

Addis Ababa University  
College of Social Sciences  
School of Social Work

Assessment of Adolescent Parent Communication Concerning Sexual and Reproductive  
Health

Issues among Ayer Tena Preparatory School Students

Solomon Zewdu Leul

Approved by:

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Advisor

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Examiner

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Signature

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Examiner

\_\_\_\_\_  
Signature

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**List of Acronyms**

AIDS	Acquired Immune Deficiency Syndrome
EC	Ethiopian Calendar
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
GOs	Governmental Organizations
HIV	Human Immune Virus
NASW	National Association of Social Workers
NGOs	Non Governmental Organizations
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UN	United Nation
WHO	World Health Organization

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### Abstract

The present study was conducted to assess parent adolescent communication on SRH issues among Ayer Tena preparatory school students, Addis Ababa. Mixed methods research design was used. A total of 393 (female =214 and male =179) adolescent students were selected using systematic sampling technique. A pre-tested, structured and self-administered questionnaire was used for the quantitative study, and an interview guideline was used to generate data from interviewee adolescents and pertinent professionals. To analyze the quantitative data of 378 (female= 208 and male= 170), Statistical Package for Social Sciences (SPSS) version 20 was used. In addition to descriptive statistics (univariate analysis), further statistical analysis such as Crude Odds Ratio and Adjusted Odds Ratio were employed to see the associations of single independent variable and dependent variable, and multiple independent variables and dependent variable respectively. 95 % confidence interval (CI) and 5% margin of error was considered during the statistical analysis. The qualitative data was analyzed thematically and integrated with the quantitative based on the study questions. Findings showed that 287 (75.9%) adolescents recognized the importance of SRH issues communication with their parents. 34.5% adolescents ever had discussed on at least two topics of SRH issues. Communication was mostly based on parent child sex similarity (mother-daughter and father-son). The study also found that there is a statistically significant relationship between having positive attitude towards parent-adolescent communication on SRH issues, having informed about SRH issues and having literate parents, and parent-adolescent communication on SRH issues. Conclusion was made and the implication was discussed.

*Key words: Parent, Adolescent, Communication, Sexual and Reproductive Health*

## CHAPTER ONE

### Introduction

#### Background of the Study

The World Health Organization [WHO] (2004) working definition of reproductive health explains sexual and reproductive health issues as experiences around pregnancy and parenthood, sexuality and relationships, abortion, STIs, HIV/AIDS, condom use, sexual partner, family planning services including infertility and contraception and etc. The WHO (2002) again defines sexual and reproductive health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. In addition to this, Fahimi and Ashford (2008) states it as a broad concept encompassing health and well being in matters related to sexual relations, pregnancies and births. It is also the most intimate and private aspects of people's lives according to them.

Many studies noted that currently adolescents SRH concerns have become on national agendas for many countries. The WHO (2002) report on analysis of adolescent sexual and reproductive health literature from around the world informs that this concern has been largely driven by the high prevalence of HIV/AIDS among young people. The report added that the concern for early child bearing and the attention to adolescents' sexual behaviors further brings the issue under consideration to national agendas. In relation to this, most of the studies focusing on adolescent SRH issues gave a solid attention to the importance of parent adolescent communication, which generally help adolescents to become less exposed towards various SRH problems. For instance, a study by Wang (2009), found that improved parent adolescent communication have a positive impact on adolescents health. The study by Atienzo, Walker, Campero, Figueroa, and Gutierrez (2009) concerning the impact of parent

adolescent communication about sex on adolescents' sexual behavior in Mexico acknowledges the importance of earlier parent adolescent communication on risk and prevention of sexual activity, one of the SRH issues, for safe sex practice which in turn improves adolescent's SRH. The study by Dessalegn Gebre'eyesus (2006) as well emphasizes the importance of parent adolescent communication on SRH issues. However, it did not highlight factors related to the pervasive nature of adolescent's SRH issues.

Despite the fact that there is no universally recognized definition of adolescence and youth, the United Nation [UN] (2011), for statistical purposes, classifies adolescents as a person aged ten to nineteen years old and those between fifteen and twenty four as youth. Alongside with its definition, the UN notifies as "the operational definition and nuances of the term 'youth' often vary from country to country, depending on the specific socio-cultural, institutional, economic and political factors" (P. 2). It is also suggested that the categorization of adolescence varies depending on adolescent's individual situations. For example, married people tend to be considered as adults while young people at school are still considered as adolescents, even if they are in the same age. Similar with the UN (2011) description, the WHO (2004) defines an adolescent as any person between ages ten and nineteen, and individuals between ages ten and twenty four as young people. The WHO also stresses that adolescence is the phase, rather than a fixed time period in an individual's life. On the other hand, in the 2004 National Youth Policy of the Federal Democratic Republic of Ethiopia [FDRE], the age of youth people cover all age group between fifteen and twenty nine years of age. Unlike the UN's and other related international organizations, the working FDRE National Youth Policy did not demarcate the age group of adolescent from that of the youths. The rationale for putting the population age group of fifteen to twenty nine as youth is also not explained.

Encyclopedia Britannica (2014) defines adolescence as: a transitional phase of growth and development between childhood and adulthood” (p. 1). The UN (2011) also explains the youth as the stage of life during which individuals reach sexual maturity. With regard to parent adolescent communication, the WHO (2004) define it as a fundamental process through which parents convey ideas, values, beliefs, expectations, information, and knowledge to their children. Parents typically have the opportunity to communicate with their children’s thinking on a daily basis, and as such, parents can play a critical role in shaping their children as they move into adolescence and eventually into adulthood. Cleland, Ingham, and Stone (2011) explains communication between parents and adolescents as a simple interactive discussion between parents and youth on issues like HIV/AIDs, sexual intercourse, menstruation, unwanted pregnancy and use of contraceptives. Cleland’s et al. (2011) explanation includes sexual socialization that typically occurs within families in which parents teach and influence their children pertaining to physical development, physical affection, modesty, nudity, gender differences, sexual behaviors, and marriage, among other topics.

Jerman and Constantine (2010) also describe sexual communication as “a principal means of transmitting sexual values, beliefs, expectations, and knowledge between parents and children” (p. 1). With no significant difference between them, all the aforementioned conceptual definitions holds the idea that parent adolescent communication involves issues revolving around youth’s physical, emotional, spiritual and sexual development. Of these broad definitions, this particular study assessed only one dimension of parent adolescent communication, communication on SRH issues. With an implication of having importance for adolescent peoples’ sexual health intervention, parent adolescent communication concerning their SRH issues has been assessed.

Given the absence of statistical demarcation between the age of adolescent and youth in the 2004 FDRE National Youth Policy, employing the age range of youths for the study group of adolescents would widen the age range beyond its relevance to this particular study. Thus, by considering the average of minimum and maximum age for students who have started their education at early age and late age, the study made use of the adolescent population as a segment of people that falls in the age range of sixteen to twenty four.

The study was carried out in Ayer Tena Preparatory school which is found in Kolfe Keraniyo Sub-City of Addis Ababa city administration. In this Sub-city there are two governmental preparatory schools and Ayer Tena Preparatory school is one of them having 2190 students, 946 and 1244 number of males and females respectively (Kolfe Keraniyo Sub-city Education Bureau: Progressive report of schools in the sub-city [2014]) & (Rebira Bekana, personal Communication, January 2, 2014). The mentioned preparatory school was selected for this particular study with the rationale that the investigator has been facing many issues concerning Sexual and Reproductive Health issues while working in Kolfe Keraneyo sub city Women, Children and Youth Affair Office, and as a representative of the respective office in Ayer Tena Preparatory School.

### **Statement of the Problem**

WHO's (2004) study with regard to Analysis of Adolescent SRH Literature from Around the World point out that "over the past decade, adolescent SRH concerns have increasingly been on national agendas" (p. 3). The study discusses as this issue has been driven by the high prevalence of HIV/AIDS among young people. STDs, HIV/AIDS and other reproductive health problems are the greatest threats to their well being.

According to Fikre Abebe (2009), regardless of the growing problems there is no adequate health service or counseling specifically suitable for this specific age group. The author further explains that youth often engage in a wide range of high risk sexual behaviors

that can result in adverse health, social and economic consequences for themselves and their families. The problem further get worsen as the FDRE Health Policy (2004) devoid an attention towards adolescents SRH issues. This is confirmed by the statements in the FDRE Ministry of Health, National Reproductive Health Strategy (2006 - 2015), that while approximately 60 percent of Ethiopia's population falls between the ages of 10-29, few national programs or policies are specifically targeted towards addressing their most pressing RH needs.

Early sexual intercourse is a serious adolescent risk behavior and it is associated with other behaviors that increase risk, including more frequent sexual intercourse and greater numbers of sexual partners, and lower probability of contraceptive use during the adolescent years. Accordingly, we can infer that individuals who initiate sexual intercourse relatively in their early adolescence age are at high risk for STIs (Fikre Abebe 2009).

A study by Assebe Mekonnen (2006) reveals that positive communication between parents and their children can help young people establish individual values and make healthy decisions. The study further reports that parents communication with their adolescent regarding sexuality is regarded as critical toward informing adolescents on risks and protective behaviors, providing guidelines on values and standards of behavior and decreasing likelihood of youth's engagement in risk behaviors.

Corroborating Assebe Mekonnen's (2006) finding, Mulatua Ayalewus's (2011) cross sectional study among Dire Dawa high school students concerning adolescent parent communication on SRH issues notifies varying levels of statistical findings. Her findings informs the following numerical results of parent adolescent communication on various SRH issues; communication on contraceptive method (50.7%), communication on HIV/AIDS and other STIs (55.9%), communication on sexual intercourse (30.6%), communication on unwanted pregnancy (34.1%), communication on premarital sex (53.1%), communication on

condom use (21.7%), communication on puberty (60.7%) and communication on menstrual period (45.8%). Taking the imperative of communication between parents and adolescents on SRH issues into account, statistical results shown by the study remains worthless. She point out sexual socialization as a principal means for transmitting sexual values, beliefs, expectations, and knowledge between adolescents and their parents. These communications on sex related topics promotes healthy sexual development and reduce sexual risk especially when parents are open, skilled, and comfortable in their discussion. Thus, communication concerning sexual matters between parents and their adolescent children serve as a protective factor and exerts a favorable influence on adolescents' sexual behaviors. A study by Wang (2009) also informs as parent adolescent communication about sexual issues indeed made a positive contribution on adolescents' sexual risk taking behaviors. A research conducted by Wamoyi, Fenwick, Urassa, Zaba, and Stones (2010) in rural Tanzania further point out that parent child communication about sexuality is an important factor in reducing young people risky sexual behaviors. Dessalegn Gebre'eyesus (2006) also emphasizes the importance of parent youth communication, in which they notifies issues of parent adolescent communication regarding sexuality as it is perceived by many to be effective means of encouraging adolescents' to adopt responsible sexual behaviors.

Likewise, a study by Mulatua Ayalewu (2011) found that higher levels of parent adolescent communication are associated with reduced sexual risk taking on the part of the adolescent. In line with the above mentioned ideas, Cleland's study (2011) show that parent youth communication on SRH matters has positive influences on good relationships between parent and their children as well as for healthy sexual behaviors of young people. Given that youth are under the burden of unwanted pregnancy and its complication, STIs including HIV/AIDS and other SRH problems to a greater extent, communication about sexuality and sexual matters is more important perhaps than any other time. A study conducted by Oladepo

and Fayemi (2011) regarding the perceptions about sexual abstinence and knowledge of HIV/AIDS prevention among school adolescents in a western Nigerian city confirms as positive parent adolescent communications about engagement in sexual behaviors impose a buffering effect to delay from sexual initiation.

Consistent with these findings, the study by Huebner and Howell (2003) on *Examining the Relationship between Adolescent Sexual Risk Taking and Perceptions of Monitoring, Communication, and Parenting Styles*, found the communication between parents and adolescents on sexual issues as a positive force within the lives of adolescents. However, incompatible with the above mentioned findings, the study by Yohannes Mulugeta (2012) on *Parent Youth Communication Concerning Sexual and Reproductive Health Issues and its Outcome on Sexual Initiation*, tells us the communication about SRH issues between parents and adolescents did not show any relations with sexual initiation of youth. The investigator attach this odd result to the literacy level of the parents, in that more than half of the respondent parents were illiterate and thus less likely to transfer a convincing SRH knowledge to their children.

Coming to the Ethiopian context, some studies conducted inside the country notifies that parent adolescent communication about sexuality is known to be very poor. For instance, Mulatua Ayalewu (2011), in her assessment of adolescent parent communication on SRH issues among high school students in Dire Dawa administrative council found as parents do not openly discuss about facts of human reproduction with their children, and as only a few parents superficially discussed. Yohannes Mulugeta (2012) also found poor communication about sexual and reproductive health issues between parents and their children. He further explains that most parents do not feel comfortable or competent in talking about sexual issues with their adolescents. Rather than dealing with the private topics, such as masturbation, the psychological and experiential aspects of sexuality such as orgasm or sexual decision-making,

and how to obtain and use condoms, they tend to limit conversations to 'safe' topics, such as developmental changes (for example menstruation and other pubertal changes), impersonal aspects of sexuality like reproductive facts, and negative consequences, such as AIDS and sexually transmitted infections. He connected this to fear and lack of communication skill of parents, feeling of shamefulness, resistance and loose of confidence of youth. Moreover, a study by Desalegn Gebre'eyesus (2006) in Benishangul Gumuz Regional State of Ethiopia on communication between high school students and their parents concerning SRH issues shows that most youth do not discuss SRH issues with their parents and preferred to discuss with friends or peers. The study was approached by the mixed method research design with a cross sectional time dimension.

In general, slight studies, to the knowledge of the researcher, informing the importance of family communication for the delay of initiation of adolescents' sexual behavior and notifying the existence of negligible communication between parents and youth on SRH issues have been conducted in Ethiopian schools. Most of these studies were related to assessing the extent or proportion of communication between parents and their adolescent children on issues of sexual and reproductive health. They did not pay attention to the challenges related the communication between adolescents and their parents concerning sexual and reproductive health issues as the major scenario. The studies have been particularly focused on the communications of parents and their youngsters in general and pay no attention to the maturity level of adolescents. For instance, not classifying them in accordance with the grade they are in like primary school, secondary school, preparatory school or higher level education. In addition to this, despite the fact that the aforementioned studies consider both adolescents and their parents views with regard to issues related to SRH's, they did not incorporate knowledge and attitude or views of professionals (might be health care professionals; health extension workers or psychologists) towards their

communication on the identified issues. Provided that family health care providers, and health extension workers, are major actors of family health, their knowledge and attitude with regard to the issue under consideration might add other dimensions. Moreover, unlike Luwaga's (2004) exploratory study concerning Parent Adolescent Communication on Sexuality in the Context of HIV/AIDS in Uganda, and Botchway's (2004) study on Parents and Adolescent Males' Communication About Sexuality in the Context of HIV/AIDS in the Eastern Region of Ghana, which employed a combination of perspectives from interpersonal communication and parenting style as a theoretical framework, other available studies conducted in Ethiopia on the communication of SRH issues did not utilize communication theories or models to best comprehend the nature of SRH communication between parents and their adolescent children.

Hence, in an attempt to fill some of the knowledge gaps discussed above and add to the existing limited literature, this particular study executed cross sectional assessment to gain a complete picture of communication between adolescents and their parents concerning SRH issues among Ayer Tena Preparatory school (11<sup>th</sup> and 12 grade) students, and to have a clear understanding of the challenges related to their communication.

### **Significance of the Study**

The assessment of factors affecting parent youth communication concerning SRH issues among Ayer Tena preparatory school students have significant relevance to social work practice. This relevance can be described in relation to the mission of social work. According to the National Association of Social Workers [NASWs] (1999) Code of Ethics:

The primary mission of social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in

poverty. (p.5)

In line with this statement, this assessment has provide information concerning the patterns of communication between parents and youths on sexual and reproductive health issues, and the determining factors affecting the communication between them. It also has significance to understand school students' exposure to sexual and reproductive health knowledge and related factors with sexual behavior of adolescent.

Since the investigation involved both preparatory school adolescents and their parents to gain a more complete picture of what is actually happening in families regarding communication about sexual and reproductive health issues, it allowed to gain clear understanding of the family adolescent interactions. The study is also useful in advancing our knowledge of adolescent sexual behavior by understanding the influence of parental monitoring on adolescent sexual initiation.

Alongside with another mission of the social work spelled out in the NASW (1999) Code of Ethics: "promoting social justice and social change with and on behalf of clients" (p. 5), assessing parent adolescent communication on SRH issues will help health planners, health service managers and providers, educational bureaus and school administrators in directing further research and in designing interventions to delay the onset of adolescences sexual intercourse among adolescents. The study could be used as a point of reference for another researcher to conduct a research on comparable areas.

### **Objective of the Study**

#### **General objective.**

The general objective of this research was to assess parent adolescent communication on sexual and reproductive health issues among Ayer Tena Preparatory School students of 2006 E.C academic year.

**Specific objectives.**

Determining the extent of communication between adolescents and parents on SRH issues in the study area

Identifying sex preferences of the study area's adolescents towards discussing SRH issues

Exploring major SRH issues preferred to be discussed by the study participants

Finding out where the study area's adolescents' obtain information on SRH issues and their preferred sources of SRH information

Determining factors influencing the study area's adolescents communication on SRH issues with parents

Identifying challenges related to the study area's adolescents SRH communication with their parents and,

Finding out the study area's adolescents and pertinent professional suggestions concerning the manner of improving the communication with their parents on the SRH issues

**Research Questions**

What is the extent of communication between parents and adolescents concerning SRH issues in the study area?

Whom do adolescents prefer to discuss SRH issues when it comes to parents?

What are the major SRH issues preferred to be discussed by the study participants?

Where do the study area's adolescents obtain information about SRH issues and where would they like to obtain?

What are factors influencing the study area adolescents communication on SRH issues with their parents?

What are the challenges that inhibit adolescents' communication on SRH issues with

their parents?

What suggestions do the study area's adolescents and pertinent professionals have to improve the communication with their parents on SRH issues?

### **Description of Variables**

In order to work on the aforementioned research objectives and questions, the following variables were considered.

#### **Dependent variable.**

Parent adolescent communication on SRH issues

#### **Independent variables.**

Based on the available literatures the subsequent independent variables are identified:

Socio demographic characteristics of adolescents [sex, and educational level i.e. grade]

Knowledge of adolescents concerning SRH issues

Attitude of adolescents towards the importance of having discussion on SRH issues with their parents

Socio demographic characteristics of parents [educational status of mother and father]

Sexual behavior of adolescents

Living arrangement of adolescents

### **Definition of Concepts**

**Parents.** Parents in this study mean biological parents, step parents or foster parents but it does not include elder siblings

**Adolescents.** In this study the adolescent implies a segment of the people who are unmarried and whose age fall in the age range of between sixteen and twenty four (16 and 24).

**Communication.** Communication in this particular study refers to the exchange and sharing of knowledge, ideas, and other information concerning SRH issues among adolescents and their parents.

**Communication between parents and adolescents on SRH issues.** In this particular study context parents and adolescents communication regarding SRH issues is a simple discussion or talking which is interactive between parents and adolescents on the following issues: STIs, HIV/AIDS, sexual intercourse, abstinence multiple partners, menarche, unwanted pregnancy and contraception.

**Knowledgeable on SRH.** Those students who score above the mean of the sexual and reproductive health components identified on the questions.

**To say there is communication on SRH.** When adolescents discussed on at least two topics among the above mentioned SRH issues with their parents.

## CHAPTER TWO

### Review of Related Literatures

A literature review is a critical summary of what the scientific research or study says about specific topic or questions (Adams, Khan, Raeside, & White, 2007). This chapter reviews studies relevant to adolescent parent communication pertaining to SRH issues in general. It is intended to convey the message of what knowledge and ideas have been established on a stated topic in general and on specific research questions or study objectives in particular. Besides to discussing it in a logical and coherent way with its strengths and weakness, these literatures have been explained and discussed in relation to the objectives of this particular study.

#### Adolescent Parent Communication

Parent adolescent communication, according to Jerman and Constantine (2010), is a fundamental process through which parents convey ideas, values, beliefs, expectations, information and knowledge to their children. It refers to their communication on a daily basis. A study by Perozzi (2007), conducted in an attempt to examine adolescent drinking and adolescents' perceptions of parental monitoring, communication, and parenting style, informs that family communication is greatly influenced by the extent of parent child interactions and by whom the child interacts. According to him, the degree or extent, types of issues raised and areas/topics of conversation covered are different among mothers and fathers. And it has been suggested that mothers tend to communicate with their adolescent children more often and covers a wider array of topics, where as fathers gives little attention to one-to-one conversation with their children and covers fewer topics on rules, academics and instrumental tasks.

Various studies have been conducted on parent adolescent communication as a significant feature that manipulates adolescent risk behavior. For instance, a study conducted by Koerner and Fitzpatrick (2005) on communication and understanding in parent adolescent relationships have found that parent child communication promotes strong parent child relationships and facilitates child self acceptance. In a causal reverse with this finding, the study also suggests that children who have high self regard and strong relationships with their parents are likely in making themselves more transparent to their parents. In an intention to describe the nature of parent adolescent communication in different types of family systems, as perceived by parents and their adolescent children, a study by Barnes and Olson (1985) indicated the importance of communication between parents and children in facilitating the development of adolescents higher levels of moral reasoning. So long as the sayings of both parents and their adolescent children are separately considered, the study's finding seems irrefutable. Though various studies found the substantial differences in the patterns of mother adolescent communication and father adolescent communication, they did not hide the contribution or importance of both types of communication (mother-adolescent and father-adolescent communication) in terms of counteracting adolescents risk behavior.

Generally, it is assumed that parent adolescent communication contributes for the positive functioning of families; it promotes mutual benefits for all family members, adds to a sense of being confirmed by others which in turn promotes their coordination, and lastly it helps them to address problems holding back families to normal functioning. Yet, many studies concerning parent adolescent communication are roughly about urban populations, in view of the fact that, only few concern to rural population. The contribution of the socio-demographic variables, other than sex, like gender and age should also be investigated to explore their influence in hindering and/or facilitating parent adolescent communication.

### **An Overview of Adolescent Parent Communication Concerning SRH issues**

Parent adolescent communication on SRH issues remains a challenging subject of discussion in many traditional communities as the social environment in them still constrains exchange of information on such issues. For instance, In the work of Bastien, Kajula, and Mohwezi (2011) entitled: Peer Reviewed Literature Published Between 1980 and April 2011, it has been suggested that even while the frequency of discussions between parents and children on SRH issues varies markedly across contexts, their discussion tends to be authoritarian and unidirectional which is characterized by vague warnings rather than direct and open discussions. So far this kind of consultation geared towards one way communication, it turns away from the very nature of discussion and can be labeled as the absence of discussions after all. Similarly, the study by Yohannes Mulugeta (2012) revealed the absence of open discussion between parents and their adolescent children on any issues related with SRH. He rather found one way communication in which some parents tell their children about unwanted pregnancy, HIV/AIDS and other venereal diseases, sexual intercourse, and dating/opposite sex relation in a superficial way or apparently by mentioning any undesirable experience in the community.

In the Dessalegn Gebre'eyesus's (2006) study on parents and their high school student's communication concerning SRH issues in Bullen Woreda of Benishangul Gumuz regional state, 87.7% of adolescent respondents and all thirty two (32) FGD discussant parents reported the importance of having SRH discussion with each other. But only 28.9% of the students discussed with either of their parents on at least two topics of SRH issues; and only two parents, sharing 6% of the total parents, attempted to discuss on a limited number of SRH issues with their children. Correspondingly, the study conducted by Zhang, Li, Shah, Baldwin, and Stanton (2007) in China concerning parent adolescent communication regarding sex affairs reveals that parent adolescent communication on sexual issues was

limited and relatively infrequent. The study employed a survey (self administered questionnaires) on unmarried 682 adolescents of 15-19 years of age, of which 322 were young men and 360 were young women. Even though the study's result is consistent with other comparable study findings, I have identified two major pitfalls; The first one is that the study generalizes the findings from 682 respondents to the most diverse and populous China, and the second is that it only considers adolescents perceptions and did not confess its limitation of not considering insights or views of parents of adolescents under study.

In contrast to the aforementioned discussed findings, a study by Wamoyi et al. (2010) in a rural part of Tanzania shows the existence of some communication concerning SRH issues between parents and their children in most families. According to this study, the prevailing communication was mainly on the basis of same sex, i.e. mother daughter and rarely father son. Even though the study concludes the existence of some communication between parents and their adolescents on SRH issues, the nature of their communication (like specific issues on which they are communicating and frequency of their communication) is not explicitly discussed. Besides this, the study characterizes their communication as it is performed in the form of warning, threats and physical discipline and as these communications reflected the worries parents had about their children's sexual health. But, in the context of this particular study, the kind of communication explained in the Wamoyi's et al. (2010) study is labeled as one way consultation instead of open communication.

In spite of these realities, parents have the responsibility of providing the SRH information to their adolescent children. In corroboration with this premises, a study carried out by Yohannes Mulugeta (2012) in Ethiopia at Garba Guracha preparatory school notifies that parents do support the ideas of providing SRH information to their adolescent children. Compatible with this idea, the study's FGD discussants agree on the importance of SRH discussion with their adolescent children, and suggests that parents should be the first and

foremost sources of information on SRH and related issues for their children at early age of puberty. In addition to this, the FGD discussant parents of Yohannes Mulugeta's (2012) study did not hide their trend of providing vague warnings on the issue instead of creating conducive environment for open discussions. One way consultation in the form of warning is not only confined to this specific study population, rather it represents the majority of our family system.

This study considers parent adolescent communication on SRH issues as a dependent variable. Socio-demographic characteristics of both parents and adolescents, knowledge of adolescent concerning SRH issues, attitude of adolescent towards having discussion on SRH issues with their parents and sexual behavior of adolescents are all considered as independent variables; their contribution in shaping the study's identified dependent variable is also investigated. In the context of this particular study, parent adolescent communication concerning SRH issue is viewed as an ongoing communication between parents and their adolescents on SRH and related issues; two way communication that takes place among parents and their adolescents in which both of them participate in the process. It is also assumed that these communications are direct and the timing, frequency and ways in which such information are exchanged can all affect the SRH communication that would occur among parents and their adolescents.

### **The Effect of Adolescent Parent Communication on Adolescents SRH Behaviors**

Communication between parents and their adolescents in general and their communication on issues related to SRH in particular can have a significant impact on the approach adolescents take to sexual behavior. Many studies conducted on parent adolescent communication on SRH issues overwhelmingly supports the notion that parents are capable of influencing their children's sexual behavior. For instance, a study by Martino, Elliott, Corona, Kanouse, and Schuster (2008) on parent adolescent communication about sexual

topics notifies that a parent have a significant potential to reduce adolescent sexual development. It further informs us that communication of parents with their children on issues of sexual behavior and decision making on related matters is one way through which parents may realize their potential of influencing their adolescent children's sexual behavior. Research on the effects of parent adolescent communication on their children's sexual behavior have shown that sexual socialization is associated with remaining abstinent, postponing sexual intercourse, having fewer sexual partners and using contraception more consistently. Parents play a significant role in the sexual development and behaviors of their children, and SRH communication is considered as a principal means of transmitting sexual values, beliefs, expectations and knowledge between parents and children (Rosenthal, 2007).

Jermain and Constantaine's (2010) study on Demographic and Psychological Predictors of Parent Adolescent Communication About Sex further informs that the study area parents begin discussing sexual topics with their child via verbal and non verbal communication early to convey their standards regarding respect for others, affection, attitudes towards others, and their implicit standards concerning adolescents sexual activities. This is an attempt to influence their children's sexual development through sexual socialization. In addition, a study by Romer, Stanton, Galbraith, Feigelman, Black, and Lee (1999) concerning parental influence on adolescent sexual behavior among African American adolescents living in high poverty urban setting identifies the contact between parents and adolescents as a major protective factor for a wide range of risk behaviors, including early sexual initiation. Romer's et al. (1999) investigation found that adolescents who reported high levels of communication and parental monitoring were less likely to report initiating sex in pre-adolescence (aged < or =10) and reported lower rates of sexual initiation as they aged. Greater monitoring and communication concerning SRH issues and sexual risks was also positively related to the initiation of condom use and consistent condom use. Agreeable with

this, a study by DiClemente, Wingood, Crosby, Cobb, Harrington, and Davies (2001) attempted to examine the associations between the communication that 522 sexually active African American adolescent females aged between 14 and 18 years old have with their parents and their sexual risk behaviors, found out a great association between less frequent parent adolescent communication and their non use of contraceptive. The study employs survey and structured interview. It also demonstrates the importance of parent adolescent communication in an effort to prevent HIV/AIDS and other STIs. A study by Aspy, Vesely, Oman, Rodine, Marshall, and McLeroy (2006) also supports the claim that parents have the opportunity and ability to influence their children's sexual behavior or decisions. Their multivariate analysis revealed that adolescents understudy were much less likely to have initiated sexual intercourse if their parents taught them and openly communicated what is right and wrong, and initiates reciprocal communication about delaying sexual activity. Here, according to the study's findings, if youths who clearly communicate at home with regard to the way to delay sexual activity and how to use birth control with their parents were sexually active, they were more likely to use birth control. Even though the perception of parents of adolescent's understudy was not considered, since other demographic factors of adolescents were controlled, the study finding is very persuasive and it seems highly valid.

In another way, in an attempt to explain the influence of parental monitoring on adolescents sexual initiation with in a context of a cognitive behavioral model, a study conducted by Sieverding, Adler, Witt, and Ellen (2005) shows that adolescents who reported successful parental monitoring significantly expressed less sexual intention, and successful parental monitoring also moderated the effect of positive attitudes towards the intention to initiate and engage in sexual intercourse among female subjects.

According to the Psychodynamic Perspective, early childhood experiences are central in the patterning of an individual's emotions, and therefore, central to problems of living

throughout life (Hutchison, 1999). The perspective asserts that when young people experience feelings of not connectedness to home, family and school, they may become involved in activities that put their health at risk. Conversely, when parents affirm the value of their children, young people more often develop positive, healthy attitudes about absenteeism from sexual intercourse, contraception and how to prevent HIV and other STIs. Hindin and Fatusi's (2009) study on adolescent sexual and reproductive health in developing countries associated teachers' adolescent communication with delayed sexual initiation as well.

Incompatible with the findings of all the aforementioned studies', Yohannes Mulugeta (2012) found no relation between parents and their adolescent children's communication on SRH issues and the sexual behavior of adolescents. According to him, the communication about SRH issues between parents and adolescents did not show any relations with sexual initiation of adolescents. The investigator attached the occurrence of this unusual result to the degree of literacy that the parents have. The inability of the vast majority of parents to transfer basic facts of SRH to their children was raised as a hindering problem.

Another finding by Jerman and Constantine (2010) shows some evidence about the associations between sexual issues communication and parents' socio-economic status. The finding seems persuasive in that the socio-economic status of parents perhaps influence parents literacy level, and the literacy level possibly do the same on their SRH knowledge, and might have influence on parents' ability to communicate with their adolescents on SRH issues.

### **Sources of SRH Information for Adolescents**

The most popular source of information on SRH issues for adolescents are the mass media (i.e. television, radio and the like), health facilities (i.e. the concerned health care professionals), schools, friends, families and various youth clubs. A study conducted by

Kasaye Shiferawu, Frehiwot Getahun, and Getahun Asres (2012) on the assessment of adolescent students communication on SRH issues with parents in Debreworkos town, North West Ethiopia found mass media (i.e. television and radio) and school as a major sources of information for adolescents on SRH issues and weighs 48.3% for mass media and 42.6% for schools. Concerning their preferred source of information, majority (75.9%) of the respondents preferred to have access of SRH information from school, and followed by television (74.3%) and radio (73.4%). Friends and mothers were also selected by 28.8% and 24.3% of respondents respectively as their preferred sources of information. Similarly, Dessalegn Gebre'eyesu (2006) has found school as the most frequent sources of information for 83.3% of his adolescent respondents, and friends as a source of SRH information follow the school by counting 27.6%. In the same study, exactly the same number of respondents who mentioned school as their major sources of information once more mentioned school as their preferred sources of SRH information, and followed by mass media (49.6%), family (38.8%), church (37.2%) and others (3.2%). In addition, according to a study by Abdu (2003) in South Gondar on Perception of the Risks of Sexual Activities Among out-of-School Adolescents, 33.4% respondents reported that school was the most frequent source of their information on sexuality and changes that occur during puberty, and 21.2% of the adolescents mentioned their parents as their source of information regarding the same issues. Radio, parents and other family members, newsletters, pamphlets, peers, health care professionals, and religious leaders are cited as their common source of information on HIV/AIDS.

