The HIV/AIDS peer education (pe) programme of Youth for Christ Mpumalanga (YFCMPU) and its impact on young adults: an exploratory study

by

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ABSTRACT

The escalation of sexual and gender-based violence, teenage pregnancy, high-risk sexual behaviour, substance abuse and subsequent HIV infections in our democratic developing South Africa needs urgent attention as it results in high mortality rates, negatively impacts on knowledge acquisition, attitudes, skills, behaviour, stigma, and discrimination in communities, especially amongst the youth from rural areas. The aim of the study is to explore the experiences amongst youth aged 18-35 in the rural areas of Mpumalanga, who underwent the Youth for Christ HIV/AIDS Peer Education programme. The Youth for Christ Mpumalanga (YFCMPU) HIV/AIDS Peer Education (PE) programme was evaluated by applying the Reaction, Learning, and Behaviour levels of Kirkpatrick's model of evaluation and training. This study adopted an exploratory approach which included thematic analysis of the data. A purposive, convenience sample was drawn from participant facilitator mentors who formed part of the training programme. Programme outcomes suggest positive subjective opinions and feelings among most participants regarding HIV/AIDS. After the training, participants felt that they had gained a heightened understanding of certain key concepts of HIV/AIDS which promoted positive attitudes regarding HIV prevention by reducing stigmatism and discrimination amongst young adults. Moreover, changes in behaviour and skills were noted, and recommendations for the improvement of the implementation of the programme are provided.

KEYWORDS: HIV/AIDS, Kirkpatrick's model of evaluating education and training programmes, qualitative exploratory methods, Youth Peer Education Programme.

NKOMISO LOWU NGA NA MONGO WA NDZAVISISO

Ku ya ehenhla ka ku xanisiwa hi swa masangu hi ku ya hi rimbewu, na ku tika emirini ka lavantshwa, na matikhomelo ya nghozi hi swa masangu na ku tirhisa swidzidziharisi hi ndlela yo biha, na ku ngheniwa hi HIV eka tiko ra hina ra Afrika Dzonga ra xidimokrasi leri ra ha hluvukaka, swi lava ku langutaniwa na swona hi xihatla hikuva swi vangela xiyenge xa le henhla xa ku fa ka vanhu, vuyelo byo biha eka ku kuma vutivi, mavonele, swikili, matikhomelo, ku xumbadziwa na xihlawuhlawu eka tindhawu ta vaaki ngopfu ngopfu exikarhi ka vantswa eka tindhawu ta matiko xikaya. Xikongomelo xa ku endla vulavisisi lebyi i ku valanga hi ntokoto exikarhi ka vantswa va malembe ya khume nhungu (18) ku fika eka makume nharhu ntlhanu (35), eka tindhawu ta matiko xikaya ya Mpumalanga, eka vantshwa lava va nghenela nongonoko wa dyondzo ya tintangha wa Vukreste hi HIV/AIDS ku nga Youth for Christ HIV/AIDS Peer Eduction (PE). Nongonoko wa dyondzo ya tintangha wa Youth for Christ Mpumalanga (YFCMPU), HIV/AIDS Peer Education, wu kambisisiwe hi ku tirhisa modlele wa nkambisiso na vuleteri wa Reaction, Learning, and Behaviour levels wa Kirkpatrick. Vulavisisi lebyi byi teke endlelo ro valanga leri ri katsaka nxopanxopo wa tinhlokomhaka ta vutivi. Ku tekiwe sampuli ya *purposive* eka lava a va dyondzisa va nga xiyenge xa nongonoko wa vuleteri. Mbele wax vulavisisi lebyi, wu ringanyeta leswaku vantshwa lavotala lava va nga va na xiavo mayelana na HIV/AIDS va nyikile mavonelo na matitwelo lamanene. Endzhaku ka vuleteri, vantshwa lava nga nghenela vuleteri, va titwile va ri na ku twisisa swinene hi minongoti ya HIV/AIDS, leswi endleke leswaku vantswa va na ku twisisa swinene na miehleketo leyinene loko swi ta eka ku sivela ku ngheniwa hi HIV, hi ku hunguta ku xumbadza na xihlawuhlawu exikarhi ka lavantshwa. Ku ve na ku cinca swinene hi matikhomelo na swikili, hikokwalaho ku bumabumeriwa leswaku ku fanele ku yisiwa emahlweni ku tirhisiwa ka nongongoko.

MARITO YA NKOKA: HIV/AIDS, modlele wa nongonoko wa Kirkpatrick wa ku kambela dyondzo na vuleteri, timethodi ta qualitative exploratory, nongonoko wa dyondzo ya vantshwa wa tintangha

DECLARATION

Student number: **42366526**

I declare that "**The HIV/AIDS Peer Education (PE) Programme of Youth for Christ Mpumalanga (YFCMPU) and its impact on young adults: An exploratory study**" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

06 December 2021

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SIGNATURE DATE

Nkateko Eudora Lowane

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LIST OF ACRONYMS

ABY	Abstinence and Be Faithful Among Youth
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CDC	Centres for Disease Control and Prevention
CHP	Community Health Practices
EMTCT	Elimination of Mother To Child Transmission
HCT	HIV counselling and testing
HIV	Human Immunodeficiency Virus
HRSBs	High-Risk Sexual Behaviours
IM	Intramuscular
IV	Intravenous (ly)
MHCU	Mental Health Care User
MPU	Mpumalanga
MRC	Medical Research Council
MSM	Men Who Have Sex With Men
MTCT	Mother To Child Transmission
NGO	Non-Governmental Organisation
PLWHA	People Living with HIV and AIDS

SIV	Simian Immunodeficiency Virus
STIs	Sexually Transmitted InfectionsUNAIDS Joint United Nations programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YFCMPU	Youth for Christ Mpumalanga
YPE	Youth Peer Education
YLWH	Youth Living with HIV

CHAPTER 1

STUDY OVERVIEW

1.1 Introduction

Young adults, according to Teitelman et al. (2016), are more vulnerable to being coerced and victimised into transactional sex regardless of their gender. Therefore, a growing body of evidence suggests that young adults experience a higher risk of being infected with the Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). To this end, it can be safely assumed that HIV and AIDS prevention programmes targeted at young adults will drastically reduce the prevalence of HIV and AIDS in Africa. For this reason, a need to conduct research that is focused on South African young adults was identified and it informs the current study. According to Statistics South Africa (2018), the prevalence of HIV/AIDS in South Africa (SA) in 2018 was approximately 13.1%, and an estimated 19% of adolescents and adults aged 15-49 were HIV positive. On a positive note, HIV prevalence among youth aged 15-24 has declined over time from 6.7% in 2002 to 5.5% in 2018.

People with HIV are taking the correct prescribed chronic medication and are therefore living longer due to maintenance of undetectable viral load, increasing CD4 count, and subsequent prevention of infections and drug resistance. SA has the largest HIV treatment programme in the world (Wilkinson, 2018). According to Eisinger et al. (2019), it was recently found that the HIV Undetectable=Untransmutable (U=U) concept was scientifically sound.

The concept implies that people living with HIV (PLHIV) who adhere to the prescribed antiretroviral therapy (ART) to a level where the viral load is undetectable cannot sexually transmit the virus to others. The emergence of a single-tablet regimen with fewer side effects improves quality of life for PLHIV, removes the associated stigma and contributes to ending the HIV epidemic. However, failure to adhere to antiretroviral regimens due to high alcohol intake and mental illness may result in loss of inhibition and could lead to the development of multi-drug-resistant HIV strains, which could be passed on to others. It is therefore important to educate young adults about HIV prevention, treatment adherence and management thereof (Lipira et al., 2019).

1.2 Background on HIV and AIDS

Most adolescents and young adults live in environments that are rapidly evolving due to technological advancements in mass media, such as radio, television, newspapers, magazines, the Internet and telecommunications (Kembo, 2014). This availability of information allows young adults to gain knowledge about HIV/AIDS prevention programmes, hence the decrease in the percentage of young adults aged 15-24 living with HIV from 7.6% in 2012 to 5.6% in 2016. Moreover, African perspective-literature supports the notion that adolescents have access to technological advancement and HIV/AIDS prevention programmes, such as Antiretroviral Therapy (ART) (Baloyi, 2013a, 2013b, 2013c; Dames, 2013; Kembo, 2012, 2014). Other alternative HIV/AIDS prevention practices that are rooted in religion are emerging. For example, a South African organisation called the Youth for Christ Mpumalanga (YFCMPU) encourages young adults to adhere to the biblical principles of abstinence before marriage.

The HIV/AIDS prevention programme of the YFCMPU focuses on abstinence and faithfulness to single partner. Kembo (2014) asserts that an awareness of the risks associated with multiple-partner sexual encounters without condom usage does not prevent young people from changing their sexual behaviour. In contrast, Holly & Cook (2017) argue that sex education does not necessarily encourage young people to engage in sexual intercourse but rather empowers them to make the right choices.

The researcher argues that ignorance, lack of knowledge, stigmatism and sex as a taboo during the 1980s contributed to the exponential growth of HIV/AIDS infection rates into an epidemic. According to Baloyi (2013c), family values and norms describing sexual morality have changed in Africa since the initial diagnosis of HIV/AIDS. Kembo (2014) further notes that young Africans do not know the world without the HIV/AIDS epidemic. Statistics South Africa (2016) has reported an increase in the prevalence of HIV/AIDS from 4.02% in 2002 to 6.19% in 2015. However, according to Holly and Cook (2017), several studies indicate that providing comprehensive sexuality education delays the onset of sexual activity, thereby extending the commencement of HIV/AIDS infection among young adults. Furthermore, young adults are sourcing information from multiple sources of media leading to them being educated about the risks of HIV/AIDS, which contributes to a decrease in HIV infection rates (Holly & Cook, 2017).

According to Statistics South Africa (2016), black Africans constitute approximately 81% of the total South African population. The traditional beliefs of this population group about HIV/AIDS appears to contribute to the spread of the virus and an awareness and treatment action campaigns in areas where these black Africans reside is therefore required.

The prevalence of HIV/AIDS among sexually active people in Mpumalanga was 23.1% in 2016, which was the second highest in all the South African provinces. Access to the ART programme almost doubled between 2008 and 2012. However, in 2006, the highest number of HIV-related deaths was estimated to be over 300 000 (Statistics South Africa, 2016). Since 2006, the number of AIDS-related deaths declined from 325 241 to 150 759 in 2016. According to the South African National AIDS Council (SANAC) (2017), between 2007 and 2010, South Africa's distribution of male condoms increased by 60% from 308.5 million to 495 million per year. In addition, over 26 million female condoms were distributed in 2016. The significant decrease in the number of HIV-related deaths in 2006 was ascribed to the increased condom distribution. SANAC (2017) purports that the prevalence of HIV among young women in South Africa is nearly four times greater than that of their male counterparts of the same age.

Poverty, the low power or status of women and gender-based violence (GBV) are contributory factors to the disparity between the genders. In South Africa, black Africans are highly likely to live in urban informal areas or rural areas that are generally under-resourced and lack of necessities, and access to preventative health services, such as ART programmes. The combined effects of the lack of these necessities have resulted in new infections.

South Africa aims to reduce the number of new infections to under 100 000 per year by 2022 and has also committed to achieving zero new infections due to mother-to-child transmission (SANAC, 2017). More than half of the PLHIV in 2016 world-wide (a record of 19.5 million people) were on antiretroviral treatment (UNAIDS, 2017). The ART programme increased the national life expectancy from 61 years in 2010 to 67.7 years in 2015.

It is estimated that 18.1% of men who engage in sex with men (MSM) in South Africa are living with HIV (UNAIDS, 2019). According to Duby et al. (2018), the constitutional rights of lesbian, gay, bisexual, transgender, questioning or queer, intersex, sexual or ally, and other non-heterosexual (LGBTQIA+) communities do not protect them from stigma and homophobic violence owing to traditional attitudes, which makes it difficult for them to access the healthcare services. In the year 2017, a total number of 126 755 deaths (i.e., 25.03% of all South African deaths) were caused by AIDS (Statistics South Africa, 2018). South Africa has the largest HIV epidemic in the world. Of the 7.7 million people living with HIV in 2018, 20.4% were adolescents and adults (i.e., ages 15-49), 62% of adults were on ART, and 63% of the children were on ART (UNAIDS, 2019). Moreover, 71 000 AIDS-related deaths and 240 000 new infections were recorded during 2018. The rate of treatment scale-up will need to increase to meet the 75% reduction target in new HIV infections and AIDS deaths between 2010 and 2020.

Furthermore, the progress towards 90-90-90 targets for all ages is currently 90% of people who are aware of their HIV status; 68% of all people living with HIV are on HIV treatment; and 87% of all PLHIV are virally suppressed (UNAIDS, 2019). Compared with 2010, HIV incidence at the global level has decreased by 16% while estimates of AIDS deaths have declined by 33%. The Joint United Nations Programme reported a similar decline of 16% in the prevalence of HIV/AIDS (Kembo, 2012). For instance, the results stated that the main reason for the observed decline in the prevalence of HIV in Zimbabwe was the change in sexual behaviour among young people. Young people need to be educated about HIV/AIDS and the ART programme to reduce the mortality rates and promote long life. ART has played a role in the decrease of AIDS-related mortality rates (UNAIDS, 2013).

1.3 African Perspective

Polygamous marriages are largely predominant in Africa. Nonetheless, due to cultural factors, condom usage is a taboo in certain marriages in the rural areas of Africa (Baloyi, 2013a). Culturally, men are the ones who should initiate sexual intercourse with or without a condom, while traditionally, women are passive recipients thereof. Furthermore, women are perceived as sexual objects in the African context (Baloyi, 2013c).

Patriarchal structures are dominant across different cultures in countries across southern Africa, as these are promoted by African-based religion and the media. Monogamy is sometimes associated with a low socio-economic status (Baloyi, 2013b, 2013c). The HIV/AIDS Youth Peer Education (YPE) training considers the African diversity of the participants, sexual behaviour, and socio-economic status in the Christian religion. As already mentioned, education plays an important role in adherence to ART. The more informed and literate the patient and those caring for the infected are, the more likely that medication will be adhered to (Shirinda-Mthombeni, 2014).

The researcher contends that, despite the current shortcomings of polygamy, in the past polygamy played a very positive role in the lives of people of the time. For example, in an informal interview with the researcher's mother-in-law, she indicated that she had never hesitated to give consent to her late husband to pay lobola for other wives as she always received a share of the lobola for her personal use. As an additional benefit, the new wife assisted her with the household chores. Her share of lobola and sharing of the household chores made her very excited and she always looked forward to her husband marrying more wives.

The researcher's mother also grew up in a polygamous family where her late mother and late sibling were married to the researcher's late grandfather to escape poverty. An additional advantage of marrying more than one wife is the increased labour resources especially during agricultural seasons as this often led to a sustainable economic status of the household (Baloyi, 2013b).

Recently, the HIV and AIDS epidemic has left women in polygamous relationships vulnerable to infections, sexual violence and abuse. A multitude of factors, including biological, behavioural, socioeconomic, cultural and structural risks in Africa, has increased the risks of women being infected with HIV (Kharsany & Karim, 2016).

In SA, the national Department of Health has played a significant role in the decline of prevalence of HIV in rural areas by rolling out the ART programmes with education at the core of adherence to antiretroviral (ARV) drug therapy (Mberu et al., 2016). Multiple sexual partners, unawareness, illiteracy, loss of inhibition, HIV/AIDS stigmatism, culture, lack of access to health services, and immigration may influence the spread of HIV/AIDS in SA (Saints, 2018). Having multiple sexual partners is being practised by both young adults and married people, and is now the leading cause of the spread of HIV in developing countries (Saints, 2018). Other than playing an important role in the economic growth of a nation, education also improves literacy and knowledge levels of HIV transmission, prevention, and adherence to ART thus contributing towards the goal of an HIV-free generation.

1.4 Educational System

As already mentioned, education plays an important role in the economic development of a nation as well as improving knowledge levels on HIV transmission, prevention and adherence to ART. To contextualise this study, this research was conducted in the rural areas of the Mpumalanga province in South Africa, troubled fraught with an undesirable socio-political history and poor quality of education and economic status. According to UNAIDS (2019), the national South African Department of Health has been at the forefront of reducing HIV infections rates through the rollout of ART programmes anchored on education. Be that as it may, it should be borne in mind that the South African education system is in crisis and is plagued by many challenges, such as low matric pass rates and high dropout rates, teacher strikes, rising pregnancy rates among learners and violent attacks by learners on educators and other learners. As if that was not enough, the recent COVID-19 pandemic has forced the introduction of a learner-rotation system maximises social distancing thus leading to fewer teaching hours. In addition, the shortage of teachers in rural areas is exacerbated by the COVID-19 pandemic.

There are rising numbers of graduates who need student funding in higher education for economic growth and transformation (South African Department of Finance, 2017). Many teachers are relocating from rural to urban areas in search of higher salaries and greener socio-economic pastures. In urban areas, teachers who are skilled in key subjects, such as mathematics and science are also lured from the often crime-ridden and under-resourced historically black township schools to the safer and more affluent suburban schools that pay higher salaries. The tertiary education sector is also reeling in challenges.

The ever-increasing number of students who cannot afford the high cost of university education often leads to violent strikes and destruction of property (South African Department of Finance, 2017).

Increased stigma of HIV is also a barrier to access to education in rural areas. Many rural residents deny that HIV exists in their community and this leads to the onset of opportunistic infections, illness and AIDS-related deaths. The Cambridge Overseas School Certificate (COSC) report has publicised that in a comparative report between high schools from urban and rural areas of Lesotho, schools from rural areas had poor accomplishment in results in the examinations than high schools in the urban areas since 1998 (Litheko, 2012). This has resulted in parents losing confidence in schools from rural areas and thus taking their children to schools from urban areas in search of high-quality education. In search of better opportunities and higher salaries, teachers have followed suit (Litheko, 2012). Across the border in South Africa, apartheid has resulted in rural areas being serviced by under-qualified teachers. This goes against the constitution of most of the countries which guarantees every child a right to good-quality education.

