London Review of Education, *Vol.* 2, *No.* 2, *July* 2004

Carfax Publishing
Taylor & Francis Group

Building on Experience: a formative evaluation of a peer education sexual health project in South Africa

IAN WARWICK & PETER AGGLETON
Institute of Education, University of London, UK

ABSTRACT In South Africa, as elsewhere in the world, the promise of peer education as a means of promoting sexual health has contributed to its increasing popularity. While structural and organisational constraints can compromise the success of peer education, many of those involved in modest local programmes in South Africa are able to address the sexual health and well-being of young people through knowing about and making the most of proximal salutogenic factors—personal qualities and local contextual characteristics that influence health. Participatory formative evaluation can contribute to the development of peer education practice by providing opportunities for educators to extend their pedagogic knowledge and skills and review and re-orient their work. However, to embed new ways of working, sustained partnerships will be necessary.

Background

In accounts of HIV/AIDS in South Africa, it is commonplace to come across reports of an 'impending catastrophe' (loveLife *et al.*, 2000), 'spiralling rates of HIV infection' (Eaton *et al.*, 2003, p. 150) and '. . . rocketing HIV levels amongst youth' (Campbell & MacPhail, 2002, p. 342). For young people, and particularly for girls and young women, sexual abuse is also of increasing concern (Human Rights Watch, 2001; Richter *et al.*, 2004). Yet, activities to promote the well-being of young people in South Africa have been neither absent nor at a standstill. They have, however, been relatively recently developed against a backdrop of other far-reaching social, political and economic changes over the last 8 to 10 years (Sparks, 2003).

This is not to be naïve about the social complexities of addressing AIDS and promoting sexual health in South Africa. Denial, indifferent leadership, deprivation and illiteracy among the population as a whole, abuse of the rights of women, pervasive gender inequalities as well as stigma and discrimination directed against people living with HIV/AIDS can combine to impede the best efforts of younger and older alike (van Niekerk, 2001; Jennings *et al.*, 2002; Wood & Aggleton, 2004). However, it *is* to emphasise that opportunities exist to build on, invest in, and make the most of existing salutogenic factors—the personal qualities as well as proximal and distal contextual characteristics that can be utilised to promote health and well-being.

ISSN 1474-8460 print; ISSN 1474-8479 online/04/020137-17

DOI: 10.1080/1474846042000229476

For example, across the world many young people and their advocates have been making the most of the circumstances within which they find themselves and have been instrumental in addressing stigma, discrimination and HIV/AIDS (Shaw & Aggleton, 2002; UNICEF, 2002; Warwick & Aggleton, 2002, 2004). In South Africa too, a great number of young people across the nine Provinces have been involved in HIV/AIDS prevention and care programmes by way of drama and songs, through the teaching of life-skills, by playing with, and raising money for, younger children with HIV, and by running support groups for people with HIV (DoH, 2002).

We know much about what constitutes successful sexual health promotion. We know it is not achieved by a single peer education project, or a few life skills classes here and there. Neither will it be realised via an individual media campaign, nor a condom distribution scheme. It does not come about through the setting up of one or another youth group or the development of a youth friendly sexual health clinic. Taken together though, a combination of initiatives that respond to young people's contexts, commonalities and differences (in relation perhaps to gender, ethnicity, sexuality, religion, values and skills) are likely to provide a way forward (Parker, 2004)

Programmes and projects should provide young people with a safe and supportive environment in which to learn about sexual health and HIV/AIDS, provide opportunities for them to clarify their knowledge and values and develop skills (so they can put into practice what has been learnt), motivate them to build attitudes of respect for human rights, and provide access to youth friendly health services (IIEP, 2002; UNICEF, 2002).

Despite adversity, a generally supportive programme of education about sexual health is being put in place across South Africa (Department of Health, 2001; South African Human Rights Commission, 2003). Specifically in relation to sexual health, the national Departments of Education and Health have since 1995 been involved in developing a Life Skills and HIV/AIDS education programme in which Master Trainers were charged with:

- providing training and technical assistance to teachers;
- conducting advocacy and motivational workshops for community leaders, traditional healers, departmental officials and parents;
- developing materials and support resources; and
- encouraging peer education.

(Deutsch & Swartz, 2002, p. 3)

A number of factors, however, have hampered the successful implementation of this programme in schools (Coetzee & Kok, 2001). Some teachers are better prepared than others to support learning about sexual health and even the most committed may be hindered in their work by few resources, such as the equipment to play video or audio cassettes, or the electricity to power the technology. Furthermore, even if time can be found in the school curriculum for education about sexual health, learners have varying degrees of interest in this area, so impacting on educators' teaching and learning strategies. Within the local community, there may be resistance among parents, carers and community leaders to education about sexual health. In some local areas, professionals appear to have done little to support teachers and help them prioritise this area of work (Coetzee & Kok, 2001).

To complement the programme of teacher-led work, greater investment is being made in peer-led education. New resources and initiatives are being developed by the national Departments of Health and Education to assist young people to educate others in and out of school settings, as well as in higher education (for further information, see www.hsph.harvard.edu/peereducation).

Concurrent with these developments, other sexual health and peer education initiatives have been underway. For example, since 1999, loveLife has combined a national multi-media campaign with countrywide youth friendly service development in government clinics, and a national network of outreach and support programs for young people [1]. The Planned Parenthood Federation of South Africa (PPASA) has also, during the 1990s, extended reproductive health provision for young people [2].

