

The Effectiveness of Africare-South Africa Peer Education Programmes among  
Pastors in the Whittlesea Area

by

Barnabas Opio Ikuya

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Supervisor: Mr Burt Davis

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## **DECLARATION**

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## **ABSTRACT**

The main purpose of this study was to investigate if/how Africare-South Africa HIV/AIDS peer education programmes can be improved among pastors and their congregations. This study focused mainly on pastors of churches the Whittlesea area of the Eastern Cape who has been participating in the Africare-South Africa Peer Education Programme as peer educators since 2004. A qualitative study was conducted using focus group discussions; peer educators (pastors) representing 12 churches participated as research respondents.

The study found that the level of knowledge pertaining to HIV/AIDS of pastors in the peer education programme was good and of a credible standard. Respondents understood all the main themes covered in the peer education programme. It was found that respondents even knew more than what they were taught in the programme, mainly because of other stakeholders e.g. the Department of Health through the District of Chris Hani also providing training in this respect. The pastors identified additional HIV information that they felt needed to be included in the current peer education programmes. It included clinical and technical information around HIV e.g. prevention of mother to child transmission of HIV and antiretroviral therapy. This would mean additional training would be required if peer educators were to implement the new information as part of their training.

Furthermore, the study also found that without additional funding, peer education programmes would not be sustainable. Basic funding sources such as promoting income generating activities within the church setups could provide a good platform to financially support peer education programmes.

In summary, the study showed that peer education is still an effective method for successfully implementing HIV/AIDS awareness and prevention messages in church settings.

## **OPSOMMING**

Die hoofdoel van hierdie studie was om die *Africare*-Suid-Afrika portuurgroep-opleidingsprogramme vir pastore en hulle betrokke gemeentes te ondersoek ten einde te bepaal hoe/of dit verbeter kan word. Hierdie studie is gedoen onder pastore in die Whittlesea area in die Oos-Kaap, wat reeds sedert 2004 aan die *Africare*-Suid-Afrika portuurgroep-opleidingsprogramme deelgeneem het. 'n Kwalitatiewe studie met fokusgroepe is gedoen; deelnemers aan die studie het bestaan uit portuurgroep-opleiers (pastore) wat 12 kerke verteenwoordig het.

Die studie het bevind dat die MIV en Vigs kennisvlakke van deelnemers goed was, dat hulle 'n goeie begrip van die hoofemas van die opleiding gehad het en dat hulle selfs meer geweet het as wat hulle in die program geleer is. Laasgenoemde was as gevolg van ander rolspelers (bv. Die Departement van Gesondheid, Chris Hani-distrik) wat ook opleiding onder die pastore in hierdie verband gedoen het. Voorts het die pastore addisionle MIV-informasie geïdentifiseer wat hulle gevoel het ook by die huidige program ingesluit moet word. Dit het kliniese en tegniese informasie rondom MIV ingesluit, bv. die voorkoming van moeder na kind oordrag van MIV en anti-retroviral middels. Dit sal beteken dat pastore addisionele opleiding sal moet ontvang indien dit as deel van die portuurgroep-opleiding kurrikulum moet dien.

Verder het die studie bevind dat sonder addisionele befondsing, die portuurgroep-opleidingsprogramme nie volhoubaar sal wees nie. Basiese bronne van inkomste binne die kerk soos bv. die bevordering van inkomste-genererende aktiwiteite word aanbeveel om hierdie programme finansieel te ondersteun.

In samevatting, die studie het gewys dat portuurgroep-opleiding steeds as effektiewe metode vir die suksesvolle implementering van MIV en Vigs bewusmaking- en voorkoming boodskappe binne kerkverband kan dien.

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## ACRONYMS

ABC	Abstinence, being Faithful and Condomise
AIDS	Acquired Immune
ART	Antiretroviral Therapy
ARVs	Antiretroviral drugs
BCC	Behavior change communication
CICT	Client Initiated Counseling and Testing
FBO	Faith-Based Organization
FGD	Focus Group Discussion
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
Non-Governmental Organization	
National Strategic Plan for HIV and AIDS 2012-2017	
OVC	Orphans and Vulnerable Children
PEP	Peer Education Program
PICT	Provider Initiated Counseling and Testing
PMTCT	Prevention of mother to child transmission of HIV
SACC	South African Council of Churches
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Agency for HIV/AIDS
United Nations Education Scientific and Cultural Organization	
UNFPA	United Nations Fund for Population Activities
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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## **Chapter 1: Introduction**

This research investigates the effectiveness of Africare-South Africa Peer Education Programme (PEP) among pastors in the Whittlesea area affiliated to South African Council of Churches-Chris Hani region. The investigation is built on the assumption that peer education as an approach to health promotion provides the best and cost-effective strategy for fighting against HIV and AIDS and other health risks among different target groups in society. Peer education is an approach to health promotion in which community members are supported to bring about health enhancing change among their peers. The assumption is that lay people rather than health professionals are better placed to educate members of the public to encourage good health behavior and practices. By using this effective strategy, peer educators as role models or change agents have been able to reach various peer groups with strategic HIV and AIDS awareness and other health prevention messages. As a result, this strategy has enabled peer educators to prevent the spread of the virus among specific peer groups across sections of the community by assisting them to change from their risky sexual choices and behaviors.

Several evidences by Family Health International have been documented to prove that PEP works and have led to considerable change in behavior among its beneficiaries (Adamchak, 2006). Examples such as the West African Youth Initiative of Nigeria and Ghana have reports of young people taking more caution by taking protective measures against sexually transmitted diseases and infections (FHI360 AIDSCAP, 2012). A similar project of Care International in Kenya reported that after peer education interventions, 12-18 year old youth displayed better knowledge, more positive attitude and signs of behavioral change towards sexually transmitted diseases and infections following a peer education intervention (Chege et al., 1995). Family Health International projects in Mexico, Jamaica and Thailand share similar PEP success stories in changing sexual behavior and increasing knowledge necessary for combating the negative effects of HIV among those who have participated in PEP previously (Townsend et al., 1987 & Randolph, 1996).

HIV and AIDS prevalence in South Africa is high with most provinces having double digits. This needs to be controlled to single digits. In the Eastern Cape Province where the research was conducted, the HIV prevalence rate is 23% of the population (Chris Hani District, District Health Information System). The most affected population groups from the onset of the pandemic remains the productive and economic age group 15-49 years of age (Chris Hani District, District Health Information System). This is also the target of the peer education program among the pastors coordinated by Africare South Africa. Africare South Africa supports 22 health facilities managing HIV and AIDS amongst the population in the Whittlesea area.

### **1.1 Rationale for the study**

With particular reference to faith-based organizations, the Africare-South Africa PEP has been working with a number of pastors from different churches in the Whittlesea area as peer educators. The concept behind this approach was that pastors have influence over their congregations; recruiting one into PEP would mean reaching a big target group through Sunday services and other functions run by churches such as funerals, weddings and candle light memorial services. In addition, pastors were also seen as having influence over their fellow pastors to effect change that will help them embrace HIV and AIDS management in their churches. UNAIDS (1999) reiterates the fact that peer education is often used to effect change at the individual level by attempting to modify one's knowledge, attitudes, beliefs or behaviors and group or societal level, by modifying norms and stimulating collective action that leads to changes in good programmes and policies. The changes explained above can also be realized in the church settings.

Whereas the above assumption remains well founded, it is also important to know that faith-based organizations have been known to be reluctant in embracing HIV and AIDS as a challenge in the 21<sup>st</sup> century because of the taboos and fears of talking about sex thereby hindering HIV and AIDS education in church settings (UNESCO, 2006). However, in Namibia, it is reported by UNAIDS that faith-based organizations have now begun changing this notion and as a result, are already fighting against three forms of stigma and discrimination related to HIV and AIDS namely: an association

between sexuality and sin, HIV and AIDS as a punishment for sin, and sin as failure to take responsibility (A Report, 2003). This thinking is also being brought to the fore by a number of researchers in church cycles today. These researchers are adding new meaning and positivity to the debate. They refute this as misleading and saying that “some people consider HIV/AIDS simply as God’s punishment for mankind’s sin” (Van der Walt, 2004; Douma, 1987 & Clifford, 2004). These researchers also note that a good number of people are fairly comfortable to say that those who are HIV-positive due to an immoral life, such as homosexuals or those who use intravenous drugs, are only getting their just reward for their lifestyle.

This research therefore focuses on the extent to which pastors as role models in Africare-South Africa PEP have positively influenced HIV/AIDS mitigation response in their churches and that of their colleagues over time arising from their increased knowledge of the virus and its effects in the community.

## **1.2 The research problem**

This research established the extent to which pastors recruited as peer educators in Africare-South Africa Peer Education Programme in the Whittlesea area have been successful in planning and implementing mitigation strategies against HIV and AIDS in their churches and surrounding communities.

## **1.3 Aim of the study**

The main aim of this research was to investigate how Africare-South Africa HIV/AIDS peer education program can be improved among the pastors and their congregation in order to ably fight against HIV and AIDS in the Whittlesea area.

## **1.4 Objectives of the research**

The objectives of the study included the following:

1. To establish the level of HIV and AIDS knowledge among pastors participating in Africare-South Africa peer education programme in Whittlesea area.
2. To find out what the knowledge aspects that is currently covered in the Africare-South Africa peer education programme.

3. To identify the gaps between the current peer education programme curriculum and the level of HIV and AIDS knowledge of the pastors involved with Africare-South Africa in the Whittlesea area.
4. To provide guidelines to improve the current peer education curriculum run by Africare-South Africa to align them with the HIV and AIDS knowledge level of the pastors in Whittlesea area.

### **1.5 Significance of the Research**

This research may generate new ideas that could be built into the already existing peer education model strategy of HIV and AIDS community mobilization, awareness and education among the pastors and their congregations in the Whittlesea area.

### **1.6 Structure of the Research Report**

The research report will be structured in the following way: chapter one will be the introduction of the research report, providing an overview of the effectiveness of peer education programmes. Chapter Two provides the theoretical framework of peer education mainly focusing on six behavior change theories namely: the theory of reasoned action, the diffusion of inoculation theory, the social inoculation theory, the social cognitive theory, the role theory and the social learning theory. All these theories relate to peer education in that they are all behavior change theories that can be used as a cost-effective means to propagate HIV and AIDS awareness and prevention education messages in target audiences and communities. The latter part of this chapter discusses the effectiveness of peer education. Chapter three focusses on the research design and methodology of the study. Chapter four handles research findings and the follow on discussion, chapter five discusses recommendations and finally chapter six handles the conclusion of the study.

