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Thoughts and feelings of lay HIV/AIDS peer educators, working in the field of mother to child transmission of HIV /AIDS, about their training and preparedness to perform their role

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THOUGHTS AND FEELINGS OF LAY HIV/AIDS PEER EDUCATORS, WORKING IN THE FIELD OF MOTHER TO CHILD TRANSMISSION OF HIV/AIDS, ABOUT THEIR TRAINING AND PREPAREDNESS TO PERFORM THEIR ROLE

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A research report submitted to the faculty of Health Sciences, University of Witwatersrand, Johannesburg, for partial requirement for the degree of Master of Science in Nursing.

Johannesburg. 2011

DECLARATION

I, Catherine Hilary Thurling declare that this research is my own work. It is being submitted for the degree of Masters in Nursing at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other university.

Signed  Date 10 May 2011

ABSTRACT

The effect of the HIV/AIDS epidemic on the South African health care system remains a serious challenge to the providers of health care. In response to the critical shortage of health care workers new cadres of health workers, such as peer educators have been trained to provide education, counselling, and treatment adherence support to people living with HIV/AIDS.

As many South African women only discover their HIV status after becoming pregnant and attending antenatal care, the supportive/educational roles of peer educators in the prevention of mother to child transmission (PMTCT) of HIV cannot be over estimated. This scenario is compounded by the high prevalence of HIV in pregnant women, who then require a comprehensive health care approach to their pregnancy and HIV positive status. This includes education about strategies for the mother to remain healthy during her pregnancy, counselling about reducing the risk of transmission of the HI virus to her baby at the different stages during and after the delivery of her baby.

The aim of this study was to investigate the current training of lay HIV/AIDS peer educators through an analysis of their training curricula. The thoughts and feelings of the lay peer educators were investigated through interviews to learn more about the training that they undertook.

The research design was a descriptive, qualitative, exploratory and a contextual study of nine participants, purposefully selected from a large tertiary hospital. The researcher reviewed three training curricula used by the peer educators during their training. Data for the nine semi-structured interviews were collected over a two month period. The use of a follow-up focus group assisted with Triangulation of the data.

The interviews were transcribed verbatim and analyzed into emergent recurring themes, which were then discussed, in relation to the reviewed literature. Five themes emerged from the study, namely: how training increased peer educators knowledge; the importance of updates in the work environment; how role-playing as a learning method built their confidence; their thoughts about what should be included in peer educator's curricula and the importance of government getting involved in the training of peer educators in PMTCT.

The study concluded with a proposed curriculum for peer educator's PMTCT training based on the findings and recommendations from the interviews, and is structured in line with the South African Qualifications Authority framework.

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This chapter will orientate the reader to the rationale for this study, and will describe the background to the research question. The purpose and significance of the study will be outlined, as well as a description of the objectives that have guided the study. The research problem and research question has been described. An explanation of the researcher's operational definitions has been included. A brief overview of the research methodology completes the chapter.

1.2 BACKGROUND

1.2.1 HIV Problems in South Africa

Southern Africa remains the epicentre of the HIV/AIDS epidemic (Dickinson, 2010:2; Van Dyk, 2008:8) with the area accounting for 67% of HIV infections worldwide (UNAIDS, 2009:21). The rate of new infections has gradually been declining due to an improvement in access to HIV treatment; however, the burden on the health facilities has not eased due to the increased volume of patients now accessing treatment. Sub Saharan Africa is also experiencing a critical health worker shortage (Campbell and Scott, 2009:1), with approximately 4 nurses per 1000 population (WHO 2006) South African health services have been struggling to respond to the health crisis (Dohrn, Nzama, Murrman, 2009:27). In response to the critical shortage of trained health care professionals and a growing necessity to train health care providers for all areas of health care provision, the World Health Organization proposed the: "Treat, Train and Retain" strategy (WHO, 2007:2) in which task shifting is a vital element. Task shifting, is the policy of the WHO's "Train" component of the strategy whereby some health care tasks can be delegated to less specialized health care workers who require a shorter training (Campbell, Gibbs, Maimane, Nair, 2008: 163; 2009:2; WHO 2007:2).

1.2.2 In response to the problem of HIV – Peer education

In South Africa new cadres of health care workers has been developed, this is in line with task shifting, these health workers provide patient education counselling and adherence support, in response to the health needs resulting from the HIV epidemic and treatment roll out (Dohrn et al. 2009: 28).

1.2.2.1 What are peer educators and their training?

A community health worker is defined as "any health worker carrying out functions related to health care delivery; trained in some way in the context of the intervention, and having no formal or professional certificate" (Daniels,Nor, Jackson, Ekström, Doherty, 2010:1). Peer educators are found under the umbrella of community health workers (Campbell and Scott, 2009:1; Lehman and Sanders, 2007:1; Schneider, Hlope, and van Rensburg, 2008:1). A peer educator is a term that refers to a lay person that in the context of AIDS helps co-workers, community members, family and friends, prevent the infection as well as providing education about ways to deal with the disease (Dickinson, 2010:2). Peer educator's training varies in length, depending on the training organisation. There is no standardisation of peer educator training, but literature indicates that most peer education programmes include training in the provision of health education, counselling of patients on adherence and other HIV related issues. Some peer educator programmes train peer educators to perform basic health worker duties such as recording patients heights, weights, and basic vital signs (Campbell and Scott, 2009: 3; Lehman and Sanders, 2007:1; Morris, Chapula, Chi B, Mwango, Chi H, Mwanza, Manda, Bolton, Pankratz, Stringer, Reid, 2009: 1).

Lay health workers can take over the non-clinical, as well as some clinical tasks in order to free up the nurses. In Maseru, Lesotho, the results of a study on task shifting, found that some of the counsellors were weighing patients, preparing laboratory forms, filing and recording blood results as well as performing HIV rapid tests (DoH, 2008:217). The result being that the health service was better

utilized as more patients could be seen, due to the service delivery being more efficient.

1.2.3 HIV Problems in PMTCT

The prevalence of HIV in pregnant women in South Africa has not followed the same pattern of stabilizing as in the heterosexual population. More than 29% of women who accessed public health services in South Africa in 2008 tested positive for HIV (Health Systems Trust, 2010:1; USAID, 2009: 28). This high rate of infection and women's vulnerability to HIV is related to their inferior standing in many communities in regards to their social economic and legal standing (UNAIDS, 2010:121).Many South African women only discover their HIV positive status after becoming pregnant and attending antenatal care (Sable, Libbus, Jackson, Hausler, 2008:160). The need to deliver an effective PMTCT programme is imperative, incomplete PMTCT services can put 40% of newborns exposed to HIV at risk of contracting the virus (IRIN, 2010:2). Therefore, the antenatal clinics are an excellent area where HIV/AIDS related education and counselling can be offered to the mothers not only to protect their unborn babies from being infected but also to empower the mother and enhance her quality of life through education and support.

Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) is complex and requires an integrated and comprehensive programme, involving a multi-disciplinary approach where peer educators have a pivotal role in education and counselling.

1.2.4 Peer education in PMTCT

Peer education, provided by peer educators in PMTCT starts at the entry point of a pregnant woman to the PMTCT services, which is first identifying her HIV status. Pre and post-test HIV counselling is done by the peer educators, and they continue to provide information, educate and communicate with the mother until after the birth of her baby, until the baby is approximately 18 months old. Education and counselling in the accelerated PMTCT Plan for South Africa (DoH, 2009:17) will include:

- Provider initiated HIV testing and counselling;
- Screening for HIV;
- Attention to gender based issues;
- Nutritional support and education;
- Education and counselling regarding infant feeding;
- Education and counselling regarding family planning;
- Education and counselling regarding ARV initiation and adherence; and
- Psychological support and bereavement counselling.

The role of peer educators in implementing the above aspects of PMTCT cannot be overestimated in health facilities where the prevalence of HIV is high and the clinic is under resourced (mothers2mothers:2006). As antiretroviral treatment becomes more advanced and clinics continue to be under resourced, community health workers and peer educators are going to be taking on more involved roles within the multi-disciplinary team.

1.3 PROBLEM STATEMENT

The response to the HIV/AIDS epidemic in South Africa has given rise to a large lay population of educators and counsellors, who have become an integrated and significant presence in the health system. Peer educators who have been trained to deliver HIV prevention and care have been finding themselves having to deal with social and often medical issues that fall out of their scope of training (Dickinson and Kgatea, 2008:294). This is especially noticeable in pregnant patients, where there is a high percentage of HIV positive patients, where education and counselling needs to include the importance of keeping the mother healthy plus reducing the risk of transmission of the virus to her baby at the different times during and after the delivery of her baby.

Nurses have found themselves unable to cope with the HIV epidemic and through task shifting are handing over traditional nursing roles to lay educators (Campbell and Scott, 2009:5). Problems have arisen with the peer educators "Cinderella" status in the health sector, and the uneven training that they have received (Aids Foundation, 2009:3). The training that peer educators and counsellors receive is

usually from a non government based organization (NGO) or faith based organization (FBO) and usually include voluntary testing and counselling (VCT), adherence to treatment regimen, bereavement and couples counselling as well as wellness programmes (Community Aids Response: Care guidelines, 2004:1).

As service providers in the field of PMTCT of HIV/AIDS develop peer educator curricula, there is a need to establish what peer educators feel are essential skills and knowledge, and that should be included in their training curricula.

1.4 RESEARCH QUESTION

The following question was posed: Do lay HIV/AIDS peer educators feel that they are being adequately trained and prepared to fulfil their role in the field of prevention of mother to child transmission of HIV/AIDS?

1.5 RESEARCH AIM

The aim of this research is to investigate the current training of lay HIV/AIDS peer educators through analysis of their current training curricula, and then to investigate the thoughts and feelings that the lay educators have about the training that they undertook, and how it has prepared them to fulfil their roles in PMTCT. Based on the findings and recommendations arising from the study, a training curriculum in line with the South African Qualifications Authority standards will be devised by the researcher.

1.6 RESEARCH OBJECTIVES

The aim of the study was achieved through the following objectives:

- To explore and describe the training manuals and curricula that were used in the training of lay HIV/AIDS peer educators.
- To explore and describe the thoughts and feelings that the lay peer educators have about their training that they have undertaken.
- To devise a peer educator PMTCT curriculum.

1.7 SIGNIFICANCE OF STUDY

In a resource limited country like South Africa, where a shortage of health care workers exists (Dohrn et al. 2009:S27; Dovlo, 2007:1373), health volunteers are playing a greater role in the provision of HIV/AIDS services and support (Campbell et al. 2008:173). Peer educators appear to be the best providers of this bridge between formal health care and the community (Schneider et al. 2008:7). A well designed educationally based, participant focused, programme with specific goals and outcomes would lead to a more competence based training, and will result in a better outcome for PMTCT programmes that include lay peer educators.

1.8 OPERATIONAL DEFINITIONS

1.8.1 Peer Education (P.E)

Peer education is a flexible strategy within a prevention and early intervention delivery system. It is a process in which trained supervisors develop and support a group of suitable people to educate, strengthen and support their peers to contend with health threats and the decisions that they face (Harvard School of Public Health, Peer Education Systems, 2009:1).

1.8.2 Peer Educators

Peer educators fall under the generic category of Community Health Workers (CHW), which also includes lay health workers, lay community health workers, traditional/indigenous health workers (WHO, 1989). Most community health workers are trained using the principles of peer education and they themselves teach using the same principles (Campbell, 2010:1)

The International Center for AIDS Care and Treatment Programmes (ICAP, 2009:2-5) defines HIV peer educators as people who are involved in HIV prevention, care and/or treatment services, they have a good understanding of HIV care, treatment, PMTCT and adherence; and have the skills to help other clients with their care and treatment. They are usually volunteers.

The most recent definition of a Community health Worker (WHO, 2008:79) states that they are health workers who have received training that is outside the nursing and midwifery medical curricula, but is standardised and nationally endorsed. This category can include health workers with a range of different roles and competencies and those that are providing essential services in a health facility, or in a community that is linked to health team at a facility.

1.8.3 Human immunodeficiency virus (HIV)

Human immunodeficiency virus is a micro organism in the family of retroviruses. The virus spreads through sexual intercourse, blood transfusions, use of contaminated needles, and from women to babies during pregnancy childbirth and breastfeeding (Oxford Illustrated Companion to Medicine, 2001:25).

1.8.4 Acquired immunodeficiency syndrome (AIDS)

Acquired Immunodeficiency syndrome, is a syndrome which is a cluster of medical conditions. It is caused by the human immunodeficiency virus that weakens the body's immune system (Oxford Illustrated Companion to Medicine, 2001:25)

1.8.5 Prevention of mother to child transmission of HIV/AIDS (PMTCT)

Is the prevention of the vertical transmission of the human immunodeficiency virus from an infected mother to her baby via the placenta during pregnancy, through blood contamination during childbirth, or breast feeding (Van Dyk, 2008:42).

1.8.6 Task Shifting

Is the name given to a process of delegating tasks from more specialized to less specialized health workers. By reorganizing the workforce in this way, task shifting can make more effective use of human resources currently available. It requires the integration of the concept and roles of new cadres, changes scopes of practice and regulatory frameworks, and enhances training infrastructure into the main health system (World Health Organization, 2007:3).

Task shifting involves the extension of the role of community health workers, including people living with HIV/AIDS, in order to enable them to assume some tasks previously undertaken by senior cadres, e.g. nurses and midwives, non physician clinicians and medical doctors (WHO, 2008: 81).

1.9 OVERVIEW OF METHODOLOGY

The following brief overview is provided, a full description follows in Chapter Two. A qualitative, descriptive, exploratory, and contextual design was used to analyse the training curricula that was used for training of the peer educators, as well as to explore the thoughts and feeling that peer educators have about their training.

The setting was selected through random sampling of the three selected sites that fitted the study's criteria.

The population consisted of peer educators who provide peer education in the field of PMTCT. The population size of peer educators who had received training in PMTCT and had been working in the field for at least six months was 13.

Purposive sampling was used for data collection and continued until saturation was achieved. The final sample size was 9.

Data were collected by individual semi-structured interviews with peer educators.

To ensure trustworthiness, Lincoln and Guba's principals of trustworthiness were used. The peer educators were invited to a focus group, whereby they could confirm the findings from the individual interviews, as well as an opportunity to correct or add any further information.

The ethical considerations that were implemented for this study included obtaining ethical clearance from the Medical Committee for Research on Human Subjects at the University of the Witwatersrand. Written consent was obtained from the Department of Health and Welfare in order to conduct the research in a public hospital. Permission was granted by the Academic Hospital where the research was conducted. Written consent was obtained from all peer educator

participants in the study, for participation in the interviews as well as for tape recording.

1.10 CONCLUSION

The background to the study, and the aim and the significance of the study were set out in this chapter. The research question aims and objectives were outlined with an explanation of the operational definitions. The research methodology is briefly covered in this chapter, and fully explained in Chapter Two.

CHAPTER TWO
METHODOLOGY

2.1 INTRODUCTION

In this chapter the following aspects of the study are discussed: the study design, the setting, population, and sampling. The method used for data collection and analysis is also discussed. The measures to ensure the trustworthiness and all relevant ethical considerations pertaining to this study are all included in this chapter.

2.2 STUDY DESIGN

This research is qualitative, descriptive, exploratory, and contextual in design as it attempts to describe the perceptions of the peer educators about their training. Through their description of their experiences future curricula can be improved to better equip them to perform their role.

2.2.1 Qualitative research

According to Creswell (2009:4) a qualitative study is a way to explore and understand the meaning that a group of individuals ascribe to a human problem. The qualitative design allows the researcher to gather rich in depth information from the participants, by using broad open-ended research questions, as it is concerned with allowing the study participants to express their point of view. The result of qualitative research is achieving an understanding of the experiences of the participants that will lead to new perspectives and insights on the phenomenon being studied (Munhall, 2001:68). It is suitable as a research method for this study, as it has enabled the researcher to explore the thoughts and feelings that peer educators have about the training that they have undertaken, in order to establish what peer educators feel are essential skills that should be incorporated in future training manuals.

