

# Social Capital Representation in Structured Peer Education for Prevention of Mother – to – Child Transmission

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**Abstract:** Women and child with HIV/AIDS deserve protection as included in the third goal of SDGs. This qualitative study with phenomenological approach aimed to study structured Peer Education in social capital-based Prevention of Mother – to – Child Transmission or PMTCT in Surakarta Indonesia. Units of analysis were mothers either infected or not with HIV, Health Service, AIDS Coping Commission and its workgroup, Solo Plus Peer Support Group or PSG, NGO and PMTCT service in Surakarta. Informants were selected with purposive sampling technique, data collection with observation, in-depth interview, and documentation, and data validation with method and data source triangulations. Data of informants' activity and experience was analyzed using interpretative phenomenology with social capital theory. Result showed that mothers either infected or not with HIV become targeted group or peer educators in structured PE for PMTCT. Peer educators recruited peer promoter, trained, and educated their peers, conducted socialization, communication, information, education, treatment, reaching, and facilitation based on norm, trust, and social network. Besides being included in PSG's activities, structured PE was conducted in social and religion activities. Strong social network and link to PMTCT stakeholders become a bridge in and between peer educators and targeted group in PMTCT service, so that HIV/AIDS case in mother and children can be controlled.

## 1 INTRODUCTION

HIV/AIDS is the leading cause of productive age women death and more than 90% of HIV-infected children cases are transmitted by mother with positive HIV (Nguyen et al, 2009; Hardon et al, 2012; Ruton et al, 2012; Koye and Zeleke, 2013). AIDS epidemic feminization occurs because AIDS infects not only commercial sex worker, high risk man, Injection Drug User (IDU), and men who have sex with men, but also housewives. Ironically, they are infected with it by their husbands frequently changing their sex partners. HIV-infected mothers can transmit it to their child/baby through pregnancy, birth, and lactation processes (Darak et al, 2012; Desclaux, 2013; Weiss et al, 2014). This medical social reality should be overcome recalling that children are our next generation.

There are 36.7 people living with HIV/AIDS (PLWHA) up to December 2016 in the world, 17.8 millions of which are female and 2.1 millions are less than 15-year children. In South East Asia there are about 3.5 millions PLWHA and 53% of which

are female (UNAIDS, 2017). In Indonesia, cumulatively there are 232,323 HIV, 86,725 AIDS cases with 14,608 deaths in the period of April 1, 1987 to December 31, 2016. By sex, 48,977 cases affecting men, 27,458 cases affecting women and 10,345 unknown cases. Meanwhile, in risk factor, there are 58,846 heterosexual, homo- 4,034 bisexual, 9,080 IDU, 222 blood transfusion, 2,587 perinatal transmission and 12,011 unknown cases. There are 5,321 AIDS cases in < 19 year-age children. Meanwhile, the number of HIV/AIDS cases in Surakarta reaches 2,428 cases, consisting of 811 HIV, 1,617 AIDS cases with 597 deaths during October 2005-September 2017. By sex, there are 518 (52%) HIV cases affecting men and 39 (48%) affecting women, and 198 (16%) AIDS cases affecting men and 518 (84%) affecting women. There are 154 HIV and 219 AIDS cases affecting housewives, while the Prevention of Mother – to – Child Transmission (PMTCT) reaches only 3799 (35%) out of 10,829 cases targeted (Directorate General CDC and EH Ministry of Health, Republic of Indonesia, 2017).

Peer Education (PE) is beneficial and effective to targeted group, thereby is used to change the health behavior of groups with high risk of being infected with HIV/AIDS and the public (Ford et al, 2000; Leonard et al, 2000; Van Khoat et al, 2003; Medley et al, 2009). PMTCT intervention had been conducted in many countries, but its implementation finds some constraints and challenges, particularly in the term of less optimum environment and society support (Nguyen et al, 2008; Kasenga et al, 2010; Auvinen et al, 2013; Auvinen et al, 2014; Peng et al, 2017; Tamir et al, 2018). Meanwhile, in every society there is a social capital serving to support the smoothness and sustainability of programs and activities including AIDS coping (Smith and Rimal, 2009; Cené et al, 2011; Webel et al, 2012; Iwelunmor et al, 2014). This research is intended to analyze the representation of social capital in structured PE for PMTCT in Surakarta, Indonesia.

