

## Original article

# The Attitudes of students, parents and teachers towards the promotion and provision of condoms for adolescents in Addis Ababa

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**Abstract:** A cross-sectional descriptive survey through a self-administered, anonymous and structured questionnaire was conducted from September to December, 1993, in ten high schools in Addis Ababa to determine the sexual behaviour of adolescents, their knowledge about AIDS, attitudes and practices regarding condoms, their attitudes towards the promotion and distribution of condoms in schools, and towards the incorporation of health and sex education into the regular teaching curricula and into the teachers' training curricula.

A total of 910 parents, 755 students and 232 teachers participated in the survey. The results showed that, of the 755 students, 39.8% of the boys and 5.6% of the girls have had sexual experience. Peer pressure (35.2%) and force (21.6%) were the most important factors that precipitated the first sexual encounter. Ten percent of the students had coital contact with a commercial sex worker. Only 42.2% of the sexually active students used condoms on their first sexual encounter, and only 27.7% used condoms continuously on their subsequent sexual encounters.

An overwhelming majority in each of the three categories, (92.6% of the students, 98.7% of the parents and 96.1% of the teachers), approved the incorporation of health education into the regular teaching curricula. The idea of sex education in schools was also approved by 80.1% of the students, 90.9% of the parents and 96.1% of the teachers.

This study, based upon the findings, recommends that education and health policy makers make relentless effort to commence health and sex education by incorporating them into the regular curricula; the implementation of subsequent surveys to identify the most effective and acceptable routes of condom distribution in school; and implementation of similar surveys in the rural settings to assess the attitudes in a different setting and acquire a more general overview for the whole country. [*Ethiop. J. Health Dev.* 1997;11(1):7-16]

## Introduction

Since its identification in 1981, AIDS has been spreading over the world at an alarming speed. By 1990, it was estimated that there were 8-10 million people infected with HIV (1). This figure was expected to reach 15 million, that is 7.4 million males, 5.9 million females and 1.3 million born with infection, world wide by 1993 (2). In Africa alone more than 3000 new infections occur every year, and if uninterrupted, this figure is expected to reach 30-40 million by the year 2000 (3). Characteristically 20% of those infected with HIV are expected to be between the ages of 20-29 (4). Given the long incubation period, with the mean latency time of the illness (eight years) (5), a

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Reports on the situation in Ethiopia demonstrate that, from January 1985 to June 1993, 6726 AIDS cases were reported from 47 hospitals. Forty one percent of these were residents of Addis Ababa. The largest reported number was in 1992, accounting for 48.41% of the total reported since 1986. By 1993 the sex ratio of those reported was 1.6:1, male to female, and the 15-19 age group accounted for 5.81% of the reported cases, while those aged 20-24 years constituted 19.81% of the total cases. About four percent of the total reported cases were students (6).

The Ethiopian National AIDS Control Programme (NACP) estimated that by the end of 1994,

substantial number of those infected may have acquired the disease at earlier ages, perhaps in their adolescence.

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536,600 persons will carry the disease, and in the same year 18,315 new cases of AIDS will be diagnosed (7).

All the above reports clearly point firstly to the rapid spread of the disease, and secondly that adolescents, the focus of this study, represent quite a significant number of those being predisposed to and even acquiring this dreadful disease.

In many countries (particularly the developing ones), adolescents account for a larger proportion, around 20-25% of the total population (8). Constituting a large proportion of the population and also from various behavioural, cognitive and developmental perspectives, adolescents are labelled as a vulnerable group and deserve attention in terms of research and prevention.

Many studies have been conducted all over the World to assess the sexual behaviours of adolescents. All these studies claim that adolescents are in fact sexually active, with figures ranging from 17.3% to 83% and that this trend is increasing. Due to all these, adolescent sexuality is not an issue to be ignored (9-20, 22).

The very few studies conducted in Ethiopia also demonstrate a similar pattern. Alarmingly, most of the above studies including those conducted in Ethiopia (8, 23, 24, 25, 26), demonstrate that those sexually active adolescents do not practice safe sex.