2.2.2 Descriptive research

A descriptive qualitative study presents the phenomenon under study as a comprehensive summary in everyday language (Polit and Beck, 2008:237). It requires that the data collection be maintained until data saturation has occurred. Followed by, an accurate transcription and account of the collected data.

2.2.3 Exploratory research

Exploratory research goes beyond just observing and describing phenomena of interest; it examines and provides insight into the full nature of the question (Polit and Beck, 2008:20). In this study it is important to explore and analyse the training curricula of peer educators, in order to gain a better insight into their training, so as to be able to explore their thoughts and feelings with the participants in greater detail. An exploration of the role peer educators play in the health care system is also vital to understanding how their training helps them to fulfil this role.

2.2.4 Contextual research

The aim of contextual research is to produce an extensive description of the phenomena that is being studied, in its specific context (Mouton, 1996). The context for this study is the maternity section of an urban academic hospital where PMTCT is practiced by peer educators.

2.3 SELECTION OF SITE

The identification of a site in qualitative research involves identifying the site or sites that are consistent with the research topic (Polit, Beck and Hungler, 2001:44). The site was purposefully selected by the researcher (Creswell, 2009:185) as it must be able to provide sufficient numbers of potential participants who are knowledgeable in the subject being studied. Access to the site by the researcher must be granted by the site management for the entire duration of the study. The researcher might then need to identify the setting for the study within the selected site. (Polit et al. 2001:44).

In order to be selected as a site for this study certain criteria had to be met:

- The extent to which the site could be generalized to other PMTCT sites, where lay HIV/AIDS peer educators are employed.
- A broad selection of Non-Governmental Organisations (NGOs) who train peer educators must be represented at the preselected site.
- All ethical clearance and permission to conduct the research could be granted by the relevant authorities of the selected site.

The researcher selected three sites that met the criteria and then selected the final site randomly, from the three identified sites.

2.4 CONTEXT OF THE STUDY

The research was conducted in the maternity department of an academic hospital in Johannesburg, where PMTCT services are provided and peer educators are included in the provision of the PMTCT services.

The South African health care system structure consists of four layers namely:

- Level 1: Primary health clinics;
- Level 2: District hospital;
- Level 3: Regional hospitals;
- Level 4: Tertiary (academic) hospitals.

The study setting being, the maternity section, of an academic hospitals, no 'walk in' patients are seen, all patients needed to be referred from primary, district or regional clinics (level 1-3), or a referring doctor. Although in the case of obstetrics, all patients were assessed on arrival at the hospital and referred to outlying clinics if not warranting admission to labour ward, or not identified as a high risk case.

The peer educators are involved in the education and counselling of the pregnant mother at all stages of her pregnancy and post delivery. To ensure reliability and replicability the various areas of care, provided to the maternity patient, have

been individually discussed, below, explaining the role of peer educators in the different areas.

The maternity section is divided into different departments that are all related to the care of the expectant mother and her infant.

2.4.1 Description of the PMTCT Areas

2.4.1.1 The antenatal clinic.

Mothers are referred to this clinic during their pregnancy. The patients are high risk with potential pregnancy complications, and pregnant women under the age of 16 years are also referred to the hospital.

- There are 6 peer educators in this area who are involved with the education and counselling of all the pregnant mothers who attend the clinic. All patients are seen by the peer educators. Patients who do not know their HIV status are encouraged to be tested, and are counselled, pre and post HIV testing. All HIV positive mothers are given PMTCT education and counselling by the peer educators.
- The PMTCT counselling that is provided by the peer educators, in this area includes providing routine HIV information and an explanation of all the PMTCT services available. Couple counselling is offered to patients where possible, to encourage the mother to disclose her status in a safe environment. The mothers are educated about HIV and how to live positively with the HI Virus. They are also educated about CD4 counts and the use of antiretroviral treatment during their pregnancy is explained during the antenatal visit. Safe infant feeding is discussed and the importance of antiretroviral treatment for the infant. The importance of regular clinic visits is also discussed with the pregnant mothers.

2.4.1.2 Maternity admissions

This area is situated near the casualty of the hospital and is open 24 hours a day. All pregnant mothers who are seen in the antenatal clinic, are seen here prior to being admitted to the maternity section of the hospital, or assessed and then

discharged. In this department, un-booked patients (patients who have not registered at any antenatal facility) are also seen by the registered nurses and/or doctors, and assessed. Where possible they are referred to outlying clinics, alternatively they are admitted to labour ward for delivery of their baby.

- No HIV testing is done in this area. If required, the HIV peer educators are called from the antenatal clinic to attend to the patient either in the admissions ward or the labour ward.

2.4.1.3 Labour ward

The patients who deliver in labour ward are all referred from the maternity admissions ward or the antenatal clinic.

- No testing or counselling is done in labour ward. If the patients admitted to labour ward do not know their HIV status they are seen by a counsellor and encouraged to test, in the post natal wards. In exceptional cases, patients may be counselled and tested in the labour ward by the registered nurses or doctors attending the patient.

2.4.1.4 Postnatal ward.

There are 2 postnatal wards in the hospital where the research was conducted.

- HIV counselling is done by two peer educators. One educator concentrates on the unbooked mothers only. The second peer educator concentrates on following up with the mothers who have already been counselled at the ante-natal clinic. Many of the patients are only in the postnatal ward overnight, therefore peer counselling in this environment is usually done with a group of mothers and not individually. The PMTCT counselling in this area involves the establishment of a safe feeding choice for the infant. Information about the importance of the infant follow up clinic visits and adherence to the antiretroviral treatment iss also discussed.

2.4.1.5 The milk room

The milk room is the area where HIV positive mothers who have chosen to bottle feed get a free monthly supply of baby formula.

- One peer educator works in the milk room, where she is involved in supporting mothers in their choice not to breast feed. To ensure that the mothers have an understanding about the importance of mixing the infant formula correctly and maintaining a sterile environment while making the infant bottles. The infant's growth is recorded at each visit.

2.4.1.6 Paediatric virology clinic.

In this clinic the infants are brought in for a PCR (polymerase chain reaction) HIV test at 6 weeks. All HIV positive babies are seen on an ongoing basis as outpatients.

- There are four peer educators working in this area. Peer educators in this area are actively involved in the education and counselling of patients who are starting ARV treatment. As the educators interact with the patients and families for a prolonged period of time, their roles become more complex and the peer educators are involved in couples counselling, nutritional advice, bereavement counselling as well as ARV adherence counselling.

2.5 RESEARCH METHOD

A two phase research method was used for this study. Phase One was a document analysis of the training curricula used by the participants. Phase two was semi-structured individual interviews. Peer educators working in the field of PMTCT at the selected site, were asked if they would be willing to answer questions about the training that they had undertaken in order to be able work as PMTCT counsellors and educators. Prior to the researcher interviewing the peer educators, the researcher asked if she could examine the training curriculum that was used for the above mentioned training.

2.5.1 Population

The population is the entire group of persons that have the common characteristic that is of interest to the researcher (Nieswiadomy, 2008:188). For this research the study population consisted of the total population of peer educators who provide peer education in the field of PMTCT at the large tertiary hospital selected (N=13). The peer educators had to have received training in PMTCT of HIV/AIDS. The final sample size was determined by the data collected and the point where data saturation occurred.

2.5.2 Sampling

In qualitative research, sampling is the process of selecting a small portion of the population to represent the entire population so that inferences to the entire population can be made (Polit and Beck, 2008:339; Miles and Huberman, 1994:27). Appropriateness and adequacy of the sample in qualitative research is important (Morse and Field, 2002:65), as sampling in qualitative research is based on the richness of the data and not the numbers of interviews performed (Munhall, 2001:287). The sample must be appropriate as to provide the researcher with relevant and informed data for the theoretical requirements of the study. Adequacy of the sample is to ensure that sufficient data are available from the selected sample so as to provide a detailed and accurate representation of the phenomenon being studied. The researcher purposively selected interviewees who provided maximum light on the issue being investigated (Henning, 2004:71; Creswell, 1009:178).

Purposive sampling is the method that involves the researcher deliberately choosing who to include in the study on the basis that they are the best people to provide the data for the research question (Parahoo, 1997:233). Purposive sampling does not allow for the findings from the interviews to be generalized to the entire population although the findings should be able to be transferable into another context by the person who reviews the research and studies the conditions, situations and the research procedures described by the researcher in the study, and then assessing if they are useful to other settings (Krueger and

Casey, 2000:203; Parahoo, 1997:240). Thus it is the responsibility of the researcher to describe the sampling method and sample in a way that the reader will be able to assess the usefulness and transferability of the data to other settings.

For this study the researcher identified the areas, at the selected site, where peer educators were employed in the field of PMTCT. The potential participants were identified by the researcher through informal discussions between herself and the peer educators who work in the area of PMTCT. The total sample size of peer educators, who fit the inclusion and exclusion criteria was established as 13.

The inclusion and exclusion criteria, depend on the aim of the study. In all studies an important criteria for inclusion is the voluntary participation of the participants (Holloway and Wheeler, 2009:144) and the willingness to sign an informed consent.

The inclusion criteria were as follows:

- The lay HIV/AIDS peer educators would have to have received training prior to being employed at the site;
- The lay HIV/AIDS peer educators would have to have a minimum of six months work experience in the field of PMTCT;
- The lay HIV/AIDS peer educators would have to be on duty and willing to be interviewed;
- The lay HIV/AIDS peer educators must be willing to sign an informed consent to participate in a semi structured interview.

The exclusion criteria were as follows:

- The lay HIV/AIDS peer educators who have not received any prior training;
- The lay HIV/AIDS peer educators who have been working for a period of less than six months in the field of PMTCT;
- The lay HIV/AIDS peer educators who are not on duty and unable to be interviewed;

- The lay HIV/AIDS peer educators who are unwilling to sign the informed consent.

The final sample was determined by the quality of the data collected. Qualitative interviews build on one another allowing the researcher to develop a broad understanding of the phenomenon being researched. When no new data emerges from the interviews saturation of the data has been reached and the researcher then stops recruiting participants (Parahoo, 1997:291). In this study the final sample was reached at 9 participants.

2.6 DATA COLLECTION

Data collection for this study was done in two phases. Phase One was an analysis of the peer educators training manuals. Phase Two was the individual interviews that the researcher held with the peer educators. Each phase will be discussed in more detail below.

2.6.1 Phase One: Analysis of the peer educators training material.

In Phase One, the researcher addressed the first objective which was to explore and describe the training manuals and curricula that were used in the training of peer educators. The researcher deemed it necessary to have an understanding of the training material prior to conducting the individual discussions with the peer educators, in order to be able to centre the interviews on their training and to establish the impact it has had on their performance.

Three different training organizations were identified by the researcher. These three curricula and training materials were analysed by the researcher, using the researcher developed curriculum analysis guide (Annexure A). The researcher developed the analysis guide based on the recognised components of a formal curriculum. The researcher compared the following in relation to the curricula; the expected learning outcomes, discussion of the subject matter, the method of delivery of the course content, including the practice/theory content, as well as review of the assessment and evaluation methods of the peer educator's curricula. The researcher noted the duration of the training of peer educators, in

respect of the curricula, as literature indicates that often the duration of the course is too short for the content material (Campbell and Scott, 2009:6; IRIN, 2009:1; Lehman and Sanders, 2007:2).

2.6.2 Phase two: Semi-structured individual interviews with the peer educators.

Phase Two was conducted in order to achieve the second objective which was to explore and describe the thoughts and feelings that the lay peer educators have about their training.

The researcher initially approached the peer educators on an informal basis and discussed the subject matter of the study with them. The peer educators were asked if they would consider participating in the study. All the peer educators said that they would be willing to participate. A date and time, for the interview was then arranged between the researcher and the individual participants. Prior to the participant signing the consent form (Annexure B) the researcher, with the aid of an information letter (Annexure C) explained the study and what she hoped to achieve through the interview. The researcher also explained that the interviews would be recorded, and that the participants would need to sign an additional consent form (Annexure D). The data collection method, as well as the approximate length of an interview, was discussed. The researcher explained that they would be invited to a voluntary feedback session in the form of a focus group once all the data had been collected and analysed in order to confirm the findings from the interviews with the peer educators. Participant's written consent for the focus group was signed on the original consent form (Annexure B) as a subsection. Once the peer educators agreed to being interviewed the written consent was obtained from the participants

The researcher conducted semi structured individual interviews with peer educators who were working in the field of PMTCT for at least six months. All of the peer educators who were interviewed had received HIV/AIDS counselling training, eight had also received additional PMTCT training, one educator had not done an additional training course in PMTCT, but the topic had been included in her basic training.

Data were collected for this study through individual semi structured interviews with peer educators working in the field of PMTCT. Data were collected from July to August 2010.

- Individual interviewing

Individual interviewing is a qualitative research method that involves a small number of respondents exploring their perspectives, experiences and expectations of an idea or situation (Boyce and Neale, 2006:3). Semi structured interviews were used as a data collection method.

- Semi structured Interviews

The semi structured interview style was selected for data collection. In a semi-structured interview, the interviewer may use an interview guide (Annexure E) to direct the interview. The interview guide is prepared in advance, containing open ended questions, although the questions may not necessarily be asked in a specific order. The flow of the interview rather than the interview guide determines how and when the questions will be asked. During the interview the researcher explained that the interviewer might engage the interviewee in relevant dialogue rather than just asking the questions from the guide (Bailey, 2007:100).

The interviews were conducted at the peer educator's work environment, in a private consulting room, at a time that was convenient for the peer educators themselves, so as not to interfere with their daily work-load. The researcher put the peer educators at ease by developing a rapport with the educators by discussing local hospital/sporting news prior to starting the interview, the educators talked freely about their perceptions of the training and their roles in the PMTCT clinics. The researcher referred to her interview guide (Annexure E) during the interviews.

The study participants were reluctant to have their interviews recorded. In these cases, to alleviate the participant's discomfort, the researcher took field notes while conducting the interview. As soon as possible after the interviews were

concluded the researcher wrote additional notes, (field notes), including any comments or observations that were considered relevant to the research question. This was done in order to aid recall when the interviews were analysed for themes as well as to add depth to the written report.

All interviews were conducted in English by the researcher. The average length of an interview was 45 minutes, the longest being one hour 15 minutes and the shortest being 30 minutes.

Data saturation is defined by Polit and Beck (2008:70) as the point which occurs when themes and categories in the collected data become repetitive and redundant, and no further new information would be gleaned with additional data collection. Once data saturation was achieved the researcher scheduled no further interviews.

2.6.3 Method of data analysis

The method of data analysis of Phase One and Phase Two are briefly discussed here. The findings are discussed in detail in Chapter Three.

2.6.3.1 Phase One: Analysis of curricula.

The three training manuals and curricula that the researcher obtained from the peer educators were analysed using the researcher developed curriculum analysis guide (Annexure A).

- The curricula were analysed as follows: The researcher studied the manuals by reading them from cover to cover.
- Notes were made by the researcher in relation to the content of the curricula.

2.6.3.2 Phase two: Analysis of peer educator's interviews

Data analysis of the individual interviews in qualitative research involves making sense out of the information gathered. Creswell (2009:184) describes the analysis of the data in three stages, moving from the specific to the general and involving multiple levels of analysis.

- Step 1. Organizing and preparing the data for analysis

  This step involves the transcribing of interviews and writing up field notes. This was done immediately after the interviews were held, so as not to lose any of the nuances that emerged during the interviews.

- Step 2. Read through all the transcribed data

  This is done to get an overall sense of the information as well as to be able to reflect on the meaning of the information, get a sense of the depth of the information, the tone of the replies as well as the credibility of the information collected.

