AN EVALUATION OF THE EFFECTIVENESS OF A PEER SEXUAL HEALTH INTERVENTION AMONG SECONDARY-SCHOOL STUDENTS IN ZAMBIA

Sohail Agha

This study investigated whether there were any changes in knowledge and normative beliefs regarding abstinence and condoms and personal risk perception of acquiring HIV among Zambian secondary-school students who were exposed to a peer sexual health intervention. Schools were randomly assigned to intervention and control groups. A baseline assessment that measured knowledge, normative beliefs about abstinence and condoms and personal risk perception was conducted in all schools. Students in the intervention group were exposed for a 1-hour-and-45-minute-long in-class peer sexual health intervention. Students in the control schools were exposed to a 1-hour-long in-class peer water purification intervention. A follow-up assessment of students was conducted after the intervention. Logistic regression analyses were conducted to determine whether significant differences between intervention and control groups emerged at follow-up. Relative to students in the control group, knowledge was higher and normative beliefs about abstinence and condoms were significantly more positive among students in the intervention schools. Students in the intervention schools also had a higher personal risk perception of acquiring HIV than students in control schools. These findings show that a school-based peer sexual health intervention implemented in Zambia was effective in increasing knowledge, positive normative beliefs about abstinence and condoms, and personal risk perception.

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Adolescents are important targets for AIDS prevention interventions because they constitute the future workforce of a country. Moreover, it may be easier to change behaviors at earlier rather than later ages. In sub-Saharan Africa, where the majority of HIV infections have occurred, adolescents are particularly vulnerable to contracting HIV. Although AIDS awareness among adolescents in Africa is generally quite high, the quality of their knowledge and their limited access to information may not be enough to motivate changes in sexual behavior such as the postponement of sexual initiation or the practice of condom use (Kelly, 2000).

School-based HIV prevention programs can be an extremely important component of efforts aimed at reaching adolescents. Because schools teach life-building skills, they are natural sites for prevention programs. However, because there can be substantial variation in the implementation of school-based interventions, it is important to identify interventions that are effective (Kirby et al., 1994; Millburn, 1995).

This study evaluates the effectiveness of a peer sexual health intervention in secondary schools in Zambia. The intervention was implemented by the Society for Family Health (SFH). The peer sexual health intervention is an important component of SFH’s social marketing AIDS prevention activities.

BACKGROUND

There is considerable confusion in the minds of Zambian adolescents about ways of preventing HIV transmission because the information they receive is often misleading and/or contradictory (Sachingongu, 2001).Advertisements in the Zambian media and entertainment industry glorify sex (Kelly, 2000), but many Zambians oppose condom use because they associate condoms with immorality (Sichone, 2001). At the same time, there are substantial barriers to acquiring reliable information about how HIV is transmitted and how its transmission can be prevented (Sachingongu, 2001).

Because of exposure to contradictory information, many young Zambians do not consider safer sex behaviors as positive lifestyle choices. Abstinence is considered by many adolescents to be old-fashioned and boring and interpreted by them to mean that they cannot have an exciting social life that includes having a boyfriend/girlfriend and dressing stylishly (Mwaba, 2000). Adolescents often feel pressure from their peers to initiate sexual relations at young ages, and girls in particular do not have the skills to firmly say no to sex or to negotiate the use of condoms (Mwaba, 2000). Girls are concerned that their boyfriends will perceive them as prostitutes if they suggest condom use (Feldman, O’Hara, Baboo, Chitalu, & Lu, 1997). Those who do use condoms do not use them consistently because they believe that condoms are ineffective at preventing HIV (Kusanthan & Suzuki, 2000), a view that is supported by many church groups (Feldman et al., 1997).

Zambian adolescents need interventions that help them overcome barriers to safer sex behavior. Young peoples’ beliefs about their friends’ behavior have a strong association with their own sexual behavior (Millburn, 1995). Because peer education involves sharing attitudes and values related to health behaviors among people of similar ages and status, and because it allows those exposed to the intervention to model attitudes and behaviors promoted by their peers, it can be effective in providing guidelines for future behaviors (Bandura, 1986).

