Are peer educators less inclined to engage in unsafe sex and in contracting HIV/AIDS?

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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

The research focuses on how peer educators and ex-peer educators are influenced by the peer education and if they have practised what they teach their peers. I focused on the impact of peer education on peer educators and to see if peer educators engaged in unprotected sex just like any ordinary youth who has not been exposed to HIV/AIDS education at school. Do youth at the schools see peer educators as role models? Is the HIV/AIDS intervention empowering the peer educators from getting HIV/AIDS infection? Does the intervention of HIV/AIDS peer education prevent the peer educators from practising unprotected sex? Are peer educators less inclined to engage in unsafe sex and in contracting HIV/AIDS than ordinary students? I sought answers to these questions.

This research was done in two selected schools in the Western Cape. The first school, Kaya Mandi High school's ex-peer educators were a product of an NGO a initiative of Christo Greyling called "I Have Hope" sponsored by Old Mutual and Love life. The second school, Fezeka High had peer educators who were products of Gold peer education a venture between the Department of Education and the Department of Health.

Data gathering was done through qualitative research by having focus groups from each school. The interview schedule used to collect data from the students and teachers of the designated schools. Data collected from the Department of Education as well as the Department of Health to show how peer education is implemented in the province.

The data analysis has shown that although peer education is effective, peer educators do engage in unprotected sex and others do fall pregnant or impregnate fellow students.

Opsomming

Die navorsing het gefokus op portuurgroep-opleiers en hoe hulle beïnvloed word deur portuuropleiding, en of hulle dit beoefen wat hulle aan hulle portuurgroepe meedeel. Daar is na die impak van portuurgroep-opleiding gekyk en daar is vasgestel of hierdie portuurgroep-opleiers ook hulself blootstel aan onbeskermde seks soos gewone jeug in die skool wie nie aan MIV/VIGS inligting blootgestel is nie. Sien die jeug in skole die portuurgroepopleiers as rolmodelle? Bemagtig die MIV/VIGS intervensie die portuurgroepopleiers teen die infeksie van MIV/VIGS? Verhoed die intervensie van MIV/VIGS portuurgroep-opleiding die beoefening van onbeskermde seks deur die portuurgroepopleiers? Is portuurgroepopleiers meer waarskynlik om in onbeskermde seks deel te neem en om MIV/VIGS te kry? Die navorsing het gepoog om antwoorde vir die vrae te kry..

Hierdie navorsing is in twee onderskeie skole in die Wes-Kaap gedoen. Die eerste skool, Kaya Mandi Hoër se eksportuurgroep leiers was ‘n produk van ‘n NRO, ‘n inisiatief van Christo Greyling genoem ‘ I Have Hope’ wat deur Old Mutual en Love life geborg was. Die tweede skool, Fezeka Hoër, het portuurgroepopleiers wat ‘n produk was van Gold portuurgroepopleiding, ‘n onderneming tussen die Departement van Onderwys en die Departement Gesondheid.

Data insameling was gedoen deur kwalitatiewe navorsing deur middel van ‘n fokusgroep in albei skole. Die onderhoudskedule was gebruik om data van die studente en onderwysers van die geselekteerde skole te verkry. Data was ook versamel van die Departement van Onderwys sowel as Departement Gesondheid om te wys hoe portuurgroepopleiding in die provinsie geïmplimenteer word.

Die analise van die data het gewys dat alhoewel portuuropleiding effektief is, portuuropleiers wel onbeskermde seks het en ander wel swanger word of mede studente swanger maak.

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1. Introduction

In most schools in sub-Saharan countries, HIV/Aids education was implemented by non-governmental organisations (NGOs) (UNAIDS, 2004). For example, in South Africa the 'I Have Hope Peer Group' implemented HIV education in some schools and not all schools did have peer education programmes. I Have Hope is a project of Old Mutual, which was devised by Christo Greyling (Hildebrandt, 1999). Only after July 2004 did most high schools implement a system of uniform peer education, called the Generation of Leaders Discovered (Gold) according to Peter Fenton, the coordinator of peer education in the Western Cape.

Young people's perception of HIV/Aids is as something that will only happen to someone else, this resulting in having high-risk sexual behaviour. They perceive their chances of contracting STIs as being low, as they think that they are infallible. For this reason, it is essential that young people become involved in Aids prevention programmes. Peer educators work by endorsing healthy norms, beliefs and behaviours within their own peer group or community, challenging those who lead unhealthy lifestyles (UNO DCACP, 2000, cited in McDonald, Grove & Youth Advisory Forum Members, 2001).

Peer education does play a role in the lives of peer educators, though some of the latter have claimed that such education has not tended to change many of the already fixed ideas. Some of the peer educators themselves engage in unprotected sex, falling pregnant or impregnating others. Peer educators have stated that they think that it is difficult to abstain from sex, once one has started to be sexually active. Not all students trust peer educators, with some students not seeing peer educators as role models.

Due consideration should be given to the question of whether peer educators are less inclined to engage in unsafe sex and consequently less prone to contracting HIV/Aids.