- Step 3. Begin detailed analysis with a coding process

  Coding is the process of organising a large amount of data into smaller segments that when needed can be easily retrieved, for data analysis (Bailey, 2007:127). Open coding was used which is the initial coding of all the data collected, with the view that at a later point, in the process of analysis, further codes might be added, and some changed (Bailey, 2007:129).

2.7 TRUSTWORTHINESS

Various methods are used in qualitative research in order to validate the results of the study (Morse, 1997:227) thus providing a sufficient level of plausibility and confidence in the study.

Trustworthiness is used to describe the degree of confidence (validity) a qualitative researcher has in her data, (Polit and Beck, 2008:768) and the persuasion that the findings of the study are meaningful and worth taking account of (Lincoln and Guba, 1985:290).

Lincoln and Guba (1985:43) developed four criteria, to establish the trustworthiness of qualitative research, namely: credibility, transferability, dependability, and confirmability. These four criteria together with documented

procedures will give trustworthiness to the findings and interpretation of the results of the research.

2.7.1 Credibility

Researchers refer to this as the "truth value" in a study (Miles and Huberman, 1994:276). The researcher has to prove the credibility of the findings to both the reader and the participants from whom the data was obtained. The research actions that were taken to increase the credibility include, triangulation, member checking and the authority of the researcher. Each method will be discussed in below.

- Triangulation

Triangulation refers to the use of additional sources in data collection, (Silverman, 1993:157; Marshall and Rossman, 1995:145) which will add to the truth value of the findings. Data were primarily collected from the participants in the form of personal interviews. Triangulation was achieved by the introduction of a focus group. All nine participants were invited to the focus group that was held after the data had been collected and analysed into themes. The researcher explained that the reason for the focus group was to allow the participants to confirm, add or alter the data to ensure the accuracy of the findings. Four participants attended the focus group, three members had been involved in the individual interviews and there was one new participant. The themes that emerged from the interviews were discussed by the researcher with the participants, during the focus group. The researcher invited the participants to comment on the findings as to the accuracy in the representation of the essence of the interviews.

- Member checking

This was done by the researcher once individual interviews had been transcribed. The researcher returned to three of the participants individually, with their transcribed interview and asked them to comment on the content, allowing them to correct any statement that they felt had been misinterpreted by the researcher.

- Authority of the researcher

The researcher had completed an academic training in research methodology and was supervised throughout the research process by a supervisor with extensive experience and training in research.

2.7.2 Transferability

This refers to how the findings can be transferred or applied to another setting or context (Marshall and Rossman, 1995:143). The researcher needs to provide sufficient thick description of the data (Lincoln and Guba, 1985:316) in order to convince the reader that the findings are credible, in order for interested persons to be able to reach a conclusion as to whether the findings can be transferred to a similar context.

- Thick description

To enhance the transferability of the study, the thick description involved a detailed written description about the methodological framework that was used in the study. This includes the population and sampling of the site, the context, the design of the study as well as a literature control to support the study integrity.

2.7.3 Dependability

The criterion of dependability refers to the reliability of the data (Polit and Beck, 2008:539). Dependability goes beyond what was discussed in defining the credibility of the study, by describing the process of data collection in detail, to form an audit trail (Lincoln and Guba, 1985:317). The study data were further strengthened by employing a consistent, documented method of data coding and recording.

2.7.4 Confirmability

The concept of confirmability is the concern about the objectivity and neutrality of the research (Shenton, 2004:72). Investigator bias must be proved to be minimal in the eventual findings of the study. Central to this process is the combination of various actions that form the basis of an audit trail (Lincoln and Guba, 1985:320).

- Audit Trail

The audit trail is a documentation of the researcher's decisions, choices and in sights pertaining to the study (Morse and Field, 2002:119).This process includes an explanation of the research process, with a semi structured discussion about the sampling method of the participants, from which the data was gathered. Detailed explanations are also given, about the recording, transcribing and coding of the in-depth interviews.

Field notes are an important part of the audit trail as they place the interview within context (Morse and Field, 2002:119; Lincoln and Guba, 1985:319), by being a detailed, accurate written account of what the researcher hears, sees and experiences during the course of data collection (Morse and Field, 2002:91). Examples of the field notes, together with an example of an interview are included as Annexure F as part of the audit trail.

The coding method used, is described, demonstrating a systematic analysis of the textual data, in order to bring meaning to the information (Creswell, 2009:186). Themes were identified by the researcher, and then placed in similar categories of similar phenomena, which allows the researcher to describe and analyse the raw data.

Triangulation, via the use of a focus group, increases the probability that the findings and interpretation of the data will be found to be credible (Lincoln and Guba, 1985:305).

2.8 ETHICAL CONSIDERATIONS

Researchers involving the use of humans as study participants must guarantee that the rights of these humans are protected (Polit and Beck, 2008:167). It is also the responsibility of the researcher to protect the integrity of the organization or institutions involved in the research process, against misconduct and impropriety (Creswell, 2009:87).

The rights of the study participants, and the institutions, were protected through the following steps been implemented:

- Permission for the research to be conducted was obtained from the Faculty of Health Sciences at the University of the Witwatersrand, on submission of the research proposal (Annexure G).
- Permission was granted from the Medical Committee for Research on Human Subjects, University of the Witwatersrand. Clearance certificate number: M091115 (Annexure H).
- Permission from the Department of Health (Annexure I) and the appropriate hospital management was granted (Annexure J).
- An information letter outlining the details of the study was handed to the participants prior to scheduling interviews. The information letter included the researcher's name and contact details (Annexure C).
- Informed written consent was obtained from all participants (Annexure B).
- Informed written consent was obtained for the use of the tape recorder (Annexure D).
- Participants were informed of their right to withdraw from the interview or the focus group, at any time and with no penalty to themselves.
- To ensure the privacy and confidentiality of the participants, the names of participants were not mentioned in the final report.
- Anonymity and confidentiality were also assured in that the tapes were kept under lock and key, and erased immediately after being transcribed.
- The foreseeable harms by participating in this study were not perceived to outweigh the possible benefits for peer educators.

2.8.1 Ethical Consideration for individual interviews and tape recording

All participants were asked if the session may be recorded on a portable tape recorder. If the participant agreed to the interview being taped then the following steps were taken:

- An additional consent form was signed by the participants for the use of the tape recorder (Annexure D).
- The participants were assured that the recording would remain under lock and key until all data was analysed.

- Participants had a full understanding of what the topic to be discussed was and the expectations hoped to be achieved.
- The data collected from the interviews was made anonymous and had no references to individuals.
- The participants were able to review the data before the research report was finalised.

2.8.2 Ethical consideration for the use of a focus group for triangulation

All the study participants were invited to the focus group, in order for them to be able to evaluate the data collected from the interviews. Prior to conducting the focus group the following steps were taken by the researcher:

- Informed written consent was obtained from all participants, either on the original consent form or on a new form.
- The participants were given an explanation of the reason for needing a focus group.
- The researcher established that they had an understanding of the topic to be discussed.
- It was explained that each other's point of view will be shared with each other in the group, the participants were encouraged to keep what they hear confidential and within the group only.
- The data collected from the group would remain anonymous and not have any references to individuals in the group.

2.9 SUMMARY

This chapter gave a detailed discussion of the study design, an explanation of the population and sampling technique, and site selection was included. Discussion followed, on how data were collected, analysed and the validity and reliability of the data were insured. The chapter concludes with all the ethical considerations that were relevant to this study.

CHAPTER THREE

RESULTS AND DISCUSSION

3.1 INTRODUCTION

This chapter describes the results from the interviews held with peer educators about their thoughts and feelings towards their training. The researcher first provides an analysis of the training curricula used in their training. This provides the reader with the contextual background to the study. An analysis and discussion of the individual interviews follows, together with supporting literature.

3.2 TRAINING CURRICULA

Objective One was to explore and describe the training manuals and curricula that were used in the training of lay HIV/AIDS peer educators. The results of the findings are discussed in detail in this section. Although the content of the curricula were not PMTCT specific, the principles of PMTCT were discussed in all the curricula studied by the researcher.

Quinn (2007:107) describes a curriculum as a training programme, which is a plan or design upon which educational provision is based and consists of four components:

- Formulating student learning outcomes,
- Discussion about the subject matter to be covered in order to achieve the learning outcomes,
- Teaching and learning processes are defined, and
- Defining the assessment method to assess that learning has taken place.

The three different curricula were analysed for the above components of a formal curriculum. The principles of adult education were also considered.

The principles of androgogy (adult education) are relevant as all peer educators have previous knowledge and experiences that will contribute towards the learning environment. According to Mellish, Brink and Patton, (1997:396);

- Adult learners are more self-directed than children, in their approach to learning. Adults can identify their need to learn, and are able to set their own learning objectives.
- Adult learning objectives are formulated through tasks and problems encountered in their everyday life as well as in their work experience.
- Adults will want to be able to apply their new knowledge and skills immediately, therefore the curriculum should have an approach to being task centred together with a relevant problem solving component.

Adults learn effectively when they fully participate in the learning experience. Adults learn collaboratively, by identifying their learning needs and interacting with fellow participants through the sharing of life stories and role playing (ICAP, 2009: xv)

The proportion of theory to practice content was also noted. Peer educators apply their theoretical knowledge in the practical environment, as part of a health team, where they use and develop their interpersonal, social and communication skills, while educating and counselling patients (Meyer, 2008:84).

In line with the literature reviewed for this study, the three curricula analysed, had very different styles of delivery. Campbell and Scott (2009:6), and Lehman and Sanders (2007:4), noted that peer educator programmes differ considerably in their duration, style and approach to training. The problem arises that without curricula standardization and clear guidelines or minimum standards relating to lay health workers training, (Dohrn et al. 2009:S25; IRIN News, 2009:2) the quality of the outcomes of peer education training is often inconsistent.

The detailed analysis and discussion of the training curricula follows. Data analysis of the peer educator's training curricula was achieved with the use of the curriculum guide (Annexure A) developed by the researcher, in line with the literature reviewed earlier.

3.2.1 Curriculum A

This curriculum appeared to be a generic ad hoc curriculum for use by health care workers working with HIV/AIDS patients, resulting in parts of the curriculum not being relevant to peer education and counselling. In particular sections of the curriculum were designed primarily for medical students, with a large technical component, which appeared to have no relevancy to patient education and counselling.

- Duration of the training: This curriculum was run over a five-week period, and the learners attended lectures every day. There was no provision made for learner follow up and supervision in the practical environment.
- The expected learning outcomes were not identified in the curriculum. Without the learning outcomes or objectives being identified, it is difficult to evaluate the success of the programme. Learning objectives and outcomes as an adult learner should be identified by the learners themselves, firstly by a diagnosis of learning needs, then the formulation of the learning objectives, (Quinn, 2007:30). Evaluation of learning was then performed against the specific learning objectives being achieved.
- Theory/practice content: This was a theoretical curriculum.

  The module's headings in the curriculum were:

  - Types of counselling;
  - Sexuality;
  - Nutrition and healthy living;
  - Listening roadblocks;
  - HIV and ARV's (PMTCT was included in this module); and
  - Course evaluation sheet.
- The methods to attain curriculum outcomes were mostly in a didactic form, with lectures. This curriculum had a large lecture content, which was verified by the note taking of a learner. The researcher observed that the notes taken by the peer educator, who was trained using this curriculum, were clearly

written and comprehensive, in relation to counselling, listening and educational skills.

The practical aspect of the peer educators training in this curriculum was achieved through role playing. There was no opportunity provided to interact with patients in the real life situation.

- The assessment/examination of competency was summative, on completion of the curriculum. This was achieved by a written test and the practical component was assessed through a role-playing scenario. (This information was given verbally to the researcher by the participant, as it was not documented in the curriculum).

  On completion, the learners received a Certificate of Attendance in HIV/AIDS counselling.

The researcher's analysis of Curriculum A

This curriculum, not being specifically developed for peer education and counselling, resulted in it not being consistent with a formal educational curriculum, and appeared to lack relevant goals and learning outcomes. Literature reviewed for this study suggests that curricula should be specifically developed for community health workers (Lehman and Sanders, 2007:4). This is achieved by the stakeholders being identified in the planning stage, by performing an in-depth situational analysis. Through participation and consultation of peer educators in the planning, this will result in the ownership of the programme by participants (MacDowell, Bonell and Davies, 2006:26).

This curriculum was entirely classroom based, with no follow up or mentoring of the learners once they had completed the course. Afterwards the learners need to rely on other peer educators or health care professionals to guide and mentor them, in the work environment, as they will lack practical experience. Supervision is not always therefore possible, as often people are busy with their own work-loads. Bhattacharyya, Winch, Le Ban and Tien (2001:23) in their study on community health workers, found that programmes that are too theoretical and

classroom based are often inadequate, but training that happens in an environment where there are hands on real life experiences with patients and a trainer, are more effective. Using peers to train peers is also an effective way of ensuring that the training is relevant to the community in which the peer educators will be working.

Assessment and evaluation, is an integral part of a curriculum, as it provides feedback about what learning has occurred in relation to the learning objectives. In this curriculum the learning objectives or expected outcomes were not identified therefore assessment cannot be a systematic or planned evaluation of the learning objectives, achieved by the learners (Meyer and van Niekerk, 2008: 149). Therefore learners could only be awarded the Certificate of Attendance, due to the lack of formal assessment and evaluation criteria of the learner's performance.

3.2.2 Curriculum B.

This curriculum was designed for HIV/AIDS counsellors specifically, it was a full time course which the learners attended lectures every day.

- Duration of the training, the course was run over a two-month period.
- Theory/practice content; this was a theoretical curriculum, although the students were followed up in the clinical area after completing the theoretical training.
    - The module headings were:
        - Self awareness;
        - Listening skills;
        - Counselling skills;
        - HIV knowledge (PMTCT was included in this module); and
        - Medication adherence counselling skills for antiretroviral therapy.
- The expected learning objectives were identified at the beginning of each, module. The assessment of the learner was achieved through written

exercises, that the learner had to complete, relating to the learning objectives. An example being, completing the end of an open sentence:

"Counselling skills involve....."

"What I have learned from the above scenario is....."

- The methods to attain curriculum outcomes included participatory training methodologies of reflective exercises, scenario teaching through role-playing and case histories were used that encourage the learner to learn from one another, through sharing of life experiences (ICAP, 2009: xv).

Short didactic lectures were given as an introduction to a new module. This is appropriate when the goal is the transmission of new knowledge or information (Egger, Spark and Donovan 2005: 79). In androgogy, the learners then built on this new knowledge by applying their previous experiences to the new knowledge acquired in class.

Role-playing was used often in this curriculum as a learning strategy. Role-playing is an effective form of learning because through the previous experiences of the learner being applied in the role playing relevance is given to knowledge (Forest and Peterson, 2006:120).

- The assessment/evaluation of competency was both formative and summative. The formative assessment was performed during the course in the format of learner's self- evaluation. At the end of each module the learner had to write a brief paragraph on a scenario, stating what they had learnt, as well as questions where the learner had to fill in a missing word, recapping knowledge learnt in the module. The summative evaluation, on completion of the curriculum was a written paper, either an essay and/or multiple choice questions, together with a student evaluation in the clinical area.
  On completion the learners received Certificates of Completion and Attendance.

The researcher's analysis of Curriculum B

In the introduction to the curriculum, the learners were asked to critically evaluate themselves during the course. Self evaluation, as a part of adult education, allows the learner to engage in deliberate thought about what has been taught, allowing for reflection on the subject and a process of internalizing the facts. It is an integral part of lifelong learning (Field, 2010: 89).

