

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

COMMUNICATIONS BETWEEN PARENTS AND SEXUALLY
ACTIVE YOUTH: IN THE CASE OF GULELE SUBCITY IN ADDIS
ABABA, ETHIOPIA

BY
ENAWGAW SISAY

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ABABA, ETHIOPIA

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Approved by Boards of Examiners

Chairman, Department Graduate Committee

Advisor

Examiner

DECLARATION

I declare that this project work entitled “Communications between parents and Sexual Active Youth in the context of sexual and reproductive health: In the Case of Gulele Sub city in Addis Ababa” is my own original work. I have carried it out independently with the guidance and suggestions of the research advisor. And it has not been presented in Addis Ababa University or any other University. *And* all the sources of materials used for the thesis have been duly acknowledged.

Enawgaw Sisay

(The researcher)

Signature_____

LETTER OF CERTIFICATION

This is to certify that Enawgaw Sisay has carried out his project work on the topic “Communications between parents and Sexual Active Youth in the context of sexual and reproductive health: In the Case of Gulele Sub city in Addis Ababa” under my supervision. This work is original in its nature and is suitable for submission in partial fulfillment of the requirement to earn masters degree in journalism and communication.

Anteneh Tsegay (PhD)

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ABSTRACT

Sexual and reproductive health problems of adolescents in Ethiopia are rising from time to time. This may be associated with different reasons. Different researches done in different countries had shown that good family communication regarding sexual risk behavior has been positively associated with open discussion between parents and adolescents. There are different factors affecting communications between parents and adolescents regarding SRH issues which are uncovered. In particular parents failed to communicate with their adolescent children on sensitive issues of sexuality. Thus Communication between them about reproductive health issues was found difficult and minimal.

The study was done in an attempt to identify those factors and the influence of parent-adolescent communication on SRH issues. More over the study was done to investigate the association between socio-cultural and economic determinants and the communications between parents and adolescents on SRH.

In the study both qualitative and quantitative methodologies were employed .A cross-sectional descriptive study involved in 382 purposively selected Students. A pre- tested structured anonymous questionnaire was used to collect quantitative data, which was entered, cleaned and analyzed using SPSS version 19.0 statistical package. The study also employed bivariate correlation to evaluate the degree of relationship between the two variables. Qualitative information was obtained from six homogenous focus group discussions of student participants (each three groups from male and female participants), depth interviews of sixteen parents and five key informants' interviewees. A total of sixteen interviews were done with parents of both sexes and the data analysis was done thematically to answer the basic research questions.

The majority of the respondents (74.3%) reported that they never discussed on SRH issues with their parents. But ninety of the respondents (25.7%) said that they discussed with their parents .The respondents who preferred their mother to discuss on SRH issues were (56.2%).Two hundred sixteen of the respondents (63.3 %) reported that they did not discuss with neither of their parents in the topics of SRH. Ninety seven of the respondents (28.4%) reported that they discussed with their parents rarely. Traditional norms, Cultures, sensitiveness of the issue and lack of communications skill, these were alleged to prohibit parents from discussing some issues of reproductive health, especially issues of sexuality with their children.

The overall research finding shows that there is low communication between parent and adolescent on different SRH issues with different reasons for not discussing. Hence, based on the findings obtained in this study it is recommended that comprehensive family life education should be initiated for the students and parents in school, home, religious institution, and health facilities (ONE to FIVE Urban Health Extension Workers Approach) for effective communication to occur on SRH. In addition programs working in Adolescent Sexual and Reproductive Health (ASRH) should include parents to address parental influences on adolescents' reproductive health and work to alleviate those factors which affect communication between parent and adolescents. There is also needed to develop appropriate interventions for empowering parents to communicate with their adolescent (children) about the full range of sexual and reproductive health issues.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Ethiopia has a predominantly young population; half of the population consists of young people between the ages of 15 and 24 years. This age group is particularly vulnerable to many health problems because adolescence is a time of self-discovery and physical as well as cognitive development. Feldman and Middleman (2002) assert that it is within this context that adolescent sexual development and sexual behavior occur.

While curiosity and experimentation are normal, risky sexual behavior leads adolescents to undesirable consequences including unintended pregnancy and sexually transmitted diseases. Hoffman & Futtermann (1996) have noted that adults often hold ambivalent attitudes towards young people, viewing them simultaneously as ‘small’ adults and as immature, inexperienced and untrustworthy children. They have also noted that many adults have difficulty acknowledging adolescents as sexual beings, and therefore adolescent sexuality is viewed as something that must be controlled and restrained. However, studies have shown that the quality parenting style in general and communication about sex and sexuality in particular appear to be strong determinants of adolescent sexual behavior (Blake et al, 2001). When parents approach their role as sex educators in positive, affirmative ways, young people are better able to make healthy sexual decisions and to build loving relationships. Studies carried out in the developed world communities have further shown that parents can affect aspects of an adolescent’s life that are beyond the reach of schools or health services.

However, despite the potential advantages of parent-adolescent communication, many parents worldwide are reported to be uncomfortable talking about issues related to sexuality, especially with their children (UNDP, 2002). In Ethiopia, too, considering the vulnerability of the youth particularly to problems associated with sexual and reproductive health (SRH), and the role of communications in promoting healthy behavior, there is a need to understand the factors and processes that constrain and/or enhance communication and dialogue on sexuality among young people and their parents.

Thus, it is against this premise that this study attempted to understand parent-child communications in relation to the latter's sexuality and reproductive health experiences. To that end, the study went into the communications practices, processes, perceptions and opinions of both parents and their adolescent children from selected study area of Medhanealem Preparatory School in Addis Ababa. This study also tried to identify the barriers of effective Parent-adolescent communication and the relationship of Socio-cultural detriments and the discussion between parents to adolescent's communications health information on the issue of sexuality among adolescents.

1.2 Statement of the Problem

"Adolescents "and "young people "are defined by WHO as the age group 10-19 years and 10-24 years, respectively. Young people make up over one quarter of the world's population. Neglecting this population has a major implication on sexual and reproductive behaviors as they develop into adults. The health threats for adolescents today are predominantly behavioral and more of today's adolescents are involved in health behaviors with potential for serious consequences. Hence, it is important to understand the Communications between parents and their adolescents to sexual and reproductive health issues.

Communications about sexuality and sexual matters is more important perhaps now than any other time. This is because adolescents are affected with the burden of unwanted pregnancy and its complication, HIV/AIDS/STI, and other sexual and reproductive ill health to a greater extent. Parent to adolescent communication regarding sexuality is perceived by many to be effective means of encouraging adolescents to adopt responsible sexual behaviors. Communication between parents and their children about sexual issues and impact of this communications on adolescents' sexual behavior has been one important research area which helps to improve the prevention of sexual and reproductive health problems and promote educational programs that meet the needs and concerns of youth. In addition, adolescents 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. Early sexual intercourse is a serious adolescent risk behavior.

Globally, rates of sexually transmitted infections among young people are soaring: one-third of the 340 million new STIs each year occur in people under 25 years of age. Each year, more than one in every 20 adolescents contracts a curable STI. More than half of all new human immunodeficiency virus (HIV) infections occur in people between the ages of 15 and 24 years. (Nakkazi, 2003; 3 PP 7-14) Particularly, adolescents in the Sub-Saharan region have low family planning utilization rates and limited knowledge about RH and services, and they account for a higher proportion of the region's new HIV infections, maternal mortality ratios, and unmet need for RH information and services (Population Reference Bureau, 2000).

The vulnerability of adolescent to different reproductive health problem is due to a number of reasons such as their scant knowledge and information on the prevention. Several strategies have been employed to provide adolescent with knowledge, positive attitudes and skills to prevent SRH problems. These include sex education programs, establishment of counseling service outlets, media campaigns and family communication about sexuality. Out of these, parent and child communication about sexuality regarded as an effective way to reduce risky sexual behavior among adolescents (Dilorio C, Kellen M, Hockenberry E.1999; 24(30):181-9). However for many parents all over Africa, one of the challenges in child upbringing is answering a child's questions about sexuality

Equally, a lot of children find it uncomfortable having a conversation about sexuality with their parents because the subject is a taboo topic in most homes. Indeed parents have traditionally not been in the forefront of sexual socialization of their children. Adolescents grow up without the guidance of elders, parents and other in the extended family. Consequently, a gap in sexuality information for adolescents is emerged. This gap has been mainly filled by another source of sexuality information; peers. Peers are able to share their personal experiences regarding sexuality and provide an ear ready to listen to that of others. A study among adolescents in Ghana indicated that adolescents interacted about sexuality more with friends than parents (Ghana Youth Reproductive Health Survey, 2001)

However, the information shared within the peer network could be false and there can be the persistence of damaging myths through interactions. Research shows that adolescents who talk with their parents about sexuality are more likely than other youth to delay the initiation of sex and, when they eventually initiate sex, are more likely to use condoms and other contraception. One

study found that Latinas in junior or senior high school who felt able to talk with their parents were much less likely to get pregnant than Latinas with fewer opportunities and less freedom to talk with their parents (Adolph C, Ramos DE, Linton KLP, Grimes DA, 1995; 51(5):303-306).

Communication between parents and their children about sexual issue and impact of this communication on adolescents' sexual behavior has been one important research area; which will help in improving the prevention and education program that meet the needs and concerns of adolescence (Deborah Holtzman and Richard Robinson, 1995; 27(6): 237-238).

The purpose of the study is to understanding the communications between parents and adolescents on SRH Issue in Addis Ababa with in selected school and the objectives are to explore parents and adolescents perceptions on the issue of sexuality and reproductive health communications , identify the major barriers of sexuality and reproductive health communications in parent to adolescent interactions in the selected subjects and investigate socio- cultural and economic determinants of parents to adolescents Communications on sexuality and reproductive health issues. The context of the adolescent's family is considered as the primary social influence, thus carrying substantial weight for the introduction of risk and/or protective factors into the adolescent's life. Although adolescence is a time of expanding one's primary social network with peers playing a vital role in the adolescent's life; family relationships, remain essential factors influencing adolescent functioning and decision making (Noller, 1995). So this research is done to fill the research gap on this issue and identification of factors which will help those who are working on Adolescents Sexual Reproductive Health (ASRH) programs to focus on parent to adolescent communications on SRH.

1.3 Research Questions

The researcher has formulated the following research questions that answered through this study.

1. How do parents and adolescents perceive/view / the issues of sexuality and reproductive health communications?
2. What are the major barriers of SRH communications on parents to adolescent are interactions in the context of the selected subjects?
3. What are the relations of socio- cultural and economic determinants of parents to adolescents Communications on sexuality and reproductive health issues?

1.4. Objective of the Study

1.4.1 General Objectives

The general objective of the study is to assess the communications between parents and their sexual active youth on SRH issues in Gulele sub-city, Medhanealem preparatory school in Addis Ababa.

1.4.2 Specific Objectives of the Study

The specific objectives of the study are:

1. To explore parents and adolescents perceptions on the issue of sexuality and reproductive health communications.
2. To identify the major barriers of sexuality and reproductive health communications in parent – adolescent interactions in the selected subjects.
3. To investigate socio-cultural and economic determinants of parents to adolescents Communications on sexuality and reproductive health.

1.5 Significance of the Study

The study is significant in the sense that it puts viewpoints on the hindrance of communications between parents and adolescents on issues concerning sexual and reproductive health Communications. The study will also have particular significances for parents, and researchers. Parents get inputs that make them particularly know how to communicate effectively with their adolescents. Moreover the study is significant in providing inputs for planning and implementation for behavioral change of communication intervention program of adolescents in the country and serves as a spring board for other studies.

1.6 Scope of the Study

This study is limited to a few sample areas which did not cover the whole households in Addis Ababa due to limited resources. And it focused only on the participants of few households in the selected sub city. The rest family in the sub city didn't include in the study due to time constraints and the focus of the research.

1.7 Limitations of the Study

Some constraints such as time and lack of sufficient fund hindered the need to include a large sample size that could nearly represent the total population of the study. In order to get a stronger picture of the issues in the different Preparatory Schools .The researcher would have liked to involve a larger number of respondents. The shortage of up to date reference materials and research works, specifically to the Ethiopian context, also narrowed the content of the study. Another barrier that the researcher faced in the process of data collection would have been be refusal by head of School to formally permit the distribution of the questionnaire for unconvincing reasons such as lack of time to fill the questionnaire, fear of sensitivity of the questionnaire contents if its results presented to public. Although the researcher would have a great group of participants who were be willing to fill the questionnaire, there were some Students who were not willing to be part of the study for unknown reasons.

1.8 Operational Definitions of key Terms

Sexuality: Sexuality in this study refers to the broader context of adolescent reproductive health encompassing puberty, emotional maturity, gender roles and sexual health.

Adolescence: According to the World Health Organization, adolescence is the age bracket between 10-19 years. For purposes of this study, adolescents refer to persons aged 15-24 years corresponding to FMOH and WHO age categorization as sexual Active Youth (SAY). In the study adolescents, sexually active youth and children are used interchangeably.

Communications: Communication in this study refers to the exchange and sharing of information, attitudes, and ideas among parents and their adolescent children regarding on sexual and reproductive health issues.

Reproductive Health (RH): Is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore implies that people are able to have responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (WHO,2002).

Woreda: The smallest administrative structure of the government in Addis Ababa.

Households (HH): In this research, it is synonyms or compatible to parents to adolescents or parents to sexual active youth

1.9 Organizations of the Thesis

This thesis is made up of five chapters. The first chapter deals with the general feature of the paper including the background of the study, statement of the problem, and also objectives, research questions, significance, scope and limitation of the study and the thesis organization. The next chapter, chapter two has mainly composed of theoretical and conceptual frame works commonly called Literature Review. In this section the various theoretical views on the barriers of communications on sexuality health issues are discussed in line with different literature and studies in the research areas. Theoretical frame work is also discussed under this chapter. In the third chapter, methodology design and data collection procedures are briefly presented; chapter four consists of data analysis, presentation, interpretation and discussion. Finally, chapter five deals on conclusions and recommendations of the research.

CHAPTER TWO

2.0 REVIEW OF THE RELATED LITERATURE

This section reviews previous studies relevant to parent to adolescent communications on Sexuality and reproductive health. The researcher made attempts to review studies relevant to the research questions being addressed by this study. A search for empirical literature using electronic databases and different secondary sources are done to identify relevant articles and books. This chapter made use of theoretical underpinnings and conceptual frame works to explore the determinant factors of the communications between parents and adolescents, the perception of parents and adolescents, and the relation between sexuality communication and socio-Cultural and economic determinants on regarding to sexual reproductive health issues.

2.1 Conceptual and Theoretical Frameworks

2.1.1 Conceptual Framework

Conceptual frame work is found for this paper after reviewing the relevant literatures. In this conceptual framework a simple linear association is considered. Socio-cultural and economic factors, perceived as openness of parents and knowledge on sexual and reproductive health (SRH) have linked with communications between parents and adolescents on SRH issues which may further be linked with adolescents decision making and sexual behavior. Socio demographic characteristics and knowledge on SRH directly linked to sexual behavior of adolescents. Socio-demographic characteristics (gender, age, Parent education & Cultural norms) are discussed in this study.

2.1.2 Theoretical Frame work

Scholars within the fields of public health, health education, health promotion, and health communication look to specific theories to explain health behavior change. These are Health Belief Model, Theory of Reasoned Action, Extended Parallel Process Model, and Social Cognitive Theory and family system theory. Among these theories, the researcher strongly believes that family system theory is an appropriate theory for this study.