In the post-apartheid South Africa, the shortage of skilled educators in schools from rural areas is compounded by experienced educators taking early retirement thus leaving young and inexperienced educators to tackle the added burden of educating a society that is riddled with poverty and HIV and AIDS. As compared to Gauteng areas where HIV/AIDS YPE programmes are common and resources are available, rural areas in poor provinces such as Mpumalanga are socio-economically deprived. On the other hand, most people from the rural areas of Mpumalanga are black. It has been well established that the poor and uneducated are more likely to contract HIV/AIDS due to lack of knowledge (Cluver et al., 2016).

Consequently not only does formal education play an important role in knowledge transfer on important aspects relating to HIV and AIDS (i.e., transmission and prevention), it also plays an important role in the adherence to the prescribed treatment regime, such as regularly taking ARVs i.e., HIV management. In support of this notion, Shirinda-Mthombeni (2014) agrees that the more informed and literate the patient and those caring for the infected, the more likely the treatment regime will be adhered to. However, it should be borne in mind that an over-reliance on the formal educational sector to transfer knowledge about HIV and AIDS places additional responsibilities on the educators. Such added responsibilities may lead to high workload, low morale and educator burnout as witnessed in areas such as the Mpumalanga province (Higgins, 2010). Ultimately, this makes it difficult for young people in rural areas to complete their matric and further their studies at tertiary education institutions

1.5 Background of Youth for Christ Mpumalanga (YFCMPU)

YFCMPU is a non-governmental organisation (NGO) based in the rural areas of Mpumalanga, which aims to provide life-long educational skills that are centred on Christian values and systems. Some of the programmes offered by the YFCMPU are centred around the following topics: Who am I?; Forgiveness; Purpose; Choosing subjects and careers; Peer education; Values and money; Dealing with the social ills of our school years; Being a young woman in a men's world / Being a young man in a world of women empowerment. The training courses are conducted randomly throughout the year and various service providers volunteer to provide the programmes that are mentioned above. YFCMPU is composed of junior and senior mentors who are young professionals and university students from various fields, such as engineering, social sciences, nursing, theology and finance. The mentors volunteer their services with no financial compensation, and act as role models in modifying attitudes, behaviours, and skills needed for a successful life (Youth for Christ, 2015).

1.6 Terminology

1.6.1 High-Risk Sexual Behaviour

High-risk sexual behaviour (HRSB) promotes the spread of HIV and other related sexually-transmitted diseases through unprotected sex and multiple sexual relationships (Kembo, 2014). Furthermore, Kembo (2014) asserts that most HIV infections in young people aged between 15 and 24 years are in Africa. Teenagers are highly unlikely to volunteer for counselling and testing; if they do so, it is difficult for them to disclose their status to their families for support out of fear of rejection from loved ones. Individual values, societal norms and economic factors are contributory factors to the high infection rates.

On a positive note, HIV prevalence is declining in most countries affected by the epidemic (including Africa), however, young people can still prevent the HIV revolution (Gouws, 2010). HIV/AIDS YPE programmes will enhance safer sexual behaviour and reduce stigma related to HIV and AIDS, since it is also the reason why many young people do not disclose their HIV status.

1.6.2 Stigma and Discrimination

Stigma discredits and discriminates against people living with HIV and AIDS (PLWHA). There is a difference between stigma and discrimination. Stigma leads to unequal or unjustifiable treatment of people (discrimination). Stigma may be internal or external. Whereas internal stigma may include isolation, low self-esteem, overcompensation and fear of disclosure; whilst external stigma includes avoidance from others, rejection, abuse, victimization, abuse of human rights and moral judgement that may include blaming PLWHA for their HIV status. It can be concluded that discrimination is a form of external stigma (Annual Report, Nhlambeto Health Services, 2015).

1.6.3 Drug Adherence

Drug adherence simply means regularly taking the correct dosage of medication at the prescribed time. Drug adherence programmes train PLWHA on how they could achieve maximum drug adherence, for instance, setting reminders for taking medication, using medicine boxes for packaging medication and keeping medication-taking records and having support group systems. Monitoring whether the patient went back for a refill to the clinic can also facilitate drug adherence (Annual Report, Nhlambeto Health Services, 2015). Drug adherence prevents further spread of HIV and promotes high health-related quality of life (HRQOL). Quality of life is a multi-dimensional concept that includes physical, social, psychological and spiritual dimensions.

1.7 Relevance and Scope of the Study

This study aims to explore the impact of the HIV/AIDS Peer Education programme on the knowledge of young adults on HIV transmission, prevention and drug adherence. The study also explores how young adults promote a positive attitude with a view to prevent HIV stigmatism and discrimination. The study was conducted among young adults who are mentors of learners who attended a training programme of an organisation called Youth for Christ Mpumalanga (YFCMPU). The findings of this study will contribute new knowledge to the field of psychology from an African religious perspective. All the participants come from black Christian families. The HIV/AIDS Peer Education training programme was conducted in English. This research was motivated by the fact that HIV/AIDS YPE programmes are very scarce in rural areas where the rate of teenage pregnancies is high due to peer pressure, drug and alcohol abuse. Over and above this, the lack of knowledge regarding the transmission of the HIV amongst young adults residing in rural areas may contribute to the spread of the HIV. In future, similar studies could be replicated in other provinces in South Africa and other neighbouring countries faced with similar problems internationally, through train the trainer projects regarding the development of HIV/AIDS programmes, to assess how the standards of this study would compare with governmental standards of existing programmes in other provinces.

Although the HIV/AIDS infection rates are generally decreasing owing to the rollout of ART, people infected with HIV continue to need the requisite care including adherence to the ARV therapy to prevent further stigmatism and discrimination. Furthermore, depression, anxiety and other psychosocial, socio-economic and spiritual problems still need to be attended to improve quality of life and health of people infected and impacted by HIV and AIDS (Shirinda-Mthombeni, 2014).

1.8 Problem Statement

Other than facilitating skills transfer amongst young people, the peer-education and train-the-trainer programmes also help to reduce HIV infections amongst this group of people and has an overarching goal of creating a future HIV-free generation. However, most programme interventions are short-lived and fail to alleviate social challenges such as violence as well as alcohol and substance abuse. In many cases these social pathologies contribute to an increase in HIV infection arising from rape induced by loss of inhibition. Such challenges often impact negatively of community health practices (CHP).

1.8.1. Research Questions

This study seeks to answer the following key questions:

- What is the impact of the HIV/AIDS YPE programme on young adults?
- What are the behavioural mechanisms, knowledge and skills that can be attained from the training?
- How can the HIV/AIDS YPE programme be improved in future?

1.8.2. Research Aim

The aim of this study is to explore the HIV/AIDS peer education (PE) programme of Youth for Christ Mpumalanga (YFCMPU) and its impact on young adults.

1.8.3. Study Objectives

To address the aim of the study, the following objectives were formulated:

- Explore the knowledge base on HIV drug adherence, transmission and prevention in young adults.
- Explore how promoting a positive attitude among young adults regarding HIV can prevent stigmatism and discrimination amongst young adults.
- Explore changes in the behaviour and skills of the facilitator mentor participants following their attendance of the HIV/AIDS Peer Education training programme organised by the YFCMPU.
- Provide recommendations for the improvement of the implementation of the HIV/AIDS Peer Education training programme organised by the YFCMPU.

1.9 **Research Methodology and Theoretical Framework**

Ethical clearance was granted through the Department of Psychology by the ethics committee of the University of South Africa (Unisa) in May 2016. The study employed an exploratory research approach. Initially, 10 volunteer facilitator participants from the YFCMPU were purposively sampled based on convenience and availabilty. Data collection method was through structured, semi-structured, open-ended questionnaires, and interview guides. A structured questionnaire was administered before and after the training of the facilitator participants to explore their preceding and post-training depth of knowledge of HIV/AIDS concepts. The second type of data was sourced from six facilitator mentor participants, who compiled focus discussion interview reports from the

training that was conducted by the researcher. Lastly, an open-ended interview guide with prompts were administered once again to the four facilitator mentor participants who were available after the training that was conducted by the researcher after the HIV/AIDS Peer Education training programme during the third phase of data collection. The focus group sessions were conducted in English and took 20 minutes for the facilitator mentor participants to complete all the questionnaires. The training was recorded by the researcher after permission was granted by the facilitator mentor participants. The sessions were subsequently transcribed. A recording of the training sessions was transcribed manually by the researcher.

The questionnaires and focus group discussions were analysed by means of thematic content analysis, which included familiarisation with the data as well as finding meaning and identifying patterns of recurring meanings by generating initial codes and themes (Guest et al., 2012). Application of the Kirkpatrick's model of evaluating training programmes was used as a framework for the study. The Kirkpatrick's model focuses on four different types of levels, namely reaction, learning, behaviour, and results. Kirkpatrick (1959) has declared the Results Level to be the most difficult to evaluate due to extraneous variables in organisations. For this reason, this level was not covered in the current study.

1.10 Outline of Chapters

Chapter 2 discusses the theoretical assumptions upon which changes in behaviour, skills and attitudes are made, thereby potentially reducing HIV infections. An exploration of previous studies in this regard is included. The origins of the HIV and the application of the Kirkpatrick's model are also included in the chapter.

Chapter 3 encompasses the research design and method adopted in the study. This includes sampling, data collection, data management, data processing and data analysis. The chapter includes ethical considerations for the study.

Chapter 4 presents the results of the thematically analysed and transcribed recordings of the focus group discussions. Questionnaires exploring the impact of the YFCMPU HIV/AIDS PE programme on the YFCMPU young adults were evaluated in terms of the learning, reactions, and behaviour levels of the Kirkpatrick's model.

Chapter 5 presents the overall conclusion, including recommendations for designing improved future programmes for controlling the spread of HIV among young people in Mpumalanga province and potentially other South African provinces and African countries.

1.11 Conclusion

This chapter furnished an overview of the general orientation of the study by stating the purpose of the study, that is, to explore the HIV/AIDS Peer Education (PE) programme of Youth for Christ Mpumalanga (YFCMPU) and its impact on young adults. Subsequent perceived changes in skills, behaviour, and attitudes regarding their knowledge of concepts in respect of the HIV/ AIDS Youth Peer Education (YPE) programme are explored. The application of Kirkpatrick's model to evaluate training programmes was used as a framework for this study.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1.Overview of the Chapter

This literature review offers an extensive synopsis of communal themes regarding the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Peer Education (PE) programme (HIV/AIDS PE). The main objective of the chapter is to review, synthesise, and appraise literature referring to the guiding notion and research questions formulated for the HIV/AIDS PE programme among young adults. The chapter commences with literature definitions of peer education (PE) within the health education context; a conceptual definition of the YFCMPU HIV/AIDS PE programme; the origins of HIV/AIDS; the epidemiology of HIV/AIDS and PE; the epistemology of HIV/AIDS PE; the integration of PE regarding HIV/AIDS; school-based PE among adolescents or young adults; context-specific HIV/AIDS prevention among the youth; religion and HIV/AIDS prevention; a political and socio-cultural stance on HIV/AIDS prevention; the treatment and prevention of HIV/AIDS; gender inequality or stereotypes related to HIV/AIDS; HIV/AIDS stigma and discrimination. In terms the theoretical framework which guides this study, the application of Kirkpatrick's model as well as its strengths and limitations are discussed. In conclusion, the review addresses the research gaps observed in terms of previous research conducted pertaining to HIV/AIDS PE programmes, particularly in the rural areas of South Africa within the context of African Christian young adults.

2.2.Introduction

Peer education (PE) is a popular HIV prevention strategy and health promotion approach that has been utilised since the 1980s. Lay people are in the best position to share their values and may share similar life experiences, or social backgrounds, as opposed to having health professionals educate members of the community across a range of contexts with the assumption that PE leads to the prevention of the spread of HIV/AIDS. Furthermore, PE can modify norms that lead to changes in programmes and policies or guidelines (Sriranganathan et al., 2012; Boyle et al., 2011; Sriranganathan et al., 2010). Peer education provides a platform for adolescents or young adults to interact confidently and comfortably while discussing sensitive, interesting topics relating to sexual health education such as HIV/AIDS. "Peer" is defined as "one that is of equal standing with another one belonging to the same societal group especially based on age, grade or status" and "education" refers to "development, training or persuasion of a given person or the knowledge" (Merriam Webster, 2020, para. 1). Peer education for adolescent sexual health is therefore defined as "the teaching or sharing of health information, values and behaviours by members of similar age or status groups" (Wikipedia, 2020, Page 1). Peer education is used as a form of health-promotion intervention. The information, which provides personal growth, communication and leadership skills, as well as the strengthening of self-efficacy, is further disseminated among fellow peers in a cost-effective manner.

2.2.1. Conceptual Definition of YFCMPU HIV/AIDS PE Programme

From a Western perspective, HIV/AIDS YPE is a social process used to empower young people, usually in a group setting, to prevent the spread of HIV and other sexually transmitted infections (STIs) through active participation and leadership, thereby educating and mentoring the younger generation while serving as role models. The 41st session of the Statistical Commission of the United Nations Educational, Scientific and Cultural Organization (UNESCO, 2010), which is an authoritative source of best-practice culture-specific sexuality education, emphasises the importance of taking into consideration the culture of the participants while educating them about sexuality as opposed to the Western perspective.

This culture-specific context informs the current research among African Christian young adults residing in rural areas. In their review in 2009, 63 studies were conducted to assess how effectively studies that involved PE had impacted on the young people. It was found that over half of the PE programmes that they had assessed had increased sexual health knowledge and a behaviour change was observed. It is important to take note that in the review, only the attitude and skills of the participants were taken into consideration. In the current study, the researcher considers knowledge, attitude, behaviour, and skills to be applied based on the Kirkpatrick's model of evaluation of training programmes.

Furthermore, the Western Australian context has emphasised the importance of a shared safe space where no disturbances will be experienced. This is supported by theories and practices in counselling psychology. The key findings of an international consultation on PE and HIV/AIDS in Kingston, Jamaica, 18-21 April 1999, indicated that reproductive health should be integrated with HIV services, and comprehensive clear selection criteria should be considered to identify peer educators followed by some form of compensation

for the volunteers. The newly-trained peer educators should also be regularly supervised and monitored; the training should convey relevant contextual information and be highly participatory by engaging the audience; the societal context and gender inequalities must be taken into consideration; and other relevant stakeholders should be engaged from the inception of the programme. The YFCMPU HIV/AIDS PE research takes into consideration the African perspective based on role modelling as indicated in the PE consultation findings, thus developing positive group norms while meeting the flexible diverse needs of young adults of today.

In the modern era, the peer educators should be trained to expect diverse questions, including personal, emotional, factual, recent research, and innovative technological advances in HIV/AIDS. Compiling a referral list for obtaining further assistance from neighbouring organisations and toll-free helplines is one of the most fundamental tools of PE. Youth for Christ Mpumalanga has a referral societal list that assists the stakeholders and trainees to form a network of communication with other organisations.

2.3.The Origins of AIDS

It is important to review the literature regarding the origin of HIV/AIDS, as furnished herein. According to Avert (2016), research estimates that HIV originated around 1930 in Central Africa. However, researchers were able to identify HIV-1 and HIV-2 only in 1980. Jacques Pepin was an infectious diseases physician and an epidemiologist who worked on HIV-2 as a clinical researcher at the Medical Research Council (MRC) Laboratories in Gambia. He defines epidemiology as a science which connects exposure to some infectious agent with an outcome of the disease (Pepin, 2011). In 1980, the Centres for Disease Control (CDC) published an article in which five cases of

pneumonia, a lung infection hitherto contracted only by patients with a severe weakening of their immune system, found among gay men, all of whom were living in Los Angeles. Formol tablets were packed together with syringes and needles in a metal box for sterilisation. However, the process killed bacteria but not viruses, which lead to contamination of syringes, which was a means of spreading HIV. Poorly-sterilised needles re-used on many patients may have increased infections to a very high level (Pepin, 2011). By 2009, HIV/AIDS was by far the most histrionic epidemic since the Black Plague that devastated Europe 500 years ago. June 1981 is the official birth date of the AIDS epidemic. More than 300 000 scientific articles and thousands of books on HIV/AIDS have been published. While most of the publications are biomedical, others have covered the psychosocial, historical, economic, geographic, and even photographic features of AIDS (Pepin, 2011). Amongst others, UNAIDS (2010) initially described its vision of zero new HIV infections, discrimination, and AIDS-related deaths. There is devastating impact of AIDS with a few stories of triumph and many catastrophes relating to the epidemic in South Africa.

The hypothesis that HIV was triggered by the contamination of an oral polio vaccine with a simian immunodeficiency virus (SIV) using chimpanzee cells is not supported by Hooper (1999). However, it is indisputable that the *Pan troglodytes* chimpanzee is the source of HIV-1 (UNAIDS, 2010). The bonobo, a chimpanzee species, has not been substantially investigated; however, there is no evidence that it is infected with the Simian immunodeficiency virus (SIV) (Pepin, 2011). Thus, to a large extent, haemophiliacs who were gay might have sexually infected other gay men who may have been volunteer blood donors.

According to Neel et al. (2010), experts maintain that medical interventions contribute to less than 5% of HIV infections, but rather, the social changes that accompanied European colonisation of Africa had led to different sexual behaviours. For example, many women had sex with many different men for remuneration. According to Schmid et al. (2004), transmission during health care was a contributory factor to the simultaneous emergence of HIV-1 and HIV-2 on the African continent about seventy-five years ago. After an incubation period of roughly ten years without ART, the CD4 lymphocytes would be progressively destroyed and develop a variety of opportunistic infections and thus AIDS was born in 1981 (Pepin, 2011). Since its origins, HIV/AIDS has presented a threat to global health and was considered a global pandemic right from the beginning. Timothy Ray Brown was the first person to be HIV-free after a bone-marrow transplant. Although the transplanted immune cells that are resistant to HIV, replaced vulnerable immune cells and cured HIV, the method is not viable for all people living with HIV. Remission resulting from bone-marrow transplants that were intended to treat blood cancer has been observed, however, it provided crucial insight into the fight against AIDS.