As part of PPASA's and loveLife's work, support has been given for the development of a youth friendly sexual health clinic in a youth centre in a semi-rural location outside of Pretoria. In what was once a settlement area under apartheid, residents now experience low rates of literacy, high levels of poverty, a poor transport infrastructure and poor access to quality health, education and other services. Since 2001, a team of peer educators operating out of the centre have run HIV/AIDS and sexual health educational activities in schools for young people who would otherwise be missed by mainstream services.

Now funded by the national Department of Health and overseen by the local Health District, the youth centre continues with its original broad aims of helping to reduce the incidence of HIV, STIs and teenage pregnancy in the local area. In addition to the peer education project, the centre provides clinical and counselling services (including contraceptive provision), treatment for STIs, pregnancy testing, HIV testing, as well as couple and relationship counselling.

The peer education project follows a model of recruitment, training and supervision developed by the PPASA. Young people take part in a five-day participatory training course. During a one-year probation period they recruit further trainees into the project, and observe and co-facilitate lessons in schools. On earning a certificate of competence, peer educators then lead classroom lessons. The team takes part in regular reviews of their practice and ongoing training [3].

Peer educators had hoped their single, one-off lessons would provide learners with the information needed to protect and improve sexual health. However, they wished to find out more about the extent to which lessons enabled young people to learn more about sexual health, and whether teachers valued their contribution. In collaboration with the Centre for the Study of AIDS, University of Pretoria, a formative evaluation of the peer education project was planned. This aimed to:

- identify whether lessons contributed to learners sexual health and HIV/AIDS-related knowledge and practices;
- identify whether and in what ways teachers valued the contribution of the peer education team; and
- consider the implications of the findings for peer educators' practice.

But what is Peer Education?

Despite the increasing popularity of peer-led education in southern Africa (UNAIDS, 1999; Campbell & MacPhail, 2002), there exists disagreement about the changes it brings about. To understand its potential, and to contextualise the work of the peer education project being evaluated, we need to clarify what peer education is, how it is put into practice and how the context in which it is implemented can affect the outcomes that are brought about.

There are a number of ways in which peer education is understood and practiced. For some, contemporary discourse about it has '. . . an almost religious tenor' (Frankham, 1998, p. 179). Peer pressure, almost always seen as negatively influencing young people (and peculiarly not often construed as influencing adult/adult relationships), can be turned

around via enlightened conversations among young people. Through peer education, it is claimed, young people can be trained to educate others in ways that are radical, relevant and life changing.

A key element of successful peer education is perceived to be the commonality between educators and educated, a shared social status, perhaps related to age, gender or ethnicity (Parkin & McKegany, 2000). This is seen to make young people more credible in 'delivering' information to their peers and so more likely than adults to bring about changes in health-related behaviours. Much peer education, however, works from a somewhat impoverished pedagogic base, with little attention being paid to the processes and contexts that contribute to effective learning (see Watkins *et al.*, 2002; Jarvis *et al.*, 2003).

We might hope that peer health education brings about behavioural change among young people, or even decreases in biological markers such as HIV incidence. However, evaluations more often than not identify changes related to young people's knowledge, understandings and values (UNAIDS, 1999; Parkin & McKegany, 2000), or social norms (Wolf *et al.*, 2000), each of which are necessary but rarely sufficient determinants of behaviour change. But even these sorts of changes are inconsistent and dependent on context of the programme and its implementation (Parkin & McKegany, 2000; Elford & Hart, 2003; Shuguang & Van de Ven, 2003).

Variations across programmes relate not only to how the work is viewed by young people, sometimes ambivalently, (Richter, 1999, cited in James, 2002, pp. 179–180) but also to the ways it is implemented. There may, for example, be a lack of clear aims and objectives for a specific initiative, a lack of training and management of peer educators, and a failure to secure multi-agency support for the work (Walker & Avis, 1999). It is also open to question whether 'peers' are any better than non-peers at educating others (Mellanby *et al.*, 2001; Ott *et al.*, 2003). Bringing about change appears to be as much about the styles of teaching and learning used as it is about who has facilitated the educational experience (Parkin & McKegany, 2000).

Developing the Formative Evaluation Framework

With work of the peer educators already underway, decisions had to be made about how best to evaluate the work. While it is often useful to design evaluation and other project activities together (Hawe *et al.*, 1990; Warwick *et al.*, 1998), this is not always feasible in real life settings (Robson, 2000). Central to the formative evaluation that was planned was building on and extending practitioners own learning (see Eraut *et al.*, 2002) and responding to their information needs as stakeholders (Patton, 1997).

The value of participatory approaches to evaluation is well known (Estrella with Blauert *et al.*, 2000; Springett, 2001; Gilliam *et al.*, 2002) and often assists practitioners to critically appraise the value of their work. Stakeholders can be involved at different points in the evaluation, including its planning and implementation, and in the utilisation and dissemination of findings (Gilliam *et al.*, 2002). However, there are a number of challenges to this style of working. These include disagreements about the aims of the work, distrust of the evaluator, unhappiness with the requirements to assure the quality of the research, too great a focus on one individual's agenda and impatience among practitioners (Gilliam *et al.*, 2002).

With some of these potential difficulties in mind, the evaluator sought to agree what would count as 'good enough' evidence in relation to the evaluation aims [4]. That is, the evaluator and peer educator worked to the principles of 'optimal ignorance'—knowing what it is not worth knowing, and 'proportionate accuracy'—recognising the degree of accuracy required to produce *useful* findings (Chambers, 1981).