Family System Theory

The proposed study is guided by the theoretical framework of family systems theory “which focuses on interactional processes of family life rather than viewing adolescents or parents in isolation” (spring, 1999). Family systems theory has its roots in sociology, biology, and cybernetics. Scientists such as Ludwig von Bertalanffy and Gregory Bateson paved the way for the central understanding that “a system is more than the sum of its parts” (Nichols & Schwartz, 1998, p. 113). This systems theory foundation, applied to family process, helps clinicians and scientists alike understand that a family system should be seen as more than just a collection of people, but also as individual members who influence one another in a variety of ways.

The application of systems theory to the family has led to the conclusion that “the family is an example of an open, ongoing, goal- seeking, self- regulating, social system, and that it shares the features of all such systems” (Broderick, 1993, p. 37); and yet the family system is also set apart from other social systems by its unique nature and characteristics. To describe a family system as “open” (Broderick, 1993, p. 37) implies that information flows back and forth among the boundaries of the family system, its individual parts, and the outside larger systems.

A family system develops its own unique set of rules which govern its interactive processes, degrees of openness, and structure pertaining to the information flow within and beyond the system (Broderick, 1993). In systems terminology, adolescence induces a process of change in family rules and roles marked by a shift toward openness to systems outside the family such as peer groups, school, and work (spring, 1999). Communication is a central component of the family system’s capability to change. For the purpose of the proposed study, family systems theory will guide the researcher to examine the influence of behaviors of subsystems (i.e., the parents, their communication, monitoring, and parenting styles) on the behaviors of other separate, but conjoint parts (the adolescent’s sexual risk-taking behaviors) of the system.

2.2 Sexual and Reproductive Health

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality: not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (World Health Organization, Draft Working Definition, 2002).

Within the framework of the World Health Organization's (WHO) definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

One interpretation of this implies that men and women ought to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control; also access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth could provide couples with the best chance of having a healthy infant. On the other hand individuals do face inequalities in reproductive health services. Inequalities vary based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment. It is possible for example, that low income individuals lack the resources for appropriate health services and the knowledge to know what is appropriate for maintaining reproductive health.

2.3 Communication

Communication is one of those human activities that everyone recognizes but few can define satisfactorily. Different scholars define communications in different ways. To mention a few, communications it is a process or form of interaction that is interpersonal, i.e., social in the narrower sense. The process is complete only when it results in some sort of understanding.

In other words, communication is never merely a case of stimulus and response in the sense in which those terms are used in individual psychology. It is rather expression, interpretation, and response.

According to Edward T. Hall (1966), communication is the mechanism through which human relations exist and develop all the symbols of the mind, together with the means of conveying them through space and preserving them in time. It includes the expression of the face, attitude and gesture, the tones of the voice, words, writing, printing, railways, telegraphs, telephones, and whatever else may be the latest achievement in the conquest of space and time. All this taken together, in the intricacy of their actual combination, make up an organic whole corresponding to the organic whole of human thought; and everything in the way of mental growth has an external existence there in. The more closely we consider this mechanism the more intimate will appear its relation to the inner life of mankind, and nothing will more help us to understand the latter than such consideration. The system of communication is a tool, progressive inventions, whose improvements reacts up on mankind and alter the life of every individual and institution. A study of these improvements is one of the best ways by which to approach an understanding of the mental and social changes that are bound up with them; because it gives a tangible framework for our ideas. The other writer, Charles H. Cooley (1966) noted that, one may conveniently distinguish between certain fundamental techniques, or primary processes, which are communicative in character and certain secondary techniques which facilitate the process of communication. The distinction is perhaps of no great psychological importance but has a very real historical and sociological significance, in as much as the fundamental process are common to all mankind, while the secondary techniques emerge only at relatively sophisticated levels of civilization. Among the primary communicative process of society may be mentioned: language; gesture, in its widest sense; the imitation of overt behavior; and a large and ill-defined group of implicit processes which grow out of overt behavior and which may be rather vaguely referred to as social suggestion.

2.3.1 Health Communications (HC)

Health Communications is types of communications that mainly focused and contented health issues like family planning, reproductive health and health preventions. As it is put in (Haregewoyin, 2013) health Communications has long been considered as an integral part of public health programs, and it has been defined in different ways .For example, CDC (2001) define it as “ the study and use of communication Strategies to inform and influence individual and community decisions that enhance health’’. US department of Health and Human Services (2005) also defines health communications as the’’ art and

technique of informing influencing and motivating individual, institutional, and public audiences about important health issues'' (P.11-12). According to Muturi (2005:78),'' the global of health communication is to increase knowledge and understanding of health related issues and to improve health related issues''. In addition, health communication draws from different disciplines including health psychology, mass communications, marketing, social marketing, anthropology and other disciplines.

Schiavo (2007) integrates the various definitions and the practice based perspective of health communication:

Health communications is a multifaceted and multidisciplinary approach to reach different audiences and share health related information with the goal of influencing, engaging, and supporting individuals, communities , health professional ,special groups ,policymakers and the public champion , introduce, adopt, or sustain a behavior, practice, or policy that will ultimately improve health outcomes (p.7)

As it is viewed in the above definition, health communications addresses how communications could inform and influence individual and community decisions about health knowledge and practices. Communications with the public, stakeholders, within the health system, schools, and numerous others during a public health emergency is critical to managing any crisis.'' Before an outbreak, communication is aimed at educating, informing, advocating, preparing and preventing. In addition to this, at the time of an outbreak communication serves ''to communicate with the public in ways that build, maintain or restore trust.

This is true across cultures, political systems and level of country development'' (PAHO, 2009, p .3).Whether it is during an outbreak or before, there are things that health communication can and cannot do. Health communications can help raise awareness of health issues to drive policy or practice changes; influence perceptions, beliefs, and attitudes that may change social norms; promote data and emerging issues to establish new standards of care; increase demand for health services and products; show benefits of behavior change; demonstrate healthy skills; provoke public discussion to drive diseases diagnosis, treatment, or prevention; suggest and prompt action; build constituencies to support health practice changes; support the need for additional funds for medical and scientific discovery; create a climate of receptivity for new health services or products; and strengthen third-party relationships .

Interpersonal communications involving groups like physicians, friends, family members, counselors, parents, clergy, and coaches of the target audiences can make health messages be presented in a familiar way.

2.3.2 Sexuality Health Communications

Communications on sexuality in Ethiopian culture is defined as a taboo, allowing only ceremonial rites or authorized persons such as paternal aunts and uncles to discuss the subject with young people (Muyinda et al, 2001, Mullen, 2001). However, in many countries, these traditional ways of communicating sexual matters between generations have broken down due to lifestyle changes (Ndyanabangi and Kip, 2001). Bohmer et al, (2000) further affirmed that female youths were traditionally educated by aunts concerning how to behave sexually in marriage, but aunts are no longer playing that role. Nonetheless, parents have the responsibility of providing this information to their children.

A study carried out in Ethiopia revealed that, when communications at family level takes place, messages on sexuality issues are usually ambiguous (Taffa et al, 1999). For example, statements such as ‘do not play with boys’ are given by mothers advising their teenage girls on sexuality. Such messages are given without explaining what this euphemism means leaving the recipient to guess.

2.3.3 Reproductive Health Communications

Reproductive health communications can be seen as the subset of health communications. Thus the researcher has already discussed it in the section of health communications. The researcher has defined the key concepts under the following section of sexuality reproductive health communications.

2.4 An Overview on Sexuality and Reproductive Health Communications

Different studies on parental to adolescent’s communications show that the barriers of sexuality communications, parents and adolescents view towards SRHC, and the relation between parental communication with different socio-cultural and economic factors is different. For instances, A survey conducted in USA shows, fifty-one percent of teens (61 percent of females; 42 percent of males) had discussed with their parents “how to know when they are ready to have sex”.

Forty- three percent of teens (53 percent of females; 33 percent of males) had also 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 percent had discussed about condoms, but only 35 percent had discussed other forms of contraception. Among female teens, 54 percent had discussed condoms and 63 percent had discussed other forms of contraception with parents. Overall, 52 percent of teens had discussed condoms with their parents; 49 percent had discussed other forms of contraception. Fifty-six percent of teens (64 percent of females; 48 percent of males) had discussed HIV/AIDS with their parents. Fifty percent of teens (56 percent of females; 44 percent of males) had discussed STIs with parents (Barbara, 2002; volume15 no1:1-4).

The Henry J. Kaiser Family Foundation had conducted a nationally representative survey in USA Teens had indicate various reasons why they may not talk to parents about sexual health issues. Eighty-three percent of teens worried about their parents' reaction. Eighty percent of teens had got worried that parents will think they have had sex or are going to have sex. Seventy-eight percent of teens named embarrassment as a big reason. Seventy-seven percent of teens (83 percent of females; 71 percent of males) said they didn't know how to bring the subject up (Sue Alford, 2002; Vol. 15, No. 1: pp. 18).

In a study of sexually active African American and Latino youth, when parents held skilled, open, interactive discussions with their teens about sex, the youth were significantly more likely than the teens of less skilled communicators to use condoms at most recent intercourse and across time (Barbara, 2002; volume15 no1:1-4). Another study conducted among African-American adolescent's ages 13-15 years shows that both male and female adolescents were likely to discuss sexual topics with their mothers than their fathers (Dilorio C, Kellen M, Hocken berry, 1999).

Adolescents were found in a South African study to have positive views about interaction with parents on several issues such as sexuality. At the same time, they reported that they cannot easily share their feelings with parents partly because they are judgmental and 72% were of the view that communication with parents about sexuality is inadequate (Pertorious, J., Ferreira, G., Edwards, D, 1999). Research on this issue in Zambia has shown that both adolescents and their parents find the sexuality communication process an embarrassing one (McCauley, A. and Salter, C., 1995).

The main reservations of mothers for not discussing sex and birth control were that the discussion would be embarrassing; that children would not take them seriously; and an apprehension that they cannot answer a child's question about sex.

Similarly, adolescents were unwilling to talk to parents because of embarrassment; a concern with invasion of their privacy; belief that mothers are not interested in listening to them and a feeling that they already know enough (Jaccard, J., Dittus, P. and Gordon, V., 2000; 15: 187-208). And a study in Philippines poor communication with parents about sex related issues were reported by 75% of the respondents (Romel saulone, Theocharis r. Theoharis, Robert Stake, Francisco's .Sy, Murray L and etal, 1997).

These researches show that parental to adolescents communication is to minimal on sexuality issues. A study in Kenya shows that males were most uncomfortable talking to their mothers, aunts, fathers, sisters, uncles and members of the clergy. They were comfortable talking to their brothers, friends and health care workers. Females were most uncomfortable with fathers, uncles, brothers and members of the clergy. They were most comfortable talking to sisters, friends, with boyfriends their same sex siblings and health workers (Karungari Kirangu, Emily abwaka, Dan odallo; 1995). In one study both female and male reported that they were most comfortable discussing sexuality topics with their friends. Males adolescent were more likely than female adolescents to discuss sex based topics with their father (Dilorio C, Kellen M, Hockenberry; 1999)

2.4.1 Sexual Reproductive Health Communications (SRHC) in Ethiopia

Sexuality education is a lifelong process of building a strong foundation for sexual health. The primary goal of school based sexuality educations is to help young people build a foundation as they mature into sexually healthy adults. Sexuality education seeks to assist young people in understanding a positive view of sexuality, provide them with information and skills now and in the future. Adolescence is a period of rapid physical, psychological and emotional development and a period of adjustments with family and society. Generally this transition is smooth; though it can sometimes be stormy. Their decision and action particularly with regard to sexual activity can significantly affect the rest of their lives (Usha Rkrishna, Vinita Salivi; 2000).

In respect to the assessment of topics for discussion between adolescents and parents communications in Bullen Woreda high school, one hundred seventy (41.3%) of the respondents reported that they had discussed on contraceptive methods. Three hundred twenty four (78.6%) of the students reported that they had discussed on STI/HIV/AIDS. Out of 412, 174(42.2%) of the students had discussed about sexual intercourse. (54.1%) had discussed about unwanted pregnancy, (55.1%) had discussed on avoiding

premarital sex. Two hundred forty four (59.2%) of the participants had discussed about condom. Three hundred nine (75%) of the respondents had discussed on physiological and psychological changes seen in youth (puberty). Out of 412, 250(60.7%) of the students had discussed about menstrual period (G/yesus, 2006).

A cross sectional study survey carried out in Zeway high school and parents on sexual matters indicates 54% of the students felt that it is culturally shameful to discuss about physical and psychological changes during adolescents (Taffa et al; 1999)

2.5 Parents and Adolescents Perceptions towards SRHC

Parent-adolescent communication is the parental factor most often linked to adolescent sexual attitudes and behaviors. While there is evidence that adolescents prefer to receive information about sexuality from their parents, in reality few have this privilege .Nonetheless, research has documented that the quantity, frequency and timing of parent-child communication are important factors in sexual outcomes, including knowledge about sexuality and reproductive health, sexual attitudes and sexual behaviors and intentions (Fisher TD; 1986; 21: 517–527).

It is important to mention that a few studies have documented that parent-child communication is associated with greater sexual behavior among youth (Jaccard, J. and Dittus,; 1993). However, in such studies it is not clear which comes first, the onset of sexual behavior or the onset of parental attempts to educate adolescents about sexuality.

Studies have indicated that adolescents most commonly rely on peers for information about sexual matters. However, parents also tend to be mentioned as being important, sometimes prominently so. Averaging across a wide range of studies, about 70 percent of parents in the United States indicate that they have talked with their adolescents about sex, whereas about 50 percent of adolescents report engaging in such conversations with their parents. These rates, however, vary considerably from one study to the next (Henry Kaiser; 1996)

2.6 Sexuality and Reproductive Health communications between Parents and Adolescents

Parent-adolescent communication regarding sexual and reproductive health issues is more likely to reduce adolescent risk-taking sexual behaviors. Communication between parents and adolescents about sexual and reproductive health issues, however, is difficult for parents. However, there is good

communication between parents and adolescents on other issues related to life for example in issues concerning politics where by fathers tend to communicate more with their adolescents compared to issues related to sexuality or reproductive health.

The findings from Burgess et al, (2005) indicated that the underestimations of the sexual behaviors of adolescents were based on erroneous assumptions made by the mothers and also positive parental perceptions of the parent-adolescent relationship increased the underestimation by the parents of their adolescent's sexual behaviors. For example, mothers (72%) were more likely than their adolescents (45%) to report that they had familial discussion about sex, and parental satisfaction with the parent-adolescent relationship was not predictive of teen satisfaction. Much of the information that children get from their parents is observational and indirect. Quite often, adolescents do not get comprehensive information from parental conversations about sex. Those who seek guidance from parents are not satisfied because the latter try to evade discussion or are not able to give satisfactory answers because parents do not talk to their children about sex, but they also do not want their children to do anything sexual, Wang, (2000).

Parents seem afraid to confront their children about what they are or are not doing sexually, mothers do not want to admit that their daughters are growing up, feel threatened by a sexually developing teenager, and thus find it difficult to discuss sexual issues with their daughters.

Miller et al, (1998), examined how adolescents' and parents' reports of conversation agreed found a modest level of correspondence, and indicated that mothers believed they were more communicative about sex than their daughters perceived them to be. The research has focused on whether any discussion about sexuality has taken place and how sexual information is transmitted. More communication about sex occurs if adolescents view talking about sex with parents as easy. Furthermore, the process of sexual communication such as the mutuality of the interchange and support for each other's comments differs by who is holding the discussion (example, parent- daughter pairs have more mutuality and support than do parent-son pairs).