There has been very little documentation of how adolescent sexual health interventions have been implemented in Zambia (Haambayi & Weiss, 1999; Salmi,
Kanyika, & Malambo, 2000). In 1999, after receiving permission from the Ministry of Education to conduct sexual health interventions in schools, SFH started a peer sexual health intervention aimed at school-based adolescents. The intervention was based on the premise that students will take preventive action if engaged in a dialogue that helps them develop a set of personal values and guidelines to support safer sexual behavior (Kelly, 2000). Intervention planners assumed that by providing an opportunity for factually correct information to be personalized by adolescents and by reinforcing positive normative beliefs it would be possible to enhance adolescents’ self-efficacy for taking preventive measures.

THE SFH PEER SEXUAL HEALTH INTERVENTION

To ensure that the intervention would be in sync with the social context in which Zambian adolescents develop their attitudes toward sexual behavior, the design of the SFH intervention was informed by focus groups with adolescents (Mwaba, 1999) and findings from other studies in Zambia (Campbell & Kelly, 1995; Pillai & Kelley, 1993; Pillai & Yates, 1993; van den Borne, Tweedie, & Morgan, 1996). Based on this information, a peer sexual health intervention was designed that focused on several important areas/issues simultaneously. The intervention was designed to enable schoolchildren to engage in discussions about abstinence and condom use with other young people who were trained as peer educators by a professional peer education trainer. The peer educators were trained to impart correct factual information about HIV prevention and transmission in a discussion oriented, interactive session. Normative beliefs that support abstinence and condom use would be strengthened and personal risk perception increased through these discussions. In addition, peer educators used drama skits to present scenarios that reflected actual experiences of many adolescents. These skits conveyed models of behavior for Zambian adolescents and provided schoolchildren with possible modes of behavior when confronted by similar situations. Thus, the SFH peer educators use a mixture of didactic techniques (discussion and drama skits) to convey factually correct information and models of behavior.

In terms of the actual implementation, a group of about four peer educators, consisting of male and females aged between 18 and 22 years, discuss sexual health issues with students in a particular secondary school. No teacher is present during the peer intervention, and an open discussion about abstinence, condom use, and the risk of acquiring sexually transmitted infections (STIs)/HIV takes place during these sessions. The peer education program has evolved over time in response to the kinds of questions peer educators have been asked during the sessions. Peer educators meet once a week to review and discuss the types of issues that were raised by students in the past week, to develop new and more effective ways of responding to students’ questions, and to practice new drama skits.

Peer educators start the session by providing factual information about how HIV is transmitted and how its transmission can be prevented. They explain that HIV is a virus that causes a loss in the body’s immunity and can be contracted through the exchange of bodily fluids during unprotected vaginal and anal intercourse. When asked questions about anal sex, they mention that anal sex has a high likelihood of HIV transmission because dryness of the anus and the friction caused by penetrative sex can lead to cuts that enhance the contact between bodily fluids. Although student questions usually pertain more to sexual transmission, other mechanisms of HIV transmission are also discussed. Student questions are used to discuss important topics such as symptomatic and asymptomatic phases of infection.
Abstinence is discussed as being effective in preventing sexual transmission of HIV and in preventing unwanted pregnancy. Peers encourage students to pursue their dreams and remind them that it is important for them not to get pregnant and not to contract HIV. Sexual networking is explained. Their emphasis is on correct and consistent condom use when abstinence is not possible. They mention that incorrect use of condoms lowers condom effectiveness.