## **Chapter 2: Literature Review**

In this section, the researcher wishes to examine a number of behavior change theories and how they relate to peer education. These theories include: the theory of reasoned action, the diffusion of inoculation theory, the social inoculation theory, the social cognitive theory, the role theory and the social learning theory. After examining all of the behavior change theories, the researcher will then discuss the effectiveness of peer education in its different aspects such as in the areas of coverage, selection and recruitment of peer educators, the peer education curriculum content, training of peer educators, peer education communication strategy, referral system and the sustainability of peer education programmes.

### **2.1 The definition of Peer Education**

The term peer education is defined by many scholars to imply an approach, a communication channel, a methodology, a philosophy and a strategy commonly used by many actors to fight HIV/AIDS (UNAIDS, 1999). Peer education has been best described by many to work within an environment of peer groups with common identity and interests to advance knowledge and social skills that can influence positive behavior among its members as they learn from each other. What they learn at this stage is critical to who they really are now and who they will be in the future. Precaution is therefore needed to ensure that whatever they learn or acquire in the present should be channeled to yield positive outcomes in the future particularly in the area of sexually choices and behavior in the fight against HIV and AIDS.

Peer groups according to the Population Council (June 2003), is best described in the context of young people (adolescents) who are just beginning to have social exposure in their communities to a new body of knowledge beyond the confines of their families. It is argued that peer groups with time slowly supersede families of the young people as a social outlet (Population Council, June 2003). Peer groups take over as the source of knowledge and social skill influence. That is why peer groups help the young people and any other groups in society to gain or develop a sense of identity and leads to the development and practice of social skills that stays with the peer groups throughout their lives (Population Council, June 2003).

The term “*peer*” alone is used to refer to individuals with equal standing, rank and one belonging to the same group characterized by age, grade, and status or shared social characteristics (The Merriam Webster Dictionary 1985: Population Council, June 2003). The term “*education*” on the other hand, refers to the development, training and acquisition of knowledge resulting from an education process (Merriam Webster Dictionary, 1985). In addition, the dictionary includes words such as the systematic instruction, development of character or mental powers to make the definition clearer.

Putting together the two words, peer education according to the Population Council (June 2003) refers to a programme designed to train selected members of any group of equals to effect change among members of that same group. The description in the document by the Population Council divides peer education into two categories namely: the peer support and leadership models. In the former, a group of people get trained as together equals (one body) but in the latter; individuals get trained and operate as individually trained peer educators endeavoring to influence a great deal of people within their ranks. In this study, focus is on the leadership model; where individual peer educators will be examined in providing leadership in influencing health behaviors of the community.

In the application of the words explained in the definition above, Svenson (1998) defined peer education as a peer to peer communication and approach where a minority of peer representatives form a group or populations actively attempting to inform, change or influence majority of the population at both the individual or group levels. According to the Population Council (June 2003), these few or selected chosen individuals (Peer Educators) then receive specialized training or information to impart on their peers with the hope that they will sustain positive behavior change among their peers using a number of methods that range from informal conversational talks to factual debates and formal information sharing sessions.

The means of information sharing and the content thereof varies from purpose of the information shared to another. This is also differs from community to community. One can seemingly conclude that there is no best way or method this can be done. It

depends as already said on the community or type of people in question vis-à-vis the intention of the particular peer education focus (Population Council, June 2003). In the context of health today, peer education in HIV and AIDS, has in most cases been done through advocacy, counseling, facilitating discussions, drama, lecturing, making referrals to services, providing support and in the distribution of information education and communication materials. Adamchak (2006) confirms that peer education has a proven record of performance, is a credible source of information, benefits those providing it, utilizes an already established means of sharing information, is acceptable when other forms of education may not be used and is used to educate those who are hard to reach through conventional methods.

## **2.2 Behavior Change Theories**

### **2.2.1 Introduction**

In this chapter, the researcher will be defining different behavior change theories and then discuss them in terms of how they relate to peer education. Aaro et al. (2006) argues that no single theory could single handedly explain the use of peer education in the fight against HIV and AIDS today. Peer education should therefore be seen as a combination of all theories. All these theories have an element of education and behavior change that have been known to contribute immensely to awareness and knowledge of HIV and AIDS but not necessarily to improved sexual risk behavior of adolescent populations. These theories include: social inoculation theory, role theory, differential association theory, subculture theories, communication of innovation theory, the diffusion of innovation theory, the theory of reasoned action, social cognitive theory, the theory of participatory education and the social learning theory as defined in the next sub-section.

### **2.2.2 The Theory of Reasoned Action**

According to Fishbein and Ajzen, (1975) cited in UNESCO, (2003), the theory of reasoned action states that, *“one of the influential elements for change of behavior is an individual’s perception of social norms, or beliefs, about what people who are important to the individual do or think about a particular behavior”*. The same scholars continue to make the theory clearer by saying that, *“Intention to perform a*

*behavior is a function of attitudes toward engaging in the behavior and perceived normative pressure to perform the behavior: Performing a behavior is a function of intention to perform the behavior”* (Ajzen and Fishbein, 1980).

This theory is based on the intentions of an individual to perform a particular behavior, driven by a given motivation arising from beliefs that particular outcomes will be the result of performing a specific behavior. It is built on perceived actions that the individual has to perform. These actions are sometimes based on norms of the society or drawn from positive role models. Behavior change according to this theory is related to observed behavior from those people who are important and influential to the individual actor. According to the theory, what influential people in society think, do or act determines the behavior of the followers. This theory may relate to peer education in that it brings out the relationship between the peer educators (Influential people in society) vis-à-vis those who draw direction from peer educators (followers). This amplifies the role of leaders (as models) in influencing behavior in the community.

### **2.2.3 The Diffusion of Innovation Theory**

According to Rogers, (1983) cited in UNESCO, (2003), the diffusion of innovation theory “*suggests that certain individuals (opinion leaders) from a given population act as change agents within that population*”. This is “*a theory concerning the spread of innovation, ideas, and technology through a culture or cultures*”. The theory according to Rogers cited in Abrahamson, (1991), has five stages in the decision making process before an innovation could be adopted by people convinced that the idea is good. These five stages are: knowledge, persuasion, decision, implementation and confirmation. According to Abrahamson, (1991), the diffusion of innovation theory relates to the peer support model (one of the peer education models) in that a group of people corporately form a group of peer educators to influence behavior in the community. As a learning process, this theory brings to the fore the fact that innovation or new ideas in behavior change in society do not come easy or automatically, it is earned through a sequential process of education.

#### **2.2.4 The Social Inoculation Theory**

According to McGuire (1961), the social inoculation theory, states that “teaching a child to resist negative peer pressure from a young age will make resisting it in the future second nature”. He continued to say that “children will build a tolerance to peer pressure in the way the body's immunity system builds a tolerance to viruses”. McGuire believed that children and young adults did not have the maturity or confidence to stand up to peer pressure unless specifically prepared for it”. The theory of social inoculation adds that “teaching children to resist peer pressure should start long before they know what it is, and before the dangers become greater and more grown-up. The theory of social inoculation could be said to link with peer education in that it lays emphasis in educating the young people as a way of preparing them for adulthood. Peer education is also a systematic process of preparing the society into having positive behavior change. Peer education equips target populations with skills to face the socio-economic challenges of life and so is the social inoculation theory that has a systematic and planned approach to life in a similar way.

#### **2.2.5 The Social Cognitive Theory**

According to Bandura, (1991), *“people possess self-reflective and self-reactive capabilities that enable them exercise some control over their thoughts, feelings, motivations and actions. In the exercise of self-directedness, people adopt certain standards of behavior that serve as guides and motivators and regulate their actions anticipatorily through self-reactive influence. Human functioning is, therefore, regulated by interplay of self-generated and external sources of influence”*.

It could be argued that peer education links to the social cognitive theory in that the essence of peer education as an external source of influence lies in equipping individuals with skills to cope with life. These skills help them to have a sense of responsibility, self-worth and confidence to direct their actions into a purposeful life. Peer education in this sense gives individuals the capability to do so and to be able to exercise self-control over their thoughts, feelings, emotions, actions and future.

### **2.2.6 The Role Theory**

According to Biddle, (1986), “the role theory states that human behavior is guided by expectations held both by the individual and by other people”. “The expectations correspond to different roles individuals *perform* or *enact* in their daily lives, such as secretary, father, or friend”. The role theory is founded on the fact that individuals in society have defined roles and responsibilities that they are expected to perform. No one else can perform them except those for whom the role is designated. This means that every individual in society is a role model in their own right and their behavior is determined by these said roles and responsibilities. Linking this theory to the principles of peer education, it could be argued that every individual in society is therefore a potential peer educator that could influence behavior based on the role they fulfill in society.

### **2.2.7 The Social Learning Theory**

The social learning theory asserts that when modeled behavior is practiced, adopting it becomes easy and successful. According to Bandura (1977), the extent to which modeled behavior influences individuals depends heavily on the characteristics of the models, the attributes of observers and the perceived consequences of adopting similar behavior. Bandura (1986) in social foundations of thought and action, further explains the assertion of the social learning theory by arguing that models of human behavior are capable of eliciting behavior change in certain individuals only based on individual values and interpretation of the system. In its relation to peer education, it could be argued that the social learning theory brings to light the fact that the behavior role models (in this scenario peer educators: change agents) and the recipients of modeled behavior (in this scenario the observers: target audiences), have a significant part to play in enforcing and effecting behavior change. The role model should regularly or constantly live by example to demonstrate or justify modeled behavior for the observers to adopt such behavior. When this is practiced by the target audiences that believe in the change agent, behavior change is bound to happen because the peer leaders have enhanced the application of modeled behavior (Klepp et al, 1986).

Having looked at the behavior change theories, the following section discusses the effectiveness of peer education programmes.

### **2.3 Effectiveness of Peer Education programmes in Church Settings**

This section will discuss the effectiveness of peer education programmes in general and in church settings in particular. It will bring to light the advantages and challenges of running peer education programmes.

