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Condom Self Efficacy among Sexually Active out-of School Male Apprentices in Anambra State, Nigeria: Effectiveness of Motivational Enhancement Therapy (MET)

*Ofole Ndidi, M.

*Department of Counselling and Human Development Studies, University of Ibadan.
Email:nm.ofole@ui.edu.ng, stainless4god@yahoo.com

Abstract

A major health concern in Nigeria is the low usage of condoms among sexually active youths despite their acknowledged benefits. This study examined the main effect of Emotional Enhancement Therapy (MET) and the interaction effect of level of HIV knowledge on condom self efficacy among identified sexually active male out-of school youths in Anambra State, Nigeria. Pre test post test control group design with 2x2 factorial matrix was adopted for the study. Ninety seven youths in the age range of 15-22 years and mean age of 18.5 (SD = 2.2) were purposively recruited from an approximated 3,301 apprentices in two major markets in Anambra State, and were randomly assigned into treatment conditions. The experimental group was exposed to ten sessions of MET, while the control group was used as the comparison group. Data was collected with three self-report questionnaires. Three hypotheses were tested at 0.05 significance level. The result of Analysis of Covariance showed a significant main effect of treatment on condom self efficacy. However, there was no interaction effect of HIV knowledge on the criterion variable. Furthermore, treatment and level of HIV knowledge jointly contributed 62.2% of the variance in condom self efficacy. In conclusion, MET was effective in enhancing condom self-efficacy irrespective of HIV knowledge. This outcome has implication for programming intervention for out-of school youths.

Keywords: Motivational Enhancement therapy, Condom Self Efficacy, Out-Of School Apprentices, Anambra

Introduction

The prevention of sexually transmitted infections (STIs) among youths is Nigeria's health priority (Federal Ministry of Health, 2015). This is due to the fact that Nigeria's development is compromised by the sexual and reproductive health challenges afflicting her youths. A meta-analysis of risky sexual behaviour among male youths in developing countries including Nigeria by Berhan and Berhan

(2015) showed that out of 19,148 male youths who reported having sexual intercourse in the 12-month period prior to the survey, 75.2% practised higher-risk sex (93% and 67% between age 15–19 years and 20–24 years respectively). In addition, the overall proportion of condoms used during the last higher-risk sexual encounter was 40% among 15–19 years old and 51% in the 20–24-year category. This observation raises concerns that youths remain at risk of contracting sexually transmitted infections (STIs) including HIV and having unintended pregnancies (National Demographic and Health Survey, 2013; Ayo, Musibau, Adeniyi & Odunaya, 2013). Hibret, Damen, Kassahun and Gail (2007) revealed that out-of-school youths were more than two times at risk of having sex with a non-regular partner than youths who were educated. In a study by Ayo *et al* (2013) and Furlong (2013), youths with little or no education in Nigeria were reported to have 1.3% chances of being infected with HIV compared to their more educated counterpart.

Missing out on formal education has been identified as a risk factor for Adolescent Sexual and Reproductive Health in Developing Countries (Hindin & Fatusi,2009; Iwuchukwu, 2013: Fearon, Wiggins, Pettifor & Hargreaves, 2015; Adebiyi & Asuzu, 2009). School attendance and school connectedness are proved developmental assets or protective factors for youths (Pettifor, Levandowski, MacPhail, Padian, Cohen & Rees, 2008). Schools offer opportunities for the development of essential intellectual, social and emotional skills and they are also the most common site for youths' health promotion in both high and low income countries such as Nigeria (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011).

One concern is that despite the effectiveness of condoms in preventing sexually transmitted infections including HIV, their usage remains unacceptably low among sexually active Nigerian youths aged 15 to 24. This is evident in the result of the National Health Survey of 2013 conducted by the National Population Commission (NPC) which showed that the percentage of people aged 15–49 who had had sexual intercourse with more than one partner in the past 12 months and who reported the use of a condom during their last intercourse was low (64.5%). As a result of an increase in STIs rate including HIV in Nigeria, efforts have been made to improve general HIV knowledge on the assumption that high knowledge would translate to adopting protective measures. Similarly, extensive prevention programmes have been conducted locally and internationally but they have only succeeded in improving HIV knowledge and awareness. In Nigeria, despite the improvement in HIV prevention knowledge, people still engage in unprotected sex. For instance, the 2013 sentinel survey showed that