Research on parent-adolescent communications about sex typically has focused on who communicates with whom. Such research is important, as it explains how parents provide information to adolescents. In general, the mother has been found to discuss sexuality with adolescents more often than the father.

However, this parental gender difference is often affected by the gender of the adolescent: Mothers communicate more often with their daughters than with their sons, while fathers rarely communicate with their daughters about sex; however, mothers and fathers discuss sex with their sons at approximately equal rates (Miller et al, 1998)

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

Thus, parent-adolescent communication regarding sexuality often is viewed as desirable and perceived by many to be effective means of encouraging adolescents to adopt responsible sexual behaviors (G/Yesus, 2006).

Barnes and Olson (1985) conducted a study on the relationship between parent- adolescent communication and the Circumflex Model of Marital and Family Systems and the analysis of the Parent-Adolescent Communication Scale data revealed substantial generational differences. As a group, mothers reported better communication with their children than did fathers. Adolescents expressed having difficulty communicating with both parents.

At the aggregate level, the perceptions varied considerably between fathers, mothers, and adolescents hence recall on the problems that indicates a lack of communication problems. And the findings clearly demonstrated no sex differences between adolescent males and adolescent females in how they perceived their communication with their mothers and fathers, or how parents of either sex perceived their communication with male or female adolescents.

Also in their study, Barnes and Olson (1985), shows that mothers consistently reported more positive communication with their adolescents than fathers did. This difference was attributable to higher levels of openness reported by mothers in their parent- child interactions. The adolescent responses also indicated more positive interactions with their mothers than with their fathers in terms of a greater degree of openness in the mother- child relationship.

The teens reported about equal levels of problems in trying to communicate with each of their parents. Compared to the adolescent reports, both parents reported significantly more openness and fewer

problems in communicating with their children. Clearly adolescents viewed their intra-family communication with greater negativism. Many parents don't discuss with their child until they discover their adolescents has already made difficult sexually related decision. By this time an adolescent has probably already engaged in sexual activity, Communication is ineffective.

The child was not encouraged to discuss sexually related issues from an early age; the teen will feel uncomfortable with the subject matter at this point in time. As a result the teen might lie or tell the parents what they want to hear in order to avoid an awkward situation. The parents may also feel uncomfortable discussing the subject matter with their child and will have difficult initiating such a conversation (G/yesus, 2006).

2.7 Factors Affecting SRHC between Parents and Adolescents

The sexual and reproductive health communications between parents and adolescents are affected by many factors .Some of them are culture, sensitiveness of the issue and give less attention and thought learning by experiences. Dutra et al., (1999) argues that only when mothers (parents) are open and receptive to discussions about sex with their adolescents, are more sex topics discussed. However, in the African context, where talking about sex is considered a taboo subject, the process might be negatively influenced by fear. A study conducted in Uganda revealed that young people fear that if they raise the topic of sexuality for discussion, their parents would interpret it as actual evidence of sexual involvement (Ndyanabangi and Kipp, 2001). Conversely, according to the same study, parents also feared that if they talked about sex they might make their children more interested in exploring and practicing sex. This perception is still pertinent, particularly when parents get involved in promoting sexuality issues. Generally, the barriers that prevent communications between parents and adolescents regarding sexual and reproductive health issue can be grouped into three categories: social, cultural, and economic barriers.

2.7.1 Social Factors

There are many factors that hindered (influenced) the effectiveness of communications between parents and adolescents people's values, attitudes, beliefs and behavior can have a strong social influence on individuals own behavior, a phenomenon that has been widely discussed in recent years. An extremely important task during the formative stages of the strategic planning process is to gain an understanding of

the extent to which interpersonal influences are likely to be important for one or more target groups (Andreasen, 1995).

Goldstein N, Martin S and Cialdini R (2007) argued that Social norms are the group rules that determine what is deemed acceptable behavior. Social norms can have a huge influence on our thoughts and behaviors and therefore appear in many different social psychological models. Goldstein, et al, (2007) also mentioned Social norms vary by group, so what the norm is for one group of young people may well be different from that adopted by another group living in different circumstances. Goldstein N, et al found Failure to act in accordance with these rules can lead to exclusion from the group. Communications can be effective in highlighting social norms and prompting people to act in accordance with them.

2.7.2 Culture

Culture refers to the pattern of human activity and the symbols that give significance to these activities. Culture manifests itself in terms of the art, literature, costumes, customs, language, religion and religious rituals. The people and their pattern of life make up the culture of a region. Cultures vary in the different parts of the world. They are different across the land boundaries and the diversity in cultures results in the diversity in people around the world. Culture also consists of the system of beliefs held by the people of the region, their principles of life and their moral values. The patterns of behavior of the people of a particular region also form a part of the region's culture. The word 'culture' that hails from the Latin word, 'cultura' derived from colere', means, 'to cultivate'. Hence the way in which the minds of the masses inhabiting a particular region are cultivated, in some way determines the culture of a region.

As Fiske (1990) put his assumption that communication is the central to the life of our culture: without it culture of any kind must die. Consequently the study of communication involves the study of the culture with which it is integrated. Culture is defined as the total way of life of a people, composed of their learned and shared behavior patterns, values, norms, and material objects. Culture is a very general concept. Nevertheless, culture has very powerful effects on individual behavior, including communication behavior. Understanding the nature of culture in relationship to communication is helpful in a number of ways. According to Michelle Le Baron (2003), all communication is cultural, it draws on ways we have learned to speak and give nonverbal messages.

We do not always communicate the same way from day to day, since factors like context, individual personality, and mood interact with the variety of cultural influences that have been internalized and

influenced our choices. Communication is interactive, so an important influence on its effectiveness is our relationship with others. In short, communication in terms of shared cultural knowledge that is learned and practiced, can be seen in terms of interpersonal communication as culturally constituted.

2.7.3 Economic Factors

Reproductive health Communications between parents and their Children can be affected by the broader Context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, Social and gender relationships, and the traditional and legal structures within which they live. Thus the communications between parents and adolescents can be affected by the economic status of the parents such as occupation, income and wealth. A study in Tanzania conducted, shows that participants interviewed for this study stated that lack of time to spend with their children due to different jobs they have, is one of the biggest problem they have.

This makes them to fail or sometimes to have less communication with their children as they are too busy with their daily activities. It is important that parents accept the responsibility to guide their children as they confront the challenges of growing up, and to find ways of doing so, including providing reading material they approve, and checking with them to make sure they understand what they read (Catherine S.Nundwe, 2012)

CHAPTER THREE

METHODOLOGY OF THE STUDY

3.1 Study Design

This study adopted mixed research methodology Design (Qualitative and Quantitative Methodologies). Both of them were employed for this study. This is because the researcher wanted to expand an understanding from one method to another and ensured findings from different data sources. The qualitative and quantitative methods were also used for this research. Questionnaires were developed and used as a tool to gather quantitative data from Students (respondents) using the survey method. Focal Group Discussions (FGD), Key Informants Interview (KII), In-depth interview were also the tools that employed to generate text (qualitative) data.

3.1.1 Qualitative Methods

Qualitative method was chosen because this choice was imperative and appropriate for exploratory studies that captured a social world of 'lived experience' that facilitated deeper understanding of phenomena in questions. The researcher needed detailed views on parent to adolescent communications on sexuality gained through personal encounters in the context. A qualitative approach took into account the insider's perspective by trying to understand a studied phenomenon in the light of the perceptions and explanations of the persons involved and in their natural settings. It also enabled the researcher and participants to interactively negotiate to produce collaborative data that kept on reflecting and unfolding realities represented in this study.

The heart of qualitative research is the attempt to study human actions from the perspective of the social actors themselves, while describing and understanding, rather than explaining human behavior are the chief goals of studies using qualitative approach (Babbie & Mouton, 2001, p.270). In essence, the purpose of qualitative studies is to describe a phenomenon from the participant's point of view, the intention of the researcher being listening to the voice of participants or observing them in their natural environments (Orb et al., 2001, p.94). It is fundamentally this quality of attempting to view the world through the eyes (perspective) of the actors themselves which is strongly tied to the epistemological foundations of qualitative research that addresses the question of methodological appropriateness to this study.

Such a principal feature of what come to be understood as phenomenology. The phenomenological theme, according to Bryman, (1984, p.70) is important to qualitative researchers as it takes the actor's perspective as the empirical point of departure. In describing the concept further, Bogdan and Tylor (1975, pp.13-14) state:

The phenomenologist views human behavior as a product of how people interpret the world. The task of the phenomenologist, and for us, the Qualitative methodologists, is to capture this process of interpretation. In order to grasp the meanings of a person's behavior, the phenomenologist attempts to see things from that person's point of view

In this light, the researcher should become more than just a mere interviewer or participant observer. He or she, according to Babbie and Mouton(2001,p.271) ,has to make a deliberate attempt to put themselves in the shoes of the people they are observing and studying and try and understand their actions, decisions, behavior, practices, ritual and so on, from their perspective

Although qualitative and quantitative researchers are interested in the description and understanding of actions and events, qualitative description primarily calls attention to what Babbie and Mouton refer as thick description a lengthy description that captures the sense of actions as they occur, placing events in contexts that are understandable to the actors themselves (2001, p.272); this is contrary to the quantitative, statistical descriptions that make up the foundations of quantitative research.

In illuminating such variance further, Fade (2003, p.140) suggests:

Qualitative research does not seek to show statistical associations or cause and effect relationships. Instead, the emphasis is on describing or illuminating social phenomena and human experience.

Apart from the features discussed so far, central to the qualitative research tradition is the attitude of understanding events, actions and processes in their context. Whereas defining and describing natural contexts of subjects or actors of a given study is of paramount importance to the qualitative researcher, the quantitative researcher seeks to analyze variables and the relationships between them in isolation or in artificial settings primarily for the sake of insuring generalizability. In this light, Natasha et al. (2005, P.2) argues:

Although findings from qualitative data can often be extended to people with characteristics similar to those in the study population, gaining a rich and complex understanding of a specific social context or phenomenon typically takes precedence over eliciting data that can be generalized to other geographical areas or populations

In this study the research conducted FGDs among the homogenous groups and survey in the students population that enables to generalize the findings .Here, it is important to take in to account the fact that context is not only imperative for the sake of a better description and eventual understanding of events and actions at stake, but also provides the boundary for generalizing results, if there is the need at all.

3.1.2 Quantitative Methods

Quantitative researchers try to recognize and isolate specific variables contained within the study framework, seek correlation, relationships and causality, and attempt to control the environment in which the data is collected to avoid the risk of variables, other than the one being study, accounting for the relationships identified. The study involved a survey of adolescents (students) of 382 students in Medehanealem Preparatory School in Addis Ababa. For the quantitative aspect of this study, data collected using self-administered questionnaires. The questionnaire has, among others, sections on socio-demographic characteristics, general pattern of parent to child communications, and parent to child communications on sexuality issues.

3.2 Subjects and Sampling Techniques

The researcher held preliminary consultation meetings with the head Medehanealem Preparatory school and later with Addis Ababa Education Bureau. The purpose is to get their endorsement on the implementation of the study on selected sub city. At the sub city purposive sampling is used to identify the research parent participants. This non-probability sampling procedure as indicated by Descombe (1998) enabled the researcher to select participants who has the requirements relevant to the study. In this instance the main features are willing parents who have adolescent in any preparatory schools in the sub city. This procedure is done with the assistance of the school director and woreda leadership who are acquainted with the community and the school leaders.

The key informants were selected basing on their availability and willingness to participate. Although for adolescents their own consent is required before enrolling. Their main issue of concern is the sample size which is perceived as too small to be representative of the sub city study population.

The study population in Gulele sub city is accepted as a suitable study area because its proximity to the researcher and relatively large number of preparatory students are found which are 650 females and 520 males in grade 11th enrollment of the year. The study the populations included adolescents and young aged between 15&24 years, parents, preferably living in the same sub city that have adolescents in preparatory Schools and Key Informants. Parents, school director and unit leaders, teacher and guidance and counselors, grade 11th Students were enrolled in the study. Ideally, the recruitment process was continued until the research reaches a point of theoretical saturation (Denscombe, 1998).

In respect to the assessment of topics for discussion between adolescents and parents communications in Bullen Woreda high school, 54.1% of the respondents had discussed about SRH issues with their parents. Therefore, the value of P (proportion of adolescents who discussed about SRH with his/her parents) is estimated from the study by (G/yesus, 2006), and which is 54.1%.

Then the sample size for the study is calculated using the following formula:

$$n = (Z\alpha/2/e)^2 P (1-P)$$

Where e is the margin of error and assumed to be 5%, and α is level of significant and assumed to be 5%. Thus, $Z\alpha/2$ for 95% confidence interval is 1.96. When substitute the above values in the formula we have

$$n = (Z\alpha/2/e)^2 P (1-P) = (1.96/0.05)^2 * (0.541) * (1-0.541) = 382.$$

An appropriate sample size for a qualitative study is one that adequately answers the research question (Marshall, 1996). It is important to recognize that the essence of the qualitative approach is that it is naturalistic, studying real people in natural settings rather than in artificial isolation. Sampling therefore has to take account not only of the individual's characteristics but also temporal, spatial and situational influences, that is, the context of the study. Therefore the sample size for this study is 9 parents of both sexes and those who have adolescents and they are chosen randomly from their respective wards until the point of saturation of information gathered.

In this study; the researcher used purposive sampling to obtain information from the parents with the understanding that parents are the ones who always tend to initiate the discussion with their children on issues concerning reproductive health. The researcher selects the respondents who best meet the purpose of the study.

3.3. Study Variables

The following variables are used to fulfill the objectives of the study.

Dependent Variables: Parent-adolescent communications on SRH. It can be categorized in to two: Those adolescents who discuss about SRH issues with their parents and those who don't discuss with their parents.

Independent Variables

- Socio-economic, demographic and cultural characteristics - sex, age, educational status, occupation, and income
- Knowledge of adolescent's reproductive health matters
- Sexual behavior of adolescents

3.4 Data Collection Tools and Procedures

The primary and secondary data comprising quantitative and qualitative data information were collected through variety of methods and tools. In this study, primary data were collected from parents, students, and key informants. The primary data were both quantitative and qualitative. The researcher collected primary data at the time of field survey. Questionnaires, FGDs and KII are the most important methods that used to collect the primary data. Moreover, the secondary data were obtained using document review.

3.4.1 Qualitative Data Collection Tools and Procedures

The data collection was carried out in the Month of April, 2014. Although a variety of methods can be used in quantitative and qualitative research, data collection in this study involved semi-structured in-depth interviews in Amharic, FGD, Key informants Interview, and Survey. Depth interview and discussion guide for both parents and Key informants were prepared, serve as primary reference during the interviews were conducted and questionnaires were developed for survey of students.

These preliminary thematic guides and questionnaires were developed by the researcher and then subject to a peer review to validate the contents. They were pilot-tested before finally being used. Analysis of the pilot test responses was resulted in modifications in both guides and questionnaires including re-wording to make items more understandable. There is however, flexibility in the structure and interviewer is able to use personal discretion to determine how closely to follow the guide and how strongly to pursue an

individual respondent's answer. Probing questions are also used to guide to important directions, and to confirm or disconfirm the interviewer's interpretations.