The fact that condoms significantly reduce the risk of HIV infection is beyond discussion (27). With the AIDS crisis and increase in other STDs and the need to develop safer and more effective barrier contraceptives, attention has been reoriented to the only available protection, the condom (28). This being the case, we can no longer ignore the association of condoms with adolescents. We cannot also rely only on talking about abstinence (though this should be promoted also). The facts will force us to reorient our efforts towards educating them to exercise safe sex, through maintaining a single partner, and if this is not possible, to always use condoms. This view has also been supported by many investigators (9, 11, 16-21, 24, 25-28).

There are two concerns that need to be addressed at this juncture. The first one is, if condoms are to be distributed to students, will this be promoting their sexuality? And secondly, is this really what they want? Perhaps the strongest and most conclusive rejection of speculations such as this was provided by the WHO (1993). It critically reviewed 19 studies conducted all over the world and disproved that sex education and availability of contraception encouraged sexual experimentation. In fact, sex/AIDS education encouraged adolescents to delay sex initiation and to practise safe sex if sexually active. It also found out that schools that promoted postponement of sex and use of condoms were more effective than those which promoted abstinence alone (29).

The above being the case elsewhere, this study tried to assess the sexual activity pattern of high school students in Addis Ababa viz-a vis their parents and teachers attitudes towards the issue of condom promotion and provision of health education in schools.

## **Methods**

A cross-sectional survey on sexual activity patterns, attitudes and knowledge regarding the use of condoms, attitudes towards the provision of condoms at schools, and attitudes towards incorporating health and sex education into school curricula was conducted among students, parents and teachers in ten high schools in Addis Ababa over a period of one month (December, 1993). The source population consisted of students, parents and teachers of all 38 high schools in Addis Ababa. The study population was obtained from ten high schools that were selected using the probability proportionate to the size (PPS) method. Students of both sexes attending grades 9-12, parents and foster parents of students in the selected schools, and teachers teaching in the same high schools were considered to be eligible for the study.

A multistage sampling procedure was used to select subjects to be included in the study.

Two structured and pretested questionnaires were developed in such a way that measurement of the following variables was attained: The sexual activity patterns of high school students, including (a) the proportion of sexually active students; and (b) the presence of any high risk behaviours, such as multi-partner sexual contact and the use/non-use of condoms; attitudinal variables (a) on the knowledge and attitudes of students regarding AIDS and condoms; (b) on the attitudes of students, parents and teachers towards the promotion and provision of condoms in high schools; and (c) on the attitudes of students, parents and teachers towards the provision of health and sex education as a separate course in high schools.

Other socio-demographic variables, such as age, sex, parental marital status, monthly income, religion and ethnic grouping were included to allow later determination on how they relate to the major dependent variables. All data were collected using trained twelfth grade data collectors and nurse supervisors.

Data were then analyzed using the EPI-INFO (30) and SAS programmes.

**Results**

A total of 755 (89%) students, 910 (91%) parents and 232 (92%) teachers participated in the study. The mean age of the students was 14.74 years (SD 5.13). The youngest participant was 12 years old and the oldest was 23 years. Almost an equal number of boys and girls participated in the study, 359 (47.5%) and 372 (49.3%), respectively. Christianity was the predominant religion (85.9%). Most of the students were Amhara (56.4%). Twenty eight percent of the students were ninth graders, 24.6% tenth graders 25.7% eleventh graders, and 20.1% twelfth graders.

Regarding the parents, the mean age of the participants was 42.25 years (SD 10.88). The youngest respondent was 20 years and the oldest 104 years. Five hundred forty three (59.7%) of the parents were females. Eighty five percent were Christians and 51.1% were Amahara. Seventy two percent of the parents were married. Fifteen percent were illiterate.

The mean age of the teachers who participated in the study was 37.4 years (SD 10.7). The youngest participant was 23 and the oldest 58 years old. One hundred ninety six (84.5%) of the respondents were males and 33 (14.2%) were females. Here also, Christianity was the predominant religion accounting for 90.1%. Fifty two percent of the teachers were Amhara whereas 64.7% of the teachers were married (Table 1).

Out of the 755 students respondent, 148 (19.5%) admitted to having had a coital experience at least once prior to this study, of which 124 (83.8%) were boys 20 (13.5%) were girls, accounting for 39.8% of the boys and 5.6% of the girls. The earliest reported age of onset of sexual intercourse for girls was fourteen years with mean age of onset being 15.30 years (SD 5.39). The earliest age of commencement of sexual activity for the boys was twelve years with mean age of onset being 16.45 years (SD 4.02).