twenty-six percent of Nigerian women and 37 percent of men had comprehensive knowledge about AIDS. That is, they knew that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chances of getting HIV; they knew that a healthy-looking person can have the AIDS virus, yet out of the many respondents who had had two or more partners in the past 12 months, only 29 percent of women and 20 percent of men reported that they used condoms during their most recent sexual intercourse (National Demographic and Health Survey, 2013). Regrettably, previous health promotion activities and interventions often assumed that improving HIV knowledge and awareness would increase condom use. However, despite the improvement in HIV prevention knowledge, many studies have shown low levels of condom use (National Demographic and Health Survey, 2013; Walque & Kline, 2012). Studies showed that psychosocial factors defined as proximate determinants (e.g., perceived risks, self-efficacy) have an indirect influence on the use of protective behaviours such as condom use (Artistico, Oliver, Dowd, Rothenberg & Khalil, 2014). Studies also showed that intervention programmes could lead people to use condoms (Miranda, 2013, Scott-Sheldon, Huedo-Medina, Warren, Johnson & Carey, 2011; Czuchry, Timpson, Williams & Bowen, 2009).

Condom Self Efficacy

It is worrisome that despite the widely acclaimed benefits of condoms, low condom usage is reported among Nigerian youths (National Demographic and Health Survey, 2013). It is natural to ask the following questions concerning the youths; why do they fail to adopt protective measures such as using a condom? Is it because they don't know that they're at risk of contracting infection? Or is it because they don't know how to talk to their partners about using a condom? Or that they don't consider themselves to be at risk? Is it because they forget to buy a condom? Theoretical and empirical evidence suggests that non condom use among youths aged 15 to 24 is due to several psychosocial and cultural barriers (Exavery, Lutambi, Mubyazi, Kweka, Mbaruku & Masanja, 2011; Lawonyin & Kanthula, 2010). For example, a study by Njau *et al*. (2006) among Tanzanian youths revealed that personal knowledge about HIV prevention, influence of significant others or peers, perceived vulnerability, and self-efficacy regarding condoms were the important motivators to use condoms. On the contrary, Ochieng, Kakai and Abok (2011) identified myths, misconceptions, and suspicion of condom accuracy in the protection of HIV infection to be responsible for its non-usage. Studies in Nigeria reported that the commonest reasons for non-condom use were that it reduces sexual enjoyment (Adebiyi & Asuzu, 2009), low educational attainment (Fagbamigbe, Adebowale & Olaniyan, 2011; Oyediran,

Feyisetan & Akpan, 2011), social factors and social supports (Adedimeji, Heard, Odutolu & Omololu (2011) and a low risk perception (Ofole, 2012).

Health Belief Model (HBM) provides a theoretical framework for explaining condom self-efficacy among high risk groups. Health Belief Model (HBM) is a psychological health change model developed to explain and predict health-related behaviour, particularly in regard to the uptake of health services (Janz, & Becker, 1984). The Model suggests that people's beliefs about health problems, perceived benefits of action, barriers to action and self-efficacy explain engagement (or lack of engagement) in health-promoting behaviour (Carpenter, 2010). Studies have shown that though individuals acknowledge that condoms reduce risks of HIV infection, they do not adopt them because they lack a sense of self-efficacy (Shawenon & Tekletsadik, 2013). Asante and Doku (2010) opined that a consistent condom use is linked to high levels of self efficacy. People need to feel confident in their ability to use condoms, or they won't use them. Someone who has high condom use self efficacy (CSE) feels comfortable buying a condom. They are willing to carry one with them when they might need it. They feel like they know how to use a condom correctly. They are ready to do so during sex. And, perhaps most importantly, they are confident in their ability to ask their partners to use a condom. They know they can say "no" to anyone who refuses to comply. Self efficacy, in this context, increases not only peoples' intentions to use a condom, it also raises the percentage of time they actually do use them.