2. Literature review

'Peer education' refers to the use of educators of the same age or the same background to convey educational messages to a target group. Peer educators endorse healthy norms, beliefs and behaviours within their own peer group or community, challenging those who are unhealthy to adopt a healthier lifestyle (UNO for Drug Control and Prevention, cited in McDonald et al., 2001). Peer education programmes have been shown to enhance academic performance and to help develop positive attitudes (McAleavy, McCrystal & Kelly, 1996). Such programmes are aimed at changing attitudes and behaviour (Coggan, cited in McDonald et al., 2001). Peer-led interventions have proved effective in facilitating the access of young people to services and in distributing HIV/Aids prevention devices (Adamchak, 2006). Young people develop their attitudes and behaviour patterns during adolescence (Maslash et al., 1997). Therefore peer education should be implemented during adolescence. For HIV/Aids programmes to be most effective, they must define the context in which those for whom the programmes are intended live. Supportive networks and institutions should be used to mobilise the key stakeholders, consisting of the parents, teachers, health workers and religious leaders, in response to the prevailing social norms and community context (Adamchak, 2006). Peer education can be considered the first step in facilitating community change (Rhodes, 1994).

During peer tutoring, many young people have been shown to complete tasks on time and to adopt a purposeful and self-directed approach, which they might not in untutored situations (Topping & Whiteley, 1993). Young people undergoing peer counselling are more likely to engage in interactive discussions following such intervention, than when they are counselled by adult health care providers (Rickert, Jay & Gottlieb, 1991). Peer tutoring promotes the development of more positive social relationships and more independent learning. Young people tend, under such tutoring, to develop a more positive attitude towards each other, as well as towards the peer education programme itself (Topping & Whiteley, 1993). Peer counsellors generally tend to be able to encourage relatively far-reaching attitude change among young people regarding their perception of

their personal risk of HIV infection, as well as a relatively high degree of positive change in personal attitude towards helping to prevent transmission (Rickert et al., 1991).

Knowing that HIV/Aids can kill, as well as be prevented through abstinence or the use of condoms, is not always enough to change a young person's behaviour (Campbell, Foulis, Maimane & Sibiya, 2004). The form of education that leads to behaviour change remains the cornerstone for the prevention of HIV/Aids infection (Slap, Plotkin, Khalid, Michelman & Forke, 1991). The information obtained by way of HIV/Aids prevention programmes appears to compete with other information coming from community and church leaders, with many of the latter, for example, preaching that sex is sinful. Many parents refuse to acknowledge that their children are sexually active. Many young people experience sex as a source of pleasure and fun, though they are afraid to admit this for fear of the disapproval of others, as well as for fear of earning themselves a bad reputation or for fear of being punished (Campbell et al., 2004). Another contradiction is that, while many people die of HIV/Aids, people tend to hide the nature of their illness. Families also tend to hide the sick, depriving young people of the chance of learning about the amount of pain and suffering associated with HIV/Aids (Campbell et al., 2004).

In a study of fifteen-year-olds, female tutors were proven to be more successful than were their male counterparts (Topping & Whiteley, 1993). Though female subjects have been found to score higher than male subjects do on knowledge and attitude scales pertaining to HIV infection, the former tend to find it difficult to change their own sexual behaviour. The higher level of self-worth found among female subjects participating in HIV/Aids-related studies is consistent with the recognition that many cultural and educational messages to do with sexual safety are often directed towards girls and young women, rather than towards boys and young man. The intention to practise safe sex has also been identified as a female quality (Siegel et al., 1998).

Generally, in line with the finding that males tend to benefit more from the use of female, than male, tutors, so, too, do males also seem to benefit more than females do from being tutored (Topping & Whiteley, 1993). Male decision-making characterises the style of

interaction within a mixed group of peer educators, with the female peer educators feeling bullied when they felt called upon to challenge their male colleagues, despite the fact that all participants in the group were assured that they had the right and chance to be heard (Campbell & MacPhail, 2002).

Young people are an important source of information and clearly influence behaviour, with peer counselling offering an effective alternative to traditional health education (Slap et al., 1991). Female participants were found, in the research conducted by Campbell and MacPhail (2002), to be more at ease in discussing sex and relationships with their same-sex peers, while the male participants in the same study tended to react with aversion to discussing such subjects with their same-sex peers.

If knowledge, self-efficacy and intention are related, change in mindset must precede change in behaviour. Females tend to respond positively to interventions aimed at inculcating the intention to practise safe sex (Siegel et al., 1998). Peer education has been shown to be an effective method of facilitating and sustaining HIV-related behaviour change (Rhodes, 1994). Interventions using peer education methods and norm-changing strategies have been proved to be relatively successful in achieving risk reduction, in relation to more individually focused health education. Peer education is aimed at supporting those social relationships that influence sexual practices. Facilitating changes in social relationships is achieved by endorsing healthy norms, beliefs and behaviour and challenging unhealthy behaviour. Peer education can be viewed as a means of encouraging social change (Rhodes, 1994). Such change in the behaviour of youth can serve to decrease their risk of contracting HIV/Aids, by encouraging them to communicate with others about HIV/Aids, as well as by encouraging them to delay their engaging in sexual acts, to practise abstinence, to reduce their number of partners and to use condoms (Gallant & Maticka-Tyndale, 2004). Peer educators have also claimed to gain a great deal from being part of the programme. They have stated that they can more easily understand those affected and infected with HIV/Aids than before they were involved in such a programme. Peer educators have also said that they found it easier to speak to their peers about sex than to talk to adults about the topic.

