

INVESTIGATION OF THE ROLE OF LESOTHO'S PHELA LIFE SKILLS
TRAINING PROJECT IN INSTILLING RESILIENCE TO HIV AMONG TEEN
MOTHERS

By

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DECLARATION

I declare that: **INVESTIGATION OF THE ROLE OF LESOTHO'S PHELA LIFE SKILLS TRAINING PROJECT IN INSTILLING RESILIENCE TO HIV AMONG TEEN MOTHERS** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and this work has not been submitted before for any other degree at any other institution of higher learning.



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Date

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ABSTRACT

INVESTIGATION OF THE ROLE OF LESOTHO'S PHELA LIFE SKILLS TRAINING PROJECT IN INSTILLING RESILIENCE TO HIV AMONG TEEN MOTHERS

The aim of the study was to investigate the role of the life skills training programme in instilling resilience to HIV infection among teen mothers. The study targeted teenage mothers who took part in a life skills training programme in a rural area of Lesotho between 2009 and 2014. The objectives of the study were to; understand what teen mothers have learnt by participating in the project; understand how useful the knowledge was in helping them to cope with HIV and AIDS; understand whether the teen mothers are still using the skills they have been taught to cope with HIV and AIDS, and to understand how the participation in the project benefited them. The research design of the study was quantitative research. A census survey was used to collect data among research participants. The study employed the Health Belief Model, self-efficacy, and resilience theories to explore levels of resilience among teen mothers.

The findings show that the teen mothers' resilience to HIV and AIDS was enhanced by the life skills training. It also shows that the information raised teen mothers' levels of awareness of health risks and mitigating actions (life skills). This in turn improved their confidence and competency to implement positive behaviour change. It has also emerged from the study that there is continued use of the acquired knowledge and skills by the teen mothers after the project. The findings also provide evidence of the value of conducting follow up studies on intervention programmes.

The study recommends life skills programme be an inseparable part of HIV and AIDS awareness, especially among teenagers. Such intervention should ideally form part of the school curriculum.

Key words; Resilience, Life skills, teen mothers, resilience building

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CHAPTER 1: INTRODUCTION

1.1. Introduction

The purpose of this chapter is to introduce the proposed research study. It does so by providing the contextual background to the study, outlining the study objectives, the method of research employed and structure of the mini-dissertation.

1.2. Background to the Study

The study on resilience of teen mothers to HIV is informed by the challenges posed by the pandemic on youth in general and teen mothers in particular. The study aims to explore the resilience to HIV and AIDS among teen mothers participating in life skills interventions. It looks at the extent to which knowledge and skills obtained from the interventions helps teen mothers to remain resilient in the face of the rampant pandemic. In the absence of the cure for HIV, focus on lifestyle is paramount. Given the importance of life skills interventions, it is important to critically look at their effectiveness on a regular basis as envisaged in this study.

Juxtaposed on the HIV and AIDS pandemic is the twin problem of the ubiquitous poverty and unemployment, and the cyclical relationship between the two. Compounding the problem is the phenomenon of migration and its ramifications for the household structure due to the spread of the pandemic. These contextual factors are critical in reviewing the impact of life skills intervention on vulnerable populations such as teen girls.

The location of this study is Lesotho, a small country of about 2 million citizens, completely surrounded by the Republic of South Africa. At 30,000 sq. km, Lesotho's highlands constitute two-thirds of its land and have less than 10% of its land suitable for cultivation. The study was carried out among teenage mothers who were resident at the Good Shepherd School during an end of programme evaluation carried out in 2014. Participants come from different districts in Lesotho.



Figure 1 Map of Lesotho (Source: Ontheworldmap.com)

Note: The specific village where the investigation was carried out does not show on the map but the different districts the girls 'reside in.

1.2.1 The HIV and AIDS Situation in Lesotho

Along with its sub-Saharan African, and Southern African countries to be specific, Lesotho is hardest-hit by the HIV and AIDS pandemic. Lesotho has the third highest HIV prevalence (23.4 %) in the world with just under one in four people in the country living with HIV (UNAIDS, 2017:32). There were about 330 000 people living with HIV in 2016 (UNAIDS, 2017:32). The prevalence of HIV and AIDS in Lesotho is impacting heavily on the ability of the country to attain the other development goals. Together with poverty, HIV and AIDS, has reduced average life expectancy of Basotho to 48.7 years (UNDP, 2013). The epidemic is concentrated in the most productive age group, which undermines the ability of people to feed and care for themselves and their families.

1.2.2 Unemployment and Poverty in Lesotho

Unemployment in Lesotho is generally high (AfDB, ECD, UNDP, UNECA, 2017:269). Unemployment, particularly amongst the youth, has been identified as a critical development challenge in Lesotho and the unemployment level for the youth is at 33% whilst the general levels are at 24% (AfDB et al., 2016: 264).

Poverty drives girls and women to exchange sex for food and to resort to sex work for survival when they are excluded from formal sector employment and all other work options are too low-paying to cover their basic needs. The exclusion of women and young girls from formal employment emanates from the fact that women in Lesotho have been subjected to gender inequality and discrimination (Chingono, 2016). The sexist ideology of the state encourages the employment of males in both the public and private sectors (Mapetla & Petlane, 2007: 30-31). Despite the “literacy levels, school attendance, and level of education completed being higher for females than for males ... labour force participation rates, at one in two males and one in four females, were much lower for females than for males” (Chingono, 2016). To fight against this political and economic marginalisation women have turned to the informal economy.

Mbirimtengerenji (2007:1) states that, extreme poverty compels most of the young women to indulge into risky behavior such as commercial sex, to get basic needs. As Mbirimtengerenji (2007:1) observes, HIV is an important outcome of poverty, with sexual trade, migration, polygamy, and teenage marriages as its predictors in the sub-Saharan region.

The high levels of poverty and unemployment are likely to expose young people, especially young women, to HIV-infection through risk survival behaviors such as sex work. It is for this reason that this social group needs a special attention.

1.2.3 Migration in Lesotho

Poverty and lack of opportunities at home has led many Basotho to migrate internally and to neighbouring South Africa resulting in negative impacts on the social nets and family structures. The country has had a long history of internal and external migration for males and an increase in female aged between 15-29 years for internal migration (IOM, 2013: 2). Internal rural–urban migration has been reported to be increasing by female migrants moving within Lesotho and internal related ‘to caregiving and other consequences of the HIV/AIDS epidemic’ (Crush et al., 2010 cited in UN- INSTRW & UNDP, 2010: 7).

Migration-fuelled HIV and AIDS affect women and young women in particular disproportionately as they are more likely to be unable to protect themselves against infection and carry a greater share of care for those who are sick or infected. There is also significant rural-urban migration to the textile industry (which is dependent on female workforce) with almost half of the workers staying away from their traditional family homes. Lesotho has a population with female majority as a result of male migration to neighbouring countries

(Tanga, Bello, Makatjane TJ & Tsikoane, 2017). Given their vulnerability, specific interventions targeting teen mothers have been developed in Lesotho.

1.2.4 HIV and AIDS Interventions in Lesotho

There are several interventions to curb the spread of HIV and AIDS in Lesotho. They are either driven by the state, donors, NGOs or CBOs. At the Government level, the Ministry Of Health has embarked on the HIV prevention programmes that are informed by the National HIV and AIDS Strategic Plan 2011/12-2015/16. The government intends to reverse the epidemic by reducing new HIV infections by 50%, strengthening coping mechanisms for vulnerable people and providing antiretroviral treatment and care for all those in need.

NGOs that have been and are involved in Life skills programs for the youth include Kick 4 Life which focuses on HIV prevention education through Sport; Help Lesotho, which uses Youth Empowerment in Schools (YES) Clubs and psychosocial support for school children, Population Services International and Lesotho Planned Parenthood Association and Phela Health & Development Communication, to mention a few. Central to all these interventions is the HIV and AIDS education and skills programmes.

Most interventions are usually preceded by situational analysis studies which inform critical areas for intervention, and provide valuable baseline data. Another noble practice by development agents is to conduct mid-term review as well as impact evaluation at the close of the intervention. What are missing are studies which follow intervention beneficiaries post-intervention to determine the value of lessons learnt in terms of their life style changes.

Phela Health & Development Communication programme is of particular interest to this study given its focus on youth in general and teen mothers in particular.

1.2.5 Phela life skills project

Phela Health & Development Communications is a non-profit making health and development communication organisation that uses the power of the mass media (radio, TV and print) communication strategies to disseminate information with the aim to have a positive impact on social and behaviour change (PHDC, 2015). It operates in 10 administrative districts of Lesotho. In 2009, the organisation received funding from Irish Aid to implement a 5-year project called Phela Friends Programme (PFP) whose aim was to train club leaders in primary and secondary schools as well as empowering juvenile inmates and teen mothers with life skills as part of their rehabilitation. The duration of the project funding was for 5 years.

The project has followed a traditional route of development interventions which involves formative, mid-term review and close-out impact evaluation studies. This data provides a rich source of information from which to draw conclusions on the lasting impact of the intervention on the beneficiaries. Detailed analysis of the studies and key findings will be provided in Chapters 3 and 4 of this mini-dissertation, respectively. A cursory reading of the respective research reports paints a positive impact of the interventions on the beneficiaries. A follow-up study is needed to explore the resilience to HIV and AIDS of the teen mothers built from their participation in the intervention. This study aims to do so.

1.3. The Research Study

1.3.1 The research problem

Most NGO interventions are time-bound by nature. The intervention time is in turn linked to funding period. A healthy practice amongst donor-funded initiatives is to conduct a baseline study – which informs the intervention – and post-intervention impact evaluation study – which assess whether the initiative achieved the stated objectives.

Whilst this practice is very noble and should be promoted, no follow-up studies are conducted post-impact evaluation study to ascertain the intervention’s impact over time. This study wishes to close this gap by conducting a follow up study on one of the HIV interventions among youth in Lesotho after the closure of the funding period. The Phela Friends Project forms the case study. The study covered the funding period of between 2009 and 2014. This study aims to explore the resilience of life skills intervention on teen mothers in Lesotho post-intervention.

1.3.2 The purpose of the study

The purpose of the study is to investigate the resilience of teenage mothers to HIV and AIDS built by their participation in interventions, post-intervention thereby exploring the value of post-intervention review research.

1.3.3 Objectives of the study

The objectives of the study are to;

- Understand what teen mothers have learnt by participating in the project
- Understand how useful the knowledge was in helping them to cope with HIV and AIDS
- Understand whether the teen mothers are still using the skills they have been taught to cope with HIV and AIDS

- Understand how their participation in the project benefited them (how their resilience was built)

1.3.4 The Research Questions

Critical questions for the study are:

1. What is the value of life skills training on teen mothers?
2. What do life skills training interventions cover?
3. How practical are life skills training interventions post-intervention – that is, are beneficiaries still able to put to use the lessons learnt from the intervention once the interventions winds up?
4. What is the value of follow up studies – that is, post-impact evaluation studies?

1.4. Definitions of Key Concepts

Resilience is a dynamic process wherein individuals overcome the negative effects of risk exposure and cope with the traumatic experiences successfully and avoid the negative trajectories associated with risks (Zimmerman & Fergus, 2005).

Resilience building- occurs when promotive factors are strengthened to the point where they overcome or ameliorate the negative effects of risk exposure (Ferguson & Zimmerman, 2005)

Teen Mothers are youth aged 13-19 years old who have children of their own and participated in the PHELA project before.

Life skills-Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life (WHO, 1997). In particular, life skills are a group of psychosocial competencies and interpersonal skills that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with and manage their lives in a healthy and productive manner. Life skills may be directed toward personal actions or actions toward others, as well as toward actions to change the surrounding environment to make it conducive to health.

1.5. The Research Methodology

A research methodology is a systematic way to solve a problem made (Creswell, 2013: 152). Creswell (2013: 152) further explains that this involves the procedures that the researcher goes about their work describing, explaining and explaining phenomena. This section discusses the method of research used in this study.

1.5.1 Research Design

This research employed a quantitative research design. A quantitative research design is defined as the investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design (Polit & Beck, 2008:763). Quantitative researches study the relationship of one set of facts to another by collecting facts by use of numerical data, structured and predetermined research questions, conceptual frameworks and designs (Bell, 2014:9). Burns & Grove (2011: 34) define quantitative research design as a formal, objective, rigorous, systematic process for generating numerical information about the world. It is conducted to describe new situations, events, and variables and determine the effectiveness of a treatment in the world. Quantitative research design uses survey which provides a numeric description of attitudes, opinions of a population by studying a sample of that population. The purpose is to generalize from a sample to a population so that inferences about some characteristic can be made (Creswell, 2013: 155). The relevance of this research design for this study is that it aims to explore behavioural change over a period of time and covers the whole sample population.

1.5.2 Research Population

The study population consists 28 teen mothers who were resident at the Shepherd of Good Hope and participated in the end of project evaluation exercise. These teen mothers were resident at the institution for a period of two years and thereafter are released back into their communities. A list and contacts of those who participated was compiled by the manager at the institution. They contacted and informed them about the study.

1.5.3 Sampling

Given the small size of the study population, all 28 teen mothers were recruited to participate in the study. All twenty eight participated in the study, representing 100 % participation rate.

1.5.4 Data sources

The data sources included organizational documents such as previous evaluations and raw data obtained through the survey questionnaire.

1.5.5 Data collection techniques

Raw data was collected through a close-ended questionnaire attached in Annexure A. The staff from the implementing organization was recruited and trained in the use of questionnaire. A letter detailing the purpose of the survey as well as confidentiality issues was sent out first to the participants requesting them to participate in the study.

1.5.6 Reliability and validity

The notion of reliability and validity is very important in social science research. Careful consideration of reliability and validity enhances the credibility of research findings. For Joppe (2000) reliability means the extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. This study employed a survey that is 100% representative of the research population. Because of the size of the population, it is sensible to contact all participants except those who can no longer be traced, are dead or refuse to participate in the study. Census is regarded as the most reliable research design given its extent of coverage.

According to Joppe (2000), validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are. In other words, does the research instrument allow you to hit "the bull's eye" of your research object? Researchers generally determine validity by asking a series of questions, and will often look for the answers in the research of others.

In this study, reliability was ensured by careful benchmarking of the research instrument and thorough process of data collection. The research instrument to be used was compared with other similar instrument used before with necessary modifications. The staff at Phela were trained in the use of the tool to ensure that they interpret and assist the respondents to capture the information correctly, in case there were challenges experienced.

1.5.7 Data analysis and interpretation

The results were analysed using SPSS, a computer based data analysis package which is used by social scientists and other professionals for statistical analysis.

1.6. Ethical Considerations

1.6.1 Anonymity

The study endeavoured to ensure that anonymity was maintained during the study by use of anonymous and self-administered survey questionnaires. During reporting and information sharing proxy names were and consent sought from research participants. All direct identifiers will be removed.

1.6.2 No harm

Harm can be both physical and/or psychological and therefore can be in the form of: stress, pain, anxiety, diminishing self-esteem or an invasion of privacy (Trochim, 2007). It is imperative that the evaluation process does not in any way harm (unintended or otherwise) participants

The main concerns in research ethics is the protection of participants from harm or the limitation of risk of harm. The researcher ensured that the questionnaire completion was done during the day and will not take more than 15 minutes to complete. Since the participants were in different locations, they chose to do the exercise in environments that are safe and space for freedom of expression.

During this study, measures like reference to counselling services were in place in the event of participants being emotionally affected by the study to mitigate potential harm arising from the research process.

1.6.3 Confidentiality

Confidentiality implies that any identifying information is not made available or accessed by anyone. It is “the obligation of an individual or organization to safeguard entrusted information.”(Centre of Genomics and Policy (CGP), Maternal Infant Child and Youth Research Network (MICYRN), 2012). During the research, all identifiable information on participants were excluded from reports and not disclosed to others without the written consent of the participants. The data was collected with consent of the participant and the researcher explained who will have access to the data and why.

1.6.4 Informed consent

Before the start of an interview, research participants were told about the study's aim and objectives, its intended use and possible benefits. They were informed that their participation is voluntary and without repercussions for non-participation. Participants willing to participate were asked to sign Consent forms attached in Annexure B.

1.6.5 Provision of debriefing, counselling and additional information

Protection from harm, which can be emotional or psychological, can be assured since the research topic can touch on sensitive issues through the various methods of research that are going to be utilized. Participants were assured of referral services if they needed further management or counselling services.

The researcher took the following steps to comply with the ethical requirements of research:

- Permission to conduct the research was requested from the PHELA and the Good Shepherd School and a research proposal shared
- A consent form was signed by the teen mothers. They were informed about the purpose of the study and that their responses would be anonymous. The completed questionnaires were placed in a sealed envelope so that no other person could link the signed consent form from the participants with any specific completed questionnaire.

1.7. Limitation of the Study

The study was targeted towards a cohort of teenage mothers who participated in the end of program evaluation. The study is limited to one institution and just 28 teen mothers' cohorts, and also non-availability of the targeted participants due to death, relocation or unwillingness to participate which can affect generalisability to other teenage mothers.

1.8. The Structure of the Dissertation

The dissertation comprises five chapters. Chapter 1 presents the introduction, background to the study, the research problem, and the aims of the study, objectives, definitions, ethical considerations, limitations and organisation of the report. Chapter 2 discusses the literature relevant to resilience to HIV for teenage mothers through life skills training in Kenya, New Zealand and Lesotho as well as the theoretical constructs. Chapter 3 outlines the research methodology used in the study. Chapter 4 presents the data analysis and discussion. Chapter 5 provides conclusions, limitations and recommendations based on the research results.

1.9. Conclusion

In this chapter, the background information of conducting this research has been highlighted. The research problem, population, sample and sampling procedure, ethical considerations and limitations of the study were discussed.