Bandura (1997) defined self efficacy as "beliefs in one's capabilities to organize and execute the courses of action required in managing prospective situations" (p. 2). More simply, self-efficacy is what an individual believes he or she can accomplish using his or her skills under certain circumstances (Snyder & Lopez, 2007). The basic principle behind Self-Efficacy Theory is that individuals are more likely to engage in activities for which they have high self-efficacy and less likely to engage in those they do not (Van der Bijl & Shortridge-Baggett, 2002). Social Cognitive Theory proposes that individuals do not simply respond to environmental influences, but rather they actively seek and interpret information (Nevid, 2013). Individuals "function as contributors to their own motivation, behaviour, and development within a network of reciprocally interacting influences" (Bandura, 1999, p. 169). Bandura's (1994) Social Cognitive Theory emphasizes how cognitive, behavioural, personal, and environmental factors interact to determine motivation and behaviour (Crothers, Hughes & Morine, 2008). Williams and Williams (2010) noted that "individuals with high levels of self-efficacy approach difficult tasks as challenges to master rather than as threats to be avoided" (Williams & Williams, 2010, p. 455. Self-

efficacy affects every area of human endeavour. As a predictor, self-efficacy facilitates the forming of behavioural intentions, the development of action plans, and the initiation of action. As a mediator, self-efficacy can help prevent relapse to unhealthy behaviour. As a moderator, self-efficacy can support the translation of intentions into action (Gutiérrez-Doña, Lippke, Renner, Kwon & Schwarzer, 2009). High Self-efficacy influences how people set their health goals (e.g., "I intend to use a condom when having sexual intercourse," or "I intend to use condoms correctly and consistently"). Individuals' Self efficacy level can be genetic or learned. According to Social Learning Theory, people can learn self efficacy from others through observation, imitation, and modelling (Margolis & McCabe, 2006; Bandura, 1997).

Motivational Enhancement Therapy (MET)

One of the therapies that may be effective in enhancing self efficacy is Motivational Enhancement Therapy (MET) which involves a variation of motivational interviewing originated by Miller and Rollnick (2002). It is both a treatment philosophy and a set of methods employed to help people increase intrinsic motivation by exploring and resolving ambivalence about behavioural change. MET is both non confrontational and nonjudgmental and typically assumes that the individual already has the resources needed for change but the wish for such change may be buried under misconceptions, habits and fear, but exposing that kernel of change could allow it to grow stronger and stronger, until people feel willing and able to change their lives for the better. It works to help an individual mobilize his or her resources in order to achieve the desired outcome. MET was selected for this study because it is well grounded in research and processes of change as outlined by Prochaska and DiClemente (1984).

The proponents of transtheoretical model posit that health behaviour change involves progress through six stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. MET assists clients in moving through the stages towards action and maintenance. In sum, MET is based on motivational principles which have the capacity to assist participants overcome their ambivalence or resistance to adopting safer sex practices and using condoms. MET focuses on increasing intrinsic motivation by raising participants' awareness of a problem associated with unprotected sexual intercourse, adjusting any self-defeating thoughts regarding condom usage, and increasing confidence in their ability to change. Instead of identifying the problem and telling the participants what to do about it, the researcher encouraged the participants in therapy to make self-motivating statements that displayed a clear understanding of the problem and encouraged them to change. In this study, the researcher adapted

treatment package in line with five motivational principles of MET namely; expression of empathy, development of discrepancy, avoidance of argumentation, rolling with resistance and supporting self-efficacy.

Researchers have consistently demonstrated the efficacy of MET in increasing one's readiness to stop drug use, reduce the severity of substance use, and in lengthening periods of abstinence (Huang, Tang, Lin & Yen, 2011; Lundahl & Burke**,** 2009). Preliminary evidence also indicates that MET may be useful in enhancing the treatment of other conditions such as anxiety, eating disorders and problem gambling (Armstrong, Atkin-Plunk & Gartner, 2016; Fiszdon, Kurtz, Choi, Bell & Martino, 2016). Studies further suggest that MET can help stimulate positive changes in health-risk behaviours among youths (Madson, Mohn, Schumacher & Landry, 2015). There is scarce literature that has examined MET's effectiveness in enhancing condom self efficacy especially among the out of school youths. Studies suggest that MET may be promising in enhancing condom self efficacy (Kanfer & Schefft, 1988; Van Bilsen, 1991; Miller & Rollnick, 1991).