Alternatively, a study by Luwaga (2004) cited radio and teachers as the most common sources of SRH information as mentioned by parents and their adolescents. In Luwaga's (2004) study, uncles and neighbors were mentioned by adolescent boys and their male parents as their sources of SRH information; but not by adolescent girls and their female parents. This possibly emanates from the expectation of many societies especially of

traditional societies in which women are supposed to hide their so called “personal affairs” like issues related to sexuality and reproductive health, and this in turn possibly contributes to the lack of discussion on SRH issues with their significant others, and other close family members. The adolescents were also not mentioned health workers as their source of SRH information. Nonetheless, the study did not explore how often these various sources are utilized by adolescents. On account of this basis, this particular study deals with the frequency of communication on SRH issues. A study by Bankole, Biddlecom, Guiella, Singh, and Zulu (2007) on Sexual Behavior, Knowledge and Information Sources of Very Young Adolescents in Four Sub-Saharan African Countries (i.e. Burkina Faso, Ghana, Malawi and Uganda) shows that mass media was the most commonly used sources of information about HIV, STI and contraceptives. However, schools and teachers were stated as slightly more frequent sources of SRH information than mass media.

In spite of this, a study by Hindin and Fatusi (2009) notifies that parents were among the most utilized sources of SRH information. Ayalew Tegegn, Mesereet Yazachew, and Yeshigeta Gelaw (2004) cross sectional study on Jimma town adolescents’ reproductive health knowledge and attitude, on the other hand, found mass media (i.e. radio for 80.4% and television for 73%) and school teachers for 71.8% of respondent adolescents as their major source of information on SRH issues. But, the study suggests that the role of health professionals and families as being source of SRH information for adolescents seems low. Provided that adolescents’ parents and/or other family members and concerned health professionals have a vital role in ensuring favorable environment for adolescent’s SRH knowledge, their SRH knowledge and ability to convey it should be improved, and they should be supported to transfer these knowledge.

The cross sectional study conducted by Matziou, Perdikaris, Petsios, Gymnopoulou, Galanis, and Brokalaki (2009) with an aim to evaluate 936 Greek students’ sexual

knowledge, and to identify sources of information concerning their sexual life and reproduction as well founds that students main sources of information on SRH are friends, parents, and school, and weighs 29.11%, 24% and 14.3% respectively. Similarly, A. Rahman, et al. (2011) study on adolescents attending school found friends (64.4%) as adolescents' main sources of SRH information.

Incompatible with what previously mentioned with regard to sources of SRH information for adolescents, a cross sectional survey by Versnel, Berhane, and Wendte (2000) on Sexuality and Contraception Among Never Married High Schools Students in Butajira, Ethiopia informs that among 752 high school students, over half of them mentioned that they had no sources of information on sexuality; only 25.9% of the total respondents mentioned school as their main sources of information on sexuality and related issues. The study also found that students have conservative attitude towards sexuality. Though the investigators assert nothing concerning this odd result, it is supposed that adolescent's conservative attitude on sexuality might negatively contribute to their communication on the issue. This in turn possibly contributes to what the majority of students mentioned as having no sources of information on sexuality and related matters.

Generally, except a study by Versnel et al. (2000) all the above cited studies mentioned mass media, school and teachers as common sources of SRH information for adolescents. Here, it seems that, these structures are replacing the roles to be played by household members. This has an important implication that mass media, school system and/or teachers should be given the necessary support in order to make them principal sources of information for adolescents, especially school adolescents. Doing so would also equip older siblings to be sources of information for their younger siblings.

### **Knowledge and Attitudes of Adolescents on SRHs, and their Sexual Behavior**

Many studies show that adolescents often lack basic SRH information, knowledge and access to health services for their reproductive health. Besides, many adolescents have less favored and do not feel comfortable to discuss SRH issues with their parents, other adults or concerned health professionals.

**Knowledge of adolescents on SRH issues.** A study by Ngrambe (2003) on appraisal of adolescent's reproductive health services in Jinja district, and specifically on the assessment of the level of knowledge of adolescents in seven reproductive health issues reveals that, adolescents were knowledgeable in most SRH issues. A study among Malaysian adolescents whose age was between fourteen to fifteen, also shows that, 50% have read pornographic materials, 44% have seen pornographic images from magazines or videos, and some have done so as early as the age of nine (Lee, 1999).

Likewise, a study by Abdu (2003) in South Gondar, Ethiopia found that more urban adolescents (79.6%) appear to know at least one modern contraceptive than rural adolescents (56.2%); oral contraceptive pills were the most frequently cited contraception as known by both urban and rural adolescents. Urban adolescents mentioned injection and condom as their second and third familiar family planning methods, respectively. Contrastingly, rural adolescents mentioned condom and injection as their second and third familiar family planning methods respectively. Though the proportion of those who have never heard about the epidemic is higher (9.1%) in rural than in urban (1.5%) adolescents, HIV/AIDS is well-known by the majority (94.1%) of the study populations (by both urban and rural adolescents). Only 45% of the respondents know the diseases, other than AIDS, that can be transmitted through sexual intercourse like gonorrhoea, syphilis, lymphogranuloma, venereum and chancroids. There are also differences among urban and rural adolescents in mentioning all the three possible methods of HIV and other STIs prevention (i.e. abstinence, be faithful to

one sexual partner, and condom use); of which 28.3% of urban adolescents and 8.3% of rural adolescents confirmed that they are familiar with possible methods of prevention of HIV and other STIs.

A research by Vermon and Dura (2004) on improving the reproductive health of youth in Mexico reveals that, the better known methods to avoid having children or to delay a pregnancy among adolescents were using condoms, and then contraceptive pills; in which almost all had heard of the condom, and 88% of males and 92% of females had heard of pills. The least known methods were emergency contraception (24%) and withdrawal (28%). More than one half of the study's respondents had also heard about STI including HIV/AIDS.

Hassan and Lema's (1994) study conducted to determine adolescents' level of awareness on STDs, HIV infection, AIDS and contraception in Nairobi, Kenya found that only three diseases, namely gonorrhoea, syphilis and HIV/AIDS infections were mentioned by 70.4%, 56.5% and 54.3% proportions of adolescents under study respectively. The adolescents were also engaged with many and different partners in which 42.4% of these adolescents reported having had sex with two or more partners during the period, and some of whom belonged to the high risk groups for HIV infection as well as STDs. According to the study, the gap in adolescents' knowledge of SRH issues invited, for instance, 37.3% of them to had sexual intercourse with strangers, bar attendants and prostitutes with males more likely to be involved with such individuals. At this juncture, the first step that should be recommended for these sexually active adolescence populations is education with regard to the nature of SRH issues and the risks of unprotected sexual activity and letting them to have communication with their significant others, especially with parents, on the same issues. To be effective in this regard, taking earlier socialization on SRH issues into consideration is of paramount.

A study by A. Rahman et al. (2011) found three related misunderstandings among many school age adolescents concerning pregnancy; the first is that 17% of adolescents mentioned that girls could not become pregnant if they had sexual intercourse only once, the second misconception by the same percent (17%) is adolescents perception as girls could not become pregnant if they washed their vagina after sexual intercourse, and the third fallacy on the same issue by 16.7% of adolescents is that if they have a hot shower after sexual intercourse. However, fortunately, the major (79.8%) students reported sexual abstinence as the best method to prevent pregnancy. This might positively contribute to sexual and reproductive wellbeing of adolescent children, because feeling absenteeism as the best method would in turn prevent them from practicing their wrong attitudes.

Overall, knowledge concerning SRH issues can be considered as influencing factors towards adolescents sexual behavior; without knowledge of SRH issues (for instance knowledge of how HIV is transmitted, knowledge of menstruation cycle, knowledge related to pregnancy and knowledge of where SRH services can be obtained) there is a little hope of healthy adolescents in their SRH traits. Hence, adolescents need to be equipped with basic fact of SRH.

**Attitudes of adolescents towards SRH issues.** According to Ngrambe (2003), adolescents have positive attitude towards discussing unwanted pregnancy, contraceptives and sexual abuse, but did not feel comfortable towards discussing about sex or about having sexual affairs. Similarly, a study by A. Rahman et al. (2011) among Malaysian adolescents who lays fifteen to twenty one (15-21) years of age found that the adolescents had positive attitudes towards having girl/boy friend, and 45% of them had dated, and 9% of them reported having had premarital sexual intercourse.

Abdu's study (2003) in South Gondar, Ethiopia, suggests that only 46% of the respondents agreed that girls could get pregnant the first time she had sex. This kind of

attitude would certainly influence the sexual behavior of adolescents in a way that they do not give a proper attention to the first time sexual intercourse they would have, especially in terms of utilizing methods of family planning. Alongside, the study discovered that a slightly more than half (53%) of adolescents mentioned that someone seeming healthy person could have HIV.

Majority of the studies concerning adolescents' attitudes to sexuality and reproductive health notifies adolescents' stance as conservative towards the issue. For instance, Versnel's et al. (2000) study in Butajira, Ethiopia shows that attitude of adolescents to sexuality is conventional, but liberal to introduction of sex education at secondary schools. The finding also demonstrates that higher percentage of boys admitted that they had exaggerated their response on sexual matters, and girls admitted under reporting.

In general, the available literatures imply the absence of significant differences in the prevalence of SRH knowledge among adolescents in various circumstances. However, slight variations were observed between urban and rural adolescent populations in terms of their knowledge on basic SRHs, their attitude towards various elements of SRH issues like condom use, their self risk protection of acquiring HIV and the occurrence of pregnancy.

**Sexual behavior of adolescents.** The period of adolescence is marked by a transitional stage of development between childhood and adulthood. It is a period in which many adolescents engage in highly risky sexual behavior. It is also a prone period for adolescents in which they are more susceptible to various unwanted health outcomes than adults. For instance, a study by Bankole et al. (2007) shows that, in four sub-Saharan African countries (Burkina Faso, Ghana, Malawi and Uganda) almost one third of eleven to fourteen (12-14) years old girls and boys in Uganda and boys in Malawi have either experienced some form of intimate sexual activity (i.e. sexual intercourse, kissing, fondling or they have had a boy friend or girl friend). In addition, a study on the perception of the risks of sexual

activities among 801 out of school adolescents in South Gondar administrative zone, Ethiopia found 42.6% of sexually active respondents. Among these sexually active respondents one third of them were never married, and urban adolescents shared 43.8% while rural adolescences weigh 42.0%. Overall, the study found that the proportion of sexually active female adolescences (56.5%) was significantly much higher than that of males (23.2%) (Abdu, 2003).

A Jinja district's study by Ngarambe (2005) as well revealed as the mean age of adolescents' first sexual debut was 16.3. Similarly, in the Veron and Dura's (2004) study none of the respondents under age thirteen (13) admitted having had sexual relations/intercourses. However, 10.7% of the study's respondents lying between the ages of ten and nineteen reported that they had had sexual relations.

### **Factors that Influence Parent and Adolescent Communication on SRH issues**

In a study conducted by Bastien, et al. (2011) on literatures published between 1980 and April 2011 concerning communication about sexuality and HIV/AIDS in sub-Saharan Africa, both parents and young people report a number of barriers of open dialogue concerning SRH issues, including lack of knowledge and skills, as well as cultural norms and taboos. Similarly, a study conducted in rural Tanzania puts the communication between parents and their adolescent children on issues of SRH as limited by cultural barriers and lack of appropriate knowledge from parents' side. The study suggests the possibility of parents as being a natural avenue for channeling and reinforcing issues concerning SRH to their adolescent children.

In relation to this, Jerman and Constantine (2010) identified nine types of SRH communication difficulties between parents and their adolescents. The first type of difficulties is related to embarrassment/discomfort. This might be either parents self reported embarrassment/discomfort or perceived adolescent's embarrassment/discomfort. The second

type of difficulties is related to knowledge and self-efficacy. This type of difficulties may emanate from a parent side; fear that come from one's perception that I might explain something poorly or give incorrect information. The third category is labeled as cultural and social influences, which include cultural, societal and social environments, religious and gender influences. The fourth type of difficulty is stated as family and intergenerational influences. This type of difficulty is related to one's thinking that one did not use to talk about SRH issues at home because family never told anything about the subject, and thus attributes what he/she learned as it is acquired at school.

The fifth category, as to the authors' is general communication issues with one's adolescent in which parents' initiate talks about sex, dating and reproductive health and the adolescent not listening. The six one is difficulties related to parental influence or control issues. This is thinking that adolescents are going to do/have it regardless of what parents say and what parents wanting them to be safe and make wise choices. The seventh is difficulties related to accepting one's adolescents' sexuality. This is a thinking related to imagination that having a conversation with adolescents concerning SRH issues lead them to have a sex. The eighth communication difficulty is related to issues of age or development. This hurdle is very much alike to the seventh difficulties; it emanates from parents thinking that their adolescents are not thinking about sexuality and related issues in their head, and then not wanting to put ideas regarding these issues in them. This resulted in being afraid of promoting sex, and being uncertain of the amount of information to provide. The final and the ninth barrier related to weakness in talking about specific topics. This is a difficulty that stem from knowledge gap on basic facts of SRH issues particularly on the parents side.

Even though the above mentioned research by Jerman and Constantine (2010) unambiguously restates findings of many studies concerning barriers of parent adolescent

communication on SRH issues, it however sees the difficulties only from parents dimension; it only examines parent's perception of parent adolescent SRH communication.

A case study by Nundwe (2012) on barriers of communication between parents and adolescents concerning SRH issues in the Kinondoni municipality of Tanzania, on the other hand, found two main barriers for the absence of effective communication between parents and adolescents with regard to SRH issues. The first one is social barriers. One of the social barriers identified by the study's parents is gender; in which all parents of both sexes fail to communicate with their children of opposite sexes on issues like physical development, STIs, puberty and condom use. Mothers prefer to talk with their daughters and fathers prefer to talk with their sons. Thus, according to this study, gender difference is a barrier in which parents feel ashamed to discuss issues of SRHs with the same sex of their adolescent children, because parents think that their adolescent children of the same sex assume them as they want to have an affair with them, and fear that they will direct their children to engage into sexual experimentation. The second type of barriers identified by Nundwe (2012) is cultural barriers. This barrier is seen in two ways; traditional norms and religion. The study participant parents mentioned that traditional norms of their culture were not allow discussion with their children on sexuality based issues, and believed that their cultural norms allow this activity to be handled by seniors or elders like grand fathers, grandmothers, aunts and uncles. Religious belief is a barrier to communication between parents and their adolescents on issues of SRHs like STIs, HIV, early pregnancy prevention as well as condom use in a way that they use statements that are provided in holy books (i.e. Bible and Quran) to guide adolescents in order to avoid sexual risk behaviors. Direct and open communication on basic facts of SRH issue is not customary among religious beliefs, and they even refuse totally to talk with their children about sexual intercourse and condom use.

### **Adolescents Sex Preferences for Discussing SRH issues**

Various studies in developed and developing countries concerning sex preferences for discussing SRH issues on both parents and adolescents showed the very existence of differing sex preferences to talk with. A study by Dessalegn Gebre'eyesus (2006) found that adolescents identified mothers as being more supportive than fathers. In this study, female adolescents reported more discussions about sex related topics with their mothers than did male adolescents. However, males were just as likely to talk with mothers as with friends and only slightly less likely to talk with fathers. Correspondingly, Atienzo et al. (2009) study on parent adolescent communication about sex in Morelos, Mexico informs that communication regarding sex and reproductive health related issues was more common with mothers. Zhang et al. (2007) also found a significant gender difference in the pattern of sexual issues communication between adolescents and their parents; with female adolescents being more likely to talk with mothers and male adolescents with fathers.

Furthermore, findings from review of studies on parent child communication about sexuality and HIV/AIDS in sub Saharan Africa reveals that young people prefer sexuality communication to take place with the parent of the same sex (Bastien et al., 2011). Consistent with this, a study by Fogarty and Wyatt (2006) indicated that mothers are usually the ones who talk about sex with their teens and they tend to be in charge of these conversations especially when they are communicating with their sons. The most interactive conversations, however, take place between mothers and daughters.

In addition to the findings concerning the occurrences of sex preferences among adolescents in communicating about SRHs with their parents, many research on the areas also found that their communication concerning the same issues is provoked by fear of danger among parents. Wamoyi's et al. (2010) study on parent child communication about SRH in rural Tanzania indicated that their communication was mainly on same sex basis (i.e. mother-

daughter and rarely father-son or father-daughter) and took the form of warnings, threats and physical discipline. As stated by the study, instead of taking preventive measures, the communication was activated by basing something a parent perceived negative, i.e. would not like the child to experience such as death attributable to HIV and unmarried young person's pregnancy.

### **Theoretical Framework**

With regard to the generalization of the investigation, the study by Adams et al. (2007) suggests that:

The ability of any research design to produce findings which are (mostly) applicable to other situations, organizations, countries and other people is dependent on the quality of underlying theory which allows us to interpret the 'world' in the context of a given research problem. (p.240)

In line with this bold statement, this study was guided by the theoretical framework of Socialization theory, and Romnetveit and Blakar Communication Model.

Theoretically, socialization theory provides a foundation for the explanation of current study's parent adolescent communication in relation to adolescents SRH behavior. According to Clawson and Reese-Weber, 2003; as cited in Wang, 2009) one of the basic assumptions of socialization theory is that children and adolescents learn certain attitudes and behaviors early in life from adult role models, such as parents.

Socialization theory with its category of sexual socialization also provides an explanation on the process through which young people learn and internalize sexual knowledge, attitude, skills, norms, and expectations for sexual relationships. As to this category of socialization, people learn to be sexual within specific cultures and contexts, and key socializing agents in the development of sexual behavior include families, schools peers and mass media (L'Engle and Jackson, 2008). L'Engle, Brown, and Kenneavy (2006)

suggests that socialization agents differentially impact adolescents' sexual behavior: parents and schools are traditional and largely health promoting socialization agents, while peers and mass media often provide information that accelerates teens' sexual activity (as cited in L'Engle & Jackson, 2008, p. 355).

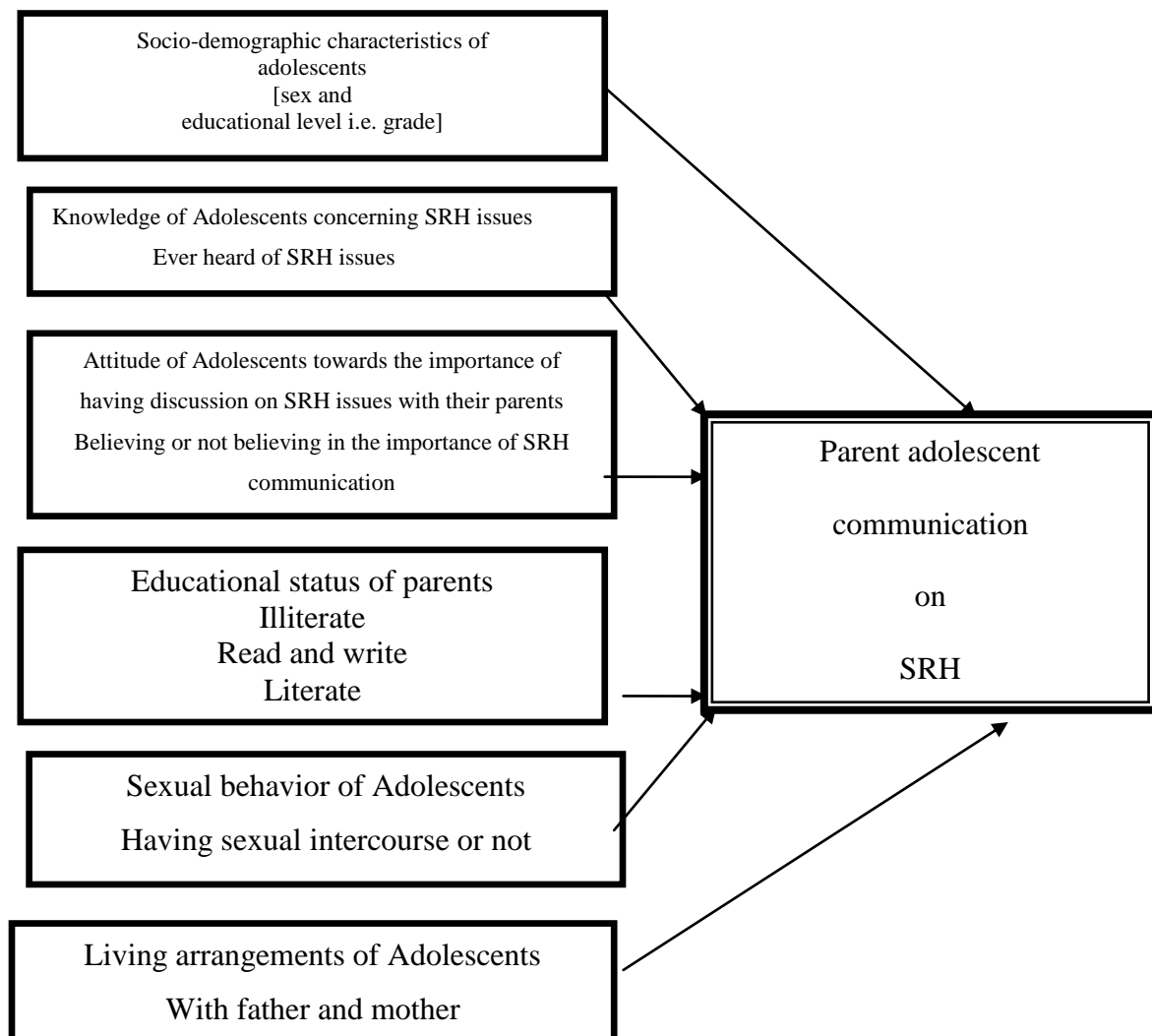
Communication, according to Lunenberg (2010) is the process of transmitting information and common understanding from one person to another and models of communication is a conceptual model used to explain the human interpersonal communication processes. The communication model was adopted into this particular study to explain the extent of SRH communication that takes place between parents and adolescents. The basic SRH communication process that took place and factors affecting their SRH communication were also described by utilizing this model.

The Shannon Weaver's Communication Model is the most influential of all early communication models. This communication model is praised with the identification of the major components of the communication; information source, transmitter (encoder), channel, receiver (decoder) and destination. The major strength of this model is its approximation towards the process of human communications. Its major weaknesses are that it is not analogous to human communication and it is concerned with the linear and unidirectional transmission of information from one location to another (Mortensen, 1972). Later on, in an attempt to improve its relatively linear nature and many other issues of the identified communication model, the Romnetveit and Blakar Communication Model was developed. Botchway (2004) notifies that Romnetveit and Blakar Communication Model have a dialogical perspective to communication in which communication is seen as an interaction between two parties with each having the ability to influence the other. The rationale for adopting the Romnetveit and Blakar Communication Model into this particular study was its

consideration of the communication modus as two way process in which sender and receiver simultaneously plays both roles of the receiver and the sender.

Given the very interpersonal nature of the study's communication, the Romnetveit and Blakar Communication Model was employed as a guiding theoretical framework. The focus was not about studying a broad concept of communication; rather the identified theoretical framework used to understand the nature of the communication between the study area's parents and their adolescent children concerning SRH issues. The major elements of the Romnetveit and Blakar's Communication Model therefore used to analyze and discuss the study results in relation to the available literatures on the issue.

### Conceptual Framework



**Figure 1: Predictors of Parent adolescent communication on SRH issues**

According to John Hopkins Bloomberg School of Public Health (2006), conceptual frame work is a set of coherent ideas or concepts organized in a manner that makes them easy to communicate to others and an overview of ideas and practices that shape the way work is done, and the way it is influenced by the ideas and research of others. Correspondingly, the conceptual framework of this particular study is developed after reviewing literatures relevant to the topic, and a simple linear association is considered. As illustrated below, parent adolescents communication concerning SRH issues is affected by socio-demographic characteristics of adolescents (like sex, age, educational level i.e. grade), knowledge of adolescents concerning SRH issues (ever heard of SRH issues), attitude of adolescents towards having discussion on SRH issues with their parents (believing or not believing in the importance of SRH issues communication with their parents), educational status of parents (whether they are illiterate, can read and write or literate), and sexual behavior of adolescents (having sexual intercourse or not). Living arrangements of adolescents (living with their father and mother or with at least one of their parents) is further associated with parent adolescent communication concerning SRH issues

## CHAPTER THREE

### Research Methodology

This section deals with the research design and data collection methods used to answer the research questions. They were explained along with their various steps and procedures, and with the rationale behind employing them in the context of this particular study.

#### Study Design

In an attempt to answer the proposed research questions, the study employed mixed research design with a cross sectional time frame. It tries to address the descriptive function. Both quantitative and qualitative types of data were collected and analyzed in an integrated fashion. The very rationale for choosing the mixed method research strategy for this particular study lies in the fact that integration of both quantitative and qualitative methods allows to come through the respondents objective and interpretive views. This in turn contributes much for the inferences of the study results. Among the mixed methods strategies, the sequential explanatory strategy was utilized for the purpose of this particular study. According to the Creswell (2007), “The sequential explanatory strategy is the most straightforward of the six major mixed methods approach characterized by the collection and analysis of quantitative data followed by the collection and analysis of qualitative data” (p.245). In accordance with this statement, both the quantitative and qualitative data were collected, and then their implementation was in a sequential (phase) ways. The priority was given for the quantitative type of data and integration occurred at an interpretation and discussion phase with some combinations.

### **Purpose of Mixing Quantitative and Qualitative Research Approaches**

The very rationale of employing mixed research method in this study was to expand an understanding from one method to another, to converge or confirm findings from different data sources. Additionally, it is more preferable than quantitative or qualitative method in measuring the variables under the study, answering the research questions and in addressing the objective of the study. The reason for using quantitative type of data for this particular study is to increase the generalization of the research findings. It was thus, employed with an intention to capture the major dimensions of heterogeneity within the population and increases the degree of inferences of the findings.

According to Barron, Diprose, Smith, Whiteside, and Woolcock (2008), “Qualitative investigation is used to verify the accuracy of matches identified through quantitative techniques in order to ensure that they reflected realities on the ground” (p.7). In line with this, qualitative type of data was collected in this particular study to assist in explaining and interpreting the findings of a quantitative data. The qualitative methods also helped to remain open to unexpected findings.

### **Study Area Description**

The study area was Ayer Tena preparatory school in which 11<sup>th</sup> & 12<sup>th</sup> grade level of education is delivered. Ayer Tena preparatory school is located in the Southeastern part of Addis Ababa city administration within Kolfe Keraneyo sub-city, about 13 kilometers far from Piazza. Ayer Tena preparatory school is one of the two governmental preparatory schools in the Kolfe Keraneyo sub city having 2190 students, out of which 917 and 1273 are male students and female students respectively. These students were attending their preparatory courses in 38 sections (HaileGebriel Berhanu, personal communication, January 2, 2012).

### **Study Participants**

The study populations for this particular study were all adolescents attending preparatory (11<sup>th</sup> & 12<sup>th</sup> grade) level of education in Ayer Tena preparatory school in 2006 E.C academic year. The study subjects were students enrolled in preparatory education (11<sup>th</sup> and 12<sup>th</sup> grade) in the academic year of 2006 E.C, and were selected from the study population using systematic probability sampling.

**Inclusion criteria.** All unmarried adolescents who fall in the age range of 16-24 years and attending the regular (day time) preparatory level of education in Ayer Tena preparatory school were included.

**Exclusion criteria.** Respondents who were unable to fill the questionnaire without assistance, except those with some impairment were excluded. Adolescents' who were not willing to give an informed consent, mentally ill, unconscious and have difficulty of communication at least at the time of data collection were also excluded from being respondents.

### **Sample Determination and Sampling Procedure**

**Quantitative part.** With an intention to collect quantitative data from the respondents, the sample size for the study (n) was determined using a single population proportion technique and the following assumptions were considered: The proportion of parent adolescent communication on SRH issue was taken from the result of the similar study conducted among Dire Dawa high school students with 36.8% proportion of communication. Accordingly, the N is =2189, P is = 36.8% = 0.368, and Q is = 63.2% = 0.632. Level of confidence, 95% ( $Z_{\alpha/2}$ ) = 1.96, 5% margin of error (d= 0.05) was considered, and an additional 10% was also taken in to account for possible non response rate.

$$\text{Hence, the sample size (n)} = \frac{(Z/2)^2 P (1-P)}{d^2} = \frac{(1.96)^2 * (0.368) * (0.632)}{(0.05)^2}$$

$$n = 357$$

By taking the non response rate of the previous studies conducted on parent adolescent communication concerning issues of sexuality and reproductive health into account; that is 2.4% and 7.8% among high school students in Dire Dawa administrative council and Benishangul Gumuz region's Bullen woreda respectively, 10% of non response rate was taken for this particular study.

The selection of study respondents was conducted first by classifying each grades into two strata, 11<sup>th</sup> and 12<sup>th</sup> grade, and then gender strata in each grade (i.e. male adolescent and female adolescent). This means there were four strata: grade 11<sup>th</sup>-male, grade 11<sup>th</sup>-female, grade 12<sup>th</sup>-male, and 12<sup>th</sup>-female. The selected two grades have clusters of sections; grade 11<sup>th</sup> and 12<sup>th</sup> had sixteen (16) and twenty two (22) sections respectively. Thereby, all adolescents in these grades (then sections) had equal chance to be a participant in the selection process. The population parameter (the total number of students) is known, and the sampling frame was prepared from the already existing students' registration book in the respective school's record office. The required sample size from each grade and section was proportionally allocated to the number of students within each grade and section. Both male and female students were included in the sample according to their proportion in the respective grade and then their section.

Finally, one of the probabilistic sampling design; systematic sampling technique was applied to select a sample from the sampling frame that represents the target population. Accordingly, every 'n<sup>th</sup>' element (the interval is determined by the size of the sample needed) was picked until the required sample size reached. The first student was taken by lottery method. It was attempted to keep the strata uninterrupted, at the time of data collection; in the case of absenteeism, the student in the next number was incorporated.

**Table 1: Number of study participant adolescents by grade level, stream of study, gender and number of sections (N=2190)**

Grade	Streams of study						Number of sections
	Social science			Natural science			
	M	F	Total	M	F	Total	
11 <sup>th</sup>	8						16
	1	191	272	391	431	824	
12 <sup>th</sup>	M	F	Total	M	F	Total	22
	8	174	256	391	448	839	
2							

Source: Ayer Tena Preparatory School

Finally, samples of 393 adolescents in the four strata were made ready for the data analysis.

**Qualitative part.** In order to deal with the qualitative part of this study, interview with adolescent population's and relevant health professionals working with adolescents was employed as techniques of data collection. The interview with adolescents and pertinent health professionals on SRH issues were conducted. Semi-structured interview was with some of the selected adolescents understudy, and with two health professionals i.e. the youth center's counseling service provider (who has Bachelor of Arts degree in Psychology) and health extension worker (who has certificate of health extension work). The two health professional were also seen as key informants of the study. The numbers of adolescent interviewee were ten; and this number was determined with an assumption that there might not be very complex heterogeneous ideas from adolescents concerning the issues understudy.

