

**ADDIS ABABA UNIVERSITY
FACULTY OF MEDICINE
CENTRALIZED SCHOOL OF NURSING**

Assessment of Factors Affecting Parents in Discussing Reproductive Health Issue with their Adolescent in Shambo town, Horo Guduru Wollega, Oromiya Region, Ethiopia, May 2009.

A thesis submitted to the School of Graduate Studies of Addis Ababa University in partial fulfillment of the requirements for the Degree of Master in Maternity and Reproductive Health Nursing.

By:

Tesfaye Assebe

July, 2009

Addis Ababa, Ethiopia

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Advisor:

Berhane Gebrekidan (RN, MSN, Ass. Professor)

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Declaration

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

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This thesis has been submitted for examination with my approval as University Advisor.

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APPROVED BY THE BOARD OF EXAMINERS

THIS THESIS BY TEFAYE ASSEBE ACCEPTED IN ITS PRESENT FORM BY THE BOARD OF EXAMINERS AS SATISFYING THESIS REQUIREMENT FOR THE DEGREE OF MASTERS OF SCIENCE IN REPRODUCTIVE AND MATERNITY NURSING.

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List of Acronyms

RH = Reproductive health

ARH = Adolescent reproductive health

STI = Sexual transmitted infection

HIV = Human immunodeficiency virus

AIDS = Acquired immunodeficiency syndrome

OCP = Oral contraceptive

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Abstract

Background: - even though sexual activity put adolescents at risk of various reproductive health (RH) challenges, many adolescent lack strong stable relation ships with parents or other adults with whom they talk to get information about their RH concern.

Objectives: - The general objective of the study is to identify factors affecting parents in discussing reproductive health issues with their adolescent.

Method: - Community based cross-sectional study was designed to determine factors affecting parents in discussing RH issue with their adolescents among families who had children aged 10 years and above living in Shambo town conducted in May 2009. A total of 262 house holds were selected using systematic sampling technique. Data was collected using structured questionnaire by six data collectors from resident of Shamboo town. Data was analyzed by SPSS soft ware version 15.0. Descriptive statistics was employed to describe the study population in relation to relevant variables. Odds ratio with 95% confidence intervals and regression was employed to describe the strength of association between the selected study variables by controlling for the effect of possible confounders

Result and discussion: - The study showed that most respondent 84.6% were found to be knowledgeable about reproductive health and also the majority 90% had positive attitude towards discussing the RH issue with their adolescent. However, small proportions 38.2% have communicated to their adolescent on reproductive health issue. Educational level, knowledge, and attitude of parents had significant association with discussion of parents with their adolescents on RH issues.

Conclusion and recommendation: - It can be concluded that, even though parents had basic information on RH, they did not practice in discussing RH issue with their adolescent. It is recommended that health workers in helping parents to become effective communicator to their adolescent as well as considering their role of educator should be considered.

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1. Introduction

1. 1 Background

Adolescence is a period of rapid physical, psychological, and emotional development and a period of adjustment in the family and society. Generally this transition is smooth: though it can be stormy. Their decision and action particularly with regard to sexual activity can significantly affect the rest of lives. The health threats for adolescents today are predominantly behavioral rather than biomedical and more of today's adolescents are involved in health behavior with potential for serious consequence. There are over one billion young people between the ages of 15 and 24 worldwide. The reproductive and sexual health decisions these young people make today will affect the health and well-being of their countries and of their world for decades to come (1, 2).

The gradual emergency of a distinct youth life style has still been consistently associated with the gradual breaking down of traditional family life, the diminishing role of parents and the large family unit, and an increasing role of peers. There is silence between parent and adolescent children, whether on the subject of puberty, menstruation, sexual relation, contraception or abortion. The silence is surpassed only by the lack of information and utter uncertainty about what to say and how to say it, which underlies the silence in so many cases (1).

In fact, in some culture, parent and family members are influential source of knowledge, beliefs, attitudes, and values for children and youth. They are role models who shape young people perception of gender roles and influence the choice that youth make about their own sexual behavior. Parents often have the power to guide children's development toward health sexuality as natural, normal and progressive experience with in the life cycle. They can help their children develop and practice reasonable sexual behavior and personal decision making. There is some evidence that teen who live in stable family environment and are close to their parents are more likely to remain sexual abstinent, post pone intercourse, have few partners, and use contraceptive (3).

Up on the realization of the sexual norms of sexual behavior, there is more emphasis on controlling sexual behavior rather than limiting sexual behavior. However, adolescent in many developing countries Asia, Latin America, and Africa have little knowledge about sex and reproduction that put them to a considerable risk of unwanted pregnancy, STD and unsafe abortion. In china for instance, parents have little communication with adolescent children on sexual and reproductive issues. Adolescents who have a close relation with their parents were less likely than other adolescents to engage in pre-marital sex (4, 5).

In Africa reproductive health interventions targeted at adolescent are a relatively new phenomenon with the first program having been established in the late 1970th. The study conducted in the part Harcourt, Nigeria revealed that 62.2 % parents suspects their adolescent daughters of being sexually active where as 87.7% of parents never discuss sexual matters with their adolescent girls (6, 7).

The situation in the Ethiopia is worse. The study conducted in Zeway rural town of Ethiopia tells us parents had a relatively no knowledge regarding adolescent sexual maturity and behavior and complication of teen age pregnancy. Nonetheless, 93% did not approve premarital sex and ironically, not more than 20% of them reported discussion of growth changes during adolescence, sexuality, and contraception in the past (8).

1.2 Statement of the problem

Educationalist quoted that “A wise father is more than a hundred school matters. The mother’s face is the child’s first lesson book. Home makes the man”. Undoubtedly, parents play a vital role towards the adolescent sexual behavior effecting the good citizenship (9).

When young people feel unconnected to home, family, and school, they may become involved in activities that put their health and well-being at risk. However, when parents affirm the value of their children, young people more often develop positive, healthy attitudes about themselves. This is also true when the subject is sex. Research shows that positive communication between parents and their children can help young people establish individual values and make healthy decisions (10, 11).

Adolescent often lack basic reproductive health information, skills in negotiating sexual relationships and access to affordable confidentiality reproductive health services. Many adolescent lack strong and stable relationships with their parents or other adults whom they can talk to get reliable information about their reproductive health concern, which put them at risk of various reproductive health challenges (1).

Although most adults want young people to know about abstinence, contraception, and how to prevent HIV and other sexually transmitted diseases (STDs), parents often have difficulty communicating about sexuality. Nevertheless, communicating about sexuality is important, positive communication between parents and their children greatly helps young people to establish individual values and to make healthy decisions. Initiating conversations about the facts of life may be difficult for some parents because they did not grow up in an environment where the subject was discussed. Some parents may be afraid they do not know the right answers or feel confused about the proper amount of information to offer. Moreover, parents were very busy, shy, and were not educated (10).

Moreover, families in the rural communities are either not knowledgeable about the subject matter, or due to their nature of extendedness they are not able to give due

consideration to the importance of communication to the importance of educating young boy and girls on sexuality, parenthood and other matter. In addition, such matters are often viewed as a sign of eroded social values and norms and thus are not welcomed by traditional societies (8).

Many parents does not discuss with their children until they discover their teen has already made difficult sexual related decision. By this time the teen has probably already engaged in sexual activity. Communication is ineffective. The child was not encouraged to discuss sexual related issues from an early age: the teen will feel uncomfortable with the subject matter at this point in time. As the result the teen might lies or tell the parents what they want to hear in order to avoid an awkward situation. The parent may also feel uncomfortable discussing the subject matter with their child and will have difficulty initiating such conversation (12).

As a result, adolescent most information for their patchy knowledge often comes from peers of the same sex who may themselves be informed or wrongly informed. This can lead to misinformation and the persistence of damaging myths, making young people vulnerable to unwanted and unprotected sexually transmitted disease and unsafe abortions. Especially in young female it is multi-dimensional including feel of guilty, low self esteem, the absence of her menstrual period, possible deterioration of family relation, abandonment of school, hasty and unpromising marriage (3, 8).

The burdens on teenage women are also high. Teenage women are twice as likely to die from pregnancy-related health complications as are women in their twenties. The survey conducted by the central statistical Authority, 75.5% was married below 18 years of age. Current statistics on HIV/AIDS indicate that one-half of all new HIV infections worldwide occur among young people ages 15 to 24. Every minute, five young people worldwide become infected with HIV/AIDS. The socioeconomic and political consequences of the HIV epidemic place these youth at further risk as the infrastructure in their countries comes under enormous strain (12).

In Ethiopia, 60% of adolescent pregnancies are unwanted. High prevalence of HIV infection in the age group 15 to 24 (12.1%). High rate of pregnancy mean the HIV infection will affect the next generation as well, putting babies at risk of vertical transmission and creating a generation of AIDS orphans. Complication from unsafe abortion is account for almost 55% of all recorded maternal deaths, some 15% of which occur among women under age 20 (3, 8).