Drama skits are used by peer educators to present models of attitudes and behavior towards sex that can help prevent adolescents fromcontracting HIV. Skits can help develop normative beliefs regarding the initiation of sexual intercourse. For example, one of the skits included a discussion between a schoolgirl and her boyfriend about sex. In spite of her boyfriend telling her how much he loves her, the girl refuses to have sex with him because she is not ready to initiate sexual activity. This skit emphasizes the importance of having the self-esteem to be able to refuse sex and helps adolescents understand that it is okay to resist the pressure of having sex and that there is no shame in being a virgin.

The drama skits enhance adolescents' personal risk perception by forcing adolescents to consider their potential partner's previous sexual history and its implications for HIV transmission. One skit features a girl who is sexually experienced and has started a new relationship. The girl is more informed/empowered than her boyfriend and refuses to have sex with him without using a condom. She tells him that she can't have unprotected sex with him because (a) she doesn't know his past history, (b) she has vowed to survive the AIDS scourge, and (c) she wants to live to see her dreams of a good future come true. The skit ends with the girl saying “No glove, no love.”

At the end of the interactive session, a leaflet about sexually transmitted infections (titled “STIs. Why Should I Worry?”) is given out by the peers. This leaflet motivates abstinent youth to maintain their status by informing them of the dangers associated with sex and encourages sexually active adolescents to use condoms (or to abstain) by telling them that a variety of STIs are spread through sexual contact. It states that STIs can be painful and can cause infertility. Moreover, many STIs can lead to death if not treated, and they may increase the likelihood of HIV transmission. The leaflet also emphasizes that most STIs can be cured if prompt medical attention is obtained but that AIDS is incurable. The brochure emphasizes the importance of using a condom every time one has sex.

DATA AND METHODS

STUDY DESIGN

The SFH peer sexual health intervention was evaluated using a randomized control group design. To reduce contamination due to the exposure of students to AIDS prevention messages on television, the evaluation was restricted to boarding schools.

Secondary schools were randomly assigned to intervention and control groups. Students in Grades 10, 11, and 12 were randomly selected in intervention and control schools and given a baseline assessment of their normative beliefs and knowledge about abstinence and condoms and their personal risk perception of contracting HIV. The baseline assessment was conducted in July 2000. The peer education intervention was implemented in the 1st week of September. Students in the intervention schools were given a 1-hour-and-45-minute-long peer education session about HIV/AIDS. Students in the control group were given a 1-hour-long peer education session about water purification. A follow-up assessment was conducted after the sexual health and
water purification peer education interventions had been implemented, in mid-September 2000.

**SAMPLING**

Because of cost considerations, the sampling frame was restricted to secondary boarding schools in those three provinces (Central, Copperbelt, and Lusaka) that were accessible by road from Lusaka. A list of secondary boarding schools in the provinces was prepared. Of the 11 schools that were part of this list, 2 were ineligible because they had received a peer education intervention from the SFH in the year 2000, and 1 was ineligible because it was a Catholic mission school for girls that was not comparable to the other schools. Two other schools could not participate because they had activities that conflicted with the timing of the data collection. A sixth school was deliberately dropped because it was far from any urban area, making transportation costs to that school prohibitive. All five remaining schools were included in the evaluation. Simple random sampling was used to select the three schools where the intervention was implemented. The remaining two schools were used as controls. A better strategy would have been to have a larger number of schools assigned to intervention and control conditions (about 30 or more in each trial arm). However, the resources available for this study did not permit sampling a larger number of schools.

Permission was granted by the Ministry of Education to conduct the evaluation in these five schools. During a preliminary visit to the schools, basic data (including names, gender, grade and ages) of all students in Grades 10, 11, and 12 in these schools was collected. A constant number of 45 males and 45 females were randomly selected from each grade of the coeducational schools, using a random number generation process. In single-sex schools, 45 males or 45 females were randomly selected from each grade, using the same random selection process. Students were assured of the confidentiality of their interviews and were told that they did not have to fill out any section of the questionnaire that they did not want to. In one of the girl schools, 28 girls in Grade 12 could not be interviewed because they were taking an examination on the day of the survey. There were no other cases of refusals. This resulted in a total of 913 completed interviews in these five schools.