A five step evaluation plan was developed. This commenced with a period of observation of the peer education team in practice. Following this, opportunities were provided to discuss what had been observed and what sorts of evaluation methods might best be used. Next, the evaluator and peer educators worked together to develop data collection methods and data collection. Following this, there was a joint analysis of information collected prior to finding being fed back to schools through a specially prepared summary sheet, and some discussion of whether and in what ways changes would be made to the peer education project.

Step One

The lesson, run by a pair of peer educators, lasted 45–60 minutes (a teacher would be present at each) with a class of around 50 learners (each class varied from 20 to 80 in number) sitting in rows, most usually at fixed desks. Addressing HIV/AIDS, sexual abuse, or loveLife, the lesson would begin with one or two 'icebreakers' to introduce the facilitators to the group, to outline what topics would be covered and to encourage some pupil participation [5]. Through a series of questions, facilitators then assessed learners' familiarity with the topic. They used this information to frame a semi-participatory lesson (chiefly asking learners questions about what they knew, providing information in a sometimes humorous, sometimes serious way, checking what had been understood and occasionally using music and movement to lead from one activity to another). To remind students what had been covered, diagrams and key words were written on the chalkboard. Following the lesson, printed materials about loveLife and HIV/AIDS were distributed among learners. Free condoms were provided to the school.

Step Two

It was apparent from the observation that collecting information from learners would add a layer of complexity to the peer educators' activities in classes. Although they assessed knowledge during the lesson, they were unused to identifying at the end what had been learned. To fit within the time in school allocated to them, peer educators had to collect information relatively swiftly.

However, mindful that evaluation findings not only had to be useful to the peer education team, but also had to have credibility with school principals and with the District Health Manager (who could influence the centre's access to resources), it was agreed to develop a feedback form containing a number of closed and open-ended questions. Closed questions asked learners for their age and gender, how difficult they felt the lesson to be, and the extent to which they liked the lesson. Open questions asked them about what they had learned, to what use they would put their learning, and what comments and advice they had for the peer educators (to improve the lesson) [6]. A separate form was developed for teachers that asked them to comment on the relevance and difficulty of the lesson, the extent to which it was well structured, and invited them to make further comments.

Steps Three and Four

Questions were developed, revised and translated into learners' first language (Setswana) by the peer educators (and checked for accuracy by two other Setswana speakers) before forms were piloted.

The team suggested that the forms could be completed by small groups of students, so limiting the amount of forms distributed and collected, and providing learners with the

opportunity to revise, through discussion, what they had just been taught [7]. Assessment of learning, they believed, should in some way contribute to learning [8]. Encouraging discussion and completion of forms in small groups, while making it impossible to identify individual responses, would consolidate what had been learned and gather 'good enough' information for the peer education team to make use of.

After each school visit, completed forms were initially reviewed by the evaluator and peer education team to identify preliminary findings. Forms were then analysed thematically to draw out common and particular learning points and issues, and findings written up by the external evaluator.

Step Five

Finally, the evaluator prepared a summary sheet of findings for each school visited. The peer education team fed this information back to schools. They used the complete set of findings during their supervision and training meetings to identify whether pairs of educators, and/or the evaluation team as a whole needed to re-orient their work.

Findings

Feedback forms were used in five schools visited by the peer education team during August 2002. Information was collected from 1,519 learners (734 girls and young women and 785 boys and young men) and 29 in-school educators (teachers) covering Grades 8–12 [9].

HIV/AIDS, STIs and Sexual Abuse

Prior to visits to schools, peer educators noted that they often found it de-motivating when school staff were sceptical of young people's expertise to teach in schools. However, comments on feedback forms highlighted that staff were almost universally positive about what they had observed. Lessons were perceived to be relevant to learners, not only because of the teaching style used, but because the content of lessons engaged with problems they perceived existed in the school community.

> The content of the lesson was excellent and relevant to pupils especially because they are already involved in sexual intercourse. (HIV/AIDS & STIs, school 1)

> This was a well-presented lesson. Learners were involved through questions. It was also a relevant lesson since some of the learners are involved sexually and are pregnant. I believe learners have acquired more information. Keep up the good work. (HIV/AIDS & STIs, school 2)

> The lesson was relevant to the learners . . . Our learners lack this information. We have got boys who were infected with STIs this year. I think it is because of lack of knowledge. (HIV/AIDS & STIs, school 4)

Learners highlighted that, on the whole, they had acquired new knowledge about HIV/AIDS and STIs. Comments about HIV transmission and the symptoms of HIV/AIDS and STIs were common.

> We learned about the STIs (how you can be infected) and symptoms of an infected person. (HIV/AIDS/STIs, school 1)

> . . . STIs. If you have STIs you'll have abdominal pains, burning urine, ulcers, discharge. (HIV/AIDS/STIs, school 5)

Some learners reported more or less accurately the symptoms of STIs (even if these were not differentiated according to the type of infection). Others confused the symptoms of STIs with HIV infection.

> We learned that HIV can affect a person. You cannot tell and see a person who is HIV positive. A person with HIV has burning urine. (HIV/AIDS/STIs, school 5)

Many learners noted that they now knew about how HIV and STIs were transmitted and outlined ways they might protect themselves. Although peer educators had covered issues relating to use of condoms, reducing partners and abstaining from, or delaying, sex, learners often highlighted just one or another form of protection:

> We learned about to abstain, be faithful and to condomise. (HIV/AIDS/STIs, school 4)

> We learned about informed choices . . . about shared responsibilities and about delaying having sex, reducing partners and protecting yourself. (loveLife, school 4)

> We learned that people must use condoms to protect themselves against STIs. (HIV/AIDS/STIs, school 5)

Peer educators were surprised to find out that some quite unintended new beliefs had arisen as a result of their lessons. For example, some young people now thought that sex and the use of condoms could be harmful. Another group stated that they should refrain from sex altogether. Yet others believed that chastity prior to marriage was the best moral option.