Parent participants were interviewed from their convenient places for them and the adolescents were interviewed at their schools. Participants were consulted to choose venues where interviews were held and the language preferred during the interviews to reduce inconvenience. This allows them to be interviewed in privacy and in a comfortable setting. However, for the adolescents who were interviewed at school, the head of school and responsible teacher assisted in identifying a suitable and quiet place for us to hold the focal group discussion with the respective adolescent. Each interview lasts approximately half an hour and it was audio taped. Permission to record the interview was obtained from each individual participant at the time of the interview and focal group discussion after establishing rapport. The transcription of the interviews was commenced during the data collection exercise and completed simultaneously.

3.4.1.1 Key Informants Interview (KII)

One of the data collection methods that were used in this research was KII which used to collect qualitative data. The information gathered through KII was used to triangulate and complement the data collected through other methods. Individuals with better knowledge and experience about parents and adolescents communications in the study area were selected and contacted to obtain the relevant data. In this study the Key informants were school director, unit leaders, teacher, and counselor. The researcher was a facilitator for KII activity. Open-ended discussion was undertaken to gather the required information from the informants. Checklists were developed and used to guide the interview.

3.4.1.2. Focus Group Discussion (FGD)

A series of focus group discussions were carried out among purposively selected adolescents who are in the age between 15 and 24 years. The criteria for selecting participants of focus group discussion were purposively after communicating with the school leaders. The school leader was told about the objectives of the study and then selected those adolescents who can explain /express their ideas thoroughly. The focus group discussion for female and male was conducted separately to increase the quality of information that can be generated and the confidence of the students. To understand their opinion fully

tape recorder was used after they have been told the objectives of the study and verbal consent obtained. A semi structured question guideline was used to lead the discussion.

Natasha and colleagues (2005, P.64) define focus group as a qualitative data collection method in which one or two researchers and several participants meet as a group to discuss a given research topic. Lunt (1996,p.80) on the other hand, states that the focus group method involves bringing together a group, or, more often, a series of groups, of subjects to discuss an issue in the presence of a moderator . A variant definition from Carey (1994,p.226) defines focus group technique as using a semi structured group session, moderated by a group leader, held in an informal setting, with a purpose of collecting information on a designated topic .

Most authors agree that the chief advantage of focus group interviews is the deliberate and purposeful use of interaction in order to generate data (Merton et al., 1990; Kitzinger, 1996; Morgan, 1996). Focus group interviews encourage participants to influence each other through their presence and their reactions to what other people say. Because not everyone will have the same views and experiences in aspects like age, gender, education, access to resources, and other factors, a variety of viewpoints will likely be expressed by participants (Natasha et al, 2005).

According to Hansen et al., (1998,P.262) focus group interviews have an edge over individual interviews in such a way that they offer dynamics and ways of eliciting, stimulating, and elaborating audience interpretations. What this essentially means is that the interaction and dynamism exhibited in group interviews takes us closer to everyday life experiences better than personal accounts conveyed in individual interviews. In relation to this, Morgan (1988, p.12) states that the hallmark of focus group is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in the group.

3.4.1.3 Individual in-Depth Interviews

In-depth interviews are an effective qualitative method for getting people to talk about their personal feelings, opinions, and experiences. They are also an opportunity for us to gain insight into how people interpret and order the world. According to Minichiello et al., (1995,p.61) in-depth interviewing is defined as conversation with a specific purpose-a conversation between researcher and informant focusing on the informants' perspective of self, life and experience and expressed in his or her own words (p. 61).

In depth interviews are useful for learning about the perspectives of individuals, as opposed to, for example, group norms of a community, for which focus groups are more appropriate (Natasha et al., 2005). According to Beale et al. (2004), in qualitative research, in-depth interviewing is an egalitarian approach to interviewing which develops research relationships and rapport with participants by focusing on the participant's experiences from their own perspective. In my case, a semi-structured interview guide is used to get views of informants on questions designed based on the objectives of the study with emphasis on areas the researcher believed would address the goal of the research.

Hansen et al. quoting Gamson (1992.p.271) stresses the need to involve people who knew each other for discussions on the participant's turf rather than in a bureaucratic setting. It is particularly important for me to find a place which my subjects would find familiar', natural, non-threatening', and not strange, bureaucratic, and formal.

3.4.2 Quantitative Data Collection Tools and Procedure

Quantitative data were also collected through survey methods. Structured questionnaire was developed and distributed among selected students. This method was used for data and method triangulation for the researcher.

3.4.2.1 Questionnaire

To collect necessary information from the sample population, sample survey was carried out using questionnaire. One set of questionnaire containing both open-ended and close- ended types were designed and administered to a total of 382 students from the total population of 1170 grade 11th preparatory students (650 females and 520 males). According to the calculated sample size of 358 respondents were completed the questioners and the remaining 24 were discarded because of incompleteness. Two hundred eleven of the respondents 211 were female students and 147 males. The number of female respondents were larger than males because in the enrollment in the school also shows that more females which are greater than 130. Initially the questionnaires were prepared in English but it was translated into Amharic, the local language to make the questions simple, clear, and understandable to respondents. The survey was also conducted through face to face interview between the respondents and interviewer. Of course, the pilot test (pre-test) was conducted prior to the survey. This helped the researcher to see whether there are any difficulties in relation to questionnaire and to modify based on the feedback of the pre-test or to check the reliability and validity of the data that the researcher collected.

3.5 Data Analysis Techniques

For analysis of the data both quantitative and qualitative methods are employed. The researcher employed descriptive data analysis for quantitative data and thematic analysis for qualitative data. The details of the analysis techniques are presented as follow.

3.5.1 Qualitative Data Analysis

In qualitative research approach data analysis took place simultaneously while the data was collected. There was a need to pause and ponder about the concepts, themes, issues and questions that have been observed during our contact with the research participants.

Qualitative data that obtained through depth interview, FGDs and KII are analyzed through descriptive method of analysis. Data obtain from the interviews was transcribed. Transcription of the audio-recorded interviews was done with care to preserve the core content of the dialogue. The transcript is later translated from Amharic into English for easy reading since the thesis report is going to be in English.

The researcher applied principles drawn from the framework analysis approaches to analyses the data. This is a content analysis method which involves summarizing and classifying data within a thematic framework. This process involves several stages. First the researcher read through the transcripts of each interview many times in order to be familiarized with the central issues. This is done at individual participant level, then at group level and for the sample as a whole. This also enables the researcher to identify the key themes emerging from the data. The content of the information is retained and a hyperlink is established to make it easy to return to the transcript to explore the point in more detail or to extract the text for verbatim quotation.

In this way the data is ordered within an analytical framework which is grounded in respondents own accounts. The files displayed within the range of views described by respondents, which make it possible to compare and contrast ‘within’ and ‘between’ cases.

After the field level preliminary data analysis the researcher applied the following steps in data analysis to produce the final finding of the research:

Step 1. Transcription:

The information collected from all study participants was transcribed with the appropriate care to the new document without missing each single word as it is meant to the participants. The transcribing was done separately for each participant that was also simplifying the task of the researcher to triangulate easily and enrich the finding.

Step 2. Theme category:

The researcher looked in to the detail raw data collected and identifies the main points that will incorporate all ramifications around the topic under study. And then, the researcher found appropriate terms or phrases that govern or convey power full message to the readers and the researcher as well. The theme guided the researcher to bring ideas come together as a cluster under one umbrella for further explanation. Under this step major themes were identified and ready for deep explanation and understanding of the phenomena.

Step 3 Thematic Analysis& discussions

The researcher analyzed each data under each theme thoroughly. Discussion of different categorized ideas theme by theme followed and triangulations was done to ensure the validity of data. The researcher was either accepting or rejecting ideas as per the finding of multiplication relationships of different themes and feedback from the triangulations. Besides, the points were discussed and analyzed against different literatures on the topic under study that was enabling the researcher to sort out the truth residing within the community.

3.5.2 Quantitative Data Analysis

Quantitative data was generated from the survey questionnaire analyzed using SPSS version 19. Descriptive statistics such as frequencies, percentage, and average and cross tabulation were applied to facilitate meaningful analysis and interpretation of research findings. The results of processed data were presented in tables and graph. Moreover, Pearson chi square correlation test was employed to identify the determinant factors for parents to adolescents SRH communications on sexuality.

An association between parental socio-demographic factors and parent-child communications was assessed at bivariate level using chi-square analysis while binary logistic regression was used for multivariate analysis.

3.6 Ethical considerations

This study was conducted in conformity with the ethical guidelines and approval of the concerned body research ethics in the sub city and school. Relevant permission was also sought at woreda level from the sub city Administration office and school leaders. At individual level after explaining the purpose of the study, verbal and written consent was obtained from all participants prior to their participation in this study. Participants were informed that their participation in the study is voluntary and that they are not obliged to provide answers to any question(s) with which they are uncomfortable. They are also advised that they are free to withdraw their participation from the study at any time they want. Participants were assuring that confidentiality that was maintained and their anonymity protected both during data collection as well as in the management of the data generated. Parents also made aware that they are not expected to demand for details about the interview from their adolescent children after the interview.

3.7 Verification of results

Verification is the process of checking, confirming, making sure and being certain of the study findings. In qualitative research verification refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and thus the rigor of the study. Kvale (1996) recommends that validity and reliability should be assessed in all the steps of the qualitative investigation. Validity in the broader concept pertains to the extent to which our observation indeed reflects the phenomena or variables of interest to us. In this study measures employ to ensure rigor include constant guidance and scrutiny by the supervisors throughout the whole process. When inconsistency and incompleteness of answer is encountered, the questionnaire is excluded from entry.

The data collection instruments was formulated ahead of time and distributed for comments among friends from different disciplines and were enriched by their inputs.

Finally, the instrument was given to my advisor for his valuable input so as to have the final draft. The instruments was further translated in to the local language, Amharic, and one day orientation was given to the data collectors on the detail aspects of the tools. The following days the instruments were piloted in another non study place within the same school and the feedback was incorporated in the instruments either by removal or additional points. The schedule was designed to conduct the actual study in the selected school in referring the appropriate time for all study participants. The actual time was informed to all groups of the participants continuously as per the time frame.

To assure the quality of the data, properly designed data collection instrument was developed. Training was given for data collectors and supervisors. Every day, the collected data was reviewed and checked for completeness and consistency by the supervisors and the principal investigator. Pre-testing and supervisions were made before and during actual data collection respectively.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.0 Introduction

This chapter presents and discusses the results of this study based on the formulated three objectives in chapter one. The objectives are to explore parents and adolescents' perceptions on SRH issues, identify the major barriers between the communications of adolescents and parents, and investigate socio-cultural and economic determinants of parents to adolescents Communications on sexuality and reproductive health. All the three research questions are answered in this chapter by both quantitative and qualitative methods. The quantitative data obtained by survey was analyzed using both descriptive (means, standard deviations, and frequencies) and inferential statistics (Pearson chi square test). Pearson chi square test was used for testing significance levels that used to analyze the association between social-cultural and economic status with the discussion on SRH issues between parents and adolescents.

The descriptive statistics presented and discussed the perception/attitude/ of parents and adolescents towards sexual and reproductive health communications. Descriptive statistics provides the means and standard deviations of the scores relating to each of the variables used in the factor analysis. The Pearson's correlation was used to find the association between variables (dependent and independent) which is bivariate correlation that analyzing the degree of relationship between two variables. Pearson Correlation (r), the most commonly used bivariate correlation technique was used to measure the association between two variables without distinction between the independent and dependent variables. The qualitative data that were found from the focus-group discussions, in-depth interviews and key informant interviews were also analyzed using thematic analysis.

As per the sample size and techniques stated in chapter three, findings from the six focus group discussions from the total of 48 participants, and an in-depth interview with 16 interviewees (9 parents of which two single parents) were analyzed thematically. In addition, qualitative data analyses results from the five key informant interviews (school director, two unit leaders, one school counselor and one teacher) are incorporated in this study. They are selected according to purposive and availability sampling techniques for parents and Key informants respectively.

The chapter is organized according to the research questions and it consists of five sections .The first section deals with Socio-demographic characteristics of the study populations .The perceptions (views) parents and adolescents on the Issues of Sexuality and Reproductive Health Communications, the major barriers of Communications between parents and adolescents on SRH such as Social , Culture , Economic barriers of SRH Communications between parents and Adolescents were analyzed under section 4.2 and 4.3 respectively.

The fourth section of the chapter (4.4) deals with the relationship/association/ between Socio- cultural and Economic determinants & parents to Adolescents Communications on Sexual and Reproductive Health Issues. Finally, summary of findings are presented in the last section of the chapter.

4.1 Socio-demographic characteristics

The socio-demographic variables of the sample population are summarized as follow.

Table 1: Characterstics of the sample students in Medhanealem Preparatory School, Addis Ababa, April 2013

Variables	n	%	Mean (SD)
Age (in years)	358		17.6 (1.13)
15 - 17	198	55.3	
18 - 20	152	42.5	
21 - 24	8	2.2	
Sex			
Female	211	58.6	
Male	147	41.4	
Religion			
Orthodox	264	72.9	
Muslim	61	16.9	
Protestant	27	7.5	
Others	10	2.8	
Living with			
Both parents	224	62.4	
Mother only	50	13.9	
Father only	10	2.8	
Friends	6	1.7	
Siblings	23	6.4	
Alone	6	1.7	
Relatives	26	7.2	
Others	14	3.9	
Family size	348		5.8 (2.12)
<=4	98	28.2	
5 - 7	180	51.7	
>=8	70	20.1	

A total of 382 preparatory students completed the questionnaire, of which 24 responses were excluded for the gross due to the inconsistency.

Therefore, the quantitative data analysis was made based on 358 questionnaires with response rate of 94%. Out of the total 358 respondents, 147(41.4%) were males and 211(58.6%) were females. The mean age of the respondents was 17.6 ± 1.13 Standard Deviation (SD) and their ages were within the range of 15-24 years and grade eleven preparatory students.

The majority of the respondents 264(72.9 %) were Orthodox Christian by religion and followed by Muslim 61(16.9%). Two hundred twenty four respondents (62.4%) were living with both parents. The majority of the respondents' parents 245(68.6%) were still in marriage. The mean family size was 5.8 ± 2.12 SD. It was also reported that the majority of the respondents have the medium family size in the range of 5-7 years. It was amounted to 180 (51.7%) of the total population of this variable categorization as it depicted in Table 1.

In the quantitative data presented in table 2 below, the marital status of respondents' parents showed that living together were 245(68.6%), twenty six divorced (7.3%) and widowed 66(18.5%).The educational status of the respondents' mothers were revealed as illiterate 41 (11.8%), read and write 75(21.6%), Primary education 66(19.0%), secondary education 82(23.6%), diploma 42(12.1%), first degree and above 42(12.1%). The result showed the majority of the respondents which were 82(23.6%), had completed primary education.

The educational status of the respondents' fathers were also reported as illiterate 14 (4%), read and write 35(10.1%), Primary education 55(15.8%), secondary education 75(21.6%), diploma 51(14.7%), degree and above 85(24.4%).The majority 82(24.4%) of the participants 'fathers had first degree and above. The majority of the students' mothers 175(50%) were housewife and followed by government employed 55(15.7%). One hundred ten (34.5%) of the participants' fathers were privately employed by occupation.

