Creating environments that support peer education : experiences from HIV/AIDS-prevention in South Africa

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CREATING ENVIRONMENTS THAT SUPPORT PEER EDUCATION: EXPERIENCES FROM HIV/AIDS-PREVENTION IN SOUTH AFRICA

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Few would disagree that social environments influence the success of health education. There is less agreement about what constitutes a 'health-enabling community context'. I recently conducted research on this topic (written up in a book on peer education and sexual health in South Africa) which evaluated a three-year HIV-prevention programme aimed at people living in particularly high risk situations for HIV/AIDS (Campbell, 2003). Young people in school were one such group (2% of boys and 13% of girls aged 15 were HIV positive), and they constitute the focus of this editorial.

Peer education was developed in reaction to the perceived shortcomings of more individual-oriented approaches such as traditional didactic health education (seeking to provide information to individuals), and self-empowerment approaches (seeking to increase individuals' health-related behavioural skills and their motivation to perform health-enhancing behaviours) (Campbell, 2004). By contrast, advocates of peer education argue that it makes more sense to target the peer group or the community as the unit of change, rather than the individual. The approach is based on the assumption that peers are an important influence

on young peoples' sexual behaviour, and that young people are most likely to change their behaviour if they see that liked and trusted peers are changing theirs.

What are the processes underlying successful peer education? Firstly peer education should provide a context in which a group of peers can collectively renegotiate their peer *identities*, based on the assumption that sexuality is shaped by peer norms as much as by individual decisions. Secondly peer education should *empower* young people in two ways. It should provide them with confidence and sexual negotiation skills, as well as a sense of 'youth ownership' of health information and health interventions (where young people see that they themselves have a key role to play in HIV-prevention, rather than seeing it as the responsibility of distant medical experts). This combination of confidence, negotiating skills and ownership ideally contributes to a sense of increased self-efficacy amongst young people, which increases the likelihood that they will feel that they are in control of their health (Bandura, 1996). Equally importantly, peer education should empower young people through teaching them to think critically about obstacles to behaviour change. Paulo Freire's (1993a, 1993b) concept of *critical consciousness* suggests that participatory educational approaches have the greatest chance of succeeding if participants have a sound understanding of the social factors which stand in the way of behaviour change. Such understandings enable peers to collectively 'brainstorm' ways in which they might act to undermine the social obstacles to behaviour change.

However, a successful peer education programme needs to aim for more than the renegotiation of identities, and the development of empowered and critically conscious youth at the level of the peer group. It also needs to contribute to the development of a "*health-enabling community context*" (Tawil, Verster and O'Reilly, 1995), i.e. a social environment that facilitates these processes.

However, our understandings of what constitutes such an environment are still in their infancy.

My colleague Catherine MacPhail and I undertook a case study of peer education for HIV prevention in a school setting (MacPhail and Campbell, 2001). Baseline research, conducted before the peer education programme was initiated, showed that young people continued to engage in high risk sex, despite having high levels of knowledge about HIV/AIDS and how to prevent it. Focus groups suggested that the following factors contributed to the spread of HIV/AIDS: low levels of perceived risk amongst young people; peer pressure to engage in unprotected sex; limited availability of condoms - in a context where conservative clinic staff were often hostile to sexually active young people, especially girls; and economic factors which made transactional sex a survival option for some young women. All these factors were located within the context of gender norms which placed young men under pressure to have frequent unprotected sex, and which limited young women's power and sometimes their willingness to insist on condom use.

Following this baseline study, we conducted a case study of a schools-based peer education and condom distribution programme in the same community (Campbell and MacPhail, 2002). We identified a number of obstacles to the development of new peer norms, youth empowerment and critical thinking that we believe are essential preconditions for programme success.