> We learned that sex is not safe for us students and that a condom is not safe. (HIV/AIDS/STIs, school 2)

> We learned that we must abstain from sex. (HIV/AIDS/STIs, school 1)

> Sex before marriage is a sin. (HIV/AIDS/STIs, school 4)

When commenting on lessons about sexual abuse, school staff again noted the relevance of lessons to pupils, occasionally noting that sexual abuse affected learners in their school. Some staff felt that learners needed ongoing encouragement to address sexual abuse.

> The lesson was relevant because sexual abuse was well discussed and we experience such abuses which are mainly carried out by boys. (Sexual abuse, school 1)

> It was a well planned lesson, but please do keep on doing this kind of lesson to motivate the learners. (Sexual abuse, school 3)

Learners often stated that they now knew more about different types of touches: some dangerous, some confusing, others caring and loving. Some made reference to their right to say 'No' to unwanted physical contact.

> We learned about sexual abuse, dangerous touch and confusing touches. (Sexual abuse, school 4)

> In our group we learned about loving touch, dangerous touch sexual abuse, rape and the right to say 'No'. (Sexual abuse, school 1)

> We did not know about the types of touches before this lesson. (Sexual abuse, school 3)

> We learned about types of touches such as caring. (Sexual abuse, school 1)

> We learned about many things such as emotional abuse, physical abuse, negligent abuse, sexual harassment. We are glad to know about these things. (Sexual abuse, school 2)

> We learned you have the right to say 'No'. (Sexual abuse, school 1)

Even though the peer education linked saying 'No' to sexual abuse, to young children's and young people's rights, they realised that this was but one step towards enabling learners to prevent sexual abuse and protect themselves from it. They also encouraged learners to talk with trusted others, whether friends, or staff and volunteers at the peer educator's youth centre. After every lesson, peer educators would spend time in the playground providing information and passing on telephone numbers to those learners who wanted to follow up on what been addressed in the class.

> We have learned that if you have a problem you must tell somebody else . . . we need a trusted person who can help with these problems. (Sexual abuse, school 3)

> We need to visit your clinic and talk about it or we can call you. (Sexual abuse, school 3)

> Speak out if someone touches you on a sensitive part where you feel uncomfortable. (Sexual abuse, school 5)

As with lessons on HIV/AIDS and STIs, peer educators were surprised by some of the learning points noted by young people in relation to sexual abuse. For example, in one school, learners stated that they now knew,

> . . . to avoid sleeping with boys, stop going out in the evening, and stop wearing short clothes. (Sexual abuse, school 2)

Peer educators noticed that learners had great difficulty in answering two particular questions: one which asked them to identify changes they might make to their lives as a result of what they had learned, and the other to identify what support they need to make these changes. Time and again, learners asked what this meant and what sort of answers they

should give. On a number of occasions, peer educators sat with learners to discuss the question and the possible answers that might be provided.

As part of their training peer educators had been encouraged to think in this self-reflective way. Indeed, one element of their role as peer educators was to use what they learned during training to conduct themselves in ways that would best prevent sexual abuse and the transmission of HIV and STIs, and to support others to do so. This encompassed their professional activities (such as referral and advocacy), as well as their personal lives (such as their personal, romantic and sexual relationships).

In schools, however, peer educators found that learners were quite unpractised in this sort of self-reflection. More used to didactic styles of teaching, learners puzzled over a question that asked them to consider how they themselves might change as a result of the information they had been given.

Improving and Extending Work in Schools

In some lessons, school staff noted that more could have been done by the peer educators to aid comprehension. Although the unanticipated learning points noted by young people were related to HIV/AIDS, STIs and sexual abuse, school staff felt that words and phrases used in loveLife lessons were too unfamiliar (the acronym and meaning of SMART objectives, for example)

> . . . the language used should be the one the learners understand and terminology should meet their standard. Anyway, everything was well organised and understood by learners as they were able to ask and answer questions at the end of the session. (loveLife, school 4)

> Ask questions after every discussion to ensure pupils are on the same track with you. Involving them in the discussion was a good idea because it is for their benefit. Otherwise, the lesson was fruitful and well understood. (loveLife, school 5)

After observing peer educators run lessons, school staff became more positive about their work. Most felt that the question and answer format had enabled the peer education team not only to build on learners' existing understandings, but also to extend their familiarity with a topic.

> The introduction of the lesson was linked to the prior knowledge of learners. Words of motivation: 'Well done and keep it up!! Bravo. (Sexual abuse, educator, school 1)

> The style of teaching was fine because the subject teacher was using question and answer methods. Learners were able to discuss and share ideas with the teacher. I wish to invite the teacher to come again and share ideas with my learners about teenage pregnancy, contraceptives, etc. (Sexual abuse, educator, school 5)

However, not all staff shared this view. Following one lesson on sexual abuse, for example, and while expressing a concern about the extent to which young people knew about this issue, one member of staff felt that a more didactic style would help increase knowledge among learners.