Table 2: Characteristics of the parents of sample students in Medhanealem Preparatory School, Addis Ababa, April 2013

Variables	n	%
Parents marital status		
Living together	245	68.6
Divorced	26	7.3
Live alone	20	5.6
Widowed	66	18.5
Mothers educational status		
Illiterate	41	11.8
Read and write	75	21.6
Primary	66	19.0
Secondary	82	23.6
Diploma	42	12.1
1 st Degree and above	42	12.1
Father educational status		
Illiterate	14	4.0
Read and write	35	10.1
Primary	55	15.8
Secondary	75	21.6
Diploma	51	14.7
1 st Degree and above	85	24.4
Mother's Occupation		
House wife	175	50.0
Private employed	53	15.1
Gov-employed	55	15.7
Merchant	41	11.7
Farmer	8	2.3
not alive	17	4.9
others	1	0.3
Father 's Occupation		
Private employed	110	34.5
Gov-employed	80	25.1
Merchant	59	18.5
Farmer	19	6
not alive	45	14.1
Unemployed	5	1.6

4.2. Perceptions of the Study Groups on SRH Communications

As the tabular data has been shown in table 3 below, two hundred fifty one (62.9%) of the respondents reported that it is important to discuss sexual and reproductive health issues with parents whereas seventy two of the respondents (22.9%) reported that the importance of the communications between them are not important. The remaining respondents which are thirty five (13.9%) revealed that they don't know on the importance of the discussion between parents and adolescents on SRH issues.

The majority of the respondents 270 (74.3%) revealed that they never discussed on SRH issues with their parents. But ninety of the respondents (25.7%) discussed with their parents. The respondents who preferred their mother to discuss on SRH issues were sixty eight (56.2%). Two hundred sixteen of the respondents (63.3 %) reported that they did not discuss with neither of their parents in the topics of SRH. Ninety seven of the respondents (28.4%) reported that they discussed with their parents rarely. The communication skills or level of the parents which rated as low, medium, high and others were 161(45.7%),133(37.8%), 49(13.9%) ,and 9(2.6%) of the respondents respectively. Nine (7.4%) of the respondents reported that their fathers were openly discuss on sexual and reproductive health related issues. In line with this, forty four of the respondents (36.4%) reported that they discuss on sexual and reproductive health related issues with both of their parents(Table 3).The majority of the respondents ,267(83.2%) revealed that they preferred to discuss with their friends on SRH issues.

Table 3: The discussion between parents and students in Medhanealem Preparatory School, Addis Ababa, April 2013

Variables	N	%
Have you discussed with Parents on SRH Issues		
Yes	90	25.7
No	129	36.9
Don't know	131	37.4
With whom do you discuss among your parents		
Father	9	7.4
Mother	68	56.2
Both	44	36.4
How often do you discuss?		
Very often	11	3.2
Often	17	5.0
Sometimes	97	28.4
Never at all	216	63.3
With whom do you discuss other than parents		
Friends	267	83.2
Sister	25	7.8
Brother	24	7.5
others	5	1.6
Parents Skills to SRHC		
low	161	45.7
Medium	133	37.8
High	49	13.9
Don't know	9	2.6

The quantitative data findings are also substantiated by the qualitative data findings. Most of the FGD participants said that they preferred to discuss with their friends with the same sex on sexuality and reproductive health issues.

And they got information about Sexuality and reproductive health education from their peers in the same sex. The key informants also said that almost all of the participants of the study populations (parents and students) did not come to school for consultation and discuss on the issues of sexual and reproductive health issues for their adolescents .They added that the involvement of parents on this issue with the school is very minimal.

The result of the qualitative data analysis that obtained from parents interview indicated that there is very minimal communications between adolescents and their parents. Majority of the participants said that there is no open discussion with their adolescents on sexuality and RH issues in the family level.

The homogenous focus group discussions were conducted in Medehanealem Preparatory students. Most of the FGDs participants reported that there is no communications/discussion/ between the two parties (parents and children). Few of the participants said in some family, there is an open discussion between brothers and sisters with in the same sex. But the frequency of discussion is very minimal. Some of the participants are also reported that talking about sexuality and reproductive health issue is unthinkable particularly within opposite sex.

One of the female participants said that “the only time I talk about sexuality and RH issues with my mother is when she wants to warn me for unintended pregnancy”. The 17 years school girl also said that “leave alone to properly teach me, my mother did not allow to me or my sisters to watch television or listen to advertisements about contraceptive and other SRH issues”. Most of the male participants said that there is no open discussion between parents and their adolescents.

One of the boy participants said that if I tell to my mother about my interest to have girlfriend she may fire me from home let alone discuss with me openly on sexuality issues. But I strongly believe that the open discussion should be started as early as possible at the age of 14. Most of the participants reported that open discussion between parents and their adolescents are very crucial. But it is still cultured in the community. It was believed and perceived that the methods and mechanism of teaching the issue is frighten.

In our culture let allow having discussion with parents openly on sexuality and reproductive health issues, most of the marriages were held without the couples have known each other instead of simple traditional arrangement of elders said one of the male participants said parents particularly fathers taught and discussed with their adolescents with scary techniques “አንዳንዱ አባት በአፋ ገጅራ የያዘ እስከሚመስለው ድረስ በማስፈራረት ከማንም ወንድ ጋር እንዳላይሽ በማለት ሊያስተምር ይፈልጋል (Some fathers who likely have silent weapons in their mouths trying to warn their girl adolescents with words). It means some fathers used scary technique while communicated to their daughters rather than let to them open discussion on the issue and educate them.

In addition, most of the participants of FGDs revealed that it is very important discussing with parents especially for female on sexuality and reproductive health. However, it is important discussing with family about SRH issues, parents do not create smooth environment to communicate on sexuality and they did not give attention because it was believed that adolescents will learn when the time comes.

Most of the participants said that the discussion on SRH was not initiated by the child and did not have the upper hand if it would have been initiated with the child or adolescent, it would be the good opportunity to discuss on the issues.

But adolescents don't have the upper hand to hold the discussion. Most of the female student participants said that the parents used as warning tools “የእኩሌ ልጅ አረገዘች ከአንዱ መንገደኛ አንችም ጠንቀቅ በይድቃላሺን እንዳትታቀፊ (Some ones daughter got unplanned pregnancy, you have to watch out from unlawful child like her said the mother to her daughter),this was the way how mothers teach and communicate to their children in their cultural contexts said one of the female student participants. Few of the participants said that open discussion could be possible if the parents are young and grown in democratic family what matters the ways they are grown. But economic status and educational level nothing to do for open discussion as reported by the FGD participants. One of the participants from educated family said that:

“ My mother is educated, one day my eldest brother who came abroad completed his master's degree talked to my immediate elder brother. The eldest advised the younger one who planned to go and study to Dire Dawa University. The eldest started discussion; there are many beautiful girls in the city watch out friend, make everything with “Chimble-Condom”. My mother was very irritated and shouted at him what you taught to my son by insulted him, did you learn this in abroad?”.

This tells that some mothers don't want initiating discussion among the family members. Even though the participants mentioned it is very important to discuss with adolescents on sexual and reproductive health, they stated they had not engaged in a serious discussion with children on SRH issues among the educated family too. But there is a discrepancy between qualitative findings and quantitative findings regarding to educational level and open discussion. It was reported in quantitative data the educated family are better to open discussion but the qualitative data report showed that there is no difference whether educated or not.

One of male parent (F2) also said that 'Let alone discussions on SRH issues, we Ethiopians are not adapted to have general family discussion except few people. Most of the discussants mentioned they do not discuss on SRH with their adolescents because they think it is not important. Few of the parents said they discuss about SRH Issues like unplanned pregnancy with their female adolescents when they feel their kids are sexually active. Discussing SRH in detail with adolescents is difficult. One female parent said I believe discussion about SRH with my adolescent means 'just go for it' so it is better not to raise the issue.

4.2.1 Perceptions of the Study Groups on Gender Preference of SRHC

As it is depicted in the table 4, the majority of the respondents which were two hundred sixteen (61.7%) reported that they have agreed to make discussion on sexuality and RH issues with their parents however there is no cemented open discussion between the parents and adolescents. The majority of the respondents (both female and male, 65.3% &74.1% respectively) reported that they don't want to discuss on sexuality issue with opposite sex.

The majority of the respondents which are two hundred fifty one (62.9%) of the study population (students) responded that it is important to hold discussion between parents and adolescents on sexual and reproductive health issues with the preference of adolescents the same sex to discuss with parents that is males preferring their father and females prefer their mothers. Furthermore they prefer their friends than parents to discuss on Sexuality and reproductive health issue (Table 4

Table 4: Perceptions of Parents and adolescents on SRH Issues in Medhanealem Preparatory School, Gulele Sub city Addis Ababa, April 2013

Variables	n	%
Agreement having discussion		
Strongly agree	112	32
Agree	104	29.7
Dis agree	60	17.1
Strongly dis agree	27	7.7
Don't know	47	13.4
Female 's discussion with opposite sex		
yes	60	22.1
No	177	65.3
Don't know	34	12.5
Male's discussion with female		
Yes	22	9.5
no	171	74.1
Don't know	37	16.0
Parents information about their adolescents (where)		
yes	247	71.8
no	57	16.6
do not know	40	11.6
Parents information about their adolescents with (whom)		
yes	217	62.9
no	79	22.9
do not know	48	13.9
Importance of discussion on SRH		
yes	251	62.9
no	72	22.9
do not know	35	13.9

In the contrary of the discussion, 247 (71.8%) & 217 (62.9%) of the respondents revealed that their parents know where and whom spent their time after school. This finding is also supported by the qualitative data because most of the participants of the FGD replied that their parents know where and whom they spend their time after school. Most of the female adolescents preferred to discuss with health professionals next to their peers with the same sex. All most all of the participants said that they never and ever wanted to discuss on sexuality issues with their teachers. The key informants also reported that parents did not come to the school to discuss on sexuality issues with their adolescents and the issue did not discuss as an issue in the school.

Lack of open and interactive discussion in the family was mentioned by most of the discussants. They said most of the parents especially fathers communicate with their sons and daughters in imperative way by saying 'do this' and 'do not do that' but not listening what their adolescents have to say. Another reason mentioned was the behavior of adolescents such as 'not listening to us', 'they think they know everything (overconfidence)', 'choosing their friends over us' and 'not respecting our ideas.' One female parent said 'when my husband tried to talk to our 18 years old son, about protecting himself from HIV and STIs our son came to me and said ““ሸባዉ ምን እያለ ነዉ ?” (What does this old person saying to me?)' So those barriers restrain the parents from discussing with their adolescents on sexual and reproductive health matters.

Parent-adolescent communication is the parental factor most often linked to adolescent sexual attitudes and behaviors. While there is evidence that teenagers prefer to receive information about sexuality from their parents, in reality few have this privilege (Kekovole J, Kiragu K, Muruli L and Josiah. P, 1997).

Similarly this study illustrates majority of adolescents believe it is important to discuss SRH with parents only one third of the study participants have discussed on at least in a few SRH issues, this is also true in other studies done abroad and in Ethiopia (Karim, A. Magnani, R., Morgan, G. and Bond, K, 2003; Pertoriosis, J., Ferreira, G., Edwards, D. ,1999; Desalegn G/yesus , 2006) which reveals dialogue about sexuality between parents and adolescents believed to be important but few of them have discussed.

According to the findings of this study ,more female adolescents prefer to discuss with mothers and more male adolescents prefer to discuss with fathers this difference were significant. This may suggest that there is sex preference in discussing sexual related issue which may indicate that discussing sexual issue with similar sex is comfortable. This may be possibly also due to the sensitiveness of the issues where adolescents preferred to have someone that they could discuss these issues and not feel shy when discussing sexual matters.

The FGD of the present study showed that there is a difference in which topics mothers and fathers comfortable to communicate their adolescents and it was seen fathers were uncomfortable talking about menses and unwanted pregnancy with their girl adolescent because they thought it is female to female discussion and responsibility of mothers this was comparable with other study done in USA (Kirkman M., Rosenthal D. and Feldman S. , 2002; 97:57-54) fathers were found not to have discussions relating to menstruation and other reproductive health issues with their daughters.

In this study many of school adolescents received information on sexual and reproductive issues from friends (peers) were preferred by most of them. Regarding to the perceptions, all discussants from the six groups thought that almost all adolescents of their age living in Addis Ababa would have information about SRH issues and where to find it if they wanted. However majority of discussants had serious doubts about whether or not most adolescents knew how to properly use.

Most discussants indicated that adolescents have different sources of information about sex and SRH issues. The most important sources are friends, media and biology class for Sexual Active Youth (SAY). The majority of discussants agreed that neither fathers nor parents were open to talk about sex and SRH issues. The key informants also reported that most of the students did not show interest in discussing on sexuality and reproductive health issues.

Some of the female student participants said discussion with fathers on sexuality issue and reproductive health is difficult. But sometimes it was discussed with mothers about unintended pregnancy, contraceptive methods and menstrual cycle. Few participants reported that even mothers wanted to hide the issues that discussed with mothers and kept it secret for the father because the culture, norm and belief that our parents wanted to be grown us as the way they were grown. Most of the participants reported that even if there is no cemented discussion with mothers on sexual and reproductive health issues, adolescents prefer to make open discussion with their mothers rather than fathers. Most of the respondents said that they prefer to talk with their mother particularly if she is young. But most of the time the upper hand to initiate discussion within the family are parents but usually the discussion is started with suddenly while watching film.

4.3 The Major Barriers of Communications between Parents and Adolescents on SRH

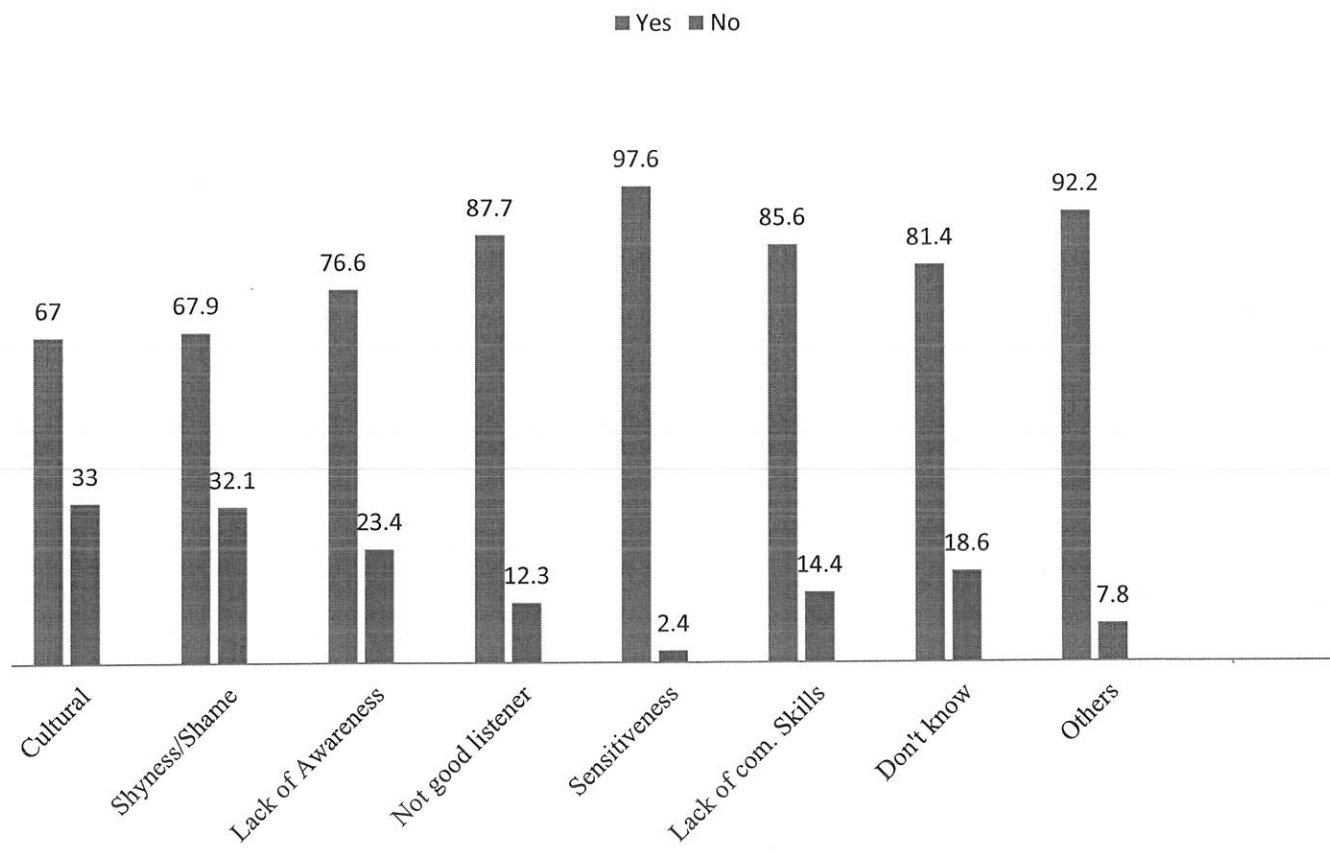
As it depicted in table 5, out of the total of three hundred fifty eight respondents who had responded for the study 223(67%), reported that the barriers as culturally unacceptable to discuss such issues with parents and 110 (33%) of the respondents reported that the barriers are not cultural. The respondents who mentioned shame as had not discussed on SRH issues were 226 (67.9%) of the study population. Whereas one hundred seven (32.1%) respondents reported that shame was not considered as the hindrance to open discussion.