Sexuality communication about sexual matters, perhaps now more than any other time in the history the issue of sexual health is important for virtual every one. This is because adolescents are affected with the burden of unwanted pregnancy and its complication, STD including HIV/AIDS, and other sexual and reproductive health issue. Generally, family can exert a stronger influence on adolescent sexual behavior, it is important to understand the role of family influence on sexual behavior.

1.3 Significance of the study

Adolescent behaviors still remain challenging, especially in developing countries due to lack of appropriate information they are vulnerable to unwanted pregnancy and STDs including HIV/AIDS. Even though, studies in many countries have found that parents are influential sources of information and advice for their children, they are not discussing reproductive and sex related issues with their children. There is therefore a need to conduct research investigating the existing communication barriers between adolescents and their parents and to identify the difficulties experienced by parents in discussing sexual issues with adolescent children.

The result of the study will also produce information that can be used by program managers and stake holders in the planning and intervention. More over, contributes to nursing science, practice, and society for improving activities in the context of prevention of adolescent from reproductive health challenges.

2. Literature review

Over view of parent adolescent communication

The consequences of adolescent sexual behavior are an enormous burden both for the adolescent and society. The problem is not that teens are sexually active but rather that they have little preparation and guidance in developing responsible sexual behavior. Developmentally, adolescents reach physical maturity before they are cognitively able to appreciate the consequences of their behavior. A teenager's primary source of information regarding sexuality is his or her peer group, all of whom are experiencing and reinforcing the same behaviors. The family, the major socializer of other behaviors, is not as powerful a force in shaping responsible sexual behavior because of parental discomfort with sex education and sexual discussions. This is the result of a social milieu in which sex is frequently portrayed but rarely linked with responsible behavior or accurate, nonjudgmental information (13).

Parents most often respond with their hopes that their children will grow into adulthood without unintended pregnancy or a sexually transmitted infection (STI). They sometimes follow this with the hope that their kids will never be a victim or perpetrator of intimate partner violence or other sexual abuse. It often takes awhile before they get to, "I hope they have a good sex life." Then we have a conversation about what that means (14).

Communication between parents and their children is increasingly important in today's society. Research indicates that teens who talk with their parents about sexuality are more likely to delay the initiation of sexual intercourse and more likely to use contraception and protection when they become sexually active. Most teens tell us that they want their parents to talk to them, but unfortunately communication around issues of sexuality can be uncomfortable for many parents. Numerous research studies have shown that increased parent-child communication leads to a raised awareness and reduction in risk taking behaviors (15).

Factors associated with parents and their adolescent children in discussing on reproductive health issue

I. Socio demographics factors

Many studies found that mothers are significantly more likely than fathers to discuss sexuality with their children. In one study, just over 54 percent of students reported discussing HIV with their parents. Percentages varied little by race/ethnicity (white, 54.1; African American, 55.7; Latino, 54.5; other, 55.5 percent) but varied significantly by gender (females, 59.7; males 49.2 percent). In another study, African American female adolescents reported more discussions about sex-related topics with their mothers than did male adolescents. Although fewer male teens talked about sex-related topics with fathers, mothers, or friends, males were just as likely to talk with mothers as with friends and only slightly less likely to talk with fathers (11,16).

In a study of African American and Latino adolescents in USA, a significantly greater percentage of Latino teens than African American teens reported discussing at least two sex-related topics—HIV/AIDS and choosing a sex partner—with their father. Latino teens were also twice as likely as African American teens to discuss choosing a sex partner with their mother. Educational level of the parents and lower family size were positively associated with free discussion on sexual matters between parents and their adolescent children (8, 16).

A study conducted in China revealed that age, education, family structure, parent's discipline; attitudes towards premarital sex, pattern of communication and dating were significantly associated with youth premarital sex. A relatively large percentage of female youth talked to their mothers about sex (33–38%). Only 2% to 8% of males talked to their mothers about sex. Both males and females chose their friends as the person with whom they were most likely to talk about sexual matters (17).

II. Knowledge of parents

Many families are either not knowledgeable about sexual matter or due to their nature of extendedness they are not able to give due consideration to the importance of communicating young boy and girl on sexuality, parenthood and other matters. Moreover, such matter are often viewed as assign of eroded social values and norms and thus are not well come by traditional societies. Study conducted in Nigeria revealed 17.9% of parents had no contraceptive knowledge. In a recent survey, 84 percent of women polled indicated that they needed help talking to their children about sex and less than two percent believe parents are doing an excellent job in educating their kids about sexuality (18, 1, and 19)

Many parents do not provide all the information about sex that young people need. In one survey, only 38 percent of young women and 25 percent of young men said they had ever gotten a good idea from their parents that helped them talk about sexual issues with their girlfriend/boyfriend (11).

A study conducted in Zeway, rural town of Ethiopia revealed that nearly 94% of parents know physical and psychological change that take place during puberty. However, only 60% of them reported the correct age range for puberty in females, and only 42.7% knew the corresponding age for male. It is only 26.4% respond who correctly told the safe period in menstrual cycle, and 83.7% mention two commonest type of STIs (gonorrhea and syphilis). On the other issue study was conducted in sheik town south west Ethiopia revealed 57.0% of parents did not have any idea about reproductive health (8).

III. Attitude of parents

Most attempts by parents to impart sexuality information to young people tend to be in a 'top down' communication style that denies teens the opportunity to discuss their own thoughts, feelings, and desires or to draw links between their own and their parents' perspectives. One study investigates the relationship between parent-child communication about sex and young adolescents' reproductive and contraceptive

knowledge and sexual attitudes in two communicating group of parents. There are correlations between parents' and children's sexual attitudes in the high-communication group were significantly higher than that of the low-communication group. Good relationships between adolescents and parents are consistently associated with positive emotional functioning and healthy self-esteem (11, 20).

According to the Sexuality Information and Education Council of the United States, 93% of adults they surveyed support sexuality education in high school and 84% support it in junior high school. In fact, 88% of parents of junior high school students and 80% of parents of high school students believe that sex education in school makes it easier for them to talk to their adolescents about sex. Also, 92% of adolescents report that they want both to talk to their parents about sex and to have comprehensive in-school sex education (21).

Study conducted in Zeway, southern Ethiopia revealed that 93% of the parent had negative attitude towards premarital sex through 61.4% approve use of contraceptive. In Nigeria a greater proportion 79.1% of parent did not favors the use of contraceptive by sexual active adolescent. However, the majority 93.2% of parents would want a sex education program in school in order to prevent unwanted pregnancy (6, 8).

IV. Parent-child communication practice

One study revealed that perception of friendly, attentive, and impression-leaving communication styles of the parent may be perceived by the adolescent as supportive; thus, contributing to less reported sexual activity. When parents were perceived as friendly, attentive and open, the participants reported more responsible on contraceptive use. Communicator style appears to have a greater relationship to sexual activity and contraceptive use (22).

Nationally representative survey of 15- to 17-year-old youth in the United States about sexual health communication between teens and their parents conducted. The survey provided a snapshot of teens' views on the subject. 51% of teens (61 % of females; 42 % of males) had discussed with their parents "how to know when you are ready to have sex." 43% of teens (53 percent of females; 33 percent of males) had discussed with their parents how to talk to a boyfriend or girlfriend about sexual health issues, such as

pregnancy, birth control, and STIs. Among male teens, 50 % had discussed condoms, but only 35 % had discussed other forms of contraception. Among female teens, 54 % had discussed condoms and 63 % had discussed other forms of contraception with parents. Overall, 52 % of teens had discussed condoms with their parents; 49 percent had discussed other forms of contraception. 56% of teens (64 percent of females; 48 percent of males) had discussed HIV/AIDS with their parents. 50% of teens (56 percent of females; 44 percent of males) had discussed STIs with parents (17).

In USA a national sample of parents, reported that 54% were never talking with their children about sex, 28 percent said discussions rarely occur, and five percent had discussions once a year. Parents who discussed sex with their children appeared to have more accurate information about reproduction and contraception than parents who did not talk to their children. In other study significantly higher proportions of mothers and adolescents reported discussions of HIV or AIDS (92% by mothers and 71% by adolescents, respectively) and STDs (85% and 70%, respectively) than of issues surrounding sexual behavior, contraceptive use and physical development (27-74%). On similar issue study conducted in China one-third of female youth talked to their mothers about sexual matters (17, 23).

The study conducted in Lesotho adolescents who were attending secondary and high schools, found that slightly over 20% of adolescents, female discuss sex related matters with their parents. Also in Nigeria, 79.3% of parents simply said they advise their daughter to keep away from men, while only 2.3% said they advised to use contraceptives, 6.5% get pregnant, and 5.4% were uncertain of what to do. In Zeway Ethiopia, 20.7% discussed about teen pregnancy and its complication, 12.6% on contraceptive use and 10.6% on physical and psychological change of the puberty (8, 19).