> It was a good lesson. With regard to style of teaching try to give more information rather than asking many questions. I realise that our pupils lack information when coming to this type of action. (Sexual abuse, educator, school 2)

Other comments about improving the lesson related to peer educators at one school speaking too swiftly and quietly. Both staff and learners, while still offering encouragement, made these comments:

> . . . The facilitator should not be too fast when talking. Try to slow down a bit for better understanding. Be audible when explaining some of the terms. Otherwise a well presented lesson. I enjoyed listening to it . . . (Sexual abuse, school 1)

> Try to talk louder and keep it up. Do not give up. (School 1)

Realising that learners themselves could have a role to play as educators, the peer education team encouraged young people to advise, guide and teach others about HIV/AIDS, STIs and sexual abuse. Some groups indicated they had learnt about the need to do this, and a few indicated that they would do so.

> We learned to give advice and guidance to others that we got because some people are unable to get this information. (Sexual abuse, school 1)

> We'll advise the others the way we have been taught today. (Sexual abuse, school 4)

> We must teach each other about sexual abuse. (Sexual abuse, school 5)

However, far more common were calls from learners that the peer education team should come again to their own and others' schools, and to work with the local community. With such requests came many words of thanks and encouragement.

> Our advice is that she/he must go on teaching others because some people think that discrimination is funny and good but it is not good. (HIV/AIDS/STIs, school 1)

> You must go to the community and teach them more about AIDS. We love you for helping us about AIDS. (HIV/AIDS/STIs, school 2)

> My advice to [the peer educators] is that they must be strong and brave in their work and God bless them because they help the people to tell them about the strong disease AIDS. (HIV/AIDS/STIs, school 3)

> Keep educating us about HIV/AIDS, STIs. (HIV/AIDS/STIs, school 4)

> They must teach at more schools about HIV/AIDS. (HIV/AIDS/STIs, school 5)

Similar sentiments were made following lessons on sexual abuse. One group, in recognition of the difficulties faced in the area in which they lived, suggested that more could be done to educate and involve the police more fully.

> Teach this sexual abuse more than here and teach us more than you did. (Sexual abuse, school 1)
>
> We want people to work together with the police and we want them to come and patrol in our area because people are raped and more crime happens. Please help! (Sexual abuse, school 2)
>
> They must not do this only at this school. They must also go to the community as this will help more people. (Sexual abuse, school 3)
>
> You are doing the right thing. Don't give up on what you are doing. Keep on giving others the light. (Sexual abuse, school 4)

School staff too, in recognition of the expertise of peer educators, both in terms of their subject specialisation and the teaching and learning styles adopted, invited the team to come again to the school. Some teachers made requests for more frequent visits, others more specifically outlined the number of times that lessons should take place, and another hoped that the school could work in partnership with the peer education team to educate learners.

> Everything she [the facilitator] said was more than relevant to learners. The style of teaching was excellent. She is a good teacher. What I liked about her was that basically on the topic of HIV/AIDS she laid out the foundation for learners. We hope that she comes again to our school frequently. PLEASE. (HIV/AIDS/STIs, educator, school 1)
>
> The presentation was well prepared and well presented. This presentation should at least be conducted twice or thrice annually. (Sexual abuse, educator, school 3)
>
> The topic was well presented . . . I suggest that topics like this be presented to our learners at least once a year. I shall be glad if we can form partnership in fighting this problem. (HIV/AIDS & STIs, educator, school 4)

Discussion

Despite the hopes of the peer education team, one-off lessons, even those that are partly interactive in nature, can only go so far in assisting learners to know more about the nature of sexually transmitted infections, the dynamics of human relationships and how to reduce sexual health-related risks. Furthermore, being used to didactic styles of teaching, learners were quite unused to clarifying their own values and developing the skills needed to put into practice what they had learnt—all of these areas outlined as being important in HIV/AIDS education (IIEP, 2002). Even with a supportive school context that has been prepared for an ongoing education programme, changes in behaviour are less common than changes in knowledge and attitudes (UNAIDS, 1999; Horizons, 2003).

Given this, the peer education project appeared to do well to encourage learning to take place among young people in school settings in which lessons on HIV/AIDS, STIs and sexual abuse were quite unexpected. Although there were some unanticipated learning outcomes, most young people indicated they had learned about the key issues addressed by

the peer educators and were keen to find out more. Teachers too perceived the content and structure of lessons to be relevant to learners and wished that the peer education team would contribute further.

Nevertheless, it is open to question what exactly led learning to take place. As noted, those writing about peer education often play up the similarities between educators and those educated. But this downplays the importance of the teaching and learning strategies adopted by the peer educators—strategies which, in this study at least, young people had spent considerable time learning, rehearsing, putting into practice, reviewing and revising. To state that the impact of peer educators lies only in the similarity of their age to those being educated, or the commonality of their background, or any one of a number of other in-group characteristics, fails to identify the effort that young people, and those who work with them, have put into the development of an educational programme. As the manuals being developed through the Department of Health, outline peer education requires careful planning, thoughtful implementation, attentive monitoring, and vigilant evaluation (see www.hsph.harvard.edu/peereducation).

Still, the team recognised that improvements could be made to their project, particularly in relation to assessing learning. Given the lack of resources available to them, it is unlikely they could regularly adopt the use of feedback forms used for this formative evaluation—except those used by school staff. However, the team did come to recognise that they wanted to adopt a style of assessment that enhanced learning and performance (see Black *et al.*, 2002) so that the evaluation process was educational too. Although this form of integration might by seen by some to compromise the 'objective' and technical/rational nature of research, it perhaps corresponds better with current understandings of the production of knowledge in education specifically and the behavioural sciences more generally (Slife & Williams, 1995; Scott & Usher, 1999).

