

THE DEVELOPMENT OF A TRAINING MODEL FOR PEER LEARNING FACILITATORS IN ADOLESCENT REPRODUCTIVE HEALTH IN ZAMBIA

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DECLARATION OF ORIGINALITY

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

Signature_____

Date_____

SUMMARY

Zambia is reported to have high levels of maternal morbidity and mortality due to low contraceptive prevalence rates, over 50% of births not being attended to by skilled persons, and teenage pregnancies. A number of organisations (stakeholders) have invested in the training of adolescent reproductive health peer educators with the aim of empowering them to be role models to their peers in reproductive health, but Zambia does not have a generic and locally developed training programme for peer educators.

The purpose of this study was to develop a training programme that would produce competent and more effective peer educators for Zambia. The objectives were to determine the characteristics of the ideal peer educator. Further objectives were to ascertain the factors that contribute to or impair the development of the ideal peer educator, and to determine whether training programmes that were being used were producing ideal peer educators and enhancing healthy lifestyle behaviours.

Key stakeholders participated in group interviews where they presented and critiqued their training programmes. Emerging out of this process was a draft training programme, developed by the stakeholders.

Focus Group Discussions (FGDs) were held with adolescent peer educators from Lusaka, Kafue, Livingstone and Maheba refugee camp. Data were analysed by triangulating the outcomes of the group interviews (with the stakeholders) with the outcomes of the FGDs and reviewed literature.

The FGDs highlighted the characteristics of an ideal peer educator as well as factors that contribute towards his/her competence development. Numerous factors were reported that had a negative impact on the development of an ideal peer educator.

The peer educators reported that their training had had a positive effect on their lifestyle behaviours. While they had gained more knowledge on HIV and AIDS, they recommended more training on other health issues. The study found that at community level, peer educators were not being given adequate respect because the concept of voluntary work was not readily accepted and they were regarded as failures in life. Major demotivating factors were the lack of payment of incentives and the fact that peer educators were not certified. Peer educators did not receive sufficient support from programme managers/coordinators to enable them to become more effective at community level. Weaknesses in the way the training programmes were conducted were also discerned.

Based on the findings of this study, it is recommended that more life skills' development be promoted for peer educators. Training should be contextualised for the communities in which the peer educators work. The developed training programme, which should be used as a guide, should be repackaged to suit the profiles (e.g. values) of the different communities. Adolescents and various social sectors (inclusive of indicated stakeholders) ought to be involved in diagnosing community needs so as to influence both peers and communities in a way that would promote adolescent reproductive health. This study also recommends a more informal way of practising peer education, which

would produce trainees who would be peer educators and role models in any given setting.

OPSOMMING

Na berig word is die hoë siekte- en sterftesyfers onder moeders in Zambië daaraan te wyte dat voorbehoedmiddels nie algemeen gebruik word nie, dat meer as 50% van geboortes plaasvind sonder die bystand van bekwame persone, en dat daar 'n hoë voorkoms van tienerswangerskappe is. 'n Aantal organisasies (belanghebbers) het in die opleiding van adolescent- portuurgroep-opvoeders in reprodktiewe gesondheid belê ten einde hierdie portuurgroep-opvoeders te bemagtig om as rolmodelle in reprodktiewe gesondheid op te tree. Zambië het egter nie 'n eie generiese, plaaslik-ontwikkelde opleidingsprogram vir portuurgroep-opvoeders nie.

Die doel van hierdie studie was om 'n opleidingsmodel en opleidingsprogram te ontwikkel wat bekwame en meer effektiewe portuurgroep-opvoeders vir Zambië sou kon oplewer. Die doelstellings was om die kenmerke van 'n ideale portuurgroep-opvoeder te bepaal en om die faktore te identifiseer wat óf tot die ontwikkeling van 'n ideale portuurgroep-opvoeder bydra óf sy/haar ontwikkeling strem. Daar moes ook vasgestel word of bestaande opleidingsprogramme ideale portuurgroep-opvoeders oplewer en gevolglik gesonde leefstylgedrag bevorder.

Die navorser het groeponderhoude gebruik en betekenisvolle belanghebbers genooi om hulle opleidingsprogramme aan te bied, te beoordeel en krities te bespreek. 'n Konsep-opleidingsprogram wat deur die belanghebbers ontwikkel is, het uit hierdie proses ontstaan.

Fokusgroepbesprekings (Engels: *Focus Group Discussions* of *FGDs*) is met adolessente portuurgroep-opvoeders van Lusaka, Kafue, Livingstone en die Maheba-vlugtelingekamp gehou. Data is ontleed deur die uitkomst van die groeponderhoude (met die deelhebbers) met die uitkomst van die fokusgroepbesprekings en die bespreekte literatuur te trianguleer.

Die fokusgroepbesprekings het die soeklig op die kenmerke van die ideale portuurgroep-opvoeder asook op die faktore wat tot sy/haar bekwaamheidsontwikkeling bydra, laat val. Talle faktore wat 'n negatiewe uitwerking op die ontwikkeling van 'n ideale portuurgroep-opvoeder het, is ook vasgestel.

Die portuurgroep-opvoeders het bevestig dat hul opleiding 'n positiewe invloed op hul lewenstylgedrag gehad het. Terwyl hulle genoem het dat hulle meer kennis oor MIV en VIGS opgedoen het, het hulle aanbeveel dat daar ook meer klem op ander gesondheidskwessies behoort te wees. In hierdie studie is daar bevind dat portuurgroep-opvoeders op gemeenskapsvlak nie met voldoende respek behandel word nie. Die begrip van vrywillige werk word nie geredelik aanvaar nie, en die opvoeders word as mislukking beskou. Faktore wat besonder ontmoedigend inwerk is die gebrek aan 'n aansporingsloon en die feit dat portuurgroep-opvoeders nie sertifikate ontvang nie. Portuurgroep-opvoeders het ook nie voldoende ondersteuning van programbestuurders/-koördineerders ontvang om hulle in staat te stel om meer effektief op gemeenskapsvlak op te tree nie. Daar is voorts swakhede opgemerk in die wyse waarop die opleidingsprogramme uitgevoer is.

Gegronnd op die bevindinge van hierdie studie, word daar aanbeveel dat die ontwikkeling van lewensvaardighede tot 'n groter mate bevorder word. Opleiding behoort gekontekstualiseer te word vir die gemeenskappe waarbinne die opvoeders werk. Die bestaande opleidingsprogram, wat as 'n riglyn gebruik behoort te word, behoort herstruktureer te word om by die profiele (bv. die waardes) van die verskillende gemeenskappe in te pas. Adollesente en verskillende sosiale sektore (insluitend die aangeduide belanghebbers) behoort betrokke te wees by die bepaling van die gemeenskap se behoeftes ten einde beide portuurgroepe en gemeenskappe so te beïnvloed dat adollesente- reprodktiewe gesondheid bevoordeel sal word. Hierdie studie beveel ook aan dat portuurgroep-opvoeding op 'n informeler grondslag beoefen behoort te word sodat die kwekelinge uiteindelik in enige gegewe omgewing suksesvolle portuurgroep-opvoeders en rolmodelle sal kan wees.

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DEDICATION

This work is dedicated to my son Siphon Nkandu.

May this inspire you to pursue and realise your ultimate dreams.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
ARH	Adolescent Reproductive Health
ARHP	Adolescent Reproductive Health Project
ART	Anti-Retroviral Therapy
ASRH	Adolescent Sexual Reproductive Health
CBoH	Central Board of Health
CD4	Cluster Differentiation Cells Type 4
CSO	Central Statistics Office
DHMT	District Health Management Team
FBO	Faith-Based Organisations
FGDs	Focus Group Discussions
GRZ	Government Republic of Zambia
GRZ/UN	Government Republic of Zambia/United Nations
HBC	Home-Based Care
HIV	Human Immuno-deficiency Virus
IMF	International Monetary Fund
KAP	Knowledge, Attitude and Practice
MoE	Ministry of Education
MoH	Ministry of Health
MMD	Movement for Multi-Party Democracy
MYSCD	Ministry of Youth Sport and Child Development
OBE	Outcomes-Based Education

PATH	Program for Appropriate Technology in Health
PHC	Primary Health Care
PPAZ	Planned Parenthood Association of Zambia
PPFA	Planned Parenthood Federation of America
PLWHA	People Living With HIV and AIDS
RH	Reproductive Health
RTI	Reproductive Tract Infection
SAP	Structural Adjustment Programme
STIs	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific Organisation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UTH	University Teaching Hospital
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association
ZDHS	Zambia Demographic Health Survey

CHAPTER 1

PROBLEM STATEMENT AND MOTIVATION FOR THE STUDY

1.1 INTRODUCTION AND BACKGROUND OF THE STUDY

Zambia is a landlocked country in Central Africa bordered by the Democratic Republic of the Congo, Tanzania, Malawi, Mozambique, Zimbabwe, Botswana, Namibia and Angola. It has a surface area of 752,614 square kilometres, which is about 2.5% of the area of Africa. The country is divided into nine provinces and 61 districts. According to the 2005 report by the Central Statistics Office Republic of Zambia (CSO) the population of Zambia is currently estimated at about 10 million. The estimates range from 9,885,591 (CSO, 2005), to 10.2 million (The World Bank, 2004) and 10,812 from both the United Nations Children Fund (UNICEF, 2005) and Williams (2005). Sixty percent of these people live in the urban areas while two-thirds of the female population live in the rural areas. A report by the CSO, the Central Board of Health of Zambia (CBoH) and ORC Macro (2003a) states that 67% of the population comprises children, adolescents and youth with a median age of 17.1 years.

At independence in 1964 Zambia had a population of about 4 million. Soon after independence, the country experienced a high rate of population growth. This was probably as a result of a good economy and a lack of a population policy. Freedom from colonial rule could have also contributed towards the population explosion. At the time the country did not see this as a developmental problem. Zambia's concern then was

with the high rate of migration of people (especially men) from the rural areas to the urban areas in search of employment. This resulted in serious imbalances in the population distribution compounded by a high population growth. For example, according to the 1990 Census, the proportion of the population living in the urban areas had steadily increased from 29% in 1969 to 42% in 1990. Currently, the decline in the economy has reduced the proportion of the population in the urban areas to 36% of the population, (CSO et al., 2003a; CSO, 2005). This proportion varies from province to province.

Prior to 1991, social services including health care services were provided at little or no cost in Zambia. By the late 1980s the health system in Zambia was in jeopardy due to the following reasons:

- The hospital and health centres had poor supply of drugs and other hospital essentials.
- Most of the health personnel were demoralized due to poor conditions of service. As a result, a good number of health personnel left the country in search of greener pastures.
- Between 1984 and 1994 the University of Zambia alone, lost 230 academic staff members. According to the United Nations Population Fund (UNFPA) 160 lecturers were doctorate holders (UNFPA, 1997:55).

The policy of free health services for all could not be maintained indefinitely as the national economy continued to experience serious difficulties. After the multi-party

election of 1991, a new government was elected and it immediately took steps to revitalise the national economy by reforming economic and social policies. In order to reverse the downward trend in health, for instance, and as part of the overall economic Structural Adjustment Programme (SAP) endorsed by the World Bank and other donors, the new government embarked on a programme of reforms. In 1992, Zambia introduced reforms in the health sector. These reforms shifted the planning, implementing, monitoring and provision of health care services from provincial level to the districts (Gaisie, Cross & Nsemukila, 1993:2). The emphasis in these health reforms was and is on Primary Health Care (PHC), though the country has a shortage of health personnel at all levels of health care provision (The World Bank, 1997). Shortage of skilled health staff is still a problem in some health centres (CSO et al., 2003a; The World Bank, 2004:98).

In the past, some of the objectives of the health reforms introduced by the Ministry of Health (MoH) had been to achieve the following by the year 2000:

- to make family planning available, accessible, and affordable to at least 30% of all adults in need;
- to reduce maternal mortality through the promotion of safe motherhood;
- to improve the quality of access to and utilisation of maternal and child health services in order to reduce maternal deaths and complications;
- to reduce the incidence of Sexually Transmitted Infections (STIs), Human Immuno-deficiency Virus (HIV), Acquired Immuno-deficiency Syndrome (AIDS) and Reproductive Tract Infections (RTIs); and

- to reduce the incidence of induced abortions in order to reduce maternal complications and deaths (MoH, 1992:5).

The targets listed above are still being achieved through a basic health care service package being provided at all levels of the health care system (CSO et al., 2003a). Currently additional primary objectives of the MoH in collaboration with the CSO have been:

- to collect up-to-date information on fertility, infant and child mortality and family planning;
- to collect information on health related matters such as breast feeding, antenatal care, children's immunisations and childhood diseases;
- to support dissemination and utilisation of results in planning and managing and improving family planning and health care services in the country; and
- to document current epidemics of STIs and HIV/AIDS through the use of specialised modules (CSO et al., 2003a:5).

It is important that the of socio-economic indicators of any country are understood as they have a strong bearing on the onset and development of disease. According to the Government Republic of Zambia/United Nations, GRZ/UN report (1996:63) the overall trend in Zambia's social indicators regarding health have been reported to be "one of early improvement during the immediate post-independence period, followed by stagnation and decay". Under the leadership of the Movement for Multi-Party Democracy (MMD), Zambia has been pursuing a programme of rapid structural economic reforms with the aim of stabilising the economy and establishing the conditions

for sustainable economic growth. These reforms have been successful in substantially stabilising the economy. The 1996 GRZ/UN report stated that the reforms have had a harsh impact on the lifestyle of a large number of Zambians and that there was little sign of an impending economic upturn. The study further reported that in some cases the introduction of the economic reforms had contributed to reduced food intake and the near collapse of nutrition oriented health delivery services.

In Zambia, poverty has reached unprecedented levels with most of the households living below the poverty datum line (or living on less than \$1 a day as per international rates). The World Bank (2004:56) has reported that in Zambia, as of 1998, 72.9% of the population was living below the national poverty line and 63.7% below the international poverty line. The report further states that out of the national estimates, 83.1% were from the rural areas. A CSO, MoH & MEASURE Evaluation Report (2004) stated that 73% of the Zambian population were poor. It also reported that poverty was more prevalent in the rural areas (83%) than in the urban areas (56%). The World Bank (2004) further reported that between 1999 and 2001 50% of the Zambian population were undernourished. In spite of this, Van Buren (2005) stated that in 2004, Zambia was experiencing the strongest period of economic growth as well as the lowest rate of inflation in 20 years. The International Monetary Fund (IMF) reported that the Zambian currency, Kwacha, had stabilized during the past year with an average of \$1 being equal to K4, 785.12 (IMF, 2005).

A number of factors cause poverty. In an earlier study UNICEF (1991) reported the following to be underlying causes of poverty:

- structural economic imbalances;
- decayed institutional capacity;
- urban bias and rural neglect;
- culture of dependency on the state;
- gender insensitivity and bias; and
- inappropriate choice of technology.

This year The World Bank Group (2005:58) outlined the following as the global social indicators of poverty:

- prevalence of child malnutrition;
- under-five child mortality rate;
- child immunization rate;
- contraceptive prevalence; and
- births attended by skilled health staff.

UNICEF (2005) reported that in Zambia (going by 2003 data), 28% of under-five children had moderate to severe malnutrition and that the under-five mortality rate was 182 children per 100,000. Meanwhile, the 2001-2002 Zambia Demographic and Health Survey (ZDHS) reported that most under-five children in Zambia (84%) have had full immunization against major diseases (CSO et al., 2003a) but also reported that 28% of

under-five children were underweight while 47% had stunted growth. The World Bank (2004) reported the same values.

In Zambia, the contraceptive prevalence rate was reported by The World Bank (2004) to have been 26% in the year 2002 for women aged between 15-49 years while CSO et al., (2003) indicated 34.5% for married women and 27% for all Zambian women. UNICEF (2005) indicated a contraceptive prevalence rate of 34% for the year 2003. Births attended by skilled health staff have been reported to be 43% (CSO et al., 2003a; The World Bank, 2004; UNICEF, 2005).

HIV and AIDS have contributed greatly to the indicators of Zambia's health. In Zambia, AIDS was first identified in 1984. The average progression time from HIV infection to AIDS was thought to be 5-7 years, with the progression from AIDS to death being 1.5 years on average. In 1995, AIDS was thought to account for at least half of all mortality cases in Zambia (UNFPA, 1997). HIV was reported to be spreading at a rate of 400-500 new persons a day in Zambia. Between 800,000 and 900,000 were estimated to be infected with HIV in 1997 (UNFPA, 1997). At the end of 1999 the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported that the adult HIV/AIDS prevalence rate was 19.95% of the Zambian population (UNAIDS, 2000).

More recently, the CSO et al. (2003) reported that 17% of the 15-19-year-olds in Zambia were HIV positive. Zambia has used antenatal care sentinel surveillance data as a principal means of monitoring the spread of HIV for almost a decade. When the ZDHS

urban and rural distribution was applied to the antenatal care surveillance results, the adjusted HIV prevalence rate for the total population was 17% compared to the overall rate of 16% as estimated in the 2001-2002 ZDHS (CSO et al., 2003a). A similar report was given by Garbus (2003).

In 2004, CSO et al. reported a decline to 15.6% of the HIV prevalence in Zambia. More people with HIV were living in the urban areas than in the rural areas. Other reports cited the following HIV prevalence rates: The World Bank (2004) 15.6% and UNICEF (2005) 16.5% of the adult Zambian population.

Based on the above it can be said that the HIV prevalence has reduced in Zambia. In spite of this reduction the UNAIDS (2004) reported that countries like Zambia and Uganda (13% in early 1990s to 5-6% by end of 2003) who have reported these declines are still over-burdened with the care of People Living With HIV and AIDS (PLWHA). Zambia's adult HIV prevalence is the sixth highest in the world (Garbus, 2003). Life expectancy at birth in Zambia dropped from 49.6 years in 2000 (CSO et al., 2004) to 37 years in 2002 (The World Bank, 2004) and 33 years in the year 2003 (UNICEF, 2005). The HIV and AIDS pandemic has contributed greatly to these trends.

South Africa has been reported to have the highest HIV prevalence in the world with over 25% (UNAIDS, 2004). The same study reported that at the end of 2003 an estimated 5.3 million (4.5 million-6.2 million) people were living with HIV in South Africa and that 2.9 million of these were women.

In Zambia, HIV/AIDS prevention efforts have concentrated on the promotion of sexual abstinence, late sexual involvement by adolescents, being faithful to one partner, and the consistent or correct use of condoms. The prevalence of HIV among Zambian youth is reported to have reduced. A recent study has attributed this drop in the HIV prevalence to the increased age of first sexual contact and the reduction of the number of sexual partners (Magnani, MacIntyre, Karim, Brown, Hutchinson, Transitions Study Team, Kaufman, Rutenburg, Hallman, May & Dallimore, 2005:303). The same authors have reported similar outcome trends in South Africa where between 1999 and 2001 HIV prevalence rates among youths aged 15-19 years have dropped from 16.5% to 15%.

Another study has indicated that in the age range of 10-19 more girls than boys are infected in Zambia. Rates of infection among adolescents are reported to be six times higher for females than for males. This is mainly because older men infect young girls as they believe that the younger girls are free from HIV (Webb, Bull & Becci, 1996:12). The more educated population is said to have a higher HIV infection rate (GRZ/UN 1996:37). This is because of the ability and willingness of some to pay more for unprotected sex. A more recent study has reported the same trends (CSO et al., 2004).

In a developing country such as Zambia, teenage pregnancy is not only common but also dangerous. Maternal death rates are high and contributory factors are frequently those that could have been avoided. The high mortality rates that were estimated to be in the range of 500-880 per 100,000 live births in 1993 depict the poor state of health among women of child-bearing age (GRZ/UN, 1996:37). In 1995 UNICEF estimated that the

number was 202, while in 1996 the World Health Organisation (WHO) set the figure at 940. More recently the following statistics for maternal mortality in Zambia have been given per 100,000 live births: CSO et al., (2003a) 729; The World Bank (2004) 750 and UNICEF (2005) 730. It can be seen that the maternal mortality rates in Zambia are still very high.

The major contributory factors to maternal mortality are young age at first pregnancy, short spacing between pregnancies, lack of knowledge concerning high risk pregnancies, high number of deliveries supervised by untrained personnel, poorly equipped health facilities, poor referral systems and the use of traditional herbs during labour. Other contributory factors are human resources constraints, poor socio-economic status, lack of money for fees and transport and long distances from health care facilities. The leading causes of maternal morbidity are anaemia, malaria, STIs, hypertension and malnutrition. It is speculated that maternal mortality and morbidity have worsened with the advent of HIV and AIDS (CSO et al., 2003a; The World Bank, 2004).

Maternal mortality is considered to be one of the most important indicators of Zambia's health status. In an effort to reduce maternal mortality in Zambia, Nsemukila, Phiri, Diallo, Benaya and Kitahara (1998:91) recommended the following:

- the need to keep girls in school longer as a strategy to increase age of first marriage/pregnancy and improve their socio-economic status;
- the need to provide health services to adolescents and youths for the prevention of HIV/AIDS/STIs and unwanted pregnancies; and

- the need to target adolescents, as they are the future.

A more recent study (CSO, Ministry of Education, ORC Macro & US Agency for International Development, 2003b) reported on how the above objectives were still being met. One of the objectives of the same survey (which is reported to be the first of its kind in Zambia) was to “measure parent/guardian attitude towards sex education and AIDS education in order to understand how the introduction of these topics into primary school would be likely to be received, (CSO et al., 2003:5b).

In Zambia, a number of donor and non-governmental organisations have invested in projects pertaining to adolescent health. For instance, the Danish government, Care International, the United Nations High Commission for Refugees (UNHCR) and some Religious Organisations, for example World Vision International, a Christian organisation, have supported projects that focus on training adolescents in reproductive health (UNFPA, 1997). The projects have trained a number of adolescents with the aim of their becoming peer educators and role models to their peers. Clearly there is need for an assessment of the quality of training that some of these programmes offer because the rate of maternal mortality among adolescents in Zambia has not been reported to have reduced in the past few years.

1.2 PROBLEM STATEMENT

Zambia lacks a structured, generic and locally contextualized training programme that can be applied to the numerous adolescent reproductive health projects as a guide to their

training of peer educators. Furthermore, none of the current programmes have had their trained adolescents assessed to determine whether the training has had an influence on their own health-related behaviour. The health beliefs and behavioural patterns of the trained peer educators have also not been evaluated. While a number of adolescents have been trained as peer educators, work has not been done to identify the requirements of the ideal adolescent reproductive health peer educator. In the advent of HIV and AIDS it is important to empower young people on issues that influence their health so that they can make informed decisions about their health. An evaluation of the training programmes of peer educators would help the trainers of trainers to effectively plan for intervention/empowerment programmes.

1.3 AIM OF THE STUDY

Against the background of this problem statement, the aim was to develop a training programme to improve adolescent reproductive health training so that future peer educators are more competent and effective in countering HIV and AIDS issues.

1.3.1 RESEARCH QUESTIONS

Various research questions (which are outlined in detail in Chapter 4) were answered in order to understand the requirements for an adolescent reproductive health peer educator in Zambia. For example:

- What characteristics constitute an ideal adolescent reproductive health peer educator?

- What factors contributed positively to or had a negative impact on the development of an ideal and effective peer educator?
- Do training programmes being followed have a component that focuses on the enhancement of healthy lifestyle behaviours?
- What components need to be embedded into the new training/educational programme to be developed?

1.3.2 SPECIFIC OBJECTIVES

Following the outlined aim of the study, the specific objectives were:

- to determine the characteristic (features, competencies, skills) requirements of an ideal adolescent reproductive health peer educator;
- to determine the factors that contribute positively or have a negative impact on the development of an effective and ideal peer educator;
- to determine whether the training programmes being followed by the stakeholders result in the enhancement of healthy lifestyle behaviours; and
- to determine whether the current training programme being used by the selected programmes (and stakeholders) contribute positively towards the development of an effective and ideal peer educator.

1.3.3 RATIONALE AND SIGNIFICANCE OF THE STUDY

Many countries in Africa are implementing economic structural adjustment programmes due to poverty and pressure from monetary organizations such as The World Bank and the IMF. This in turn has influenced the health sectors in these countries. Vienonen

(1997:8) stated that during the past two decades health policy reforms have been driven to a large extent by the rising cost of health care. In Zambia, the 1992 ZDHS showed that the health services offered to women (especially those of child-bearing age) prior to the implementation of the health reforms were inaccessible, inadequate and did not meet the women's needs. One WHO report (1998:3) stated that "the future of human health in the 21st century depends a great deal on a commitment to investing in the health of women as their health largely determines the health of their children who are the adults of tomorrow". In 2005, the concerns of the WHO are still that "over 70 million mothers and their new born-babies, as well as countless children are still excluded from health care to which they are entitled" (WHO, 2005a:xi).

Since today's adolescents are tomorrow's adults, investing in their health will mean taking care of the health issues of a nation for tomorrow. Taking care of the influencing factors pertaining to their health now, would mean a healthier nation later. It is hoped that the training programme will contribute effectively to the training of adolescent reproductive health peer educators (or peer learning facilitators, as this study would like to recommend that they be called) who will be more competent, effective and hopefully better role models.

1.4 RESEARCH DESIGN AND METHODOLOGY OF THE STUDY

1.4.1 EPISTEMOLOGY

The understanding of the various designs and methodologies of research enables one to make an informed choice of the instruments to use to best answer raised questions or reach the intended goals. According to Mouton (2001:5) “research design is a plan or a blueprint of how you intend conducting the research. Researchers often confuse the terms **Research Design** and **Research Methodology**, but these are two very different aspects of a research project.” Mouton tabulates the differences between the two concepts as indicated in the table below.

TABLE 1.1 A metaphor for research design

Research Design	Research Methodology
Focuses on the end product: What kind of a study is being planned and what kind of results are aimed at?	Focuses on the research process and the kind of tools and procedures to be used
Point of departure = Research problem or question	Point of departure = Specific tasks (data collection or sampling) at hand
Focuses on the logic of research: What kind of evidence is required to address the research question adequately?	Focuses on the individual (not linear) steps in the research process and the most “objective” (unbiased) procedure to be employed

(Source: Mouton, 2001:56)

Mouton (2001) compares the process of conducting research to building a house. The whole process would initially start with an idea. The type of house that one wishes to build will then be described to an architect who will put these thoughts on paper. This process would go through a few changes until the person who wants the house is satisfied with the design. Once this is done a contractor would then be engaged who would then

take the design or blueprint (as the point of departure) and start building the desired house. In relation to this study, the ultimate aim was to develop an effective training programme for competent peer educators in Zambia. The point of departure was determining the problem and the questions that needed to be answered. In the research methodology component the point of departure was determining the most appropriate and scientific way of answering these questions.

1.4.2 EPISTEMOLOGICAL QUESTIONS

In the light of the above discussion, this study raised the following epistemological questions:

- What **methods** are going to be used in the study? **Methods** indicate the techniques or procedures that are going to be used in the gathering and analysing of data relevant for this study (Crotty, 1998).
- What **methodology** governs the choice and use of these methods?
Methodology indicates the strategy, plan of action, process of design underlying the choice and use of particular methods and linking the choice and use of these methods to expected outcomes (Crotty, 1998).
- What **theoretical perspective** lies behind the methodology in the question?
The “**theoretical perspective** indicates the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria” (Crotty, 1998: 5).

- What **epistemology** informs this theoretical perspective?

The **epistemology** is the theory of the knowledge embedded in the theoretical perspective and thereby in the methodology (Crotty, 1998:2-9).

In this regard Mouton (1996:18) states “How one defines the goal of scientific inquiry (the epistemological dimension of the science) clearly determines which road or route should be taken (the methodological dimension).” He further argues that the epistemological dimension is the fundamental dimension of the research, meaning that the research is the search for the truth (Mouton, 1996:20). The process of conducting research is compared to the process of taking a journey. The traveller (or researcher) decides on a destination (research objectives). The route is compared to the phenomenon or aspects of the social world to be investigated, while the mode of transport is seen as the methodologies to be used (Mouton, 1996:26).

Related to this Tones and Tilford (1994:83) state that there are a wide range of measures which should be taken in order to develop or evaluate any health programme and that these measures should not be selected randomly but should be based on a sound theoretical framework, as this provides a substantial base for practice. The authors further stress that a framework of this nature enables one to justify choices with confidence. For example, a sound theoretical framework would help explain how people make health-related decisions, individually and as a group. The theoretical framework attempts to

...define the ways in which social and environmental factors influence these decisions and will provide insight into the nature of both inter-

and intrapersonal dynamics governing behaviour. If we have some understanding of the constellations of the factors influencing human behaviour in health and sickness, we will be in a better position to develop strategies and formulate methods which will achieve our health education goals (Tones & Tilford, 1994:83).

These authors are of the opinion that whatever philosophy or framework researchers choose to follow, there is a need for an understanding of the existing relationships between, for example, knowledge, beliefs, skills, attitudes and social pressures and environmental constraints. Further, having insight into the likely effects would enable researchers to select indicators of success in a more rational and meaningful way (Tones & Tilford, 1994) instead of just relying on facts, as all evidence requires interpretation (Bush, 1995:18).

Bush furthermore claims that theories of education and social sciences are very different from scientific theories: “These perspectives relate to changing situations and comprise different ways of seeing a problem rather than a scientific consensus as to what is true” (Bush, 1995:20). Based on the above, this study was not only built on medical/health-related models, but included educational theories and a conceptual framework used in an earlier study that focused on poverty and its impact towards sustainable human development (GRZ/UN, 1996:66, CSO et al., 2003b). In this study a combination of research methods was thus used in a systematic manner to generate and develop a training programme for the purpose of making a unique contribution in this academic field.

As part of this research, a workshop with the stakeholders was held where training programmes were presented, reviewed, critiqued and improved upon by the stakeholders. Group interviews were used to develop a training programme which all the stakeholders' views, expectations and objectives were well articulated.

Thirty participants attended a 3-day data collection workshop that deliberated on the review and development of a standard training programme for all the stakeholders. The following stakeholders were represented: World Vision International, UNHCR, Catholic Youth Peer Education Programme, Young Women Christian Association (YWCA) and Young Men Christian Association (YMCA). Using Focus Group Discussions (FGDs) the draft document developed at the end of three days of deliberations was then tested among trained adolescent reproductive health peer educators from the Planned Parenthood Association of Zambia (PPAZ), Libuyu Skills Training Centre (a youth peer education programme in Livingstone), Kafue District Health Management Team (DHMT) Adolescent Reproductive Health Project (ARHP) and the adolescent peer educators in Maheba refugee camp.

The details of the choice of the study design, sample size, sampling processes, data collection instruments, data collection procedures, data processing and data interpretation are outlined in Chapter 4 which explains the research design and methodology of the study.

1.5 SCOPE OF THE STUDY

The study was delimited to the development of the training programme. Study participants from both rural and urban regions of Zambia. These participants were drawn from adolescent reproductive health projects/programmes in the following areas of Zambia: two areas in urban regions of Zambia (Lusaka and Livingstone), one semi-urban area (Kafue) and one rural area (Maheba refugee camp) which acted as a comparison group.

While there are many issues that affect adolescents, this study focused only on their training needs as adolescent reproductive health peer educators. Training programmes reviewed were those from organisations that had trained the highest number of adolescents, namely MoH and UNFPA/ARHP, World Vision International, CARE International Catholic Youth Adolescent Reproductive Health Programme, PPAZ, YWCA and YMCA and those trained by the UNHCR. In this study these organisations were referred to as stakeholders. It needs to be pointed out that the study was not able to embrace all adolescent reproductive health training programmes or projects. The assumption was that the results of the study would give useful information as well as a generic programme to areas of Zambia not included in the study, in other words, the outcomes of the study are generalisable as most of the stakeholders run similar projects throughout the country.

Zambia hosts a number of refugees from surrounding countries. The UNHCR Newsletter of December 2004 reported that Zambia had 173,907 refugees. Of these, 19,347 were in

Maheba camp (UNHCR, 2004:13). Maheba, a refugee camp in Solwezi in the North-Western Province of Zambia, was included in the study as a comparison site to the other programmes. While the needs of refugees are unique (UNHCR, 1999) the outcomes of FGDs held in Maheba made useful contributions to this study because the participants were also trained adolescent reproductive health peer educators.

1.6 ETHICAL STATEMENT

As the study involves human participants, ethical clearance was sought and acquired at various levels. Permission to conduct the study in Zambia was obtained from the University of Zambia Research Ethics Committee who gave ethical clearance (Appendix 1). Consent was also sought and obtained from the stakeholders to take part in the study (Appendices 2 and 3). This was for the purpose of using their staff and training programme documents and also of using their adolescents as research participants. For Maheba, permission to conduct the study was also sought and obtained from the Zambia Ministry of Home Affairs to obtain clearance to enter the refugee camp.

Individual consent to participate in the study was sought and obtained from all the adolescents to take part in the study (Appendix 4). The research participants were assured of confidentiality and their rights. The purpose of the study, potential risks (though none were foreseen) and benefits were outlined to the potential participants so that they could make informed decisions to take part in the study. It was explained that outcomes of the study would be communicated to the various stakeholders.

1.7 CLARIFICATION OF CONCEPTS

Various concepts that are used in the study will subsequently be clarified. General concepts or definitions provided are given, and the way in which they are used in this study is explained.

- **Adolescence**

Sikes (1996:15) argues that age alone is not sufficient to determine membership into the adolescent group and militates for the more elaborate WHO definition of “adolescence” as the progression from the appearance of secondary characteristics (puberty) to sexual and reproductive maturity, development of adult mental processes and the transition from the socio-economic dependence to relative independence (WHO, 2004a; 2004c). Sikes’s (1996:15) argument stems from the fact that adolescents fall into diverse groups, namely in school, out-of-school, single, married and further those who are sexually active and those who are not.

Heaven (1996:1) has defined adolescence as one of the most turbulent yet exciting phases of life: (first stage childhood, second stage adolescence and third stage adulthood). What happens or does not happen during this second stage of life has the potential to affect the health of the individual and that of the public (WHO, 1999; WHO, 2004c).

- **Adolescent**

In 2004 the WHO reported that one in every five persons in the world was an adolescent with the majority of these living in developing countries. This organization stressed the importance of the health of these adolescents and specifically their reproductive health. The WHO (2004a; 2004c) definition of adolescent refers to an individual aged between 10-19 years. For the purpose of this study this age description of the term *adolescent* was used.

- **Adolescent reproductive health**

The WHO defined adolescent reproductive health as not merely the absence of disease or disorder in the reproductive process, but a condition in which the reproductive process was accomplished in a state of physical, mental and social well-being (WHO, 2004a; 2004c). The WHO definition as described above was used in this study.

- **Adolescent reproductive health peer educator**

This term refers to an adolescent who had undergone reproductive health training with the aim of training other adolescents. For the purpose of this study, this meant an adolescent trained in reproductive health and other health related issues (such as sexuality, sex, HIV and AIDS and health-related behaviours) with the aim of this person becoming an educator of peers or fellow adolescents.

- **Peers**

In general terms the term *peer* could mean any person with whom one shares the same denominator, for example workmates, fellow students, same gender, same marital status

and people who have to deal with similar issues. In this study the term refers to fellow adolescents.

- **Trainers of trainers**

This term refers to individuals responsible for the training and educating of adolescent reproductive health peer educators. These are usually much older persons who have had some training or who have specialized in some way in reproductive health. It is not unusual to come across trainers who may also be adolescents. As long as they had the mandate to educate those referred to as peer educators they were referred to as trainers of trainers in this study.

- **Health-related behaviour**

A behaviour is defined as the outward deportment, carriage, manners, conduct of a person or the manner in which a thing or person acts (Uitenbroek, Kerekovska & Festchieva, 1996). Studies have been done that have outlined behaviour (Calnan, 1989; Carmel, 1990; Fishbein, 1990; Nakajima & Mayor 1996; Nkandu, 1996; Uitenbroek et al., 1996). These behaviours include diet, personal hygiene and health beliefs and practices. Other studies (Dean, 1989; Rubin, Sobal & Moran, 1990; Bjorgvinsson & Wilde, 1996; Nkandu, 1996) have shown that indulging or ignoring some of these behaviours (in the past or present) could have implications on the health status of an individual or a society now or in the future. Graeff, Elder and Booth (1993:15) state that “behaviour is learned within a cultural, socioeconomic and individual context and therefore can be relearned or unlearned, or new behaviours can be introduced.” They point out that “behaviour including health-related behaviour is shaped by events and reactions in the social and

physical environment.” In this study health-related behaviours therefore generally refer to the behaviours that have the potential to influence one’s health status (positively or negatively) either now or in the future.

- **Lifestyle behaviour**

This term refers to lifestyle practices such as smoking or exercise which is characteristic of a person’s routine behaviour. Lifestyle is defined as the characteristics surrounding an individual or group (Cassell, 1994: 118 & 786). In this study this term refers to behavioural norms or practices that have the potential to influence one’s health status.

- **Stakeholders**

This term refers to organisations that fund(ed) and train(ed) adolescent reproductive health peer educators. In General terms the term *stakeholder* should include the above stated organizations, peer educators and the communities in which they operate. In this study *stakeholders* refers specifically to MoH/UNFPA, World Vision International, Catholic Youth Peer Education Programme, YWCA, YMCA, Care International, PPAZ, Family Life Movement, Family Health Trust and those trained by the UNHCR.

1.8 FRAMEWORK OF STUDY

This component of the study provides highlights of the chapters to follow.

1.8.1 CHAPTER 1: PROBLEM STATEMENT AND MOTIVATION FOR THE STUDY

Chapter 1 gives background information on health issues in Zambia with a focus on adolescent reproductive health. An understanding of the political and socio-economic situation of a country is very important as this has the potential to influence the health of the nation. Zambia is no exception. This is because the factors stated above have the ability to influence the way people behave in their search for health. Adolescents are a very vulnerable population group, making their health matters of particular importance.

The “health status” of adolescents in any nation contributes greatly to the current and future health status of that nation. The health policies made by the nation will need to influence the health of these citizens in a positive manner. Chapter 1 therefore highlights some health issues in order to clarify the situation in Zambia. The chapter also gives the rationale for and the significance of the study. Other issues included are a summary of the research design and methodology, ethical statement, description of key terms and the delimitation of the study or the scope of the study.