Purpose of Study

This study investigated the main effect of Motivational Enhancement Therapy and the interaction effect of level of HIV knowledge on condom self efficacy among sexually active out-of school male apprentices in Anambra State, Nigeria. Specifically, the study tested the following hypotheses at 0.05 level of significance.

Hypotheses

H_1: There will be no significant main effect of treatment on condom self efficacy among sexually active out-of school male apprentices in Anambra State, Nigeria.

H_2: There will be no significant interaction effect of level of HIV knowledge on condom self efficacy among sexually active out-of school male apprentices in Anambra State, Nigeria.

H_3: There will be no composite effect of treatment and level of HIV knowledge on condom self efficacy among sexually active out-of school male apprentices in Anambra State, Nigeria.

Materials and Method

Study Setting

Anambra State was purposively selected for this study due to the fact that when compared with their female counterparts the literacy rate among the male is comparatively low (National Commission for Mass Literacy, Adult and Non-Formal Education (NMEC, 2010). Two major markets in Onitsha and Nnewi were equally selected because they are fast-growing commercial cities located in Anambra State that developed to become a huge conurbation in West African Economy. Onitsha has the largest market of its kind in the ECOWAS sub-region while Nnewi (the Taiwan of Nigeria) is a rapidly developing industrial and commercial centre. According to Iwuchukwu (2013), those who dropped out of school in Anambra State boast that they are studying at UNN which stands for "University of Nkwo Nnewi", representing various markets where Igbo boys who dropped out of schools attach themselves to prosperous businessmen for "igba odibo" or "igba boy" (apprenticeship). Apprentices are majorly male youths within the age range of 12-24 years. They serve their masters for between 5-8 years and afterwards disengage from the masters who establish or "settle" them with the sum of money which is commensurate with the quality of services rendered to the masters (Iwuchukwu, 2013).

Design

Pre-test post test control group experimental design with 2x2 factorial matrix was adopted for the study. The rows consist of Motivational Enhancement Therapy Group and the Control Groups while the column comprised the participants' level of HIV knowledge at two levels (High vs. low).

Sample and Sampling Technique

Ninety-seven males in the age range of 15-22 years and mean age 18.5 years (SD=2.2) participated in the study. Non randomized sampling technique was adopted to select two major markets (Nnewi and Onitsha) located in Anambra State. Similarly, two trade unions (Electrical/ Electronic and Motorcycle Spare Parts) were purposively selected from the 32 trade unions that made up Main Market Association. These groups were purposively selected because most of their apprentices are male and they suited the purpose of the study. Thereafter, the simple random sampling technique was used to select a sample size of 97 apprentices from the two trade unions. A similar procedure was adopted to select apprentices from Nnewi Traders Association.

Measures

Youth Risk Behaviour Survey

The High School version of reversed Youth Risk Behaviour Survey developed by Centres for Disease Control and Prevention (2009) was adapted to screen the participants who are sexually active. The questionnaire was originally developed to monitor six types of health-risk behaviours. Only items 59- 65 were utilized to measure the prevalence of sexual activity, number of sexual partners, age at first intercourse, alcohol and other drug use related to sexual activity, condom use, and contraceptive use among participants. Typical items on the questionnaire were; "*Have you ever had sexual intercourse?"* "*The last time you had sexual intercourse, did you or your partner use a condom"?* "*The last time you had sexual intercourse, what one method did you or your partner use to prevent yourself"?* The items on the questionnaires were worded in simple English Language and were considered culturally fair to Nigerian respondents. Ugoji (2014) and Umoh and Umoh (2011) concluded that the instrument was valid and reliable and had a reliability index which ranged from 91.1% to 71.7%. Similarly, Wang, Yi, Cai, Hu, Zhu, Yao and Auerbach (2012) reported satisfactory Cronbach's alpha of 0.086 using Chinese youths.