#### **2.3.1. Effectiveness of Peer Education in Area of Coverage**

An effective peer education program should be able to cover the geographical areas intended for the programme in order to reach more people that are most deserving but disadvantaged by a number of circumstances. Peer education services widen the impact of the peer education programme by reaching other sections of society that could have been easily left out to maximize the importance of peer education. Such populations include: street children, young sex workers and generally hard to reach areas and minority populations (United Nations, 2009). This is true in the church settings because peer program cover wide areas due to the fact that peer education messages are passed on to the community through community events such as funerals, weddings and political meetings attended by several people of all walks of life (Africare South Africa Phase out Report, 2010).

Peer education messages in church settings can also be passed to the masses through a peer to peer approach on a one to one basis where individuals or few people are reached using a definite curriculum achieved in a specific period of time. Africare South Africa considers the peer to peer approach to be more effective peer education approach because there is quality attached to the messages passed onto the target population (Africare South Africa Phase out Report, 2010). In both church functions and community events, peer education programs remain the most effective in reaching more people with little resources across a great expanse of regional coverage (United Nations, 2009). Given that peer education programmes are constrained by meager resources, this approach stands out to be a sustainable means to pass HIV and AIDS prevention education messages across target populations and audiences (Africare South Africa Phase out Report, 2010).

### **2.3.2 Effectiveness in the Selection and Recruitment of the Peer Educators**

According to Adamchak (2006), peer education processes of selection and recruitment are initiated from the community with the full involvement of key stakeholders from the onset to ensure productivity, peer educator retention, motivation and sustainability of programs. These processes include, among others, recruiting peer educators from the community by the community members themselves. Depending on the peer education need, peer educators are then trained on a given set curriculum by organizations or people that need them. When training is over, peer educators are then deployed to work with particular target groups mainly using a peer to peer approach where one peer educator works with people on an individual or group basis. Usually peer educators are volunteers who are not paid or work with little remuneration. However, they need supervision to ensure quality in their work and continuity of the programmes.

Selection and recruitment of PEP volunteers in most churches is usually the role and responsibility of the church leadership as noted by Adamchak (2006). Church leaders nominated all the PEP volunteers in their capacities as leaders in search of section leaders of their churches and hence engaged them in their roles and responsibilities as PEPs. In churches there are usually different types of peer educators that contribute to the pool of peer educators to propagate HIV and AIDS prevention messages in their right as leaders of the different sections of the church. These are: Sunday School Teachers, Child Leaders, Youth Leaders, Women Leaders, Pastor Father's Union, Mother's Union and Women's Manyano. Each of these peer educators wield authority and positions of influence that has been useful in promoting PEP in the church. This is in agreement with the purported role of peer educators as role models in the fight against HIV and AIDS cited in Adamchak (2006). Although this remains true, selection of peer educators by church leaders can also be counterproductive in that those selected accept their roles and responsibilities sometimes because of fear and respect for their pastors not coming from their own free will. As a result, this can lead to a high level of attrition amongst the peer educators (Adamchak, 2006).

Similarly, Adamchak (2006) confirms that peer educators from other churches get recruited during the meetings where congregations from other churches gather such as

funerals, weddings, interdenominational meetings. Pastors who are peer educators communicate HIV and AIDS prevention education messages such as faithfulness and stigma reduction during their one on one formal information sharing sessions. This becomes the role of peer educators to encourage the church to fight against HIV and AIDS amplifying the importance of involving the entire congregation in the fight.

### **2.3.3 Effectiveness of the Peer Education Programme Curriculum Content**

According to Siemens South Africa (2003), the training curriculum for peer educators can include the following: epidemiology, transmission, HIV counseling and testing, disease progression, positive living, stigma and discrimination, treatment, care and support, trends in the statistics of HIV and AIDS and its impact globally, HIV and AIDS and the law, HIV and AIDS policy, peer education training, communication skills, facilitation skills, planning, implementation, monitoring and evaluation. The extent and depth of training according to Siemens South Africa can be determined by the level of education and target group for which the peer educators are wanted. Also, the curriculum design in any peer education program can touch on many other aspects in addition to those mentioned above depending on the creativity and need of those designing the program. What is presented by Siemens South Africa (2003) is not an end or exhaustive list.

The PEP curriculum is usually designed with a particular content in mind for a specific target population. HIV and AIDS has been a new area for a majority of the people but with constant sharing with the congregations coupled with support from other stakeholders like government health facilities; knowledge levels of the pandemic has indeed improved. The challenge is however, measuring the attitudes of the congregations and sexual choices and practices remains something that needs to be established; unfortunately not handled in this research. In the church set up, the PEP curriculum usually handles critical areas of PEP such as basic HIV knowledge, spiritual counseling, group facilitation, communication strategies skills and training.

### **2.3.4. Effectiveness in the Training of the Peer Educators**

Peer educator trainings are usually designed to cover specific number of days covering specific topics or curriculum content. However, the effectiveness of such a

peer education program depends on a number of factors such as careful training, support, materials, monitoring and feedback mechanisms (United Nations Report, 2009). This was observed in Cambodia, China, Sri Lanka and Philippines where the peer to peer approach in peer education was used for strengthening life skills for positive youth health behavior with tremendous results (United Nations Report, 2009). In these four countries mentioned, participants received the necessary capacity-building required to influence peer behavior among their colleagues (United Nations Report, 2009). In the church settings, a similar approach is possible through training of peer educators in HIV management in a definite program package with topics to be covered such as: basic HIV, spiritual counseling, group facilitation skills, and training and communication strategies. With the increase in knowledge in the HIV and AIDS field, new topics could emerge for inclusion.

### **2.3.5. Effectiveness in Peer Education Communication Strategies**

Communication strategy in peer education according to Singhal et al. (2003), hinges around behavioral change communication (BCC) for social change. In most cases this includes speeches, pamphlets, books, music, dance, drama, group discussions and teachings earlier explained in the definition of peer education above. BCC strategies focus mainly on individual level change but can also be used for behavioral change in small groups or multi-level cultural change that goes beyond individuals to culture, art, crafts and artifacts (Singhal et al., 2003). Sriringanathan et al. (2010) adds to the list of possible methods to peer education to include: concerts, school assemblies, workshops, posters, message boards, newsletters, stickers, buttons, theater, art, song contests, essay contest and the distribution of articles that help to reach a number of target audiences with limited resources.

UNESCO (2006) states that culturally appropriate HIV and AIDS messages across all segments of society should have a wide range of methods of approach. Ideally, peer education approaches should be diverse and can be in different forms as long as these methods help change risky sexual behavior that can be used to reduce the chances of the target groups from getting infected with HIV. The most important aspect of peer education is that it teaches or provides knowledge to both the peer educator and the target audiences and populations.

There seems to be no one best way to conducting peer education messages as long as messages are being passed on to the target populations about risky sexual behavior and choices that could exposed them to the risk of contracting HIV in the most effective way that best suits them (Gange et al., 2003). Any opportunity to avert such a danger from the target population would be deemed success in peer education programmes.

In church settings, there are two main methods of communication: One where HIV awareness and prevention messages are shared in large community events such as funerals, weddings, church services and interdenominational meetings and another where individuals are met in small groups. In the former, HIV and AIDS prevention messages are shared at community functions and gatherings (Africare South Phase out Report, 2010). This strategy gets people when they are most attentive to what is going on and inevitably have to get peer education messages passed on to them. It is very effective and communicates to masses of people. The method is also cost effective with little resources needed.

In the peer to peer communication strategy the peer educators works with a very small number of target groups to pass HIV awareness and prevention messages with a defined programs over a period of time. According to Africare South Africa, this method has worked well with the small groups like Sunday school, Women Church Groups and the Youth in the church mentioned earlier. School children are also reached this way. The communication strategy targets a particular group of people who have to undergo a complete a set modules to be counted as individuals reached with the programme (Africare South Africa Phase out Report, 2010).

The peer to peer communication strategy is very effective in that people are reached and there is room to interrogate the peer educator for clarity if anything was not well understood unlike in the scenario with mass events. Those who participate in peer to peer method approach are also peer educators in their own right because they have effectively gone through the entire peer education syllabus. Whereas in mass events many people are reached, however, the quality of the messages cannot be compared to when individuals are reached as a small target group. In both methods, messages are

passed on to people to fight against HIV pandemic. Both methods serve the purpose and are very effective. Both methods are supported with the use of other behavioral change and communication strategies such as fliers, music, dance and drama as mediums to pass on messages (Africare South Africa Phase out Report, 2010).

### **2.3.6. Effectiveness in Peer Education Program Referral Linkages**

The mission of peer educators cannot be successful without referral systems. According to UNFPA (2005), the management of PEP should ensure a functioning system of linkages to appropriate healthcare services by different role players at the onset of the programme. This should happen before peer educators start on their assignment because peer education is meant to be an eye opener to clients to see a wide range of available health services provided by different actors. There needs to be an established referral framework where different community health care services can be linked to different service providers managed by an effective monitoring and evaluation system which ensures that all referrals received due attention and services for which they were referred. An effective referral system is best when it is a two way system; from the one referring clients for a service and from the service provider who provided a service to clients. This two way system can be enhanced by the use of a referral slip.

The referral linkages in church settings can be effective if it works with all the health facilities surrounding churches in the community. It should also have a functional smooth referral process between the institutions involved with clients providing a continuum of care. These usually include the Police, traditional leaders and the local government administration structures such as Ward Councilors. These referral links helped clients who needed counseling, clinical help and any form of assistance (Africare South Africa Phase out Report, 2010).

### **2.3.7. Effectiveness and sustainability of Peer Education Programmes in the Church**

Sustainability of PEPs is a critical factor in the continued provision of services to clients. Maretha (2007) argues that establishing a sustainable structure for management of PEPs should be a routine function of all institutions providing peer

education. Advocates of peer education maintain that PEPs globally remains a challenge in that it is difficult to ensure sustainability of programs without funds to keep up with a high standard (UNAIDS, 1999). Funds are needed to adequately train peer educators, support and to equip them with resource materials. Funds are also required for the supervision of the work done by peer educators. Peer educators also need some stipend or remuneration to ensure their commitment to PEPs because they have family responsibilities and contractual obligations to meet their financial requirements. Creating avenues for raising funds for support in the short, medium and long term will be paramount in creating a sustainable environment in the fight against the pandemic using PEPs as a strategy now and in the future.