2.4.Epidemiology of HIV/AIDS

The Human Immunodeficiency Virus (HIV) is considered by certain authors to be a worldwide pandemic (Cohen, 2008). However, according to the World Health Organisation (WHO) (2020), HIV/AIDS is a worldwide epidemic. According to UNAIDS (2019), globally, approximately 81% of people knew their HIV status and approximately 38 million individuals were HIV positive in 2019, of which 36.2 million were adults, and 1.8 million are children under 15 years of age. Young adults comprise more than 75% of the population of people living with HIV; hence the current focus on this group of the population. Furthermore, an estimated 1.7 million people contracted HIV in 2019, marking

a 23% decline in new infections globally since 2010. Of the said 1.7 million people, 1.5 million were adults, and 150 000 new infections occurred among children younger than 15 years old. The estimated total number of new infections recorded in 2019 is more than three times higher than the target of UNAIDS 2020; hence the need to increase the prevention of HIV transmission through health promotion strategies such as PE. By the end of 2019, 25.4 million people with HIV had access to ARVs globally, which means that approximately 12.6 million people still do not have access to treatment and pose a major threat to public health. However, with close monitoring to encourage adherence to the prescribed treatment, levels where the viral load is undetectable or suppressed and not transmissible to their HIV-negative partners could be reached over time. However, disclosure, substance abuse, domestic or gender-based violence (GBV), mental illness, Covid-19 and stigmatism remain elements of potential threats to HIV treatment and prevention. In line with the 90-90-90 UNAIDS 2020 goals, 81% knew their HIV status in 2019, 82% had access to ART, and 88% of all those receiving ART had an undetectable HIV viral load.

As part of the goal towards the elimination of mother-to-child transmission (EMTCT), in 2019, 85% of pregnant women received ART but there is still no cure for HIV. In 2019, an estimated 690 000 people died from AIDS-related illnesses globally, compared with 1.1 million in 2010. Sub-Saharan Africa is the most affected region with 61% of new HIV infections recorded in 2018 for the region (UNAIDS, 2019). Furthermore, in 2019, there were 20.7 million people with HIV (54%) in eastern and southern Africa and 4.9 million (13%) in western and central Africa. Southern and eastern Africa contributed to the reduction of the ratio of new HIV infections and mortality among HIV positive individuals in Africa from 0.11 in the year 2000 to 0.04 in 2017. In terms of

the contribution of the western and central Africa, a reduction ratio of 0.06 in 2017 was recorded. South Africa remained the largest population of 7.06 million people living with HIV in 2017 (UNAIDS, 2019).

2.4.1. Epistemology of HIV/AIDS PE

It is vital to explore the relationship between HIV/AIDS and PE in recent research with a specific focus on young African adults. According to Winberg and Makua (2019), the integration of epistemological access with an ontological foundation of disciplinary knowledge amongst South African university students was argued to be essential upon the commencement of tertiary education studies, consequently leading to an individual conversion of understanding concepts that were taught and attainment of knowledge through mentoring and role modelling. The leading role of peer educators was to provide ontological access to disciplinary characteristics to university students. Peer educators who had similar previous experiences as the university students were well-positioned to deliver ontological access to disciplines and fields offered. Peer educators specifically focus on support, culture, and communal and epistemic justice. Epistemic justice concerns the optimal distribution and fair use of knowledge and power that is crucial in organising societies. Gaining access to disciplinary knowledge through more broad participation in society may satisfy dimensions of recognition and representation to theorise the achievement and generalisation of peer education. Similarly, the adoption of reflecting on the taught concepts in a critical manner is an epistemological stance that combines a postmodernist perspective with essential humanist goals. This was found to be fundamental in the acknowledgement of communal and cultural stimuli, which contributed to acquiring knowledge and the promotion of social justice and human rights among students in Kwa-Zulu Natal, South Africa (Raniga & Seepamore, 2017).

This informal peer education on its own cannot yield ontological or epistemological understanding and it therefore needs to be integrated with more formal HIV/AIDS education. In a study conducted by Mahat et al. (2016), the results showed that HIV/AIDS knowledge improved significantly in both grade seven and nine high school students in an urban high school in the United States after the implementation of the PE programme called Teens for AIDS Prevention (TAP).

2.4.2. Integration of Peer Education with HIV/AIDS

Buhari and Kamaldeen (2013), who conducted a study among youth in Nigeria, concluded that a change in attitude and avoiding risky sexual behaviours may assist in curbing the prevalence and incidence of HIV/AIDS among adolescents in society. It is vital to take into consideration the religion and culture of the community, which are key factors in understanding human behaviour in the African Christian context. Attitudes can be changed by the approach adopted by peer educators to address the topic. In studies conducted among young South African University students, Cooper and Dickinson (2013) argue that humour and informal training in PE encourages freedom to discuss matters that are taboo, encourages the continuation of conversations and changes boring topics to interesting and enjoyable peer interactions. However, the use of humour has been criticised for making comprehensive knowledge superficial (Cooper & Dickinson, 2013). Corfield and Stellenberg (2013) recommended interactive and peer-led groups using role-play in HIV/AIDS PE to maximise interaction and participation. Moreover, since the context-specific approach plays an important role, it was concluded that the responses of South African Christian communities to HIV/AIDS have shaped the lives of HIV-positive individuals, the youth, and the communities they live in (Burchardt, 2015). Religion, culture, and peer pressure have reshaped the perception of sexuality, medical responses,

and research innovation. Subsequently, improving the identification of young people living with HIV (PLWH) is crucial. Such improvement can be achieved by the inclusion of instruction manuals in HIV self-testing kits, especially since people have experienced a lack of privacy in medical settings since the approval of the HIV Voluntary Counselling and Testing (VCT) in the US in 2012 (Schnall et al., 2016). Early testing and diagnosis as well as immediate treatment could optimise the prognosis of HIV/AIDS and reduce transmission thereof.

Asylum seeker were found to be at higher jeopardy of delaying HIV testing and therefore result in delayed diagnosis (Aung et al., 2017). Peer education, which has its strengths and weaknesses, has been criticised for being superficial. Owing to the informal education and the possible superficial nature of PE, it was recommended that PE should be integrated with other existing programmes to ensure a change in behaviour rather than focusing only on a change in knowledge and attitude (Meilianingsih et al., 2017). Integration of PE with HIV/AIDS education can be an effective and easy means to increase knowledge and modify attitudes regarding HIV/AIDS (Khosravi et al., 2018). However, peer-led education was found to be less efficient and less sustainable in reducing risky sexual behaviour over the long-term period (Khosravi et al., 2018). Furthermore, Khosravi et al. (2018) recommended that future research should be conducted to determine the factors that contribute to young adults not changing their risky sexual behaviour despite the instrumental role played by peer educators. The Youth for Christ Mpumalanga (YFCMPU) HIV/AIDS PE programme focused on young adults and adolescents with the integration of spiritual programmes, such as forgiveness and others as mentioned in Chapter 1. School-based PE offers a stable environment for interaction, monitoring and supervision of peer educators and the train-the-trainer project that gave birth to PE.

2.5.School-Based Peer Education Among Adolescents/ Young Adults

This section focuses on empirical research on school-based PE. Research has found that school-based PE is an effective approach to informing students or adolescents or young adults about unsafe sexual behaviour with significant improvements in terms of knowledge, attitudes, and practices (KAP) (Mohammed et al., 2015). Studies conducted among Egyptian substance users to improve prevention methods, such as health or sex education in peer groups investigated knowledge, attitude, and practices (KAP) to improve the prevention of sexually transmitted infections (STIs). Stigma, gender, and religion were found to exert a significant influence on substance use and sexual behaviour (Bakhoum, 2015). About 50 % of all new cases of HIV/AIDS infections occur among the youth between 15 and 24 years of age globally. Peer-led youth education that is school-based has been implemented since the early 1990s to prevent the spread of HIV among school youth in Addis Ababa, Ethiopia (Takele et al., 2015). Recommendations to allocate adequate resources to secondary school-based PE to prevent HIV/AIDS among adolescents were made, and upon implementation, the research found that the learners improved their knowledge, interest, and prevention of risky sexual behaviour (Takele et al., 2015). Peer educators who are of the same age can build healthy relationships, involve parents with train-the-trainer projects, avoid HIV/AIDS stigma, and encourage abstinence. According to Thomas (2004), Love Life has been extensively involved in campaigns to change attitudes towards the early diagnosis of HIV infections. Young adults are a potential resource in education regarding the prevention of HIV/AIDS. The implementation of school-based sexual education, which recognises sexual values, was recommended. Lawrence et al. (2015) found that students in Cape Town raised concerns regarding privacy and confidentiality before the launch of school-based HIV counselling and testing

(HCT). The prevalence of STIs was high among adolescents in Madagascar even though it is located some 250 miles (400 km) from the African continent. Post-comprehensive reproductive sexual education revealed that there was a significant improvement in the knowledge of HIV/AIDS and self-efficacy; thus, it was recommended that such education be integrated into the school curricula (Klingera & Asqary, 2016).

The HIV peer educators and facilitators in Cape Town, South Africa, revealed that contextualised, tailored, gendered expectations, experiences, and identities that reinforce gender stereotypes, such as teenage pregnancy may lead to female peer educators presenting it as a failure to be exemplary. Peer educators experienced contextualised lived experiences, which influenced their lives with the assumption that knowledge leads to sexual behaviour change (Wolf & Africa, 2017). More than 85% of African American students reported being sexually active for both pre- and post-tests for the HIV; however, less than 50% of the students reported using condoms during sexual intercourse (Heaston, 2018). Kikula (2018) recommended that motives for engaging in risky sexual behaviours be explored to evaluate peer-led young adult health education programmes.

With the assumption that youth are capable of economic development, it is important to make them the target audience to prevent the exponential growth of HIV/AIDS. It is a strategic stance to focus on PE among the youth, which has been implemented in many universities. However, the gap between the systematic evaluation and sustainable monitoring of these programmes still exists (Kikula, 2018).

It was recommended that information regarding HIV transmission and prevention be incorporated into school-based educational curricula (Mahat, 2019).

In a study conducted among jailed adolescents in a non-formal education setting, a peer-led HIV/AIDS education programme contributed to the development of HIV-related health literacy (Naserirad et al., 2019). Susanti et al. (2019) emphasised the influence of PE on the level of knowledge of HIV/AIDS to high school students in Padang City and recommended an out of school schedule of facilitated coaching for a PE programme to increase the supporting infrastructure for peer educators. This training of adolescents in an informal setting was implemented in the YFCMPU HIV/AIDS PE programme where the training was conducted among the youth at the secondary school level in an informal setting, at a camp away from the school premises. Faith-based organisations, such as Youth for Christ (YFCMPU) respond to the HIV/AIDS issue by addressing the interplay between spirituality and HIV stigma in their community.

Peer education has proven to be effective in sexual decision-making among small groups of adolescents in high school. Morality and spirituality were also found to be important factors in effective sexual decision-making, while adolescent efficacy could lead to the implementation of effective sexual health education (Smith, 2019). The YFCMPU HIV/AIDS PE training programme was conducted among facilitator participants, who were from the social, theological, educational and health fields to become mentors. The imparted information included acquisition of knowledge and skills as well as changes in attitude and subsequent behaviour in the long run, and the monitoring and care of HIV/AIDS patients on treatment.

2.6.Context-Specific HIV/AIDS Prevention Among Youth

The YFCMPU HIV/AIDS PE programme takes into consideration the culture of the learners. This was the case among Teens for AIDS Prevention (TAP) in a convenience sample of American and Nepalese grade nine students, and the HIV/AIDS knowledge scores were found to be significantly higher among American adolescents than their Nepalese counterparts, both at the pre-intervention and post-intervention stages (Mahat et al., 2014). Moreover, Mahat et al. (2014) emphasise the importance of culturally appropriate programmes for the effective improvement of adolescent HIV/AIDS knowledge and self-efficacy as well as limiting sexual risk behaviours. To be context specific, an innovative model was utilised for an exchange of an HIV test for a hip-hop music concert ticket among African American youth and young adults (Hill et al., 2014).

Implementation of such culturally appropriate interventions targeting youth for the prevention of HIV is essential. In a study conducted to evaluate the PE programme, which was aimed at promoting the prevention of HIV/AIDS among young people in Gauteng and Limpopo, South Africa, the negative consequences, health risks of transactional sex, and the adverse contexts which forced youth into transactional sex due to poverty and unemployment were taken into consideration. Poverty and unemployment have been implicated for the spread of HIV/AIDS due to the engagement of young adults with older men for payment (van der Heijden & Swartz, 2014). It is therefore recommended that a resilience-based approach, protective skills, economic, and social circumstances that lead to safer sexual practices should be employed. Research conducted among young people in the rural communities of Kenya was conducted to understand the environmental factors that influence HIV-related sexual risk and resilience to elicit ideas for HIV prevention interventions.

The results relevant to the YFCMPU HIV/AIDS PE programme included culturally and developmentally appropriate HIV prevention community/ group workshops, HIV-related stigma reduction campaigns, and HIV/AIDS activities led by young people in the rural communities of Kenya (Harper et al., 2014).

Research that is context-specific while fully incorporating effective strategies for HIV prevention by reporting and including community, society, and an informative and relevant sample is recommended. Behaviour change techniques (BCT) are recommended to reduce the risk of acquiring or transmitting the HIV (Johnson, 2014). The value of interactions between culturally diverse peers is more important than the number of peers for the development of intercultural communication skills (Senteio et al., 2018).

2.7.Religion and HIV/AIDS Prevention

Botswana is one of the countries with the highest HIV prevalence in the world (Mpofu et al., 2014). A study was conducted among Pentecostal church youth in Botswana to investigate the conceptual framing of HIV prevention. The findings suggested that both nonspiritual and faith-oriented perspectives should conceptually frame their HIV prevention strategies while biblical teachings should be prioritised. Furthermore, the findings suggested that suppressed influences of the church undervalue nonspiritual oriented concepts. The YFCMPU HIV/AIDS PE study considers the ways in which the YFCMPU should interpret nonspiritual health concepts in the context of their religious beliefs in terms of the recommendations of Mpofu et al. (2014). A comprehensive context-specific HIV prevention strategy is crucial in understanding the social risk factors regarding HIV, improving communication skills, and reducing stigma before implementing interventions in South Africa (Lippman et al., 2014).

The HIV and AIDS infection rate in South Africa is one of the highest in the world, especially in KwaZulu-Natal, owing to the barriers to HIV/AIDS Care in rural communities, such as stigma, isolation, lack of privacy, anonymity, and awareness (Mbatha, 2014).

The Bible cites male circumcision being performed by Jews in the Old Testament. As an HIV prevention strategy, millions of Voluntary Medical Male Circumcisions (VMMC) were performed in 14 countries in Africa on adolescent and adult men prior to 2015 (Price et al., 2014). In line with this strategy, South Africa implemented a national plan to scale-up male circumcision (MC) from 2012 to 2016. Hygienic practices for male circumcision have been implemented throughout Africa as an HIV-prevention strategy. A high morbidity risk was recorded in 2012 in rural areas of Ghana due to lack of training on hygiene practices among circumcision practitioners (Gyan et al., 2017).

In a baseline survey conducted in Kenya among men aged 25-39 years, men with post-primary education and who were employed were more likely to be circumcised (Odoyo et al., 2017). Research findings indicated that risk compensatory behaviours (RCBs) among some of the females from Durban, Kwa-Zulu Natal, South Africa included mistaking MC as protection against contracting HIV and several participants recommended the involvement of females in such campaigns. The media were also found to be a contributory factor to stigmatism of PLHIV and substance users, leading them to suffer unemployment, shame, abandonment, captivity, and isolation (Greevy et al., 2018). Sex education programmes were recommended in drug rehabilitation programmes.

Hallonsten (2017) found that people from an Anglican Church in the Western Cape, South Africa were generally aware of HIV but did not speak about it. In another study, van Dyk (2017) found that more than 85% of clergy agreed that the Afrikaans-speaking churches have a task to teach the young congregants about sexuality and the prevention of HIV/AIDS. Moreover, the said clergy were prepared to teach young congregants only about abstinence as prevention against contracting the HIV by telling the young congregants that their bodies are the temple of the Lord (van Dyk, 2017). Approximately 15% of the clergy (mostly women) were prepared to conduct a comprehensive sexuality education programme that included abstinence. Van Dyk (2017) has also recommended a context-specific approach to address today's morality and reality. However, most of the women did not report RCBs despite the lack of knowledge (Greevy et al., 2018).

Research conducted through interviews with church leaders and caregivers, as well as focus group discussions with church members as a form of assessment of the response of the Free Methodist Church of Southern Africa (FMCSA) in KZN to HIV and AIDS found that a response to the epidemic had been neglected. Religious congregations play an important role in HIV prevention and care (Williams et al., 2018). Most of the studies undertaken on congregation-based HIV activities have focused on prevention. The said research has found that more educated clergy is associated with a greater likelihood of lending support, raising awareness, and donating to HIV/AIDS prevention activities. The findings of a nationally representative survey carried out in the United States revealed that congregations that were predominantly African American were less likely to engage in HIV/AIDS prevention (Williams et al., 2018).

HIV/AIDS is one of the major worldwide public health concerns regarding the youth who are at greater risk, including India, which historically had an early presence in East Africa. The members of various churches, such as nurses, social workers, and ministers who volunteered to be part of YFCMPU PE Programme are religious health assets, which should not be neglected in response to HIV and AIDS.

2.8.Political and Socio-Cultural Stance on HIV/AIDS Prevention

The global community has poured billions of dollars into the HIV pandemic since 1980. The new HIV treatment guidelines, which includes formulation of the fixed dose combination and offering ART earlier, need to be carefully fine-tuned to meet the needs of most vulnerable groups such as young adults who have child-bearing potential to allow informed decision making. Moreover, research has shown that the treatment and prevention of HIV are compromised owing to, among others, corruption in materials that were never purchased, and false claims of treatment; procurement and distribution issues; health workers using non-sterile equipment; exploitation of the sale of ART drugs; theft; official increasing of budgets; lack of community consciousness; lack of transparency into the billions of dollars of donations (Duarte and Hancock, 2017).