1.8.2 CHAPTER 2: A REVIEW OF LITERATURE ON FUNDAMENTAL CONCEPTS INFLUENCING ADOLESCENT REPRODUCTIVE HEALTH IN ZAMBIA

Any given population or group of people will be governed by its own cultural norms and values. These in turn will influence the societal beliefs and practices. Chapter 2

highlights the situation in Zambia in relation to the above. Furthermore, an understanding of the various concepts of health promotion and health education are also highlighted. The understanding of the above forms a strong foundation in the structuring, evaluation or monitoring of reproductive health programmes, and more so in the training of adolescents. Literature giving a situation analysis of aspects related to maternal morbidity and mortality in Zambia is also reviewed in this chapter.

1.8.3 CHAPTER 3: ASPECTS OF PEER EDUCATION, PEER EDUCATORS AND LEARNING AMONGST ADOLESCENTS

Concepts of peer education with special emphasis on variables applicable to adolescent reproductive health are highlighted in this chapter. These include the various learning and training models that can and have been used in the training of adolescents. A comparison of the strengths and weaknesses of commonly used models and theories are critiqued in this chapter. Lastly, generic principles of the training of adolescents are discussed.

1.8.4 CHAPTER 4: DESIGN AND METHODOLOGY OF THE STUDY

In this chapter a detailed outline of the various stages /phases of this study are given. The chapter gives information on how the research questions were answered and the specific objectives were realized. The choice of research design and methodology used in this study is motivated. The epistemological questions are stated in the quest to obtain the truth about the matters that ought to be considered in the development of effective

adolescent reproductive health peer educators. The epistemological dimension of this study was followed by the methodological dimension which provided the reasoning for the appropriate design and methodologies used in order to appropriately tackle the specific objectives of the study. Choices of design and methodologies were therefore not made in the abstract, but were based on theoretical understanding of scientific evidence as to the best and most effective way to answer the epistemological questions.

1.8.5 CHAPTER 5: PRESENTATION, ANALYSIS AND INTERPRETATION OF THE RESULTS

The outcomes of the group interviews with the stakeholders informed the researcher of the themes for the FGDs with the trained adolescents. The outcomes of the group interviews and the FGDs plus reviewed literature formed the basis for the developed programme.

1.8.6 CHAPTER 6: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This last chapter gives an overview of the study. The summary gives a synonym of the study design and methodology and study outcomes. The outcomes of the triangulation of the group interviews, the focus group discussions and reviewed literature formed the basis for the development of the training programme. The training programme is presented in this chapter and is followed by recommendations.

1.9 SYNTHESIS OF CHAPTER 1

Zambia is reported to have high levels of maternal morbidity and maternal mortality. The high HIV and AIDS prevalence and poverty levels have contributed negatively to the health situation in Zambia. Earlier studies have stressed the need to empower adolescents as one of the tools to reverse the poor maternal health of the country.

Adolescence is a very crucial time of development. This is a time when young people strive for independence and it is also a time when they are most exposed to peer pressure and various vices which could have a negative impact on their health. The power of peer pressure can, however, also be used to influence other peers towards good, healthy or positive lifestyle behaviours. Probably using the above rationale (that is, the positive influence of peer pressure) a number of organisations invested in the reproductive health of adolescents in Zambia and went further to train adolescent reproductive health peer educators. These organisations (stakeholders) have trained their adolescents in a way perceived to be best. This study reviewed training programmes that were used by the various stakeholders so as to identify their common ground, strengths and weaknesses. Literature pertaining to adolescent reproductive health peer learning and teaching was also reviewed. The stakeholders' and trained peer educators perception of an ideal adolescent reproductive health peer educator was determined. The common ground of all stakeholders was determined and compared with the perception of the trained adolescents. This formed the basis for the development of the training programme for adolescent peer educators in Zambia.

1.10 SUMMARY

Chapter 1 gives the geographic and demographic information on Zambia. The chapter introduces health issues in Zambia and the health status of the country with an emphasis on adolescent reproductive health. The study objectives, rationale for and significance of the study are discussed. The research design and methodology including the epistemological questions of the study are highlighted. This is followed by the scope of the research, clarifying the key concepts and stating the ethical issues relevant to the study. The chapter concludes by giving an overview of how the different chapters to follow interact with each other.

Chapter 2 reviews literature on the factors that were or are still contributing to the reproductive health status of Zambia.

CHAPTER 2

A REVIEW OF THE LITERATURE ON FUNDAMENTAL CONCEPTS INFLUENCING ADOLESCENT REPRODUCTIVE HEALTH IN ZAMBIA

2.1 INTRODUCTION

In order to address the issues raised in this study, some health concepts are defined and discussed before making a situation analysis of factors related to maternal morbidity and mortality in Zambia. Before the definition of *health promotion* is given it is necessary to define health so that there is an understanding of what it is that is being promoted. This has implications for this study as adolescent reproduction health peer education is an arm of health promotion.

Naidoo and Wills (2000:6) have defined *health* in two ways. Their negative definition states that it is the absence of disease or illness, and their positive definition defines it as a state of well-being as indicated in the WHO constitution of 1946.

The WHO defines *health* as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Nakajima & Mayor, 1996:3; WHO, 2005b). The term *well-being* is understood in terms of people's perceptions of their quality of life as individuals, families or communities. These perceptions are shaped by

the values that prevail in their culture. As the cultural understanding of the human body, time, death and disease varies, so people's approaches to steps taken in prevention and treatment of diseases differ (Nakajima & Mayor, 1996:3; WHO, 2005a; 2005b). Sexuality, childbirth, weaning, disease, death, suffering and other health issues are not just private experiences but all have an intrinsic social dimension. The communities in which these experiences occur are often influenced as much by cultural practices as by biological and environmental factors. The environmental factors include shelter, clothing, food, proper sanitation, safe drinking water, education (both formal and informal) and poverty. Addressing health issues is therefore not about discussing the absence or presence of disease but about how the above factors influence or contribute towards the promotion of health in both individuals and communities.

2.2 THE CONCEPTS AND PRINCIPLES OF HEALTH PROMOTION

Health promotion emerged in the 1980s as a distinct integrated approach to health development. It is the process of enabling people to take or increase control over their health in order to improve the quality of their lives (WHO, 1986; WHO, 2005b). It is also the process of enabling people to reach or attain a state of physical, mental and social well-being. Health promotion encompasses health education and empowerment. An individual or a community should be able to identify and realise aspirations, to satisfy their needs and to change or cope with their environment (WHO, 2005b).

The WHO (2005a; 2005b) has further reported that health promotion strategies are not limited to a specific health problem or to a specific set of behaviours. As an organisation the WHO applies the principles and strategies of health promotion to a variety of population groups, risk factors, diseases, and in various settings. Health promotion and the associated efforts when put into education, community development, policy or legislation and regulation are valid for the prevention of communicable diseases, injury and violence, mental problems as well as the prevention of non-communicable diseases. In relation to this study the importance of health promotion and health education can be illustrated graphically as in Figure 2.1.

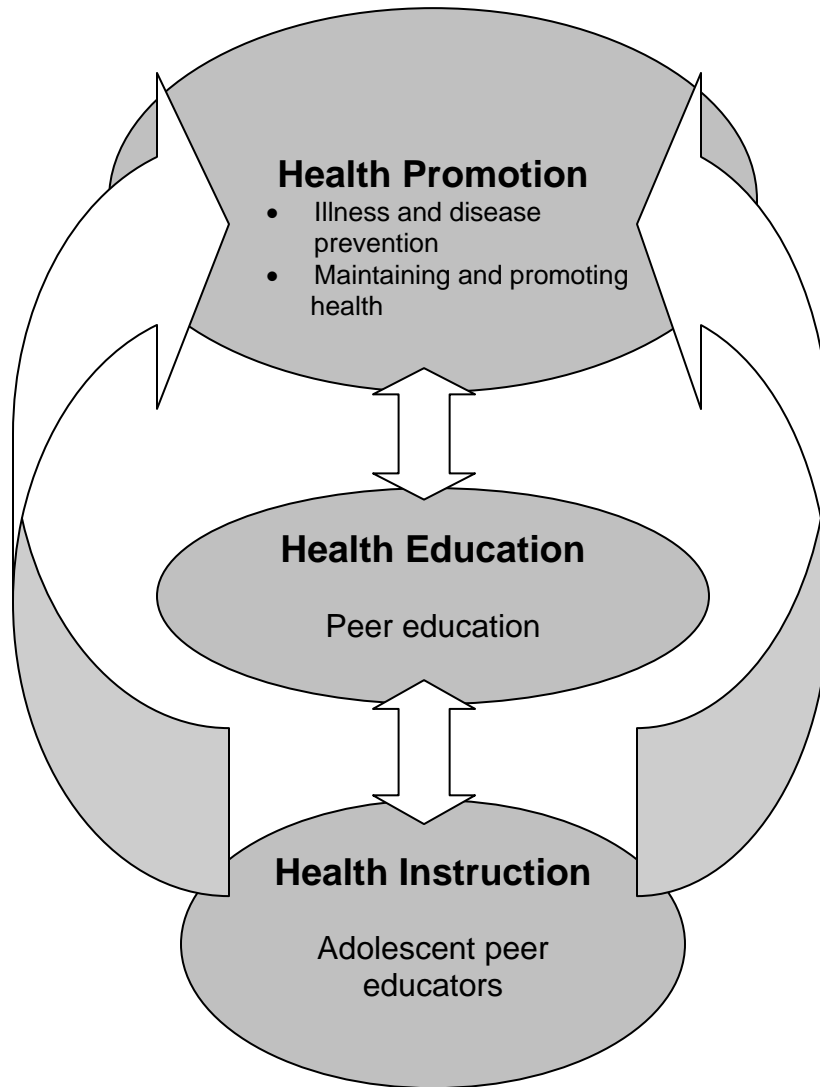


FIGURE 2.1: The relationship between health promotion, health education and peer education

The promotion of health is therefore not in the hands of the health professionals/health sector alone as it goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibility to health (WHO, 2005a; 2005b). In other words, people in authority would have to deliberately make an effort to make communities habitable and conducive to health and to empower communities to take

control of their health. A change in lifestyle (for example, patterns of life, work and leisure) would therefore have a significant impact on people's health.

Given the challenge of altering long-standing unhealthy behaviour or risky behaviours, some health educators are calling for dynamic theoretical models in training programmes to enhance changes in lifestyle behaviour as they see this as the remedy to the high prevalence of preventable diseases (Pinto & Marcus, 1995:3; WHO, 2004a; 2005b). As lifestyle behaviour is influenced by one's cultural setting, the relationship between culture and health is discussed below.

2.3 CULTURE AND HEALTH

Culture is the collective consciousness of a people. It is shaped by a sense of shared history, language and psychology (UNAIDS, 1999:34a). Certain elements of culture tend to remain over time while others change. Armed with a list of negative individual health beliefs and practices, the unenlightened practitioner, who regards culture as static sets of never changing values and norms, inevitably blames those beliefs and identifies them as cultural barriers. Beliefs are often a product of culture, but the reverse is not true. Beliefs are often seen as a proxy for culture, so that beliefs about illness become the focus of culturally appropriate messages and intervention. In fact, the term *belief* is often contracted with knowledge. From the perspective of biomedicine, *belief* sometimes connotes erroneous ideas that constitute obstacles to appropriate behaviour (UNAIDS, 1999:35a). Consequently it is reasoned that individual negative practices or behaviours could be labelled as cultural beliefs and are often regarded as barriers.

Culture is often viewed as an exotic collection of beliefs and practices and is mistakenly believed to exist only in Africa, Asia, Latin America and the Caribbean (UNAIDS, 1999:35a). An example of this occurs when health educators and campaign planners ignore local health knowledge and seek information about local idioms of expression to better communicate health messages. In other words, there is little attempt to convey understanding through viable channels of local beliefs and practices. Instead, these channels are used to disguise imported knowledge by presenting it in the local idiom. Beliefs or knowledge of illness and traditional health practice should become the substance of local (or culturally appropriate) messages and interventions. Graeff et al., (1993) reported that health professionals who have worked in international settings have often found that communication strategies used successfully in one country yielded negative results in another setting because the communication strategies were not contextualised for the new site. In terms of messages, those which have an affective (i.e. emotional or subjective) appeal are reported to be more successful as they are often better remembered by an audience. In this type of communication, according to Maibach and Parrott (1995:82, 89) factors to be considered are:

- How familiar is the message?
- How strong are the arguments?
- How involved is the audience with the message?

Skinner, Morrison, Bercovitz, Haans, Jennings, Magdenko, Polzer, Smith, and Weir, (1997:23); CSO et al., (2003a) and CSO et al., (2004) have reported that although the youth in the 20th and 21 century have been exposed to more health information than their

counterparts in the past, it has not contributed much to their behavioural patterns. In the Caribbean the mass media is reported to have had a negative influence on adolescent reproductive health (McBean, 1996:13) since the media encourage adolescents to indulge in sexual behaviours which would have a negative influence on their health. The WHO (1996:3) has raised similar concerns over the mass media. Other authors (Manuel, Molines, Dubuc & Marco, 1998:295; Hugo & Smit 1999:18) have stressed the need for health education via the mass media to be culturally appropriate and effective in a positive way. The notion here is that messages must be adapted to the context in which the message is being communicated, bearing in mind the literacy levels of the population groups being targeted, influencing factors such as culture and the choice of technology or media through which the information is to be communicated.

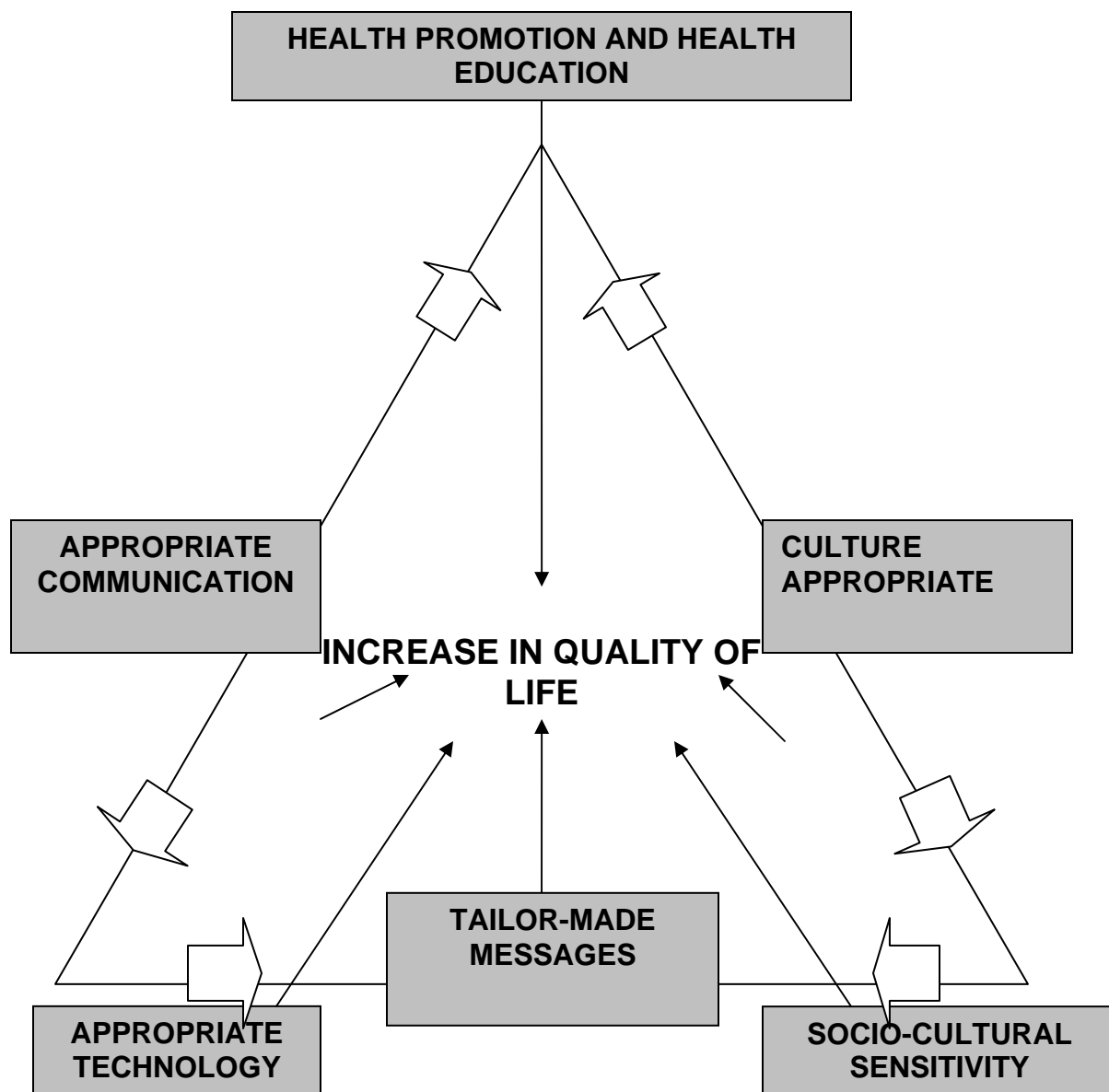
Culture is the central feature of any society. All people belong to a culture, and some might even share more than one culture. It is crucial for health communicators working on HIV and AIDS prevention, care and support to examine thoroughly not only negative behaviours but also contextual and individual values. These include positive elements that need to be promoted and existential elements that are unique to the culture but that do not pose a threat to health and well-being (UNAIDS, 1999a).

Helman (1994:118-119) reported that some life-threatening diseases such as cancer, heart disease and AIDS have become much more than mere “folk illnesses”. Folk illnesses are “often linked in the public imagination with traditional beliefs about the moral nature of health, illness and human suffering”. Helman explains that a number of images or

metaphors of AIDS have been identified, for example “a plague”, “an invisible contagion”, “moral punishment”, “an invader” and “war”. AIDS has also been regarded as a primitive or pre-social force or entity. Sontag, as quoted by Helman commenting on metaphors, stated that diseases whose origin was not understood and whose treatment was not very successful became metaphors for all that was “unnatural” and socially or morally wrong with society (Helman, 1994:116)

Norms and beliefs about illness are culturally encoded everywhere, while the language of symptom and disease is often also culturally embedded. Therefore a need exists for health interventions to be sensitive to the cultural perceptions of diseases and the local disease terminology (Hubley, 1993; UNAIDS, 1999b).

In relation to this study it was important to contextualise the training programme as this was being developed for Zambian adolescent peer educators who are in a setting that has specific norms, values, cultural beliefs and practices. Therefore the type of communication strategies would have to be appropriate to the setting and the messages would have to be tailored to them. Hugo and Smit (1999) communicated the above sentiment as presented in Figure 2.2.



(Adopted from: Hugo & Smit, 1999).

FIGURE 2.2: Contextualising communication strategies in health promotion and health education

2.4 LIFESTYLE BEHAVIOUR

Lifestyle is defined as “the characteristics surrounding an individual or group”, while behaviour is defined as “the outward deportment, carriage, manners, conduct or the manner in which a thing or person acts” (Cassell, 1994:118 & 786). Uitenbroek et al., (1996:368) state that *lifestyle* refers to behaviours that are in principle open to an individual’s choice and in which individuals differ. However, the concept of lifestyle is not limited to an individual’s behaviour, but also emphasizes behaviours that are shared with people in similar environments and circumstances.

Most lifestyle theories stress the multi-causal aspect of many of the “modern” chronic diseases that disease is not caused by the operation of a single agent, but more by the interaction between behavioural factors, environmental circumstances and physiological characteristics. Unhealthy lifestyles concern behaviours that are found to be harmful to health or well-being for example smoking, while healthy lifestyles concern the “positive” behaviours like exercise (Uitenbroek et al., 1996:369; WHO, 2004c; 2005a).

In the 21st century, issues of health cannot be fully addressed without bringing in the matters of lifestyle affecting not only individuals but also communities. There is an increase in non-communicable diseases such as cancer, diabetes and also in preventable diseases such as HIV and AIDS, hypertension and stroke (Steyn, Fourie & Bradshaw, 1992:227; UNAIDS, 2004; WHO, 2005a, 2005b). Addressing lifestyle behaviours would help reduce the prevalence of these conditions. For example, a health-related behaviour (or health risk behaviour) such as smoking is generally accepted as part of social life

despite its addictiveness and its dangers to the health of the individual and those around him or her.

A number of factors influence health behaviour. The beliefs and practices in which one is raised have a strong influence on one's behaviour, and changing the behaviour would mean changing the underlying cognitive structure (Fishbein, 1990:37). Further, a number of theories have been formulated in order to understand human health behaviour. First used in 1967, the theory of Reasoned Action hypothesised that "humans are reasoning beings that systematically utilise or process the information available to them" (Fishbein, 1990:37). According to this theory, one's underlying beliefs ultimately determine behaviour. The more one believes that performing a particular behaviour will lead to negative consequences, the more negative the attitude. In real life, people's behaviours are further influenced by other factors. Some individuals may make decisions in order to please their friends, family or community. These decisions could make them susceptible to unhealthy behaviours depending upon values they or their friends hold.

Persons who have knowledge that performing a particular deed would make them susceptible to some disease will most probably not perform the deed. Bjorgvinsson and Wilde's study (1996:27) indicated that people who expect a great deal from the future are less likely to jeopardise it by taking risks in respect of their health and safety. Health and safety behaviour affects the probability and quality of survival in the long run. For example a person who values the future highly would be more willing to accept

constraints today (e.g. they would drive more slowly, or use seat belts) for future benefits of arriving safely or reducing the possibility of injury should an accident occur.

The Attitude Theory (Fishbein, 1990:39; McDonald, Roche, Durbridge & Skinner, 2003) and the Health Belief Model (McDonald et al., 2003) are theories often used in health behavioural research. The Attitude Theory recognises three interrelated components, namely Knowledge, Attitude and Behaviour or Practice (KAP) and suggests that since people strive for consistency, a change in one component should lead to a change in the others. However, this hypothesis has proved to be inadequate on its own in the studies of HIV and AIDS, as increase of knowledge does not guarantee a change in behaviour. The Health Belief Model states that health-related action depends upon three factors:

- the existence of sufficient motivation in an individual to make health issues relevant;
- the perceived threat that one is susceptible to illness; and
- the belief that following health recommendations would reduce the perceived threat at an acceptable cost (Carmel, 1990:73; McDonald et al., 2003).

Some of the limitations of the Health Belief Model are that it does not address efficacy or locus of control.

Hubley (1993:25) highlighted the fact that when dealing with communities, what health planners consider important may not be the same thing(s) that a community may consider important. He cautions health educators on the dangers of blaming communities for the

failure of a health education programme saying that the community “had no interest”. Hubley (1993:27) refers to a distinguished health educator namely Lawrence Green, who developed a useful concept he called Enabling Factors. Hubley states, “Sometimes a person may intend to perform a behaviour but still not do it. This is because of the influence of enabling factors such as time, money, equipment, skills or health services.” The same author further states, “In real life we are constantly under pressure to act in different ways. Some people may approve of us doing something, others may be against. How we respond will depend on whose opinions have the most influence on us.”

The term *subjective norm* was introduced by the psychologist Fishbein to “describe the overall social pressure” on an individual or community and to show how these social factors contribute towards the processing and making of informed health decisions (Hubley, 1993:30). Hubley improved the Health Believe Model and produced the BASNEF Model – Belief, Attitude, Subjective Norm and Enabling Factors. He states that applying the BASNEF approach involves examining behaviour from the perspective of the community. He cautions that this may not be as easy as it sounds, as even if health planners originated from the same community, their education and health training would make them look at issues differently (Hubley, 1993).

A number of lifestyle behaviours in which people indulge may not appear to be harmful, but could have detrimental effects on their lives in the near future. In other words, unhealthy lifestyle behaviours in which an individual indulges now have the potential to have a direct impact on their health status. Examples of such behaviours are smoking,

unhealthy eating habits and not exercising regularly. Naidoo and Wills (2000:95) indicate that behavioural change is a “complex process” and that “unless a person is ready to take action, it is unlikely to be effective”.

Two other factors that influence behaviour are religious beliefs and health beliefs. People who believe in God and reverence Him will probably not indulge in certain lifestyle behaviours as they would be considered sinful. Their healthy lifestyles would rather be influenced by their underlying belief of righteousness and holiness rather than for health promotion purposes.

In relation to HIV and AIDS, Louw (1994) highlights the challenges that churches and especially church leaders have to deal with. These include the challenges to love and to care for HIV and AIDS patients in the communities and to determine the role of the church in these settings. Some of the issues that the church leaders deal with are moral values, stigma, myths, condemnation, apathy, cultural beliefs and practices and the AIDS patient as a person.

Van Dyk (2001:290) avers that giving emotional or spiritual counselling to someone with HIV is often difficult, because HIV and AIDS are largely considered to be STIs, and “rational understanding of its origins, progress and ultimate effects are often clouded by sexual taboo, denial, superstitions, stigmatisation and the irrational fears that are evoked in many people by sexuality and sexually transmitted diseases”.

Reviewed literature in this study has reported that Uganda is one of the few countries that have had a major decline in the prevalence of HIV infection. A study done in Uganda reports that “religion is inextricably woven into their every aspect of life in Uganda” and that more religious ministers are taking a more open and non-judgemental approach to HIV prevention, including the use of condoms. Furthermore, people are acting on the knowledge that they have about AIDS: “...to be open about AIDS is not just a matter of saying yes I know AIDS exists you have to act upon that knowledge” (Williams, Williams, Kaleeba, Kadowe & Kalinaki, 2000:58, 61).

There are numerous theories and models that influence and explain behaviour, but this study will only focus on the following which are relevant to the study:

- The Theory of Reasoned Action
- The Attitude Theory
- The Health Belief Model
- The BASNEF Model

The above theories will be presented in this chapter while the rest (listed below) will be presented in Chapter 3.

- The Social Cognitive (Learning) theory
- The Social Identity Theory
- The Social Comparison Theory
- The Diffusion of Innovation Theory
- The Cognitive Dissonance Theory
- The Theory of Planned Behaviour

In Chapter 3 of this study a more detailed synthesis is made on how all the stated theories contribute towards behavioural change and training of adolescent reproductive health peer educators. The first four-mentioned theories are compared in Table 2.1, and their relationships are shown.

TABLE 2.1: A comparison of behavioural theories

THEORY	DESCRIPTION OF THEORY	POSITIVE ATTRIBUTES	NEGATIVE ATTRIBUTES	COMMENTS
Theory of Reasoned Action	<p>Humans are reasoning beings that systematically utilise or process information available to them.</p> <p>One's underlying beliefs ultimately determine behaviour.</p>	<p>It is true that humans are reasoning beings and that one's underlying beliefs ultimately determine behaviour.</p>	<p>An assumption was made by the authors of this theory that all human beings analyse or process information available to them systematically.</p>	<p>The ability to process information made available to a person is based upon the ability of that person to take the information and then process it. This is dependent upon many factors such as the level of sanity, education, exposure and religious beliefs. On its own this theory leaves many gaps that do not fully explain why some people do not process information given to them to their benefit. On its own it does not explain why, for example, individuals would fail to understand information given to them and use it to enhance healthy lifestyle behaviour.</p>
Attitude Theory	<p>The Attitude Theory recognises three interrelated components, namely Knowledge, Attitude and Practice (KAP) and suggests that since people strive for consistency a change in one component should lead to a change in the other.</p>	<p>Knowledge is believed to be power as it has the capacity to allow one to make informed decisions.</p>	<p>Studies, especially those done on HIV and AIDS have shown that an increase in knowledge does not result in a change in behaviour.</p>	<p>The theory does not consider the willingness of an individual to change attitude or practice. It does not examine the factors that would enable individuals to understand the information made available to them or their ability to process it or use it to bring about a desired or expected change in behaviour. This theory does not address the KAP gap.</p>

Table 2.1 (continued)

THEORY	DESCRIPTION OF THEORY	POSITIVE ATTRIBUTES	NEGATIVE ATTRIBUTES	COMMENTS
<p>Health Belief Model</p>	<p>The Health Belief Model states that health-related action depends upon three factors:</p> <ul style="list-style-type: none"> -existence of sufficient motivation in the individual to make health issues relevant; -perceived threat that one is susceptible to illness; and -belief that following health recommendations would reduce perceived threat at an acceptable cost. 	<p>This theory informs individuals that following health recommendations would reduce perceived threats at an acceptable cost.</p>	<p>The authors of this theory assume that individuals would have sufficient motivation to regard health issues as being relevant to them. It does not specify how much motivation one needs to make health issues relevant. This model does not address efficacy and locus of control.</p>	<p>Health issues vary in various cultural and economic settings. What would be of concern in one community (for example purified tap water) would be a matter of little concern in a village where there is no water and where the people have to draw water from a river kilometres away. Health issues about contaminated water in these two settings would be perceived very differently by the inhabitants unless the common denominator of having tap water is dealt with then one could address issues of purified water. The community without tap water can be given information about the dangers of river water but unless factors are considered that would enable this community to have clean water are put in place, information given would have been given in vain.</p>
<p>BASNEF MODEL</p>	<p>This is a modification of the Health Belief Model. This model considers beliefs, attitude, subjective norms, (social pressure) and enabling factors.</p>	<p>The model considers more factors than the other models.</p>	<p>The model does not discuss the cost to the individual to make health issues relevant.</p>	<p>Of the five theories discussed above, this theory deals with issues related to making health issues relevant, in a more holistic manner.</p> <p>Enabling factors are a key in this model which the other theories do not include. Subjective norms should address peer pressure and consider the cost of making recommended decisions.</p>

(Source: Fishbein, 1990; Hubley, 1993; King, 1999; UNAIDS, 1999a; McDonald et al., 2003).

It is obvious that no single model can completely bring about behavioural change, but it can be achieved by an interaction of training and behavioural models as each have their strengths and weaknesses. For example, the Attitude Theory does not address the gaps that would exist between Knowledge Attitude and Practice (what is known as the KAP gap). In other words, factors that influence how given information is processed and how this in turn contributes to practice or behaviour, is not addressed. The use of the Theory of Reasoned Action together with the Attitude Theory would help explain why an individual would behave in a particular manner. This is because the theory highlights underlying beliefs which determine behaviour. On the other hand, the strengths and weaknesses of the Health Believe Model are complemented well by the BASNEF Model which considers enabling factors (which are greatly influenced by culture). In the light of the above, appropriate theories need to be used in order to obtain desired results. A trainer of trainers advocating for behavioural change or change in lifestyle behaviour would therefore need to use appropriate theories to achieve a desired behaviour.

As stated earlier more detail of this will be given in Chapter 3 where all the theories relevant to this study will be synthesised in reference to the training of adolescent peer educators. The planning for and the application of these theories would not yield much if the cultural context in which they were to be applied was not understood or known. Therefore beliefs related to culture and health will be discussed because of their relevance to this study. To set the context for this, reproductive health and its contributory factors with special emphasis on adolescent reproductive health in Zambia, is subsequently presented.

2.5 REPRODUCTIVE HEALTH

In the past, issues pertaining to reproductive health were grouped under the umbrella of maternal and child health. The World Bank (2004:99) defined reproductive health as "a state of physical and mental well-being in relation to the reproductive system and its functions and processes." The WHO (2004b) described it as not merely the absence of disease or disorder of the reproductive process, but rather, the condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being. Sadana (2002:407) defined reproductive health as "a human condition (including the level of health and related areas of well-being; as an approach (policies, legislation and attitudes; and service (the provision of services, access to them and their utilization)." This definition of health focuses on all parties involved or who have the potential to be involved in the process of reproduction. Zurayk (1994) gave a more structured and women-centred definition of reproductive health: This consists of four components namely dignity, reproductive choice, successful bearing and the absence of gynaecological disease or risk.

Some studies have reported that each year, more than half a million women die throughout the world from pregnancy and pregnancy-related problems (Al-Qutob, Mawajdeh, & Raad, 1996:423; AbouZahr, 1998:8; WHO, 1999; The World Bank, 2004, WHO, 2004b). Most of these deaths occur in the poorer parts of the developing countries. In a much earlier study, Armstrong and Royston (1989) reported that one in every three women died in the reproductive years from maternal problems. As indicated earlier in this study, the tragedy was and still is that many of these deaths are preventable.

The latter authors identified three major contributory factors to maternal mortality:

- poverty and disease;
- health institutions in developing countries not being able to prevent the occurrence of maternal deaths; and
- high fertility rates.

According to the WHO (1990) women who seek abortion in unhygienic surroundings, face possible complications and even death in preference to carrying pregnancies to full term. A study done in South Africa on backstreet abortion (Maforah, Wood & Jewkes, 1997:79) reported that all the women in their study had heard of contraceptives, but had used them incorrectly. Some had just stopped using them, which resulted in unwanted pregnancies and ultimately abortions. Contributory factors to unwanted pregnancies were:

- the fear of side effects;
- women being "lazy" to use contraceptives;
- assurance by partners that they would not get pregnant;
- partners' disapproval of the use of contraceptives;
- forceful demands for sex by their partners resulting in the women not being able to negotiate for contraception; and
- some women who thought that they were too young to become pregnant (Maforah et al., 1997).

Some of these women became pregnant because they had insufficient knowledge about their bodies' reproductive functioning or because their partners had controlling influence

over contraceptive use. It is evident from the above discussion that there are a number of issues that contribute towards reproductive health. Seeing that adolescents are young people who are still maturing, the possibility is that they would face more challenges pertaining to their reproductive roles.

2.5.1 ADOLESCENT HEALTH

Heaven (1996:1) regards adolescence as one of the most turbulent yet exciting phases in life. The author points out that that increased autonomy, usually experienced during adolescence, brings with it new health risks, ranging from drugs and sexually transmitted diseases to eating disorders, suicidal depression and even violence. Adolescence has been recognized as crucial for the later emotional development of an individual. Adolescent health no longer requires justification, as one in five persons in the world is an adolescent with the majority of these living in developing countries. As has been indicated earlier, what happens or does not happen during this stage of life has the potential to affect both the health of the individual and that of the public (WHO, 2004c). Generally, adolescents are thought to be healthy (WHO, 2004c). By adolescence, they would have survived early childhood and all the health problems associated with it. Health problems associated with aging would still be many years away. Death is so far removed that it is unthinkable but many adolescents die prematurely. The main causes of death amongst adolescents are accidents, suicide, violence, pregnancy-related complications and other preventable and treatable illnesses. It is estimated by the WHO (2004c) that 1.7 million adolescents die each year.

During this period of life, female adolescents tend to be more concerned about their physical appearance and their eating habits than male adolescents who tend to be more concerned about being “masculine”. In order to achieve these goals, adolescents begin to change in health-related behaviours - both positively and negatively. Healthy behaviours include physical activity (exercise), better eating habits and better hygiene. Unfortunately it is also a time when adolescents indulge in unhealthy or health risk behaviours such as substance abuse, unhealthy eating habits and unhealthy sexual behaviours. Putting them at greater risk is the stress or pressure they get from their peers. The implication for their current and future health status is that they run the risk of early and unwanted pregnancies, unsafe abortions and contracting STIs such as HIV infection and AIDS. Substance abuse ranges from the use of tobacco to other hard substances, which impair judgment, for example the ability to say no to having sex or the ability to recommend or negotiate for condom use. Consequently the adolescents would make themselves susceptible to unwanted pregnancies or infections. The use of substances like tobacco increases the risk of cancer and cardio-respiratory diseases while alcohol abuse increases the risk of accidents and injuries due to poor judgement and violence. Compounding these problems is the influence of the mass media and more recently the Internet on which a number of negative vices are promoted, for example pornography.

2.5.2 ADOLESCENT REPRODUCTIVE HEALTH

Young people of the 20th and 21st century are becoming sexually active much earlier than was the case in the past. Besides being sexually abused, some primary school children are already sexually active. Buga, Amoko and Ncayiyana, (1996:523) reported that

learners in standard 5 (grade 7) were sexually active in South Africa. They further reported a high incidence of teenage sex in the Northern Cape. These findings are not unique to South Africa but also applicable to other countries, including Zambia (Gaisie, Cross & Nsemukile, 1993:62; Baboo, Ahmed, Siziya & Bulaya, 1994:111; Nkata, 1997:344) and Zimbabwe (Rusakaniko, Mbizvo, Gupta, Kinoti, Mpanju-Shumbushu, Sebina-Zziwa, Mwateba & Padayachy, 1997:3).

Amuyunzu (1997:16) reported that a lack of accurate Sexual and Reproductive Health (SRH) information and services targeting Adolescent Sexual and Reproductive Health (ASRH) have been related to engagement in early unsafe sexual activity, resulting in STIs/HIV/AIDS and unwanted pregnancies.

More recently the WHO (2004c) reported that adolescents do not have adequate information but that they need to go through sexual development in order for them to postpone sex until they are physically and socially mature and able to make well informed responsible decisions.

Various studies have stressed the need for health providers, health educators (O'Donoghue, 1996:10; Rice, 1996:7; WHO, 1999:3) and teachers (Nyamwaya, 1996:18; Allensworth, 1997:42) to be involved in the adolescent reproductive health programmes though there are sometimes controversies on what the content of the training programmes should be (CSO et al., 2003b; Forrest, Strange, Oakley and the RIPPLE study Team, 2004; Hirst, 2004; Hull, Hasmi & Widyanoro, 2004). Jejeebhoy (1998:1275) states that

adolescents' reproductive health needs are poorly understood and ill served. The author recommends that research studies be undertaken to determine how sexually transmitted morbidity and the adolescents' socio-economic status and behavioural profiles correlate.

Lieberman and Feierman (1999:109) indicate that restricting adolescent reproductive health care places additional stress on adolescents which in turn delays treatment and even leads to young women resorting to dangerous alternatives. Foster (1998:17) emphasises the need to reduce the number of adolescents who become HIV infected and to lessen adolescent vulnerability. Peer-led interventions are recommended. Roos (2000:24) recommends the peer education approach for HIV and AIDS training in the workplace. While it is important to educate adolescents on their sexuality, it is important to understand the numerous variables that can contribute towards their maintaining their reproductive health status. Of concern are variables such as level of education, economic status of the family, recreation, influence of the mass media, and policies and provision of environments supportive of ASRH.