Taking the very personal nature of issues under consideration into account, in the process of interview with adolescents the concept of consent was applied in its fullest sense. Here, parents or legal guardians of adolescents were not contacted for their authority is

replaced by the school authority while the students are in the school compound. Instead consent and permission were received from the school. This helped to increase the quality of information and generate a great deal of it on the issues. The interview process was held by the researcher. Notes were taken and a tape recorder was used after having approval of interviewees so that not to miss the information in the interview session.

Those adolescents who fulfilled the following criteria were selected for the interview; adolescents who were members of the population under study; but not being selected for the survey; who were within the age range of adolescent as per the study; and not fearful in exposing their personal information with regard to SRH concerns; and lastly who showed their consent to talk about their SRH experiences concerning the SRH communication they have with their parents and challenges they face in doing so.

### **Data Collection Instruments and its Procedures**

**Types of data collected.** In order to meet the objectives of this particular study primary data: both quantitative and qualitative types of data were collected.

**Data collection instruments and its procedures.** Survey and interview techniques were employed for the purpose of data collection. Questionnaire and interview guides were used as tools of data collection. A questionnaire holding close ended questions was designed to collect quantitative data. Qualitative data was gathered from the selected adolescent interviewees and health professionals via questions on interview guides. Quantitative data collection instrument was developed in relation to the research objectives of this particular study by revising relevant literatures, and by adopting with slight modifications from questionnaires developed for comparable studies. Questions on the interview guides of the qualitative data, on the other hand, were derived primarily from the study objectives or research questions intended to be replied qualitatively, and from an intention to substantiate the quantitative data.

*Questionnaire.* Because of the sensitive nature of the issues under study, self administered questionnaire was preferred to minimize bias and distortion that often resulted from the use of face to face interview. The main contents of the questionnaire include socio-demographic characteristics of both adolescents and their parents, knowledge of adolescent respondents on selected SRH issues, attitude of adolescent respondents towards major selected SRH issues, and items concerned with the communication between parents and adolescents on SRH issues. Four data collectors who had completed 10<sup>th</sup> and 12<sup>th</sup> grade education having previous experience in data collection and who are able to speak, write, read and listen Amharic language were appointed, and orientation was given on the specific data collection techniques. After the researcher adjusted the potential respondents number in terms of grade and gender, orientation about the study was delivered by dividing the potential respondents in to two rough groups; one in the library hall and the other in the school's sports ground. It was after this that the school's staffs (the school's unit leader and coordinator of the school's HIV/AIDS club) arranged 35 minutes immediately after students' tea break in order to manage the questionnaire. The Amharic version questionnaires were filled in the respondents' respective sections and it was done in a way that the teaching and learning process was not being affected. Assistance was given for the participants by the data collectors and other peers following their request. The minimum time to complete the questionnaire was 28 minutes and the maximum was 42 minutes.

The principal investigator of the study supervised the data collectors throughout the data collection. There was no non response rate. However, of 393 sample sizes, including the expected non response rate, 40 samples were identified as having various degrees of missed data. By giving a weight for each questions (items) in the questionnaire, their extent of missing up data were categorized in a percent. The questionnaires having greater than 5% missed data were rejected. Accordingly, among 40 questionnaires 18 were discarded and the

rest, which considered as having tolerable extent of missed data, were entered to EPI INFO and exported to SPSS along with other questionnaires. Of the total 393 samples, the number of questionnaires analyzed therefore, weighs 375; this gets ahead the originally calculated sample size i.e. 353 samples.

**Interview.** An interview, as a second type of data collection instrument was used. It was utilized to collect information from selected adolescents of the population understudy; the youth center's counseling officer, and health extension worker in the surrounding study area.

Alston and Bowles (2003) divide the method of collecting information through personal interview into three dimensions; structured interviews, semi-structured interviews, and in-depth interviews. A structured interview involves the use of a set of predetermined questions and of highly standardized techniques of recording. The authors' labeled this type of interview as questionnaires conducted by an interviewer and as it follow the same principles of questionnaires. In an attempt to ensure that every interview is conducted as similarly as possible, an interviewer using structured interview should try to use exactly the same wording, prompts and tone of voice for each interview. Semi-structured interview is explained by the authors as an ideal research instrument for exploratory and descriptive designs and as it fall somewhere between structured and in-depth interviews. It contains many open ended questions and probes. In a semi-structured type of interview, the interviewer is usually allowed to explore additional information that the respondent would raise and to ask other questions not originally included in the interview schedule. The third and last type of interviews, in-depth interview, is the most flexible type of instrument and is used in qualitative research. This type of interview enables us to focus on the given experience of the respondent and often seen as being more of a discussion ideally guided by the respondent rather than the interviewer.

Among the aforementioned interview methods, semi-structured type of interview best fitted with the all interviews conducted in this study.

*Interview with selected adolescents.* Unlike many other studies in the country on parent and adolescent communication concerning the SRH matters, this study employed in-depth interview with adolescents under study. Interview guide was used to facilitate the discussion. It was conducted with an intention to address some issues which were unreachable by quantitative data, and with a purpose to collect unquantifiable information like the way SRH issues are discussed between parents and their adolescent students in the study area, adolescents' perception regarding challenges related to the communication with their parents on the SRH issues in the study area, and adolescents' suggestions concerning the manner of improving the communication with their parents on the SRH issues in the study area. It was held to be open to new ideas relating to the issue understudy. Besides, it also helps to triangulate research findings gained through survey and also served as a tool to check the reliability of their answer.

*Interview with the youth center's counseling officer.* Different from other similar studies conducted on SRH issues, this particular study used interview with the practitioners of youths SRH (i.e. the youth center counseling service officer) with an intention to bring other dimensions to the proposed research questions of the issue understudy. These health care practitioners were seen as key informants. The process was started by identification of the concerned youth's health care practitioners, and staffs from the study area youth center which is located in the Wereda <sup>1</sup>4 administration of Kolfe Keraniyo sub city. Among other community health care practitioners, Youths Counseling Service Practitioner from the

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<sup>1</sup> *Woreda* is typically to mean districts. It is the third-level administrative division of Ethiopia which composed of *Kebelles* (the smallest unit of government structure in Ethiopia) and managed by a local government.

identified youth center was believed to provide plenty of information concerning the communication between adolescents and their families on SRH issues. After having consent from this individual, a brief interview was conducted. Subsequent to assuring that he (the youths counseling service practitioner) have information concerning SRH issues, particularly issues related to the communication between adolescents and their parents on SRH, open ended questions directly pertinent to the study's research questions, especially to qualitative research questions was served as a medium of interview. The conducted semi structured interview was revolved around general information like their view on the extent of SRH communication between adolescents and their parents, the kind of SRH issues discussed between adolescents and their parents, adolescents sources of information on SRH issues, and works needs to be done to enhance their communication on SRH issues.

*Interview with the health extension worker.* Provided that health extension workers are the one who are very much involved with families, particularly for consulting health related issues, the questions with regard to the general information on sexual and reproductive health issues were asked in a semi structured way. The process of data saturation was treated in a way that the researcher continued collecting data from the interviewees until the point at which no new insights were obtained.

The very reason for not conducting FGD among the study's adolescents was that the data generated via interview can answer the research questions expected to capture by qualitative investigation. Another reason for using interview instead of FGD was that interview as an instrument of data collection is free from some problems listed by Adams et al. (2007) as they can occur in the process of FGD. One is silence of discussants from participation due to shyness. The second problem is related to domination; one or two people may dominate the entire discussion. The third and the last problem of FGD as identified by the authors is 'group think' which can occur where discussants fall into line with the group

view and resulted due to their fear of humiliation from being contradicted by other members of the group.

### **Data Quality Assurance**

According to Adams et al. (2007), three criteria's namely reliability, validity and generalization are generally used for testing and evaluating measurements of variables and ensuring the quality of data, research design, and the overall accuracy of study results. Accordingly, in order to ensure the reliability of the questionnaire or the consistency of measurement, pre-test method was applied. The questionnaire was pretested prior to actual data collection in a similar setting (among another preparatory school students) to ensure understandability and consistency of the questions for respondents. Accordingly, six percent of the sample (i.e. 23 questionnaires) was pretested in Yekatit 12 preparatory school. A pre-testing discussion was held with the students on the problems they encountered in filling out the questionnaire. For instance, In order to assess knowledge of adolescents on selected SRH issues, students were asked, via the questionnaire, asked the kind of STIs they were aware of. Some of the students in the pre-test filled the blank space prepared to explore a kind of STIs they know beyond those specified in the questionnaire by saying "I do not know". This obliged me to add other 'Yes or No' questions, i.e. I felt that before asking the kind of STI they were aware of, I have first make sure either they know it or not. Another adjustment was on the skipping patterns. The participants of the pre test survey detects that the skipping arrangements of the questionnaires were not correct.

The finalization of the instrument therefore considers the remarks and corrections recommended by the students during pretesting. These instruments were designated in English and translated into local language (Amharic) and back to English to validate that their original meaning was maintained [this was done by a well experienced personnel on the comparable research of SRH issues and having Master degree in Public Health (MPH) and

BA in Environmental Health]. At the last, Amharic version questionnaires were distributed for respondents. An Amharic version interview guides holding open ended questions were prepared.

Because of the fact that the concept of validity is routinely used in quantitative research, and disliked by many qualitative researchers, Onwuegbuzie and Johnson (2006) concluded that the use of the word validity in mixed research can be counterproductive. Instead, they recommended that the concept of 'inference quality' be used as the mixed research term for validity to denote the generalization of the findings. Building on the 2006's work of Onwuegbuzie and Johnson, the degree of inferences of this particular study was at least depend on its subsequent characteristics: (1) Descriptions and statistical generalizations were made from the quantitative and qualitative data obtained exactly from the same respondents, (2) As to the authors, both the inference quality and generalization would likely be poorer if the quantitative sample is non random. Contrastingly, this study's sample selection was carried out based on probability type of sample selection. This made the inference quality higher. (3) A researcher was not so involved with the group understudy. This minimizes the degree to which the researcher holds bias and determines the degree to which accurately presents and utilizes the respondents view. (4) Quality of the inferences was also heightened in that the weakness from one approach was compensated by the strengths from the other approach. In addition to this, content validity was conducted to find out if the questions were representing what they were intended to measure in a proportional way. In doing so, the components of SRH issues and other variables intended to be measured were well identified and defined and then the proposed questions were given to a well experienced personnel on the comparable research of SRH issues.

The quality of the qualitative data, on the other hand, was assured by different mechanisms. First, each item of the interview guides were commented by the advisor and

some items were discarded since the items were either repeated or unrelated with what was intended to measure. Thus, trustworthiness was assured by avoiding double barreled, long and complex questions. Efforts were also made to avoid leading questions and false premises. In line to this, three peers were invited to comment and debrief on the prepared questions (Peer debriefing). The data quality was also ensured via building good rapport, orientation given for data collectors with regard to the purpose and procedures of the data collection. Completeness of the data was checked immediately after data collection and any incomplete questionnaire was rejected.

**Triangulation technique.** The term triangulation is defined by Harper and Marcus (2003) as a technique of finding out where something is, by looking on it from two or more places. This holds the idea of looking at the same thing from different points of view and in different ways. In accordance with this definition of triangulation, it was conducted with an intention to confirm the trustworthiness of the data by applying multiple sources of data; questionnaire with randomly selected respondents, interview with the adolescents from the unit of analysis understudy, and another interview with the suitable health professionals.

### **Data Analysis and Interpretation Procedure**

**Analysis method for quantitative part.** Bhattacharjee (2012) notifies that descriptive analysis refers to statistical description, aggregation and presentation of the results or findings or association between these findings and results, where the authors refers inferential analysis as the statistical testing of association between variables. It is explicitly used to reach conclusions about associations between variables. Basing these definitions, the very nature of the topic and research questions of the phenomena understudy led to employ descriptive and inferential analysis.

After the collection of both quantitative and qualitative data, its completeness and consistency was checked. Data was entered using EPI INFO Version 3.5.4 computer software.

Prior to actual data entry five percent of responses were randomly selected and checked for the consistency. Lastly, data was analyzed using Statistical Package for Social Science (SPSS) Version 20 computer application program. The results of analysis were reported using frequency, tables, proportion, and odds ratio for association. In order to determine the general properties of one variable and association between two or more variables; univariate analysis, binary logistic regression and multiple logistic regressions with a 95% confidence interval was employed. The statistical significance or the maximum level of risk during inference from the sample to the population was less than 0.05; denoted as p-value  $P \leq 0.05$ . Univariate analysis (descriptive statistics) in which a range of properties of one variable (for instance demographic data) was analyzed and reported by using frequency distribution, measures of central tendency (mean), as well as measures of dispersion (standard deviation and range). In the case of bivariate analysis, crude odds ratio was employed to see the association of single independent variable and dependent variable. In doing so, the properties of both independent and dependent variables were considered in relation to each other; for instance, the association between adolescents attitude towards SRH communication with their parents and the communication between adolescents and parents concerning SRH issues. In the case of multi variate analysis, adjusted odds ratio was employed to see the association of multiple independent variables and dependent variable. Prior to performing data analysis using multiple regression models, a test was conducted to determine if assumptions of linear regression were met.

Even though there was no non response rate, of 393 sample sizes, including the expected non response rate, 40 samples were identified as having various degrees of missed data. By giving a weight for each questions (items) in the questionnaire, their extent of missing up data were categorized in a percent. The questionnaires having greater than 5% missed data and with gross incompleteness and inconsistency were rejected. Accordingly,

among the total 393 samples 15 questionnaires were discarded and the rest 378 were entered to EPI INFO version 3.5.4 and exported to Statistical Package for Social Sciences (SPSS). The number of questionnaires analyzed therefore, weighs 378; this gets ahead the originally calculated sample size i.e. 357 samples.

**Analysis method for qualitative part.** The qualitative information from interview was transcribed by the investigator in Amharic language (local language). It was done word for word from the audio recordings. An effort was also made to make the English translations less inaccurate in relative to the original statements. Various speech figure or body languages, for instance, expressed by adolescent interviewees were confronted in the translation process.

The process of analyzing qualitative data was started by coding, classifying and categorizing the obtained text data from interviewees via note taking and tape recording, into concepts or codes. The qualitative data acquired from adolescent interviewees and family health care professionals were coded, classified and categorized separately. Bhattacharjee (2012) describes the existence of three coding techniques for analyzing text data open, axial, and selective. The study employed open coding technique in which the researcher identifies, and name concepts with text and data to explain the phenomenon understudy.

Thematic guides were served as a primary references for all the interviews held with selected adolescents, the youths counseling service practitioner and health extension worker. The thematic guides contained an outline of topics and sub topics explored during the interview. They were developed by the researcher and then subjected to peer review and sent to the investigator's advisor to validate its content. It finally resulted in modifications, including rewording to make items more understandable. The interviewer used his personal discretion to determine how to closely follow the guide or how strongly to pursue an individual respondent's answer. Probing questions were also used to guide to important directions and to enable participants to elaborate on their opinions. The researcher was also remained open to and tried to seek new concepts important for the qualitatively posed questions in particular and to the study in general.

Though probes did not led to new insights which were not incorporated in the preliminary themes, they were very valuable in collecting the required information in accordance with the already produced themes. The final qualitative result was used to assist in explaining and interpreting the findings of a quantitative data.

### **Integration Plan**

In an attempt to establish an ongoing dialogue between the two types of data, integration was took place at analysis and interpretation phases of the study in which the results from quantitative data that was collected via questionnaire's structured questions was compared with the qualitative themes established from the findings of both in-depth interview with selected adolescents and semi-structured interview with family health practitioners.

### **Human Subject Protections**

Ethical approval and clearance was obtained from Addis Ababa University Graduate School of Social Work. Responsible officials at all levels were contacted and permission was obtained. Once it was permitted, the general purpose of the study, their right to decide whether or not to participate on the study without any penalty or negative consequences, the time of duration, the participants right to stop at any time they want were carefully described for the adolescents so that they can feel free and decide to participate or not. The study units were also informed that the information they release was confidential. The questionnaires were thus, filled by each respondent in a separate place thereby the privacy of participants and confidentiality of the information was kept. Generally, the study was conducted after the aforementioned explanations were briefed and then the quantitative respondents' written consent, and interviewees verbal consent was acquired.

## **CHAPTER FOUR**

### **Findings of the Study**

In this chapter the raw data of quantitative figures and qualitative information are presented according to the theme developed during the data collections and analysis. The data collected from questionnaire, interviewee adolescents, and interviewee professionals represents study participants' perceptions on communication between adolescents and their parents concerning SRH issues. The qualitative data obtained through interview is coded, categorized and developed into themes. The major findings of the qualitative part are presented within six sub topics. Some of the responses which the researcher felt were exemplars of the views under consideration have been presented in the text. Both the quantitative and qualitative data presentation began by presenting the socio-demographic characteristics adolescents who participated in the survey and interview process. A summary of the key quantitative findings will also be presented.

## Quantitative Data Results

### Socio-demographic characteristics.

#### *Socio-demographic characteristics of adolescents.*

**Table 2: Socio-demographic characteristics of adolescents**

Components of adolescents		
socio demographic characteristics	Number (n=378)	Percent (%)
Sex		
Male	170	45
Female	208	55.0
Age		
15 – 19	325	86.0
20 – 24	52	13.8
25 – 29	1	0.3
Educational level		
Grade 11	189	50.0
Grade 12	189	50.0
Ethnic Group		
Oromo	110	29.1
Amhara	125	33.1
Tigre	37	9.8
Gurage	85	22.5
Others*	21	5.6
Religion		
Orthodox	250	66.1
Muslim	77	20.4
Protestant	46	12.2
Catholic	2	0.5
Others**	3	0.8
Living Arrangement		
Father and Mother	290	76.7
One parent	44	11.6
Relatives	35	9.3
Friends	5	1.3
Alone	4	1.1

NB: Sample size varies due to missing response, analysis done on valid n = 378.

Others\*= refers to ethnic groups other than those stated in the structured questions like *Silte*, *Gamo* and *Sidama* ethnic groups.

Others\*\*= Indicates the number of adolescents who are not affiliated to any religious groups.

A total of 393 adolescents were involved in the study. Though there were no non responses, 15 responses/questionnaires were discarded for their gross incompleteness and

inconsistency. Thus, analysis was made based on 378 completed questionnaires making response rate of 96.2%. Out of 378 adolescents considered for analysis 189 (50.0%) were from 11th grade and exact the same number, 189 (50.0%), were from 12<sup>th</sup> grade. Concerning the sex composition of the study participants, two hundred eight (55.0%) and one hundred seventy (45%) were female and male respectively. The mean ( $\pm$ SD) age of respondents was 18.3( $\pm$ 1.2SD) with the minimum and maximum age of 15 and 28 years. Median age was 18 years. Regarding the ethnic group of respondents, 125 (33.1%) were belongs to Amhara ethnic group, and followed by 110 (29.1%) which were belongs Oromo ethnic group. Two hundred fifty (66.1%) of the study respondents' religion was Orthodox Christian followed by 77 (20.4%) Muslim religion followers. Two hundred ninety (76.7%) of participants were living with their biological parents (i.e. father and mother) (Table 2).

*Socio-demographic characteristics of parents.***Table 3: Socio-demographic characteristics of adolescents' parents**

<b>Components of parents socio demographic characteristics</b>	<b>Frequency (n=469)</b>	<b>Percent (%)</b>
Marital status of parent		
Together	297	78.6
Live far apart	23	6.1
Divorced	21	5.6
Widowed	37	9.7
Perceived monthly Income of parent in Birr (n=367)		
100 – 1500	6	1.6
1600 – 3000	7	1.9
3100 – 4400	8	2.2
>4400	48	13.1
Don't know	298	78.8
Family size (n=370)		
1 – 5	155	41.9
6 – 10	201	54.3
11 – 15	11	3.0
16 – 20	3	0.8
Educational level of father (n=371)		
Illiterate	14	3.8
Read and write	53	14.3
Primary (1-8)	71	19.1
Secondary (9-12)	75	19.8
Diploma	51	13.7
First degree and above	104	28.0
Other*	3	0.8
Educational level of mother (n=373)		
Illiterate	41	11.0
Read and write	74	19.8
Primary	82	22.0
Secondary	84	22.5
Diploma	45	12.1
First degree and above	45	12.1
Other*	2	0.5
Occupation of mother (n=371)		
House wife	142	38.3
Government employee	54	14.6
Private employee	79	21.3
Merchant	90	24.3
Others**	6	1.6
Occupation of father (n=373)		
Has no work	7	1.9
Government employee	96	25.7
Private employee	155	41.6
Merchant	103	27.6
Others**		

Others\*= Educational status like technical and vocational training which were specified as level I,II,III.  
 Others\*\* = Occupation such as tailor, security or guard, driver, work in small scale industry.

The majority of the respondents' parents 297(78.6%) were married. Three hundred sixty one (96.8%) of respondents fathers and 223 (60.2%) of mothers were employee in which they are engaged in different income generation activities. One hundred forty two (38.3%) mothers were house wives. One hundred fifteen (30.9%) of respondent's mother had no formal education (in the status of illiterate and only read and write) while fathers who holds first degree and above (104) (28%) exceeds mothers holding the first degree and above (45) (12.1%) in greatan two times (Table 3)

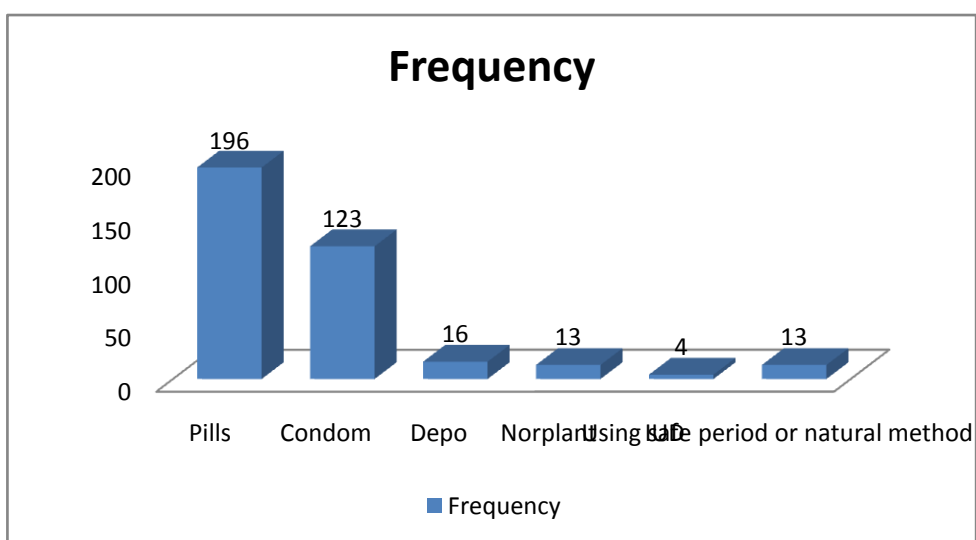
### **Knowledge of adolescents regarding selected SRH issues.**

**Table 4: Knowledge of Adolescents Regarding Selected SRH Issues**

<b>Components of SRH knowledge</b>	<b>Number</b>	<b>Percent (%)</b>
Ever heard of reproductive health		
Yes	365	96.6
No	13	3.1
Do you know about sexually transmitted infections		
Yes	369	97.6
No	8	2.1
Types of sexually transmitted infections		
HIV/AIDS	273	72.2
Chancroid	10	2.6
Gonorrhea	83	22.0
Syphilis	3	0.8
Do you know about contraceptive method		
Yes	365	97.3
No	10	2.7
Do know when menstruation cycle starts (female only n=208)		
Yes	198	95.2
No	10	2.6
Age at the onset of menstruation cycle (n=198)		
9 – 13	95	48.0
14 – 18	103	52.0
Do you Know Physical and behavioral changes during puberty		
Yes	352	93.1
No	9	2.4
Attributes of Physical and behavioral changes during puberty		
Breast development in female	306	81.0
On set menstruation in females	23	6.1
Change in voice in both sex	19	5.0
Refuse parent command	6	1.6
Interest towards opposite sex	21	5.6
Feel angry for minor reasons	2	0.5

From the total 378 respondents 369 (97.6%) knew STIs. The most commonly known STIs among adolescents was HIV/AIDS which accounts 273 (72.2%) number of adolescents followed by Gonorrhoea, maintaining 83 (22.0%) respondents. From the 208 female adolescent respondents almost all, 198 (95.2%) mentioned that they know the age at initiation of menstruation cycle. Accordingly, More than half 103 (52.0%) female adolescents responded that menstruation cycle started between the age of 14-18 and the remaining 95 (48.0%) of them replied as its onset is between the age of 9 and 13.

Regarding the physical and behavioral changes during puberty, 736 (78.6%) of respondents knew the physical and behavioral changes occurred during the period of puberty. The most commonly known physical and behavioral changes during puberty among the respondents was breast development in female 306 (81.0%) followed by the onset menstruation in females and change in voice in both sex 23(6.1%) and 19 (5.0%) respectively. Feeling angry for minor reasons was the least mentioned 2 (0.5%) physical and behavioral change characteristics among the adolescents. Questions revolving on sexual desire and interest towards opposite sex and refusing parents commands were also incorporated to measure physical and behavioral changes during puberty (Table 4).



**Figure 2: Adolescents knowledge about contraceptive method**

Contraceptive methods were also known by 365 (97.3 %) adolescents out of 378 adolescent respondents. The most commonly mentioned contraceptive methods by respondents were pill, keeping 196 (51.9%) adolescents and followed by condom which counts 123 (32.5%) adolescent respondents (Figure 2).

### First source of information on SRH issues.

**Table 5: Adolescents first source of information on SRH issues**

About sources of SRH information	Number	Percent
<b>Ever heard of reproductive health</b>		
Yes	365	96.6
No	13	3.1
<b>First source of information about SRH issues</b>		
Mass media	248	65.6
Parents (Father and Mother)	42	11.1
Brothers and sisters	9	2.4
Relatives	16	4.2
Other sources*	1	0.3

*Other sources\*= Indicates one adolescent's responses of mentioning 'Religious leader'*

Majority of the students 365 (96.6%) have been heard of issues related to SRHs. The most frequently mentioned source of information for SRH was mass media 248 (65.6%). Though parents (father and mother) appear as a second source of information, it only counts 42 (11.1%) adolescents; about six times less than mass media (Table 5).

**Attitude of adolescents towards having discussion on SRH issues with their parents, and towards related SRH matters.**

**Table 6: Attitude of adolescents towards having discussion on SRH issues with their parents, and towards related SRH matters**

Attitudes of adolescents on SRH	Number	Percent
Is Premarital sex acceptable (n=368)		
Yes	95	25.1
No	273	72.2
Boy has to force girls to have sex if he loves her (n=366)		
Agree	19	5.1
Disagree	324	85.7
Not sure	29	7.7
A girl have to remain a virgin until she marries (n=374)		
Agree	250	66.1
Disagree	62	16.4
Not sure	62	16.4
A boy have to remain virgin until he marries (n=373)		
Agree	210	55.6
Disagree	73	19.3
Not sure	90	23.8
Parent adolescent communication on SRH issues delay first sexual intercourse (n=369)		
Agree	268	70.9
Disagree	69	7.7
Not sure	72	19.0
Do you believe that, if unmarried couples want to have sexual intercourse before marriage they must use condom (373)		
Yes	252	66.7
No	121	32.0
Do you believe that, STIs and HIV/AIDs can be prevented using condom (n=368)		
Yes	265	70.12
No	103	27.2

Two hundred seventy three (72.2%) of adolescent respondents do not accept premarital sex, and the rest ninety five (25.1%) had no matter towards having premarital sex or believe in having sex before marriage. Of the total 374 adolescents who responded about girls virginity, 250 (66.1%) of respondents agree that girls have to remain virgin until they get married, Similarly, from the total of 373 adolescents 210 (55.6%) adolescents agree that boys have to remain virgin until they married. From the total 368 adolescent respondents 265 (70.12%) believe that HIV/AIDs and other STIs can be prevented using condom during

sexual intercourse. Inversely, 103 (27.2%) respondents do not have a confidence on condom. Two hundred fifty two (66.7%) believed that if unmarried couples want to have sexual intercourse before marriage they must use condom, and 121 (32.0%) of them do not believe in this way. Two hundred fifty two (66.7%) student believe that unmarried couples should use condom if they want to have sex. Out of 366 respondent students majority of them, 324 (85.7%), disagree that boy has to force girl to have sex if he loves her. Parent adolescent communication on SRH issues is also believed by 268 (70.9%) out of 369 adolescent respondents that it can delay first sexual intercourse (Table 6).

### Adolescents' sexual and other reproductive health behavior.

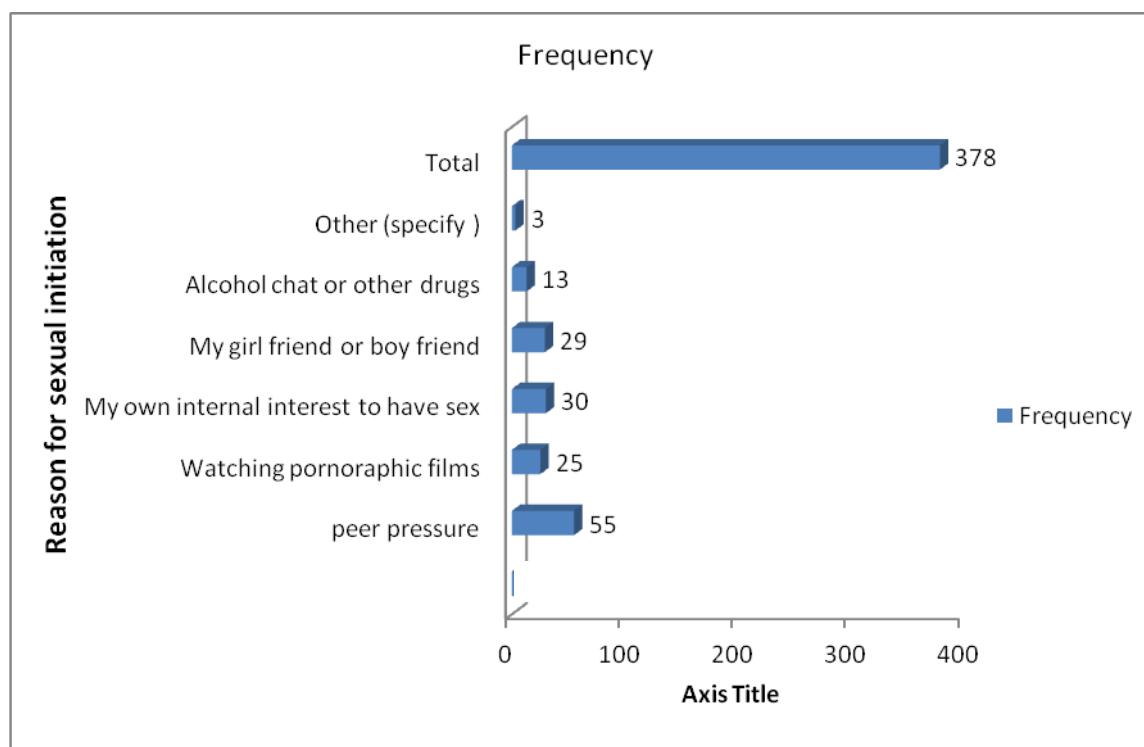
**Table 7: Showing adolescents sexual behavior**

<b>Adolescents sexual behaviour</b>	<b>Number</b>	<b>Percent (%)</b>
Ever had sexual intercourse (n=378)		
Yes	90	23.8
No	288	76.2
Age at sexual initiation (n=90)		
12 – 17	47	52.2
18 – 20	43	47.8
Number of sexual partners (n=90)		
One	47	52.2
Two	18	20.0
Three and above	25	27.7
Either of the two partners use condom at first sexual intercourse (n=90)		
Yes	24	26.6
No	60	66.6
I don't remember	6	6.6
Use condom consistently (n=90)		
Yes	28	31.1
No	52	57.7
I don't remember	9	10.0
Either of the two partners use any birth control method except condom at first sexual intercourse		
Yes	26	28.8
No	60	66.6
I don't remember	6	6.6
Cause of first sexual intercourse		
Peer pressure	55	61.1
Watching pornographic films	25	27.7
My own internal interest to have sex	30	33.3
My girl friend or boy friend	29	32.2
Alcohol, Chat or other drugs	13	14.4
Other	3	3.3

Of 378 study respondents 90 (23.8%) were sexually active. Among sexually active adolescents 47 (52.2%) started sexual intercourse between the age of 12 and 17 years. The rest 43 (47.8%) started sexual intercourse between the age of 18 and 20 year. The mean ( $\pm$ SD) age of first sexual initiation of respondents was  $17.16 \pm (1.53SD)$  and the median age of sexual initiation was 17 years of age. The minimum and maximum age of first sexual initiation was 12 and 20 years of age respectively. Twenty four 24 (26.6%) of adolescents were used condom during first sexual intercourse, and 26 (28.8%) of respondents used birth control methods at first sexual intercourse. Regarding the number of sexual partners, 47 (52.2%) respondents have one sexual partner. 18 (20.0%) adolescents have two sexual partners, and 25 (27.7 %) adolescents have three and more sexual partners (Table 7).

