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Communication of life skills to in-school adolescent girls with special reference to HIV/AIDS

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Abstract

Ethiopia, like many countries of the developing world, has a huge proportion of youth. Young people between the age of 10 – 24 years constitute one third of the population.. At the same time the country has one of the highest numbers of people living with HIV/AIDS in the world.

It is an established fact that thee major route of transmission of HIV AIDS is unprotected sex. . As youth and specially adolescence (mainly 10 – 19 years of age) is a period of high developmental changes in physical, mental and social conditions. Specially the onset of strong sexual awareness and development renders them venerable to HIV AIDS as problems arise from lack of understanding and proper response to the changes and related emotional loads, peer pressure and lack of experience in the social system, in short lack of life skills. The fact that the highest HIV prevalence still occurs in the age group 15 – 24 years. Is strong evidence.

The situation is even worse in the case of adolescent girls. The culturally deep entrenched gender inequality and the dependent socio economical standing of women and girls have deprived them of any chance to develop the life skills that would help them fight through life renders them the most vulnerable in everyway.

This vulnerability, however, could be minimized if life skills development opportunities were provided with an appropriate communication strategy.

In this study the Social Cognitive Theory (SCT), which describes a dynamic, ongoing process in which personal factors, environmental factors, and human behaviour influence one other to bring a behavioural change,.has been the basis for

the investigation as it encompasses useful constructs that have proved to be successful predicting behavioural change among young people..

According to SCT, psychosocial life skills, which are related to behavior and social interaction, are essential to adapt skillful behaviors, which in turn help the adolescents protect themselves and enjoy life safely.

Though the concept of life skills is not new in Ethiopia, the attention given to it by the, government, the community, and those working in the prevention of HIV AIDS, sill leaves a lot to desire.

This is evident from the fact that the range of life skills adolescents possess at a skill level is very minimal as compared to their knowledge and awareness of it. . Furthermore, the fact that studies done on this issue and the local literature available on this issue are very minimal.

In dealing with adolescents, schools hold a social position and that is where a large number of adolescents are found together at the same time and conveniently grouped more or less by level of development.

The general objective of the study is to establish the role of communication in promoting life skills of in school adolescent girls in relation to HIV/AIDS

The study was conducted in Addis Ababa Schools. The study population wee reached through the help of Addis Ababa Education bureau and the respective school administrations. Data was collected using a multistage probability sampling using and close-ended questionnaire, quantitatively and in-depth interview and focus group discussion, qualitatively.

A total of 400 adolescent girls were surveyed. The age group level is almost equally distributed between 10 – 14 year olds (44.3%) and the 15 – 19 year olds (55.3%) The orthodox religion followers constitute 70.3% of the entire sample followed by Muslims 17.8%.

Irrespective of their age, economic back ground, parents education level or the type of school they attend to, the adolescent girls showed that they are aware of the life skills and know how to avoid risk. However, their capacity to put this knowledge to use i.e. the life skills is very minimal.

The major and preferred sources of life skills for the adolescents are their parents followed by their peers. The information and level of skill available in these sources is not even sufficient for them let alone to pass it to the needy adolescents. The school environment, which possesses huge structural advantages, is hugely underutilized.

Further study is recommended to deeply investigate find out the effect of life skill communication and the methods and sources with the highest impact on them. Also to investigate and establish mechanisms that assure life skill development opportunities are provided to the adolescents and are reconfirmed and fostered in their homes, in their schools and in the community as well.

The introductory part of this document gives the background and problem situation and of adolescents in general, and adolescent girls in particular, in Ethiopia in the context of the rampant HIV AID pandemic. The objective of the study and its limitations are also described here.

In the second chapter extensive coverage is given to the description of adolescence in relation to HIV AIDS and life skills. In chapter three the methodology of the study

is described Chapter four contains the results of the survey, focus group and in-depth interview conducted regarding in school adolescent girls in Addis Ababa. In chapter five, the results are discussed with some detail. In the last chapter, chapter six, conclusions and recommendations are given.

The survey questionnaire, the list of key informants with the leading questions for the interviews and some detailed findings have been annexed.

Chapter 1 Introduction

1.1 Background

All human beings have a right to be understood, be informed, impart their views and get help from their surroundings. Adolescents in particular should be understood and helped by parents, teachers, peers, counsellors and their community. Their stage of development, which demands a special attention, must be tracked cautiously.

Otherwise several problems related with adolescence that highly expose them to the rampant HIV/AIDS pandemic such as drug and alcohol abuse, casual sexual practices, unwanted pregnancy, high-risk abortion, rape and sexually transmitted diseases will crop up. The eminent risk is especially evident among young girls where lack of access to life skills development opportunities, economic resources and opportunities fostered by the social norms render them vulnerable to HIV/AIDS infection and related diseases. The visible fact that in the adolescent age group girls out number boys in the infection rate as 5 times higher is a valid indicator. (UNAIDS 2005).

In Ethiopia, according to The Centre for National Health Development in Ethiopia, about a third of the population is between the ages of 10 – 24. And significant proportions of this population is involved in a number of risky behaviours such as unsafe sex, drug and alcohol abuse, delinquency etc, which resulted in a high exposure to HIV/AIDS. This is evident from the highest HIV prevalence occurring in

the age group of 15 – 24 year olds. In addition 11.9 % of urban population in the age group 15 – 24 lives with HIVAIDS (Cnhde 2006)

The period of adolescence is, “a period of high developmental changes in physical, mental and social conditions. Most problems related to adolescence arise from lack of understanding and proper response to the changes that occur during development, related emotional behaviours, peer pressure and lack of experience in the social system and its interactions.” (Cnhde 2006) In order for the adolescents to be better informed and gain capacity for responding to these challenges, they need to acquire wide-ranging knowledge and skills on broad issues.

These skills, generally referred to as Life skills, are abilities or aptitudes that make one live more positively and effectively. These skills are required for young people to function confidently and competently with themselves, with other people, and with the wider community.

Unlike other diseases, HIV/AIDS affects not only the health of our people but also the social structure of our society. Realizing the effects of this disease, governmental and non-governmental organizations are undertaking several interventions to reach the youth in and out of school. For instance, with regard to the in-school interventions, the Addis Ababa Administrative Region Education Bureau has prepared manuals on life-skills education and HIV/AIDS in three categories targeting students in grade 1-4, in grades 5-8 and in grade 9 to preparatory as well as in technical and vocational schools. In addition, various non-governmental organizations, UNICEF being among the leading, are involved in organizing trainings

for, as well as strengthening Anti-AIDS clubs and peer groups in order to instil life skills in the school environment.

However the researcher believes that, from the continued susceptibility of adolescent girls to the rampant pandemic, it seems that enough is not being done in communicating the relevant life skills the adolescent girls need to avert the threats of HIV/AIDS

Though it may not be representative of the whole nation, due to limitation of time and resources, this study is designed to assess the situation regarding life skills communication in relation to HIV/AIDS with in – school adolescent girls aged 10 – 19, in Addis Ababa.

1.2 Statement of the problem

Ethiopia, home of 1.5 million people living with the HIV virus is among those countries with a high risk of HIV infections. Half of all new infections occur among the young: 15 – 24 years olds (MOH 2004, p.5). According to the Behavioural surveillance Survey (BSS) of 2002, most youth respondents (93.5%) felt not at risk or at low risk of HIV infection (MOH 2004, p.14). This shows that though the HIV infection is rampant in this age group, they don't consider themselves in a risky position with regard to acquiring the disease and consequently do not protect themselves from being infected.

Moreover, data collected from 16 youth conversation/dialogue sites of Addis Ababa shows that factors contributing to early sexuality in the city include: peer pressure to involve in sexual activity, lack of parental guidance, increased cost of living, pornography, curiosity, pressure from teachers and alcohol. (UNICEF Ethiopia 2006, p.3) In this age group, the girls are more exposed to a higher risk and the consequences of the diseases are widespread among them due to cultural, social and economical pressures. These girls do not acquire the necessary skills to make rational decisions, communicate assertively and express their views i.e. they do not acquire the relevant life skills to protect themselves.

Further more, the period of adolescence is a period characterized by various changes. These changes include biological, development of sexuality and development of ideas about one's identity and future roles (Hubley 1993, p.171).

It is evident that at this level of development adolescents must be supplied with specially targeted interventions of life skills that help them to successfully negotiate healthy personal relationships. It is especially important for adolescent girls to have the skills to assert themselves so that they are able to make healthy choices, make the right decisions among several alternatives, and avoid risky behaviours. Changes in behaviour inevitably require new skills. Though in this research, life skills are considered from the perspective of HIV/AIDS, their usefulness is not limited to HIV/AIDS prevention only.

Parents, schools, peers and different relevant institutions, albeit at various levels of influence, are believed to equip adolescents with life skills. Though schools claim that life skills constitute part of the school curriculum, it is a theme that did not get the coverage it deserves. For instance, Schools in Addis Ababa, the research area, include life skills in their curriculum in civics education, on the other hand awareness raising and information to - combat HIV/AIDS is mainly left for the different clubs in the school environment.

However, despite the presence of several manuals, Anti Aids clubs and the invaluable opportunity the school environment provides, adolescents in schools lack the basic life skills - which help to prevent the spread of HIV/AIDS. The efforts being made are not properly targeted at effectively communicating life skills relevant to HIV AIDS and further more, these efforts are not based on a thorough study on how and by whom these skills are and should be communicated.

Thus, this study is targeted at finding out the situation of life skills communication with regard to in- school adolescent girls and attempts to answer the following questions.

1.3 Research questions

1.3.1. What is the range of life skills these adolescents acquired, in relation to HIV/AIDS prevention?

1.3.2. What are the sources, contexts and frequency of communication about life skills related to HIVAIDS for these adolescent girls?

1.3.3. What factors impede effective and harmonious life skills communication to combat HIV/AIDS, and how could this be improved?

1.4 General objective

The objective of the study is to establish the role of communication in promoting life skills of in school adolescent girls in relation to HIV/AIDS.

1.5 Specific Objectives

1.5.1. To find specifically the range of Life skills the adolescents have acquired in relation to HIV/AIDS;

1.5.2. To find out the sources, contexts and frequency of life skill communication to adolescent girls in relation to HIV/AIDS;

1.5.3. To identify factors that impede effective and harmonious communications on life skills;

1.6 Significance of the study

In countries like Ethiopia where poverty and ignorance prevail, it is very important for communities and concerned bodies to be alarmed of the current dire situation of the adolescents –growing without the necessary skills and the catastrophic consequence it has on them and the social fabric as a whole. One of the basic challenges for Ethiopia is the problem of HIV/AIDS. It is proven that the main route to HIV/AIDS infection is unprotected sexual intercourse. Adolescents are the forefront victims of peer pressures and biological pressure to engage in unsafe sexual practices. Therefore it is vital that adolescents be provided with various knowledge and skills to minimize the risk of HIV infection. Among these skills are HIV relevant life skills, which help them to lead a healthy and protective life style. The communication of these skills is the main concern of this study.

This study, as a pioneering study on life skills communication with relation to HIV/AIDS, will benefit the society in finding out the proper strategies and channels of life skills communication to capacitate in school adolescents girls to avert the risk of HIV/AIDS. It also could assist policy makers; schools, parents as well as other influential bodies like the mass media in indicating how the communication with the adolescents should be to produce life skilled and confident individuals. The result of this study will also pave a way to further, deeper research and indicate appropriate measures to be taken.

1.7 Limitation of the study

Due to limitation of time, other segment of the population like parents, who could have been quite beneficial for the study could not be included.

Further more, sensitive questions like sexual activities and involvement with boyfriends were included in the questionnaire, which may not generate a genuine reply. But the following measures were taken to make the results dependable:

- Avoiding questions related to specific identity of the respondent; and giving the necessary assurance that responses are absolutely confidential and nobody can identify one questionnaire from the other;

- Generating a sense of responsibility among the respondents by emphatically explaining that successful outcome of this research depends solely on their genuine responses;

- Putting across sexual behaviour questions in such a way that the respondents respond to them with reference to their female best friends as there is a proven fact that adolescent girls would answer better if they were asked about their friends instead of about themselves directly.

1.8 Definition of Terms

AIDS stands for Acquired Immune Deficiency Syndrome. It occurs when an HIV-positive individual has such lowered immune levels that he/she falls prey to a variety of opportunistic infections.

HIV/AIDS - the acronym used in most countries to refer to human immunodeficiency virus and acquired immunodeficiency syndrome.

Entertainment-Education is the process of purposely designing and implementing a media message to both entertain and educate in order to increase audience members' knowledge about an educational issue, create favorable attitudes, shift social norms, and change the overt behavior of individuals and communities.

Efficacy: The degree to which one believes they are able to effectively, feasibly, easily do a recommended response that would impede or avert a threat,

Self-efficacy is the degree to which an individual believes in his/her capacity to organize and execute the actions required to manage prospective situations to produce desired attainments.