3. Limitations of peer education

Milburn (1995) states that, in order to achieve behaviour change among young people, a multisystem approach is needed to convey a consistent message to them. Such an approach should consist of five levels: the individual intrapersonal; the school; the interpersonal and peer system; the family; and the community. In other words, changing behaviour requires an approach that involves the whole community (Milburn, 1995). Stewart et al., (2001) found that many programme planners tend to see schools as a convenient venue for the implementation of HIV/Aids prevention programmes. Whether school programmes can do more than teaching about the need to adopt safe sexual behaviour is debatable. Peer education entails the implementation of positive youth development programmes. However, human behaviour and environmental contexts are difficult to control, manipulate and measure (Meyer et al., cited in Milburn, 1995). Campbell et al. (cited in Flisher, Wolf, Selikow, Ketye, Pretorius & Mathews, 2006) state that knowledge is not equal to behaviour change, and that change cannot be viewed in isolation. It is increasingly acknowledged, both in Africa and elsewhere, that factual knowledge about HIV/Aids, although necessary, is only a weak determinant of sexual behaviour. Establishing a system of peer educators should never be considered the sole goal of an Aids prevention project, though. A peer education system is only one of many preventative activities, including seminars, workshops and regular field activities, which can be employed to ensure the implementation and maintenance of an effective sex education programme (Brussa & Mongard, 1998).

An evaluation report into prevention research criticises aspects of peer education, including its limited nature, its lack of theoretical roots, its inadequate dissemination and its inadequate grasp of the concept of empowerment. The concept of peer education is not grounded within a specific theory, meaning that the related programme strategy does not envisage clearly delineated outcomes (Milburn, cited in Goren & Wright, 2006). According to Walker and Avis (cited in Goren & Wright, 2006), the programme design of peer education has not yet succeeded, due to factors relating to its design and implementation. They found a lack of clear and realistic aims and objectives for the

project; an inconsistency between the project design and the external environment constraints; a lack of social and financial investment in peer education; and a lack of awareness that peer education is a complex process, intended to be managed by highly skilled personnel.

According to Polis and Upenieks (2003), peer education is not a panacea for all problems. An appropriate environment is crucial for peer education to be successful, with project coordinators having to be able to respect the views of young people and having to be able to work with them. Such a form of education requires adaptation to specific surroundings, which should help to ensure the provision of age- and stage-appropriate education. Peer education should be just one element of a comprehensive education. However, McCrady (cited in Goren & Wright, 2006) found that many evaluation studies have tended to rely almost exclusively on self-reported changes in attitudes and behaviour.

Peer educators have tended to disseminate information within a relevant peer network, with them lacking the power to determine the nature and the type of information being delivered. As such, they have spoken with the voice of adults, who have had the ultimate responsibility for the dissemination of information (Milburn, 1995; Parkin & McKeganey, cited in Goren & Wright, 2006). Young people have, in the past, been so flooded with HIV/Aids-related information, that they have grown tired of it. As a result, they have started to ignore such information (Campbell & MacPhail, 2002).

Female peer educators have felt so bullied in the past that it has led to some such educators resigning from the project (Campbell & MacPhail, 2002). According to Cowan (2002), initiating prevention interventions while young people are still sexually naïve and before patterns of risky sexual behaviour have become entrenched, is better than trying to change established behaviour. According to Slap et al. (1991), “few strategies have been able to improve adolescent protective behaviour. They found that most studies have failed to demonstrate either improvements in actual preventative behaviour, or an improvement in attitudes towards sexual behaviour. However, young people have been

shown to mistrust peer education about HIV/Aids, with them valuing the information provided by adult health care professionals more than that coming from their peers.

The dissemination of information is more effective while students are still young and naive. Peer educators have stated that they think that it is difficult to abstain from sex, once one has started to be sexually active. Not all students trust peer educators, with some students not seeing peer educators as role models. Peer education does play a role in the lives of peer educators, though some of the latter have claimed that such education has not tended to change many of the already fixed ideas. Some of the peer educators themselves engage in unprotected sex, falling pregnant or impregnating others. Community involvement has been found to be very limited both in, and between, schools. Only individual peer educators tended to participate and become involved in their communities.

4. Methodology

4.1 Research objective

Are peer educators less likely to engage in unsafe sex and in contracting HIV/AIDS?

The objective of this research is to see if peer educators are less inclined to engage in unsafe sex and contracting HIV/AIDS. Can peer education be used as an HIV 'vaccine'? The term 'vaccine' is used to refer to the possibility of using education to limit or even prevent HIV infections among the youth. The research made use of focus groups and dealt with ex-peer educators and peer educators. The major objective is to see whether peer educators do adhere or conform to the teaching that they have received. The designated schools were Kaya Mandi High and Fezeka High School.

4.2 Research design

This is a qualitative research which consisted of two focus groups, which were made up of six ex-peer educators in Kaya Mandi High School in the Stellenbosch area and the other focus group was with peer educators from Gugulethu, Fezeka High school near Cape Town. Two teachers from each of the designated schools. Six students who from each school who are not peer educators. There was an interview with the coordinator of peer education in the Western Cape Education Department (WCED). Focus group research entails an organised discussion with a selected group of individuals to gain information about their views on and experience of a topic. Benefits of this type of research include gaining insights into people's shared understanding of everyday life and the way in which individuals are influenced by others in a group situation.

4.3 Sampling

All the students that participated in the focus groups were peer educators and ex-peer educators who had been trained peer educators, plus six students from each school who were not peer educators. One of the two teachers was directly involved in peer education, one was not. All the teachers and students were from the designated schools. Also involved; from the Western Cape Education Department, was the coordinator of peer education and from the Generation of Leaders Discovered (Gold). From the NGO the

person was directly involved in training peer educators and was also a coordinator of the NGO. The Young adults were between the ages of 18 and 20. There were six young people in each group.