**Table 8: Adolescents reasons for their first sexual initiation**

Reasons	Frequency	Percent
Peer pressure	55	14.6
Watching pornographic films	25	6.6
My own internal interest to have sex	30	7.9
My girl friend or boy friend	29	7.7
Alcohol chat or other drugs	13	3.4
Other (specify )	3	1.3
Total	378	100.0



**Figure 3: Cause of adolescents' first sexual initiation**

The most outstanding reason for sexual initiation among sexually active youth was peer pressure which account 55 (61.1%) followed by internal interest to have a sex that account 30 (7.9%) (Table 8) & (Figure 3).

#### Reasons for not having sexual intercourse.

**Table 9: Showing adolescents' reasons for not having sexual intercourse**

Reasons (n=288)	Number	Percent (%)
I want to wait until I am older	44	15.2
I want to wait until I am married	157	54.5
I do not want to risk getting pregnant/made some one pregnant	24	8.3
I do not want to risk getting a sexually transmitted infections such as HIV/AIDS	16	5.5
I have not had a chance to have a sex or mate anyone that I wanted to have sex with	3	1.0
It is against my religious values	46	15.9
Fear of my parents	2	0.6

More than half of adolescents 288 (76.2%) did not have sex (Table 7). The main reason for not having sex before marriage was waiting till married 157 (54.5%) followed by believe that it is against their religious values which accounts 46 (15.9%) of adolescents.

Within a shortest far from an attributes to religious values 44 (15.2%) of adolescents reported that they are waiting until they get older. The fear of getting risk of pregnancy and STIs accounts 24 (8.3%) and 16 (5.5%) of adolescents respectively. Fear of parents as a reason for not having sexual intercourse accounts the least figure of adolescent respondents; only 2 (0.6%) (Table 9).

### Communication between parents and adolescents concerning SRH issues.

**Table 10: Showing adolescents status concerning the communication on SRH issues**

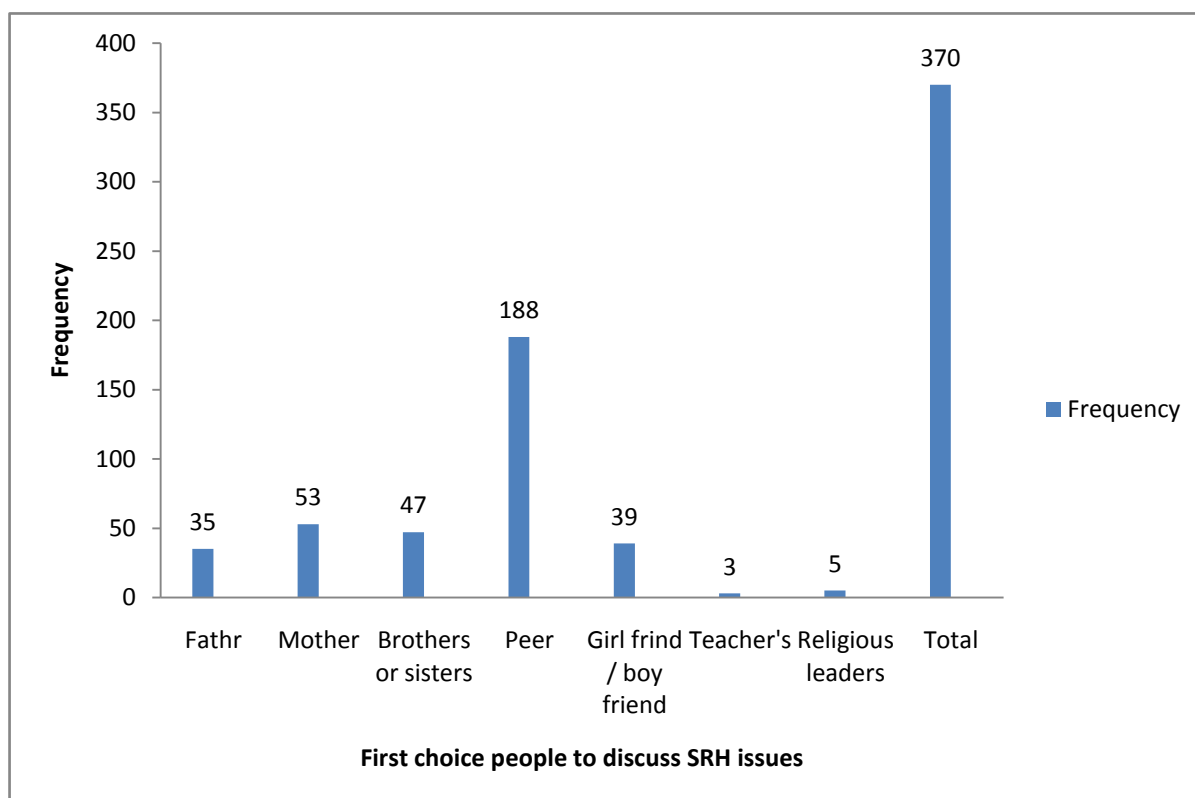
Questions on SRH communication	Number of adolescents	Percent (%)
Communication about SRH issues is important		
Yes	287	75.9
No	47	12.4
I do not Know	43	11.4
Discussed SRH related issues with either father or mother		
Yes	119	31.5
No	259	68.5
With whom do you discuss about SRH issues		
Father	33	8.7
Mother	26	6.9
Brothers or sisters	41	10.8
Peer	39	10.3
Girl friend/boy friend	205	54.2
Teacher's	23	6.1
Religious leaders	4	1.1
Other	7	1.9

The majority of participants 287 (75.9%) reported that it is important to discuss about SRH issues with their parents, and 119 (34.5%) of students had ever discussed on at least two SRH topics with their parents (either father or mother). Forty seven (12.4%) adolescents did not accept its importance, and approximately a comparable number of adolescents 43 (11.4%) reported that they did not know the importance of having discussions with their parents on such issues. Even though majority of the respondents accept the importance of communication between parents and their adolescents on SRH issues, a greater number of them 259 (68.5%) do not discuss SRH related issues with their either father or mother.

Rather, the vast majority of adolescent respondents 205 (54.2%) discuss about SRH issues with their girl friend/boy friend, and those who are discussing with their peers 39 (10.3%) follow track. Discussion with the religious leaders is the least mentioned one; reported by only 4 (1.1%) adolescent respondents (Table 10).

**Table 11: Adolescents preference to discuss issues related to SRH.**

First choice to discuss SRH issues	Frequency	Percent
Father	35	9.50
Mother	53	14.30
Brothers or sisters	47	12.70
Peer	188	50.80
Girl friend / boy friend	39	10.50
Teacher's	3	0.80
Religious leaders	5	1.40
Total	370	100.0



**Figure 4: Depicting adolescents' first choice of person to discuss about SRH issues**

Majority 188 (50.8%) of adolescent students preferred peers as their first choice of person to discuss about SRH issues. This is followed by the choice of mother 53 (14.3%) and

girl friend/boy friend 39 (10.5%). Siblings (brothers or sisters) and fathers are chosen by 47 (12.7%) and 35 (9.5%) of adolescents respectively. Religious leaders 5 (1.4%) and teachers 3 (0.8%) are chosen by a very few number of adolescents as their primary person to discuss about SRH issues (Table 11) & (Figure 4).

**Table 12: Parent adolescent communication on SRH issues by sex and adolescents preference (among their parents)**

Variables	Male		Female	
	With Fathers	With Mothers	With Fathers	With Mothers
Contraceptive method	10(6.0)	14(8.4)	9(4.4)	49(24.0)
STI and HIV/AIDS	23(14.0)	13(7.9)	26(12.8)	20(9.9)
Sexual intercourse	19(11.7)	15(9.2)	11(5.5)	21(10.4)
Unwanted pregnancy	10(6.1)	31(18.8)	9(4.5)	53(26.2)
Condom use	11(6.7)	-	4(2.0)	2(1.0)
Physical and behavioral changes during puberty	14 (8.5)	12(7.3)	30(15.1)	29(14.6)
Menstrual period	-	12(80.0)	7(3.7)	142(74.3)
SRH necessary for youth	23(14.0)	8(4.9)	20(9.7)	24(11.7)
Opposite sex relationship	19(11.4)	14(8.4)	23(11.5)	27(13.5)
Preference for discussion (from father and mother)	15(9.0)	17(10.2)	20(9.8)	36(17.6)

*Adolescent parent communication on various elements of SRH issues.***Table 13: Showing adolescents response whether they are communicating or not on various elements of SRH issues**

Adolescents response on the communication concerning SRH components	Adolescents in number and percent	
	Yes	No
Discuss about contraception methods (n=373)	183(49.1)	190(50.9)
Discuss about STI and HIV/AIDS (n=375)	312(83.2)	63(16.8)
Discuss about sexual intercourse (n=372)	90(24.2)	282(75.8)
Discuss about unintended pregnancy (n=376)	241(64.1)	135(35.9)
Discuss about use of a condom (n=376)	201(53.5)	175(46.5)
Discuss about physical and psychological changes during puberty (n=371)	294(79.2)	77(20.8)
Discuss about menstrual period (n=208)	195(93.8)	13(6.3)
Discuss SRH services of adolescents (n=373)	132(35.4)	241(64.6)
Discuss about opposite sex relationship (n=373)	353(94.6)	20(5.4)

**Table 14: Showing adolescents response concerning with whom they discussed on major selected SRH issues**

Topics of SRH discussion	With whom SRH topics discussed							
	Father	Mother	Brothers or sisters	Peer	Girl/Boy friend	Teachers	Religious leaders	Other
Contraception methods	16(8.7)	37(20.2)	21(11.5)	77(42.1)	28(15.3)	3(1.6)	1(0.5)	-
STI and HIV/AIDS	38(12.2)	30(9.6)	21(6.7)	189(60.6)	14(4.5)	17(5.4)	-	3(1.0)
Opposite sex relationship	36(10.2)	28(7.9)	43(12.2)	239(67.7)	6(1.7)	1(0.3)	-	-
Unintended pregnancy	19(10.8)	47(19.5)	19(7.9)	104(43.2)	38(15.8)	5(2.1)	-	2(0.8)
Use of a condom	9(4.5)	4(2.0)	9(4.5)	135(67.2)	32(15.9)	10(5.0)	1(0.5)	1(0.5)
Physical and psychological changes during puberty	39(13.3)	34(11.6)	38(12.9)	144(49.0)	9(3.1)	28(9.5)	2(0.7)	2(0.7)
Menstrual period	6(3.1)	74(37.9)	16(8.2)	92(47.2)	3(1.5)	2(1.0)	-	2(1.0)
Sexual and reproductive health services of youth	19(14.4)	11(8.3)	15(11.4)	59(44.7)	7(1.9)	21(15.9)	-	-
Sexual intercourse	21(23.3)	15(16.7)	10(11.1)	38(42.2)	5(5.6)	1(1.1)	-	-

**Table 15: Showing adolescents' first preferences or choice of people for discussion on the major elements of SRH issues**

Topics of SRH discussion	First preference or choice of people for discussion							
	Father	Mother	Brothers or sisters	Peer	Girl friend/boy friend	Teachers	Religious leaders	Other
Any SRH issues (n=370)	35(9.5)	53(14.3)	47(12.7)	188(50.8)	39(10.5)	3(0.8)	5(1.4)	-
Contraception methods (n=370)	19(5.1)	63(17.0)	26(7.0)	183(49.5)	72(19.5)	6(1.6)	1(0.3)	-
STI and HIV/AIDS(n=369)	49(13.4)	33(9.0)	30(8.2)	210(57.2)	34(9.3)	10(2.6)	-	1(0.3)
Opposite sex relationship (n=367)	42(11.4)	41(11.2)	43(11.7)	231(62.9)	8(2.2)	2(0.5)	-	-
Unintended pregnancy (n=367)	19(5.2)	84(22.9)	22(6.0)	190(51.8)	51(13.9)	1(0.3)	-	-
Use of a condom (n=365)	15(4.0)	2(0.5)	10(2.7)	263(72.1)	73(20.0)	2(0.5)	-	-
Physical and psychological changes during puberty (n=364)	44(12.1)	41(11.3)	50(13.7)	202(55.5)	13(3.6)	14(3.8)	-	-
Menstrual period (n=206)	7(3.4)	154(74.8)	8(3.9)	34(16.5)	2(1.0)	1(0.5)	-	-
Sexual and reproductive health services (n=370)	43(11.6)	32(8.8)	59(15.9)	172(46.5)	26(7.0)	38(10.3)	-	-
Sexual intercourse (n=364)	30(8.2)	36(9.9)	22(6.0)	222(61.0)	53(14.6)	1(0.3)	-	-

**Table 16: Adolescents frequency of communication on the major elements of SRH issues**

Variables	Frequency of communication					
	Often (%)		Some time (%)		Rarely (%)	
	number	%	number	%	number	%
Contraceptive methods (n=195)	20	10.3	67	34.3	108	55.4
	26	8.4	123	39.7	161	51.9
STI and HIV/AIDS (n=310)	11	12.2	48	53.3	31	34.4
Sexual intercourse (n=90)	18	7.6	117	49.4	102	43.0
Unwanted pregnancy (n=237)	29	14.9	89	45.9	76	39.2
Condom use	23	7.9	142	49.0	125	43.1
Physical and behavioral changes during puberty (n=290)	25	12.8	127	65.1	43	22.1
Menstrual period (n=195)	12	9.1	52	39.4	68	51.5
SRH service necessary for youth (n=132)	83	24.1	177	51.3	85	24.6
Opposite sex relationship (n=345)						

**Table 17: Reason for not adolescents having discussion with their parents on major selected SRH issues**

Variables	Total number (%) of adolescents not discussing	Reason for not discussing with parents					
		Shame	Culturally unacceptable	Lack of knowledge	Lack of communication skill	Fear of parents/ embarrassing	Others
Contraceptive (n=373)	190(50.9)	84(27.0)	149(47.9)	10(3.2)	7(1.9)	54(17.4)	7(2.3)
STI and HIV/AIDS (n=375)	63(16.8)	62(16.6)	61(16.3)	7(2.4)	18(6.1)	59(15.8)	3(1.0)
Sexual intercourse (n=372)	282(75.5)	124(40.7)	214(70.2)	29(9.5)	12(4.2)	259(74.4)	3(0.9)
Unwanted pregnancy (n=376)	135(35.9)	105(36.6)	126(34.3)	9(3.1)	13(4.5)	129(35.1)	5(1.7)
Condom use (n=376)	175(46.5)	144(41.4)	170(39.7)	59(17.0)	19(5.5)	173(49.7)	4(1.1)
Physical and behavioral changes during puberty (n=371)	77(20.8)	88(31.1)	87(30.6)	9(3.5)	10(3.5)	88(31.0)	5(1.8)
Menstrual period (n=208)	13(6.3)	12(10.7)	13(11.6)	9(7.4)	2(1.8)	13(11.6)	1(0.9)
SRH service necessary for adolescent (n=373)	241(64.6)	40(14.7)	41(15.0)	2189(79.9)	10(3.7)	76(27.8)	3(1.1)
Opposite sex relationship (n=373)	20(5.4)	20(37.7)	20(37.7)	3(5.7)	4(7.5)	19(35.8)	5(9.4)

*Communication about contraceptive methods.* One hundred eighty three (49.1%) of adolescents ever had discussed about contraceptive methods, and 190 (50.9%) of adolescents have been never discussed (Table 13). Of those participants who ever had discussed about contraceptive methods majority of them 77 (42.1%) was with peers (Table 14), and majority of the adolescents 183 (49.5%) preferred peer as their primary choice to discuss about contraceptive method. Peer is followed by the preferences of siblings 72 (19.5%) (Table 15). It has been rarely discussed by 108 (55.4%) number of adolescents among adolescents who reported that they had ever been discussed about it (Table 16). One hundred ninety (50.9%) of respondents did not discussed about contraceptive methods and the reason for not discussing was culturally not acceptable 149 (47.9) followed by shame to discuss the issue 84 (27.0%) (Table 17).

*Communication about HIV/AIDS and other STIs.* The vast majority 312 (83.25%) of adolescents ever had discussed about HIV/AIDS and STIs (Table 13). Of those, 189 (60.6%) were discussed with peers (Table 14), and 210 (57.2%) preferred peers which is followed by the preference of fathers 49 (13.4%) (Table 15). One hundred sixty one (51.9%) respondents discussed about HIV/AIDS and other STIs rarely (Table 16). Among 63 (16.8%) who are not discussing HIV/AIDS and STIs 62 (16.6%) was because it was shame followed by 61 (16.3) was not culturally acceptable and 59 (15.8) fear of parents (Table 17).

*Communication about HIV/AIDS and other STIs.* The vast majority 312 (83.25%) of adolescents ever had discussed about HIV/AIDS and STIs (Table 13). Of those, 189 (60.6%) were discussed with peers (Table 14), and 210 (57.2%) preferred peers which is followed by the preference of fathers 49 (13.4%) (Table 15). One hundred sixty one (51.9%) respondents discussed about HIV/AIDS and other STIs rarely (Table 16). Among 63 (16.8%) who are not discussing HIV/AIDS and STIs 62(16.6%) was because it was shame followed by 61 (16.3) was not culturally acceptable and 59 (15.8) fear of parents (Table 17).

*Communication about sexual intercourse.* From 372 adolescents who reported on their communication status about sexual intercourse, 90 (24.2%) ever had discussed about sexual intercourse (Table 13). Of those participants who ever had discussed about sexual intercourse majority of them 38 (42.2%) was with peers followed by fathers 21 (23.3%) (Table 14). The preference towards discussing sexual intercourse issues also goes to peers 222 (61%) which is followed by siblings (brothers and/or sisters) that accounts 53 (14.6%) of adolescents (Table 15). It has been discussed sometimes by 48 (53.3%) number of adolescents among adolescents who reported that they had ever been discussed about it (Table 16). The vast majority, 282 (75.8%) of the respondents did not discuss about sexual intercourse with parents and the reason for not discussing was fear of parents 259 (74.4%) followed by culturally not acceptable that accounts 214 (70.2) (Table 17).

*Communications on unwanted/unintended pregnancy.* Two hundred forty one (64.1%) of respondents had ever discussed about unwanted pregnancy (Table 13). From those who ever had discussed about unwanted pregnancy 104 (43.2%) discussed with peers (Table 14), and 190 (51.8%) of adolescents preferred peers. Mothers are preferred by 84 (22.9%) of adolescent respondents; one times less than the preference of peers (Table 15). One hundred seventeen (49.4%) respondents discussed about unwanted pregnancy sometimes (Table 16). The most frequently mentioned reason for not discussing about unwanted pregnancy was fear of parents and embarrassing 129 (35.1%) followed by culturally not acceptable 126 (34.3) (Table 17).

*Communication about the use of condom.* Of 376 respondents who reported about the use of condom, 201 (53.5%) respondents ever had discussed about it (Table 13), and majority of them 135 (67.2%) discussed with their peers (Table 14). Peer is also preferred by 263 (72.1%) adolescents and followed by 73 (20.0%) of adolescents who preferred girl friend/boy friend as their primary choice to discuss issues related to condom use (Table 15). And among

those 201 (53.5%) respondents who ever had discussed about use of condom 89 (45.9) discussed sometimes (Table 16). Fear of parents was the most frequently mentioned reason for not discussing about the use of condom. The adolescents most frequently mentioned reason of not discussing about use of condom with their parents is the fear of parents. It was mentioned by 173 (49.7%) adolescents. This is followed by the reason; culturally not acceptable, reported by 170 (39.7%) adolescents (Table 17).

*Communication about physical and psychological changes during puberty.* From the total of 371 adolescents, 294 (79.2%) had ever discussed about physical and behavioral changes during puberty (Table 13). Among these adolescents 144 (49.0%) of them mentioned that they discuss with peers followed by father 39 (13.3%) (Table 14). Concerning the preference of persons to discuss with on changes occurred during puberty 202 (55.5%) of adolescents chosen as their primary favorite; this is followed by the choice of siblings (brothers and/or sisters) by 50 (13.7%) adolescent respondents (Table 15). One hundred forty two (49.0%) respondents discussed sometimes (Table 16). Seventy seven (20.3%) who did not discussed about puberty mention shame, fear of parents and culturally not acceptable that accounts 88 (31.1%), 88 (31.1%) and 87 (30.6%) respectively (Table 17).

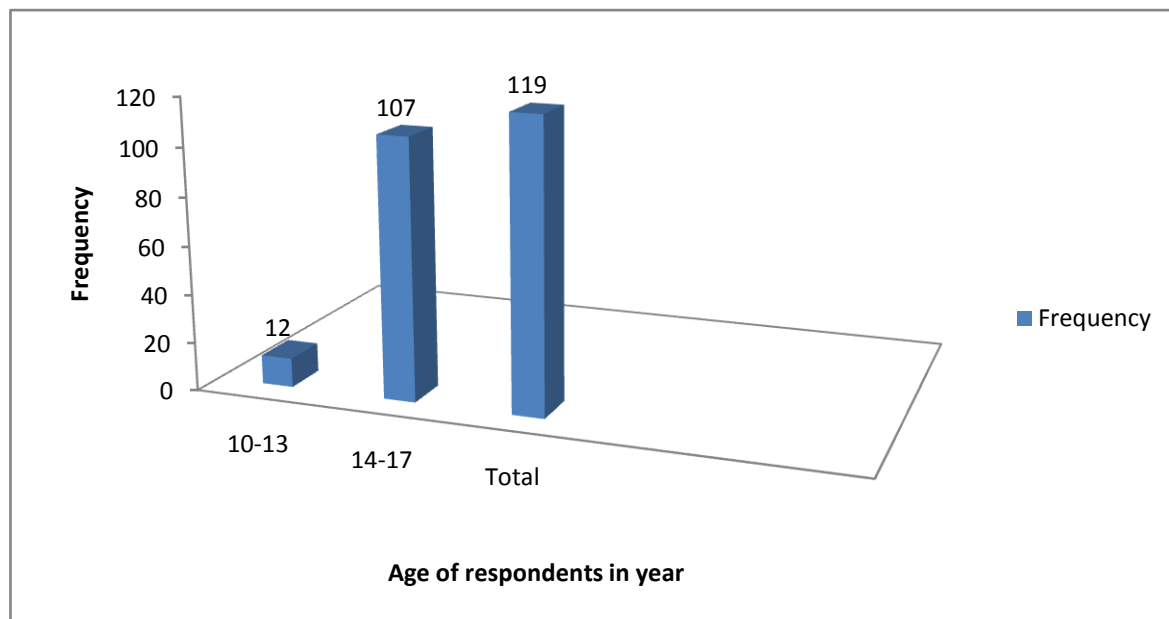
*Communication about menstrual period.* From 208 female participants almost all 195 (93.8%) never had discussed about menstrual period (Table 13). Most of them had discussed about it with peers 92 (47.2%) and followed by mothers 74 (37.9%) (Table 14). Mothers are chosen by the majority of adolescents 154 (74.8%) as the primary alternative to discuss with; next to mothers peers are preferred by 34 (16.5%) of adolescents (Table 15). Regarding the frequency of their discussion 127 (65.1%) of female participants discuss about menstrual period sometimes (Table 16). That main reason raised for not discussing about menstrual period was culturally not acceptable 13 (11.6%) and fear of parents 13 (11%) followed by shame 12(10.7%) (Table 17).

*Communication on SRH services for adolescents/youth.* One hundred thirty two (35.4%) of the study participants never had discussed about SRH services necessary for adolescents (Table 13). The vast majority of them 241 (64.6%) were never discussed about it; small number of adolescents who have it 59 (44.7%) were yet with their peers (Table 14). One hundred seventy two (46.5%) adolescents favored discussing issues related with SRH services necessary for adolescents with peers; followed by 59 (15.9%) adolescents who preferred siblings as their primary choice (Table 15). More than half 241 (64.6%) of adolescents did not discuss about SRH services essential for youth (Table 16), and the major reason mentioned was lack of knowledge about the issue 2189 (79.9%) followed by fear of parents 76 (27.8%) (Table 17).

*Communication about opposite sex relationship.* Immense number of adolescents 353 (94.6%) ever had discussed about opposite sex relation (Table 13). From those who ever had discussed about opposite sex relations 239 (67.7%) were with peers; this is followed by the discussion with siblings (brothers and/or sisters) which accounts 43 (12.2%). The discussion with fathers and mothers follow after these and it weighs 36 (10.2%) and 28 (7.9%) respectively (Table 14). Two hundred thirty one (62.9%) adolescents preferred peers as their primary alternative and almost the same number of respondents preferred fathers 42 (11.4%) and mothers 41 (11.2%) as their primary choice (Table 15). A little bit more than of the respondents 177 (51.3%) discuss sometimes (Table 16). The most prominent reason for not discussing about opposite sex relation was shame and culturally not acceptable which accounts 20 (37.7%) followed by fear of parents 19 (35.8) (Table 17).

**Table 18: Adolescents age at first discussion, their response on adequacy of SRH information, and parents' openness status**

Variables	Number	Percent
Age at first discussion of SRH issues		
10 – 13	12	10.1
14 – 17	107	89.9
Adequacy of information on SRH issues discussion		
Yes	80	21.9
No	286	78.1
Father open for discussion		
Yes	37	10.2
No	327	89.9
Mother open for discussion		
Yes	74	20.2
No	393	79.8



**Figure 5: Depicting adolescents' SRH discussion status in relation to their age range**

Out of respondents who ever had discussed on at least two topics of SRH related issues 107 (89.9%) start the first discussion with in the age range of 14-17 years of age. The mean ( $\pm$ SD) age of respondents at first discussion was  $15.18 \pm (1.34D)$  with minimum and maximum of 10 and 17years respectively. Eighty (21.9%) of adolescents declare that they got adequate information during their discussion with either father or mother. Mothers were

perceived as open in SRH communication than fathers in a relative way, in which it maintains 74 (20.2%) for mothers and 37 (10.2%) for fathers (Table 18) & (Figure 5).

**Table 19: A summary on the significance levels of variables associated with parent adolescent SRH communication**

<b>Discussion on sexual and reproductive health issues</b>				
<b>Variable</b>	<b>Yes</b>	<b>No</b>	<b>Crude OR</b>	<b>Adjusted</b>
<b>Sex</b>	<b>Number (%)</b>	<b>Number (%)</b>	<b>(95%CI)</b>	<b>OR (95%CI)</b>
Male	53(31.2)	117(68.8)	1.00	1.00
Female	142(68.3)	66(31.7)	<b>1.03(0.66, 1.59)</b>	<b>0.80(0.48, 1.34)</b>
<b>Grade</b>				
11 <sup>th</sup>	55(29.1)	134(70.9)	1.00	1.00
12 <sup>th</sup>	64(33.9)	125(66.1)	<b>1.25(0.81, 1.93)</b>	<b>2.43(1.32, 4.46)</b>
<b>Ever heard of SRH</b>				
Yes	113(31.1)	250(68.9)	<b>1.48(0.51, 4.24)</b>	<b>2.14(0.57, 7.99)</b>
No	6(40.0)	9(60.0)	1.00	1.00
<b>Believe that parent youth communication about SRH issue important</b>				
Yes	108(37.6)	179(62.4)	<b>4.33(2.21, 8.51)</b>	<b>5.83(2.57, 13.22)</b>
No	11(12.2)	79(87.8)	1.00	1.00
<b>Educational status of mother</b>				
Illiterate	10(24.4)	31(75.6)	1.00	1.00
Read and write	16(21.6)	58(78.4)	<b>0.86(0.35, 2.11)</b>	<b>0.63(0.20, 1.93)</b>
Literate	93(36.0)	165(64.0)	<b>1.75(0.82, 3.72)</b>	<b>0.99(0.35, 2.79)</b>
<b>Educational status of father</b>				
Illiterate	1(7.1)	13(92.9)	1.00	1.00
Read and write	9(17.0)	44(83.0)	<b>2.66(0.31, 22.98)</b>	<b>3.13(0.28, 34.42)</b>
Literate	108(35.5)	196(64.5)	<b>7.16(0.93, 55.50)</b>	<b>8.12(0.79, 83.31)</b>
<b>Had sexual intercourse</b>				
Yes	15(16.7)	75(83.3)	1.00	1.00
No	104(36.1)	184(63.9)	<b>2.83(1.54, 5.17)</b>	<b>2.45(1.24, 4.83)</b>
<b>Living Arrangement</b>				
Father and mother or at least one parent	110(33.5)	222(66.9)	<b>2.04(0.95, 4.37)</b>	<b>1.20(0.46, 3.15)</b>
None parents	9(19.6)	37(80.4)	1.00	1.00

The result of Adjusted odds ratio revealed that female students were more likely to communicate on SRH issues compared to male students (AOR = 0.80; 95% CI 0.48 to 1.34). Grade 12<sup>th</sup> students were 2.43 times more likely to have odds of discussing about SRH issues

with their parents as compared to grade 11<sup>th</sup> students [AOR= 2.43; 95%CI=1.32-4.46].

Adolescents who ever heard about SRH issues have 2.14 times more likely to have odds of discussing about SRH issues compared to those who did not ever heard about SRH issues [AOR=; 95%CI=2.14(0.57, 7.99)]. Additionally, positive attitude of respondents towards the importance of parent youth communication on SRH issues [AOR=5.83; 95%CI=2.57-13.22], and having literate father [AOR=8.12; 95%CI=0.79-83.31], having literate mother [AOR=0.99; 95%CI=0.35, 2.79] and not having sexual intercourse was statistically significant with parent youth communication on SRH related topics (Table 19).

### Findings of the Qualitative Data

**Table 20: Qualitative data participants' demographic profile**

Serial number	Pseudonym	Sex	Age	Grade
1	Yitbarek	M	19	12 <sup>th</sup>
2	Addiskidan	F	18	11 <sup>th</sup>
3	Tewodros	M	18	12 <sup>th</sup>
4	Mekdelawit	F	18	12 <sup>th</sup>
5	Hailegebriel	M	18	12 <sup>th</sup>
6	Yonas	M	19	11 <sup>th</sup>
7	Abduselam	M	17	11 <sup>th</sup>
8	Mahlet	F	19	12 <sup>th</sup>
9	Ayda	F	18	11 <sup>th</sup>
10	Bezawit	F	17	11 <sup>th</sup>
11	Tigist	F	27	Certificate in Health Extension
12	Fasika	F	28	BA in Psychology

A total of twelve (12) participants were involved in the interview. Ten were adolescents selected from the population understudy, and the remaining two interviewees were the youth center's counseling officer and the health extension worker. Among the ten

adolescents, five were females and the rest five were males. Both the youth center counseling officer and the health extension worker were females. Since no new themes were emerged during the interview, findings of the qualitative data were organized and written based on the already developed discussion guide of interview with both adolescents and professionals.