In Zambia the reformulated PHC programme aimed, among other things, to tackle the health problems in the community, focussing on the needs of the under-served, high-risk and vulnerable groups. One of the "high risk" and "vulnerable" population groups is adolescents. According to the 2001-2002 ZDHS, a third of the female teenagers interviewed had had a child while two-thirds of the 19-year-olds were mothers or pregnant with their first child. At least one in every four female teenagers had begun child bearing. Zambia has approximately 2,370,000 adolescents aged 10-19, constituting

24% of the population. It is reported that adolescents between the ages 15-19 were responsible for 17% of the births and that 33% of these were unplanned (CSO et al., 2003a). Yet the Sexual Behaviour Survey by CSO et al. (2004) has stated that female adolescents were more likely to use condoms than much older women. Condom use among adolescents increased during the years 1998-2000, but declined in the years 2000-2003.

Discussing issues concerning sex with their off-spring is not easy for most Zambian parents, especially in the rural areas where strong cultural beliefs are adhered to. Generally, parents do not talk to their children about these issues because it is considered to be insulting and taboo. As stated earlier this is compounded by the early commencement of sexual activity by adolescents (Gaisie et al., 1993:62; Baboo et al., 1994; Buga et al., 1996:523; Ruskaniko et al., 1997:1; Shah, Zambezi & Simasiku, 1999:11; CSO et al., 2004; WHO, 2004c). Consequently many girls do not know much about menstruation until their first period. According to the UNFPA (1997:33) report a significant number of adolescent boys and girls in Zambia had not received advice on sex at all. The report also states that rates of infection with HIV were six times greater among adolescent girls than among adolescent boys. According to the MoH (1992), between 1988 and 1991 40% of primary and secondary school students in Zambia had a sexually transmitted infection. The use of contraceptives among adolescents was very low, with condoms and contraceptive pills the most commonly used forms. Similar findings are still being reported (CSO et al., 2003a; CSO et al., 2004).

A study conducted by the USAID/Zambia (1999:13) reported that there was no data available in Zambia on the prevalence of unwanted pregnancy amongst adolescents, but that some children born to teenagers are unplanned and unwanted, particularly where the mothers are unmarried. Although abortion is legal under the 1972 Termination of Pregnancy Act, the general public does not seem to be widely aware of the legality and availability of abortion services (UNFPA, 1997:33). Consequently, many schoolgirls who become pregnant and fear expulsion from school, resort to unsafe and illegal abortions. At the University Teaching Hospital (UTH) in Lusaka, Zambia, it was estimated that 23% of incomplete abortions that presented at the hospital were for women aged 19. However, it must be stated that the Zambian government through the Ministry of Education (MoE) has reversed its decision of expelling girls upon become pregnant. However, some schools do not comply with this ruling. Politically, Zambia is a declared Christian nation and so the abortion is usually frowned upon in society even though it does take place.

Traditionally in Africa, having a large family was considered a measure of one's success. This God-given gift of child bearing was not to be controlled. Some communities consider having many children as a form of security during old age. Certain groups felt that by having more children they would be able to "accommodate" death if it occurred to some of the many children. The unforeseen consequence was the cost of educating, feeding, clothing and even looking after these children when they fell sick. These situations placed a lot of health risks on the woman who had to bear and rear all these children. This is worsened by the fact that most women did not and many still do not

have the "ability" to take full control of their fertility (UNFPA, 1997). Armstrong and Royston (1989) stress that if women could control their fertility, there would be a considerable decrease in maternal mortality. The WHO report on family planning (1996:71) states that "the basis for action in family planning must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children, to have the information and means to do so, to ensure informed choices and to make available a full range of safe and effective methods." Other authors have recommended the same (CSO et al., 2003a; CSO et al., 2004).

In most societies marriage is associated with having children. Many marriages end because of a partner's inability to perform this expected reproductive role. It has become very common for a woman to become pregnant prior to marriage, especially in the rural areas of Zambia. This is because it gives the girls a kind of security in the awaited marriage because of their fertility (CSO et al., 2004). Peer pressure is a contributory factor to high fertility rates as young people are sometimes forced or coerced to indulge in a number of health risk behaviours such as unprotected sex.

The use of contraceptives is a major problem amongst women of child-bearing age. A number of factors contribute to this problem. In Zambia, for many years the use of contraceptives, especially by single women, was associated with prostitution. Married women were only permitted to use contraceptives if they had written consent from their husbands. Only then could they use any modern form of contraceptives that was available from health providers. This made it very difficult (and still is in some circles)

for a number of women to take control of their reproductive health. A number of rural women resorted to the use of traditional substances that sometimes proved ineffective or dangerous. New contraceptive technologies have shifted attention from the promotion of a particular technology to an emphasis on the method mix: the capacity to provide services with quality of care, reproductive choice, the users' perspective and needs.

In Zambia some of the contributory factors to abortion were, and in some cases are, fear of being expelled from school, unwillingness to reveal a secret relationship, traditional beliefs to protect the health of their previous baby and common knowledge and belief that postpartum sexual taboos had been transgressed.

Maforah et al. (1997:81) and CSO et al. (2004) emphasise the need for family planning to be targeted at men as well. Since the process of reproduction involves both male and female, there is a need for both to take responsibility of this process so that it occurs at a time when both parties are ready for it. A study done in Zimbabwe reported that 60% of the women who reported at the Harare Hospital with incomplete abortions had unintended, unplanned or unwanted pregnancies (Mbizvo, Bonduelle, Chaduka, Lindmark, & Nystrom, 1997:202). These findings were in spite of Zimbabwe having been reported to be the highest user of contraceptives in southern Africa (CSO, 1995; Mbizvo et al., 1997:200). It was reported that a number of women in the study by Mbizvo et al. (1997:203) did not discuss family planning with their partners, which constitutes a risk for unplanned pregnancies. The participants reported to have lacked basic or adequate knowledge of contraceptives and the working of their reproductive

system.

In 1993, 3104 women were treated at Harare Hospital for abortion-related complications (Mahomed, Healy & Tandon, 1993:206). These numbers are undoubtedly very high. The study by Mahomed et al. emphasised the need for eliminating abortions by providing adequate family planning services. The Zambia Sexual Behaviour Survey of 2003 (CSO, et al., 2004) reported the reluctance of sexual partners to readily discuss issues pertaining to contraceptive use or HIV testing.

The findings reported above have contributed to high maternal morbidity and mortality rates. Recent estimates by the WHO (2004b) and UNICEF (2005) have shown that the dimensions of this problem are greater than was originally thought. The WHO concluded that there is little indication that the intervention(s) needed to reduce maternal morbidity and mortality are reaching more women today than was the case over 10 years ago (AbouZahr, 1998:8). More recently, the WHO (2004b) has reported that more governments have committed themselves to making the health of women and children one of their priorities.

The UNFPA (1997:32) reported that some of the schoolgirls in Zambia who were sexually active indulged in sex with much older working men, teachers and truck drivers who in return gave them money, transport or higher marks at school. One of the reasons given for pre-marital sexual relations among adolescent girls was the desire for economic support. USAID/Zambia (1999:20) reported reasons why some Zambian adolescents

were sexually active. The main reasons given by the boys as to why they (or other boys) had sex were:

- It gave them pleasure.
- They could not withstand peer pressure.
- They did it for fun.
- They loved their girls-friends and it made their love grow stronger.
- They wanted to prove their manhood.
- It was difficult to refuse when girls requested for sex.
- They were aroused by pornographic films.
- They were imitating their elders' behaviour.

Reasons given by the girls were:

- They did it for money or material benefits.
- They gave in to peer pressure.
- It gave them pleasure.
- They believed it would keep the boy from leaving.
- It would prove to boyfriend that they love him.
- They were curious to try sex after seeing elders do it in the open.
- They had sex to become pregnant to prove their fertility.

As stated earlier, in Zambia, the prevalence of HIV is high. This problem is compounded by high levels of maternal mortality, and the lack of adequately trained medical staff to deal with preventable and treatable conditions. It is the opinion of the researcher that besides

other strategies being taken by the country it gives Zambia very few options but to focus on or invest in the health of the future generations.

It is to be concluded that adolescents are generally very physically active and that their actions are often inspired by the desire to appear up to date with what is happening to their peers or role models. Most adolescents are well versed with issues of sexuality although they do have many questions on the implications of possible sexual activities. Focussing on abstinence and the correct or consistent use of condoms would save many lives but this information will have to be given with understanding of what their concerns are. Therefore, adolescents need to be given correct information and not myths, as they are, in any case, able to access a lot of information for themselves via the media or from peers.

Structured sources of information which are not intimidatory or judgemental (offered by health providers, church organisations or trainers) would make it possible for peer educators to be up-to-date with information necessary for fellow adolescents. As a result of this they would be able to model desired behaviours to their peers. Adolescents of the 21st century are intelligent and they will require meaning answers to their questions. Answers like “Because I say so” will not do for them as they would want to understand why, for example, they should not be sexually active at this stage, or what the possible effects of substance abuse will be on their reproductive health. They would probably know that if they got drunk today they would not necessarily become alcoholics in the future but they might not understand that intoxication could make them susceptible to violence, accidents and

unprotected sex, because the alcohol would have reduced their capacity to make healthy or right decisions.

The above issues were discussed to provide an understanding of the kinds of issues that would affect adolescents. This component highlighted the cultural and socio-economic factors as they could influence training of peer educators in Zambia (this will be examined in greater detail in the following chapters). The training programme developed needed to be specific to the cultural and socio-economic setting for which it was being designed, in this case Zambia.

The second component of this chapter highlights factors influencing maternal mortality in Zambia.

2.6 A SITUATION ANALYSIS OF CRITICAL FACTORS INFLUENCING MATERNAL MORBIDITY AND MORTALITY IN ZAMBIA

2.6.1 SOCIO-ECONOMIC FACTORS

Up to this point, Chapter 2 of the study discussed the concepts of health promotion and reproductive health in general, and focussed on adolescent reproductive health. The next component that highlights various issues that contribute to maternal morbidity and mortality in Zambia.

Socio-economic factors such as environmental sanitation, nutrition, housing, poverty and unemployment have a direct influence on individual or community health status. Other socio-demographic factors like social status, age, gender and educational background are highly associated with health-related behaviours. While individual beliefs about health-related behaviours may influence the decision to adopt a particular behaviour, socio-economic circumstances provide a setting that causes or constrains the practice of that health-related behaviour. In other words, poverty could cause an individual to indulge in health-risk behaviour, such as prostitution as a way of generating income.

Uitenbroek et al. (1996:368) showed that employment status is highly related to social background, the level of income, living circumstances, social deprivation and various kinds of socio-psychological and stress factors. They further indicated that higher educational levels are related to having a better health status and better health-related lifestyle behaviours. It was further stressed by Dean (1989:137) as well as Ross and Bird (1994:162) that females tend to have a more careful lifestyle than males and that they regard possible health effects of behaviours as being more important than do males. An assumption was also made that older people would probably have a better lifestyle behaviour due to their experiences in life (Uitenbroek et al., 1996:670).

In some developing countries, health issue problems are compounded by policies such as the SAP. The implications of the SAP for the poor are often rapid price rises of food and transport, and introduction of school and medical fees (Logie & Woodroffe, 1993:41; The World Bank, 2004). All these factors could further influence health behaviours. In a

world where there is an increase in preventable diseases the only remedy seems to lie in change of lifestyle behaviour (Fishbein 1990:55; Carmel 1990:83). The challenge is to balance all the above stated variables that contribute towards health in both individuals and communities.

In Zambia there are eight main languages inclusive of English, the official language. Every individual in Zambia has a right to education. A long-standing goal in Zambia has been that every child who enters Grade 1 should be able to complete grade 9. This is what is referred to as basic education (MoE, 1992:71; CSO et al., 2003b). As a result of this, the percentage of the Zambian population that is literate is 86% of the males and 71% of the females (The World Bank, 1997:226). Similar trends have more recently been reported (CSO et al., 2003a; The World Bank, 2004; UNICEF, 2005). The Zambian government has committed itself to the socio-economic empowerment of women through various programmes of affirmative action. Within this framework, the national policy on education gives high priority to the education of girls. However at tertiary level there is one female to every four male students (UNFPA, 1997:64). Contributory factors are early teenage pregnancies, introduction of higher user fees by education and health providers, poverty and a bias towards the education of the male-child (Nkandu, 1996:8) in some communities in comparison to that of the girl-child.

2.6.2 MARRIAGE IN ZAMBIA

The legal age for marriage in Zambia is 21 for both males and females. However, under customary law, women often marry as soon as they reach menarche. Generally, women

in Zambia marry much earlier than the men. Rural girls tend to start sexual activity earlier than their urban counterparts, with many girls experiencing sex before the age of 15 years. One of the reasons contributing to this factor is that the education of the girl-child is not a priority in a number of homes in the rural areas. Poverty is a major contributing factor. While many families would like to send their daughters to school, some are unable to do so due to financial constraints. A number of these girls assist their parents in making a living by working as child-minders and domestic workers. Some resort to unhealthy behavioural patterns such as prostitution (Nkandu, 1996:4).

Girls are prepared for their roles as mothers or caregivers as they commence looking after younger brothers and sisters at a very young age. In the Zambian context it is a common phenomenon where the girl-child learns to be a caregiver very early in life (Nkandu, 1996:4). As some of these girls and women are generally regarded to be "marginalised" and that they "lack the ability" to make decisions over some issues that affect their lives like the number of children they should have, the use of contraceptives, and sometimes, major issues such as marriage. These factors have negatively contributed to the health status (in holistic terms) of some adolescents.

2.6.3 ANTENATAL AND MATERNAL CARE SERVICES IN ZAMBIA

Maternal health care services are a component of reproductive health. Women who become pregnant and give birth perpetually pay a high price in terms of maternal morbidity and mortality. Both the United Nations and the WHO have reported that the lifetime risk of a woman in a developing country dying during childbirth was 1 in 25 to 1

in 40 compared with 1 in 3000 in developed countries (United Nations, 1995; WHO, 2004b). High levels of maternal mortality and morbidity in developing countries have prompted many health professionals and organizations to seek better ways of preventing maternal deaths and improving women's health care.

Health providers have only recently started paying attention to the attitudes of women towards antenatal care programmes (Murira, Munjanja, Zhanda, Nysstrom & Lindmark, 1997:131). Previously, the benefits of antenatal care were considered so self-evident that the consumers could not question how the services were delivered. Al-Qutob et al. (1996:432) state that a satisfied pregnant woman is more likely to continue receiving prenatal care than a non-satisfied one. In their study done in Jordan, to assess prenatal services, these authors reported that antenatal care was not administered in a private and interactive manner. In a study done in South Africa on "satisfaction with antenatal care services" among Blacks, Westaway, Viljoen and Chabalala, (1997:133) reported that the women in their study sample were satisfied with antenatal care services that were being offered.

In Zambia, it is estimated that 90% of pregnant women attend antenatal services, with an average of five visits for each pregnant woman (CSO et al., 2003a). The survey found a positive correlation between literacy levels and attendance of antenatal care services. The MoH (1992) further revealed that over 91% of women who attend antenatal clinics would like to deliver their babies in health institutions but in practice only 50% of the women in urban areas and 30% of those in rural areas used the facilities. Some of these

women preferred to deliver at home with the help of a traditional birth attendant (TBA). CSO et al. (2003a) reported that deliveries at home had increased in Zambia from 49% (1992) and 53% in 1996 to 56% in 2001-2002. During the same period TBA assisted deliveries dropped from 9% (1992) 5% (1996) and then increased to 12% (2001-2002). A more recent study has reported a drop in TBA assisted deliveries to 2.4% (CSO et al., 2004).

A study done in Zambia to identify the routine care of women experiencing normal deliveries reported poor quality of care of both the mother and child (Maimbolwa, Ransjo-Arvindson, Ngandu, Sikazwe & Diwan, 1997). In a much earlier study The World Bank in (1997) reported similar concerns. More recently The World Bank (2004) highlighted similar findings.

The 1992 ZDHS reported that access to health facilities was a serious constraint to most women in Zambia. This was because these facilities were - and in some cases still - concentrated in urban areas despite the fact that stated two-thirds of women live in rural areas. The study also reported that the nutritional status of women was generally poor with widespread chronic under-nourishment of 10% of the female population. The 1996 ZDHS found that there had been a slight decline in the number of institutional deliveries. In urban areas, 68.9% of births were assisted by a nurse/midwife and 7.5% by a doctor. In rural areas, only 24.8% of births were assisted by a nurse/midwife and 1% by a doctor. More recently, (CSO et al., (2003a) reported that during the year 2001-2002, 85.1% of the deliveries were assisted by a nurse or a midwife, 6.3% by clinical officers, 1.7% by a

doctor and 2.4% by TBAs. While there has been an increase in the number of women being attended to by nurses or midwives, the general indicators have been reported to be poor contributors to the health status of Zambia (The World Bank, 2004).

As stated earlier, in a study conducted by Maimbolwa et al. (1997) women experiencing normal deliveries reported poor quality of care for both the mother and the child. The study reports that on admission, expectant mothers had standard routines performed on them. Upon admission, women were told to undress while no hospital gowns were made available to them. Though most hospitals had adequate numbers of screens they were not used effectively. Furthermore, the study reported that in all governmental institutions where the study had been conducted, when women approached the second stage of labour, the top blanket or sheet was removed without their consent, leaving the women naked throughout the third stage of labour. The authors assumed that the patients were given no top sheet because the staff would reserve the clean linen to cover the patient after delivery, as most hospitals were reported to be experiencing a great shortage of linen. Though the authors did not give the mothers' view/comments about the above practices, these factors possibly contribute to women delivering their babies at home as they may not be satisfied with the quality of maternal services in some government hospitals.

A study by Al-Qutob et al. (1997:426) reported that the information conveyed to pregnant women by providers was insufficient and lacked specificity. More than half the women in the study sample were satisfied with the quality of information given to them. The

authors further reported that women's satisfaction with the health care could ensure ethical standards of care not only at policy level but also at the local community level. Holroyd, Yin-King, Pui-Yuk, Kwok Hong and Suhk-Lin (1997:66) reported that a positive birth experience has shown to foster a woman's self worth, promote maternal role attainment and help to establish rich and successful family relationships.

Sikosana, Hlabangana and Moyo (1997:94) reported that "women in developing countries experienced an unfair share of life threatening chronic and other significant problems related to pregnancy or child birth". In a study on peri-natal mortality rates in Zimbabwe, Kambarami, Chirenje, Rusakaniko and Anabwani (1997:161) found significantly high maternal mortality rates amongst women who had higher levels of education. This finding is in contrast with the results found in Zambia where maternal mortality rates were positively correlated to low levels of education (Maimbolwa et al., 1997:131). They concluded that these high mortality rates were a challenge to health providers and called for urgent implementation of effective peri-natal programmes to address them. However, Bryanton, Fraser-Davey and Sullivan, (1994:638) state that perceptions of childbirth hold cultural variations as to what constitutes a positive and satisfying experience. They recommend that providers of maternal services should probably consider offering the services with an understanding of the culture surrounding the different people groups. A "balance" in such planning may be necessary so as not to compromise professional conduct.

2.7 COMMON HEALTH BELIEFS AND PRACTICES RELATED TO SEXUALITY AND PREGNANCY IN ZAMBIA

There are certain traditional beliefs and practices that are embedded in the Zambian society. Not everyone follows these traditional beliefs and practices; even those who believe in them do not necessarily follow them all the time (Nsemukila et al., 1998:80). However, beliefs and practices have an important bearing on how the Zambian society functions. These serve to mould many people's lives from as early as birth. Examples of these are initiation ceremonies for boys (circumcision in some tribes) and girls (preparation for marriage), seclusion of a woman who has had an abortion and performing of rituals on the surviving spouse and children when death occurs. Traditional medicine is commonly used to the extent that some patients in hospitals choose to take traditional medicines alongside modern ones (Nsemukila et al., 1998:81). The importance of traditional healers to the society is such that the government has been trying to formalise their role in treating and curing illnesses.

Witchcraft remains a powerful influence on the people's attitudes in Zambia's rural areas. It is commonly invoked to explain misfortunes, provide magical charms for protection and ensure success. Rural communities are organised on the basis of villages, normally led by a village headman who is assisted by elders. Overall traditional authority is invested in chiefs covering groups of villages of a common tribe. Traditional leaders in these communities enjoy considerable respect from the people. Their influence was - and still is - recognised by government to the extent that some traditional leaders have been appointed to political positions (GRZ/UN 1996:27).

In rural areas and in a number of families in the urban areas, the extended family system supports a wider family unit including parents, children, grandparents, cousins, nephews, nieces and other relatives living in the same household. The extended family provides security, as they are able to draw on the support of the relatives in times of need, such as funerals, famine and in connection with farming. The strong family support/links provided at funerals is a common phenomenon in the urban areas as well. As a result of these strong family networks during funerals, the UNAIDS (2000) have reported that a number of businesses in urban Zambia were operating below their potential because of the numerous hours being lost due to employees attending funerals of both immediate and extended family members. The study further reported that the HIV and AIDS pandemic had worsened the situation over recent years. In Zambia, one large company reported that in 1998 AIDS-related illness and deaths had cost more than its total profits for the year. In the same vein, a senior bank official stated, “The threat of AIDS and the problems arising from it cannot be left to government and non-governmental organisations alone ...We are committed to the dire need to control the spread of AIDS and of the discrimination against people with HIV-infection...The way forward is to accept that AIDS is a national problem at every employer’s doorstep – it is a management problem” (UNAIDS, 1998:3; UNAIDS, 2004).

Nsemukila et al., (1998) highlighted some of the common beliefs and practices related to sexuality and pregnancy in Zambia:

- “Teenage sexuality is not good, as it will result in sexual transmitted diseases.”
- “Family planning is good for child spacing, recovering from previous pregnancy,

- avoiding too many children, avoiding over population and controlling bleeding.”
- “Family planning is for prostitutes and also encourages prostitution.”
 - “Family planning has side effects and is also against the will of God.”
 - “Husbands disapprove of family planning.”
 - “During pregnancy a woman should not eat foods such as eggs, some types of meat and fish as these could affect her or the baby.”
 - “Obstructed labour is as a result of either the woman or the man having had an extra-marital affair/s. The remedy is to mention all the names of the persons that the man or the woman has had sex with in order to facilitate the progress of labour.”
 - “A couple should not have sex during the third trimester because the baby would be born with sperms.”
 - “A woman should not have sex for two-three years until the baby is weaned because the baby will be sick from the sperms that the baby is sucking from the mother’s milk.”
 - “Husbands should not have sex outside marriage as this would result in the baby crying and vomiting continuously when touched/held by the father.”
 - “The husband should first have sex with another woman before having sex with his wife for at least two months after delivery to avoid chest pains.”
 - “When twins are born, the couple should not have sex until after being cleansed.”
 - “A pregnant woman should not work hard as this would result in the birth of a weak baby.”
 - “A pregnant woman should not do hard work or lift heavy things.”

- “A pregnant woman should not be lazy as this would result in prolonged labour.”
- “A pregnant woman should take oral herbs to prevent problems during pregnancy.”
- “A husband should not wear a necktie and a woman should not wear chains, belts, bangles, necklaces or tie knots, as the child would be born with the cord around the neck.”
- “A pregnant woman should not go back when she remembers what she has forgotten as the baby would do the same during labour and would delay delivery.”
- “A woman should not cross legs as this would result in a breech delivery.”
- “A woman should not carry things in both hands as this would result in the baby being born with extra digits on both hands and legs.”
- “A woman should not sit or stand in the doorway as this would lead to obstructed labour” (Nsemukila et al., 1998:157, 159).

Some of the above stated beliefs and practices have the potential to have a negative impact on adolescent reproductive health. This is because help may not be sought when these problems occur because those involved may want to solve the problem based on the beliefs stated above instead of seeking for medical assistance.

2.8 SYNTHESIS OF CHAPTER 2

The promotion of health in Zambia is being negatively influenced by many factors. Zambia is experiencing economic problems which are manifested in the high poverty levels, high levels of maternal morbidity and mortality, and unwanted pregnancies.

The numbers of adequately trained health staff have improved but are still not meeting the demands, especially in the rural areas. In the meantime, adolescents are facing many challenges due to negative peer pressure and inadequate recreation facilities.

It is evident from the above discussion that any adolescent growing up in Zambia will be exposed to various cultural beliefs and norms. Therefore, in order to train such an adolescent to be an effective peer educator, a programme that understands the factors peculiar to Zambia will have to be highlighted. What may be considered an ideal peer educator in the western or developed world may not particularly be the sort of person the adolescents in Zambia may want to learn from or consider as a role model. Since it is common knowledge that the world has become “smaller” with the advent of modern technology, adolescents are learning and probably practising norms and values that are considered “acceptable” in other countries. It would be important to evaluate health behaviours of these adolescents, but this was not the focus of this study. This study focussed on the review of training programmes and the development of a training programme for peer educators that will be able to consider all the above discussed variables, but still be relevant to Zambia.

2.9 SUMMARY

Chapter 2 reviewed literature that dealt with the concepts of health promotion, norms, values, cultural beliefs and practices. The chapter further pointed out the factors that contribute to maternal morbidity and mortality in the Zambian setting. Information was given on the factors that contribute positively and those that have a negative impact on

adolescent reproductive health. The chapter further highlighted practices commonly practised in Zambia in relation to reproductive health. A conclusion was made by synthesising Chapter 2 and indicating its relevance to the study as a whole. Chapter 3 will review training models with a focus on the training of adolescents as peer educators.

CHAPTER 3

ASPECTS OF PEER EDUCATION, PEER EDUCATORS AND LEARNING AMONGST ADOLESCENTS

3.1 INTRODUCTION

The purpose of this study was to develop a training programme for adolescent reproductive health peer educators in Zambia, or peer learning facilitators as this study would like to recommend that they be called (see Chapter 1:14). Firstly, it is important to define peer education and secondly to have an understanding of their role and how peers learn from each other.

3.1.1 DEFINING PEER EDUCATION

Svenson (1998:7) defines peer education as “those of the same societal group or social standing educating each other”. UNAIDS (1999:5c) defines peer education as “a popular concept that implies an approach, a communication channel, a methodology, a philosophy and a strategy”. In 2003 the United Nations Educational Scientific Organisation (UNESCO) outlined peer education and adolescence in this manner:

The beginning of adolescence is a formative period in everyone’s social development. It is a time when choosing friends and belonging to various groups take on new importance. Most often as the adolescent develops, peer groups slowly super cede family as a young person’s social outlet (UNESCO, 2003:11).

The same publication states that peer groups help individuals to have a sense of their own by providing a social identity which in turn leads to the development and practice of social skills that last throughout their lives: “Peer education seeks to utilise the positive aspects of adolescent peer groups by helping them learn from each other – something they do naturally anyway” (UNESCO, 2003:11).

Green (2001:65) defines peer health education as the “teaching or sharing of health information, values and behaviours by members of similar age or status groups”.

The English term *peer* refers to:

- one that is of equal standing with another; or
- one belonging to the same societal group especially based on age, grade or status.

The term *education* refers to development, training and persuasion of a given person or thing resulting in the educational or learning process (Cassell Concise English Dictionary, 1994).

UNESCO (2003:11) defines a peer as a person who “is of equal standing with another: one belonging to the same societal group, especially based on age group or status”. An adolescent peer group is usually not defined only by age, but also by interests such as participation in sport, non-participation in sport, school activity and other shared social characteristics. A peer educator is therefore “someone who belongs to a group as an equal participating member, but who receives special training and information so that this person may bring or sustain positive behavioural change among group members” (UNESCO, 2003:11).

In practice, peer education has taken on a range of definitions and interpretations concerning a peer and what peer education is. Peer education typically involves the use of members of a given group to effect change among other members of the same group. It is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs or behaviours. However, "peer education, may also effect change at the group or societal level by modifying norms and stimulating collective changes in programmes and policies" (UNAIDS, 1999:5c).

3.2 THE PRINCIPLES AND CONCEPTS OF PEER EDUCATION

3.2.1 UNDERLYING THEORIES

Peer education as a behavioural change strategy draws on several well-known behavioural theories.

- **The Social Learning Theory**

This theory asserts that people serve as models of human behaviour and that some people are capable of eliciting change in certain individuals, based on the individual's value and interpretation system (UNESCO, 2003:12).

- **The Theory of Reasoned Action**

The Theory of Reasoned Action (see Chapter 2:40, 45) states that one of the influential elements for behavioural change is an individual's perception of the societal norms or beliefs about what people who are important to the individual, do or think about a particular behaviour (UNAIDS, 1999:5c). This is worth noting amongst adolescents, as they tend to

follow the behaviour of persons they consider important or whom they admire. These could range from parents, teachers, celebrities to fellow youths (Drummond, McGuire & Bennett, 2002).

- **The Diffusion of Innovation Theory**

This theory posits that certain individuals (opinion leaders) act as agents of behavioural change by disseminating information and influencing group norms in their community (UNAIDS, 1999:5c).

- **The Theory of Participatory Education**

The Theory of Participatory Education has also been important in the development of peer education. This states that “powerlessness at the community or group level and the economic and social conditions inherent to the lack of power is a major risk factor for poor health” (UNAIDS 1999:6c). Jensen (2004) motivates for this theory although the theory is referred to as an “action-oriented perspective”. Peer education draws from elements of each of these behavioural theories as it implicitly asserts that certain members of a given group can be influential in eliciting behavioural change among peers.

McDonald et al., (2003) define peer education as an umbrella term that refers to a range of activities that:

- are simple and reflect a commonsense understanding of peer education;
- describe a particular approach to peer education in detail; and
- attempt to cover all approaches to peer education in detail.

Based on the above it can be extrapolated that peer group membership could be a complex and dynamic phenomenon that could vary between group types and situations. People use sophisticated sets of criteria to determine who they consider themselves to be, and who they accept as a peer. Young people generally belong to several groups, each of which may be defined by different characteristics. The various groups to which a young person may belong include close friends and acquaintances with common interests who may not even be known to the young person (Shiner, 1999)

3.2.2 CHARACTERISTICS AND ROLES OF A PEER EDUCATOR

A peer educator is a person who possesses the necessary characteristics to be considered a peer, is credible and influential and has received peer education training. The role of a peer educator could therefore be that of a facilitator, counsellor, information resource (including referral to other information sources), support worker or tutor (Gonzalez, 1990; Milburn, 1995; Prendergast & Miller, 1996; Coggans, 1997). Roles that are taken by peer educators can be categorised as either peer support or peer leadership. The support role establishes the peer educator and other young people as equals. In this role, the peer educator engages in organised activities such as health promotion initiatives, role modelling or simply discuss issues in spontaneous everyday situations (Badura, Millard, Peluso & Ortman, 2000). In the peer educator's role as leader he or she takes on more responsibility in dissemination of information and decision making.

McDonald et al. (2003) support the rationale for using peer education, stating that peer educators would be seen as being more credible and less threatening than adult educators.

They would be role models to peers, be more outgoing, would access hidden populations, be more cost effective and would benefit the peer educators themselves. Other studies (DiClemente, 1993; Norman, 1998; Mason, 2003) support the same rationale.

Based on the above rationale, it is widely believed by both the youth and persons involved in peer education initiatives that peer educators would be seen to be more credible than adults when delivering some types of information. This is because young people are more likely to share characteristics with the peer educator, such as age, dress code, language, style, interests and membership of the same social groups. Harrison (1996) states that people tend to perceive those they identify with to be more credible sources of information regardless of the objective accuracy of the information. In the same way, young people may perceive peer educators as being less threatening than adult educators (Norman, 1998; Mason, 2003). Douthwaite (1997) states that the changes in identification that occur during adolescence do not only impact on the credibility of young people as an information source, but also as confidants, as young people are likely to talk to their peer(s) about their concerns because they feel understood and less embarrassed. Bond and McConkey (2001) acknowledge role modelling as a well established and powerful method of learning and subsequent determinant of behaviour. This is because peer educators are more likely to be effective role models for young people since their behaviour provides social information relevant to fellow young people.

Turner and Shepherd (1999) indicate that there is evidence that peer education may have a more widespread and longer-term impact on target groups than other forms of education. This

is because peer educators may have ongoing social interaction with the target group. The ongoing contact can reinforce learning, facilitate additional opportunities to information, and model desired behaviours. Peer educators may also interact with a broader cross-section of the target group during everyday life besides what would occur during formal training sessions (Prendergast & Miller, 1996; Ward, Hunter & Power, 1997).

Peer education is perceived to be cost effective. This is attributed to the low cost of paying peer educators which is less than the remuneration required for adults. Unfortunately, when this aspect of managing peer education programmes is not properly addressed, it could be a major de-motivating factor to peer educators.

3.2.3 BENEFITS OF PEER EDUCATION

Some authors (Badura et al., 2000; McDonald, Ashenden, Grove, Bodein, Cormack & Allisop, 2000; Green, 2001; Mason, 2003) have highlighted the fact that besides the advantages to participants of being trained in peer education, peer educators themselves would benefit in the following ways:

- increased self-esteem and self-discipline;
- enhanced sense of self-efficacy;
- development of facilitation and communication skills;
- development of leadership skills in peers and their community and better understanding of diversity;
- involvement in programme design and operation;
- development of skills in assessing and accessing information and resources;

- development of valuable experience that may facilitate job seeking efforts later;
- increased knowledge in decision making, clarifying values, and acting in accordance with those values;
- increased knowledge and skills about health-related issues;
- ability to master sexuality information relevant to their health and lives; and
- decreased risk behaviours.

In other words both the trainers and the trainees in peer education training are empowered.

3.2.4 LEARNING METHODS IN PEER EDUCATION

The degree to which students are truly “peers” varies across the range of possible peer tutoring applications. While it was thought in the past that adults on their own knew how to educate youths, more recent studies have identified peer groups and peer learning as the single most powerful influence in undergraduate education (Bullough & Kridel, 2003; Jensen, 2004; Thorkildsen, Sodonis & White-McNulty, 2004). In peer learning, students learn with and from each other, normally within the same class or cohort. Interaction with peers can result in the development of cognitive or intellectual skills or an increase in knowledge or understanding. The range of skills that can be established or developed with peer collaboration and adult guidance is greater than anything that can be attained alone (Falchikov, 2001:3). Peer groups are widely regarded as an important influence on individuals. Piaget (1971, as quoted in Falchikov, 2001:3) states that “co-operation between peers is likely to encourage real exchange of thought and discussion”. UNAIDS (1999:6c) agrees with the above and concludes that advocates of peer learning or horizontal processes of peers talking among themselves and determining a course of action is a key to peer

educators' influence on behavioural change. More recent studies are still advocating for this type of learning and for the use of adolescent peer educators (Shannon, 1998; Agha, 2002; Erulkar, Ettyang, Onoka, Nyagah & Muyonga, 2004; Forrest et al., 2004).

Some authors have discussed learning methods that they have found to be most effective among peers. Bonwell and Elison (1991:43) recommended co-operative learning which is two fold: firstly to enhance student learning and secondly to develop students' social skills. During the same year other authors (Johnson & Johnson, 1999; Johnson, Johnson & Smith, 1991; Soyibo & Evans, 2002) defined co-operative learning as the instrumental use of small groups so that students work together to maximise their own or each other's learning. It is a learning method which produces higher achievements, more positive relationships among students and healthier psychological adjustments as compared to competitive or individualistic experiences. However, the authors caution that these outcomes do not automatically appear when students are placed in a group, but that the facilitators or educators should carefully structure learning groups.

Gravett (2001:38), motivating for co-operative learning, reported that this method connotes "working together, being helpful and sociable, sharing, collaborating and joint effort". Examples of learning methods are drama, role-playing, simulations and games. These methods are reported to have the ability to help students experience stressful, unfamiliar, complex or controversial situations by creating circumstances that are momentarily real, thereby letting the students develop and practise skills necessary for coping (Shah et al., 1999; Deutsch & Swartz, 2003).

Since reproductive health and associated risks are caused by multiple factors, efforts to affect behavioural changes must be multidimensional (Rice, 1996:8). Ryan and Martens (1989:20) and Jensen (2004) recommend “active learning” in which students do other things besides just listening. *Participatory Learning and Action, Active Listening or Action Learning* are some of the methodologies that have been reported to be successful in projects involving youth in Zambia (Shah et al., 1999:5, 21; The International Bank for Reconstruction and Development/The World Bank, 2003; Van Ginneken, Granston, Moynihan, Takele, Breslin & Groenendijk, 2004).

3.2.5 COMMUNICATION STRATEGIES IN PEER EDUCATION

The role that communication plays in peer education is very important as it is the medium through which transference of information is done. “Dialogue or communication (spoken or written communications) occurs whenever an individual with particular aims communicates with another person in order to arrive at an understanding about the meaning of a common experience so that they may co-ordinate their actions in pursuing their respective aims” (Mezirow, 1991:65).

Minton (1991:74) states that, “communication is not just about transmitting messages” and emphasises that “no amount of improvement in transmission will help if the radio is switched off”. The author points out that students usually watch and learn from what is being verbally and non-verbally communicated. They would look out for verbal and non-verbal communication such as body language, behaviour or mannerisms that either re-enforce or dispute what is being communicated. Peer learners also look out for the same things and

begin to imitate traits or behaviours that are sometimes unconsciously being “taught” by their peers. Common communication methods reported in studies conducted in Zambia are group forums, drama, poems, songs, games and print materials followed by video/film counselling, debates, talent shows, radio, television and formal lectures (USAID/Zambia, 1999:56; The International Bank for Reconstruction and Development/The World Bank, 2003). Other authors have emphasised the use of radio, drama, pictorial messages, mass and interpersonal media (De Fossard 1996; 1998). This is supported by the 2002 report on the Program for Appropriate Technology in Health (PATH). The above mentioned authors aver that in programme design, communication skills should not only look at the content of the information or knowledge but also at how it is packaged. This includes language, enthusiasm, social interaction skills, value systems, dress code, mannerisms, convictions and visual aids.

