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A Comparative Study on HIV Self-Efficacy on Adolescents who Receive Peer-Led Sex Education and Adolescents who Receive Adult-Led Sex Education: A Case Study of Mafeteng District

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Abstract
Worldwide, the youth continue to be affected by multiple health threats that include HIV and AIDS infection and other risk-taking behaviors such as substance and alcohol abuse among others. The proliferation of poor health outcomes among the youth globally, and especially in developing countries reflects their unmet needs and the insufficient investments. Tackling the issues that affect adolescents can help to improve a country's overall health status. Such effective interventions may require interdisciplinary and collaborative efforts. The use of Social Work professionals and their expertise and wide scope of involvement with the youth and families, schools and health service institutions are important to the achievement of good health outcomes for young people. Adolescents are considered a vulnerable population which calls for the social work profession to advocate for them by highlighting their strengths and assets on which to build. The Social Work profession values the basic underlying need for a constructive youth development as an effective method in improving adolescent health. The profession has a role to play by advocating for programs, policies and practices that promote adolescent health. The literature review deals with theories major concepts on HIV and AIDS among the youth and its effects. Self- efficacy, a cognitive factor that influences attitude is examined as well as the HIV and AIDS preventive measures with an emphasis on attitudes towards abstinence.

Key words: HIV Self-Efficacy, Adolescents, Peer-Led Sex Education, Adult-Led Sex Education, Mafeteng District

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A Comparative Study on HIV Self-Efficacy on Adolescents who Receive Peer-Led Sex Education and Adolescents who Receive Adult-Led Sex Education: A Case Study of Mafeteng District

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Introduction

Informal (traditional) education was a responsibility of the family and the community and included a prescribed element whereby children were initiated into adulthood via residential schools that catered to them during puberty for a couple of weeks. The purpose of traditional education was to create functional individuals integrated into their society who were self-reliant, loyal and with skills that maintained a self- sustaining lifestyle (Ambrose, 2007). Formal education in Lesotho began in mid-nineteenth century under the guidance of the Christian missionaries. In 1876 Basutoland (Lesotho) became a British territory in 1868 and was annexed to the Cape Colony in 187l. The Paris Evangelical Mission Society (PEMS) and the Roman Catholic Mission (RCM) started work respectively in 1833 and 1864. It ceased being a British territory in 1884 and became the Crown Colony of Basutoland, but not without a profound influence on its educational system. The English Church Mission (ECM) commenced work in 1876. During this period the Cape Colony government provided grants to missions that established and administered the schools. In 1885 the British imperial government replaced the Cape Colony government and continued with the already established relationship between government and missions in the organization of education in Lesotho (The Education Sector, 1983).

In pre-independent/ before 1966) Lesotho, the education system was influenced by colonialism which emphasized English, and arithmetic geared towards acquisition of skills essential to serve the colonial master's in government and church employment. Additionally, missionary education had the objective of propagation of foreign religion by producing teachers and catechists to work in churches. There was no apparent difference between the evangelistic and educational responsibilities of teachers (Institute of Education, 2000). However, in post-independent (1966) Lesotho, emphasis shifted to enhancement of secondary and high school education, with a key focus on mathematics and sciences (Ministry of Education, 1995). In recent years there has been a shift to teaching life skills to address prevailing socio-economic transformations. There are two types of schools in Lesotho; government and church owned. In both systems the government through the Ministry of Education pays staff salaries, sets curriculum guidelines, administers all examinations, and supervises all appointments. The schools owned and operated by churches were established in the 19th century during the spreading of Christianity in Africa (Ministry of Education, 1984)

Background of the Study

In 1997 that Lesotho's Ministry of Health and Social Welfare proposed the National Adolescent Health Promotion and Development program which was implemented in 1998. This program

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proposed interventions to promote healthy lifestyles and behavior of the youth vital in the rapid transformations such as urbanization, weakening traditional family structures, migration and intensifying infectious diseases such as HIV and AIDS (MOHSW, 1997). The major goal of the National Adolescent Health Promotion Program was to raise awareness and increase HIV and AIDS knowledge and other health issues among the youth through workshops at district level. If the youth are to act safely, they must have accurate information about HIV and AIDS and be able to apply it. Adolescents need to know general facts about HIV and AIDS, such as its transmission, prevention, and HIV testing.