Peer pressure was the frequently reported factor that led to the first sexual encounter, accounting for 35.2% of the sexually active respondents, followed by being forced (21.6%), alcohol (11.5%) and drugs (10.3%). Twenty seven percent admitted that they first performed sex in hotels, followed by partners' house 20.2%, and own house 20.2%. Hotels are also the most frequent places where the sexually active students had sex after the first sexual encounter, accounting for 29.1% of the responses.

Table 1: Social and demographic characteristics of students, parents and teachers who participated in the survey (Addis Ababa, December, 1993)

| Socio-demographic characteristics | Students<br>No. (%)<br>(n=755) | Parents<br>No. (%)<br>(n=910) | Teachers<br>No. (%)<br>(n=230) |
|-----------------------------------|--------------------------------|-------------------------------|--------------------------------|
| *Age                              |                                |                               |                                |

|                                    |              |            |            |
|------------------------------------|--------------|------------|------------|
| 10 - 12                            | 2 (0.3)      | -          | -          |
| 13 - 14                            | 74 (0.8)     | -          | -          |
| 15 - 16                            | 280 (37.1)   | -          | -          |
| 17 - 18                            | 279 (37.0)   | -          | -          |
| 19 - 20                            | 42 (5.5)     | -          | -          |
| no response                        | 76 (10.1)    | -          | -          |
| 20 - 30                            | -            | 119 (13.1) | 15 (6.5)   |
| 31 - 40                            | -            | 354 (38.9) | 115 (49.6) |
| 41 - 50                            | -            | 282 (31.0) | 80 (34.5)  |
| 51 - 70                            | -            | 143 (15.7) | 10 (4.3)   |
| 71 - 90                            | -            | 11 (1.2)   |            |
| >90                                | -            | 1 (0.1)    |            |
| no response                        | -            | 119 (13.1) | 12 (5.1)   |
| <b>*Sex</b>                        |              |            |            |
| males                              | 359 (47.5)   | 367 (40.3) | 96 (84.5)  |
| females                            | 372 (49.3)   | 543 (59.7) | 33 (14.2)  |
| no response                        | 24 (3.2)     | -          | 3 (1.3)    |
| <b>*Religion</b>                   |              |            |            |
| Ortodox Christian                  | 629 (83.3)   | 780 (85.7) | 192 (82.7) |
| Muslim                             | 52 (6.9)     | 70 (7.7)   | 12 (5.2)   |
| Protestant                         | 45 (6.1)     | 26 (2.9)   | 14 (6.0)   |
| Catholic                           | 13 (1.7)     | 25 (2.7)   | 5 (2.2)    |
| Other                              | 9 (1.2)      | 9 (1.0)    | 5 (2.2)    |
| No response                        | 6 (0.8)      | -          | 4 (1.7)    |
| <b>*Ethnic group</b>               |              |            |            |
| Amhara                             | 426 (56.4)   | 465 (51.1) | 121 (52.2) |
| Oromo                              | 128 (17.0)   | 177 (19.5) | 35 (15.1)  |
| Tigian                             | 73 (9.7)     | 98 (10.8)  | 26 (11.2)  |
| Gurage                             | 74 (9.8)     | 94 (10.3)  | 17 (7.3)   |
| Other                              | 40 (5.3)     | 76 (8.3)   | 29 (12.5)  |
| No response                        | 14 (1.8)     | -          | 4 (1.7)    |
| <b>*Marital status</b>             |              |            |            |
| Married                            | 533 (70.6)** | 657 (72.2) | 150 (64.7) |
| Never married                      | 22 (2.9)     | 107 (11.8) | 66 (28.4)  |
| Separated                          | 12 (1.6)     | -          |            |
| Widowed                            | 123 (16.3)   | 2 (0.2)    | 2 (0.9)    |
| Divorced                           | 52 (6.9)     | 92 (10.1)  | 12 (5.2)   |
| No response                        | 13 (1.7)     | 52 (5.7)   | 2 (0.8)    |
| <b>*Family income (birr/month)</b> |              |            |            |
| 0 - 100                            | -            | 345 (37.9) |            |
| 101 - 200                          | -            | 203 (22.3) | 1 (0.4)    |
| 201 - 400                          | -            | 198 (21.8) | 5 (2.2)    |
| 401 - 800                          | -            | 98 (10.8)  | 175 (75.4) |
| 801 - 1200                         | -            | 35 (3.8)   | 39 (16.8)  |
| >1200                              | -            | 31 (3.4)   | 8 (3.4)    |
| no response                        | -            | -          | 4 (1.7)    |
| <b>*Educational level</b>          |              |            |            |
| 9                                  | 211 (27.9)   |            |            |
| 10                                 | 186(24.6)    | -          |            |
| 11                                 | 194 (25.7)   | -          |            |