The most commonly mentioned reasons for which they didn't discuss with their parents about SRH issues were lack of awareness which were 255 (76.6 %) and followed by 292 (87.7%), parents lack of interest on the issue. Parents' lack of communications skill were accounted 285 (85.6%) of the respondents. Three hundred twenty five (97.6%) respondents reported as one of the hindrances for the open discussion was the difficulty and embarrassing (sensitiveness) of the issues according to the multiple responses of the respondents. The reasons that stated frequently for not having open communications between parents and adolescents were unacceptable culturally and the issue is considered as a taboo, shame, traditional norms, sensitiveness of the issue, feelings of the parents that their children are young and led to wrong direction, lack of awareness and communication skills (Table 5).

Table 5: The major barriers of communications between Parents and adolescents (students) in Medhanealem Preparatory School, Addis Ababa, and April 2013

No	Variables	Response (Frequency)		%	
		Yes	No		
1.	Culture	223	110	67	33
2.	Shyness/shame/	226	107	67.9	32.1
3.	lack of awareness	255	78	76.6	23.4
4.	Parents are no good listener to SRH	292	41	87.7	12.3
5.	Difficult and embarrassing (sensitiveness)	325	8	97.6	2.4
6.	Lack of Communication skills	285	48	85.6	14.4
7.	Don't know	271	62	81.4	18.6
8.	Others	306	26	92.2	7.8
	Total	2183	360		

Figure 1. The major barriers of effective Communications between parents and thier SAY(%)



Most of the discussants of the FGDs and interviewees of the key informants and parents mentioned their reason not to discuss with their adolescents on SRH matters was culturally unacceptable. They said it is an intergenerational problem ‘since we had been growing in a culture talking about SRH was a taboo so we passed this to our children’. Embarrassment and lack of knowledge were another reasons mentioned by the participants. They said because of our insufficient knowledge we could not provide our kids with adequate information.

Naturally kids in now days need detailed information so they do not stop questioning till they get a response that satisfy them; if parents had limited knowledge they feel embarrassed so they may not raise the issue ever. Different reasons/ barriers of effective communications between parents and adolescents were raised and discussed by the students. Most of the female participants said that parents don't want to communicate about sexuality issue with their adolescents because parents think that talking about sex led the adolescents in the wrong direction and encouraged them to have sex. Most of the participants said that talking about sex and reproductive health is believed to be the duty of naughty children or person.

Most of the respondents reported that most of the reasons that hinder the open discussion between parents and adolescents are norms, culture and belief in the society, lack of awareness and communications, wrong perception the parents to the issue and hold the power of discussion. One of the male adolescents said that his father doesn't talk with him about sexuality and reproductive health issues, he said me you can reach it and the time will come soon for you. Most of the participants also reported that talking about sexuality and reproductive health issue is considered as the symbol or model of calm and cool. One of the boy adolescents said that if I tell to my parent I am in need of girlfriend , I know the response they say me “ፈጥህን ሳትጠርግ ሴት ታስባልህ” I prefer to talk my friends with the same sex because they are culturally tied with the community. In this finding, the qualitative report strongly substantiated the quantitative report in regarding to the barriers of effective Communications between parents and adolescents on SRH.

4.3.1 Social Barriers of SRH communications

Gender is one of the barriers to effective communication between parents and adolescents concerning reproductive health issues as it revealed in this study. Most of the parents fail to communicate with their children of the opposite sex on the issues of sexuality and SRH. In most cases it has been observed that this kind of communication tends to be gender based as parents prefer to speak or discuss with children of the same sex. Mothers prefer to talk with their daughters and fathers to talk with their sons. Parents also feared that their children will feel that their parents want to have an affair with them especially when the discussion is about sexuality.

One of the interviewed fathers (F1) said that:

“ I can’t communicate with my child of any sex, about Sexual and RH because it is shame for me. My child will not understand me. She or he will feel shame too. If she is a girl she might feel that I want to have an affair with her, and for the boy, he will not understand me”.

Most of Parents who were interviewed in the study explained that it was shameful for them to discuss with their children of the opposite sex on the matter of sexuality and reproductive health. “....it is challenging to talk to my child about sexuality and reproductive health issue, I feel shy said one of the interviewed mothers (M4).one of the female parent explained her experiences with his child as follow:

“I have never discussed with my children issues of sexuality and reproductive health because it is shame for me as a parent to talk about those issues and traditionally it is abomination for a parent to talk with his children about these issues. These are the responsibilities of elders like grandfathers and grandmothers and not of a parent as they teach a child how to act and behave as an adult”.

Parents with a high level of education also failed to communicate with their children orally or face to face, they decide to use other means of communication, like giving them learning materials to ensure that their children understand and get to know all the information about reproductive health issues compared to others with low education who have not seen other option to communicate with their children. “I have never tried to discuss directly with my child on sexuality. But I used to bring materials like books and brochures that explain about those issues when I saw some changes. However I did not crosscheck whether they read it or not” said one of the mothers (M7). The other father (F9) added that “I have never tried to talk with my child about sexuality because I know that he knows everything as there are many things to give information including Media of which I think for my child knows everything. I did not talk on sexuality because I thought in so doing I would get him to have sex”.

Sensitiveness of the issue was reported as one of the barriers .Some parents explained that it is difficult to discuss with their children on the issues of sexual and reproductive health as they fear that they can direct them into engaging sexual activities. “I can’t talk with my child issues of sexuality because it will be like I’m directing him or her to engage into sexual activities” said one of the mothers (M1).She also added that “If I need to talk with my child on issues of how to prevent STIs, HIV and early pregnancy I will tell her to abstain only and not about other ways because if I tell her about other ways, it will be like I will be directing and encouraging her to engage into sex activities” . One of the father (F8) said that “It is very difficult for me as a parent to tell my child about sexuality because when I tell them it is like I will be directing him to practice sex” .

Some of the participants said that being married and lived together tends to be a barrier to communication between parents and their adolescents concerning reproductive health issues as parents within the marriage tend to have different perception about who has the responsibility to communicate with the child concerning reproductive health issues like early pregnancy, STIs and HIV/AIDS. Parents who are divorced assume that they have all the responsibilities in ensuring that their children, regardless their sex, have all the information about different issues of reproductive health. They do not communicate in a direct way with so as their children. One of the interviewed mothers said (M1) I can’t talk with my child of opposite sex issues of STIs, firstly I don’t know even how to start, even if I want to talk with him I will direct him to ask his father , It will depend with the sex of the child, if the child is a girl then I will talk with her, and if it is a boy then his father has to talk with, because it is easy for each parent to talk with the child of his or her sex. It is shame for me to talk with a child of the opposite sex issue relating to reproductive organs.

4.3.2 Culture Barriers to SRH Communication between Parents and Adolescents

All most all of the interviewed participants explained that traditional norms of their culture were not friendly for them to discuss issues of SRH with their children as it was not allowed because it is based on sexuality discussion. They believe that they are not the right people to talk with their children about those issues as their cultural norms allow this activity to be handled by senior or elders like grandfathers, grandmothers, aunts and uncles. Hence this is the barrier that makes them fail to talk with their children about issues of SRH.

One of the interviewed mothers (M2) “My traditional norms do not allow me to direct my child on issues of SRH because it is shame for parent to talk about SRH issues to his or her child. This needs to be done by grandfathers and grandmothers”. “No, I can’t talk with my child of any sex issues because my traditional norms prohibit me as a father. It is an insult for me as a parent to discuss issues like these” said one of the father (F9). Religion was reported as one of the hindrances to effective communications between parents and their adolescents on issues of sexuality like STIs, HIV and early pregnancy prevention as well as condom use. Religious parents use statements that are provided in holy books (Bible and Quran) to guide their children to avoid sexual risk behaviors. They tend to use religious teaching rather than direct communication about sexuality and reproductive health. “My religion help me very much in communicating with my child as it prohibits adultery which is a sin to God. My religion also prohibits me to use condom, so I can’t direct my child about condom use and I don’t like him to use condom as it is not the will of God” said one of the mothers (M5).

The other father (F6) said that “It is abomination to talk with my child of any gender issues of sexual even my religion prohibit me to talk those issues. This job is provided to seniors who are not the parents of the child”. Occupation in which other parents are engaged to tend to be the barrier for parents to discuss with their children issues of reproductive health as they have little time to be with their children. He added that “My job keeps me very busy. I used to travel frequently, which make me to have little time to be with my children and discuss with them. Furthermore, my tradition prohibits me to talk with them about issues of reproductive health Issues”

4.3.3 Economic barriers of SRH Communications between Parents and Adolescents

Economic is one of the elements that maintain the wellbeing of individuals to do its daily demands and needs. In social institution, economic was perceived as one of the measurement of standards or living conditions. In this study the findings both in qualitative and quantitative data showed that the economic status of the parents did not have correlation to open discussion on SRH issues.

Income of parents doesn't have any effect to the parent- adolescent communication concerning reproductive health issues as parents interviewed explain that their income was nothing to do with the discussion with their children as communication doesn't need money to communicate in the family level.

One of the interviewed mothers (M8) "Issues of SRH are discussed regardless of income because this issue doesn't select people who have or who do not have. So I used to tell my children". One of the interviewed fathers (F4) shared the idea stated by M8 in that "Income is nothing because if I have or do not have it, still children need to be told and mother is the only person to tell them everything. Money is not needed" , "Income is never needed to discuss with my child; to me I think this discussion is free as income is not needed. What is mostly important is to use strategies that will help a child to understand the issues of SRH" . The role of wealth in parent to adolescent communications was not found, as parents interviewed declared that it doesn't have any effect to hinder communications between them and their children." Wealth is not necessary, what is required for my child to know and understand risk sexual behaviors, so educating her doesn't cost anything.

4.4 Association between Socio-cultural and Economic determinants and Communications between Parents & Adolescents on SRH Issues.

As shown in table 6, Pearson Chi square Test was done to assess factor related to communication between parents and adolescents on sexual and reproductive health issue. The Socio demographic variables that analyzed in Pearson Chi square test are sex, age, religious, parents' marital status, family size, and Educational status of parents (father and mother). The analysis was done to investigate socio-cultural and economic determinants of parents to adolescents Communications on sexuality and reproductive health issues. The analysis test indicated that the relation between sex and open discussion on sexuality and reproductive health showed that the P-value<0.001 which means their correlation had strongly statistical significance .One hundred twenty seven females (51.2%) reported that they discussed on SRH issues where as 91 males (27.5%) discussed on SRH issues. This inferred that there is a strong correlation between being female and SRH open discussion. The variable age was categorized in two groups, the first group 15-17 years old and the second group was 18-24 years old. The two aged groups discussed on SRH issue were 40.3% and 41.2 % respectively. And the P-value is 0.893. Therefore, there is statistical insignificant being in the two age groups for open discussion on sexuality and reproductive health issues.

Table 6: Association between SRH discussion and characteristics of sample students in Medhanealem Preparatory School, Addis Ababa, April 2013

Variables		n	% not discussed	% discussed	p-value
Sex					
	Female	127	48.8	51.2	<0.001
	Male	91	72.5	27.5	
Age (in years)					
	15 - 17	119	59.7	40.3	0.893
	18 - 24	97	58.8	41.2	
Religion					
	Orthodox	160	53.8	46.3	0.033
	Muslim	37	75.7	24.3	
	Protestant and others	22	68.2	31.8	
Parents marital status					
	Living together	149	58.7	41.3	0.952
	Not living together	68	58.8	41.2	
Family size					
	<=4	55	45.5	54.5	0.092
	5 - 7	110	61.8	38.2	
	>=8	44	63.6	36.4	
Educational Status_F					
	Illiterate ,read and write	27	70.4	29.6	0.017
	primary	36	75	25	
	Secondary	44	61.4	38.6	
	Diploma	31	38.7	61.3	
	Degree and above	55	50.9	49.1	
Educational Status_M					
	Illiterate ,read and write	72	63.9	36.1	0.119
	primary	37	59.5	40.5	
	Secondary	54	66.7	33.3	
	Diploma	20	60	40	
	Degree and above	29	37.9	62.1	

One hundred sixty of the respondents (46.3%) discussed on SRH issues were orthodox Christian and thirty seven of the respondents (24.3%) discussed on the issue openly were Muslim Pearson chi square test resulted in P-value, 0.033 which had statistical significance. Thus open discussion on SRH is strongly correlated with religion as p-value as sated above. Parental marital status of the participants who are living together and nonliving together, was statistical insignificant which has the P-value 0.952. The respondents discussed openly on SRH and living together with their parents were 41.3% and 41.2% of the participants discussed on SRH and their parents were not living together. This implied that parental marital status and open discussion on SRH issue were not correlated and they did not have association between them.

Family size and open discussion on SRH were statistically insignificance. As it is indicated in table 6, coefficient of correlation (P-value) is 0.092 which mean the number of family members in the family level and the open discussion on sexuality and reproductive health did have association or correlation. But, the SRH discussion on the three family size groups has been shown slight variation from small size family to medium and extended family. The educational status of male parents of the participants and the discussion on SRH were correlated. The coefficient of correlation of father educational and mother educational status were 0.017 and 0.119 respectively. Mothers who have degree and above discussed more about SRH issue with their adolescents.

Whereas fathers who have diploma did not discuss with their adolescents as it is indicated by Pearson chi square test, p-value 0.119 indicated that statistically insignificant correlation between female parents' educational level and SRH discussion. This study illustrates that parents (in depth interview) realize the importance of discussing with their children about sexuality but as many of them find that they are unable to address the subject comfortably. Most of them believe it is culturally unacceptable, they don't know enough and feel embarrassed. Consistent with the finding other studies the main reservations of parents for not discussing sexual and reproductive health were that the discussion would be embarrassing; that children would not take them seriously; and an apprehension that they cannot answer a child's question about sexual or RH.