Condom Self-efficacy

The participants' condom self efficacy was assessed with Condom Use Self-Efficacy (CUSE) developed by Brafford and Beck (1991). The instrument was originally developed to assess the confidence of American college students in the use of condoms. It consisted of 28 items describing an individual's feelings of confidence about being able to purchase condoms, put them on and take them off, and negotiate their use with a new sexual partner. It has four subscales namely: mechanics (1, 27, 14, 22), partner's disapproval (9, 10, 16, 17, 18), assertiveness (4, 5, 6) and intoxicants (24, 25, 28), and left 13 items unassigned. The items elicited responses using a five-point Likert scale that ranged from 'strongly disagree' to 'strongly agree'. In this study, the responses for each item were scored as 0 = strongly disagree, 1 = disagree, 2 = undecided, 3 = agree and 4 = strongly agree. Typical items on the scale included; "I *feel confident in my ability to discuss condom usage with any partner*" "*I wouldn't feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have a STD"* "*I feel confident that I would remember to use a condom even after I have been drinking".* Participants who obtained (56-112) were considered to have high condom self efficacy and they were excluded from the study while the treated participants scored between 1-55. Brafford and Beck (1991) reported

that the CUSE is a reliable measure with a Cronbach's α of 0.91.They also found acceptable levels of discriminant validity and convergent validity for the instrument. Forsyth, Carey and Fuqua (1997) reported that CUSES possessed adequate internal consistency and that individuals' attitudes about condoms were correlated with the overall score on the scale. During the pilot study, the researcher re-established the stability index using 30 randomly out-of school youths in Agbeni and Alesiloye Markets and obtained a reliability index of 0.71 within one week interval.

HIV knowledge Questionnaire

HIV knowledge questionnaire, an 18-item questionnaire developed by Carey, Morrison-Beedy and Johnson (2007), was used to measure the participants' level of HIV transmission and prevention knowledge. Typical items on the questionnaire included: "*HIV and AIDS are the same*; "*HIV can be spread by mosquitoes"*, "*You can tell if someone has HIV by looking at them"*. Scores obtained were used to classify the participants into two levels of HIV knowledge (high and low). The response options were true or false. Fourteen items (14) were negatively worded while four (4) items were positively worded. Reversed scoring was adopted for questions 4, 7, 8 and 17 which were positive statements on HIV/AIDS. The higher the number of the true options chosen by the respondent, the lower the level of HIV knowledge. Respondents who scored 29-50 and 01-28 were classified as having high and low HIV knowledge respectively. HIV K-Q has been found to be reliable across different age groups, gender and sexual orientation. Data on the instrument from five different samples (primary care patients, uniformed personnel, university students, community based samples, and high risk group) yielded an average Cronbach alpha of 0.91(Carey, et al., 2007). For the purpose of this study, some items were modified in order to suit the target population. Researchers such as Ofole (2010) certified that the instrument was valid and reliable for the Nigerian population. The researcher reported a correlation coefficient of r=0.89 using the Federal Road Safety personnel**.** However, for the purpose of this study, the reliability index obtained using test-retest within one week interval was r=0.77

Ethical Consideration

Ethical clearance was obtained from the chairmen of Onitsha Main Market Traders Association and the Nnewi Traders Association. Following the official permission secured from the authorities, the masters (*oga)* consented to release their apprentices *(nwa boy*) after explaining the purpose, objectives and benefits of the research to them at a meeting summoned by the Association. They were

assured of no harm in the research. Only those who volunteered to participate were recruited to the study. Further, for purpose of confidentiality, the participants' identification data was not included in the questionnaire. They were informed that should they become dissatisfied at any point in the programme, they could *opt out*. The design and implementation of this intervention study were conducted in accordance with the ethical laws pertaining to researches and practices in the counselling profession.

