews need to review the results of the interviews (both verbally and by sharing notes) compare and discuss findings from the different groups and make the final rating for the items on the checklist. Different groups may have different views on the same issue. For example, peer educators, programme staff, parents; stakeholders may have different opinions along with the other information from the assessment. The assessment team asked key respondents to give a rating of 1 to 5 to a specific item on a checklist.

A five –point scale used for rating each check item was classified as:

1-2 low;

3 Medium;

4-5 high.

The summary of results presents of the individual checklist scores and averages help to understand the strengths and the weakness of a programme.

Number of average checklist Items Rated Total Score

items	rating	items	means/average
Gender equity and equality	11	4	2.75
Parents involvement	14	7	2
Stakeholders cooperation	25	12	2.08
Peer educators involvements	37	19	1.94
Programme implementation	27	11	2.45
items			rating

Checklist -1 **programme implementation**			
The programme has a clearly defined audience	2		
The programme is based on sound behavioural and social science theory.		3	
The programme is focused on reducing specific risk behaviours.		3	
The programme provides many opportunities for PEs to practice relevant skills.		3	
There is a realistic schedule for the implementation	2		
Staffs are adequately trained to be sensitive to the needs of young people.		3	
PEs is trained to deliver the core elements of the intervention.		3	
Core elements of the intervention are clearly defined for staff and PEs.	2		
The programme is embedded in a context that is relevant to youth and community.		3	
There are sufficient resources for the current implementation training and supervision.	1		
Adult decision-makers are flexible and open to youth input.	2		
Checklist 2 **stakeholder cooperation**			

The stakeholder feels adequately informed of the programme's goals and activities.	2		
The stakeholder supports the programme directly or indirectly	2		
The stakeholder feels one's voice is heard and one has influence on the programme	1		
The programme collaborates with the stakeholder in the planning and implementation.	1		
The stakeholder and the programme cooperate to avoid duplication of activities.	1		
The stakeholder provides financial or in-kind support to the programme.		3	
The stakeholder and programme share a common vision to promote health	2		
The stakeholder is satisfied with the quality of communication in the programme.	2		
There is a high level of trust between the stakeholder and the programme.	2		
The stakeholder and the programme exchange information and skills.		3	
The stakeholder has confidence in the programme's level of competence.		3	
The stakeholder benefits from collaborating with the programme.		3	
Checklist-3 **Parental involvement**			
Parents are satisfied with the programme's goals and activities.		3	
Parents support the programme's goals and activities.		3	
Parents support their children's involvement and see benefits for them.	2		
Parents see benefits for the community in involving their children.	2		
Parents perceive that they are involved in the programme and have an influence.	2		
The programme has recurring contact and outreach to parents.	1		
The programme has meetings and activities for parents.	1		
Checklist-4 **peer educators involvement**			
Peer educators (PEs) have a clear understanding of the activities they carry out.	2		
PEs are directly involved in the design and development of the activities they set up.	1		
PEs have the opportunity to revise existing materials.	2		
PEs feel that they have a platform to voice their opinions be heard by management.	1		
Small cash incentives or in-kind tokens of appreciation are provided to PE.	2		
PEs has representation on the programme's board decision-making body.	2		
PEs has a sense of ownership of the activities they implement.	2		
PEs has a sense of ownership of the programme.	1		
Budgetary issues that affect the PEs are transparent and properly explained to them.	1		
PEs feels they can influence the direction of the programme.	2		
PEs is satisfied with their level of involvement and influence in the programme.	2		
PEs has a sense of ownership of the activities they implement.	2		
PEs feels they can influence the direction of the programme.	1		
There is trust and mutual respect between the PEs and programme coordination.	2		
PEs experience that management takes their input and suggestions seriously.	2		
PEs do not feel manipulated by adult staff nor experience themselves as tokens.		3	
PEs are given credits for their activities and achievements.		3	
Adult staff finds that PEs understands their responsibilities and constraints.		3	
Programme staff does not show favouritism, resulting in PE conflict and confusion.		3	
Checklist -5 **Gender equity and equality**			
Teamwork skills are taught and promoted in the programme.		3	
Gender equity and equality are promoted, and include adequately in the PEs training.	2		
Male and female PEs fell respected by the opposite sex.		3	
The programme teaches gender sensitivity to PEs for use during activities.		3	

Annex 4. KAP evaluations

-Key results from evaluation using control groups

The research has used the experimental research design; a between-participants post test-only research design with young people, parents, stakeholders, staff manager and supervisor, condom use and support /policies. the survey were conducted with 350 peer or contacts from the Douala community municipality regarding the use of peer education in HIV/AIDS prevention intervention, the sample of key informants was obtained using a nomination method of recruitment. Members of the consultations planning committee and other professionals' workings in HIV/AIDS selected peer education. Nominated informants were contacted by e-mails, phone and word of mouth.
Outcome indicators: HIV knowledge and attitudes practices, self-efficacy, sexual risk behaviour, STI and HIV incidence.

Keys informants	Number out of 70	Percentage %
Peer educators	35	50
Staff management	10	14.28
Parents	15	21.42
stakeholders	10	14.28

The funding reveals that the intervention that included HIV/AIDS peer education had a positive impact on STI or HIV incidence and risk behaviour. Key results indicate significant changes in Knowledge Attitudes Practices and self-efficacy of young people and managers. Significant reduction in STI clinic attendance and incidences were observed in intervention sites as compared to the control site.
HIV test results indicated zero new infections in the interventions sites and 10 sero-positives in the control groups.

-Educational activities to build knowledge, attitudes, values and skills.

It is not enough to teach young people to' just say' no to drugs or sex. Young people should be given learning opportunities to practise effective and successful behaviour for living healthy lives (Pies, 1988). Peer educations use various methods for instilling the necessary knowledge, attitudes, values, and skills.

These include (Edwards et Louw, 1998):

Graphic activities: illustration, charts, maps.

Oral activities: panel discussions, debates, talks and interviews.

Written activities: articles, press releases, TV programmes, reviews, interviews and dialogues.

Audio-visual activities: slides with commentary, stories on tape, pictures or photographs with commentary and videos.

KAP questionnaire on general safe sex rules yes or no questions.

questionnaire	Yes	non
Is oral sex safe?		
Does the female diaphragm prevent HIV infection?		
Does the contraceptive pill prevent HIV infection?		
Is there still a risk of HIV infection if the penis withdrawn from the vagina (or anus) before ejaculation?		

Does cleaning (washing) the vagina or anus after sex reduce the risk of HIV infection?		
Are condoms really safe and effective?		
Is it still necessary to use condoms if both partners are HIV positive?		
Is it perfectly safe to receive a blood transfusion?		
Can you state the guest the status of someone simply by looking at him?		
Is STI made a person more vulnerable to HIV infection?		
Is baby can be infected through breastfeeding?		
Is there any vaccine against HIV?		
Can the antiretroviral medications cure AIDS?		
Do I still have to practice safe sex when I am on antiretroviral?		
Can lesbians get AIDS?		