Chapter 2 will review literature relevant to resilience to HIV for teenage mothers. It will also discuss the theoretical framework which include Health Belief Model, empowerment theory, resilience theory, feminist theory and the self-efficacy theory.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This study on the resilience of teen mothers to HIV is informed by the challenges posed by HIV and AIDS, migration, unemployment and poverty in Lesotho, as highlighted in Chapter 1. A review of these contextual factors is critical in ascertaining the impact of life skills intervention on the teen mothers, that is, the extent to which knowledge and skills obtained from the interventions helps teen mothers to remain resilient in the face of the pandemic. A focus on lifestyle is paramount, therefore, it is also important to regularly, look at the effectiveness of life skills interventions as envisaged in this study.

Against this background, this chapter addresses pertinent issues on HIV and AIDS knowledge and high risk sexual behaviour among young people and lifestyle change interventions. The first section discusses the HIV and AIDS epidemic, its evolution, and spread and intervention measures. The second section discusses the factors contributing to the spread of HIV and AIDS, that is, unemployment, poverty and migration. The third section discusses the phenomenon of teenage pregnancy, globally, in sub-Saharan Africa and in Lesotho. The fourth section will discuss life skills in general and interventions in Lesotho and the fifth section articulates the preferred theoretical framework. The conclusion of the chapter is provided in the sixth section.

2.2 HIV and AIDS in Numbers

2.2.1 Evolution and spread of HIV

The world's most serious health and development challenge is the human immunodeficiency virus (HIV), the virus that causes AIDS. It is believed that HIV originated in the Democratic Republic of Congo around 1920 but the current epidemic started in the 1970s (WHO, 1989). Between 100 000 and 300 000 people could have been infected during this period. The WHO (1989) further reported that there were an estimated 5-10 million people living with HIV and AIDS world-wide and 400 000 AIDS cases. A number of cases were reported in America, Africa, Europe and the Oceania with 145 countries having reported 142 000 AIDS cases by the end of the 1980s (WHO, 1989).

The epidemic continued to spread and the figures rising in the 1990s with UNAIDS (2014) estimating 30 million people living with HIV worldwide which equates to 16,000 new infections a day. At the end of the 1990s period, WHO (1989) announced that HIV and AIDS

was the fourth biggest cause of death worldwide and number one killer in Africa. An estimated 33 million people were living with HIV and 14 million people had died from AIDS since the start of the epidemic.

As the epidemic progressed in the 2000s, there were global initiatives to fight it including research of antiretroviral drugs as well as efforts by countries and organisations to combat its spread through prevention, treatment and care initiatives. In its 2013 report, UNAIDS (2014), stated that AIDS-related deaths had fallen by 30% since their peak in 2005 and an estimated 35 million people were living with HIV.

At the end of 2014, there were approximately 36.9 million people worldwide living with HIV and AIDS and of these, 2.6 million were children younger than 15 years (UNAIDS, 2014). Most of these children live in sub-Saharan Africa and were infected by their HIV-positive mothers during pregnancy, childbirth or breastfeeding. During the same year, UNAIDS called for new targets, to scale up HIV prevention and treatment programmes to avert 28 million new infections and also end the epidemic by 2030 (UNAIDS, 2014).

2.2.2 HIV Burden

There are 36.7 million (30.8–42.9 million) people were living with HIV at the end of 2016 (WHO, 2017). An estimated 0.8% (0.7-0.9%) of adults aged 15–49 years worldwide are living with HIV. The majority of the people living with HIV are in low- and middle-income countries. According to WHO, sub-Saharan Africa is the most affected region, with nearly 1 in every 25 adults (4.2%) living with HIV and accounting for nearly two-thirds of the people living with HIV worldwide in 2016. It is reported that 1.0 million people died of HIV-related illnesses worldwide in 2016 (WHO, 2017).

Ten countries, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe accounted for 81% of all people living with HIV in the region and half of those are in only two countries, Nigeria and South Africa. Lesotho's HIV prevalence among adults aged 15-49 is 25% (Ministry of Health and Social Welfare (MOHSW), 2014:239). In 2015 an estimated 310,000 people were living with HIV and 18,000 died from AIDS-related illnesses in Lesotho (UNAIDS, 2016).

There are 2.9 million children (aged 0–14), 2.9 million young people (aged 15–24) and more than 2.5 million people aged 50 years and older living with HIV in sub-Saharan Africa (WHO, 2014). More women than men, are living with HIV in sub-Saharan Africa and they account for 58% of the total number of people living with HIV. There has been a reported increase in

prevalence among women from 26% in 2004 to 30% in 2014, while prevalence among men has remained stable at 19% over the same period (MOHSW, 2014:234).

Young women and adolescent girls are disproportionately vulnerable to HIV and AIDS and are at higher risk of contracting it. There are about 380 000 new HIV infections among adolescent girls and young women (10–24 years old) around the world every year. Globally, 15% of all women living with HIV are young women 15–24 years old and of these, 80% live in sub-Saharan Africa (WHO, 2014). In this region, women acquire HIV infection at least 5–7 years earlier than men. It is reported that young women 15–24 years old in sub-Saharan Africa are twice as likely as young men to be living with HIV (WHO, 2014). In Lesotho, 13% of young women and 6% of young men in the 15-24 age range are reported to be living with HIV (MOHSW, 2014:234).

Young women and adolescent girls face issues such as, gender-based violence including sexual abuse, lack of access to education and health services, as well as social protection. How they cope with these inequities and injustices determines their ability to protect themselves from HIV or access antiretroviral therapy while they are young and as they move into adulthood (WHO, 2014). If young women and adolescent girls had the means to protect themselves, the picture of the epidemic in the region would look different. Unfortunately in sub-Saharan Africa, young women and adolescent girls are being left behind (UNAIDS, 2015).

2.2.3 Interventions

There has been a variety of global efforts to address the epidemic which include prevention and treatment strategies and these have helped to reduce HIV prevalence rates in a number of countries. About 15.8 million people living with HIV were accessing antiretroviral therapy (ART) globally (UNAIDS, 2015). Progress has been noted in preventing mother-to-child transmission of HIV and keeping mothers alive with 73% of the estimated 1.5 million pregnant women living with HIV globally accessing antiretroviral therapy to avoid transmission of HIV to their children. New HIV infections among children were reduced by 58% from 2000 to 2014 (UNAIDS, 2014).

2.3 Factors Contributing to the Spread of HIV and AIDS

2.3.1 Unemployment

Unemployment, in particular for the youth, has been identified as a critical development challenge. It has been noted that “jobs are the cornerstone of economic and social development. Indeed, development happens through jobs. People work their way out of poverty and hardship through better livelihoods. . . . Jobs are thus transformational – they can transform what we earn, what we do, and even who we are” (World Bank, 2013:2).

Youth unemployment rate, as defined by the World Bank, is the rate of the labour force aged 15-24 without work but available for and seeking employment. Despite the attainment of high literacy rates (80.9% for men and 96.9% for women in the 15-49 year age group), Lesotho, has high unemployment rate of 23% (AfDB et al., 2016:294).

This is partly blamed on its education system which has a strong emphasis on formal education while neglecting the technical education that is relevant to the labour market demands, low access to labour market information; lack of work experience; low aspiration for self-employment; poor support for starting and sustaining businesses; declining job opportunities in South Africa (UNDP, 2015:100; AfDB et al., 2015:12). The youth unemployment rate is 30.5% and was reportedly higher in rural areas (36.4%) compared to 29.4% in the urban areas (UNDP, 2015). Youth labour force (aged between 15-24 years) participation rate stood at 45.1%, during the 2008 labour force survey (AfDB et al., 2012:1). Unemployment is higher among the less educated or skilled, 57% of people with primary education are not employed and 25 percent of youth are employed in subsistence agriculture or the informal sector due to low educational attainment (UNDP, 2015: 111).

2.3.2 Poverty

Poverty plays a critical role in the spread of HIV in the sub-Saharan Africa. Literature indicates that there is a relationship between poverty and the spread of HIV and AIDS. Poverty facilitates the transmission of HIV as well as exacerbating it through mobility and morbidity of the productive adult population (Ganyaza-Twalo & Seager, 2005:1). The ILO notes that, ‘there are strong bi-directional linkages between HIV and AIDS and poverty in resource –poor setting’ (ILO, 2005:1). Poverty increases the risk of HIV and AIDS when it ‘propels the unemployed into unskilled migratory labour pools in search of work’ (*Ibid*). This relationship was referred to by Konkel (2010:1) as a ‘vicious circle’, that is, when the experience of poverty increases HIV infection, while AIDS contributes to poverty and forms of social deprivation.

Stillwaggon (2006) also noted that, the conditions of poverty facilitate HIV transmission and increase susceptibility to infection both biologically and socially. Biologically, this is through the undermined immune system response to diseases like malaria, malnutrition, parasitic infections which are rife across sub-Saharan Africa. On the social side, the existence of gender inequalities, another dimension of both poverty and HIV transmission. In this situation, men engage in sex with multiple partners and dominate sexual decision making. Women, on the other hand are unable to negotiate condom use or transactional sex due to their economic dependence on men.

In 2014, poverty affected 57.1% of the total Lesotho population and 35.1% of the population were reported as very poor (AfDB et al., 2015:12). Poverty has decreased in urban areas, while it has increased in rural areas, where about 80% of Lesotho's population resides. As mentioned in Chapter 1, almost 30% of Lesotho's population lived below the extreme (or food) poverty line and hardly had enough food for survival (World Bank, 2015:13).

HIV is an important outcome of poverty, with sexual trade, migration, polygamy, and teenage marriages as its predictors in the sub-Saharan region. It drives girls and women to exchange sex for food and to resort to sex work for survival when they are excluded from formal sector employment and all other work options are too low paying to cover their basic needs (see Chapter 1). This was also noted by Mbirimtengerenji (2007) when he stated that, extreme poverty compels most of the young women to indulge into risky behaviour, such as commercial sex, to get basic needs (Mbirimtengerenji, 2007:1).

2.3.3 Migration

Migration is defined as the movement of a person or a group of persons, either across an international border, or within a state, whatever its length, composition and causes (IOM, 2013: 2). Migration may have negative effects on families. It increases the risk of family breakdown, fragmentation of social networks and psychological stress. It has been reported that, men abandon their wives as soon as they get to their destinations, leaving the children inadequately cared for (United Nations, 2004). Children end up spending their early years without one or both parents as noted in Latin America and the Caribbean (Siddiqui, 2012:19). This impacts negatively on the children and their mothers as the left behind wives report '...difficulties in bringing up children alone' (Siddiqui, 2012:19).

Lesotho has had a long history of internal and external migration for males and recently a reported increase in female aged between 15-29 years for internal migration (IOM, 2013: 2).

The increase in internal migration for female migrants has been for the purposes of care-giving and other consequences of the HIV and AIDS epidemic (Crush et al., 2010 cited in UN-INSTRW & UNDP, 2010: 7).

It is estimated that 40% of the male labour force in the 20-39 age group is away in South Africa at any given time (UN-INSTRW & UNDP, 2010: 9). Poverty and lack of opportunities at home has led many citizens of Lesotho to migrate internally and externally, to neighbouring South Africa, resulting in negative impacts for social nets and family structures. The drivers for migration have been cited as disease and unemployment and about 51% of women move from Lesotho to South Africa for economic reasons, with 'one out of five' leaving because their husbands are not employed or have ill-health due to TB, HIV and AIDS or disability (UN-INSTRW & UNDP, 2010:9). Also the concentration of economic activities in few urban centres (Maseru and Maputsoe) has contributed to the increased vulnerability to the HIV and AIDS pandemic as young adults leave their families to seek jobs in these cities.

In relation to HIV and AIDS, migrant labour has been identified as one of the key drivers behind the HIV epidemic. This is due to the fact that it almost always results in prolonged spousal and parental separation which disrupts normal family life, and in the process encouraging marital infidelity. Migration-fuelled HIV and AIDS affect women and young women in particular disproportionately, as explained Chapter 1. Given their vulnerability, specific interventions targeting teen mothers have been developed in Lesotho.

2.3.4 HIV and Youth

In sub-Saharan Africa, HIV is largely sexually transmitted. Lesotho is a very young country demographically, with about 40% of the population comprising of the youth (15 – 35years), a subset of which are persons aged 10-19 years, known as adolescents or teenagers. Lesotho has the third highest HIV prevalence in the world, 23.1%, with just under one in four people in the country living with HIV (360 000 people living with HIV) (UNDP, 2013). The epidemic has stabilised but is still at a very high level (Ministry of Health and Social Welfare, 2015:2).

The prevalence of HIV and AIDS in Lesotho is impacting heavily on the ability of the country to attain the other development goals. Together with poverty, HIV and AIDS, has reduced average life expectancy of Basotho to 48.7 years (UNDP, 2013), as pointed out above. The epidemic is concentrated in the most productive age group, especially people of school-going age. The prevalence of HIV among females aged 15–49 is estimated at 27.9% and that among males aged 15-49 is 18.7% (World Economic Forum, 2013). The prevalence rate among

adolescent girls aged 15-19 is at 4.1% and 2.9 % for boys aged 15-19 (MOHSW, 2014). About 2000 new HIV infections occur annually among adolescents aged 15-19 (*Ibid*).

2.4 The Phenomenon of Teenage Pregnancy

2.4.1 Teenage Pregnancy Globally

Teenage or adolescent pregnancy is noted as a major public health and demographic problem with medical, psychological, social and demographic implications. It remains a challenge requiring urgent resolution the world over as these pregnancies have ‘irreparable consequences’ (Loiza & Liang, 2013:3). The average global birth rate among 15 to 19 year olds is 49 per 1000 girls according to the 2014 World Health Statistics and the country rates range from 1 to 299 births per 1000 girls, with the highest rates in sub-Saharan Africa (WHO, 2014). In 2014 the WHO reported that 11% of all births were from women aged 15-19 years (WHO, 2014:15).

Approximately 95% of teenage pregnancies occur in developing countries with 36.4 million women becoming mothers before age 18 (UNDP, 2013). It is reported that about 16 million adolescent girls between 15 and 19 years of age and 1 million below the age of 15 years give birth each year. Their babies account for roughly 11% of all births worldwide.

Adolescent pregnancy and childbearing have distinct and important deleterious consequences at global, societal and personal levels (Mondal & Shitan, 2013). Teenage pregnancy is a major health concern because it is associated with higher maternal child mortality and morbidity and carries high risks such as pregnancy induced hypertension, obstructed or prolonged labour and unsafe abortion. Although adolescents aged 10-19 years account for 11% of all births worldwide, they account for 23% of the overall burden of disease (disability-adjusted life years) due to pregnancy and child birth (WHO, 2014:15). WHO (*Ibid*) estimates 3 million unsafe abortions are conducted every year.

For some young women, pregnancy and childbirth may be wanted and planned, but for many others, they are not. Factors like social pressure to marry and bear children early, inadequate sexual and reproductive health knowledge and inability to negotiate safe sex or resist coerced sex have contributed to the early pregnancies and motherhood. Adolescent pregnancies have an impact on countries’ development goals as many girls who become pregnant would have to drop out of school. A girl with little or no education has fewer skills and opportunities to find

a job. This leads to losses in a country's annual income. From an economic point of view, a young woman would have earned over her lifetime, if she had not had an early pregnancy.

2.4.2 Teenage Pregnancy in sub-Saharan Africa

The majority of countries with teenage pregnancies levels above 30% occur in sub-Saharan Africa (Loaiza & Liang, 2013). In some societies, early marriage and traditional gender roles are important factors in the rate of teenage pregnancy (Chibuzo, 2010 cited in Sibanda & Mudhovorzi, 2012). In some sub-Saharan African countries, early pregnancies are often seen as a blessing because it is proof of the young woman's fertility (Sibanda & Mudhovorzi, 2012:323). Government and non-governmental organisations (NGOs) have attempted to address this through policies and other initiatives, but despite huge investments and refinement of these policies, they continue to reach crisis proportions in most African countries (UNFPA, 2012).

Studies conducted on factors that contribute to teen pregnancy found the following as major contributors; earlier occurrence of menarche, risk taking behaviour, psychological problems, peer influence, coercive sexual relations, dysfunctional family patterns, poor health services, socio economic status, the breakdown of cultural traditions, reproductive ignorance and the cultural value placed on children (Yako & Yako, 2007).

2.4.3 Teenage Pregnancy in Lesotho

According to the LDHS (2014), 19% of women aged 15-19 have begun childbearing. The report notes that the proportion of teenagers who have begun childbearing rises rapidly with age, from 3% at age 15 to 40% at age 19. By age 19, nearly 40% of adolescent girls would have begun child-bearing. There has been a decline in the proportion of teenagers who have a child or who are pregnant from 20% in 2004 and 2009 compared with 19% in 2014 (*Ibid*). Factors like wealth status and location, that is, districts, rural and urban areas influence the child bearing rates among teenagers. Teenagers in the rural areas are more likely to begin childbearing earlier than their peers residing in urban areas as shown in the UNFPA report which stated that 23% of rural teenagers have had a live birth or are pregnant, compared with 12% of urban teenagers (UNDP, 2014).

Poverty is one of the drivers of the HIV and AIDS epidemic in Lesotho and the majority of people living in the rural areas are poor, as mentioned earlier. The teenagers born into poverty are less likely to have access to education, educated parents or family members who can talk to them about safe-sex practices and if they are female they are likely to turn to prostitution

as a way of supporting themselves and their families (UNDP, 2015:56). The rates are also different across the districts from a low of 14% in Maseru to a high of 25% in Butha-Buthe (MOHSW, 2014:75). Wealth status has an influence on child bearing as shown by a lower rate amongst wealthiest household compared to lowest wealth quintile, 6% compared to 28% in the lowest wealth quintile (MOHSW, 2014:11).

In Lesotho, most girls engage in sexual activities to avoid cultural ridicules, for example, being called 'mafetoa' (unmarried women) (Molapo, Adams & Zulu 2014:1270). The issue of adolescent fertility in Lesotho is important from both the health and social perspective. On the health perspective, as discussed above, teenage pregnancies come with higher maternal child mortality and morbidity and carries high risks such as pregnancy induced hypertension, obstructed or prolonged labour and unsafe abortion.