Students:	Six students from each designated school (three female and three male and they were not peer educators)
Peer educators:	Six students from each designated school (three female and three male that were peer educators.)
Teachers:	One teacher involved in peer education
	One teacher not involved in peer education
Gold peer education:	Coordinator of peer education
Western Cape Education:	Coordinator of the Western Cape Peer Education Department
Criteria Sampling:	Six students from designated school attending school at that time (three male and three female students)
	Two teachers from each designated school
	Promoter of peer education from Department of education
Education:	Peer educators Grade 9-12 and ex-peer educators
	Students between Grade 9 and Grade 12
Ethnicity: Xhosa Speaking)	Xhosa (Kaya Mandi and Gugulethu is predominantly
Areas, location:	Kaya Mandi (in Stellenbosch, Western Cape)
	Gugulethu (near Cape Town, Western Cape)

4.4 Data Gathering

I collected all the data from interviewees: two teachers from each school and six students who participated in peer education at each school. Information was collected from each focus group from each high school and data from the Department of Health and from the coordinator of the Western Cape Education. Information was also collected from a coordinator of Gold peer education and a peer education facilitator in Gugulethu.

5. Research findings

The first stage of the research report entails presenting what I have found in my research, which will be followed by the comparison and analysis of the research data. Finally, I will analyse the disparities between effective and limited peer education and clarify why they exist.

My visit to Kaya Mandi High School led to a discovery that the person who was running the programme of peer education in the school could not provide any tangible information as to what the peer education programme in their school consisted of, though she was informed of my visit in good time. She claimed that all the personnel who were involved in the peer education project were no longer at the school. Her response encouraged me to find out what peer education was actually run in the Western Cape schools.

I had assumed that all the schools in the Western Cape had peer education programmes that had been uniformly and effectively implemented, but through my preliminary investigation the WCED coordinator of peer education confirmed that not all schools in the Western Cape had uniformly and effectively implemented peer education. This resulted in my redirecting the whole research project, as I was going to do a research only in Kaya Mandi on ex-peer educators and how they were affected by HIV/AIDS infection. Having discovered that in the Western Cape not all schools receive peer education, and I had to do research on the peer education in the Western Cape schools, my first stop was the Western Cape Education Department.

The objective of my visit to the Western Cape Education Department (WCED) was to find out more about their peer education programme. I discovered that the schools I was doing research on were on different peer education programmes in different periods. Their first was Love Life peer education, then they predominantly implemented programme is Generation of Leaders Discovered (GOLD) peer education. Both the GOLD peer education programme and Love life intervention were school based interventions. Kaya Mandi High school's ex-peer educators were products of Love life

while the peer educators of Fezeka High School were products of the GOLD peer education programme.

Love life was started in September 1999, it was a broad-based coalition of international foundations working on HIV/AIDS prevention for the government of South Africa. Love Life's main aim is to establish a new model for effective youth-targeted HIV prevention to substantially reduce the HIV infection rate among South African youth (Goozner, 2003). Their approach aims to move beyond do-or-die type of messages and to focus on the real social context in which young people are at a high risk of becoming HIV infected. Some of the Love life strategies to reach out to young people are through a variety, such as television and radio programmes and the Love Train to reach out to communities that do not have youth centres (Flisher et al., 2006). In Kaya Mandi High school it was a school-based community outreach, a peer education programme, that was a Faith-Based Organisation (FBO) initiative of Christo Greyling called "I Have Hope", which was sponsored by Old Mutual and Love life (Hildebrandt, 1999).

At the WCED I found out that peer education was a joint venture between the WCED, the Department of Health (DoH) and the Global Fund Peer Education Project (GFPEP) from July 2001 to July2004, which was before GOLD peer education was formed (Flisher et al., 2006). The selection of schools for the peer education programmes is based on the following criteria which Kaya Mandi and Gugulethu meet: The school must be in either a rural or semi-rural area, preferably a disadvantaged area, and there must be an NGO in the area with the potential to act as service provider (a service provider can be an NGO FBO. The idea is to work with school-going adolescents within communities or people involved in existing youth intervention programmes) (George, 2005). Before the intervention of the three above-mentioned stakeholders (the WCED, DoH and GFPEP), most of the schools in the Western Cape had different approaches to peer education, but that had changed according to the WCED coordinator of peer education. The peer education coordinator of WCED said that the NGOs involved in peer education were for instance, focusing on peer education in HIV/AIDS, music, sport, drama and theatre. There were also Faith Based Organisations (FBOs) with their own peer education programmes, including Moslems, Christians and Jews.

With help from the School of Public Health of Harvard University USA, the above-mentioned stakeholders developed a programme called the Higher Education AIDS Programme. Some of the funds were provided directly by the National Government to the WCED. The WCED coordinator of peer education claimed that the National Government feared embezzlement, that the funds might not reach the WCED, so they were delivered directly to the WCED. Reason for fear of embezzlement was that there was no structure directly involved in managing peer education at the time. The stakeholders could neither afford to run the programme on their own nor could they afford to pay a tender, so an NGO had to be formed to run the programme. This was before the Global Fund peer education programme was the responsibility of HIV/AIDS monitored and evaluated by the Life skills Unit of the Western Cape Department of Education (Flisher et al., 2006).