V. Other Associating Factors in Parent Child Communication about Reproductive Health

A study done in Uganda the main communication problem faced by adolescent daughters to talk about sexuality to their mothers were 42% reported that they feared their mothers, followed by mothers did not want to talk to them about sexuality 24%, mother were too busy with their work 24%, other reason gives were, the daughter was feeling shy to ask her mother 8%, mothers were not educated 4%. The main communication problem faced by mother was shyness to talk the daughter 68.4%, daughters were stubborn and would not listen to them 34.2%, and mother were very busy 10.5% (12).

Also teens indicate various reasons why they may not talk to parents about sexual health issues. 83% of teens worried about their parents' reaction. 80% of teens worried that parents will think they have had sex or are going to have sex. 78% of teens named embarrassment as a big reason. 77% percent of teens (83 percent of females; 71 percent of males) said they didn't know how to bring the subject up (16).

Teens who transmit clear messages and report previous discussions of sexual matters with parents are seven and a half times more likely to feel able to communicate with a partner about AIDS than those who have not had such discussions with parents and describe themselves as low frequency participants in risky behaviors (parent child communication resource (16).

When talking about sexuality and young people in our culture, we are much more comfortable discussing disasters (teen pregnancy, for example), disease (HIV and other STIs), and dysfunction (coercive sex, etc.). It's much easier for us to talk about what we DON'T want for our kids' sex lives than about what we DO want. Parent child discussion that adapt to indigenous traditions can be both acceptable to communities and associated with significant changes in young people's behavior (14).

A study conducted in the USA showed adolescents whose sexual communication with their parents involved more repetition and more new topics felt closer to their parents, felt more able to communicate with their parents in general and about sex specifically, and perceived that discussions with their parents about sex occurred with greater openness

than did adolescents whose sexual communication with their parents included less repetition and fewer topics (24).

Study conducted in selective region of Ethiopia to assess young people's HIV/AIDS and RH needs in utilization of services revealed that socio-cultural, religious beliefs and sense of morality is the main barrier to young people obtaining adequate RH information. 71.7% of participants agreed that the socio-cultural norm were the major barriers to youth-parent communication. 66.2% of participants thought that parents considered discussing RH to young people promoting premarital sex and promiscuity. Due to constraining social norms and taboos, communication between parents and young people is not open. Studies conducted in China, Kenya and Sweden indicate that it is shame full to discuss physical, psychological and body changes during adolescents with parents (25).

3. Objective

General objective

To assess factors affecting parents in discussing on reproductive health issue with their adolescents.

Specific objectives

1. To identify the socio-demographic effect on discussing reproductive health issue between parent and adolescent.
2. To identify association of parent's knowledge, attitudes and practice in discussing reproductive health issue with their adolescent.
3. To assess influences of tradition/culture, believing **sexuality discussion initiating pre marital sex** and time constraint that influence parent's in discussion on reproductive health issues with their adolescents.

4. Methods and materials

4.1 Study area

The study was conducted in Shambo town, Horo Guduru Wollega Zone in Oromya Region, Western Ethiopia. It is a town located 285 km away from the capital city, Addis Ababa to west. Administratively, Shambo town is divided in to two kebles. The total population of the town is estimated to be 18,327 when projected for 2004 by considering 2.7% as rate of national increase (RNI) for the country and with a total house hold of 2,170. There are two secondary schools and one governmental Hospital, one middle level health clinics, two low level clinics rendering health services in the town.

4.2 Study design and period

A cross sectional community based study was conducted to assess factors that influence parent in discussing reproductive health issues with their adolescents. The study was conducted from May 15 - 25, 2009.

4.3. Population

- **Source population:** All parents who reside in Shambo town of both kebele o1 and o2.
- **Study population:** parents, who are resident in the town of both kebeles and who have children age 10 years and above.
- **Study unit:** either father or mother available in selected house hold of the town in both kebeles.

Inclusion and Exclusion criteria.

Inclusion criteria.

- Parents who had child/children age 10 years and above.

Exclusion criteria.

- Parents who had no child/children age 10 years and above.
- Parents who were not willing to give an informed consent, mentally ill, unconscious and have difficulty of communication were excluded from the study.

4.4 Sampling technique and size

Sampling technique

Systematic random sampling was used to identify the required households with the sampling interval of 8 from the total households of the town as a study unit and one

eligible was selected from each household to satisfy the sample size required by the town.

Interval (K) calculated by:

$$K = N/n \quad 2170/262 = 8$$

Where K = interval

N = total number of house holds in both kebeles

n = sample size

Sample size

Sample size is estimated based on the formula for single population proportion designated as:

$$n = \frac{(Z_{1-\alpha/2})^2 P(1-P)}{d^2} = \frac{(1.96)^2 \times 0.2(1-0.2)}{(0.05)^2}$$

Where,

n= sample size

P= the prevalence of parent children communication on reproductive health issue (0.2)

d = marginal error (0.05)

z= Critical value at 95% certainty (1.96)

The calculated sample size is 238. Considering 10% non response rate, the overall sample size is 262

4.5 Variables

Independent variables

- Socio-demographic characteristics of parents(age, sex, religion, occupation, family size, educational level, and ethnicity)
- Knowledge of parents to ward discussion on reproductive health
- Attitude of parents to ward discussion on RH issue with their adolescent
- Practice of discussion.
- Time constraint, traditional influence, and belief initiating sex

Dependent variable

- Parent - adolescent discussion on reproductive health issues.

4.6 Measurement Tool and Data Collection

Questionnaire

After review of relevant literature and previous studies pre tested interview questionnaire that can satisfy the objective of the study was adopted especially from a standard questionnaire of family health international utilized for STI/HIV/AIDS behavioral surveillance survey. The questionnaire had two part namely socio-demographic characteristics of the parents and factors affecting parent's and their adolescent children on discussing reproductive health issues. The questionnaire was developed in English and translated to local language that was Afaan Oromo and then back to English to check for its consistency.

Data Collection

Both the interviewers and supervisors were given an interview guide line prepared in local language. The structured standard questionnaire was administered within 10 days time as of May 15th – 25th 2009 to the respondents by six data collectors who completed 10th or 12th grade and two supervisors who had diploma in nursing. Data collectors and supervisors were selected those who were resident in the town and can speak Afaan Oromo, Amharic and English language was trained and recruited. The responsibilities of the data collectors were to fill questionnaires after obtaining verbal consent from the study subject. The supervisors were provided all items necessary for data collection on each data collection day, checked filled questionnaire for completeness, clarity, and consistency. Correction was made accordingly and problem solved which rose during data collection period. During data collection more than one eligible were found in the same house hold one was chosen by lottery method where as in case of absenteeism thrice visits were attempted after which an eligible in the adjacent house hold was interviewed.

4.7 Pre Test

The questionnaires were pre-tested for clarity, flow, repetition and time requirement on the same eligible residing in town which were not included in the study. Findings and experiences from the pre-test was utilized in modifying the data collection tools.

4.8 Operational Definitions

Reproductive health: refers to the state of complete physical, mental and social well being in all matters related to the reproductive system and process.

Adolescent reproductive health: refers to adolescents' state of complete physical mental and social well being in all matters related to the reproductive system and process.

Knowledgeable: respondents were considered as had good knowledge if they scored more than the average for thirty four dichotomous questions related to RH knowledge. If less than the average considered as had poor knowledge.

Positive attitude: respondents are considered as having positive attitude to wards communication if they have scored more than the average.

4.9 Data Quality

To assure the quality of the data, properly designed data collection tool was prepared, training was be given to data collectors and supervisors, and on each data collection day some of the percent of collected data was reviewed by principal investigator, and any problems that may be faced in the time of data collection was discussed and immediate solution was given accordingly.

Interview was conducted at a private place to ensure good discussion site between the trained data collectors and clients. The principal investigator was communicating with his advisor, supervisor and data collectors through all available means of communication to follow the progress. The principal investigator was training for 2 days for data collectors and supervisors prior to data collection on objective of the study and technique of presenting the questions in understandable manner for respondents.

4.10 Data Analysis

Pre-coded data was entered and cleaned in SPSS soft ware version 15.0 and analyzed. Frequencies, proportion and summary of descriptive statistics was employed to describe the study population in relation to relevant variables. Contingency table was used to see the association between the explanatory and out come variables. Odds ratio with 95% confidence intervals and regression was employed to describe the strength of association between the selected study variables by controlling for the effect of possible confounders.

4.11 Ethical Consideration

Ethical clearance for the proposed research was obtained from Centralized School of Nursing and the Institutional Review Board (IRB) of FOM Addis Ababa University. Official letter of cooperation was written from Addis Ababa University Faculty of

medicine Centralized School of Nursing to the town administrator. Letters of support was also received from Oromiya health Bureau and other relevant organization. In formed consent was obtained from each study participants after clear explanation about the purpose of the study was given. Confidentiality of the information was assured by omitting names of the study subjects from the questionnaires and maximum effort was made to maintain privacy of the respondents during the interview.