However, changes to the content of lessons or teaching styles used can only go so far in improving learning. The schools visited by the peer education team did not have a programme of HIV/AIDS education in place, and were said to be struggling to address life orientation, a compulsory learning area of the curriculum [10]. A bigger impact in terms of learning might come about by addressing meso-level factors that influence learning (see Alheit, 2002), and which here might include: taking a whole-school approach to sexual health, addressing the general ethos of the school (including the quality of relationships among staff and pupils), gaining support of the senior management team, improving teaching and learning practices and giving pupils a voice (DfEE, 1999). But even with a broadly supportive policy context that includes a concern to develop schools as health promoting organisations (see DoH/MRC/WHO, 2003) a lack of resources and specific local factors can disorient the best of intentions (Coetzee & Kok, 2001).

When reviewing their work, the peer education team were somewhat disappointed to learn that their intervention had only partly met their expectations. They then faced a dilemma relating to the project's coverage and quality. If they focused on fewer schools, they could engage each in developing a programme of sexual health-related work, which may well improve its impact. Yet if they focused on fewer schools, they would reach fewer young people, a particular concern when hardly any other initiatives would reach learners in their area. In the end, they decided to support one or two schools in developing a school-wide programme of work, and pay periodic visits to others to raise awareness about sexual health and well-being.

The opportunities provided to peer educators by the evaluation—to access the perspectives of learners and school staff, to review what constitutes effective school-based education about sexual health, and to consider the implications for practice—were made possible by a joint commitment among the team, and of the evaluator, to improve sexual

health education with and for young people. Being adaptable in terms of evaluation methods (and having in mind Chamber's (1997) cautionary tales about *Whose reality counts*) meant that enough information was collected to consider how improvements might be made to this particular peer education project.

On its own, one modest project of this kind may do little to alter sexual meanings and practices among young people. However, as we learn more about the emerging history of successful work to address young people's sexual health and well-being in South Africa, we may well come to value those initiatives that draw and build on the commitments and enthusiasms of local leaders, campaigners, advocates and practitioners, as much as we recognise the importance of more sizeable programmes (Reproductive Health Research Unit, 2001; DoH, 2002) [11]. Research to support the development of critical and reflective practice at a local level, while not yet having the *cachet* or funding of multi-component evaluations, could do much to identify the sorts of proximal and contextual characteristics that, along with sufficient resources and learning from best practice, result in more positive outcomes (see Pawson & Tilley, 1997). If such evaluation support were also action-oriented in nature, and engaged people over time, much could be done to concurrently build research and practitioner capacity (Bradley *et al.*, 2002). Even so, how best to strike a balance between informal, voluntary and statutory sector activities so as not to stifle leadership and innovation, remains open to question (Save the Children, 2001).

The greatest problem with peer education is not that it is successful at one place and time and not another. If anything, we should be seriously surprised if a single programme engendered the same effects regardless of learners and their context. This would go against what we know about learning (Harrison *et al.*, 2002), and about the nature of the social behaviour itself (Slife & Williams, 1995). The greatest problem with peer education is that we have neither significantly explored its educational dynamics nor committed ourselves to the critical development of its greatest resource: its practitioners.

Correspondence: Ian Warwick, Thomas Coram Research Unit, Institute of Education, University of London, 27/28 Woburn Square, London WC1H 0AA, UK. Email: i.warwick@ioe.ac.uk

Acknowledgements

Our thanks to: staff at the Centre for the Study of AIDS, University of Pretoria; and staff and volunteer educators at the youth centre for their support, guidance and advice.

Notes

[1] For further information see www.kff.org/about/southafrica.cfm and www.lovelife.org.za/kids/index.html

[2] For further information see www.ppasa.org.za

[3] The centre was managed by a trained nurse (who also oversaw the peer education project). A peer education coordinator (a trained teacher) had responsibility for the day-to-day management of the peer education project. During the financial year 2002–2003, around 115 young people took part in peer education training and at any one time around 20 peer educators were involved in education and counselling activities.

[4] Campbell, in reporting on a study in a South African township, describes the tensions generated between researchers and community members involved in the study. Such tensions '. . . ran very high over time, with players on each side almost coming to

physical blows at one stage. The survey team were driven by notions of "independent scientific rigour" and "technical expertise", which derived from an academic world which was very far removed from local people's everyday lives' (Campbell, 2003, p. 177).

[5] The lesson on HIV/AIDS and STIs covered symptoms of HIV/AIDS and STIs; ways in which HIV and STIs are transmitted; how to prevent transmission of HIV and STIs (including delaying having sexual intercourse, reducing numbers of sexual partners, using condoms); links between acquiring HIV and STIs (such as inflammation of genital tract making it easier for HIV to be transmitted); skills needed to protect oneself from HIV (such as communication skills and decision-making).

The lesson on sexual abuse covered different types of abuse (including rape, incest, harassment and neglect as well as physical, emotional and verbal abuse); different types of touching (good and dangerous touching); where someone who is abused could go for help (teachers, social workers and the police).

The lesson on loveLife covered what loveLife is (a South Africa-wide campaign to raise awareness about HIV/AIDS) and how young people can be involved in it (such as becoming a 'groundbreaker' to help others learn about HIV/AIDS); how to prevent HIV transmission (delay sex, reduce partners and/or protect by using condoms); from where to get help (such as the youth centre); the importance of setting and working towards personal goals.