|                       |            |            |            |
|-----------------------|------------|------------|------------|
| 12                    | 151 (20.1) | -          |            |
| no response           | 13 (1.7)   | -          |            |
| Not educated          | -          | 144 (15.8) |            |
| Elementary incomplete | -          | 239 (26.3) |            |
| Elementary complete   | -          | 109 (12.0) |            |
| Secondary incomplete  | -          | 71 (7.8)   |            |
| Secondary complete    | -          | 169 (18.6) | 4 (1.7)    |
| University incomplete | -          | 29 (3.2)   | 82 (35.3)  |
| University complete   | -          | 51 (5.6)   | 138 (59.5) |
| Other                 | -          | 98 (10.8)  | 7 (3.0)    |
| No response           | -          | -          | 1 (0.4)    |

N.B. \* Socio demographic characteristics

\*\* Parents of students

Regarding the duration of acquaintance with the first sexual partner, 14.9% were acquainted only for hours, 3.0% for less than one week, 18.2% for two or more weeks, 20.9% for many months, and 44.6% for many years.

Ten percent of the sexually active male students admitted having sex with commercial sex workers. Of the respondents, 37.2% never changed sexual partner since their first encounter, followed by 18.2% once, 18.2% twice, 5.4% three times, and 12.2% four or more. Sixty one percent of the sexually active students admitted to having had sex within the last three months.

Only 43.2% of the sexually active students knew about condoms on their first coital encounter.

Eighty two percent of those did not use condoms on their first sexual encounter. Only 27.7% of the sexually active students claimed that they had continuously used condoms (Table 2).

Fifty two percent of the parents thought that most high school students are sexually active. A substantial proportion of the parents (40.9%) said that they knew nothing about high school students' sexual behaviours. Also on this issue, 81.5% of the teachers thought that most students are sexually active (Table 2).

Forty seven percent of the students felt that the majority of the students do not have enough knowledge about AIDS. Only 38.1% of the parents on the other hand felt that a majority of students do not have enough knowledge about AIDS. More than half of the teachers (52.2%) thought that most students do not have adequate knowledge about AIDS.

Regarding the source of information about AIDS for students, the majority (64.1% of the students, 56.2% of the parents and 52.2% of the teachers) acknowledged mass media to be the most important source of information about AIDS.

When asked about the overall students' knowledge of condoms, 42.4% of the students thought that most students do not know what a condom is, while only 23.8% of the parents and 28.9% of the teachers felt that the majority do not know about condoms. Further more, only 42.8% of the students, 38.8% of parents and 34.9% of teachers felt that most students know how to use condom properly.

Table 2: **Distribution of knowledge and behavioural factors among sexually active students in Addis Ababa, 1993.**

| Behavioral factors  | Students No. (%) |
|---|------------------|
| <b>*Factors which led to the First sexual encounter</b>         |                  |
| Peer pressure   | 52 (35.2)        |
| Being forced  | 32 (21.6)        |
| Alcohol   | 17 (11.5)        |
| Drug  | 16 (10.8)        |
| No response   | 31 (20.9)        |
| <b>*Knowledge of condom prior to the first sexual encounter</b> |                  |
| Yes   | 64 (43.2)        |
| No  | 66 (44.6)        |
| No response   | 18 (12.2)        |
| <b>*Use of condom on the first sexual encounter</b>             |                  |
| Yes   | 26 (17.6)        |
| No  | 103 (69.6)       |
| No response   | 19 (12.8)        |
| <b>*Continuous use of condom on subsequent encounters</b>       |                  |
| Yes   | 41 (27.7)        |
| No  | 81 (54.7)        |
| No response   | 26 (17.6)        |
| <b>*Frequency of sexual encounter during the last 3 months</b>  |                  |
| None  | 59 (39.9)        |
| Once  | 33 (22.3)        |
| Twice   | 15 (10.1)        |
| Three times   | 9 (6.1)          |
| Four or more  | 6 (4.1)          |
| No response   | 26 (17.5)        |
| <b>*Last sexual encounter</b>                                   |                  |
| 1 - 5 days  | 18 (12.3)        |
| 1 - 2 weeks   | 14 (9.5)         |
| 3 - 4 weeks   | 16 (10.8)        |
| 1 - 3 months  | 15 (10.2)        |
| More than 3 months  | 59 (39.7)        |
| No response   | 26 (17.5)        |