To alleviate HIV and AIDS in Lesotho, the Mafeteng Health Corner adolescent program covers such topics as condom use and reducing numbers of sexual partners but also emphasizes abstinence plus education, also known as comprehensive sex education. This approach promotes delay in sex debut, presents to the youth the opportunity to explore and develop values. Acknowledging that many youths may be sexually active, information about contraceptive and condom use as well as discussion about abortion, sexually transmitted infections and HIV and AIDS is included. In contrast, abstinence only education approach puts emphasis on discussion on values, character building and sometimes refusal skills. It teaches that sex outside marriage has negative emotional, physical, and social penalties. The abstinence only approach emphasizes one set of values as morally right for all the youth. In addition, it avoids discussions on abortion and argues that sexually transmitted infections and HIV and AIDS are all reasons why the youth should practice abstinence.

Unlike the comprehensive sex education, the abstinence only education ignores the fact that many young people will be or are sexually active. Condoms are discussed only in terms of failure rate (Kay & Jackson, 2008; Policy Monograph Series, 2002). In a nutshell, this method promotes abstinence from sex. With the intensifying recognition that the youth in sub-Saharan Africa are at the epi center of the HIV and AIDS pandemic, the program aims to makes sure that the youth between the age 15-24 have access to information. This can be done by rising to the challenge of attaining the Millennium Development Goals (MDGs) on HIV and AIDS and contributing towards the decrease of HIV prevalence among the youth by realizing universal access to prevention, treatment, and care (UNAIDS, 2006). In June 2001 United Nations General Assembly Special Session (UNGASS) on HIV and AIDS set two grand goals. First, to reduce HIV prevalence among the youth aged 15-24 by 25 percent in the most affected countries by 2005, and by 25 percent globally by 2010. Second, guarantee that 90 percent of these youth have the knowledge, education, life skills and services to protect themselves from HIV by 2005, and 95 percent by 2010.

Statement of the problem

According to UNESCO (2000), HIV & AIDS has the potential to affect education through methods such as reduction in demand and supply, adjustment in response of increasing number of orphans, modified roles that must be adopted by teachers and the education system, reorganization of schools and the overall educational system, and donor support for education.

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Nonetheless, in the context of the epidemic, education can generate hope due to its potential to work at the three levels where HIV & AIDS interventions are mostly required and can facilitate knowledge to provide information, strengthen the ability to cope with personal or family infection, and lastly assist in coping with death. This study is important because it seeks to augment the existing sparse quantitative data of comparative studies on adolescent HIV & AIDS programs in sub–Saharan Africa.

Young people globally are heavily infected with HIV and AIDS. Youth, ages 15 to 24, have the highest rates with over 5,000 - 6,000 (The Joint United Nations Programme on HIV and AIDS, 2005) (UNAIDS) infections each day of sexually transmitted diseases that include HIV. Even though the epidemic has been going on for over two decades, the great majority of the youth have difficulty in understanding HIV & AIDS and how to protect themselves from this deadly disease. Even though they keep hearing about HIV/AIDS, they are not fully aware of the transmission mode and do not consider themselves to be at risk at all. Those youth, who are aware of HIV & AIDS do not protect themselves since they do not know how to, or they do not know how to adopt safe behaviors.

The significance of averting HIV & AIDS infections among the youth has been a consistent message by many relevant organizations such as UNAIDS (2005), United Nations Population Fund (UNFPA), (2005) and the World Bank, (2006). Combating HIV & AIDS amid other diseases- a global goal among others is one of the eight Millennium Development Goals set for the year 2015 by United Nation General Assembly Special Session (UNGASS) (UN, 2001). These goals are based on the core elements of the collaborated WHO, UNFPA, and United Nations Children's Fund (UNICEF) document known as Action for adolescent health: towards a common agenda (WHO, 1997). These international organizations aimed to promote adolescent health in an organized manner in both developing and developed countries. This global partnership responds to the challenge of halting and reversing the proliferation of HIV/ AIDS. This partnership believes that young people must be accorded top priority by engaging them in the fight against the scourge through sexual health education with a focus on HIV/AIDS. The youth are more likely than adults to adopt and maintain safe behaviors and thus, they are the world's greatest hope in the effort against this deadly disease.