Social Cognitive Theory - A theory which states that one's behavior and cognition together will affect future behavior. In this model, behavior, personal factors, and environmental influences all interact. The theory underlines the concept that an

individual's ability to symbolize behavior, to anticipate outcomes, to learn through observation, and to have confidence in performing the behavior are all crucial.

Communication strategy - a combination of methods, messages and approaches by which planners seek to achieve a communication objective.

Peer education - dissemination of information and discussion about specific topics by members of a person's own age group, occupation, or social group.

Chapter 2 Literature Review

2.1 Adolescents: their behaviour

"No longer children, not yet adults" says a joint study of WHO, UNFPA and UNICEF about adolescents. The word adolescent derives from the Latin verb "*adolescere"* meaning, "to grow up" (Wikipedia 2005,). WHO (1999) identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19.

Although age is not often an exact measure because of variations in cultural norms and expectations, such categories can be practical as a basis for understanding the process of adolescence (WHO, UNFPA, UNICEF 1997).

The biological determinants of adolescence according to James-Traore (2001, p.1) are fairly universal; however, the duration and crucial characteristics of this period may vary across time, cultures, and socioeconomic situations. Furthermore, this period has been fundamentally changed for the past century by earlier onset of puberty, later age of marriage, urbanization, global communication, and changing sexual attitudes and behaviors (ibid). In short, adolescence is by and large a cultural and social phenomenon and therefore its endpoints are not easily tied to physical milestones.

Hubley (1993, p.171) describes a biological approach of adolescence as the time when the human beings acquire the ability to reproduce. At this period, dynamic

change, referred as secondary sexual characteristics, occurs representing the transition from childhood to adulthood that begins at puberty. For girls, puberty is a process generally manifested by the production of estrogen, the growth of breasts, the appearance of pubic hair, the growth of the external genitals, and the start of menstruation (menarche). For boys, it is marked by the production of testosterone, the enlargement of the testes and penis, a deepening of the voice, and a growth spurt. As per the WHO, adolescence (10-19 years) is progression from appearance of secondary sexual characteristics to sexual and reproductive maturity, development of adult mental process and identity, and transition from total socioeconomic dependence to relative independence (Population Reports 1995 cited in Taffa, N., et al 1997)

This study identifies adolescence as a period of rapid development when young people acquire new capacities and are faced with many new situations. These changes require psychological and social adjustments on the part of the adolescent, family and other adults.

In some societies special ceremonies of initiation often mark the point when the child becomes an adult. These ceremonies publicly recognize that the child has become an adult and often include practical instruction on adult behavior and sex education (Hubley 1993, p.170 - 171).

As this period is the transition period from childhood to adulthood, where reproductive readiness sets in, adolescents become vulnerable to the dangers

inherent in undertaking sexual activities, including the risk of HIV infection (Konde - Lule et al., 1997, p.79).

Furious growth and development, which characterizes adolescence, exposes young people to exciting new opportunities and also to risks (James-Traore2000, p.3). As a period of preparation for adulthood, behavior patterns that are established during this process, such as drug use or non-use and sexual risk taking or protection, can have long-lasting positive or negative effects on future health and well being. (ibid) Several studies identified that most young people around the world become sexually active between the ages of 10 and 20 years. (Greene et al. 2004, p.3)

2.2 Adolescence a challenge but also an opportunity

During this period, the community around adolescents has unique opportunities to influence young people. "As adolescents face the challenges of the second decade of life, a little help can go a long way in channeling their energy towards positive and productive paths. Neglect of adolescents can lead to problems, both immediately and in the years ahead" (WHO 1997, p.3)

Especially in early adolescence from the ages of 10 - 14, it is a time when stable patterns of healthy behaviours can be established, including postponing the onset of sexual activity, which can subdue the spread of HIV/AIDS. Establishing healthy patterns from the start is easier than changing risky behaviours already ingrained. (UNICEF 2002, p.7) These young people are often concrete thinkers and therefore have difficulty projecting themselves into the future. This phenomenon is problematic

when young people are asked to modify their behaviours and delay gratification to achieve a distant future goal. (Haffner, 1995)

A study by McKee and colleagues (2004), vividly expresses the fact that young people present the greatest hope, yet the largest challenge, in stating:

> "If all young people were to reach their 25th birthday, free of HIV and AIDS, the number of people living with HIV/AIDS will be halved. Unfortunately, because of their social, emotional and physical immaturity and because societies often make it difficult for them to learn about sexuality and HIV/AIDS, young people are especially vulnerable". (McKee *et al*. 2004, p.110)

However, although some problems that occur or that are magnified during adolescence require special attention, adolescents should be viewed as assets to society rather than as problems. Society can and should greatly benefit by channeling this vibrant and joyful period of adolescence into meaningful activities and positive directions, reducing the difficulties of today and assuring a better tomorrow.

2.3 Why focus on adolescents?

Young people constitute one-third of the total population in Ethiopia (Govindasamy *et al*. 2002). Besides, according to a summery document done in Ethiopia, the proportion of young people has reached as high as 42 percent in some of the Regions, such as Addis Ababa. This high population of theirs coupled with the fact that they are the most vulnerable to health risks related to their sexuality and reproduction: unwanted pregnancy, unsafe abortion, sexually transmitted infections including HIV/AIDS makes them worthy of special attention. Besides, at this period,

the decision they take regarding their health and general well being affects them for the rest of their lives.

Further more, young people between the ages of 15 and 24 have the highest rates of sexually transmitted infections (STIs) worldwide, representing over two-thirds of all cases in the developing countries (Greene *et al*. 2004, p.2)

But because young people do not receive the explicit information or skills they need to deal with their sexuality and reproductive health, they are often unprepared for sexual relations. Therefore, paying special attention to this group would avoid the inevitable massive economic and social costs that would result from ignoring them.

Young people have a right to physical integrity and, where and when possible, to participate in decisions on matters that will affect them for the rest of their lives. Particularly adolescents have distinct needs at different stages of the process of their development and, therefore, different approaches are required for reaching and serving them. Although they are a heterogeneous group, many common characteristics define their lives and affect their ability to access and use reproductive health information, skills and services. Specifically, adolescents, unlike most adults, are not fully capable of understanding complex concepts, or the relationship between behavior and consequences, or the degree of control they have, or can have, over making sexual decisions. This inability may render them particularly vulnerable to sexual exploitation and high-risk behaviors (James-Traore 2001, p.2).

2.4 The prevailing situation:

On a study made concerning youth reproductive health in Ethiopia, it was found out that young people have limited access to reproductive health services that focus on the special needs of adolescents. Inadequate knowledge about adolescent sexual behavior, cultural influence, and the limited capacity of implementers hinder the provision of reproductive health education and services to young people (Govindasamy *et al*. 2002).

Furthermore, Laws, customs, and practices may also affect adolescents differently than adults. For example, laws and policies often restrict access for adolescents to reproductive health information and services, especially when they are unmarried. Even when services do exist, provider attitudes about adolescents having sex often pose a significant barrier to the use of those services. (James-Traore 2001, p.2)

Adults in many part of the world get offended over the behavior of young people, however are often unable to communicate effectively with them about their affairs, especially on their sexual and reproductive lives. Parents, teachers and other adults fail to prepare young people with the information, skills and resources needed to plan a steady and healthy course through the transition to adulthood. Parents' difficulties in cultural beliefs about parenting, sexuality, and gender all constrain their ability to prepare young people. Failing to provide critical information, skills and support to young people sends them out into the world inadequately prepared for life. (Greene *et al.* 2004, p.4)

A study conducted in high schools in Addis Ababa indicated that, 54 percent of sexually active youth have experienced sex with more than one partner; 43 percent of sexually active students reported knowing about condom at the time of their first sexual experience, but only 18 percent said they had ever used condoms. (Eshetu et al., 1997 cited in Govindasamy *et al*. 2002)

2.5 HIV/AIDS and Adolescence

HIV/AIDS is a matter of global concern, posing one of the most urgent health and development challenges facing societies, robbing us of our strong ones and our future. It is now more than 20 years with HIV/AIDS crisis with no cure in sight, and relatively few effective and sustainable prevention programs.

Despite the growing AIDS crisis, the world is making poor use of behavior change and communication strategies to combat HIV/AIDS- Over half of the 15 million persons living with HIV worldwide are believed to have been infected during their adolescence (Goldsmith 1993 cited in Rotheram-Borus, et.al. 1998, p.75).

It is also estimated that 50% of all new HIV infections are among young people (about 7,000 young people become infected every day), and that 30% of the 40 million people living with HIV/AIDS are in the 15-24 year age group. The vast majority of young people who are HIV positive do not know that they are infected, and few young people who are engaging in sex know the HIV status of their partners. This shows that adolescents are at the centre of the pandemic in terms of

transmission, impact, and potential for changing the attitudes and behaviours that underlie this disease. (WHO 2004)

Taking in to consideration the importance of focusing on young at a global level, the 2001 UN General Assembly Special Session on HIV/AIDS, endorsed a number of goals for young people, including

> "By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15-24 in the most affected countries by 25% and by 25% globally by 2010..." (Paragraph 47)

> "By 2005, ensure that at least 90%, and by 2010 at least 95% of young men and women have access to the information, education, including peer education and youth-specific education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health care providers..." (UNGASS 2001 Paragraph 53)

WHO, along with its partners, UNICEF and UNFPA, advocates an accelerated approach to promoting the health and development of young people in the second decade of life.

It outlines the action needed to provide adolescents worldwide with the support and the opportunities to:

- Acquire accurate information about their health needs
- Build the life skills needed to avoid risk-taking behaviour
- Obtain counselling, especially during crisis situations
- Have access to health services (including reproductive health services)
- Live in a safe and supportive environment

In order for adolescents to take the risks that are important for their development and avoid those that will do them irreparable harm, their rights to health and

development need to be fulfilled. This includes their rights to information and skills, a range of services, a safe and supportive environment, and opportunities to participate. (WHO 2004)

Consequent to all mentioned above, one can duly conclude that focusing on adolescents is one of the most correct and potentially effective approaches to tackle the pandemic, particularly in high prevalence countries such as Ethiopia.

2.6 Girls are very vulnerable

Gender disaggregated HIV/AIDS prevalence data demonstrates that, female adolescents are at significantly increased risk of HIV/AIDS compared to male adolescents. For example, in Kenya, the prevalence of HIV/AIDS peaks in young women aged 25 – 30 years comparable to 10 years later in males. Since the latency of HIV/AIDS is 5 – 10 years, this prevalence data implies that a lot of these women were infected during adolescence. (NACP, Kenya 1994 cited in Nduati *et al*, 1997) UNAIDS reports that worldwide only 47 per cent of people with HIV are women, but that proportion rises to 55 percent in sub-Saharan Africa and globally woman are contracting the disease at a faster rate than men. Young women between the ages of 16 and 24 are particularly vulnerable; worldwide 60 per cent more young women than men are living with HIV, and in some countries they are up to five times more likely to be HIV-positive.

According to Govindasamy *et al* (2002), 45 percent of the total births in Ethiopia occur among adolescent girls and young women. Sexual violence and commercial

sex work have become common phenomenon among young girls. As a result, they have become primary victims of the HIV/AIDS crisis that has spread throughout the country.

A household study of adolescents in Addis Ababa revealed that the median age at first pregnancy was 16 years with two in three women becoming mothers before the age of 20. (Tadesse et al., 1996 cited in Govindasamy et.al, 2002)
Girls in much of the world “are having unprotected, unsafe, not fully voluntary (and likely un-pleasurable) sex and bearing children soon after marriage, at the behest of their families.”(Greene et al 2002, p.2)

“As elsewhere in the world”, says the draft program document of UNICEF, "values and attitudes that perpetuate gender inequalities are instilled in childhood. Adolescence may be one of the last opportunities to offer alternatives. Negative gender-based norms and practices can be gradually transformed through educational, Life skills education, social, legal and other processes that promote equality of girls and boys". (UNICEF Ethiopia 2006, p.5)

2.7 What is life skill and what is its significance to prevent HIV/AIDS?

In today’s world of information and knowledge, information is a pre-requisite for building thinking skills. However, it is not automatically consequent that the person loaded with information will be able to make rational decisions, solve problems, establish relationships with others and negotiate rationally and effectively.

Individuals need life skills to operate effectively in a society in an active and constructive way. WHO defines life skills as, "the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life" (WHO 2004).

Generally life skills are divided in to four types;

- Livelihood or vocational skills: Sewing, carpentry, woodwork metal work…
- Physical skills: Sport and other physical works…
- Cognitive skills: Numeric and literacy
- Psychosocial Skills: Skills related to behaviour and social interaction.

According to a publication of UNICEF Ethiopia, The first three are knowledge and information based, where as the last one is directed at what we do with our knowledge, skills and relate to our attitudes, values and believes.

These psychosocial life skills are “the skills needed for the promotion of psychosocial competence, to enable individuals get along with other people and deal with the problems, pressures, stress and challenges of everyday life.” (UNICEF unpublished material, p.3). Further more, these skills enable us to translate knowledge, attitude and values into actual abilities – i.e. “what to do and how to do it”

Life skill's benefit expands into consumer education, environmental education, peace education or education for development, livelihood and income generation, among

others. These skills empower young people to take positive action to protect themselves and promote health and positive social relationships. Further more; they can be utilized in many content areas: prevention of drug use, sexual violence, teenage pregnancy, HIV/AIDS prevention and suicide prevention.