4.12 Dissemination and Utilization of Results

The finding of this study will be communicated Addis Ababa University; School of Nursing and Authorities of the study area to governmental and non-governmental organizations and institution or individuals that have direct or indirect in put in the study and in the prevention of adolescent from reproductive health issue challenges in Ethiopia. This can be accomplished through submission of reports, presentation of finding at appropriate meetings and workshops and through publications on scientific Journals.

6. Results

A total of 262 (100%) parents participated in the study. Table 1 showed that the majority of the study participants were in the age group of 30 to 45 years (50.5%) with mean age of 40.3(\pm SD10.4). The majority were females 175 (66.8%), had adolescents 3–5 in number 110 (42%) and 113 (43.1%) house wives in occupation. Related to religion aspect majority were Orthodox Christian that accounted for 175 (66.8%). Oromo and Amahara ethnic groups were constituted 216 (82.4%) and 39 (14.9%) respectively. Majority of the study participants, 441 (60.7%) earn more than 300 Ethiopian birr per month. Almost one-third of respondents were 92 (35.1%) were on grade 10 and above.

Table 1: Socio –Demographic Characteristics of Parents, Shambo town, Horo Guduru Wollega, Ethiopia, May, 2009.

Variables	Number	percentage
Total respondents	262	100
Age		
• <30years	58	22.1
• 30- 45 years	132	50.4
• >45 years	72	27.5
Sex		
• Male	87	33.2
• Female	175	66.8
Number of Adolescent family had		
• 1 – 2	83	31.7
• 3 – 5	110	42
• >5	69	26.3
Ethnic group		
• Oromo	216	82.4
• Amhara	39	14.9
• Others	7	2.7
Continuation of table 1 ...		
Religion		

• Orthodox	175	66.8
• Muslim	24	9.2
• Protestant	57	21.8
• Others	63	22.2
Marital status		
• Married	213	81.3
• Single	2	.8
• Separated	7	2.7
• Divorce	13	5.0
• Widowed	27	10.3
Educational level		
• Illiterate /Read and write only	71	27.1
• 1-4 th grade	24	9.2
• 5-8 th grade	54	20.6
• 9-10 grade	21	8.0
• Above 10	92	35.1
Occupation		
• Government employee	81	30.9
• House hold	113	43.1
• Daily laborers	7	2.7
• Merchant	30	11.5
• Others	31	11.8
Income		
• < 400 Birr	68	26
• 400 – 1000 Birr	44	16.8
• 1000 Birr	51	19.5
• Not know	99	37.8

A total of thirty four closed ended questions were included to assess the knowledge status of the study population about reproductive health issue. Respondents were asked whether they know what RH means and 227 (86.6%) acknowledge that they know about it. As

showed on Table 2 concerning the specific components of RH issue the majority identified STIs 250 (95.4%) followed by physical change that occur during pregnancy 246 (93.9) and unsafe sex 236 (90).

Table 2. Knowledge of Respondents on Adolescent Reproductive Health components at Shambo town, Horo Guduru Wollega, Ethiopia, May, 2009.

Knowledge	frequency	percentage
• STIs	250	95.4
• Contraceptive /FP	209	79.8
• Unwanted pregnancy	223	85.1
• Unsafe sex	236	90.1
• Unsafe abortion	188	71.8
• Sexual violence	192	73.3
• Early marriage	93	35.5
• Physical change	246	93.9

Six questions were asked to assess the knowledge of respondents about specific methods of family planning. 199 (76%) respondents identified oral contraceptive and 127 (48.5%) of them calendar method. Generally 174 (66.4%) of the respondents scored above the average and had good knowledge of family planning.

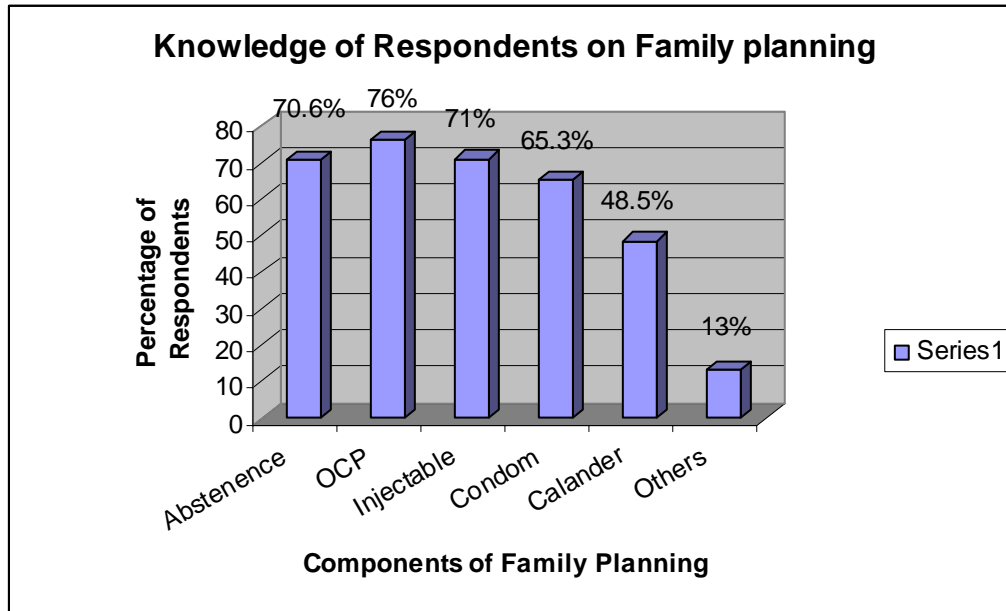


Fig1. Knowledge of Respondents on Method of Family Planning Shambo town, Horo Guduru Wollega, Ethiopia, May, 2009

Respondents were also assessed for the consequence of unsafe sex. The majority of the respondents 225 (85.9%) identified as unsafe sex exposes to STIs, followed by 178 (67.9%) said it exposes to unwanted pregnancy, and 178 (67.9%) said unsafe sex exposes to unsafe abortion. Also a clear cut point of age for early marriage was asked and only 93(35.5%) respondents answered correctly.

Concerning the specific components of STIs the majority identified HIV/AIDS 248 (94.7%) followed by gonorrhoea 231 (88.2%) and syphilis 228 (87%).

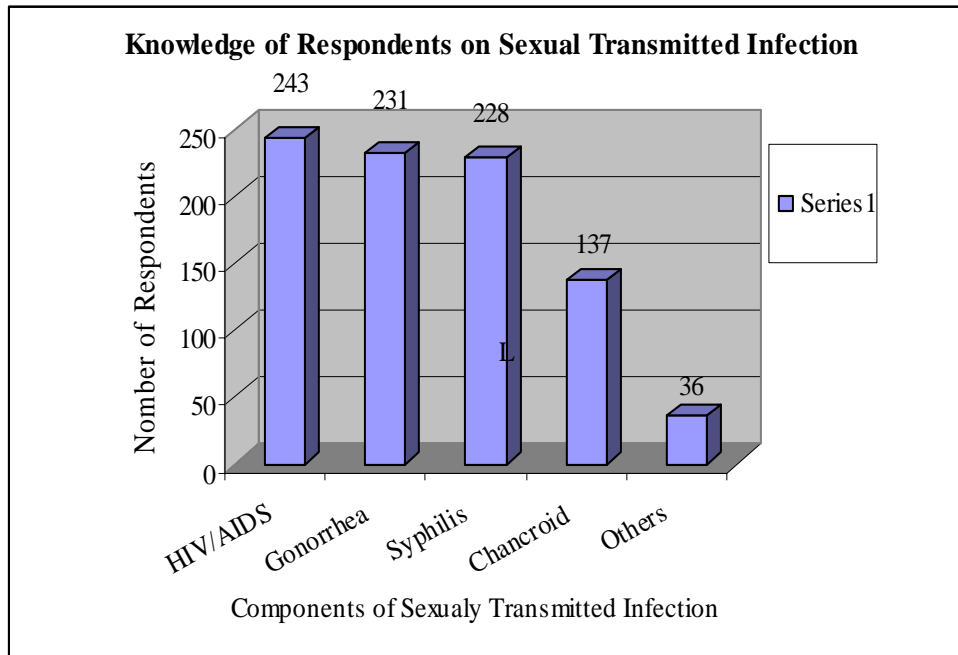


Fig 2 Knowledge of Study Participants on Components of STIs Shambo town, Horo Guduru Wollega, Ethiopia, May, 2009

Concerning the assessment of effects of unwanted pregnancy, 209 (79.8%) respondents mentioned excessive bleeding, 204 (77.9%) of them mentioned unsafe abortion and 198 (75.6%) of them said it predispose in to STIs.

Also respondent were assessed for knowledge of behavioral and physical change that occurs during adolescent. 238 (90.8%) mentioned that breast development in female, 241 (92%) mentioned on set of menstruation and 237 (90.5%) mentioned change of voice in male. Generally out of the total 262 respondents, 222 (84.6%) scored for thirty four knowledge question above the average and had good knowledge of reproductive health issues.