Literature Review

Anderson, Kermyt, and Beutel (2007) concur with Slomin-Nevo and Mukuka (2005) in their study of HIV & AIDS prevention knowledge and its correlates among youth in Cape Town, South Africa. The study had a sample of 4, 174 youth residing in Cape Town. Data were extracted from the Cape Area Study and included respondents of ages 14 - 22. An open-ended questionnaire was used. Nearly all the respondents named at least one method of HIV & AIDS prevention. Condoms, abstinence, and having only one sexual partner were the mostly frequently named prevention methods. Multivariate analysis was utilized to analyse correlates of specific forms of HIV & AIDS prevention. Results indicated that older youth were less likely to mention condom use and more likely to mention limiting the number of sex partners or being in a

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monogamous relationship. Hence age was positively associated with only one measure of HIV & AIDS knowledge, limiting sex partners or monogamy. In this study, males were less knowledgeable about HIV & AIDS prevention than the females. Males were less likely to mention abstinence or limiting the number of sex partners and named fewer methods of prevention compared to females.

Conversely, a study (Ocansey, 2006) that examined gender differences in adolescents' knowledge, attitudes and practices on HIV & AIDS in Ghana reported a higher level of HIV & AIDS knowledge for males than the female students. The study had a sample of 406 students from eight urban public high schools comprising 216 males and 190 females. Results also revealed that despite higher levels of knowledge on HIV & AIDS among students, deficiencies in this area existed. On the other hand, Eaton and Fisher (2000), in a study carried out in South Africa on HIV & AIDS knowledge among South African youth, found no association between age and HIV and AIDS.

Thirty-four studies were carried out beginning in 1990. These studies included high school and college students. They found that young people knew about HIV & AIDS and its deadliness. However, they did not know the mode of transmission and prevention methods. Kirby, Obasi and Laris (2006) suggested that behavioral Adult-led interventions have positive effects regardless of whether the respondents are secondary or college students. However, studies by Dinkelman, Levinsohn and Majelantle, (2006), Kalichman and Simbayi (2004) demonstrated that knowledge per se is not sufficient to influence attitudes or behavior. The former study notes that there are differences in bargaining power over scarce resources, low education, and high gender inequality, while the latter alludes to other determinants of health care behaviors that include attitudes and beliefs, all which impact knowledge.

While increased knowledge is not sufficient to guarantee attitude and behavior change, it is a necessary starting point. According to Kirby (2000) in most credible models of behavioral change, improvement in knowledge, attitudes, risk perception and prevention skills is important in that these variables are regarded as precursors for change in sexual behavior. Laukamm-Josten, Mwizarub, Outwater, Mwaijonga, Valadez, Nyamwaya, et al. (2000) carried out a study in Tanzania to prevent HIV & AIDS through peer education and condom promotion among truck drivers and their sexual partners. The study found a considerable increase in STD knowledge as well as related symptom episodes. The study attributed symptoms episode reporting to increased knowledge, awareness and care seeking which may be considered as an early sign of behavior change. In this study, Knowledge, Attitude and Practice (KAP) surveys were administered three times. KAP 1 was the baseline data followed by KAP II and III data collection in 18 and 24 months respectively. It appeared that for HIV & AIDS knowledge to be increased and maintained, peer educators must be active members of the client group with whom they are working for a long time.

Perceived self-efficacy concerns control of personal action (Bandura, 1992). Behavioral change is facilitated by a personal sense of control. Thus, self-efficacy makes a difference in how people feel, think and act. Hence self-efficacy levels can enhance or impede motivation to act.

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An individual's confidence in performing the behavior affects whether they will engage in the behavior. Bandura (1977) suggested that a sense of competence can be attained by verbal persuasion, and mastery of explicit experience. Consequently, adolescents with low self-efficacy are less likely to be influenced by HIV & AIDS knowledge imparted to them. Among the wide range of factors associated with HIV & AIDS reduction are the presence of a risky situation, and self-efficacy or confidence in one's ability to adhere to targeted behavior (Bandura, 1989).