For the sake of scope and time, but with out disregarding the importance of all the life skills, this research considers only the psychosocial life skill category, which is believed to be the most essential for the adolescents to acquire with regard to preventing HIV/AIDS. -The psychosocial life skills considered in this research are, decision-making, communication skill, healthy life style choices and self-responsibility:

2.8 The Life skills

2.8.1 Decision making

Decision making means choosing among several alternatives. Acquiring this skill enables adolescents to carefully review their options before making a decision, think about what might happen because of their decision and later on evaluate the decisions they have made.

It helps adolescents to deal with their own emotional pressure, peer pressures, desperation from being overwhelmed by their socioeconomic situation and other influences that could expose them to risky situations and behaviors.

2.8.2 Communication skill

Communication is the exchange of thoughts, information, or messages between individuals using speech, writing, gestures, and artistic expression. Communication involves listening carefully to what others say, clearly state one's thoughts, feelings, and ideas to others; also settle disagreements in ways that are not hurtful.

It is essential for adolescents to be able to express what they really want in an assertive, understandable and appealing manner. Often, shyness and inability to assertively communicate exposes young girls to sexual harassment, intimidation and exposure to the risk of HIV infection.

2.8.3 Healthy lifestyle choices

A healthy lifestyle choice is selecting a way of living that is in accord with sound condition of body and mind, prevention of disease and injury.

This skill involves, making healthy food choices, choose activities that promote physical health and well being, manage stress positively in life, as well as avoid risky behaviors including those that could increase the chances of contracting HIV.

2.8.4 Self-responsibility

Self-responsibility is taking care of oneself; being accountable for one's behavior and obligations; choosing for oneself between right and wrong. This skill involves doing what is right for oneself when with a group, admitting the mistakes one made, understand that it is important to follow through on commitments one made and have control over ones own personal goals/future. This skill is crucial for adolescents

if they are to withstand and overcome peer and other external pressures and the limitations being young and inexperienced.

2.9 Communication of life skills to Adolescents

Life skills are delivered in different channels by different sources including parents, schools, peers, media and the community in general. They are also included in the education sector in different subject areas as family life education, coping skill educations as well as sex and health educations.

Though studies show that it is often difficult for adults to communicate with and influence young people who are exploring their own independence, parent child communication helps adolescents to refrain from engaging in high-risk practices including early sex. However, often peer's opinions and actions carry more weight in influencing young people's behavior than those of their parents and elders in the community. (McKee *et al*. 2004, p. 74)

Among the several strategies to communicate life skills to young people, Entertainment Education, In School Intervention and Youth Clubs stand out.

2.9.1 Entertainment –Education

Throughout the world young people are the largest consumers of entertainment formats as, music videos, educational videos, sports, television and radio programs and community-based entertainment channels. Many programs have tapped in to

this popularity to reach young people with HIV/AIDS information and motivation to adopt healthy behaviors and avoid risk. (Ibid)

2.9.2 In-School Intervention

Schools are an ideal place to reach large numbers of young people with life skills educations, whether during school hours of through school clubs as extracurricular or community-based activities. In many countries, ministries of education have integrated family life education or life skills education in to primary and secondary school curricula. In recent years, the life skills approach has become more popular because of teachers' and parents resistance to teaching curricula labeled "sex" "family life" or "reproductive health" education (UNICEF - UNAIDS- WHO, 2001 cited in McKee *et al*. 2004, p.110)

Significant number of young people in many parts of the world are denied sex and health education in schools because of this resistance of parents, teachers and other authorities fearing that discussing sex related issues in school does encourage early sexual activity. However, there is compelling evidence from studies conducted around the world and in many different cultures that, in fact, sex education encourages responsibility among the young.

In the school set up, the intervention requires, pre-service or in-service training for teachers on both the content and methodology, which must be interactive and participatory rather than informational and didactic. Emphasizing that, teachers must be interactive communicators. In addition to be most effective, “life skills training

must involve the students' parents and community so that skills introduced in the classroom are supported and reinforced at home" (Carnegie and Weisen, 2000; Horizons,2001a;UNICEF, 200a;USAID, 2002b cited in McKee et al. 2004, p. 114)

2.10 Theoretical framework to adolescent communication

In order to get accustomed with new behaviors and behave in a healthy manner, theories on behavior change propose various stages which individuals progress through

Using those theories help interventions to systematically understand events or situations. It also provides a road map for studying problems, develop appropriate intervention and help the dynamics of health behaviors including processes for changing them.

Theory guides the search for reasons why people do or do not engage in certain behaviors. To develop and choose among interventions in changing human behavior, it is useful first to understand why people behave as they do and how the behavior change occurs.

Even though there is an inevitable overlap in the categorization of the existing communication theories in the health spectrum, these theories are of different domains. They focus on 1) Individual change 2) Social theories and models 3) structural and environmental issues (UNAIDS 1999, p.5).

Individual change

The individual change theories are generally created using cognitive – attitudinal and affective – motivational constructs. (Kalichman, 1997 cited in UNAIDS 1999, p.6). They put the individual in the center of things and put him/her in charge of the change process. In this category we find Health Belief model, Social Cognitive theory, Theory of Reasoned action, Stages of change model and AIDS risk reduction model. (UNAIDS 1999, p. 6,7)

Social theories and models

In these theories and models, it is a valid contention that beyond the emphasis on the individual behavioral change, societal norms, religious criteria and gender power relations introduce meaning into behavior. Thus, social theories and models focus at changes at the community level. The interventions guided by this principle include theories as Diffusion of Innovations theory, Social influence theory or social inoculation model, Social network theory and theory of gender and power. (Ibid.)

Structural environmental factors

Here the it is again validly argued that targeting a change in sexual behavior is not limited to individual and social levels only. It needs considering the structural and environmental factors as well. (Carael, 1997, Sweat, 1995, Tawil, 1995 cited in UNAIDS 1999, p.10). These factors include civil and organizational elements as well as policy and economic issues. Theories under this level are theory for individual and social change or empowerment model& social ecological model for health promotion.

2.11 Social cognitive theory – the theory of choice

Choosing a theory or model, which fits in to a particular issue, is one of the greatest challenges for those concerned with behavior change. (US Dept. of Health 2005, p. 6)

A “good fit” is characterized by assumptions about a behaviour, health problem, target population, or environment that are: logical; consistent with everyday observations; similar to those used in previous successful programs; and supported by past research in the same area in related idea.(Ibid)

Accordingly “Skills training, attitudes, norms and self efficacy have all proven effective in predicting behavioural change among young people. In intervention research, these constructs have also been useful in mediating actual risk behaviours.” (UNAIDS 1999)

Similarly, a comprehensive international review of 110 outcome evaluations with youth (Peersman, 1998 cited in UNAIDS 1999 p.29) found that effective programs among others included:

- Focused on understanding social and/or media influences on sexual behaviour to be able to strengthen group norms against unprotected sex
- Listened to what young people think and believe to ensure acceptable and appropriate programs
- Included modelling and practice of communication or negotiation skills.

In the reviews conducted, the study also suggested "although a clear pattern and full understanding are lacking, social learning theories have a greater potential than other theoretical frameworks in changing youth behaviour."(Ibid)

Thus, social cognitive theory, chosen for this study as it encompasses all the above mentioned useful constructs and more, will be discussed in relation to its relevance in youth behaviour change intervention in general and life skills transmission in particular.

This theory evolved from research on Social Learning theory (SLT), which asserts that people learn not only from their own experiences, but by observing the actions of others and the benefits of those actions. Then SLT was updated by adding the construct of self-efficacy and renaming it Social cognitive theory (SCT). Social cognitive theory describes a dynamic, ongoing process in which personal factors, environmental factors, and human behaviour influence one other. (US Dept. of Health 2005, p.19)

According to this theory, three main factors affect the likelihood that a person will change health behaviour. These are environmental influences, personal factors, and attributes of the behaviour itself (Bandura 1986, cited in University of South Florida 1999).

A person must believe in his/her ability to perform a behaviour (posses self efficacy) and must perceive an incentive to do so. Self-efficacy can boost in several ways, for example, by providing clear instructions, by offering the opportunity for skill development and training and by modelling the desired behaviour.

The three major factors which lead a person to change his/her behaviour interrelate in certain ways. The first concept of interrelation is Reciprocal Determinism. In this concept, behaviour is explained in a harmonious, dynamic and reciprocal interaction of the environment, personal factors and behaviour, though not all factors have equal influence. For example a person's expectations, beliefs, self-perceptions, goals and intentions give shape and direction to behaviour. However, the behaviour that is carried out will then affect one's thoughts and emotions. A bi directional interaction also occurs between the environment and personal characteristics, thus in the process, human expectations, beliefs and cognitive competencies are developed and modified by social influences and physical structures within the environment. (Ibid.). As Bandura (1986) puts it, "people are both products and producers of their environment". A person's behaviour will determine the aspects of their environment to which they are exposed and behaviour is in turn modified by the environment. "Inherent within the notion of reciprocal determinism is the concept that people have the ability to influence their destiny, while at the same time recognizing that people are not free agents of their own will" (Bandura 1986, cited in University of South Florida 1999)

The second concept in social cognitive theory that interlinks environment, behaviour and personal factors is Symbolizing Capacity. This faculty helps humans to model observed behaviour. The capacity to form symbols enables humans to store information in their memory that can be used to guide future behaviours. Forethought is a person's capability to motivate them and guide their actions anticipatorily. This could manifest in problem solving and engaging in fore-sighting

action resulting in fore-sighting the consequence of behaviour, without actually performing it.

The third interrelationship is explained in Vicarious Capability, which refers to the human ability to learn not only from direct experience, but also from the observation of others. This capacity helps in developing an idea of how a new behaviour is formed without actually performing the behaviour oneself. (Bandura1986, cited in University of South Florida 1999).

The fourth concept is Self Regulatory Capability: Self-regulation occurs through the interaction of self-produced and external sources of influence, including motivational standards and social and moral standards.

According to the SCT, people develop perceptions about their own abilities and characteristics that subsequently guide their behavior by determining what a person tries to achieve and how much effort they will put into their performance (Bandura 1977b, cited in University of South Florida 1999)

Social comparison of one's own performance to the performance of others, especially peers or siblings, also serves as a strong source of self-efficacy. Further more; schools are considered a strong source of self-efficacy

As the main focus of social cognitive theory is self-efficacy, let us now see the ways self-efficacy is best communicated. Perceived self-efficacy often is more difficult to influence than the other theoretical variables because those with low perceived self-

efficacy have often faced failure and are in need of a good dose of hope and success.

Bandura (1977 cited in University of South Florida 1999) has noted that an individual's self-efficacy perceptions are developed from four sources of information:

- Role playing or modeling (i.e., performance accomplishments)
- Verbal persuasion (e.g., instruction, persuasive messages, suggestions)
- Watching live modeling (i.e., vicarious experiences)
- Physiological states (e.g., relaxation, biofeedback, and symbolic desensitization)

Performance accomplishments, such as role-playing (or performing) the recommended behavior, often work best in increasing self-efficacy perceptions. When people have the opportunity to role-play difficult behaviors or recommended responses, it provides them with ideas and strategies for how to act in real situations. Role-playing is an especially useful means to increase perceived self-efficacy with regard to a recommended response. If mass media are used, then one might have actors who are similar to the target audience role-play these same scenarios (this would be a vicarious experience). Finally, it is critical to address perceived and actual barriers when addressing self-efficacy in a message. (Bandura 1986, cited in University of South Florida 1999).

The social cognitive theory has very many complex components, which makes the application of its entire constructs extremely difficult. However it has proved to be

very practical in designing programs for youth. In this study some essential aspects of its components are used to interpret this research.

2.12 Existing life skill communications efforts in Ethiopia.

The concept of "life skills" is not new in Ethiopia. In the 1970s, civic education, with elements of life skills, was introduced in junior and secondary schools of the country. However the syllabus of this subject includes only skills such as respecting their majesty, older brothers and sisters, parents, teachers and adults. Some other skills which were given as information to students were more of religious.

It was recently that life skills education began to be recognised and be promoted as essential skills by including them in school civic education curriculum, though unsystematically. Currently in all 2nd cycle grades and preparatory level, (grade 5 to 10), and civic education is given to students. Some attempt has also been made to include these issues in subjects like biology.

Organizations such as UNICEF and HAPCO and even the several Anti AIDS clubs where skills are developed through peer education, albeit again unsystematically, some efforts are being made to provide life skills to adolescents,

Chapter 3 Methodology of the study

This chapter presents methodology used to carry out this study with the objectives of:

- Assessing the range of life skills the adolescents acquired, in relation to HIV/AIDS prevention
- Identifying the sources, contexts and frequency of communication about life skills related to HIVAIDS for these adolescent girls
- Identifying factors that impede effective and harmonious life skills communication to combat HIV/AIDS, and the way this could be improved.