Another request made in the introduction of the curriculum, was for the learners to maintain an atmosphere of openness, trust and acceptance. For adult learners to share their experiences they need to believe that they will not be judged or stigmatized by the other learners in the class. This is especially relevant in the field of HIV/AIDS where discrimination and judgement of people is still an everyday occurrence. The learners, as HIV positive people, might have experienced this themselves and be reluctant to expose themselves to further discrimination. It is therefore important at the beginning of any interaction to establish an environment of trust and openness.

An awareness of the relevance of peer educator's experiences, through their own experiences with living with HIV together with a process of sharing and providing feedback between each other, enables them to understand the complexities of people living with HIV/AIDS and facilitates them in assisting the mothers in making healthy choices through their own life experiences. Quinn (2007: 29) describes this as an atmosphere conducive to learning. The learner is actively involved in the learning process through reflection of his own experiences (Beard and Wilson, 2007:15).

Role-playing was used as a learning strategy, which is an appropriate method in this curriculum. In addition the role playing scenarios were presented with a role playing checklist for the peer educator to consult during the activity, in order to guide the interaction. This enhances the learning experience as the learner has a structure, identifying the critical points that she can refer to during the role playing session.

The check list for the role playing scenario of a patient receiving his/her HIV positive result from a peer educator, included the following steps;

- Inform the client that their results are available;
- Provide results;
- Review the meaning of the results;
- Allow time for the client to absorb the results;
- Explore client's understanding of the results;
- Assess client's coping skills;
- Acknowledge the challenges and
- Discuss living positively.

The assessment and evaluation component to this curriculum was strengthened by both the inclusion of assessment in the learner's clinical area, thus providing the learner with feedback on her practical skills, providing a form of practical supervision. As well as the formative assessment requesting the learner's to reflect on what they had learnt at the end of each module, reflection on learning that has occurred, by the learner is an integral part to lifelong learning, as it makes them aware of their strengths and weaknesses (Mellish et al. 1997: 227).

3.2.3 Curriculum C

This curriculum for HIV/AIDS has been accredited with the Health Workers Sector Education and Training Authority (HWSETA) at a National Qualifications Framework (NQF) level 4 and therefore had a more formal structure than the other two curriculums that were analysed for this study. The role of the HWSETA is to provide an appropriate skills development strategy, in an attempt to bridge the skills gap, as well as to monitor the standard of education and training within the health care sector.

- Duration of the course: This HIV/AIDS curriculum is run over one year; the learners attended training (theory) for one week a month and practical training in their work environment for 3 weeks. The PMTCT curriculum was run as an individual module for peer educators and counsellors already working in the PMTCT area. The educators were taken out of their work environment for a

week (theory) and then had a week's practical with supervision in their work environment.

It was not a prerequisite requirement for learners to have completed the full time accredited counselling course, but it is a prerequisite that learners had PMTCT experience in order to be accepted onto the PMTCT training module.

For the duration of the theoretical part of the module learners had the opportunity to interact with other counsellors who may be working in a different health care facility. This allowed for the sharing of different experiences and a more diverse learning opportunity. Interaction between CHWs also plays a great motivational role, as the CHWs feel part of a community and can mutually reinforce each other's commitment to making a difference (Bhattacharyya et al. 2001:24).

The following aspects of this curriculum were noted:

- The expected learning objectives are clearly identified at the end of each module pertaining to the subject matter.
- Theory/practice content: this curriculum, both in respect of general HIV/AIDS counselling and the PMTCT module, had clearly defined theory/practical components.
- Methods to attain curriculum outcomes: facilitating methods of instruction are used, namely group discussions and role play.
  Group discussions are used as a teaching method in androgogy, where the learners can share their experiences and problem solve as a collective unit.
- Assessment/evaluation of competency: assessment of learning was done on completion of the module, in the class room environment, as a knowledge-based written test.

The practical assessment will be attained through the completion of a Skills Log Book, that required the witnessing and signature of a supervisor observing the learner performing the skill. The learners needed to submit their Portfolio of Evidence in order to complete the module.

On completion of the year course in HIV/AIDS learners received a Certificate of Competence, documenting the NQF level attained as well as the credits awarded to them.

On completion of the PMTCT module the learners received a Certificate of Completion.

The researcher's analysis of Curriculum C

This curriculum had all the components of a formal curriculum. Learners who completed this course, had a qualification that would allow them further progression into the field of Higher Education. The opportunity to develop a career path, based on their experience and training, is cited by Schneider (2008: 7) as a motivational factor in CHW as reasons for applying to become peer educators and counsellors,

The learners who were trained using this curriculum all expressed their satisfaction with the theory content, but they felt that the practical part of the curriculum was lacking in supervision and monitoring.

Literature indicates that supervision and mentorship of peer educators on site, is vital to peer education programmes, due to the limitations of the training that they have received and the short duration of their training (Adamchak, 2006:13; Campbell and Scott, 2009:5; Daniels et al. 2010:2; Morris et al. 2009:6; Population Council undated:iii). The supervision and mentoring part of a peer educator's curriculum is as important as the theoretical part, and should be structured into the planning phase of the curriculum. Task shifting was often informally applied and peer educators often had to take on additional clinical responsibilities that needed their ongoing guidance, education and supervision (Morris et al. 2009:2).

3.3 DATA ANALYSIS METHOD OF INDIVIDUAL INTERVIEWS

The second objective was to explore and describe the thoughts and feelings that the lay peer educators had regarding their training. Nine participants were interviewed, the demographic details of note are, eight of the participants were

female with one male participant. The ages of the peer educators ranged from the youngest being 25 years old with the oldest participant being 45 years old. Four of the peer educators had a matriculation certificate and the remaining five all had Grade 11.

Data analysis of the individual interviews in qualitative research involves making sense out of the information gathered. Creswell (2009: 184) describes the analysis stage in three stages, moving from the specific to the general and involving multiple levels of analysis. A detailed explanation of the process of the data analysis was provided in Chapter Two.

Five themes emerged from the data, and five sub themes emerged these are illustrated in Table 3.1

Table 3.1 Themes and sub-themes

Themes	Sub-themes
1. Training increases knowledge	
2. Updates are important	Supervision and support from nurses
3. Role playing teaches you confidence	
4. Thoughts about what should be included in the content of a peer education programme	Bereavement counselling Home based care Tuberculosis knowledge Nutritional information
5. Government should be responsible for the training	

3.4 RESEARCH FINDINGS AND LITERATURE CONTROL

The five themes that emerged from the data collection will be discussed in detail.

The actual participant's quotes are in italics, and the number in brackets refers to the participant number. Participants were randomly assigned a number for the

process of analysis, this number then appears, in brackets, at the end of the participates quote.

3.4.1 Theme one: Training increases knowledge

Eight of the nine participants in this research study were HIV positive themselves, while one of the participants had HIV positive family members and she was actively involved in their care. In the discussions they all said how the training had increased their own knowledge of the virus and helped them cope better with living positively.

> *"The training helped me know about my status" (9).*

> *"The best thing about the training - it builds confidence and gave information on HIV" (1).*

Peer education curricula should be designed to acknowledge and build on the existing knowledge of the trainees, through the personal experiences that they have already experienced as people living with HIV (ICAP 2009:xv). Training of mothers who are HIV positive makes them important educators while their experiences makes them credible advocates and powerful role models (mothers2mothers, 2006:5).

Through their own experiences of being positive they have an understanding of effective ways to educate other expectant mothers.

> *"Training was more than good, it gave us knowledge, we learnt to share information and learnt respect for others" (3)*

Although one participant had reservations about how well she had been trained, she expressed it in these terms:

> *"The training was good, it gave me a lot of information" (2).*

Then she went on to expand on her thoughts by saying:

> *"I'm not trained sufficiently, I need to tell the Moms the real thing not what I have heard from someone else. You learn your job from the Sisters" (2)*

This participant was referring to how the formal health care providers, mainly the registered nurses, have become her source of educational material, especially regarding new initiatives and information.

> *"Training was good enough – it gave me strength" (4)*
>
> *"In training we learnt to share information, knowledge. We learnt respect" (3)*
>
> *"Training helped us get the skills. A lot of the training was around VCT we were taught how to deal with the emotions"*

A lot has been written about designing peer education programmes from the bottom up, involving the peer educators in the design of programmes to ensure that the needs of the community are met (Colton et al. 2009:4; Campbell et al. 2008:163). Meaningful participation by the community in planning of HIV programmes, facilitates the information being "translated" into action plans relating to their own lives (Nair and Campbell, 2008:164) contributing towards meaningful learning.

Peer educators are trained to provide health education, counsel patients on ARVs and adherence, plus other HIV related issues, they also record patient demographic information, in some circumstances they are trained to record height and weights and basic vital signs using digital equipment (Campbell and Scott, 2009:3; Morris et al. 2009:3). PMTCT peer educators are trained to provide counselling services to the mother, education about the importance of infant feeding options, adherence counselling and education for the mother and her infant as well as to assist families with disclosure counselling.

In conclusion, participants felt that their training built confidence and increased their knowledge of HIV/AIDS, which they could apply to their own lives.

3.4.2 Theme two: Updates are important

When asked about the value of the update courses, or referred to as refresher courses all the participants commented on the value of the refresher courses. The participant's comments were:

"Worthwhile" (1)

"Important to have" (5)

"We need them" (3)

"We need debriefing, we went once it was good, and we came back strong like soldiers!" (5)

One participant felt that updates were very important although she had not been on any update courses.

"No-one tells us about updates, everything changes all the time" (2)

Lehman and Sanders (2007:4) suggests that refresher courses are just as important as the initial training. If refresher courses are not available, then acquired skills and knowledge are quickly lost. There is strong support for ongoing training that involves refresher courses and advancement sessions (Adamchak, 2006:13; Campbell and Scott, 2009:6). Peer educators learn the most while they are working, with patients. Ongoing supervision, monitoring and refresher courses would ensure that they are performing to programme goals, as well as providing the opportunity to inform the educators of new information updates and technical support for new interventions (Adamchak, 2006:15; Daniels et al. 2010:2; Morris, et al. 2009:6). On-site training, with practical sessions, together with the active inclusion of the multidisciplinary team and the peer educators, would assist in the process of task shifting thus improving the overall improvement of the quality and continuity of PMTCT programmes (Colton et al. 2009: 32).

3.4.2.1 Role of trained nurses in the peer educators training

A sub-theme that indicated that there is a need for refresher courses was the role that the registered nurses and doctors in the clinical area, play in updating and

teaching the peer educators. From the interviews conducted, all the peer educators said that they learnt a lot from the registered nurses that they worked with and how they can move into a nursing role when required.

> *"(They) have taught me a lot, almost 10 years; I am really like a Nurse now, when the Sisters are sick I have learnt to run the clinic." (5).*
>
> *'The Sisters in this clinic teach us, we have good staff' (8).*
>
> *"I have learnt through the Doctors and Nurses, by listening in"(2).*
>
> *"Nurses think they are Doctors then who are the Nurses? When Nurses are short staffed they need us" (7).*
>
> *"Everything changes all the time, then you don't know, but you learn from the Sisters" (9).*

Programs for community health workers thrive when there is a good relationship with other members of the health team (Campbell and Scott, 2009:7). ICAP (2009:32) makes a similar point that the active involvement of hospital staff, for practical supervision improves the overall quality and continuity of PMTCT. Schneider et al. (2008:5) found in their study that the majority of professional nurses were positive about the contribution from community health workers in regard to counselling and education, but expressed their fears about delegating sensitive tasks, to a relatively untrained cadre of health workers. Although as Campbell and Scott (2009:5) noted, in some instances where nurses are taking primary responsibility for management and supervision of the peer educators, they often respond to this burden by transforming the lay health worker into a nursing assistant.

Supervision and support of the peer educators (community health workers) is essential due to the brief training that the peer educators have received (Campbell and Scott, 2009:5; Lehman and Sanders, 2007:2). Training should not be done in isolation without the necessary follow up through mentorship and supervision in the work environment. Also, their training is too brief for the large amount of subject matter (Morris et al. 2009:3). Continual mentorship will improve

peer educators contribution to health care, but unfortunately this appears to often be the weakest link in the community peer education programmes (Lehman and Sanders, 2007:5). The WHO guidelines on task shifting suggest that extra workers should be hired in a supervisory capacity (WHO, 2009:32).

In conclusion the peer educators expressed their perceptions of the importance of updates and refresher courses. They commented on registered nurses being particularly important in providing the new information in the absence of updates and refresher courses.

3.4.3 Theme Three: Role-playing teaches you confidence

The researcher asked the participants about how they were taught and which mode of delivery they felt best suited their learning.

Seven of the participants said role-playing was included in the training and the peer educators felt that it was their preferred learning method.

"I learnt a lot role playing" (4)

"Role playing I learned too much" (5)

"Role playing is better than supervised teaching" (9)

"Role playing taught us to see inside the patient, not just the outside" (8)

Role-playing is an ideal way of teaching health education that should be built on real life situations (Mellish, 1997:131), it is a way of creating a reality in a learning situation, that a discussion on a subject can't do (Visser, Mundell, de Villiers, 2005:340). Role-playing is also a way of creating empathy between two different points of view, after some initial self-consciousness the student can then project her own character on to the role that will form the basis for later debriefing and experiential learning (Quinn, 2007: 256).

Role-plays offered the peer educators a chance to practice their counselling skills. An emotion that was expressed often was that they felt they were not

confident to educate or counsel women but through role playing they gained in confidence.

"I was initially shy but role-playing teaches you confidence" (3)

Two of the participants preferred formal classroom lectures; they felt that they gained the most knowledge through this form of learning. One peer educator expressed the opinion that factual knowledge was learnt better in this format.

"Classroom, best with a teacher you can ask questions and get answers" (7)

Both formal (core) lectures and role-playing are essential parts to a peer educator's curriculum. The purpose of a lecture is to convey information to the learners (Quinn, 2007:223), which in peer education would include the technical facts about HIV/AIDS and PMTCT. Role-playing as mentioned above offers the student an opportunity to practice their counselling skills, but it is important that the student has the necessary facts in order to counsel and educate accurately. Peer educator training needs to focus not only on how to impart the HIV/AIDS information but on how to engage the audience in problem-solving dialogue, this will empower them to be able to make the right health decisions in order to live positively.

In conclusion, role-playing is important when teaching education and counselling skills, as it is a participatory form of teaching that helps the learner practice their required skill, as well as building confidence in the learner. Core lectures are important for the imparting of new information and knowledge that forms the basis of all HIV/AIDS programmes.

3.4.4 Theme four: Thoughts about what should be included in the content of a peer education programme.

Four subjects emerged from the data collected, in reply to the question of what the peer educators thought should be included in their training curriculum. They include: bereavement counselling, home based care, tuberculosis knowledge, and nutritional information. They will now be discussed in detail.

3.4.4.1 Bereavement counselling

Bereavement counselling was mentioned by four of the counsellors that were interviewed. Due to the nature of PMTCT, the counsellors/educators clients are often inter generational, bereavement counselling should be geared towards the possible loss of a child, a mother or a grandparent.

> *"We are not trained for trauma and bereavement counselling, we are trying but parents die, children die it is very stressful" (5)*

> *"We don't know where to start with bereavement counselling.... the mother's hearts are bad, they give their baby's ARV's but not for themselves" (6)*

The researcher explored the role of the social workers in the role of bereavement counselling, the peer educators felt that often their clients were reluctant to consult the social worker as they had build up more of a rapport with themselves and did not want to involve a new person.

> *"We try to refer to the social workers for trauma counselling, but the clients feel safe with us, then want to stay" (6)*

Peer educators also have to deal with the loss of their community members.

> *"I have lost three neighbours, as they would rather die than test" (5)*

Peer educators and counsellors may experience bereavement overload (van Dyk 2009: 300) which occurs when the peer counsellor is relentlessly exposed to loss and death, without an opportunity for debriefing, and not sufficient support being available, burnout could lead to the educator leaving her position.