**Adolescents understanding of SRH issues.** Eight out of ten interviewee adolescents were attempted to relate SRH issues to the sexual relations between males and females (a man and a woman), and to other interrelated elements. For instance, Hailegebriel stated that “Sex and reproductive health issues are concerns related with sex and other sex related health issues. It also includes HIV/AIDS and other venereal diseases” (April 16, 2014). They also stated as it includes issues like contraceptives, age of puberty, menstruation, unwanted pregnancies, child delivery and family planning methods. However, two interviewee adolescents indicated that SRH issues are all about sex and reproduction health package and as sex and reproduction health package in turn is concerned with sex and sex related issues, and mothers issue like no mother should die of delivery.

**Communication between adolescents and their parents on SRH issues.** Nine out of the ten participants mentioned that they did not openly discuss issues related to SRH, and other facts of human reproduction with their parents. They, instead, mentioned that they superficially told by their parents about limited topics related with SRH like HIV/AIDS, opposite sex relations (about girl/boy friend), unwanted pregnancy, few lectures on avoiding sex before marriage, and very rarely about sexual intercourse. For instance, Parents have never set aside a time for such talks but they do it simply in time they would pick related words or subjects causally from mass media (television and radio), and when they [adolescent] bring their friends home. According to the adolescent interviewees, most of the time their parents attempted to persuade them by mentioning any undesirable experiences

related to SRH issues in the community, and also provide vague warnings rather than direct open discussions. For instance, Yonas said that:

I never supposed to discuss about SRH with my parents. They would rather advise me about the issues based on the movie characters when we sit at home watching movies by claiming ‘oh disgusting!’ And also by saying ‘she/he is too young for it’. (April 17, 2104)

Mahlet also mentioned that she never discussed about SRH issues and she sometimes tells her mom that she is having problems with her menstruation. But her mom has never deliberated to talk to her about the subject; rather they [both mother and father] would insist on doing her academic homework and other school stuff but not about sex and reproductive health. She further reports that she feel at ease talking about it with her friends (April 17, 2014). With regard to the same issue, Mekdelawit replied:

I do occasionally chat about HIV/AIDS and other sex and reproductive health issues with my friends. Never have I had any formal discussion with anyone including my family, because there has been no opportunity for that. I don’t even discuss about menstruation. (April 16, 2104)

Seven out of ten adolescents witnessed that parents, especially mothers has tried to probe into their life concerning SRH issues or their experiences regarding SRH matters instead of openly discussing about it with them. This is not a talk, as to them; it is rather queries and they regard their parents as being judgmental, and perceived the process as overly protective and disrespectful of their privacy and autonomy. For instance, when adolescent children happen to bring their schoolmates home, parents [mothers for this specific case] inquire who they are and what relations their adolescents have with them. None of the adolescents mentioned that they had some sort of discussion and/or talk with their fathers on SRH issues, and not preferred to talk with their fathers on the same as well. They rather

avored to declare that their fathers are silent on these issues. Corresponding to this, Addiskidan; an adolescent girl said that:

Fathers habitually think winning bread is the most important thing. My father usually comes home late at night and won't bother discussing such issues with me. I would discuss such matters at ease with my mother ...like my menstruation ... but my father would only provide for my wants... he knows a lot about such issues but he would not want to talk. (April 16, 2104)

In contrast with the aforementioned ideas, only three participants mentioned that they do sometimes talk about SRH issues only with their mothers. For instance, Yitbarek described that his mother started discussing such issues with him since he was in elementary school. According to him, although they [he and his mother] do not have any fixed time set aside for such purposes, his mother would pick some literature on such issues and invites him to talk about it. She also lectures him on how to control his sexual urges, and how to use condom. Addiskidan reported her experience regarding SRH issues as:

We do discuss about the experiences of my mother in relation to sex and reproductive health issues. She disclosed me that she had aborted when she was at my age and was exposed into various problems. And she told me that she wouldn't resist the pain to see that experience in me ... and what-s- more the church condemns abortion as one of the deadly sins. This is not discussion; rather it is my mom tells what to do and not to do by telling her personal experiences on the issues. (April 16, 2104)

Eight of the interviewee adolescents reported that they have had discussion about these issues with their peers in various youth clubs, and fear discussing with their fathers. They also preferred to have such discussions with their peers. Though the interviewee adolescents are not in the position to openly communicate (discuss) SRH issues with their parents, HIV/AIDS is the most common SRH issue that easily and informally chatted among

adolescents and their parents. The awareness level about HIV/AIDS among various members of the community was raised by adolescents as the major reason for their ability to easily chat about it. Next, majority of them preferred discussing the physical and physiological changes (age of puberty) that accompany adolescence; including menstruation [by female adolescents]. Regarding the difficult topics they found to communicate on with their parents, all participants mentioned the very difficulty of discussing about dating or courtship and sex. They labeled sex as the very core private life. Concerning the use of condom, Yonas worryingly replied: "... I do not think that I would discuss issues related to condom use with my parents even if I will get crazy" (April 17, 2014). In addition to this, in comparison, eight out of ten participants perceived their mothers as more open and communicative on SRH issues than their fathers.

Besides, the youth center's counseling officer believed that young people are not discussing SRH issues in general and particularly at home with their parents, and the vast majority of parents do not discuss such issues with their children. Furthermore, the health extension worker stated the absence of an open discussion about SRH issues among young people and their parents in almost all families, by taking families with which she is currently working, as an example.

Nine out of ten interviewee adolescents agreed on the importance of SRH discussion between adolescents and their parents. They believed that discussing such matter is important with the family, and would embolden them to take reaction and pre-emptive measures.

Abduselam mentioned that:

I believe parents should have to talk openly with their children, because they can use opportunity to share their experiences. Otherwise silence would mean allowing the young people to have promiscuous sexual life. And uncommunicativeness about such matters may have negative consequences. On the other hand, if there is a degree of

openness at home then this would in turn initiate openness in the future affairs of the couples. (April 17, 2014)

Ayda also stressed the importance of having discussion with her parents via her statement:

I believe it is important to talk about these issues. But parents would rather cut back such initiatives saying “you are too young for this staff”. This is the way of parents especially men parents. If young people are ignored while they are young it would be too late to fix their behavior in their puberty. (April 17, 2104)

In a resemblance with this idea, Mahlet stated that:

I believe parents should be discussing such issues with their children. I know young girls of my age who are immersed in sexual relations. This is a destructive habit not only to them but also to the nation. The ultimate fate of such girls is dependency on the male partner. They should begin discussing the sex and reproductive health packages with their family and have the right awareness in order for them to fix their attitudes. And they would be able to have their own source of income. (April 17, 2104)

Furthermore, all adolescents believed that parents should take initiation to discuss about SRH issues with their children. According to them, parents are responsible to commence the discussion on such issues; and it is only after those adolescents should openly participate in the discussion. Concerning this instigation Hailegebriel suggested that:

I believe it is easier for parents to create the discussion about sex and reproductive health packages between themselves and their children. It is very helpful for children to have awareness about such issues and avoid the consequences of ignorance or \ tackle the problems in case they occur. (April 16, 2104)

Bezawit also mentioned "...I think parents should take the initiative to bring such issue into the fore. They should visit youth centers and read whatever they can comprehend about it" (April 17, 2104).

**Sources of information for adolescents on issues related to SRH.** Regarding the sources of information on various issues related to SRHs 9 out of 10 interviewee adolescents mentioned mass media as their dominant source. As per their report, mass media is inclusive of television and radio. Subsequent to television and radio, these adolescents mentioned other press products like magazines, pamphlets and posters. School is the third category which has been serving as a source of SRH information for adolescents. Family/parents and the youth center existing in their surrounding area are also mentioned. Taking the number of interviewee adolescents who mentioned family/parents and youth center as their source of SRH information into consideration, it can be categorized as the fourth and fifth sources of SRH information for adolescents understudy respectively.

**Feelings of adolescents to discuss about SRH issues with their parents.** Nine adolescents, except Yitbarek who mentioned that he was started discussing such issues with his mother when he was in elementary school, reported that they do not discuss issues related to SRH with their parents. Here, Bezawit believed that she do not feel at ease discussing such issues with her family; however, she also certain of as they would be supportive when she insists on telling them. Nonetheless, nine of them stated that they do not have a problem (find any difficulties) to discuss with their parents on such issues if their parents take initiatives; especially feel more comfortable of discussing SRH issues with their mothers. With regard to this, Mekdelawit reported: "... I feel more at ease with my mom to discuss such issue... because she is closer to me" (April 16, 2104).

On the other hand, Yonas feel that they have adequate knowledge on SRH issues and believe that the discussion they would have with their parents on any SRH issues add nothing

for them. Concerning this he replied: "...I think enough has been said about sex and reproductive health issues on the media, and I have sufficient knowledge about such matters" (April 17, 2104).

**Reason for not discussing on issues of SRH with their parents.** Culture was the most common barrier of communication about sexuality and other reproductive health issues mentioned by all participants i.e. discussion on such issues was not common because it is believed by the majority as shame to discuss.

Almost all of the interviewee adolescents mentioned that they were unable to discuss issues of SRH with their parents because of cultural constraints. They were largely attached to cultural constraints as a paramount reason for the absence of SRH discussion among them and their parents; by stressing that SRH and related issues were considered as a taboo and something to withdraw away from a society in which they were brought up. In line with this, Tewodros said:

One of the obstacles we have in bringing this issue out for discussion with our parents is cultural constraints. Our parents were brought up without discussing with their parents, and they are doing the same to us. And we young people are embarrassed and panic about such matters, and whenever raise such issues we would take it personally, and worry ourselves by thinking again and again that 'what have they seen in me anyway?' Young people would rather be unresponsive about discussing such issues. (April 16, 2014)

Moreover, adolescents stated that both parents feel ashamed and prefer keeping silent. They rather desire to discuss with their peers and with their members of extended families like, aunts, uncle, grandfather and/or grandmother. The adolescents also believe that chatting on such issues repetitively would push one into having open discussion unreservedly. For instance, Mahlet mentioned that:

Of the sexual and reproductive health issues, I am more prone into having discussions about HIV/AIDS. There were times when people thought the very act of saying the name AIDS would infect them, but nowadays the media and people in general are discussing about it and it would be no harder for me to engage in one. And next to this, I like discussing about other venereal diseases. (April 14, 2104)

Furthermore, all of the interviewee adolescents loudly blame their parents for the absence of dialogue among them on such issues. Regarding this Addiskidan states that: "...my parents would insist me on doing my home work and other school stuff/academic affairs but not about sex and reproductive health. I was brought up this way and fear talking about them nowadays" (April 14, 2104).

Likewise the adolescents, the health extension worker discussed a rationale for the absence of SRH communication between adolescents and their parents in relation to the existing culture. She stated that: "...I think the major constraint is culture, people think they should be silent on such issues, and retreat at the very idea of bringing them up to an open discussions" (April 18, 2014). In addition to this, she exposed that parents are unable to talk not only with their children but also with professionals like them, and associated this with the shyness of parents on the issue. She further reports: "...some parents even think as they are corrupting their children for informing them about SRH issues" (April 18, 2104). The youth center's counseling officer also associated the absence of communication to fear; which in turn emanates from the overall culture.

**Suggestions forwarded by adolescents in order to advance adolescent parent communication on SRH issues.** Interviewee adolescents put forward various ideas pertaining to communication about SRH matters among them and their parents. Though the vast majority of their suggestions were tasks to be done with parents, they [adolescents] forward manner of improving SRH issues communication in three (3) aspects; the first ideas

was concerned with what is to be done by parties other than themselves and their parents, the second ideas was regarding what is expected from parents, and the third dimension deals with what adolescents should do. In view of this, Bezawit said:

One of the things we should do to improve our openness on such issues is to increase parents' awareness about the importance of discussing such issues unguarded. And parents should heed unto the urgency of the situation and discuss them (at least when their daughter in the menstrual week). (April 17, 2014)

And Yitbarek replied on what should be done by parties other than parents and adolescents as:

Some parents think that discussing sex and reproductive health packages is the same as corrupting one's children. Therefore, I think to build up the trust more should be done to augment the level of awareness parents have on such issues. When in the age of puberty there is a strong urge for sex not to mention the irresistible peer pressure, and schools should be introducing subjects that inform students on how they should safeguard themselves from dangerous influences. (April 16, 2104).

The role of media in empowering both parents and adolescents on the issues under consideration was also explicitly stated.

The adolescents, on the other hand, suggested what parents should do in bringing desired SRH communication with their adolescents. In accordance with their statements, it would be much easier for parents to take the initiative and they should be taking the lion share of responsibility to initiate adolescents. Here, Addiskidan mentioned:

If I boldly take the initiative they would think I am crazy! It is unusual and I don't think I will ever get the guts to initiate such talks. And I fear my parents would think I am experimenting on sex. I don't think I will be ready to join such discussions. It would have been favorable had they started doing these at an earlier age. (April 16, 2014)

Both the youth center's counseling service officer and the health extension worker divert much responsibility from adolescents in their suggestion stating that parents should play a proper role in creating the discussion about sex and reproductive health packages between themselves and their children. Children would not get involved into such matters. As to them, parents should eagerly share their knowledge to their children. They also urge parents to approach their adolescents on these issues from their early age, because starting it on later ages is difficult for both.

The adolescents attached responsibility of encouraging them to talk freely about their life outside the school compound to parents. They suggested that parents can do so if they had already started having a sort of discussion with their children since the early childhood years. As to them, parents' should approach their children well like any best friend would do, and they should realize the benefits they can gain from such discussions and equip themselves for that effort.

Lastly, in the third dimension, all interviewee adolescents attached a very much lesser responsibility to themselves. Ayda assertively stated: "...and children too should be equally ready to bring issues to the table" (April 17, 2014). In line with the above idea, Hailegebriel mentioned "...young people too should show readiness to learn from the experiences of their parents" (April 16, 2014). All adolescents restate the exact message of these statements via other sayings. By stressing the very importance of communication between adolescents and their parents, both the youth center's officer and the health extension worker recommends what to be done in order to bring what they mentioned as a desired communication. The youth center's counseling officer assigned a bulk of responsibility to parents; and said that they [parents] should initiate their adolescence children to break the silence and also responsible for educating them about sexuality and related issues. Not only for parents, she also allotted another assignment for body's other than parents and their adolescent children

via her statement which says: "...in order to eradicate such problems parents and adolescents should be encouraged to discuss on SRH issues openly" (April 18, 2104). The phrase 'such problems' in her statement context signified problems like HIV/AIDS and other STIs which are resulted partly because of the absence of parent adolescent communication on SRH issues.

The health extension worker too recommended that a desired communication can come if parents took the initiative and warmly invite their children to talk about SRH issues. Besides, as to her, parents should be empowered on the issues under consideration. Alternatively the roles to be played by clubs (gender clubs, HIV/AIDS prevention and control clubs), peers, religious institutions (Churches and Mosques), and forums held in their surrounding districts (Weredas) were all mentioned in a very lesser degree.

Nevertheless, harmoniously with what reported by the dominant number of interviewee adolescents, both the youth center's counseling officer and the health extension worker mentioned mass media and other press products as the major sources of SRH information for adolescents.

## CHAPTER FIVE

### Discussion of Major Findings

This study has attempted to assess parent adolescent communication on SRH issues among Ayer Tena preparatory school students in Kolfe Keraniyo sub city, Addis Ababa, Ethiopia. In the subsequent section, the results of both the quantitative and qualitative data will be discussed correspondingly with the objectives and research questions of this study. More specifically it is endeavored to compare the findings of this particular study with analogous previous studies; accordingly, it was discussed in connection with studies done in the Ethiopian context and also abroad. However, in an attempt to bring to the country's contexts and advance the reliability of the study, studies conducted in the Ethiopian context were given much emphasis. The basic tenets of the proposed theoretical framework were also discussed in association with the findings of the study. By bearing the findings of this study and other comparable studies in mind, the researcher has incorporated his personal reflection as well.

The sex compositions of the survey were 208 female and 170 male adolescents. Among the ten adolescents participated in the interview, five were females and the rest were males; and both health professionals were females. The size of female adolescents who were participated in the survey can be rationalized as it is consistent with the current student enrollment ratio in general and in the Addis Ababa city administration in particular in which female students are exceeding male students.

### **The Extent of Communication between Adolescents and Parents on SRH issues**

This study indicated that the majority of school adolescents (75.9%) have positive attitude on the importance of parent adolescent communication concerning SRH issues. likewise, a study done in Garba Guracha town among 936 in and out school adolescents

revealed that 82.2 percent respondents believed that it is important to discuss about SRH issues with parents. Similarly, a study in Benishangul Gumuz region's Bullen wereda high school students shows that 87.9 percent of school adolescents believed on the importance of parent adolescent communication on SRH issues. Another study in Dire Dawa conducted on high school students indicated that 76.9 percent deemed it is important to discuss about SRH issues with their parents. Relatively the current study's response on the importance of SRH communication between parents and adolescents is lower as compared to the statistical results of the study done in Garba Guracha town and Dire Dawa. This slight statistical difference among these findings can be attached to the respective populations' knowledge of SRH issues; in which the current study adolescent's knowledge on SRH issues is statistically better; being perceived as knowledgeable about the issue may make them to question the importance of discussion. Nonetheless, all the above mentioned studies revealed that the study participants had positive attitude towards parent adolescent communication on SRH issues (Dessalegn Gebre'eyesus, 2006; Mulatua Ayalewu, 2011; and Yohannes Mulugeta, 2012).

Furthermore the qualitative findings from the adolescent interviewees corroborate the aforementioned quantitative results; in which the majority of interviewee adolescents agreed on the importance of SRH discussion between themselves and their parents. They believed that discussing such matters is important with the family, and would embolden them to take reaction and preventive measures.

Both the youth center's counseling officer and the health extension worker stressed the importance of SRH communication among parents and their adolescents by mentioning the consequences of the current happenings among families in which they are presently working with.

One hundred nineteen (34.5%) of adolescent students had ever discussed on at least two SRH topics with their parents [either father or mother]. The very consistent result with this is a finding from a study conducted in Debre Markos in which 36.9 percent of students had discussed SRH issues with their parents, and a study in Dire Dawa high school students in which 36.8 percent of adolescent students had ever discussed on at least two SRH topics with their parents. The study conducted in Benishangul Gumuz's Bullen woreda high school students too signifies that 28.9 percent of adolescents communicate on at least two topics of SRH issues. Twenty percent of in and out school adolescent students in Garba Guracha high school also discussed on at least two topics of SRH issues. Except Mulatua Ayalewu's (2011) study in Dire Dawa which is more or less statistically comparable with the current study's findings, the two other mentioned studies, were not steady with the findings of the present study; adolescents communication with their parents was to some extent lesser as compared to the current study concerning SRH issues. Besides to the differing levels of accessibility of information related with sexuality and other reproductive health issues and knowledge on SRH issues, inconsistencies across studies likely point to contextual or methodological differences. This is consistent with the suggestions given by Bastein et al. (2011) after a review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. They identified a range of socio-demographic characteristics (including sex, age, urban or rural residence, socio-economic status, school attendance, and level of education, religious affiliation and other household characteristics such as family size and marital status of the parents.) as being associated with parent-child SRH communication.

The other justification for the very lesser percentage of SRH communication among in and out school adolescents in Garba Guracha town may be due to the fact that it incorporated study subjects from out of school adolescents whom the study's investigator

found that out of school adolescents discuss about SRH issue rarely with their parents; this would probably bring down their percentage of communication.

The findings from the qualitative data of the present study too substantiate the quantitative results in which majority of the interviewee adolescents mentioned that they did not openly discuss issues related to SRH, and other facts of human reproduction with their parents. Instead, parents simply pick words or subject related to sexuality and human reproductive health causally from mass media (television and radio), and then attempted to chat about these issues by mentioning any undesirable experiences related to SRH issues in the community, and also provide vague warnings rather than direct open discussions. This sort of communication process is related to the Romnetveit and Blakar Communication Model's principles of 'mutual trust and confidence'. This refers that participants must have the mutual trust and confidence in each other for communication to be effective (Blakar, 1984). The current study's qualitative finding notifies that parents are not discussing SRH issues with their adolescent children, instead they are attempted to probe in to their life/experiences regarding sexuality and reproductive health which referred by adolescents as queries. The adolescents furthermore regard their parents as being judgmental, and perceive the process as overly protective and disrespectful of their privacy and autonomy. Such circumstance may weaken the perceived fidelity of the parent as an information source. This would in turn make communication ineffective, likewise among the current adolescents and their parents.

Attitude of respondents towards the importance of parent adolescent communication on SRH issues was also identified as important factor that may influence parent adolescent communication on various topics of SRH.

In addition to what parents communicate about SRH with their children, the timing for communication is also important. In line with this, the majority of the interviewees

suggested that their parents waited for clues that they were sexually active before they warned and threatened them about the consequences of engaging in sex and related affairs. According to them, parents were tempted to communicate with them only after they realized that their children were sexually active. This would likely to have had little impact on their protection use. This finding corroborates the recommendations advanced in other comparable studies with regard to initiating sexual discussions with adolescents or young people's in general before the sexual debut for a more desired SRH impact.

### **Sex Preferences of Adolescents towards Discussing SRH issues and major SRH issues Favored to be Discussed by the study area's Adolescents**

Comparing the male and female respondents the current study showed that females discussed SRH issue more than male respondents in which it maintains 68.3 percent for females and 31.2 percent for males. The study done in Garba Guracha was also comparable with this finding that more frequent communication was reported by females; 48.7 percent and 51.3 percent reported by males and females respectively. A study in Dire Dawa also substantiates this finding in which females maintained 52.5 percent and males 47.4 percent.

Various studies on the other hand indicated that the communication on SRH issues was mainly on same sex basis. For instance, a study by Sneed (2008) suggested that a larger percent of participants reported that they discussed issues related to sex with their mothers in comparison to their fathers, and more females than males reported they discussed sexual topics with their parents. Similarly, Rosenthal and Fieldman's (2009) study informs that mothers were reported as more frequent communicators about sexuality than fathers and girls receive more communication than boys. The study by Fogarty and Wyatt (2006) showed that the most interactive conversations take place between mothers and daughters. Uniformly, the present study indicated same sex [daughter-mother and son-father] preference to discuss SRH issues. And comparatively mothers were preferred by 14.3 percent of the current adolescents

than fathers who preferred by 9.5 percent of the same adolescents. Mulatua Ayalewu's (2011) FGD finding further notifies that fathers most of the time discussed with their sons and mothers with daughters. A study by Diiorio, Kelly & Eaton (1997) however, showed that both male and female adolescents were more likely to discuss sexual topics with their mothers than their fathers, and male adolescents were more likely than female adolescents to discuss sex based topics with their fathers. Likewise, Atienzo's et al. (2009) study on parent adolescent communication about sex in Morelos, Mexico notifies that communication was more common with mothers.

Away from the comparative explanation of adolescents discussion with their parents [either father or mother], the current study also indicated that except in the case of menstrual period in which majority of the female adolescents (74.8%) preferred mothers as their primary choice to discuss on the issue, In no other SRH issues mothers and fathers are preferred as the adolescents' primary choice. Instead, the overall adolescent respondents of this study preferred peers for other SRH discussion. This is consistent with the studies conducted by Yohannes Mulugeta (2012) in Garba Guracha on in and out of school youths, Mulatua Ayalewu (2011) on Dire Dawa high school students, Dessalegn Gebre'eyesus (2006) in Benishangul Gumuz's Bullen Wereda school students, and with the study among out of school youths done in China. Zhang's et al. (2007) study on parent adolescent sex communication in china presents a significant gender difference in the pattern of sex communication; with male adolescents being more likely to talk with fathers and female adolescents with mother.

Coming to the qualitative findings of the current study, majority of the interviewed adolescents do not openly discuss SRH issues with their parents in general though some of them had a sort of queries from their mothers. Of their parents, they also favored to have such discussion with their mothers, and none of them mentioned that they have some sort of

discussion and/or talk with their fathers rather feels panic discussing these things with their fathers. Instead, majority of them reported that they have had discussions about these issues with their peers in various youth clubs. Similarly with the quantitative findings, peers as well are preferred by adolescents for SRH discussions.

Majority of the female respondents (47.4%) discuss the menstrual period with their peers, and the next majority (37.9%) were preferred discussing with their mothers. Alternatively, the vast majority (74.8%) of them preferred their mothers to discuss issues related with menarche. Mother's preference is followed by those who preferred peers (16.5%). Suitably, in a study conducted in Benishangul Gumuz both the findings from female adolescents who participated in the survey and FGD discussant parents notifies that the majority of parents did not discuss on menstrual issue with their female adolescents. Consistently, studies conducted in Garba Guracha town and Dire Dawa reveals the same; in which 46.9 percent and 34.8 percent of adolescents discussed with their peers and mothers respectively in the study conducted in Garba Guracha, and 70 percent and 60.2 percent of adolescents discussed with their peers and mothers respectively in the study conducted in Dire Dawa. In the study under investigation, female adolescents are preferred their mothers to discuss issues related to menstruation, but the statistics and the qualitative results shows that they are not discussing with their moms. Instead much of their discussion on the issue is with their peers. Provided that parents, especially mothers, are supposed to be the primary care givers of their children [for their female adolescents in this case] not gaining attention on the issue or not discussing on menarche may have negative psychological impact on female adolescents. The problem might get worse when females saw the menstruation for the first time.

STIs was known by the vast majority (97.6%) of adolescents, and the most commonly known STIs was HIV/AIDS counting 72.2 percent of adolescents followed by Gonorrhea,

maintaining 22.0 percent of adolescents. The most commonly discussed SRH issues among the current study's adolescents was about opposite sex relationship in which it maintains 94.6 percent of adolescents and followed by the discussion about HIV/AIDS and other STIs (83.2%). However, the study conducted by Yohannes Mulugeta (2012) on in and out school adolescents in Garba Guracha, and Maleta's (2006) study concerning parent child communication on SRH matters in Malawi indicated issues of avoiding premarital sex as the most frequently discussed SRH issues among adolescents; this is followed by the discussion about HIV/AIDS and other STIs in both studies. Another similar study conducted in Bullen worda of Benishangul Gumuz region school students showed STI and HIV/AIDs as the most frequent topics of discussion followed by pubertal age. These changes in the prioritization of issues of SRH discussion may be seen due to the fact that community culture differs in attitudes towards various SRH issues; this in turn may emanate from the respective societal culture itself and the issues induced by both governmental and nongovernmental organizations in the respective communities. The FGD conducted by Yohannes Mulugeta (2012) among adolescents parents support this claim by stating that the discussant parents had given much attention to avoiding premarital sex because of the fact that avoiding premarital sex was a hot issue given much notice at the research time.

The exposure of both adolescents and their parents to various SRH issues might also determine topics of discussion. In line with this, the qualitative finding of the current study notifies HIV/AIDS as the most commonly discussed SRH issue. Adolescents attached their major reason for being so to the awareness level of various members of the community about HIV/AIDS. In the other sense it may be related to the information that is widely disseminated through different Medias and the adverse effect of the problem that HIV is bringing on people in the area and the country at large. Next to HIV/AIDS, majority of the adolescent interviewee preferred discussing the physical and physiological changes (age of puberty) that

accompany adolescence; including menstruation by female adolescents. Small number (only 24.2%) of adolescents discuss about sexual intercourse. This is followed by the discussion on SRH services of adolescent and discussion about the use of condom; holding 35.4 percent and 53.5 percent respectively. The inability of the adolescents to discuss about sexual intercourse and condom use was also reflected in the qualitative findings in which all the interviewee adolescents persistently reported dating or courtship and sex as the most difficult topics they found to communicate on with their parents; especially majority of the adolescents were scared when they asked about their status of communication with their parents on the use of condom. Inability to discuss about SRH services necessary for adolescents might be due to the lack of knowledge on the issue. This is taken as a case because 79.9 percent of adolescents in the survey reported lack of knowledge or awareness on SRH services necessary for them as a reason for not discussing about services related to SRHs.

Concerning the openness of discussion, 10.2 percent of the adolescents reported that their fathers are open to discussing sexual issue and 20.2% percent of the adolescents mentioned that their mother are open to discussing the same issue. This is approximately similar with a comparable study conducted in Dire Dawa in which fathers' openness was rated by 17.9 percent of students and mothers' openness was rated by 25.4 percent of adolescents to discuss on SRH issues. Yohannes Mulugeta's (2012) work on out and in school youth in Garba Guracha town was also revealed low proportion of fathers openness by (29.7%) and a little bit higher openness of mothers by (34.6%) to discuss SRH issues as perceived by their children.

Studies conducted in Bullen wereda of Benishangul Gumuz on the other hand showed that 41.6 percent of students reported that fathers and 43.4 percent of students reported that mothers were open to discuss SRH related issues. Even though their statistics varies, all the

aforementioned findings attached the greater degree of openness to mothers. Coherently with those findings, some interviewee adolescents of this study mentioned that they do sometimes talk about SRH issues with their mothers and perceived them as more open and communicative than their fathers on SRH issues. However, according to them, parents [either mothers or fathers] are delayed for such discussion and wait until adolescents display bad behaviors related to SRH matters. This is consistent with the findings of FGD conducted by Yohannes Mulugeta (2012) among Garba Guracha in and out school student's parents, and another FGD by Dessalegn Gebre'eyesus (2006) among Benishangul Gumuz's Bullen wereda school student's parents. The majority of discussant parents participated in both FGDs admitted that they were not communicating with their adolescent children on SRH issues; instead they stay behind until undesired deeds on the sexuality and related reproductive health issues would displayed among their adolescent children. Equivalent FGD done by Mulatua Ayalewu in 2011 among Dire Dawa school student's parents revealed the same result.

### **Factors associated with parent adolescent SRH communication**

In the bivariate analysis (crude odds ratio analysis) adolescents' perceived importance to discuss SRH issues with parents, adolescents' ever getting SRH information, educational status of parents, adolescents never having sexual intercourse, adolescents living arrangements (being live with both parents or at least one parent) sex of the adolescents (being female or male), and school grade of respondents (adolescents), were found to be significantly associated with communication on SRH issues (Table 19).

The result of multiple regression analysis (Adjusted odds ratio) revealed that adolescents who have positive attitude on discussion of SRH issues with parents were 5.8 times more likely to discuss about SRH issues with their parents compared to adolescents who had not accepted the importance. This might be due to the reason that the adolescents'

perceived importance of communication on SRH issues lead them to engage in such communication. This finding is also consistent with the study done in Garba Guracha among in and out school students and with the study conducted in Benishangul Gumuz and Debre Markos town among school students (Yohannes Mulugeta, 2012; Dessalegn Gebre'eyesus, 2006; and Kasiye Shiferaw, Frehiwot Getahun and Getahun Asres, 2014). Besides, the current study result demonstrates that those students who have ever got information related to SRH were more likely to communicate SRH issues with their parents than those who have never got SRH information. This is also consistent with Kasiye Shiferawu's et al. (2014) study and it may be due to the case that adolescents who have some information and awareness might be more eager to communicate SRH issues and the information they got may pave the way for initiation of communication.

Educational status of father and mother shows statistical significance with parent adolescent communication about SRH issues. This has an implication that the educational status (level) of parents has an influence on the extent of SRH communication adolescents would have with their parents. This is consistent with the current study's interview result; for instance, Yitbarek, the only interviewee who sometimes used to chat some SRH issues with his mother reported that his mother has attended a formal education and used to teach for years. This result is consistent with the study done in Garba Guracha among in and out school students, and with the study in Benishangul Gumuz and Awassa among school students (Dessalegn Gebre'eyesus, 2006; Fikre Abebe, 2009; and Yohannes Mulugeta, 2012) in which maternal education reveals statistical significance. Similarly, a study conducted on parent and child communication on sexual and reproductive health matters in Malawi corresponds with this finding in which most of the parents who had primary and secondary education arranged the modified system of sex education for their children compared to parents who had formal education (Maleta, 2006). Furthermore, a study by Oladepo and Fayemini in Western Nigerian

city on perceptions about sexual abstinence and knowledge of HIV/AIDS prevention among in school adolescents indicated that lower parent adolescent communication on reproductive health issues was positively associated with lower educational levels of parents.