The new HIV treatment guidelines have exerted an impact on the political response to HIV/AIDS treatment and the decision to allow all HIV positive patients to start with ARVs upon diagnosis rather than waiting for a low CD4 count. Among the estimated seven million individuals infected in South Africa, 6.7 million are adults aged 15 years and above (UNAIDS, 2015a); hence the focus on young adults who are mentors at a university level or working class in the YFCMPU HIV/AIDS programme. In 1988, December 1 was declared the global world AIDS Day.

Research has emphasised the importance of taking into consideration the socio-cultural and political contexts in implementing HIV prevention strategies in schools (Lightfoot et al., 2015).

The findings after pre and post-test quasi-experimental evaluation in grade nine public high schools in North Carolina showed statistically significant increases in the knowledge of participants regarding HIV as well as changes in attitudes and awareness. Similarly, research findings among 23 HIV-vulnerable groups of women, youth and MSM showed that human rights approach to HIV-prevention were more participatory than in previous HIV prevention efforts among the youth (Choolwe et al., 2015). The conceptualisation of context-specific implementation of human rights, including the cultural and religious systems of the target groups, is effective in HIV prevention (Choolwe et al., 2015). Furthermore, Beeckman (2015) asserts that an individual perspective as opposed to an institutional one to inspire a change of mindset and behaviour towards culture, values, intra- and interpersonal skills, and the Youth as Agents of Behavioural Change (YABC) initiative, using a non-cognitive learning approach, increases the ability of participants to serve as role-models by applying the individual's skills' to implementing the principles of PE.

Adolescents living in dire poverty and violence-stricken communities face a higher risk of contracting HIV in South Africa. However, research findings suggest that social protection is fundamental in HIV/AIDS prevention strategies (Cluver et al., 2016). Adolescents and young people account for 40% of all new HIV infections each year, with the largest population of PLHIV found in South Africa. Research findings suggest that family-based interventions should be included in adolescent HIV prevention programmes (Kuo et al., 2016).

Communication between parents and their children regarding sex-related topics was described as a taboo and perceived as an initiator by parents for their young adults to engage in high-risk behaviour, and the adolescents who talked about sex were perceived to be disrespectful. However, context-specific strategies that build efficacy between parents, educators, communities, and adolescents in terms of talking about sexuality were identified (Kuo et al., 2016).

Furthermore, according to Adams and Balderson (2016), the efficacy of pre-exposure prophylaxis (PrEP) was an important factor for care providers in making HIV-related decisions about prescribing PrEP, considering the cost of and adherence to the regimen, including follow-up for the care of HIV-negative people who are at high-risk, such as men who engage in sex with other men (MSM) heterosexuals, Concordance couples and injection drug users (IDUs). Contraction of HIV can be prevented through a drug treatment called PrEP. This treatment needs to be taken as prescribed by individuals who are HIV negative, as the drug prevents the virus from entering the bloodstream permanently (Adams and Balderson, 2016).

Furthermore, in the researcher's opinion, abstinence remain effective in the prevention of HIV among young Christian adults. Researchers have found that most bisexual and younger men from the MSM population in Kenya, who contributed to 15% of the HIV incidence, showed a willingness to take oral PrEP to stay HIV negative and protect their partners. Nonetheless, stigma and side effects of the medication were identified as barriers to drug adherence (Robinson et al., 2016). However, access to health care did not facilitate the receipt of HIV-prevention interventions among black men who have sex with men (BMSM) in Columbia, although 60% of BMSM had accessed a community-based clinic during the last six months (Levy et al., 2016).

In 2015, emanating from the findings of a study carried out among adolescent girls and young women aged 14-24 years in Zimbabwe, a developing country, it was suggested that sociocultural influences could also decrease the high risk of morbidity and mortality among others, and suggested that peer education could be beneficial during pre-pregnancy planning (Tinago, 2016). Similarly, Makos (2016) conducted a context-specific study to assist women to resist peer pressure among peer educators to conform to the notion that a thin female body is beautiful. After the training, Makos (2016) found that the females were more comfortable with their weight and exerted an impact on the self-image and self-worth of peer educators. Sex education is globally applied as an HIV prevention strategy among the youth to address gender inequality. A South African ethnographic study suggested that sex education is necessary to propose alternative political reasons for the provision of sex education debate in the school curriculum where others perceive sexual education as enticing the youth to experiment with sexual behaviour, whilst others may become more vigilant regarding High Sexual Risk Behaviour (HSRB) (Gacoin, 2017).

2.9.Treatment and Prevention of HIV/AIDS: Pre-Exposure Prophylaxis (PrEP)

The YFCMPU Peer educators believes that PrEP could cure HIV; hence, the current researcher reviewed the relevant literature to clarify the myth. The World Health Organisation recommended a PrEP regimen as an additional choice to HIV prevention to people at risk of HIV (Govender and Abdool, 2018). Since women from urban areas of the KwaZulu-Natal (KZN) province in South Africa associated the acceptability of the tenofovir gel microbicide with confidence and classiness, this would encourage the use of the PrEP regimen. Furthermore, women from the rural areas of KZN associated the gel with confidence, respect, and responsibility with an increased focus on the individual and collective family/ community benefits of limited HIV prevention options.

The findings indicated that women were willing to take HIV prevention options that were aligned with their reproductive health routines, were efficient for the longest duration, and required minimal or no partner involvement. In contrast, male participants were not supportive of their partners using any form of PrEP under any circumstances. This reveals female personal preferences on an intrapersonal level and male dominance in a cultural context, as mentioned above, and gender-specific norms or stereotypes on an interpersonal level. Recommendations to educate women regarding current HIV prevention innovations and technologies were made (Govender & Abdool, 2018). Furthermore, according to Holt et al. (2018), trends of condom-less anal intercourse with casual partners (CAIC) and PrEP use by gay and bisexual men indicated that a rapid increase in PrEP use by gay and bisexual men was accompanied by an equally rapid decrease in condom use. It is thus necessary to consider the potential for community-level increases in CAIC when modelling the introduction of PrEP and in monitoring the effects thereof.

In 2012, Truvada was approved for daily use as an HIV PrEP. A sample of 18 transgender women from New York City reported uncomfortable side effects, difficulty with taking pills, stigma and a lack of research on transgender women and PrEP. The participants recommended that increasing the types of available prevention products would facilitate PrEP intake (Christine et al., 2018).

Efficacy of the tablet, ring, and injection as options (TRIO) among young women from Soshanguve, South Africa, was a strong determinant of a stated choice for biomedical HIV prevention with an injection every 2-3 months being the most preferred method and the oral tablet was least preferred (Minnis et al., 2019). Similarly, young women from Kenya preferred monthly injections and a monthly ring was least preferred.

Moreover, young women from both Kenya and South Africa preferred multipurpose combinations for the prevention of HIV/AIDS and pregnancy. Preference for injections underscored an interest in PrEPs (Minnis et al., 2019).

Motivation and limited access were identified as barriers to VMMC uptake among young men from Zimbabwe, whilst adolescent girls and young women (AGYW) were found to lack risk perception (motivation), and limited access was regarded as barriers to the uptake of PrEPs after a six-step prevention cascade formulation of HIV prevention intervention (Moorhouse et al., 2019).

2.10. Gender Inequality/ Stereotypes and HIV/AIDS Prevention

Lesbian, gay, bisexual, transgender, queer, intersex, asexuality and all other sexualities that are not included (LGBTQIA+) community needs to be prioritised in health and education regarding sexual orientation and gender in the education of the African health professions. Discrimination of victims in the LGBTQIA+ community were observed because of their gender orientation and sexual preferences due to the origins of AIDS, as mentioned above. However, organisations empower the victims, and, in many cases, they have become good leaders (Hassan et al., 2018).

Women and children suffer the consequences of patriarchy in many African cultures where it is the norm to view patriarchy as being superior, which renders them vulnerable to HIV infections (Dellar et al., 2015). Young women (15-24 years) contributed a disproportionate 24% to all new HIV infections in South Africa; more than four times that of their male counterparts (Dellar et al., 2015). Similarly, Patra and Singh (2015) found that young women in Uganda were almost twice as vulnerable than young men in acquiring HIV.

A meta-analysis has also demonstrated that the practice of risky sexual behaviour by male young adults was incomparably higher than female young adults (Berhan & Berhan, 2015).

Research conducted among MSM in Burundi suggested that they were at risk because they have poor access to community-based HIV testing, counselling services, and comprehensive prevention tools, as well as social and psychological support (Coulaud et al., 2016). Kushwaha et al. (2017) suggested that implementation of effective strategies for the improvement of HIV prevention among peer-networks of MSM in Ghana reflected a desire for a multi-level approach to educating MSM, health care providers, and the general population on HIV and human rights. The HIV/AIDS prevention accorded priority to MSM in the global HIV prevention, treatment, care, and support by the WHO in 2016.

Nonetheless, research findings indicated that the LGBTIQA+ safe spaces that were operational in Cape Town, South Africa, were not stable nor always safe (Hassan et al., 2018). This could be attributed to stigma and discrimination. The current study focuses on young adults aged 18-35, who are at the age where lobola negotiations, childbearing period, and various challenges experienced during young adulthood may lead to teenage pregnancy and polygamy. However, lobola was not explored in the current study.

2.10.1. Pregnancy in the African Context

According to Baloyi (2013c), perceptions regarding the length of abstinence from sex during pregnancy amongst Black African Christian young adults may contribute to polygamy. The main aim of sex in marriage among young adults is giving birth to children and is a private young adult's affair and a source of ritual impurity "hot blood" (*madi a bollo*) (Baloyi 2013c). Sexual intercourse is discouraged for three years from conception until a goat is slaughtered as a sign of purity and permission to engage in sexual intercourse amongst Zulu and other cultures. According to Baloyi (2013c), from the medical point of view, sexual intercourse during pregnancy poses no threat, sexual deprivation is stealing and taking from the spouse what God says is theirs. The abstinence of young female adult from sexual intercourse before marriage, during pregnancy, after giving birth, during menstruation and post menopause gives men an excuse to have extra marital affairs and polygamy, thereby increasing the susceptibility to HIV infections among young adults.

Elimination of mother-to-child transmission (EMTCT) has played a very important role in the prevention of the spread of the virus to children during pregnancy and encourages pregnant young adults to visit their nearest clinic within the first trimester of their pregnancy. However, the lack of privacy and confidentiality in clinics and hospitals has led to children being born HIV positive and their mothers dying of AIDS thus leaving many children as orphans or living in child-headed households (CHHs) and vulnerable to HIV. Education may affect decisions to engage in crime, HRSB and subsequent polygamy in the African Context.

2.10.2. Polygamy in the African Context

Various African cultures have taken a polygamist stance that is discussed herein. Baloyi (2013b) explores whether polygamy is acceptable in contemporary Christian communities. There are two types of polygamous marriages. The first type includes paying lobola for a second wife and seeking permission from the first wife. The second type of polygamous marriage is one which the woman stays on her own and the male visits her regularly. This type of polygamous marriage may result from a man taking care of his late brother's widow or other forms of levirate. The latter is generally more bearable for women. In cases where the first wife is blamed for inability to give birth to children and the husband marries a second wife for child-bearing purposes, the practice is oppressive to women who are blamed for not giving birth to children and have no choice but to give consent to their husband to pay lobola to the second wife.

Having two wives can be compared to having two eyes that can see far more rather than having only one spouse. Other cultures regard polygamy as having more eyes to see further. King David and Solomon were polygamists in the bible and when missionaries came to Africa, they made efforts to abolish polygamy on the basis that it is incompatible with the bible. According to Baloyi (2013b), a Sesotho saying *Monna ke tshewene, o ja ka matsogo a mabedi* ("a man is a baboon, he eats with both hands") encourages young adult males to have more than one wife thus making women more vulnerable to HIV infection.

Other churches in Malawi insist that polygamist men should divorce their wives and remain with only one upon baptism; this leaves women that were economically dependent on their husbands in poverty and children being deprived educational and financial stability.

According to Baloyi (2013b) treatment for men and women regarding employment, working conditions, vocational training, and promotion should be equalised as per the Customary Marriages Act 120 of 1988 in South Africa. Husbands and wives have equal status and the Bill of Rights emphasises that women should not be discriminated against and the children have a right to education.

2.11. HIV/AIDS Stigma and Discrimination

Djibuti et al. (2015) argue that HIV has been stigmatised since its diagnosis, and both young and old are afraid of testing for HIV. This level of fear often leads to many people discovering their HIV status very late when their CD4 count is very low and they display AIDS symptoms. Some individuals are fortunate to recover upon taking ARVs, but they are stigmatised for the rest of their lives. Others end up dying because of denial and refusal to take medication. In many African cultures, AIDS is blamed on witchcraft.

Sexuality education was difficult to discuss in Africa before the advent of HIV/AIDS because many stakeholders believed that it promoted high-risk sexual behaviour (HRSB) (Okonofua, 2015). However, this picture has changed in the last decades and sexuality educations is now generally accepted as key to the eradication of the HIV/AIDS (Okonofua, 2015). Peer-led sexual-health education interventions among young adults are crucial for the development of norms and protection against vulnerabilities at their age and could be a powerful tool that is effective in changing knowledge and attitudes (Sun et al., 2018). HIV/AIDS youth PE (YPE) is an intervention that is meant to prevent the spread of the virus.

Abstinence and Be Faithful Among Youth (ABY) projects are recommended for YFCMPU to mitigate stigma and discrimination. Peer education is one potential method to increase self-assurance, trustworthiness and resilience while also improving HIV knowledge of youth living with HIV (YLHIV).

2.12. Application of Kirkpatrick's Model Theoretical Framework

Global viewpoints and relational and intercultural socioeconomic communication skills are viewed as a priority among adolescents/ young adults. The train-the-trainer project has been developed to improve the management of peer educators. However, this approach does not form part of the study due to the time limitations, scope and extraneous variables of the organisation. International peer education flexibility and the broadening of the imprints thereof are necessary. This process affords opportunities for modernisation, contextualisation, and internationalisation of the PE programme.

The practical application of the Kirkpatrick's Model within a theoretical context of the PE programme encourages peer educators to transform and intensify the YFCMPU PE programme. The outcomes achieved in the PE programme are based on the three-levels of the popular Kirkpatrick framework model (Paull et al., 2016). As mentioned earlier, level four of Kirkpatrick's model will not be applied to the study. There is an increasing appreciation of the notion that the traditional methods of PE and knowledge may not meet the needs of the increasingly diverse group of peers nor sustain the demands of PE which calls for innovative approaches to programme planning, training, and mentoring of peers.

The current PE programmes must be universal and value cultural and linguistic diversity. Peer education affords peer educators opportunities to advance interpersonal and intercultural communication skills, which prepares them to be good leaders and enables

them to be employable; hence the application of the Kirkpatrick model in the current study. The Kirkpatrick's model of training evaluation is structured into four levels (see Figure 2.1.), with each level measuring complementary aspects of a training programme as well as the evaluation of the training (Kirkpatrick, 1959).

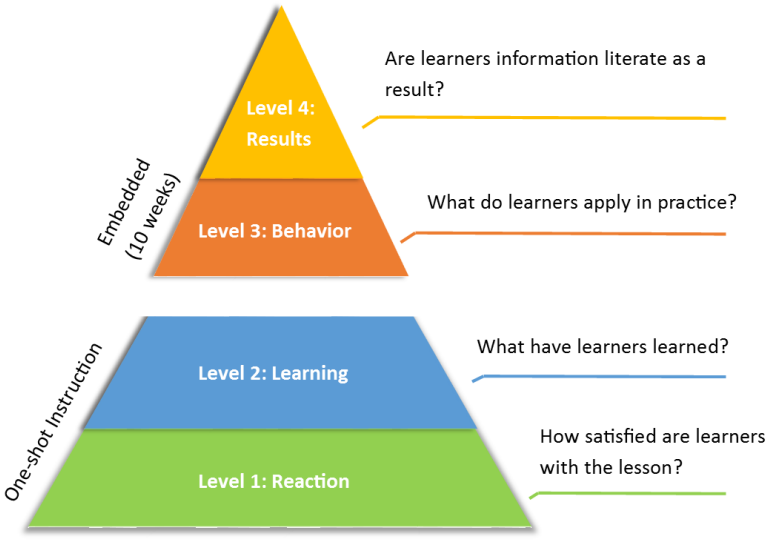

Figure 0.1 Kirkpatrick's model of evaluation

2.12.1. Level 1 Evaluation – Reaction

Reaction level: Data is gathered about personal opinions or feelings such as the likes or dislikes of the participants at the end of the training. This level does not evaluate the content of the training but may ask questions regarding its relevance and whether the training was worthwhile. Furthermore, all the preparations and logistics relating to the training are also evaluated through questionnaires or smile sheets. An online survey, and interviews could be used to evaluate the outcome of the training. The reactions on whether the training was enjoyable and useful could be evaluated.

The recommendations for the improvement of the learning tools are evaluated on this level. These include PowerPoint presentations, focus group discussions, training manuals and flip charts, which are usually employed by the facilitator or programme coordinator. The expectations of the participants could also be explored at this level to ensure that their needs are met.

2.12.2. Level 2 Evaluation – Learning

Learning level: The evaluation can be performed before (pre-test) and after (post-test) the training to determine whether the content and concepts of the topic have been fully comprehended and the training has achieved the main aim and objectives of the training; whether the skills have been transferred to the participants; whether the participants have learned what was intended to be taught through interviews (unreliable), printed questionnaires or observations, self- or group-assessment. This evaluation could be challenging when compared with level 1, time-consuming and inconsistent. To avoid inconsistency, a concise scoring process should be carried out. The evaluation should fall in line with the training objectives.

2.12.3. Level 3 Evaluation – Transfer

Behaviour level: This level evaluates the usefulness of the training, change in behaviour, routine performance, knowledge, attitude, or skills immediately after training and several (3-6) months thereafter at their organisation, through interviews, surveys, and close observations rather than opinions of the interviewer. Methodological challenges may be experienced at this level due to the inability to anticipate when and how the acquired training will be applied, and the difficulty in post-assessment evaluation of the participants.