In this chapter, the research design and physical location, method of data collection, the research procedure, the selection of schools as well as data analysis and processing will be discussed.

3.1 Study site & design

The study was conducted in primary and secondary schools that encompass adolescent age groups in Addis Ababa, the capital of Ethiopia. The selected schools are all given accreditation by the Addis Ababa City Government and concerned Sub City Education Bureaus. According to the statistics of 2004/2005 obtained from the Education Bureau of the city government of Addis Ababa, a total of 392,328 students are enrolled in all the primary and secondary schools, females representing about 54% in primary level (1 to 8 grade) and 51% in secondary level (9 to 12 grade).

This research concentrates on the primary cycle two, which is 5 to 8 graders and secondary levels, which mainly include adolescent age groups.

3.2 Study population

The study population is all adolescent female students in grades 5-12 in Addis Ababa, enrolled in regular primary and secondary levels. These account for about 235,821 of the total number of 5-12 graders, of which females amount to 122,633(52%).

3.3 Sample size

The sample size was calculated using the following formula:

$$n = \frac{pq\,N}{(SE)^2 N + pq}$$

Where:

n = sample size

p = 0.5 or 50% (proportion of population possessing the major attribute)

q = 1 - p

N= 122,633

SE =.025 (margin of error divided by 1.96 at 95% confidence level)i.e Assuming that the proportion (p) of people who have been communicated with life skills in relation to HIV/AIDS to be 50%, with 95% confidence level and a 5% margin of error.

Thus:

$$n = \frac{pqN}{}$$

$$\frac{(SE)^2 N + pq}{}$$

$$\frac{.05 \times 0.5 \times 122{,}633}{(0.025)^2 \times 122{,}633 + 0.5 \times 0.5}$$

$$\frac{30{,}658}{(0.000625 \times 122{,}633) + 0.25}$$

$$\frac{30{,}658}{76.6 + 0.25}$$

$$\frac{30{,}658}{76.85}$$

398.93

3.4 Sampling Procedure

A multi-stage probability sampling method was used for this study. The first stage was the selection of schools - i.e. Government, Public, Private, Church/Mosque, using purposive sampling. Thus 2 schools from each category were selected.

Next, Stratified sampling was used to differentiate the early adolescents (10- 14) and late adolescents (15-19). A section of the grade level, section "A" was selected for the sake of consistency and similarity. Finally individual students were selected using systematic random sampling method from the selected schools with the use of the class roasters.

3.5 Data collection Techniques

Quantitative and qualitative research methods were used to collect data required for the study. Initially, observation method was used to first identify the issues around adolescents' problems and their manifestations in their livesin relation to life skills. As a next step, key informants who are involved in adolescents' affairs were used as further sources of information and to generate ideas regarding what type of questions should be included in the questioner to be developed.

Secondly, a questionnaire was developed in the English language, translated in to Amharic, pre-tested and was used to interview the respondents. This was a structured; self administered questionnaire, which was prepared to address relevant questions regarding communication of life skills to adolescents, about their risk perception on HIV/AIDS, the range of life skills they have acquired as well as the source, context, and frequency of communications of life skills in their environment.

The questionnaire also sought to address questions about the role played by this communication to the knowledge of in school adolescent girls regarding life skills essential to prevent HIV/AIDS and in what ways this could be improved.

Four trained research assistants/facilitators administered the questionnaires in addition to the researcher herself. The respondents filled the questionnaires at the presence of the facilitators to ensure the quality of the response.

After administering some questionnaires and assessing the feedbacks, 4 focus group discussions were conducted with groups from 4 different schools: 2 private,

one missionary and 1 government -. Each focus group consisted of 7 - 8 respondents randomly selected from among those who participated in answering the questionnaire. The researcher herself facilitated the focus group discussions. These discussions were employed to address questions on how life skills are communicated to adolescents, how far the adolescents have acquired these life skills and the barriers to effective communication. They were characterized by extensive probing and open-ended questions that focused on participant's feelings and experiences (Using the interview guide and FGD guide).

Finally 4 in-depth interviews of key informants consisting of AIDS club leaders, teachers and an NGO representative were conducted to compare the results gained from the above methods and to evaluate if any controversial issues emerged.

3.6 Quality Control

Training of facilitators: The 4 facilitators, with previous experience in reproductive health research issues, were sufficiently briefed about the objectives, sampling method and administration issues in general and the questionnaire in particular, for one day.

Pre - testing the questionnaire: Twenty early and late adolescents were selected to respond to the pre-test. The results of the respondents were not included in the final study. After pre-testing and revising the questionnaire, copies of the final draft of the questionnaire were produced and made ready for data collection.

Data Cleaning: Data cleaning was done at the end of each working day of the data collection and this involved cross checking all the completed questionnaires to make sure that all the questions were answered properly and clearly recorded.

Chapter 4 Results

4.1. Socio-demographic characteristics

Almost all of the 400 female adolescent students that were randomly selected responded to the questionnaire for this study.

Age of students in the study includes 44.3% of early adolescents, 10 –14 years, and 55.3% late adolescents, 15- 19 years. The median age was 15 years, the mean 14.6 and the mode was 17years. Most of the respondents, 70.3%, were followers of the religion of Orthodox Christianity followed by Muslims who account for 17.8% and Protestants 9% of the total number of respondents. Majority (98.5%) of students were single. Very few are either engaged or married. **(See table 1)**

Table 1. Socio demographic characteristics

Characteristics		Number	Percent
Age	10 - 14	177	44.3
	15 - 19	221	55.3
Grade level	5^{th}	23	5.8
	6^{th}	80	20.0
	7^{th}	78	19.5
	9^{th}	125	31.3
	11^{th}	94	23.5
School Type	Government	136	34.0
	Private	131	32.8
	Public	65	16.3
	Mission	68	17.0
Religion	Orthodox	281	70.3
	Muslim	71	17.8
	Protestant	36	9.0
	Catholic	7	1.8
	Others	5	1.3
Marital Status	Single	394	98.5
	Engaged	3	.8
	Married	3	.8

Fifty percent of student's fathers are college educated, 22.5% are at secondary level, elementary and read and write constitute 10.8 % each and 4.3% are illiterate. Regarding mother's education level, 37% of them were college educated, 25% are at secondary level, elementary and read/write constitute 15% and 13% respectively. Nine percent of the mothers are illiterate as indicated in table 2.

Table 2. Parents education level and occupation

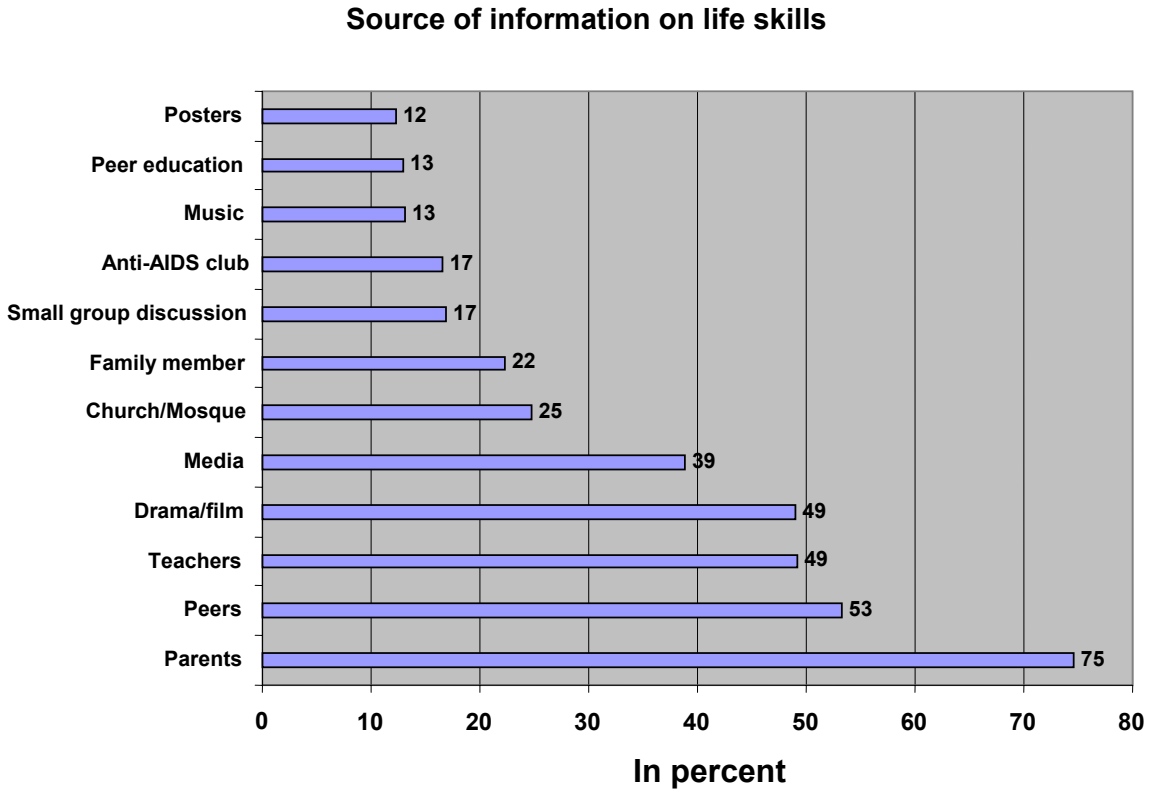
Characteristics		Number	Percent
Father's education level	Illiterate	17	4.3
	Read & write	43	10.8
	Elementary	43	10.8
	Secondary	90	22.5
	College	200	50.0
Mother's education level	Illiterate	36	9.0
	Read & write	52	13.0
	Elementary	61	15.3
	Secondary	100	25.0
	College	148	37.0
Father's Occupation	Government employee	116	29.0
	Business person	95	23.8
	House head	6	1.5
	NGO employee	82	20.5
	Pensioner	20	5.0
	Other	78	19.5
Mother's Occupation	Government employee	112	28.0
	Business person	60	15.0
	House wife	170	42.5
	NGO employee	28	7.0
	Pensioner	2	.5
	Other	27	6.8

N.B. The numbers may not add up to 400 and percents may not add up to 100% because there are some students who have not replied & because of rounding up.

4.2 Source of information

Respondents were asked to choose more than one answer on their source of information regarding Life skills.

Figure 1.



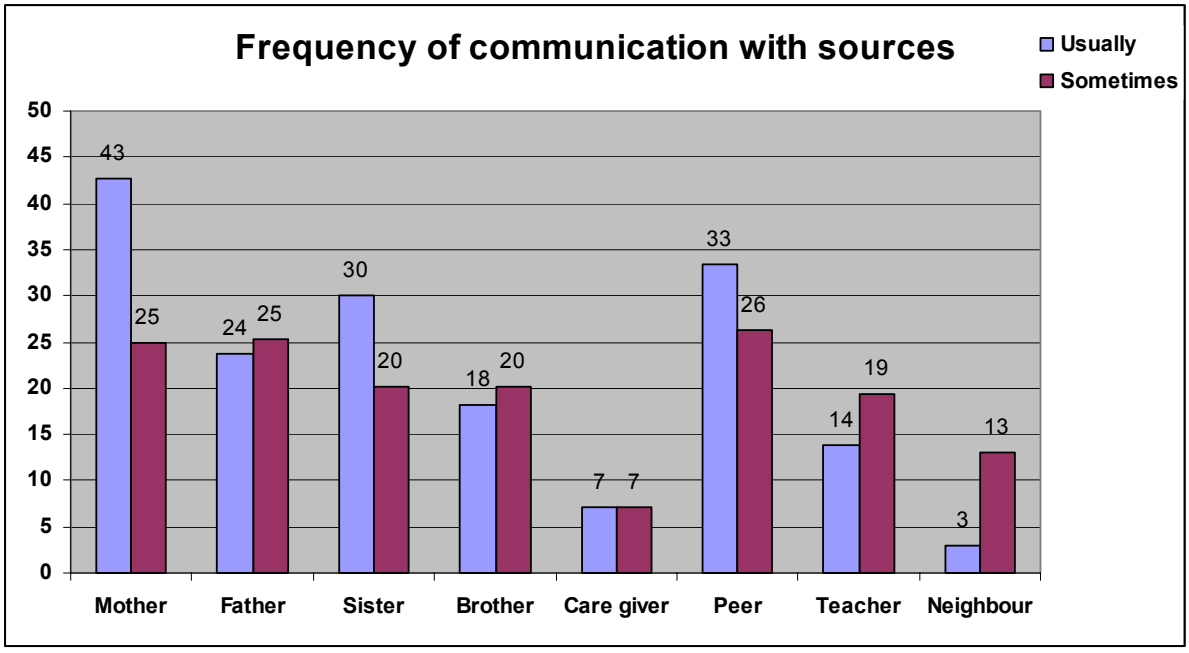
The major sources of information on life skills for the respondents were parents and peers followed by information through peers and drama/film.