A total of four closed ended questions were included to assess the attitude of the study population to wards discussing reproductive health issue. Respondents were asked whether they agree in discussing reproductive health issue with their adolescent or not. The larger proportion 237 (90.5%) respondents reported that they agree in discussing of

RH issue with their adolescents, 236 (90%) agree that parent could encouraged to discuss RH issue with their adolescents, 233 (88.9) agree that adolescents encouraged to ask their parents about RH issues, and 209 (79.8%) of respondent agree use of family planning by adolescents. Generally out of the total 262 respondents, 237 (90.5%) scored for four attitude questions above average and had positive attitude towards in discussing RH issue with their adolescents.

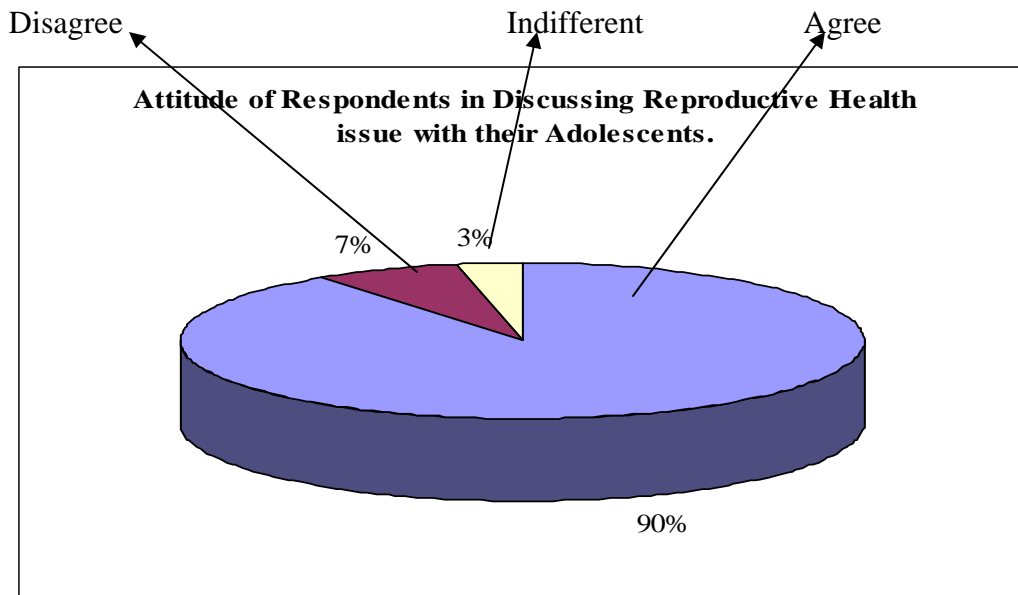


Fig 3. Attitude of Study Participants in Discussing RH issue with their Adolescents
Shambo town, May, 2009

Participants were also asked whether they have ever discussed with their adolescents. Among the total 262 study participants, a large proportion about 162 (61.8%) were not discussed on reproductive health issue with their adolescents at all. Only 100 (38.2%) parents were discussed on the topic. Out of this 99 (99%) discussed on STIs, 96 (96%) discussed on early marriage, and 84 (84%) discussed on contraceptive (Table 3).

Table 3. Topics discussed by parents on adolescent reproductive health issues with their children Shambo town, Horo Guduru Wollega, Ethiopia, May, 2009.

Variables	No	%
Total participants	262	100
Total respondents	100	100
STDs including HIV/AIDS	99	99
Early marriage	96	96
Physical change	92	92
Unsafe sex	90	90
Unwanted pregnancy	86	86
Unsafe abortion	85	85
Contraceptive /FP	84	84
Sexual violence	81	81
Others	38	38

**the excess number are due to multiple response.*

Also parents mentioned various reasons why they did not discussed with their adolescents about reproductive health issues. 109 (67.3%) of parents were related with culture, 107 (66.0%) of parents claimed difficulty of initiating due to fear and shyness and 93 (57.4%) of parents worried that discussion on sexual matter with adolescents initiate pre marital sex (Table 4).

Table 4: Reason given by parents for not discussing RH issue with their adolescent, Shambo town, Horo Guduru Wollega, Ethiopia, May, 2009.

Variable	Frequency	Percentage
Total respondents	162	100
Culture	109	67.3
Difficulty of initiating	107	66.0
Belief initiate sex	93	57.4
Lack of awareness	30	18.5
Difficulty of explanation	21	13.0
Religion believe	18	11.0
Ethnic	12	7.4

Continuation of table 4...		
Other factors	11	6.8

**multiple answers are possible.*

Assessment of association between reported parents and their adolescent discussion on reproductive health issue was made by employing logistic regression statistical model. This model was employed with the assumption that it helps to predict the extent by which parent and their adolescent discussion could be affected by the socio demographic characteristics, knowledge, and attitude to wards reproductive health issues.

Level of education of the study participants had significant association with discussion of RH issue with their adolescents. As showed on table 5 below, those parents who were grade 1–4 [OR (95%CI); 7.649 (2.161, 27.06), discussed better than illiterate/read and write only. Similarly those respondents who were grade 5-8 [OR (95%CI); 4.25 (1.42, 12.69), grade 9-10 [OR (95%CI); 6.09 (1.51, 24.43) and those parents who were above grade 10 [OR (95%CI); 23.99 (7.12, 80.75) discussed more than illiterate/ read and write only. In this study Age, Sex, Marital status, Occupation, monthly Income of the house hold and Family size had no significant association with discussion of parents with their adolescent on reproductive health issues.

Good knowledge of family planning and good knowledge of unsafe abortion had significant association with discussion of RH issue with their adolescents as shown below. Those parents who had a good knowledge on FP [OR (95%CI); .037 (.005, .289) and good knowledge of unsafe abortion [OR (95%CI); 404 (.181, .902) discussed better than those who had poor knowledge on both components of RH issues (Table 5).

Attitude towards discussing RH issue had significant association with discussion of RH issue. Those parents who had negative/indifferent attitude [OR (95%CI); 0.08 (0.008, 0.87) discussed less on RH issue when compared with parents who had positive attitude.

Table 5: - Association between independent and dependent variable Shambo town, Horo Guduru Wollega, Ethiopia, May, 2009.

Variables	communication		Crude OR(95% CI)	Adjusted OR(95% CI)
	yes	No		
Age				
<3oyears	33	25	+1	
30- 45 years	77	55	.508 (.244, 1.059)	.752 (.266, 2.124)
>45 years	52	20	.538 (.289, 1.002)	.910 (.388, 2.134)
Sex				
• Male	48	39	+1	
• Female	114	61	1.518 (.899,2.566)	.921 (.394, 254)
Marital status				
• Married	137	92	+1	
• Single	2	0	3.734(.809,17.233)	2.195(.355, 13.577)
• Separated	4	3	.000	.000
• Divorce	8	2	4.125(.493, 34.499)	2.508(.177, 35.639)
• Widowed	11	2	1.375(.158, 11.937)	.816(.063, 10.558)
Educational level				
• Illiterate/Read and write	65	6	+1	
• 1-4 th grade	15	9	.042(.017, .109)	7.649(2.161,27.06)*
• 5-8 th grade	39	15	.276(.108, .704)	4.25(1.42, 12.69)*
• 9-10 grade	14	7	.177(.084, .631)	6.09(1.51, 24.43)*
• Above 10 th grade	29	63	.230(.084, .631)	23.99(7.12, 80.75)*
Occupation				
• Government employ				
• House wife	30	51	+1	
• Merchant	83	30	5.829(2.243, 15.148)	2.349(.689, 8.003)
• Daily laborer	20	10	1.2399(.484, 3.172)	2.252(.641, 7.910)
	5	2	1.371(.217, 8.664)	2.732(.304, 24.5680)

Continuation of table 5 ...

• Others	24	7	1.714(.552, 5.326)	1.911(.508, 7.188)
Income				
• < 400 Birr	43	25	+1	
• 400 – 1000 Birr	19	25	2.159(1.084, 4.302)	1.870(.809, 4.322)
• >1000 Birr	22	29	4.887(2.270, 10.522)	1.677(.583, 4.822)
• Do not know	78	21	4.896(2.349, 10.204)	.930(.311, 2.783)
Family size				
• 1 – 2	17	13	+1	
• 3 – 5	65	48	1.569(.693, 3.552)	1.019(.360, 2.882)
• Above 5	80	39	1.515(.888, 2.585)	.969(.498, 1.885)
Knowledge F/P				
• Good	99	111	+1	
• Poor	1	51	.022(.003, .162)	0.037(.005, .289)*
Unsafe abortion				
• Good	90	98	+1	
• Poor	10	64	.170(.082, .351)	.404(.181, .902)*
Early marriage				
• Good	62	104	+1	
• Poor	38	58	1.099(.656, 1.84)	1.225(.695, 2.160)
Attitude				
• Agree	99	138	+1	
• Disagree/indifferent	1	24	17.21(2.29, 129.39)	0.08(0.008, 0.87)*

* $p < 0.05$

*Adjusted for related factors

*+1 indicate reference variable

Knowledge of respondents on reproductive health issue had significant association with educational status as shown below. Parents who were illiterate and only read and write had less knowledge of RH issue when compared to grade 1-4th [OR(95%CI); 33.204 (3.305, 329.98) and grade 1-8th [OR(95%CI); 18.868 (1.564, 227.654). There is no significant association between sex and occupation with knowledge of the study participants.