The training must be refined until behaviour modification is perceptible, after which a more in-depth investigation instrument can be applied, for example, 360-degree feedback and relevant job/role Key Performance Indicators (KPI). Online evaluations tend to be more challenging to integrate in the evaluation of observable behaviour. The 360-degree feedback is a tool with many uses but is not necessary to use before starting the training programme. It is much better utilised after training because the participants will be able to work independently and figure out what they need to do differently to improve the training programme. Once the changes have been observed over a period, the performance/ results of the individual can be reviewed by others/self with broadly set guiding principles for proper assessment.

2.12.4. . Level 4 Evaluation – Results

Results level: The cost-containment measures and benefits/ success of the training model are evaluated. Kirkpatrick (1959) declared this level to be the most difficult due to extraneous variables in organisations, hence will not be covered in the current study. The elements that are evaluated on this level are based on the implementation and the income generated by the train-the-trainer project that was created by PEs. The PEs should be clear about what is going to be evaluated and given enough time to implement positive changes with relevant feedback. The YFCMPU mentors and staff should evaluate their targets based on the KPIs annually and possibly introduce a performance bonus to enhance the outcomes. The application of the framework has not yet given rise to peer-reviewed publications. The model has both strengths and limitations; these and the critiques are outlined below (Kurt, 2016).

2.13. Strengths and limitations of the Kirkpatrick's Model

The Kirkpatrick's model has been easily understood since its initial launch and has become one of the main evaluation models. The model is sound and well recognised because it gives structure and requires a minimum amount of time to apply. Although the model has been criticised, it has become influential in evaluation, monitoring and training. Nonetheless, it provides a useful starting point for the evaluation of the YFCMPU HIV/AIDS PE programme.

While popular, the model has been criticised by many researchers who have established new models using Kirkpatrick's theoretical framework. However, the model has been criticised for its hierarchical, simple, and systematic approach.

2.14. Conclusion

In this chapter, empirical studies on HIV, AIDs, HIV/AIDS YPE programmes, and how they can be cultivated, were reviewed. The application of Kirkpatrick's model was also outlined. In the next chapter, the methodology that was adopted for exploring the impact of the HIV/AIDS YPE programme on the facilitator participant mentors and trainees is discussed.

CHAPTER 3

RESEARCH METHODOLOGY

3.1.Introduction

This chapter outlines the aims and objectives of the study, the research design methods employed to identify the facilitator participants in the study, and to what extent these methods were suitable for answering the research questions. The chapter also has a section on how data was collected, managed, analysed, and interpreted, including a highlight of the limitations and strengths of the methods used. The chapter concludes with the study outcomes and conclusions.

3.2.Aim and Objectives of the Study

As mentioned in Chapter 1 of the thesis, the aim of this study is to explore the HIV/AIDS peer education (PE) programme of Youth for Christ Mpumalanga (YFCMPU) and its impact on young adults.

The objectives of this research study are to:

- Explore the knowledge base on HIV drug adherence, transmission and prevention in young adults.
- Explore how promoting a positive attitude among young adults regarding HIV can prevent stigmatism and discrimination amongst young adults.
- Explore changes in the behaviour and skills of the participants following their attendance the training programmes organised by the YFCMPU.

- Provide recommendations for the improvement of the implementation of the programme

3.3.Research Design

Research design involves a description of tools or measures for gaining access and obtaining a sample, and the strategy used to collect, explore, and analyse data. Although it contributes new knowledge, the research design is aligned to the research questions, aims, and objectives of the study (McGregor, 2018). The research design incorporates the framework chosen to answer the research questions. There is a difference between the planning, implementation, and modification of the research design, all of which affect the conceptualisation of the study (Maxwell, 2019). During the planning phase, the researcher employed an exploratory, mainly qualitative, research design, as an approach for gathering data during the implementation of the study through training and evaluation. Ten participants were initially involved in the study for the individual, introductory structured interviews. For the implementation phase of the research study, only six participants of the original ten were able to avail themselves for the training owing to logistical training challenges and other commitments. Only four participants were available for the last phase of data collection process.

3.3.1. An Explorative and Qualitative Research Approach

Data was collected by employing an emergent exploratory research design. Evaluation and critical thinking were undertaken at each stage of the design process (Loseke, 2017). The researcher is an African Black Christian female and young adult with potential experiences that the participants may have gone through. However, the researcher attempted to think critically about the work to avoid being biased in all phases of the research.

For data to reach an acceptable point of saturation and to answer the research questions, a combination of structured and semi-structured interview questions can be useful for collecting information (Johnson, 2017). Exploratory research attempts to scope a better understanding of a problem and makes recommendations for future research.

Qualitative research requires a broader research design and is referred to as an emergent research design that is nonlinear (McGregor, 2018). This study is explorative in nature and primarily makes use of a qualitative approach. Qualitative studies aim to understand and interpret participants' lived experiences through the connotations that people attach to these experiences. It requires the researcher's open and vigilant assessment of their social position and expectations, while interpreting the participants' words or characteristics from other data changed into difference of opinion by the researcher, who is the main data collection tool, expert, and transcriber.

However, the approach in conducting research aims to create the same level between the researcher and the participants and ensure that neither the participants should feel like subjects nor the researcher should feel superior. Qualitative research is largely exploratory in nature. It is used to gain an understanding of primary motives, thoughts, and inspirations; and discover trends in thought about challenging situations by studying those who are affected through unstructured or semi-structured techniques, such as individual interviews or semi-structured questionnaires. Language use allows for an original analysis of specific moments of making meaning, role playing, and relationship building in qualitative interviewing. Regardless, the results, data collection, analyses, interpretation, and discussion lead to conclusions and implications, and recommendations are made.

The HIV/AIDS Peer Education training was held at the Africa School of Missions in the Mpumalanga province, in a camp that was organized by YFCMPU. The training was conducted during the period 16 to 18 December 2016.

3.4.Sampling Method and Process

The study adopted a purposive sampling technique. The sample size in a qualitative cohort is characteristically smaller compared to quantitative research. The purposive convenience sampling method used by Ramathuba et al. (2014) was adopted for this research study to select the 10 participants who initially volunteered to take part in the initial phase of the study, where structured questionnaires were administered. Six of the ten participants underwent training, and the balance were only involved in the semi-structured interview sessions after the training was conducted, which were audio-recorded and transcribed after obtaining permission from the participants. During the conceptualisation phase of the study whereby prospective participants were introduced to and explained about the aims of the study, six males and six females were initially available to participate in the research study. However, two of the participants were unable to present themselves on the date of the HIV/AIDS Youth Peer Education training due to other commitments. Therefore, a decision was taken by the researcher to involve only those who attended the training to form part of the research study.

The participants who participated in the research study were made up of YFCMPU staff members and university students volunteering in the organisation. A total of ten participants (i.e., young adults) attended the camp and training on HIV/AIDS. All data was kept confidential, and the participants were identified using a random numbering system designated 1-10.

The participants were initially given the information sheet (refer to Appendix A) and the informed-consent forms (refer to Appendix B) that were to be signed by the participants. A biographical questionnaire was used to obtain relevant biographical information about the key participants (Appendix C). The exact same pre-and post-programme exploratory evaluation structured questionnaires were administered before and after the training, respectively (refer to Appendix D). A semi-structured open-ended evaluation form was administered after the training programme (refer to Appendix E). Interview guides (refer to Appendix F) were administered during the last phase of data collection process. The Power Point presentation (refer to Appendix G) was used during the training

An important aspect of purposive sampling is that it enables the researcher to select informative and relevant individuals. The participants met all the requirements for participating in the study by them being attendees of the camp and the HIV/AIDS training, as well as constituting the sample for the study. Furthermore, purposive sampling is acceptable for social situations where the sample size is small and for specific cases and events involving in-depth investigation of the problem being studied.

The disadvantage of purposive sampling is that it can be “judgmental” as the researcher makes decisions about the sample based on the most characteristic, relevant, and typical attributes of the population that best serve the purposes of the study. The learners and facilitator participants were given a presentation on HIV/AIDS with resource manuals and certificates of attendance (refer to Appendix H). All key participants were given an equal chance of being selected in the study, and were accessible via email and cell phone numbers, details of which were kept confidential.

3.5.Data Collection

The initial data collection phase was undertaken through structured biographical questionnaires (refer to table 4.1) administered to 12 volunteers. The type of data was collected during the period 1 to 30 June 2016. This was followed by structured pre- and post-programme exploratory evaluation questionnaires, which were administered immediately before and after the training and are in line with the Knowledge Level of Kirkpatrick's model. The pre- and post-programme exploratory evaluation questionnaires were distributed to the 10 of the 12 participants (the other two participants were unavailable for the training that was scheduled for 17 December 2016.

The second phase of data collection was undertaken by the six of the 10 facilitator mentor participants, who compiled focus discussion interview reports from the training that was conducted by the researcher. Furthermore, an open-ended semi-structured questionnaire and interview guide with prompts were administered to six facilitator mentor participants who were available on 25 March 2017 to evaluate the change in attitude and knowledge because of attending the training.

Lastly, the exact same semi-structured open-ended interview guide were distributed to four of the six participants on 30 June 2017 to evaluate the change in behaviour because of attending the training in line with the Behaviour Level of Kirkpatrick's model.

3.5.1. Data Collection Process and Study Inclusion Criteria

Data collection is the process of gathering information (Flick, 2018). An application of Kirkpatrick's model of evaluating training programmes serves as a framework for the study and guided the data collection process. The model consists of four levels, namely Reaction, Learning, Behaviour, and Results.

Due to extraneous organisational variables, the Results level was not evaluated. Originally, ten participants from the YFCMPU facilitators volunteered to participate in the study, in effect making this a purposive convenience sample of volunteers who attended the camp and training. The data were collected in three phases in line with the Reaction, Learning, and Behaviour levels of Kirkpatrick's model of training and evaluation. In line with the Reactions level of Kirkpatrick's model, structured evaluation questionnaires were administered to 10 of the 12 participants to explore reactions and suggested recommendations for improving the HIV/AIDS training. Semi-structured open-ended interview guides were used for further exploration.

The participants' reactions to the training were obtained by means of open-ended questionnaires in line with the Learning level of Kirkpatrick's model, administered to 10 of the facilitator participants before and after the training to explore their depth of knowledge of HIV/AIDS concepts. Semi-structured interviews were also conducted three months after the training on six of the 10 facilitator participants. Lastly, in line with the Behaviour level of Kirkpatrick's model, open-ended questionnaires were once again administered by the researcher to four of the six facilitator participants, six months after the training, and during the third phase of data collection.

The semi-structured interviews were conducted in English with an estimated time of 20 minutes being allocated for the completion of all the questionnaires. Permission to conduct research was requested from two organisations in Mpumalanga. The criteria for finding the organization relevant to the research plan was as follows: The organisation had to be a Christian organisation based in South Africa due to the researcher's African Christian faith. The organisation also had to be an NPO/NGO to minimise the cost and expenditure for conducting the research. The target audience had to be youth who are

involved in mentorship of learners of a younger generation. The sample had to be young adults of the age group 18-35 and were required to attend the training to be part of the study. The organisation had to be actively involved in HIV/ AIDS PE. The participants were required to have been part of the organisation for at least a year to form part of the study.

The YFCMPU met the above-mentioned requirements and gave the researcher permission to conduct the study. A letter of authority was requested by the researcher to conduct research, and permission to conduct research was granted by YFCMPU. The researcher compiled a training manual and further conducted the training on HIV concepts. The trainings were highly interactive and required maximum participation from all the facilitator participants. Each participant was given an opportunity to participate in the training, which was facilitated by six of the 10 participants.

3.5.1.1. Training.

Training was conducted over three days from 16 to 18 December 2016, at Africa School of Missions in Mpumalanga province, South Africa. The facilitator participants divided learners into seven groups who focused on HIV/AIDS concepts. The training was facilitated by the six of the 10 facilitator participants and the researcher over a period of one hour. A scribe was selected from the learners of each of the seven groups to record the responses on a flip chart and a presenter was selected to convey a summary of the discussions to all the attendees of the camp. The groups were given thirty minutes to discuss the topics and information generated was record on flip charts, which was then presented to all the attendees by the group leader. The method was heavily content driven as it was conducted through different phases by using the Kirkpatrick's model of training and evaluation.

Each group was given a unique topic with assistance from the six facilitator participants and the group leaders were given an opportunity to present on the following topics: common acronyms relating to HIV/AIDS Youth Peer Education; stigma and discrimination; disclosure and case scenarios; self-awareness; side effects of ARVs; substance abuse defence mechanisms; recent statistics on HIV infections; and project management of HIV/AIDS YPE programme. A letter of authority was granted to the researcher by the YFCMPU giving permission to conduct the research. The names of the ten out of 12 mentor participants are known to the researcher, but as per the signed consent sheet, were anonymised in the research write-up.

3.5.1.2. Trainees.

The broader population in this study involves 112 camp learner attendees during the implementation phase, which included 52 females, of which 42 (81%) were informants, 6 (11%) were junior mentors, and 4 (8%) were senior mentors, and 60 males of which 45 (75%) were informants, 10 (17%) were junior mentors and 5 (8%) were senior mentors. The researcher was the main facilitator of the group discussions and was assisted by six co-facilitator participants. The Kirkpatrick's model of training and evaluation is the most popular model that has been used since the 1950s. However, the application of the model has been used to measure the effectiveness of training on the HIV/AIDS YPE programme. The Kirkpatrick's model of training and evaluation is delineated in the sub-section that follows.

3.5.1.3. Application of Kirkpatrick's Model

Application of Kirkpatrick's model of evaluating training programmes serves as a framework for the study. In this study, the model focuses on three levels (i.e., Reaction, Learning, and Behaviour) and was applied to explore and describe the research questions as outlined above. Satisfaction reactions were drawn and the data was structured and critically analysed using Kirkpatrick's model of training and evaluation. One of the main aims of evaluating the impact and effectiveness of training is to identify strengths and weaknesses and to make recommendations for improvements.

Level 1 Evaluation – Reaction

Reaction level: At the end of the YFCMPU HIV/AIDS PE programme, the participants gave responses about their subjective opinions or feelings about the programme. This is in line with process evaluation, a form of formative evaluation. The open-ended semi-structured questionnaires evaluated whether the participants found the YFCMPU HIV/AIDS PE programme relevant and worthwhile. Data were gathered at the end of the training session about personal opinions and feelings, such as the likes and dislikes of the participants. This level asked open-ended questions through two questionnaires about whether the training was relevant and worthwhile (refer to Appendix D and E).

Level 2 Evaluation – Learning

Learning level: An exploratory evaluation was performed before (pre-) and after (post-) the training to determine whether the content and concepts of the topic had been fully comprehended and whether the training had achieved the intended aim and objectives (refer to Appendix D). The exact same forms were used for both pre- and post- programme exploratory evaluations.

Level 3 Evaluation – Transfer

Behaviour level: This level explored the usefulness of the training, changes in behaviour, routine performance, knowledge, and attitude of the participants immediately after receiving training and several (3-6) months thereafter at their organisation. This was conducted through open-ended interview guides (refer to Appendix F). The semi-structured interviews took approximately 20 minutes to complete.

3.6.Qualitative Data Analysis

Data collected was analysed by means of thematic content analysis, which included familiarisation with the data as well as finding meaning and identifying patterns of recurring meanings by generating initial codes followed by generating themes that run through these meanings (Guest et al., 2012). A structure of themes and subthemes as well as interrelationships is common in thematic analysis and includes making sense of the data by means of a coding scheme, which is a complementary tool to be used when analysing data for these themes (Schwartz-Shea & Yanow, 2020).

Thematic analysis involves the retrieval of data through the identification of common themes. Also called qualitative thematic analysis and interpretive content analysis, this is a shared universal method to investigating qualitative basic information (Schwartz-Shea & Yanow, 2020).

The researcher assigned numbers to each participant upon receipt of the questionnaire and saved the data as hard and soft copies (computer an external hard drive). Data management involves the way in which data collected in a research study is controlled, categorised, filed, and organised to allow for efficient duplication and retrieval. All data was transcribed and stored in computer folders that were accessible to the researcher and the supervisors. All hard copies of the raw data were stored safely in an access-controlled office and duplicate copies were stored in a locker for security reasons. Furthermore, hard copies were printed and stored in two separate offices for accessibility and security purposes. Each emerging finding and interpretation were constantly compared to existing codes and categories (Butler-Kisber, 2018). A detailed discussion of the findings is provided in the next chapter.

3.6.1. Strengths and Limitations of the Research Design

This research was subject to the inherent limitations of the interpretive nature of qualitative, exploratory research, and was challenging to conduct and analyse contextually. Online evaluations tend to be more challenging to integrate when evaluating observable behaviour. The strengths of qualitative research were outlined, and the methodological precautions and protocols were adhered to minimise interpretive bias. Interpretive bias was addressed by using ‘bracketing’, which is a qualitative research process where the researcher is aware of and sets aside his or her own notions about the topic.

Qualitative research in behaviour relating to the topic, methodology, analytical approach, model and findings may be useful as a starting point to formulate valid variables for advanced future research (Dholakia & Saiyed, 2017).

3.7.Research Ethics

Research ethics include the standards by which behaviour should be regulated in research. The following ethical standards were considered during the research study:

Confidentiality: The participants' private data gathered is only revealed to third parties, such as supervisors after receipt of consent from the participants.

Anonymity: The participants are assured that their identities, and responses would be protected and not disclosed by identifying them using numerical values 1-10.

Sensitive topics: These are topics that may impose a threat or emotional risk to the participants or pose challenges in terms of data collection or the dissemination of research. There were no sensitive topics in the study and the participants could skip questions that they deemed uncomfortable.

Ethical approval: This includes a process of research governance that seeks to ensure that research projects adhere to ethical standards. Ethical clearance for this study was granted by the ethics Committee of the University of South Africa through the Department of Psychology in May 2016.

Data ethics: The gathering, analysis, and use of data such as personal information, which included biographical information of the participants, required asking for permission to use the personal information without disclosing the identity of the

participant should the information be shared with supervisors. The data was kept private and secured by preventing unwanted access and sharing of the data.