3.4.4.2 Home based care

Peer education by definition should be community based; they are members of the community where they work (Dickinson, 2010:88; ICAP, 2009:2-5; Schneider et al. 2008:2). They are well known members of their community, and are often involved educating, caring and supporting community members outside of work.

The participants in this study felt that aspects of home based care, should be included in future curricula in order for them to help their communities.

"Home based care is important for me, for follow-up" (3)

"The mothers are in the hospital for one night, we need to know about problems that can happen at home, so we can answer the questions" (2)

With the issue of task shifting becoming more embedded in health facilities, peer educators have become more facility orientated and away from the community-focused health care. Both Campbell and Scott (2009:9) and Schneider et al (2008:2) talk about the need for peer educators, although facility based to still be able to provide their communities with basic health care. One study participant expressed her need to be able to assist her community by saying:

"The community knows you are a counsellor they ask for advice" (3)

3.4.4.3 Tuberculosis knowledge

People living with HIV/AIDS are more at risk of contracting tuberculosis (TB) than those without HIV/AIDS (Partners in Health 2010: Unit Three). TB accounts for one third of AIDS related deaths worldwide and an infection of TB may accelerate the progress of HIV into AIDS (USAID, 2009). Peer educators who see mothers on an ongoing basis may be the first to notice TB symptoms or non compliance with TB treatment, thus they need a comprehensive HIV/AIDS and TB training to be able to identify mothers at risk. The peer educators, who were interviewed for this study, identified the following aspects of TB knowledge as lacking in their present curricula:

"We need to be included in TB programmes in order to protect ourselves" (5)

"People have TB and we need to know in order to be able to help them" (9)

"Side effects of TB drugs" (8)

Peer educators, being part of the community are well placed to be able to identify possible new TB infections in the community and facilitate early referral and diagnosis.

3.4.4.4 Nutritional information

This theme was mentioned by three of the peer educators, who felt that nutritional advice should be included on a more practical level. Knowledge about nutritional assessment and intervention is important for the peer educator to be able to offer practical food guidelines (DoH, 2009b). Nutrition is not specific to HIV/AIDS support and education. It is a community issue especially in marginalized areas where poverty plays an important part in the patient's nutritional status.

> *"General nutritional guidelines are given, but they are not practical in the peer education experience. What if the patient can't afford healthy food? Then What?(1)*

> *"We tell the patients about healthy eating but their bodies don't respond to it, then what? We don't have dieticians here" (9)*

> *"Nutrition is important to teach people how and what type of food they are supposed to eat" (3)*

In some PMTCT work environments the peer educators are weighing the infants and offering feeding advice, which includes the use of infant percentile charts and the evaluation of the results. This task includes the well being of the mother, if she has chosen to exclusively breastfeed. It also provides a platform for nutritional education during the contact with the client.

The subjects that the peer educators highlighted as needing to be included in future curriculum, are very relevant to the care and treatment of all people living in South Africa, not only people HIV positive people. Knowledge and the ability to educate about home care, combined with TB and nutritional knowledge can improve the quality of life of the community members. In South Africa, with life expectancy of 51 years (DoH,2010) bereavement counselling is an important part of community care.

In conclusion the peer educators felt the bereavement counselling, home based care, tuberculosis knowledge and nutritional information are all important in the role as educator, as their roles are not limited to the work environment, but carry over into the community where they live, and community members ask their advice.

3.4.5 Theme five: Government should be responsible for training

All the participants said that Government should be involved in the training of peer educators and not leave the responsibility to NGOs. Community health worker's programmes need careful planning and active government leadership to be successful (Lehman and Sanders, 2007:1).

> *"It would help us if government gave the training, we would be better informed about initiatives. Doctors and Nurses get the training; we just get the new consent forms for HCT (HIV counselling and testing) – no training" (1)*

> *"If government did the training we would be better informed and get a proper certificate" (8)*

Peer education has been on the margin of the health system, and although the state has been the driver in funding the development of community health workers they have not been incorporated into the civil service as formal employees. Community health workers do not have the same employment rights as other health workers, but are expected to work regular hours (Schneider et al. 2008:2).

> *"We want to be able to move from Lay health educators to Professional health educators, we need a clear picture of where we are going in the next 2 – 5 years the government must give us direction" (8)*

The peer educators interviewed for this study felt that they had no opportunity for advancement in the health system and that this would not change without Government getting more involved in their training. This could be achieved by a standardization of training and curricula at basic and advanced levels, allowing

for progression and creating a perceived fairness in the distribution of opportunities for entry into the formal health sector (Dohrn et al. 2009:S29; Harvard School of Public Health (Education Systems) 2009; Schneider et al. 2008:7).

> *"This is the problem with NGOs they go and then what? We should all be trained to move up, with NGOs you go no further" (9)*

Peer educators feel vulnerable because of the possibility that if the NGOs who are involved in the training and support of peer educator programmes, were to leave the country where they are active, the peer educators said that they might not feel that their training is transferable as there is no clear policy governing the training and minimum standards expected of health workers and peer educators (IRIN, 2009). The base of the health care structure is also at risk if health care management is relying on volunteers, this system is not sustainable as CHW often leave due to their perceived lack of recognition by the formal health care sector (IRIN 2009; Schneider et al. 2008:6).

Thus government needs to invest in training and absorbing these community health workers into the formal health care sector, improving their training, working conditions, remuneration and recognizing their contribution to health care.

3.5 CONCLUSION

This chapter has given an account of the findings of the researcher both of the analysis of the peer educator's curriculum, in terms of formal curriculum principles, as well as principles of androgogy. The findings from the individual interviews with the peer educators then followed, with supporting literature. The researcher has used the findings from this chapter in the development of a PMTCT peer educator specific curriculum that is discussed in Chapter Four.

The researcher found it surprising that there were no boxes of free condoms available in the consulting rooms, although there are condoms freely available in the reception areas. The researcher felt that if condoms were available in the consulting room, the peer educators could include a discussion on the importance

of protection as part of PMTCT education, stressing the importance of the family planning clinic follow up visit. Bundling activities such as VCT counselling and family planning and condom use during pregnancy, would improve the quality of the PMTCT education.

CHAPTER FOUR

A PMTCT PEER EDUCATOR'S CURRICULUM

4.1 INTRODUCTION

A curriculum is, as described by Meyer and van Niekerk (2008:49) a plan or outline of a course of study; it is a scientific, accountable, written document containing selected, ordered and evaluated content, as well as the didactic considerations that are instrumental to the realisation of the set and selected outcomes of the study course. Meyer goes on to state that the aim of developing a curriculum is a way to ensure that educational institution are accountable for all its educational activities and learning opportunities that are generated for learners.

The peer educator PMTCT curriculum that is presented in this chapter is based on the findings from the research conducted, and aspects of the three curricula that were analysed in the document survey that the participants felt were of value in their training. The researcher also included aspects of peer education that were relevant to the study through a literature review of existing works.

The latest definition of peer educators by the World Health Organization (WHO, 2008:79) has documented the importance of lay health workers curricula being standardised and nationally endorsed. Therefore this PMTCT curriculum is guided by the regulations and guidelines of SAQA (South African Qualification Authority) whose function is to oversee the implementation of the NQF (National qualifications framework) outcomes.

4.2 NATIONAL QUALIFICATIONS FRAMEWORK

The findings in this study indicate that peer educators wanted their training to be standardized and accredited; this would be achieved through a NQF accreditation, allowing them to be able to progress in the health care profession.

The NQF is a quality assurance system (Vasuthevan and Viljoen, 2003:5) with the development and registration of standards and qualifications. The NQF facilitates education and training being brought together with the learners being able to move between education, training and the work environment. It is based on a credit

system, whereby the learner in order to be awarded credits is assessed against clearly defined standards (Meyer and van Niekerk, 2008:12), allowing the qualification to be nationally recognized, as well as internationally comparable (Meyer and van Niekerk, 2008:15).

The curriculum resulting from this study would be in accordance with the requirements for registration with the NQF as a unit standard for PMTCT peer education. A unit standard is a set of standards that are grouped coherently within a context to guide both the learners and the educators to achieve specific outcomes (Vasuthevan and Viljoen, 2003:57).

4.3 THEORETICAL FRAMEWORK

Peer educational programs draw on various theoretical approaches to shape interventions (Adamchak, 2006:6). The methods adopted in peer education vary considerably, and are guided by the expected outcomes of the education session. In some instances formal tutoring in a class room situation is used and in some situations informal group discussions in an unstructured setting may be appropriate (Turner and Shepherd, 1999:235).

Androgogy, as discussed in Chapter Three, is the basis of peer education as the peer educators draw on their past experiences as a person living with HIV, or their experiences with HIV community members, and their role as educators and counsellors in the community. These experiences will be the basis for acquiring new knowledge, within the PMTCT field.

A theory that is often cited when discussing peer education is the participatory education theory, which was proposed by Paulo Freire in 1970 (Adamchak, 2006:6; Colton et al. 2009:3) This theory states that empowerment and full participation of the people affected by a given problem is a key to behavioural change (FHI, 2009:16). Thus true empowerment can result from full participation of the individuals affected by the problem (Colton et al 2009:3). Participation of the peer educators in developing and managing peer education curricula, will empower them to take ownership and responsibility for their role in the health care system.

Peer educators have credibility in their community, (Colton et al. 2009:3; Dickinson, 2010:26; ICAP 2009: xv) and this enhances their effectiveness as educators. Two

educational theories that use the position of the individual in the community to enhance learning are:

- Social Learning theory. This theory claims that role modelling is an important part of the learning process, if the educator has credibility and/or high status in the community the greater the influence (Turner and Shepherd, 1999:238)
- The Diffusion of Innovation Theory. This explains how community leaders can become agents of change by disseminating information and influencing group opinion and norms within their community (Colton et al. 2009:3; Turner and Shepherd, 1999:243).

4.4 SITUATIONAL ANALYSIS

The need to develop a PMTCT specific peer educator's curriculum, has arisen through the HIV/AIDS epidemic which has placed increasing pressure on existing health care workers, who in turn through task shifting have been handing over additional tasks and responsibilities to peer educators. This study investigated the thoughts of these peer educators about their training and established the need to develop a PMTCT specific curriculum, that can help them cope through training, with these additional health issues (Chopra, Doherty, Jackson, Ashworth, 2005:362; Lehman et al. 2007: 1; Morris et al. 2009: 8). It is important that the curriculum can be accredited with the relevant Educational and Training Quality Assurance Body (ETQA).

A situational analysis provides the context of the unmet educational needs of the peer educators. It will also need to provide information on the health needs of the community that the peer educators serve.

This study forms part of the situational analysis, the researcher did not undertake to do the entire situational analysis as it was beyond the scope of the study's objectives. The following section includes elements of the situational analysis that would need to be included in the curriculum planning.

It is essential to have an understanding of the PMTCT context in South Africa, to learn from previous projects and to avoid replication of strategies that haven't been successful therefore, knowledge of any already existing HIV/AIDS policies and strategies in South Africa should be pre requisite in the planning of future curricula.

In 2009 the Accelerated roll-out plan for PMTCT of HIV/AIDS was launched, a curriculum developed at this stage would have to be congruent and include the philosophies, aims and implementation of this national plan.

In order to fully understand the educational needs of the peer educators and the health needs of the community, an in depth observation of the existing health care facilities and services would need to be undertaken. This would be achieved by:

- Discussions with the relevant health authorities serving the specific area.
  - This will identify the socio-economic status of the community. As both the trainers and the learners will be from the local community.
  - Assist in ensuring the relevance of the curriculum to the health needs of the population.
  - Prevent any duplication of services.
- Spending time with peer educators in their place of work observing and asking relevant questions.
  - Assessment of participant's background and experience of HIV/AIDS.
  - Understanding the educational needs of the peer educators.
  - Identifying existing knowledge and the knowledge gap of the learners.
  - Knowing what other support /referral systems are in place for PMTCT peer educators, e.g. Social Workers or dieticians.
  - Ensuring that the curriculum is practical in the intended environment.
  - Understanding the needs of the patients, with specific attention to the PMTCT aspect of their care.
  - Observing the needs of their families and partners, and including their health needs in the curriculum for the peer educators.
- Collaborating with local NGOs, FBOs and CBOs that are involved with the delivery of HIV/AIDS prevention, care a treatment in the PMTCT field, as they will be likely partners and stakeholders in the delivery of peer education.
- Engaging with the managers of the health facilities where the curriculum will be utilized.
  - To establish the time frame for teaching in the work environment.
  - The budget allocated for teaching.
  - Identifying the clinical leaning facilities that are available.

- The traditional healers and community leaders must be included in the planning process as they are often aware of the social, political and environmental factors that must be considered when planning a curriculum for the needs of their community.
  Traditional healers are involved in the health of the community, and therefore need to be involved in the curriculum planning.

The researcher recommends that an in depth situational analysis be performed in order for the PMTCT curriculum to be accredited.

4.5 Ownership of the Curriculum

According to the principles of androgogy, participant involvement in the development of a curriculum is essential. Peer education programmes are vulnerable if not driven, owned by and firmly embedded in the community (Lehman and Sanders, 2007:5). Peer educators must be involved with the decision making and be given broader responsibilities when it comes to programme design, implementation and evaluation (Population Council: undated: 13).

4.6 OUTLINE OF CURRICULUM

4.6.1 Title

A curriculum for peer educators working in the field of PMTCT

4.6.2 Level on NQF

NQF level (Still to be determined)

4.6.3 Notional Hours/Credits

- Per Week: Contact hours: 6 hours (per week/module). These will be done consecutively, once a week for twelve weeks.

  Notional hours: 34 hours (per week/module)

  NQF Credits: 4 credits (per week/module)
- Practical notional hours will be done at the learner's place of work.
- Assessment will include self assessments throughout the module and a formative assessment on completion.

4.6.4 Purpose of the curriculum

This curriculum is designed to equip peer educators, with the relevant knowledge, skills, attitudes and values to effectively educate and council expectant mothers and fathers on PMTCT of HIV.

This module is intended for all those peer educators working in the field of PMTCT of HIV/AIDS based in health facilities, working for NGO's FBO's or CBO's.

4.6.5 Learning assumed to be in place

- Basic communication skills;
- Basic writing skills;
- Basic counselling skills; and
- Basic knowledge of HIV/AIDS

4.6.6 Recommended reading list

Department of Health (2010) The national Guidelines for the prevention of mother to child transmission of HIV.

Harris C., (2010) The prevention of mother to child transmission of HIV. Juta: Cape Town.

Van Dyk A., (2008) HIV/AIDS Care and Counselling. A multidisciplinary approach. Fourth edition. Pearsons Education. South Africa.

4.6.7 Range statement of module

The following scope and context applies to the entire module:

Peer education by peers in the specific field of PMTCT in a health care facility or a community clinic. The intention is to encourage positive choices, enhance health seeking behaviour and promote an empowering environment. It includes but is not limited to, targeted interventions, sustained engagement and ongoing support and education.

4.6.8 Outcomes and Assessment Criteria

Specific Outcome 1

Identify and describe the roles and responsibilities of the peer educator in the field of PMTCT, to the mother, family and multidisciplinary team.

Assessment Criteria 1

- A definition of peer education is supplied
- A definition of PMTCT is discussed.
- Identify key concepts of PMTCT, with regards to reducing the risk at every stage, pre birth, during birth and post delivery. The use and importance of ARV's during PMTCT.
- Identification of multidisciplinary team, and their roles.
- Acquire basic nursing skills which may include, but not restricted to taking patients vital signs, weighing patients with accurate recording and reporting, where necessary.

Specific Outcome 2

Plan and facilitate a PMTCT peer education session.

Assessment Criteria 2

- Demonstrate counselling skills through active participation in the learning environment; this would include role-playing, and sharing experiences.
- The acquisition of sound knowledge in PMTCT
- Knowing and understanding the barriers to PMTCT, and developing strategies to help the client overcome these barriers.