In the follow-up assessment, 759 of these 913 students (83%) could be located for reinterviewing. The remaining students did not return for the new term. There were no refusals during the follow-up. This follow-up rate compares favorably with several other school-based interventions (eg., Kirby, Korpi, Adivi, & Weissman, 1997; Klepp, Ndeki, Leshabari, Hannan, & Lyimo, 1997; Harvey, Stuart, & Swann, 2000). However, to reduce loss to follow-up, a better strategy might have been to conduct the baseline and follow-up assessments in the same term.

**QUESTIONNAIRE DEVELOPMENT AND DATA COLLECTION**

Because the study population was literate and fluent in English, a self-administered questionnaire was used. This made data collection more efficient and reduced costs. Self-administered questionnaires have been widely used in gathering sexual behavior and attitudinal information in both developed and developing country settings and produce reliable results (Gagnon & Godin, 2000; Kirby et al., 1997; Klepp et al., 1994; Klepp et al., 1997).

The questionnaire and study were designed to simultaneously evaluate two peer education interventions: a peer sexual health intervention and a peer water purification intervention. The first part of the questionnaire consisted of a section about the respondent and their family background. Respondents were asked questions about
their demographic characteristics, about the education and occupation of their parents and about household amenities (such as electricity, sanitation) and assets (such as television, radio). The second part of the questionnaire was the Family Health section. This had four subsections in which respondents were asked about information on household water storage, about their knowledge of the causes and prevention of cholera and diarrhea, about their knowledge and use of a water purification agent, and about family health and hygiene practices. The Sexual Health section was the third main part of the questionnaire. This had six subsections, including knowledge and perception of sexual health, knowledge and perception of abstinence, knowledge and perception of condoms, sexual experience with a steady partner, sexual experience with a casual partner and knowledge and perception of the peer education intervention.

The questionnaire was based on the questionnaires used for the 1996 Zambia Demographic and Health Survey (DHS; Central Statistical Office, 1997), on other sexual behavior studies conducted in Zambia (Agha, 1997; Kusanthan & Suzuki, 2000), and on a questionnaire used for a study on water purification (Chege & Agha, 1999). The questionnaire was pretested in a secondary school that was not part of the evaluation. Changes were made to questionnaire items based on the results of the pretest.

Four days training was given to 30 research assistants who were used for collecting the data. During the training, research assistants gained familiarity with the study methodology and the questionnaire. Administrative and logistical aspects of the study were also discussed in detail. At the end of the training, a test was administered to the research assistants to assess their comprehension of the study methodology and their ability to implement the study. Six research assistants who performed well on the test were given supervisory duties, five assistants who performed poorly were not included in the interview team. Prior to the follow-up data collection, research assistants were given a 1-day long refresher training. On average, data collection teams spent about 2 1/2 hours at each school. During this time, peer educators explained the nature of the study to study participants and showed them how to mark multiple-choice questions. Students were then allowed to complete the questionnaire. Data quality checks were conducted during data collection and during analysis and showed that the data was of good quality.

DATA ANALYSIS

It is important to note a design limitation of this study. When few units of randomization are used (as in this study), there is a high likelihood that an imbalance might occur between trial arms, resulting in differences in the sociodemographic composition of student/community characteristics (Hayes et al., 1997). We use statistical controls to minimize the possible effect of this on our findings. To determine the extent to which such differences might produce a bias in our conclusions, we reviewed the literature, identified student characteristics that previous studies had found to be related to similar outcome measures, and compared schools in terms of these characteristics. We used the chi-square test of independence to measure whether these differences were statistically significant at the bivariate level. There were important differences between schools in the distribution of student characteristics (see next section). To control for differences in student characteristics between intervention and control schools, we conducted multivariate logistic regression analyses. To adjust for differences in the sociodemographic composition of student characteristics, we con-
trolled for age of respondent, being in Grade 12, having had sexual experience, socio-economic status, religion, and prior exposure to peer educators.