## 2 THEORETICAL

The way of coping with AIDS, including PMTCT, is culturally sensitive particularly to HIV status, reproductive health and sexuality. Targeted group tends to disclose the problem more comfortably to the closely related person. Therefore, peer educators are selected from those acceptable to their peer group. They are educated and trained to reach and to facilitate a program's targeted group (Flanagan and Mahler, 1996; Centre for Development and Population Activities, 2003).

PE sustainability will be more effective using structured peer network model. In this model, PE activists prepare an early planned network by recruiting and training peer educators; then peer educators recruit a number of peer promoters, educate and train their peer group with the material they have learnt. Having gotten training, peer promoters recruit peer contact and discuss what they have learnt in the training. Structured PE has group norms including those of preventing risky behavior, improving social network, developing and reinforcing targeted group systematically, training and discussing formally, conducting planned activities to achieve the objective of program, and supervising systematically and facilitating peer educators intensively (Horizons Project, 2007).

The implementation of structured PE for PMTCT is supported by social capital. A collection of resources including strong social

network, familiarity, recognition, and institution in society becomes social capital. Social capital is represented as social network participation, trust, social norm, and reciprocity pattern (Fukuyama, 1995; 2003). Social capital is inherent to the structure of inter-individual relation creating a variety of social obligations and mutual trust, becoming information channel, and determining social norm and sanction to their members. Through social capital, community unites to achieve its objective based on value and norm bonding growing and complied with collectively, so that there is cooperation between those involved in it (Adler and Kwon 2002).

In social bonding capital, individuals affiliated with the group are usually homogeneous, for example, all members of group are HIV-infected women. They are more inward looking in the context of idea, relation, and attention than outward looking, and attempt to maintain the agreed values and to undertake them as a community's code of conduct and code of ethics. Diverse relationship between different networks becomes a bridging of heterogeneous group members with different social cultural backgrounds, thereby constructing relation complexity. Existing constructed trust and norm provides the opportunity of establishing relation with outside world, so that external potency and opportunity of other communities can be accessed. Meanwhile, linking social capital has a weaker and more formal bonding connecting the members of group at different social strata. The members' trust in and obedience to community norm are the key to this social capital (Fukuyama, 2003; Field, 2008; Demartoto et al, 2016).

## 3 METHOD

This qualitative research with phenomenological approach was taken place in Surakarta Indonesia. The target of research consisted of women infected or not infected with HIV, including stakeholders related to PMTCT such as Health Service, Surakarta City's AIDS Coping Commission, and its workgroup, Spek HAM NGO, Solo Plus Peer Support Group (PSG), PMTCT service provider in Dr.Moewardi Hospital and Manahan Public Health Center. The sampling technique used was purposive sampling one. Data collection was conducted through observation, in-depth interview, and documentation. To validate and to test the reliability of data, data source and method

triangulations were used. Data analysis was conducted in-depth using interpretative phenomenology to study the activity and experience of informants conducting structured PE in PMTCT with social capital theory (Moustakes, 1994; Padgett, 2012).

#### **4 RESULT AND DISCUSSION**

Surakarta City's AIDS Coping Commission and its workgroup cooperate with Spek HAM NGO in conducting structured PE. The selected women, either infected or not-infected with HIV, were educated and trained to be peer educator. As peer educator, they obligatorily discuss HIV/AIDS-related topics informally with their peer group. Supervision is conducted to encourage the sustainability of AIDS coping activity, particularly over those who have not been accustomed with discussing about taboo personal matters.

Solo Plus is present to strengthen the mentality of PLWHA newly finding out their HIV status, thereby achieving the better life quality. PLWHA initiates group and meeting, and recognizes their needs. Their activities include study club, seminar/workshop, and HIV/AIDS training. As an independent group, Solo Plus operates in social area and concentrates on empowering, improving life quality and equality of PLWHA. For that reason, Solo Plus employed structured PE model.

HIV-infected women affiliated with Solo Plus become targeted group and peer educator all at once for PMTCT in PSG. They have received knowledge, information and training related to HIV/AIDS prevention earlier than other PLWHA newly joining PSG. Purposive agent is the role assumed by peer educator. Peer educators are authorized to recruit peer promoter and then to educate and train their peer group. They play an important role in giving psychological support to prevent PLWHA's psychological condition from being worse, communicating, delivering information and education related to HIV/AIDS, and treatment and medication, reaching and facilitation including cyber outreach using social media such as sms gateway, twitter, facebook, Whatsapp, BBM, and instagram.

