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policy brief

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Ensuring an optimal environment for peer education in South African schools: Policy options for healthy and effective learning

Executive summary

Peer education has long been seen as a key health promotion strategy and an important tool in preventing HIV infection. In South African schools, it is currently one of the methods employed to achieve these aims. Based on a recent research study of peer education across 35 schools and drawing on multiple previous studies in South Africa, this policy brief examines the key elements of peer education that contribute to its effectiveness and asks how these key elements of peer education align with current educational and health policies. From this research, it summarises shared goals and aims, minimum standards of implementation and the necessary infrastructure required for peer education to be effective. In light of these findings, it makes policy recommendations regarding who should be doing peer education and the status peer education should have in a school's formal programme.

Introduction

Peer education has long been seen as a key health promotion strategy. It is regarded as an important mechanism to challenge and shift youth behavioural norms, especially with regard to sexual behaviour – an issue still not easily discussed between adults and youth in South Africa. Peer education achieves this through providing opportunities for candid and genuine examinations of attitudes and choices, and by providing youth with opportunities to learn about different ways of being healthy from young people like themselves (Swartz et al. 2012). With nearly half a million young people (7.1% of the 6.4 million people in South Africa who are HIV-positive; Shisana et al. 2014) aged between 15 and 24 HIV-positive, peer education is of critical importance.

Some of the reasons why HIV infection continues for this age group include a lack of information and knowledge of how to access help (testing, contraceptives and psychosocial support), the early age at which young people begin to have sex, that they engage in age-disparate sexual relationships (usually young women with older men), the social status temptation to have multiple sexual partners (especially for young men), and the fact that recreational drug use and the consumption of alcohol lowers young people's ability to practice safe sex (Shisana et al. 2014). These factors are made worse by social reluctance and cultural taboos that prevent adults from speaking openly to young people (Campbell & MacPhail 2002; Oluga et al. 2010), young people's experiences of clinics as unfriendly (Tylee et al. 2007), young people's tendencies to deny risk and consider themselves invincible in the face of danger (Wickman et al. 2008), as well as AIDS education fatigue (Campbell et al. 2002; Swartz et al. 2012). However, it has been shown that when young people participate in well-implemented peer education programmes, they change their sexual behaviour, including using condoms, visiting clinics and reducing the number of sexual partners.

In light of these facts, this policy brief identifies the key elements of peer education that contribute to its effectiveness and examines how these elements are reflected in or supported by current educational and health policies and practice as they relate to schools.

What makes for effective peer education in schools?

The Human Sciences Research Council has been involved in researching peer education for the past 13 years. While some of this research has taken the form of evaluating the impact of existing programmes (Chandan et al. 2008; Swartz et al. 2009; Swartz et al. 2010; Swartz et al. 2014), we have also been involved in consultative and mapping processes (Deutsch & Swartz 2002; Ward et al. 2008) that have looked at best practices with regard to peer education implementation and we have served as reviewers and advisors to others (Flisher & Klepp 2009; Visser 2011). In all of these activities it has become clear that there are certain elements that distinguish peer education from other forms of health promotion and intervention.

The goals and aims of peer education

The studies and processes described above indicate that there seems to be consensus about what peer education should and should not do. Peer educators are not substitutes for teachers. They are not trained or equipped to teach technical content (including factual content) – this is best done by professional educators. Nor are they best used simply to raise awareness through displays, events and talks. Rather, according to the studies referred to above, their role should be fivefold:

1. To build trusting relationships with their peers in order to facilitate their other roles, with the aim of promoting and supporting their decisions towards healthy outcomes.
2. To educate their peers in a structured manner over time, using participatory techniques and on topics not easily discussed with adults.
3. To role-model diverse healthy behaviours and pro-social values that allow young people to choose among a range of available options.
4. To recognise youth in need of additional help and refer them for assistance with confidence and sensitivity.
5. To advocate for, and advise stakeholders about, youth needs and perspectives with regard to resources, services, equity and struggles.