Another factor that has a bearing on this analysis is that observations (in this case, individual students) were not independently selected. Rather it was the clusters (in this case, schools) that were independently selected. Because students in the same school are likely to have common characteristics, this increases the standard errors of parameter estimates. Unless this effect is taken into account in the analysis, it can lead to estimates that appear to be statistically significant when they are not (in other words, an overestimation of the impact of the intervention). Therefore, we computed the analysis using the Huber-White correction. This is a robust estimator of variance that allows a relaxation of the assumption of independence of observations and requires only that the observations be independent across the clusters (Huber, 1967; White, 1980). The analyses were conducted with unweighted data.

We present results from the multivariate regression comparing individuals in intervention and control locations at baseline and then at follow-up. Although this does not fully take into account the longitudinal character of the study design, it does make the presentation and interpretation of results easy to follow.

Due to randomization, we expected there to be no significant differences between intervention and control students in terms of their knowledge, attitudes, beliefs and risk perceptions at baseline. In addition, we expected that if the intervention were effective, knowledge, attitudes and beliefs about AIDS and personal risk perception would be significantly better among students in the intervention relative to the control schools at follow-up.

**SAMPLE CHARACTERISTICS**

Table 1 shows the percentage of students in different sociodemographic categories, by school and gender. Overall, 42% of students were between 14 and 17 years of age (mean age of 17.9 years). About one third (33%) of respondents were in Grade 12. About 71% had their biological father alive and 83% had their biological mother alive. More than half (54%) of respondents had had sexual intercourse. About 23% of students were from households with 10 or more assets, 28% were Catholic and 67% had had previous exposure to peer education.
The overall distribution of adolescent characteristics in this sample is consistent with other survey data on adolescents (Central Statistical Office, 1999; Kusanthan & Suzuki, 2000). However, there was significant difference in several characteristics between intervention and control schools. The intervention group had a smaller proportion of males (50%) than the control group (66%). About 52% of respondents in the intervention group were aged 14-17, compared with 31% in the control group. Consistent with their younger age, a smaller proportion of respondents in the intervention group were in Grade 12 (30% in the intervention group vs. 38% in the control group). Students in the intervention group were also less likely to have had sexual experience than students in the control group (43% vs. 68%) and more likely to be from households with 10 or more household assets (32% vs. 13%).

**RESULTS**

**KNOWLEDGE OF AND NORMATIVE BELIEFS ABOUT ABSTINENCE**

Table 2 shows the odds ratio of a person in the intervention group relative to a person in the control group expressing their knowledge and normative beliefs about abstinence, at baseline and at follow-up. An odds ratio larger than 1 indicates that a person in the intervention group was more likely to have that particular belief than a person in the control group, net of other factors. Similarly, an odds ratio of less than 1 shows that a person in the intervention group was less likely than a person in the control group to have that belief, net of other factors.

At baseline there was only one significant difference between intervention and control groups: intervention students were 1.3 times as likely as control students to feel that some people find it difficult to abstain from sex. At follow-up (i.e., after the intervention), significant differences emerged between intervention and control groups in their knowledge of abstinence. Respondents who received the peer sexual health intervention were 3.4 times as likely as respondents in the control group to report that they had ever heard of abstinence. There were also changes in normative beliefs.