In their study, Kirby Obasi and Laris (2006) indicated that self-efficacy played a major role in an array of life situations, ranging from avoiding risky sexual behaviors that might lead to contracting HIV & AIDS among other sexually transmitted infections (STIs), refusal of unwanted sex, and condom use. Studies conducted in Ghana by Tweedie, Flagby, Banful, Lokko, and Boulay (2002) and Cote d'Ivoire by Babalola, Ouedraogo, and Vondrasek (2006) investigated self-efficacy in using condoms or in convincing sexual partners to use condoms. These studies indicated noteworthy differences between the control group and the intervention group. Adolescents in Ghana exposed to the "Stop AIDS Love Life" educational campaign had higher scores on a scale that measured condom-related self- efficacy than those who were unexposed to the campaign.

Similarly, adolescents exposed to the campaign in Cote d'Ivoire reported significantly higher scores in consistent condom use compared to the control group. Like the Tweedie et al. and Babalola et al. studies in Ghana and Cote d'Ivoire respectively, Ergene, Cok, Turner and Unal (2005) in their study, whose purpose was to assess the impact of Peer-led and Adult-led education among Turkish students, included fostering self-efficacy in condom use to alleviate HIV & AIDS and STls infections. Results indicated that the Adult-led approach improved HIV & AIDS knowledge with modest attitude change. Peer-led approach generated the greatest attitude changes. The results suggest that Peer-led education can be an effective alternative to the traditional Adult- led approach in HIV & AIDS preventive educational interventions.

Brieger, Delano, Lane, Oladepo, and Oyediran (2001) in a descriptive study on implementation and evaluation of adolescent reproductive health Peer-Led education programs in two West African countries, Nigeria, and Ghana, found that Peer-Led education was a most effective approach in improving knowledge, and promoting attitude and behavior change among the youth in school settings. HIV & AIDS knowledge and self- efficacy were among the Key outcome's variables; However, these authors noted that the Peer-Led approach was not easy to organize due to its relying on volunteers and was not effective in reaching the youth who not in school settings. Strange, Forrest, -and Oakley (2002) in a study that used 16 and 17year old peers to deliver classroom-based sex education to students aged 13 and 14 years old in England reported an increase in positive changes in sexual knowledge. Thus, Peer-Led education may not only be beneficial to the' students participating in the intervention but to the peer educators themselves who are in the same age range.

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Research Methodology

A randomized two group pre-post, quasi-experimental, exploratory design was used; the study population was high school students that included eleventh and twelve Grades in Johnson Baker and Masentle high schools in Mafeteng district in the kingdom of Lesotho. These are to public high schools in the same district with students from similar socioeconomic backgrounds. Both schools had a total of 17 streams of classes of eleventh and twelfth grade students. The number of students in each class ranged between 35 and 55 students. The convenience sample used in this study included 180 students. Two groups of 45 students were drawn from both grade levels. Those that picked a "No" would not participate. This way, the sample would be representative, and each participant had an equal chance of being selected. After obtaining a sample of 180 students with ninety from each school, six groups comprising 15 participants were randomized to a Peer-led or Adult-led approach five-hour active participatory type HIV & AIDS education training.

The Adult-Led classes were conducted by a registered nurse specifically trained in adolescent health and the Peer-Led group was conducted by a 20-year-old male high school student. The student had received peer education training prior to being selected to facilitate the HIV & AIDS education training. The researcher read the consent forms to all the participants before they started responding to the questions or statements from the three surveys to ascertain they were understood. The parents had been furnished with the consent forms which they signed and returned to school before the training began.

Self-efficacy is conceptually defined as a person's action control or a belief in one's own competency (Bandura, 1992). The variable was operationalized in a study (Reese &Vera, 1995) by use of the Risky Situation Self-Efficacy Scale (RSSES). It is a 10-item five-point Likert scale with Cronbach's Alpha of .72. Response options are as follows: I- very true, 2- sometimes true, 3- not true at all, 4-Sornetimes false, 5- always true. Risky Situation Self-Efficacy scale was developed to gauge 'social self-efficacy beliefs when faced with risky peer situations, particularly situations involving conflict and peer pressure. A study with the RSSES instrument was conducted among urban adolescents. The purpose of the study was also to investigate the relationship between conflict resolution and self- efficacy. There is evidence indicating that individuals who have high self-efficacy beliefs are likely to use condoms (Faryna & Morales, 2000).