Structured PE for PMTCT is also applied to 51 local residents concerning with AIDS in Surakarta. Peer educator recruitment is conducted directly in the local residents surrounding after a coordination with an area's leader. Training starts with preparation to make peer educators being in

acquaintance with each other and ready to cooperate with program executor; teaching formal knowledge on Sexually Transmitted Diseases and HIV/AIDS; personal development training and certain topics becoming taboo to be discussed; skill; supplementation and assistance.

Then reinforcement training or field training that is participatory in nature such as games, physical exercise and group dynamics and communication ability related to attention and support to PLWHA is provided. Data collection and supervision techniques are employed to help improve motivation for PLWHA. The form and type of supervision and support needed by peer educator is dependent on the type of activities conducted. Peer educator organizing structured PE in large group needs larger supervision and support than those educating peer group only. Meanwhile, evaluation of performance is intended to get input and feedback on the output achieved and peer educator's field experience. Peer educator evaluation is conducted based on post-test sheet that has been filled in, after delivering information and knowledge on HIV/AIDS to peer group.

Peer educator in structured PE contributes to the achievement of PMTCT's objective by means of interacting, cooperating, and coordinating with each other repeatedly and sustainably. All partners in PMTCT give feedback, cooperate, and coordinate with each other among stakeholders establishing network continuously, as they are supported with potential facility and human resource beneficial to everyone.

PMTCT program in Surakarta involves hospital's role and Public Health Center as PMTCT service provider. PMTCT intervention requires social, economic, and cultural capitals departing from social interaction between targeted group and stakeholders (Field, 2008). Concretely, there is social capital in the form of network between Health Service, Surakarta City's AIDS Coping Commission and its workgroup, Spek HAM NGO, Solo Plus, hospital and Public Health Center as PMTCT service provider with HIV-infected women as PMTCT service recipients. Individual institutions have different but complementary duties and functions. Stakeholders and community as service recipient benefit from the existence of PMTCT service (Centre for Development and Population Activities, 2003).

Stakeholders make trust a reference in PMTCT and maintain the trust. Social norm in PMTCT is complied with by HIV-infected women and stakeholders when using PMTCT service and is

reciprocal in nature. In addition, targeted group having same blood (lineage), religion, or origin has moral obligation to help each other, including giving and taking. It is an opportunity that can be utilized to grow and develop social bonding capital. In Surakarta, religion activity becomes an effective media in PMTCT when the member of (Islam) *pengajian* (studying) group or (Christian/Catholic) community alliance is a peer educator. The characteristics of social bonding capital group are more exclusive and even distinguish us from others (Doherty et al, 2009).

Because of their agreed norm and joint consensus, and trust between them, social bridging capital develops (Field, 2008). Peer group helps each other in family and religious activities. In addition, the social institution plays a very important role in their neighborhood. Social solidarity becomes social bridging capital of targeted group to give access to potential capital and to reinforce and to develop relation between groups. It supports the smoothness of PMTCT process by means of structured PE. The members should no longer adapt to and should establish cooperation with other groups (Balcha et al, 2011).

Solo Plus orientation tends to be outward looking, thereby allowing mutually beneficial connection and network with PSG out of its group. Solo Plus is opened to PLWHA with diverse social, economic, and cultural backgrounds, including not discriminating risk factors causing HIV/AIDS transmission. Solo Plus is the heterogeneous group that can bridge the relation between PLWHAs with different origin identities. In addition, cyber outreach is conducted with the members or non-members of its group through social media. Information and education around PMTCT can run more maximally due to the presence of norm, trust, and reciprocity. All members feel having interest in disseminating information broadly to the members of its group, even can reach other group. Meanwhile, social linking capital is found from social network between stakeholders in PMTCT either inside or outside Surakarta. The presence of hierarchy and obedience to norm and clear mechanism becomes connector of all stakeholders (Leung et al, 2016). In the presence of social potency and capital, structured PE for PMTCT is more effective, so that HIV/AIDS incidence can be controlled.

## 5 CONCLUSION

Structured PE in PMTCT becomes an appropriate means of disseminating information and a communication channel to women either infected or not-infected with HIV. As targeted group and peer educator, they construct social network, trust, social norm, and reciprocity pattern manifested into bonding, bridging, and linking. The activities of PSG, family association, *pengajian* (Islam study), community alliance and social activity become the domain of structured PE. Peer educator facilitates and reaches its peer group and beyond. The incidence of HIV/AIDS case in mother and children can be prevented, through stakeholders supporting PMTCT.

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