Specific Outcome 3

Integrate non-HIV related health issues into peer education sessions, in order to offer a comprehensive education and counselling session.

Assessment Criteria 3

- Knowledge of other health issues that HIV infected people may experience, would include tuberculosis, an awareness of the signs and symptoms,

information about treatment and the side effects, and would assist the peer educators to refer when necessary.

- Knowledge of how to maintain a healthy lifestyle, goals to be identified within the patient's context including nutritional advice.
- Demonstrate knowledge of family planning methods and the use of condoms, with referral to a family planning clinic when appropriate.
- Knowledge of practical guidelines to assist with bereavement. These include verbal, and non verbal communication skills, listening skills and a referral system when needed.

Formative assessment will be achieved by:

- Ongoing supervision and assessment of the learner in the work environment, by the facilitator, is essential to ensure that learning has occurred and that the curriculum is yielding optimum results.
- A portfolio of evidence. The learner will be given guidelines on formatting their portfolio of evidence.
- The learner will be assessed through various activities during the course of the module; the facilitator will discuss the assessment with the student prior to it occurring.

Summative evaluation of the learner is through a theory (test) and practical (demonstration) format on completion of the module.

Learning objectives, that were identified in Module One, together with the preset learning objectives, are assessed on completion of the module, and determined as to whether they were met. Finally the learners are offered an opportunity to give feedback on the course, to ensure that future courses cover all their learning needs.

4.7 CONTENT MAP

The modules are designed around the principles of androgogy, where the learning needs of the participants are determined in the first module through student input. Experiential learning will contribute towards the learning experience. Each module contains an activity that involves the learners sharing their past experiences and building on this with new knowledge.

The facilitator will provide core lectures when required, but will assist the participants by guiding the group by actively listening, encouraging the participants to reflect on ideas, in terms of relevance and appropriateness (Mellish, 1997:75).

The modules are organised in topics, working from the known to the unknown. The role and responsibilities of the peer educator are discussed, HIV/AIDS as an epidemic is covered in terms of the effect it has had on communities, families and individual. PMTCT as a subject is covered under the headings:

- Introduction to PMTCT;
- Key PMTCT concepts;
- PMTCT services;
- Barriers to PMTCT; and
- The use of ARVs during PMTCT

The curriculum also looks at the role of the peer educator in the multidisciplinary team and at the community's referral system, in order for the educator to be able to interact and refer patients when required, in the provision of holistic management of their patients.

Tuberculosis is covered in a module, peer educators need to be able to tackle health issues that are part of the TB epidemic as PMTCT patients often present with concurrent TB infections, and will be requiring education when being counselled.

Nutrition is a vital part to healthy living, and the module on nutrition covers food gardens, with a case study being presented. The educator should be able to refer her patient to access a food parcel if necessary.

Bereavement and psychosocial support will be discussed in a module. PMTCT bereavement counselling needs to include the loss of a child or parent, which is stressful for the counsellors to deal with without coping strategies. It is the belief that many peer counsellors and educators neglect their own psychosocial needs, concentrating on their patient's grief and loss. Through this model anawareness will develop to address these needs.

Assessment and evaluation of both the curriculum and the learner are covered in the final module. Establishing if the learning objectives in module one were realised.

The learners are also asked for their feed back in the curriculum, and how they feel it could be improved. Details of each module follow:

MODULE 1 – Introduction to counselling

Contact Hours: 6 hours

Notional Hours: 34 hours

1. Aims

The aim of this module is to get to know each other, and introduce yourselves. As well as to provide a framework for the course, by setting the ground rules and identifying your collective objectives and learning needs. By understanding that all the participants have a wealth of pre-existing knowledge, as a group you need to draw on these experiences to make this course a collaborative learning experience. Due to the nature of the course and the subject matter there is a need to stress the right's of each other and patients to confidentiality, and that information shared in group discussions remains within the group.

2. Specific learning outcomes

On completion of this module the learners should be:

- Comfortable to be able to work, contribute and share experiences and knowledge, within the group environment
- Be able to identify what we all hope to achieve at the end of the course.
- Document your learning objectives, in order to be able to refer to them during the duration of the course.

3. Assessment of Competence

3.1 Practical Competence

- To be able to talk freely and confidentially to each other, through familiarity.
- To document the group's learning objectives.
- To understand the importance of sharing past experiences to facilitate learning.

4. Methodologies

- Pair-share, to pair up with your neighbour, introduce yourselves to each other, and then introduce your partner to the group;
- Large group work and brainstorming learning objectives.

MODULE 2 – HIV/AIDS overview in South Africa

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

The aim of this module is to assess the participant's baseline knowledge of HIV/AIDS, to facilitate the learner building new knowledge on their previous experiences. To be able to understand the context of HIV/AIDS within South Africa, and the social economic and political effects that HIV has had on the communities. A discussion about the relevant policies and strategic plans of PMTCT, and identifying their priorities and implementation strategies: and the involvement of the lay peer educator, counsellor or community worker in the challenges.

2. Specific learning outcomes

On completion of this model the participants will have:

- An understanding of the history of HIV/AIDS, and how health issues are affected by the past management of the epidemic.
- Knowledge about the DoH aims for grassroots-level of participation in PMTCT programmes.
- Be able to understand the relevance of PMTCT programmes within the South African national HIV/AIDS policies.

3. Assessment of competence

3.1 Practical competence

- To demonstrate an understanding of the effect of past HIV/AIDS policies on the families and communities;
- To have an awareness of campaigns and community communication strategies that will support the peer educator's messages to their clients.

4. Methodologies

- Trainer presentations, about DoH policies and strategies.
- Small group work, to develop a poster for communicating to their community some of the DoH policies and aims.
- Role-playing, a discussion with a sceptical community member about the DoH strategies for the HIV epidemic.

MODULE 3 – Roles and responsibilities of Peer educators in PMTCT

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

The aim of this model is to define and understand the roles and responsibilities of lay peer educators, with special attention to PMTCT. To be able to identify members of the multidisciplinary team, and what their roles are perceived to be.

2. Specific learning outcomes

On completion of this module the learner will:

- Be able to define what a lay peer educator is;
- List qualities of a good peer educator;
- Understand the roles of lay peer educators in PMTCT; and
- Be able to identify members of the multidisciplinary team and how the team works together, including the lay peer educators.

3. Assessment of competence

3.1 Practical competence

- Reflect back to their individual journeys with HIV and what made them want to become lay educators, write a paragraph on this subject for their portfolio of evidence;
- List and identify the team members in the multidisciplinary team, create a referral system for possible referrals e.g name of the dietician.

4. Methodologies

- Guest speaker (lay peer educator working in PMTCT);
- Case study presentation, to demonstrate the positive role of lay HIV peer educators in PMTCT; and
- Small group work, to share their journey with HIV, with each other, and to discuss their hope for the future.

MODULE 4 - Introduction to PMTCT

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

The aim of this module is to introduce the learner to the concepts of PMTCT and why the need for PMTCT to be a specialized subject. This module will examine the vulnerability of women to HIV, identify ways women can protect themselves and their families, and to offer support for those women who are already infected.

2. Specific learning outcomes

On completion of this model the learner will be able to:

- Define the objectives of PMTCT:
  - Prevent transmission of HIV through an uptake of PMTCT preventative programmes;
  - Prevent transmission of HIV in child bearing population through behaviour change implementation;
  - Understand the importance of the use of condoms to prevent further exposure to the HI Virus; and
  - Improve the quality of life and survival in HIV infected women and families.
    (Tanzanian District Health Services: 2003)
- Discuss the impact of HIV/AIDS on women in the community; and
- Discuss possible measures to get partner involvement in PMTCT

3. Assessment of Competence

3.1 Practical Competence

- To be able to discuss the issue sorrounding the vulnerability of women in the community;
- Be able to use and explain abbreviations in the correct context;
- Analyse the key policies that guide PMTCT services in South Africa; and

4. Methodologies

- Trainer presentation, overview of PMTCT;
- Small group work, to discuss the status of women in the community; and
- Role playing, a scenario involving a woman who is worried about her husband's reaction to her positive status.

MODULE 5 – Key PMTCT concepts

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

The aim of the model is to equip learners with a thorough knowledge on the key concepts of PMTCT, to enable them to assist and educated women in the PMTCT programme.

2. Specific learning outcomes

- Discussion of the concepts of PMTCT (ICAP, 2009: 7.5):
  - Healthy Mothers;
  - Reduce the risk of infection at every stage:
    - During pregnancy, labour and delivery;
    - Infant feeding practices;
  - All moms will need ARVs;
  - All babies of HIV positive moms will need ARVs;
    - Importance of follow up post delivery;
    - Understanding the reason why all infants need to be tested at 6 weeks and 2-3 months if breastfeeding; and
    - Importance that her infant is vaccinated.

3. Assessment of competence

3.1 Practical competence

- Be able to explain the importance of the women/community understanding the need to being healthy before becoming pregnant:
  - VCT, family planning and information about STIs;
- Have formulated retention strategies for women in the PMTCT programme during and after labour:
  - Linking the mother to support groups, and other agencies that offer help;
- Be able to educate as the mother about care of her infant and herself post-delivery; and
- Being able to explain the concepts of exclusive breast/bottle feeding and mixed feeding and why it is important for the mother to adhere a feeding method.

4. Methodologies

- Trainer presentation, concepts of PMTCT;
- Case study, of two mothers, one on a PMTCT programme and the other not;
- Demonstration of preparing a bottle feed, and role playing.

MODULE 6 – PMTCT Services for home based care.

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

The aim of this model is to inform learners about the range of PMTCT services that are available to assist in providing home based care for new mothers in the community. It is important for the peer educator to realise that effective care and support of HIV positive people and new mothers, requires a continuum of care between hospital based facilities and community based services. Hospital and clinic based peer educators need to be able to refer patients to services that will support and educate the mother and infant within their home community.

2. Specific learning outcomes

On completion of this module the peer educators will be able to refer her patients, to the relevant services.

- Be able to list the services that are available to patients, including:
  - Mothers and women support groups at community level;
  - Self-help groups, and how to start one;
  - Food distribution; and
  - Social and legal support;
- Identify the procedure necessary for referrals;
- Be able to access advice, even though a referral is not necessary;
- Be able to follow up with the patient after referral.

3. Assessment of competence

3.1 Practical competence

- Draw up a resource map for the area where the peer educator practices;
- Create and inventory of all community based resources;
- Demonstrate knowledge of the referral procedure necessary for effective referrals;
- Be able to receive referrals from outside agencies and
- Be able to follow up with patients that are referred.

4. Methodologies

- Group work; brainstorm all relevant resources that are available in the community.
- Discuss possible problems that a new mother might have when she returns home from the clinic, as well as possible solutions.

MODULE 7 – Barriers to PMTCT

Contact hours: 6 hours

Notational hours: 34 hours

Aims

The aim of this module is to inform and educate learners about the factors that prevent the uptake of PMTCT services and account for the high dropout rate from programmes.

2. Specific learning objectives

On completion of this module the learner will be able to:

- Identify the societal, economic, cultural factors which affect the uptake of PMTCT;
- Discuss how health care workers attitude can also be a barrier to PMTCT;
- Discuss how the counselling facility, may be inadequate and do not offer privacy and confidentiality to the patients;
- Understand the role of good quality counselling in effective PMTCT programmes; and
- Discuss different approaches to the issues around fear of disclosure in the case of a positive test result.

3. Assessment of competence

3.1 Practical competence

- Strategies that can help a mother to disclose her status to a family member or friend, for ongoing support;
- To formulate strategies that will overcome the community's negative perceptions of PMTCT;
- Through role play demonstrate counselling skills that encourage mothers to stay within the PMTCT health care system, by identifying the reasons why she is reluctant to return for counselling; and
- Awareness of the quality of counselling and the transference of incomplete knowledge, and mixed messages that does not address the mother's needs.

4. Methodologies

- Group discussions, sharing their experiences with stigma and discrimination as reasons that patients do not return for follow up; and
- Role-playing, helping a mother to disclose to her partner her positive test result.

MODULE 8 – Antiretroviral therapy in PMTCT

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

The aim of this model is to educate the learners about the importance of ARV therapy for both mother and baby in PMTCT.

2. Specific learning outcomes

On completion of this module the peer educators will be aware of the role that ARV's play in the PMTCT of HIV/AIDS, and be able to demonstrate:

- An understanding of types of ARVs used for PMTCT;
- An understanding of why ARV therapy will be initiated with the mother;
- To explain to the mother the importance of continuing with the ARV therapy as specified by the doctors;
- To explain to the mother why her baby will need ARVs after the birth;
- The role of Bactrim, as part of the therapy for both mother and baby;
- The importance of the follow up visits; and
- Be able to discuss the possible side effects of the ARVs.

3. Assessment of competence

3.1 Practical competence

- To be able to discuss with their clients, topics that are related to the use of maternal and infant ARV's which would include:
  - Information about the infants ARV regimen;
  - Knowledge about the importance of the correct dosage of ARVs;
  - Be able to demonstrate how to administer the baby's ARV medication;
  - To explain possible ways that the mother can reduce the side effects of her ARVs..

4. Methodologies

- Trainer presentation;
- Large and small group work; and
- Demonstration of the ARVs that will be used by the mother and those needed by her infant.

MODULE 9 - Nutrition Education

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

The aim of this module is to enable to peer educators to be able to encourage healthy eating, to enhance their patient's health, whether they are ill or healthy.

2. Specific learning outcomes

On completion of this module the learner will have an understanding of:

- Good nutrition is part of the HIV care and treatment, pre-ARV, clients on HAART, expectant mothers, and HIV infected infants and children.
- Reason why good nutrition is important:
  - Makes a healthy body that can fight infection;
  - Helps the absorption of medicines and helps reduce the side effects of ARV's;
  - Helps pregnant and breastfeeding mothers stay healthy; and
  - Helps HIV infected children grow.
- Reasons why patients may not be eating healthy:
  - Poverty, and loss of an income due to illness;
  - Problems eating, mouth ulcers diarrhoea and vomiting;
  - Side effects of ARV may alter the taste of food; and
  - Depression and isolation due to the illness

3. Assessment of competence:

3.1 Practical competence

- Help patients understand that good nutrition is part of their comprehensive care plan;
- Help patients learn what food is locally and seasonally available that is affordable that can be eaten as part of their balanced diet;
- Knowledge about food gardens;
- Ability to create a food garden, by devising guidelines; and
- Be able to refer the patient for food packages, where necessary.

4. Methodologies

- Interactive trainer presentation;
- Guest speaker (dietician);
- Case study: Food gardens; and
- Small group work.

MODULE 10 – Tuberculosis and HIV

Contact Hours: 6 hours

Notational hours: 34 hours

1. Aims

The aim of the module is to equip lay peer educators working in PMTCT with the required knowledge about Tuberculosis (TB), in order for them to be able to include TB education and counselling in their practice, as TB can affect up to a third of mothers requiring PMTCT education (Partners in Health 2010)

2. Specific learning outcomes

On completion of this module the learner will have:

- Knowledge of prevention, treatment, side effects and risk factors for TB;
- Knowledge about the effect of TB on a person infected with HIV;
- Skills to be able to include the adherence of TB drugs when discussing ARV adherence; and
- The knowledge to refer patients to TB facilities when appropriate.

3. Assessment of competence

3.1 Practical competence

- To be able to integrate TB counselling and care into PMTC, where applicable; and
- The ability to liase with the TB services.

4. Methodologies

- Group work to explore existing knowledge of TB;
- Interactive trainer presentation; and
- Role playing, acting signs and symptoms.