On the social side, teenage mothers are more constrained in their ability to pursue educational opportunities and find decent employment than young women who delay childbearing and thereby adversely impacting their long term well-being (MOHSW, 2014:11; UNDP, 2013). There are many emotional problems associated with teenage pregnancy, for example depression could make the mother feel like she is no good and a worthless person, resentment to her partner, fear that they cannot be the mothers they want to be (Whitman et al., 2001) and frustration that they will not be able to do the things that the rest of their peers are doing (Kaplan, 1997). This would result in lower self-esteem, and to lack purpose in life (Clement, 1998 cited in Sibanda & Mudhovorzi, 2012). According to Molapo et al. (2014:1270), school drop out for teenage mothers is also exacerbated by the educator's attitudes influenced by cultural perspectives.

The pregnancy also has a negative impact on their lives and those of their babies. These include difficulties in raising them due to lack of finances, lack of contact with their boyfriends and loneliness (Yako & Yako, 2007:77), as the babies' fathers denied responsibility which meant the fathers did not provide either social or financial support for the children (Chigona & Chetty, 2008:273).

2.5 HIV and Aids Interventions

2.5.1 HIV and AIDS Interventions in general

There are various initiatives that have been implemented to curb the impact of HIV and AIDS and the life skills interventions is one of them. In this study, focus is on life skills interventions with interest on the role it plays in building the resilience to HIV and AIDS among teenage mothers. UNAIDS (2014) describes life skills-based education as a methodology that uses participatory exercises to teach behaviours to young people that help them deal with the challenges and demands of everyday life (*Ibid*). The use of life skills education is seen as a good thing, and an essential part of the package of interventions needed to help young people successfully respond to HIV and AIDS that was endorsed by the United Nations Declaration of Commitment on HIV and AIDS in 2001 (*Ibid*).

A life skills based approach is said to help young people understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. It can have a positive effect on behaviours, including delay in sexual debut and reduction in number of sexual partners (Clarke & Aggleton, 2012:8). According to the 2010 UNGASS reporting on Indicator 11, a significant number of countries have coverage rates of life skills based HIV education in schools that are close to 100% (>75%) with Lesotho in the 75-99% range (cited in Ministry of Health and Social Welfare & National AIDS Commission, 2010).

The work of Collins (2010) offered insights into the issues around resilience building for teen mothers. This follow up study on the resilience in teenage mothers in New Zealand contributes to the existing body of evidence on the resilience building by social support interventions, in this case, teen parent unit. New Zealand is reported as having the second highest rates of teenage pregnancies among the developed countries. The study undertaken in 2008, followed up on a study undertaken in 2001. The report shows that the accounts given by the mothers of their lives over the seven years demonstrate factors known to be associated with resilience. It also notes that the services they have received have helped them build skills and competencies to support educational, social and economic participation. Although the study was carried out in a developed country, the work provides an idea of how resilience can be built through participation in social support initiatives which enhances life skills as well as highlighting the value of follow up studies.

Mainthia et al. (2013) study found that the life skills training programme had helped improve the health and quality of life of the single mothers and their children. The study noted that if

girls are given an opportunity ‘for economic development and hope for their future, they can in turn become sexually responsible’ (Mainthia et al., 2013:14). The women under the study had suffered from a range of problems including poor health, incomplete schooling, stigmatization and economic hardships. A follow up study conducted after the two years revealed that there was an improvement in their knowledge on sexual reproductive health shown by their increased use of contraceptives, their degree of literacy, individual incomes, and were now more positively perceived by their communities. The conclusion from the study is that education and an increased repertoire of life skills could facilitate a reduction in health risk behaviour as noted by Pharaoh, Frantz & Smith (2011:70).

The same trend was observed in girls who underwent a girl’s empowerment programme held in 2010 in Lesotho focusing on HIV and AIDS reduction and prevention, life skills and entrepreneurial training. Berry et al. (2013), concluded that such training and financial independence were essential to enable rural girls to complete their secondary schooling and help them to be less susceptible to transactional sex and its associated risks. A follow up study conducted after one year showed that most participants went on to develop their own small businesses after the programme (Berry et al., 2013).

There is consensus, from the studies above that education on the prevention of health risk behaviour and an increased repertoire of life skills could facilitate a reduction in such behaviours. The studies also show that there is value in conducting follow up studies to project beneficiaries to see whether the benefits, that is building resilience to HIV, from participation are still being enjoyed, in other words, the sustainability of benefits.

2.5.2 HIV and AIDS Interventions in Lesotho

The Government of Lesotho, in compliance with UN declarations on acceleration of efforts against the spread of HIV and AIDS among youth, has turned attention to the education sector. It has put in place the Education Sector Policy on HIV/AIDS and adopted as the 2008-2013 National Behaviour Change (NBCC) strategy. The Government has prioritised the country’s youth for a target audience for implementation of the anti-HIV and AIDS BCC strategy. This is justified on three counts. Firstly, youth make the largest component of the national population. Secondly, age renders youth the future of the nation. Thirdly, youth are more likely to outgrow habits that make them vulnerable to HIV and AIDS, than the elderly are (PHELA, 2009) and their behaviours are not yet solidified and hence more amenable to change than elders (Tiendrebeogo et al., 2003:6). Targeting them therefore affords greater opportunity for

security and cultivation of anti-HIV and AIDS BCC thus securing and promoting healthy behaviours that help prevent HIV infection.

Knowledge and awareness about HIV and AIDS in Lesotho is relatively high, being estimated at above 70% (PHDC, 2009:4). But there is no correlation between knowledge and practice as demonstrated by the high HIV rates – see chapter 1. There is a lot of enthusiasm, at the policy level, in dealing with the HIV as shown by the Government's adoption of the 2008-2013 national behaviour change (NBC) strategy against the spread of the HIV and AIDS among youth and efforts by the Ministry of Education and Training (MOET) to develop the Education Sector HIV and AIDS Policy. These instruments are meant to provide guidance on HIV and AIDS to all levels of the education system that is, learners, employees, employers and other providers of education and training in all formal and non-formal learning institutions.

The Government also undertook comprehensive review of the curriculum using UNESCO's International Technical Guidance on Sexuality Education incorporated the Life skills curriculum in the primary and secondary school levels of the education. The revised Life-skills Education (LSE) incorporates gender transformation, comprehensive sexuality education that is scientifically accurate, age appropriate, and culturally relevant for grades 4 (9 year olds) to Grade 10 (15 year-olds).

It is the Life Skills curriculum in the primary and secondary schools of Lesotho that has been cause of concern due to the non-responsiveness of its materials to HIV and AIDS (PHDC 2010:4). According to Tiendrebeogo et al. (2003:6), providing young people with life skills such as self-esteem, high efficacy help them to translate information about HIV and AIDS into protective behaviours against HIV infection. They must know effective prevention methods and have skills to adopt them. Bulled (2014:104) notes that the life skills curriculum did not 'directly address taboo topics such as sex and substance abuse' due to some local sensitivities around the topic. Schools as a result were encouraged to collaborate with NGOs to ensure that students received a complete set of skills and messages that complemented rather than contradicted each other (Bulled, 2014: 104).

The issue of pedagogical autonomy on the teachers was also raised as it may 'reduce the fidelity of the intervention' implementation by failing to address or inappropriately addressing disease prevention knowledge and skills according to Bulled (2014:104).

2.5.3 Resilience and life skills among teen mothers

Resilience is defined as a positive adjustment to hardship (Van Rensburg, Theron & Rothman 2015:1) and a process of overcoming the negative effects of risks exposure, coping successfully with traumatic experiences and avoiding the negative trajectories associated with risk (Zimmerman & Fergus, 2005:1). A precondition, as emphasized by Van Rensburg et al. (2015:1), is that resilience should be a lived experience of risk that is personally threatening and for it to occur, promotive factors need to be strengthened until they ‘overcome or ameliorate the negative effects of risk exposure’. In articulating adolescent resilience, they note that for youth to avoid negative effects of risk there should be an existence of promotive factors, that is, assets and resources. Assets refer to the factors that are within an individual; for example, self-efficacy, competence and coping skills and resources are those that are external to an individual such as community organisations and parental support.

Teenagers are capable of learning the skills that it takes to be resilient and be able to utilize them to cope and recover from problems and challenges through life skills training from external resources like the community groups. External resources can be a focus of change to help adolescence face risks and prevent negative outcomes. Lekganyane (2014:80) notes the inequities in terms of gender power, lack of proper interventions and psycho social support for teenage mothers as challenges that teenagers and teenage mothers in South Africa face.

For nearly 20 years, “life skills” education has been advocated as a key component of HIV and AIDS education for children and young people as it increases knowledge and supportive norms through teaching skills and increasing motivation and intention to change behaviours (Yankah & Aggleton, 2008). In support of this notion, Molapo et al. (2014:1271) point out that life skills programmes would sensitise all learners (male and female) about preventing pregnancies, enable school going as well as out of school mothers to adapt and deal effectively with the demands and challenges of life. Life skills programmes including economic empowerment components hold promise for reducing extreme poverty, interrupt the nexus between gender-based vulnerability and a host of harmful outcomes including violence, transactional sex and HIV infection. This is also supported by the end of programme evaluation findings that are discussed above where positive impacts of the project on the teen mothers were realised. In their review of literature on effectiveness, nature of life skills programmes in developing countries, Yankah et al. (2008) found that, overall, effective interventions were shown to have positive effects on knowledge, attitudes, and skills and sometimes on behaviours.

2.6 Phela Life Skills Project

PHELA Health & Development Communications is a non-profit making health and development communication organisation that uses the power of the mass media (radio, TV and print) communication strategies to disseminate information with the aim to have a positive impact on social and behaviour change (PHELA, 2015). In its company profile, PHELA describes itself as a health and development communication non-profit-making NGO striving to contribute to an empowered, healthy, HIV-free Basotho nation where people are empowered to make choices, take control of their lives and participate actively in the development of Lesotho (www.phela.org.ls).

Phela operates in 10 administrative districts of Lesotho. In 2009, the organisation received funding from Irish Aid to implement a project called Phela Friends Programme (PFP). The aim of the Phela Friends (life skills) project was to train club leaders in Primary and Secondary Schools around Lesotho. These leaders were trained on life skills so as to act as peer educators to others.

The major objectives of the Phela Friends (Life skills) programme were:

- To compliment life skills curriculum in Lesotho
- To establish extra curriculum activities
- To involve pupils in practical activities through clubs
- To equip young people with knowledge and skills to make informed life choices
- To equip young people with correct and up-to-date information on HIV and AIDS (PHDC, 2009).

Club members and leaders were involved in various activities such as drama, debates, competitions, game and income generating activities (PHDC, 2009). The project also provided juvenile inmates and teen mothers with life skills as part of their rehabilitation initiative. The duration of the project funding was for 5 years.

The project addressed capacity building for Basotho youth to gain knowledge on needed information and skill for them to avoid HIV infection and take charge of their lives from an early age. It further equipped them with skills to disseminate information to others in their schools and communities. Both mass media and social mobilisation were used to implement this life skills project.

The project was implemented through social mobilisation consultations with the Ministry of Education, districts education offices and schools authorities in order to get permission to work with the pupils in the schools. Teachers were also sensitized on life skills so that they can support the activities and motivate the club leaders to do their work. Three teachers in each school were selected to support the life skills programme and to ensure that pupils who were sensitized and trained as life skills club leaders in their school hold sessions for other pupils in schools.

For mass media; pupils participated in debate competitions, songs and dramas with life skills messages, radio and TV programmes were broadcast in the national and other radio stations within the country whereby the project was further shared with the general population. Pupils were also exposed to TV shows, whereby they disseminated messages to the other youth in the country and they were engaged in questions and answers as the shows were live and phone in TV programmes. Moreover, the project has produced and aired a life skills drama called Palesa ea Bocha (The beauty of youth) and a booklet called “Skeem Saka” (My Friends) was produced and distributed to the general population of young people. Furthermore, Phela Friends has developed the Life Skills manual to guide life skills trainings and dialogues between club leaders, club members and teachers.

2.6.1 The pilot study- Formative study

At the beginning of the project – 2009 – a formative study was undertaken with the aim of establishing need for PHDC’s intervention towards helping Lesotho achieve its aim of ensuring anti-HIV and AIDS BCC in its youth. A pilot known as the Phela Friends Programme (PFP) life skills was also run concurrently with the study. The primary aim of the PFP programme was to build life skills capacity in youth as a way of empowering them with anti-HIV and AIDS and other life threatening hazards behaviour change.

The formative study established that there was general appreciation of having the Life skills curriculum as an extra-curriculum intervention as the spread of HIV among the youth was of major concern. It was accepted that Phela’s intervention had great potential to make a difference. A recommendation to revive some of Basotho cultural ways to implement guided peer-to-peer education and the adoption of a joint collaborative approach to anti-HIV BCC was put forward. The study also recommended a context-based approach to activities for prevention of HIV and messages for anti-HIV BCC activities. These findings informed Phela’s

intervention in Lesotho's efforts to bring about anti-HIV and AIDS behaviour change among youth.

The PFP targets youth in school and those out of school. At primary school level, beneficiaries are pupils aged between 9 and 13 years. While at secondary level the project interacts with pupils of the ages of 13 to 18. In 2011 this was expanded to reach the out of school youth, targeting the juvenile inmates (18 years and below) and in 2012 incorporated teenage mothers based at the Good Shepherd Home in the Berea Plateau (PHELA, 2014).

2.6.2 Baseline study

In response to the findings and recommendations from the formative study PHDC decided to commission a baseline study in order to ascertain relevance and impact aimed at providing an empirical assessment and monitoring of the implementation of the life skills PFP. The study was carried out in the first quarter of 2012 and covered the other objectives of the programme except the teen mothers since this component was fully implemented during Financial Year 2012/13. The aims of the study was to establish the potential successes, challenges, perceived improvements and sustainability of the PFP as an intervention aimed at collaborating and cooperating with the Ministry of Education and Training (MOET) in her attempts to pursue and enable the Lesotho Government to realize the goal of an HIV and AIDS-free youth in Lesotho.

The overarching finding from the study was that the PFP was a viable *botho*/humaneness-building intervention through which the Lesotho Government through continual, supported consultations, collaboration and cooperation of the MOET and NGOs such as PHDC in particular, can realize its dream of an HIV and AIDS and other life hazards-free youth. The study however, pointed to challenges which, if left unattended, can threaten effectiveness of the PFP and therefore of failure to effect the desired BCC among youth. One of such findings is continued non-enforcement of the policy on implementation of the school Life Skills curriculum which poses as one of the major constraints in Phela's efforts to effectively implement PFP.

The study also observed that PFP has potential to be sustained and bring about desired BCC, but provided there is support and commitment from the MOET which could be in the form of, among others, provision of intensive life-skills content and pedagogy for teachers and teacher education institutions.

2.6.3 Impact evaluation study

In 2014, an end of programme evaluation covering the period 2010-2014 was carried out on PHELA's life skills programme (PHELA, 2014). The purpose was to assess the extent to which the projects' objectives were achieved, facilitate self-analysis of overarching lessons learned, and made recommendations that will influence future interventions. The results of Phela were examined in the context of the Life Skills curriculum covering the following topics: facts on HIV and AIDS, ART Education, defining life skills and its categories, self-confidence, self-esteem, peer pressure, problem solving, decision making, listening skills, reproductive health (Physiological changes of the body) and improving the reading culture.

The evaluation focussed, among other things, on assessing to what extent the teen mothers at the Shepherd of Good Hope institution had been equipped through the PHELA skills to reconstruct their lives and make positive choices in future. The PHELA objective "To equip the beneficiaries with skills to reconstruct their lives and possess skills to make positive choices going forward", applied more to the young people at the Juvenile Ward and Shepherd of Good Hope as these two groups represent young people who have experienced the consequences of high risk behaviour.

For the purposes of this study, focus is going to be on these teen mothers. To a large extent it was found that the project had an impact on the lives of the teen mothers, especially on issues pertaining to self-esteem, self-confidence, anger management, knowing how to be independent and protecting oneself from HIV and AIDS. However, the challenge of continuity was identified. It was noted that the knowledge sharing and use would continue beyond the project life span although the activities might not without funding (PHELA, 2014).

2.7 Theoretical Framework

The Health belief model (HBM), self-efficacy, and the resilience theories have been used to explain the resilience building to HIV and AIDS of teenage mothers through life skills training offered. Understanding the behaviour of teenage mothers, requires focusing attention from the individual to the social organisation, that is, the ongoing social networks and relationships between them. The three theories help in the understanding of teenage behaviours as they bring in different facets into understanding teenage health behaviours. The HBM focuses more on the individual and postulates that people will take action to prevent illness if they regard themselves as susceptible to a condition (perceived susceptibility), if they believe it would have

potentially serious consequences (perceived severity), if they believe that a particular course of action available to them would reduce the susceptibility or severity or lead to other positive outcomes (perceived benefits), and if they perceive few negative attributes related to the health action (perceived barriers) (Jones, Jensen, Scherr, Brown, Christy & Weaver, 2015).

The Self efficacy theory on the other hand puts more emphasis on the global influence of perceived self-efficacy as it affects health habits directly. It states that human behaviour is dynamic and influenced by the interaction of internal and external forces and their interactions with their environment. The resilience theory brings in the 'personality characteristic that moderates the negative effects of stress and promotes adaptation' (Sagonea & De Carolia, 2013:839). It focuses on understanding healthy development in spite of risky exposure through the use of promotive factors which help the teen mothers to overcome the negative effects of exposure to risk by focusing on positive things.

2.7.1 The Health belief Theory

The behaviour of the teen mothers can be explained by the Health belief model (HBM) which argues that a person's readiness to act is influenced by the people's beliefs about whether or not they are at risk for a disease or health problem as well as their perceptions of the benefits of taking action to avoid it. Also assumed in this is that the individual should feel competent to take action. This explains the model that Phela used, where through life skills training, teen mothers are made aware of health risks (HIV and AIDS awareness) and actions to mitigate as well as ensuring they feel confident and competent to implement positive behaviour change. The theory is based on the understanding that an individual takes health related action if he or she:

1. Feels that they can avoid a negative health condition (for example HIV)
2. Has a positive expectation that by taking a recommended action they will avoid a negative health outcome
3. Believes in herself that she can take the recommended health action and succeed

The model was developed in the 1950s in an attempt to understand why people did not participate in programmes designed to prevent or detect disease. According to Banana (2007:2), the model can describe or predict a person's behaviour as an expression of his/her health beliefs and a justification to interventions that alter the maladaptive health behaviours.