Media (TV/Radio/magazine/Newspaper) was also chosen as a preferred source of information by 39% of the adolescents that participated in this study. Apparently, life skills do not seem to be major issues in poster productions, at peer education sessions, and in Anti-AIDS clubs.

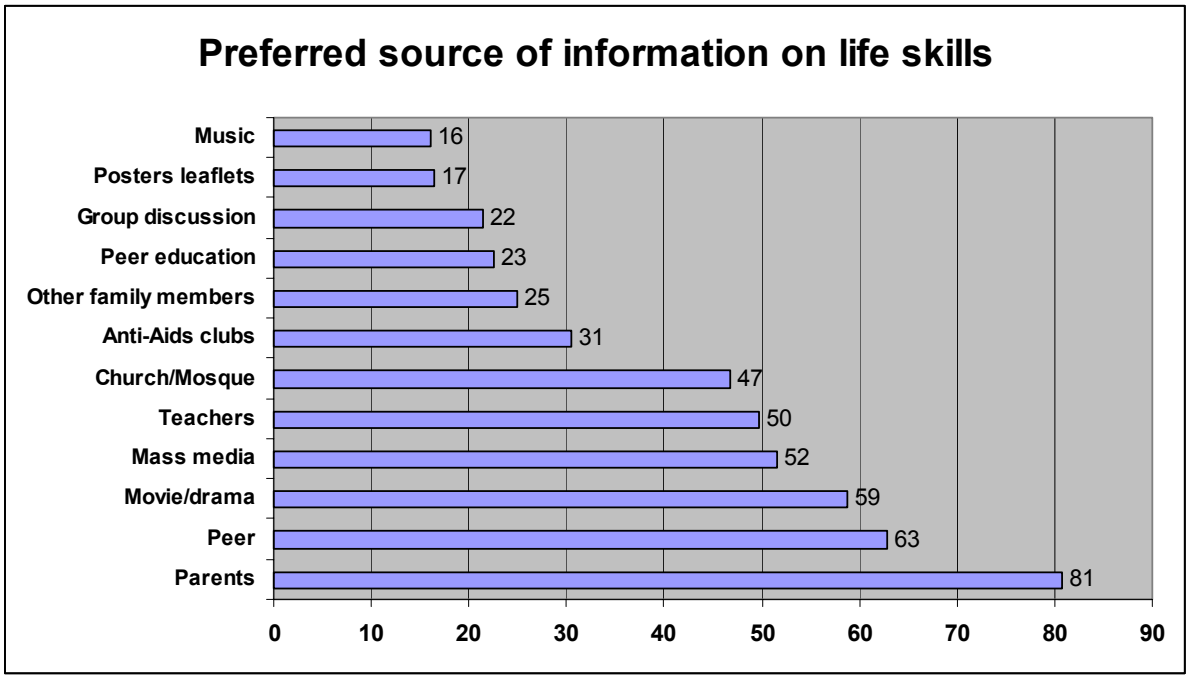
4.3 Frequency of communication with sources

Forty five percent of the adolescents frequently communicate with their mothers. Next to their mothers, adolescents frequently communicate with their peers (33%). Following peers, one third of the adolescents frequently communicate with their sisters. (See figure 2 below)

Figure 2



4.4 Preference of source the adolescents express, for life skill communication
Figure 3



The above figure, Figure 3 shows students' preferences for source of information on Life Skills. Again parents (81%) are highly preferred sources followed by Peers and Movie/drama. Almost half of the students wanted mass media and teachers to be their source of information on life skills.

4.5 Score for life skill knowledge and risk perception

Table 3. Life skill score

Attributes		No.	%
Assert themselves against peer pressure	Yes	364	91
	No	22	5.5
Avoiding undesired/unprotected sex through a win-win situation	Yes	50	12.5
	No	322	80.5
Decision making considering pros & cons	Yes	287	71.75
	No	84	21

N.B. The detailed scores are attached in the appendix.

Regarding the knowledge of life skills on assertive behaviour, which measures their communication skill, 91% of them identified the correct answer on how to react to peer pressure. Where as, only 12.5% of them identified the correct ways of dealing with their partners when challenged with undesired sex. This skill requires creating a win- win situation for both parties, reflecting the fact that their capacity to deal with sexuality leaves a lot to desire.

Table 4 Risk perception with and without boyfriends

Risk perception		No.	%
HIV/AIDS Risk perception among those with boyfriends	Yes	22	20.6
	No	82	76.6
HIV/AIDS Risk perception among those without boyfriends	Yes	53	18.2
	No	236	81.1

With regard to the participants' self risk perception towards contracting HIV/Aids, a staggering majority of both categories; with and without boyfriends (76% and 81% respectively) don't perceive themselves being at risk at all (though they were

supposed to be assessing the situation of a best friend, where normally confidence level should go down).

Figure 4

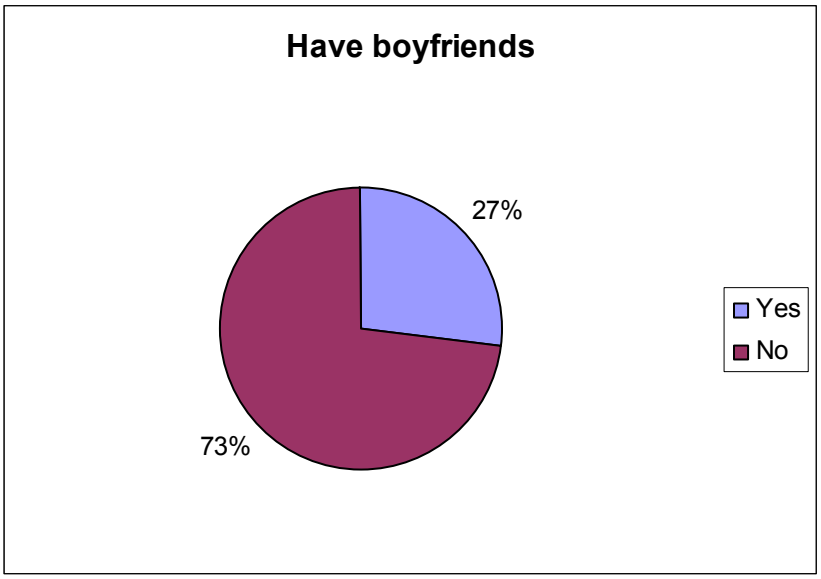
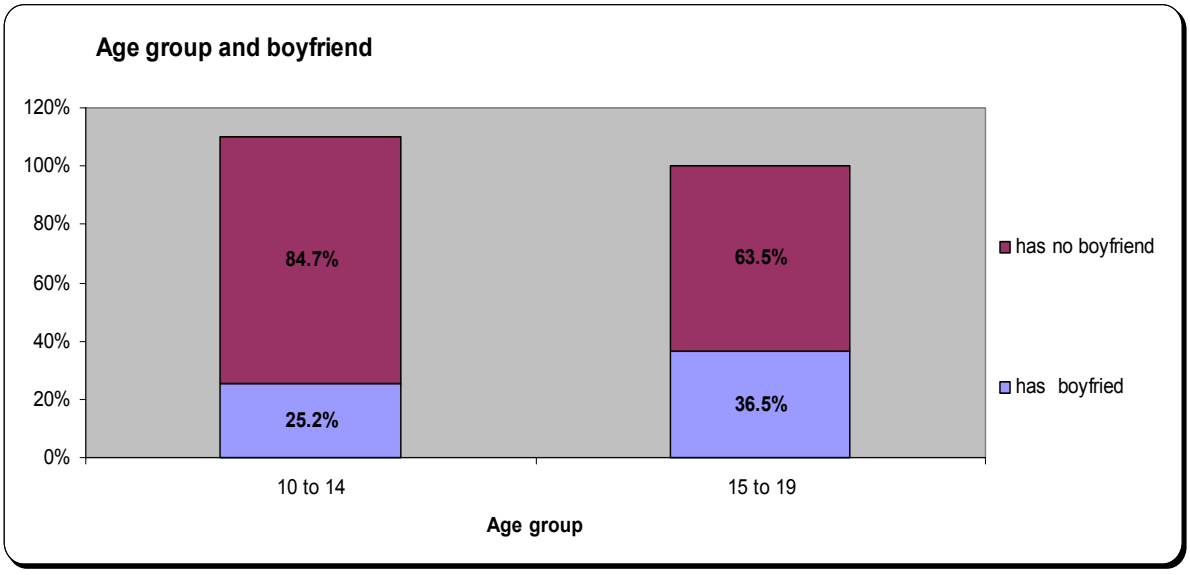


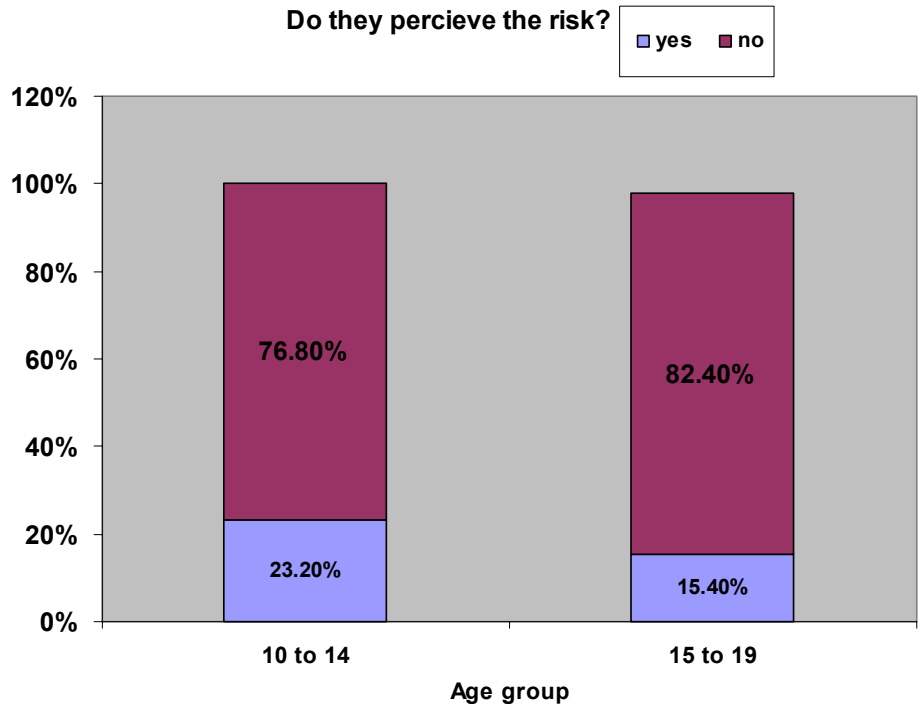
Figure 5



The above two figures (Fig. 4 and 5) show the percentage of respondents who witnessed their best friend having a boyfriend, which is 27% of total respondents. Of

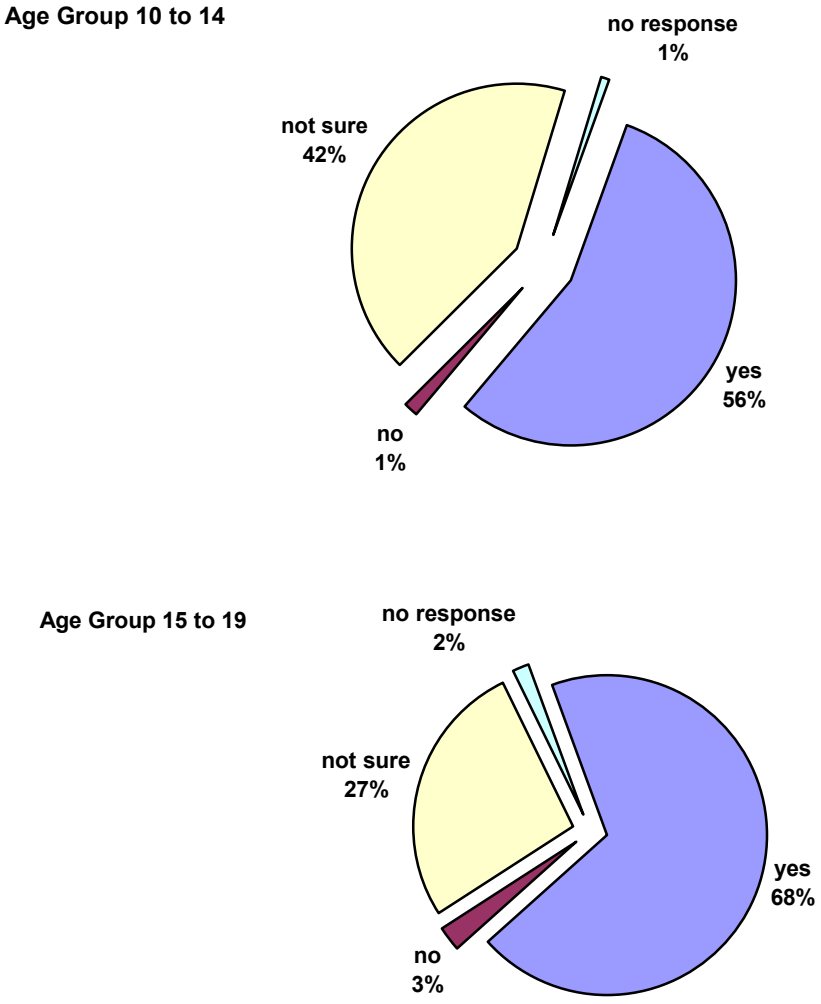
those who have boyfriends 36.5 % are from age 15 - 19 (late adolescents) and 25.2% are early adolescents age 10 - 14.