Procedures

A systematic four phase which consisted of pre-treatment, treatment, evaluation and termination was adopted for the study. The pre-treatment activities involved advocacy visit, obtaining of stakeholders' consent, random assignment of group into treatment condition and administration of screening instruments (HIV Knowledge questionnaire and Condom self efficacy scale). Participants in the experimental group were exposed to ten sessions of Motivational Enhancement Therapy. The treatment lasted for 90 minutes per session and it spanned a period of ten weeks, i.e, one session per week. For ease of understanding, the two research assistants who were recruited from Obosi and Nnobi (neighbouring communities to Onitsha and Nnewi) translated the items on the questionnaires to Igbo Language for 45% of the participants who dropped out of school early and could not read or write, while the remaining 55% participants who could read and write were not supported. The control group was not treated with MET but they filled the pre and post test questionnaires. They were however, compensated with a talk on goal setting skills. The summary of the treatment session adapted from (Miller & Rollnick 1991) Project Match is presented thus:

Summary of Sessions

Session One: Building Rapport with the Participants and General Orientation.
Session Two**:** Exploration of Participants' Discrepancies.
Session Three: Eliciting Participants' Self-Motivational Statements.
Session four: Didactic Instruction on Benefits of Correct and Consistent Condom Use.
Session five: Negotiating a Plan for Change.
Session Six: Developing Condom Self-Efficacy.
Session Seven: Communication of "Free choice" and Consequences of Inaction.
Session Eight: Goal-Setting Session Nine: The Change Plan Worksheet.
Session Ten: Termination of Therapy**.**

Data analysis

Data was analysed using the 2x2 Analysis of Covariance (ANCOVA) with the pretest scores as the covariates and the post test scores as criterion measures. ANCOVA was adopted because of its capacity to correct any initial differences (differences in age, experience, socio-economic status) which if not properly controlled could contaminate the study's outcome.

Results

Table 1: Analysis of Covariance (ANCOVA) of post-test scores on sexual decisions of participants by treatment and level of HIV knowledge

Source of variation	Sum of squares	DF	Mean square	F	Sig
Covariates	786.455	1	786.455	24.341	.000
Pre test	786.455	1	786.455	24.341	.000
Main Effects	6569.773	2	3284.887	41.20	.000
Treatment Group	5433.111	1	5433.111	131.322	.000
Level of HIV knowledge	32.667	1	32.667	1.682	.244
2-way interaction	3.534	1	3.534	0.101	.370
Treatment x HIV knowledge	3.534	1	3.534	0.101	.370
Explained	5288.888	4	1322.222	53.422	.000
Residual	3112.107	92	33.827		
Total	8400.995	96	87.510		

* Significance at 0.05 level

The null hypothesis which stated that there would be no significant main effect of treatment was rejected. From the result of Analysis of Covariance (ANCOVA) presented in table I, the participants' post test scores on sexual decision using their pretest as covariates revealed a significant main effect of treatment ($F(1,96)=41.20$, $P<0.05$). This result suggested that Motivational Enhancement Therapy (MET) was effective in enhancing condom self efficacy of the participants.

The second hypothesis which predicted no significant interaction effect of level of HIV knowledge on condom-self efficacy was retained as shown in table 1. The result revealed that there was no significant ($F(1, 96) =0.101$, $P<0.05$) interaction effect of HIV knowledge on condom self efficacy. The implication of this result was that Motivational Enhancement Therapy was effective in enhancing condom-self efficacy irrespective of the participants' level of HIV knowledge. The result of hypothesis three showed there was a significant composite effect of the treatment and level of HIV knowledge on condom-self

efficacy among sexually active out-of school male apprentices in Anambra State, Nigeria. The null hypothesis was therefore, rejected.

Table 2: Multiple Classification Analysis (MCA) of post test scores of participants based on treatment and level of HIV knowledge

Grand mean=43.22

Variable + category	N	Unadjusted Deviation in %	Eta	Adjusted for independents + Covariates Deviation	Beta
Treatment					
1.Experimental	50	9.61		9.61	
2.Control	47	-9.61		-9.61	
			5.2		.71
Level of HIV knowledge					
1. High	39	.65			
2. Low	58	-55			
			.23		.08
Multiple R Squared					.622
Multiple R					.875

The result of Multiple Classification Analysis (MCA) presented in table 2 revealed multiple R^2=.622, while the multiple R was .875. It implied that the treatment and level of HIV knowledge jointly accounted for 66.2 % of the variance of the criterion measure (condom self efficacy) while the remaining 33.8% could be attributed to other factors not incorporated into the present study.