The study revealed that those adolescents who did not ever have sexual intercourse were 2.4 times more likely to discuss about SRH issues compared to those who had sexual intercourse. This finding can be interpreted in two dimensions; One is it may be due to fear on the side of adolescents that their engagement in sexual initiation or activity might be exposed if they attempted to communicate about it. The interpretation is that parent adolescent communication on SRH issues delay first sexual initiation. Though these interrelated interpretation need to be addressed more systematically in future comparable studies, unable to communicate with adolescents engaged in sexual activity would in turn worsen their SRH condition.

Being live with both parents also shows statistical significance with parent adolescent communication. This may be due to the fact that the presence of both parents allow for the normal functioning of family and this would in turn permit adolescents to communicate SRH issues by preferring convenient parent (among father and mother). But in contrary to this, if parent is only one (let's say only father) and adolescent preferred to have discussion with mother; adolescent is then forced to quit communication or discussion he/she should have.

The result of multiple regression models (Adjusted odds ratio) revealed that female students were more likely to communicate on SRH issues compared to male students (AOR = 0.80; 95% CI 0.48 to 1.34). This may be happen due to fear of risks on side of parents that their female children are more susceptible to various problems emanating from issues related to SRHs.

Grade 12 students were 2.43 times more likely to discuss about SRH issues with their parents compared to grade 11<sup>th</sup> students. This might be due to the differing level of SRH

awareness or knowledge of adolescents in grade twelve from that of grade eleventh and adolescents maturity level. The interview results of the current study also shows that grade twelve's adolescents' (for instance, Yitbarek) are more communicators than adolescents from grade eleventh in a comparative way. Consistently, Dessalegn Gebreeyesus's (2006) logistic regression finding of discussing in at least two topics showed that only grade 11 and grade 12 are statistically significant. It can also be inferred that as education increases the more one engage in communication.

The aforementioned findings of this study is also consistent with some findings of a study conducted in Debre Markos town, North West Ethiopia among secondary and preparatory school students, in which mothers who able to read and write (AOR=2; 95% CI 1.3 to 3.1), adolescents accepting discussion of SRH issues (AOR=2.5; 95% CI 1.3 to 4.5), and with adolescents who ever got SRH information (AOR=2; 95%CI 1.4 to 2.9). But finding of the current study which says that adolescents who never had sexual intercourse were found to have significant positive associations and grade twelve adolescents were more communicators were incompatible with the findings of the Debre Marko's study in which adolescents who ever had sexual intercourse (AOR= 1.7; 95%CI 1.1 to 2.6) found to have significant positive associations with the SRH communication they have with their parents, and being grade twelve students (AOR= 0.4; 95% CI 0.2 to 0.7) showed significant negative associations with the SRH communication they have with their parents.

### **Adolescents' Perception Regarding Challenges Related to the Communication with their Parents on the SRH issues**

Regarding challenges for not discussing SRH issues with their parents, the adolescents participated in the survey replied the major reasons separately for various SRH issues in accordance with the items in the questionnaire. On average, the reasons: culturally unacceptable, shame and fear of parents were mentioned by the majority of adolescents on

each item. Similarly, cultural taboos, fear of parents, shamefulness and lack of communication skills are all major justifications demonstrated by adolescents in the comparable study of Bullen woreda, and studies done in Garba Guracha and Dire Dawa towns. Unlike other studies, lack of communication skill was not mentioned by adolescents in the present study as their major blocking factor for not having communication on SRH issues. This might be due to the very familiarity of the present study's adolescents concerning the major elements of SRH issues and their exposure to various media and youth clubs. This in turn makes the adolescents perceive themselves as having adequate knowledge on SRH issues and skills of communication on the same. The reason 'lack of knowledge' is reported by the majority of the adolescents (79.9%) only in the case of not discussing SRH services necessary for adolescents. But it is the least mentioned one as the reason of not communicating in the case of other SRH issues.

The qualitative findings of the study from the adolescent interviewees too corroborate the quantitative findings in which culture was cited as the most common barrier of communication about sexuality and other reproductive health issues. All of the adolescents mentioned that they were unable to discuss issues of SRH with their parents because of cultural constraints. One adolescent interviewee clearly articulates the thoughts expressing the ideas of all adolescent interviewees by saying:

One of the obstacles we have in bringing this issue out for discussion with our parents is cultural constraints. Our parents were brought up without discussing with their parents, and they are doing the same to us. And we young people are embarrassed and panic about such matters, and whenever raise such issues we would take it personally, and worry ourselves by thinking again and again that 'what have they seen in me anyway?' Young people would rather be unresponsive about discussing such issues (April 14, 2014).

This adolescent's articulation is congruent with one of the basic assumption of socialization theory that attitudes and behaviors modeled by parents are learned by their children and portrayed in adolescence and adulthood (Philliber, 1980; as cited in Perant, 2009, p. 31).

This after all informs us that adolescent's stance to remain unresponsive is not only because of adolescents' failure to communicate, it is rather a multifaceted issue that needs urgent intervention on all concerned parties.

Besides, both the health extension worker and the youth center's counseling officer associated the absence of communication between adolescents and their parents to the existing culture. They further exposed that fear emanating from culture is making parents not only unable to communicate with their adolescent children but also with professionals like them.

The challenges related to culture can also be explained via Romnetveit and Blakar communication model. In view of that, one conceptualization of the communication process, according to the Romnetveit and Blakar Communication Model is that, participants must be willing and able to produce a message. This is to mean that, both sender and receiver should be cooperative or prepared so that communication takes place. For instance, in case parents and their adolescents perceive communication about SRH issues as culturally a taboo entity, and feel shy towards sexuality communication, interaction on the sexuality and any related reproductive health issues is unlikely to occur. This is what happened among the current study's adolescents and their parents. Adolescents participated in the study's quantitative part, interviewee adolescents and health professionals mentioned the reason behind not communicating as cultural constraints. Furthermore, all the study's subjects perceived inability of parents to communicate as something culturally constructed.

### **Suggestions Concerning the Manner of Improving the Communication with their Parents on the SRH issues**

In bringing up the desired SRH communication between them and their parents, the interviewee adolescents were asked to forward their suggestions in three outlooks; what is to be done by other concerned parties outside them, what is expected from parents, and lastly, what adolescents should do. Since adolescents were projecting the very nature of the problem as emanating from their parents naiveté on the issue, much of their suggestion on what is to be done on them and their parents was inclined to their parents. Thus, all of the adolescents stressed on raising and/or creating awareness for parents on various SRH issues, and concurrently advised giving short term trainings for parents regarding how to communicate about various SRH issues with their children. Mass media was also given much emphasis to play a paramount role. The health professionals also projected what is to be done by other concerned parties in the same fashion and gave some responsibility for adolescent and youth based clubs, religious institutions, and also to weredas through their various forums for different purposes. In line with this, Romnetveit and Blakar Communication Model advised that participants must have meaningful and relevant information to transfer. Thus, prior to calling for adolescents and their parents to discuss about SRH communication, they [especially parents] need to have equipped with all relevant sexuality and reproductive health information. Though doing this is a prerequisite and will push a step towards the desired communication, it is not an end by itself. There should also be an ability to communicate. All the study's participants [adolescents participated in the questionnaire, interviewee adolescents and health professionals] perceived that parents are not only lacking SRH awareness or knowledge but also the ability to communicate about it. This difficulty can be tackled by employing another basic tenet of the Romnetveit and Blakar Communication Model which states that in order for the communication to occur, participants must have the ability to relay

messages to each other. Thus, by basing the suggestions of all the study participants, the postulations of the mentioned communication model and the researcher's reflection on what to be done, potential participants of SRH communication should also be trained on how to discuss on sexuality and other reproductive health issues.

With regard to what is expected from parents, majority of the adolescents suggested that it would be much easier for parents to take the initiative and recommends that they should take the lion share of responsibility to initiate their adolescents for communication on the SRH issue. The adolescents also insisted that their parents should approach them from their early age, because starting it on later age is difficult for both, as to them. The health professionals assigned a bulk of responsibility to the parents by saying that parents should initiate their children to break the silence and then socialize/educate about sexuality and related issues. Providing such duty to parents seems compelling as it goes with one of the notion of socialization theory that parent and school system might have a positive impact on adolescents' sexual cognitions and practices as long as adolescents look to and value these socialization agents for information about norms and behaviors (Azjen & Fishbein, 1980; Bandura, 1986; as cited in L'Engle & Jackson, 2008, p. 356). Comparably, adolescents who possess strong connections to families and schools are likely to internalize values and standards that support postponing sexual intercourse, especially if adolescents are well aware that these socialization agents disapprove of teen sexual activity (Miller, 1998; as cited in L'Engle & Jackson, 2008, p. 356). It is also consistent with another postulation of socialization theory that families have an early and ongoing role in the socialization of children, and adolescents who have positive connections to their families and schools have less advanced sexual behavior (L'Engle & Jackson, 2008).

Lastly, all interviewee adolescents divert much of the responsibility away from them or attach a very much lesser responsibility to them. Regarding this, one adolescent stated: "...

young people too should show readiness to learn from the experience of their parents” (April 14, 2014). The health professionals did not say anything concerning what is expected from adolescents. This seems alike with what adolescents suggested i.e. ‘only readiness’... just keeping their silence till parents initiate them.

### **Adolescents’ Sources of Information on SRH issues**

In this study, many school adolescents received information on SRH issues from mass media. Friends (peers) and school were preferred sources of SRH information by most of them. Persistently, the dominant number of interviewee adolescents and both health professionals mentioned mass media and other press products as the major source of SRH information for adolescents, and the present study’s adolescents most outstanding reason for sexual initiation among sexually active youths was peer pressure maintaining (61.1%) of adolescents. According to Erikson (1968), a central developmental task for young people is gaining autonomy and developing close relationships with same and opposite-sex peers that help adolescents become more independent (as cited in L’Engle & Jackson, 2008, p. 356). Thus, young people have a propensity to shift their orientation from parents to peers during adolescence. This is justified by L’Engles and Jatson’s (2008) study that peers are more powerful sexual socialization agents than parents, particularly for information about sexual intercourse. Peers transmit sexual information that is often more accepting, and influential, than standards espoused by adults.

This may imply that there is a need to equip school friends (peers) and mass media with the appropriate SRH information and other supportive materials on the issue. By doing so, we can perhaps furnish peers (friends) with the major SRH information which may in turn influence sexual initiation. Similarly, school, friends (peers) and mass media are mentioned in the studies conducted at Bullen woreda and DireDawa high schools students as their sources of SRH information.

### **Summary and Conclusion**

The study was conducted with the objective of assessing the communication between parents and adolescents on SRH issues. It was conducted in one purposively selected preparatory school; i.e. Ayer Tena preparatory school. And so the study and its findings are delimited to this school. To go through the central questions of the study, survey instruments and interview guides suitable to the objectives of the study were employed. Before the main data was collected, a pilot study [for the survey part] was conducted on 22 adolescents who were attending the 11th and 12th grade in Yekatit 12 School to ensure the reliability of the instrument. In view of that, based on the pilot study, some modifications on the items of the questionnaire were made before the actual data collection. Ultimately the questionnaire was administered to 393 adolescents [354 adolescents from the basic sample size and additional 10% of non response rate, maintaining 39 adolescents; together 393 adolescents] from the mentioned school. Out of these, 378 questionnaires were made ready for the quantitative data analysis. The qualitative data was generated from ten interviewee adolescents and two pertinent health professionals.

The major findings of the study were summarized as follows: Adolescents in the study area have knowledge on various components of SRH issues. Additionally, majority of them have positive attitudes towards the importance of parent adolescent communication on SRH issues. Though parent adolescent communication on at least two SRH topics was found to be on average relative to other studies, it is so less in comparison to adolescents perception of its importance . Adolescents from literate parents discuss more as compared to adolescents from illiterate ones. Parent adolescent communication might be influenced by variables such as gender, attitude of respondents on the importance of parent adolescent communication concerning SRH issues, age of adolescents, ever heard about SRH issues and educational level of parents (mother and father). The analysis of both quantitative and qualitative results

informs that the most commonly communicated SRH issue was HIV/AIDS, and communicating about sexual intercourse and condom use were mentioned as the most difficult SRH topics.

Communication about SRH issues has same sex basis; mother-daughter and father-son. Comparing mothers and fathers, adolescents perceived that mothers involved more than fathers on discussing about SRH issue with them. Adolescents mostly feel comfortable discussing SRH issues with their partners. Except for discussion related with menstruation in which mothers are highly favored, adolescents mostly preferred their peers to discuss other SRH issues.

Findings from both types of data revealed mass media as the primary source of SRH information by adolescents in the study area, and peers and school were preferred to have SRH information by most of them.

Cultural constraints; keeping both shamefulness and fear of parents, and lack of communication skill [for only one SRH issue i.e. SRH services necessary for adolescents , but mentioned by the vast majority of adolescents] were also the most commonly raised reasons for adolescents not discussing SRH issues with parents. The findings of the qualitative result also supported these ideas.

In order to bring the desired SRH communication between adolescents and their parents, various approaches were suggested. But both knowledge promotion on various elements of SRH issues and the way to transfer or communicate them to parents is the most frequently advised modus operandi.

Much has been done to generate a complete or unbiased account of the issue under consideration but yet adolescents self reported data might not provide absolute or impartial information on the communication they have with their parents. Thus, further study incorporating the perception of parents should be conducted. Quality of parent adolescent

communication on SRH issues and mode of communication which were not addressed in the present study also need further investigation. Other studies considering intensity/depth and timing of SRH communication between parents and adolescents, and effect of parent adolescent communication on sexual behavior of adolescents are areas of investigation on the issue for other researchers. The Effects of various parenting styles on the extent parent adolescent communication has on SRH issues also can be another area of investigation for future research.

**Scope of the Study**

The study was delimited to focus on the review of adolescent parent communication concerning SRH issues. The specific experiences of preparatory school students on the identified issues as research objectives and questions were assessed. It was conducted from January 07, 2014 G.C – May 15, 2014 G.C. on unmarried adolescents who at the time of the study were pursuing their preparatory education in Ayer Tena Preparatory school of Kolfe Keraneyo Sub city administration, Addis Ababa, Ethiopia. The school is found in Kolfe Keraneyo Sub city administration's Wereda<sup>1</sup> one.

**Strengths of the Study**

In addition to following the rules and procedures of mixed research method; the maximum number of samples were utilized, the sayings of the concerned professionals was counted, and the communication model unlike the many other comparable studies in the country was employed. The study's potential to provide information for comparable studies that might be conducted in the future, and its capacity to offer a hint for social workers or other practitioners in the areas of adolescent's SRH problems could be taken as the strength of the study.

### **Implications of the Study**

This part is concerned with the implications of the study to various entities. It was articulated based on the findings obtained from the study.

#### **Implications for research**

Though this study pinpointed a number of issues as a research question, all related topics about the communication of adolescents with their parents on SRH issues could not be addressed by a single research. Thus, social workers should undertake related searches inclusive of adolescents' parents so that to fully grasp a complete or unbiased account on the issue. Besides, in spite of the critical nature of the topics under consideration, there are very few researches directly linked to these issues. Then, the study calls for further investigation in these areas to fill the knowledge gap, thereby inform the practice in the area.

To the best effort of the researcher of this study, an attempt was made to review the studies that are already conducted about SRH communication between parents and adolescents and related issues in the country. But it was found that the vast majority of the studies were conducted in urban settings. Thus, this study also recommends that the majority of the Ethiopian rural population should be assessed on the issue. It is clear that in order to be good one, a research should utilize theories and/or models to support its findings. But to the maximum literature searching capacity of the researcher, no other studies in the country which employed a communication theory and/or model was found. For this reason, in an attempt to create a common understanding of the issues under consideration, this study utilized one theory and one communication model into the communication between parents and their adolescents on SRH issues. It is therefore suggested that other researchers who need to conduct more inclusive study on the issue should employ relevant theories and/or models of communication to create understanding of the issues in a broader sense.

**Implication for social work education**

The Council on Social Work Education (CSWE) has mandated that social work education pay special attention to the diverse needs and interests of clients, practitioners, social work students, and educators (Kreuger and Neuman, 2005). Accordingly this particular study informs the social work education in a way that the social work education system in general and courses related to adolescents in particular should take the circumstances of the country's adolescents into account instead of adopting the whole content from abroad. In other words, (Specific curriculum related to adolescents should be designed in the context of the country). Another important implication is that engaging parents and adolescents' towards communication between them on SRH issues is necessary for social work education in general and teaching social work courses in particular. Because most courses of social work needs experiential learning and reflective processes to make the course materials relevant and real. In addition, one of the ten competencies of the social work profession is that social workers should have knowledge informed practice and practice informed knowledge. Thus, in order to bring this kind of competency among the social work graduates, such research findings should be incorporated in the social work teaching processes in general and in the processes of teaching students from the children, youth, and family concentration in particular. It further informs that in the field placement processes some social work students should be placed in organizations giving service to adolescents SRH issues.

**Implication for social work practice**

Studying the communication between parents and their adolescents has important implication for social work practice; it can provide an important input for practice on families in general and parents and/or adolescents in particular. Accordingly, based on the findings of this study, the respective preparatory school has to bring the way to break the gap that hinder parent adolescent communication on sexuality; through incorporating SRH issue in the

school curriculum and giving home take assignments to be completed by both parents and adolescents.

According to one of the findings of this study, the vast majority of adolescents get information related to sexuality and other reproductive health from public medias; hence, local medias has to focus not only on delivering facts on SRH, but they should also prepare programs having a potential to promote parent adolescent communication concerning various SRH topics.

The surrounding woreda Health Office in collaboration with the respective woreda's Women, Children and Youth office, and with the concerned GOs and NGOs should create system of educating parents about basic information of SRH and the importance of communicating with their adolescent children about it. The same organizations should also facilitate adolescent-friendly services in order to enhance sex related education and the way of parent adolescent communication on SRH issues for adolescents (for instance, separating service delivery places of parents and adolescents). As per the findings of this study, most adolescents discuss SRH related issues with their peers. Hence, a kind of peer mentoring trainings on the issue should also be facilitated.

The study also informs us that in order to overcome the highly mentioned taboos, fears and shames emanating from the existing culture, the respective sub city's Health Bureau, Women, Children and Youth Affairs Bureau, and Culture and Tourism Bureau should create various seminars and/or sessions with the respective sub-city adolescent parents, religious leaders, influential community members, and community elders.

### **Implication for policy-making**

The 2004 FDRE Health Policy did not give attention to adolescents' SRH. Deducing the issue underconsideration, one can say that policy is not expected to articulate each and

every issue explicitly. Yet, the issue under consideration is not included, at least implicitly. Thus, the current study implies that the FDRE Health Policy should incorporate an entity directly related to enhancing parent adolescent communication concerning SRH issues which can be implemented via its various health care programs.

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**APPENDICES: APPENDIX A****English Version Questionnaire****General Information and Study Participant's Consent Form**

Identification No \_\_\_\_\_  
(To be filled by the researcher)

Dear respondent,

My name is Solomon Zewdu. I am studying Masters Degree of Social Work in Addis Ababa University, School of Social Work. Now I'm going to conduct study on adolescent parent communication concerning sexual and reproductive health issues among Ayer Tena preparatory students. The study is mainly focused on assessing the extent of communication of study areas adolescents and their parent's on SRH issues, factors affecting their communication, and manners of improving their communication. This study had been approved by the Addis Ababa University School of Social Work to be conducted in partial fulfillment of Masters Degree in Social Work. Even though you will not gain a very direct benefit from this study, the results of the study will be used by the government's and other concerned stakeholders in order to intervene in to a comparable issues. Hence, the genuine and honest information you provide me is very essential in responding to the study questions/ to attain the objectives of the study. All the information you give me will kept private, and anyone who will not be willing to participate in the study will have the right to stop. Furthermore, your confidentiality and privacy will be maintained by allowing you to answer the questions in a separate place where no one can interrupt you.

**Procedures in filling the questionnaire:** It takes about 20 minutes to complete this questionnaire. After reading the questions, give your answers from the given alternatives basing your own life experiences. If your answer is out of the given alternatives, fill in the blank space saying 'others (specify)'.

In any questions concerning the study you can contact me via my telephone number and Email address.

Telephone number: 0913-26-16-81

Email address: [slmnzwd@gmail.com](mailto:slmnzwd@gmail.com)

Addis Ababa University, School of Social Work

**I thank you in advance for your time!**

Would you be willing to participate in the study? 1. Yes 2. No

If yes, proceed to the next page.

If no, please stop here.

**Thank you!!**

**Adolescent's Consent Form**

I the undersigned have been informed that this study is going to be conducted for the purpose of assessing parent adolescent communication on sexual and reproductive health issues in Ayer Tena Preparatory School. I am informed that the information I give will kept confidential and only used for the purpose of this study. I am also conscious that I have the right not to respond to any question without my interest. Hence, I agree to participate in the research voluntarily with the hope of contributing to the effort of assessing communication of adolescents and their youth with regard to sexual and reproductive health issues.

Signature\_\_\_\_\_

Date\_\_\_\_\_

**Structured/Close ended Questions**

<b>1. Socio Demographic Characteristics of Adolescent Respondents</b>		
<i>S.No</i>	<i>Questions</i>	<i>Response</i>
1	Age	_____ in years
2	Grade	_____
3	Sex	1. Male 2. Female
4	Religion	1. Orthodox Christian 2. Protestant Christian 3. Muslim 4. Catholic 5. Others(specify) _____
5	Ethnicity	1. Oromo 2. Amhara 3. Tigre 4. Gurage 5. Others (specify) _____
6	With whom you are currently living	1. Live with father and mother 2. Mother only 3. Father only 4. With brothers /sisters 5. With friends 6. Living alone 7. With relative
<b>2. Socio Demographic Characteristics of Parents of adolescent Respondents</b>		
1	Marital status of parent	1. Together 3. Divorced 2. Living far apart, but not separated 4. Widowed 5. Mother not alive 6. Father not alive
2	Family size of your parent (including mother and father)	_____ in number
3	Educational status of mother	1. Illiterate 2. Read and write 3. Primary (1-8) 4. Secondary (9-12) 5. Diploma 6. First degree and above 7. Others (specify) _____

4	Educational status of father	<ol style="list-style-type: none"> <li>1. Illiterate</li> <li>2. Read and write</li> <li>3. Primary</li> <li>4. Secondary</li> <li>5. Diploma</li> <li>6. First degree and above</li> <li>7. Others(specify)_____</li> </ol>
5	Parent income/per month (Ethiopian birr)	<ol style="list-style-type: none"> <li>1. _____birr</li> <li>2. I don't know</li> </ol>
6	Occupational status of mother	<ol style="list-style-type: none"> <li>1. House wife</li> <li>2. Government employee</li> <li>3. Private employee</li> <li>4. Merchant</li> <li>5. Other specify_____</li> </ol>
7	Occupational status of father	<ol style="list-style-type: none"> <li>1. Has no work</li> <li>2. Government employee</li> <li>3. Private employee</li> <li>4. Merchant</li> <li>5. Other specify _____</li> </ol>

### 3. Knowledge of Adolescent Respondents on Selected Sexual and Reproductive Health Issues

1	Have you ever heard about reproductive health? <b>(If your answer is No skip to question number 4).</b>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
2	If yes to question number 1, at what age	_____years of age
3	What was your first Source of information about reproductive health? <b>(More than one answer is possible)</b>	<ol style="list-style-type: none"> <li>1. School</li> <li>2. Peer including girl or boy friend</li> <li>3. Mass media (TV, Radio, Magazines, News paper)</li> <li>4. Family (father and mother)</li> <li>5. Brothers /sisters</li> <li>6. Relatives</li> <li>7. Other specify</li> </ol>
4	Do you know about sexually transmitted infections?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
5	If <b>yes</b> to question number 1 what type? <b>(more than one answer is possible)</b>	<ol style="list-style-type: none"> <li>1. Gonorrhea</li> <li>2. Chancroid</li> <li>3. HIV/AIDS</li> <li>4. Syphilis</li> <li>5. Others(specify)-----</li> </ol>

6	Do you know about contraceptive method for youth?	1. Yes 2. No
7	If <b>yes</b> to question number 6, which one do you know? <b>(more than one answer is possible)</b>	1. Pills 2. Condom 3. Depo 4. Norplant 5. IUD 6. Using safe period or natural method 7. Others (specify)
8	<b>(only for female respondents)</b> Do you know when the menstruation cycle starts?	1. Yes 2. No
9	<b>(only for female respondents)</b> If your answer is yes to question number 9, at what age?	_____ Years of age
10	Do you know physical and behavioral changes during puberty	1. Yes 2. No
11	What are behavioral and physical change occurs during adolescence <b>(multiple answer is possible)?</b>	1. Breast development in female 2. On set of menstruation in females 3. Change in voice in both sex 4. Refuse parent command 5. Interest towards opposite sex 6. Interest to have sex 7. Feel angry for minor reasons 8. Other specify

#### 4. Attitude of Adolescent Respondents Towards Major Sexual and Reproductive Health issues

1	Is premarital sex acceptable?	1. Yes 2. No
2	Boy has to force girls to have sex if he loves her.	1. Agree 2. Disagree 3. Not sure
3	A girl have to remain a virgin until she marries	1. Agree 2. Disagree 3. Not sure
4	A boy have to remain virgin until he marries	1. Agree 2. Disagree 3. Not sure
5	Parent adolescent communication on SRH issues delay first sexual intercourse	1. Agree 2. Disagree 3. Not sure

6	Do you believe that, if unmarried couples want to have sexual intercourse before marriage they must use condom?	1. Yes 2. No
7	Do you believe that, STIs and HIV/AIDs can be prevented using condom?	1. Yes 2. No
8	Have you ever had sexual intercourse? <b>(If your answer is No skip to question number 15).</b>	1. Yes 2. No
9	If yes to question number 8, at what age did you start sexual intercourse?	_____ Years of age
10	If yes to question number 8, with how many partners did you have sexual intercourse?	1. One 2. Two 3. Three and above
11	If yes to question number 8, did you or your partner use condom in your first time sexual intercourse?	1. Yes 2. No 3. I don't remember
12	If yes to question number 8, Did you use condom consistently?	1. Yes 2. No 3. I don't remember
13	During the first time you had sexual intercourse; did you or your partner use any other method of birth control except condom?	1. Yes 2. No 3. I don't remember
14	During the first time you had sexual intercourse; what initiate you to have sexual intercourse? <b>(multiple answer is possible)</b>	1. Peer pressure 2. Watching pornographic films 3. My own internal interest to have sex 4. My girl friend or boy friend 5. Alcohol, Chat or other drugs 6. Other (specify)____ _____
15	If no to question number 8, what is the main reason you have not had sexual Intercourse? <b>(multiple answer is possible)</b>	1. I want to wait until I am older 2. I want to wait until I am married 3. I do not want to risk getting pregnant/made some one pregnant 4. I do not want to risk getting a sexually transmitted infections such as HIV/AIDS 5. I have not had a chance to have a sex or mate anyone that I wanted to have sex with 6. It is against my religious values 7. Fear of my parents 8. Other specify _____

<b>5. Concerning the Communication Between Parents and Adolescents Concerning Sexual and Reproductive Health Issues</b>		
1	Do you think it is important to discuss about sexual and reproductive health issues with parents?	1. Yes 2. No 3. I do not know
2	With whom do you discuss about sexual and reproductive health issues?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teacher's 7. Religious leaders 8. Other specify _____
3	With whom do you prefer more (first choice) to discuss issues related to sexual and reproductive health?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teacher's 7. Religious leaders 8. Other specify _____
4	Have you ever discussed sex related issues and reproductive health issues with your father or mother?	1. Yes 2. No
5	Have you ever discussed contraception? <b>(If your answer is No skip to question number 9)</b>	1. Yes 2. No
6	If yes to question number 5, with who do you discuss issues related to contraception?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers 7. Religious leaders 8. Other specify _____
7	With whom do you prefer more (first choice) to discuss issues related to contraception?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers 7. Religious leaders 8. Other specify _____
8	If yes to question number 5, how frequent do you discuss about contraception?	1. Often 2. Some times 3. Rarely
9	If you don't discuss contraception with your parents what is your reason? <b>(multiple answer is possible)</b>	1. Shame 2. Culturally unacceptable 3. Lack of knowledge 4. Lack of communication skill

		5. Fear of parents 6. Other (specify)_____
10	Have you ever discussed STI and HIV/AIDS? <b>If your answer is No skip to question number 14</b>	1. Yes 2. No
11	If yes to question number 10, with whom do you discuss issues related to STI and HIV/AIDS?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers 7. Religious leaders 8. Other (specify) )_____
12	With whom do you prefer more (first choice) to discuss issues related to STI and HIV/AIDS?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers 7. Religious leaders 8. Other (specify) )_____
13	If yes to question number 10, how frequent do you discuss STI and HIV/AIDs?	1. Often 2. Some times 3. Rarely
14	If you don't discussed STI and HIV/AIDs with your parents what is your reason? <b>(multiple answer is possible)</b>	1. Shame 2. Culturally unacceptable 3. Lack of knowledge 4. Lack of communication skill 5. Fear of parents 6. Other (specify)_____
15	Have you ever discussed sexual intercourse with your parents? <b>If no skip to question number 20.</b>	1. Yes 2. No
16	If yes to question number 15, on what issues?	1. Having sex before marriage 2. Not having sex before marriage 3. Other (specify)_____
17	If yes to question number 15, with who do you discuss issues related to sexual intercourse?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers' 7. Religious leaders 8. Other (specify) _____
18	With whom do you prefer more (first choice) to discuss issues related to sexual intercourse?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers'

		7. Religious leaders 8. Other (specify) _____
19	If yes to question number 15, how frequent do you discuss?	1. Often 2. Some times 3. Rarely
20	If you don't discuss about sexual intercourse with your parents what is your reason? <b>(multiple answer is possible)</b>	1. Shame 2. Culturally unacceptable 3. Lack of knowledge 4. Lack of communication skill 5. Fear of parents 6. Other (specify) _____
21	Have you ever discussed unintended pregnancy? <b>If no skip to question number 25.</b>	1. Yes 2. No
22	If yes to question number 21, with who do you discuss issues related to unintended pregnancy?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teaches 7. Religious leaders 8. Other (specify) _____
23	With whom do you prefer more (first choice) to discuss issues related to unintended pregnancy?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teaches 7. Religious leaders 8. Other (specify) _____
24	If yes to question number 21, How frequent do you discuss unintended pregnancy?	1. Often 2. Some times 3. Rarely
25	If you don't discuss unintended pregnancy with your parents what is your reason? <b>(multiple answer is possible)</b>	1. Shame 2. Culturally unacceptable 3. Lack of knowledge 4. Lack of communication skill 5. Fear of parents 6. Other (specify) _____
26	Have you ever discussed the use of a condom? <b>(If No skip to question number 30)</b>	1. Yes 2. No