Table 6: - Association between socio-demographic character with knowledge of parents Shambo town May, 2009.

Variables	Knowledge		Crude OR(95% CI)	Adjusted OR(95% CI)
	Yes	No		
Sex				
• Male	79	8	+1	
• Female	148	27	.555(.241, 1.279)	1.215(.355, 4.153)
Educational level				
• Illiterate /Read and write	48	23	+1	
• 1-4 th grade	19	5	43.604(5.713, 332.810)	33.204(3.305, 329.98)*
• 5-8 th grade	49	5	23.94(2.64, 216.82)	18.868(1.564,227.654)*
• 9-10 grade	20	1	9.286(1.055, 81.73)	6.809(.614, 75.494)
Above 10 th grade	91	1	4.550(.273, 75.859)	3.744(.204, 68.756)
Occupation				
• Government employ	79	2	+1	
• House wife	90	23	.132(.024, .720)	.636(.088, 4.612)
• Merchant	27	3	2.080(.312, 13.889)	1.130(.291, 4.386)
• Daily laborer	5	2	1.329(.460, 3.840)	1.921(.238, 15.513)

* $p < 0.05$

*Adjusted for socio demographic factors

*+1 indicate reference variable

Discussion

Parents are lacking stronger and stable relationship with their adolescent children. They can provide reliable information about RH concern to their adolescent, which protect them at risk of various RH challenges. Parents are a role model which shape and often have the power to guide their children's development towards healthy sexuality. There are evidences that adolescent who live in stable family environments and are close to their parents are more likely to remain sexual abstinent, postpone intercourse, have few partners, and use contraceptives. Most parents do not discuss reproductive health issue with their adolescents. This study was designed to identify factors that affect parents in discussing RH matters with their adolescents in Shambo, town, 2009.

In this study it was found that majority of study participants had knowledge on contraceptive 79.8%. This finding is almost in line with study done in Nigeria (82.1%) related to contraceptive knowledge (6, 19). In this study it was also found that majority of the study subjects mentioned different types of STIs. Out of the total (94.7%) mentioned HIV/AIDS, (88.2%) mentioned gonorrhea, and (87%) mentioned syphilis. Moreover, this finding is in harmony with other similar studies done in Zeway, rural town of Ethiopia 83.7% mentioned two commonest type of STIs (gonorrhea and syphilis) (8). Majority of the study respondent had knowledge of physical and psychological change that take place during puberty (93.9%). It is similar with the result obtained in the same issue at Nigeria that 94% of parents mentioned physical and psychological change taking place during puberty (6, 19).

Those participants who attend primary, secondary and higher level of school had more knowledge on reproductive health issue. This might be attributed to the fact that education influence reproductive health related information. Respondents who clearly identify early marriage were only (35.5%). This impact might be explain why early marriage prevalent was high (75.5%) in Ethiopia (12).

Literature showed that parents and adolescent do not discuss sexual matters. Further more such matters are often viewed as eroded social value and norms and thus are not well come by traditional society (8, 10). So, the attitudes are in the negative inclination. However this is not the case in this study as the majority of the respondent (90.5%) of parent had positive attitudes towards discussing RH issues with their adolescents. It is almost comparable with the result obtained on the same issue at Nigeria (93.2%) of parents had positive attitude in discussing with their adolescents (6). This may be partly attributed the advent of HIV/AIDS which enhance public discussion on sexual matters and this could be indirectly inferred from the usual topic of discussion chosen by the parents (23).

Although, most parents included in the study approved the importance of discussing RH issue with their adolescent, only few (38.2%) practice it. This was in line with the study conducted in china about one-third of female youth talked to their mothers about sexual matters (17). But the proportion of discussion was high among the study participants when compared with similar study done in Lesotho (20%) and Zeway (20%) (8, 19). This might be attributed to the time of study with increasing awareness of RH burden particularly HIV/AIDS from time to time. It was less proportion when compared to study done on the same issue in USA (51%) discussed with their adolescents (17). It might be discussed as level of development affecting the availability and awareness of the subject matter.

Parents who attend higher level and primary level of education had better discussed on reproductive health issue when compared to parents who were illiterate and only write and read. This finding was consistent with study done in USA revealed that Educational levels of the parents were positively associated with free discussion on sexual matters between parents and their adolescent children (8, 16) and study done in selected region of Ethiopia also similarly revealed that educated parents were more likely to communicate and discussed matters of RH with adolescents than non educated patents (25). This might

be attributed that education influences discussion of parents on reproductive health issue with their adolescents.

Similarly respondents who had good knowledge of family planning and had good knowledge of unsafe abortion had discussed on reproductive health issue than those who had poor knowledge on family planning and poor knowledge on safe abortion. This might be attributed that knowledge influence discussion of parents and their adolescent on reproductive health issues.

Parents who had positive attitude towards discussing RH issue discussed more when compared with those parents who had negative attitude and indifferent. This might be attributed attitude influence discussion of parents with their adolescents on reproductive health issues.

Also parents indicated various reasons why they did not discuss with their adolescents about reproductive health issues. The majority (67.3%) of parents worried about their culture which was less proportion with study conducted in selective region of Ethiopia. To assess young people's HIV/AIDS and RH needs in utilization of services revealed that, (71.7%) of participants identified the socio-cultural norm were the major barriers to youth-parent communication (25). This with less proportion of finding might be due to the study area, the study subject in this study including only urban area but the latter study subject were selected from urban and rural site.

A great proportion (66.0%) of parents claimed difficulty of initiating due to fear and shyness. It was consistent with study done on similar issue in Uganda (68.4%) that mother feel shyness in discussing with their adolescents (12). It is also in harmony with Studies conducted in China, Kenya and Sweden that indicated that it is shame full to discuss physical, psychological and body changes during adolescents with parents (1, 17, 25) Moreover, parents were very busy, shy, and were not educated (10).

Also 57.4% of parents worried that discussion on sexual matter with adolescents initiate premarital sex. This finding is also less proportion when compared with study conducted

in selective region of Ethiopia, almost 66.2% of participants thought that parents considered discussing RH to young people promoting premarital sex and promiscuity (25). This finding might be discussed as study area difference.

Strength of the study

- Probability sampling method was used to include all kebeles in the town to be representative of the whole population in the town

Limitation of the study

- There were few researches/studies done in this area which makes it difficult to get literatures for comparison and discussion.
- The sensitivity nature of RH issue might have affected the response of respondent.
- Limitation of time

Conclusion

Parents can provide basic RH information to their adolescent children. By providing information and the means to sexual health, they actually reduce the risk of young people inflicting harm on them. It is important to examine the role of parent on the issue. From the study it concludes that most parents informed and have positive attitude toward discussing RH issue. However not practiced by the majority and thus, there have been a gap between knowledge of parent and their practice, also between attitude and practice.

In this study data obtained from parents revealed that, due to socio-cultural norm, difficulty of initiating discussion due to fear and shyness, and worried that discussions on sexual matter with adolescents initiate premarital sex were the major barriers to adolescent-parent discussion on reproductive health matters.

Recommendation

Based on the above results, the investigator come up with the following recommendation.

1. Shyness, ignorance on sexual matter or societal norms (culture and tradition) that do not encourage open discussion between parent and children should be avoided. More over, parents' role as educator should be considered.

2. Health workers should educate parent themselves for the better awareness and change of practice towards adolescent sexuality. Giving due consideration to this aspect is also important.
3. Communities have not yet visualized the long term effect of adolescent problems and risk behavior. Open discussion on ARH in religious institution and other social organization including 'Edir' should be considered.
4. Government is expected to support to alleviate adolescent challenging problem and realistic measures should be built in to the program focusing on ARH issues.
5. Non governmental sector available in the area should give considerable attention to design and utilize strategies for enhancing and sustainable activities on this issue.
6. Further need to conduct research on the existing factors influencing communication barriers between parents and children on Reproductive Health issue.

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Annex two

ADDIS ABABA UNIVERSITY FACULTY OF MEDICINE

SCHOOL OF NURSING

Subject information sheet

My name is Tesfaye Assebe I am trying to investigate factors that affect parents in discussing on reproductive health issue with their adolescent at Shamboo Town. Adolescents lack appropriate information on reproductive health information. They are vulnerable to reproductive health related problem. Their families are a good source of information. Your participation is very important to identify the problem and help the vulnerable adolescents. Parents who have children 10 years of age are involved in this study. In any case you can contact me with telephone number 0911705707 or Addis Ababa University School of Nursing.