The GFPEP started their pilot project in 2001, which resulted in the formation and implementation of GOLD, which was completed in 2004. GOLD peer education was first implemented in 2005. GOLD is an umbrella body that had to see that their peer education programme was implemented as required by the service providers. Service providers are normally organisations or independent consultants who are experts in the field of peer education or youth development (Flisher et al., 2006). The service provider of Fezeka High School for example was Leadership South that used to operate in schools before the Gold peer education programme was implemented. GOLD peer education aimed at developing a Common Curriculum and Building Capacity for service providers to enable them to deliver a standardised and monitored product and to evaluate the projects.

Not all the schools in the Western Cape qualified for peer education; out of three hundred and twenty schools only a hundred schools were included in the GOLD peer education programme. All the service providers, NGOs, and other organisations for example Leadership South, implemented peer education before the Gold programme was implemented. According to the WCED they were now expected to provide only Gold peer education in the Western Cape schools. This was the result of the formulation of Gold peer education and the funding from the Global Fund peer education programme. In one of the two schools I selected, Gold peer education was implemented and in the other not. When staff was asked about the peer education programme their response was

positive. When I asked the same question to the peer educators, their response was different. They claimed that very few teachers took an interest in the peer education programme. When I asked students how they perceived peer educators, they claimed that peer educators did not behave better than them, as peer educators engaged in unprotected sex and they knew of peer educators who impregnated fellow students.

During the time I was recruiting ex-peer educators for the focus groups, I came across a ex-peer educator who could not participate in the focus group due to an HIV/AIDS-related illness. I also encountered a peer educator at the Anti Retroviral Clinic (ARV), who was HIV positive. One of the students participating in one of the focus groups was referred to me for CD4 count counselling, (a CD4 count is a test that doctors use to monitor your immune system mostly no HIV positive person to determine the level of the HIV infection / Cell depleted of OKT4) in my capacity as an HIV/AIDS lay counsellor. This incident took place after I had a discussion with the first focus group at my work place as a HIV/AIDS counsellor.

5.1 Response from students from both designated schools

When asked the question of how they feel about peer education they claimed to be well on the way with communicating with their peers. When asked how the school feels about the peer education programme, respondents in both the schools claimed that the teachers who were directly involved in the peer education project were encouraging them to participate in the HIV/AIDS intervention. When I asked the question on the participation of the general teaching staff in the peer education, the students in both schools claimed that teachers in general show little interest in the HIV/AIDS intervention.

I asked whether the students view and see the peer educators as role models. In both schools they claimed that very few peer educators are viewed as role models. Asking why they say so, students quoted of peer educators that had fallen pregnant and others that had impregnated their partners. They claimed that peer educators were appointed by the school project leaders because they were favourites or liked by the teachers involved in the HIV/AIDS intervention.

5.2 Focus group findings

From both focus groups the peer educators claim that most teachers who were not directly involved in peer education were less supportive of the programme than the teachers who were involved.

I enquired about the support the peer educators were receiving from their teachers in the two designated schools. The following are some of the claims made by the two focus groups, meaning ex-peer educators and peer educators:

“We do not talk to our teachers as peer educators.”

“Our teachers do not understand the peer education programme.”

“The teachers do not see the value of peer educators.”

“When you try to participate in class activities as a peer educator the teacher will tell you 'I am not going to stop what I am doing just because you want to do this peer education'.”

“We had peer education for the whole year but most of the teachers did not even know that there was a programme like this in our school.”

“Some of the parents do not want their children to be part of sex education, so the teachers are afraid to teach students about sexuality.”

“Teachers feel that we are not good enough to teach fellow students about HIV/AIDS”

When questioned how peer education affected their lives, male peer educators in both focus groups had common sentiments of what the programme’s impact is on them. They claimed that being peer educators enhanced their image and boosted their self esteem. The female peer educators in both focus groups did not share the same sentiments.

Regarding peer pressure, male respondents in both focus groups claimed that peer pressure was not significant in changing their lives (ironically), while female respondents in both focus groups claimed that peer pressure did play a significant role in their lives.

The higher level of self-efficacy, I found among females, correlated with the fact that most of our cultural and educational messages about sexual safety are directed at girls and young women. The intention to behave in safer ways concerning sex was also a female attribute in this study, which is a theoretically consistent extension of the self-efficacy (Siegel et al., 1998). This caused me to question whether females are more social beings than males.

When I asked the question of how many of them were sexually active before they became peer educators, the majority of the ex-peer educators claimed to have been sexually active before they became peer educators. Three out of six from the second focus group claimed that they had been sexually active before they became peer educators. When asked the question what they think causes young people to be sexually active at an early age, all the groups agreed that good upbringing was crucial in delaying young people from engaging in sex at an early age. When asked if they think that they were engaged in sex at an early age, most of the participants were vague in giving a direct answer. When I insisted on getting a clear answer to the question of early sexual activity, it became clear that the peer education that they had already been exposed to had an influence and that others felt that they were going to expose themselves should they give a clear answer.

When the groups were asked why young people fall pregnant or had impregnated their partners, both groups agreed "teenagers do not care and want to impress their boy or girlfriends". When the groups were asked how many of them fell pregnant or had impregnated their partners during the period that they were peer educators, the peer educators claimed that they knew peer educators who fell pregnant or impregnated their partners. It was always someone who was no longer part of the focus group, but had been part of the previous peer education projects. I asked ex-peer educators whether they had impregnated their partners or have fallen pregnant after they had been peer educators. Some peer educators claimed to have fallen pregnant or to have impregnated their girlfriends and claimed that they wanted to know whether they could procreate. When asked about the possibility of contracting HIV/AIDS, most of them claimed that they had gone for HIV testing first, and only after the result of the test was negative they began planning a baby. The ex-peer educators from the first focus group claimed that it was

difficult to abstain from sex because they had already been sexually active. They stated that it's much easier to abstain if you are not yet sexually active and they raised the question of socialisation as one of the crucial elements in delaying sexual activity among the youth.