[6] In response to the closed question, almost all learners indicated they had liked the lesson and had not found it too hard so these responses are not specifically reported below.

[7] Learners were asked to complete the form in English unless they had difficulty doing so. A small number of forms were completed in Setswana and translated.

[8] The peer educators understood evaluation of knowledge, attitudes and behaviour, or, cast in educational language, assessment of pupil learning, as an opportunity to enhance learning. Recent debates in education highlight just how important assessment can be to enhancing pupil self-esteem, motivation, understanding and performance (Assessment Reform Group, 1999; Black *et al.*, 2002).

[9] The differences in female and male pupils reached reflected proportions of learners in schools rather than any focusing of work by peer educators or school staff.

[10] The Life Orientation Learning Area aims to prepare learners for life and its possibilities. Specifically, it seeks to equip learners for meaningful and successful living in a rapidly changing and transforming society. It is concerned with the social, personal, intellectual, emotional and physical growth of learners, and with the way in which these facets are interrelated (DoE, 2002).

[11] Although Parker (2003) offers a critique of the impact of loveLife.

References

Alheit, P. (2002) On a contradictory way to the 'learning society': a critical approach. In R. Edwards, N. Miller, N. Small & A. Tait (eds) *Supporting Lifelong Learning, Volume 3: making policy work*, London, RoutledgeFalmer.

Assessment Reform Group (1999) *Assessment for Learning. Beyond the Black Box*. Cambridge, University of Cambridge School of Education.

Black, P., Harrison, C., Lee, C., Marshall, B. & Wiliam, D. (2002) *Working Inside the Black Box: assessment for learning in the classroom*, London, Department of Education and Professional Studies.

Bradley, J.E., Mayfield, M.V., Mehta, M.P. & Rukonge, A. (2002) Participatory evaluation of reproductive health care quality in developing countries, *Social Science & Medicine*, 55, 269–282.

Campbell, C. (2003) *'Letting them Die'. Why HIV/AIDS Intervention Programmes Fail*. Oxford, James Currey.

Campbell, C. & MacPhail, C. (2002) Peer Education, gender and the development of critical consciousness: participatory HIV prevention by South African youth, *Social Science and Medicine*, 55, 331–345.

Chambers, R. (1981) Rapid rural appraisal: rationale and repertoire, *Public Administration and Development*, 1, 95–106.

Coetzee, A. & Kok, J.C. (2001) War verhoed die suksesvolle implementering van die HIV/VIGS, seksualiteit en lewensvaardighededeprogram in skole? *South African Journal of Education*, 21, 6–10.

Department of Education (2002) *Revised National Curriculum Statement Grades R-9 (Schools). Life Orientation*, Pretoria, DoE.

Department for Education and Employment (1999) *National Healthy School Standard. Guidance*, London, DfEE.

Department of Health (2001) *Policy Guidelines for Youth and Adolescent Health*, Pretoria, Department of Health.

Department of Health (2002) *Our Young People Take It On. Life skills and HIV/AIDS Education Initiatives to Turn the Tide*, Pretoria, Department of Education/Department of Health.

Deutsch, C. & Swartz, S. (2002) *Rutanang. Towards Standards of Practice for Peer Education in South Africa*, Pretoria, Department of Health.

DoH/MRC/WHO (2003) *Healthy Environments for Children. A Report on Events in South Africa to Observe World Health Day April 2003*, Pretoria, Medical Research Council.

Eaton, L., Flisher, A.J. & Aarø, L.E. (2003) Unsafe sexual behaviour in South African youth, *Social Science and Medicine*, 56, 149–165.

Elford, J. & Hart, G. (2003) If HIV prevention works, why are rates of high-risk sexual behaviour increasing among MSM? *AIDS Education and Prevention*, 15, 294–308.

Eraut, M., Alderton, J., Cole, G., & Senker, P. (2002) Learning from other people at work. In R. Harrison, F. Reeve, A. Hanson & J. Clarke (eds) *Supporting Lifelong Learning, Volume 1: perspectives on learning*, London, RoutledgeFalmer.

Estrella, M., with Blauert, J., Campilan, D., Gaventa, J., Gonsalves, J., Guijt, I., Johnson, D. & Ricafort, R. (2000) *Learning from Change. Issues and Experiences in Participatory Monitoring and Evaluation*, London, Intermediate Technology Publications.

Frankham, J. (1998) Peer education. The unauthorised version, *British Educational Research Journal*, 24, 179–194.

Gilliam, A., Davis, D., Barrington, T., Lacson, R., Uhl, G. & Phoenix, U. (2002) The value of engaging stakeholders in planning and implementing evaluations. *AIDS Education and Prevention*, 14, 5–17.

Harrison, R., Reeve, F., Hanson, A. & Clarke, J. (2002) *Supporting Lifelong Learning. Volume 1: perspectives on learning*, London, RoutledgeFalmer.

Hawe, P., Degeling, D. & Hall, J. (1990) *Evaluating Health Promotion. A Health Worker's Guide*, London, Maclennan & Petty.

Horizons (2003) *Programming for HIV Prevention in South African Schools*, Washington DC, Horizons.

Human Rights Watch (2001) *Scared At School: sexual violence against girls in South African schools*, London, Human Rights Watch.

IIEP (2002) *HIV/AIDS and Education: a strategic approach*, Paris, IIEP.