3.2.6 CONTEXTUALISATION IN PEER EDUCATION

In the light of what has been discussed above (concerning who peer educators are and their roles), peer educators further need to have an understanding of the social context in which they operate so that they are not offensive to peers, parents or elders in their process of facilitating learning on sensitive issues like HIV and AIDS and reproductive health in general. This necessitates good interpersonal and communication skills to enable them to interact with their peers. The ability to adequately integrate theory and practice is essential as it would help them develop conscious intensions to facilitate and enhance learning amongst their peers.

Peer educators use the knowledge they gain to educate their peers. This education may take place through formal education programmes or through less structured one-to-one or small group contacts with peers. According to the 2000 report by the Planned Parenthood Federation of America (PPFA), the premise of peer education is that people (particularly adolescents) are highly influenced by their peers and that information coming from “like individuals” will be valued more highly than information coming from adults or individuals who are not seen as part of one’s peer group.

3.3 THEORETICAL MODELS APPLICABLE TO PEER EDUCATION

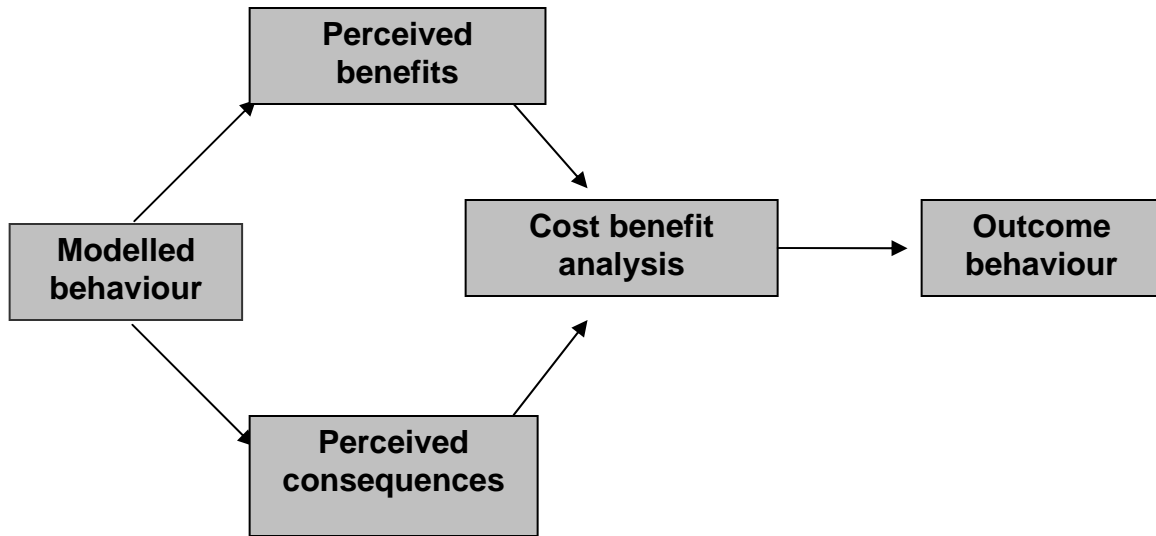
McDonald et al. (2003) state that the theoretical basis of peer education is rooted in psychology literature. An earlier study (Turner & Shepherd, 1999) has reported that in the past, peer education was based on intuition and observation rather than on sound theoretical principles. However, various social psychology theories help explain the impact that peer education may have on young people’s knowledge, attitude and behaviour. McDonald et al. (2003:45) reported that “the central purpose of peer education initiatives is to influence or modify young people’s knowledge, attitude and behaviour”. Allott, Paxton and Leonard (1999) add that it is commonly assumed that enhancing knowledge on a particular topic would influence attitudes and ultimately behaviour. However, such a linear knowledge-attitude-behaviour relationship is not consistently supported by research evidence as these relationships are complex and not always unidirectional in nature.

Behaviour change is influenced by a number of factors related to the individual (e.g. pre-existing knowledge, attitudes and beliefs) the social environment (e.g. groups and cultural

norms, peer influence, family influence) and cognitive factors (e.g. self-esteem and self-efficacy). An understanding of factors most likely to impact on behaviour is therefore pivotal to the success of peer education initiatives (Gronder, 1991; Kaplan, Sallis & Patterson 1993; Grube & Voas, 1996; Armitage, Conner, Loach & Willietts , 1999; McDonald at al., 2003).

Earlier in this study (Chapter 2) the way in which a number of social, cognitive and medical theories influence behaviour was discussed. This component of the study will consider the implications of these theories for peer education.

Bandura's (1977) Social Learning Theory is concerned with how the social environment influences an individual's behaviour and places particular emphasis on the importance of modelling. The author argues that social behaviours are learnt by observing the behaviour of others in the social group. Factors influencing the likelihood of behaviour include characteristics of the model (i.e. how influential they are) and the perceived nature and severity of the consequences (reward or punishment) of the behaviour. This theory is outlined in Figure 3.1.



(McDonald et al., 2003:46).

FIGURE 3.1: The relationship between perception of consequences and behaviour

Based on the above, this theory implies that the increased influence of peers and the “diminished” influence of adults during adolescence would cause the peer-led education to have more influence than adult-led education.

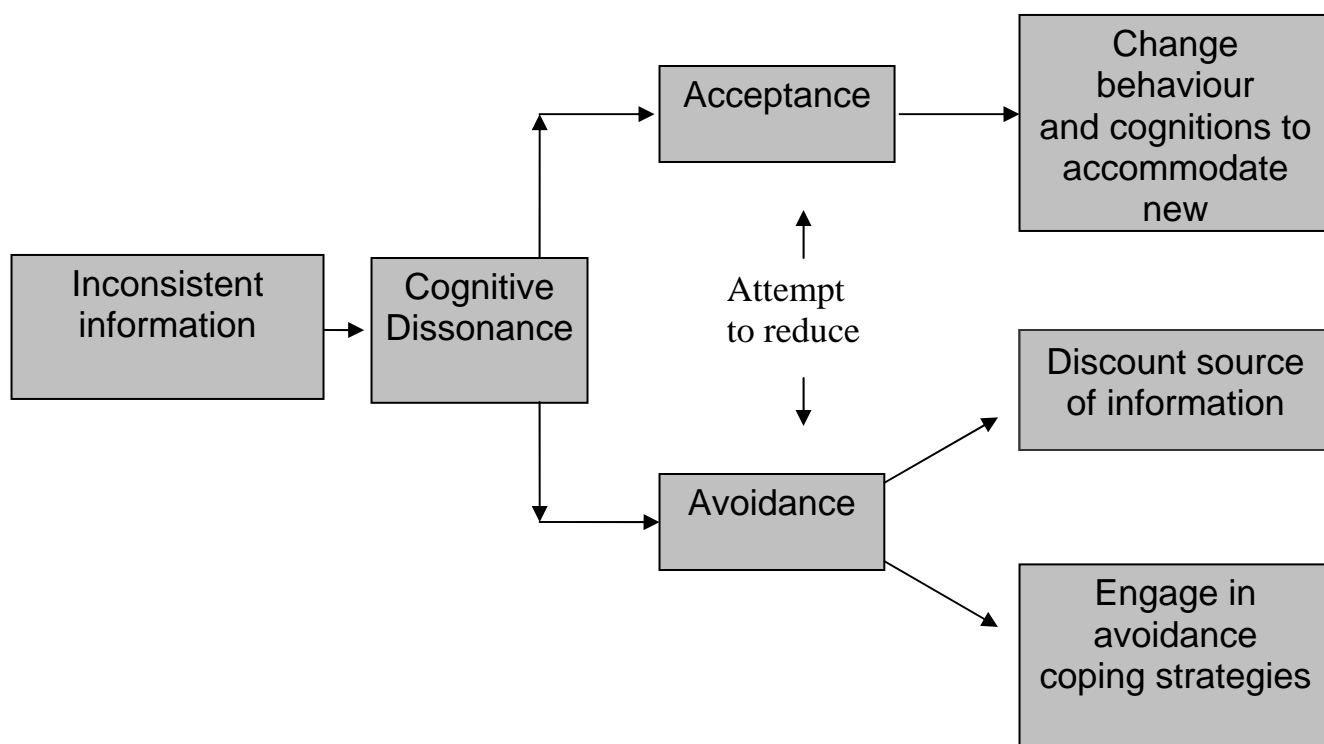
The Social Identity Theory (McDonald et al., 2003) is based on the concept of in-group and out-group influences. It is well established that people are more strongly influenced by individuals with whom they share a common social identity. Social influence in relation to in-group operates through a number of channels including exposure (frequency of contact with group members) and social comparison (modelling of appropriate/desirable attitudes and behaviours). The degree to which an individual conforms to the group norms depends on his or her desire for acceptance and status with the group and a wish to avoid rejection

(Wilder, 1990). The implications of this theory for peer education are that a peer educator is more likely than an adult to be perceived as an in-group member. Peer educators who therefore match the target group in relation to key social and personal characteristics are more likely to be perceived as in-group members than peer educators who only match the target group on single characteristics such as age. Careful selection of peer educators is therefore required to optimise the probability of effectively influencing young people's attainment of knowledge, attitude and behaviour (McDonald et al., 2003).

The Diffusion of Innovation Theory describes the communication of innovations through social networks over time. The time taken for innovations to diffuse through a social network depends on how members of the network perceive the relative advantage, compatibility, complexity, trialability and observability of the innovation (Rodgers, 1995; 2002; Larkey, Alatorre, Buller, Morrill, Buller, Taren & Sennott-Miller, 1999). This theory suggests that new information and behaviour diffuse throughout a group as more and more group members discuss the information and it subsequently contributes to change of behaviour (Rodgers, 2002). The Diffusion of Innovation Theory supports the use of informal approaches to peer education that rely on ongoing contact and behavioural change. Following training, peer educators disseminate the newly learnt information and enact newly formed behaviours which increase the observability of desired behaviours (McDonald et al., 2003). "Forceful" peer educators in terms of character and role modelling would be able to influence peers.

According to the Social Comparison Theory, people form beliefs about their own abilities and opinions by comparing themselves with others who are similar in relation to relevant characteristics. The process of evaluating self against similar others has an informative and motivating effect: adolescence is a time when young people feel a heightened sense of identification with their peers and realise that they share many characteristics with other young people (Ranson, 1992; Bond & McConkey, 2001). The implications of this theory are that young people who are similar to the target group may positively influence norms within the target group and potentially motivate them to adopt safer attitudes and behaviour.

According to the Cognitive Dissonance Theory, cognitive dissonance occurs when a person receives information inconsistent with his or her existing knowledge, attitude and beliefs. This produces feelings of conflict or guilt, depression, lowered self-esteem and decreased self-efficacy (Marlatt & Gordon, 1985). When dissonance occurs a person may reduce unwanted feelings by either accepting or avoiding the new information. This is illustrated in Figure 3.2



(McDonald et al., 2003:50)

FIGURE 3.2: Cognitive Dissonance and potential responses

The Cognitive Dissonance Theory highlights the importance of tailoring peer education initiatives to the expectations and experience of the target group. The theory also provides some insight into the strategies for enhancing the acceptability of the peer education content.

The Health Belief Model (see Chapter 2:41) has already been explained in detail earlier in the study, but in summary the theory states that the probability of engaging in a given behaviour is determined by beliefs concerning the perceived threat of a negative health outcome and perceptions of recommended health action in response to the threat. Implications for peer education are that the content of peer education initiatives should focus

on young people's perceptions of susceptibility to the severity of harm. Peer educators should therefore focus on providing fellow young people with information, skills and support needed to overcome potential barriers to performing such behaviours. Examples of barriers are negative peer pressure, existing dependency and poor coping skills (McDonald et al., 2003; WHO, 2004c).

The theory of Planned Behaviour describes the mechanisms that influence an individual's behavioural intention and how this in turn influences actual behaviours (Ajzen, 1991). The implications for peer education are that peers are perceived as being significant in the lives of adolescents and that they play a key role in determining behaviour. Given the influence of peers, information that peers provide to fellow young people about social consequences and norms may influence behavioural intentions and actual behaviours (McDonald et al., 2003).

The understanding of these theories informed the researcher on the study design and methodology and was also essential information that formed baseline information prior to conducting the group interviews and the focus group discussions. The information shed light on the development of the training programme and understanding of the peer educators' viewpoint in the process of interpreting the outcomes of the focus group discussions. The theories gave the qualitative data more meaning as outcomes were correlated to the theories discussed above.

3.3.1 ASPECTS OF PEER GROUP WORK

Adolescent groups may either be formal (those with reasonably permanent structures like clubs and fraternities) or informal (those which tend to appear and disappear, depending upon the occasion). Participation in organised clubs is very important to adolescents for several reasons. Students gain experience in co-operatively and intellectually planning goals, programmes and activities. They have the opportunity of sharing special interests and skills like hobbies and sport. They learn group roles such as constructive leadership and followership. Of particular interest to adolescents are issues of sexuality. During adolescence, individuals are often more open to others as they seek to determine who and what they are, and they gain from their peers' feedback concerning their strengths and weaknesses. The power of peer pressure is very real and should not be underestimated, especially amongst adolescents who still lack experience in comparison to adults.

There are various ways in which adolescents acquire information. One of the most common ways of communicating information is *adult to adolescents*. Resource persons are usually family members, teachers and health workers. However, on sensitive subjects such as sexuality and the use of illegal substances, adults are commonly unable or unwilling to discuss these issues, especially with their own children (WHO, 1999:59; WHO, 2004c). Contrary to this, Hirst (2004:115) has reported that young people interviewed in her study “desired the affirmation and support of adults and recommend sex and relationship education as the most appropriate vehicle for providing this”.

Another form of interpersonal communication used amongst adolescents is *adolescents to*

adolescents. Although typically used in peer education and provided by trained young people of a similar age, this method is sometimes used among friends who are equally uninformed. In countries where cultural or religious barriers obstruct the information of adolescents on sexuality and reproductive health, the young are obliged to obtain their information from their friends. Myths are thus perpetuated, with the result that wrong information can have disastrous consequences. Expanding the capacity for proper peer education by adequate training, education, learning, supervision and support can help reduce the misinformation of adolescents (WHO, 1999:59).

Peer to peer education has also been found to be an effective approach to sharing information amongst the youth. Young people are often willing to listen and to follow advice from their peers. As role models, peers can be very effective in enhancing information as an intervention (Perry & Sieving, 1991). While a number of studies support the concept of peer to peer education (as has been discussed earlier in this study) there appears to be a gap in that trainers of peer educators are not involving potential or trained peer educators in the development of training programmes by identifying the training needs of the youth and the needs of the communities where the peer educators would work in. Overlooking these needs could be a problem as the trainers would disseminate information which they think or perceive to be relevant to the adolescents and not take into account their actual training needs.

Recent studies (Forrest et al., 2004; Hirst, 2004) have reported that identifying the needs of a target group is an important component of the development of health promotion activities.

The same authors discovered out that assessment of expressed needs was not a common feature of interventions in peer-led health promotion interventions. Forrest et al. (2004), in their study that set out to determine out what young people want from sex education, concluded that there was much more that the young people wanted to know outside that which the trainers would have considered important or even relevant. Their outcomes correlated with earlier studies (Measor, Tiffin, Miller, 2000; Strange, Forrest, Oakley & The RIPPLE Study Team, 2003) that were done to establish what youth want from sex education. The researcher, in this work, embraced the input of peer educators in the development of the training programme.

3.3.2 THE PRINCIPLES OF LEARNING AND PEER LEARNING

The main purpose of teaching is to enable people to learn. Gravett (2001:17) points out that when discussing learning it is important to distinguish between rote learning (memorization) and meaningful learning. Memorization (which is done by repeating something until it is committed to memory) plays a definite role in learning. Unfortunately, many learners and adult educators, though often unconsciously, equate learning with memorization. Isolated pieces of information that are memorized are generally soon forgotten because they are not placed in a meaningful organizing structure in the brain. Unlike in memorization, information that “makes sense to a learner, is categorized and placed in an organized structure...” Gravett (2001:17). The extent to which one’s knowledge is structured or connected would result in better access and use of the same information when it is needed.

What Gravett raises here is the role the researcher sees in peer educators; that of learning facilitators. They need to be empowered to deal with a variety of issues, which would sometimes include unexpected situations that their peers may be dealing with. Peer educators should then be able to process information given to them by peers and give advice, guidance and counsel.

Learning has at times been equated to change. In its simplistic terms learning could be said to be change although not all change is learning. Changes that are brought about by ageing or other physical processes can hardly be described as “learning changes” though they may have necessitated learning, for example through experiences of life. Some forms of learning are confirmation rather than changes of existing knowledge and behaviour. In other words, learning can be defined as a permanent change brought about voluntarily in one’s patterns of acting, thinking and/or feeling. As Jensens, (2004:410) says: “...before any action there will always be a conscious making up of one’s mind”.

There are three basic domains of learning namely the cognitive, affective and psychomotor domains. Rodgers (1986:43) suggests that “learning changes occur in skills, in cognitive patterns (knowledge and understanding) and in motivation and interest”. The same author identifies five domains of learning, namely:

- motor skills, which require practice;
- verbal information, that is facts, principles and generalizations which when organized into larger bodies of information become knowledge;
- intellectual skills, which rely on prior learning;

- cognitive strategies which imply the way knowledge is used and the way the individual learns, remembers and thinks; and
- attitudes and beliefs of the individual.

Learning is said to take place in a number of domains. These can be distinguished in this manner:

- New skills can be developed; not only physical skills but also skills of thinking, learning, coping and even survival strategies.
- In the collection of information that could be largely memorized, new knowledge may be learnt. Such knowledge may be held uncomprehendingly as experience will testify; "...we thus need to learn to relate our new material in ways that lead to new understanding" (Rodgers, 1986:44).
- "The learning of attitudes is a distinct sphere of learning" (Rodgers, 1986:44), as we can learn new skills, knowledge, understanding without necessarily changing our attitude.
- Learning changes can be brought about without alterations in one's way of life or behaviour. "It is therefore necessary to apply our newly learned material to what we do and how we live, to carry out our new learning into changed ways of behaving - to learn wisdom in short" (Rodgers 1986:44).

Rodgers concludes by stating that he does not know how the above areas of learning domains relate to each other. In a way, he concedes that an increase or attainment of knowledge does not necessarily guarantee a change in behaviour. This informed the researcher on the need to link educational and health-related theories in order to bring about purposeful learning.

While the traditional methods of learning would benefit peer educators to some extent, action learning methodologies would be most beneficial as they would prepare them for their roles as leaders and role models to their peers.

Marquardt and Waddill (2004:185) state that “action learning has the ability to solve complex problems and significantly increase the speed and the quality of individual, team and organizational learning”. The authors outline the six critical components of action learning as:

- a problem or a task;
- a group;
- the reflective inquiry process;
- action;
- learning; and
- an action learning coach.

Jensen (2004:408) has a similar approach, although his approach has eight dimensions aimed at developing students’ action competence. These are:

- Which topic or theme should be worked on?
- Which problem within the topic should we work with?
- What are the causes of this problem?
- Why did it become a problem?
- What alternatives can we imagine?
- What action possibilities exist to secure these alternatives?

- What barriers will be brought to light through these actions?
- What actions will be initiated?

Marquardt and Waddill (2004:186) highlight the fact that while there have been multiple forms of the concept of action learning, “all forms of action learning share the elements of real people resolving and taking action on real problems in real time, and learning through questioning and reflection while doing so. The uniqueness of action learning is its power to simultaneously and resourcefully solve difficult challenges and develop people ... at minimal costs ...”. Coughlan and Coughlan (2004:43), commenting on action learning, state that “since its initial articulation and implementation in practice action learning has proven to be a usable and useful approach ...”.

Vince (2004:65) comments that “action learning constructs a learning space within which assumptions and power relations can be explored” and that it “effectively serves a desire to organize change, but it also reflects what is controlling about, legitimized, by or excluded from attempts to change”. Further motivating for action learning, Donnenberg and De Loo (2004) contend that action learning seems appropriate in circumstances and contexts of unclear futures and choices of action. Where the path ahead is preordained or obvious or clear, there is little room in the process for action learning: “Where times or individuals are undergoing change and uncertainty then action learning can be a powerful tool” (Donnenberg & De Loo, 2004). This seems very appropriate to adolescent peer educators. This is because of the uncertainty of the adolescence period whereby they are undergoing

significant change, both physically and emotionally, and could make decisions based on inadequate knowledge and experience.

While action learning has had a bias towards adult learning (andragogy), adolescents are in the transition period from pedagogy learning theories to an andragogical type of learning. This study motivates for andragogical type of leaning for adolescent reproductive health peer educators. Additional reasons for this choice are given in the synthesis component of this chapter.

This study therefore borrowed theories or schools of thought in adult learning to motivate ways in which peer educators could learn. The strengths and weaknesses of these theories are presented in Table 3.1.

TABLE 3.1: A comparison of learning theories

THEORY	EXPLANATION	STRENGTHS AND WEAKNESSES
BEHAVIOURIST THEORY	<p>Behaviourists concentrate on learning through control of external environment. The emphasis is on changing behaviour through the processes such as operant conditioning. Behaviourists believe that learning is built on three assumptions:</p> <ul style="list-style-type: none"> • Changed behaviour indicates learning. • Learning is determined by elements in the environment. • Repetitions and re-enforcement of learning behaviours assist in the learning process (Merriam & Caffarella, 1991). 	<p>In a class setting, for example, the teacher controls the stimuli by choosing the correct response and awards the students (usually verbally) when they give the correct response.</p> <p>In this school of thought the assumption is that a change in behaviour is learning or since the student is able to give the desired response, the student will have learnt. There is also a possibility that the response is as a result of imitating the stimuli or the behaviour given and not that there is understanding.</p> <p>While this is good for the short term it may not be sustainable when the peer educator has to take a leading role of empowering others (peers) as would require understanding of information being presented.</p>
COGNITIVIST THEORY	<p>Cognitivists focus on how humans learn and understand using internal processes of acquiring, understanding and retaining knowledge.</p> <p>Cognitivists believe that humans are capable of insight, perception and attributing meaning. Learning occurs when humans reorganize experiences, thereby making sense of input from their environment (Merriam & Caffarella, 1991).</p>	<p>This is more useful when compared to the Behaviourist Theory, as the theory focuses on the processes involved in the creating of responses and the organization of perceptions that goes on in the mind for the development of insight (Rodger, 1986:47). This enables the learner to have better understanding of materials being learnt.</p> <p>In this theory, there is need for understanding for learning to take place. In other words, the material must be comprehended step by step and then mastered. A combination with the behaviourist theory would enable the learners (or in this case the peer educators) to understand and also to show through behaviour that they have learnt.</p>
HUMANIST THEORY	<p>Humanists emphasise the development of the whole person and place emphasis on the effective domain. This orientation views individuals as persons seeking self actualization through learning, and being capable of determining their own learning. Self-directed learning is embraced by members of this school of thought (Merriam & Caffarella, 1991).</p>	<p>In the Humanist Theory, an analysis of the nature of personality and society are required. In other words, the learners' actions largely create the learning situation.</p> <p>This theory, when used on its own for learning, could be very limiting to learners who have not had exposure from societies other than those from which they originate. Learners who are not motivated would be very limited as they would not be able to direct their own learning.</p>

Table 3.1 (continued)

THEORY	EXPLANATION	STRENGTHS AND WEAKNESSES
CONSTRUCTIVIST THEORY	<p>Constructivism stresses that all knowledge is context bound and that individuals make personal meaning of the learning experiences through internal construction of reality. This school emphasizes the importance of changing oneself and the environment. Reflective practice is a key manifestation of this orientation.</p> <p>Constructivism is not a single unified theory of learning. The term is used to denote a cluster of related issues namely radical and social constructivism, socio-cultural approaches and emancipatory constructivism.</p>	<p>These views all rest on the assumption that learning is a process of constructing meaning or knowledge construction ...it is urged that learners are not passive beings that respond to stimuli. Learning is an active process of constructing meaning and transforming understanding in interaction with the environment.</p>
SOCIAL LEARNING THEORY	<p>The Social Learning Theory (often referred to as the Social Cognitive Theory) focuses on the social context in which people learn; how they learn through interacting with and observing other people. People can learn from imitating others (thus the importance of role models and mentoring). Social learning, for example, occurs when the culture of the organisation is passed on to new employees teaching them how to be effective in that organisation (UNAIDS, 1999c; McDonald et al., 2003)</p>	<p>The possible outcomes of this school of thought are fundamental to the development of effective peer educators and peer learners as adolescents naturally have the tendency to imitate one another so that they are seen to be doing the “in” thing. Again, on its own it would have shortcomings. Embracing the behaviourist theory would strengthen the social learning theory further.</p>
TRANSFORMATIONAL THEORY	<p>In this theory learning is defined as a “social process of using prior interpretation to construe and appropriate a new and revised interpretation of meaning of one’s experience in order to guide future action” (Gravett, 2002:23).</p>	<p>Learning in this theory is seen as a psychocultural process of meaning or making, resulting in meaning structures, which in return shape and delimit the meaning or making process (Gravett, 2001:23).</p> <p>The limitation of this school of thought is that it does not give the learners the opportunity to verify whether their original interpretation was accurate in order for them to draw on the past knowledge so as to establish new meaning. Like the above stated theories, on its own this theory would yield limited results and would need to be re-enforced by other theories.</p>

(Source: Merriam & Caffarella, 1991; Gravett, 2001; Marquardt & Waddill, 2004.)

It is the opinion of the researcher that all the above theories are fundamental to learning and necessary for the development of meaningful learning tools or rather training programmes for adolescents. Firstly, one needs understanding of what is being learnt. Secondly one draws meaning from what has been learnt and experienced in the past. From literature that has been reviewed so far on peer educators, it can be seen that elements need to be drawn from each of the above stated theories in order to effectively prepare peer educators for their roles.

3.4 PLANNING A CONTEXTUALISED LEARNING PROGRAMME

In order to plan for a programme designed for learning, one will need to have a full understanding of the problem at hand. In this study, maternal mortality and morbidity and the HIV and AIDS pandemic, adolescence and peer educators were key issues.

The former Director General of the World Health Organisation, Dr Hiroshi Nakajima as quoted by Hubley (1993:1), stated that “we must recognise that most of the world’s major problems and premature deaths are preventable through changes in human behaviour and at low cost. We know how this should be done and the technology to be used but this has to be transferred into effective action at the community level”. Hubley (1993:1) raises the question: “What decisions do we have to make to plan and implement health education and health promotion programmes in our communities?” This question is relevant to the study as the study outlines what is required in planning for programmes designed for learning with a focus on adolescents.

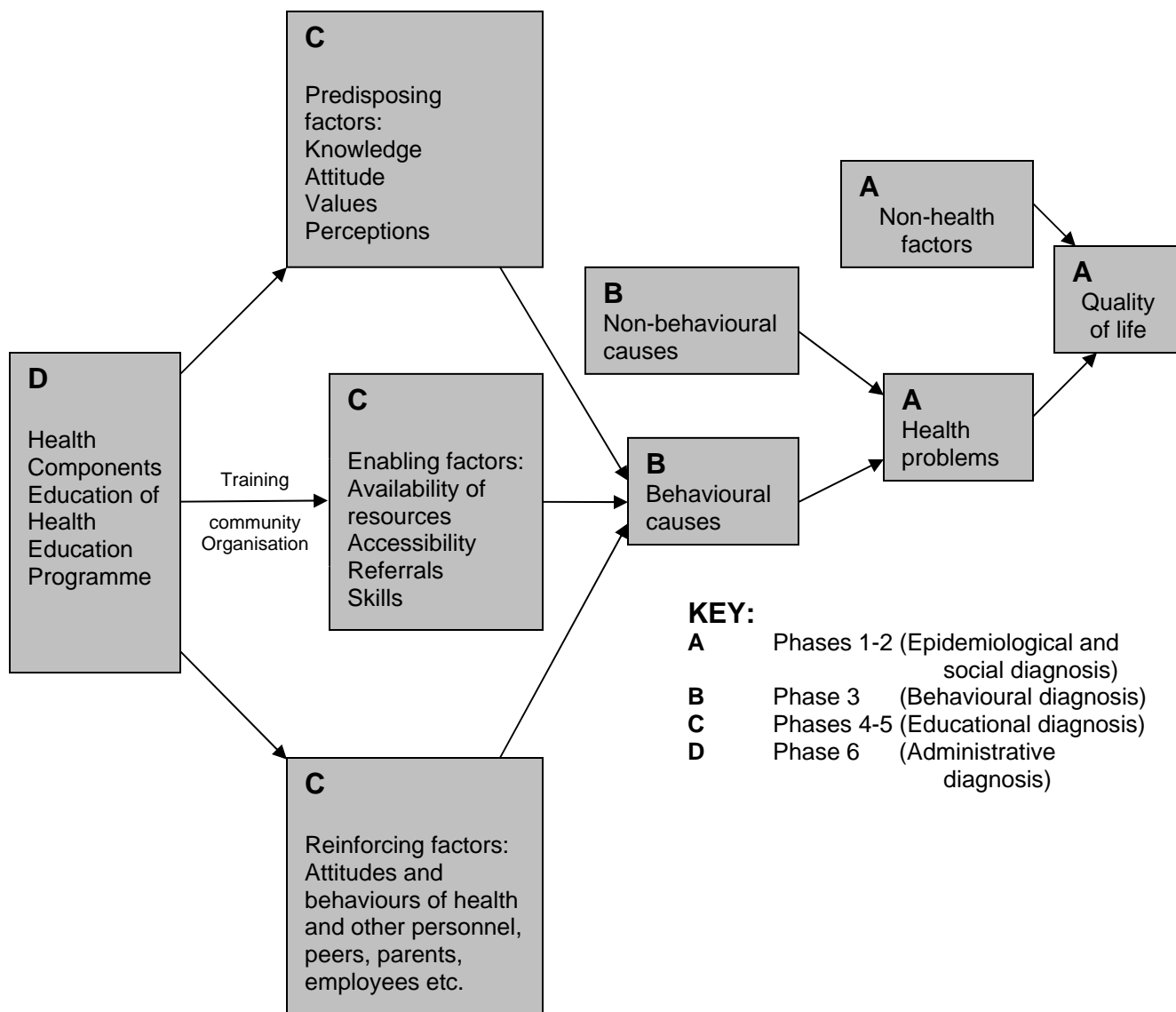
Drugs and treatment alone cannot deal with most health issues. The promotion of health and prevention of disease usually involves some changes in lifestyle or human behaviour. Hubley (1993:16) points out that most health promotion programmes seek to influence families, the community and decision makers to make changes that affect other people's lives, or in policy that affects the peoples' health. Health education, on the other hand, is one of the most important components of health promotion and involves the combination of the following:

- motivation to adopt health- promoting behaviours; and
- helping people to make decisions about their health and acquiring the necessary confidence and skills to put their decisions into practice.

Greene and Simons-Morton (1984:232) present a framework which they recommend as a standard approach in health education programme planning. The framework, PRECEDE, which stands for Predisposing, Reinforcing and Enabling Causes in Educational Diagnosis and Evaluation, is designed to assist planners to move from the identification of educational needs to the development of a programme designed to fulfil those needs. The strength of PRECEDE in comparison to other planning frameworks is that it "delineates the type of data and information on which planners focus their attention". The framework is divided into six phases, namely:

- Phases 1-2 Epidemiological and social diagnosis;
- Phase 3 Behavioural diagnosis;
- Phases 4-5 Educational diagnosis; and
- Phase 6 Administrative diagnosis.

The authors of this framework have presented it in this manner:



(Greene & Simons-Morton, 1984).

FIGURE 3.3: The PRECEDE framework

The authors of this framework have elaborated on their presentation. In Phases 1 and 2 the framework looks at the non-health factors and the various health problems that determine the individual or communities quality of life of individuals and communities. Some of the vital indicators of health problems are morbidity, fertility and mortality. Social indicators in this

phase are population welfare and unemployment while some dimensions to be taken into consideration are incidence and prevalence of the vital indicators. Phase 3 of the framework looks at the behavioural and non-behavioural causes of health problems. Phases 4 and 5 present predisposing, enabling and reinforcing factors to educational diagnosis. Phase 6, which deals with administrative diagnosis, focuses on communication, staff development, training, supervision and providing feedback (Greene & Simons-Morton, 1984:233).

The modes of communication in the planning and implementing phases are key factors, as information will need to be transformed at various levels for example from individuals to family, district or to cover a whole country. Hubley (1993) cautions that there is need for planners to have empathy or understanding of other people's perspectives as health planners often complain that communities ignore advice to follow healthy behaviours:

...the reason for this is that we look at actions from our point of view as health workers and place too much emphasis on health and medical factors as a reason for action. The community may consider other values such as economic survival, status, prestige, physical beauty, attractiveness to opposite sex, conforming to moral or religious rules and family honour. Our own motives, values and understanding may be very different from that of the community, especially if we come from different backgrounds (Hubley, 1993:24).

An example from Hubley (1993:25), highlighting the different perspectives on family planning of a health planner and an individual in the community, makes this very clear (see Table 3.2). The background of this could be a health planner in his/her office designing a family planning as opposed to a husband and wife with six children, probably in a rural setting.

TABLE 3.2: Different perspectives on family planning

PLANNER'S PERSPECTIVE	INDIVIDUAL/FAMILY'S PERSPECTIVE
If you have fewer children, you will be able to spend more money on each and have a higher standard of living.	More children will mean more help in the homes and fields.
You will have fewer mouths to feed.	We can send some to the city to work.
The country cannot produce enough food for everyone, build sufficient number of schools, and provide health services and jobs.	Enough will survive to look after me in old age.

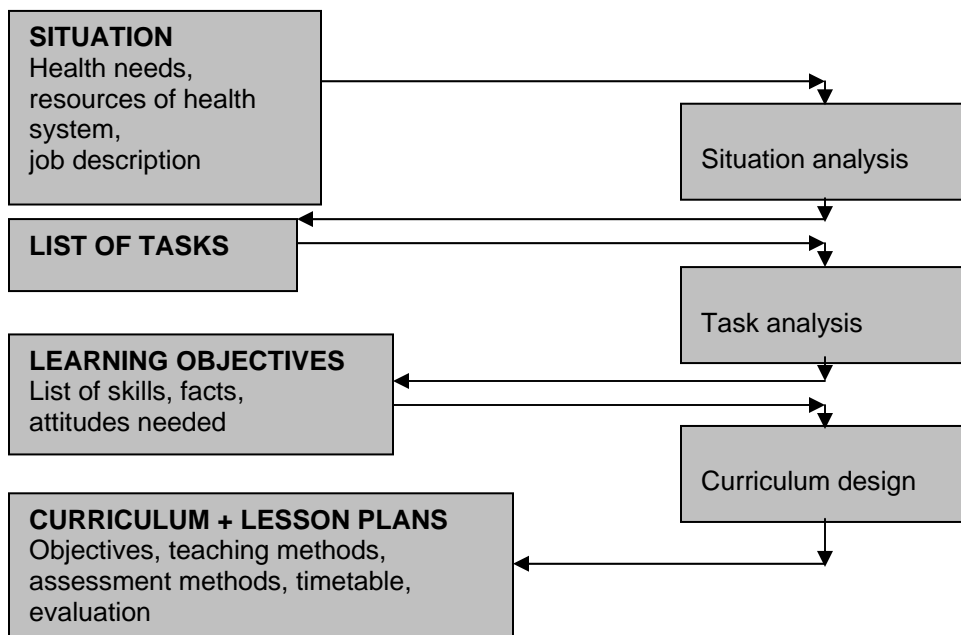
(Source: Hubley, 1993:25)

It is obvious from Table 3.2 that the perspectives of the health planner and the community member differ greatly. What would have been required is for the health planner to have discussions with the individual/community so that informed decisions can be made on issues of health or finances. The point here is that, in order to have effective learning outcomes, the community (in this case adolescents and stakeholders) should be involved in the planning and development of the training programme. The researcher needed to have a clear understanding of the research setting in terms of culture, norms, traditions beliefs and practices because of their capacity to influence training or formulation of training programmes. In this study, peer educators and the stakeholders were included in the training programme review and formulation process so that the developed training programme would be relevant and appropriate to them. In this way they could take ownership of the document. Their involvement has enabled the researcher to understand their perspective of maternal morbidity and mortality, HIV and AIDS and their rationale to use adolescent peer educators. Abbatt (1992) describes a curriculum in two ways: what happens on a course or what should be included in the curriculum. This study focused on what was to be included in the training

programme. This author indicates that a written curriculum is needed to help facilitators organise their course, and advises that a curriculum should contain the following:

- the objectives of the course: (the tasks and subtasks that the students must do);
- the general objectives that should be used to teach the various objectives;
- the time table; and
- the assessment methods.

This information is presented graphically in Figure 3.4 below.



(Abbatt, 1992:36).

FIGURE 3.4: Curriculum design

In the development process of the training programme the researcher saw the need to interrelate the content of the training programme with methods to be used for learning and on the other hand to interrelate training programme objectives with the methodologies to be

used for evaluation. The point is that these factors are interrelated and that changes in one arm would mean changes in the others. This concept is presented graphically in Figure 3.5.