\* Behavioral actors

Some of the reasons that the respondents felt prevent sexually active students from using condoms include the following: for students the two outstanding reasons were negligence (28.2%) and embarrassment in buying from the shops or pharmacy (26.4%); for parents, fear to buy from shops and pharmacies (30.0%) followed by lack of information and knowledge (23.8%); and for teachers, lack of information and knowledge (24.1%) followed by fear to buy from pharmacies or shops. Most students (53.6%), parents (70.2%) and teachers (56.5%) said that mass media is the most important source of information about condoms followed by health professionals.

Distribution of condom in schools was approved by 61.6% of the students, 60.0% of the parents and 61.6% of the teachers with 47.0% of the students, 35.4% of the parents and 44.0% of the teachers preferring that condoms be distributed to students freely, while 20.5% of the students, 23.8% of the parents and 31.5% of the teachers chose a very cheap price (Figure 1).

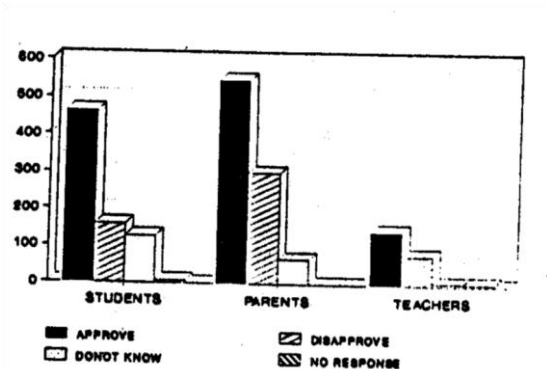


Figure 1: Attitude towards condom provision in schools, Addis Ababa, 1993.

When asked who should distribute condoms in schools, 37.2% of the students chose primarily AIDS Club members (students) followed by school clinics (23.8%). Parents, on the other hand, preferred school clinics as their first choice (24.3%), followed by school guidance officers (19.2%). Teachers preferred school guidance officers (24.6%) followed by school clinics (18.5%).

A stratified analysis that was conducted to measure the effect of the various socio-demographic variables on the attitudes towards distributing condoms in schools revealed only age for parents (the older generation tending to disapprove), sex of students (females tending to disapprove), and religion for teachers (Muslims tending to disapprove), to have a statistically significant influence upon the particular attitude taken by the different groups. This was found to be the case both before and after controlling for the other factors.

The majority of the students (92.6%), parents (98.7%) and teachers (96.1%) thought that there is an urgent need to start health education in schools. Forty one percent of the parents and the 40.9% teachers preferred that it should start at the elementary level (1 - 5) while 46.8% of the students chose the secondary level (9-12). As to how it should be provided, 37.0% of the students, 57.4% of the parents, and 53.0% of the teachers thought that it should be given as a separate course with its own curriculum (Figure 2).

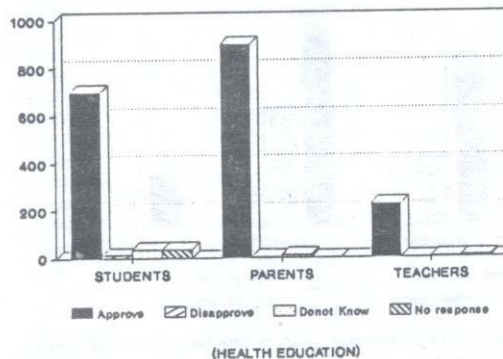


Figure 2: Attitudes towards health and sex education in schools, Addis Ababa 1993.