The HBM is based on the desire to avoid a negative health consequence as the major motivation. For example, a negative consequence to be avoided could be HIV transmission. Teenagers can avoid engaging in risk behaviour in order to prevent HIV transmission. The major components of the HBM are, individual perceptions, modifying factors and variables affecting likelihood of taking action (see figure1 below). There are three components which are; perceived susceptibility, perceived severity, perceived benefits and barriers to engaging in a behaviour, cues to action and self-efficacy (Fisher & Fisher, 2000:5).

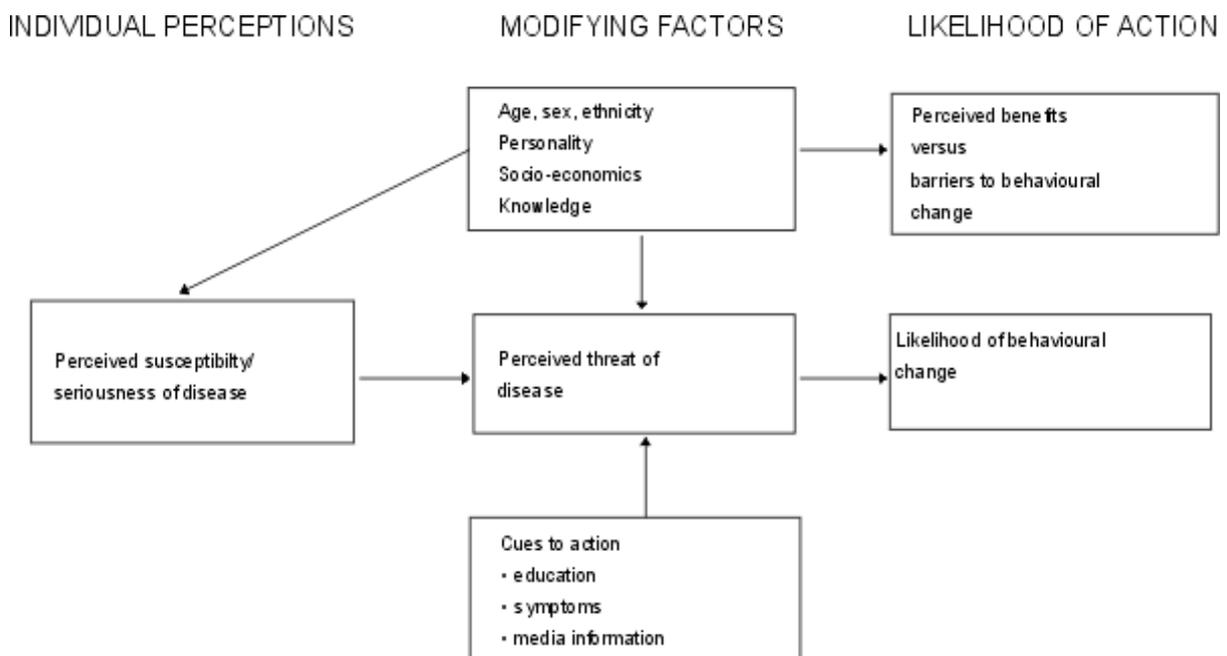


Figure 2 Health Belief Model (Adapted from Glanz et al., 2002:52)

Perceived susceptibility

This is the belief about the likelihood of getting a disease or condition, for example, if the teen mothers believe that they are going to get HIV if they engage in risk behaviours, may prompt one to take action. Teenagers, teen mothers included, have a low perception of risk of HIV transmission, there is therefore need for adequate and correct information on HIV and how it is transmitted in order to increase their perception of vulnerability to transmission.

Perceived Severity

This is the belief about the seriousness of contracting an illness or condition. This includes physical conditions for example death and social consequences. Perceived severity of HIV transmission refers to how seriously individuals view the consequences of HIV transmission. Teenagers should be made aware of how serious the consequences of HIV transmission are

and be helped to understand that HIV and AIDS is an incurable condition that can be prevented. This can be done through the life skills training and awareness trainings.

Perceived Threat

Perceived benefits are beliefs about positive features or advantages of a recommended action to reduce threat. The benefits might reduce the threat of a disease or its consequences. Here we are looking at the beliefs one has about the effectiveness of the options that are available to reduce the threat of the disease. Teenagers can benefit from the information provided during the life skills training about what actions are available to prevent disease transmission, in this case, HIV, where the services are and how to access them.

Perceived barriers

These are the possible obstacles to taking action which can include negative consequences resulting from an action (Skinner, Tiro & Champion, 2014:7). These refer to the cost and effort of taking measures to prevent HIV transmission (Banana, 2007:17). Teenagers encounter barriers that prevent them from taking measures such as inability to communicate with sexual partners on preventive measures like condom use. The life skills' training empowers the teenagers to be able to negotiate with partners and being able to make healthy decisions. The benefits of taking action are weighed against the perceived barriers and that analysis determines the likelihood of taking action.

Cues to action

These are cues that prompt individuals to act. These can be in the form of messages through various media like posters, billboards, messages on pens and others. The messages can be various healthy behaviour ones like HIV prevention, condom use, HIV testing and counselling. The cues can also be internal, that is, feeling a symptom that increases a perceived threat. Cues operate mainly through perceived threat according to Rosenstock & Strecher (1997).

Self-efficacy

Self-efficacy refers to confidence in one's ability to perform an action. Information and skills on resilience building is provided through life skills training as well as HIV knowledge can be provided to teenage mothers. The taught skills, encouragement from peers and facilitators as well as watching others do it would make them also take action.

Modifying factors

According to the Health Belief Model demographic, socio-psychological and structural variables (e.g. knowledge) are regarded as modifying factors that impact on the perceived threat of a disease. They affect indirectly the preventive behaviour of an individual and hence their

perceptions and likelihood to take action (Banana, 2007:19). Banana (2007) further explains that age and gender have an effect on the perceived individual threat of an illness and the ability to avoid the risk. Adolescents are considered the most at risk age group as they experiment with sex. Gender on the other hand has an impact on the individual perception especially where there is disparity in access to health information. Women in patriarchal societies like Lesotho, in this case, feel helpless to take action even if they see the threat due to various reasons including poverty and power disparities (Banana, 2007:15).

Likelihood of taking action

Likelihood of taking action to prevent a disease is influenced by the degree of individual perceptions of severity of the disease, as well as how threatening the individual feels the diseases is to him/her (perceived vulnerability) (Banana, 2007: 20). If the teen mothers see the severity of the disease as well as their likelihood to get it, they are bound to take action. These are viewed with the cost-benefit analysis of taking preventive action.

The HBM model is appropriate for this study as the survey will explore individual perceptions with regard to HIV infection, transmission and prevention. In this case, preventive behaviour will be a result of training in life skills and practicing the skills learned.

2.7.2 The Self Efficacy Theory

Self-efficacy, a construct of the Social Cognitive theory by Bandura, is the belief in one's own ability to accomplish something and perceiving an incentive to do so, that is, one's capabilities to organise and execute the courses of action required to manage prospective situations (Bandura, 1995:2). It is about what a person can do rather than personal judgments about one's physical or personality attributes (Zimmerman & Cleary, 2006). Given that self-efficacy has got powerful effects on individuals' behaviour there is need to identify its origins. There are four principal sources of self-efficacy identified by Bandura (1997); past performance, vicarious experience, verbal persuasion, and emotional cues as shown in the diagram below. These components help individuals determine if they believe they have the capability to accomplish specific tasks.

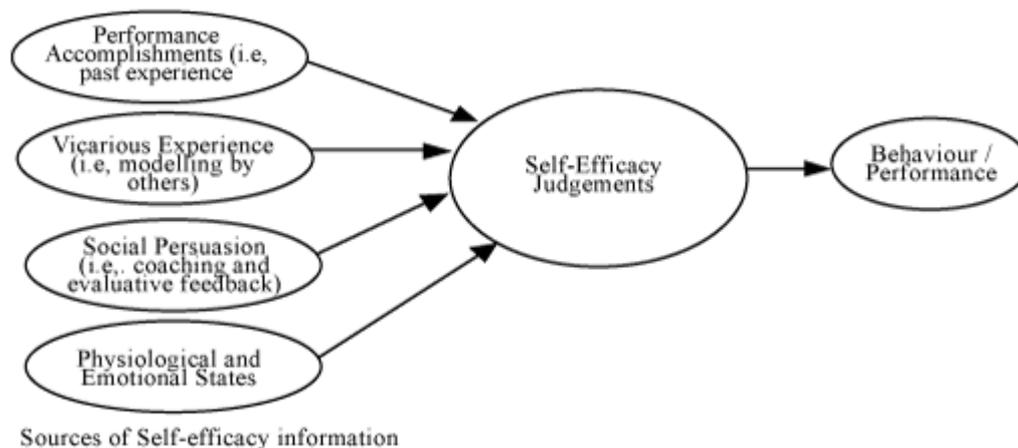


Figure 3 Source of Efficacy information (Source: Bandura 1997)

Past performance/ Mastery experience

Individuals need to attempt tasks, work through obstacles and succeed to develop a sense of efficacy. Positive and negative experiences can influence the ability of an individual to perform a task. If one has performed a task well previously, he or she is more likely to feel confident and perform well at a similarly associated task (Bandura, 1997). During the life skills training, the teen mothers gain the skills to perform certain actions, if they succeed, they will be willing to perform again.

Vicarious Experience

Individuals can develop high or low self-efficacy vicariously through other people’s performance. If a person sees someone similar to them succeed, like another teen mother or a person of same age, it can increase or boost their self-efficacy. Vicarious experience is most effective when one sees oneself as similar to the person that is being modelled. Watching other teen mothers succeed in regaining their lives might increase another teen mother’s confidence.

Verbal Persuasion

This involves convincing or persuading an individual that she or he has or doesn’t have the ability to succeed at a particular task. This is more effective when it is used through the Pygmalion effect, which is a form of ‘self-fulfilling prophesy in which believing something to be true can make it true’ (Lunenburg, 2011:4). Using verbal persuasion in a positive light leads individuals to put forth more effort. The power of the persuasion would be contingent on the leader’s credibility and their influence on the individuals (Lunenburg, 2011:3). In the life skills training, the peer supporters and the project facilitators are respected and have an enormous influence on the teen mothers.

Emotional Cues / Somatic and emotional States

According to Bandura, emotional cues dictate self-efficacy. Physical and emotional states that occur when someone contemplates doing something provides clue as to the likelihood of success or failure. There are physiological symptoms associated with the expectation of failure like a pounding heart, feeling flushed, sweaty palms, headaches, and so on. These however vary from individual to individual. Their persistence may become associated with poor performance.

The project approach of empowering teen mothers with life skills and training to tackle the issues of HIV and AIDS is based on the notion that youth learn from the actions of their peers (vicarious experience) mastery experiences through the life skills training programme, verbal persuasion during the trainings, interactions and social persuasion. Emotional and physical state also affects self-efficacy and therefore the behaviour of teen mothers. This can be increased by providing clear instructions, providing the opportunity for skill development or training and modelling the desired behaviour. In support, Bandura (2004) mentioned that an effective preventative programme includes four major components; informational, where children/youth are informed of the health risks and benefits of different lifestyle habits, development of social and self-management skills for translating informed concerns into effective preventative practices. Also, building a resilient sense of efficacy to support the exercise of control in the face of difficulties and setbacks that inevitably arise as well having social support for desired personal changes.

2.7.3 The Resilience theory

Resilience is a dynamic process wherein individuals overcome the negative effects of risk exposure and cope with the traumatic experiences successfully and avoid the negative trajectories associated with risks (Zimmerman & Fergus, 2013:399). It is a process rather than a particular character trait and is seen as being built upon the complex interaction and operation of risk and protective factors at individual, family and community levels (Mitchell, 2011:1). Research has demonstrated that many youths overcome overwhelming risks in their environment and develop successfully into competent and resilient individuals (Fergus & Zimmerman, 2005). It is understood that exposure to adversity does not necessarily result in negative outcomes, the presence of one or more protective factors can reduce the effects of exposure to adversity. The more protective factors available, the more resilient a young person will be. Adolescents living in adverse developmental conditions benefit from protection or

support to overcome obstacles and adversities, and thereby enhance their own powers of resilience within their environment (Mampane, 2014:1).

The term resilience is often confused with positive adjustment, coping, or competence. Although related, they are distinct. Positive adjustment refers to an outcome of resilience. When youth overcome a risky situation they have adjusted to their new context. In this situation, positive adjustment is a resilient outcome, but the process of overcoming the risk is resilience. Competence is an asset that can be a vital component in a resilience process. Competent youth are expected to be more likely to overcome the negative effects of a risk and competence is only one of many assets that help adolescents overcome adversity.

The resilience theory focuses on understanding healthy development in spite of risky exposure through the use of promotive factors. These help the youth to overcome the negative effects of exposure to risk by focusing on positive things. These are positive social and individual variables that disrupt 'developmental trajectories from risk to problem behaviours and poor health outcomes' (Zimmerman, 2013:2). The theory provides a framework to understand the development of a child and adolescent, why some adolescents exposed to high risk do not develop negative health and social outcomes. This will inform the design of programmes or interventions for the adolescents, who should not be viewed as the problem that need to be 'fixed' but rather as change agents that possess positive assets and resources in and /or around them (Brindis, Sattley & Mamo, 2005: 26).

A key requirement for resilience is both risk and positive factors. Positive factors can be the compensatory factors, those that neutralise risk exposure in a counteractive form as well as protective factors, which lessen or modify the impact of risk (Ostaszewski, 2012). The promotive factors constitute resources and assets, with resources being the positive factors that reside outside individuals like parental support or youth programmes that provide them with opportunities to learn and practice skills (Zimmerman, 2013: 2). Assets on the other hand, are attributes that reside within an individual like self-efficacy and self-esteem. A combination of the two provides the youth with all the necessities for healthy development. There are three models of resilience; compensatory, protective, and challenge that explain compensatory model is defined when a promotive factor counteracts or operates in an opposite direction of a risk factor. A compensatory model therefore involves a direct effect of a promotive factor on an outcome. This effect is independent of the effect of a risk factor.

Figure 3, below depicts how compensatory factors operate to influence outcomes. It implies that positive factors, which have been labelled as ‘compensatory factors’ can neutralise or counteract the effects of risk factors. They do not interact with risks but have direct and independent influence.

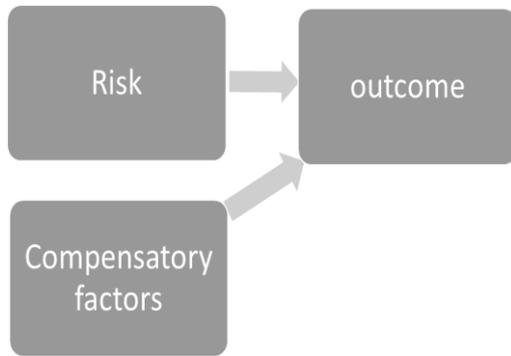


Figure 4 Compensatory model

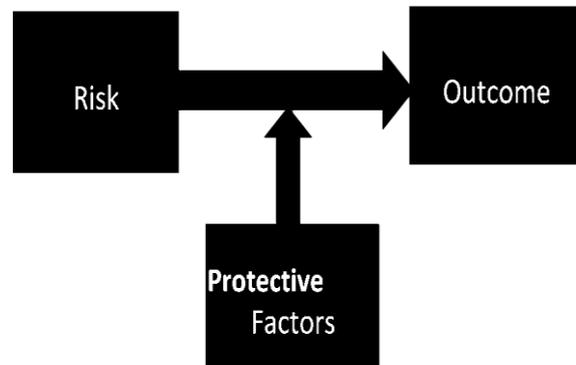


Figure 5 Promotive model

Another model of resilience is the protective factor model. In this model, assets or resources moderate or reduce the effects of a risk on a negative outcome. In Figure 4 above positive factors have been labelled as “protective factors.” Positive factors interact with risk factors and modify/lessen their impact.

A third model of resilience is the challenge model. In this model, the association between a risk factor and an outcome is curvilinear suggesting that exposure to low levels and high levels of a risk factor are associated with negative outcomes, but moderate levels of the risk are related to less negative or positive outcomes (Luthar & Zelazo, 2003:513). Adolescents that have been exposed to moderate levels of risk are confronted with enough of the risk factor to learn how to overcome it but are not exposed to so much of it that overcoming it is impossible. Adolescents exposed to moderate level of risk learn how to overcome it and repeated exposure to moderate level of risk may help to prepare adolescents to overcome more serious risks. The youth are provided with a chance to practice skills or employ resources. In the project, the youth were trained in life skills that promote positive factors that reside in themselves like self-efficacy and self-esteem resilience. For resilience to be experienced there should be the presence of both the risk and promotive factors and the risk is the HIV and AIDS and its associated impacts.

2.8 Conclusion

This Chapter discussed the literature review pertinent to the study. This included; unemployment and poverty in Lesotho, migration in Lesotho, HIV and AIDS situation in Lesotho, HIV and Youth, Causes and impacts of teenage pregnancies, HIV and AIDS interventions in Lesotho, resilience and life skills among teen mothers and the impact evaluation of Phela. On the theoretical framework, a review of the Health belief model, Self-efficacy and Resilience Theory was conducted. Chapter 3 describes the research methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research method that was used in the investigation. The first section discusses the research methodology. Negotiating access to study site is discussed in section two. Section three discusses data gathering techniques used and the analysis strategy employed. Section four discusses the ethical considerations that were adhered to in the study. The challenges encountered during fieldwork are outlined in section five. A conclusion is provided in section six.