Informed consent: The participants have a right to distinguish that they are taking part of a research study, as well as what the purpose, potential risks, and benefits are, and they can pull out from the research at any period or phase of the research study (Silverman, 2020). In the current study, informed consent forms were signed by the participants, namely, facilitator mentors. The learners did not form part of the study as they were classified into vulnerable groups, who needed permission from a legal guardian to form part of the study. Indemnity forms were signed for them to take part in the camp activities, but not to form part of the study.

Qualitative data collection takes serious consideration of ethical guidelines in the study, including the cultural norms, beliefs, values, and behaviours of the participants. The participants gave permission to be part of the study before the commencement of the research, and permission was requested before any recordings could be undertaken for the semi-structured interviews (Mertens, 2015). Researchers should always show honesty and trustworthiness and remain neutral and non-violent. They must not exploit the participants' rights. Ethical research is meant to support community transformation and principles of ubuntu (Mertens, 2018). The participants were informed that their interviews and questionnaires, would form part of data collected for a study on HIV/AIDS Youth Peer Education Programme's impact on youth aged 18-35 from rural areas in Mpumalanga. An information sheet was compiled in this regard. No risk was anticipated with regards to participation in the study. The individual interviews and questions that were asked did not evoke emotions of anger or sadness as they involved reactions to the training and subsequent implementation of the Youth Peer Education (YPE) through application of

Kirkpatrick's model of training and evaluation. However, there were cases where participants felt uncomfortable answering specific questions due to the confidential information required to answer the question. Therefore, in some cases some questions were not answered. In the camp, ministers, social workers, and professional nurses were available and formed part of the facilitator participants who were there to attend to learners who were emotional or needed further details about certain concepts. It is essential that the research participants' anonymity be protected throughout the research. Therefore, numerical values were used to identify the participants (on 25 March 2017 to evaluate the change in attitude and knowledge because of attending the training in line with the Learning Level of Kirkpatrick's model e.g., Participant 1, 2, and so on) anonymise the participants. These ethical precautions were adhered to protect the legitimate rights of the participants. All the data or information was recorded in writing after transcription of the audio recordings of the discussions. The respondents' responses were shared with only the researcher and the research supervisors.

3.8.Communicating and Disseminating Research

The study outcomes are presented in the form of a thesis, which will be made available to all stakeholders and participants upon finalisation. The research impact is demonstrated by the change in culture and YFCMPU HIV/AIDS policy, which is not included in the research due to extraneous variables of the organisation. Changes in services, knowledge, attitudes, and behaviour were also demonstrated.

3.9. Conclusion

This chapter outlined the descriptive research method employed to explore the impact of the study on the participants' knowledge, attitude, and behaviour. The thematic content analysis method was also explained. The sampling employed was purposive in nature. The primary sources of data were structured, semi-structured pre- and post-programme exploratory evaluation questionnaires, open-ended interview guides, structured interviews on demographics, and the participants' knowledge on HIV/AIDS. The contextual research process that was followed was outlined in this chapter. The next chapter presents the results of the study.

CHAPTER 4

RESULTS

4.1.Introduction

The chapter outlines the results of the study in which the HIV/AIDS Peer Education (PE) programme of Youth for Christ Mpumalanga (YFCMPU) and its impact on young adults was explored. This is in line with Reactions, Learning and Behaviour Levels of Kirkpatrick's model of evaluation and training (Kirkpatrick, 1996). As mentioned in Chapter 3, the Results Level 4 of the Kirkpatrick's model of training and evaluation were not covered in the current study due to extraneous variables of the organisation.

The Results Level needs to be evaluated over a long period of time. This posed a serious risk to the continuation of the study over a longer period of time because many of the young adults who are the core participants of this study are tertiary students and volunteers and their availability to participate in a future period could therefore not be guaranteed. The results presented herein aim to elucidate future research questions, thereby offering an evidence base for improving the HIV/AIDS Peer Education training of YFCMPU. The qualitative interpretation of results is evolving in the field of psychology and thematic analysis was applied to find meaning in the results (Willig and Rogers, 2017).

4.2.Results

Behavioural and socio-economic risk factors relating to HIV/AIDS and the biographical information of the participants were evaluated by administering individual structured interviews. All the individual interviews, which were conducted in English over a period of one hour, were used as the primary method of data collection. The consent of the participant was obtained before focus group discussions were audio-recorded. Audio recordings were transcribed after the training to ensure accuracy and save time while also allowing the researcher to remain focused and achieve eye contact with the participants, as prescribed by various researchers (Chauke, 2012; Vassos, 2012).

All self-administered questionnaires were completed without assistance from the researcher. Table 4.1. gives a summary of the biographical and risk factor information provided by the participants. An analysis of this data follows immediately after the table.

Table 4.1

Biographical and risk factor details of the participants

Participant	Age	Gender	Marital status	Occupation	No of sexual partners	Age of first sexual encounter	Alcohol or Drug intake	Condom usage
1	26	Male	Single	Volunteer	1	15	None	Yes
2	23	Male	Single	Student	1	22	None	Yes
3	33	Female	Married	Employed	1	16	None	No
4	18	Male	Single	Student	1	18	None	Yes
5	26	Female	Single	Volunteer	1	26	None	Yes
6	35	Male	Married	Employed	1	27	None	No
7	22	Female	Single	Student	0	Never	None	Yes
8	35	Male	Married	Employed	1	17	Recently stopped	No
9	30	Female	Single	Employed	1	18	None	Yes
10	26	Female	Single	Employed	1	19	None	Yes

The study comprised a total of ten participants (n=10). Their ages ranged from 18 to 35. Table 4.1 shows that the participants comprised of a total of 50% (n=5) female and 50% (n=5) males. All the participants were black South Africans. Most of the participants (n=7; 70%) were single and a few (n=3; 30%) were married**.** Half of the participants (n=5) were employed; it is highly likely that these participants possess a post-matric qualification because they work in administrative positions as well as professional (i.e., medical nursing, and social work) and theological fields. Only a few of the participants. (n=2; 20%), were volunteers at YFCMPU and others (n=3; 30%) were full-time students. Only a single participant (10%) in the form of a 22-year-old female student had never engaged in sexual intercourse. Most of the participants (n=7; 70%) used condoms during sexual intercourse and only a few (n=3; 30%) reported not to have used condoms - this might be attributed to the fact that the 3 (30%) were married. Most participants (n=5; 50%) reported using condoms throughout the course of the study while some participants (n=3; 30%) reported using condoms sometimes. Interestingly, only 20% of the participants (n=2) have never used condoms at all. This provides evidence that some young adults still engage in protected sex and this may lead to the spread of the HIV virus. Only 10% of participants (n=1) indicated that they have recently stopped consuming alcohol while the rest (n=9; 90%) indicated that they were not taking any alcohol or drugs. The average age at which the participants first engaged in sexual intercourse was 17.8, with the youngest being 15 years old and the oldest being 27 years old. The average age for the first sexual encounter for males in the current study was 15.8 years and 16.4 for females.

These results corroborate results of study conducted over a six-year period by Blignaut et al. (2015), which established that the average onset age for sexual encounters was approximately 15.6 years for males and 16.7 years for females. This study therefore validates the proposition by Blignaut et al. (2015) that males are more likely to start having sex at a relatively younger age.

4.2.1. Kirkpatrick's Model: Reactions Level

The following questions were asked in a semi- structured open-ended interview guide, namely:

- How did you feel about this training?
- Did you like the training?
- If yes, what did you like the most?
- Was the training worthwhile?
- Did you like the venue and related domestics?
- How was the level of participation?
- Were you at ease and comfortable during the training?
- Were you upset or disappointed during any stage of the training? If yes, when and why?

The training offered to the participants was evaluated. Furthermore, all the preparations and logistics relating to the training were also explored and evaluated by means of a questionnaire.

Facilitators' reactions were investigated in rural areas of Mpumalanga province with the aim of evaluating the impact of the YFCMPU HIV/AIDS PE programme on the mentors' experience and feelings through the application of Kirkpatrick's model as a framework (Manganyana et al., 2020). The responses given in the current study were positive and showed that the participants were satisfied with the training, and this was evident from the responses given regarding liking the facilitator, and the training.

Facilitator evaluation questionnaires can explore whether the facilitator's method of delivery was effective, the facilitator was well-prepared, the facilitator was clear regarding explanations of key concepts, the facilitator presented the programme in a well-organised manner and showed an in-depth understanding of the concepts, and the facilitator improved the learning process by stimulating interest in the programme. Rating scales can be used to ask questions about whether the facilitator was dynamic, passionate, confident, filled with humour, creative, encouraged active participation, conducted the research in the best interest of the participants, or communicated effectively (Bruce, 2018). Facilitators must have leadership skills to maintain successful training programmes. Research findings showed that the plan and conveyance of the training programme gave rise to high levels of participant gratification (Sowcik et al., 2018). The research investigated a virtual journal club's effect on satisfaction, knowledge, and practice. Researchers used the Kirkpatrick Learning Evaluation Model, which considered offering continuing education credits to encourage participation (LaMar, 2017).

The interaction between the facilitator and the participants were found to be influential (McGuire et al., 2015). Similarly, learner-teacher, learner-learner, and learner-content interaction are recognised as key elements for meaningful learning and effectiveness in the course and its impact on satisfaction, knowledge transfer, and return on

expectations (Rodriguez and Armellini, 2015). Barriers to using emerging technology for teaching and learning have been identified (Alkhawaldeh and Menchaca, 2014). Methods of content delivery have also become very technological in the medical discipline (Pullen, 2013). According to Garmston and von Frank (2012), facilitation is an essential component for group success and a good facilitator prepares and plans for what is needed before, during, and after the training. It is essential for the facilitator to arrive earlier before the training begins and to check the venue logistical arrangements as regards facilitator audibility and visibility. It is essential to first get the attention of the group by using nonverbal cues. The facilitator should clarify the goals of the training and ask the participants what their expectations or desired outcomes are.

An analysis of the responses to the questions posed in the questionnaire indicates that the participants found the training to be satisfactory and the facilitator to be competent. A selection of responses relating to the evaluation of the training and the facilitator are as follows:

Evaluation of the Training: “The training was well organised …;Informative;…;Well and topics very relevant…; It is well and informative”

Evaluation of Facilitator: “The facilitator was friendly and helpful”, ‘Liked training and knowledge”, “Participation was good and “The facilitator was well prepared and there were no interruptions”

Four of the participants found the training to be relevant and worthwhile and liked the venue. These participants also felt comfortable during the training and were not upset or disappointed at any stage of the training. Furthermore, the participants found the level of effort required for optimal learning to be good.

The application of the content was found to be practical in everyday life. In general, the participants said that they would likely recommend the training to others as "The training was well organised", "Informative", "Well and topics very relevant" and "It is well and informative".

Regarding the evaluation of the learning the respondents had the following to say:

Evaluation of Learning: participants said the following was more information than necessary: "Process on contracting HIV more in depth"; and learned "More about HIV…Side effects of ARVs"

Communication using animations that automatically play (the second life platform) creates space for interaction (Tan, 2013), as opposed to first life/ iconic gestures, which are produced by children when they start with feeding or changing routines. The fast increase and advance of information technology has presented a improved platform to discover the innovative schooling model. As a result, expertise plays an integral part in the English Language. Technology supports new ways of teaching and learning. However, for teaching and learning to improve, technologies must be used (Flanagan and Shoffner, 2013).

Subjective evidence shows that radical resources on the internet play a critical role in the radicalisation processes among young adults (Thomas, 2021). Online settings propose substitutes to old-style learning, which is considered classy and inefficient. The lack of interaction on such platforms was found to be the main problem for online learning. A questionnaire survey was administered, and the findings revealed that game fundamentals may be used as sustenance online events to occupy students (Abdulaziz et al., 2020). The results showed that using online technology can foster motivation to learn to develop student skills in simulating learning models and learning can be efficient and

effective, while training students to innovate learning models used in technology (Kustandi et al., 2020). Recent progress in technology has transformed the learning behaviours of students and reshaped the education itself, empowering students to learn more efficiently and effectively and with more satisfaction.

Technology helps students profit from all types of resources and intellectual tools, stimulates understanding of the background, and leads to higher levels of accomplishment (Kausar et al., 2020). Communication and learning are realities that permeate human existence. ICT has been acknowledged as a influential instrument that converts teaching. Numerous governments have capitalised enormous sums of money in enhancing schools with technology and providing them with Internet access to inspire educators to use these innovative methods. New ideas have been extracted from students' responses to online reading, such as likeness and paving the way for upcoming studies (Yaghi & Abdullah, 2020). However, many barriers still need to be well-thought-out prudently when technology is used for education and knowledge purposes. The findings indicated that the most common barriers identified were external obstacles, such as a absence of technology, limited Internet access, and a lack of managerial and technical support (Tarman et al., 2019).

Organisation social responsibility and performance for the setting is needed in schools for explicit purposes to afford a harmless and contented learning setting with the equivalent excellence of education as in regular schools. The participants are volunteers at YFCMPU and they hope to acquire valuable experience in the organisation to use in their respective jobs. Research findings display that labour engagement and job gratification are imperative influences that must be well-thought-out in cultivating organisational social responsibility and performance for the setting (Sari et al., 2019).

Studying student assessments at the close of the semester offers an chance to reorganise online courses to improved aid for students (Warren & Bartlett, 2019). Touch screen tablets such as iPads are becoming progressively common as educational apparatuses to sustenance of first language learning. The categories in which the applications scored highly were interactivity, cultural awareness, usability, and language and literacy content. The applications scored lowest in the categories of collaboration and provision of learning outcomes (Neumann et al., 2019). Teachers have perceived technology as not addressing individual needs. They did not report conducting formal needs assessments; implementing sustainability and continuity; or collecting more systematic evaluation data (Karlin et al., 2018). Research results specify that reaction evaluation remains the most commonly taking place evaluation training (Marshall, 2018).

Furthermore, in support of these findings, all six participants responded positively to the questions above through the semi-structured questionnaires from the interview guide, after the training, namely: Did you learn what was intended to be taught? Did you experience what was intended for you to experience? What was the extent of advancement or change after the training in the direction or area that was intended? A selection of the responses is as follows:

"It is a very good extent because although I learned about it at school, I still needed refreshing from this information" …

"Yes, although I have attended similar trainings, I have learned new things…"

people on ART…;

" Mostly to consider our youth those are sexually active…

"Positive"

"I will appreciate this kind of training twice per year

. "…enjoyed new information about HIV statistics…my parents would never be able to"

"Young people gained extra information and I am grateful…"

" Provide this information…

"I will appreciate this kind of training twice per year.

Kirkpatrick's model of training and evaluation showed an enhanced culture among the youth (Sakthi & Moshi, 2020). Research supported the efficacy for implementation of level four of Kirkpatrick's evaluation (Susan et al., 2019). An exploratory study observed the influence of the programme by means of pre- and post-programme student investigations. The outcomes were organized according to Kirkpatrick's evaluation model. The interviews propose that the programme had a optimistic effect on students on all three levels (Wartenweiler, 2018). Kirkpatrick's model of training and evaluation of training programmes was applied in the medical industry, and it showed that the execution of a continuing education programme reduced occupation exposure to needle stick injuries (Mostafa et al., 2018; Kamal et al., 2018; Gabriel et al., 2018; Tiffany et al., 2015). Tampere University of Applied Sciences in Finland has used student suggestions to develop an effective postgraduate programme. The challenges and successes regarding the implementation help provide guidelines for future development (Teräs et al., 2012).

In this study, the participants made the following suggestions and comments on the administered post-programme exploratory evaluation questionnaire:

Suggestions and comments. The participants all gave positive suggestions and comments, which may be attributed to the positive feedback that they gave regarding the ways in which the training can be improved. Most of the participants commented that they enjoyed and liked the mode of presentation during the training, which was said to be inclusive in terms of the participation of all trainees.

Venue and Catering: "…Perfect because there was no interruptions and the food was great", "It was well organised "

From the above-mentioned responses, it is evident that the participants found the training to be satisfactory. Only two out of the six participants (n=2, 33%) who attended the training did not give responses to the structured open-ended questionnaire due to commitments or unavailability as well as their responsibility as organisers of the camp to facilitate arrangement of catering after the training. Most of the participants (n=4; 67%) were available to complete open-ended evaluation questionnaires regarding their feelings and opinions about what they learned, what more information they needed, the facilitator, and the venue and catering. Therefore, a common and consistent theme could be established when analysing the responses received from these participants.

Most importantly, the participants who were present were able to provide suggestions for improvement or comments regarding the training. The semi-structured evaluation questionnaire was administered after the training and due to work commitments of other participants, only four participants who were volunteers at YFCMPU were able to give responses to the questions in the evaluation questionnaires.

4.2.2. Kirkpatrick's Model: Learning Level

In line with the Learning Level of Kirkpatrick's model the following questions were asked:

- Have you experienced a change in attitude, knowledge, and/or skills from having participated in the HIV/AIDS Youth Peer Education programme?
- Are the objectives of the organisation in line with the programme?
- Did you learn what was intended to be taught? Did you experience what was intended for you to experience? What is the extent of advancement or change in you after the training, in the direction or area that was intended?

The participants gave their expected outcomes from the workshop at the beginning of the training session. Pre- and post-programme exploratory evaluation questionnaires on HIV drug adherence, side-effects of ARVs, HIV transmission, and prevention, which were the main themes of the learning level, were administered. The Kirkpatrick's learning level of evaluating training programmes explored the extent to which participants experienced a change in terms of knowledge regarding HIV/AIDS concepts after undergoing training. The Kirkpatrick learning levels explored the learning experiences of participants by asking questions related to HIV/AIDS as per the questionnaires in the appendices.

The Kirkpatrick learning levels were used to evaluate the HIV/AIDS YPE programme. It basically evaluates the extent to which participants experienced a change of opinion and knowledge on HIV/AIDS following attendance of a training session (Kirkpatrick, 1996). The pre- and post-training responses were compared. Moreover, the model established whether the participants' attitudes regarding their learning had changed

and whether there were any changes in skills acquired. This level is in line with summative evaluation, which involves the extent to which participants change as a result of participating in the training.