Research Findings

The ANCOVA analysis examined whether the type of training influenced student self-efficacy-at post-test while controlling for students' age, gender, grade, school, and change in student knowledge 'of HIV and attitude towards abstinence. The findings revealed the following information: The tested model showed an overall statistical significance, explaining 39 percent of the variance in the post-test self-efficacy (Adj. R Square = .39). This model met the expected assumption for homogeneity of variance through the Levene's test (p =.41). In addition, it also met the assumption for homogeneity of regression slopes in a separate ANCOVA, which tested

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the multiple interaction between the independent variable (type of training) and the selected covariates on the dependent variable (p=.78).

The significance of this model, however, was primarily driven by the following results: Students with higher mean levels of self-efficacy at pretest also had significantly higher mean levels of self-efficacy at posttest. This relationship explained 33 percent of the variance in the post-test self-efficacy. The $Mean_{pre}$, = 41.78 (SO = 5.02), and Mean $_{post}$ = 43.70 (SD = 4.89), t_{paired} = 5.54, df 171, p < 001; effect size is very modest $\eta^2 = .15$ Students' gender and age had also significantly affected students' self-efficacy at post $_{test}$. That is, at post-test, boys had a slightly but significantly lower mean level of self-efficacy ($Mean_{boys}$=42.93, SE=.49) compared to girls ($Mean_{girls}$=44.82 SE=.49). In addition, at post-test, the younger age-group of students (aged 16 to 19 years) had slightly significantly lower mean level of self-efficacy (Mean16. -19yr.= 43.24, SE = .49) compared to older students (aged 20 to 22 years) (Mean20-22yr, = 44.95, SE = .49).

The results also showed a statistically significant interactive effect between the type-of training and grade level (p = .031). Specifically, students in 11^{th} grade who were in adult-led training had slightly higher mean level self- efficacy ($Mean_{adult11gr}$= 44.92, SE = .65) at posttest compared to students in peer-led training ($Mean_{peer11gr}$= 42.70, SE = .61). In contrast, students in 12^{th} grade, who were in adult-led training had lower mean level self-efficacy ($Mean_{adult11gr}$= 43.16, SE =.80) at posttest when compared to students in peer led training ($Mean_{peer11gr}$= 44.52, SE = .71). All other interactions among the various variables had no statistically significant effects.

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Table 4:10 ANCOVA for Post-test on Self-Efficacy (N=172)

Table 4:10					
	ANCOVA for Post-test on Self-Efficacy (N=172)				
		Mean			
Source	df	Square	Fa	p	Partial Eta square η^2
Corrected Model	33	62.80[b]	4.253	.000	.51
Intercept	1	909.07	61.556	.000	.31
RSSScale[c]	1	989.97	67.034	.000	.33
DiffATA[d]	1	4.27	.289	NS	
DiffHIVK[e]	1	.280	.019	NS	
Gender	1	142.03	9.617	002	.07
School	1	11.98	.811	NS	
Grade	1	4.74	.321	NS	
Age-group	1	68.38	4.630	.033	
Type of training	1	10.08	.683	NS	
Trainer x Grade		65.34	4.425	.037	03
Other Variable				NSt	
Interactions					
Error	137	14.77			.03
Total	171				

a Computed using alpha = .017.
b R^2 = .51 (Adjusted R2 == .39).
c Self-Efficacy at pre-test.
d Change of attitude toward abstinence from pre-test to post-test.
e Change of knowledge of HIV from pre-test to post-test

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t Interaction among all covariates was not statistically significant; thus, meeting the assumption of homogeneity of regression slopes.

The social work profession has the responsibility to develop empirical evidence on the effectiveness of interventions used with vulnerable individuals. The profession can respond to the needs of adolescents in HIV & AIDS education through appropriate interventions that utilize effective approaches at several systems levels that include individual/family, program/agency, and community. While focusing on individual behavior change is still important, increasing rates of HIV & AIDS in Southern Africa, and particularly Lesotho, suggest that it is equally important to identify suitable methods to combat the pandemic.