27	If yes to question number 26, with who do you discuss issues related to the use of condom?	<ol style="list-style-type: none"> <li>1. Father</li> <li>2. Mother</li> <li>3. Brothers or sisters</li> <li>4. Peer</li> <li>5. Girl friend/boy friend</li> <li>6. Teachers'</li> <li>7. Religious leaders</li> <li>8. Other (specify) _____</li> </ol>
28	With whom do you prefer more (first choice) to discuss use of condom?	<ol style="list-style-type: none"> <li>1. Father</li> <li>2. Mother</li> <li>3. Brothers or sisters</li> <li>4. Peer</li> <li>5. Girl friend/boy friend</li> <li>6. Teachers'</li> <li>7. Religious leaders</li> <li>8. Other (specify) _____</li> </ol>
29	If yes to question 26, How frequent do you discuss condoms use?	<ol style="list-style-type: none"> <li>1. Often</li> <li>2. Some times</li> <li>3. Rarely</li> </ol>
30	If you don't discuss condom use with your parents what is your reason? <b>(multiple answer is possible)</b>	<ol style="list-style-type: none"> <li>1. Shame</li> <li>2. Culturally unacceptable</li> <li>3. Lack of knowledge</li> <li>4. Lack of communication skill</li> <li>5. Fear of parents</li> <li>6. Other (specify) _____</li> </ol>
31	Have you ever discussed the physical and psychological changes during puberty? <b>(If no skip to question number 35)</b>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
32	If yes to question number 31, with who do you discuss issues related to physical and psychological changes during puberty?	<ol style="list-style-type: none"> <li>1. Father</li> <li>2. Mother</li> <li>3. Brothers or sisters</li> <li>4. Peer</li> <li>5. Girl friend/boy friend</li> <li>6. Teachers'</li> <li>7. Religious leaders</li> <li>8. Other (specify) _____</li> </ol>
33	With whom do you prefer more (first choice) to discuss issues related to physical and psychological changes during puberty?	<ol style="list-style-type: none"> <li>1. Father</li> <li>2. Mother</li> <li>3. Brothers or sisters</li> <li>4. Peer</li> <li>5. Girl friend/boy friend</li> <li>6. Teachers'</li> <li>7. Religious leaders</li> <li>8. Other (specify) _____</li> </ol>
34	If yes to question number 31, how frequent do you discuss physical and psychological changes during puberty?	<ol style="list-style-type: none"> <li>1. Often</li> <li>2. Some times</li> <li>3. Rarely</li> </ol>

35	If you don't discuss physical and psychological changes during puberty with your parents what are your reasons? <b>(multiple answer is possible)</b>	1. Shame 2. Culturally unacceptable 3. Lack of knowledge 4. Lack of communication skill 5. Fear of parents 6. Other (specify) _____
36	<b>(Only for females)</b> Have you ever discussed the menstrual period? <b>(If no skip to question number 40)</b>	1. Yes 2. No
37	<b>(Only for females)</b> If yes to question number 36, with who do you discuss issues related to menstruation?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers' 7. Religious leaders 8. Other (specify) _____
38	<b>(Only for females)</b> If yes to question number 36, with whom do you prefer more (first choice) to discuss issues related to menstruation?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers' 7. Religious leaders 8. Other (specify) _____
39	<b>(Only for females)</b> If yes to question number 36, how frequent do you discuss the menstrual period?	1. Often 2. Some times 3. Rarely
40	<b>(Only for females)</b> If you don't discuss the menstrual period with your parents what are your reasons? <b>(multiple answer is possible)</b>	1. Shame 2. Culturally unacceptable 3. Lack of knowledge 4. Lack of communication skill 5. Fear of parents 6. Other (specify) _____
41	Have you ever discuss the sexual and reproductive health services necessary for adolescents? <b>If no skip to question number 45.</b>	1. Yes 2. No
42	If yes to question number 41, with who do you discuss issues related to sexual and reproductive services necessary for youth?	1. Father 2. Mother 3. Brothers or sisters 4. Peer 5. Girl friend/boy friend 6. Teachers' 7. Religious leaders 8. Other (specify) _____

43	With whom do you prefer most (first choice) to discuss issues related to the sexual and reproductive services necessary for youth?	<ol style="list-style-type: none"> <li>1. Father</li> <li>2. Mother</li> <li>3. Brothers or sisters</li> <li>4. Peer</li> <li>5. Girl friend/boy friend</li> <li>6. Teachers'</li> <li>7. Religious leaders</li> <li>8. Other (specify) _____</li> </ol>
44	If yes to question number 41, how frequent did you discuss the sexual and reproductive health services necessary for adolescents?	<ol style="list-style-type: none"> <li>1. Often</li> <li>2. Some times</li> <li>3. Rarely</li> </ol>
45	If you didn't discuss the sexual and reproductive health services necessary for adolescents what is your reason? <b>(More than one answer is possible)</b>	<ol style="list-style-type: none"> <li>1. Shame</li> <li>2. Culturally unacceptable</li> <li>3. Lack of knowledge</li> <li>4. Lack of communication skill</li> <li>5. Fear of parents</li> <li>6. Other (specify) _____</li> </ol>
46	Have you ever discussed opposite sex relationship (girl/boyfriends) <b>If no skip to question number 51?</b>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
47	If yes to question number 46, on what issues of opposite sex relationship?	<ol style="list-style-type: none"> <li>1. Having girl/boy friend before 18 years of age</li> <li>2. Not having boy or girl friend before 18 years of age</li> </ol>
48	If yes to question number 538, with whom you discuss issues related to opposite sex relationship?	<ol style="list-style-type: none"> <li>1. Father</li> <li>2. Mother</li> <li>3. Brothers or sisters</li> <li>4. Peer</li> <li>5. Girl friend/boy friend</li> <li>6. Teachers'</li> <li>7. Religious leaders</li> <li>8. Other (specify) _____</li> </ol>
49	With whom prefer to discuss (your first choice) issues related to opposite sex relationship?	<ol style="list-style-type: none"> <li>1. Father</li> <li>2. Mother</li> <li>3. Brothers or sisters</li> <li>4. Peer</li> <li>5. Girl friend/boy friend</li> <li>6. Teachers'</li> <li>7. Religious leaders</li> <li>8. Other (specify) _____</li> </ol>
50	If ye to question number 46, how frequent did you discuss?	<ol style="list-style-type: none"> <li>1. Often</li> <li>2. Some times</li> <li>3. Rarely</li> </ol>
51	If you didn't discuss opposite sex relationship what is the reason? <b>(multiple answer is possible)</b>	<ol style="list-style-type: none"> <li>1. Shame</li> <li>2. Culturally unacceptable</li> <li>3. Lack of knowledge</li> <li>4. Lack of communication skill</li> <li>5. Fear of parents</li> <li>6. Other (specify) _____</li> </ol>

52	Is your father open to discussing sexual issues?	1. Yes 2. No
53	Is your mother open to discussing sexual issues?	1. Yes 2. No
54	If you have ever discussed at least one of the above issues, at what age have you started discussing it?	_____ Years of age
55	If you have discussed on some issues of SRH, was the information adequate?	1. Yes 2. No

**THANK YOU FOR YOUR COOPERATION!**

## APPENDIX B

### Interview guide with adolescents

#### The guidelines was as follows:

- ✓ Welcoming and Greeting
- ✓ Explain the objectives and the overall procedures of the interview
- ✓ Ask the willingness of the selected adolescents for participating in the interview.
- ✓ After recapping that their confidentiality was maintained ask for to use a tape recorder

### Questions to be asked under major thematic areas

#### I) Questions revolving around the basic facts of sexual and reproductive health and their sources of information

1. Can you tell me about your understanding of SRH?
  - What is sexual and reproductive health issues mean to you?
2. Have you ever tried to know what SRH is?
  - If yes, from where did you get information?

#### II) About discussion on sexual and reproductive health issues

3. Have you ever discussed about sexual and reproductive health issues?
4. If you have been discussed so far, with whom you discussed? When you discussed?
5. Do you think parents should chat about sexual and reproductive health issues with their adolescent children?
6. What is the importance of adolescents' discussion about SRH issues with their parents?
7. Have you ever discussed about it with your parents? If yes, when you discussed? With whom?
8. Do you feel comfortable in discussing issues related to SRHs with your parents?

#### III) Contents of Parent Adolescent Communication on SRH issues

9. What type of sexual and reproductive health issues you discussed with your parents?
10. Who decides on what to talk?

11. Where do you have such discussion? Are you feeling comfortable with these places?
12. What do you think concerning the adequacy of information you get from your parents?

**IV) Adolescents perception regarding the challenges related to the communication between the adolescents and parents**

13. What is hard (challenge) for you in having communication/discussion concerning SRH issues with your parents (barriers for not communicating?)  
What are the reasons?
14. Are there topics you find easy/difficult to discuss? Which are these? Why so?

**V) Adolescents suggestions concerning the manner of improving**

15. What do you think to be done to improve the communication of sexual and reproductive health matters among adolescents and their parents?
16. What advice would you give to other adolescents in order to deal with the issues of sexual and reproductive health?
17. What advice would you give to parents in order to deal with their adolescents' issues of sexual and reproductive health?

**Thank you!!**

## APPENDIX C

### Interview guide for Youth Center's Counselor

#### The guidelines was as follows:

- ✓ Welcoming and Greeting
- ✓ Explain the objectives and the overall procedures of the interview
- ✓ Ask the willingness of the selected adolescents for participating in the interview.
- ✓ After recapping that their confidentiality was maintained ask for to use a tape recorder

#### Questions to be asked

**NB: all the below mentioned questions are intended to comprehend our contexts, not the global contexts)**

1. As a counselor of this youth center, what are the central /main points of discussion while counseling youths?
2. Did you give counseling for youths in relation to sexual and reproductive health issues? If yes, in which related issues your service are revolving around?
3. Did you come across with youths who have faced sexual and reproductive health related problems? If yes, how do you explain about the extent of these problems?
4. Did these problems are associated with the youth's communication with their parents? If so, how? Have you tried or trying to work with the families of these youths?
5. Other than this youth center, are there any centers in your surroundings involving on awareness creation or provision of services related to sexual and reproductive health issues for youths? If yes, what kind of services they are delivering and in what way?
6. What are the available sources of information for youths concerning sexual and reproductive health related issues?
7. Among the available sources of information, which one is accessible and effective?
8. Basing your experience, how do you explain the discussion of youths about sexual and reproductive health related issues with their parents?
9. If you think the discussion between youths and their parents is not satisfactory, as a professional what do you think is the reason?
10. How do you explain the problems resulted in the failure of youths to discuss about sexual and reproductive health related issues with their parents?
11. What do you suggest to improve the discussion?

## APPENDIX D

### Interview guide for Health Extension Worker

#### The guidelines was as follows:

- ✓ Welcoming and Greeting
- ✓ Explain the objectives and the overall procedures of the interview
- ✓ Ask the willingness of the selected adolescents for participating in the interview.
- ✓ After recapping that their confidentiality was maintained ask for to use a tape recorder

#### Questions to be asked

**NB: all the below mentioned questions are intended to comprehend our contexts, not the global contexts)**

1. As a health extension worker, in which health related issues you are working with parents?
2. Did you facilitate discussion about sexual and reproductive health related issues to parents?
3. How do you explain the discussion between youths and their parents concerning sexual and reproductive health related issues?
4. Concerning sexual and reproductive health related issues, which sources of information are available for youths and their parents?
5. Among the available sources of information, which one do you think is accessible and effective?
6. In your professional carrier, did you encountered youths who have faced sexual and reproductive health related problems?
7. Did youth's sexual and reproductive health problems have resulted in their relationship with their parents? If so, how?
8. Basing your experience, how do you explain the discussion of youths about sexual and reproductive health related issues with their parents? If youths and parents are not discussing sexual and reproductive health related issues, or the level of discussion is not satisfactory, as a professional, what do you think are the reasons?
9. How do you explain the problems resulted in the failure of youths to discuss about sexual and reproductive health related issues with their parents?
10. What do you suggest to improve the discussion between youths and their parents concerning sexual and reproductive health related issues?

APPENDIX E

የአየር ጤና መሰናዶ ትምህርት ቤት ተማሪዎች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ጉዳዮች ላይ የሚያደርጉትን ውይይት ለማጥናት የተዘጋጀ መጠይቅ አጠቃላይ መረጃ እና የጥናቱ ተሳታፊዎች ፈቃደኝነታቸውን የሚያሳዩበት ቅፅ

የመለያ ቁጥር \_\_\_\_\_  
(በአጥኚው የሚሞላ)

**ውድ የጥናቱ ተሳታፊዎች!**

ስሜ ሰለሞን ዘውዱ ይባላል። በአሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ የሶሻል ወርክ ትምህርት ክፍል በሶሻል ወርክ የሁለተኛ ዲግሪዬን ትምህርት እየተከታተልኩ እገኛለሁ። የሁለተኛ ዲግሪዬን ለመጨረስ ይረዳኝ ዘንድ በአየር ጤና መሰናዶ ትምህርት ቤት ውስጥ ያሉ ወጣቶች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ የሚያደርጉትን የውይይት መጠን፣ እንዳይወያዩ የሚያደርጓቸው ምክንያቶች፣ ቢወያዩ ምን ጥቅም እንደሚያገኙ እና ውይይታቸውን ለማሻሻል መደረግ ባለበት ሁኔታ ላይ ጥናት እያደረኩ እገኛለሁ። ጥናቱ በአዲስ አበባ ዩኒቨርሲቲ ሶሻል ወርክ ትምህርት ክፍል የፀደቀ ነው።

ስለሆነም ከላይ የተዘረዘሩት የጥናቱ ዓላማዎች ይሳኩ ዘንድ በእናንተ በኩል በእውነታ ላይ የተመሠረተና ትክክለኛ የሆነ መረጃ እንድትሞሉ እየጠየኩ በመጠይቁ የምትሞሉት በግላችሁ ስለሆነ እና በመጠይቁ ላይ የምትመልሱት መልስ ግላዊ እና ስማችሁን ያላከተተ በመሆኑ በከፍተኛ ሚስጥራዊነት የሚጠበቅ ይሆናል። ከዚህም በተጨማሪ በጥናቱ ላይ የምትሳተፉት በፈቃደኝነት ስለሆነ ከማይመለከታችሁ ጥያቄዎች ውጭ ያልተመቻችሁ ጥያቄዎች ካሉ ባዶ ቦታ መተው ትችላላችሁ፤ መጠይቁንም መሙላት ባለስፈላጊነት ጊዜ ማቆም/ማቋረጥ መብታችሁ ነው።

በዚህ ጥናት ላይ በመሳተፋችሁ በቀጥታ የምታገኙት ጥቅም ባይኖርም ከጥናቱ በሚገኘው ግኝት መንግስትና ሌሎች ባለድርሻ አካላት በትምህርት ቤት ውስጥ ያሉ እናንተን መሰል ወጣት ተማሪዎች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ውይይት ባለማድረግ የሚከሰትባቸውን ችግሮች ለመቅረፍ እጅግ ጠቃሚ ነው።

**የመረጃ አሞላል ሂደት**

ይህን መጠይቅ ለመሙላት 25 ደቂቃ ሊወስድባችሁ ይችላል። መጠይቁን በግላችሁ ካነበባችሁት በኋላ መልሶቻችሁን ከተሰጡት አማራጮች ውስጥ በራሳችሁ ህይወት ላይ ተሞርኩዛችሁ መልስ ሊሆን የሚችለውን አክብቡበት፤ ከተዘረዘሩት አማራጮች ውጭ ሌላ መልስ ካላችሁ ሌላ ከሆነ ግለፁ በሚለው ምርጫ ስር መልሳችሁን ያፋ።

ጥናቱን በተመለከተ መጠየቅ የምትፈልጉት ጥያቄ ካላችሁ በሚከተለው አድራሻ ደውላችሁ ወይም ኢ-ሜል አድርጋችሁ መጠየቅ ትችላላችሁ፡

ሰለሞን ዘውዱ ስልክ ቁጥር 0913 26 16 81

ኢ-ሜል: [slmnzwd@gmail.com](mailto:slmnzwd@gmail.com)

**ጊዜያችሁን ስለሰጣችሁኝ በቅድሚያ አመሠግናለሁ።**

መጠይቁን ለመመለስ ፈቃደኛ ነህ/ሽ? 1. አዎ

2. አይደለሁም

መልሳችሁ አዎ ከሆነ ወደሚቀጥለው ገፅ እለፍ/እለፊ፤ አይደለም ከሆነ ከዚሁ አቁም/ሚ።

**አመሠግናለሁ!!!**

### የጥናቱ ተሳታፊዎች ፈቃደኝነት ቅፅ

እኔ የጥናቱ ተሳታፊ የሆንኩኝ ተማሪ ይህ ጥናት የአየር ጤና መሠናዶ ትምህርት ቤት ወጣት ተማሪዎች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ጉዳዮችን በተመለከተ የሚያደረጉትን ውይይት ለመዳሰስ የተዘጋጀ መሆኑን አውቄያለሁ። የሚሰጠውም ግላዊ መረጃዬ በሚስጥራዊነት እንደሚጠበቅ እና ለዚህ ጥናት አላማ ብቻ እንደሚውል ተነግሮኛል። ጥናቱ ውስጥ ያለፍላጎት ተሳታፊ ሆኜ መቀጠል እንደሌለብኝ እና መቀጠል ባልፈለኩ ጊዜ ማቆም እንደምችል ተረድቼአለሁ። በአጠቃላይ ከላይ የተዘረዘሩትን መብቶቼን በማወቅና የእኔ በዚህ ጥናት ላይ መሳተፍ ጥቅም አለው ብዬ በማመን በሙሉ ፈቃደኝነት ለመሳተፍ ተስማምቼአለሁ።

ፊርማ \_\_\_\_\_

ቀን \_\_\_\_\_

**ጥያቄዎች**

ተ.ቁ	ጥያቄ	መልስ
<b>1. የወጣቶች መሠረታዊ የግል ማህበራዊ ጥያቄዎች</b>		
1	ዕድሜህ/ሽ	_____ ዓመት
2	ክፍል	_____
3	ፆታ	1. ወንድ 2. ሴት
4	ሀይማኖትህ/ሽ	1. ኦርቶዶክስ ክርስቲያን 2. ኘሮቴስታንት ክርስቲያን 3. ሙስሊም/ኢስላም 4. ካቶሊክ 5. ሌላ ከሆነ ይገለፅ _____
5	ብሔርህ/ሽ	1. ኦሮሞ 2. አማራ 3. ትግሬ 4. ጉራጌ 5. ሌላ ከሆነ ይገለፅ _____
6	በአሁኑ ወቅት ከማን ጋር ነው የምትኖረው/ሪው	1. ከእናትና አባቱ ጋር 2. ከእናቱ ጋር 3. ከአባቱ ጋር 4. ከወንድሞቹ/እህቶቹ ጋር 5. ከጓደኛዬ ጋር 6. ለብቻዬ 7. ሌላ ከሆነ ይገለፅ _____
<b>2. የቤተሰብ መሠረታዊ የግል ጥያቄዎች</b>		
1	የወላጆችህ/ሽ የጋብቻ ሁኔታ	1. አብረው የሚኖሩ 2. ተፋተዋል 3. ያልተፋቱ ነገር ግን ተለያይተው የሚኖሩ 4. እናት በህይወት የሌለች 5. አባት በህይወት የሌለ
2	የቤተሰቦችህ/ሽ ብዛት ስንት ናቸው? (እናትህን/ሽን እና አባትህን/ሽን ጨምሮ)	በቁጥር _____

3	የእናት-ህ/ሽ የትምህርት ደረጃ	<ol style="list-style-type: none"> <li>1. ያልተማረች</li> <li>2. ማንበብ እና መጻፍ የሚችሉ</li> <li>3. የአንደኛ ደረጃ ትምህርት (1-8)</li> <li>4. የሁለተኛ ደረጃ ትምህርት (9-12)</li> <li>5. ዲግሎማ</li> <li>6. የመጀመሪያ ዲግሪ እና ከዚያ በላይ</li> <li>7. ሌላ ከሆነ ይገለጹ _____</li> </ol>
4	የአባት-ህ/ሽ ትምህርት ደረጃ	<ol style="list-style-type: none"> <li>1. ያልተማረ</li> <li>2. ማንበብ እና መጻፍ የሚችሉ</li> <li>3. የአንደኛ ደረጃ ትምህርት (1-8)</li> <li>4. የሁለተኛ ደረጃ ትምህርት (9-12)</li> <li>5. ዲግሎማ</li> <li>6. የመጀመሪያ ዲግሪ እና ከዚያ በላይ</li> <li>7. ሌላ ከሆነ ይገለጹ _____</li> </ol>
5	የቤተሰብ-ህ/ሽ የወር ገቢ (በኢትዮጵያ ብር)	<ol style="list-style-type: none"> <li>1. _____</li> <li>2. አላውቅም</li> </ol>
6	የእናት-ህ/ሽ የሥራ ሁኔታ	<ol style="list-style-type: none"> <li>1. የቤት እመቤት</li> <li>2. የመንግስት ሠራተኛ</li> <li>3. የግል ሠራተኛ</li> <li>4. ነጋዴ</li> <li>5. ሌላ ከሆነ ይገለጹ _____</li> </ol>
7	የአባት-ህ/ሽ የሥራ ሁኔታ	<ol style="list-style-type: none"> <li>1. ስራ የለውም</li> <li>2. የመንግስት ሠራተኛ</li> <li>3. የግል ሠራተኛ</li> <li>4. ነጋዴ</li> <li>5. ሌላ ከሆነ ይገለጹ _____</li> </ol>
<b>3. ወጣቶች በስነ ወሲብ እና ስነ ተዋልዶ ጤና ላይ ያላቸውን ዕውቀት በተመለከተ</b>		
1	ስለ ስነ ወሲብና ስነ ተዋልዶ ጤና ስምተህ/ሽ ታውቃለህ/ሽ? (የዚህ ጥያቄ መልስ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 4 ይለፉ)	<ol style="list-style-type: none"> <li>1. አውቃለሁ</li> <li>2. አላውቅም</li> </ol>
2	ስምተህ/ሽ የምታውቅ/ቁ ከሆነ ለመጀመሪያ ጊዜ በስንት ዓመት-ህ/ሽ ነው የሰማኸው/ሺው	_____ ዓመት
3	ለመጀመሪያ ጊዜ ስለ ስነ ወሲብና ስነ ተዋልዶ	<ol style="list-style-type: none"> <li>1. ትምህርት ቤት</li> <li>2. ጓደኛ (የሴት/የወንድ)</li> <li>3. ሚዲያ (ቴሌቪዥን፣ ራዲዮ፣ መፅሐፍት)</li> </ol>

	ተዋልዶ ጤና ስትሰማ/ሚ የመረጃ ምንጭ/ሽ ምን ነበር? (ከአንድ በላይ መልስ መመለስ ይቻላል)	ወይም ጋዜጣ) 4. ወላጅ (አባት/እናት) 5. ወንድም/እህት 6. ሌላ ከሆነ ይገለፅ _____
4	ስለ የአባላዘር በሽታዎችን ታውቃለህ/ሽ?	1. አላውቅም 2. አውቃለሁ
5	መልስ/ሽ አውቃለሁ ከሆነ የትኛውን ዓይነት ነው የምታውቀው/ቂው? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ጨብጥ 2. ክርክር 3. ኤች አይ ቪ/ኤድስ 4. ቂጢኝ 5. ሌላ ካለ ይገለፅ _____
6	ስለ ወጣቶች የወሊድ መቆጣጠሪያ ዘዴ ታውቃለህ/ቂያለሽ?	1. አላውቅም 2. አውቃለሁ
7	መልስ/ሽ አውቃለሁ ከሆነ የትኛውን ዓይነት ነው የምታውቀው/ቂው? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ፒል 2. ኮንዶም 3. በመርፌ የሚሰጥ 4. በክንድ ውስጥ የሚቀበር 5. ወደ ማህፀን ውስጥ የሚገባ 6. በተፈጥሮ/በካሌንደር መጠቀም 7. ሌላ ካለ ይገለፅ _____
8	<u>በሴቶች ብቻ የሚመለስ</u> አንዲት ሴት የወር አበባ ዑደት መቼ ማየት እንደምትጀመር ታውቂያለሽ?	1. አውቃለሁ 2. አላውቅም
9	<u>በሴቶች ብቻ የሚመለስ</u> መልስሽ አውቃለሁ ከሆነ በስንት ዓመት ነው? ማየት የምትጀምረው	_____ ዓመት
10	ለአካለ መጠን በሚደረስበት ወቅት በወጣቶች ጊዜ ወቅት የሚከሰቱ የሰውነትና የባህሪ ለውጦችን ታውቃለህ/ሽ?	1. አውቃለሁ 2. አላውቅም
11	መልስ/ሽ አውቃለሁ ከሆነ በወጣትነት	1. የሴቶች ጡት ማደግ

	<p>ወቅት የሚከበቱ የሠውነትና የባህሪ ለውጦች የትኞቹ ናቸው? (አንድ በላይ መልስ መመለስ ይቻላል)</p>	<ol style="list-style-type: none"> <li>2. ሴቶች የወር አበባ ማየት</li> <li>3. የድምፅ ለውጥ በሁለቱም ያታወቃል</li> <li>4. የቤተሰብን ትዕዛዝ አለመቀበል</li> <li>5. በተቃራኒ ያታ ላይ ፍላጎት ማሳየት</li> <li>6. የግብረ ስጋ ግንኙነት ፈላጎት መኖር</li> <li>7. በጥቃቅን ምክንያቶች መናደድ</li> <li>8. ሌላ ካለ ይገለፅ _____</li> </ol>
<p><b>4. ወጣቶች በስነ ወሲብና ስነ ተዋልዶ ጤናን በተመለከተ ያላቸው አመለካከት እና ባህሪ</b></p>		
<p>1</p>	<p>ከጋብቻ በፊት የሚደረግ የግብረ ስጋ ግንኙነት ተቀባይነት አለው?</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. የለውም</li> </ol>
<p>2</p>	<p>አንድ ወጣት ወንድ የሆነችን ልጅ ከወደዳት ለግብረ ስጋ ግንኙነት ማስገደድ አለበት። (አንድ መልስ ብቻ ስጥ/ስጪ)</p>	<ol style="list-style-type: none"> <li>1. እስማማለሁ</li> <li>2. አልስማማም</li> <li>3. መወሰን አልችልም/አላውቅም</li> </ol>
<p>3</p>	<p>አንዲት ሴት እስከምታገባ ድረስ በድንግልናዋ መቆየት አለባት/ድንግልናዋን መጠበቅ አለባት። (አንድ መልስ ብቻ ስጥ/ስጪ)</p>	<ol style="list-style-type: none"> <li>1. እስማማለሁ</li> <li>2. አልስማማም</li> <li>3. መወሰን አልችልም/አላውቅም</li> </ol>
<p>4</p>	<p>አንድ ወንድ እስኪያገባ ድረስ በድንግልናው መቆየት አለበት/ድንግልናውን መጠበቅ አለበት።(አንድ መልስ ብቻ ስጥ/ስጪ)</p>	<ol style="list-style-type: none"> <li>1. እስማማለሁ</li> <li>2. አልስማማም</li> <li>3. መወሰን አልችልም/አላውቅም</li> </ol>
<p>5</p>	<p>ወጣቶችና ወላጆቻቸው በስነ ወሲብ እና ስነ ተዋልዶ ዙሪያ መወያየታቸው ያለ ዕድሜ ከሚደረግ የግብረ ስጋ ግንኙነት ይቆጥባል/ቀድሞ ሊከሰት የሚችለውን የግብረ ስጋ ግንኙነት ያዘገያል። (አንድ መልስ ብቻ ስጥ/ስጪ)</p>	<ol style="list-style-type: none"> <li>1. እስማማለሁ</li> <li>2. አልስማማም</li> <li>3. መወሰን አልችልም/አላውቅም</li> </ol>

6	የፍቅር ጓደኛዎች ከመጋባታቸው በፊት የግብረ ስጋ ግንኙነት ለማድረግ ከፈለጉ የግድ በኮንዶም መጠቀም አለባቸው ብለህ/ሽ ታምናለህ/ኛለሽ?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላምንም</li> </ol>
7	በኮንዶም መጠቀም ኤች አይ ቪ/ኤድስንና ሌሎች ልቅ በሆነ የግብረ ስጋ ግንኙነት የሚተላለፉ በሽታዎችን ይከላከላል ብለህ/ሽ ታምናለህ/ኛለሽ?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላምንም</li> </ol>
8	የግብረ ስጋ ግንኙነት ፈፅመህ/ሽ ታውቃለህ/ቂያለሽ? (መልስህ/ሽ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 15 እለፍ/እለፊ)	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> </ol>
9	ፈፅመህ/ሽ የምታውቅ/ቂ ከሆነ በስንት አመትህ/ሽ ነው? የጀመርከው/ሺው?	በ _____ ዓመቱ
10	ፈፅመህ/ሽ የምታውቅ/ቂ ከሆነ እስካሁን ከስንት ሰዎች ጋር ፈፅመኃል/ሻል?	<ol style="list-style-type: none"> <li>1. ከአንድ ሰው ጋር</li> <li>2. ከሁለት ሰው ጋር</li> <li>3. ከሶስት እና ከዚያ በላይ ሰዎች ጋር</li> </ol>
11	ፈፅመህ/ሽ የምታውቅ/ቂ ከሆነ በመጀመሪያ የግብረ ስጋ ግንኙነትህ/ሽ ወቅት አንተ/ቺ ኮንዶም ተጠቅማችሁ ነበር?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አልተጠቀምንም</li> <li>3. አላስታውስም</li> </ol>
12	የግብረ ስጋ ግንኙነት የምትፈፅም/ሚ ከሆነ በምትፈፅምበት/ሚበት ወቅት ሁሌ በኮንዶም ትጠቀማለህ/ሚያለሽ?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አልተጠቀምንም</li> <li>3. አላስታውስም</li> </ol>
13	ፈፅመህ/ሽ የምታውቅ/ቂ ከሆነ በመጀመሪያ የግብረ ስጋ ግንኙነትህ/ሽ ወቅት ከኮንዶም	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አልተጠቀምንም</li> <li>3. አላስታውስም</li> </ol>

	ውጭ ሌላ የወሊድ መቆጣጠሪያ ዘዴዎችን ተጠቅማችሁ ነበር?	
14	ፈፅመህ/ሽ የምታውቅ/ቁ ከሆነ የመጀመሪያ የግብረ ስጋ ግንኙነት እንድትፈፀም/ሚ ምን ነበር ያነሳሳህ/ሽ? (ከአንድ መልስ በላይ መመለስ ይቻላል)	<ol style="list-style-type: none"> <li>1. የጓደኛ ግፊት</li> <li>2. የግብረ ስጋ ግንኙነትን የሚያሳይ ፊልም በመመልከት/በማየት</li> <li>3. ግንኙነቱን ለማድረግ ከውስጤ የመጣ ፍላጎት ስለነበረ</li> <li>4. የሴት ጓደኛዬ/የወንድ ጓደኛዬ</li> <li>5. አልኮል፣ ጫት ወይም ሌላ አይነት መድኃኒት</li> <li>6. ሌላ ካለ ይገለፅ _____</li> </ol>
15	የግብረ ስጋ ግንኙነት ፈፅመህ/ሽ የማታውቅ/ቁ ከሆነ ላለመፈፀምህ/ሽ ምክንያት ምንድነው? (በአንድ መልስ በላይም መመለስ ይቻላል)	<ol style="list-style-type: none"> <li>1. እድሜዬ ከፍ እስኪል ድረስ እየጠበኩ ነው</li> <li>2. እስካገባ ድረስ እየጠበኩ ነው</li> <li>3. ማስረገዝ/ማርገዝ ስለምፈራ ወይም ስለማልፈልግ</li> <li>4. ኤች አይ ቪ/ኤድስን ጨምሮ በግብረ ስጋ ግንኙነት የሚተላለፍ በሽታዎችን ስለምፈራ</li> <li>5. የግብረ ስጋ ግንኙነት የምፈፀመበት ዕድሉን ስላላገኘሁ</li> <li>6. ኃይማኖቱ ስለማይፈቅድልኝ/ኃይማኖቱን ስለሚፃረር</li> <li>7. ወላጆቼን ስለምፈራ</li> <li>8. ሌላ ምክንያት ካለ ይግለፁ _____</li> </ol>
<p><b>5. ወጣቶች በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ከወላጆቻቸው ጋር የሚያደርጉትን ግንኙነት/ውይይት በተመለከተ</b></p>		
1	ከወላጆች ጋር ስለ ስነ ወሲብና ስነ ተዋልዶ ጤና መወያየት አስፈላጊ ነው/ይጠቅማል ብለህ/ሽ ታስባለህ/ቢያለሽ?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላስብም</li> <li>3. አላውቅም</li> </ol>
2	ስለ ስነወሲብና ስነተዋልዶ ጤና ከማን ጋር ነው የምትወያየው/ይው?	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> </ol>