When the two focus groups were asked about how other students view them as peer educators the ex-peer educators as well as the peer educators claimed that their peers made them feel like outcasts when they talked about HIV/AIDS in a group situation. A remark such as "you think that you know everything since you became a peer educator" is normal. They claimed that while their peers were irritated with them when they talked about HIV/AIDS prevention in a group situation, those same peers would come to them to talk to them on a one-on-one basis. The peer educators considered correct upbringing to be a crucial element in guiding teenagers to abstain from sex or to practice safer sex.

Peer educators claimed that students who fell pregnant or impregnated their partners were "teenagers who do not care and those who want to impress their boy or girlfriends". Both focus groups claimed that their peers suffered from HIV/AIDS fatigue, and do not want to hear about HIV/AIDS. When I asked whether females should carry condoms (male condoms) the first focus group was divided across the gender line, as females were for it while males were against it. When I asked the same question to the second focus group they did not see anything wrong with females carrying condoms. Regarding the difference between safe and safer sex, most peer educators in the first focus group were confused about what the real difference between safe sex and safer sex was and did not know that safe sex is no sex at all. When the same question was put to the second focus group, six out of eight new the difference. Both focus groups agreed that they were in a better position to understand HIV/AIDS and could relate it to their training as peer educators that they were no longer afraid of people who were HIV positive.

5.3 Comparing the two focus groups

The first focus group from Kaya Mandi High School were ex-peer educators who were no longer attending school. They claimed not to have support outside school. While the second four out of the eight peer educators claimed to have support from their different churches. On the other side the second focus group from Fezeka High School peer educators were school going. The second focus group had support outside school from the Faith Based Organisations (FBOs) with which they were mainly involved. The respondents claimed that they neither engaged in any activities nor had the time to implement the programme in school, as their teachers were negatively compromising any available chances for them to participate in the class environment by not giving them a hearing. In contrast, the first focus group claimed to have engaged in more activities at school in HIV/AIDS prevention programmes. But when asked about activities outside school they claimed that in their community there were no organisations that could be approached to act as vehicles for implementing the programme outside school. They also claimed that they could not even introduce the HIV/AIDS issue in their congregation, as the church elders would never allow them a platform. The reason they gave for this was that the church elders did not understand what HIV/AIDS was all about and that, secondly, it was difficult for them to talk to their elders about matters concerning sex, especially in church. This is one of the contradictions between the two groups.

The respondents from the first focus group claimed that it was difficult to abstain from sex, since they had already been sexually active. They argued that it would be much easier to abstain when one had not already been sexually active. Again the question of how one was brought up was raised. Both focus groups agreed that peer education was important but that upbringing was the crucial point. For the second focus group, abstaining from sex was not an issue, although no-one claimed to be sexually active.

All the respondents agreed that peer education played a vital role in modifying their lives. The respondents were asked whether they knew of any peer educators who were HIV positive, impregnated a girlfriend or of any peer educator that fell pregnant. The respondents claimed that they did know peer educators who were positive, had fallen pregnant or had impregnated their girlfriends.

6. Discussion of findings

In most of the literature that I have read about peer education and the HIV/AIDS intervention, and the effects of peer education including peer educators, the most common debate is the emphasis that peer education is an excellent vehicle for informative purposes. In the informative side of peer education most researchers promote peer education as a leading vehicle. HIV/AIDS intervention should be more about preventative methods and behaviour change according to (Slap et al., 1991), (Meyer et al (1993) cited in Milburn, 1995), (Siegel et al., 1998) behaviour change is more complicated to be measured. Problem about peer education implementation for positive youth development programmes would be simple and neat if human behaviour and environmental contexts could be easily controlled, manipulated and measured (Meyer, 1993 cited in Milburn, 1995).

School based programs aimed at HIV risk among young people seem to have some successes, consistently in the area of knowledge change and in self efficacy and attitudes, but only in the context of substantial content and duration (Siegel et al., 1998). There are many factors that could contribute to the effectiveness or the non-effectiveness of a peer education programme, with many variables that might make a contribution to the effectiveness of the programme concerned. Sexual abstinence and condom use increased during the time young people are exposed to HIV intervention .It is not known however, if this effect will diminish with the time (Slap et al., 1991). Most studies, however, have been unable to demonstrate either improvements in actual preventive behaviour or improvement (Slap et al., 1991).

According to Flisher et al., (2006), George (2005) and Gallant & Maticka-Tyndale (2004), local knowledge, attitudes and culture are taken into consideration in the development of all programmes of HIV prevention, through prior research in the community or meeting with youth and community representatives to identify issues of concern. Yet the peer educators in both focus group claimed that they did not have any NGO active in their area. Those peer educators that were active in their congregations (church) claim to have done that on their individual capacity. Leadership South the

NGO that is said to be operating in Fezeka High schools has its offices situated about twenty kilometres away in an area called Claremont Cape Town. The focus group of peer educators from Fezeka High school did not know that their peer education project its service provider was Leadership South. The NGO Leadership South claimed to be operating at that designated school. Gold peer education states that its programme is inclusive and that all the community stakeholders are represented (George, 2005). The peer educators from the Fezeka High school focus groups disagreed. The inability of older students to translate their greater knowledge and self-efficacy into safe behavioural intention points out the urgent need to focus prevention interventions on the younger population. It may, however, also suggest that for young people the link between self efficacy and behaviour intention is not as tight as theory might otherwise propose (Siegel et al., 1998). Young people develop their attitudes and behaviour patterns during adolescence. If adults tell young people how they should behave themselves, they will resist that and might think that adults want to keep young people from experiencing the pleasures of sex (de Ruijte, 2001).