### Table 2. Adjusted Odds Ratios (AOR) of a Person in the Intervention Group Relative to a Person in the Control Group Expressing their Knowledge and Normative Beliefs about Abstinence, at Baseline and at Follow–Up

<table>
<thead>
<tr>
<th></th>
<th>Baseline (n = 759)</th>
<th></th>
<th>Follow–Up (n = 759)</th>
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<tbody>
<tr>
<td></td>
<td>AOR 95% CI</td>
<td>AOR 95% CI</td>
<td></td>
</tr>
<tr>
<td>Ever heard of abstinence</td>
<td>1.27 0.62, 2.61</td>
<td>3.42 1.01, 11.54</td>
<td></td>
</tr>
<tr>
<td>Abstinence is effective in preventing HIV.</td>
<td>0.99 0.67, 1.50</td>
<td>1.38 0.62, 3.10</td>
<td></td>
</tr>
<tr>
<td>Abstinence is effective in preventing STIs.</td>
<td>1.15 0.68, 1.96</td>
<td>1.72 0.79, 3.72</td>
<td></td>
</tr>
<tr>
<td>Abstinence is effective in preventing pregnancy.</td>
<td>1.15 0.75, 1.78</td>
<td>1.73 0.82, 3.66</td>
<td></td>
</tr>
<tr>
<td>A person can avoid HIV by abstaining.</td>
<td>1.16 0.60, 2.26</td>
<td>3.89 2.21, 6.85</td>
<td></td>
</tr>
<tr>
<td>Normal for a woman to propose abstinence.</td>
<td>0.95 0.42, 2.13</td>
<td>2.28 1.11, 4.70</td>
<td></td>
</tr>
<tr>
<td>Normal for a man to propose abstinence.</td>
<td>0.85 0.38, 1.95</td>
<td>1.96 1.06, 3.62</td>
<td></td>
</tr>
<tr>
<td>Some people find it difficult to abstain from sex.</td>
<td>1.31 1.06, 1.60</td>
<td>1.25 0.73, 2.15</td>
<td></td>
</tr>
<tr>
<td>I approve of individuals abstaining.</td>
<td>1.18 0.88, 1.59</td>
<td>1.98 1.24, 3.16</td>
<td></td>
</tr>
</tbody>
</table>

**Note.** CI = confidence interval. *Adjusted for age of respondent, whether respondent is in Grade 12 or not, whether respondent has had any sexual experience, household socioeconomic status (assets), religion, and prior exposure to peer education. Odds ratios and confidence intervals are estimated with the Huber–White robust variance estimator, which provides more accurate parameter estimates.
beliefs about abstinence. Students in the intervention group were 3.9 times as likely as those in the control group to believe that a person can avoid HIV by abstaining from sex. Intervention respondents were 2.3 as likely as controls to believe that it is normal for a woman to propose abstinence and 2 times as likely to believe that it is normal for a man to propose abstinence. Finally, individuals in the intervention group were two times likely as individuals in the control group to approve of abstinence.

KNOWLEDGE OF AND NORMATIVE BELIEFS ABOUT CONDOMS

Table 3 shows the odds ratio of a person in the intervention group expressing their knowledge of and normative beliefs about condoms relative to a person in the control group, net of other factors. As expected, at baseline there were no significant differences in beliefs regarding condoms between intervention and control respondents.

Significant differences in knowledge and normative beliefs about condoms emerged at follow-up. Relative to control students, intervention respondents were 2.5 times as likely to report having received information on condom use and about 2.3 times as likely to report having received information on condom use from peer educators. Respondents in the intervention group were also two times as likely as respondents in the control group to report that they knew where to obtain condoms.

Moreover, intervention respondents were 1.5 times as likely as control respondents to believe that condoms are effective in preventing HIV and about 1.3 times as likely to believe that condoms are effective in preventing STIs. Intervention students were also 4.8 times as likely as control students to report that a person can avoid HIV by using a condom during sexual intercourse.
The belief that it is normal for a woman to propose condom use was significantly more prevalent in the intervention group than in the control group—about 1.7 times as likely to be reported by a person in the intervention group than by a person in the control group. Intervention students were 1.5 times as likely as control students to believe that it is normal for a man to propose condom use. Finally, respondents in the intervention group were 2.3 times as likely to approve of condom use.