Figure 6. Perception of risk of HIV infection among all respondents – in age group



Out of the adolescents' aged 10 – 14, it is only 23.2% and out of 15 – 19, only 15.4% of the respondents perceive they could acquire the HIV virus.

Figure 7. Do the adolescents believe they can protect themselves from HIV/AIDS?



The above two figures show us the belief adolescents have whether they can protect themselves from HIV/AIDS. 42% of adolescents aged 10 – 14, are not sure of their capability to protect themselves from HIV/AIDS. With the same token, 27% of them aged 15 – 19 are not sure of their capability to protect themselves from HIV/AIDS.

Table 5. Socio-demographic factors related to life skill knowledge

Schools, which represent the economical factor, mothers' education level as a major source of adolescents' life skill knowledge and the adolescents' age were the selected socio demographic variables

Variables	High score
School	
Government and Public	180(90.9%)
Private and Mission	186(93.9%)
	Chi-Square value (1.298) df=1 p value = 0.255
Mother Education level	
Illiterate	32 (88.9%)
Read & write	50 (98.0%)
Elementary	49(81.7%)
Secondary	94(94.9%)
College	138(93.9%)
	Chi – Square value (14.100) df=4 p value =0.007
Age (years)	
10 - 14	163(93.1%)
15 - 19	201(91.8%)
	Chi – Square value(.257) df=1 p value= 0.613

The high score of students on life skill knowledge is shown to have no significant association with the school they attend, their age group or even with the mothers' education level.

4.6 Results from the focus group discussions and key informants interview

Source of information, Frequency of communication and source preference level of life skills acquired:

Respondents reported that the major sources of information on life skills are parents. Current civic education in the classroom is also an important source of information for age groups, 10 - 14 and 15 - 19. The younger groups also mentioned children's program in ETV and the different Radio programs that air different dramas as their source of information regarding life skills. In preference of media use, Mothers again,

are preferred most; 16 years old mission school student the importance of the mothers' role by saying;

> "A Mother is a school for her child; she can better communicate in several matters".

Regarding their teachers the participants commented;

> "We expect more from the teachers in school. Especially the elderly ones do not communicate".

Family members like sisters are also mentioned as best sources, as they understand the issue and can share their experience. Strong tendency to discuss life skills with peers is observed in the Muslim religious environment.

Among the second group of students, i.e. late adolescents, sources include films and books. –

Regarding the school environment and the mass media, an 18 years old private school student commented:

> "The real life in school and your environment teaches you a lot. Each day we witness a lot of things, the majority of the girls do not have the life skills and expose themselves to risk. You see that and you take your lessons. You also see what happens to your relatives and others and learn a lot from it",

she further added,

> "Media also plays a vital role specially in changing our parents' attitudes in communicating with us. But still the big challenge with parents is that they don't realize that we are growing up".

With regard to School/Anti aids clubs one participant commented:

> "They make some efforts but it is not personalized and coordinated, many students don't give attention to them. In the school environment you see when something happens to your peer and you learn from her. The ideal place to learn such things *(life skills*) would

> have been the school. However, once in a while some organizations come to the school and start some initiatives and then disappear. It is not continuous". (Age 13, Private school)

One other girl describing the less frequent discussions with fathers commented

> "My father, when he gets the time, tells me about the inappropriateness of putting myself in risky situations." (Age 13, Private school)

Interview with Ato Dhaba Feyissa, UNICEF HIV/AIDS Officer:

UNICEF is one of the leading none governmental organizations that acknowledge the importance of life skill development among the young to combat the HIV/AIDS pandemic and has undertaken the pioneering work of preparing a training manual and educators guide book on life skills as well as conducting trainings for peer educators and teachers. The interview with Ato Feyissa is included in this document in its entirety as it emanates from a direct experience in the field and vividly depicts the current situation.

Regarding the situation of life skills information, he stated that

> "The Psychosocial life skills are usually transmitted as an information knowledge or awareness. But these should be finally accompanied by practical skills training so that this information could be used. Skill is determinant for behavioral change.

When asked how the skills such as communication or decision-making should be imparted into the students He replied:

> "After giving the information and the knowledge which is very important as a first phase, it is important to create a real life/practical situation to exemplify the case such as using role play, one to one communication, drama (for instance to indicate how peer pressure). They should be enabled to practice and acquire the skill of negotiating and consensus reaching, and not giving one's right over."

Regarding methodology he further explained;

> “Under normal circumstances life skills training should not take less than 10 days; that is to provide sufficient time for the trainees to exercise practical life situations in a setting. For example assertiveness only should take a minimum of 8 hours. Especially if we take peer pressure, when the children discuss these issues with their peers, they are really exercising it. For the younger ones (10 – 14 year olds) different games and pictures would be more effective in assisting them to internalize the skills.

When asked about any specific theory used by them, he said:

> ”We do not use any specific theory but we are developing our strategies through our practical experience. We have collected and documented our best practices for over 10 years and are basing our interventions on them. We are observing encouraging results - Most people have changed their behaviors through our education.”

He further added

> “In our community, those people who talk assertively are labeled as those who “go over the board." The culture/society encourages aggressiveness and submissiveness (especially for girls rendering them highly vulnerable).

Asked as to what efforts are being made to communicate life skills to the young, given the culture and the prevalence of HIV/AIDS in the country;

> “Currently we are working in collaboration with international NGOs such as Save The Children, Government Organizations such as the Addis Ababa city HIV AIDS Secretariat and several HIV AIDS Clubs, on the issue of life skills. The HIV AIDS clubs are the main routes of the knowledge transfer. To date more than 40,000 young people have participated in the life skills trainings. This is just a start and it is like a drop in an ocean. The quality also depends on how the facilitators do their job. If they just limit themselves to transferring knowledge and information, the youth are less likely to bring about behavioral change.

Regarding experience in other countries he commented:

> In Zimbabwe, life skill has its own chapters in Civics and Governance subjects. Twenty-one days are assigned every year for training on one specific life skill. . Students exercise the skills in the classrooms practically. As the class size is 40 and less, participatory methods are adopted. -. Botswana has included "life skill" in the school curriculum. So, it is already institutionalized.

Regarding adolescents' preference of parents as the best source of life skills information he commented;

> We acknowledged the special role of parents and there are efforts to device programs to enhance parenting skills of the parents. The problem is how to institutionalize it. From adults, it is the parents who play the major role in instilling life skills in relation to Reproductive Health and HIV/AIDS in the young. We have piloted life-skill training for parents screened from Edirs in Diredawa, one of the major towns in Ethiopia, and the experiment has shown promising improvements in good parenting and life skill communication.
>
> Though skills interrelate cognition, attitude and practice, they do not need a higher-level comprehension. A local carpenter can teach how to hammer a nail to a university professor; it is a skill therefore it needs practice. So it makes sense to work with parents from all walks of life.

The challenge and what is and needs to be done:

> Life skill issues are included in the civics and biology subjects in the school curriculum. But with mostly about 90 students in a classroom, this are at best addressed theoretically and thus inadequately.
>
> There is no national life skill framework. There are no guidelines on the strategies to follow, for example, on how to reach the parents, how to conduct training of trainers, etc. More advocacy is needed..

. Regarding communication methods he commented

> Media like Posters and leaflets and other IEC materials as well as mini medias can be effective at knowledge and awareness creation level. But skill development requires more practice-oriented measures such as role-plays, brainstorming, drawing exercises etc.
> Regarding what should happen at policy level he commented
> Though not comprehensive, life skills are packed in different forms in different policies of the country. What we are advocating for is a human rights based program approach i.e. Children as "Claim holders", the community as "Duty Bearer" and when in need of resources the community becomes the "Claim Holder" and the Government the "Duty bearer"
>
> Right based question, are questions of Human rights, they are not only needs but claimable rights (entitled at birth) and one needs skills even to ask for ones rights. Asking the right (human right question) not only need but it is right and you need skill to ask for that right. (entitled at birth).
>
> Life skill issues are included in the civics and biology subjects in the school curriculum. But with mostly about 90 students in a classroom, this are at best addressed theoretically and thus inadequately. There is a need for a national framework and guideline. If not a separate framework, the national framework for HIV AIDS should incorporate a strong life skills component and also it should be properly incorporated in the school curriculum to institutionalize it and assure sustainability..

Ato Yohannes Tekalegn, Anti AIDS club representative in a public school

Despite the complaints heard from students that these club is weak and unattractive an a similar general assessment by different operators in the field, he emphatically stated that they are doing well saying;

> "We are close to the students. Students come to talk to us personally. The club is doing well in motivating our students".

Ato Abebe Hidoto, a teacher and secretariat of the Anti AIDS club of his school

Talking about the roll of teachers and the situation in the school environment, he explained;

> “Teachers are midfielders between societies and students. However, our culture does not encourage open discussions; greatly limiting what could and should be done.
>
> Civic education in the last 3 to 4 years, though challenged by the resistant culture, has helped the students a lot. Girls have come to know their rights and have started protecting themselves from HIV and peer pressure. For reinforcement, some points regarding the issue also appear in tests and examinations".

Describing the involvement of NGOs in the school environment regarding life skills and HIV AIDS, he stated;

> “CARE Ethiopia and ISAPSO, international and local NGOs respectively, do provide us with trainings, leaflets and posters on life skills as well as HIV/AIDS. They have also provided us with TV sets for audiovisual communication. (For HIV/AIDS)”

On the involvement of parents regarding the issue, he stated;

> Parents who come to the school to enquire about their children’s affairs are very few in number. Parent Teacher Association (PTA) would have been an excellent route to channel these efforts, however this association is weak and inactive as many things are in our society.

Asked for his evaluation of the current status of the in school adolescents;

> “We are not yet there, you find only 3 or 4 students in a classroom that take up the chance and develop their skills. Of course these few pioneer students deserve all the support.
> I propose that life skills should be properly placed in the curriculum and should be given at least 3 periods in a week. Furthermore, the mass media and prominent personalities should work harder in promoting good behavioral models. Teachers also need to be properly trained to handle the issue”.

Regarding barriers to communication

> The culture, especially the male dominance at home, is an environmental factor/effect that is making life skills communication very difficult. .

Chapter 5 Discussion

Life skills, as has been repeatedly underlined throughout this document, are vital armaments for every individual to sustain the daily hurdle of life and be able to enjoy it a bit. Especially adolescents need these skills in order to survive their - societal norm, exercise their rights, and influence their tomorrow and the norms of tomorrow.

As exhaustively explained before, being in the process of intensive as well as extensive biological and physiological change, adolescents are highly vulnerable and it is at this time that basic skills need to be at hand. To put it in the words of Ato Abebe Hidoto, secretariat of a school Anti AIDS club (personal interview on 28 June 2006)

> "…this period is the junction for them to march either in the direction of life or in the direction of utter destruction"

This study investigated the major source of information, the contexts these skills are transferred as well as the major barriers to the communication of life skills among in-school adolescent girls in Ethiopia.

A total of 400 adolescent girls were involved in this study from schools in Addis Ababa which constituted Government, public private and mission schools. This selection of schools is intended to assure the inclusion of the different types of schools that could represent the economical variable in to the study. Adolescents in government and public school, representing low to modest income family, constitute 201 (50.3%) of the entire population where as the private and mission school, representing middle to high income family standing, constitute 199 (49.8%).

Though not overwhelmingly the majority, 62 % of adolescents' mothers are at the level of secondary and college education. Seventy three percent of fathers constitute the level of above high school and college. Regarding mothers occupation 42.5% of them stay at home as house wives, which might give them a greater opportunity to spend time with their children and discuss on issues related to life skills.

Source/Context/Frequency

The survey result indicates that 75% of the source of information for life skills is parents. Again 81% of the respondents stated their parents to be their preferred source among others. According to the Social cognitive theory, safe and supportive environment for adolescents is very important to bring about behavioral change. Furthermore, observational learning and modeling are among the major building blocks of behavioral change. As preferred sources, parents have the responsibility to provide accurate information and practically demonstrate the life skills. But it is the contention of adolescents as well as experts in the field that parents themselves lack the skills and also do not know how to communicate them. Also it is a proven fact that adults most of the times find it difficult to talk to adolescents and adolescents are influenced by their peers much more than by their parents (McKee et al, 2004, p.74)

Second to parents, sisters and peers come as preferred sources. This suggests that there is a need to equip both parents and peers with correct information and skills, which they can pass on to their daughters, and peers. This will have a positive implication in that the more adolescent are knowledgeable, the higher the correct life skill is transmitted.