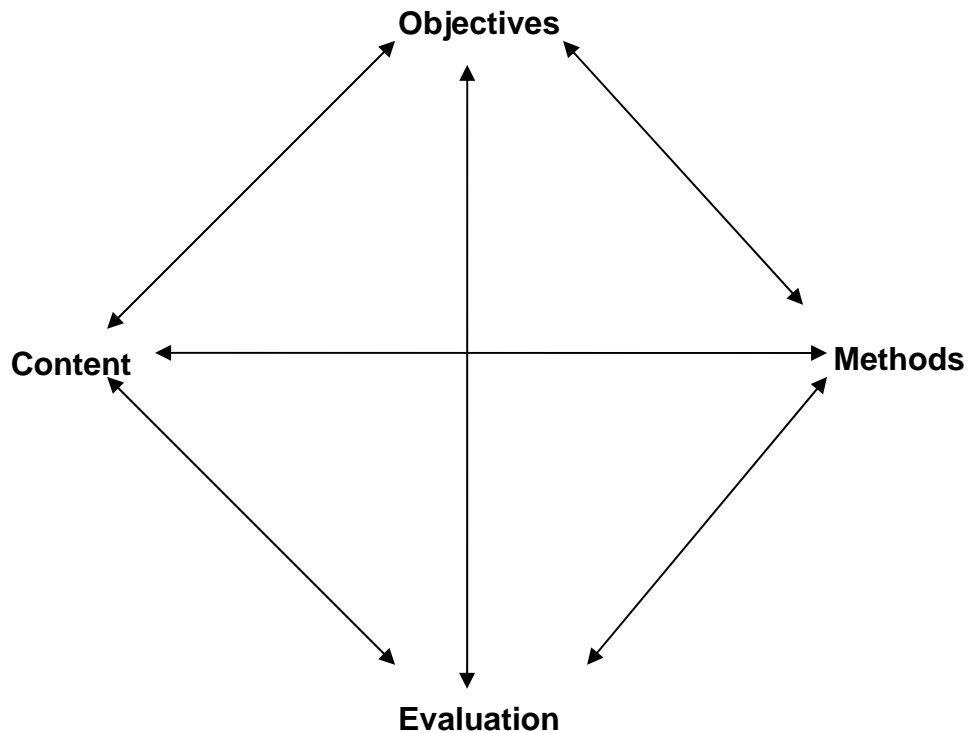


FIGURE 3.5: Elements of the curriculum

In the first three chapters of this study both the situation analysis and the task analysis were presented. Additional skills and attitudes needed for peer educators will be outlined in the training programme after the results of the study have been presented. All these factors contributed towards the formulation of the training programme.

3.5 GENERIC CONCEPTS PECULIAR TO TRAINING PROGRAMMES FOR ADOLESCENTS

Rodgers (1981:244) suggests that “society is becoming increasingly peer oriented. As the gap between generations increases, age groups are drawn more toward each other. Unpopularity in childhood suggests a poor prognosis for personal adjustment later on in life. Individuals having poor peer relationships as children are said to have the poorest adjustments in adulthood”. Rodgers (1981:246) is also of the opinion that youth’s identity with their peer groups is strong or very important to them and that their influence is correspondingly great as youth are more likely to be influenced by peer opinion than to be guided by their personal needs. Other authors concur with this viewpoint (McDonald et al., 2000; McDonald et al., 2003).

The influence that adolescents can get from a peer group, although vital, is often portrayed as “strangling the individual’s personality” (Rodgers, 1981:247). Many adolescents believe that they must conform in order for them to be popular and they manifest this belief by sometimes-slavish submission to peer norms: “It is often difficult to find a bona fide teenager because each youth is so busy proving his or her individuality in standardized ways. Determined not to jeopardize their status, adolescents go to extremes to avoid offending someone who counts” (Rodgers, 1981:250). Individual popularity with their peers depends on a combination of personality and physical characteristics. Adolescents believe that popularity is based on physical characteristics such as being strong, handsome and sporting for boys and pretty for girls. If adolescents are to acquire effective social skills, they must have a genuine chance to participate as citizens, as members of a household, as workers in

general and as responsible members of society: “Youths cannot learn responsibility through pure tokenism as their participatory activities have a real quality about them” (Rodgers, 1981:251). Investing in adolescent health and rights would therefore yield large benefits to adolescents now and in generations to come (UNFPA, 2003).

3.6 GENERIC PRINCIPLES IN PLANNING OF LEARNING PROGRAMMES

Based on the discussions above, the researcher learnt that a programme should be designed with a particular purpose in mind. In other words, if the programme is to solve a problem, it would need to be identified and understood so that appropriate methods could be used to solve it. The right persons would have to be engaged or trained in order to solve the problem. Outcomes would need to be planned for, as they should not happen by accident but would have to be a result of evidence-based practice together with adequate planning, training and monitoring.

In motivating for Outcome-Based Education (OBE) Lubisi, Wedekind, Parker and Gulting (1997: v) state that:

good teachers have always measured the worth of their teaching by assessing what their learners have achieved when they leave education ... they assess education by examining the outcomes, they do this broadly, in order that these outcomes include cognitive as well as affective development in learners.

The researcher is of the opinion that assessment of what learners know when they “leave education” is not sufficient, but that the OBE concept of continuous assessment and encouraging life-long learning is a much better option.

The curriculum to be followed in the use of OBE needs to be learner-centred, relevant to the future needs of the individual and society, should promote the development of a nation’s identity, and should promote learners’ ability to think logically and analytically as well as holistically and laterally. Holistically means “demonstrating an integrated way of seeing things” and “laterally means, experimental, creative and explorative ways.” Further the OBE curriculum should be flexible, credible and quality assured. It should be noted that “although learning programmes for education and training should adhere to a coherent framework of principles ... the means of reaching these ends should be determined by providers in accordance with the needs of the learners (Lubisi et al., 1997:8). These authors confirm what has been highlighted in reviewed literature on the basic need to include peer educators in the development of their training needs (Bullough & Kridel, 2003; Forrest et al., 2004; Hirst, 2004).

Gravett (2001:51) raises seven questions that need to be answered when planning an educational event – namely Who? Why? When? Where? What? What for? and How?

- WHO? implies the profile of the participant.
- WHY? relates to the situation and outcomes.
- WHEN? deals with the timeframe.
- WHERE? relates to the site.

- WHAT? relates content, skill, attitude.
- WHAT FOR? applies to achievement- based objectives.
- HOW? implies learning tasks and materials.

This study focuses on two of the seven steps for designing educational events listed above. In answering the WHY question, Gravett (2001:52) states:

A good way to respond to this pre-situation WHY? question is to complete the sentence that begins with “...the participant needs ...” thus specifying the primary identified learning needs or expected outcomes. Outcomes are formulated using action verbs such as analyse, apply, categorise, define, design, develop, differentiate, distinguish, draw, explain, formulate, generalise, list, organise, outline, plan, reconstruct, summarise, synthesise, theorise and write.

The second question would identify the “achievement-based objectives” or measure WHAT a learner should be able to do, for example after undergoing specific training.

The purpose of the above quotation is to emphasise the fact that in order to achieve specific outcomes they will need to be adequately planned for, and assessed.

What has been described above was particularly noted in the development of the training programme for peer educators in Zambia. The choice of the research design and methodology and the development of the training programme were planned for. Deliberate steps were taken to ensure that the outcomes would develop a competent and more effective adolescent reproductive health peer educator.

3.7 SYNTHESIS OF CHAPTER 3

In the process of developing the training programme for adolescent reproductive health peer educators in Zambia, it became necessary to define terms such as *peer*, *peer group*, *peer education* and *peer educators*. The roles of a peer educator are defined in this section of the study in order to inform the researcher on the sort of training that is required in meeting the needs of an adolescent peer educator. It is evident from literature that unless the youth themselves are involved in the development of their training programme, they could be trained in that which may not be appropriate, necessary or even interesting to them. Unless they become involved, they could be totally disempowered since they would not be given the opportunity to plan or implement action they would regard as best for their population group.

Various learning theories are discussed in this chapter so as to highlight the learning methods available to peer educators and to those that run such programmes. The advantages and disadvantages of these theories informed the researcher on the need to have a broader approach to the methods available in order to answer the epistemological questions that were to be tackled in the study. One may argue that some of the theories used are relevant to adults only. The question that would then arise is: Should we use adult learning theories or learning theories for children seeing that adolescents are transitioning from childhood to adulthood? It is evident from literature that the outcomes being aimed for in adolescent peer educators can only be achieved by using some of the theories pertaining to adult learning, such as cognitive, behavioural and social learning theories.

Adolescents are a unique group of people with very special needs. In order to use this cohort in training or educating others there is a need to understand how they learn, what factors influence their learning (both positively and negatively), what theories should be used in their process of learning, and the power of peer pressure. In the advent of HIV and AIDS young people need to be informed and trained to make the correct health-related decisions. While a change in health-related behaviour is highly desired, there is a need for peer educators to know why they are doing what they are doing so that they can adequately and intelligently explain their beliefs and conduct (behavioural change) and/or action to peers. Behavioural change is good, but it must be accompanied with understanding and purpose. Peer educators should be encouraged to embrace life-long learning for various reasons: their role is not a static one as they deal with a dynamic group (adolescents), and sometimes with communities that are faced with challenging situations such as HIV and AIDS where new information is emerging all the time.

3.8 SUMMARY

Chapter 3 commences by defining a *peer* and discussing the aspects related to adolescents' education and learning. Various theories that define the way individuals learn are mentioned and comparisons of some key theories are made. Focus is placed on how adolescents learn and factors that contribute to the learning process as peer educators. In preparation for the coming chapters (especially the training programme), Chapter 3 motivates for the use of peer educators in the development and implementation phase of training programmes. Some of the issues that adolescents have to deal with in every day life in order to be considered "relevant" or "an up to date peer" are pointed out. Generic concepts in the planning for

programmes designed for learning are also discussed. This chapter concludes by discussing OBE and the need for life-long learning. The strengths of co-operative learning are emphasised especially those that are evident among school-going children, and the benefits of this style of learning in the training of adolescent peer educators is highlighted. In Chapter 4 the design and methodology of this study are discussed.

CHAPTER 4

DESIGN AND METHODOLOGY OF THE STUDY

4.1 INTRODUCTION

Research can be said to be one's quest to find answers, to have a better understanding or to have more knowledge about a particular topic of interest. This quest for understanding of true knowledge (authentic knowledge or episteme) needs to be approached using truthful models and theories. This is in contrast to a search involving mere opinion or doxa.

Of great importance to this study were the epistemic and the sociological models. However one defines the goal of scientific inquiry, or the epistemic dimension of science, the methodological dimension determines the route to be taken. Before the researcher decided on the design and methodology to be used, four dimensions were looked at in more detail, namely the epistemological, methodological, sociological and ontological dimensions. Constraints that a researcher can face in these paradigms were also considered. These dimensions will be presented in more detail in this chapter. The first dimension to be discussed is the epistemological dimension.

4.2 PRESENTATION OF RESEARCH DIMENSIONS

4.2.1 THE EPISTEMOLOGICAL DIMENSION

As the predominant purpose of all research is to arrive at results that are as close to the truth as possible, it is necessary to enter into a moral contract or epistemic imperative which "refers to the intrinsic moral and binding character that is inherent in the pursuit of truthful knowledge" (Mouton, 1996:28). Some authors (Mouton, 1996:29; Babbie &

Mouton, 2001; Fern, 2001) have highlighted three kinds of constraints that researchers could encounter in their search for truth. These constraints are sociological, ontological and methodological.

- **Sociological constraints** originate from the researcher. This involves a lack of knowledge about the object of inquiry, which is exacerbated by poor review of literature and poor judgment and decisions in the research process. A lack of training in research practices is an additional factor, especially when compounded by a lack of experience in conducting research. These constraints are strong prejudices that might bias the interpretation of the data (Mouton, 1996:29; Babbie & Mouton, 2001; Fern, 2001).
- **Ontological constraints** are features of the object of the study. “This could include the complexity of human behaviour, the fact that most social actions and events take place in open systems ... it is impossible to predict future behaviour” (Mouton, 1996:29). Another difficulty raised by the same author is related to the fact that certain aspects of human behaviour such as moral, emotional and spiritual stands are extremely difficult to observe or measure systematically.
- **Methodological constraints** are related to the use of inappropriate research methods and techniques and ignoring the limitations that are peculiar to a particular approach or instrument (Mouton, 1996:29; Babbie & Mouton, 2001; Fern, 2001).

In order for a researcher to attain results, he or she would therefore need to have a good understanding of the topic or subject to be studied, the research setting, the theories relevant to the subject being studied, and the strengths and weaknesses of the various designs and methodologies applicable to the study topic.

The next aspect to be taken into consideration is the methodological dimension.

4.2.2 THE METHODOLOGICAL DIMENSION

The term *methodology* is derived from the Greek words “methodos” (“meta” meaning alongside with and “hodos” meaning journey or road) and “logos” (study). Therefore “meta-hodos” denotes the means or method of doing something (Mouton, 1996:35) or an “approach to systemic inquiry” (Mertens, 2005:9).

Mouton (1996:35) points out that “research involves the application of a variety of standardised methods and techniques in the pursuit of valid knowledge”. Evidently, from this description, methods are not abstractly developed as one proceeds on the research journey but standardised forms of “transport” are used in order to obtain valid outcomes.

As scientists seek or aim to generate truthful knowledge, they ought to use objective methods and procedures that increase the likelihood of attaining validity. The methodological dimension therefore refers to the knowledge of how (or know-how) to do things, or means that scientists use in the pursuit of valid knowledge. There are three levels in the methodological dimension, namely research techniques, research methods and methodological paradigms.

- **Research techniques in the methodological dimension**

These are the specific and concrete means or ways that the researcher uses to execute specific tasks such as sampling, measurement, data, simple random sampling and analysis. Examples are simple random sampling or ANOVA in the domain of statistical analysis.

- **Research methods in the methodological dimension**

Mouton (1996:36) defines the methodological dimension as the “means required to execute a certain stage in the research process”. This study found this definition to be informative as it highlighted the need to look at the study in stages and determine the appropriate means of executing each phase. Details seen in research methods are:

Methods of definition – theoretical and operational definitions

Sampling methods – probability and non-probability methods

Measurement methods – scales, questionnaires and observation schedules

Data collection methods – participant observations, interviewing, unconstructive measurement and systemic observation

Data analysis methods – statistical methods, mathematical methods and qualitative methods (Mouton, 1996; Babbie & Mouton, 2001; Neuman, 2003; Mertens, 2005).

The distinction between the research techniques and the research methods is therefore that of degree of scope. Research methods include components of research techniques, skills and instruments.

The third level in the methodological dimension is the methodological paradigm.

- **Methodological paradigms in the methodological dimension**

Quantitative, qualitative and participatory action could all be referred to as methodological paradigms. Mertens (2005:7) defines a paradigm as “a way of looking at the world” and indicates that it is “composed of certain philosophical assumptions that guide and direct thinking and action”. Mouton (1996:37) cautions that methodological paradigms are not merely a collection of research methods and techniques but include “assumptions and values regarding their use under specific circumstances”. At this level what is encountered is not only the methods and techniques but also the “underlying philosophy regarding their use...the philosophy which would include a theory of when and why to apply” (Mouton, 1996:37). In other words, it points to using quantitative methods rather than qualitative methods but understanding the limitations of each paradigm in the light of the subject being studied.

The third dimension is the sociological dimension.

4.2.3 THE SOCIOLOGICAL DIMENSION

Social research is a social practice. This means that social scientists belong to various organisations or groups and institutions that both constrain and enable their behaviour as social scientists, for example to have access to resources or equipment – a factor that would vary from one social researcher to the other. In other words, researchers are social beings with specific beliefs, values and interests, who follow certain implicit and explicit rules and conduct research in organised institutionalised frameworks that impose certain constraints, rules or guidelines on what is acceptable.

The fourth dimension is the ontological dimension.

4.2.4 THE ONTOLOGICAL DIMENSION

The term *ontology* means the study of being or reality while the term *social ontologies* refers to the “conceptions of the ontology of social reality” (Mouton, 1996:46). Grammatically this is quite difficult to understand as the author uses the term ontology to define social ontology. However, the author admits that the definition of social reality is a contestable matter but states that “there are various interpretations of the nature of the social world that affect the manner in which it is studied” (Mouton, 1996:46). Mertens (2005) simply defines ontology as the “nature of reality”.

4.3 THEORIES AND METHODOLOGIES RELEVANT TO THE STUDY

Various theories in the social world present different pictures and accounts of the social world. Examples of these are constructivism, positivism, behaviourism and interpretivism.

Zuber-Skerritt (1996:50) has highlighted three educational research methodologies, namely:

- Functional (technical);
- Transactional (interpretive); and
- Critical (emancipatory).

In these are embedded three educational paradigms: curriculum, curriculum evaluation and leadership. Brief discussions of two of the paradigms (curriculum and curriculum evaluation) are discussed below as they are relevant to this study.

4.3.1 CURRICULUM PARADIGM

The functional or technical aspect of this paradigm is concerned with prescribing how the body of knowledge is taught by teachers who reproduce the curriculum developers' idea. The transactional (i.e. practical, interpretive or process) aspect is concerned with "liberal ideas about humans as members of society, education as making decisions and solving problems, along with their students, within a complex context of learning" (Zuber-Skerritt, 1996:53). Curriculum developers who work within this paradigm are more concerned with "who teaches, who learns, and how attitudes and values as well as knowledge can be learned" (Zuber-Skerritt, 1996:53).

The critical (or emancipatory) aspect is based on the "critical theory involving dialectical reasoning" (Zuber-Skerritt, 1996:53). In other words, the teacher or the students stand outside a situation in order to critique it. Curriculum developers using this paradigm are more concerned with how and when learning occurs and whether curriculum should be changed or not.

The second paradigm is the curriculum evaluation paradigm.

4.3.2 CURRICULUM EVALUATION

The functional aspect of this paradigm focuses on standardisation in education. The transactional aspect focuses on "ideas about liberal humanism and subjective ethics...which acknowledge the variety of experiences and values underlying perspectives and perceptions for teachers and learners in the same program" (Zuber-Skerritt, 1996:54). Evaluators using this paradigm usually involve a group of programme stakeholders in the development of the criteria and in the enactment of the

evaluation process. Evaluation reports are illuminative, descriptive and targeted at the stakeholders. The stakeholders, in response to the evaluation, make judgments and decisions on any changes. The critical aspect is based on ideas about learning communities as self evaluating and “critically reflecting on entities which are empowered to set their own standard. Stakeholders initiate and control the evaluation process which is ongoing, cyclic, and change-oriented” (Zuber-Skerritt, 1996:55). These two educational research paradigms contributed towards the informed choice of methodology and design used in this study.

Mouton (2001) and Mertens (2005) recommend both quantitative and qualitative designs in document analysis. In qualitative research, the investigator usually works with a wealth of rich descriptive data collected through methods such as participant observation, focus group discussions, and interviewing and document analysis. Mouton (2001:165) describes “content analysis as analysing content of texts or documents for words, meaning, pictures, symbols, themes or any messages that can be communicated”. The strength of this sort of design is that it is an in-obstructive (non-reactive) method in which errors that are associated with interaction between researchers and subjects (such as observation effects) are avoided.

Mouton (2001:166) recommends the use of quantitative content analysis for large volumes of text but points to limitations as being “authenticity of the data sources, (and) representativeness of texts analyzed which make the overall external validity of the findings limited”. The above discussion informed the researcher in this manner:

- Curriculum paradigm and curriculum evaluation are used for the purpose of validating who teaches on the peer education programmes, who they teach and how they teach.
- To determine whether there was a need to change the current training programmes.
- To involve stakeholders in the criteria development and enactment of the evaluation.
- To enable stakeholders the opportunity to initiate and control the evaluation process. The result of this process is that stakeholders would take ownership of the outcomes.

Based on Mouton's (2001) and Stead, Mort and Davies's (2001) recommendations, qualitative methods were preferred over quantitative methods for the following reasons:

- It would give the researcher the opportunity to review the training programmes without having interaction with the participants.
- It would take away the limitations associated with quantitative methods in which authenticity of data sources and representiveness of analysed text limit external validity of findings.

In the light of what has been discussed above the research design and methodology for the study is motivated for and outlined. Mash (2002) condensed the key attributes of research paradigms as indicated in Table 4.1.

TABLE 4.1: Key attributes of research paradigms

KEY ATTRIBUTES	RESEARCH PARADIGMS		
	Empirical – Analytical	Interpretative Hermeneutic	Emancipatory Critical
Relationship with research reality	Testing Measuring	Exploring Interpreting Constructing	Changing Creating Transforming
View of researched person	Object to be studied and measured	Subject to be understood and interpreted by researcher	Participants in the research
View of truth	Correspondence to facts	Coherence within the data	Consensus of each person's learning
Research process	Predominantly quantitative measurements	Predominantly qualitative interpretations	Participatory using both qualitative and quantitative techniques
Research question	Fixed hypothesis Set by researcher	Open-ended hypothesis Set by researcher	Part of the research process Negotiated in dialogue between participants
Implementation of results	Recommendations made for action by people other than the researcher	Insights offered for use by other people	Findings implemented as part of the research process and the implementation studied
Concept of methodological objectivity	Generalisability	Transferability	Transferability
Concepts of reliability and validity	Standardisation and control of bias, chance and confounding factors Statistical analysis	Triangulation Respondent validation Thick description Reflectivity Deviant case analysis Fair dealing	Practical application Alignment with purpose Ownership Group process Documentation Reflectivity Knowledge construction

(Source:

Mash, 2002:24.)

4.4 MOTIVATION FOR THE RESEARCH DESIGN AND RESEARCH METHODOLOGY FOR THE STUDY

Mouton (1996:37) points out that in one's search for the truth, the methodological paradigms that can be used are quantitative, qualitative or participatory action paradigms. A review of the specific objectives and research questions showed that the study was a scientific quest that was to be conducted in the social world. In other words, two dimensions were being looked at, namely the epistemological and the sociological dimension.

The researcher evaluated existing training programmes and further developed an appropriate training programme based on the outcomes of the study. Based on the presentation by Mash (2002) the research paradigm that this study was categorised in was the interpretive paradigm, for the following reasons:

- The study was explorative in nature and the outcomes were to be interpreted by the researcher.
- The data collected was predominantly qualitative in nature.
- No hypothesis was stated. This is common practice in qualitative research.
- The research questions were set by the researcher.
- The researcher was able to validate data collected with the stakeholders at the data collection workshop while data from the FGDs was reported verbatim.
- Management of data was by triangulating the outcomes of the group interviews with the FGDs and reviewed literature.

More detail on the rationale for the above stated choices and decisions are presented below.

It has already been stated that the overall aim of this study was to develop a training programme to be used in the development of effective adolescent reproductive health peer educators (or peer learning facilitators). While the specific objectives and research questions were stated earlier in the study, in the process of implementing the study these were categorized into the following:

- those involving the stakeholders and their training programmes;
- those involving adolescents; and
- those involving the development of the training programme.

The purpose of this categorization was to determine the design and methodological dimensions to be used for each phase. Each of these phases was looked at in detail.

4.4.1 SPECIFIC OBJECTIVES AND RESEARCH QUESTIONS INVOLVING STAKEHOLDERS AND TRAINING PROGRAMMES

The specific objectives for using stakeholders and training programmes were:

- to determine whether training programmes being used by the stakeholders contributed positively or had a negative impact on the development of the ideal peer educator;
- to determine whether the training programmes being used by the stakeholders contained a component on enhancement of healthy lifestyle behaviours; and
- to determine whether there is a need to make changes to training programmes being used by the stakeholders.

The research questions were:

- Do training programmes being used contribute positively or have a negative impact on the development of an ideal peer educator?
- Do training programmes being followed by the stakeholders have a component that focuses on the enhancement of healthy lifestyle behaviours?
- Do training programmes being used need to be changed?

This study was delimited to developing the training programme and not testing the training programme. At first glance it seemed that action research would have been the most appropriate research paradigm to use, but the delimitation stated above meant that the ACTION part of the action research would not be done, meaning that the full cycle of action research would not be achieved, thus cancelling out the use of action research. Based on Mash's (2002) presentation and comparison of research paradigms it informed the researcher to use group interviews for this component of the study. This was because based on the objectives of the research paradigms presented, the study fell under an Interpretative-Hermeneutic paradigm which entails predominantly qualitative interpretations. The methods of choice were interviews and focus group discussions. Considering the number of stakeholders who were to be invited for the study the design of choice was group interviews for the purpose of training programme review and development. Motivating for the use of group interviews Mertens (2005:386) states that "they can be used in needs sensing for training and service programs, for instrument review, and for many other research purposes". The author further cites one of the benefits of this design as "insight gained from the interaction of ideas among the group participants." The stakeholders

would therefore have an opportunity to critique the training programmes and then come up with a common document.

4.4.1.1 DATA COLLECTION AND DATA ANALYSIS METHODS

Arrangements were made whereby all the stakeholders were invited to a three-day data collection workshop. The stakeholders were requested to present their training programmes at the workshop, to allow participants to review them and also to avail to the researcher their training programme documents. In the opening remarks of the workshop the participants were reminded of the workshop objectives. They were further reminded that the workshop was part of a research process and that they needed to give consent to take part in the study as was stated in their invitation letters (Appendices 2 and 3).

The study objectives were outlined and the participants were assured of confidentiality and informed that all individual contributions made were not going to be passed on to their organizations but that the final document would be made available to them.

Each organization presented its training programme in about 30 minutes followed by an open discussion on the same document at the end of the presentation. This was to enable other participants (probably those not familiar with the document) to ask questions, make contributions and also highlight what they considered to be the strengths or weaknesses of the document.

With the help of two research assistants all discussions were recorded in writing and the key points of each document were noted. The rationale for using two research assistants was for the purposes of checking the accuracy of the information recorded at the end of each session. All participating stakeholders went through the above stated process as indicated in the programme for the workshop (Appendix 5).

As part of the planning process it was assumed that the researcher would have access to all training programmes from the stakeholders prior to the data-collection workshop. This was not possible as most stakeholders only availed their training programme documents at the workshop.

As stated earlier and recommended by Mouton (2001:165), “document analysis is done by analyzing the documents for words, meaning, pictures, themes ...” The researcher played the role of facilitator at the data-collection workshop in line with what has been recommended by various authors (Zuber-Skerritt 1996; Mouton, 2001; The World Bank Group, 2003; Mertens, 2005) in this form of qualitative research. Mertens (2005:243) states that “the stakeholders are responsible for collecting and analysing information as well as generating recommendations for actions based on the interpretation of the results”.

At the end of each day there was a brief review session to validate information collected. Using notes taken, the researcher did a recap of the deliberations for validity purposes.

After all training programmes had been presented the researcher, with the aid of the research assistants, developed a draft training programme that embraced all the key components from all training programmes presented. This draft training programme was presented and given to all participants to review in order to determine whether this was the best training programme to meet their peer educator's training needs and to determine whether there was need for change to the document.

Participants were divided into their groups to work on the draft document (at registration all participants were randomly assigned to one of three groups). They were requested to appoint a chairperson for their groups who would then present the group discussion outcomes. Each group consisted of about 10 persons. Presentations from each group were then done and again all comments, changes and recommendations were recorded and condensed into one document.

Day one and the morning of day two were used for presentation of training programmes, and question and answer sessions on training programmes presented. The afternoons of day two and day three were used for group interviews with the stakeholders so that they would develop a generic training programme.

A draft of the first summary of the training programme was presented on day two in the afternoon. Between the afternoon of day two and the morning of day three, the participants regrouped twice more before a final document was developed that all three groups felt did not need further changes. At this stage the researcher presented the final document to the participants and asked for comments. No further recommendations for change were received from the participants.

All stakeholders involved in this exercise were based in Lusaka. The following Stakeholders were invited to the data collection workshop:

- Adolescent Reproductive Health Project/UNFPA/Ministry of Health;
- CARE International;
- World Vision International;
- Young Women's Christian Association;
- Young Men's Christian Association;
- Kabwata Home-Based Care (A Catholic adolescent reproductive health project);
- Family Life Movement;
- Family Health Trust; and
- United Nations High Commission for Refugees.

The generic training programme as developed by the stakeholders is presented in Chapter 5.

4.4.2 SPECIFIC OBJECTIVES AND RESEARCH QUESTIONS INVOLVING ADOLESCENTS

In this study the specific objectives involving the adolescent reproductive health peer educators were:

- to determine the requirements (characteristics and competencies) of an ideal reproductive health peer educator;
- to determine the factors that contribute towards the development of an effective peer educator; and
- to determine whether the new training programme would meet the training needs for an ideal peer educator.

The research questions were:

- What characteristics constitute an ideal adolescent reproductive health peer educator?
- What factors contribute positively towards the development of an effective and ideal peer educator?
- What factors have a negative impact on the development on an effective and ideal peer educator?
- Does the new training programme meet the training needs of an ideal peer educator?

Firstly an assumption was made that the peer educators in the process of their previous training and practice had attained information or had an “opinion” on what an ideal peer educator was. Literature discussed earlier in this study (Johnson et al., 1991; Johnson & Johnson, 1999; Badura et al., 2000; McDonald et al., 2003) has shown that adolescents learn best from each other and that their inclusion in the development of their training needs is important (Bullough & Kridel, 2003; Deutsch & Swartz, 2003; McDonald et al., 2003; Forrest et al., 2004; Hirst, 2004). It was assumed that the trained peer educator would know the factors that positively contribute and those that could have a negative impact on the development of an ideal peer educator.

The methodological paradigm of choice was FGDs so as to obtain in-depth information. The research questions were exploratory in nature, which usually do not require a hypothesis. The strength of qualitative data was that it did not only give in-depth insights but was also an opportunity for rapport with the research participants.

The limitations of this paradigm as reported by Mouton are “lack of generalisability of results, non-standardisation of measurements and data collection and analysis being a time consuming process” (Mouton 2001:148). Some of the limitations were overcome as the sample selected could be said to represent some major provinces of the country, as the stakeholders run similar programmes in most parts of the country.

4.4.2.1 DATA COLLECTION METHODS

Arrangements were made with the help of the various stakeholders for the FGDs. Managers/coordinators of the programmes for adolescents were requested to arrange for FGDs with at least five to a maximum of 10 peer educators from their organizations. Some organizations sent peer educators to represent them at the workshop. In such cases, the researcher requested that only peer educators not involved in the data-collection workshop were to attend FGDs. Plans were made to have FGDs with the following:

- YMCA, YWCA, Kabwata Home-Based Care – Lusaka
- Planned Parenthood Association of Zambia – Lusaka
- Peer educators from Kafue District Health Management Team (DHMT)
- Peer educators from Livingstone DHMT
- Peer educators from Maheba Refugee Camp in Solwezi. They were used as a comparison group.

As most of the stakeholders were based in Lusaka and because of the high numbers of peer educator programmes in Lusaka, the researcher arranged to have two FGDs as stated above. The second reason for this was the overwhelming response from Lusaka-based stakeholders to send their peer educators to the FGDs.

The FGDs were scheduled to commence a week after the data collection workshop (October 2004) and were only completed in March 2005. This was because of the logistics of training a research assistant to collect qualitative data in Kafue, Livingstone and Maheba and in order to obtain permission from the various stakeholders and sites. The researcher collected data from Lusaka only. The purpose was to determine the nature of the process before training the research assistant, and to eliminate bias. An independent individual was brought into the study to collect data without having been involved with the review of the training programmes. In order to try to standardise the data collection process a schedule was developed on the way all the FGDs were to be conducted (Appendix 6). Furthermore, an assistant was engaged because of the difficulties the researcher had to leave work and travel to all the stated towns.

Accessing Maheba was particularly “difficult” because of the process of clearance in Lusaka to get to the area. Clearance was sought from the UNHCR, then from the Ministry of Home Affairs, then from the Permanent Secretary in Solwezi (provincial capital of North-Western Province) and then the refugee camp. A second limiting factor (which was overcome) was the distance to the various areas. Generally the distances of the various areas are:

- Kafue - about 45 minutes’ drive from Lusaka;
- Livingstone – about 5 hours’ drive from Lusaka; and
- Maheba – over 8-10 hours’ drive from Lusaka (because of the poor state of the road from Solwezi to Maheba Refugee camp).

Data from peer educators was collected using tape recording facilities so that it could be reported verbatim. Notes were also taken for the purpose of describing the research settings (Babbie & Mouton, 2001; Fern, 2001; Mertens, 2005). Prior to the FGDs, the purpose of the study was outlined to the peer educators and then consent was sought from them (Appendix 4). They were assured of confidentiality and their rights. They were further informed that they could express themselves in any of the languages commonly spoken in the various study sites.

Factors that could influence the FGDs process as outlined by Fern (2001) were dealt with before commencing the FGDs. These included lack of privacy, social influence (such as fear of disclosure of names, self awareness, and group dynamics, to name but a few). Privacy was ensured before commencement of the FGDs. Stakeholders were requested not to attend the FGDs or to be within hearing range of the same. The participants were encouraged to actively participate in the discussions and were assured that if names were mentioned they would not be stated in the scripts. They were further assured that the tapes would not be available to the stakeholders but only the final outcomes of this study.

4.4.2.2 DATA ANALYSIS

In the study, specific questions or topics were given to the participants so the capturing of data was organised by noting the various themes and factors as they arose from the participants during the FGDs. The second part of the FGDs involved the review of the new training programme. Data analysis was by context analysis or by noting the words, topics or phrases that the participants wanted included or excluded from the new training programme.

4.4.3 SPECIFIC OBJECTIVES AND RESEARCH QUESTIONS INVOLVING THE DEVELOPMENT OF THE TRAINING PROGRAMME FOR PEER EDUCATORS

The third category of the study was to attain the main aim of the study. This was to develop a training programme for peer educators. The research question was: What components need to be embedded into the training programme to be developed?

Concepts discussed above were considered in the process of the group interviews with the stakeholders. The role of the researcher was that of a facilitator (being careful at all times not to influence or interfere with the discussions in the process of the research).

4.4.4. PREPARATION FOR THE TRAINING PROGRAMME DEVELOPMENT

Prior to the development of the programme, there was a need to synthesise all the data that has been listed above. Outcomes of the FGDs were reported verbatim and compared with the content of the training programme that had finally been developed by the stakeholders. The method used to bring all the components of the study together was triangulation. This was done using the outcomes of the group interviews with the stakeholders, the outcomes of the FGDs and reviewed literature.

Fern (2001:8) explains that triangulation occurs “when a researcher wants to compare results across different methods” for validation purposes and that “most authors on focus group issues echo the position that qualitative methods are justified for triangulation purposes” (Fern, 2001:146). Neuman (2003:138), commenting on

triangulation, states that it entails observing something from different angles or viewpoints so as to get the true position: “It is better to look at something from several angles than to look at it in only one way.” More recently, Mertens (2005:256) has stated that triangulation involves “the use of multiple methods and multiple data sources to support the strength of interpretations and conclusions in qualitative research” but has emphasised that the data sources need to be factual.

The outcomes of the triangulation formed the basis for the development of the training programme. The processes that have been described in this chapter are represented in Figure 4.1.

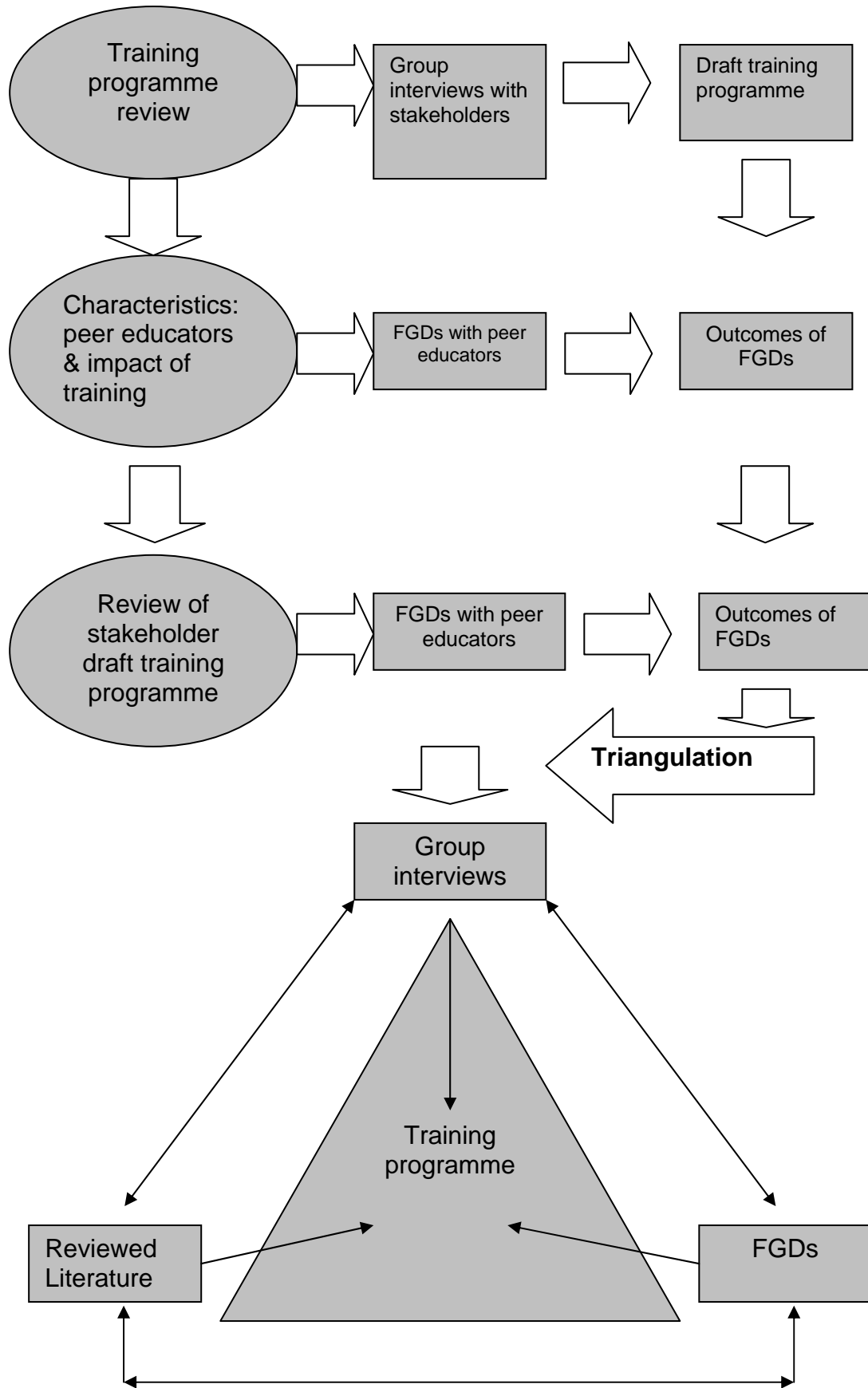


FIGURE 4.1: Training programme development - design and methodology

4.5 SYNTHESIS OF CHAPTER 4

In order for choices to be made regarding the design and methodology to be used in this study it was necessary to understand the theories, various dimensions and paradigms in research. The end result was that the researcher was able to make informed decisions as to the kind of design and methodology to use. The study used the following designs and methodologies prior to developing the training programme:

- **Focus group discussions** – to collect data from the adolescents on the characteristics of an ideal peer educator and the factors that contribute positively and those that can have a negative impact on the development of such educators.
- **Document analysis** – to assess content of the training programme being used by the stakeholders. Ultimately a checklist was developed that listed themes, topics, and meanings and in general content that is being communicated from or in these documents.
- **Group interviews**– This provided stakeholders with the opportunity to closely examine their training programmes so that they could develop them into a document that would best reflect what they want to achieve. The outcomes of the FGDs were also embedded into the training programme so that the input of the adolescents was given attention in the development of the training programme.