Another mentioned reason by parents in interview was the way parents (especially fathers) themselves communicate with them is kind of imperative which is also true in other studies (Yowell CM, 1997; 17:172-96.) showed 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 and another study noted that men have the tendency to lecture or attempt to rectify a perceived problem while women focus on establishing trust and confidence with children.

It was also seen adolescents in this study perceive similar barriers for not discussing with parents on SRH issues mostly feeling shame to discuss; believe discussing on SRH as a taboo; parents' lack of knowledge and communication skill; embarrassment, those barriers are also commonly seen in other studies done in Zambia and Zeway in Ethiopia . In the present study adolescents were more comfortable discussing SRH issues with mothers than fathers. This is may be due to mothers create trust and confidence with children as previous studies showed . In addition, both female and male adolescents prefer their peers for discussion on SRH issues. Similarly, studies in Kenya and Gahanna showed that both male and female adolescents would be most comfortable discussing sexual matters with their friends of same sex (Kiragu, obswaka E ,Odallo. D van hulzen, 1996;(3): 11-3) and. Ghana Social Marketing Foundation, 2001).

Discussing a number of sex-based topics with friends rather than parent may have a negative impact on adolescents' sexuality and sexual behavior if their peer is not equipped with appropriate information on sexuality. One of the female students said that the probability to be held open discussion in educated family relatively better. But most of the female student participants said that the level of education is not determining factors to openness of the discussion with in the parents and their children. There are many educated people who did not change their mind regarding to open discussion as it was and stubborn people who wanted to grow their children as they had been grown.

Regarding to the status of education, most of the participants said there is no difference seen among the educated and uneducated parents on discussing openly on sexual and reproductive health issue, what matters is not the level of education of parents. What is important the culture that the parents had been grown. They reflect the culture, the norm and the traditional belief that they were shaped within the community/ society/.It was also reported that religion does not affect whether to have open discussion or not.

The same is true that economic status did not determine the open discussion between parents and adolescents. What makes different the rich children may use their money to mitigate the problem as long as they have the money they use it when problems encountered them such as unintended pregnancy and other intended purposes.

Almost all the participants of the FGDs reported that economic and educational statuses don't have significant contribution to open discussion between parents and adolescents. One of the female participants said that if someone has MSc with Engineering doesn't mean discuss openly with his adolescents what determined the culture they have been grown in the community. But , there is discrepancies between the qualitative report findings and the quantitative part. In the quantitative part it says, there is a correlation between the educational status of parents and discussion between them as indicated in Table 6, P-value 0.017. The discrepancy may come from the probing of the researcher as an instrument during the data collection.

4.5 Discussion on the results of the study

This study has attempted to understand communications between parents and their sexual active youths with in Medehanealem preparatory school students on sexual and reproductive health issues in Addis Ababa Gulzele Sub city. The basic demographic characteristics of the study population are not different from other similar school population like high school students in south Gondar (Kidane A. , 2004) and SNNPR's Buluhera School. The sex compositions of the students were 58.6% females and 41.4% Males. This can be explained by the enrollment of Males were possibly low in the school. The majority of the respondents were Orthodox Christian, which reflected the national picture in general. The study has also obtained important information in assessing major barriers to effective parents to adolescents Communications on Sexuality and reproductive health issues.

It has tried to enroll those who are 15-24 years with the assumption that wider ranges of sexually active segment of the population were targeted in WHO and Ethiopian Government as Sexual in school Active Youth. Though the data collection was conducted during the working hours, the proportion of male respondents was unfortunately lower than that of female respondents because of the enrollment difference in the school. Using Pearson Chi Square Correlations, the socio- demographic variables were compared with the selected dependent variables

Some of the socio-demographic variables have shown significant associations with the three outcome variables. For instances sex, religion, family size, educational status of parents were significantly associated with open discussion between them on sexuality and SRH issues. In the contrast, marital status of the parents and age of the students were insignificantly associated with open discussion (communications) between the parents and their in school Sexual Active Youth (Table 6).

In the quantitative data of the current study indicated that religion had shown significant association the outcome variables but the focus group discussants reported that religion did not show any significant difference on open discussion on sexuality and reproductive health issues, but some of the focus group discussants reported that it can influence open discussion.

The relationship of the socio-demographic variables with the outcome variables implies that some socio-demographic factors have influenced on open discussion (communications) of the two parties concerning to SRH issues. Majority of the key informants and the FGD discussants of the current study reported that there was no open discussion between the parents and their in school Sexual Active Youth (SAY). However there are few parents to make the issue in the family level as scary tools

Communications regarding sexuality often is viewed as desirable and perceived by many of the participants and respondents to be effective means of encouraging adolescents to adopt positive behavior. Moreover, this study illustrates that most parents realize the importance of discussing with their children about sexuality but as many of them find themselves unable to address the subject comfortably. A study at Adelphi university Garden city in New York shows parents who were unwilling or unable to discuss this important and sensitive part of life with their children considered it as a negative and a taboo rather than as a natural part of being human (Crouter AC, 2002: 461– 83)

This finding is consistent with the present study of the depth interview of the parents. This may indicate that there is a need to put an effort to improve discussion between parents and their adolescent through increasing their knowledge and communication skill. On the other hand, positive communication about sexual information, feelings, attitudes, values and behavior when children are young often leads to ongoing discussions as they mature. Establishing an environment conducive to open and comfortable communication is therefore, it is extremely important.

In addition, a study in Ziway showed the impact of cultural taboo, shamefulness, and communication skill of adolescents in many developing countries makes adolescents to discuss rarely on sexual matters explicitly with their parents (Taffa N, Haimanot R, Desalegn S, Tesfaye A, Mohamed K. ,1999; 13(3):207)

This is also a comparable finding with the present study. In this present study adolescents were more comfortable discussing SRH issues with mothers than fathers (See table 3). Moreover, both female and male adolescents prefer similar sex. This shows similar picture with present findings.

This may suggest that there is sex preference in discussing sexual related issue which may indicate that discussing sexual issue with similar sex is comfortable. This may be possibly also due the sensitive issues where youth preferred to have someone that they could discuss these issues and not feel shy when discussing sexual matters. Moreover, in this study adolescents reported discussing a number of sex- based topics with friends and this supports the importance of peers. Discussing a number of sex-based topics with friends rather than parent may have a negative impact on adolescents' sexuality and sexual behavior if their peer is not equipped with appropriate information on sexuality. A study on secondary school girls in Zambia 30% felt it was easy to discuss sexual matters with their mothers and 77% felt it was difficult to discuss sexual matters with their fathers (Pillaivk, Yates DL, 1993 Jul, 25(3):411-4). Similarly, in this study result showed that 56.2 % the school girls felt it was easy to discuss sexual matters with their mothers while 92.3% felt it was difficult to discuss sexual matters with their fathers (Table 3)

This may suggest that there is a need to equip school friends (peers) with the appropriate information and communications materials on SRH issues. Ninety (25.7%) of the school adolescents had discussed on SRH with their parents and 83.2% of the respondents said that they discussed with their peers of same sex about SRH issues which is slightly low as comparable to the study done in Dessie preparatory and high school students in that 85.8% of the students had discussed on sexuality and RH issues and 61.9% with their peers of same sex (Shiferaw S. 2004)

Regarding the influence of culture in this study 67% of the students reported that it is culturally shameful to discuss about SRH issues with parents. But the result is a bit high as compared to study done in Ziway where 54% of the students felt that it is culturally shameful to discuss about it (Taffa N, Haimanot R, Desalegn S, Tesfaye A, Mohamed K, 1999; 13(3):207)

Communication within the family appears to be particularly important during the adolescent years especially concerning sexual and reproductive health issues. Family communication affects adolescent identity formation and role-taking ability (Cooper et al., 1982). Cooper et al. suggest that adolescents who experience the support of their families may feel freer to explore identity issues. The research findings indicate that some communication takes place on particular reproductive health issues but not others. In particular parents fail to communicate with their adolescent children on sensitive issues of sexuality like condom use, puberty, STIs, and physical development. This implies that communication between parents is not comprehensive and informative.

Furthermore the study found that that even when communication takes place it is inadequate as the process does not always involve direct conversation between parents and their adolescents. Parents prefer using indirect communication methods like providing reading materials to their children. This implies that the children do not get direct assistance and clarification of complex information they come across as they read the material. It can be concluded that the children do not benefit fully from such communication.

For parents who try to have direct communicate with their children they tend to use threats rather than giving explanations and direction on “what to do and how” .Hence the barriers revealed by the study tend to relate to communication about sexuality and reproductive health issues discussion between parents and their children of both sexes tend to be difficult on all issues based on sexuality.

4.5.1 Cultural barriers to SRH Communications between Parents and Adolescents

It is worth noting that the role of traditional norms that limit communication between parents and their children on issues of sexuality was also found to operate in other societies, as a study done in Kenya (Mbugua ,2007) reported. Parents are not expected to discuss with their children issues of physical development and puberty. This task is given to other people who are senior like grandmothers, grandfathers, aunts and uncles. Not only is found to be shameful by parents, society finds it to be an abomination for parents to talk about these issues with their children as the discussion should be about sexuality. In this study also similar findings revealed about the culture as hindrance of communications between parents and adolescents.

The communications between the two parties are found to be minimal because of the sensitiveness of the issue and considered as a taboo with in the community.

4.5.2 Social barriers to SRH Communications between Parents and Adolescents

This study found that when communication takes place it tends to be gender based as parents prefer to speak or discuss with children of the same gender as themselves. Mothers prefer to talk with daughters and fathers prefer to talk with their sons. Parents fear that any discussion of this nature can lead the children to engage into sexual experimentation. Parents with high level of education do not talk to their children as they assume that they know each and everything from television, radio, and the internet. So they let them find for themselves the information they want. While this is going on parents need to check with their children because not everything they come across in the social media is correct, and misinformation abounds.

The division of roles and responsibility for guiding children among parents is different, whereby mothers feel that it is fathers who are supposed to tell their sons this, and vice versa. This is particularly the case in the context of pressing economic activities which mean that either the father or mother may not be available to sit down and discuss issues with an apparently perturbed daughter or son. Divorced parents in turn assume that they have all the responsibility in ensuring that their children regardless their sex have all the information about different issues of reproductive health and will use any methods of communication. These results are similar to that of South African study (Wang, 2000).

4.5.3 Economic barriers to SRH Communications between Parents and Adolescents

Participants interviewed in this study stated that lack of time to spend with their children due to different jobs they have, is one of the biggest problem they have. This makes them to fail or sometimes to have less communication with their children as they are too busy with their daily activities. It is important that parents accept the responsibility to guide their children as they confront the challenges of growing up, and to find ways of doing so, including providing reading material they approve, and checking with them to make sure they understand what they read

CHAPTER FIVE

CONCLUSION AND RECOMMENDATION

5.1 CONCLUSION

Communications between parents and their in school Sexual Active Youth (SAY) requires ongoing attention and time. Open discussion on Sexuality and reproductive health is difficult for both parents and adolescents. Parents do not talk to their children about sex and want their children to do anything sexual. They also avoid confronting their children on what they are doing concerning sexuality and RH issues. There was positive perception towards open discussion between parents and their children on SRH issues. Furthermore, there were also good attitude toward the importance of communications on SRH in both the study population (students and parents). However, the communications of Sexual Active Youth (SAY) on sexual and reproductive health issues were more with their friends/peers of similar sex than parents.

This could have two important impact if peers are not equipped with appropriate information on SRH related may influence each other in negative way where as if they are equipped with appropriate information on SRH related they can pass easily and influence each other positively. This finding concludes that there was low parent to adolescents' communications on SRH issues. The focus group discussion, survey and Key Informant Interview revealed that the content of parent-adolescents communications focus more on the negative outcomes of sexual and RH and poor on what adolescents should know and understand how they are growing and developing this will make adolescent unlikely to turn to their parents to discuss with them comfortably.

The study also concluded that students and parents have low communications on sexual and RH related issues still continues to be cultural taboo and shame by both students and their parents. Lack of awareness, parents being passive for the issue, sensitiveness, lack of communication skills, traditional norms, religious belief, marital status, fear of directing their children to engage into sexual activities, feelings that their children are young, and nature of the parents work tend to be the barriers that exist and tend to make the process to be not easy.

The most common mentioned reasons for low communication were embarrassment, limited knowledge and cultural taboo to discuss the issue. Parental education is a significant factor for parent-adolescent communication on SRH issues and parent adolescent communication is a predictor factor for adolescents' knowledge on different sexual and reproductive health.

However the study indicated that there was no association between parent-adolescent communication on SRH and sexual activity with parental education. There is preference of adolescents the same sex to discuss with parents that is males preferring their father and females prefer their mothers. Furthermore they prefer their friends than parents to discuss on SRH. Based on the focus group discussion, survey and Key Informant Interviews of this study there is a difference between mother and father on what to communicate their adolescents. In addition the content of parent- adolescent's conversation focus more on the negative out comes of sexuality and they initiate the discussion after changes occur in adolescents. Generally, the study concluded that parent-adolescent communication on SRH issue is low communication due to different reasons such culture, shyness, sensitiveness of the issue, lack of awareness and communication skill.

5.2 RECOMMENDATIONS

Based on the findings of the study as well as the suggestions of the Key informants and FGD Participants, the following recommendations are made:

- There is a need to equip and educate parents on different SRH issues with appropriate Communication material and communication skills.
- It is important to encourage and empower parents to start to communicate with their children on sexual matters while the children are still in late childhood or early teenage years. There is also the need to empower and encourage parents to provide with positive role models and guidance to their male and female adolescents
- Comprehensive family life education should be initiated for the students and parents in school, home, churches, mosques, and health facilities.
- Sensitize the community to encourage open discussion among family members in general and between parents and children in particular via woreda administrations and Urban Health Extension Workers (UHEW) using the strategy of ONE to FIVE Government approach.
- Schools should incorporate SRH issues in the syllabus to empower parents to adolescents communications on SRH issues in the syllabus
- Sensitization to both parents and adolescents need to be done so as any of them can initiate the discussion about sexual and reproductive health issues.
- Training and education about sexuality and reproductive health need to be provided to parents on how to communicate with their children of the opposite sex
- SRH and Sexuality should be one of the agenda in school programs and on the school day of parents.
- These factors need to be researched among larger group of parents in different parts of the country including out school youths so as to give the magnitude of the problem and to justify development of appropriate interventions
- Further studies should be conducted to examine what triggers, quality and timing of parent–adolescents communications on sexuality and reproductive health related issues and the effect of communication on safe sexual behaviors.

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Appendix I. Questionnaires for Survey in English and Amharic languages

Dear respondents;

This questionnaire is designed for a research work which is approved by AAU, School of Journalism and Communications to be conducted in partial fulfillment of Master's degree in Journalism and Communications. I hope you will help me by answering these questions. None of your answers will be available to anyone .Do not write your name .All the information you give me will be kept private. Confidentiality and privacy will be maintained by ensuring the respondents answering the questions on a separate place where no one can see them. Therefore, we really need your honest and genuine response to questions prepared is highly appreciated and helpful to attain the objective of the study.

Thank you in advance for taking your time to answer our questions.