3.2 Research Methodology

A research methodology is a systematic way to solve a problem (Creswell, 2014). This involves the procedures that the researcher goes about their work describing, and explaining phenomena. This section will discuss the methodological issues that are applicable to this study.

3.2.1 Research Design

This study employed a quantitative research design. A quantitative research design, is defined as the investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design (Polit & Beck, 2008:763). Quantitative research studies the relationship of one set of facts to another by collecting facts using numerical data, structured and predetermined research questions, conceptual frameworks and designs (Bell, 2014:9). Burns & Grove (2011:34) define quantitative research design as a formal, objective, rigorous, systematic process for generating numerical information about the world.

In this research, the quantitative design allowed for measurable variables such as knowledge, information, likelihood of use and usefulness of skills and information among the teenage mothers to determine the effectiveness of the life skills in building the teen mothers' resilience to HIV and AIDS.

3.2.2 Research method

A survey research method used. Survey involves the use of standardized questionnaires to collect data about people and their preferences, thoughts, and behaviours in a systematic

manner. This method is best suited for studies that have individual people as the unit of analysis (Bhattacharjee, 2012:73) as envisaged in this research study.

A survey has several inherent strengths compared to other research methods. They are considered as an excellent economical vehicle for measuring a wide variety of unobservable data, such as people's preferences, attitudes or factual information (Blackstone, 2012:192). A survey enables the collection of information from one or more groups at the same time (Babbie, 2015) and are suited for remotely collecting data about a population that is too large to observe directly. In this study information was gathered from the 28 teen mothers who had previously participated in the end of project evaluation and were now located at different sites. Respondents also prefer their unobtrusive nature which enables them to complete at their convenience. The method does have disadvantages, such as non-response bias, sampling bias, social desirability bias and recall bias.

3.2.3 Research Population

The study population were 28 teen mothers who were resident at the Shepherd of Good Hope and participated in the 2014 end of project evaluation exercise. These teen mothers were resident at the institution for a period of 2 years and thereafter released back into their communities. A list and contact details of those who participated in the intervention was compiled by the manager at the institution. They were contacted and informed about the study. All 28 teen mothers were recruited to participate in the study and they all responded.

3.2.4 Sampling strategy

Sampling involves selecting individual units or cases from a much larger collection or population, such that the researcher can study the smaller group and produce accurate generalizations about the larger group. Sampling methods which are common include probability sampling which encompasses simple random sampling, systematic sampling, stratified random sampling, cluster sampling and panel sampling (De Vos et al., 2005).

The sample was drawn from the teenage mothers who were resident at the Shepherd of Good Hope and had participated in the 2014 end of project evaluation. This study used the total population sampling, which is a type of purposive sampling technique where a researcher chooses to examine the entire population that has a particular set of characteristics. It is acceptable when the sample being investigated is very small. The entire population was chosen in this study due to its size. Twenty-eight teen mothers who participated in the Phela Life skills project and its end of project evaluation exercise.

The advantage of total population sampling is that the involvement of all members within the population of interest provided deep insights into the study and reduced risk of missing potential insights from members that are not included.

3.3 Negotiating Access to the Research Site

Contact was first made with the Phela, the organisation that provided life skills and HIV and AIDS training (See Annexure C and D attached). An arrangement was done for Phela to meet with the Good Shepherd of Hope during one of their field visits. The staff at the institution helped with the identification and location of the teen mothers, including their contact details. One of the teen mothers who is now a trainer at the institution offered to coordinate the exercise. This made access to the teen mothers, who had already left the institution easier. The staff at the institution was made familiar with the questionnaire as well as the research proposal. They then contacted the teen mothers and sought consent for their participation and conducted interviews.

3.4 The Method of Data Collection Employed

3.4.1 Data collection tool

3.4.1.1. Questionnaires

This study used structured questionnaire to collect data. The structure of the questionnaire covered close-ended questions and the use of Likert Scale to rate responses. Likert Scale is a method that uses standardised response categories with end-points (such as the use of a response category: “Relevant”, “Irrelevant”, “Totally Irrelevant” and “I don’t know”) to determine the respondents’ views. These response categories allow the respondents to express their degree of agreement that might vary in terms of relative intensity.

3.4.1.2 The structure of the Questionnaire

The questionnaire (see Annexure A) was divided into four sections:

Section A- Biographical Information - covered background information with a series of questions designed to elicit demographic information about the teen mothers like age, education level, marital status, number of children and others.

Section B -Effectiveness of Training -The section explored the usefulness of the training programmes in helping participate to cope with HIV and AIDS and how the skills provided helped them deal with HIV and AIDS

Section C - explored the participants' level of knowledge of HIV and AIDS issues before, during and after their participation in the programme (where 0 represents least knowledgeable and 5 represents most knowledgeable)

Section D- explored the benefits from participating in the programme basing on the BEFORE, DURING and AFTER phases. This section focused on what they can now do using the skills and knowledge from the training.

3.4.2 Data collection strategy

Data was collected through as interview questionnaire. The management at Good Shepherd of Hope provided a list of all the girls that participated in the 2014 end of programme evaluation. These were also contacted and consent was sought from them. Following the process of getting informed consent, and face-to-face interviews were conducted.

3.4.3 Reliability and validity

The notion of reliability and validity is very important in social science research. Careful consideration of reliability and validity enhances the credibility of research findings. For Joppe (2000), reliability means the extent to which results are consistent over time and an accurate representation of the total population under study. If the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. This survey was 100% representative of the research population. Because of the size of the population all the participants were contacted and all the 28 participants were available to participate.

According to Joppe (2000), validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are. In other words, does the research instrument allow you to hit "the bull's eye" of your research object? Researchers generally determine validity by asking a series of questions, and will often look for the answers in the research of others. In this study, reliability was ensured by careful benchmarking of the research instrument and thorough process of data collection. The research instrument used was compared with other similar instrument used before with necessary modifications. Personnel from the institution were sufficiently trained in the use of the tool to ensure that they interpret and help the respondents if and when they needed assistance to complete the instrument correctly.

3.5 Data Analysis and Interpretation

Kawulich (2004: 97) describes data analysis as a process of reducing large amounts of data to make sense out of it. After all questionnaires had been received, the results were analysed using a computer based data analysis package SPSS. The process included data quality checks, descriptive statistics, checks for assumptions before selecting the most appropriate statistical technique, running analysis and writing up the findings.

3.6 Ethical Considerations

3.6.1 Anonymity

The study ensured anonymity was maintained by the use of anonymous and self-administered survey questionnaires as well as ensuring that during information sharing and reporting the use of proxy names and consent seeking was employed.

3.6.2 No harm

Harm can be both physical and/or psychological and therefore can be in the form of; stress, pain, anxiety, diminishing self-esteem or an invasion of privacy. It is imperative that the evaluation process does not in any way harm (unintended or otherwise) participants. The main concerns in research ethics was the protection of participants from harm or the limitation of risk of harm. The researcher ensured that the questionnaire completion was done at their own convenient time and place. Since the participants were in different locations, they chose to do the exercise in environments that were safe and with space for freedom of expression. There were no reports of participants who were emotionally affected by the study.

3.6.3 Confidentiality

Confidentiality implies that any identifying information is not made available or accessed by anyone. It is “the obligation of an individual or organization to safeguard entrusted information.”(Centre of Genomics and Policy (CGP), Maternal Infant Child and Youth Research Network (MICYRN), 2012). During the research, all identifiable information on participants were excluded from reports and not disclosed to others. The data was collected with consent of the participant and an explanation on who will have access to the data. It was indicated that only the researcher would have access to data.

3.6.4 Informed consent

All research participants were told about the study's aim and objectives, its intended use and possible benefits. They were informed that their participation was voluntary and without repercussions for non-participation. Participants willing to participate were asked to sign Consent forms attached in Annexure B.

3.6.5 Provision of debriefing, counselling and additional information

Protection from harm, which can be emotional or psychological, can be assured since the research topic can touch on sensitive issues through the various methods of research that were used. Participants were assured of referral services if they need further management or counselling services. There were no reports of participants who suffered emotionally during the study.

3.7 Limitations of the Study

The study is limited to one institution and just 28 teen mothers which can affect generalisability to others. Sample size of 28 was very small to make general findings on all HIV and AIDS interventions in Lesotho on teenage mothers. The survey targeted a small sample of teen mothers which might not be a fair representation of the whole teen population.

Another limitation of this study was that a quantitative method was used, the study only recorded participants' responses without verifying behavioural change. Therefore, what is reflected is what they say and less what they do. The quantitative analysis does not give an opportunity of further probing. However, a quantitative research design was ideal for the intended purpose of the study.

3.8 Conclusion

Chapter 3 described the research design that was used in the study, which is the quantitative. It described the survey as the method as well as the questionnaire and its items. It also described the process of data collection, data analysis, limitations to the study and the ethical considerations.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter presents findings from the research exercise described in Chapter 3. It starts by providing an overview of the respondents in the first section. The usefulness of the information in helping the teen mothers cope with HIV and AIDS is discussed in the second section. Section three discusses the level of knowledge on HIV and AIDS and Life skills. The results from the analysis on the benefits derived by the teen mothers from participation in the project are presented in the fourth section. Fifth section presents the limitations to the study. The conclusion is presented in the sixth section.

4.2 Characteristics of Respondents

The nature of the sample is reflected through descriptive statistics generated as outlined below. These include age, current residence, educational qualification, employment status, marital status, and number of children each of the respondents has. Table 1 outlines the distribution of responses across the various categories as outlined. Twenty-eight teen mothers took part in the survey.

The general characteristic of the respondents reveal that it is composed of teen mothers whose ages range from 15- 21 years, with the majority (9) aged 20 years at the time of the interview. The results indicate that 20 out of the 28 have children of their own and 8 (aged 16-19) do not have children. The implication is that their children may no longer be alive. According to the statistics, the youngest age the teen mother fell pregnant was 12 years old, after discounting the two years they participated in the program, and the eldest was 19 years of age.

Table 1 Characteristics of respondents

Age	15	16	17	18	19	20	21	Total
Number	1	3	4	2	7	9	2	28
Number of children	1	2	2	2	4	8	1	20
Education								
Primary	1	2	2	2	0	3	0	10
Secondary	0	1	2	0	7	6	2	18
Place of residence								
Urban	1	1	2	1	3	7	2	17
Semi-urban	0	2	1	1	2	2	0	8
Semi-rural	0	0	1	0	2	0	0	3

In terms of educational achievement, Table 1 indicates that 10 of the respondents achieved higher primary level while 18 which is the majority, obtained secondary school level. For those who have attended higher primary, 7 out of 10 are below the age of 18 and only 3 are above 18 years (20 years). Given their level of life skills training and age, the 7 that are below 18 can possibly consider going back to school as an option in an effort to improve their livelihood.

The table above shows that the majority of the teen mothers (17) reside in urban areas, followed by those residing in the semi-urban and in the semi-rural areas, 8 and 3, respectively. Research further reveals that 13 out of 17 teen mothers who are 18 years and above live in urban areas. One can conclude that some of these were born there but probably others relocated in search of employment opportunities considering their age.

Twenty-seven of the 28 teen mothers who participated in the study were never married and only one was married at one time. The one that was married was probably married at the age of 14 years, after discounting the years of participating in the program as well as her age at the time of interview.

The work status of respondents indicates that the majority were self-employment. Seventeen of the 25 teen mothers were self-employed and running their own income generating activities. It is believed that 8 respondents were back in school after participating in the training programme.

4.3 Usefulness of the HIV and AIDS Information and Life Skills in Helping Teen Mothers to Cope With HIV and AIDS

The study sought to explore the usefulness of the AIDS information and life skills in helping teen mothers to cope with HIV and AIDS by probing their perceptions. This was based on the fact that Life skills which are central to psychological theories help young people to navigate the challenges of everyday life by enabling them to develop into healthy, responsible, and productive adults. These theories aim to understand how skills and competencies develop and according to the HBM constructs of '*perceived benefits*' and '*likelihood of taking action*' HIV and AIDS information fosters a sense of self efficacy regarding HIV prevention as well as taking action to prevent it from using the life skills. The training that teenage mothers underwent brought awareness of health risks (HIV and AIDS awareness) and actions (life skills) to mitigate by ensuring they feel confident and competent to implement positive behaviour change. This was supported by Fisher & Fisher (2000: 24), when they stated that

HIV and AIDS training provided information about the possible dangers of certain behaviours as well as instructing them in how to be safer.

The results on the usefulness of HIV and AIDS information as well as the life skills training in helping teen mothers to cope with HIV and AIDS were examined in the context of the 15 topics that they had been trained on. The topics covered included facts on HIV and AIDS and Life skills and the responses were measured in terms of the likelihood the skills were going to help cope with HIV and AIDS and the usefulness of the information in dealing with HIV and AIDS. It was noted from the survey that all the respondents indicated that they had been trained on all the topics and an assessment of the respondents' perception on the usefulness of the training is presented below.

4.3.1 Usefulness of HIV and AIDS information and life skills training

Questions used to assess the usefulness of the HIV and AIDS information and Life Skills training were based on whether they were: *relevant*, *irrelevant* and *totally irrelevant* to participants.

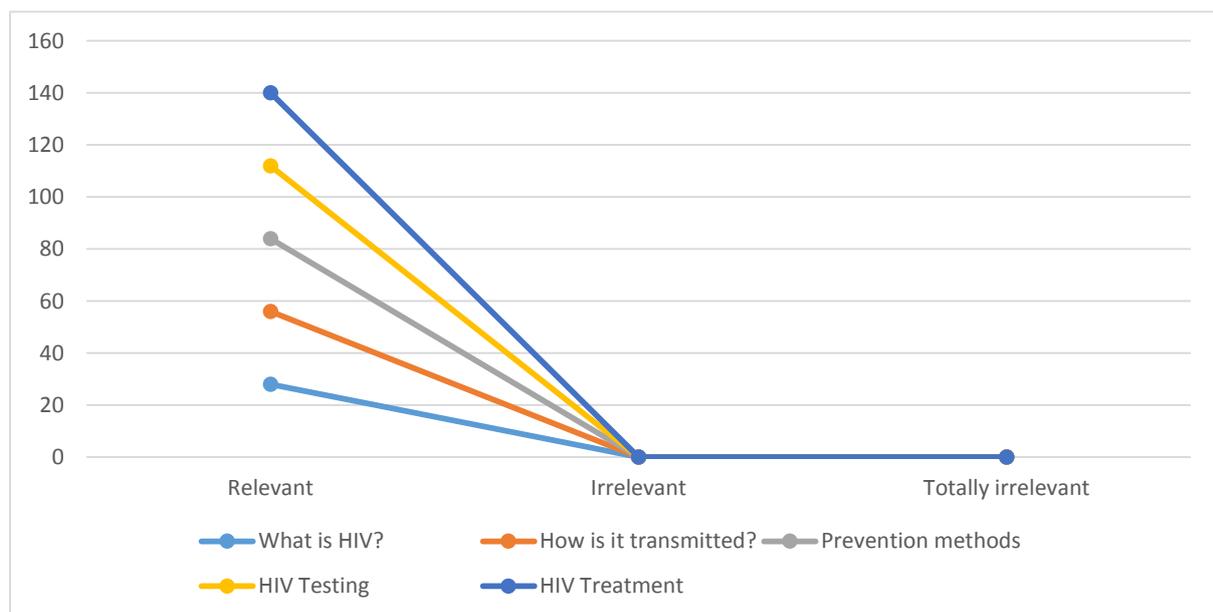


Figure 6 Usefulness of HIV Information

Figure 6 shows that all the respondents (100%) agreed that information on what is HIV, how it is transmitted, prevention methods, testing and treatment was relevant.

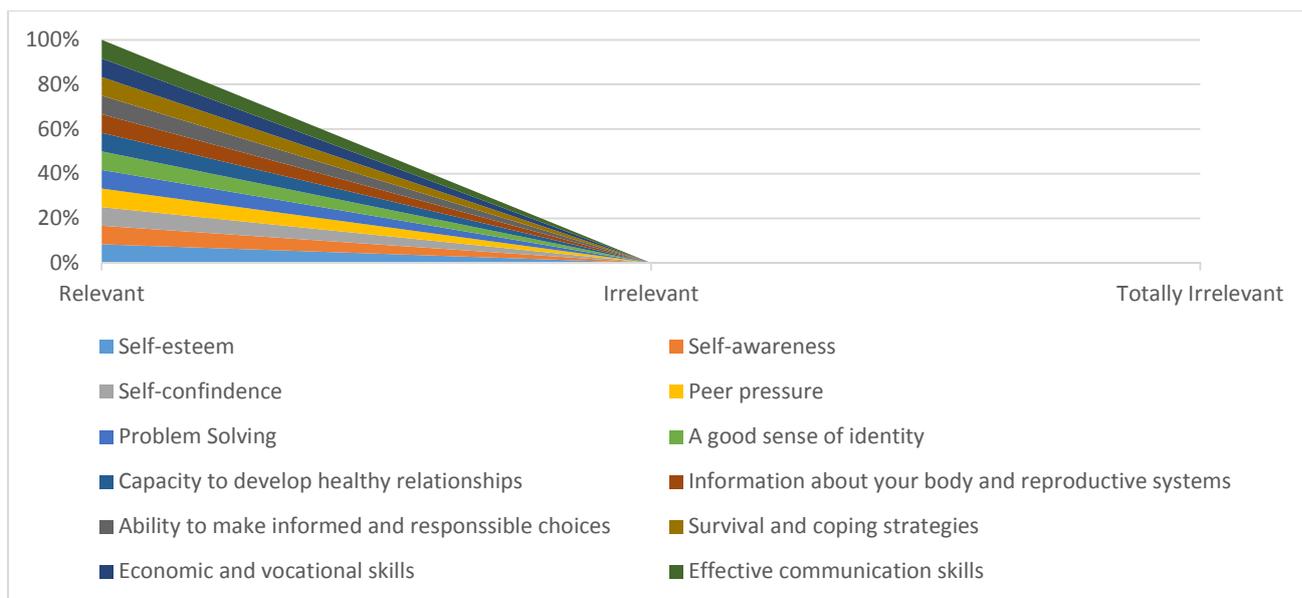


Figure 7 Usefulness of facts on Life skills

In Figure 7 above, all the respondents indicated that the facts on life skills training were relevant. These results show that the life skills training and information on HIV and AIDS the teen mothers received helped them shape their attitudes and develop interpersonal skills. This enhanced the teen mothers’ ability to take responsibility for making healthier choices, resisting negative pressures and avoiding risky behaviours.