		8. ሌላ ምርጫ ካለ ይግለፁ _____
3	ስለ ስነወሊብና ስነተዋልዶ ጤና ከማን ጋር ብትወያይ ትመርጣለህ/ጨያለሽ?	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ _____</li> </ol>
4	የስነ ወሊብና ስነ ተዋልዶ ጤና ነክ ጉዳዮችን ከአባት ወይም እናትህ/ሽ ጋር ተወያይተህ/ሽ ታውቁያለህ/ቁያለሽ ወይ?	<ol style="list-style-type: none"> <li>1. አውቃለሁ</li> <li>2. አላውቅም</li> </ol>
5	ስለ ወሊድ መቆጣጠሪያ ዘዴዎች ተወያይተህ/ሽ ታውቃለህ/ቁያለሽ (መልስህ/ሽ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 9 አለፍ/አለፊ)	<ol style="list-style-type: none"> <li>1. አውቃለሁ</li> <li>2. አላውቅም</li> </ol>
6	ስለ ወሊድ መቆጣጠሪያ ዘዴዎች ተወያይተህ/ሽ የምታውቅ/ቁ ከሆነ ከማን ጋር ነው የምትወያየው/ይው?	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ _____</li> </ol>
7	ስለ ወሊድ መቆጣጠሪያ ዘዴዎች ከማን ጋር ብትወያይ ትመርጣለህ/ጨያለሽ?	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ _____</li> </ol>
8	ስለ ወሊድ መቆጣጠሪያ ዘዴዎች የምትወያይ/ይው ከሆነ የውይይታችሁ ሁኔታ ምን ይመስላል?	<ol style="list-style-type: none"> <li>1. አብዛኛውን ጊዜ</li> <li>2. አንዳንድ ጊዜ</li> <li>3. አልፎ አልፎ</li> </ol>

9	<p>ስለ ወሊድ መቆጣጠሪያ ዘዴዎች ከቤተሰቦችህ/ሽ ጋር የማትወያይ ከሆነ ምክንያቱ ምንድነው ብለህ ታስባለህ/ሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል)</p>	<ol style="list-style-type: none"> <li>1. ስለማፍር</li> <li>2. በባህል ተቀባይነት ስለሌው</li> <li>3. ዜዴዎቹን በተመለከተ እውቀት ስለሌለኝ</li> <li>4. የመወያየት ችሎታ ስለሌለኝ</li> <li>5. ወላጆቹን ስለምፈራ</li> <li>6. ሌላ ምክንያት ካለ ይግለፁ_____</li> </ol>
10	<p>ስለ አባላዘር በሽታዎችና ኤች አይ ቪ/ኤድስ ተወያይተህ/ሽ ታውቃለህ/ቂያለሽ?</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> </ol>
11	<p>መልስህ/ሽ አዎ ከሆነ ከማን ጋር ነው የተወያየሽው/ሽው?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
12	<p>ስለ አባላዘር በሽታዎችና ኤች አይ ቪ/ኤድስ ከማን ጋር ብትወያይ ትመርጣለህ/ጨያለሽ?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
13	<p>ስለ አባላዘር በሽታዎችና ኤች አይ ቪ/ኤድስ ተወያይተህ/ሽ የምታውቅ/ቂ ከሆነ የውይይትህ/ሽ ሁኔታ ምን ይመስላል?</p>	<ol style="list-style-type: none"> <li>1. አብዛኛውን ጊዜ</li> <li>2. አንዳንድ ጊዜ</li> <li>3. አልፎ አልፎ</li> </ol>
14	<p>ስለ አባላዘር በሽታዎችና ኤች አይ ቪ/ኤድስ ከ ቤተሰቦችህ/ሽ ጋር የማትወያይ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ለህ? (ከአንድ በላይ መልስ</p>	<ol style="list-style-type: none"> <li>1. ስለማፍር</li> <li>2. በባህሌ ተቀባይነት ስለሌው</li> <li>3. ጉዳዩን በተመለከተ እውቀት ስለሌለኝ</li> <li>4. የመወያየት ችሎታ ስለሌለኝ</li> <li>5. ወላጆቹን ስለምፈራ</li> <li>6. ሌላ ምክንያት ካለ ይግለፁ_____</li> </ol>

	መመለስ ይቻላል)	
15	ስለ ግብረ ስጋ ግንኙነት ከቤተሰቦችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ቂያለሽ?  (መልስህ/ሽ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 20 እለፍ/ፊ)	1. አዎ 2. አላውቅም
16	ተወያይተህ/ሽ የምታውቅ/ቂ ከሆነ በምን ዙሪያ ነው የተወያየችሁት?	1. ከጋብቻ በፊት የግብረ ስጋ ግንኙነት ስለማድረግ 2. ከጋብቻ በፊት የግብረ ስጋ ግንኙነት ስላለማድረግ 3. ሌላ ከሆነ ይግለጹ_____
17	መልስህ/ሽ አዎ ከሆነ ከማን ጋር ነው የተወያየሽው/ሽው?	1. ከአባቴ ጋር 2. ከእናቴ ጋር 3. ከወንድሞቼ/እህቶቼ ጋር 4. ከጓደኞቼ ጋር 5. ከፍቅር ጓደኞቼ ጋር 6. ከመምህራ ጋር 7. ከኃይማኖት አባት ጋር 8. ሌላ ምርጫ ካለ ይግለጹ_____
18	ስለ ግብረ ስጋ ግንኙነት ከማን ጋር ብትወያይ ትመርጣለህ/ጨያለሽ?	1. ከአባቴ ጋር 2. ከእናቴ ጋር 3. ከወንድሞቼ/እህቶቼ ጋር 4. ከጓደኞቼ ጋር 5. ከፍቅር ጓደኞቼ ጋር 6. ከመምህራ ጋር 7. ከኃይማኖት አባት ጋር 8. ሌላ ምርጫ ካለ ይግለጹ_____
19	ስለ ግብረ ስጋ ግንኙነት ተወያይተህ/ሽ ከሆነ የውይይትህ/ሽ ሁኔታ ምን ይመስላል?	1. አብዛኛውን ጊዜ 2. አንዳንድ ጊዜ 3. አልፎ አልፎ
20	ስለ ግብረ ስጋ ግንኙነት ከቤተሰቦችህ/ሽ ጋር የማትወያይ ከሆነ ምክንያቱ ምንድን ነው ብለህ/ሽ ታስባለህ/ቢያለሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ስለማፍር 2. በባህሌ ተቀባይነት ስለሌላው 3. ጉዳዩን በተመለከተ እውቀት ስለሌለኝ 4. የመወያየት ችሎታ ስለሌለኝ 5. ወላጆቼን ስለምፈራ 6. ሌላ ምክንያት ካለ ይግለጹ_____

21	<p>ስለ አሳስፈላጊ/ያልታቀደበት እርግዝና ተወያይተህ/ሽ ታውቃለህ/ቂያለሽ? (መልስህ/ሽ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 25 እለፍ/ፊ)</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> </ol>
22	<p>መልስህ/ሽ አዎ ከሆነ ከማን ጋር ነው የተወያየኸው/ሽው?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
23	<p>ስለ አሳስፈላጊ/ያልታቀደበት እርግዝና ከማን ጋር ብትወያይ ትመርጣለህ/ጪያለሽ?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
24	<p>ስለ አሳስፈላጊ ያልታቀዱበት እርግዝና ተወያይተህ/ሽ ከሆነ የውይይትህ/ሽ ሁኔታ ምን ይመስላል?</p>	<ol style="list-style-type: none"> <li>1. አብዛኛውን ጊዜ</li> <li>2. አንዳንድ ጊዜ</li> <li>3. አልፎ አልፎ</li> </ol>
25	<p>ስለ አስፈላጊ ያልታቀደ እርግዝና ከቤተሰቦችህ/ሽ ጋር የማትወያይ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስባለህ/ቢያለሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል )</p>	<ol style="list-style-type: none"> <li>1. ስለማፍር</li> <li>2. በባህሌ ተቀባይነት ስለሌው</li> <li>3. ጉዳዩን በተመለከተ እውቀት ስለሌለኝ</li> <li>4. የመወያየት ችሎታ ስለሌለኝ</li> <li>5. ወላጆቼን ስለምፈራ</li> <li>6. ሌላ ምክንያት ካለ ይግለፁ_____</li> </ol>
26	<p>ስለ ኮንዶም መጠቀም/አጠቀቀም ተወያይተህ/ሽ ታውቃለህ/ቂያለሽ? (መልስህ/ሽ አላውቅም ከሆነ ወደ ጥያቄ</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> </ol>

	ቁጥር 30 እለፍ/ፊ)	
27	መልስህ/ሽ አዎ ከሆነ ከማን ጋር ነው የተወያየሽው/ሽው?	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
28	ስለ ኮንዶም መጠቀም/አጠቃቀም ከማን ጋር ብትወያይ ትመርጣለህ/ጨያለሽ?	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
29	ስለ ኮንዶም መጠቀም/አጠቃቀም ተወያይተህ/ሽ ከሆነ የውይይትህ/ሽ ሁኔታ ምን ይምስላል?	<ol style="list-style-type: none"> <li>1. አብዛኛውን ጊዜ</li> <li>2. አንዳንድ ጊዜ</li> <li>3. አልፎ አልፎ</li> </ol>
30	ስለ ኮንዶም መጠቀም/አጠቃቀም ከቤተሰቦችህ/ሽ ጋር የማትወያይ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስባለህ/ቢያለሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	<ol style="list-style-type: none"> <li>1. ስለማፍር</li> <li>2. በባህሌ ተቀባይነት ስለሌው</li> <li>3. ጉዳዩን በተመለከተ እውቀት ስለሌለኝ</li> <li>4. የመወያየት ችሎታ ስለሌለኝ</li> <li>5. ወላጆቼን ስለምፈራ</li> <li>6. ሌላ ምክንያት ካለ ይግለፁ_____</li> </ol>
31	ለአካለ መጠን በሚደረስበት ወቅት የሚታዩ አካላዊና ስነ ልቦናዊ ለውጦችን በተመለከተ ተወያይተህ/ሽ ታውቃለህ/ሽ? (መልስህ/ሽ አላውቅም ከሆ ወደ ጥያቄ ቁጥር 35 እለፍ/ፊ)	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> </ol>

<p>32</p>	<p>መልስ/ሽ አዎ ከሆነ ከማን ጋር ነው የተወያየኸው/ሽው?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
<p>33</p>	<p>ለአካለ መጠን በሚደረስበት ወቅት የሚታዩ አካላዊና ስነ ልቦናዊ ለውጦችን በተመለከተ ከማን ጋር ብትወያይ ትመርጣለህ/ጪያለሽ?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
<p>34</p>	<p>ለአካለ መጠን በሚደረስበት ወቅት የሚታዩ አካላዊና ስነ ልቦናዊ ለውጦችን በተመለከተ ተወያይተህ/ሽ ከሆነ የውይይትህ/ሽ ሁኔታ ምን ይመስላል?</p>	<ol style="list-style-type: none"> <li>1. አብዛኛውን ጊዜ</li> <li>2. አንዳንድ ጊዜ</li> <li>3. አልፎ አልፎ</li> </ol>
<p>35</p>	<p>ለአካለ መጠን በሚደረስበት ወቅት የሚታዩ አካላዊና ስነ ልቦናዊ ለውጦችን በተመለከተ ከቤተሰቦችህ/ሽ ጋር የማትወያይ ከሆነ ምክንያቱ ምንድ ነው ብለህ/ሽ ታስባለህ/ቢያለሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል)</p>	<ol style="list-style-type: none"> <li>1. ስለማፍር</li> <li>2. በባህሌ ተቀባይነት ስለሌው</li> <li>3. ጉዳዩን በተመለከተ እውቀት ስለሌለኝ</li> <li>4. የመወያየት ችሎታ ስለሌለኝ</li> <li>5. ወላጆቼን ስለምፈራ</li> <li>6. ሌላ ምክንያት ካለ ይግለፁ_____</li> </ol>
<p>36</p>	<p><u>በሴቶች ብቻ የሚመለስ</u> ስለ የወር አበባ ተወያይተሽ ታውቂያለሽ? (መልስሽ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 40 እለፊ)</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> </ol>

<p>37</p>	<p><u>በሴቶች ብቻ የሚመለስ</u> መልስሽ አዎ ከሆነ ከማን ጋር ነው የተወያየሽው?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
<p>38</p>	<p><u>በሴቶች ብቻ የሚመለስ</u> ለውይይቱ ማንንስ ነው የምትመርጧልው?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
<p>39</p>	<p><u>በሴቶች ብቻ የሚመለስ</u> ስለ የወር አበባ ተወያይተሽ ከሆነ የውይይትሽ ሁኔታ ምን ይመስላል?</p>	<ol style="list-style-type: none"> <li>1. አብዛኛውን ጊዜ</li> <li>2. አንዳንድ ጊዜ</li> <li>3. አልፎ አልፎ</li> </ol>
<p>40</p>	<p><u>በሴቶች ብቻ የሚመለስ</u> ስለ የወር አበባ ከቤተሰቦችሽ ጋር የማትወያይ ከሆነ ምክንያቱ ምንድነው ብለሽ ታስቢያለሽ?</p>	<ol style="list-style-type: none"> <li>1. ስለማፍር</li> <li>2. በባህሌ ተቀባይነት ስለሌው</li> <li>3. ጉዳዩን በተመለከተ እውቀት ስለሌለኝ</li> <li>4. የመወያየት ችሎታ ስለሌለኝ</li> <li>5. ወላጆቼን ስለምፈራ</li> <li>6. ሌላ ምክንያት ካለ ይግለፁ_____</li> </ol>
<p>41</p>	<p>የወጣቶችን ስነ ወሲብና ስነ ተዋልዶ ጤና አገልግሎት በተመለከተ አስፈላጊ የሆኑ ጉዳዮች ላይ ተወይተህ ታውቃለህ/ቂያለሽ?  (መልስህ/ሽ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 45 እለፍ/አለፊ)</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> </ol>

<p>42</p>	<p>መልስህ/ሽ አዎ ከሆነ ከማን ጋር ነው የተወያየኸው/ሽው?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
<p>43</p>	<p>የወጣቶችን ስነ ወሲብና ስነ ተዋልዶ ጤና አገልግሎት በተመለከተ አስፈላጊ የሆኑ ጉዳዮች ላይ ከማን ጋር ትመርጣለህ/ጨያለሽ?</p>	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
<p>44</p>	<p>ስለ ወጣቶች ስነ ወሲብና ስነ ተዋልዶ ጤና አገልግሎት ተወያይተህ/ሽ ከሆነ የውይይትህ/ሽ ሁኔታ ምን ይመስላል?</p>	<ol style="list-style-type: none"> <li>1. አብዛኛውን ጊዜ</li> <li>2. አንዳንድ ጊዜ</li> <li>3. አልፎ አልፎ</li> </ol>
<p>45</p>	<p>ስለ ወጣቶች ስነ ወሲብና ስነ ተዋልዶ ጤና አገልግሎት ከቤተሰባችሁ/ሽ ጋር የማትወያይ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስባለህ/ቢያለሽ?</p>	<ol style="list-style-type: none"> <li>1. ስለማፍር</li> <li>2. በባህሌ ተቀባይነት ስለሌላው</li> <li>3. ጉዳዩን በተመለከተ እውቀት ስለሌለኝ</li> <li>4. የመወያየት ችሎታ ስለሌለኝ</li> <li>5. ወላጆቼን ስለምፈራ</li> <li>6. ሌላ ምክንያት ካለ ይግለፁ_____</li> </ol>
<p>46</p>	<p>ስለ ተቃራኒ የታ ግንኙነት ወይም ስለ ሴት/ወንድ ጓደኛ (girl or boy friend) ተወያይተህ/ሽ ታውቃለህ/ቲያለሽ? (መልስህ/ሽ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 51 እለፍ/ፊ)</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> </ol>
<p>47</p>	<p>መልስህ/ሽ አዎ ከሆነ በየትኛው ጉዳይ ላይ ነው የተወያየኸው/ሽው?</p>	<ol style="list-style-type: none"> <li>1. ከ18 ዓመት በፊት የሴት/የወንድ ጓደኛ ስለመያዝ ዙሪያ</li> <li>2. ከ18 ዓመት በፊት የሴት/የወንድ ጓደኛ ስለመያዝ ዙሪያ</li> </ol>

48	ስለ ሴት/ወንድ ጓደኛ ተወያይተህ/ሽ የምታውቅ/ቁ ከሆነ ከማን ጋር ነው የተወያየሽው/ሽው?	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
49	ስለ ሴት/ወንድ ጓደኛ ከማን ጋር ብትወያይ ትመርጣለህ/ጨያለሽ?	<ol style="list-style-type: none"> <li>1. ከአባቴ ጋር</li> <li>2. ከእናቴ ጋር</li> <li>3. ከወንድሞቼ/እህቶቼ ጋር</li> <li>4. ከጓደኞቼ ጋር</li> <li>5. ከፍቅር ጓደኞቼ ጋር</li> <li>6. ከመምህራ ጋር</li> <li>7. ከኃይማኖት አባት ጋር</li> <li>8. ሌላ ምርጫ ካለ ይግለፁ_____</li> </ol>
50	ስለ ሴት/ወንድ ጓደኛ ተወያይተህ/ሽ ከሆነ የውይይትህ/ሽ ሁኔታ ምን ይመስላል?	<ol style="list-style-type: none"> <li>1. አብዛኛውን ጊዜ</li> <li>2. አንዳንድ ጊዜ</li> <li>3. አልፎ አልፎ</li> </ol>
51	ስለ ሴት/ወንድ ጓደኛ የማትወያይ ከሆነ ምክንያቱ ምንድን ነው ብለህ/ሽ ታስባለህ/ሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	<ol style="list-style-type: none"> <li>1. ስለማፍር</li> <li>2. በባህሌ ተቀባይነት ስለሌው</li> <li>3. ጉዳዩን በተመለከተ እውቀት ስለሌለኝ</li> <li>4. የመወያየት ችሎታ ስለሌለኝ</li> <li>5. ወላጆቼን ስለምፈራ</li> <li>6. ሌላ ምክንያት ካለ ይግለፁ_____</li> </ol>
52	አባትህ/ሽ ስለ ስነ ወሲብ በግልፅ ያወያዩሃል/ሻል?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አያወያየኝም</li> </ol>
53	እናትህ/ሽ ስለ ስነወሲብ በግልፅ ያወያዩኃል/ሻል?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አታወያየኝም</li> </ol>
54	ከዚህ በላይ በተዘረዘሩት የስነ ወሲብና ስነ ተዋልዶ ጤና ጉዳዮች ቢያንስ በአንድ ጉዳይ ዙሪያ ተወያይተህ ከሆነ በስንት ዓመትህ/ሽ ነበር ውይይቱን የጀመርሽው/ሽው?	በ _____ ዓመቱ

55	<p>ስለ ስነውሳኔና ስነ ተዋልዶ ጤና ተወያይተህ/ሽ የምታውቅ/ቂ ከሆነ ያገኘኸው/ሽው መረጃ በቂ ነበር/ነው ብለህ/ሽ ታምናለህ/ኝያለሽ?</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላምንም</li> </ol>
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### ስለትብብራችሁ አመሠግናለሁ

APPENDIX F

**መመሪያ: ከወጣቶች ጋር ለሚደረገው ቃለ መጠይቅ**

የመጠይቁ አካሄድ እንደሚከተለው ይሆናል፡፡

- መደበኛ የሰላምታ አካሄድን ባልተከተለ መልኩ ሰላምታ መለዋወጥ
- የቃለ መጠይቁን አላማና አካሄድ ጠለቅ ባለ መልኩ መግለፅ/ማብራራት
- በቃለ መጠይቁ ውስጥ በመሳተፋቸው ምን እንደሚያገኙ እና በቃለ መጠይቁ አካሄድ ውስጥ ሊኖራቸው ስለሚችል መብቶች ማብራራት
- ቃለ መጠይቁን ለማድረግ ፈቃደኛ መሆናቸውን መጠየቅ
- በቃለ መጠይቁ ወቅት የሚነሱ ግላዊ ጉዳዮች/ሚስጥሮች በጥብቅ እንደሚጠበቁ በመግለፅ ቃለመጠይቁ እንዲቀዳ ፈቃደኛ መሆናቸውን ማረጋገጥ

**የጥያቄዎች ርዕሶችና ነጥቦች**

- I. አጠቃላይ በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ያላቸውን ዕውቀትና የመረጃ ምንጭ የተመለከቱ ጥያቄዎች፤
  1. የስነ ወሲብና ስነ ተዋልዶ ጤና ጉዳዮች ማለት ምንድን ነው? ምን ምን ያካትታል?
  2. የስነ ወሲብና ስነ ተዋልዶ ጤናን በተመለከተ መረጃ ከየት ነው የምታገኘው/ኒው/የመረጃ ምንጭህ/ሽ ምንድን ነው?
- II. በስነ ወሲብና ስነተዋልዶ ጤና ጉዳዮች ላይ ያሉ ውይይቶችን በተመለከተ፤
  3. ስለ ስነ ወሲብና ስነ ተዋልዶ ጤና ተወያይተህ/ሽ ታውቃለህ/ቂያለሽ?
  4. ተወያይተህ/ሽ የምታውቅ/ቂ ከሆነ ከማን ጋር ነው የተወያየሽው/ሽው? መቼ ነው የተወያየሽው/ሽው የምትወያየው/ይው?
  5. ወላጆች ከወጣት ልጆቻቸው ጋር ስለ ስነ ወሲብና ስነ ተዋልዶ ጤና መወያየት አለባቸው ብለህ/ሽ ታምናለህ/ኒያለሽ?
  6. መወያየት አለባቸው ብለህ/ሽ የምታምን/ኒ ከሆነ አስፈላጊነቱ ምንድን ነው?
  7. አንተ/አንቺ ስለ ጉዳዩ ከወላጆችህ/ሽ ጋር ተወያይተህ/ቂያለሽ ታውቃለህ/ለሽ? ተወያይተህ/ሽ ከሆነ መቼ ነው የተወያየሽው/ሽው?
  8. ስለ ስነወሲብና ስነ ተዋልዶ ጤና ከቤተሰቦችህ/ሽ ጋር ስትወያይ ምንት ይሰመኝል/ሻል/ይሰጥኝል/ሻል?
- III. በወጣቶችና ወላጆቻቸው መካከል የሚደረገው የስነ ወሲብና ስነ ተዋልዶ ጤና ውይይት ይዘትን በተመለከተ፤
  9. በምን ዓይነት የስነ ወሲብ ስነ ተዋልዶ ጤና ጉዳዮች ዙሪያ ነው ከወላጆችህ/ሽ ጋር የምትወያየው/ይው?
  10. በምን የስነ ወሲብና ስነ ተዋልዶ ጤና ጉዳይ ዙሪያ መወያየት እንዳለባችሁ ማን ነው የሚወስነው?
  11. ውይይቱን የት ነው የምታካሂዱት? ቦታው ምንት ይሰጥሃል/ሻል?

12. ስነ ወሲብና ስነ ተዋልዶ ጤናን በተመለከተ ከወላጆችሽ የምታገኘው/ኘው መረጃ በቂ ነው ብለህ/ሽ ታምናለህ/ኚያለሽ?

IV. ወጣቶች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ጋር በተያያዘ ስለሚኖራቸው ውይይት ተግዳሮት ነው ብለው የሚያስቡትን ምልክታት በተመለከተ፤

13. ከወላጆችህ/ሽ ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ እንዳተወያይ የሚያደርግህ/ሽ ችግር ምንድነው ብለህ/ሽ ታስባለህ/ቢያለሽ?

14. ከስነ ወሲብና ስነ ተዋልዶ ጤና ጉዳዮች ውስጥ ለውይይት የሚቀልህ/ልሽ ወይም የሚከብድህ/ሽ ጉዳይ አለ? ምን ምን ናቸው? ለምን እንደዛ እንደሆነ ልታብራራልኝ/ሪልኝ ትችላለህ/ያለሽ?

V. ውይይታችን የሚሻሻልበትን ሁኔታ በተመለከተ የወጣቶች ሀሳብ/አስተያየት፤

15. በአንተ/ቺ እና በወላጆችህ/ሽ መካከል ያለውን ስነ ወሲብና ስነ ተዋልዶ ጤና ውይይት ለማሻሻል ምን መደረግ አለበት ብለህ/ሽ ታስባለህ/ቢያለሽ?

16. በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ያለውን ውይይት ለማሻሻል ለወጣቶች ምን ትመክራለህ/ሪያለሽ?

17. በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ያለውን ውይይት ለማሻሻል ለወላጆች ምን ትመክራለህ/ሪያለሽ?

APPENDIX G

**መመሪያ፡ ከወጣት ማዕከል የወጣቶች ምክር አገልግሎት ባለሙያ ጋር ለሚደረገው ቃለ መጠይቅ**

**የመጠይቁ አካሄድ እንደሚከተለው ይሆናል፡፡**

- መደበኛ የሰላምታ አካሄድን ባልተከተለ መልኩ ሰላምታ መለዋወጥ
- የቃለ መጠይቁን አላማና አካሄድ ጠለቅ ባለ መልኩ መግለፅ/ማብራራት
- በቃለ መጠይቁ ውስጥ በመሳተፋቸው ምን እንደሚያገኙ እና በቃለ መጠይቁ አካሄድ ውስጥ ሊኖራቸው ስለሚችል መብቶች ማብራራት
- ቃለ መጠይቁን ለማድረግ ፈቃደኛ መሆናቸውን መጠየቅ

**ጥያቄዎች ለወጣት ማዕከል የወጣቶች ምክር አገልግሎት ባለሙያ**

1. እርሶ በዚህ ወጣት ማዕከል ውስጥ የወጣቶች ምክር አገልግሎት ባለሙያ ከመሆኑም አንጻር በማዕከላችሁ በምን በምን ጉዳዮች ዙሪያ ነው ወጣቶችን የሚያማክሩት
2. በስነ ወሲብና ስነ ተዋልዶ ጤና ጉዳዮች ዙሪያ ለወጣቶች የምክር አገልግሎት ይሰጣሉ የሚሰጡ ከሆነ እስኪ በምን በምን ጉዳዮች ዙሪያ ነው አገልግሎቱ የሚያውጠነጥነው
3. የስነ ወሲብና ስነ ተዋልዶን ጤና ችግር የደረሰባቸው ወጣቶች አጋጥመው/ክ/ሽ ያውቃል አጋጥመው/ክ/ሽ ከሆነ የችግረን ሁኔታ ስፋት እንዴት ይገልፁታል
4. ችግሩ ወጣቶቹ ከወላጆቻቸው ጋር ካላቸው ግንኙነት ውይይት ይያያዛል ከተለያዩ በምን መልኩ እንደሆነ ሊገልፁልኝ ይችላሉ እናንተስ ከቤተሰቦቻቸው ላይ ትሰራላችሁ ለመስራት ሙከራ ታደርጋላችሁ
5. በወጣት ማዕከላችሁ ከሚሠጠው የምክር አገልግሎት ውጭ በአካባቢያችሁ ለሚገኙ ወጣቶች በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ አገልግሎት የሚሰጥ ወይም ግንዛቤ የሚያስጨብጥ ሌላ የአገልግሎት ጣቢያ አሉ ካለ ምን አይነትና ለምን መልኩ አገልግሎት እንደሚሰጥ ልታስረዳኝ ትችላላህ ቺያለሽ
6. ስነ ወሲብና ስነ ተዋልዶ ጤናን በተመለከተ በአካባቢው ላሉ ወጣቶች ዝግጁ የሆነ የመረጃ ምንጮች ምንድናቸው
7. ዝግጁ ከሆኑ የመረጃ ምንጮች ውስጥ የትኛው የመረጃ ምንጭ ነው ተደራሽና ውጤታማ ነው ብለው የሚያስቡት
8. በአጠቃላይ በስራዎት ሂደት ውስጥ ካዩት ሁኔታዎች ተነስተው ወጣቶች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ያላቸውን ውይይት እንዴት ይገልፁታል

9. የማይወያዩ ወይም የውይይታቸው ሁኔታ አጥጋቢ ካልሆነ እንደ አንድ ባለሙያ የማይወያዩበት ምክንያት ምንድን ነው ብለው ያስባሉ
10. ወጣቶች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ስላልተወያዩ የሚደርሰውን ችግር ውጤት እንዴት ይገልፁታል
11. ውይይታቸውን ለማሻሻል ምን መደረግ አለበት ብለው ያስባሉ

APPENDIX H

**መመሪያ: ከጤና ኤክስፐርትስ ባለሙያ ለሚደረገው ቃለ መጠይቅ**

**የመጠይቁ አካሄድ እንደሚከተለው ይሆናል፡፡**

- መደበኛ የሰላምታ አካሄድን ባልተከተለ መልኩ ሰላምታ መለዋወጥ
- የቃለ መጠይቁን አላማና አካሄድ ጠለቅ ባለ መልኩ መግለፅ/ማብራራት
- በቃለ መጠይቁ ውስጥ በመሳተፋቸው ምን እንደሚያገኙ እና በቃለ መጠይቁ አካሄድ ውስጥ ሊኖራቸው ስለሚችል መብቶች ማብራራት
- ቃለ መጠይቁን ለማድረግ ፈቃደኛ መሆናቸውን መጠየቅ

**ጥያቄዎች ለጤና ኤክስፐርትስ ባለሙያ**

1. እርስዎ የጤና ኤክስፐርትስ ባለሙያ ከመሆኑም አንፃር ምን ምን የጤና ጉዳዮች ዙሪያ ነው ከወላጆች ጋር የሚሰሩት
2. በስነ ወሲብ ስነ ተዋልዶ ጤና ጉዳዮች ዙሪያ ወላጆችን ያወያያ
3. የስነ ወሲብና ስነ ተዋልዶ ጤና ጉዳዮችን በተመለከተ ወላጆች ከወጣት ልጆቻቸው ጋር ያላቸው ግንኙነት/ውይይት ምን ይመስላል እንዴት ይገልፁታል
4. ስነ ወሲብና ስነ ተዋልዶ ጤናን በተመለከተ የትኞቹ የመረጃ ምንጮች ናቸው ለወጣቶችም ሆነ ለወላጆቻቸው ዝግጁ የሆኑት
5. ስነ ወሲብና ስነ ተዋልዶ ጤና በተመለከተ ዝግጁ ከሆኑት የመረጃ ምንጮች ውስጥ የትኞቹ የመረጃ ምንጭ ነው ተደራሽና ውጤታማ ነው ብለው የሚያስቡት
6. በተሰማሩበት የስራ ሂደት ውስጥ በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ችግር የደረሰባቸው ወጣቶች አጋጥመውህ/ሽ ያውቃሉ
7. የወጣቶቹ የስነ ወሲብና ስነ ተዋልዶ ጤና ችግር ከወላጆቻቸው ጋር ካላቸው ግንኙነት/ውይይት ጋር ይያያዛል ወይ ከተያያዘ በምን መልኩ እንደሆነ ሊገልፁልኝ ይችላሉ
8. በአጠቃላይ በስራዎች ሂደት ውስጥ ካዩት ሁኔታዎች ተነስተው ወጣቶች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ያላቸውን ውይይት እንዴት ይገልፁታል
9. የማይወያዩ ወጣቶች ከወላጆቻቸው ጋር በስነ ወሲብና ስነ ተዋልዶ ጤና ዙሪያ ወይም የውይይታቸው ሁኔታ አጥጋቢ ካልሆነ እንደ አንድ ባለሙያ የማይወያዩበት ምክንያት ምንድን ነው ብለው ያስባሉ
10. ዙሪያ ስላልተወያዩ የሚደርሰውን ውጤት እንዴት ይገልፁታል
11. ውይይታቸውን ለማሻሻል ምን መደረግ አለበት ብለው ያስባሉ

### Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for degree in any other University and that all sources of materials used for this thesis have been duly acknowledged

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Place: \_\_\_\_\_

Date of Submission: \_\_\_\_\_

This thesis has been submitted for examination with my approval as a university advisor.

Name of Advisor: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_