As evidenced by the response to the structured close-ended questionnaire administered at the end of the training shown below, additional information is still required on the transmission of HIV:

"Process on contracting HIV more in depth"

The topics that were perceived by the participants to be informative were topics in which the participants felt they had learned additional and new concepts. The topics that the participants perceived they had gained new and valuable information on the modes of HIV transmission included unprotected sexual intercourse, sharing of needles, blood transfusion, and mother to child transmission (MTCT). The participants also indicated that they had acquired additional information on the side effects of ARVs, such as anaemia, headache, rash, fatigue, abdominal pain, nausea, vomiting, hypersensitivity, sedative effect, diarrhoea, and sleep disturbances. The participants also indicated that they had learned more about the topic related to disclosure, such as the types of disclosure, namely full or public disclosure, partial disclosure (disclosure to specific people), indirect disclosure (disclosure by using one own's pictures and not necessarily referring to oneself), involuntary disclosure (someone revealing your status without our knowledge or permission), and non-disclosure (not revealing your status personally or in public). The participants also indicated that they have learned more about stigma and discrimination.

The participants' responses were as follows regarding what they have learned more from the training:

"More about HIV transmission…", "Disclosure; Side effects of ARVs…" and 'Stigma and Discrimination"

Most of the participants (n=4; 60%) stated that anaemia is a side-effect of ARVs, and this was not mentioned before the training. All the participants (n=6; 100%) mentioned headache as a side-effect of ARV's after the training. This shows that the training was successful in providing participants with more information regarding anaemia and headache as side-effects of ARVs. Rash and fatigue as potential ARV side effects were only mentioned before the training. Half of the participants (n=3; 50%) listed abdominal pains after the training as one of the side effects; this result contrasts sharply with the single person that listed before the training abdominal pains as one of the side effects. Nausea was not mentioned both before and after the training. Most of the participants (n=4; 60%) listed vomiting as a side effect after undergoing training (compared to only one participant before the training).

Participant 6 is the only one who mentioned 'hypersensitivity' before and after training and gave sedative effect after the training, while dizziness was listed by half of the participants (n=3) as a side effect prior to undergoing the training. Most of the responses listed after the training were similar to those provided in the presentation. This suggests that the training may have contributed positively to the changes in responses before and after the training side effects, such as sleep disturbances were only mentioned after the participants had undergone training.

Following training, Participant 6 listed the highest number of side-effects mentioned in the presentation. This provides further evidence that the training was successful in teaching and helping participants learn more about side effects of ARVs. Participants 5, 6, 9, and 10 listed the highest number and variety of accurate side effects of ARVs. This might be attributed to them attending the training. Being a health worker, Participant 8 appears to have been much more knowledgeable about the ARV side-effects even before the training was offered. The responses that were given before and after the training regarding the prevention and transmission of HIV/AIDS were similar to those that were given in the presentation and were included as topics that were facilitated by the participants and recorded on flip charts in focus group discussions. Some of the modes of HIV transmission are captured in the comments below.

"Unprotected sexual intercourse", "Blood transfusion, mother to child transmission and sharing of needles with an HIV positive patient"

According to the participants, HIV can be prevented through abstinence, being faithful, using condoms, and maintaining an undetectable viral load.

The following side-effects of ARVs were listed in the presentation: anaemia, headache, rash, fatigue; abdominal pain, nausea, vomiting; hypersensitivity; sedative effect, diarrhoea; sleep disturbances. The responses that were listed by all the participants (n=10) before the training were as follows:

Headaches; Rash… feeling very tired…; Painful stomach…; painful/ swollen legs…; vomiting…; Hypersensitivity; diarrhoea; dizziness

The following responses were given by the participants after the training:

Anaemia; headache; fatigue; abdominal pains); nausea; diarrhoea; sleep disturbances; Vomiting; Hypersensitivity; Sedative effect

All the participants responded that they learned what was intended to be taught and have also experienced what they were intended to experience. Furthermore, the participants learned the relevant and new information in terms of the extent of advancement or change in the participants after the training in the area that was intended. Some of their responses were as follows:

> "It is a very good extent because although I learned about it at school, I still needed refreshing from this information."

> "Yes, although I have attended similar trainings, I have learned new things…"

> "My provincial history and statistic of people living with the pandemic and people on ART. Mostly to consider our youth those are sexually active…"

4.2.3. Kirkpatrick's Model: Behaviour Level

It is imperative that organisations support their employees in continuing to be efficient about novel and developing skills and learning. A natural and complete method is required to advance education settings and improve these settings for innovative advances in education and technology (Redmond & Macfadyen, 2020). Findings suggest a weak link between teacher use of technology and the lesson objectives, with several explicit and implicit tensions at the teacher, school, and system levels that affect technology integration. The implications of this study, especially regarding the sociocultural issues behind the integration of technology into schooling, contribute further to our

understanding of the requirements for successful implementation of the initiative at different, but certainly interactive and interdependent, levels (Mama & Hennessy, 2019). In a pre-and-post survey of a convenience sample of faculty to assess their readiness for professional development, it was found that faculty initiative in having a choice of technology led to statistically significant positive outcomes, including a stronger sense of initiative, greater self-efficacy, and a higher receptiveness to educational technology (Gummess, 2019). Measuring and evaluating learning outcomes is traditionally done through tests or exams, which can only represent a short-term memory. Long-term learning success is not only hard to measure but also a matter of expectations.

There are ways to visualize it by collecting proper data and defining success as an improvement of knowledge retention (Schimanke & Mertens, 2019). Flip charts were used for ~~to~~ recording all the information generated from the group discussions. The flipped classroom (FC) is a novel teaching mode combining traditional class-room and computer network technology. The results confirm that the system can meet the teaching demand, arouse the students' interest in learning, and improve the effect of English teaching (Zhang, 2019). An investigation proposal involved Kirkpatrick evaluation model wherein improvement and restructuring of the education curriculum at different levels was allowed, with an impact on the teaching and learning process, in a technological way, and including students and educators of all levels (Almeida et al., 2019).

Research reveals a direct educational impact can be achieved through learners' participation in evaluation activities. Most importantly, learners' curriculum evaluation experiences were consistent with their other flipped learning experiences, which emphasizes a learner-centred approach (Chen & Bradley, 2018). Research equated a half-semester flipped classroom and an old-style classroom, where the investigational class

reverted to the old-style format after the midterm for evaluating students' receptiveness towards two learning settings. The results discovered that student knowledge attainment and inspiration were enhanced according to assessment scores by the application of the flipped classroom. However, student's receptiveness towards flipping varied because of the great quantity of time and energy used up on the course. The research recommends that blended flipped and old-style programmes be arranged together for intensification of student receptiveness (Chien & Hsieh, 2018). The envisioned future direction is prompted from ICT integration, and character education (Lubis, 2018).

The skills acquired from the training were evaluated three months after the training. As a result, only four volunteers were available to provide responses to the follow-up semi-structured interview guide. A change was noted in skills of the participants following participation in the HIV/AIDS YPE programme. The developed skills include communication, presentation, informative, networking and negotiation skills, and this is listed from the questions in the participant interview guide. One of the participants (*Participant 6*), however, indicated that the change might not be noticeable, as he/she had already attended similar trainings in the past. Disclosure was defined as follows in the presentation:

The participants seem to have acquired an in-depth understanding of the term ‘Disclosure’ from the training as more relevant responses were given after the training. An analysis of the data indicates that, before and after the training, all of the participants (100%, n=4) gave responses that were similar to those that were in the presentation. Participants that provided the same answer as before the presentation included Participant 6 and 7. This may be attributed to Participants 6 and 7 having attended training relating to disclosure in the past.

The participants' pre-programme exploratory responses to meaning of "Disclosure" (n=4) were as follows:

"When someone is opening about their status…"

"Coming out like speaking your mind…"

"Telling people about your condition…"

"Not afraid, telling people about your condition"

The Participants' post-programme exploratory responses were as follows:

All of the participants' (n=4; 100%) responses before and after the training were similar. Participants with same answer as before the presentation included Participant 6 and 7. This can be attributed to participants 6 and 7 having attended training relating to disclosure in the past. Their responses are as follows:

"Is to expose…"

"It is opening about your status, unknown thing…"

"Telling someone something you were keeping for a very long time…"

"To reveal certain information about yourself to people"

4.2.3.1. The Impact of the Training on the Participants' Attitude

The responses below provide evidence for the changes in attitudes regarding HIV in terms of abstinence and making informed decisions. When talking about the change in attitude, one participant said the following:

"…especially in the province on what social issues are affecting my society…"

According to Kebaso (2016), there was a lack of Zimbabwean studies to assess the impact of stigma and discrimination on the AIDS Strategic Framework between 2014 and 2019.

The presentation defined two types of stigma as follows:

- External stigma: Oppression, rejection, punishment, harassment, blame or exclusion, discrimination, and abuse
- Internal stigma: feels shame, fear of rejection and rejection, self-exclusion and social withdrawal

The impact of the training on participants' opinions in terms of attitude attached to "Stigma" was evaluated.

Stigma

During pre-programme evaluation only two participants gave the following responses:

"Isolation"

"Being called names"

After the training, the following responses were given:

"Discriminant"

"Isolation"

"Oppression"

"Rejection"

" Harassment"

" Shame"

" Individual is seen less in the eyes of other:

Half of the participants (n=3; 50%) gave responses before the training. Participant 4 and 6 gave responses that were descriptively similar to the themes on the presentation. Understanding stigma forms part of changing attitudes towards HIV/AIDS. Half of participants (n=3; 50%)gave responses that resonated with the presentation before the training. Six participants attended the training and Participant 5 and 6 gave the responses that were descriptively similar to those in the presentation.

Discrimination

To evaluate the impact of the training on participants' attitude towards HIV/AIDS and understanding the meaning of "discrimination", participants were asked before and after the training about their knowledge and understanding with regard to the meaning of "discrimination".

Participants' pre- programme exploratory responses to the meaning of "Discrimination" were as follows" (n=10)*:*

"Not understanding a person because of his disability"

"When someone is treated bad because of skin colour, race or culture"

"Being disadvantaged and not given fair treatment"

Participants' post-programme exploratory responses were as follows:

"Discriminated against race and gender"

"To be discriminated according to your race and culture"

"One is not treated well, because of their skin colour".

The same participants evidently responded to this item before and after the training, which shows that they were knowledgeable about the concept of discrimination. Furthermore, all four participants indicated that they noted a change in the attitude, knowledge, and skills of the participants following participation in the HIV/AIDS YPE programme. This was seen from the analysis of the participant interview guide, which was completed by the participants three months after the training. One of the participants (Participant 6), however, indicated that the change might not be that noticeable because he/she had already attended similar trainings in the past. Participant 9 indicated a change in attitude by saying:

"…especially in the province on what social issues are affecting my society".

Generally, participants felt that the objectives of the organisation were in line with the programme, as illustrated by the following responses:

> "…to get more young people to value themselves, to get young people to be aware of the disease and how it can affect their lives. To equip them with information that would help them in learning about HIV. To help young people to abstain from sex activities and creating faith-based

leaders."

"Yes, very much."

"Create young people with life skills that are enough for them to make informed decisions within the community context regarding social issues that affect the well functionality of the society at large."

"Peer education in decision making and HIV/AIDS training."

4.2.3.2. The Impact of the Training on the Participants' Skills

Four participants were interviewed regarding their behaviour and skills that changed training attendance. The following questions were asked:

- Did participants use their newly acquired knowledge and/skill that result from training?
- Did the participants put their learning into effect when back on the job or at school?
- Were the relevant skills and knowledge used?
- Was there noticeable and measurable change in the activity and performance of the trainees when back in their roles?
- Would the trainee be able to transfer the learning and skills to another person?
- Is the trainee aware of his/her change in behaviour, knowledge or skill level?

The behaviour level was evaluated six months after the training and only four participants were available for this phase of the study. Two of the participants reported having had an opportunity to use the newly acquired knowledge and skill to teach young adults from Mpumalanga through peer education training and disseminating the information that was learned from the study. Presentation and communication skills were applied in train-the-trainer projects that were implemented but did not form part of this study. Participant 6 indicated that the time was too limited to measure any noticeable changes. The participant recommended that the monitoring and evaluation of behaviour should be conducted after six years. Responses included "not sure yet and too early to tell". The researcher concurs with Participant 6 and suggests that, for future research, the behaviour level should be evaluated after six years to allow for the quantifying of behaviour and skills through performance appraisals with specific scores. The appraisal can be done twice a year or every six months and can performance bonuses for reinforcement and post programme exploratory responses by the line-manager. The comments of the participants were as follows:

> "The information provided to them was very useful and very effective especially looking at the fact that, some of them are not getting this information in their families. It was awesome."

> "We should take seriously the issue of peer education in teaching all the aspect that contributes to HIV infection with our society respectively."

> "Level of understanding increased, this was shown by the maximum participation of the participant."

When asked what the effect of the training was on the organisation or environment,

the participants responded as follows:

> “Increased level of knowledge, increased awareness of the number of people that are infected, increased level of understanding for the virus.”
>
> ”It will help young people to teach their peers.”
>
> “Quality facilitators are created with base knowledge about the pandemic as related issue that encourages it impact in communities.”
>
> “Similar information that is distributed”

When asked what the outcomes of the study relating to the costs and benefits of the organisation were, the participants responded as follows:

> “The organisation benefited a lot and they enjoyed being part of it;"
>
> “It has impacted our organisation a lot because we could not afford training like this with the funding, we have…”
>
> “Well informed facilitators that will distribute similar information to young people.”
>
> “It produces quality facilitators who are well trained, based on HIV & AIDS.”

The evaluation of the effectiveness of training courses at Islamic Azad University of Islamshahr in Iran by applying the Kirkpatrick Model showed that reaction, learning, behaviour and organizational levels need to be improved (Shahrooz, 2012).

Expert advance, communication, and co-operation were the key learning results from content analysis using Kirkpatrick's model of training and evaluation on survey-based feedback responses (Bhatia et al., 2021).

When asked what the outcomes of the study were in terms of the objectives of the organization that were achieved in line with the training, the participants responded as follows:

> "Yes, they have been, because now the children are aware that having sex is not good and that should you be pregnant, you might be out of the centre. We are promoting them to wait until marriage so it is good, because by then, they will be matured enough to make decisions."
>
> "It has because we are trying to help young people to be responsible leaders."
>
> "Excellence and creating young people with enough information in bases of issues that affects the society or their surroundings."
>
> "To create young people who have quality life skills in decision making."

4.3.Conclusion

The results of the HIV/AIDS YPE training were presented in this chapter. Briefly, data analyses were conducted by means of thematic content analyses, with reference to Kirkpatrick's model of Reaction, Learning, Behaviour (Fugard & Potts, 2019). The participants displayed changes in attitude regarding HIV stigma and discrimination and appear to have acquired knowledge in terms of HIV/AIDS disclosure and drug adherence. In Kirkpatrick's learning level, the extent to which participants experienced a change in terms of knowledge because of having undergone the training was explored. The conclusion is based on the positive responses. An overwhelming majority of the participants (n=10; 90%) enjoyed the training and gave favourable responses as identified in the themes in this chapter. In the chapter that follows, the conclusions to the study are presented.

CHAPTER 5

CONCLUSION

5.1.Introduction

In line with Kirkpatrick's model of evaluation and training applied as a framework for the current study, the HIV/AIDS Youth Peer Education (YPE) training was selected from eight personal development training programmes identified by the researcher (this is detailed in Chapter 3). According to Kirkpatrick's model, the participants' feelings towards the training are explored. Whereas the Reaction level of Kirkpatrick's model focuses on the participants' feelings towards the training, the Learning level explores the participants' knowledge. The last level that was considered for this study, that is, the Behaviour level, explores the participants attitudes, and skills following intervention in the form of training (Kirkpatrick, 1996). The outcomes of the training, which are in line with the aim and objectives of the study, were also considered. The aim of this study is to explore the HIV/AIDS peer education (PE) programme of Youth for Christ Mpumalanga (YFCMPU) and its impact on young adults.

and to address the aim of the study, the following objectives were formulated:

- Explore the knowledge base on HIV drug adherence, transmission and prevention in young adults.
- Explore how promoting a positive attitude among young adults regarding HIV can prevent stigmatism and discrimination amongst young adults.
- Explore changes in the behaviour and skills of the facilitator mentor participants following their attendance of the HIV/AIDS Peer Education

training programme organised by the YFCMPU.

- Provide recommendations for the improvement of the implementation of the HIV/AIDS Peer Education training programme organised by the YFCMPU.

The aim and objectives of the study have been achieved because the knowledge, attitude, behaviour, and skills of the participants relating to HIV/AIDS training were found to have changed after the participants had undergone training, and specific recommendations for improvements were also made by the participants.

5.2.Kirkpatrick's Model: Reactions Level

The main aim of the study was to explore the HIV/AIDS PE of YFCMPU and its impact on young adults to get their perspective in understanding what the training means to them. Most participants enjoyed the training and found it exciting. The exercises were found to be enjoyable, collaborative and made it easier for the learners to understand HIV concepts being discussed. However, despite lauding the high-quality training afforded by the researcher to the YFCMPU, one participant indicated a previous attendance of a similar training session. It is evident from the results obtained that the training programme goals and expectations were achieved and some recommendations for improvement of the YFCMPU programme were made by the participants.

5.3.Kirkpatrick's Model: Learning and Behaviour Levels

The qualitative thematic analysis of the training has proven to be of benefit to the current study. There is some evidence in the qualitative analysis that there was a discord between the participants' understanding of the HIV/AIDS concepts before and after the training. The concepts that were asked about changed to closely reflect more of what was taught after the training. Therefore, the results reveal that the intervention was successful in ensuring that a thorough understanding of the HIV/AIDS concepts. The way in which the information was presented to the participants during the training session also facilitated the learning, thereby offering guidance on how the programme needs to be presented to produce effective results. However, the small sample size makes it impossible to generalise the findings.