PERSONAL RISK PERCEPTION

Table 4 shows the odds ratio of a person in the intervention group expressing their beliefs about the severity of AIDS and their personal risk perception relative to a person in the control group, net of other factors. At baseline, respondents in the intervention group were 3.1 times as likely as respondents in the control group to believe that it is possible for a healthy looking person to have HIV. There were no other significant differences between intervention and control groups in beliefs about disease severity and risk perception prior to the intervention.

At follow-up, intervention respondents were 1.9 times as likely as control respondents to report having heard of HIV from peer educators and 1.9 as likely to report that AIDS is incurable. Intervention students were also more likely to feel at risk of acquiring HIV: they were 0.7 times as likely as control students to report that there was no chance that they would contract HIV. Lastly, intervention respondents remained more likely than control respondents to believe that it is possible for a healthy looking person to contract HIV.

DISCUSSION

These findings show a consistent picture of the impact of the peer sexual health intervention. Secondary school students who were exposed to the 1-hour-and-45-minute-long peer sexual health intervention were significantly more likely than secondary school students who received a peer water purification intervention to report higher levels of knowledge of and more positive normative beliefs about abstinence and condom use. Intervention students’ beliefs in the efficacy of abstinence and condom use in preventing HIV and that condoms can protect against STIs were significantly greater than those of the control students. Previous research has shown that the lack of these...
beliefs can be an important deterrent to condom use in Zambia (Central Statistical Office, 1999; Kusanthan and Suzuki, 2000). Relative to control students, it was more acceptable among intervention students for a woman or a man to propose abstinence or condom use to their partner. Consistent with these changes, students in the intervention group were more likely than students in the control group to approve of abstinence and condom use.

The belief that AIDS is incurable was stronger among students in the intervention schools. Intervention students were also more likely to have higher personal risk perception than students in the control schools. Overall, these findings show that the peer sexual health intervention was effective in increasing knowledge of and positive normative beliefs about abstinence and condom use and in increasing personal risk perception.

Because this study measured the impact of the peer sexual health intervention soon after the intervention was implemented (the follow-up assessment was conducted within 2 weeks of the peer sexual health intervention), we cannot assess whether these changes in beliefs are likely to persist. Moreover, it is not possible to tell whether improvements in beliefs and attitudes are likely to result in the adoption of protective behaviors. In spite of these limitations, however, the usefulness to program managers of knowing this particular intervention had an impact (at least) in the short run cannot be underestimated.

Because no alternative peer sexual health intervention was implemented to compare/contrast with the SFH intervention, we can only hypothesize why the SFH intervention was effective in changing knowledge and normative beliefs about abstinence and condoms. One of the strengths of this intervention was that it relied on research that had been conducted on adolescent sexuality (both by project researchers and by independent researchers) in order to develop the peer intervention. Thus, a component of the intervention was to engage schoolchildren in a discussion during which they could obtain correct factual information in areas where they had previously received misleading information (e.g., that sexual intercourse causes AIDS, whether or not a person has HIV) or no information at all.

Another component of the intervention was to use drama skits to present schoolchildren with scenarios that they could associate with. It was assumed that choices made by the actors would help develop positive normative beliefs among schoolchildren. The aim of the intervention to develop positive normative beliefs (e.g., that it is acceptable to remain a virgin) and practical guidelines (the need to use a condom in every act) may be particularly important in a social context where adolescents receive mixed messages about sexuality and where interventions targeted towards adolescents have tended to be extremely moralistic (Harland, Shenton, and McMillan, 1995).

These findings have important implications for AIDS prevention efforts in Zambia. Young Zambians are eager to obtain reliable sexual health information (Feldman et al., 1997). Schools are a logical and convenient entry point for AIDS prevention interventions and interventions implemented at schools tend to have greater credibility among young people. With 51% of Zambians below 18 years of age (Central Statistical Office, 2000), scaling up school-based peer sexual health interventions may be an effective strategy to limit the spread of HIV in Zambia.
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