4.3.2 Likelihood of the skills to help respondents deal with HIV and AIDS

All the 28 respondents indicated that the information they gained through training on the facts on HIV and AIDS were likely to help them deal with HIV and AIDS (see Table 2 below).

Table 1 Likelihood of use of HIV and AIDS information

	Likely	Most likely
Likelihood of use of HIV and AIDS information		
What is HIV?	28(100%)	0(0%)
How is it transmitted?	28(100%)	0(0%)
Prevention methods	28(100%)	0(0%)
HIV Testing	28(100%)	0(0%)
HIV Treatment	28(100%)	0(0%)
Likelihood of use of Life skills		
Self-esteem	20 (71.4%)	8 (28.6%)
Self-awareness	20 (71.4%)	8 (28.6%)
Self-confidence	20 (71.4%)	8 (28.6%)
Peer pressure	20 (71.4%)	8 (28.6%)
Problem solving	28 (100%)	0 (0%)

A good sense of identity	28 (100%)	0 (0%)
Capacity to develop health relationships	28 (100%)	0 (0%)
Information about your body and reproductive systems	20 (71.4%)	8 (28.6%)
Ability to make informed and responsible choices	20 (71.4%)	8 (28.6%)
Survival and coping strategies	20 (71.4%)	8 (28.6%)
Economic and vocational skills	20 (71.4%)	8 (28.6%)
Effective communication skills	28 (100%)	0 (0%)

Table 2 shows the results on the likelihood of life skills taught, helping them cope with HIV and AIDS. It shows that the facts on life skills were likely to be useful to the teen mothers in coping with HIV and AIDS. However the responses ranged from likely to most likely, with 28.6% (8) responses indicating most likely on 8 out of 12 topics. None of the respondents indicated *unlikely* or *I don't know*, which is an indication that the training gave them useful information and skills to cope with HIV and AIDS.

According to the HBM, a person's readiness to act is influenced by the people's belief about whether or not they are at risk for a disease or health problem. An individual should feel competent to take action. The training made them aware of health risks (HIV and AIDS awareness) and actions to mitigate as well as ensuring they feel confident and competent to implement positive behaviour change. The training empowered the teen mothers with life skills and training to tackle the issues of HIV and AIDS.

4.4 Knowledge Test on HIV and AIDS and Life Skills Facts

The research sought to examine the effects of Phela intervention on respondent's knowledge levels about HIV and AIDS and life skills facts for them to develop and identify skills necessary to cope with the pandemic. According to Fisher & Fisher (2000) and Bandura (2004), an effective behaviour change intervention includes an informational component where children/youth are informed of the health risks and benefits of different lifestyle habits, development of social and self-management skills for translating informed concerns into effective preventative practices. The life skills promotes social, cognitive emotional and behavioural competencies that are critical in reducing negative or high risk behaviours as well as positive attitudes, social adjustments and healthy life styles. The research looked at the knowledge levels on HIV and AIDS and life skills of the respondents during the different phases of the project in order to gauge the adequacy and appropriateness of the information as well as the knowledge levels during the different phases of the project. This topic also helped

in assessing the impact of the training in imparting knowledge. The focus on the levels of knowledge before, during and after their participation in the intervention.

4.4.1 Knowledge test on HIV and AIDS facts

The knowledge-test on HIV and AIDS was examined on the following topics: Difference between HIV and AIDS, the acronym for “human immune virus”, “Effects of HIV on the defence system of the body”, “Transmission of HIV from an infected mother to the baby during pregnancy”, “Methods of HIV transmission”, “HIV Prevention methods”, “Infections that increase the risk of getting HIV”, “HIV treatment methods”, “Benefits of HIV status disclosure” and “Benefits of taking an HIV test”.

Respondents were asked to rate their level of knowledge before, during and post- their participation in the intervention. They were requested to rate their level of knowledge on: “Least Knowledgeable”, “Slightly Knowledgeable”, “Less Knowledgeable”, “Knowledgeable”, “More Knowledgeable” and “Most Knowledgeable”. The results are presented in the table below.

Table 1 HIV and AIDS facts

Variable	Least knowledgeable	Slightly knowledgeable	Less knowledgeable	Knowledgeable	More knowledgeable	Most knowledgeable
Differences between HIV and AIDS						
Before	0%	0%	78.6%	14.30%	7.10%	0%
During	0%	0%	0%	10.70%	3.60%	85.70%
After	0%	0%	0%	3.60%	10.70%	85.70%
Acronym for Human Immune Virus						
Before	0%	35.70%	57.10%	7.10%	0%	0%
During	0%	0%	0%	7.10%	67.90%	25.00%
After	0%	0%	0%	3.60%	10.70%	85.70%
Effects of HIV						
Before	0%	85.70%	7.10%	7.10%	0%	0%
During	0%	0%	0%	3.60%	67.90%	28.60%
After	0%	0%	0%	10.70%	3.60%	85.70%
Mother to Child Transmission						
Before	7.10%	85.70%	7.10%	0%	0%	0%
During	0%	0%	0%	3.60%	7.10%	89.30%
After	0%	0%	0%	7.10%	7.10%	85.70%
Methods of HIV transmission						

Before	7.10%	7.10%	85.70%	0%	0%	0%
During	0%	0%	7.10%	10.70%	7.10%	75.00%
After	0%	0%	0%	10.70%	75.00%	10.70%
HIV prevention methods						
Before	0%	82.10%	10.70%	7.10%	0%	0%
During	0%	0%	7.10%	14.30%	3.60%	75%
After	0%	0%	0%	7.10%	7.10%	85.70%
Infections increasing HIV						
Before	0%	85.70%	7.10%	7.10%	0%	0%
During	0%	0%	0%	10.70%	7.10%	82.10%
After	0%	0%	0%	3.60%	10.70%	85.70%
HIV treatment methods						
Before	82.10%	7.10%	7.10%	3.60%	0%	0%
During	0%	0%	0%	14.30%	67.90%	17.90%
After	0%	0%	0%	10.70%	10.70%	78.60%
Benefits of status disclosure						
Before	78.60%	7.10%	10.70%	3.60%	0%	0%
During	0%	0%	10.70%	17.90%	57.10%	14.30%
After	0%	0%	0%	10.70%	10.70%	78.60%
Benefits of HIV tests						
Before	82.10%	7.10%	7.10%	3.60%	0%	0%
During	0%	0%	3.60%	14.30%	57.10%	25%
After	0%	0%	0%	3.60%	10.70%	85.70%

The results displayed on Table 3 above table show that overall knowledge levels were low before the project and became higher after the project across all the topics. The majority of the respondents (78.6 – 85.7%) were less knowledgeable on most of the topics covered on HIV and AIDS facts before the intervention.

The results also show that the level of knowledge on HIV and AIDS facts was not necessarily low but the intervention seem to have increased awareness through its programmes. Topics such as the difference between HIV and AIDS had 14.3% respondents indicating some knowledge, Effects of HIV, Prevention methods, and infections that increase HIV had 7.1% and treatment methods, benefits of status disclosure and HIV had 3.6% indicating some knowledge prior to the project. The percentage of respondents that indicated being most knowledgeable after the project ranged between 78.6-85.7% across all topics showing an increase in knowledge due to participation in the program. Discussed below are topics that indicated significant shifts.

4.4.1.1 Methods of transmission including Mother to child transmission

The results show that the levels of knowledge on how HIV is transmitted increased after training since before the training, none of the respondents indicated they had, knowledge on how HIV was transmitted, mother to child transmission, and infections that increase HIV. This changed during training when 75% of the respondents reported being most knowledgeable and 85.7% indicating most knowledgeable after the training.

With regards to child transmission, the results show that participation in the training increased awareness of mother to child transmission as 85.7% of the respondents reported being most knowledgeable after the training. Of interest is the fact that the majority (100%) indicated having slight knowledge on the topic before the training. This is a disturbing result when one would expect this knowledge to have been shared at ante natal clinics visits during the teen mothers' pregnancies. However, during the project, the level of knowledge improved with 89.3 % becoming most knowledgeable and 85.7% reported being most knowledgeable. The slight decline could be attributed to forgetfulness by some since the trainings have stopped. However, the results indicate that the knowledge of how HIV was transmitted was improved by the training and also the retention of knowledge is remarkable.

4.4.1.2 Methods of Prevention and Treatment

Before undergoing the training, very few (7.1 %) of the respondents had some knowledge on the methods of preventing HIV infection. An increase in the knowledge levels was seen during the project when 75% reported being most knowledgeable and 85.7% reported being most knowledgeable on how to prevent HIV infection after the training.

With regards to the treatment methods, the results show that before the training only 3.6% had some knowledge and this increased to 17.9% and 78.6% during and after the project respectively

4.4.1.3 Effects of HIV

The results displayed in the table show that all the respondents (100%) reported being knowledgeable of the effects of HIV after undergoing the training. However, before the training, 92.8% of the respondents had indicated being less knowledgeable and only 7.1% having some knowledge. This indicates that the knowledge levels on the effects of HIV were enhanced by the training.

4.4.1.4 Benefits of status disclosure and HIV testing

The results displayed in the table above indicate that a small percentage (3.6%) of the respondents indicated having some knowledge on benefits and HIV testing and status

disclosure before participating in the training. The proportion increased to 25% of respondents reporting being most knowledgeable during the training and 78.6% and 85.7% most knowledgeable on the benefits of status disclosure and HIV testing respectively after the training.

4.4.1.5 Meaning of HIV and AIDS, difference between HIV and AIDS, Acronym for HIV

The table above shows that 78.6% and 92.8% of the respondents indicated that they were less knowledgeable on the difference between HIV and AIDS and the acronym of HIV, respectively before participation in the program. This changed to 85.7% indicating being most knowledgeable during and after the project for the two topics. Accurate knowledge on HIV and AIDS is critical in ensuring prevention of the spread of the disease and its management, thus possession of correct and up-to-date information by the teen-mothers means that they are equipped to protect themselves.

4.4.2 Knowledge Test about life skills

The researcher looked at the knowledge levels of life skills among the teen mothers as this reflects on their knowledge of what skills they can employ in the different situations of their lives. Life skills enable them to develop social and self-management skills for translating informed concerns into effective preventative practices. It is important therefore, to assess the knowledge of life skills (protective factors) they can employ as these promote the critical resiliency skills for the teen mothers to overcome HIV and AIDS vulnerability. In this project, the teen mothers are provided with a chance to practice skills or employ resources. The table below displays the knowledge levels during the different phases of the project.

The knowledge-test on life skills was examined on the following topics: “Self-esteem”, “awareness and confidence”, “peer pressure”, “problem solving”, “a good sense of identity”, “capacity to develop healthy relationships”, “ability to make informed and responsible choices”, “survival and coping strategies” and “effective communication skills”. These were assessed in the before, during, and after the project periods and the results are presented in Table 4 below.

Table 2 Knowledge on Life skills facts

Variable	Least knowledge able	Slightly knowledg eable	Less knowledg ea ble	Knowledge able	More knowledg ea ble	Most knowledge able
Learning about me						
Before	85.70%	3.60%	7.10%	3.60%	0%	0%
During	0%	0%	7.10%	7.10%	3.60%	82.10%
After	0%	0%	0%	7.10%	10.70%	82.10%
Rights and responsibilities						
Before	78.60%	10.70%	7.10%	3.60%	0%	0%
During	0%	3.60%	0%	3.60%	85.70%	7.10%
After	0%	0%	3.60%	10.70%	75%	10.7
Understanding people						
Before	82.10%	3.60%	7.10%	7.10%	0%	0%
During	0%	0%	7.10%	7.10%	10.70%	75%
After	0%	0%	0%	10.70%	10.70%	78.60%
Caring for people with AIDS						
Before	75%	10.70%	7.10%	7.10%	0%	0%
During	0%	3.60%	3.60%	14.30%	14.30%	64.30%
After	0%	0%	0%	10.70%	10.70%	78.60%
Assertive Communication						
Before	78.60%	10.70%	7.10%	3.60%	0%	0%
During	0%	0%	7.10%	14.30%	21.40%	57.10%
After	0%	0%	3.60%	10.70%	10.70%	75.00%
Using Assertiveness						
Before	85.70%	7.10%	7.10%	0%	0%	0%
During	0%	0%	7.10%	17.90%	14.30%	60.70%
After	0%	0%	7.10%	14.30%	10.70%	67.90%
Making objective judgements						
Before	96.40%	3.60%	0%	0%	0%	0%
During	0%	0%	3.60%	7.10%	10.70%	78.60%
After	0%	0%	3.60%	7.10%	10.70%	78.60%
Resisting media Influence						
Before	82.10%	3.60%	7.10%	7.10%	0%	0%
During	0%	0%	7.10%	3.60%	14.30%	75.00%
After	0%	0%	0%	3.60%	10.70%	85.70%
Coping with emotional stress						
Before	89.30%	3.60%	3.60%	3.60%	0%	0%
During	0%	0%	7.10%	10.70%	21.40%	60.70%
After	0%	0%	0%	3.60%	10.70%	85.70%
Understanding effect of emotions						
Before	85.70%	3.60%	3.60%	7.10%	0%	0%
During	0%	0%	10.70%	14.30%	14.30%	60.70%

After	0%	0%	3.60%	10.70%	10.70%	75.00%
Adopting to social circumstances						
Before	85.70%	7.10%	7.10%	0%	0%	0%
During	0%	0%	3.60%	21.40%	21.40%	53.60%
After	0%	0%	3.60%	10.70%	10.70%	75.00%
Developing capacity to think						
Before	82.10%	7.10%	3.60%	7.10%	0%	0%
During	0%	0%	7.10%	17.90%	25.00%	50.00%
After	0%	0%	3.60%	7.10%	10.70%	78.60%

The table above displays the knowledge levels of the various life skills, that is, set of abilities that empower teenage mothers were taught to take positive steps to promote health, positive social relationships and positive contributions to society. The results displayed in the table above indicate knowledge levels about life skills across all taught topics were improved by the participation of respondents in the training. Before the training the majority (78.6%-96.4%) of the respondents had no knowledge of the various skills with 3.6-7.1% having slight knowledge on some topics. During the training, the majority (92.9%) of the respondents reported having knowledge during the project and 92.9 % of the respondents' knowledge levels were in the knowledgeable to most knowledgeable categories. Topics such as coping with emotional stress, resisting media influence and making objective judgements had the highest percentages of respondents reporting being most knowledgeable.

4.4.2.1. Making objective judgments

The table shows the majority, 100%, say they had no knowledge to deal objectively with decisions about their lives by exploring the available alternatives and various consequences of their actions or non-action through objectively analysing information and experiences. After undergoing the training, 96.4% reported having knowledge to recognise and assess the factors that influence attitudes and behaviour, for example peer pressure, and the media.

4.4.2.2 Assertive communication and using assertiveness

The findings show that before participating in the project, the majority of the respondents (96.4%) indicated that they did not know how to stand up for their own or other people's rights in a calm and positive way, without being either aggressive, or passively accepting 'wrong', that is assertive communication and use of assertiveness. This however changed during the project as 57.1%-60.7% indicated being most knowledgeable during the training and with 67.9%-75% indicating being most knowledgeable after the training.

4.4.2.3 Self-awareness (learning about me)

The majority (96.4%) of the respondents indicated that they were less knowledgeable in recognizing themselves, their character, their strengths and weaknesses, desires and dislikes before participating in the project. The knowledge levels increased to 82.1% during and after the project indicating that they were most knowledgeable and able to recognise when they were stressed or felt under pressure as well as being able to communicate effectively and improving interpersonal relations.

4.4.2.4 Understanding people and caring for people with AIDS

The results show that before undergoing the training, only 7.1% of the respondents had some knowledge on understanding people, that is, the ability to imagine what life is like for another person. This helps to understand and accept others who may be very different as well as encouraging nurturing behaviour towards people affected by AIDS. During the training, 75% and 64.3% indicated being most knowledgeable about understanding people and caring for people with AIDS respectively and 78.6% indicated being most knowledgeable after undergoing the training.

4.4.2.5 Coping with emotions

This involves recognising emotions in themselves and others, being aware of how emotions influence behaviour, and being able to respond to emotions appropriately. The results show that between 3.6% and 7.1% of the respondents had some knowledge on how to cope with emotions before the project and this improved to between 75% and 85% after the project showing that the training enhanced their ability to cope with emotions.

4.5 Benefits of Participating in the Project

The research further looked at the benefits of participating in the project by assessing the skills used by teenage mothers in their everyday lives as well as the extent to which the capability to use the skills was developed during the different phases of the project. It is important to assess the life skills (protective factors) they can employ as these promote the critical resiliency skills for the teen mothers to overcome HIV and AIDS vulnerability. Resilient adolescents overcome their vulnerability because of “protective factors” within themselves or in support systems. Empowering teen mothers involves the development of life skills in decision making, problem solving assertiveness and conflict resolution which gives them control over themselves and their environment.