James, D. (2002) 'To take the information down to the people': life skills and HIV/AIDS peer educators in the Durban area, *African Studies*, 61, 169–191.

Jarvis, P., Holford, J. & Griffin, C. (2003) *The Theory and Practice of Learning*, London, Kogan Page.

Jennings, R., Mulaudzi, J., Everatt, D., Richter, M. & Heywood, M. (2002) *Discrimination and HIV/AIDS*, Wits, AIDS Law Project, University of the Witwatersrand.

LoveLife (no date) *loveLife. South Africa's National HIV Prevention Programme for Young People*. Available online at: www2.kff.org

LoveLife & ABT Associates (2000) *The Impending Catastrophe: a resource book on the emerging HIV/AIDS epidemic in South Africa*, Parklands, Colorpress.

Mellanby, A. R., Newcombe, R. G., Rees, J. & Tripp, J.H. (2001) A comparative study of peer-led and adult-led school sex education, *Health Education Research*, 16, 481–492.

Ott, M.A., Evans, N.L., Halpern-Felsher, B.I. & Eyre, S.I. (2003) Differences in altruistic roles and HIV risk perception among staff, peer educators, and students in an adolescent peer education program, *AIDS Education and Prevention*, 15, 159–171.

Parker, W. (2003) Re-appraising youth prevention in South Africa: the case of loveLife, paper presented at the South African AIDS Conference, Durban, August. Available online at: www.cadre.org.za

Parker, W. (2004) Re-thinking conceptual approaches to behaviour change: the importance of context. Available online at: www.cadre.org.za

Parkin, S. & McKeganey, N. (2000) The rise and rise of peer education approaches, *Drugs: Education, Prevention and Policy*, 7, 293–310.

Patton, M.Q. (1997) *Utilization-Focused Evaluation: the new century text*, London, Sage.

Pawson, R. & Tilley, N. (1997) *Realistic Evaluation*, London, Sage.

Reproductive Health Research Unit (RHRU) (2001) Looking at loveLife. The first year. preliminary monitoring and evaluation findings of the first year of loveLife activity: September 1999–September 2000. Available online at: www2.kff.org

Richter, L., Dawes, A. & Higson, Smith, C. (2004) *Sexual Abuse of Young Children in Southern Africa*, Cape Town, HSRC.

Robson, C. (2000) *Small-Scale Evaluation*, London, Sage.

Save the Children (2001) *Pathways to Action. HIV/AIDS Prevention, Children and Young People in South Africa. A Literature Review*, Pretoria, Save the Children.

Scott, D. & Usher, R. (1999) *Researching Education. Data, Methods and Theory in Educational Enquiry*, London, Cassell.

Shaw, C. & Aggleton, P. (2002) *Preventing HIV/AIDS and Promoting Sexual Health Among Especially Vulnerable Young People*, Southampton, Safe Passages to Adulthood Programme. Available online at: www.socstats.soton.ac.uk/cshr/SafePassages.htm

Shuguang,W. & van de Ven, P. (2003) Peer HIV/AIDS education with volunteer trishaw drivers in Yaan, People's Republic of China, process evaluation, *AIDS Education and Prevention*, 15, 4, 334–345.

Slife, B. D. & Williams, R.N. (1995) *What's Behind the Research? Discovering Hidden Assumptions in the Behavioural Sciences*, London, Sage.

South African Human Rights Commission (2003) *Fourth Annual Economic and Social Rights Report: 2000–2002*, Pretoria, South African Human Rights Commission.

Sparks, A. (2003) *Beyond the Miracle. Inside the New South Africa*, Johannesburg, Jonathan Ball.

Springett, J. (2001) Appropriate approaches to the evaluation of health promotion, *Critical Public Health*, 11, 139–151.

UNAIDS (1999) *Peer Education and HIV/AIDS: concepts, uses and challenges*, Geneva, UNAIDS.

UNICEF (2002) *Young People and HIV/AIDS. Opportunity in Crisis*, New York, UNICEF.

van Niekerk (2002) Moral and social complexities of AIDS in Africa, *Journal of Medicine and Philosophy*, 27, 2, 143–162.

Walker, S.A. & Avis, M. (1999) Common reasons why peer education fails, *Journal of Adolescence*, 22, 573–577.

Warwick, I. & Aggleton, P. (2002) *The Role of Education in Promoting Young People's Sexual and Reproductive Health*, Southampton, Safe Passages to Adulthood Programme. Available online at: www.socstats.soton.ac.uk/cshr/SafePassages.htm

Warwick, I., Fines, C. & Toft, M., with Whitty, G. & Aggleton, P. (1998) *Health Promotion with Young People. An Introductory Guide to Evaluation*, London, Health Education Authority.

Watkins, C. (2001) *Learning about Learning Enhances Performance*, London, Institute of Education, University of London, National School Improvement Network.

Watkins, C., Carnell, E., Lodge, C., Wagner, P. & Whalley, C. (2002) *Effective Learning*, London, Institute of Education, University of London, National School Improvement Network.

Wolf, R.C., Tawfik, L.A. & Bond, K.C. (2000) Peer promotion programs and social networks in Ghana: methods for monitoring and evaluating AIDS prevention and reproductive health programs among adolescents and young adults, *Journal of Health Communication*, 5, 61–80.

Wood, K. & Aggleton, P. (2004) *Promoting Young People's Sexual and Reproductive Health: stigma, discrimination and human rights*, Southampton, Safe Passages to Adulthood Programme. Available online at: www.socstats.soton.ac.uk/cshr/SafePassages.htm