Institutional Review Board (IRB) of Faculty of Medicine Addis Ababa University.

Tel No 0115538734, or email. aaumfirb@yahoo.com.

Thank you

UNIVERSITY ADDIS ABABAATI
FAAKALIITY MEDICINII
MANA BARUMSAA NEERSII

Odeefannoo waa'ee isa qorataa

Maqaan koo Tasfayee Asabaa ani maatiin waa'ee walhormaata fayyaa dorgagoo ijoollee isaanii wajjin akka hin marridhan kan taasisan addani baasuuf qoranoo kana magaala Saambooo tin an gaggeesa. Dorgagooni waa'ee walhormaata fayyaa odeefannoo gahaa hin qabani. Kanaaf rakkoo walhormaata fayyaa waliin wal qabatee jiruti saaxilamaniiru. Maatiin dargagoota isaaniiif mada odeefannoti. Qorannoo kana irrati hirmaachuun keesan fela barbaaduuf baka guda qaba. Maatiin ejoolee waga 10 fi isaa ol qaban irrati hirmaatu. Waan fedheti yoo nabarbaadan bilbila kanaan 0911705707 na argachuu dandeesu yookiin Univeersiitii Addis Ababa Mana Barumsaa Neersii.

Universiiti Adis Ababaati fakaality medicinii institutii riivuwu boordii (IRB).

Tel No 0115538734, or email. aaumfirb@yahoo.com

Galatoomaa

Annex three

ADDIS ABABA UNIVERSITY FACULTY OF MEDICINE SCHOOL OF NURSING

Consent form

For the selected parents read the following

I am going to ask you some question about reproductive health, your responses are completely confidential, your name will not be written on the form and will never be used in connection with any of the information you provide. You don't have to answer to any question you do not want to answer; however you honestly answer those questions that will help us to understand factors affecting parent communication on reproductive health issue with their children. We would like to thank you in advance for your help that you are going to continue. Do you agree to participate in the interview?

If yes (agree), continue

If no (disagree), stop

Contact person: Name and address. Tesfaye Assebe Yadeta Addis Ababa University Tel No 0911705707.

Institutional Review Board (IRB) of Faculty of Medicine Addis Ababa University.
Tel No 0115538734, or email. aaumfirb@yahoo.com.

Interviewer: Name _____ signature _____

Supervisor: Name _____ signature _____

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FAAKALIITY MEDICINII
MANA BARUMSAA NEERSII

Walii Galtee

Maatii gaafatu hundaaf kana dubbis

Ani gaaffii waa'ee wal hormaata fayyaa dargaggoo kan ta'an ijoollee keessan waliin akka mariidhatan sin nan gaafa dha . Deebii isin naaf laattani icciitiitii nan eega, maqaan keessan as irratti hin barreefamu deebii isin deebistan waliin wal hin qabatu. Fedha hin qabdani taanaan deebii laachuu dhiisuu dandeesu, garuu deebii dhugaa irratti hundaa'e isin naaf laatan rakkoo maatiin akka daa'imman isaan waliin waa'ee walhormaata fayyaa akka hin mariidhane orku adda baasuudhaan fala barbaaduuf akka gargaaru baka guddaa qaba. Waa'ee gaaffii kanaaf deebii waan naaf laattaniif sin galateefa dha. It fufuu ni dandeenya

Eeyyee (walii galeera): itti fufna

Walii hin gale : ni dhaabna

Nama wal qunamuu dandeesan: Tasfaayee Asabaa Lak. Bilbilaa 0911705707

Universiiti Adis Ababaati fakaality medicinii institutii riiviwu boordii (IRB).

Tel No 0115538734, or email. aaumfirb@yahoo.com.

Maqaa isa gaafatuu _____malattoo_____

Maqaa to'ata _____malattoo _____

Annex four

Questionnaire

Interview question on assessment of factors affecting parents in discussing reproductive health issue with their adolescent in Shamboo town 2009.

Instructions:

- A. Please create a good atmosphere to the respondents introduce your self first and then explain the purpose of the study clearly.
- B. This questionnaire has two part socio demographic and factors influencing parent adolescent discussion on reproductive health issues. Under each part there are an open or closed questions. Put a “√“sign for choice made by the responds and with down the response of the client for open ended question on the space provided.
- C. Contact person name and address. Tesfaye Assebe Yadeta , Tel No 0911705707.
- D. Institutional Review Board (IRB) of Faculty of Medicine Addis Ababa University.Tel No 0115538734, or email. aaumfirb@yahoo.com.

I. Socio –demographic data

1. Respondent status
 - a) head of house hold
 - b) spouse
2. Age in year _____
3. Sex male female
4. Do you have children aged 10 years and above?
 - a) Yes b, No
5. If yes to question number 4
 - a. Male _____ b. Female _____ c. current with you _____
6. Religion
 - a) Orthodox
 - b) Muslim
 - c) Catholic
 - d) Protestant
 - e) Others, specify
7. Ethnic group

- a) Oromo
- b) Amhara
- c) Tigre
- d) Gurage
- e) Others specify

8. Marital status

- a) Married
- b) Single
- c) Separated
- d) Divorced
- e) Widowed

9. Educational level

- a) Illiterate
- b) Read and write
- c) 1 -4 grade
- d) 5 – 8 grade
- e) 9 – 10 grade
- f) Above 10

10. Occupation

- a) Government Employed
- b) House wife
- c) Jobless
- d) Merchant
- e) Others, specify

11. Number of children

- a) 1- 2
- b) 3 – 4
- c) 5 and above

12. Monthly family income

- a) < 400 birr
- b) 400 – 1000 birr

c) Above 1000 birr

d) Not know correctly

II. Factors Affecting Parent in Discussing Reproductive Health Issue with Adolescents

A. Knowledge Related Question

13. Have you ever heard reproductive health?

a) Yes

b) No

14. If yes to question number 13 what are the component?

a) Adolescent family planning

b) STI including HIV

c) Early marriage

d) Unsafe sexual practice

e) Unwanted pregnancy

f) Unsafe abortion

g) Sexual violence

h) Physical and behavioral change related to age and sex

i) Others,(specify)

15. Can you mention available method of adolescent use family planning?

a. Yes

b. No

16. If yes to number 15 mention them

Abstinence

Oral contraceptive

Inject able contraceptive

Condom

Calendar use

Others (specify)

17. Have you ever heard STIs?

Yes

No

18. If yes to question number 17 mention them

- HIV/AIDS
- Gonorrhea
- Syphilis
- Chancroid
- Others(specify)

19. Mention age that considered as early marriage

- a) Before 15 years
- b) Before 18 years
- c) Before 20 years

20. What are complications of unsafe sexual practice?

- a) STIs including HIV/AIDS infection
- b) Unwanted pregnancy
- c) Unsafe abortion
- d) Others (specify)

21. What are the consequences of unwanted pregnancy?

- a) Unsafe abortion
- b) Excessive bleeding
- c) STI
- d) Others (specify)

22. What are behavioral and physical change occurs during adolescent?

- a) Breast development in female
- b) On set of menstruation
- c) Change of voice in male
- d) Other (specify)

B. Attitude related question

23. Do you believe that discussion on reproductive health issues with children is helpful?

- a) Agree

- b) Disagree
- c) Indifferent
24. Do you encourage adolescent to ask question related to reproductive health?
- a) Agree
- b) Disagree
- c) Indifferent
25. In your opinion, do you agree that sexually active adolescent should use contraceptive?
- a) Agree
- b) Disagree
- c) Indifferent
26. Do you believe that, family should be encouraged by their adolescent children to ask question related to reproductive health?
- a) Agree
- b) Disagree
- c) Indifferent

C. Practice style related question

27. Have you ever talked to your children about reproductive health issues?
- a) Yes
- b) No
28. If yes to question no 27, which of the following were used topic for discussion?
- a) Adolescent family planning
- b) STIs including HIV/AIDS
- c) Early marriage
- d) Unsafe sexual practice
- e) Unwanted pregnancy
- f) Unsafe abortion
- g) Sexual violence
- h) Physical and behavioral change related to age and sex
- i) Others specify
29. If yes to question number 27 for how many times?

- a) Daily
- b) Monthly
- c) Yearly
- d) I do not remember

30. During you communication with your adolescents, what problem you faced?

- a) Difficulty of initiation
- b) Difficulty of explanation

D. Other related factors

31. If you were not talking to your adolescent children about reproductive health issue, what are the reasons communicating not?