The section explored the benefits from participating in the program. Respondents were asked to rate the benefit of participating in the project by indicating whether they *strongly Disagreed*, *Agreed*, *Don't Know*, *Agreed* or *Strongly Agreed*. They were requested to rate their level of agreement during different stages of the intervention – that is, Before, During and After their participation in the training intervention. It focused on what they can now do using the skills and knowledge from the training and was examined along the areas where they showed ability. The results are presented in the table below:

Table 1 Benefits of participating in the project

Variable	Strongly disagree	Disagree	Don't know	Agree
Ability to stop and think before acting				
Before	64.3%	14.3%	7.1%	14.3%
During	0%	21.4%	10.7%	67.9%
After	0%	0%	3.6%	96.4%
Ability to make informed decisions				
Before	60.7%	21.4%	7.1%	10.7%
During	0%	3.6%	14.3%	82.1%
After	0%	0%	3.6%	96.4%
Ability to have new ideas				
Before	53.6%	25.0%	7.1%	14.3%
During	0%	10.7%	0%	89.3%
After	0%	3.6%	3.6%	92.9%
Ability to balance risks				
Before	57.1%	25.0%	7.1%	10.7%
During	0%	10.7%	7.1%	82.1%
After	0%	0%	3.6%	96.4%
Ability to set and achieve objectives				
Before	71.4%	14.3%	7.1%	7.1%
During	0%	7.1%	7.1%	85.8%
After	0%	3.6%	0%	96.4%
Ability to describe self in positive terms				
Before	50%	17.9%	7.1%	25%
During	0%	10.7%	7.1%	82.1%
After	0%	3.6%	0%	96.4%
Ability to understand own emotions				
Before	67.9%	17.9%	7.1%	7.1%
During	0%	3.6%	14.3%	82.1%
After	0%	0%	0%	100%
Has ideas about how to cope with stress				
Before	57.1%	17.9%	10.7%	14.3%
During	0%	14.3%	7.1%	78.6%
After	0%	0%	3.6%	96.4%
Ability to take on tasks to help the community				
Before	57.1%	14.3%	17.9%	10.7%
During	0%	17.9%	0%	82.1%
After	0%	3.6%	3.6%	92.9%
Ability to work with others to achieve a common goal and compromise when needed				

Before	50.0%	21.4%	7.1%	21.4%
During	0%	14.3%	0%	85.7%
After	0%	0%	3.6%	96.4%
Ability to express own ideas and perspectives even when different from others				
Before	35.7%	25.0%	17.9%	21.4%
During	0%	0%	3.6%	96.4%
After	0%	0%	0%	100%
Ability to resist pressure to participate in risky behaviour				
Before	71.4%	21.4%	7.2%	0%
During	0%	3.6%	3.6%	92.9%
After	0%	3.6%	0%	96.4%
Ability to overcome obstacles				
Before	75.0%	17.9%	7.1%	0%
During	0%	7.1%	3.6%	89.3%
After	0%	3.6%	0%	96.4%
Ability to articulate and act upon plans to build a better future				
Before	3.6%	75%	10.7%	10.7%
During	0%	7.1%	3.6%	89.3%
After	0%	3.6%	3.6%	92.9%

The results in the table above show that all the respondents by participating in the project, had their critical life skills developed and enhanced as shown by the 92.7%-96.4% of the respondents who indicated being able to use the life skills after participating in the training initiative. Overall the results indicate that capability levels of the respondents to use the skills were low before they were trained and improved with the training. As displayed on Table 5 the majority of respondents (60.7% - 92.9%) were not able to use the skills before they underwent the training and a few (7.1- 25%) indicated they were able to use them before the training, showing the existence of some ability to use life skills before the training. These include life skills in decision making, problem solving, assertiveness, conflict resolution and increased control over themselves and their community.

There were other topics like “the ability to resist pressure to participate in risky behaviour” or “the ability to overcome obstacles before they were trained” where none (0%) of respondents had indicated ability to use the skill before undergoing training. Also shown by the results is the fact that the training enhanced their capabilities as 67.9-96.4% reported being able to use the various skills during the training with 92.9%-100% able to use the skills after the training.

Below is a presentation of how the respondents benefited in terms of gaining life skills from the participating in the project.

4.5.1 Decision making

The results show that the majority of the respondents (78.6%) were not able to stop and think before acting before the training and all of them (100%) indicated being able to do so after the training. The same trend is observed for the ability to make informed decisions, to resist pressure to participate in risky behaviour and to balance risks. Prior to training 81.2% -93.8 had indicated they were unable to use these skills before the training and 96.4-100% indicated being able to use the skills after the training. This reflects that most of those who had reported inability to use skills and their skills enhanced by the training.

4.5.2 Self-Awareness

The results show that the majority of the respondents (67.9-95.7%) were not able to describe themselves in positive terms, set and achieve objectives, have new ideas and overcome obstacles before they underwent the training, this however changed after the training when the majority (93.4- 96.4%) indicated that they were able to use the taught skills in their everyday lives.

4.5.3 Inter personal relationships

The results in the table show that after undergoing the training, the majority of the respondents could use the life skills they were trained on to relate to others better. It shows that 67.9-95.7% indicated not being able to take on tasks to help the community, work with others to achieve a common goal, express own ideas and perspectives even when different from others before they were trained. After the training, 93.8-96.4% of the respondents reported that they were now able to use these skills in their day to day lives.

CONCLUSION

This chapter presented the findings from the study on all the topics which included; the demographics of the respondents, number of children they had, education level, residential places, marital and employment status. The results also show the usefulness and likelihood of use of the information in helping teen mothers cope with HIV and AIDS and the benefits of participating in the program. Limitations of the study were also presented. Chapter 5 provides the discussion of results, conclusion and the recommendations.

CHAPTER 5: RESEARCH FINDINGS AND CONCLUSION

5.1 Introduction

This chapter will present a discussion of research key findings which were presented in Chapter 4. The interpretation involves making sense of the data and also compares the key findings of the study and information from the literature review including the theoretical perspective. The first part of this chapter will present the main findings and indicate how the findings support the theory and literature review. The last part will present the conclusion and recommendations.

5.2 Interpretation and Discussion of Findings

The purpose of this study was to explore the resilience to HIV and AIDS among teen mothers as a result of their participating in life skills interventions. It looked at the extent to which knowledge and skills obtained from the interventions helps teen mothers to remain resilient in the face of the pandemic. The following were the research questions;

- (1) What is the value of life skills training on teen mothers?
- (2) What do life skills training interventions cover?
- (3) How practical are life skills training interventions post-intervention – that is, are beneficiaries still able to put to use the lessons learnt from the intervention once the interventions wounds up?
- (4) What is the value of follow up studies – that is, post-impact evaluation studies?

5.2.1 Data Analysis Approach

The data were analysed thematically. The key themes included: Attributes of respondents, Perspectives of respondents on the usefulness and likelihood of use of knowledge and life skills in coping with HIV and AIDS, Knowledge levels of life skills and HIV and AIDS information, Resilience building through life skills.

5.2.2 Attributes of research respondents

The general characteristic of the respondents is that teen mothers age range from 15- 21 years. The majority (60.7%) reside in urban areas. Twenty out of twenty-eight have children of their own and 8 (aged 16-19) do not have children. They could have lost the baby either at birth or due to pregnancy complications or diseases. Also reflected is that those who are older than 18 years and living in urban areas could be there for employment since they are at employable ages.

Based on the data, the youngest age the teen mothers fell pregnant was 12 years, after discounting the two years they participated in the program, and the eldest was 19 years of age. This is a worrisome statistic as early pregnancy exposes teenagers to negative health impacts which affects them and their children. WHO estimates that adolescents aged 10-19 years account for 23% of the overall burden of disease (disability- adjusted life years) due to pregnancy and child birth complications (WHO, 2014). Also, as mentioned in Chapter 2, perinatal deaths are 50% higher among babies born to mothers under 20 years of age than among those born to mothers aged 20 to 29 years.

The study brings to light the fact that pregnancy for the majority of girls does not result in marriage. The majority of the teen mothers (27 of the 28) were never married and only 1 was married and got divorced. By implication, the teen mothers were left to look after the pregnancy and eventually children on their own without any support from the responsible male partners. This has serious repercussions on their economic and emotional wellbeing; like difficulties raising the children due to lack of finances, lack of contact with their boyfriends and loneliness (Yako &Yako, 2007:77).

The lack of support from the fathers of the children multiplies the challenges experienced by the teen mothers and because the girl feels insecure, she might resort to other unhealthy behaviours like prostitution and drug abuse (Chigona & Chetty, 2008:273). It has been noted that teenage mothers are subjected to greater risks of socio-economic disadvantage throughout their lives and as reported, 66.7 % of the women between the ages 15-49 and who were never married are unemployed (MOHSW, 2014). The teen mothers fit into this category and if the situation is left undealt with, it could drive them to engage in risky behaviours so as to fend for themselves and their children. In support of this point Mbirimtengerenji (2007:1) notes that extreme poverty compels most of the young women to indulge into risky behaviour, such as commercial sex, to get basic needs. This finding confirms the literature as well as the significance of the study.

The majority of the respondents (64.3%) have gone up to secondary school level and (35.7%) up to higher primary level. Lack of reproductive health knowledge, especially at primary level can be attributed to the cause of pregnancy in this case. Teenagers who are uneducated about sex are more likely to engage in unprotected sex, and have an unintended, unplanned, or unwanted pregnancy. Lack of experience, resources or information can lead people to make decisions that are risky and unsafe, because they may not be fully aware of the possible outcomes (such as pregnancy and Sexually Transmitted Infections). Molapo (2011) supports

this notion of reproductive playing a major role in the high incidence of teenage pregnancy as some girls have not been educated about the right and wrong birth control methods. This has been blamed on the crumbling social structure due to HIV and AIDS which has left girls without guidance on growing up. Girls are said to need support to grow up in a safe environment with access to essential education and skills in order for them to become valuable decision-makers and leaders in their society (Molapo, 2011; Agheneza, 2009 cited in Berry et al., 201). For those at secondary school level, the causes could be associated with other factors like peer pressure, poverty, abuse and others.

Regarding their economic status, the majority are employed, 3 (aged 18-20) in formal employment and 17 self-employed. It can also be concluded that 8 (aged 15-17) who did not indicate non formal employment, were probably back in school after undergoing the life skills training in which case they do not fit the definition of '*unemployed*'. The respondents' understanding of employment referred only to formal employment. By inference, these teen mothers were unemployed before they joined the programme, meaning they did not have any means to provide for either their children or themselves. The unemployment situation in Lesotho is at crisis level (MOHSW, 2014:45).

The finding brings to light the fact that given the age at which they fall pregnant, the majority are still at middle school and haven't completed their secondary school education and therefore unemployable. Reports show that women aged 15-49 years with more than secondary education, in Lesotho, are twice as likely as women with no education and incomplete primary education to be employed (MOHSW, 2014:43). There are 52.2 % and 55.4 % of women from this age group who have completed their primary and secondary education, respectively, who are unemployed (MOHSW, 2014:44). This unemployment situation in Lesotho makes the teen mothers further vulnerable to risky sexual behaviour for livelihood. As noted by Mbirimtengerenji (2007), girls and women exchange sex for food and for survival, due to exclusion from formal sector employment and when all other work options are too low-paying to cover their basic needs. Where poverty and lack of job skills are strongly associated with early childbearing, there is a vicious circle of teen mothering and poverty (Sibanda & Mudhovorzi, 2012).

5.2.3 Knowledge levels after participating in the project

The Phela project's Life Skills curriculum covered the life skills, HIV and AIDS facts. The topics included HIV and its impacts, transmission modes, testing, treatment and prevention

methods, benefits of testing and disclosure. The facts on life skills included; defining life skills and its categories, self-confidence, self-esteem, peer pressure, problem solving, decision making, listening skills, reproductive health (Physiological changes of the body) and improving the reading culture. The results indicate that all the respondents (28) received training on all the topics.

The knowledge levels on HIV and AIDS facts and life skills, for the majority, were low before the project and increased during and after the project phases, though at varying levels. Generally there were no indications of less knowledge reported; although a slight decline in the level of knowledge on one component was reported which was attributed to forgetfulness due to time lag since the project ended. Interestingly, there were however some topics, like knowing the acronym HIV, effects of HIV, differences between AIDS and HIV, Treatment and Prevention methods, benefits of testing and disclosure where a few (7%) reported having some knowledge prior to the intervention probably due to exposure to other HIV and AIDS awareness initiatives in the community. It could be concluded that knowledge existed prior to the project but it was enhanced by the training.

There was however a concerning result where the majority reported being slightly to least knowledgeable on the prevention of mother to child transmission. One would expect this knowledge to have been shared during ante natal clinics during at pregnancy. This calls for a need for strengthening of the information sharing at antenatal clinics.

Although knowledge might not be sufficiently protective in and of itself, having accurate information about HIV may benefit sexual health by impacting health-promoting attitudes necessary for successful engagement in healthcare-seeking behaviour. This phenomenon can be explained by the conceptual model of the Health Belief Model (HBM). It states that an individual takes health related action if he or she can avoid a negative health condition or has a positive expectation that by taking a recommended action he/she will avoid a negative health outcome and believes in herself that the action will yield positive outcome. This is through accessing accurate information. According to Fisher & Fisher, (2000) and Bandura, (2004), an effective behaviour change intervention includes an informational component where children/youth are informed of the health risks and benefits of different lifestyle habits, development of social and self-management skills for translating informed concerns into effective preventative practices.

Generally, the results show that the teen mothers were more knowledgeable after the project indicating that their participation in the project improved their knowledge on HIV and AIDS and life skills enabling them to develop and identify skills necessary to cope with the HIV pandemic.

5.2.4 Usefulness of HIV and AIDS knowledge and life skills in coping with HIV and AIDS

In examining the usefulness of the knowledge on life skills and HIV and AIDS in helping teen mothers to cope with the pandemic, the study looked at the likelihood to use the skills and the usefulness of the information to the teen mothers.

All the respondents (28) indicated that the information on HIV and AIDS and Life skills facts was relevant and likely to help them deal with HIV and AIDS. None of the responses indicated *unlikely* or *I don't know*, showing the training gave them useful information and skills to shape their attitudes and develop interpersonal skills.

The results on the usefulness of HIV and AIDS information as well as the life skills training in helping teen mothers to cope with HIV and AIDS were examined in the context of the 15 topics that they had been trained on. All the respondents indicated that the information was useful. HIV and AIDS training provided information about the possible dangers of certain behaviours as well as instructing them in how to be safe (Fisher & Fisher, 2000: 24) and the life skills helped them to navigate the challenges of everyday life by enabling them to develop into healthy, responsible, and productive adults.

The purpose of the training was to enable young people to make informed life choices that would enable them to have bright futures free from diseases such as HIV and AIDS. It also helped equip the beneficiaries with skills to reconstruct their lives and make positive choices going forward.

The Health Belief Model and the Self Efficacy theories state that the major motivation for an individual is their desire to avoid a negative health consequence. The teen mothers avoid engaging in risk behaviour in order to prevent HIV transmission but can only do so if they were made aware of the risks, had accurate information and felt competent to act on it. Their readiness to act is influenced by their belief about whether or not they are at risk of a disease or health problem. The teen mothers, through the training, were made aware of HIV and its severity as well as their likelihood to get it, hence they took action.

The knowledge has shown to be useful as it has helped promote their mental well-being (self-esteem, awareness and confidence) and made them feel competent to act as they face the

realities of life and HIV and AIDS. Literature states that there are many emotional problems associated with teenage pregnancy, like depression, which could make the mother feel like she is no good and a worthless person, resentment to her partner, fear that they cannot be the mothers they want to be (Whitman et al., 2001) and frustration that they will not be able to do the things that the rest of their peers are doing (Kaplan, 1996). This would result in lower self-esteem and lack of purpose in life (Clement, 1998 cited in Sibanda & Mudhovorzi, 2012). In support of the intervention and its effect on the mental well-being of teen mothers, Corcoran (2016:6) states that participating in these interventions that focus on the development of coping skills, especially in the domain of social skills and choosing pleasant daily activities offer cognitive behavioural therapy to the teen mothers. The training enhanced the teen mothers' ability to take responsibility for making healthier choices, resisting negative pressures and avoiding risk behaviours as shown by the results on their abilities to use the life skills in their day to day lives.

The training also enhanced their survival and coping strategies through the economic and vocational skills they were exposed to. This was something they could not do before participating in the project.

The findings show that the knowledge helped the teen mothers to understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. Developing life skills also helped the teen mothers in translating knowledge, attitude and values into healthy behaviour that makes their life fruitful.

5.2.5 Benefits of participating in the training (Resilience building using life skills training)

The study explored the benefits the teen mothers gained from participating in the programme. It looked at the level of changes on teen mothers BEFORE, DURING and AFTER their participation in Phela project. Some of the life skills included, as highlighted in Chapter 4, ability to have new ideas, ability to balance risks, ability to set and achieve objectives and ability to describe themselves in positive terms among others.

The respondents indicated that they were able to and are still utilising the skills and knowledge in their everyday life. This has been shown by the reported increase in self-esteem as they can now describe themselves in positive terms, make informed and responsible choices and express their own ideas and perspectives even when these were different from others. There was a notable high knowledge retention level across all the topics, indicating the use of it in future.

The majority of the participants indicated that the information was useful and likely to help them cope with HIV and AIDS.

The results show that to a large extent the project had a positive impact on the lives of the teen mothers, especially on issues pertaining to self-esteem, self-confidence, anger management, knowing how to be independent and protecting oneself from HIV and AIDS and other life ills. The use of the information to cope with HIV and AIDS is also reflected by their ability to balance the risks /benefits of any course of action. This can only be done by someone who has been exposed to or made aware of some information or skill. This indicates that they were now competent in the core life skills they were trained on.

The study findings are in line with what was reported in the resilience follow-up study done in New Zealand by Collins (2010) where it was noted that the skills received by the teen mothers helped them build skills and competencies and supported educational, social and economic participation. This also provides an idea of how resilience can be built through participation in social support initiatives which enhances life skills. The same findings were reported by Mainthia et al. (2013) in a study on a group of young single mothers who had participated in an empowerment programme. They found that the life skills training programme had helped improve the health and quality of life of single mothers and their children. It also revealed an improvement in their knowledge on sexual reproductive health, individual incomes, and was now more positively perceived by their communities. In support of this, a study on girls who underwent a girl's empowerment programme held in 2010 in Lesotho concluded that such training and financial independence were essential to enable girls to complete their secondary schooling and help them to be less susceptible to transactional sex and its associated risks (Berry et al., 2013).