According to Ford Inman (1992), sustaining peer education programmes also motivates and benefits peer educators. He argues that peer education in one way or the other also benefits peer educators themselves in that it equips them with life skills. He further argues that the nature of training offered to peer educators constitutes personal development necessary for their career development. This can significantly boost the commitment of peer educators in a positive way. As careers develop in the process and skills are acquired along the way, Ford Inman argues that these serve as good motivation to peer educators to continue sustaining peer education programmes. According to Africare South Africa, peer education in church settings could be effective and sustainable as long as funding and structured support is secured. Structured support could be rendered as formal training to support the peer educators and the continuous mentorship of the peer education programs which includes updating the peer educators with new information and strengthening their existing knowledge. It also includes providing peer educators with materials and any form of motivation to keep peer education programmes running. Continuous monitoring and evaluation of programmes managed by peer educators also adds to structured support (Africare South Africa Phase out Report, 2010).

Another factor cited in Asia by the United Nations Report (2009), was that for sustainability to be attained in peer education programmes, collaboration between stakeholders is important and should be attained because it ensures that the skills acquired in peer education programmes are integrated into other activities affecting

the different target groups. This also goes alongside creating networks with groups and institutions that will matter for the sustainability of a particular peer education programme. It was for example noted in the same report that governments can forge strength with her partners to promote the attainment of government goals and objectives. Governments are good and have strength in promoting, advocating and initiating programmes but are not good in maintaining or sustaining them (United Nations, 2009). In which case, partners or other stakeholders known to be good in implementing programmes could then take up the initiative to run programmes that have been conceived and have a future as way to complement government efforts in community development (United Nations, 2009). Such collaboration could also help in transforming HIV management programmes in the communities through the skills acquired (United Nations, 2009).

### **2.3.8 Summary**

In this chapter, the discussion focused on understanding how the various behavior change theories are defined and how each of them may be linked to peer education. The latter part of the chapter discussed the effectiveness of the different aspects of peer education in terms of geographical area and population coverage, selection and recruitment of peer educators, the peer education curriculum content, training of peer educators, peer education communication strategy, referral system and the sustainability of peer education programmes. The following sub-section discusses research design and methodology as applied in the case study.

### **Chapter 3: Research Design and Methodology**

This brief chapter is dedicated to research design and methodology highlighting [paradigm and design, the target population, the sampling method used in the study describing how data was collected and analyzed in the study. It also emphasizes the issue of ethical consideration involved in the study.

#### **3.1 Paradigm and design**

The study only used qualitative research methods to conduct this study.

#### **3.2 Target Population**

This research focuses mainly on pastors of churches in the Whittlesea area that have been participating in the Africare-South Africa Peer Education Programme as peer educators since 2004 when the programme started.

#### **3.3 Sampling Method / Inclusion Criteria**

The researcher used a sample of peer educator pastors randomly selected from a list of churches that have been actively involved in the Africare-South Africare peer education programme, with functional peer education programmes in their churches that have been in existence for more than one year. The researcher worked with a sample size of 12 peer educators in a target population of 40 per educators in 40 churches.

#### **3.4 Data Collection**

For the measuring instrument, the researcher used a focus group discussion (FGD) guide as a means to collect data. FGD guides were set up in themes or specific topical areas that lay the foundation for data collection and analysis. As the discussion progressed so was the data collection. In the study all the 12 peer educator pastors were put into one group and used the opportunity to discuss with them the effectiveness of their peer education programmes. Data collection involved taking notes on each of the topical areas under discussion. In addition, the researcher also used peer education guide questions for individual churches to establish performance of each peer education program in each church. This was individual one to one

discussion with representatives of each of the churches that gave the overall picture of the functionality of each of their PEPs.

Focus group discussions were based on the understanding of pastors and their level of HIV and AIDS knowledge as church peer educators propagating HIV and AIDS awareness and prevention education messages in their congregations and surrounding communities.

### **3.5 Data Analysis**

In data analysis, qualitative data analysis principles and techniques were used to establish the effectiveness of peer education programmes in churches participating in the study. Data analysis was based on the questions set against each objective that provided a guide to the focus group discussion and the one to one discussion with individual churches in establishing the functionality of peer education programmes.

### **3.6 Ethical Considerations**

To conduct this study, the researcher sought permission from the South African Council of Churches Secretariat in Queenstown, Eastern Cape Province to request for the participation of its members in this exercise. The researcher also sought consent from each of the pastors who were to be involved in the focus group discussion. For this matter, the researcher provided consent forms for each one of them to sign before commencing the research. The researcher also gave each pastor who participated in the research an explanation why they were chosen to participate in the study, the importance of their role and contribution in the exercise. The following section of this study report is dedicated to the results or findings of the study.

## **Chapter 4: Results and Discussion**

### **4.1 Introduction:**

This chapter gives a summary of the results from the focus group discussion with 12 Pastors from Whittlesea area involved in the Africare-South Africa PEPs. The discussion is a qualitative presentation of the proceedings of the focus group discussions. The first part gives the actual responses of some or all the pastors during the discussions and then the second part is the organizational analysis and conclusive remarks of each of the churches analyzed to the needs of the specific question related to the objectives of the study: knowledge of HIV and AIDS, knowledge aspects covered in the PEPs, gaps in the current curriculum of PEPs and the provision of guidelines to improve the current peer education curriculum run by pastors in the study.

### **4.2 Background of the Africare South Africa Peer Education Programme**

Africare South Africa is an international non-governmental organization (NGO) involved in HIV and AIDS management at the community level in the Eastern Cape Province particularly in the districts of Amatole, Cacadu and Chris Hani (Africare Phase out Report 2010). Pastors in the Whittlesea (Chris Hani District) area were engaged with Africare South Africa in HIV/AIDS Peer Education Programme (PEP). One faith-based organization (FBO) coordinator worked with about 300 churches and spiritual leaders to try and prevent the spread of HIV/AIDS (Africare Phase out Report, 2010). Given that congregations had so much faith in their pastors, it was envisaged that a population close to 401941 people would be reached easily through this way. Activities of churches such as church services, weddings, funerals and other related functions were avenues for such prevention education messages. Also, churches would establish functional HIV and AIDS programmes that could be cascaded to include other congregations within the same or similar church settings within and across geographical areas of influence of peer education pastors (Africare Phase out Report, 2010).

In a period of four (4) years (2005-2009), the PEP reached 31 areas of Hewu villages namely Shiloh, Sada, Mabuyazze, Madakeni, New Zone, Zola, Chibini, Mbekweni, Bollpoint, Oxtan village, Sihlabeni, Yonda, Zweledinga, Didimana, Lower

Zanqokwe, McBride, Ensum, Mceula, Ntabelanga, Qhwabi, Strato, Ekuphumleni, Braakloof, Extension 2, Extension 4, Old Location, Poplar Grove, Tambo, Bothashoek, Merino Walk and Who Can Tell. This is an area inhabited by over 500 000 people and covering about an estimated land area of 10 square kilometres. Those reached with abstinence and being faithful messages were close to 329291 (Africare Phase out Report 2004-2009) over this period.

Peer educators were trained on a structured curriculum to provide care and support to the members of the church. The training curriculum included the following topics: HIV and AIDS, opportunistic infections, dealing with myths, stigma and discrimination, cultural issues and its impact on vulnerable populations, HIV and AIDS counseling, crisis counseling, pastoral counseling, human sexuality, HIV and AIDS and the church (Africare Phase out Report 2010). The scope of the PEP program was limited to the understanding how the church could be involved in HIV and AIDS mitigation amidst a deepening crisis that claimed lives of its members with no apparent solution. The 100 peer educators each establish a health desk forum: an HIV and AIDS program in their respective churches to mitigate against HIV and AIDS and its impact on the church community (Africare Phase out Report 2010).

The respondents in the focus group discussion comprised of 12 pastors from 12 out of 40 churches namely: African Methodist Church, Apostolic Holy Church, Baptize African Church, Bantu Congregation Church, Bethesda Church, Church of Christ, Evangelical Church, Faith Mission Church, Fountain of Grace Church, New Light of Life Church, United Reformed Church and Uniting Reformed Church (Africare Phase out Report 2010).

### 4.3 Findings from the Focus Group Discussions

The results of the study are hereby presented below. This was obtained from a focus group discussion of pastors of churches involved in the Africare-South Africa PEP in the Whittlesea area. The discussion was based on four objectives the study discussed earlier. Each of these objectives had more detailed questions guiding the discussion as will be presented in the discussion presented in the following sub-section (see appendix for a full set of the focus group discussion guide questions).

#### 4.3.1 Levels of HIV and IDS knowledge among pastors participating in Africare-South Africa Peer Education Program in the Whittlesea area.

**a). Definition of HIV:** In the definition of HIV, responses to this question were as follows: *“it is a germ that you find in a person”*; *“it is a virus that lives in a person’s body or only in human beings”* and *“it is an infectious disease that can kill a person but it is manageable like other chronic diseases such as diabetes and high blood pressure”*. The three responses provided in the question above suggests that the participants in the FGD seemed to have a fair understanding of the term HIV but read on the merit of the actual definition of the terminology HIV, one can easily conclude that they might have had the meaning wrong and hence underscored them on the level of understanding of HIV. One could also argue that there is a possibility that medical terminology such as HIV could have been difficult for the respondents to explain in the local language hence only three giving their try. Medical terminology or English language has a considerable interference with the interpretation and understanding of concepts presented to people because of their level of understanding of the English language. In some cases, similar words have different words or set of words to depict or denote the meaning of given words under discussion but do not necessarily have the same meanings.

**b). Definition of AIDS:** In the definition of AIDS, the responses were varied: *“AIDS is something that you live with not a disease then when you contract HIV that is when you get sick”*; *“AIDS is something that you get when you have HIV which means it is a build-up”*; *“AIDS is when HIV is full blown, such as when your CD4 count is less than 200 then you get AIDS as a disease”*; *“AIDS is a condition when you do not protect yourself or monitor the HIV in the immune system becomes weak”*; *“AIDS is*

*an infectious disease that is fatal and you can get it through sleeping with people who are infected without using protection: and "AIDS is a disease that you have such as cancer as a result of HIV". Also, "AIDS is an incurable disease coming from inside, one gets AIDS first then HIV next".*

The responses given in the question above suggests that the respondents seemed to have had little knowledge and understanding of the term "AIDS". The responses are presented in a confusing manner that gives the impression that the respondents' level of knowledge of the term "AIDS" seems to be low. However, as explained in the previous question, one would think that it is probably the difficulty in explaining the terminology that the respondents struggled with rather than the knowledge of it despite repeated explanation of the term before the focus group discussion started.