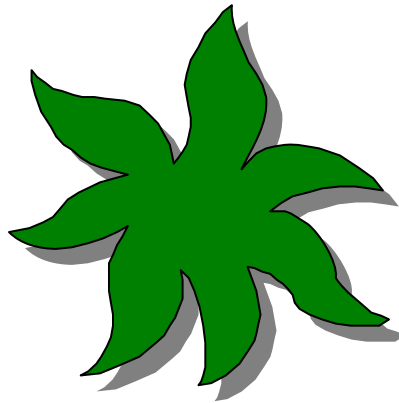
- a) Has no ethnic acceptance
- b) Has no cultural acceptance
- c) Has no religious acceptance
- d) Difficulty of initiating due to fear and shyness
- e) Initiate pre marital sex
- f) Lack of awareness
- g) Others (specify)

Date _____

Name and signature of data collector _____

Name and signature of supervisor _____

Thank you



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Gaaffilee

Gaaffii Waantota maatiin dargaggoo isaan wajjin waa'ee wal hormaataa fayyaa akka waliin hin mariidhanee tasisan addaan basamee beekuuf magaala shambootti taasifame bara 2009

Dursitanii

- A. Gaaffii dura walii galtee uumaa, maqaa keessan of beeksisaa, kaayyoo isaa ibsiif
- B. Gaaffileen kun waa'ee debii laatu fi maatiin akka dorgaggoo isaanii waliin waa'ee wal hormaataa fayyaa akka hin mariidhne kan orku ta'a. deebii lataniif mallato “,/” kana kaayaa.
- C. Nama wal qunamuu dandeesan: Tasfaayee Asabaa Lak. Bilbilaa 0911705707
- D. Universiiti Adis Ababaati fakaality medicinii institutii riiviwu boordii (IRB). Tel No 0115538734, yookin email. aaumfirb@yahoo.com.

I. Waa'ee maatii deebii deebisuu

- 1. Ga'ee maatii keessa qabdu
 - A. Gageessa maatii
 - B. Haadha manaa
- 2. Umurii _____
- 3. Saala A. Dhiira B. Dubartii
- 4. Ijoollee umuriin isaanii waga 10 fi isaa ol ta'an qabda?
 - A. Qaba B. Hin qabu
- 5. Yoo gaaffii lakoofsa 4 qaba jete
 - A. Dhiira _____ Durba _____ Aamma sin wajjin kan jiran _____
- 6. Amantii
 - A. Ortodoxii
 - B. Islaama
 - C. Kaatolicii
 - D. Protestaantii
 - E. Kanbroo (addaan baasi)

7. Qomoo

- A. Oromoo
- B. Amaara
- C. Tigree
- D. Guragee
- E. Kan biro (addaan baasi)

8. Waa'ee fuudhaa fi heerumaa

- A. Fuudheera (heerumeera)
- B. Hin fuune (hinheerumne)
- C. Addaan baneerra
- D. Wal hiikneera
- E. Abbaa manaa yookin haati manaa kan du'e

9. Sadarkaa barumsaa

- A. Hin barane
- B. Barresuu fi dubisuu danda'a
- C. Kutaa 1 – 4
- D. Kutaa 5 – 8
- E. Kutaa 9 – 10
- F. 10 nii fi isaa ol

10. Hojii

- A. Hojeta mootuma
- B. Haadha manaa
- C. Hojii dhabaa
- D. Daldala
- E. Kan biraa (addan baasi)

11. Baa'ina ijoollee qabdan

- A. 1 – 2
- B. 3- 5
- C. 5 fi isaa ol

12. Galii maatii

- A. Qarshii 400 gadi

- B. Qarshii 400 – 1000
- C. 1000 fi isaa ol
- D. Sirriti hin beeku

II. Waantota maatii fi dargagoon isaan waa'ee wal hormaata akka hinmarii'an taasisan

A. Beekumsa waliin kan wal qabate

13. Waa'ee wal hormaata fayyaa dargagoota ni beektaa?

- A. Beeka B. Hin beeku

14. Yoo lakoofsa 13 nan beeka jete maal maal faa beekta

- A. Qusana maatii dargagoota
- B. Dhukuba wal qunamtii salaam darban HIV dabalatee
- C. Umuriin osoo hin gadhiin heerumuu
- D. Ofi eegannoo malee wal qunamtii saala raawachuu
- E. Ulfa hin barbaachifne
- F. Ulfa ogeesa malee baasuu
- G. Dirqiin gudeeduu
- H. Jijiirama fi amalaa qaama dargagoota irrati mul'atu
- I. Kanbiroo (addaan baasi)

15. Qusanno maatii dargagooni itti fayadamuu danda'an naaf himuu dandeesa?

- A. Eeyyee B. Hin beeku

16. Gaaffii lakoofsa 5 yoo nan beeka jete maal maalfaa naaf himi

- A. Walqunamitii saalaa rawachuu dhiisuu
- B. Dawaa liqimfamu fayadamuu
- C. Dawa lilmoon fudhtamu
- D. Kondomii
- E. Lakofsaan tajaajilamuu
- F. Kanbiroo(addan baasi)

17. Waa,ee dhukuba wal qunamtii salaam darban dhageese beektaa?

- A. Eeyyee B. Hin beeku

18. Gaaffii lakoofsa 17 yoo nan beeka jette maalfaa?

- A. HIV/AIDS

- B. Fanxoo
- C. Cuftoo
- D. Kerkirii
- E. Kanbiroo (addaan baasi)
19. Dubartiin tokko osoo umuriin ishee hin gadhiin heerumte kan jedhamu waga meeqaa gadi?
- A. Waggaa 15
- B. Waggaa 18
- C. Waggaa 20
20. Ofi eegannoo malee wal qunamtii saala raawwachuun rakina maalii fida?
- A. Dhukuboota walqunamtii saalaan darban HIV dabalatee
- B. Dhulfa hin barbaachifne
- C. Seeraan ala ulfa baasuu
- D. Kan biroo(addan baasi)
21. Dhulfi hin barbaachifne maaliif saxila nama baasa?
- A. Seeran ala dhulfa baasuu
- B. Dhiiga garmalee dhangala,uu
- C. Dhukuba walqunamtii saalaan dardarban
- D. Kanbiroo (addaan baasi)
22. Jijjiramni amalaa fi qaama dargagoota irrati mul\,atu maal maalii?
- A. Dubartoota irrati guddina harmaa
- B. Adafiin dubartii jalqabuu
- C. Sagaleen dhiira jalqabuu
- D. Kanbiroo (addan basi)

Gaaffii fedhii irrati hundaa'e

23. Waa'ee wal hormaata fayyaa irratti maatii fi dargaggoon isaanii wal mariidgachiin gaarii dha jettee ni deegartaa?
- A. Nan deegara
- B. Hin deegaru
- C. Yaada hin qabu

24. Dargagoonii waa'ee wal hormaato fayyaa matii isaanii akka gaafatan ni jajjabeesuun gaarii dha jettaa?

- A. Nan deegara
- B. Hin deegaru
- C. Yaada hin qabu

25. Akka yaada mataakeeti dargaggoni qusannaa maatii fayyadamuu isaanii ni deegartaa?

- A. Nan deegara
- B. Hin deegaru
- C. Yaada hin qabu

26. Dargaggooni maatiin isaanii waa'ee wal hormaata faya akka gaafachuuf jajjabeesamuu qabu jettee ni amantaa?

- A. Nan deegara
- B. Hin deegaru
- C. Yaada hin qabu

Gaaffii akkaataa marii waliin wal qabateeru

27. Waa'ee wal hormaata fayyaa dargaggota ijooleekee waliin marii gootee beektaa?

- A. Beeka
- B. Hin beeku

28. Gaaffii 27f marii godhee beeka yoo jette maal maal faa irratii?

- A. Qusannaa maatii dargagoota irrati
- B. Waa'ee dhukuboota wal qunamtii saalaan darbani
- C. Dhumurii malee heerumuu
- D. Dhuf eegannoo malee wal qunamtii saala raawwachuu
- E. Ghulfa hin barbaachifne
- F. Seeraan dhla dhulfa baasuu
- G. Waa;ee yaka wal qunamtii salaa
- H. Jijjiraa amalaa fi qaamaa dargaggota irrati mul'atu
- I. Kan biro (addan baasi)

29. Gaaffii 27 irrati yoo marriyadheera jete hamamiif

- A. Guyyaa guyyati

- B. Baatiiti
- C. Waggaati
- D. Hin yaadadhu

30. Yeroo waliin mariidhatu rakina maaltu simudate?

- A. Jalqabuu
- B. Ibsuu

Kan biro akka waliin hinmariidhanee taasisan

31. Yoo ijoollee kessan warra dargaggo waliin hin mariidhane ta'e, maaltu akka hin mariidhane sini taasise

- A. Qomoo keenya birati fudhatama hin qabu
- B. Aada keenya keessati fudhatama hin qabu
- C. Amantii keenyatti fudhatama hin qabu
- D. Wal qunamtii dargaggon akka raawatan kakaasa
- E. Soda fi qaanii
- F. Hin beeku
- G. Kanbiroo (ibis)

Guyyaa _____

Maqaa fi malato daataa isa funanee _____

Maqaa fi mallato to'ata _____

Galatoomaa