According to Tiendrebeogo et al. (2003:6), providing young people with life skills such as self-esteem, and high efficacy help them to translate information about HIV and AIDS into protective behaviours against HIV infection. The findings indicate that the knowledge and skills gained from the project is still being used by the teen mothers to engage in healthy behaviour and improve their lives.

According to the Self-efficacy theory, one has to believe in one's own ability to accomplish something and perceiving an incentive to do so. Competence is an asset that can be a vital component in a resilience process. Competent teen mothers are expected to be more likely to overcome the negative effects of a risk and embark on healthy development in spite of risky

exposure through the use of promotive factors. The Resilience theory also supports these findings as the youth were trained in life skills that promote positive factors that reside in themselves like self-efficacy and self-esteem resilience. For resilience to be experienced there should be the presence of both the risk and promotive factors and the risk in this case is HIV and AIDS and its associated impacts.

Teen mothers, like all teenagers, are capable of learning the skills that it takes to be resilient and be able to utilize them to cope and recover from problems and challenges through life skills training from external resources like the Phela project.

The project provided vocational and income generating skills to the teen mothers. This gave them financial independence making them less susceptible to transactional sex and its associated risks thereby dealing with poverty and HIV and AIDS. The results show that most of the participants were now employed or engaged in their own income generating or self-sustenance activities to improve their livelihoods. Learning income-generating activities and associated life skills are essential to lifting girls out of the poverty cycle and empowering them to resist pressure to exchange sex for money – an activity that exacerbates their vulnerability to HIV and AIDS (Berry et al., 2013: 447).

The training facilitated the development of the teen mothers to function effectively as social beings. Their assertiveness, which is a way of relating with others, was enhanced. This means that one not only respects or values their needs, drives and feelings but also respects those of others, thereby, achieving what you want without hurting others. They are now able to explore alternatives, weigh pros and cons and make rational decisions in solving each problem or issue as it arises. They indicated that they could now participate in community activities; work with others to achieve a common goal and compromise when needed, among other skills.

One can conclude that their participation in the programme enhanced their resilience to HIV and AIDS by restoring their self-esteem, assisting them adapt to their changing social circumstances (reconstruct their lives), enabled them to be economically independent and assisted in their reintegration into the community.

5.2.6 Role of post intervention study

The purpose of a follow up study is to provide evidence that the programme accomplished its goals. The evidence strongly suggests that the intervention was worthwhile and has achieved its long term goals of building the resilience of teen mothers to HIV and AIDS through life skills and HIV and AIDS information. It has also shown the beneficial lasting effects of the

intervention for the teen mothers, as shown by the knowledge retention levels for life skills and HIV and AIDS information as well as the use of life skills in coping with HIV and AIDS. The information from the findings can be used to influence the design of similar interventions as well as in policy development. The study has yielded some insights into other teenage challenges like early sexual debut and marriages in Lesotho which can be used in policy design and development as well as in designing better similar programs.

The results of the study were consistent with those found in the end of project evaluation demonstrating continued beneficial effects of the intervention on life skills and resilience building for teen mothers in the face of HIV and AIDS.

5.3 Conclusion

The study responded to the gaps identified in literature by providing evidence of the value of conducting follow up studies as well as showing the effectiveness of life skills training in resilience building to HIV and AIDS for teen mothers. The findings show that the teen mothers' resilience to HIV and AIDS was enhanced by the life skills training as shown by their restored self-esteem which enabled them to adapt to their changing social circumstances (reconstruct their lives), reintegration into the community and being economically independent as they improve their lives by engaging in healthy behaviour.

The study also indicates that the information imparted during the life skills training was useful as it helped the teen mothers become aware of health risks (HIV and AIDS awareness) and actions (life skills) to mitigate as well as ensuring they felt confident and competent to implement positive behaviour change. The training thus enabled them to translate knowledge, attitude and values into healthy behaviour as they were now able to understand and assess the individual, social and environmental factors that rise and lower the risk of HIV transmission. It has also emerged that there is continued use of the acquired knowledge and skills after the project.

There is consensus from the findings in this study with literature and findings from the other resilience building for teenage mothers' studies conducted elsewhere. They all concur on the fact that prevention of health risk behaviour and an increased repertoire of life skills could facilitate a reduction in health risk behaviours. Also, the three theories, Health Belief Model, Self-Efficacy and resilience theory were relevant in providing the analysis and insight into how the life skills training builds the resilience of teen mothers to HIV and AIDS. The information

from this study can be used to improve related interventions or replicate similar projects in other areas so that more teenage mothers in similar circumstances can benefit.

5.4 Recommendations

While the results from this study cannot be generalised to other teenage mothers, there is need for this type of intervention for a larger population of teenage mothers. As shown in the study, the benefits of a similar life skills intervention would be beneficial to more teenage mothers, hence a replication or scale up of a similar intervention is recommended.

A recommendation based on the outcome of the study is that in research studies of this nature, a qualitative research design be included in order to probe further.

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ANNEXURES

Annexure A- Questionnaire

Questionnaire

Study title: Investigation Of the Role of Lesotho's Phela Life Skills Training Project in Instilling Resilience to HIV among Teen Mothers

Introduction

My name is Sophie Hamadziripi, (Student number 44529856). I am a student at UNISA and currently registered for Master's Degree (Social Behaviour Studies in HIV and AIDS). As part of my studies I am expected to undertake a research project to demonstrate my ability to investigate socio-economic or political phenomena.

The aim of my study is to investigate the role of the life skills training in instilling resilience to HIV among teen mothers. The objectives of the study are to; understand what teen mothers have learnt by participating in the project, their views about the Friends For Project, how Friends For Project helped them to deal with HIV issues, and whether their behaviour has changed due to their participation in the Project. I would like you participate in my study.

The study will be administered through a questionnaire on your knowledge of HIV and AIDS, and life skills, before joining Phela, during participation and after the project ended. Your information will be used by the researcher and her supervisors for the purposes of this study only and will be destroyed as soon as they are no longer needed.

Your participation in this study is voluntary and you are under no obligation to participate. Even after agreeing to participate, you have the right to withdraw at any time during the study. There is no benefit for participating in the study.

Your name and any form of identification will not be revealed to anyone. Please give honest answers.

SECTION A: Biographical information

How would you like us to refer to you in this interview (pseudonym)?		
Where do you current stay?	Urban	<input checked="" type="checkbox"/>
	Semi urban	<input type="checkbox"/>
	Rural	<input type="checkbox"/>
	Semi-Rural	<input type="checkbox"/>
Is this (Place mentioned) your place of birth?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
If not, where were you born?		
When did you move to (Place mentioned as current place of abode)?	Year	<input type="checkbox"/>
		<input type="checkbox"/>
How old are you (Please indicate in years)		<input type="checkbox"/>
What is your highest level of formal education:	None	<input type="checkbox"/>
	Lower primary	<input type="checkbox"/>
	Higher Primary	<input type="checkbox"/>
	Secondary	<input type="checkbox"/>
	College	<input type="checkbox"/>
Please indicate whether you are (Indicate with \surd):		<input type="checkbox"/>
	Employed	<input type="checkbox"/>
	Unemployed	<input type="checkbox"/>
What is your marital status? (Indicate with \surd):		<input type="checkbox"/>
	Single (never married)	<input type="checkbox"/>
	Married	<input type="checkbox"/>
	Divorced	<input type="checkbox"/>
	Widowed	<input type="checkbox"/>
Do you have children of your own? (Indicate with \surd):	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>

If yes, how many children do you have?

SECTION B: Effectiveness of Training

Please rate each of the following statements by means of an X in the appropriate box

	Tick the topics you were trained on (ü)	How useful is the information in helping you cope with HIV/AIDS?				How likely will the skills help you to deal with HIV/AIDS?			
		Relevant	Irrelevant	Totally Irrelevant	I do not know	Likely	Most Likely	Unlikely	I do not know
A. FACTS ON HIV AND AIDS									
What is HIV?									
How is it transmitted?									
Prevention Methods									
HIV Testing									
HIV Treatment (ART)									
B. FACTS ON LIFE SKILLS									
Self esteem									
Self-awareness									
Self confidence									
Peer pressure									
Problem solving									
A good sense of identity									
Capacity to develop healthy relationships									
Information about your body and reproductive systems									
Ability to make informed and responsible choices									
Survival and coping strategies									
Economic and vocational skills									
Effective communication skills									

SECTION C: Knowledge Test

Out of 5 (where 0 represents least knowledgeable and represent most knowledgeable) rate your level of knowledge of HIV and AIDS issues before, during and after your participation in FFP.

HIV/AIDS FACTS	BEFORE					DURING					AFTER							
	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
Difference between HIV and AIDS																		
The acronym for “human immune virus”																		
Effects of HIV on the defence system of the body																		
Transmission of HIV from an infected mother to the baby during pregnancy																		
Methods of HIV transmission																		
HIV Prevention methods																		
Infections that increase the risk of getting HIV																		
HIV treatment methods																		
Benefits of HIV status disclosure																		
Benefits of taking an HIV test																		
KNOWLEDGE ABOUT LIFE SKILLS																		
Learning about me as a special person																		
My rights and responsibilities																		
Understanding how people are alike, how they differ																		
Caring for people living with AIDS																		
Assertive communication in the face of peer pressure																		
Using assertiveness to resist pressure to engage in potentially health damaging activities (unprotected sex)																		
Making objective judgements about choices and risks																		
Resisting media influence on attitude towards smoking and alcohol																		
Coping with emotional stress																		
Understanding how emotions affect the way we behave																		
Adapting to changing social circumstances																		
Developing capacity to think in creative ways																		

SECTION D: Please indicate the appropriate response by means of an X

Please rate each of the following statements focusing on your knowledge BEFORE, DURING and AFTER the FFP

BENEFIT OF PARTICIPATING IN THE PROJECT	Before				During				After			
	Strongly disagree	Disagree	Don't know	Agree	Strongly disagree	Disagree	Don't know	Agree	Strongly disagree	Disagree	Don't know	Agree
Plases rate each of the following statements with a tick												
I am now:												
1. Able to stop and think before taking action												
2. Able to make an informed decision that is specifically to win situation and that may be again the tide												
3. Have new ideas for solving problems												
4. Able to balance the risks/benefits of a course of action												
5. Able to set and achieve goals												
6. Able to describe myself I positive terms												
7. Able to understand own emotions												
8. Has ideas about how to cope with stress												
9. Able to take on tasks to help the community												
10. Able to work with others to achieve a common goal ad compromise when needed												

BENEFIT OF PARTICIPATING IN THE PROJECT	Before				During				After			
	Strongly disagree	Disagree	Don't know	Agree	Strongly disagree	Disagree	Don't know	Agree	Strongly disagree	Disagree	Don't know	Agree
Plases rate each of the following statements with a tick												
11. Able to express own ideas and perspective s even when different from others												
12. Able to resist pressure to participate in risky behaviour												
13. Able to overcome obstacles												
14. Articulate and act upon plans to build a better future												

Thank you for your participation!

Annexure B: Consent Form for Participants

I, Sophie Hamadziripi, (Student number44529856) am a student at UNISA. I am currently registered for Master's Degree (Social Behaviour Studies in HIV and AIDS). As part of my studies I am expected to do a research project.

The study aims to investigate the role of the life skills training in instilling resilience to HIV among teen mothers. The objectives of the study are to; understand what teen mothers have learnt by participating in the project, their views about the FFP project, how FFP helped them to deal with HIV issues, and how their behaviour changed due to their participation and whether they are still applying lessons learnt from FFP.

I would like to administer a questionnaire on the knowledge for HIV and AIDS, and life skills, before joining Phela, during participation and after the project ended. The study will be strictly anonymous and confidential. Your details such as names and contact details will be disclosed to anyone. We will use pseudonyms to safeguard your identity. The information you provided will be stored safely to protect you against any harm. The completed questionnaire will be used by the researcher and her supervisors for the purposes of this study only and will be destroyed as soon as they are no longer needed.

Your participation in this study is voluntary and you may stop your participation at any stage of the research.

Should your participation in the study revoke painful emotions in you, we have organised a counselling service through PHELA. We will refer you them for you to receive the necessary support.

Thank you for your participation in this study. If you agree to participate in this study please indicate by completing the form provided below.

S.Hamadziripi (Researcher)

CONSENT OF Teen Mothers

I..... hereby give my personal consent to participate in the PHELA friends project research project . I understand that the information will be treated with the utmost confidentiality and that my anonymity will be protected.

I have read through the information letter above, which explains the research purpose and the objectives of the research and understand that I have the right to withdraw at any time without any fear of coercion or emotional black mail.

I also understand that I have a right to insight into all the proceedings of the research and that I can contact the researcher about anything to the research.

SIGNATURE..... (Participant)

Date...

Researcher's signature: _____ Date: _____

Annexure C: Access Letter to PHELA

TO: The Director

PHELA

Dear Madam,

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT YOUR ORGANISATION

My name is Sophie Hamadziripi. (Student number 44529856) I am a student at UNISA.

I am currently registered for Master's Degree in Social Behaviour Studies in HIV and AIDS. As part of my studies I am expected to conduct a research project with significant contribution to policy of the body of literature on HIV and AIDS. My study aims to investigate the role of the life skills training in instilling resilience to HIV among teen mothers. The objectives of the study are to; Understand what teen mothers have learnt by participating in the project, their views about the FFP project, understand how FFP helped teen mothers to deal with HIV issues and their behaviour changed due to their participation in the FFP and whether they are still applying lessons learnt from FFP.

I hereby request for permission to do this research within your organisation. In this study I will administer a questionnaire with the teen mothers, who participated in the end of project evaluation for PHELA life skills programme. I will do a literature review using PHELA organisational reports (evaluation and other exercises).The completed questionnaires will be used by the researcher and her supervisors for the purposes of this study only and will be destroyed as soon as they are no longer needed. As for the organisational documents, these will be used solely for the purposes of this research and will not be shared with the public other than the research supervisors at UNISA.

If you have queries regarding this study you contact me on the details below, UNISA Research Committee (zunguli@unisa.ac.za) or my supervisor Dr. T .Tamasane (t.tamasane@gmail.com or 011 276 9600).

Your positive response will be appreciated.

S Hamadziripi (Researcher) Cell: +27 718818729

PHELA Email Communication

5/13/16

sophiehama@gmail.com

to hope

Dear Mme Hope,

Hope I find you well. Following our discussion last year, I finally got the ethical clearance. I know it took like forever due to the new regulations at UNISA. As explained, I am hoping to do a survey of the teen mothers who participated in the end of project evaluation, supported by Irish Aid in 2014.

Is it possible to share my field work plan with you or any designate over the phone first before I travel to Lesotho? My worst fear, due to the delay, is that we might lose track of the teen mothers. I hope that will not be the case.

Your assistance in this regard will be much appreciated.

Regards

Sophie

From: Hope [mailto:hope@phela.org.ls]

Sent: 03 June 2015 10:40

To: Hamadziripi Sophie PRETORIA EM

Subject: RE: testing and follow up

Dear Sophie,

I went to visit with the Good Sheppard School for young mothers and this is the outcome:

I could not meet the Sister in charge, Sister Jasanta, but I met her deputy, Sister Phillipina.

She said that the school runs a 2 year programme for the young mothers after which they go back to their homes or find placing in different place. There is only one from that period who is with them working as a Tutor. She can be reached at the school at any time. To find her it would be best to reach either the Sister in Charge or the Deputy. The old students will be

coming for a get together meeting sometime in June, the date is not yet set. 

She has contacts of three other former students, one is in Qacha' s Nek running a successful small business and two are in Quthing starting up a business.

She will give you their details when you talk to her.

Contact: Sister Phillipina - [+266 5885 9271](tel:+26658859271) and [+266 6307 4527](tel:+26663074527) She will give you sister Jasanta's number. I hope this is helpful.

Thank you.

Hope.

Annexure D: Letter of Access to Shepherd of Good Hope

TO: The Manager – Shepherd of Good Hope

Berea Plateau

Dear Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Sophie Hamadziripi (Student number 44529856). I am a student at UNISA. I am currently registered for Masters Degree in Social Behaviour Studies in HIV and AIDS. As part of my studies I am expected to conduct a research project with significant contribution to policy of the body of literature on HIV and AIDS. The purpose of the research is to investigate the role of the life skills training in instilling resilience to HIV among teen mothers. The objectives of the study are to; understand what teen mothers have learnt by participating in the project, their views about the FFP project, understand how FFP helped teen mothers to deal with HIV issues and how their behaviour changed due to their participation in the FFP and whether they are still applying lessons learnt from the participation.

I hereby request your permission to do this research at your organisation (The Shepherds of Good Hope). In this study I will administer questionnaires to teen mothers who participated in the end of project evaluation exercise.

I will also need your assistance in identifying teen mothers who can, if they want, participate in this study. The completed questionnaires will be used by the researcher and her supervisors for the purposes of this study only and will be destroyed as soon as they are no longer needed.

If you have queries regarding this study you contact me on the details below, UNISA Research Committee (zunguli@unisa.ac.za) or my supervisor Dr. T. Tamasane (t.tamasane@gmail.com or 011 276 9600).

Your positive response will be appreciated.

S. Hamadziripi (Researcher)

Researcher's signature: _____ Date: _____

Good Shepherd School Communication

to jntsoaki

Sophie
Hamadziripi <sophiehama@gmail.com>

5/29/16

to jntsoaki

Dear Sister Jasinta,

Reference is made to the call we had earlier on today and thank you for your time. As per our discussion, kindly find attached;

- Research proposal
- The Phela end of project evaluation
- Consent letter (access letter)

Your assistance will be greatly appreciated.

Regards

Dear Sister,

Thank you for your time and willingness to assist me in my study. I have attached the data collection tool (questionnaire) to be used in the study. As per our discussion, my data collection strategy was to email the questionnaire to the 'girls', they complete it and then it is send back to me .

Thank you for helping with their contact details. I will try and follow them up.

Regards

Sophie