Considering sex education, the majority in all the groups, students (80.1%), parents (90.9%), and teachers (96.1%) felt that sex education should also be provided in schools commencing in the junior secondary grades (7-8). **Discussion**

This study gives important information regarding the sexual behaviour of students in Addis Ababa, their high risk behaviour, and possible protective measures that could be implemented in an effort to help control the spread of AIDS among adolescents.

Nineteen percent of the participating students admitted to having sexual experience accounting for 39.8% of the boys and 5.6% of the girls. These figures are relatively lower when compared with the results of similar studies. In U.S.A and Canada the figures were between 46% - 72% for boys and 24% - 72% for girls (9, 10, 11, 12, 31); in Europe it was between 18.9% - 78% for boys, and 17% - 45% for girls (15, 16, 17); in Latin America 42% - 78% for males, and 12% - 55% for females (14); in Africa the figures in general were above 30% (18, 19, 20, 21, 22); in Ethiopia in Harar 20% for females, 65% for males (8), in Jimma 40% for both sexes (23), Northwest Ethiopia 52.8% for both sexes (24) and in Addis Ababa 53% for boys and 24% for girls (25).

The result for the boys was fairly comparable to most of the previous findings. But when compared with the other studies the girls' data appeared to be relatively low. This could probably be due to the cultural influences, which, despite the strong assurance of anonymity, the girls did not provide their true response, or, it may be due to boys being more sexually active. The fact that boys are more sexually active than girls has been demonstrated by most of the above studies. Also, that there is a tendency for the girls to persistently under-report their sexual behaviour has again been confirmed by some of the studies (11, 15). This may have also been the case in this study.

Seventy eight percent of the sexually active respondents claimed that their first intercourse was initiated by either peer pressure (35.2%), being forced (21.6%), alcohol (11.5%) or drugs (10.3%) indicating either unplanned encounters or circumstances creating unfavourable situations for making responsible decisions.

Thirty six percent of the sexually active students had had very minimal acquaintance (less than one month in most cases) with the person that they had sex with. An important majority of them (10.1%) admitted to having had sex with a commercial sex worker. Fifty four percent of the sexually active students reported also that they had had multiple sexual partners. All the above findings clearly and alarmingly indicate to a prevalence of high risk behaviour. This has also been the finding of various other previous investigations (10, 12, 25).

Another characteristic feature which makes adolescent sexual activity high risk is their either non or very minimal use of any protective measure, specifically the use of a condom. Only 17.6% of the sexually active students used condoms in their first sexual encounter, and only 27.7% claimed to have used a condom continuously on their subsequent sexual encounters. Similar studies conducted in Kenya, Nigeria and U.S.A also support this finding (8, 12, 18, 18, 21). Although condoms are available in many places, a substantial number of the sexually active adolescents claimed that they did not know about condoms when they had their first sexual encounter (44.6%). This indicates that information pertaining to condoms is not provided to adolescents early enough, that is when they are at the period of initiation of sexual activities. This was also the attitude of a substantial proportion of students (42.4%) who thought that most students do not have adequate information about condoms and AIDS (47.2%).

This study, therefore, demonstrates that students are sexually active, and they continue to practise risky behaviours due to either lack of adequate information related to condoms and AIDS or barriers preventing them from easily acquiring condoms when they need them. To improve on this situation two possible intervention measures are possible: bringing about behavioural changes such as exercising abstinence or, if this is not possible, pushing them to remain steadfast with only one partner, through education, and make condoms more accessible and through acceptable routes.

Schools are the places where students acquire most of their knowledge. The role schools could play to bring about desired behavioural changes among their pupils is also potentially great. In



schools, students are provided with information on various aspects of life through well organized and developed instruction methods. This makes schools ideal places to commence and continue educating them on aspects of life. Since issues related to health are also one aspect of life, these should be given due attention and emphasis in the school educational environment if an overall desirable behavioural change is to be achieved among the learners.

The role schools have played in the provision of information and education on matters related to health has, up to now, been very minimal or nonexistent. This is evident in this study, that mass media rather than schools are more important source of information followed by health professionals. Very few students, parents and teachers considered schools to be important sources of information for adolescents.