5.4.The Strengths of the study

Exploring the strengths of a study bears positive implications. The evaluation revealed the inadequacies or ineffectiveness as well as the strengths of the study. The following positive implications were observed in the present study :

- The study indicates a change in opinion and knowledge regarding HIV/AIDS concepts when he requisite training is offered to participants.
- A comparative analysis of administering questionnaires versus interviews revealed that the questionnaires are much more cost effective because interviews require and additional transcription step that comes with an additional cost in cases where interviews had been conducted.

This study acknowledges the fundamental contributions of theories in the literature review and Kirkpatrick's model of evaluating training programmes, which increases the credibility of the study and allows for the evaluation of participants' knowledge, reactions, skills, attitude, and behaviour. It is envisaged that other researchers can learn and benefit from this research study. This study also provided the participants with a platform to air their opinions and knowledge regarding HIV/AIDS, which adds to their existing knowledge.

From the responses of the participants from the questionnaires, it can be resolved that their general familiarity on HIV/AIDS was good. The reports, group discussions and presentations of the participants as well as their observable behaviour led to the conclusion that there were changes in knowledge, skills and behaviour after undergoing the training. Overall, the evaluation of the training has rendered the training relevant, worthwhile, and serves the intended purpose.

5.5.The Limitations of the Study

The study focused on a non-governmental organisation based in rural Mpumalanga. Therefore, the results of this research study may not be generalised to learners outside this organisation, area, and region. The participants selected to take part in the study were consisted a small sample, because it was impossible to conduct structured open-ended explorative questionnaires with 112 learners in one room within a short period of time. For this reason, the research study focussed on the ten participants only. This sample represent only a small proportion of learners and therefore cannot be generalised to a larger population. The results of the study are valid but not generalizable to other young adults, which were not part of the study. The participants' subjective feelings may not be representative of all the opinions of the learners.

5.6.Suggestions for Improving the YFCMPU Peer Education Programme

The content covered by the peer education programme was found by the participants to be generally satisfactory. However, as outlined above, the time allocated for the training, monitoring, and evaluation was found to be insufficient. It is therefore suggested that more time be allocated to a research study. This suggestion might, however, have financial implications and may warrant a suitable venue, catering, and accommodation to accommodate the participants, especially in the case where the training takes a longer period of time.

5.7.Suggestions for Future Research

The results level of Kirkpatrick's model could be monitored over a six-year period after the implementation of the training to obtain meaningful results. By doing so, a holistic understanding of the application of all four levels of Kirkpatrick' over the suggested period would be acquired and may also include the younger generation of high school learners.

A larger sample is recommended to allow the application of statistical significance and generalisability calculations. It would be valuable to compare the gender-based experiences of the participants. Using instruments such as a Likert scale (commonly used in public health research) to measure attitudes and skills is also recommended for future studies as such measures can enhance the validity and reliability of research.

A need also exists to examine the impact of parental and other influences on sexual abstinence. Furthermore, prevention efforts should be targeted over a six-year period at participants who are not yet sexually active to give support to adolescents during their childbearing years in terms of prevention of adolescent pregnancy by ensuring accessibility to different types of contraception methods, consistent condom use, and HIV prevention (Blignaut et al., 2015).

Furthermore, the researcher concurs with Ramathuba et al. (2015) that educational and outreach programmes should also focus on home-based carers and health-care workers to provide educational information, reach out to the poor, and transfer interpersonal skills as well as resources. Abstinence and Be Faithful Among Youth (ABY) projects are recommended for YFCMPU.

Furthermore, it is recommended that the strategies to combat the spread of HIV should be culture specific. HIV and AIDS reduction interventions should be conducted comprehensively on university campuses in Africa and not only on world AIDS day (Djibuti et al., 2015).

However, culture and religion play an important role in sexual health education. Considering persons' connection with God is fundamental to beliefs and sexual health education programmes. Research shows that many spiritual persons experience God as a foundation of resilience (Aaron et al., 2021).

5.8. Conclusion

This chapter furnished an overview of the general orientation of the study by stating the purpose of the study, that is, to explore the HIV/AIDS Peer Education (PE) programme of Youth for Christ Mpumalanga (YFCMPU) and its impact on young adults. Subsequent perceived changes in skills, behaviour, and attitudes regarding their knowledge of concepts regarding the HIV/AIDS Youth Peer Education (YPE) programme were outlined. The application of Kirkpatrick's model to evaluate training programmes assisted as a basis for this study. The researcher concurs with Tadesse et al.'s (2013) findings that interventions aimed at reducing High Risk Sexual Behaviour (HRSB) among street youth should be conducted. Future research should then determine whether successful interventions reduce HRSB while youth remain homeless (Carmona et al., 2014). The researcher has identified a need to strengthen religious organisations to teach about HIV/AIDS and target non-religious youth with HIV and AIDS information. Health-care planners should consider HSRB in improving perceived HIV- vulnerability in both youths with disabilities and able-bodied populations (Umoren & Adejumo, 2014). Ma et al. (2014) recommended a gender and race/ethnicity-specific HIV/AIDS curriculum for future interventions. The researcher suggests that HIV-prevention interventions in South Africa should be aimed at building resilience and thus focus on the potential and strengths of young people. According to Agardh et al. (2012), youth-friendly mental health needs to be coordinated to meet the needs of Mental Health Care Users (MHCU). HIV-positive women rely on spirituality to enhance psychological well-being and health-related quality of life (HRQOL). The current intervention integrated context-specific culture to change the attitude regarding HIV/AIDS stigmatization and discrimination among young adults (Smith, 2019).

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APPENDIX A PARTICIPANTS':

INFORMATION SHEET

THE HIV/AIDS PEER EDUCATION (PE) PROGRAMME OF YOUTH FOR CHRIST MPUMALANGA (YFCMPU) AND IT'S IMPACT ON YOUNG ADULTS: AN EXPLORATORY STUDY

INTRODUCTION

My name is Nkateko Lowane. I am a PhD student in psychology at the University of South Africa (UNISA). I am inviting you to permit me to facilitate an HIV and AIDS Youth Peer Education programme and subsequent evaluation and monitoring of the impact on knowledge of HIV/AIDS concepts, change in attitude, behaviour and skill development as a result of participating in the training. This information sheet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what the study involves. You are welcomed to ask any questions should you seek clarity in the information given herein. Please ensure that you understand completely all the procedures involved. Below are some questions you might have about the study and brief answers thereof.

WHY ARE WE DOING THIS?

Learning evaluation is a widely researched area. This is understandable since the subject is fundamental to the existence and performance of education around the world, not least universities, which of course contain most of the researchers and writers. We are conducting this research to find out:

- What is the impact of the HIV/AIDS YPE programme on young adults?

- What are the behavioural mechanisms and skills needed in order to facilitate and monitor the Train-the-Trainer project?

- How can the HIV/AIDS YPE programme be improved in future?

WHAT DOES THE STUDY INVOLVE?

This study will be conducted through questionnaires, interviews and focus groups. You will be requested to complete all forms which will be evaluating the training and are at liberty to skip any of them for any reason.

HOW LONG WILL THE STUDY LAST FOR?

The entire study will last for up to twelve months maximum, the questionnaires will take 20 minutes at most to complete. Focus group interviews will be conducted at the end of the training as well as observations of the participants. The training will take eight hours maximum with tea, lunch and icebreaker brakes in between.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your decision to give me permission to conduct the observations is entirely voluntary. You can refuse or withdraw your permission at any time without stating any reason.

WILL ANY OF THE STUDY PROCEDURES RESULT IN DISCOMFORT OR INCONVENIENCE?

No, you will not feel uncomfortable at any stage of the research. The training and the study will not at any stage require you to divulge your HIV status.

WHAT ARE THE RISKS INVOLVED IN THIS STUDY?

There are no risks anticipated to be associated with participation in this study

WHAT ARE THE BENEFITS INVOLVED IN THIS STUDY?

The benefits to the participants will be the opportunity to speak about their lives to an independent researcher. The research is expected to be beneficial to the youth from the Mpumalanga community. The participants will receive accredited certificates of attendance from Nhlambeto Health Services, manuals on HIV and AIDS and T-shirts to identify them as peer educators.

WHERE CAN YOU GET MORE INFORMATION IF YOU HAVE QUESTIONS OR PROBLEMS?

If you have any questions or problems concerning this study, you can contact Miss Nkateko Lowane, tel. (012) 429 3417; Cell no: 0827175584; e-mail: lowanne@unisa.ac.za.

CONFIDENTIALITY

All information obtained during this study is strictly private and confidential. The written information will be stored in locked cabinets when not in use and the transcriptions will be stored in the computers which require passwords. If you are happy to allow me to conduct the research, please read and sign the attached consent form.

APPENDIX B

INFORMED CONSENT FORM TO PARTICIPATE IN THE STUDY

I hereby confirm that I have been informed by the investigator, Nkateko Lowane about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information (participant information sheet and informed consent) regarding the study.

I am aware that the results of the study, including any personal details regarding my sex, age, date of birth, initials, and address will not be stated in any study reports.

I understand that I may, at any stage, withdraw my consent and participation in the study, without having to give a reason. I am aware that I will not suffer any consequences if I withdraw my permission at any time. I have had enough opportunity to ask questions. I freely declare myself prepared to participate in the study.

(Please print)

_____

Participant's name

_____ _____

Participant's signature Date

APPENDIX C

BIO GRAPHICS

1. What is your age……?
2. Are you male or female…….?
3. Are you single/ married/ divorced/widower…..?
4. What is your occupation……?
5. What is the no of sexual partners you have……?
6. At what age did you start having sex……?
7. Do you take alcohol/ drugs / none……?
8. Do you use condoms…..?

APPENDIX D

PRE- AND POST-EXPLORATORY PROGRAMME QUESTIONNAIRE

YOUTH FOR CHRIST

TRAINING: **HIV/AIDS YOUTH PEER EDUCATION**

VENUE: **Africa School of Missions, Mpumalanga Province**

DATE: **16-18 December 2016**

PRE-EVALUATION QUESTIONNAIRE

FACTS ON HIV/AIDS

1. Mention 4 ways in which HIV can be transmitted

   a…….

   b……

   c……

   d……..

2. Mention 4 ways in which HIV can HIV be prevented

   a……..

   b……..

   c……..

   d……

3. How does HIV testing help?

4.Stigma means:

_____

5.Discrimination means:

_____

_____

6.Disclosure is:

_____

_____

7.The side-effects of ARVs include:

_____

_____

APPENDIX E:

TRAINING EVALUATION FORM

Learning programme:

_____

Facilitator/s:

_____

Date: _____

Venue:

_____

I learned

_____

_____

_____

_____

_____

I need more information on

_____

_____

_____

_____

The facilitator/s

_____

_____

_____

_____

Venue and catering

_____

_____

_____

_____

Suggestions/ comments

_____

_____

_____

_____

APPENDIX F

PARTICIPANT INTERVIEW GUIDE

EVALUATION OF HIV/AIDS YOUTH PEER EDUCATION TRAINING

Interview Guide	
Number	
Interviewer	
Number	

BACKGROUND AND AIMS OF THE STUDY

The aims and objectives to answer the above questions were as follows:

- Explore the knowledge base on HIV drug adherence, transmission and prevention in young adults.
- Explore how promoting a positive attitude among young adults regarding HIV can prevent stigmatism and discrimination amongst young adults.
- Provide recommendations for the improvement of the implementation of the programme.

The interview should take about 20 minutes at most. Please note that there are no right or wrong answers to the questions asked. Please feel free to answer just what you think. If there are questions you really do not want to answer, you may skip them; however, we encourage you to attempt answering all questions.

Please note that your answers will be recorded in writing and taped without identification. Responses will be represented in reports. No identifying information will be included in the reports.

Please answer the following questions:

SECTION 1: REACTION EVALUATION LEVEL

How did you feel about this training?

What are the strengths of the organisation?

Notes

_____
_____
_____
_____

Prompts

- Did you like the training? If yes, what did you like the most?
- Was the training relevant?
- Was the training worthwhile?
- Did you like the venue and related domestics?
- How was the level of participation?
- Were you at ease and comfortable during the training?
- How was the level of effort required to make the most of the learning?
- How practical is the application of the learning?
- Were you upset or disappointed during any stage of the training? If yes, when and why
- Would you recommend this programme to anyone else? Why?
- Would you recommend this programme to anyone else? Why?

SECTION 2: LEARNING EVALUATION LEVEL

2.1 Have you experienced a change in attitude, knowledge, and/or skills as a result of having participated in the HIV/AIDS Youth Peer Education programme?

2.2 What are the objectives of the organisation in line with the programme? This will also be confirmed by comparison between pre and post evaluation questionnaires.

Notes

_____
_____
_____
_____

Prompts

- Did you learn what was intended to be taught?
- Did you experience what was intended for you to experience?
- What is the extent of advancement or change in you after the training, in the direction or area that was intended?

SECTION 3: BEHAVIOUR EVALUATION LEVEL

3.1 Did participants use their newly acquired knowledge and/ skills that result from training.

Notes

_____
_____
_____
_____

Prompts

- Did the trainees put their learning into effect when back on the job?
- Were the relevant skills and knowledge used?
- Was there noticeable and measurable change in the activity and performance of the trainees when back in their roles?
- Would the trainee be able to transfer their learning to another person?
- Is the trainee aware of his/her change in behaviour, knowledge or skill level?

APPENDIX G: PRESENTATION

ACRONYMS

• AI	Appreciative Inquiry approach
• AIDS	Acquired Immunodeficiency Syndrome
• HIV	Human Immunodeficiency Virus
• NGO	Non-Governmental Organisations
• NPO	Non-Profit Organisations
• YPE	Youth Peer Education

STIGMA & DISCRIMINATION

Two types of stigma:

Give practical examples

1. External stigma: Oppression, rejection, punishment, harassment, blame or exclusion, discrimination, abuse

2. Internal stigma: feels shame, fear of rejection and rejection, self-exclusion and social withdrawal

DISCLOSURE & CASE SCENARIOS

- Full: publicly
- Partial: certain people
- Indirect: without referring to oneself but pictures
- Involuntary: someone revealing our status without our knowledge or permission
- Non-disclosure: not revealed
- Personal and public

Johari's window

- THERE ARE THINGS YOU KNOW ABOUT YOURSELF AND THINGS THAT YOU DO NOT KNOW ABOUT YOURSELF
- THERE ARE THINGS OTHER PEOPLE KNOW ABOUT YOU AND THOSE THAT THEY DO NOT KNOW ABOUT YOU
- AS YOUR RELATIONSHIP GROWS WITH PEOPLE, AS YOU DISCLOSE MORE AND MORE YOUR FREE AREA GROWS AND YOUR HIDDEN AREA DECREASES
- YOUR RECEIVE MORE AND MORE FEEDBACK, REDUCING YOUR BLIND AREA AND ENLARGING YOUR FREE AREA

Appreciative Inquiry

THINK OF ALL THE THINGS YOU DO WELL, ALL THE THINGS WHICH YOU ARE PROUD OF HAVING DONE, ALL THE THINGS FOR WHICH YOU FEEL A SENSE OF ACCOMPLISHMENT. LIST ALL OF THEM. BE SPECIFIC

DIVIDE INTO FOURS AND SHARE YOUR PAST ACCOMPLISHMENTS WITH EACH OTHER. WE THE HELP OF YOUR PARTNERS, EXAMINE YOUR PAST SUCCESSES TO IDENTIFY THE STRENGTH YOU UTILIZED TO ACHIEVE THEM

ASK YOUR PARTNERS – WHAT ADDITIONAL STRENGTHS DO YOU SEE IN MY LIFE? THE FEEDBACK SHOULD BE SPECIFIC. IF YOU MENTION A STRENGTH, BACK IT UP WITH EXAMPLES.

SIDE EFFECT OF ARVs

- Anemia, headache, rash, fatigue
- Abdominal pain, Nausea, vomiting
- Hypersensitivity
- Sedative effect, diarrhoea,
- Sleep disturbances

DEFENSE MECHANISMS

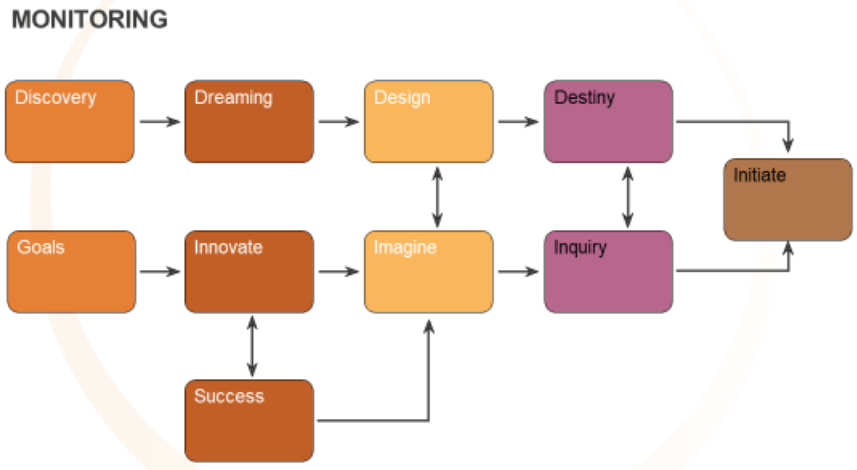
- Denial: “I can handle it, I don’t do drugs”
- Euphoric/selective recall: “I made the party exciting”
- Repression: Choose to forget the negative part
- Projection: blame others
- Rationalisation: Excuses “was depressed, was celebrating, everyone was drinking”
- Regression: Repeat performance, cry, temper tantrums, screaming
- Minimising: “I only had 2 drinks, I didn’t hit hard”

STATISTICS ON HIV/AIDS

- 7 Million living with HIV
- 19.2 % adult HIV prevalence
- 380 000 new HIV infections
- 180 000 Aids-related deaths
- 48% adults on ART

(Source: UNAIDS GAP report 2016)

PROJECT MANAGEMENT



APPENDIX H:
CERTIFICATE TEMPLATE

HIV/ AIDS Process, Implementation and Practice; Who am I; Forgiveness; Purpose; Choosing subjects a
Education; Values and Money; Dealing with the social ills of our school years; and being a young woman
being a young man in a world of women empowerment

Name :

Date : 13-16 December 2016

Venue : Africa School of Missions Mpumalanga