A number of obstacles lay at the level of programme delivery. The highly regulated nature of the school environment militated against the development of autonomous critical thinking by learners. Rigid teacher control of the programme undermined any sense of 'youth ownership' of programme activities and programme goals. Young people had been schooled in a tradition of didactic teaching methods, which meant that neither peer educators nor their target groupings were familiar with the participatory and interactive methods which

characterise the critical thinking that underpins successful peer education. Peer educators tended feel more comfortable focusing on biomedical aspects of HIV/AIDS than the social aspects, with this also undermining the development of critical thinking skills. Youth peer education activities tended to be male-dominated, thus replicating the very gender dynamics the programme should ideally have challenged. Finally negative learner attitudes to the programme, within the context of the heavy stigmatisation of HIV/AIDS-related issues, also greatly undermined programme efforts.

Our study also focused on the ways in which learners' beyond school environments that had the potential to undermine programme success. The first of these was the lack of opportunity to communicate about sex with peers and sexual partners. This undermined the ease with which learners were able to transfer learning from peer education sessions into their daily social and sexual lives. The second was limited opportunities for communication with adults about sex, and parental denial of youth sexuality in general, and of the dangers of the HIV/AIDS epidemic in particular. Young people are less likely to take sexual risks when they grow up amongst adults who feel comfortable talking about sex and relationships (Aggleton and Campbell, 2000). Adults in our study community generally offered poor role models of sexual relationships, with young people often having had little first hand contact with adults who related to their sexual partners in an egalitarian or co-operative way. Finally young peoples' lives were blighted by macro-social environments characterised by poverty, lack of educational opportunities, unemployment, which undermined their confidence and their sense of personal agency to take control of their lives in general, or their sexual health in particular.

The creation of 'partnerships' or 'alliances' has been put forwards as a strategy for creating health-enabling community contexts (Gillies, 1998). In relation to HIV/AIDS, partnership approaches have been advocated in the light of the insight that the problem of HIV is too complex and too multi-faceted for any one

stakeholder constituency to deal with. This is particularly the case given the high levels of social marginalisation of many of the communities in which HIV/AIDS flourishes. It is essential that members of youth peer education groups develop links to actors and agencies with the political and economic influence to assist them to meet their goals.

Efforts to build ‘multi-stakeholder partnerships’ or ‘bridging social capital’ seek to build links between local HIV-affected communities and relevant local and extra-local groups and agencies whose cumulative efforts increase the likelihood of addressing the problem – through pooling groups’ very different skills and resources. In the original project proposal, our youth HIV-prevention programme of interest proposed to build links between local youth peer education teams, and a range of more powerful groupings drawn from civil society and the public and private sectors. These included an HIV-prevention programme aimed at adults in the community, national networks of youth peer educators, local political and community development groups, employers, parents’ groups, and representatives of local hospitals, clinics and educational departments. However, as is often the case with ambitious projects, many obstacles stood in the way of linking youth into these wider networks.

What are some examples of the way in which such partnerships might have facilitated peer education success in an ideal world? Bridges between local hospital representatives and peer educators might have drawn hospital attention to the way in which clinic sisters’ open disapproval of youth sexuality was deterring young women from asking for condoms. Bridges with educational leaders might have provided opportunities for youth and educators to debate the way in which school settings were inhibiting programme success. Local employers might have been prepared to assist in the development of income generation programmes by young people. Links with community development and political groupings might have drawn attention to the importance of including young peoples’ voices in political and community decision making. Contact with

local parents groups might have contributed to promoting parental awareness of the negative health impacts of their refusal to acknowledge the reality of youth sexuality.

The research concluded that one important reason for the failure of HIV-prevention programmes lies in the over-optimism of those who believe that peer education programmes can change behaviour in marginalized communities in the absence of appropriate partnerships. Programme success is unlikely without parallel efforts to create supportive social environments, through building alliances between peer educators and more influential groups. There is an urgent need to develop more refined understandings of contextual influences on peer educational programme success or failure; the types of partnerships needed to facilitate contexts that are supportive of schools-based peer education; and factors which promote or hinder the development of such partnerships. In the absence of concerted efforts to build community contexts which enable health-enhancing behaviour change, the best-intentioned peer education programmes are doomed to have less than optimal results.

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