Gebre, (1990) also came up with similar findings in Addis Ababa, in that 63.8% of the students chose mass media to be the best source of information for the same subject followed by health institutions and professionals (25). In his survey, only 10.3% chose schools to be the best sources of information. Other studies conducted elsewhere, on the other hand, indicate that schools rather than mass media to be the major source of information. For example, in Kenya, where there is an elaborate Health Education in schools, students rely more on schools as their most important source of information on AIDS and related matters than mass media. This indicates the potential that schools have in becoming important and reliable sources of information for students on issues related to sexuality and AIDS (19, 32).

It is obvious that information provided by the mass media is targeted at the general public and does not particularly address adolescents. It is also fragmented and lacks continuity, not all issues pertaining to sexuality, STDs and adolescence are emphasized. In fact students may not understand the message, especially in their earlier years when they are conceptually not well versed on these issues, but in reality there is an urgent need to start the education before they actually become sexually active and risky behaviours become well established.

This is the reason why almost all of the students, parents and teachers look to schools to assume an increased role in the provision of health education for adolescents. The vast majority of students, parents and teachers felt that there is a need to commence health education immediately. Moreover, most of the teachers and the parents preferred that health education start at the elementary level, while most of the students felt that it is better to start it in high schools, moreover most parents, teachers and students also felt that it is better if health education is provided in schools as a separate course.

Teachers and similarly, most students wanted health professionals to assume an important role in the provision of health education in their schools. A vast majority of the teachers also approved the incorporation of health and sex education in the teacher's training curricula.

Regarding sex education, the majority of the students (80.1%), parents (90.9%) and teachers (96.1%) felt that there is a need to start sex education. Parents (42.0%) and teachers (47.8%) felt that junior secondary grades (7-8) are better places to start sex education, while students (53.8%) preferred secondary grades.

This study, therefore, has quite strongly demonstrated that there is a strong desire by the participants for health and sex education to start in schools, with many of the parents and teachers desiring that it starts even at earlier grades.

Besides the provision of education another equally important intervention possibility that needs to be given similar attention is the provision of condoms in schools. This is not only to protect students from acquiring AIDS but also from other STDs and unwanted pregnancies.

It has been described in detail above that despite their availability elsewhere, sexually active adolescents do not use condoms as hoped. This obviously led us to look for more accessible and effective ways of providing them, like in the schools.

This is because at least a substantial proportion of adolescents are present in schools particularly in urban settings. Therefore, if condoms are made accessible to them in schools, this may relieve

them from the fear of buying condoms from other exposing places, which was shown in this study to be one of the major obstacles.

Another equally important issue that should be given due attention, if increased condom provision is anticipated, is the presupposition that the public may fear that it might promote promiscuity and

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## The attitudes of students towards condoms

therefore not accept this idea. No study has substantiated this, and infact, most studies conducted in this area have recommended the provision of protective measures. This is also what is strongly recommended by the WHO (13, 17, 26, 28, 29, 31).

The findings in this study might come as a surprise. But, in a strongly cultural, religiously dominated and more traditional country, coming up with such a finding may suggest the following: first, it may indicate that the population is becoming more aware of the consequences of AIDS and is gradually accepting whatever measures it has to be taken to stop the spread even if it is entirely against its religious and/or traditional beliefs; and secondly, it may also suggest that modernization is gradually eroding the traditional cultural values. On the other hand since this study was conducted in an urban setting, where the population appears to be culturally liberal, it may not reflect the true feelings of the general population.

A change in the traditional values for parents is also suggested by the finding in this study through stratified analysis that indicated a decreasing trend to accept this idea as age increases.

This study has demonstrated that many adolescents students in Addis Ababa high schools are sexually active. Not only are they sexually active, but they exercise risky sexual behaviours, despite large mass media campaigns about AIDS and its consequences and the availability of condoms. Most students, parents and teachers were not found to be fully confident of students' knowledge about AIDS and condoms. An overwhelming majority of the students, parents and teachers supported the idea of immediate commencement of health and sex education in schools. A substantial proportion of them also approved the promotion and distribution of condoms in high schools.

Therefore the conclusion generally is that the population in general and policy makers in particular could no longer continue to ignore the issue of steadily growing and alarming risky sexual behaviour of adolescents. This, therefore, indicates for an urgent implementation of comprehensive education and prevention programmes.

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