**c) How the virus infects people:** The next question asked the respondents how one could be infected with the virus. The responses were as follows: *"by having unprotected sex"; "breastfeeding"; "by nursing or helping someone who has HIV then you touch their blood without using gloves" and "through sharing of needles (drugs), blades in initiation schools during circumcision"*. The respondents in the above questions demonstrated that they seemed to have had a fair knowledge of how the virus infects people and hence suggesting that the respondents might have the right message that they communicate to members of their churches in the peer education programmes.

**d) Use of gloves to avoid direct contact with HIV-infected clients:** The follow-up question was whether it was common in the Whittlesea community to touch someone who is HIV-infected randomly or accidentally when helping them. They all unanimously responded saying, *"no after Africare taught us about HIV and AIDS we are now very careful about touching clients without gloves"*. All the respondents understood that touching HIV-infected clients can lead someone to contracting HIV if the person providing care has open cuts in the skin or wounds. The respondents commented that through their peer education programs and that of other actors in the community such as Department of Health is helping them to improve the

understanding of people in the community about HIV and AIDS and how people get infected.

**e) HIV modes of transmission:** In the questions about the modes of transmission, the responses were numerous: *“unprotected sex”*; *“semen and bleeding from friction during sex”*; *“through menstruation”*; *“through blood transfusion”*; *“during labor or when delivering a baby”*; *“at the dentist when the doctor is careless with the needles and repeatedly uses it without changing it”*; *“when a woman who is infected has sex without using protection”* and *“when there is a cut or when the woman has any type of sexually transmitted infections”* and *“when a woman gives off fluids they can be transferred to a man”*. The answers of respondents suggest that they seem to have full knowledge and understanding of the modes of transmission of HIV.

**f) HIV infection through kissing, sharing cups, plates and clothes.** In the question, can someone be infected with the virus by kissing, sharing cups, plates and clothes with someone who is already infected with HIV? The responses were decisive; *“No, these are myths people cannot contract the virus through these”*. *“HIV lives in human blood not on the skin but if one is infected and has a cut, kissing such a person can lead to infection”*. *“The virus can go through the cut to the next person”*. The response given by the FGD participants suggests that pastors seem to be having a fair knowledge and understanding of the virus and its modes of transmission. These pastors also seem to understand some of the myths surrounding HIV transmission that people confuse or misunderstand such as contracting HIV through kissing, sharing cups, plates and clothes with someone who is already infected with HIV.

**g) Cure of HIV:** The question whether HIV had a cure. The answers were also decisive: *“No there is no cure for HIV it is controllable or manageable by using ARVs”*. The response given by the focus group discussion participants indicates that they seem to understand that HIV does not have a cure.

### 4.3.2 Knowledge aspects currently covered in the Africare-South Africa Peer Education Program

**a). Topics covered in peer education programs:** The first question here was to find out topics covered in the Africare-South Africa PEP for pastors in Whittlesea. The responses to this question were as follows: *“human sexuality”, “stigma”, “how to manage HIV”, “how to protect yourselves”, “how to care for people living with HIV and AIDS”, “how to deal with stress related to HIV and AIDS”, “communication with partners and faithfulness”, “educating other women and how to care for their siblings who are infected”, “how to prepare and provide healthy meals and what is important in their diet”, “how to care for Orphans and Vulnerable Children (OVC)” “positive living”, “how to deal with discovering your HIV status because young people have difficulties dealing with it, hence, usually leading to people committing suicides”*.

The responses above indicated that the pastors seem to know the knowledge aspects of their peer education programmes. They were able to mention them one by one with confidence without wavering. However, issues such as communication with partners, educating women on how to take care of clients and how to care for their infected siblings with suicidal tendencies and how to take care of OVC, were new additions that respondents mentioned that the curriculum did not cover during the first PEP training for peer educators. These additional knowledge aspects mentioned by the respondents in the FGD are as a result of interaction with other stakeholders such as the Department of Health Chris Hani District training them on more aspects of HIV and AIDS management.

Despite new additions suggested for inclusion into the PEP curriculum, the respondents did not mention other aspects of the peer education program curriculum they were trained on, hence, leaving out other critical knowledge aspects such as opportunistic infections, discrimination, cultural aspects of HIV and AIDS and its impact on vulnerable populations, HIV/AIDS counseling, pastoral counseling and the relationship between HIV/AIDS and the church even when probed to mention more aspects of the PEP curriculum. This omission could be due to lack of knowledge or

out of practice of these knowledge aspects of the curriculum since some of them do not even ever practice all the peer education curriculum aspects that they were trained on years ago by Africare South Africa.

**b) Difficult topics in the peer education program among the pastors:** In this question, the study wanted to find out whether the topics passed on to the members of churches were easy or difficult for the masses. The responses to this question were as follows: *“it is not always easy or sometimes to talk about some topics because some church members do not want to hear anything about HIV and AIDS saying these are worldly not meant to be discussed in holy places; some Christians had a problem with discussing HIV and AIDS because it is associated to sexual immorality”*. In addition, respondents gave the impression that women and the youth have not yet embraced peer education programmes in their communities. Despite this, respondents acknowledged the fact that there seems to be some interest developing towards a liking for the peer education program leading some of them to start opening up to peer educators as they disclose their HIV status and seek support on various issues of the programme.

According to the respondents, people living with HIV in the church feel uncomfortable and unwelcome so they do not easily disclose their status if they were not sure whom they are talking to. Respondents also commented that some pastors judge them by saying that they are living in sin and hence being punished by God. The respondents continued by saying that *“once pastors begin talking about HIV and AIDS such members of the church immediately think pastors are preaching about them; forcing them to leave the church”*. In the discussion, respondents emphasized the sensitivity of disclosure of ones HIV status to the members of the church as hampering free participation in the peer education programmes across churches. In their comments, they gave disclosure as one of the reasons why some members of the church did not want to participate in the peer education programmes. According to the respondents, people were comfortable to disclose their HIV status to peer educators who maintain a level of confidentiality. Respondents said that there was also lack of confidentiality at family level rife with stigma and discrimination, hence, an equally unreliable place to disclose ones HIV status.

The responses above seem to indicate that communicating HIV and AIDS knowledge in church is not easy because of the church belief system. The first responses above seem to show that communicating HIV and AIDS to the church members is a challenge not because of the difficulty or understanding of the knowledge aspects of the curriculum or topics per se but because when it comes to the church; HIV and AIDS is marred with misconceptions arising from religious, cultural and moral beliefs of people in society. According to the responses, the church is a holy place and pastors are holy people that should not have anything to do with the HIV and AIDS because it is associated with sexual immorality, worldly life and sin as noted by Van der Walt (2004); Douma, (1987); Clifford, (2004). Involvement in HIV and AIDS was seen as being a negative influence in the church particularly to women and children.

**c) Understanding peer education program topics:** The research also sought to find out whether members of the church understood the topics or areas of peer education programs mentioned above or whether they were able to identify with the implementation of the topical areas. Again, the responses were varied as shown: some agreed they understand all the topics because it was evident in behavior change among the congregation with certain people changing behavior for the better. The respondents continued to say that those who were found to be abusing alcohol and drugs, being unfaithful to their partners stopped the habit completely as a result of the peer education programs within the churches. Such people lead a good life and changed for good. These sentiments are similar to an observation by Chege, et al, (1995), where the 12-18 year old youth displayed better knowledge, more positive attitude and signs of behavioral change towards sexually transmitted diseases and infections following a peer education intervention.

Respondents also commended treatment defaulters as having changed for the better because of peer education. On the other hand, some people according to the discussion deliberately refused to understand some topics in peer education because they are living in denial; so they would rather not want to know anything about HIV and AIDS. According to the respondents, some clients seemed not to understand HIV

and AIDS arising from their attitudes towards the peer educators. Client concerns seems to stem from the fact that HIV and AIDS issues are always handled by one person (Church Pastor) creating bias and misunderstanding between them.

The responses above seem to show that peer education programs in their churches are understood. According to the responses, people who chose to follow instructions in the peer education program have better living outcomes compared to those who did not want to participate. The responses seem to indicate that people who went for counseling stopped bad habits such as smoking and drinking. The responses also seem to show that those who have changed for the better are also now adhering to treatment and are faithful to their sexual partners.

#### **4.3.3 Gaps between the current Peer Education Program curriculum and the level of HIV and AIDS knowledge of Pastors involved with the Africare-South Africa Peer Education Program in the Whittlesea area**

**a) Remembering all topics covered in the peer education program:** This question wanted to establish whether the pastors still remembered all the topics or areas covered in Africare South Africa PEP. The responses in this question were also unanimous and decisive; they had all forgotten some of the topics and areas of PEP. This could be due to the fact that it has been more than three years since the roll out of the PEP in the churches. This could also be due to pastors no longer using some knowledge aspects of the curriculum, as something commonly used is usually remembered with ease. From the original plan, one could say that there are gaps in the current peer education curriculum. This also seemed evident in the earlier question already discussed above that revealed the respondents did not exhaustively mention all the topics in the peer education programs currently communicated to the churches today, hence, possible gaps exist in the current peer education curriculum.

**b) Understanding current topics in the peer education program by pastors:** In this question, the focus group discussion wanted to establish whether pastors in Whittlesea still understood all the current topics or areas covered in the PEP. All

respondents agreed they still understood the topics in the peer education curriculum given that they have been practicing the program ever since then.

**c) Topics to be included in the current peer education program:** In the next question, pastors were asked which topics or areas they wanted to include in their PEP curriculum that they thought were left out initially in their peer education program in the church. Participant response came up with the following topical areas: ARV treatment, nutrition and HIV, using soup kitchens as a means of client care, how to relieve stress or deal with it when you are living with HIV, the introduction of extracurricular activities / programs for the young people. This they thought would help the young people out of trouble, for example, Kulanyana Drama Group in Whittlesea, marriage counseling, after school care for the OVC, skills development, how to form support groups and more ways to teach people how to live and sustain their lives while living with HIV and AIDS.

The responses above seem to show that there were a number of topics that needed to be added to the current peer education programmes. This is in agreement with the current South African HIV/AIDS national strategic planning (NSP) document 2012-2016 that advocates for a comprehensive approach to HIV and AIDS management (NSP, 2012-2016) involving all actors. Time has passed and yet the peer education program curriculum has not been revised or updated to suit new developments in the management of HIV and AIDS in the church setting.