Both focus groups agreed that peer education played a greater role in modifying their behaviour than when they are taught by older people. The strength of the peer counselling, evaluated in Slap study, is its association with self-reported changes in protective sexual behaviour.

The female respondents in both focus groups, they claimed that peer pressure did play a significant role in their lives. While male peer educators disagreed with them. The higher level of self-efficacy I found among females correlated with the fact that most of our cultural and educational messages that about sexual safety are directed at girls and young women. According to Siegel emphasis of good behaviour is always focused to females (Siegel et al., 1998).

Both focus groups claimed that they are made to feel like outcasts if they talked about HIV/AIDS in a group with their peers: “you think that you know everything since you became peer educator”. Topping say about the tutor and tutee relationship. That

teachers may be worried that peer tutoring could promote unequal relationships and have undesirable effects on the social dynamics in the class, or that the system may foster dependence on the tutors in the tutee, Topping concludes that all these fears can be shown to be without foundation, both through research as well as practical experience (Topping & Whiteley, 1993). According to Slap there is evidence that shows adolescents mistrust peer education about AIDS and prefer that the information come from adult health care professionals (Slap et al., 1991).

In my research when the two focus groups were asked what the teaching staff's response was towards the peer education programme, the respondents claimed that they were mostly deprived an opportunity to implement the programme, especially by teachers who were not directly involved in the programme. The PlusNews confirms this point of teachers not having interest in Life Orientation (LO), a research was done in the University of Pretoria in 2005 and it has been documented that school's ability to carry out LO classes successfully and according to national standards often depends on the teacher's passion for the subject and support from administration, the school principals view mathematics and science as the most important subjects but when it comes to LO any teacher whose available will be asked to fill the LO position sad Peter Fenton chief education specialist manager of HIV/AIDS education of Western Cape Province
(PlusNews 2008).

When I was recruiting peer educators for the focus groups I came across a peer educator who could not participate in the focus group due to illness. One of the students who participating in one of the focus groups was referred to me for CD4 count counselling where I was an HIV/AIDS lay counsellor. In Stewart's research one of the findings was that risk perception can be said to be more affected by the public perception of risk than by an accurate assessment of the student's own behaviour (Stewart et al., 2001). According to de Ruijte young people think they are infallible and this attitude results in high risk sexual behaviour (de Ruijte, 2001). Although the acquired immunodeficiency syndrome (AIDS) is relatively uncommon among adolescents, the high rate in young

adults coupled with the long incubation period of the disease, makes it likely that many infections occur during adolescence (Slap et al., 1991).

When I asked about peer pressure both groups were divided into two camps. Ironically in both focus groups males claimed that peer pressure was not that significant, while females claimed that peer pressure did play a significant role. Going on with this point male peer educators felt that being a peer educator enhanced their image while female peer educators felt otherwise, this supporting the point maid by Campbell that gender does play a divisive role. Campbell also claimed that in one of the peer education projects one of the female peer educator resigned (Campbell & MacPhail, 2002).

In Denmark, youth is seen as a separate phase, and the aim of peer education is to assist in the construction of oneself as a young person. In South Africa and England youth is conceived as a transition to adulthood and emphasis is placed on learning the skills appropriate to adult life (Modern Youth and peer education). "The higher level of self-worth we found among females is consistent with recognition that many of our cultural and educational messages about sexual safety are directed at girls and young women, and not to boys and young men. Intention to behave in safer ways concerning sex was also a female attribute in this study, a theoretically consistent extension of the self-efficacy findings" (Siegel et al., 1998). This led me to question if female students are more socialised to social being than the way males are socialised.

It needs to be an approach that will consist five levels of analysis which are the individual intrapersonal processes, the school, interpersonal and peer system, the family, the community and the social system, in other words to change behaviour an approach is required that involves all the stakeholders. Yet some of the students claimed "we had peer education for the whole year but most of the teachers did not even know that there was a program like this in our school". In a Keith Ross article, 2008, Harrison of Love Life said that teenage pregnancy remains a problem in South African schools, and he goes on to say sex education properly done at schools could protect against both pregnancy and HIV infection because there was a link between early pregnancy and HIV.

The director-general of the Department of Education Palesa Tyobeka sad in the same article that teenage pregnancy was clearly a problem, that the department do not have a subject called sex education but LO its about teaching children about life and is very broad (Ross, 2008).

The contradiction about peer education not working is found in Siegel's research is stated in the following way: "The inability of older students to translate their greater knowledge and self-efficacy into safe behavioural intention points out the urgent need to focus prevention interventions on the younger population. It may, however, al suggest that for adolescents the link between self efficacy and behaviour intention is not as tight as theory might otherwise propose" (Siegel et al., 1998).