A recent research study of 35 schools

When this is done, peer education has the potential to achieve a great deal. In our most recent study (Swartz et al. 2014), funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and implemented by the Western Cape departments of health and basic education in collaboration with various NGOs, we used a research design with both qualitative and quantitative components. The study assessed the impact of a peer education programme that dealt with topics such as finding help and support for problems, how to make decisions, recognising healthy relationships, HIV risk, alcohol, and teenage pregnancy. The target group were first-year high school learners with peer education delivered by same-age peers with support and training from NGOs and teachers. Changes in participants' knowledge, attitudes and intentions were measured at three intervals (immediately before the intervention, immediately after the intervention, and between five and seven months later) and compared with a control group. Thirty-five schools, stratified by district, were randomly selected out of 236 schools in the Western Cape where peer education was being implemented. The initial sample at baseline comprised 2 904 learners, with some dropping out over time. For the qualitative study, eight of these schools were chosen to serve as in-depth case studies of how the programme was implemented as well as to closely consider the contexts in which peer education took place. We also conducted focus groups with peer educators and programme participants, as well as individual interviews with adult stakeholders such as those from NGOs, teachers supervising peer education programmes, school principals, and education and health department officials.

The impacts of peer education

There were four statistically substantive findings from the study. Peer education

1. helped young people become more confident about making safe sexual decisions (including the use of contraceptives);
2. resulted in them becoming more positive about the future and their sense of being in control of it;
3. improved knowledge about how HIV is spread and avoided;
4. improved understanding of what constitutes a healthy relationship.

We also uncovered the more subtle effects of peer education through our qualitative interviews and observations. Peer education resulted in participants

1. demonstrating caring and compassionate attitudes towards each other and reports of improved communication (both at home and at school);
2. doing better at school in general, including displaying leadership skills at school and eliciting favourable reports from teachers;
3. becoming better equipped to deal with traumatic life experiences, such as abuse and exposure to violence.

Since we had the opportunity to conduct the study over three years and had 27 schools in the study (along with 8 control schools), and we had the benefit of looking back over the findings of other evaluations (Swartz et al. 2009; Swartz et al. 2010; Swartz et al. 2012), we took the opportunity to compare the impact of the school context (urban/rural, demographics) and ways

of implementing the programme. We concluded that aside from adhering to the five goals and aims of peer education (listed above), a number of factors needed to be in place to ensure effective peer education outcomes. We divided these into *implementation* and *infrastructure* requirements for effective peer education.

Table 1: A summary of the goals, standards and systems recommended for peer education programmes in schools

Conceptual aims and goals	Implementation standards	Infrastructural systems
1. Build trust and support peers 2. Educate peers 3. Role-model diverse healthy behaviours 4. Recognise and refer peers in need of help 5. Advocate for equity, resources and services	1. Plan and contextualise 2. Develop an adult infrastructure 3. Develop a peer educator infrastructure 4. Ensure gender sensitivity 5. Manage and reward performance 6. Monitor and evaluate inputs and impact	1. School climate 2. Linkages with parents and community services 3. Learning programme 4. Funding and oversight 5. Policy articulations

Implementation standards for peer education

With regard to *implementation standards*, there is consensus among studies that an effective programme centres on careful planning during which the school makes space in its programme for peer education and determines the particular needs of learners in *their* communities. It then ensures that committed expert adults (teachers and NGO and youth specialists) are available to oversee the programme and are equipped to select, support, train and supervise peer educators. They need to ensure that peer educators reflect the various kinds of learners in a school (their risk profile, personality and youth culture). They also need to ensure that peer education is made attractive to boys as well as girls – since in all our evaluations more girls than boys were enrolled as peer educators. Finally, in order to ensure the sustainability of the programme, peer educators need to be managed and rewarded and the quality of the programme monitored.

What school infrastructure is required to support peer education?

With regard to *infrastructural* systems, it was apparent that in schools with supportive and compassionate relationships between learners and educators, peer education was most effective. This was especially important when these traits were not readily experienced in learners' home and community contexts. This has been termed 'school climate' and has been articulated by Haynes, Emmons and Ben-Avie (1997), who include staff behaviour, expectations from learners, parental involvement in a school as well as school–community interactions (among other things) in their definition. Other infrastructural systems necessary for effective peer education include a network of services that learners can access – from clinics to counselling services.

Related to understanding the contextual needs of learners is the centrality of a learning programme (or curriculum) that addresses the issues that young people in a particular community face. Most schools got this right and supplemented the existing peer education curriculum when they felt this was necessary. Financial resources are required for peer education to ensure successful implementation – including being able to pay for training retreats, rewards for peer educators and lesson materials. Finally, the alignment with existing educational and health policies is critical to ensuring smooth and sustainable peer education programmes. The key question to be asked is how or whether the existing policy environment supports these agreed-upon standards.