- **Triangulation** –The outcomes of the above components informed the content of the training programme that were developed.

4.6 SUMMARY

Chapter 4 introduced research as a quest for knowledge. Theories and their use in the stated paradigms were pointed out. The chapter then highlighted the specific objectives of the study and discussed the rationale and significance of using a particular type of research design and methodology for each component. The chapter concluded with the research design and methodology that was used in the study.

This chapter is followed by Chapter 5 which presents the results of the study.

CHAPTER 5

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

5.1 INTRODUCTION

This chapter presents and discusses the results of the study. The outcomes of the FGDs are reported verbatim and direct quotes are presented in italics. In some instances the grammar may not be correct, but the responses were retained unaltered, as reporting of qualitative data requires that outcomes be presented verbatim. In cases where expressions used are understandable only in the Zambian context, the researcher inserted the meaning of such expressions in brackets.

The data collection workshop with the stakeholders was held on 20 to 22 October 2004 in the board room of the Dean of Medicine at the University of Zambia. Thirty participants from the following organisations attended the workshop:

- Kabwata Home-Based Care (Catholic Peer Educators);
- The Young Men's Christian Association;
- The Young Women's Christian Association;
- The Family Health Trust;
- The Family Life Movement;
- World Vision International; and
- The United Nations High Commission for Refugees.

No representation was received from the following organisations:

- Adolescent Reproductive Health Project/UNFPA/Ministry of Health (The reason was that at the time of the workshop it was reported that the project had ceased running.)
- CARE International (Although confirmation to attend the workshop was received telephonically no representation was made at the stakeholders' workshop.)

All the participants consented to take part in the study. Prior to presentation, each presenter was requested to provide the researcher with a copy of their training programme. This was done, but World Vision International and the United Nations High Commission for Refugees (UNHCR) also provided other participants with handouts of their presentations and brochures. The role of the researcher was to facilitate the proceedings of the workshop while two research assistants documented the discussions and outcomes.

5.2 PRESENTATION OF STAKEHOLDERS' TRAINING PROGRAMMES AND RELATED DISCUSSIONS

Each stakeholder was requested to present his or her training programme in about 30 minutes. This would be followed by a question and answer session. The researcher asked the seven "categories" of stakeholders present whether they had their own or self developed training programmes. It was noted that Kabwata Home-Based Care, the YWCA, the YWCA and UNFPA did not have their own training programmes but had adopted the document developed by the Family Life Movement of Zambia. The Family Health Trust and World Vision International had their own training programmes. A

decision was made by the researcher to use the Family Life Movement training programme as a baseline in the process of collecting data. Presented below are the outcomes of these presentations and the questions and discussions that followed each presentation. Comments that are presented verbatim are in italics. The first group to present their training programme was Kabwata Home-Based Care.

5.2.1 TRAINING PROGRAMME AS PRESENTED BY KABWATA HOME BASED CARE

The presenter from Kabwata Home-Based Care informed the participants that their programme had commenced two years before (2002) because of the high prevalence of HIV especially among the youth. They explained that their organisation did not have its own training programme but that it had adopted the document developed by the Family Life Movement of Zambia. The title of the document is *Family Health Education* and was reported to have been developed by PPAZ, the YWCA, the Family Life Movement of Zambia and Adolescent Reproductive Health Project (ARHP/GRZ/UNFPA) between the years 1998 and 1999. It was furthermore reported that the development of the said document was funded by the Margaret Sanger Center International in the USA and the UNFPA.

The Kabwata training programme runs for 18-20 weeks. The presenter indicated that as an organisation, they did not only confine themselves to the above stated training programme but embraced other documents, depending on the age group of the

participants that they were training. As adopted from the Family Life Education document, the key components of their training were:

- values;
- family structure;
- self awareness;
- self esteem;
- decision making;
- sexuality;
- gender;
- preventing pregnancies;
- relationships;
- responsible parenthood;
- STIs;
- HIV/AIDS;
- abuse and violence;
- substance use and abuse;
- planning for the future;
- advocacy;
- sexual abstinence;
- behavioural change processes; and
- home-based care (HBC).

The content of the Family Life Education Document is included as Appendix 7.

At the end of the presentation one of the participants wanted to know why their training period was so long, considering that the developers of the programme took two to three weeks to train their peer educators. The presenter reported that there were numerous issues that they needed to deal with in the training process and that they were of the opinion that three weeks was not sufficient for them to develop competent peer educators. Another participant wanted to know whether Kabwata Home-Based Care peer educators were paid allowances for the work they were doing. It was reported that they were not paid but were given T-shirts as identifiers that they were peer educators. About five other peer educators from Kabwata Home-Based Care were present at the stakeholders' workshop and were all dressed in black T-shirts with the organisation's name printed on them. The presenter for Kabwata Home-Based Care was an adolescent and was also dressed like his peers.

The second group to make a presentation was the YMCA.

5.2.2 TRAINING PROGRAMME AS PRESENTED BY THE YOUNG MEN'S CHRISTIAN ASSOCIATION

The presentation from the YMCA was very brief. Introducing the YMCA, the presenter stated that it was a Christian Non-Governmental Organisation. The YMCA also followed the Family Life Education training programme. As his *prepared presentation* was very *similar to the presentation given prior* to his, he stated that there was no need to repeat the same information except to say that their initial training programme was five days followed by a four weeks' training session. Their age inclusion criterion for training as

peer educator was 12-20 years. He further reported that the YMCA ran an adolescent reproductive health programme in refugee camps in conjunction with Zambia's Ministry of Home Affairs and the UNHCR. The question of whether peer educators were paid was again raised. The presenter reported that their peer educators were volunteers and were not paid allowances. The third presentation was made by the YWCA.

5.2.3 TRAINING PROGRAMME AS PRESENTED BY THE YOUNG WOMEN'S CHRISTIAN ASSOCIATION

The presenter from the YWCA commenced her presentation by stating that her organisation also used the Family Life Education training programme. The training programme was in English and they were yet to translate it into some Zambian languages. An overview was again given similar to that given by Kabwata Home Based Care. The Organisations' target group was youth aged between 15-25 years, in and out of school youths or anybody who would understand reproductive health issues. The training period was initially 10 days followed by refresher courses later. The Organisation had so far trained 288 peer educators in Zambia and out of these only 58 were actively engaged in peer education. Reasons why they had so few peer educators training others was not given, although a lack of incentives could play a major role. The focus of their training was on life skills and the following were the modalities reported to be used during training:

- videos;
- discussions;
- focus group discussions;

- sketches;
- role playing; and
- energisers for peer educators.

It was reported that their training also contained some “technical topics” which were outlined as:

- voluntary counselling and testing (VCT);
- cluster differentiation cells type 4 (CD4);
- viral load; and
- gender violence.

Although the focus of the YWCA training was on abstinence, they encouraged those who could not abstain to use condoms. The presenter used the opportunity to highlight some of the Organisation’s concerns, namely that some of the advertising in the media was donor driven. Some of the donors’ advertisements implicitly encouraged sexual activity in order that their products (mainly condoms) would be sold. The motivation therefore was to make money rather than to promote the use of condoms as a preventative measure against STIs or pregnancy. This sparked a lot of discussion among the participants who were of the same opinion. It was concluded that the various stakeholders and other organisations should promote networking (as stakeholders) with their trainees (peer educators) so that together they would fight against such vices. On the issue of payment to peer educators the YWCA reported that they too did not pay their peer educators but that those who attained a certain level or status in the organisation (like trainer of

trainers) received an allowance. This was considered to be very unfair especially by peer educators present. One of the participants wanted to know whether it was true that the YWCA dismissed adolescent peer educators who fell pregnant. This was confirmed but very strongly disapproved of by most stakeholders as they were of the opinion that the pregnant peer educator would use herself as an example to others to deter other adolescents from following her path. The YWCA reported that they were a Christian organisation and that potential peer educators who were single and wanted to be trained and work with the YWCA needed to know that they had certain principles to which they would have to adhere to. This raised much discussion, but the debate had to be discontinued as their available time had run out. The Family Health Trust presentation was next.

5.2.4 TRAINING PROGRAMME AS PRESENTED BY THE FAMILY HEALTH TRUST

The presenter from the Family Health Trust reported that they had their own training programme which was based on a document developed by the Curriculum Development Centre of Zambia's Ministry of Education entitled *Happy, Healthy and Safe*. The programme content is appended (Appendix 8). Their training package for peer educators which fell under the Family Health Trust Anti-AIDS Project covered the following topics:

- global overview of HIV/AIDS;
- basic facts about HIV/AIDS;
- stigma and discrimination;

- tuberculosis (TB) and its relationship with HIV and AIDS;
- STIs;
- drug and substance abuse;
- reproductive health:
 - family planning;
 - maternal deaths;
 - abortion;
 - reproductive organs;
- basic peer counselling;
- relationships (being a boy/girl);
- risk reduction;
- interactive/participatory methodologies;
- youth friendly corner service management;
- management of anti-AIDS clubs;
- VCT;
- anti-retrovirals (ARVs);
- gender;
- HBC;
- using the Happy, Healthy and Safe learning activities;
- facilitation skills;
- life skills; and
- human development.

It was reported that the Family Health Trust had trained 20 peer educators since 2001.

Their training programme is five days and their pre-training criteria are:

- a minimum of a Grade 12 pass in Biology and English;
- between 18 and 25 years of age;
- should reside in the area of operation;
- must be a role model:
 - girls are dismissed if they got married;
 - boys are dismissed if they impregnated someone;
- behaviour:
 - no drug use;
 - all negative lifestyle behaviours are discouraged; and
- must be able to use appropriate language.

Generally the above-mentioned criteria were given credit. When asked whether the organisation paid peer educators' allowances, the presenter reported that monthly allowances were paid to all peer educators. This impressed the other participants, but they were not impressed with the fact that a young girl would lose her job as a peer educator when she got married. The presenter reported that those were company policies. Asked whether the organisation would employ a peer educator trained by other stakeholders, the presenter said that "*experienced peer educators would be taken as peer educators or trainers of trainers*", although the term *experienced* was not qualified. Much discussion was entered into about how much the organisation paid. The presenter did not give exact figures but insisted that their allowances were "modest" and the peer

educators would be able to “live off the allowance”. A point that was not raised in the discussion was whether a male peer educator would also be dismissed if he got married. This would amount to gender discrimination if the same did not apply to male peer educators. As time had run out the workshop was adjourned for lunch.

After lunch a presentation was given by the Family Life Movement.

5.2.5 TRAINING PROGRAMME AS PRESENTED BY THE FAMILY LIFE MOVEMENT

The presentation from Family Life Movement was very brief as the presenter was of the opinion that their training programme had already been presented by three other organisations that used their document. They were of the opinion that there was a need to revisit the training programme and that they would appreciate comments from other stakeholders. It was however reported that peer educators trained under this organisation were also volunteers and were not paid any allowances. The participants did not enter into any discussions about their training programme probably because they felt that a lot of discussion had already been done on the same document.

The brief discussion was followed by reviewing of two training programmes (as Kabwata Home Based Care, YMCA, YWCA and Family Life Movement had presented from the same document while Family Health Trust had a different training programme). The discussions continued after a tea break. The researcher then presented the highlights of the two programmes and requested for comments to determine whether what was

presented was what they would consider as key points. Using the Family Life Movement training programme as a base line, the following were the topics to be included from presentations made.

- stigma and discrimination;
- TB and its relation to HIV and AIDS;
- basic peer counselling;
- risk;
- youth friendly corner service management;
- VCT;
- ARVs;
- CD4;
- facilitation skills; and
- human development

When this was verified with the participants the researcher concluded the meeting as the end of Day one's session. Day two commenced with a presentation from World Vision International.

5.2.6 TRAINING PROGRAMME AS PRESENTED BY WORLD VISION INTERNATIONAL

World Vision International presented their training programme entitled *Adventure Unlimited* which was reported to have been developed by Scripture Union in 1993 (Appendix 9). The programme is an HIV/AIDS prevention programme for children aged between 5-15 years through life skills training. The organisation considers children in

this age group as the *Window of Hope* for HIV prevention. It is assumed, by World Vision International, that these children are not sexually active, have the lowest HIV prevalence rate and that focusing on prevention in this age group would make an enormous impact. The challenge the organisation has is providing education and skills that these children need to protect themselves before they enter the high risk group of late adolescence and young adulthood. The presenter described life skills as *strategies or abilities that help one live positively with oneself, with others and with the environment.*

The focus of their training is to:

- deal with issues that confront young people as they face an unknown or changing future;
- help young people acquire life skills that would enable them enjoy their teenage years to the full;
- address issues that are likely to cause vulnerability; and
- address issues of risk behaviour that would expose young people to HIV infection.

World Vision International reported that their training programme was user friendly and age appropriate (catering for ages 5-10 and 11-15 years). This Organisation is a Christian organisation which focuses on abstinence and marital fidelity as the primary modes of HIV prevention. Their core topics include:

- self esteem;
- family;
- friendship;

- sexuality;
- HIV/AIDS; and
- choices and consequences.

Unlike all the other stakeholders' programmes, the programme run by World Vision International is not a "typical" adolescent peer education programme, as they focus on training teachers who then train students who then influence children - in other words, training of trainers. Their training methodology is highlighted by some authors as being acceptable (PPFA, 2002; UNESCO, 2003). The organisation works hand in hand with Zambia's Ministry of Education and covers 22 Zambian districts in over 50 schools. The Organisation also works very closely with other Faith-Based Organisations (FBOs). Their training programme ranges between three and five days. The presenter emphasised that her organisation did not distribute condoms as one of their intervention strategies in HIV and AIDS prevention. Other participants questioned the presenter on why this was so. The presenter reported that as a Christian organisation it was against their institutional policy to distribute condoms, and although they shared information on the use of condoms, they focused on abstinence and marital fidelity. The question whether World Vision International paid its peer educators was not raised.

5.2.7 TRAINING PROGRAMME AS PRESENTED BY THE UNITED NATIONS HIGH COMMISSION FOR REFUGEES

The presenter from the UNHCR reported that their training programme for adolescent reproductive health peer educators was run by its stakeholders, namely Zambia's

Ministry of Home Affairs, the UNHCR and the National Council of the YMCA. The project commenced in 1994. Since its inception, their focus has been on asylum seekers in Zambia and their strategy has been:

- public campaigns on HIV/AIDS in Lusaka and refugee settlements;
- a VCT referral system;
- distribution of information packages on STIs and HIV/AIDS;
- HBC for the terminally ill;
- sensitising refugees on STI, HIV/AIDS; and
- reproductive health care at the YMCA and refugee settlements.

The presenter reported that since 1994 the project had trained 65 peer educators in Maheba and that out of these only 34 were still residing in Zambia (some had returned to their home countries through the repatriation programme in process; others had settled outside the Maheba refugee camp). They explained that their training programme lasted for five days and their selection criteria were:

- youth 12-20 years;
- literate; and
- ability to interpret information into different languages.

It was reported that their training programme also enrolled youths who were not refugees. The UNHCR did not have its own training programme but used information from UNFPA and the Family Health Trust. In certain situations they had incorporated a

“trainer of trainers” from the Family Health Trust to assist at their training workshops.

Their points of emphasis in the training sessions were:

- basic counselling;
- psycho-social life skills; and
- reproductive health with a bias on STIs and HIV/AIDS.

The presenter reported that, although they had many challenges, UNHCR intended to train more peer educators. The main challenge was dealing with youth from different cultural backgrounds and languages. When asked whether the organisation paid their peer educators it was reported that no incentives were given to them as their *work was based on goodwill*. The presenter stated that lack of payment caused most peer educators to feel unmotivated. He emphasised that peer educators from the various organisations should interact with each other and that the organisations running *youth education programmes* needed to *compare their training programmes and methodologies*. His conclusive remarks were that there was a need for the development or improvement of youth-friendly corners (youth friendly corners are youth manned services for example in regular clinics meant to encourage youths to participate in for example VCT), information and counselling centres and that peer educators should be taught counselling skills.

At this stage of the data collection workshop new themes raised were:

- challenges facing young people;
- life skills for teenage life;

- risk behaviours for HIV infection;
- choices and consequences; and
- psychosocial life skills.

On day two the researcher presented the outcomes of day one together with the above-mentioned new themes that had been presented. On day two (midday), the participants were given handouts of key training programme content themes of each of the stakeholders' presentations. The participants were instructed to work in their groups and validate information presented. The researcher further stressed that it was the intention of the study to give stakeholders the opportunity to review what they now had as content in their training programmes to determine whether there was a need to improve on what they had.

Day three commenced with the researcher presenting handouts of the summaries of the themes raised for the training programme by the stakeholders during the previous two days. The researcher posed the question:

Do these themes (if put together as a training programme content) meet the training needs of your peer educators?

After group consultations, the three groups responded by stating that

- the themes did not meet their peer educators' training needs;
- there was a need to present the contents in the draft training programme in a more logical manner so as to facilitate learning; and

- there was a need to standardise the length of the training period.

At this stage one of the groups had gone further and developed what they felt would have been a more ideal training programme. Other groups felt they needed more time to do the same. Time for more group work was given after all the groups had presented their initial outcomes. Based on the stakeholders' outcomes listed above the researcher presented the following questions:

- What sort of a training programme would meet your peer educators' training needs?
- In what logical manner should this training programme be?
- How long should the training period be?

The stakeholders returned to their groups to discuss the given questions. Presentation was again done after the stipulated time had elapsed. An amalgamation of the outcomes of the three groups was done by the researcher and the research assistants. Answering the given questions, the participants presented their proposed training programmes in a manner they considered logical for training. They suggested that the length of the training period should range from three weeks to three months, but after discussion the participants were of the opinion that once the draft training programme had been field tested, it would give a better indication of the length of time required for training.

After lunch of day three the participants were given a summary of the new training programme which included all their changes. They were then asked:

Are there any other changes that need to be made to the document?

The participants again worked in groups but this time the changes generally focused on shifting topics around into what they called a *logical and meaningful format*. As the document presentations at this stage were very similar, the researcher presented the changes and worked with the whole group and requested additional changes. Two minor changes were made (one was moving the section on abstinence to much earlier in the document and the second was moving the section on palliative care to come after HIV and AIDS and not towards the end of the document). After these changes the researcher made another presentation of the document and at this stage no more changes were recommended.

Before the draft training programme developed by the stakeholders is presented later in this chapter, a synthesis will be given of this component of the study.

5.3 DISCUSSION ON THE OUTCOMES OF THE DATA

COLLECTION WORKSHOP

All stakeholders present at the workshop were given an opportunity to present their training programmes. It was noted that the length of time it took for training varied from three to five days (World Vision International, Family Health Trust, UNHCR & YMCA) to 10 days and more (YWCA, Kabwata Home-Based Care and Family Life Movement). Further, the inclusion criteria to adolescence varied greatly amongst the stakeholders:

- Kabwata Home-Based Care 18-20 years

No report reviewed in this study has stipulated the exact or appropriate length of time that should be taken to train an adolescent peer educator. Stakeholders that took part in this study also had different training periods sometimes even when using the same training programme. Two recent studies (Peltzer, 2005; Sloan & Myers, 2005) have reported that literature indicates that programmes of this nature have not been reviewed to determine impact at individual or community level.

The outcome of the review of the training programmes presented by the stakeholders, indicated that most of the stakeholders in this study used programmes that had been developed in the USA. These had been slightly altered to “suit” the Zambian adolescent. In spite of changes made, some of the phrases do not particularly make sense to the researcher, for example in the introductory remarks of the Family Life Education training programme content which states: “find some who”. This is incomplete and does not make much sense to a trainer who may not be familiar with the training document or programme. Errors in the training programme which equated content and activities in the training programme were seen in both the USA and Zambian documents. Further components like “condom line-up” or “STI football” may not be meaningful in the Zambian context. A review of literature showed that these were exactly the same statements used in the second edition of a document developed by Renfrew, Fothergill, Hauser, Jackson and Kilindera (2002:50-51). Renfrew and his colleagues set out to develop a guide for teenagers in AIDS prevention. It is the researcher’s opinion that this would explain why most of the stakeholders’ training programmes focused on HIV and AIDS prevention while neglecting other essential components in adolescent reproductive

health in Zambia such as norms, cultural beliefs and practices, risk factors, peer pressure, life skills for teens, psychosocial skills and counselling, to name but a few.

Using the Family Life Movement training programme as a baseline, the draft training programme content as developed by the stakeholders will subsequently be presented.

The new additions to the document are in bold and italics. The document presented below was endorsed by the stakeholders in terms of content, sessions and sequence.

5.3.1 DRAFT TRAINING PROGRAMME AS DEVELOPED BY THE STAKEHOLDERS

DRAFT TRAINING PROGRAMME FOR ADOLESCENT REPRODUCTIVE HEALTH PEER EDUCATORS IN ZAMBIA

Introductory Activities

- A. Find someone who...
- B. Introduction to family life education
- C. Values voting
- D. Developing a group contract
- E. Ground rule session
- F. T-shirt symbols
- G. Introduction to life skills for behavioural change***

Session 1 Values

- A. Introduction to values
- B. Family values
- C. Values voting
- D. Values and behaviour
- E. Norms of Zambian societies***
- F. Cultural and traditional beliefs***

Session 2 Family and Parenting

- A. Family structure
- B. Family relationships
- C. Family roles

- D. Values and attitudes about parents
- E. Challenges of parenting
- F. Qualities of a good father/mother

Session 3 Self-awareness

- A. What is adolescence
- B. Physical changes during adolescence
- C. Social and emotional changes
- D. Male and female reproductive organs
- E. Pre-adolescent health education***

Session 4 Self-esteem

- A. Building self-esteem
- B. Body image
- C. Communicating assertively
- D. Leadership training***

Session 5 Decision Making

- A. Introduction to decision making
- B. Three C's to good decision making
- C. Practising resisting pressure when making decisions

Session 6 Sexuality

- A. Introduction to sexuality
- B. Human sexuality
- C. Feelings, fears, frustrations
- D. Sexual decision making

Session 7 Sexual Abstinence

- A. Defining sexual abstinence

Session 8 Gender

- A. Early memories
- B. Gender roles and expectations
- C. Defining gender terms
- D. Myths and popular culture
- E. Institutions and systems

Session 9 Family Planning and Fertility Awareness

- A. Preventing an unwanted pregnancy
- B. Social and health consequences of early pregnancy
- C. Abortion

Session 10 Relationships

- A. Introduction to relationships
- B. Assessing relationships

- C. Who makes a good friend?
- D. Qualities to look for in a relationship

Session 11 Sexually Transmitted Infections (STIs)

- A. Sexually transmitted infections
- B. STIs football
- C. Condom line-up

Session 12 HIV and AIDS

- A. Question cards
- B. HIV/AIDS password
- C. News about HIV/AIDS and other STIs
- D. HIV transmission game
- E. Voluntary Counselling and Testing (VCT)
- F. Mother to child transmission
- G. *Opportunistic infections*
- H. *Positive living*
- I. *Stages of HIV and AIDS*
- J. *Anti-retroviral therapy*

Session 13 Palliative Care

- A. *Love and care for HIV and AIDS patients*
- B. *First aid*
- C. *Psychosocial counselling*
- D. *Spiritual counselling*

Session 14 Abuse and Violence

- A. Domestic violence
- B. Sexual abuse and family violence
- C. Rape and date rape
- D. Child rights
- E. *Defilement*
- F. *Child labour*
- G. *Child abuse*

Session 15 Substance Use and Abuse

- A. *Types of drugs and substances (old and new)*
- B. Drug use and abuse
- C. Making decisions about drugs
- D. The truth about tobacco
- E. Alcohol – telling it as it is
- F. Ways to say NO to sex, drugs and other pressures

Session 16 Planning for the Future

- A. Setting short- and long-term goals
- B. Values and vocations

- C. Preparing a resumé
- D. *Entrepreneurship skills***
- E. *Project proposal writing skills***
- F. *Monitoring and evaluation skills***
- G. Working parents: a panel discussion

Session 17 Advocacy

- A. What is advocacy?
- B. Advocating for youth issues
- C. Personal advocacy plan of action

In general, a number of positive changes were made to the document that was used as a baseline. These included topics like pre-adolescent health education, leadership training, palliative care, abuse and violence, and entrepreneurship skills. It can be noted from the presentation above that some of the concerns raised by the researcher are still evident in the stakeholders' draft training programme and that some of the new themes that they raised during presentation of their programmes were not included in the above document. The reason for this is not fully understood. One can only hypothesise that while they would want change they are still caught up in the mindset of what they have as content in their training programmes.

Some of the stakeholders advocated for abstinence as their major prevention strategy, but their training programme only defines abstinence and does not provide for discussion of coping mechanisms or life skills that will enable adolescents to abstain from early sexual activity. The formation or improvement of youth-friendly corners was discussed at the workshop, but the training document did not explain the peer educator's role in such a centre. There was also no plan for the empowerment of peer educators to run such a centre. These issues were noted in the development of the training programme and model for peer educators.

The presentation of the results of the focus group discussions will follow.

5.4 RESULTS OF FOCUS GROUP DISCUSSIONS WITH PEER EDUCATORS

The second component of the programme development process was FGDs with the trained adolescent reproductive health peer educators. Two FGDs were held in Lusaka: one with peer educators from the YWCA, the YMCA, Kabwata Home-Based Care, the Family Health Trust and Family Life Movement, and the second one with peer educators from PPAZ. All FGDs were conducted in English. One participant in Maheba expressed himself in the vernacular although he could understand and speak English and another participant interpreted in English. The first FGD was held in the Department of Physiotherapy of UNZA's School of Medicine while the second was held at the PPAZ clinic in Lusaka. World Vision International did not send a participant to attend the FGDs. Ten peer educators attended each of the FGDs. At the first FGD there were more male participants (eight) than females (two), while the second FGD with PPAZ peer educators had an equal gender distribution.

This FGD was followed by FGDs in Livingstone, Kafue and Maheba refugee camp. The Livingstone FGD was held at Libuyu Skills' Training Centre with six peer educators (four males and two females). The person organising the FGDs was reported to have had difficulties arranging for a FGD with the Livingstone District Health Management Team (DHMT). In Kafue, the Kafue DHMT arranged for the FGD at one of their clinics (Nangongwe Health Centre) with 10 peer educators (six males and four females). In

Maheba 10 participants of equal gender distribution attended the FGD. This was held in a classroom at a school in the refugee camp. A shortcoming of this study is that the researcher did not ask the adolescents to state the age bracket of an ideal adolescent reproductive health peer educator. Participants who took part in the FGDs were between 19 and 25 years old. A gender distribution of the adolescents that attended the FGDs is presented in Table 5.1.

Table 5.1: Gender distribution of participants who attended the FGDs

FGD No.	STAKEHOLDER	MALE	FEMALE	TOTAL
1	LUSAKA			10
	YWCA	-	2	
	YMCA	2	-	
	KABWATA HOME-BASED CARE	2	-	
	FAMILY HEALTH TRUST	2	-	
	FAMILY LIFE MOVEMENT	2	-	
	WORLD VISION INTERNATIONAL	-	-	
2	PPAZ	5	5	10
3	LIVINGSTONE			6
	LIBUYU SKILLS' TRAINING CENTRE	4	2	
4	KAFUE			10
	KAFUE DHMT	6	4	

Table 5.1 (continued)

FGD No.	STAKEHOLDER	MALE	FEMALE	TOTAL
5	MAHEBA			
	MAHEBA REFUGEE CAMP	5	5	10

In order to avoid repetitions in this study, the characteristics of an ideal peer educator as reported by all the FGDs will be listed, and followed by discussion.

5.4.1 CHARACTERISTICS OF AN IDEAL PEER EDUCATOR

The characteristics of an ideal peer educator as expressed by all the participants in the respective FGDs are presented in Table 5.2. These are not arranged in order of priority but are listed as they arose in the FGDs.

TABLE 5.2: Characteristics of an ideal peer educator

GROUP OF PEER EDUCATORS	CHARACTERISTICS
LUSAKA	<ul style="list-style-type: none"> • knowledgeable • assertive • speak good English • communicate well in other languages • intelligent • a Christian • smart • must not drink • non-smoker • not take drugs • know other things besides HIV/AIDS • not be immoral • a role model • approachable • must be friendly

Table 5.2 (continued)

GROUP OF PEER EDUCATORS	CHARACTERISTICS
LIVINGSTONE	<ul style="list-style-type: none"> • motivated and attend workshops • concerned about work (committed) • must dress smartly • must not drink • must keep confidential information • not boastful • humble • not judgmental • have a “heart” (sympathetic) • kind and sociable • able to solve problems and not blame others • respectful, trustworthy and not a thief • must not take drugs • a Christian
KAFUE	<ul style="list-style-type: none"> • a good time keeper • must be brief • must know many tactics of handling things • knowledgeable • lead by example • a good listener • must be well trained • able to train others and transfer information • should have vision and commitment
MAHEBA	<ul style="list-style-type: none"> • must have undergone correct training • confident and committed • an ambassador of the community • good listener • mirror of the community • knowledgeable • keep confidential matters to themselves • well behaved • good repute in community • respectful • honest • trustworthy • sociable • easily approachable • not judgmental • must give reliable information • creative • must prepare for educational sessions • smart • humble • a role model

In general, the Lusaka-based peer educators were more concerned about the outward traits such as dress code, communication, assertiveness, being knowledgeable, friendliness and healthy lifestyle behaviours. In Livingstone, while they were also concerned about knowledge and healthy lifestyle behaviours, they seemed to have been more concerned about the peer educators' interrelation and public relations skills with other peers. Peer educators in Kafue were more interested in someone who had managerial and training skills while members of the comparison group, Maheba, were more interested in a peer educator who was an all rounder or who was knowledgeable, had training skills, displayed healthy lifestyle behaviours and was also a role model.

The characteristics of an ideal peer educator as expressed by the peer educators can be divided into the following categories:

- recommended outward traits;
- role model;
- knowledgeable;
- training and managerial skills;
- communication skills;
- lifestyle behaviour;
- beliefs and practices; and
- ethical behaviour.

While the above categories were developed by the researcher for easy presentation, some of the recommended characteristics may not neatly fit into the above, for example

trustworthiness and being honest. For the purpose of easy discussion the researcher formulated the above categories. Each of the above categories is discussed in more detail below.

Category 1: Recommended outward traits

The peer educators were of the opinion that a good peer educator needed to be someone who was assertive, smart, confident and committed, approachable, sociable and not boastful. The following were some of their comments:

Lusaka - *A good peer educator must be assertive.*

Livingstone - *A peer educator must be confident and committed to his work.*
- *Must be just involved in his work that a peer should do and the way he carries himself as a peer should show a good example.*
- *A peer educator must have motivation.*

Maheba - *A peer educator is one who is committed and confident in whatever they are doing so that he delivers correct information.*

On being smart they commented:

Lusaka - *A peer educator must be smart.*

Livingstone - *...the way he dresses. He should look smart.*

Maheba - *You must be an example. When you are teaching people on cleanliness you have to be clean. Since you are clean, if you tell the people that they must be clean they can follow because you are also clean.*

- ...when we go out into the community we should look smart. If a peer educator is smart, the community will look up to him and also listen to what he has to say...

Nearly all the sites reported the need for a good peer educator to have good social skills, for example the need to be approachable, kind, sociable, friendly, respectful and humble.

Livingstone - *A good peer educator should be active and should not boast but should be humble. He must not expose himself to his friends: that I can do this and I have that but should be humble.*

- *He must be sociable with everyone ...*

...how one socialises with people, welcomes people who approach him and the way he solves their problems.

Maheba - *A peer educator must be humble and not proud otherwise the people will not listen to what you have gone to each them.*

Category 2: Role model

Most of the peer educators reported the need for a peer educator to be a role model. A term that was continuously used in the Maheba FGD group was the need for the ideal peer educator to be a *mirror* of the community.

- *A good peer educator must be a mirror of the community.*

- *The community must see the peer educator as their mirror.*

- *A peer educator must be a mirror and behavioural change must start with a peer educator.*

- ...if you are a mirror of the community then the people just have to look at you then they will change.

- If you are a peer educator and then you are doing bad things in the community then you are not a mirror for the community.

It is the opinion of the researcher that the peer educators would like to see themselves as reflectors of what an ideal community should be like in terms of healthy lifestyle behaviour. Other sentiments reported on being role models were:

Lusaka - *A good peer educator must be a role model.*

Kafue reported that a good peer educator needed to *lead by example.*

Maheba - *... an ambassador to the community. This way the community will know and learn what is happening.*

- *A person who is of good service and a good example in the community he is serving and someone who has good behaviour when attending to the community.*

Category 3: Knowledge

All the sites except the peer educators in Livingstone were of the opinion that an ideal peer educator needs to be intelligent.

Lusaka - *When it comes to information as a peer educator you must be able to contribute intelligently in any conversation.*

- *A good peer educator must know a lot of things. He or she must be knowledgeable on other things besides HIV and AIDS. When we go in the community our friends ask us other things besides HIV and AIDS and so a*

good peer educator should be knowledgeable about other things and be intelligent because this is what our friends want to see.

Maheba - *A peer educator should have gone through correct training so that they can give correct information to the community.*

- ...peer educators need to have more information than the community.

His information should be that which people can rely on. It should be factual things other than something out of emotions.

- A peer educator should suit the community that he or she is going to deliver the information to and must give the correct information to the community.

- ...of course a peer must take the right information to the people and not the wrong one.

The characteristics that trained peer educators would like to see in an ideal peer educator highlighted the concerns of adolescents as seen in reviewed literature. They want someone smart, one who communicates well, one who is knowledgeable, someone they can confide in and someone who will not judge them for their deeds but one who will be able to offer solutions to their problems and have up-to-date information to meet their needs as adolescents (McDonald et al., 2000; McDonald et al., 2003). Piltzer (2005) reported that his study showed that peer educators do not have a significant impact on HIV/AIDS knowledge and support for People Living with HIV and AIDS (PLWHA). Another study (Sloan & Myers, 2005) reported that they found that HIV peer education was ineffective and could have involved an opportunity cost on the companies in their study. It is the opinion of the researcher that the second study had a number of

limitations ranging from the inadequacies in the training programme of their peer educators to the self reported limitations in their study design.

Category 4: Training and managerial skills

Most peer educators in Maheba and Kafue wanted someone who would be able to solve problems, a good listener, time keeper and trainer.

Kafue - *...must be a good time keeper, must be brief, and know so many tactics of handling things ...*

- *As a peer educator you must be able to train others and must be able to transfer information from them (trainers) to other peers of the same age group.*

- *...should have a vision and commitment at the same time.*

Maheba - *A peer educator must be creative. He must prepare how he or she is going to give the information that he is going to give... you must prepare yourself because if you go without preparing yourself definitely you will fail to express yourself.*

Category 5: Communication skills

Participants in Lusaka reported that a good peer educator was one who was able to communicate well in English. When asked whether someone who did not speak English would not be a good peer educator their response was that

- *...he or she needs to communicate well in other languages.*

As stated above, the Maheba participants recommended someone who was *creative* while Kafue peer educators said they desired

- ...someone who is able to transfer information to others.

Category 6: Lifestyle behaviour

A number of comments were raised on lifestyle behaviour. One peer educator in the Livingstone FGD felt:

- If you are a peer educator and you are involving yourself in sexual activities publicly then you will not disseminate information to the community.

This seems to suggest to the researcher that it was acceptable for a peer educator to be involved in sexual activities as long as it was done in private. Other participants contributing to the same discussion said,

- ...His behaviour... well he should not be someone who drinks or who does nasty things but should be someone who is respectful.

- Some bad peers are those who smoke when they are not counselling.

- If you drink, smoke dagga and steal you can not be a good peer educator.

Category 7: Beliefs and Practices

Lusaka and Livingstone peer educators recommended that an ideal peer educator needed to be a Christian:

Lusaka *- Must be a Christian*

- ...*must not be immoral*

Livingstone - ...*and should be a Christian for him to counsel someone freely and respectfully.*

Supa (2005), in a study which set out to investigate the influence of culture and religion on HIV and sexuality education in South African secondary schools, reported that 47.4% (n=71) teachers indicated that religion and culture independently or together influenced their HIV and sexuality education sessions with their students. The author concluded that culture and religion interfered with the standard HIV and sexuality protocol. A similar situation is observed in this study where policy, decisions and training (by stakeholders and their trainees) are influenced by their religious and or cultural beliefs.

Category 8: Ethical behaviour

Issues of ethics pertaining to peer educators were discussed at length at all study sites.

The need for peer educators to be able to keep confidential information to themselves was pointed out very strongly.

Livingstone - *You should keep secrets as a peer educator because if you do not keep secrets everyone will run away from you. The people will start saying that that person does not keep secrets which is bad ...then you can say that that peer educator is not a qualified peer educator.*

Others said, - *...confidentiality is important. You find that people come to share a problem but the bad peer educator goes and starts telling others their problem and exposes them to the community.*

- *Someone who keeps secrets...has relationships with people in the community so that they can share their problems.*

Most peer educators were very passionate about not judging others:

Livingstone - *A bad peer educator is one who blames others for a problem. When people come to him to share a problem he would say: But why did you do this? instead of solving the problem. You can call this person a very bad peer educator.*

- *If someone comes to you as a peer educator and tells you that they are HIV positive then a bad peer educator would say, how did you get that and who told you to get that and what and what. That would contribute to being a bad peer educator.*

Furthermore, most participants were of the opinion that a good peer educator needed to be trustworthy and non-judgmental. He or she should have integrity and compassion.