**d) Topics to be excluded in the current peer education program:** The focus group discussion was also focused on asking pastors the topics or areas they wanted excluded from the PEP introduced by Africare South-Africa. The response was decisive; all said in unison, *“we do not want to exclude anything from what we are currently implementing in the HIV and AIDS program in the church”*. Based on the response in the previous question, it seemed clear that more areas needed to be included in the PEP curriculum than excluded. It also confirmed that the respondents seemed to have knowledge and understanding of the importance of PEP to the members of the church.

#### **4.3.4 Guidelines to improve the current Peer Education Program Curriculum run by Africare-South Africa to align them with HIV and AIDS knowledge of the pastors in the Whittlesea area**

**a) Guidelines to improve peer education programs:** The following were the responses of the participants in the focus group discussion: *“establishing guidelines on youth empowerment programs that include video viewing”, “visual arts”, “sex education”, “games and sports activities”; “guidelines on the importance of condom use in a church setting”. “The church is not comfortable to talk about condom use saying peer education promotes sexual immorality in the church”. “Guidelines that will make pastors and members of their congregations streamlined to HIV and AIDS and not stereotyped about the pandemic as they associate it to sexual immorality”. “Introducing guidelines to reduce women and child abuse in homes, child and women’s rights vis-à-vis HIV and AIDS and involving men in activities that help manage HIV and AIDS”.*

For improvement of the current PEP curriculum, respondents provided hints to issues that might be raised in the development of guidelines. Focus group discussion participants provided hints to areas that will help in the development of guidelines or standard operating procedures in implementing the new PEP curriculum. The respondents brought to the fore: ideas around the empowerment of the youth, their involvement or participation in the PEP, the whole concept of condom use as a PEP methodology opposed by the church, the reality that HIV is not a sexual immorality issue that the church needs to recognize as argued by UNAIDS in the A Report, (2003) in the case of Namibia. The respondents also argue for more male involvement in PEP saying that the more men get involved in HIV and AIDS management the faster messages will go across to target populations because they are equally responsible for making poor and sometimes uninformed sexual behavior and choices that are susceptible to contracting HIV. All the discussions raised by the respondents in the focus group discussion seemed to be good ground for further discussion and critical to the improvement of the new PEP curriculum.

**b) Topics in the peer education program to be communicated differently:** In the focus group discussion, pastors were asked which topics in the current curriculum of PEP Africare-South Africa they thought would be communicated differently to the members of their respective churches given that some messages discussed above are viewed differently by members of the church. In response, the two main topics that the respondents felt could be brought to the fore for more constructive discussion were: condom use and treatment adherence. In terms of condom use, as much as the church opposes the use of condoms for HIV prevention on the grounds that it promotes immorality in the church as noted by the UNESCO Report (2006), respondents would like the church leadership to understand the importance of condom use in HIV prevention and to allow it to be spoken about without reservation in the church. For treatment adherence, the participants in the focus group discussion emphasized the importance of clients following guidelines on how they should take their treatment because treatment adherence promotes long life (some respondents had clients who were already on treatment and therefore they understood exactly how best to help them).

**c) New information provided to the peer educators by stakeholders on HIV and AIDS management:** The final question wanted to establish whatever new information has been provided by Government or by other stakeholders such as Africare-South Africa for inclusion that was not been available at the time of the peer education training (2005-2009). The responses are summarized as below:

**HIV Counseling and Testing (HCT):** this was suggested to be included by the respondents in the new curriculum for peer education. HCT was called Voluntary Counseling and Testing then. From 2010, the Government of South Africa introduced Provider Initiated Counseling and Testing (PICT); this is where the health facility initiates counseling and testing at the time of service provision to clients. Government also introduced Client Initiated Counseling and Testing (CICT). This is where the client initiates counseling and testing before the service provider. Although counseling and testing was there at the time of peer education training, it was not included in the peer education training curriculum then for reasons that this was a health facility function (National Strategic Plan (NSP) 2012-2016).

**PMTCT:** New information to be added in the proposed peer education program also included the prevention of mother to child transmission (PMTCT) (PMTCT Guidelines 2012). Transmission of HIV from the mother to their unborn babies was also not included in the peer education program. In the National Strategic Plan (NSP) 2012-2016, the Government of South Africa now expects mother to child transmission to be at zero by 2015. Breastfeeding options where the mother decides to exclusively breastfeed her baby for at least 6 months is now the preferred option and which information would be good to include in the peer education program such that the church peer educators can also instill the same ideas within the church setting.

**Use of antiretroviral drugs (ARVs):** The other new information provided by stakeholders that could be included in the revised peer education curriculum is the use of antiretroviral drugs (ART / ARV) by all clients eligible for the taking the therapy. The respondents in the research study argue that it will not be possible to take about prevention awareness education without talking about the use of ARVs as already discussed above. Coupled with this is also the knowledge of CD4 Count Cells ceiling of 350 for the initiation of ART declared by the President of the Republic of South Africa on the World AIDS Day 2011. This was a serious commitment by the head of state that improved eligibility for ART initiation from a CD4 count of 200 or below to 350 and below for the adults. For children today, once a child is HIV positive, s/he is initiated straight away (NSP 2012-2016; ART Guidelines 2012). The respondent also want to participate in this national drive in their own right as peer educators supporting national strategies set by the president of the country and as a matter of urgency because it is the right thing to do.

**Side effects of drugs:** Peer educators also want a topic on side effects of drugs to be added information in in their revised peer education curriculum. Respondents confirm they did not have this information before in their peer education programs but this becomes an increasing concern when a good number of clients in the peer education program were stopping to take ARVs due to the side effects of the drugs. Peer educators have always referred clients to seek further medical advice on such matters. On the same issue of ARVs, peer educators also learnt that certain ARV drugs cannot be taken with certain foods such as fatty foods but rather they have to

wait for about an hour or so before taking the drugs for the medication to be effective (Personal communication from facility nurses to church peer educators). Not only was this new information given to the peer educators but something they were proposing to be added into the new peer education program. Although this is proving to be highly advanced for peer educators in the church set up with minimal medical training or background, peer educators felt they needed such information included into the new curriculum. Peer educators also wanted the addition of Pharmacovigilance to the new curriculum be able to understand something about food and drug interaction in order to ably support patients under their care.

In the above chapter, the focus group discussion responses or report was given according to the answers given by the respondents. The chapter addressed issues such as the HIV and AIDS knowledge level of pastors in the Whittlesea area, HIV and AIDS knowledge aspects, the gaps left to be filled in the knowledge content of the peer education curriculum and propositions of what the research participants wanted added in the peer education program in the future to make the program more effective than it is currently. Having looked at participant responses, the following chapter focused on the analysis and more recommendations that would generally improve the effectiveness of a functional peer education programme.

## **Chapter 5: Recommendations**

This chapter provides analysis to improve on the peer education program within the Whittlesea area. Focus of analysis is on the objectives of the study and key areas arising from issues raised by respondents that will benefit the peer education program.

### **5.1 HIV and AIDS knowledge level among pastors participating in Africare-South Africa peer education programme in Whittlesea area**

All the 12 respondents (pastors) seemed to have had a fair knowledge level of HIV and AIDS and were confident they had the capability of propagating awareness and prevention messages within their areas of jurisdiction. This was also because the knowledge aspects were basic and specific to the task of the respondents. Part of the curriculum was based on the spiritual aspects of the church such as spiritual counseling that the pastors were familiar with. This also helped them to be able to handle stigma and discrimination issues through general HIV and AIDS counseling. The design of the curriculum to the pastors in particular was quite good. This was also good in that the pastors were not trained as the ultimate HIV and AIDS consultants but conduits to palliative care services managed by the health care facilities. The design of the peer education program by Africare South Africa was that pastors operated as a means to enable the church to increase access palliative care services among the stakeholders providing such services in that time when a good number of HIV clients were in denial and did not want to access care and support services. Therefore a fair knowledge of HIV and AIDS knowledge was good enough for pastors to make referrals to service providers. This should be continued in the future.

### **5.2 Knowledge aspects currently covered in the Africare-South Africa peer education programme**

As discussed before, knowledge aspects in the peer education program seemed to suit the needs of pastors providing HIV and AIDS awareness and prevention messages to the congregations. With time, these aspects have become limited in the sense that there has been a huge evolution in the management of HIV and AIDS among stakeholders which now requires peer educators of all sorts to be more conversant and abreast with a number of ideas. It is now advisable that any form of peer education

program should have all or most of the aspects of HIV and AIDS management. Apart from basic HIV and AIDS information and knowledge, communication strategies and spiritual counseling, other knowledge aspects such as understanding the entire process of care and support are critical to HIV and AIDS management. This embraces knowledge aspects such as treatment and palliative care aspects namely: environmental hygiene, clinical or medical care, social care, spiritual care, clinical nutrition and integrated HIV prevention education. The richer the care and support program the more effective it will be for managing clients who are either infected or affected by the virus. This will however require training a high cadre of peer educators that will understand concepts at a high level to effectively run the peer education programmes. Peer educators need to be all round HIV and AIDS awareness campaign agents in the community.

### **5.3 Gaps between the current peer education programme curriculum and the level of HIV/AIDS knowledge of the pastors involved with Africare-South Africa in the Whittlesea area**

Ideally there seemed to be no gaps between the current peer education program and the levels of understanding of pastors because the design of the curriculum seven years ago was meant to be that way; with basic information and knowledge of HIV and AIDS for pastors, communication strategies and spiritual counseling were the main content of the peer education program. However, with more research and information becoming more available, peer educators are finding themselves in a position where they are unable to cope with the level of demand for new information by clients in the peer education programmes. Members of the church are increasingly coming across new information that needs to be included in the revised peer education curriculum. A number of clients have updates in the HIV and AIDS management that will require peer educators to likewise update themselves with a series of trainings if their role as peer educators will still remain relevant in the present time. As discussed before, new information is in the areas of HIV Counseling and Testing, PMTCT, palliative care services, ART, nutritional assessment and counseling, breast feeding of mothers on ART and TB/HIV integration. All these are new fields that peer educators in church settings will contend with unless they are addressed now.

#### **5.4 Guidelines to improve the current peer education curriculum run by Africare-South Africa to align them with the HIV and AIDS knowledge level of the pastors in Whittlesea area**

Based on the discussion in the previous sub-section, guidelines to improve peer education programs will cover some of the following areas:

**5.4.1 Geographical coverage of the current peer education program:** peer education programs need to increase in coverage from Whittlesea where it was operational to new other areas within Chris Hani district as a starting point. These areas include Queenstown, Ezibeleni, Ilinge and the surrounding communities. More pastors and members of the congregation also need to be trained to take care of the proposed expansion of the program in the new areas. This is also to acknowledge the fact that the current content of the peer education program is still very relevant to the masses in HIV and AIDS management.