The policy environment for peer education in schools

The role of schools as 'health promoting' (DoH 2003) has long been supported by the Department of Basic Education (DBE) and the Department of Health (DoH). Since the advent of democracy, both departments have formulated policies that support both sexual health education and peer education in schools, alongside various enabling policies. The South African Schools Act (No. 84 of 1996) wisely supports sex education in schools, eschews discrimination against teachers and learners who are HIV-positive, and has made it a matter of public policy to include NGOs and CBOs in providing expert resources to schools to assist with sex education and in other areas of social intervention. The introduction of life skills education further formalised this policy through curriculum statements for each phase of schooling (DoE 2003a; 2003b).

More recently, the DBE has articulated a Care and Support for Teaching and Learning (CSTL) programme (DBE & MIET Africa 2010) that addresses barriers to teaching and learning and places a critical focus on protecting the rights of vulnerable children and youth by strengthening schools as centres of learning. Specifically, the DBE's Action Plan to 2014: Towards the Realisation of Schooling 2025 (DBE 2011) documents 27 goals for transforming schooling in South Africa (mainly through obtaining better school results and maintaining high enrolment of learners), but also includes how and where peer education is located within the broader policy framework. The document refers to the 'associated' needs of learners as they progress through the school system.

In particular, Goal 25 focuses on using the school as a location to promote access among learners to the full range of public health and poverty reduction interventions, and acknowledges peer education as a useful method to achieve this goal. Besides the health benefits of peer education, this document also acknowledges the wider contribution peer education makes in terms of helping learners develop critical thinking, decision-making and coping skills that will contribute to their staying in school and remaining responsive to learning. CSTL was also careful to protect teaching time to ensure positive academic outcomes for learners and limited peer education to a co-curricular activity – meaning it had to happen outside formal learning time.

However, the DBE's Integrated Strategy on HIV, STIs and TB 2012–2016 (DBE 2012) explicitly describes peer education as part of its life skills strategy – opening the door for it to be recognised as a formal part of the curriculum. The Integrated School Health Policy 2012 (DoH & DBE 2012) reiterates the importance of the school environment to improving preventable health conditions, and allows for a strong collaboration between the departments of basic education and health to achieve these aims. More recently the DBE has published Guidelines for the

Figure 1: Transforming schooling

Source: DBE (2011)

Implementation of Peer Education Programmes for Learners in South African Schools: A Guide for Programme Managers (Visser 2011), which to date offers the most explicit policy guidelines that frame peer education. The DBE has also commissioned various training materials to support the implementation and roll-out of peer education programmes in schools.

Overall the policy environment clearly supports peer education in schools. It does so by

1. promoting schools as spaces of 'associated' learning to ensure the health and well-being of children and youth;
2. including in its core curriculum content on human health, sexuality, HIV and AIDS, and the skills required to make health promoting decisions;
3. making allowance for NGOs and CBOs to complement work done by professional educators in schools;
4. encouraging collaboration between the departments of health and education to reach these goals.

What the policy environment does not speak to are three areas crucial to the success of peer education, as discovered by recent research:

1. *Encouraging* peer education within the *formal* curriculum rather than outside it as a co-curricular or extracurricular activity.
2. *Allowing* older peers from different grades to deliver peer education to younger peers.
3. *Ensuring* the presence of teachers in a classroom during peer education lessons.

These policy omissions could be summarised as the *when* and *who* of peer education.

When: In our research, peer education's goals and aims are best supported when lessons are planned and *structured* into the daily curriculum. (Despite the policy that peer education be co-curricular, in our research experience many schools flaunted this policy.) Peer educators were happy for training to occur on an extra-curricular basis. However, when peer education lessons became a voluntary activity, few participants attended and impact lessened. When peer education lessons took place in the context of formal life orientation lessons, learning was most effective. This location of peer education also ensured that schools planned for and included peer education in their annual programme, allocating resources and committing educators to exercising oversight. It had the secondary effect of ensuring equal numbers of boys and girls participating as peer educators – critical for reaching both sexes.

Who: In the school environment, same-age peer educators struggled with issues of trust, credibility and basic classroom management when attempting to deliver peer-led lessons. When there was at least a two-year gap between peer educators and participants, these struggles ceased. In addition, when teachers were present in the classroom (visible but silent), peer educators were better able to facilitate lessons. Too frequently, however, teachers took the opportunity when peer-led lessons were in progress to retire to the staffroom.

Recommendations that emerge from research

As is evident from the above analysis, there are four key policy recommendations to ensure effective peer education in schools.

1. The goals and aims of peer education, implementation standards and infrastructural systems should be *formalised* for peer education programmes.
2. Peer education be included as part of the *formal* curriculum in schools in South Africa.
3. Teachers should be mandated to remain in classrooms when peer education takes place.

4. Provision should be made for older learners to act as peer educators for younger peers during classroom time under the supervision of educators.

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