- *He/she must not be a thief... and ...must have a heart (have compassion)*

5.4.2 IMPACT OF PEER EDUCATION ON TRAINED PEER EDUCATORS IN ZAMBIA

When the participants were asked whether their training programme had had an impact on their lives as peer educators they responded as follows:

Livingstone - *Before the DHMT came to tell us about peer education...I was a commercial sex worker. Training as a peer educator has changed my lifestyle and what I need is more training.*

- *Yes ... we now know everything and we teach people about HIV/AIDS. They come to ask us about contracting HIV/AIDS.*
- *We were helped in our training when we did (learnt) STIs because now I know how to keep myself so that I can live longer.*
- *I think so...This course I did has helped me to know the dangers if I do something bad.*
- *I have learnt a lot from this training. I have learnt how to abstain...and with this disease which has come up now (HIV), we have been told that we can use condoms but for those who can not afford condoms, they can just abstain.*

Maheba and Kafue peer educators reported that as a result of the training they were more assertive, and had developed better self-esteem and self-image.

- *As peer educators if you don't have self esteem then being a peer educator is just out. We must believe that if others can do it then why can't we? It (the training) has helped us a lot to get this (self-esteem and better self-image).*
- *Training as a peer educator has contributed to my living as I now know what is good and what is bad...and for these people who do not know what it takes, I can help them in some ways. They (trainers) have given us some magazines and at our age we need to practice safe sex. Safe sex is good for us because we are not yet married.*

Some comments from the Kafue FGD on the benefits of training as a peer educator were that:

- *As youths we have re-organised ourselves because we have benefited from the training programme. But what about the youths out there who need behavioural change.*

- *We have learnt self-esteem and have been exposed – as you can see from the way we are talking.*

- *I have been helped but we need to be empowered.*

- *Yes... without the programme we would not have been here.*

- *I have changed personally even in my interaction with others. All I can say is I need more training.*

Maheba - *We have been taught to have good self image and self esteem....*

- *We are well prepared.*

- *... we have skills but we need materials to use in the communities.*

5.4.3 FACTORS THAT CONTRIBUTE POSITIVELY TOWARDS THE DEVELOPMENT OF AN IDEAL PEER EDUCATOR

Very few factors were reported in the FGDs that were considered to contribute positively to the development on an ideal peer educator. The participants reported that there was a need for an ideal peer educator to have undergone appropriate training by attending workshops. Additional factors that were reported to help were:

Lusaka - *...if you are a Christian.*

- *...if you come from a supportive family.*

5.4.4 FACTORS THAT HAVE A NEGATIVE IMPACT ON THE DEVELOPMENT OF AN IDEAL PEER EDUCATOR

There were numerous issues that were raised by the peer educators as having a negative influence on the development of an ideal peer educator. As all study sites articulated similar concerns, the outcomes are presented in Table 5.3 followed by some verbatim reports and discussion.

TABLE 5.3: Factors that have a negative impact on the development of an ideal peer educator

FACTOR TYPE	SPECIFIC FACTORS
LEADERSHIP AND MANAGEMENT	<ul style="list-style-type: none"> • Lack of incentives • Lack of identifiers as peer educators • Lack of networking with other peer educators • Lack of preparation of peer educators for the future • Lack of adequate support • Lack of communication facilities • Lack of encouragement from management • Peer educators not given enough time to practise what they have learnt • Lack of transport • Lack of resources
TRAINING PROGRAMME	<ul style="list-style-type: none"> • Training period too short and content not sufficient • Not given enough time to practise new skills • No certificates • Inadequate knowledge • No resource centre
ROLE AS PEER EDUCATORS	<ul style="list-style-type: none"> • Training and counselling persons who are much older or much younger • Peer educators not given opportunity to take on leadership roles
COMMUNITY	<ul style="list-style-type: none"> • Lack of teaching materials to use in community • Need to learn more approaches to use in community • Teased by some communities for doing work without pay

Nearly all the peer educators indicated that managers or coordinators of peer education programmes contributed greatly to the factors that had had a negative impact on the development of an ideal peer educator. Comments made by the peer educators are stated and discussed under the four above-mentioned sub-headings.

Leadership and management-related factors

All the participants reported that they had not been given any incentives or money and that they had had to find their own transport to travel to the places where they were expected to educate others in the community. One of their biggest concerns was that they had not been given certificates to show that they had undergone training as peer educators:

Livingstone - *I have been trained twice...they told us that we would be given certificates to show that we have been trained but up to now they have not come up with the certificates. Maybe there is something that we still have to learn.*

- *We do not have anyone to encourage us...at least you could go with papers (certificates) and introduce yourself but we do not even have that.*

Maheba - *...our leaders and project coordinators are not telling us the truth about the project. They keep telling us that one day this training will help. If it is really voluntary we need to get the papers (certificates) to show that we are trained...*

- *When we had the last workshop they promised the 30 of us who were trained that they would give us certificates and that we would be*

representatives in the community but even today they are saying hold on, be patient...in future we will do this and that.

- According to me, if you are a coordinator then you must tell the truth. I have left my child at home where there is no food...if they are telling us lies about the certificates it means that they will not employ us as peer educators... We just don't know what these people think of us.

- There has to be some recognition. We know that anyone can wear a T-shirt but if you have a certificate no matter how much people argue with you they will still know that you have a certificate...not where you come to a workshop and go back home with nothing. When you go back into the community people definitely ignore you.

The lack of incentives and financial support provoked much discussion in all the sites as most participants reported that they were having difficulties meeting their transport needs to go to the areas where they were expected to train peers.

Kafue *- Another thing that is affecting us here is transport. You find that you want to reach out to someone or our fellow youths in the community. The way we are going to transport ourselves is something else. So you find that we are only limited to this place.*

Lusaka *- They (programme managers and coordinators) don't give us transport, we have no money for lunch and there is no way of identifying us that we are peer educators. Some peer educators from other programmes get T-shirts but we don't even get a badge or a cap. We know that the work is voluntary but they must give us something to motivate us.*

Some complained of the long distances to their work areas while others, who had been promised bicycles by programme coordinators, mentioned that they had not received them.

Maheba - *We have transport problems. I am not a refugee but represent the chief's area. Each chief has two peer educators. We were told that we would be given bicycles but up to now we are still waiting.*

- *I am also from a chief's area. We are two of us and we live far apart...about 26 kilometres from each other and we were told that we would be given a bicycle to share. How are we going to communicate so that we can use the bicycle?*

- *...we were told at the last workshop that there was no problem with the bicycles and T-shirts but when we finished our training we were told that we were volunteers and that we should help ourselves and others. Anyway the knowledge was good but what do we have to show that we did some training? The certificates would help.*

In the Kafue FGD a very irritated participant said:

- *...we have been trained in these things (HIV/AIDS) and people out there need this information. But how do we take this information? We need to be empowered. And who can empower us? The same people who trained us: by giving us an allowance so that we can get into the community...but if all this is not done, how do you expect us to stand on our feet and get to these people? We will keep the information to ourselves and the people*

out in the community will suffer meanwhile we have the information and we just keep having more and more training.

Further, participants reported that they were not being given the opportunity to take up leadership roles or to communicate with peer educators from other institutions.

Kafue - *Elders (programme managers or coordinators) do not give us the chance to work as peer educators because they think that as youths we do not have the knowledge. We the youths have a vision but when elder people come, they just cut us and make us not to go very far.*

- *These big people (programme managers or coordinators) know that it is us the youths who can do the work because we are the ones who can influence other youths. But when the big people are here they want to take charge. The big people must take the role of monitoring and evaluation and not leading the whole thing because what am I going to do if the ball is in their hands. Then it is meaningless and I don't even need to be there.*

- *We the youths have good ideas and can spearhead our own projects because we plan but these big people are intimidating us. We the youth who organise these programmes are being frustrated. The big people must focus on monitoring and evaluation - they must know their roles.*

- *I agree with what he has said. These big people say that we the youths are the leaders of tomorrow but they are not giving us a chance to lead or have experience. They must give us a chance to lead...*

- *You will find that these organisations that train peer educators just keep training more and more peer educators and then what after that – just*

training and when you talk about motivation they say: what motivation. I know that we are volunteers but HA HA HA (Others joined in the laughter).

- For example there is World Health Day. We as peer educators come and teach using songs, dance, drums and sketches. At the end of the day they give you a drink. They cannot even give you K10, 000 (approximately R14). ...because what do these peer educators leave at home? If they got that money they could buy kapenta (type of fish) or kapamela (small packet of maize meal) to eat with their families at home. We just need a little empowering. We don't need much just a little empowering. Just something to excite us is very important (amidst much laughter from others).

Maheba *- We had a workshop for 14 days and then another one for seven days. Imagine no sitting allowance. We are still waiting for them. Some of us are single and have children, how can we manage?*

Commenting on the need for them to liaise with peer educators from other organisations the participants said:

Maheba *- As peer educators it is important for us to build relationships but what we see is that our facilitators are the ones who travel from one town to another instead of peer educators. We are the ones who are supposed to build relationships with other peer educators from other towns and communities. We should be visiting places like KARA counselling or*

Hope House so that we are exposed instead of receiving visitors all the time.

Nearly all the peer educators were concerned that after the age of 25 when they would cease to be peer educators there was nothing that their organisations were planning for their future. They were of the view that management should put some mechanisms in place so that when they “ceased” to be peer educators, they would graduate into some other skills or training that would set them up for their careers.

Kafue - *Trainers must guide youths on how to live positively. Where do we go from here? ...we are trained and then after that there is no planning for our future – there is no direction. What is our future going to be like? If we were well empowered, we would be self reliant as you know these days jobs are difficult to come by.*

Reviewed literature has shown that some of the advantages of training and participating in peer education were an increased self-esteem, assertiveness, better communication skills and a reduction in risky lifestyle behaviour (Badura et al., 2000; McDonald et al., 2000; Green, 2001; Mason, 2003 – see chapter 3:81). Based on the reports received from participants from this study, the peer educators had attained the above listed traits and were also advocating for them in what they considered the ideal peer educator. The situation in Zambia does not seem to provide the opportunity for the peer educators to be involved in programme design and operation, development of skills in assessing and accessing information resources and development in valuable experiences that would facilitate job seeking efforts later.

Training programme-related factors:

Most peer educators indicated that the knowledge that they had attained as peer educators was good while others were of the opinion that the training was not sufficient. They were often challenged when they went into communities as they found out that some community members had more information on some topics than they had. They added that because of the many problems in the society they felt that they needed more knowledge. They cited a number of training-related factors that could have a negative impact on the development of an ideal peer educator.

- Maheba
- *The training is not adequate 'cause you find that in the community you have youths involved in alcohol and drug abuse and then we have only been taught on HIV issues.*
 - *The knowledge we are getting is enough but the problem is that a..a.. (some hesitation) let me say that our directors are a problem and are somehow disorganised in the sense that they tell you that you are going to be given this and that but by the end of the day you find that they don't fulfil.*
 - *We get enough education from them but the problem is that there is no sitting allowance and no tissues (toilet paper) if you want to go to the toilet you just use your initiative. So on hygiene it is not good.*
 - *...knowledge is good but the coordinators are the problem. They are not telling us the truth. We are confused because even in the workshops there is no pen or paper. You can just imagine?*

Another participant indicated the need for programme managers or coordinators to structure their programmes in a way that would allow adolescents and pre-adolescents to train separately.

- When we were being trained, we had very young people in our group training with us. It was difficult to ask some questions as you know this is taboo. So they must put us alone and the young ones alone when they train us so that we can ask questions freely.

- Our training and counselling should separate us according to age groups so that it would be in line with our cultural beliefs and traditions. When we are mixed we cannot ask questions.

The concerns that the peer educator raised here are valid as it would defeat the whole purpose of peer education if adolescents are not trained with fellow peers with the purpose of them influencing other adolescents. After training they should share information and values with people with whom they share the same age and/or status (Svenson, 1998; Green, 2001; McDonald et al., 2003; UNESCO, 2003). See chapter 3:75-76.

A participant who hadn't said much when asked to comment on whether the training he had undergone was sufficient for the development of an ideal peer educator said:

Maheba *- The answer is no – we need more training. (Would you like to elaborate?) Well just like the others have said, we need more knowledge on training youths. You find that the community has more knowledge than the peer educator. You see, the things that affect youths*

are all ours – things like drug abuse, pregnancy, child abuse and not just HIV which we have done (or studied).

- It is not enough in the sense that some training only takes two days or five days instead of more than seven days. The things are just mixed up. You find that some peer educators leave the training programme with no information at all... For example we have not seen a curriculum document before so we don't know whether what we learnt was everything. At workshops they should give us the curriculum document so that we can know that today we are doing this and that.

Most peer educators in this study advocated for more knowledge to meet their inadequacies in the communities. It is the opinion of the researcher that additional knowledge would not necessarily solve some of the problems they were facing at community level as this required them to have more skills. As recommended by Hugo (2005), training programmes of this nature (pertaining to reproductive health and peer education) should start with a firm bases of knowledge and this should gradually decrease as the programme develops. Complementary to this, life skills development should increase as the programme develops. This is illustrated in Figure 5.1.

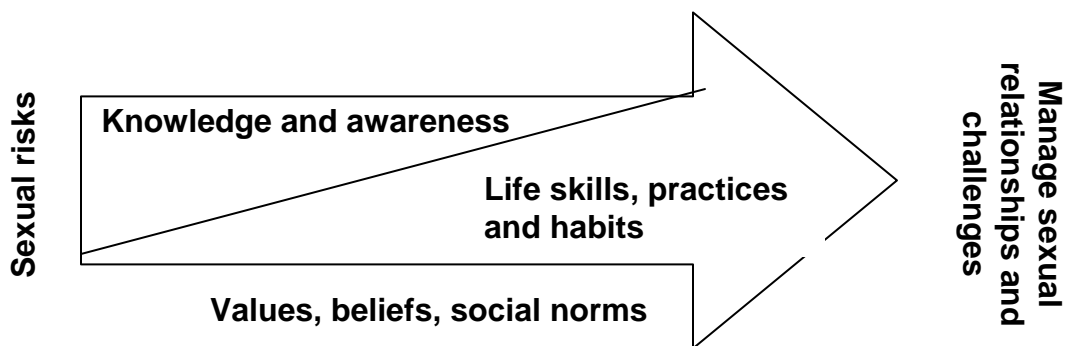


Figure 5.1: Knowledge versus skills in sexuality education

Role-related factors:

At all study sites the peer educators complained of the lack of support from management and a lack or shortage of teaching materials for use in the communities they operated in.

Lusaka - *I don't think that they (management) even know what we do in the communities. Without us these programmes wouldn't run but when we get donations like computers they go to the bosses' offices and we only have one old one at the clinic. We can't even use the internet to check for the latest information or communicate with other peer educators. We are not even allowed to use the phone.*

Other concerns raised were that there were no sources of information to enable them to access current information.

Lusaka - *We do not have a library where we can learn more about peer education. We also don't have a system of networking with other peer educators in other towns so that we can exchange information.*

A participant who was of the opinion that the training was sufficient said:

Maheba - *The information is enough but we need a link as information on HIV is something that is changing from time to time. We need more materials to keep updated all the time.*

- *We need more information so that educators can give updated information.*

- *As specialists are studying on this pandemic we should also have more workshops so that we can also have more information for the communities where we go.*

Livingstone - *In the community you are met with people from different backgrounds. You are faced with different challenges. There are many developments on HIV/AIDS and you find that you do not have enough knowledge to support yourself.*

Livingstone and Maheba reported a concern they were sometimes expected to counsel people who were much older than they were.

- *The training was good but we have to learn how to counsel people who are much older than us because in our training we were only taught to counsel people who are of the same age. .*

When asked whether they actually counselled much older persons they said,

- *Yes we do. Sometimes even married people on HIV/AIDS but we have to learn how to do this.*

Another factor raised was that the peer educators were not given enough time to practise their skills before they were sent into communities to do peer education. Other peer educators who advocated for being smart and presentable when they go out into the communities had this to say:

Maheba - *As a peer educator you are told that you must be clean. In order for someone to be clean at least there must be something to help you be clean.*

Community-related factors:

Generally, peer educators reported great challenges at community level which could have a negative impact on their self-worth and self-esteem.

Lusaka - *People in the community do not understand why we are still peer educators. In some communities they laugh at us that we are doing work for nothing.*

Maheba - *Sometimes people laugh at us that we are failures in life that is why we are doing this voluntary work.*

Similar comments were received from Kafue but not from Livingstone. When asked why they were still continuing to serve as peer educators they reported that they believed in what they were doing and had also proved the benefits of the training in their own lives. An observation made by the researcher and research assistant was that all the peer educators who took part in the study were very passionate about being peer educators. In spite of all the “problems” that they were facing, they were willing to persevere in what they believed was a *just cause*.

When asked if they had plans for the communities in which they were operating if they were given the opportunity to *lead* as per their proposal, they said (in a conversation that took place between two of the participants):

Kafue

Participant one

- *We should be given resources as peer educators to hold workshops – we would buy food and let them (fellow peers) ask questions... we the youths should organise this instead of just going into the community every time and beat drums. But if we are given a classroom once in a while, we*

would tell youths that there would be a peer education workshop and they would all come and ask questions.

Based on the above, the researcher is of the opinion that what is being reflected here is a similar methodology that some stakeholders use - workshop, food, allowances for instructors and then sending trainees into the community without much practice. The contributions continued in this manner:

Participant two

- But I believe that the best counsellor is a parent. Before you organise the youths you must call the parents because once the parents can see that we the youth can teach, (as their children) they will tell other children to come.

Participant one

- We are talking about peer education, but parents should talk to fellow parents who are their peers but we the youth should talk to fellow youths.

Participant two

- Why I have insisted on parents is because parents don't like HIV even at church. They don't like to talk about it. But if we talk to our parents, they will be challenged. Then they will tell their other children about us then they will all come to join us.

Participant one

- This all falls under cultural and traditional beliefs because parents believe that this topic is taboo but it is covered in the curriculum.

Participant two

- Parents feel shy to talk about HIV/AIDS to their children, then their children go astray and contract the same disease because they have shallow knowledge about the disease as they are only able to hear about it from their friends or the media for example on television so I think it is important how the approach is from parents.

Participant one

- But parents only talk to their children when they do something wrong.

5.5 DISCUSSION OF RESULTS IN THE LIGHT OF REVIEWED LITERATURE

It can be seen from the above exchange of ideas that adolescents know what fellow adolescents need in terms of training (Bullough & Kridel, 2003; Forrest et al., 2004; Hirst, 2004; Jensen 2004; Thorkildsen et al., 2004 – see chapter 3:82-83) but their ideas need to be directed so that they can be more effective but at the same time they would like to be affirmed by their parents (Hirst, 2004) and stakeholders (see chapter 3:92).

Reviewed literature in this study has already highlighted the fact that adolescents learn best from one another (Johnson et al., 1991; Johnson & Johnson, 1999; Badura et al., 2000; McDonald et al., 2003 – see chapter 3:83). By identifying the sort of person they think they would best learn from, they enhance the process of learning, as they would be more willing to emulate a peer educator whom they look up to than one who would not have challenging characteristics (McDonald et al., 2003; Forrest et al., 2004; Hirst, 2004 – see chapter 3:88-91). This has implications for peer educators who are being trained in

Zambia in the present dispensation. Although these trainees have the zeal to continue with their training as peer educators, they are frustrated by the many factors that have a negative impact on them and that are reportedly caused by the programme managers/coordinators. This would prevent them from being regarded as ideal role models. Some peer educators have reported that they are sometimes *laughed at* in the communities and are sometimes considered as *failures*.

Adolescents will model after persons they find to have challenging attributes and not those that are regarded as failures. Generally people would like to be associated with successful persons, therefore in order for Zambian adolescents to model after the trained peer educators, programme managers will need to deal with the issues that are causing frustration among their peer educators. For example, there is no reason why trained peer educators would not be certified after being trained as this is standard procedure when anyone attends any type of formal training. The fact that Zambian peer educators do not get any form of printed recognition cannot be justified, as printing of certificates does not cost much (assuming that a budget line for training exists).

Furthermore, the peer educators are not asking for things that are not attainable by the stakeholders, for example T-shirts, badges and caps or even some money for lunch. If stakeholders intend to opt for the formal type of training, they will need to invest money and quality time into the lives of the peer educators under their patronage. All persons appreciate recognition and appreciation, but more so young people. This study believes that the stakeholders are trying to do a remarkable job in training effective peer

educators. Results from the Sexual Behaviour Survey in Zambia (CSO et al., 2004) have reported positive outcomes in condom use among adolescents. Contrary to the above, the outcomes of this study show that the methodologies that are being applied in the training of peer educators are not as effective as they ought to be. This results in the production of ineffective and frustrated peer educators. What this study proposes will be discussed later.

Various theories were discussed in Chapter 3 of this study. Results in correlation to some of the discussed theories will subsequently be presented and taken into account.

Theory of Reasoned Action

According to the Theory of Reasoned Action, individuals or communities model after people that they consider important or admire and who therefore influence their behaviour (Drummond et al., 2002). The situation amongst the peer educators involved in this study is that they will not be able to have this sort of impact on individuals or communities unless programme managers or coordinators give them more support so that they are more admirable. This could range from getting them identifiers such as T-shirts, caps or nametags and factoring in some incentives such as lunch or transport money (see chapter 2:40, 45; chapter 3:77).

Social Identity Theory

Peer educators in this study knew that they were the ones who could influence others to undergo behavioural change as they seemed to have understood the power of positive

peer pressure. Based on the Social Identity Theory (McDonald et al., 2003) a peer educator is more likely to be seen as an in-group member. This can only happen if the peer educators have traits that others admire and feel challenged to achieve. Again the situation in Zambia will require more input from trainers and those funding the programme for this to happen (see chapter 2:44; chapter 3:88).

Diffusion of Innovation Theory

Based on the Diffusion of Innovation Theory, new information and behaviours diffuse throughout a group as more and more group members discuss the information, subsequently contributing to behavioural change (Rodger, 2002; McDonald et al., 2003). In the meantime, the outcomes of this study demonstrate that the peer educators are advocating for resource centres so that they would be able to access current or up-to-date information to disseminate to their peers. Without this support, peers in communities that have better access to information, for example internet services, libraries and other current technologies, will be better informed than the peer educators thus making them more susceptible to being challenged and confronted by peers. Organisations funding programmes for adolescents in liaison with programme managers/coordinators need to invest in communication, information centres and networking so that their peer educators from various organisations can share information, experiences and strategies (see chapter 2:44; chapter 3:88-89).

Social Comparison Theory and Cognitive Dissonance Theory

In accordance with the Social Comparison Theory, young people who are similar to the target group may positively influence norms within the target group (Ranson, 1992; Bond & McConkey, 2001). As already stated, in Zambia this can only be achieved if the frustration factors are removed from the programmes and peer educators are empowered. Peer education initiatives would need to be tailored to the expectations of the target groups in line with the Cognitive Dissonance Theory (McDonald et al., 2003). In the Zambian situation the peer education initiatives are stakeholder driven, which may prevent the expectations of the adolescents from being met (see chapter 2:44; chapter 3:89-90).

Health Belief Model

Peer educators in this study reported the need for more training and better skills. As a result of such, they would be able to tackle issues of susceptibility and perception of severity of harm resulting from their peers' beliefs and practices. They reported that they did not have enough time to practise what they had learnt and further required new methodologies or skills to deal with the *many problems in the community*. Empowering the peer educators in this manner would result in their providing their peers with information, skills and support that they would need to overcome barriers to performing some health-related behaviours (McDonald et al., 2003; WHO, 2004c). This reasoning is based on the implications for peer education using the Health Belief Model. Based on the above, peer educators would need to internalise their peers' health-related problems, followed by structuring intervention strategies with practice (and under guidance from

stakeholders) to be effective. This is because they will not be able to provide appropriate information, skills and support to their peers for as long as the intervention methodologies are stakeholder driven (see chapter 2:41, 44, 46-47; chapter 3:90-91).

Peer educators in this study reported that they knew what their responsibilities were as peer educators:

Everything to do with peers is ours.

This shows that they are aware of their roles and know that they are the best persons to influence behaviour in their peers.

The notion that the use of adolescent peer educators is cost effective is not necessarily correct, as peer educators also need incentives. If the programmes in this study are to fully succeed they will have to invest time, money and other resources for the development of ideal and effective peer educators, especially if they intend to continue using the formal type of training.

Bond and McConkey (2001) report that peer educators are more likely to be effective role models for peers as they are able to provide social information relevant to peers. The Zambian peer educators in this study seem to be aware of this, since they said that they had a *vision* for the peers and the community and did not see their role as that of *just beating drums*. This study agrees with their reasoning as this form of communication is only appropriate in certain settings.

Programme managers or coordinators need to tap into the power of peer learning by investing adequately (Bullough & Kridel, 2003; Jensen, 2004; Thorkildsen et al., 2004 – see chapter 3:82). In Zambia, if the promotion of health is to be attained, the proper use of peer educators will have to be planned for as this will not happen in a vacuum. Peer educators will have to be empowered to carry out their roles where they talk among themselves and determine the course of action (Agha, 2002; Erulkar et al., 2004; Forrest et al., 2004 – see chapter 3:82-83). In this way they will take ownership of the programmes in their settings or communities. Cooperative learning (see chapter 3:83-84) as advocated for by Johnson et al. (1991); Johnson and Johnson (1999) and Soyibo and Evans (2002) would yield positive outcomes in the training of adolescent health peer educators in Zambia. This would need to go beyond HIV and AIDS issues (though these form an important part of reproductive health) and ensure a holistic approach encompassing all factors that can influence the health of adolescents. For example, drug use, safety, sport and exercise, personal presentation and dress code, planning for the future, assertiveness and self-esteem should all be included.

Since adolescents are young they tend to have very short attention spans. Their request for something to excite them is peculiar to their age group as they easily get bored. Programme managers or facilitators need to have a wide range of teaching methodologies which peer educator trainees can learn and use on fellow peers at individual or community level. It is the opinion of the researcher that this is why the peer educators in this study are asking for an opportunity to prove what they are capable of doing and not just what is expected of them by trainers.

Peer educators in this study understood the need for them to *suit the community* which they were practising/working in. They highlighted factors such as:

- *be respected by community;*
- *be ambassador of the community; and*
- *be mirror of the community.*

What they pointed out was the need for contextualising their role and messages. In the same vein, they pointed out values, traditional beliefs and practices when they indicated that the training needed to be age appropriate. One can conclude that in this study, the participants appeared to have presented the age issue more from the cultural perspective than from their needing to train with fellow adolescents, as they reported:

This is in line with our cultural beliefs.

A number of issues presented above resulted from triangulating the outcomes of the group interviews, the FGDs and reviewed literature. The highlights of this triangulation process are presented in Table 5.4

Table 5.4: A presentation of triangulation of research results

CONCEPT	PEER EDUCATORS	STAKEHOLDERS	REVIEWED LITERATURE
Adolescence	FGD participants: Age range 19-24 years. Study definition was 10-19 as defined by WHO.	Age as presented by stakeholders for training ranged from 11-25 years	<ul style="list-style-type: none"> • WHO, 1999 • Sikes, 1996 • CSO et al., 2003a • The world Bank, 2004 • UNICEF, 2005
Peer education	Reported that they counselled persons who were much older or trained with persons who were much younger.	Need to make training sessions age appropriate so as to prepare peer educators to train and fellow peers	<ul style="list-style-type: none"> • Svenson, 1998 • Green, 2001 • McDonald et al., 2003 • UNESCO, 2003
Learning	Adolescents learn best from each other. Peer educators were aware of this concept.	Were on the same opinion that adolescents learn best from each other.	<ul style="list-style-type: none"> • Johnson et al., 1991 • Johnson & Johnson, 1999 • Badura et al., 2003
Benefits of including peer educators in identifying training needs and programme design	Hold opinion that their contributions would be useful in programme design and development as they know and understand peer needs.	Underutilising the resources they have in peer educators and youth in the communities.	<ul style="list-style-type: none"> • Bullough & Kridel, 2003 • Forrest et al., 2004 • Hirst, 2004 • Jensen, 2004 • Thorkildsen et al., 2004
Benefits of peer education	Benefited much from training as peer educators	Achieved "benefit" outcome in their trainees.	<ul style="list-style-type: none"> • Badura et al., 2000 • McDonald et al., 2000 • McDonald et al., 2003 • Green, 2001 • Mason, 2003
Knowledge gain	Peer educator are advocating for more training so as to obtain more knowledge. What is actually required is more knowledge at beginning of training programme which then progresses to more skill.	Are adding more components to training programme but need to factor in more time for learning and practising skills.	<ul style="list-style-type: none"> • McDonald et al., 2003 • Hugo, 2005
Contextualisation: Culture appropriate messages and communication	Aware of Zambian cultural values, beliefs, traditions and practices.	Advocating for contextualisation	<ul style="list-style-type: none"> • Graeff et al., 1993 • Hubley, 1993 • Helman, 1994 • Maibach & Parrott, 1995 • UNAIDS, 1999 • Manuel et al., 1998 • Hugo & Smit, 1999
Affirmation by parents and stakeholders	Advocating for affirmation from parents and support from stakeholders	Need for better supervision, collaboration and support of peer educators	<ul style="list-style-type: none"> • Hirst, 2004

Table 5.4 (continued)

CONCEPT	PEER EDUCATORS	STAKEHOLDERS	REVIEWED LITERATURE
Christian belief system	Had influence on peer education.	Some stakeholders made decisions based on their Organisations' Christian policies	Supa, 2005
Costs	Peer educators advocating for payment of incentives	Most stakeholders were of the opinion that their (Peer educators) work was voluntary and therefore peers did not have to be paid.	-
"Life after being a peer educator"	Advocating for more empowering so as to help them get employment or be accepted into training institutions after "ceasing" to be peer educators	Draft training programme made provision for future plans Need to focus on skills that would enable their trainees have valuable experience that would facilitate job-seeking efforts later	<ul style="list-style-type: none"> • Badura et al., 2000 • McDonald et al., 2000 • Green, 2001 • Mason, 2003
Lifelong learning	As above	As above	<ul style="list-style-type: none"> • Lubisi et al., 1997 • Gravett, 2001 • UNFPA, 2003
Impact of peer education	Piltzer (2005) reports that peer education is not effective Peer educators in this study do not hold this opinion.	Stakeholders are of a different view to that presented by Piltzer (2005).	<ul style="list-style-type: none"> • Piltzer, 2005 (the study self reports short comings in the training programmes of companies reviewed and in their own methodology.
Theory of Reasoned Action	Will model after admirable peer educators	Need to empower their trainees so that they are more admirable	<ul style="list-style-type: none"> • Drummond et al., 2002.
Social Identity Theory	In-group members are better able to influence others to have behavioural change	Need to empower their trainees to be more socially acceptable.	<ul style="list-style-type: none"> • McDonald et al., 2003
Diffusion of Innovation Theory	More interaction with peers would lead to more information dissemination, discussion and contribute towards behavioural change	Training programme to focus on training peer educators who will be peer educators in any setting.	<ul style="list-style-type: none"> • Rodger 2002 • McDonald et al., 2003
Social Comparison and Cognitive Dissonance Theory	Peer educators similar to target group will positively influence target group	Need to empower their trainees so that they are more admirable and socially acceptable.	<ul style="list-style-type: none"> • Bond & McConkey, 2001

5.5.1 CONCLUSIVE REMARKS ON OUTCOMES

Peer education has been defined by a number of authors (Svenson, 1998; Green 2001; McDonald et al., 2003; UNESCO, 2003; WHO, 2004c – see chapter 3:75-76) and their role of educating peers with the hope of influencing healthy behaviour has been investigated. The challenges that the peer educators in this study are facing will make it difficult for them to be effective at both individual and community levels. Based on the results of this study it is evident that Zambian peer educators are placing much emphasis on formal training. This is probably because the trainers are also doing the same instead of developing peer educators who will do peer education or facilitate learning as a “lifestyle”. In other words, peer educators who will not necessarily need to hold a workshop to inform or influence others but those who would be able to “drop” pieces of information and counsel peers as they interact on a day-to-day basis. This phenomenon is sometimes referred to as a “peer moment”.

The problem with formal training is that the peer educators are loaded with information that may not be necessary for peer education. For example, some stakeholders are advocating for peer educators to have “technical knowledge” on CD4, viral load and various other aspects. The researcher is of the opinion that this information will not be of much use to the adolescent peer educator when there are qualified persons in the clinics who will measure/evaluate and interpret these aspects. The role of the peer educator should be to understand basic knowledge on HIV and AIDS (and other reproductive health issues) and the need to refer and encourage others to go for VCT, but not to interpret blood results.

The purpose of peer education should be to have peer educators who are relevant to the community in which they work. The aim should not be to cram a great deal of superfluous information into peer educators, or to provide them with virtually meaningless certificates. Peer education should be contextualised in such a way that it meets the needs of the particular community in which the peer educator is assigned. While there is need to develop training programmes, these should not be cast in iron as the needs of adolescents vary greatly. In Lusaka alone the needs are wide-ranging, and the diversity of needs is increasingly obvious when one works with a training programme that is imported to Zambia from another country. For example: the reproductive health needs of adolescents in Kabulonga or Avondale will be different from those in Kanyama or Misisi Compound. (In comparison to Cape Town, the reproductive health needs of an adolescent in Constantia or Durbanville will be different from those in Nyanga or Guguletu.) This is because their socio-economic status, upbringing and exposure will influence the way in which they rationalise issues, and this in turn will influence their attitudes, beliefs and behaviour. Generic factors that define adolescence, such as age, physiological changes and peer pressure, may be the same, but the above-mentioned factors will play a role. Therefore, the way in which information is packaged and/or communicated has to be contextualised for the specific community.

There is a need for relevancy in the various settings even though adolescents are in the same town or country. This study recommends that programme managers/coordinators should familiarise themselves with the training programme that has been developed, but only as a guide, and use the developed model so that they can make informed decisions.

There are various steps that should be taken. Programme managers/coordinators should:

- **Familiarise themselves** with the community or site and the adolescents that they would like to train or influence, for example Kabulonga or Avondale in relation to Kanyama.
- Do a **situation analysis** by asking the following questions:
 - What are the health issues of adolescents in this setting? (Demographic health surveys/data as well as the adolescents would be able to provide input.)
 - What would we like to achieve?
 - How can we achieve this?
 - How will this be evaluated?
- **Involve the community** in that particular setting by asking them how they (adolescents/peer educators) in that setting or community would solve the problem/s.
- **THEN repackage the information** in the training programme to suit the community making sure that all sectors that can be used to solve the problem are involved in the process. The developed training programme has modules instead of sessions as recommended in the draft training programme developed by the stakeholders. This is to enable the process of repackaging the training programme to suit the various settings and people groups in which it will be employed for contextualisation purposes.

For example, if the problem is occurring at schools in a particular community then the education sector may need to be used as the vehicle/channel. By using a forum that is acceptable or familiar to the young people, such as sport, dance and plays, information would be conveyed by making use of communication methodologies that are recommended for the youth. Education and training would be achieved, resulting in the promotion of health. As the youth would take ownership of the training programme, they would develop it in manner that is culturally and value appropriate for the particular school. This would result in sustainable capacity building as it would be in line with youth interests and in a natural environment. This concept is more clearly explained in the PEER Z MODEL that has been developed.

The term *Z* was used in the naming of the model as it is common practice for Zambians to refer to Zambia as “Z”. As this model was developed for Zambia the term *Peer Z Model* is used.

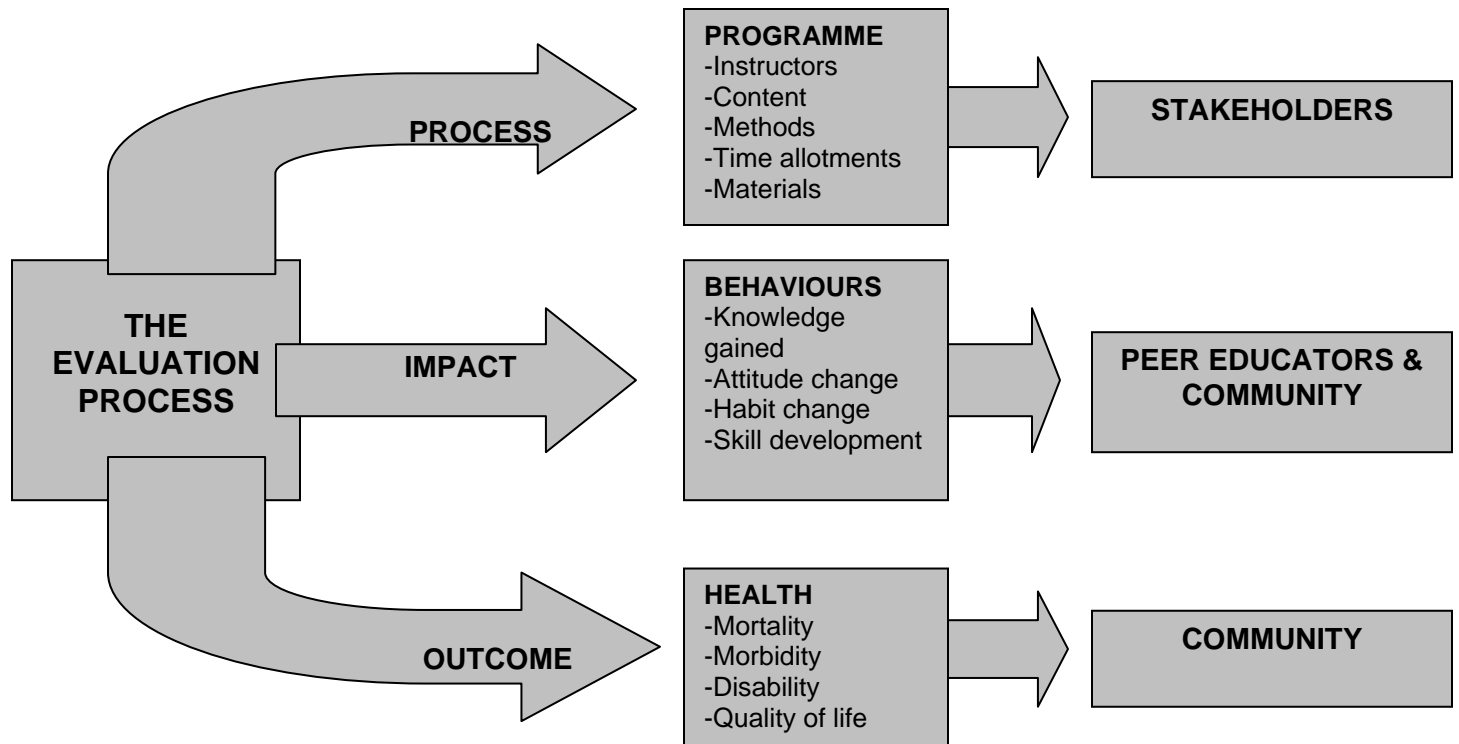
Some stakeholders in this study need to plan for outcomes for the education programmes that they are running (Lubisi et al., 1997; Gravett, 2001). The researcher recommends that they ask themselves the following questions:

- In our training programme how do we define a community?
- How effective is our training programme?
- How would we like our training programme to influence our peer educators?
- What do we want our peer educators to achieve in a one-to-one contact session with peers and at community level?