**5.4.2 Population coverage:** Given that peer education programmes are effective in reaching masses at minimal costs as already discussed; more people need to be reached with HIV and AIDS awareness and prevention education messages. The relevance of these messages as explained above is still being emphasized despite the fact that these messages have been shared for a long period of time. One would think they have lost their significance in the fight against HIV and AIDS but they have not, instead peer educators have advocated for increase in focus areas as explained, for example, in the areas of ART treatment, side effects and adherence education rather than prevention education as discussed in the focus group discussion. To increase population coverage, the church peer educators would seemingly need to recruit more peer educators to absorb some members outside church cycles to include peer educators such as migrant farm workers, sex workers, informal traders, long distance truck drivers in specific designed spots and those abusing alcohol and drugs. These are very vulnerable groups of people that need assistance from as many peer educators as possible but have inadequate help in the region especially Queenstown and Tarkaastad with high levels of such target groups. The church is a respectable institution with membership of all the groups of people mentioned above. The church remains a potential vanguard of change if the peer education programmes is well

developed and managed by peer educators because of the influence they wield over the people belonging to their respective faiths.

**5.4.3 Selection, recruitment and deployment of peer educators:** The peer educators in the church settings should undergo a more democratic process in the selection, recruitment and deployment of new peer educators. Leaving the entire process to be controlled by pastors or only key members of the leadership can in a long run be counterproductive in that it is authoritarian. Although this may not be easy to change given the nature of church politics and administrative protocol. Open systems will encourage innovative capabilities of the youth. The democratic process of selection, recruitment and deployment of peer educators will ensure that only committed and those recommended by the congregation get to play an active role as a model to promote HIV and AIDS awareness and prevention education among the church members. This in turn influences deployment of the already trained peer educators to places where the peer educators are most wanted in the church. This also promotes willing participation, ownership, accountability and transparency; healthy for organization development.

**5.4.4 Curriculum content of the peer education program:** from the discussion above, the curriculum content of the peer education program needs to be expanded to include current issues in HIV and AIDS management. These areas of inclusion need to be based on a consultative process involving the church as a whole and other stakeholders directly working with the church. A consultative process is important in that it promotes participation, ownership, accountability, transparency and sustainability of the peer education program as mentioned in the previous sub-topic above. The other stakeholders include; the Government, Department of Health, Social Development, Education, Police and Correctional Services that are stakeholders with the peer education program in the Whittlesea area.

**5.4.5 Selection, recruitment and training of Peer Educators:** Given that the current peer education program runs for 5 days to complete a basic content; revised curriculum content will definitely affect the number of days needed for training in the revised peer education program. The selection and admission for training also needs a

rigorous, clear and transparent process that will give the peer education programme a big boost. In addition, aligning training of peer education programmes to accredited institutions may create a sense of commitment among the peer educators. Accredited trainings in South Africa provide career paths for a number of community health care workers who in most cases are volunteers with no clear professional direction. This therefore provides hope to these community health care workers. Accredited trainings also mean that peer education as role models get to train other peer educators as accredited trainers with the authority from awarding institutions; usually universities or other level tertiary institutions.

Whereas selection of peer educators heavily lies in the hands of the church leadership, it would be productive to have peer educators chosen in their own merit and preferably by the church board than a single church leader. This can be of help when addressing issues on continuity of programmes. Peer educators should participate from their own free will and arising from the needs of the community. In the 12 churches that participated in the FGD, they have a number of peer educators that include among others: Sunday school teachers, Youth leaders, women leaders, Father's Union, Mother's Union and Women's Manyano. Effective participation and sustainability of all these leaders and others within the peer education programmes will depend on their free will offer and the perceived benefits from the programme.

**5.4.6 Peer education communication strategy:** As far as the peer communication strategy is concerned, the two methods used; large community events and peer to peer approach are still so far the most effective methods of communicating peer education messages to the masses. The merits of peer education worldwide are being able to reach a good number of people across a geographical divide with limited resources and quality communication (Singhal et al., 2003 and Sriringanathan et al., 2010). These same approaches to peer education are still good and reliable even when peer education is improved to increase coverage and content. However, what needs to be emphasized is that peer to peer approach yields more quality results than large community events that runs a risk of duplication of the same people reached since in large community events, there is a possibility of the same people being reached with the same messages and thereby causing message fatigue. In the case of peer to peer

approach, it becomes much easier to measure the quality of the programme and behavioral change (change of attitudes and practices of healthy sexually choices). The two areas discussed above can be measured more effectively with the peer to peer message approach particularly through close touch interaction with the peer educators.

**5.4.7 Peer education linkage and referral systems:** As communicated before, the linkage and referral system is mainly being done with the 22 health facilities in the Whittlesea area. Clients are referred for services in these health facilities and in some instances clients get referred from the health facilities to other stakeholders depending on which service is being offered by a particular stakeholder. This linkage provides a continuum of care for the clients who are HIV-positive between the health facility and the churches in the community. The only challenge with this system is that documentation of client encounters is limited and sometimes lacking. There are no indications that referrals being made between the church and the health facilities ever took place. Secondly, even if referrals were made, there are also no indications that clients ever got the services for which they were referred. This also includes all forms of interactions and encounters with referral service providers.

One of the basic requirements of an effective system is the use of referral slips between service providers UNFPA (2005). This referral slip is usually a two way type communication between the facility as a receiving institution and church and back again. From the sender, it is referring a client to a particular service provider and on the side of the receiver of the client (institution); it clearly stipulates the services to be received by the client. Also the design of this referral slip should be done in such a way that all stakeholders are involved in the design such that all their needs are met in the referral slip. This also creates a sense of ownership of the referral slip by all the stakeholders involved. Once referral slips are put in the provision of the continuum of care, the peer education agenda in the church will inevitably improve as well.

**5.5 Peer education sustainability plans:** The peer education programme has been a very good and effective approach to HIV and AIDS management as discussed earlier in the Whittlesea area. However, the programme began having a challenge soon after

Africare South Africa withdraw her funding support in 2009 arising from a structural adjustment within their organization. As a result of this, the peer education programme with the pastors suffered a great deal. The peer education program could no longer function effectively. A number of peer educators lost their clients and as some peer educators also lost confidence in working with the organization and left on their own free will. Peer educators lost direction to run the peer education program as well. Funding of any program therefore becomes critical in running any peer education programme. It is now advisable that peer education programmes seek alternative funding sources to keep their organizations running. Funding opportunities need to be diversified to take care of financial instability of organizations. Secondly, ownership and accountability of the organization should involve parent organizations of the church such as the South Africa Council of Churches, Government Departments of Health, Social Development and Education who sometimes have alternative source of funding.

Thirdly, the peer education programmes need to be designed with exit strategies such that by the time the project ends; there is a clear strategy on how to move the project forward beyond donor funds. This strategy includes training the human resources to prepare for takeover with a huge budget placed on long term sustainability of the human resources running the peer education program on their own. The resources of the organization should be set in such a way that capacity has been built to deal with hard times. This would require building human capacity needs in such a way as to prepare for hard times ahead when resources have dwindled.

Finally, programme reports should be available at all times to demonstrate the viability of the peer education programme and its effectiveness to promising funders. These reports should be shared with any available donor on a regular basis. In this way, donor funding does not affect the sustainability of the peer education programmes rather it should be seen as a critical support aspect for the continuity of any peer education programme.

## 5.6 General Recommendations

Based on the above, the study further recommends the following:

**a). Comprehensive training with an expanded curriculum content:** Pastors as peer educators should be given more comprehensive peer education programme training with an expanded curriculum content if they have to remain relevant as role models in peer education programmes within the church setting.

**b). Inclusion of more pastors into the Peer Education Programme:** More pastors need to be trained to effectively manage the expansion of the peer education programme in the church and the surrounding communities given the relevance of peer education programmes.

**c). More funding required to run Peer Education programmes:** Sustainable peer education programmes in the church will require more funding. The church is challenged to seek alternative sources of funding to run their programmes after donor funding. Peer education programmes in this case should have clear exit strategies where their programmes have definite ends.

**d). Central position of health desks:** The use of health desks should be strengthened because they remain the centre of peer education programmes in the church today.

**e). Development of a new Peer Education Curriculum:** Developing new peer education curriculum content needs a consultative process involving all stakeholders in the church and surrounding communities.

**f). Accredited peer education training required:** All peer educators in the church should undergo accredited peer education training where they receive certificates of training from a recognized tertiary institution. This will enable peer educators to have career paths for those who would like to move on with peer education and also to motivate peer educators to be fully committed to the peer education programmes.

**g) Regulated peer education programmes nationwide:** All peer education programmes in South Africa should be regulated and controlled by a central authority

irrespective of the type of target group peer educators. This will ensure that standards in peer education across the country are maintained with basic minimum standards to serve the community anywhere in the country.

In all, this chapter provided some insights processes of peer education programmes among the pastors in the Whittlesea area. In particular, it was able to give alternative ways of understanding main ideas that have been discussed from the beginning of the study report as a way of improving peer education programmes. Some of the ideas include expanding the peer education programmes, increasing the participation of the stakeholders in peer education programmes and increasing participation, ownership, accountability, transparency and sustainability of the peer education programmes particularly diversifying the sources of finances to enable programmes run effectively beyond done support.

## Chapter 6: Conclusion

**6.1 Conclusion:** In conclusion, the study has shown that peer education is still a good programme that can be effectively used as an approach to run HIV and AIDS awareness and prevention education programmes particularly in church settings where congregations are already mobilized. Peer education programmes in the church have been able to reach a good number of the people with minimum resources. The use of large community events during weddings, funerals and interdenominational meetings facilitated by pastors has been effective in reaching the masses meanwhile the peer to peer approach to peer education has been more effective and provides quality to the programme. Meeting individuals in small groups and as individuals ensures that clients are able to finish peer education programmes. With this one may hope that people involved can be able to change their behavior positively for the better; which is the essence of the peer education programme.

The study also established that the level of knowledge of pastors in the peer education seemed to be good and up to standard. This is because peer education had a specific curriculum content tailored to pastors familiar to them. This also enabled them to reach their specific target groups in the congregations with basic HIV and AIDS information, abstinence and being faithful messages. These target groups included: Sunday school, women groups and the youth.