However, there is not as yet a program or strategy aimed at equipping parents with these life skills and facilitating the skill transfer to the adolescents. The example of UNICEF stands witness to this.

Mothers outrank all with regard to the frequency with which the adolescent girls communicate regarding life skills. Furthermore, almost forty three percent of mothers stay at home as house wives, having more access to their children. However, Being the product of the male dominated socio cultural situation of this country, it is automatic that mothers and their daughters are with limited access to information and under tremendous pressure to conform, rendering life skill development and transfer very difficult. Especially the all-important aspect of the life skills, self-efficacy, can hardly develop in the environment where the available model is not able to demonstrate it.

In the survey 53% of the respondents chose peers as their source of information. Also in the focus group discussions the discussants revealed that mostly they learn from what happens to their peers in the school environments. According to the social cognitive theory, modeling a behavior heavily depends on “self likeness” and accepting the model, hence, peer influence and the information available for circulation among peers is very vital in developing life skills that the adolescents require to deal with life.

On the other hand, the formal peer to peer communication structures in the school environment: peer education with 13% and Anti AIDS clubs with 17%, appeared to be the lowest sources of life skills communication. The focus group discussants also

stated that these organs in the school are not attractive to the students and they are not consistent in their activities. As comparing oneself with peers and siblings enhances ones self-efficacy, the opportunity provided for the adolescents by this peer circles is quite essential.

The adamant stance of Ato Yohannes Tekalegn, anti AIDS club representative in a public school, that the anti AIDS clubs are doing fine, indicates that there is a capacity gap in assessing the real situation and acting on it.

This needs to be given due attention as properly utilized, school environment is the best place to communicate life skills to adolescents. Peersman (1998 cited in UNAIDS 1999, p. 29) found that effective youth programs among others:

- Focused on understanding social and/or media influences on sexual behaviour to be able to strengthen group norms against unprotected sex
- Listened to what young people think and believe to ensure acceptable and appropriate programs
- Included modelling and practice of communication or negotiation skills.

Range of life skills adolescents acquired

The skills essential to prevent HIV/AIDS as selected by this study, psychosocial skills, were the main components of the skill assessment.

However, it has to be stated here that, with surveys like this, skills are much harder to assess than attitudes or beliefs because strategies other than paper-and-pencil,

like role-playing test or experimental qualification are needed. However, to come up with indicative results, major components of these skills were included in the research questionnaire for the adolescents' response.

Real life scenarios were presented for the respondents and they were instructed to choose the response/reaction they would show if they were in those situations,

The categories included skills of:

- Communicating assertively with peers and the capability of resisting peer pressure:
- Insisting on refusing undesired and unprotected sex assertively and - negotiating protected sex
- Identifying good and bad consequences of decision making, weighing up pros and cons of decisions that they make in their life.

The result shows that adolescents know what to communicate against peer pressure, 91%, and decide on challenging situation like economic pressure against undesired sex 71.75%, which indicates that the majority of the respondents seem to know how to behave assertively. Where as in the skill, that demands an in-depth negotiating skill and would create a win- win situation between partners, the result is quite the opposite with the above; only 12.5% of them identified the correct ways of dealing with their partners when challenged with undesired sex. Most respondents missed the component of creating a win-win situation for both parties and their responses were more defensive.

The above results show that, however skin deep it might be, the adolescents possess some knowledge and information on the psychosocial skills. However, the real life situation, as expressed in focus group discussions and in the in-depth interviews with operators in the field reveal that this knowledge is not so deep and not yet developed into practiced skills. -.

As an operator in the field puts it;

> "Say in one class room if you have about 80 or 90 students, it is only 3 or 4 students who could really demonstrate the above skills. We know it is a process and process takes time. But we capitalize on the potential of those 3 or 4 students to bring about change in their environment; including their parents, peers and community". (Ato Abebe Hidoto, Anti-AIDS club secretariat personal interview)

Finally in an attempt to relate the respondents' life skill knowledge with socio-demographic factors, the respondents' school, representing the economical variable, their age difference i.e. early adolescents and late adolescents (10-14 and 15-19) and mother's education level versus the adolescents score on life skill knowledge, there is no major linking factor on the adolescents' skill acquisition. With regards to mothers' education level versus adolescents' knowledge, there seems to be a relationship between mothers' high level of education and adolescents high score of life skill knowledge.

Since the over all actual exercise of life skills very low, the reliability of the associations and significance tests is low.

With regards to the barriers of life skill communication;

In their school environment, the efforts being undertaken to transfer life skills to the adolescents are very limited, in contrast to the structural advantage of the school environment to reach these adolescents.

The crowded classroom situation forbids the student the opportunity to exercise real life situations through role-plays and group discussions the limited life skills they learn in the civics class, so the verbal communication from the teachers could not be retained by the students and transformed into modelled behaviours. Similarly, the Anti – Aids clubs, as the students mentioned, are not yet strong and stable enough to provide life skills development opportunities for the adolescents.

Parents, especially mothers, as the main and preferred source of information are the important models for adolescents that should practically demonstrate these life skills in real life. However, as stated before, the traditional drawbacks are prevalent among many mothers, and hence cannot apply these skills for themselves let alone teach it to their daughters. So the vicarious learning (as per the social cognitive theory) is missed here.

Chapter 6 Conclusion and Recommendation

The study showed that the range of life skills the adolescents acquired, as a knowledge level seems to be - high. But when it comes to practical situations they are yet far from exercising these skills.

The limitations of the parents (the major source (75%) and the most preferred (81%) in possessing the life skills as well as in transferring them to their children greatly limits the communication of life skills. Peers, also the most frequented discussants on life skills are in the same situation with parents. Furthermore, the school environment, though it offers immense opportunities for communication, is highly under-utilised.

Life skills are not as yet among the major issues for the Ethiopian mass media, both electronic and print. Here again a great opportunity to influence the whole community in favour of the adolescents and its own self goes wasted.,

Thus the following recommendations are forwarded;

- Further research should be undertaken in order to further investigate the effect of life skill communication especially using experimental methods to investigate the real skills the adolescents acquire and the methods and sources with the highest impact on them. Further more indicators or should be developed to measure the extent to which one is said to be life skilled.
- It is also recommended to undertake a similar study consisting of parents with adolescent girls, to know their perceptions and to device a communication strategy that accommodates their situation.

- The education structure should take into consideration the necessity of developing a guideline/policy to include life skills in the curriculum and ensure enough time and skilled personnel are allocated to provide adolescents a chance to exercise in a practical situation. Furthermore, potential advantage of entertainment education to address both adolescents and their parents should be an issue of intensive research in adopted not only for life skills education but to impart the use with vital knowledge.

- The school environment could intervene by strengthening the existing structure of Parent Teacher Association, which is devised to assure the quality of education and raise some social issues. Life skills should be part of these institutions objectives and a better platform to utilize the school's structural advantage to link parents, teachers and students to reinforce the skill building.

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Annex 1 The survey questionnaire

Survey on Life skills communication
School of Journalism and Communications
Addis Ababa University
June 2006

Questionnaire

This questionnaire is designed to assess the communication of HIV/AIDS related life skills among in school female adolescents in Addis Ababa.

I appreciate your willingness to participate in this study and your genuine answers plays an important role in the success of this study. The answers you give are strictly confidential and there is nothing that identifies you out of the many respondents. Try to respond to all the questions provided and if you need clarification you can communicate with the facilitator available.

Explanation of life skills related to HIV/AIDS

Life skills according to this research is referring to

Decision-making: choosing among several alternatives

Communication skills: involves listening carefully to what others say, clearly state one's thoughts feelings, and ideas to others, also settle disagreements in ways that are not hurtful.

A healthy lifestyle choice is selecting a way of living that is in accord with sound condition of body and mind, prevention of disease and injury.

Self responsibility is taking care of oneself; being accountable for one's behavior and obligations; choosing for oneself between right and wrong

I. Socio -demographic factors

Circle the Number of your choice from the right side of the table.

No.	Questions	Answers
101	Age (years)	_____ in years
102	Which grade are you?	_____th grade
103	Type of school you attend	1. Government 2. Public 3. Private

No.	Questions	Answers
		4. Mission
104	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. Other_____
105	Marital status	1. Not married 2. Married 3. Engaged
106	Education level of Father	1. Illiterate 2. Elementary 3. Secondary 4. Diploma 5. Degree and above
107	Education level of Mother	1. Illiterate 2. Elementary 3. Secondary 4. Diploma 5. Degree and above
108	Mother's occupation	1. Civil servant 2. Business woman 3. House wife 4. Pensioner 5. Other(specify)_____
109	Father's occupation	1. Civil servant 2. Business man 3. Pensioner 4. Other(specify)_____

II. Communication

No.	Questions	Answers
201	Which of the life skills do you know from the listed ones? (You can choose more than one)	Decision making, Communication skills, Healthy life style choices, Self responsibility
202	Do you believe these skills are important to prevent HIV/AIDS	Yes No

Decision making skill: choosing among several alternatives

203. If you know about "Decision Making" skill, which are your **sources**? (you can choose more than one answer)

1. Peers
2. Parents
3. Family members
4. Teachers
5. Church/mosque/Religious institutions
6. Media outlets as (TV, radio/newspapers/Films/Magazines)
7. Anti-AIDS clubs
8. Small group discussions
9. Coffee ceremony
10. Drama/films
11. Peer education
12. Posters/leaflets
13. Music
14. Others specify_____

204. Which **sources** do you **prefer** from the above choices? Write down the numbers of your choices from above. (you can choose more than one answer) _____

205. Whom **can** you discuss about decision making?

1. My mother
2. My father
3. My care givers
4. My brother
5. My sister
6. My peer friends
7. My teachers
8. My neighbors
9. Others (specify)_____

206. Have you **ever discussed** about "Decision making skills"? At what frequency?

Ser. No.	Choices	Always	sometimes
1	My mother		
2	My father		
3	My sister		
4	My brother		
5	My care givers		
6	My peer friends		

Ser. No.	Choices	Always	sometimes
7	My teachers		
8	My neighbors		

Healthy life style choice: is selecting a way of living that is in accord with sound condition of body and mind, prevention of disease and injury.

211. If you know about skill of "Healthy life style", which are your **sources**? (you can choose more than one answer)

1. Peers
2. parents
3. family members
4. teachers
5. church/mosque/Religious institutions
6. Media outlets as(TV, radio/newspapers/Films/Magazines)
7. Anti-AIDS clubs
8. Small group discussions
9. coffee ceremony
10. Drama/films
11. Peer education
12. Posters/leaflets
13. Music
14. Others specify_____

212. Which **sources** do you **prefer** from the above choices? Write down the numbers of your choices from above. (you can choose more than one answer)

_____

213. Whom **can** you discuss about Healthy life style choices ?

1. My mother
2. My father
3. My care givers
4. My brother
5. My sister
6. My peer friends
7. My teachers
8. My neighbors
9. Others (specify)_____

214. Have you **ever discussed** about "Healthy life style choices"? At what frequency?

Ser. No.	Choices	Always	sometimes
1	My mother		
2	My father		

Ser. No.	Choices	Always	sometimes
3	My sister		
4	My brother		
5	My care givers		
6	My peer friends		
7	My teachers		
8	My neighbors		
9	Others ,specify___		

Self responsibility is taking care of oneself; being accountable for one's behavior and obligations; choosing for oneself between right and wrong

215. If you know about "Self responsibility" skill, which are your **sources**? (You can choose more than one answer)

1. Peers
2. parents
3. family members
4. teachers
5. church/mosque/Religious institutions
6. Media outlets as(TV, radio/newspapers/Films/Magazines)
7. Anti-AIDS clubs
8. Small group discussions
9. coffee ceremony
10. Drama/films
11. Peer education
12. Posters/leaflets
13. Music
14. Others specify_____

216. Which **sources** do you **prefer** from the above choices? Write down the numbers of your choices from above. (You can choose more than one answer)

_____

217. Whom **can** you discuss about Self responsibility?

1. My mother
2. My father
3. My care givers
4. My brother
5. My sister
6. My peer friends
7. My teachers
8. My neighbors
9. Others (specify)_____

218. Have you ever discussed about "Self responsibility skills"? At what frequency?

Ser. No.	Choices	Always	sometimes
1	My mother		
2	My father		
3	My sister		
4	My brother		
5	My care givers		
6	My peer friends		
7	My teachers		
8	My neighbors		
9	Others ,specify___		

III. Range of life skills the adolescents acquired.

Put "✓" mark to your choices below.

301. Your friend tries to convince you to drink some beer with him after school. You don't feel very good about drinking alcohol and you feel uncomfortable about the situation. What would you do? Put "agree" "do not agree" or "No opinion"

No.	Response	Agree	Disagree	No opinion
1	I would thank him for his invitation			
2	explain that I do not drink beer			
3	propose that we rather drink tea			
4	propose that we discuss the issue some other time			
5	say no firmly and leave			
6	create some false excuses and leave without offending him			
7	go along but either drink very little (careful)			
8	order soft drinks			
9	go along and drink nothing			

302. Most of your friends have had sex and tease you about the fact that you have not. It is hurting you. What would you do?