MODULE 11 – Bereavement and psychosocial support

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

To discuss the general guidelines of bereavement counselling, which include the process of bereavement. Acquiring an awareness that bereavement might extend not only to the loss of a loved one, but to the loss of one's health as well. Special attention will be paid to the loss of a child or parent. Develop an awareness that counsellors may also experience grief and know the importance of regular debriefing sessions.

2. Specific learning outcomes (Van Dyk, 2009:300)

- Be able to explain what bereavement is;
- Be able to discuss the Kubler Ross stages of bereavement;
- Be able to explain the guidelines for bereavement counselling;
- Be able to discuss how bereavement affects Children; and
- Describe different ways to deal with the counsellors own grief.

3. Assessment of competence

3.1 Practical competence.

Write a short diary/journal about one's own experiences of loss and of those around them, mentioning how they felt and what they did to overcome their feelings of loss, coping mechanisms.

4. Methodologies

- Guest speaker;
- Small group discussions; and
- Role playing

MODULE 12 – Evaluation and summary

Contact hours: 6 hours

Notational hours: 34 hours

1. Aims

To establish whether learning has occurred, was the content of the curriculum internalised by the participants to assist them in their roles as lay peer educators in PMTCT. Were the learning objectives that were identified in Module 1 realised. When a curriculum has been completed, evaluation of the curriculum by the participants must occur so that improvements can occur where necessary.

2. Specific learning outcomes

2.1 Practical competence

- Completion of the learners portfolio of evidence;
- To return to module 1, and determine if the participants identified learning objectives have been met;
- Through scenarios be able to demonstrate their learned educational and counselling skills in PMTCT;
- To be able to answer a preset post curriculum test that would assess the learners knowledge of subjects covered during the 12 weeks;
- To have an opportunity to report back on the curriculum, both verbally in the classroom, as well as confidentially through a written report; and
- Follow up and supervision in the work environment by the course facilitator, to offer support and guidance for the peer educator on an ongoing basis.

Methodologies

- Submission of the learners portfolio of evidence;
- Role playing;
- Small group discussions;
- Written work;
- Large group discussions; and
- Ongoing facilitation in the work environment.

4.8 CONCLUSION

This chapter has explained the process of developing a peer educator curriculum that is specifically designed for PMTCT education and counselling. The findings from the study were included in the situational analysis and planning stages of the curriculum. This resulted in a peer education PMTCT curriculum being developed by the researcher that is evidence-based and relevant to the working experience of peer educators in the field of PMTCT.

Topics were included in the curriculum that the peer educators that participated in the study mentioned as important in their work experience. These were: bereavement counselling, home based nursing care, tuberculosis knowledge and information on nutrition. The researcher included the need for family planning advice wherever relevant in the modules, as it is an integral part of PMTCT. Basic nursing skills have not been included in this curriculum, as none of the peer educators that took part in the study mentioned it as part of their work activities.

The researcher applied principles of androgogy, which included encouraging individuals to be able to share previous experiences as a person involved or living with HIV, as well as ,identifying as a group what the learning objectives of the group are, this resulted in a participatory and facilitator orientated curriculum. Supervision and mentorship of the learners, in their place of work is an essential element of any curriculum, this remains true for this curriculum.

CHAPTER FIVE

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

This chapter consists of the researchers conclusions drawn from the findings in Chapter Three. The limitations of the study are also discussed under a separate heading in this chapter. The researcher's recommendations drawn from the findings in Chapter Three are put forward in Chapter Five in the form of a peer educator curriculum specifically designed for the field of PMTCT.

In Chapter Three an account of the research findings from both the analysis of the trainer's curricula as well the peer educator's thoughts about their training were given. The curricula were found to be very different in style, duration and approach to delivery of the material, which is consistent with the literature.

The results from the individual interviews found that the training the peer educators had completed had increased their knowledge of HIV/AIDS and that their counselling skills had been well taught, but they felt that there were opportunities where they could be better trained. All of the participants expressed a desire to be able to progress from being lay workers, and be included in the health care system as more formal health care workers.

5.2 DISCUSSION

As stated in the introduction to the study, due to the impact of the HIV epidemic on the health care facilities in South Africa, and in response to the human resource crisis, the roles of peer educators have expanded (Campbell and Scott, 2009:5; Dickinson and Kgatea, 2008:294). Community health workers and peer educators have become more involved in the care and education of people living with HIV. The role of many lay community workers has shifted away from the community-focused primary health care to a more facility focused health care (Campbell and Scott, 2009:2), where peer educators and counsellors have become an integral part of the interdisciplinary health team. Therefore the

research question that was asked, was do lay HIV peer educators feel that they are being adequately trained and prepared to fulfil their role in the field of prevention of mother to child transmission of HIV/AIDS?

The World Health Organization's policy of task shifting has been adapted to respond to the critical shortage of health care workers and the HIV epidemic, and new cadres of health care providers have been developed. Task shifting has required that certain clinical tasks have been transferred to a less specialized health worker (WHO, 2007:3). The roles of peer educators and community health workers have been affected by task shifting. They have been trained as counsellors and educators but gradually have had more general tasks shifted to them as patient loads have increased (Schneider et al. 2008:5). However this study questions the level of education and training that the peer educators have presently, in relation to their role as PMTCT health care educators and providers.

Analysis of the peer educator's curricula indicates that the peer educators training remains more socially orientated at present. This is evident in the focus on counselling and listening skills that was present in all three of the curricula.

The results of the peer educator's interviews indicated that although their training had increased their knowledge of HIV/AIDS, there were areas that they felt had not been adequately covered in their training curriculum. These were not nursing based skills tasks, but rather broader in depth counselling skills.

The findings from the individual interviews also indicated that the peer educators would like the government, as the major provider in HIV/AIDS care and treatment, to become responsible and manage their training. The end result of this proposal being, that the peer educators would have a nationally recognized accreditation, which would allow for progression into higher education learning facilities. As the wish was expressed in the interviews by the peer counsellors that they would like to become professional educators and counsellors, rather than remain lay educators. Being part of the formal health team would also give them access to benefits and a more market related remuneration.

As the literature suggests supervision and monitoring of peer educators was shown to be a weakness in any community programme (Daniels et al. 2010:2), since community health workers and peer educators were often situated on the periphery of the health care system (Campbell and Scott, 2009:2). This became evident in this study with an ad hoc system of the PMTCT registered nurses becoming the supervisors and mentors of the peer educators. Although the training made provision for refresher courses, this was not enforced, and the peer educators often opted not to attend the refresher of update courses. This could inhibit the development of the educator as they would not be benefiting from updating their knowledge, learning about new initiatives, or being able to interact with educators from different health care facilities, which would provide them with the opportunity to interact and grow from the experiences of other peer educators in different facilities.

The researcher views the absence of family planning in PMTCT peer educator's training manuals that she reviewed, as an oversight and a missed opportunity for maternal education. Women living with HIV/AIDS have a need for family planning, which is not being met by the health care workers in the PMTCT environment, strengthened family planning services would result in better outcomes for both mother and babies (UNAIDS, 2010:78). When the researcher raised the absence of family planning education, with her participants, they unanimously said that they refer the mothers to a nearby family planning clinic and that they do not discuss family planning with their patients during any stage in their interaction. Family planning needs to be included in all PMTCT programmes. With education about family planning methods that are available the mother can prevent further pregnancies, make informed decisions about spacing her children, as well as protecting herself from further exposure to the HI virus. Bundling of activities such as VCT, counselling and family planning would improve the quality of PMTCT education.

5.3 LIMITATIONS

A limitation of this study was that the study was based in an academic urban area. The researcher recognises that the peer educators working in the field of

PMTCT in the rural areas may have additional work experiences that they feel should have been included in the PMTCT curriculum. There is a future need to include consultation with a wider range of peer educators, to ensure that all aspects of peer education are included in the final curriculum, before any curriculum could be formalized.

Another limitation of the study was the language barrier; the peer educators that took part in this study did not speak English as their first language. All the interviews were conducted in English, the researcher when necessary, during the interviews would ask for clarification if she felt that the full meaning of the idea may be misunderstood by herself.

The scope of this study did not include the performance of an entire situational analysis. The findings from the peer educator's interviews form part of a situational analysis, and should be referred to when a PMTCT peer educator's curriculum is developed as part of the National Qualifications Framework and registered with the South African Quality Assurers. The researcher suggests performing a complete situational analysis prior to the formalizing of the PMTCT curriculum.

5.4 CONCLUSION AND RECOMMENDATIONS

If task shifting is to be an effective answer to the human resources shortage in providing health care to HIV patients the limitations of lay peer counsellors training must be kept in mind. With attention being given to their future training and education and ongoing support and monitoring peer educators can become an integral part to the formal health care team.

Training of peer educators needs to be adapted to meet the requirements of task shifting in relation to the extended role that peer educators are experiencing. Peer educators must become more involved in the ownership and delivery of the training material. This study has highlighted the thoughts and feelings of the peer educators towards their training and how they felt the training could be improved.

A process of standardization of the curriculum will allow for accreditation of the training and facilitate access of peer educators to continuing education and more importantly access to become a formal health care provider. This process has begun with providers of peer education training applying for accreditation, of their unit standards with the South African Quality Assurers.

The problems associated with the lack of formal mentorship and supervision, need to be addressed. A programme in Lusaka, Zambia (Morris et al. 2010:2) has implemented a task shifting programme that deals with the training of the technical aspect to HIV/AIDS, in a didactic, class room manner, followed by an intensive period of mentorship in the field addressing the practical and clinical aspects to education and counselling. These trained peer educators then can progress to become mentors themselves for a new generation of community health workers.

As Dohrn et al (2009: S29) in their article on, The Impact of HIV and the time for a new approach, says, "Training and credentialing systems need to be adapted, curricula standardized at the basic and advanced levels, and access to continuing education supported".

This research report can be used as part of the work that is needed to be done in devising a specific peer educator's curriculum that specializes PMTCT.

REFERENCES

Adamchak S., (2006) Youthnet. Youth Peer Education in Reproductive Health and HIV/AIDS: Progress, Process and Programming for the future. Paper 7.

Aids Foundation South Africa: http://www.aids.org.za/hiv.htm (accessed 17/08/2010)

Bailey C., (2007). *A Guide to Qualitative Field Research*. Second Edition. Pine Forge Press: California.

Bhattacharyya k., leBan K., Winch P., Tien M., (2001) Community health workers. Incentives and Disincentives. How they affect Motivation, Retention and Sustainability. Basics II. Accessed: October 2010 http://www.aed.org/Publications/upload/CommunityHealthWorkers.pdf

Beard C., Wilson J., (2007) *Experiential learning: A best practice handbook for educators and trainers.* Second Edition. Logan page Limited. United Kingdom

Boyce C., Neale P., (May 2006) Pathfinder International. Conducting In-depth interviews http://www.pathfind.org/site/DocServer/m_e_tool_series_indepth_interviews.pdf

Campbell C., (2004) Creating environments that support peer education: Experiences from HIV/AIDS - prevention in South Africa. Pre-publication of editorial that appeared in: Health education, 104(4), 2004, pp197-200.

Campbell C., Gibbs A., Maimane S., Nair Y., (2008) Hearing community voices: grassroots perceptions of an intervention to support health volunteers in South Africa. Journal of Social Aspects of HIV/AIDS Vol. 5 (4) 2008.

Campbell C., Scott K., (2009) Retreat from Alma Ata? The WHO's report on Task Shifting to community health workers for AIDS care in poor countries. Global Public Health. Routledge.

Campbell C., (2010) personal e-mail <C.Campbell@lse.ac.uk>; "Re: retreat from Alma Ata" Received; 13/04/2010.

Chopra, M., Doherty, T., Jackson, D., Ashworth, A., Preventing HIV transmission to children: Quality counselling of mothers in South Africa. Acta Paediatrics 2005; 94 357-363.

Colton T., Costa C., Twyman P., Westra L., Abrams E., (2009) Planning Managing and Monitoring Peer Education programs: An Implementation manual. Version 1.0. International Centre for AIDS Care and Treatment Programs.

Community Aids Response: Guidelines (2006) Accessed 25/09/2009 at http://www.care.co.za/index.asp?Content=41

Creswell J., (2009). *Research Design, Qualitative, Quantitative and Mixed Method Approaches.* Third Edition. Sage Publications: California.

Daniels K., Nor B., Jackson D., Ekström E., Doherty T., (2010) Supervision of community peer counsellors for infant feeding in South Africa: an exploratory qualitative study. Human resources for Health http://www.human-resources-health.com/content/8/1/6 (accessed 29/10/2010).

Dickinson D., Kgatea K. D., (2008) Workplace peer educators and stress. African Journal of Aids research 20087(3):293-303.

Dickinson D., (2010). *Changing the course of AIDS. Peer Education in South Africa and its Lesson for the Global Crisis.* Wits University Press. Johannesburg.

DoH: (2008) http://www.doh.gov.za/aids/hiv/task-shifting.pdf

DoH: (2009) http://www.doh.gov.za/docs/hivaids-progressrep.html

DoH: (2009b) http://www.doh.gov.za/docs/misc/hiv/presentation/part1.pdf

DoH: (2010) http://www.statssa.gov.za/publications/P0302/P03022010.pdf

Dohrn J. Nzama B. Murrman M., (2009) The impact of HIV Scale-up on the role of Nurses in South Africa: Time for a new approach. Journal Acquired Deficiency Syndrome 52(1) Supplement 1. 2009.

Dovlo D., (2007) Migration of Nurses from Sub Saharan Africa: A review of Issues and challenges. Health Services Research June 42(3 pt 2) Accessed 17/10/2010) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955380/

Egger G., Spark R., Donovan R., (2005) *Health promotion Strategies and Methods.* Second Edition. McGaw Hill. Sydney.

Family Health International (FHI). Youthnet training materials. http://search.fhi.org/sitesearch.asp?query=training+manuals&Go.x=0&Go.y=0&Go=Go

Field, J., (2010) Life Long Learning. International Encyclopaedia of education (Third Edition)

Forest S. P., and Peterson T.O., (2006) It's called Androgogy: Academy of management, learning and education. (Accessed October 2010) http://www.scribd.com/doc/15336352/Adult-education-Andragogy

Harvard School of Public Health (2009): Peer Education Systems (Accessed 20/09/2009) http://www.hsph.harvard.edu/peereducation/pe_goals.html

Health Systems Trust (2010) Prevention of Mother to Child Transmission Indicators. http://www.hst.org.za/news/20041976 (accessed 27/10/201).

Henning, E., (2004) *Finding your way in qualitative Research.* Van Schaik Publishers. Pretoria.

Holloway, I Wheeler, S., (2009) *Qualitative research in Nursing and Healthcare. Third Edition.* John Wiley and Sons (Blackwell) United Kingdom.

ICAP (2009) Poster http://www.columbia-icap.org/news/posters/Implementers2009/Multi_PE_Manual.pdf

ICAP (2009) Comprehensive Peer education Training Curriculum: Trainer manual.

IRIN PlusNews (2009) Kenya: Can lay counsellors fill the health gap? http://www.plusnews.org/Report.aspx?ReportId=85692 (Accessed 16/08/2009).

IRIN Plus News (2010) South Africa: Who's tracking the world biggest ARV programme? http://www.plusnews.org/Report.aspx?ReportId=89624 (accessed 27/10/2010)

Krueger R., Casey M.A., (2000) *Focus Groups. 3rd Edition. A practical guide for applied research.* Sage Publications. California.

Lehman U., Sanders D., (2007) *Community health workers: what do we know about them? The state of the evidence on programmes, activities, costs and the impact on health outcomes of using community health workers.* Geneva department of Human.

Lincoln Y., Guba E., (1985) *Naturalistic Inquiry.* Sage Publications California.

MacDowell W. Bonell C. Davies M., (2006) *Health promotion practice.* Open University Press. McGraw Hill. England.

Marshall C. Rossman G., (1995) *Designing Qualitative research.* Second Edition Sage publications. California.