The study also identified gaps in the current peer education program. This is due to the fact that the tailor made curriculum content did not include all the knowledge aspects of an all-encompassing peer education program. As a result, the study found it fitting to recommend that the curriculum content currently under use be expanded to include the missing gaps in peer education programmes. This should be designed for use in the HIV and AIDS management in such areas as HCT, PMTCT, ART and adherence, nutritional assessments and counseling and breastfeeding for HIV-infected mothers that heavily impact on care and support for clients infected with the virus.

## **6.2 Limitations of the study**

The use of one moderator could have provided a short fall and increasing the risk of bias in the study because the results are solely dependent on the moderator's interpretation of the responses although the instructions to the moderator was to record verbatim whatever the participants were answering in response to the questions they were being asked in the focus group discussion. The use of at least two moderators would have helped rule this out. Secondly, the use of only 12 pastors out of 40 participating in the peer education program from a pool of 300 churches in the entire Whittlesea area is also limiting as it does not make it possible to generalize the findings from this study to the general population. Responses generated from the study cannot be established as concrete facts but proxy answers. A big population could have given the study the benefit of generalizing the results of the study.

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## Appendices

### Appendix 1: Focus Group Discussion Guide Questions



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jou kennisvenoot • your knowledge partner

Objective 1: To establish the levels of HIV/AIDS knowledge among pastors participating in Africare-South Africa Peer Education Programmes in the Whittlesea area.

1. What is HIV?
2. What is AIDS?
3. How can a person be infected with virus?
4. What are the modes of HIV transmission?
5. Can someone be infected with the virus by kissing; sharing cups, plates and clothes with someone is already infected with HIV?
6. Does HIV have a cure?

Objective 2: To find out what the knowledge aspects currently covered in the Africare-South Africa Peer Education Programme.

1. Do you find these topics / areas easy to pass across to members of your church?
2. Do you think that members of your church understand these topics / areas?

Objective 3: To identify the gaps between the current Peer Education Programme Curriculum and the level of HIV/AIDS knowledge of pastors involved with the Africare-South Africa Peer Education Programme in the Whittlesea area.

1. Do you know all the topics / areas covered in your peer education programme?
2. Do you understand all the topics / areas currently covered in your peer education programme?
3. What topics / areas would you want to include in your peer education programme that you think are currently not included or left out in your programme?
4. What topics / areas would you want to exclude in your peer education programme?

Objective 4: To provide guidelines to improve the current Peer Education Programme Curriculum run by Africare-South Africa to align them with HIV/AIDs knowledge of the pastors in the Whittlesea area.

1. What suggestions would you provide to help improve your peer education programme?
2. What topics / areas in your current curriculum would you share or communicate differently to members of your church?
3. What new information has been provided by Government or Africare-South Africa that needs to be included in your current curriculum of peer education programme?

## Appendix 2: Peer Education Guide Questions for Individual Churches



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- 1). Explain how this particular church recruited peer educators from within the church to do the peer education programme?
- 2). Explain how this particular church recruited peer educators from outside the church to do the peer education programme in their churches? (This is if the pastor recruited another pastor from another church)
- 3). Explain who in your church was involved in recruiting pastors from outside the church for the peer education programme?
- 4). Explain who in your church was involved in recruiting members of the church for the peer education programme?
- 5). Give the number of peer educators that you recruited in your church for the peer education programme.
- 6) Give the number of peer educators that you managed to recruit from other churches?
- 7). How many people did your peer educators reach in your peer education program in the church?
- 8). How many people did your peer educators (recruited by you) reach in other churches in their peer education program?

### Appendix 3: Informed Consent Form



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jou kennisvennoot • your knowledge partner

#### STELLENBOSCHUNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

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#### **The Effectiveness of Africare-South Africa Peer Education Programme among Pastors in the Whittlesea area.**

You are kindly requested to participate in a research study that will be conducted by Barnabas Opio Ikuya as part fulfillment of his Masters of Philosophy, HIV/AIDS Management Degree, from the Economical Management Science Department at the University of Stellenbosch. You were selected as a possible participant in this study because of your involvement in the Africare-South Africa Peer education Programme as a Church Peer Educator in the Whittlesea area. I would like to find out how being a Peer Educator in the church setting has helped you to conduct HIV/AIDS activities in your church.

#### **1. PURPOSE OF THE STUDY**

The purpose of this study is to investigate how Africare-South Africa HIV/AIDS Peer Education Program can be improved among the pastors and their congregations in order to ably fight against HIV/AIDS in the Whittlesea area.

#### **2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

- a. Arrival early to the venue of the discussion. You will be a group of 12 Pastors from Whittlesea. You need to arrive on time such that the discussion can begin on time and end on time. The time of arrival will be 8.30 a.m. and the discussion will then start at 9.00 a.m.
- b. Focus group discussion: The discussion will be called a focus group discussion. This is a discussion where I will ask you questions about your Peer Education Programme. We shall all

be seated in a circle facing each other. I will introduce you the topic, aims and objectives of the study and answer all questions that need clarity before we start the discussion. Before starting the discussion, we shall briefly formulate a few rules to help us go through the discussion exercise.

- c. Questions and answers during the focus group discussion: When I ask a question, it will be answered by one pastor at a time because I will need to know how this question applies to all the pastors with their Peer Education Programmes. Every answer should last about 2 minutes to allow others to respond to the same question or to have further discussion of the topic under discussion. I will have 10 questions to ask during our discussion.
- d. The length of discussion: The discussion will last about 2 hours only. I will request you to be patient for the 2 hour discussion.
- e. Participation: All pastors will be expected to freely share their ideas about their Peer Education Programmes because each pastor in the discussion comes from a different church with different backgrounds, levels of achievements, lessons learnt and best practices to share in their Peer Education Programme. All participants will be expected to respect the opinions and ideas of the other.
- f. Recording and note taking: I will also record and take notes of our discussion that day to help me remember about our discussion when writing my final research report. I will have two people who will help me with recording and note taking. I will need your permission to be part of the video recording. After writing up the report of the discussion, I will no more keep the video recording of the discussion. I will erase the video recording after the research study exercise.
- g. Rules: We shall formulate rules for that day to allow us finish the exercise smoothly and in an orderly manner.

### **3. POTENTIAL RISKS AND DISCOMFORTS**

I do not foresee any serious potential risks and discomforts in this study.

### **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

This study will benefit all the pastors who participate in this research study in that the results of this discussion and evaluation will help each one of them to improve their work on HIV/AIDS Management in their church Peer Education Programmes. The study is establishing the knowledge gap in the implementation of their Peer Education Programmes. When the study identifies this as a need, a mini plan to address this will be shared with the South African Council of Churches at Queenstown Regional level. I plan to provide guidelines to improve the current peer education curriculum run by Africare-South Africa to align them with the HIV/AIDS knowledge level of the pastors in the whole Whittlesea area.

Overall, this study or research will generate new ideas that will be built into the already existing peer education model strategy of HIV/AIDS community mobilization, awareness and education among the pastors and their congregations in the Whittlesea area.

## **5. PAYMENT FOR PARTICIPATION**

All the pastors who will participate in this research will be doing this out of their own free will to assist me and will not be paid any money whatsoever. Again, whoever wants to pull out of the study because of none payment or any other reason is free to do so at any time.

## **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of keeping the information from the focus group discussion secret. I will keep the information from the focus group discussion in my computer that has a password. Nobody has access to my computer. All discussions will be produced in a report which will be my dissertation to the part fulfillment of the Masters of Philosophy Degree in HIV/AIDS Management at the University of Stellenbosch.

My direct Study Leader Mr. Burt Davies guiding me in this study from the University of Stellenbosch and the University of Stellenbosch Africa Centre for HIV/AIDS Management will have the privilege of receiving this information for the purpose of assessing my research work from the pastors in the community as part of my studies at the University.

As mentioned earlier, all the participants of the focus group discussion will have a right to review or edit all the materials produced and generated from the discussion. After writing my research findings, I will provide the pastors with a copy of the report produced from the focus

group discussions. I will also supply a copy of this report to Africare-South Africa to identify with the findings of the study given that they are stakeholders in the church peer education programmes in Whittlesea area.

Finally, I will erase all video recordings of the proceedings of the focus group discussions and any other written materials other than the final or research report arising from the research study after the research exercise.

## **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

## **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact Mr. Barnabas Opio Ikuya [Investigator], cell number 079-515-2569, Address: 7 Ridgeway Road, Amalinda, 5201, East London; email address: [Banapati@gmail.com](mailto:Banapati@gmail.com) and Mr. Burt Davies [Study Leader] telephone number 021-808-3707; email address [burt@sun.ac.za](mailto:burt@sun.ac.za) University of Stellenbosch, Africa Centre for HIV/AIDS Management.

## **9. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms. Maléne Fouché [[mfouche@sun.ac.za](mailto:mfouche@sun.ac.za); 021808 4622] at the Division for Research Development.

## **10. PERMISSION TO ACCESS AND USE PROJECT PERFORMANCE RECORDS**

As a member of this church / pastor, I hereby sign below (bottom of consent form), on the behalf of the church, as consent to allow you [Researcher] to access and use information that has been generated and documented by your Peer Education Programme project.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to [*me/the subject/the participant*] by [*name of relevant person*] in [*Afrikaans/English/Xhosa/other*] and [*I am/the subject is/the participant is*] in command of this language or it was satisfactorily translated to [*me/him/her*]. [*I/the participant/the subject*] were given the opportunity to ask questions and these questions were answered to [*my/his/her*] satisfaction.

[*I hereby consent voluntarily to participate in this study / I hereby consent that the subject / participant may participate in this study.*] I have been given a copy of this form.

\_\_\_\_\_  
**Name of Subject / Participant**

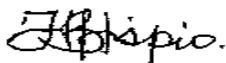
\_\_\_\_\_  
**Name of Legal Representative (if applicable)**

\_\_\_\_\_  
**Signature of Subject/Participant or Legal Representative**

**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_ [*name of the subject/participant*] and/or [*his/her*] representative \_\_\_\_\_ [*name of the representative*]. [*He/she*] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/\*English/\*Xhosa/\*other*] and [*no translator was used/this conversation was translated into \_\_\_\_\_ by \_\_\_\_\_*].



05 April 2011

**Signature**