No.	Response	Agree	Disagree	No opinion
1	I would tell them that this is not the time to indulge in sex			
2	I have a plan for my future and I am not missing out any thing in life!			
3	I would pretend that I had sex			

No.	Response	Agree	Disagree	No opinion
4	I would tell them firmly that it is none of their business			
5	Tell them they should stop teasing me			
6	Avoid them			
7	I will find a boyfriend			
8	I'll have sex and be like tem			

303. Your parents are away and you are alone with your tutor. After doing the homework he grabs you and tries to kiss you. You protest and push him off. But he persists. What would you do?

No.	Response	Agree	Disagree	No opinion
1	I will kiss him			
2	I'll kiss him but take care that it does not lead to sex			
3	I will shout to call for help			
4	I'll beg him to stop			
5	I'll try to run away			
6	I'll kick him on his weak spots, to weaken him			

304. An elderly friend of your family offers you a ride home after school. You do not feel very good about this person, and you feel uncomfortable about the situation. What would you do?

No.	Response	Agree	Disagree	No opinion
1	I refuse the offer			
2	Threaten him that I 'll tell my parents if he tries again			
3	I thank him for the offer			
4	Create some pretext to avoid offending him			
5	Tell him firmly that I prefer to walk home / to be my own			
6	I will accept his invitation but remain alert that the situation does not go far.			
7	I'll accept his invitation			

305. Your boyfriend thinks it is time to have sex. You love him but you feel that sex before you are ready is wrong. Your boyfriend says, ‘‘you're just scared. If you really loved me, you'd show it". You are afraid this will end the relationship. What would you do?

No.	Response	Agree	Disagree	No opinion
1	I would tell him to stop bothering me			
2	I'd break the relationship.			
3	I'd convince him that if he really loves me he will respect my decision			
4	I will agree to show my love by having sex			
5	I would try my best to satisfy his desires with safe and none penetrative sexual practices			

306. You are a 15-year-old girl living in a small town. You are taking care of four younger siblings, and you cannot find money for food. You have a friend near the market who has been offering you nice gifts and buying some food for you. Recently, he has suggested that you should meet together at a rest house (inn or motel). What will you do?

No.	Response	Agree	Disagree	No opinion
1	I will thank him for his kindness			
2	Refuse his suggestion			
3	Stop taking gifts from him try to			
4	Find other alternatives to take care of my siblings			
5	I would find some pretexts to avoid going out with him			
6	I would accept the suggestion but I'll take care that it does not lead to sex			
7	I 'd refuse to meet him in an inn or a motel and propose to meet him at a public place and discuss the issue thoroughly			

IV. Sexual behavior

When attempting the following questions, think your school best friend:

No.	**Questions**	**Answers**
401	Does she have boy friend/boyfriends? [If no go to Q. No. 409]	1. Yes 2. No
402	If yes, how many?_____	
403	Did she have intimate relationship with him?	1. Yes 2. No
404	If yes, did she have physical relation?	1. Yes 2. No

No.	Questions	Answers
405	Has she ever had sexual intercourse?	1. Yes 2. No
406	At what age did she start intercourse? State the age	_____ Years old
407	Give the frequency	1. Once 2. Sometimes 3. Regularly
408	Was she willing to have sexual intercourse?	1. Always with her agreement 2. Sometimes with her agreement 3. Against her willingness
409	Why doesn't she have a boyfriend? State her reason/s	_____ _____
410	Does she perceive herself at risk of contracting HIV/AIDS?	1. Yes 2. No
411	Does she believe she knows how to protect herself from HIV/AIDS?	1. Yes 2. No 3. I don't know

Annex 2 List of Key Informants and leading questions

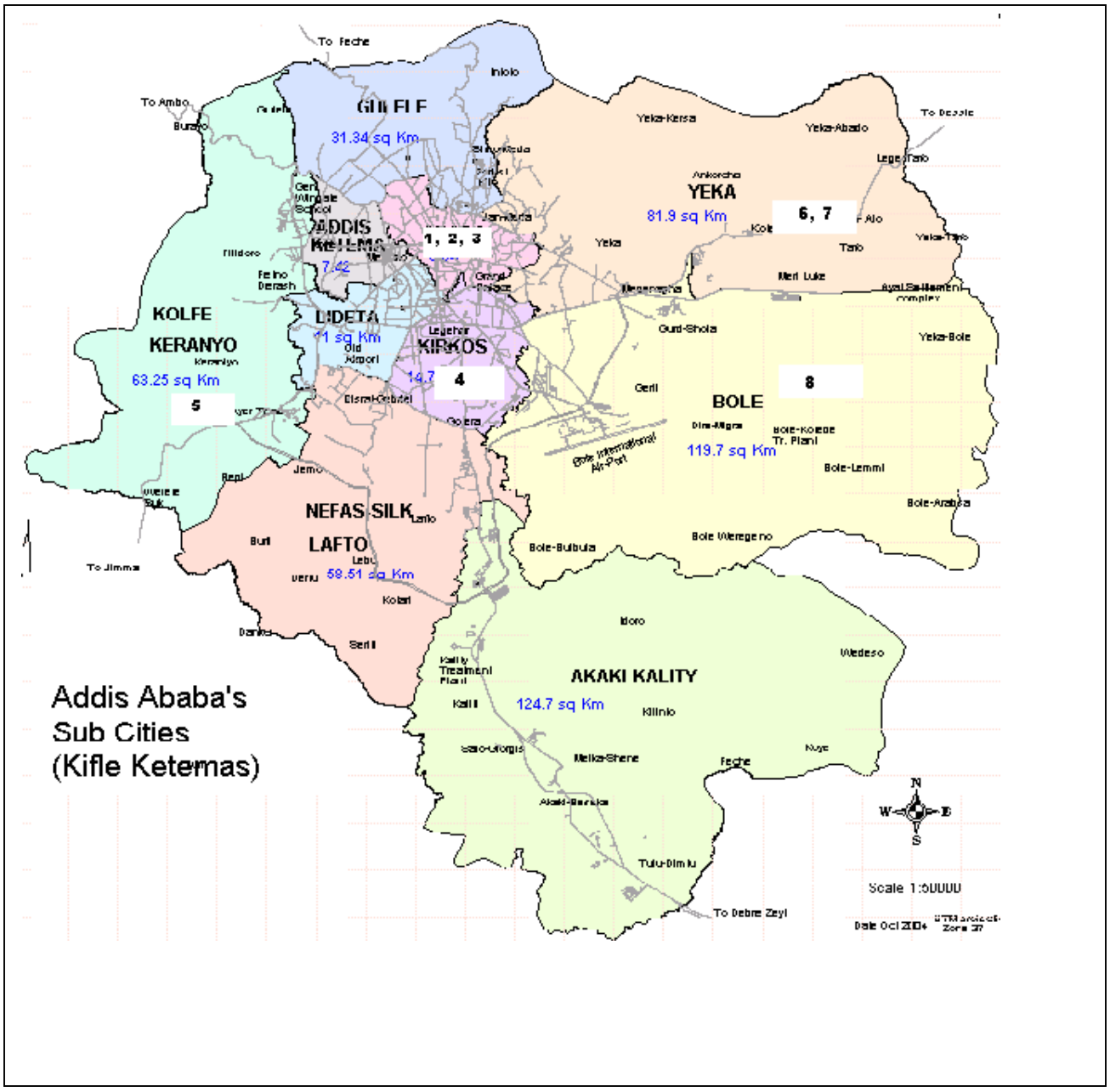
List of Key Informants

Nr.	Name	Organization	Position	Interview Date
1	Ato Tamiru Gebre	Consultant	Life skill Trainer, (core facilitator)	11 June 2006
2	Ato Yohannes Tekalegn	Ethiopia Andnet Public School	Ant Aids Club Representative	27 June 2006
3	Ato Abebe Hidoto	Ethiopia Andnet Public School	Teacher & HIV AIDS Club Secretariat	27 June 2006
3	Ato Dhaba Feyissa	UNICEF	HIV/AIDS officer	29 June 2006

Leading questions for key informants and focus group discussants

- Name, organization, current responsibility,
- Are Life skills essential to prevent HIV/AIDS?
- What efforts are being taken by govt. NGO's and the community?
- What is your evaluation of the current effort of life skill communication?
- What is your evaluation of the level of life skills of the adolescents in your area ?
- Do you think the adolescents have been provided with sufficient guidance in life skills with regard to protecting themselves from HIV/AIDS?
- What communication materials have been made available to them in the last 12 months?
- Do you think the messages and communication approaches are relevant and appropriate to the development level and context of the adolescent environment?
- How does the policy environment support life skill communication?

Annex 3 Selected survey schools in Addis Ababa



1 = Bethlehem Primary Public School
2 = Menilik II Primary & Secondary Government School
3 = Lideta Catholic Cathedral Elementary & Secondary Mission School
4 =DandiBoru Elementary & Secondary Private School
5 =Awoliya Elementary & Secondary Mission School
6 =School of Tomorrow Elementary & Secondary Private School
7 =Ethiopia Andinet Elementary Public School
8 =Bole Secondary Government School

Annex 4 Survey Results - detailed

A. Range of life skills the adolescents acquired

Reaction for invitation to drink beer

	Agree		Disagree		No comment	
	No.	%	No.	%	No.	%
Thank him for invitation	160	40.0	179	44.8	41	10.3
Explain i don't drink beer	**314**	**78.5**	**47**	**11.8**	**18**	**4.5**
Propose we rather drink tea	**151**	**37.8**	**188**	**47.0**	**40**	**10.0**
Promise to discuss the issue some other day	116	29.0	186	46.5	69	17.3
Firmly say no and leave	**201**	**50.3**	**125**	**31.3**	**48**	**12.0**
Create false excuse and leave not to offend	**121**	**30.3**	**206**	**51.5**	**41**	**10.3**
Go along but drink very little	11	2.8	339	84.8	20	5.0
Go along but drink a soft drink	**92**	**23.0**	**240**	**60.0**	**40**	**10.0**
Go along but drink nothing	35	8.8	262	65.5	74	18.5

Reaction when get teased on not having sex with boyfriend

	Agree		Disagree		No comment	
	No.	%	No.	%	No.	%
Tell them it is not time to indulge in sex	**360**	**90.0**	**21**	**5.3**	**9**	**2.3**
Have plan for my future life	**371**	**92.8**	**9**	**2.3**	**10**	**2.5**
Tell them that I am not missing anything	**339**	**84.8**	**21**	**5.3**	**22**	**5.5**
Pretend that I had sex	17	4.3	321	80.3	33	8.3
Tell that it is none of their business	**244**	**61.0**	**56**	**14.0**	**71**	**17.8**
Tell them to stop teasing	**222**	**55.5**	**67**	**16.8**	**75**	**18.8**
Avoid them	**191**	**47.8**	**133**	**33.3**	**56**	**14.0**
Will find a boyfriend	7	1.8	348	87.0	14	3.5

Reaction when tutor trying to kiss you

	Agree		Disagree		No comment	
	No.	%	No.	%	No.	%
I will kiss him	28	7.0	330	82.5	20	5.0
will kiss him but take care that it doesn't lead to sex	30	7.5	313	78.3	32	8.0
shout to call help	231	57.8	74	18.5	75	18.8
beg him to stop	233	58.3	98	24.5	42	10.5
try to run away	276	69.0	51	12.8	49	12.3
kick him on his weak spots	81	20.3	171	42.8	114	28.5

When an elderly offers you a ride -

	Agree		Disagree		No comment	
	No.	%	No.	%	No.	%
refuse the offer	342	85.5	27	6.8	21	5.3
threaten him that I will tell my parents	261	65.3	61	15.3	55	13.8
thank him for the offer	163	40.8	176	44.0	37	9.3
create some pretext not to offend him	124	31.0	201	50.3	45	11.3
tell him that I prefer to walk	330	82.5	25	6.3	21	5.3
accept invitation but alert	31	7.8	312	78.0	30	7.5

Boyfriend urges to have sex when you don't want

	Agree		Disagree		No comment	
	No.	%	No.	%	No.	%
tell him to stop bothering me	311	77.8	29	7.3	36	9.0
break the relationship	174	43.5	145	36.3	59	14.8
Convince him to respect my decision	343	85.8	24	6.0	21	5.3
agree to show my love	13	3.3	339	84.8	17	4.3
satisfy his desire by non-penetrative sexual	56	14.0	258	64.5	64	16.0

An elderly suggested to meet at a rest house

	Agree		Disagree		No comment	
	No.	%	No.	%	No.	%
Thank him for his invitation	252	63.0	89	22.3	34	8.5
Refuse his suggestion	331	82.8	39	9.8	16	4.0
Stop taking gifts	273	68.3	62	15.5	47	11.8
find other alternative to take care of my siblings	354	88.5	19	4.8	16	4.0
find pretext to avoid going out with him	193	48.3	126	31.5	51	12.8
accept the invitation with care	36	9.0	292	73.0	30	7.5
propose to meet him in a public place	206	51.5	123	30.8	48	12.0