Mellish J. M., Brink H., Paton F., (1997) *Teaching and learning the practice of nursing.* Heineman. Johannesburg.

Meyer S., and van Niekerk S., (2008) *Nurse Educator in Practice.* Juta Cape Town.

Miles M., Huberman A. M., (1994) *An expanded Sourcebook. Qualitative Data Analysis.* Second Edition. Sage Publications California.

Morris M. B., Tambatamba Chapula B., Chi, B., Mwango A., Chi H., Mwanza J., Manda H., Bolton C., Pankratz D., Stringer J. S., Reid S. E., (2009) Use of task shifting to rapidly scale-up HIV treatment services: experiences form Lusaka, Zambia. Biomed Central Health Services Research. http://www.biomedcentral.com/content/pdf/1472-6963-9-5.pdf (accessed 28/09/2009)

Morse J. M., (1997) *Completing a Qualitative Project.* Sage Publications London.

Morse J. M, and Field P. A., (2002) *Nursing Research: The application of qualitative approaches. Second Edition.* Nelson Thornes. Cheltenham.

Mothers2Mothers (2010) Communication Initiative network http://www.comminit.com/en/node/267100/347 (Accessed 29/08/2010)

Mothers2Mothers (2006) Annual report. (accessed 30/08/2010) at:

http://www.aidstar-one.com/sites/default/files/g3p_documents/78/M2M-2005_2006_Annual_Report.pdf

Mouton J., (1996*) Understanding social research.* Van Schaik Pretoria.

Munhall P.L., (2001) *Nursing Research. A Qualitative perspective. Third Edition.* Jones and Bartlett Publishers. Massachusetts.

Nair Y., Campbell C., (2008) Building partnerships to support community led HIV/AIDS management: a case from rural South Africa. African Journal of AIDS research. 2008, 7(1).

Nieswiadomy R. M., (2008) *Foundation of nursing research.* Fifth Edition. Pearson prentice Hall. New Jersey.

Partners in Health (PIH) (2010) Model on Line reference tools, resources and guidelines for global health delivery: http://model.pih.org/node/514 (Accessed 25/08/2010)

Parahoo K., (1997) *Nursing research. Principles, Process and Issues.* Macmillan. London.

Polit D., and Beck C., (2008) *Nursing Research: Creating and Assessing Evidence for Nursing Practice.* Eighth Edition. Lippincott Williams and Wilkins. Philadelphia.

Polit D., Beck C., and Hungler B., (2001) *Essentials of Nursing research: methods Appraisals and Utilizations.* Lippincott Williams and Wilkins. Philadelphia,

Population Council. Horizons. Peer education and HIV/AIDS. Past experiences and future directions. (Undated) http://www.popcouncil.org/pdfs/peer_ed.pdf (Retrieved on 09/08/2010)

Population Council. (Accessed 6/11/2010) http://www.popcouncil.org/countries/southafrica.asp and http://www.popcouncil.org/who/about.asp

Quinn F. M., (2007) Quinn's *Principals and practice of Nurse Education.* 5th Edition. Nelson Thornes. London. United Kingdom

Sable M., Libbus K., Jackson D., Hausler H., (2008) The role of pregnancy intention in HIV prevention in South Africa: a proposed model for policy and practice. African Journal of AIDS research. 2008, 7(2)

Schneider H., Blaauw D., Gilson L., Chabikuli N., Goudge J., (2004) Health system strengthening and ART scaling up: Challenges and opportunities. Centre for health policy. School of Public Health. University of Witwatersrand .

Schneider H., Hlope H., Van Rensburg D, (2008) Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. Health policy and Planning Access published April 3, 2008.

Shenton K., (2004) Strategies for ensuring trustworthiness in Qualitative research. Education for Information 22(2004)63-75. (Retrieved on 05/10/2010) http://www.angelfire.com/theforce/shu_cohort_viii/images/Trustworthypaper.pdf

Silverman D., (1993) *Interpreting Qualitative Data. Methods for analysing Talk, Text and Interpretation.* Sage Publications. London. United Kingdom.

Tanzanian Health District Services (2003) Guidelines for Prevention of mother to child transmission (PMTCT) in Tanzania. Ministry of Health. Dar es Salaam Tanzania. http://www.districthealthservice.com/cms/upload/policycat_54_9100.pdf

The Oxford Illustrated Companion to medicine., (2001) Third Edition.

Turner G., Shepherd J., (1999) A method in search of a theory: peer education and health promotion. Health Education research. Theory and Practice. Vol14(2) 1999.

USAID (2010)The twin epidemics: HIV and TB co-infection (Accessed 26/08/2010) http://www.usaid.gov/our_work/global_health/aids/TechAreas/caresupport/coinfection.html

USAID (2009) Aids Epidemic Update/Sub Saharan Africa (Accessed 25/10/2010) http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pd

Van Dyk A., (2008) HIV/AIDS Care and Counselling A multidisciplinary approach. Fourth Edition. Pearsons Education. South Africa.

Vasuthevan, S. Viljoen, M., (Editors) (2003) *Educating For Better Health.* Juta. Landsdowne.

Visser, M., Mundell, J. De Villiers, A. Sikkema, K. Jeffrey, B., (2005) Development of structural support groups for HIV-positive women in South Africa. Journal of Social Aspects of HIV/AIDS Vol 2(3)

WHO (1989) Strengthening the performance of community health workers in primary health care. Report of A WHO Study Group Geneva. Technical Report Series 780.

WHO (2006) Health Services Research: (Accessed 17/10/2010) at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955380/

WHO (2007) Taking Stock: Task shifting to tackle health worker shortages. Health Systems and Services.

WHO (2008) Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines. WHO Press. Geneva. Accessed on: http://www.who.int/healthsystems/TTR-TaskShifting.pdf

ANNEXURE A

Analysis of Peer educators Training Material

The content of the curriculum will be examined establishing:

- Duration of the training,
- Identification of learning objectives.
- The expected outcomes of the curriculum,
- The theory/practice content,
- Methods used to attain the curriculum outcomes,
- The assessment/examination of competency.

ANNEXURE B

Informed Consent for participation in a masters Research Report

Faculty of Health Sciences, University of Witwatersrand.

I Catherine Hilary Thurling, am a masters student in the faculty of Health Sciences at the University of Witwatersrand. I am undertaking a study on peer education, in the perinatal area of healthcare, examining what is taught in peer education and what peer educators are doing in their communities.

As a participant in this study:

- I will interview you, about your training tat you experienced in order to become a peer educator.
- The interview will be taped and the tapes will be kept by myself. Only myself and my supervisor will have access to these tapes.
- You will only be expected to attend one session.
- You will be invited to attend a voluntary feedback session by myself, to verify the text before I submit the report to the University of the Witwatersrand.
- You may withdraw at any time from the interview without penalty to yourself.
- The benefits to yourself are negligible, but to the development of peer education programmes, your input will be valuable.
- Your confidentiality will be protected, I will not be requiring to name my participants.

Please feel free to contact me at Tel 082 555 7003 or my supervisor Candice Harris at Tel 082 879 6528 if you require any further information.

I _____ understand and agree to voluntarily participate in this study to be held on_____ (date)
at_____(place)

Signature_____ Date_____

ANNEXURE C

Are educators working in the field of prevention of mother to child HIV/AIDS adequately trained and prepared to perform their role?

Information Letter

Dear Sir/Madam,

My name is Catherine Hilary Thurling, and I am a nurse presently reading for my Masters degree in the Faculty of Health Sciences of the University of the Witwatersrand and, as part of the degree, I am required to complete a study under the guidance of an experienced researcher.

As someone who is involved in peer education in the field of HIV/AIDS, may I invite you to consider participating in a study that will be looking at the training peer educators receive and the reality of the work that they accomplishing in the community.

Your participation will be completely voluntary, and you will be able to withdraw at any time, without penalty to yourself. If you agree to participate I will be interviewing you and other fellow peer educators, individually, asking you questions related to your experiences in the community, and how you feel the training that you received prior to becoming a peer educator, has helped you perform your job. I will also be asking you to look at ways that training can be improved.

The interview will be taped, and then transcribed by myself. Prior to my research being submitted to the University I will undertake to discuss my findings with you, to verify the content.

The information I obtain in these interviews will be completely anonymous. No names or any identifying information will be written down, only myself, as the researcher and my supervisor will have any access to the transcripts of the interview.

If you do agree to participate in my study, I would require that you sign a consent form permitting me to use the texts of our conversations, in my research report, which will be submitted to the University of the Witwatersrand.

Yours Sincerely

Catherine Hilary Thurling

petert@hixnet.co.za (082 555 7003)

ANNEXURE D

Informed Consent for use of a tape recorder during a focus group for the purpose of a Masters Research report, University of the Witwatersrand.

Thank-you for considering being a participant on peer education in the field of prevention of mother to child transition of HIV/AIDS and the relevant training you received, prior to you becoming a peer educator.

In order for an accurate recording of what points are discussed in our interview, on peer education, and your feedback on the training that you received, I as the researcher will be requiring to tape the discussion at the focus group.

- At no point will you need to identify yourself on the tape recorder.
- The tapes will only be listened to by myself as the researcher, and my supervisor for the purpose of transcribing the essence of the discussions.
- I will ensure that the tapes are kept under lock and key, at all times.
- Only myself as the researcher will have access to the tapes.
- The tapes will be destroyed once the research report is completed and has been examined.

You, as a participant in the study, are required to sign an informed consent form, acknowledging the use of the taping of the interview.

For any further information, please feel free to contact me on 082 555 7003 or my supervisor Candice Harris on 082 879 6528.

I _____ understand and agree to the discussions held in the focus group being taped for the purpose of accurate transcription.

Signed on this day_____

at_____

Signature_____

ANNEXURE E

Interview Schedule

Demographics:

- Age
- Male/female
- Highest qualification achieved:
- How long have you been working as a PMTCT peer educator?

Training:

- When did you complete your training
- How has the training helped you prepare for your role?
  Please explain.
- Have you experienced problems that you feel you weren't adequately trained to address? Please elaborate.
- Have you experienced problems that you feel you were adequately trained to address? Please elaborate.
- Are update training sessions scheduled? How frequently are they offered? How often do you attend them? Do you find them beneficial?
- What do you think should be included in your training to help you perform your role?
    - How do you think your training should be conducted in order for you to gain the most benefit out of your training?
- Is there anything you would like to add to the discussion, that you feel I haven't covered?

ANNEXURE F

Interview with a study participant peer educator.

This interview was done with a peer educator who is working at the research site. She was enthusiastic and willing to talk about her job and her perceptions of how her training had helped her in her job. She was confident appeared happy and had a desire to study social work via UNISA. She had a manner of authority and her colleagues referred to her during my interview with them at a later stage. She attended the focus group as well.

Researcher (R): How old are you?

Peer educator (PE): 40 years

R: What is your highest qualification?

PE: I have Grade 12.

R: How long have you been working in PMTCT Education?

PE: 4 years, before I was working with the adults.

R: When did you complete your training?

PE: In 2001 I did my initial training for 3 months, twice a week for 3 months. There were 45 of us, it was a big class.

Initially there was no clarity (in the training) when I started, after the second week I felt better, and I could do role playing where I learnt too much. For role playing and discussions we were groups of 10 people.

R: How has the training helped you prepare for your role?

PE: The best thing about the training was that it gave you confidence and gives you information about HIV. But being HIV teaches us to go beyond that, listen to peoples, problems, everything, emotional. What can I say (Shrugs).....Teaches us confidentiality and to be positive (pause).

R: Did they teach you about HIV?

PE: Yes! (enthusiastically) They taught us about the virus and CD4 counts. Adherence, counselling and ARV's, healthy life style.

R: Have you experienced problems that you feel you weren't adequately trained to address?

PE: 1st of all, we need to know about trauma counselling, mothers die babies die. We are trying but we are not trained for bereavement and trauma counselling (pause),(reflectively, speaking softly) I myself have lost 3 neighbours; they are scared they come to me in the community, but we are not trained.

At work we should refer to the social workers, but your patients don't feel safe going to the social worker, they want to stay with you.

We need the skills.

We need help with couples counselling.

As more women are positive then men. We need to break the stigma. We educate, but sometimes we don't win, I had a mother who took all her ARV's to commit suicide. (Silence, PE looks out of the window) We educate the mother about feeding, and we let them decide. Still, some don't listen. We try, need to follow up.

R: Have you experienced problems that you feel you were adequately trained to address.

PE : I have done conflict counselling, from my side I stress each and everything.

Disclosure is difficult in PMTCT, assistance to disclose to a partner, when the kids have to start ARV's. The fathers come nowadays; we have started a support group.

We have success testing them, out of nearly 18, 7 tested the same day.

(Silence)

So far, when I assess myself I am more skilled. For me in my case, I am part of the nursing here, when the Sisters are sick. I have seen that they (PE points to the Nurses Station) have helped me. So I give them support and I try and help them.

Weights and correlations, I can do more but I am not trained, but when short staffed I help them.

R: Are updates scheduled? Do you attend them?

PE: Three years ago! It is important to have it. They promise but they don't deliver. We haven't had in-service training for three years, things change they need to tell us. In April they changed to HCT, they should tell us, but

they get in outside people to tell us. We have to find out about the courses, no-one want to tell us. The Sisters teach us.

R: What do you think should be included in your training to help you perform your role?

PE: TB must be included in the curriculum. Patients some have the MDR TB, we need to protect ourselves. Sometimes the Sisters don't tell us. We should work together. We have a too big job for not enough pay. We are not dieticians but we have to talk to the mothers about healthy food, we should be trained.

(Silence)

R: Is there anything you would like to add to the discussion that I haven't covered?

PE: (Silence) No, I enjoy my job too much. But we need benefits and housing, we are not subsidized.

R: Thank-you for sharing this with me, I appreciate your time and honesty. When I have finished interviewing the other peer educators I will ask you to join a focus group, where you will have the opportunity to add or change any of the information that will be used in the report. If you need to contact me I am available on my cell phone.

The interview was then terminated.

ANNEXURE G

ANNEXURE H

ANNEXURE I

ANNEXURE J

Dr Selebano
CEO Charlotte Maxeke Hospital
7 Jubilee Road
Parktown
Johannesburg

30th March 2010

Permission to conduct research at the Charlotte Maxeke hospital

Dear Dr Selebano,

My name is Catherine Hilary Thurling, I am a part-time student in the Department of Nursing at the University of Witwatersrand, reading for my MSc in Nursing Education. I hereby apply for your permission to conduct a qualitative research in the antenatal clinic (Area 157) at The Charlotte Maxeke Hospital.

My proposed research report will look at peer education in the field of HIV/AIDS in the South African context. The purpose of the research is to establish how related the training of lay peer educators in the field of mother-to-child prevention of HIV/AIDS is, to the actual work that they are performing in the communities that they serve. The relevance of this research will be in establishing more effective training guides where peer educators will be better equipped to deal with the broader aspects that are associated with the HIV/AIDS pandemic in South Africa.

With your permission, I will be interviewing peer educators, using in-depth interviews, with the aid of a tape recorder, discussing the training that the peer educators undertook, in order to establish the areas in peer education that need to be included in future training programmes. I will be referring to those peer educators that are working in the Charlotte Maxeke Hospital, in the field of prevention of mother transmission of HIV/AIDS, who are willing to participate in this research, and relating their experiences, to the training that they have received in order to become a peer educator. The confidentiality of participants will be ensured by the resulting report being written with no reference to institutions or people by name.

I will not be approaching patients who are attending the clinic, as my research is only relevant to the peer educators working in the clinic.

I have attached a copy of my research proposal, and the interview guide that I will be using to conduct my focus groups.

Please feel free to contact me at petert@hixnet.co.za alternatively on 082 555 7003, if you have any further questions.

Sincerely,

Catherine Hilary Thurling.