- How will we measure the impact of our training programme on our peer educators and on the community?
- What traits would we want our “retired” adolescent peer educators to take with him or her into adulthood?
- Do our trainees cease to be peer educators or peer learning facilitators?

To answer only the last question this study would like to state that peer education does not cease, as knowledge and skills acquired should only prepare them for the future. The study recommends lifelong learning which would make them (peer educators) to be better citizens, employees, who would be able to influence peers at any stage of life they may be in, and in line with the UNFPA (2003) they would influence generations to come. The key issue is that this will require the input of the adolescents themselves.

Various approaches can be used to evaluate programmes for effectiveness. Figure 5.2 represents the approach which was adopted and modified from Green and Simons-Morton (1984). The researcher was of the opinion that programme evaluation of this nature needed to indicate the various categories of persons that were to be targeted at the various stages of evaluation and therefore modified their figure to suit this study. The modification as recommended by this study is presented in Figure 5.2.



(As adopted from: Greene & Simon-Morton, 1984:308)

Figure 5.2: Three approaches to reproductive health evaluation and responsible stakeholders

5.6 CONTRIBUTIONS OF PEER EDUCATORS TO THE TRAINING PROGRAMME DEVELOPED BY THE STAKEHOLDERS

In each of the FGDs held, after discussing the factors that had a negative impact on the development of an ideal peer educator, the participants were given a copy of the draft training programme as developed by the stakeholders and were requested to comment on them. Generally the peer educators found the content of the document to be acceptable but recommended that the following topics be included:

- Role modelling

- Circumcision
- Myths (e.g. sex with a virgin is a cure for HIV/AIDS)
- Communicating assertively
- Self-esteem, including:
 - Passivity
 - Aggression
 - Positive self-regard
 - Critical thinking
 - Creative thinking.
- Decision making, including:
 - Underlying factors to decision making, such as
 - Social factors
 - Poverty
 - Upbringing
- Entrepreneurship, including:
 - Youth-generated projects
 - Developing good ideas
 - Avoiding corrupt practices
- Leadership
 - Roles of the peer educator
 - Roles of the programme manager
- Family and parenting, including:
 - The working parent

- Dangers (disadvantages) of working parents
- Parents who are not at home (non-resident parents)
- Parent-child dialogue
- Palliative care including:
 - People living positively
- HIV and AIDS, including:
 - Stigmatisation
- Decision making, including:
 - Networking.

At the end of each FGD the participants were asked if they had any questions or comments:

Lusaka: The participants wanted to know whether the training programme to be developed would be available to them. They were assured that each organisation would get a copy, and an open invitation was given to the participants to discuss study outcomes with the researcher after completion of the study.

Livingstone: None

Kafue: One of the participants wanted an explanation of the term *date rape* as seen in the draft training programme. An explanation was given.

Maheba This study site raised a few questions. One of the participants wanted to know whether they would need to pay for training using

the training programme to be developed. The participant was assured that they would not need to pay for the training.

Another participant in Maheba was concerned that since the training programme focused of Zambian norms, values, traditional beliefs and practices he was not sure which norms to use in the refugee camp. The research assistant apologised that the programme was being developed for Zambia but encouraged the peer educators in the refugee camp to use the norms, values, cultural beliefs and practices of the population groups that they had been assigned to as they needed to contextualise their input. The participants were further encouraged to familiarise themselves with the Zambian setting so that as peer educators they would be more versatile.

Another participant wanted to know whether they could keep the draft training programme documents that they had just critiqued. They were informed that they could.

In closing one of the peer educators in Maheba had this to say:

We have seen a number of researchers come to collect information from this refugee settlement but whatever we put in does not come back to us ...we expect that after the research we will get feedback so that this programme is strengthened.

The participants were thanked for participating in the study and were assured that the study outcomes would be made available to them.

5.7 COMMENTS ON OUTCOMES OF FOCUS GROUP

DISCUSSIONS

The FGDs informed the researcher of the traits of an ideal peer educator as envisaged by the peer educators. It was evident from the way the participants interacted with each other and with the researcher/s that they had developed good self-esteem and were proud of who they were as peer educators.

While they were facing numerous obstacles that were a challenge to their roles, they appeared focused on what they wanted to achieve and seemed convinced that they would be able to do something about the plight of peer educators and HIV and AIDS sufferers in the country. Generally they were burning with zeal (typical of youths) to get their hands onto the problems so as to solve them. It is strongly recommended that this resource of youths should not be allowed to go to waste. Youths are indeed the future and investing in their health issues would influence the health of Zambia and future generations.

5.8 SYNTHESIS OF CHAPTER 5

Outcomes of the group interview with the stakeholders ended with the development of a draft training programme that was then critiqued by the peer educators. Based on the amount and quality of input received from the peer educators it is evident that the adolescents need to be incorporated in the development of their training needs such as training tools or programmes, as they have a better understanding of what they would like to learn and need to learn. It was interesting to note that what the peer educators saw as factors that had a negative impact on the development of an ideal peer educator were

included in the draft training programme developed by the stakeholders. This indicates their knowledge of some of the factors that have a negative impact on the development of an ideal peer educator. The comparison group Maheba was most intriguing as they raised the same issues that other peer educators who were not refugees. This confirms the viewpoint that the issues surrounding adolescent health (with an emphasis on adolescent reproductive health) are universal (The International Bank for Reconstruction/The World Bank, 2003; CSO et al., 2004; Hirst, 2004; UNHCR; 2004; WHO, 2004c).

The concept of paying people so that they can attain information that they need for their everyday life or that of their community should be a thing of the past, as this is an expensive venture and raises expectations that financial institutions cannot meet, resulting in frustration. On the other hand, those entrusted with the responsibility of running such programmes should be sensitive to the needs of the communities in which they operate. Stakeholders should focus more on how they would attain planned for outcomes and at the same time should factor into their programmes all the variables that would result in a meaningful and sustainable learning process.

5.9 SUMMARY

Chapter 5 presents the results of the study under two main headings. Firstly, the chapter presents the outcome of the group interviews with the stakeholders and secondly, it presents the outcomes of the FGDs. In the discussion of the results the outcomes of the group interviews, FGDs and reviewed literature are triangulated. Implications of outcomes on the peer educators trained in Zambia are presented and observations and

recommendations are made. The chapter highlights the fact that while the participants in this study were relatively knowledgeable on HIV and AIDS and their role as peer educators, they were not as effective as they ought to have been because strategies used by most stakeholders were not effective. The final chapter of this study (Chapter 6) contains the summary, conclusions, and recommendations of the study.

CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

Zambia is reported to have high levels of maternal morbidity as well as maternal mortality. The high level of HIV and AIDS infection and prevailing poverty have had a negative impact on the health of the population. Adolescents have been identified as one of the population groups that are considered to be vulnerable to a number of health-related problems. A number of organisations in Zambia have invested in the training of peer educators, essentially so that they may be role models to peers and hopefully to influence their behaviour. Zambia does not have a generic and locally developed training programme for adolescent reproductive health peer educators. This study set out to evaluate training programmes being used by stakeholders in order to determine the modules that need to be included in the local training programme that is being developed. It is evident from literature reviewed that adolescents growing up in Zambia will be exposed to various cultural beliefs, norms and practices. Therefore, in order to train such an adolescent to be an effective peer educator a training programme was required that would be contextualised to Zambia. The specific objectives of the study were:

- to determine the characteristics of an ideal peer educator;
- to determine the factors that contribute positively and those that have or could have a negative impact on the development of an ideal peer educator;

- to determine whether the training programmes being used by the stakeholders had had an impact on the healthy lifestyle behaviours of the peer educators; and
- to determine whether training programmes being used by the stakeholders contribute positively towards developing an ideal peer educator.

6.2 SYNTHESIS OF THE STUDY

Adolescence is a very crucial time of a person's development. This is a time when young people strive for independence and it is also a time when they are most exposed to peer pressure and various vices which could have a negative impact on their health. The power of peer pressure can, however, be used to influence other peers towards good, healthy or positive lifestyle behaviours. Using this rationale, a number of stakeholders in Zambia trained peer educators with the hope of their being role models to their peers. This study reviewed literature that highlighted the many factors that influence the health of adolescents in Zambia. Factors considered were the socioeconomic factors, values, norms, and beliefs, attitudes and practices connected to health that are common in Zambia and how these could influence the health of adolescents with an emphasis on their reproductive health.

As adolescence is a distinctive time in one's development it was important to define terms such as *adolescence*, *peer*, *peer educator* as well as the factors that determine membership into these categories. Various theories attempt to explain why adolescents behave the way they do, and the ways in which they learn. The advantages and disadvantages of these theories informed the researcher on the need to have a broader

approach to the learning methods available in order to answer the epistemological questions that were to be tackled in the study. Studies have shown that adolescents learn best from one another and that there is a need to embrace their views in the development of their training programmes, as they would give valuable input in their training needs. It is also evident from literature that unless the youth themselves are involved in the development of their training programmes, they could be trained in that which may not be appropriate, necessary or even interesting to them. This would result in their not taking ownership of the training programmes.

The understanding of the research theories and the various dimensions and paradigms in research informed the researcher on the choices to be made on the design and methodology of the study. The study design used was programme evaluation and the following methodologies were used prior to developing the model and training programme.

- Group interviews with stakeholders so as to review their training programmes and also to develop a training programme that would produce a competent peer educator as visualised by the stakeholders.
- FGDs with the peer educators to determine their view of the characteristics of an ideal peer educator and the factors that contribute towards the development of the ideal peer educator.

Further, the study determined the factors that would have a negative impact on the development of an ideal peer educator. The impact of peer education on the peer

educator was also determined. Lastly the peer educators were given the opportunity to critique the draft training programme that had been developed by the stakeholders to determine modules that needed to be included or excluded from the document. Using triangulation the outcomes of the group interviews with the stakeholders were compared with the outcomes of the FGDs, the peer educators and reviewed literature.

6.3 CONCLUSIONS

The group interviews with the stakeholders showed that the training programmes being used by the stakeholders were not adequate in producing the ideal peer educator in Zambia. The outcome of this process was the development of a draft training programme which the stakeholders felt embraced all the training needs of their trainees.

The FGDs with the peer educators revealed that while the participants in this study were relatively knowledgeable on HIV and AIDS and their role as peer educators, they were not as successful as they ought to have been because some strategies used by most stakeholders and peer educators were not effective. The peer educators also raised a number of factors that were reported to have had a negative impact on the development of an ideal peer educator. Besides this, the peer educators in this study were very zealous and reported that they had benefited greatly from peer education although they were facing a number of hurdles which had contributed to their frustration as peer educators. Their frustration was caused by trainers/managers/programme coordinators not meeting the expectations that they had created in their trainees. These ranged from a lack of

certification to a lack of incentives such as transport, money or food to facilitate the adolescents to conduct their work.

The researcher is of the opinion that the design and methodologies that are currently being used in Zambia to develop ideal peer educators are not sustainable for the following reasons:

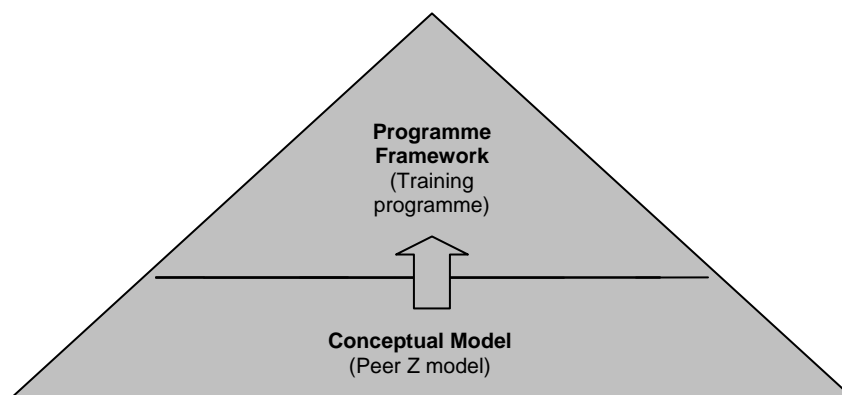
- Stakeholders profess to be unable to pay for incentives.
- There appears to be no support or collaboration between the stakeholders and the peer educators.
- Peer educators have not taken ownership of the programmes as they have not been involved in the development or implementation process of the training programmes.
- There is a need for stakeholders to have a paradigm shift from a formal type of training of peer educators to training peer educators who will be able to train others in very informal settings.

The work done for this study has shown that there is a need to critically reflect on the procedures and methodology of training peer educators in Zambia. This has resulted in the development of the Peer Z model and the training programme presented below. The Peer Z model was developed as a set of guidelines on using the training programme. The Peer Z model proposes the following steps:

- Do a **situation analysis**:
 - What are the health issues of adolescents in this setting? (Demographic health surveys/data plus input from the adolescents.)

- What should be achieved?
- How can this be achieved?
- How will this be evaluated?
- **Involve the community** in that particular setting. How would the adolescents/peer educators in that setting or community solve the problem/s?
- Then **repackage** the information in the training programme to suit the community making sure that all sectors that can be brought into play to solve the problem are involved in the process.
- The developed training programme has modules to allow for the process of repackaging of the training programme to suit the various settings and people groups in which it will be employed for contextualisation purposes.

The conceptual process that was employed in the development of the model and the training programme is presented in Figure 6.1.



(Hugo, 2005)

Figure 6.1: Conceptualisation of model and training programme

6.4 RECOMMENDATIONS

The Peer Z model that has been described is presented graphically in Figure 6.2 below.

6.4.1 PEER Z MODEL PRESENTATION

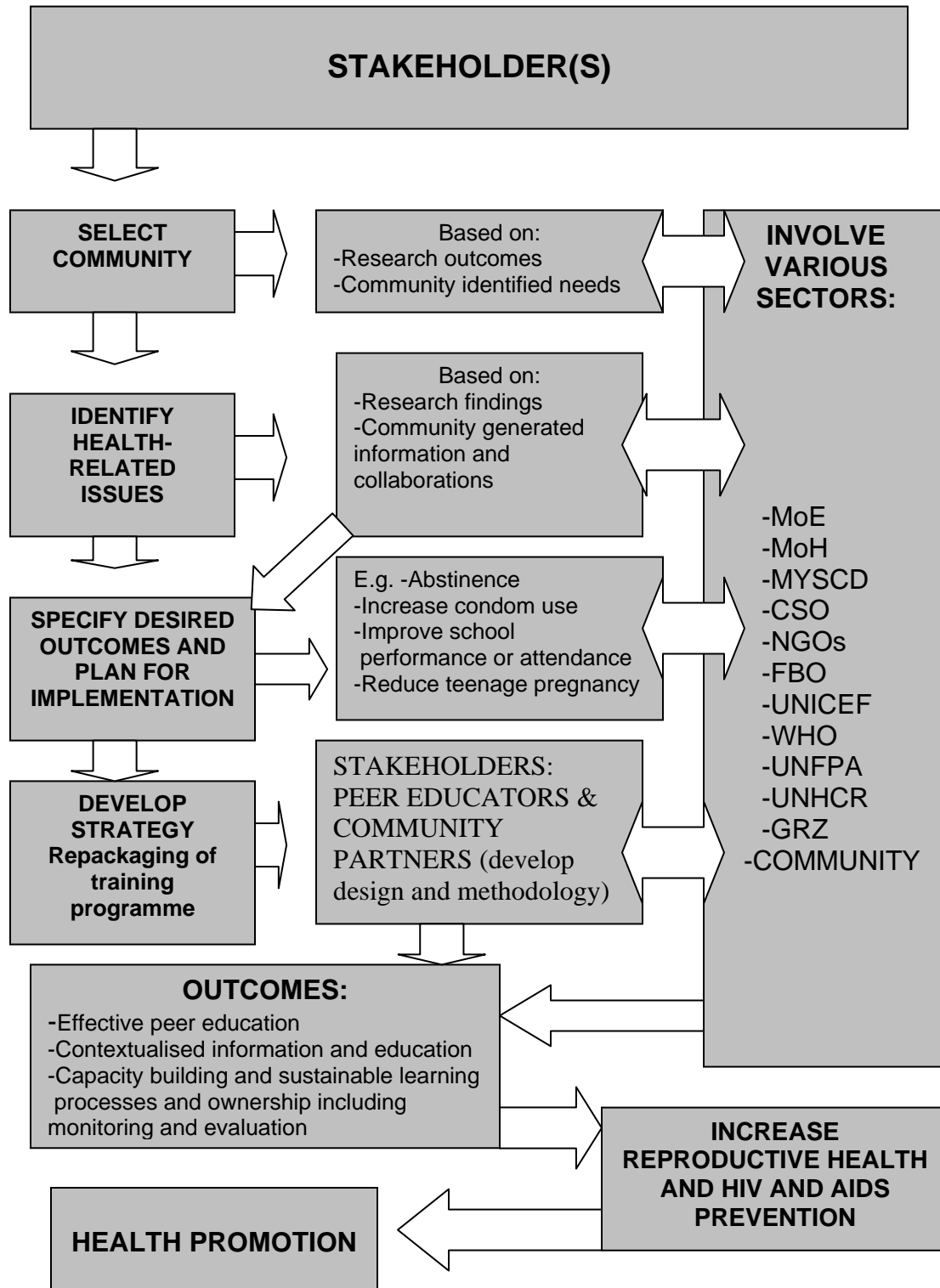


Figure 6.2 The Peer Z Model

This study would like to recommend to the stakeholders that they shift from a formal way of training peer educators to an informal method so as to empower their trainees to conduct their role as a lifestyle that they will carry into adulthood. This would result in more competent and effective role models whom this study would like to believe would have the capacity to contribute towards behavioural change. Another recommendation that this study brings is the need for greater involvement and collaboration with more sectors in peer education, especially with those that play a role in the health issues (in holistic terms) of the adolescent. The following are highly recommended:

- Ministry of Education;
- Central Statistics Office;
- Ministry of Health;
- Ministry of Youth Sport and Child Development;
- Donor agencies, e.g. UNICEF, UNFPA, WHO, UNHCR;
- Faith-based organisations, e.g. World Vision International; and
- Various communities.

This study would also like to recommend that additional research be done as a follow-up to this work so that training tools are developed for the training programme that has been developed. This would only be achieved after the training programme and model (with the help of the stakeholders and peer educators) are tested in some communities. The training programme that has been developed is presented below.

6.4.2 TRAINING PROGRAMME FOR ADOLESCENT REPRODUCTIVE HEALTH PEER EDUCATORS IN ZAMBIA

The purpose of this training programme is to develop a peer educator who will be competent and effective in communicating to fellow adolescents' information on adolescent reproductive health and also be a role model to peers.

At the end of the training programme the peer educator should be able to:

- Understand basic adolescent reproductive health issues in Zambia;
- Disseminate acquired information to peers on adolescent reproductive health;
- Demonstrate that he or she is able to practise acquired life skills and is further able to empower others;
- Be a role model to peers and the community where he or she resides, attends school or works.

Before tackling the specific modules, the training programme will commence with an introductory session(s) that will present the themes listed below under the introduction.

INTRODUCTION

- Introduction to peer education
- Purpose of the training
- Training objectives
- Formal versus informal training
- Expected training outcomes
- Evaluation

MODULE 1 ADOLESCENCE

- A. Introduction
- B. What is adolescence?
- C. Physical changes during adolescence
- D. Challenges facing young people
- E. What adolescents find exciting
- F. Risk and health-related behaviours
- G. Psychosocial life skills
- H. Pre-adolescent health education

MODULE 2 VALUES

- A. Introduction to values
- B. Family values
- C. Values voting
- D. Values and behaviour
- E. Norms of Zambian societies
- F. Cultural and traditional beliefs
 - Circumcision
 - Myths and popular culture

MODULE 3 FAMILY AND PARENTING

- A. Family structure
- B. Family relationships

- C. Family roles
- D. Values and attitudes about parents
- E. Challenges of parenting
 - Advantages and disadvantages of the working parent
 - The non-resident parent
- F. Qualities of a good father/mother
 - Parent-child dialogue
- G. Working parents: a panel discussion

MODULE 4 SELF-AWARENESS

- A. Social and emotional changes
- B. Male and female reproductive organs

MODULE 5 SELF-ESTEEM

- A. Building self-esteem
- B. Body image
- C. Passivity
- D. Aggression
- E. Positive self-regard
- F. Critical thinking

MODULE 6 COMMUNICATION SKILLS

- A. Various ways of communicating

- B. Verbal and non-verbal communication
- C. Appropriate information technologies in communication
- D. Communicating assertively

MODULE 7 DECISION MAKING

- A. Introduction to decision making
- B. Underlying factors to decision making
 - Social factors
 - Poverty
 - Upbringing
- C. Three Cs of good decision making
- D. Practising to resist pressure when making decisions
- E. Leadership training
- F. Facilitation skills
- G. Networking

MODULE 8 SEXUALITY

- A. Introduction to sexuality
- B. Human sexuality
- C. Feelings, fears, frustrations
- D. Sexual decision making
- E. Risks

MODULE 9 SEXUAL ABSTINENCE

A. Defining sexual abstinence

- Cultural beliefs regarding abstinence
- Advantages of abstinence

MODULE 10 GENDER

A. Gender roles and expectations

B. Defining gender terms

C. Institutions and systems

MODULE 11 FAMILY PLANNING AND FERTILITY AWARENESS

A. Preventing an unwanted pregnancy

B. Social and health consequences of early pregnancy

C. Abortion

MODULE 12 RELATIONSHIPS

A. Introduction to relationships

B. Assessing relationships

C. Who makes a good friend?

D. Qualities to look for in a relationship

MODULE 13 SEXUALLY TRANSMITTED INFECTIONS (STIs)

A. Sexually transmitted infections

B. Types of STIs

C. Prevention of STIs

- Condom use

MODULE 14 HIV and AIDS

A. Introduction and questions

B. HIV/AIDS and other STIs

C. HIV transmission

D. Voluntary counselling and testing (VCT)

E. Mother to child transmission

F. Opportunistic infections

- TB

G. Positive living

H. Stages of HIV and AIDS

I. Anti-retroviral therapy

MODULE 15 PALLIATIVE CARE

A. Love and care for People living with HIV and AIDS (PLWHA)

B. First aid

C. Psychosocial counselling

D. Spiritual counselling

E. Stigmatisation and discrimination

MODULE 16 ABUSE AND VIOLENCE

- A. Domestic violence
- B. Sexual abuse and family violence
- C. Rape and date rape
- D. Child rights
- E. Defilement
- F. Child labour
- G. Child abuse

MODULE 17 SUBSTANCE USE AND ABUSE

- A. Types of drugs and substances (old and new)
- B. Drug use and abuse
- C. Making decisions about drugs
- D. The truth about tobacco
- E. Alcohol – telling it as it is
- F. Ways to say NO to sex, drugs and other pressures

MODULE 18 PLANNING FOR THE FUTURE

- A. Setting long-and-short-term goals
- B. Values and vocations
- C. Preparing a resumé
- D. Entrepreneurship skills
 - Youth-generated projects

- Good and bad ideas
- Avoiding corrupt practices

E. Project proposal writing skills

F. Monitoring and evaluation skills

MODULE 19 ADVOCACY

A. What is advocacy?

B. Advocating for youth issues

C. Personal advocacy plan of action

MODULE 20 YOUTH-FRIENDLY CORNERS

A. What is a youth-friendly corner?

B. The role of a peer educator in a youth-friendly corner

C. Management of a youth-friendly corner

- Basic peer counselling

MODULE 21 ROLE MODELLING

A. Defining role modelling

B. Factors that influence good role modelling

C. Practising to be a role model

MODULE 22 ETHICS IN PEER EDUCATION

A. The role of the peer educator in various settings

- B. Confidentiality
- C. Privacy
- D. Integrity
- E. Self-presentation
 - Dress code
 - Personal hygiene
 - Interpersonal skills
 - Identifiers for peer educators
 - Incentives for peer educators

Evaluation:

Evaluation of the trainees who will undertake this training will be done by:

- Quizzes on knowledge acquired during the training period
- Demonstration of their acquired skills.
- Checklists on acquired knowledge, acquired skills and their impact at individual and community levels.
- Observation of trainees so as to evaluate knowledge and mostly skills acquired
- Reports from peers and communities.
- Impact on peers and community attitudes, beliefs, knowledge and practices.

6.5 CONCLUSION

Against all that has been presented and discussed above, this study was able to highlight the health issues in Zambia with special emphasis on adolescent reproductive health. A

young person growing up in Zambia will at one time or another be exposed to the cultural beliefs, norms, values, attitudes and practices common in Zambia and in reference to this study, to those issues that have the capacity to influence one's reproductive health.

A review of literature highlighted the generic role of peer educators, the general impact that training can have on their lives (both as peer educator trainees and as trainers). The study points out the various theories that can be used when training adolescents. The implication of these theories in the training of an effective peer educator is one of the things that this study brings to light. The study gave the researcher the opportunity to have group discussions with some of the key stakeholders in Zambia who train adolescent reproductive health peer educators; a process that resulted in the formation of a draft training programme which was improved upon after receiving input from peer educators and reviewing relevant literature. This study was delimited to the development of the model and training programme and so recommends follow up studies that will develop a training manual that would complement the developed training programme.

The objectives that this study set out to accomplish were fully attained as:

- it has been resolved that training programmes that were used by the stakeholders were not meeting the training need of the ideal peer educator for Zambia;
- the characteristics of an ideal peer educator for Zambia have been determined;
- factors that contributed towards the development of an effective Zambian adolescent reproductive health peer educator have been highlighted;
- factors that had or could have a negative impact on the development of an ideal peer educator have been fully discussed; and

- the benefits of peer education to the peer educators have also been noted.

A synthesis of all the above outcomes contributed to the development of a model and training programme that would develop more competent, effective educators (peer learning facilitators) and more admirable role models.

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APPENDIX 1

APPROVAL LETTER FROM UNIVERSITY OF ZAMBIA RESEARCH ETHICS COMMITTEE

APPENDIX 2

INVITATION LETTER TO STAKEHOLDERS



THE UNIVERSITY OF ZAMBIA SCHOOL OF MEDICINE

DEPARTMENT OF PHYSIOTHERAPY

Telephone: 252641
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753

Dean's Office
P.O. Box 50110
Lusaka, Zambia

13th October 2004

The Country Representative
UNHCR
17C Leopards Hill Road
P.O. Box 32542
LUSAKA

Dear Sir

**RE: WORKSHOP ON ADOLESCENT REPRODUCTIVE HEALTH
TRAINING FOR PEER EDUCATORS**

We are pleased to inform you that we will be holding a workshop on Adolescent Reproductive Health Training of Peer Educators from the 20th to 22 October, 2004. The workshop will be held in the Dean's Board Room, University of Zambia, School of Medicine at University Teaching Hospital, Lusaka.

The workshop is a data collection workshop towards a PhD qualification for the understated. We would like to invite you to participate in the workshop. Consent is being sought from you to:-

1. Present your curriculum to the participants.
2. Allow us to evaluate your curriculum.
3. Allow us to hold Focus Group Discussions (FGDs) with at least ten (10) of your trained Adolescent Reproductive Health Peer Educators at a later stage. Individual consent will be sought from your adolescents for the FGDs. The themes of these FGDs will be based on the outcomes of the group interviews that will take place at the data collection workshop.

The outcomes of this research will be used for academic purposes only and will not be published in any journal without your prior written consent. For any queries you may contact the undersigned or Mrs Theresa Chanda on 256067 or 097-801373

We look forward to your participation to a wonderful workshop.

Yours sincerely,

E. Munalula-Nkandu
Dip PT, BSc (Hons) PT, MSc, PgD Ethics
HEAD – DEPARTMENT OF PHYSIOTHERAPY

APPENDIX 3: LETTER OF REQUEST TO COLLECT DATA



THE UNIVERSITY OF ZAMBIA SCHOOL OF MEDICINE

DEPARTMENT OF PHYSIOTHERAPY

Telephone: 252641
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753

Dean's Office
P.O. Box 50110
Lusaka, Zambia

3rd March, 2005

The Country Representative
UNHCR
17C Leopards Hill Road
P.O. Box 32542
LUSAKA

ATT: Ms Maureen Mushinge

Dear Madam,

RE: REQUEST TO COLLECT DATA IN MAHEBA REFUGEE CAMP

Reference is made to your e-mail. The details of the data I need to collect are as follows:

The specific objectives of the study are:

- To determine the characteristic requirements of an ideal Reproductive Health peer educator.
- To determine whether the curricula being used by the selected programmes (or stakeholders) contribute positively towards the development of an ideal and effective peer educator.

- To determine the factors that contribute positively towards the development of an ideal and effective peer educator.
- To determine the factors that have a negative impact on the development of an ideal and effective peer educator.
- To determine whether the curricula being followed by the stakeholders focus on the enhancement of healthy lifestyle behaviours.

The research questions that will need to be asked in the process of collecting data are as follow:

- What characteristics constitute an ideal adolescent reproductive health peer educator?
- What factors contribute positively towards the development of an effective and ideal peer educator?
- What factors have a negative impact on the development of an ideal and effective peer educator?
- Does curricular being followed have a component that focuses on the enhancement of healthy lifestyle behaviours?
- What components need to be embedded into the new training/educational model to be developed?

It should be stated here that the review of curricular was done at the data collection workshop in Lusaka . Focus Group Discussions (FGDs) with stakeholders in Lusaka, Kafue and Livingstone have already been conducted. Maheba is to be used as a control group. While the needs of refugees are very unique, the study will test the hypothesis that the needs of adolescents are the same whether they are refugees or not.

I am hoping that permission will be granted for the collection of the remaining data. In line with your guidance, I have written to the Commissioner of refugees requesting for permission to enter Maheba Camp and conduct the study.

The contribution of the Meheba trained youth peer educators will indeed be very useful to this study.

Yours faithfully,

E. Munalula-Nkandu
 Dip PT, BSc (Hons) PT, MSc, PgD Ethics
HEAD – DEPARTMENT OF PHYSIOTHERAPY

APPENDIX 4

CONSENT FORM FOR ADOLESCENTS

INFORMATION SHEET

Dear Potential Participant,

I am a postgraduate student with Stellenbosch University in Cape Town and I am seeking your permission to take part in this study.

The purpose of the study is to develop a training model that will be suitable for adolescent reproductive health peer educators in Zambia.

There may be no direct benefits in you taking part in this study. This study will assist me as a researcher to determine what makes an ideal Adolescent Reproductive Health Peer Educator. The study will also determine whether curricular being used by the various organizations (that train peer educators) contributes positively or has a negative impact on the development of an ideal peer educator. Your participating in this study may give you an opportunity to contribute towards the development of more effective and competent Adolescent Reproductive Health peer educators in the future.

Your participation in this study is purely voluntary. You have the right to withdraw from this study or discontinue your participation in the group discussions without having to give an explanation.

Please note that all information that will be collected from you will be treated as confidential. Your participation in this study will in no way influence your work as a peer educator with your organisation as your personal response will not be communicated to them.

Should you have any queries about the study please contact the researcher on the address or numbers below

Ms Esther Nkandu
University Teaching Hospital
Department of Physiotherapy
LUSAKA

OR

Ms Esther Nkandu
Department of Physiotherapy
University of Zambia
School of Medicine
P.O. Box 50110
LUSAKA
Telephone: 01 252641 or 256067

INFORMED CONSENT FORM

The purpose of this study has been explained to me and I understand the purpose of the study. I further understand that:

- If I agree to take part in this study I can withdraw at any time without having to give an explanation.
- Taking part in this study is purely voluntary.

I _____(NAMES)

Agree

to take part in the focus group discussion.

Signed/Thumbprint

(Participant)

Date

Signed

(Researcher/Research Assistant)

Date

APPENDIX 5

PROGRAMME FOR DATA COLLECTION WORKSHOP 20-22 OCTOBER 2004 IN DEAN'S BOARDROOM – SCHOOL OF MEDICINE, UNZA

PROGRAMME FOR DAY 1 (20th October, 2004)

- 08:00-08:30 Registration and assignment to groups
- 08:30-08:45 Welcome remarks
- 08:45-09:15 Presentation from Kabwata Home Based Care (Catholic Peer educators)
- 09:15-09:30 Question and answer session
- 09:30-10:00 Presentation from YMCA
- 10:00-10:15 Question and answer session
- 10:15-10:30 TEA BREAK**
- 10:30-11:00 Presentation from YWCA
- 11:00-11:15 Question and answer session
- 11:15-11:30 Official opening of workshop
- 11:30-12:00 Presentation from Family Health Trust
- 12:00-12:15 Question and answer session

12:15-13:50 LUNCH BREAK

14:00-14:30 Presentation from Family life Movement

14:30-14:45 Question and answer session

14:45-15:00 TEA BREAK

15:00-16:00 Discussions/recapping

PROGRAMME FOR DAY 2 (21st October, 2004)

08:30-09:00 Presentation from World Vision International

09:00-09:15 Question and answer session

09:15-10:15 Presentation from UNHCR

10:15-10:30 Question and answer session

10:30-11:00 TEA BREAK

11:00-11:30 Presentation of highlights

11:30-12:30 Group discussions

12:30-13:50 LUNCH BREAK

14:00-15:30 Group presentations

15:30-16:00 Discussions/recapping

PROGRAMME FOR DAY 3 (22nd October, 2004)

08:30-09:30 Summary of group presentations

09:30-10:00 Preparation for curriculum review

10:00-10:30 TEA BREAK

10:30-12:30 Curriculum review

12:30-14:00 LUNCH BREAK

14:00-14:15 Presentation of changes

14:15- 15:15 Curriculum review

15:15-15:30 TEA BREAK

15:30-16:00 Curriculum review

16:00-16:30 Presentation of Final Document

16:30-17:00 Closing remarks

APPENDIX 6: FOCUS GROUP DISCUSSIONS (FGDs) FORMAT

**At most 10 participants but not less than 5
Makes notes on how these participants were selected (if less than 5
participants do one-to-one interviews)**

(If more than 15 participants consent to take part in study break into 2 groups and do 2 FGDs)

- Introduce yourself
- Let the potential participants introduce themselves
- Explain purpose of your visit
- Purpose of the study
- Benefits of the study
- Risks of the study
- Rights of participants
- Assure them of confidentiality

Seek for consent

- Assure them refusal to participate in the study will not affect their rights
- Thank potential participants who do not want to take part in the study and allow them to leave.
- Allow each consenting participant to fill in consent form.

Explain your use of a tape recorder

- Assure them that raw data collected or tapes will not be given to (e.g. UNHCR, DHMT) authorities as this is not the purpose of the study
- Names not to be used while having the FGDs – should this happen they are not to be concerned as scripts will not include names and tapes will be destroyed after downloading.

Conduct focus group discussion - Make sure you involve everyone as much as possible Encourage those not freely participating to make comments (NB: it is a discussion not an interview)

NB take notes on the research setting – e.g. Place where FGD is being held, is there privacy? Do participants look relaxed or fearful, are they all participating in the discussion, are they challenging each other, etc

Ice breaker questions (examples)

- How long have you been in eg Maheba Camp?
- Which is your country of origin?
- When and where did you train to be a peer educator?

- How long was your training?

Then proceed to research questions

1. So what do you think makes an ideal or good peer educator?

- Proceed with rest of the questions and probe as necessary

(What factors contribute positively towards the making of an ideal peer educator?

What factors have a negative impact on the development of an ideal peer educator?

Are you familiar with the curriculum document that is followed for the training of peer educators?

Distribute copies of new curriculum document. Give participants about 10 minutes to go through the document.

- Are there any topics that they feel should be included or excluded from the new curriculum document?

When all is covered thank the participants for taking part in the study - Stop tape

APPENDIX 7

FAMILY LIFE EDUCATION TRAINING PROGRAMME CONTENT

(Stakeholders: PPAZ, Family Life Movement, YWCA,
ARHP/GRZ/UNFPA)

Introductory activities

- Find someone who...
- Introduction to Family Life Education Programme
- Voting values
- Developing a group contract
- Session ground rules

UNIT 1 THE FAMILY

- Family structures
- Family relationships
- Family roles

UNIT 2 SELF AWARENESS

- Who am I?
- Human development

- Adolescence
- Decision making

UNIT 3 GENDER AND SEXUAL EXPRESSION

- Gender identity information
- Sexual orientation
- Sexual expression

UNIT 4 FAMILY PLANNING AND CONTRACEPTIVES

- Traditional family planning practices
- Reversible methods of birth control/Permanent methods of birth control
- Emergency contraception
- Abortion
- Contraceptive use in special situations

UNIT 5 RELATIONSHIPS

- Friendship
- Dating
- Love
- Marriage and other life partnerships
- When relationships sour

UNIT 6 RESPONSIBLE PARENTHOOD

- On parenting

- Demands of parenting
- Pregnancy and child birth
- Breast feeding

UNIT 7 PERSONAL AND SEXUAL HEALTH

- Zambia's health goals
- Critical health concepts
- Basic First Aid
- Preventative health and hygiene
- STIs
- HIV and AIDS
- How to use a condom

UNIT 8 DRUG AND MOOD ALTERING SUBSTANCES

- Drugs
- Alcohol

UNIT 9 YOUTH RIGHTS

- Bill of rights
- The juvenile Act
- Youth and reproductive Health care

APPENDIX 8

FAMILY HEALTH TRUST

HAPPY HEALTHY AND SAFE

TRAINING PROGRAMME CONTENT

APPENDIX 9

**WORLD VISION INTERNATIONAL
TRAINING PROGRAMME**