Discussion

The outcome of this study as presented on tables 1 & 2 suggests that Motivational Enhancement Therapy (MET) was effective in enhancing condom self efficacy of the participants. This outcome could probably be as a result of the following five reasons; (1) The researcher guided the participants to set specific treatment goals for themselves and therefore, focused only on the problems associated with condom usage that the participants had at that time; (2) Another possible reason for the effectiveness of MET could be because unlike traditional therapies whereby people are pushed to change even when they don't have the motivation to do so, MET sessions followed a predictable format that moved slowly, building upon each tiny step the participants made towards improving

their condom self efficacy. Participants were not pushed, contradicted or challenged. They were instead allowed to move slowly towards their own solutions; (3) Additionally, most traditional therapies are known to be conducted in group settings giving room for little individualized attention. In this case, the researcher personalized the training experience by allowing the participants to demostarte the skills after observing the model and the researcher provided vicarious reinforcement; (4)The non confrontational and nonjudgmental style adopted by the researcher may also have contributed to the effectiveness of MET in the enhancement of condom self efficacy of youths who may be experiencing identity issues and/or trying to assert their independence; (5) Finally, the researcher emphasized the importance of self efficacy in whatever one does. This may have enabled the participants to realize that they had the capability of achieving many things in life, including having the strength to determine to purchase and actually use condoms successfully during sexual relationships. These findings corroborated previous studies (Lundahl & Burke**,** 2009; Huang, Tang, Lin & Yen, 2011; Madson, Mohn, Schumacher & Landry, 2014; Armstrong, Atkin-Plunk & Gartner, 2016; Fiszdon, Kurtz, Choi, Bell & Martino, 2016). However, unlike Fiszdon, Kurtz, Choi, Bell and Martino's (2016) study which enhanced motivation for adherence to drugs, the present study emphasized acquisition of belief in ones' capacity and skills to purchase and use a condom. While Fiszdon et al (2016) utilized clients with psychotic symptoms, the present study utilized participants without any clinical condition.

There are mixed results concerning the impact of HIV knowledge on condom self-efficacy. For example, a positive effect of HIV prevention knowledge was found among a sample in Uganda, Kenya and Zambia (MacIntyre, Brown & Sosler, 2001). However, several other studies showed little impact of HIV knowledge on condom self efficacy use (Biraro, Shafer, Kleinschmidt, 2009; Essien, Mgbere, Monjok, Ekong, Abughosh & Holstad,2010; Ankomah, Omoregie, Akinyemi, Anyanti, Ladipo & Adebayo, 2011). Reasons for the mixed results found in the literature could be that different measures for HIV knowledge were used and that outcomes may have been gender or context specific. This outcome is not surprising since it is well documented that people are involved in risky sexual behaviour in spite of being aware of the level of risk of contracting HIV when having unprotected sex. Other researchers argued that risk perception rather than HIV knowledge is positively related to condom self-efficacy (Meekers & Klein, 2002; Ofole & Aremu, 2007; Ofole, 2012). These groups of researchers agreed that despite the improvement in HIV prevention knowledge, people still engage in unprotected sex and are unwilling to adopt protective measures.

Implication for Counselling

The outcome has both practical and theoretical implications. From a practical perspective, the findings have provided evidence that individuals without condom self-efficacy can be empowered by counselling psychologists using psychological treatment tailored towards their goals. Another practical implication of this study is that programmed designers can utilize MET in the treatment of high risk group irrespective of the group's level of knowledge. Another practical implication derived from this study is that people who did not attend a formal school could still be provided with general skills including sexuality education that can help them to engage in healthy behaviours such as adopting a protective measure and using condoms during sexual acts.

Conclusion

In conclusion, this study has provided empirical evidence to suggest that Motivational Enhancement Therapy is effective in enhancing condom self efficacy of sexually active male youths in Anambra State, Nigeria. In addition, the outcome of this study reveals that the intervention can be adopted irrespective of the participants' level of HIV Knowledge. The findings therefore, highlight the importance of developing strategies to motivate consistent and correct condom use by improving the self efficacy of the target group.

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