Looking in both Gold peer education as well as I have hope project from what I could get out of the two focus groups is that most emphasis was placed in the behavioural intervention and nothing coming from the focus groups even mentioned the structural intervention. Although if you read the literature of both Love life as well as Gold peer education a lot is said about structural intervention. According to the students in both schools the claim is that peer educators are no role models. A female peer educator fell pregnant, with the support of the teacher she was persuaded to continue as a peer educator. Another female peer educator left home to live with her boyfriend, and her mother blamed the programme for teaching her things she was not ready to know (Harrison et al., 2004). I do not think that school programs can ever be strong enough to go beyond improving knowledge and attitudes to increasing the adaptation of safe sexual behaviour (Stewart et al., 2001).

7. Conclusion

The literature supported the notion that young people are rebellious by nature, and the question is do they see this pandemic just as a problem for old people, or as their problem as well? In fact, as previously stated, during my research I came across peer educators who were HIV positive and sick as a result, and could not participate in the focus groups for my research. In my research it has been seen that young people do not do things because these things are right. In most cases they will engage in activities that could be detrimental to their health, among other reasons because they are rebellious. This rebellious nature exists, be it in a peer educator, or in a non-peer educator. An aspect which both focus groups agreed upon, no matter how good peer education program is, it is socialisation that mostly enables youth to delay sexual activities.

Peer education has great overall potential, but as a method it must be adapted to local needs and requirements, catering to the specific characteristics of young people in each individual country (Modern Youth and pee education). It has also been found that prevention intervention of education targeting single ethnic group is more effective than those aimed at more heterogeneous populations the study was done in United States (Cowan, 2002). According to Goren & Wright, the consistency within the research literature, all practitioners agree that in reality peer education primarily benefits the peer educators rather than those being educated. The effectiveness of the programmes cannot be solely placed on knowledge about HIV/AIDS alone but mostly to the empowerment of peer educators being able to perform their roles and able to educate their peers (Goren & Wright, 2006). “Peer education is associated to large part from social learning theory which argues that learning occurs naturally in a social context through observation, imitation and modelling. Such learning does not necessarily result in behavioural change and is mediated by individuals cognitions” (Goren & Wright, 2006). The argument goes on to say the field of peer education has suffered from not having high quality evaluation, which could not provide sound set of guidelines, for example, process evaluation, impact or outcome evaluation studies are needed but they are costly (Goren & Wright, 2006).

The two focus groups in my research were from communities that did not have strong community-based structures to interact with the focus groups. A lack of parental consent was also a limiting factor for both focus groups, and parental consent was required. Gary Svenson says there is a lack of strategic vision to effectively link programmes to multiple levels of influence needed to create a comprehensively targeted programme capable of reducing vulnerabilities and creating an enabling environment for individual and collective behaviour change (Svenson et al., 1999-2000).

Gallant says more research is needed to identify, with certainty, the factors that drive successful school-based HIV/AIDS risk reduction programmes in Africa (Gallant & Maticka-Tyndale, 2004). According to Campbell, you cannot isolate peer education from social conditions if you want to cause a health enhancement change in behaviour. Conditions should be right, for example relations in communities should be characterised by trust and reciprocal help and support a positive community identity, people should feel that their needs and views are respected and valued and that they are given a platform to participate in making decision in the contest of the family, school and neighbourhood (Campbell & MacPhail, 2002). Rhodes considers peer education as the first step towards facilitating community change. Rhodes also says community empowerment is useful in conceptualising peer education and community change intervention (Rhodes, 1994).

Peer education programmes should entail developing policies that encourage the development of young people's autonomy and capacity for critical thinking, so that young people may exercise real leadership in and real ownership of HIV prevention and peer education programmes. Achieving behaviour change cannot only be attained by creating a community context that enables and support the behaviour change that peer education seeks to promote, but also by understanding the need to create critical consciousness, and so peer education programmes need to be explicit.

Promoting discussion of gender relations on sexual health is needed if peer education is likely to have added value over traditional health education (Campbell & MacPhail, 2002). Campbell suggests that conceptualising empowerment is not enough to boost

youth emotional confidence, to hear empowerment also involves development of intellectual understanding that reduce social relations which contribute to HIV transmission. Gender awareness is a key ingredient for creating critical consciousness that can encourage behaviour change (Campbell & MacPhail, 2002).

Milburn says peer influence may in fact only be seen to have a visible effect on more ascribed adolescent health issues such as being overweight (Milburn, 1995). Awareness and knowledge are not sufficient for behaviour change, but they are needed for behaviour change. The following are also variables that play a vital role in behaviour change in a person: emotion, impulse, deep-seated attitudes and experience. The peer educators in both focus groups agreed that it is difficult to abstain from sex if one had already been exposed to sexual activities. The majority is influenced by their environment as well as socialisation, or as both of the groups claimed: "the way one is brought up is vital to what one is able to accept or adopt".

In spite of all the programs available in peer education, and in spite of all the education peer educators receive, peer educators themselves claim that they knew peer educators that were infected by HIV/AIDS after receiving peer education. I personally also had experience of peer educators who could not participate in the focus groups because they were sick due to HIV infection. One of the peer educators who were in one of my focus groups was referred to me, as I am a lay HIV/AIDS counsellor, to receive her CD4 count.

I therefore conclude that being a peer educator will not by itself guarantee a HIV negative status. Emphasis needs to be placed in all schools on getting teachers to accept and acknowledge the existence of peer education in their schools. There needs to be more collaboration between the schools and all the community stakeholders. The peer education on its own will not be significant in preventing HIV/AIDS infection. It has been demonstrated that it may be unrealistic to expect individual behaviour change when the broader societal and cultural context is not supportive of the change, but that does not mean that all should come to a standstill until complementary structural adjustment is implemented to the wider community (Cowan, 2002).

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