Social workers are well positioned to augment contemporary HIV & AIDS prevention with a community level and structural focus as well as advocacy. This augmentation can be done by modifying norms (in some societies in sub-Saharan Africa, the youth have no voice) and stimulating collective action that contribute to transformations and changes in policies and programs. Peer education should be integrated with adolescent health services that include voluntary counseling and HIV & AIDS testing and sexually transmitted infection management and medical care. Peer education should be integrated with community health and development initiatives. Additionally, social workers have a duty to add voices to messages that educate, encourage, and empower to help the alleviation of HIV & AIDS among the vulnerable population such as the youth.

The choice of educator represents a balance among the science or profession of teaching, existing culture, and infrastructure capacity. Adult professionals often commonly implement curriculum-based interventions because they tend to have more experience, knowledge and skills required. However, peer educators have been popularized as an alternative to adult teachers for their ability to relate more closely to the youth than often reported by the adult teachers. Nevertheless, peer educators are less likely to be knowledgeable about relevant topics as well as the skills required to instruct in a curriculum.

Although the socia1 work profession has been actively involved in the alleviation of the disease from the onset of the HIV & AIDS pandemic, the profession has not empirically examined which educational method better improves youth knowledge of HIV and AIDS. Therefore, this study's findings lay the groundwork for future research in this area. While there are various limitations in this study, these initial exploratory findings empirically support the importance of a Peer-Led approach in training and education about HIV & AIDS knowledge. Theoretically, these research findings indicate that youth are more likely to emulate individuals who are closer to them in age, grade level and socio-economic status.

Conclusion and recommendation

Testing of the hypothesis, which expected that the type of training may influence students' self-efficacy at post-test while controlling for all other variables, revealed no statistical support from the results of ANCOVA testing. However, the results uncovered a statistically significant

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interactive effect between the type of training and grade level (p=.037) on student self-efficacy. Students in 11th grade who participated in Adult-led training had slightly higher mean level self-efficacy (44.92, SE=.65) at post-test compared to those participants in Peer-led training (42.70, SE= .61). Conversely, students in the 12th grade participating in the Adult-led training had a lower mean level self-efficacy (43.16, SE = .80 at post-test compared to students in Peer-led training (44.52, SE = .71). The other interactions among all other variables had no statistically significant effects on student self- efficacy.

Research has suggested that attitude is viewed as a main predictor of behavior (Fazio & Powell, 1989; Ajzen & Fishbein, 1980). An individual's attitude toward behavior can lead to an intention to act or not to act. The intention may lead or not lead to a specific behavioral action. Hence, attitude toward abstinence might be shaped by how an individual interprets the event and its consequences before making the decision, as well as how the significant others might think of the decision. As sexual intercourse is a major transmission mode for HIV & AIDS infection, abstinence is hence seen as a primary prevention method.

Theoretically, self-efficacy is associated with an individual's action control (Bandura, 1992). Behavior alteration is eased by a personal sense of control. Consequently, self- efficacy is responsible for how individuals feel, think, act, and therefore can enhance or hinder motivation to act. A person's belief that they can motivate themselves to regulate their own behavior plays a vital role in whether they even consider changing habits harmful to health. Belief in an individual's self-efficacy to exercise control over one's sexual behavior emerged as the best predictor of sexual risk-taking behavior. There was realization that the lower the self- efficacy, the higher the likelihood of engagement in sexual practices that carry a high risk of HIV & AIDS infection (Kirby et al., 2006). Findings in this study indicate that type of training had no differential effect on self-efficacy while all other variables were controlled based on the type of training. The study found that youths who had more self-efficacy at pre-test also had more self-efficacy at post-test. Additionally, the study had differential effects for self-efficacy based on gender and age. Findings revealed that at post-test boys had slightly lower self-efficacy than the girls. Additionally, at post-test, the younger age-group of students (age 16to 19 years) had slightly but significantly lower self-efficacy compared to older students (aged 20 to 22) years.

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