I. Demographic Data of the respondents		
No	Questions	Response
1	Age	----- in years
2	Grade	-----
3	Sex	1. Male 2. Female
4	Religion	1. Orthodox christen 2. Muslim 3. Protestant
5	Marital status of the Mother and Father	1. Together 2. Separated 3. Divorced
6	With whom are you living?	1. lives with father and mother 2. with mother only 3. with father only 4. with friend 5. living alone
7	Family size	-----
8	Mother's educational status	1. illetrate 2. read and write only 3. Primary school 4. Secondary school 5. Diploma 6. Degree and above

9	Father's educational status	1. illetrate 2. read and write only 3. Primary school 4. Secondary school 5. Diploma
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10	Occupation of the Mother	1.House wife 2.employed (private) 3.employed (gov't) 4.Small scale merchants 5. farmers
11	Occupation of father	1.empolyed (private 2.empoplyed (gov't) 3.small scale merchants 4.farmer 5. no father
12	Parents in come /Month	Mother: _____ Father: _____ I don't know

II. The trends and the perceptions of Adolescents and Parents on SRH Communications and Issues

13	Do you agree that parents to adolescents Communications on SRH issues important?	1.Strongly agree 2. agree 3. disagree 4 Strongly disagree
14	For male only , did parents forbid you not to play with female?	1.yes 2.no
15	For female only , did parent forbid you not to play with male?	1.yes 2.no
16	Do parents know where you are, When outside of home?	1.yes 2.no
17	Do parents know with whom are you, when out of home?	1.yes 2.no

III. The discussion between parents and Adolescents on SRH issues and the barriers to effect Communications and their relations with Socio cultural detriments

18	Is it important to discuss (Communicate) sexual issues with	1.yes 2.no
----	---	---------------

19	Have you ever discuss about SRH issues with your parents? If your answer is yes skip to Q 21	1.yes 2.no 3.don't know
----	--	-------------------------------

20	If yes with whom (circle all answer you think)	1.Father 2.mother 3.peer(friends) 4.sisters
21	How frequently you have discussed about SRH issues?	1. very often 2. often
22	If yes with whom (circle all answer you think)	1.Father 2.mother 3.peer(friends) 4.sisters
23	If you don't discuss on sexual intercourse and SRH issues with parents, what are the reasons?(circle all answer you think)	1.culturally un acceptable 2.shame 3.lack of knowledge 4.lack of communication skill 5. parents are not a good listener
24	How do you rate parents SRH Communications with you about sexual matters and SRH issues?	1.low 2.medium 3.high

	1. መሰረታዊና ማህበራዊ ጉዳይን በተመለከተ	
ተ	ጥያቄ	መልስ
1	የዕድሜ	_____ዓመት
2	ክፍል	_____
3	ጾታ	1.ወንድ 2.ሴት
4	ሀይማኖት	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ሌላ ካለ ይገለፅ_____
5	የአባትና የእናት የጋብቻ ሁኔታ	1. አንድ ላይ ናቸዉ 2. ተፋተዋል 3. ለየብቻ የተለያ አገር ይኖራሉ 4. አንዱ በሞት ምክንያት የለም
6	የምትኖረው/ሪው ከማን ጋር ነው?	1. ከእናትና አባትህሽ ጋር 2. ከእናት ጋር ብቻ 3. ከአባት ጋር ብቻ 4. ከጓድኛ 5. ከእህትና ወንድም ጋር 6. ብቻየን 7. ከሌላ ዘመዶቼ ጋ 8. ሌላ ካለ ይገለጽ_____
7	የቤተሰብ ብዛት	_____በቁጥር
8	የወላጆች የገቢ መጠን በወር ስንት ነዉ?	1.የአባት _____ 2.የእናት_____ 3. አላውቅም_____
9	የእናት የትምህርት ደረጃ	1. ያልተማረች 2. ማንበብና መጻፍ 3. አንደኛ ደረጃ 4. ሁለተኛ ደረጃ 5. ዲፕሎማ 6. ዲግሪ እና ከዚያ በላይ 7. እናት በህይወት የለችም
10	የአባት የትምህርት ደረጃ	1 ያልተማረ 2 ማንበብና መጻፍ 3 አንደኛ ደረጃ 4 ሁለተኛ ደረጃ 5 ዲፕሎማ 6 ዲግሪ እና ከዚያ በላይ 7 አባት በህይወት የለም

11	የአናት የስራ ሁኔታ	1. የቤት እመቤት 2. በግል ተቀጣሪ 3. በመንግስት ተቀጣሪ 4. ነጋዴ 5. ገበሬ 6. እናት በህይወት የለችም 7. ሌላ ካለ ይገለፅ-----
12	የአባት የስራ ሁኔታ	1. በግል ተቀጣሪ 2. በመንግስት ተቀጣሪ 3. ነጋዴ 4. ገበሬ 5. አባት በህይወት የለም 6. ስራ አጥ 7. ሌላ ካለ ይገለፅ.....

2. ወይይት በወላጆችና በጎረምሳ ልጆቻቸው እይታ ምን እንደሚመስል ለመዳሰስ

13	በወላጆችና በልጆቻቸው መካከል ስለ ሴክሽዋል /ግብረ ስጋ ግኑኘት) ጉዳይ እና ስነ ተዋልዶ ጤና ላይ የሚያደርጉትን አግባቦት/ወይይት/ መኖሩን ምን ያህል ትስማሙበታላቸው?	1. በጣም እስማማለሁ 4. በጣም አልስማማም	2. እስማማለሁ 5. ስለ ሁኔታ አላቅም	3. አልስማማም
14	ለሴቶች ብቻ፤ወላጆቻችሁ ከወንድ ልጆች ጋር እንዳትጫወቱ ይከለክላሉ?	1. አዎ	2. አይከለክሉም	3. አላወቅም
15	ለወንዶች ብቻ፤ወላጆቻችሁ ከሴት ልጆች ጋር እንዳትጫወቱ ይከለክላሉ?	1. አዎ	2. አይከለክሉም	3. አላወቅም
16	ቤተሰቦች ከቤት ውጪ ሰትሆኑ የት እንዳላቸው ያወቃሉ	1. አዎ	2. አይ	3. አላወቅም
17	ቤተሰቦች ከቤት ውጪ ሰትሆኑ ከማን ጋር እንዳላቸው ያወቃሉ ?	1. አዎ	2. አይ	3. አላወቅም

3.የወይይት ቱ ሁናቴ እና ተግዳሮቶቹን ለማግኘት የተዘጋጁ ጥያቄዎች

18	በሴክሽዋል ጉዳይ እና በስነ-ተዋልዶ ጤና ላይ ከወላጆችህሽ ጋር መወያየት አስፈላጊ ነው ትላለህ?	1. አዎ	2. አይ	3. አላወቅም
19	በሴክሽዋል /ግብረ ስጋ ግኑኘት) ጉዳይ እና በስነ ተዋልዶ ጤና ላይ ከወላጆችህሽ ጋር ተወያይተህ/ሽ ታወቃላችሁ?	1. አዎ	2. አይ	3. አላወቅም
20	አዎ ካልክሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህሽ?	1. ከእባት ጋር	2. ከአናት ጋር	3. ከሁለቱም
21	ምን ያህል ጊዜ በሴክሽዋል/ግብረ ስጋ ግኑኘት) ጉዳይ እና በስነ-ተዋልዶ ጤና ላይ ከወላጆችህሽ ጋር ተወያይተሻልህል?	1 በጣም በብዛት 3 አንዳንዴ	2 በብዛት 4.በፍጹም አላወቅም	
22	ከወላጆች ውጪ ከማን ጋር ትወያያለህ/ለሽ	1. ከጳጳሮች ጋር 3. ከወንድም ጋር	2. ከእህት ጋር 4. ሌላ ካለ ይገለፅ	

23	በሴክሽዋል /ግብረ ስጋ ግኑኘነት) ጉዳይ እና በስነ-ተዋልዶ ጤና ላይ የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህሽ ታስቢያለሽህ?- ከአንድ በላይ መልስ መምረጥ ይቻላል?	1 በባህል ተቀባይነት የለውም 2 እፍረት 3 የእውቀት ማነስ 4 ወላጆች ጥሩ አዳማጮች አይደሉም 5 ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6 በእርሶቹ ከባድና የሚያበሳጩ ናቸው 7. አላውቅም 8 ሌላ ካለ ይገለፅ
24	የወላጆችህንሽን በስነተዋልዶ ጤና እና በሴክሽዋል ጉዳዮች ላይ ለመወያየት ያላቸውን ችሎታ ምን ያህል ነው ብለህሽ/ታስቢያለሽህ?	1. ዝቅተኛ 2. መካከለኛ 3. ከፍተኛ

Appendix II: Discussion Guide for Adolescents

1. Perceptions on Sexuality communications

- Have you ever attended sex education lessons in school? Or have you ever heard of sex education in schools? What do you think it is about?
- What is your opinion about providing sex education to children
- Do you think parents should discuss with their children about sexuality? Why?
- Are there any parents in your community discussing with their children on sexuality related issues? If yes what issues do they discuss?

2. Experience of parent and adolescent on sexuality communication

- Have you ever discussed with your parents on sexuality related issues?
Can you share with me your experience on discussing sexuality issues with your parents? If not with whom do you discuss?
- What issues did you discuss?
- Where else do you get information on sexuality?
- Based on your own experience where would you prefer to get information on sexuality? Probe for preference; parents, teachers and other sources.
- What role do you play in a typical discussion on sexuality?

3. Factors perceived to influence the communication process on sexuality

- Why do you think parents talk to their children on sexuality? If they don't have with whom do they discuss?
- Who initiates the communications/ have the upper hand? If you communicate?
- Are there parents who do not talk to their children on sexuality issues? What are the reasons?
- Culturally do you think children discuss the SRH issues with parents
- What do you think encourages parents to discuss with their children on sexuality issues?
- For those who do not discuss what do you think hinders them?

4. Frequency of interaction on sexuality

- When do you decide to talk with any of your parents about sexuality?
- Who begins the discussion?
- Do you think that what you share with your parents on sexuality is sufficient/ appropriate?

5. Contents of parent adolescent communication on sexuality.

- What do you think children talk with their children about sexuality?
- What issues do you discuss with your own parents?
- Who decides on what to talk about?
- How do you compare the content of discussion with your parents with information you get from school or friends?
- In your view do you think these discussions give you adequate information? Probe for reasons
- Where do you hold such discussion? Are you comfortable with these places?

6. Challenges/dilemmas related to parent-adolescent interpersonal communication on sexuality related issues.

- Are there topics you find easy to discuss? Which are these?
- Are there topics you find difficult to discuss? Which ones are these?
- In your opinion how can difficulties in discussing topics on sexuality be overcome?
- What advice would you give other adolescents on how they should deal with these issues with their parents?
- What advice would you give parents concerning discussion sexuality related issues with their children?

8. Background information

- Age
- Gender
- Date of interview
- School where applicable
- Number of siblings
- Geographical location
- Living with parents?

Thank you for this information

Appendix III: In-depth Interview guide for parents

In-depth Interview English Version for parents.

Basic Information

- 1. Date of Interview
- 2. Time
- 3. Interviewee Name

Introduction

Self-introduction, name, general affiliation and the purpose of the study

I appreciate that you have taken the time to participate in this research process which we know ,it will greatly help us to understand the barriers to effective communication between parents and adolescents concerning reproductive health issues. The issues we discuss here are completely confident. At any time during the interview, if you feel you need a brake or you are not comfortable answering any question let me know.

Demographic data:

- i. Sex
- ii. Education Level
- iii. Religion
- iv. Occupation
- v. Marital status

Interview Guide Questions

1. Do you communicate with your child about SRH issues? Probe: If no, who do you think is responsible for bringing up your child and directing him or her on all issues of puberty?

Why do you decide it to be like that?

Do you think the one you assign the task is very capable than you? (This question will be posed if the respondent say he or she assign someone for directing his or her child on issues of puberty)

Do you see changes concerning on what is aimed to be attained?

2. How do you communicate with your child of the opposite sex on issues concerning sexually transmitted diseases?

Probe: Since when you started discussing with him or her?

Why you started at that time?

How does you know that he or she understand what you say?

Does he or she ask you any questions concerning the topic?

What methods of prevention you are telling your child?

3. How does your current level of education help you in discussing with your child about early pregnancy and methods to use to prevent it?

Probe: How did you get the knowledge of early pregnancy?

Do you think you have enough knowledge about early pregnancy?

How do you direct your child on the methods to prevent pregnancy?

How did he or she take the information?

4. Whom do you think is responsible for discussing with your child about HIV and AIDS in your marriage?

Probe: Why?

What is mostly discussed? The causes of the disease or its effects?

Does the methods of prevention is discussed?

How do you ensure that your child is going to use prevention methods like condom?

5. How do your daily activities enable you to discuss with your child issues of physical development?

Probe: How often do you speak with your child?

What facilitates the discussion to be on physical development issues?

What materials are you using when the discussion is going on?

6. How do you use traditional norms in guiding and directing your child about puberty?

Probes: Who is given a responsibility of directing your child about puberty?

Do you think he or she send a message to your child?

How does he or she direct your child about puberty?

How does your child perceive it?

7. How does your religion help you in your communication with your child about sexual risk behaviors like multiple partners and inconsistent condom use?

Probe: Does it allow you to tell your child about what methods to use to avoid sexual risk behaviors? If it does not allow, then how do you communicate with your child about such sexual risk behaviors?

What challenges are you facing when directing your child on such sexual risk behaviors?

8. How does your income help in discussing with your child about HIV and AIDS?

Probe: How do you use your income to make sure that your child understands issues of HIV and AIDS?

Does it help or not? How?

9. Does any discussion concerning sexual risk behaviors need you to have enough wealth?

Probe: Why do you think so?

What will you do if you do not have wealth, will you stop discussing with your child?

(This question will be posed to the respondent if the answer for the first question is yes.)

Appendix IV: Demographic Characteristics of Parents

ID	Gender	Age	Education	Religion	Occupation	Marital Status	Child Sex	Child age
M1	Woman	43	Illiterate	Muslim	Business	Married	Boy	18
F1	Father	55	Primary					
M2	Mother	36		Christian	Business	Married	Girl	17
F2	Father	48	First Degree					
M3	Mother	42	College	Christian	Teacher	Married	Boy	17
F3	Father	56	Master's degree		Lecturer			
F4	Father	54	Primary	Muslim	Business	Divorced	Girl	17
M4	Mother	43	Illiterate	Muslim	Tailor	Divorced	Boy	18
F5	Father	49	Secondary	Christians	Truck driver	Married	Girl	17
M5	Mother	38	Secondary					
F6	Father	60	First degree	Christians	Government	Married	Girl	18
M6	Mother	48	Diploma					
F7	Father	48	Diploma	protestant	Private Employed	Maried	Boy	17
M7	Mother	40	Secondary					
F8	Father	49	Illiterate	Muslim	Business	Married	Boy	19
M8	Mother	43	Illiterate					

Appendix V: In-depth Interview for Key Informants.

Basic Information on the setting

- 1. Date of Interview
- 2. Time
- 3. Interviewee Name

Introduction

Self-introduction, name, general affiliation and the purpose of the study

I appreciate that you have taken the time to participate in this research process which we know will greatly help us to understand the barriers to effective communication between parents and adolescents concerning reproductive health issues. The issues we discuss here are completely confident. At any time during the interview, if you feel you need a brake or you not comfortable answering any question let me know.

Demographic data:

- i. Sex
- ii. Education Level
- iii. Religion
- iv. Occupation
- v. Marital status

Interview Guide Questions

- 1. Do you communicate with y Students about SRH issues? Probe: If no, who do you think is responsible for bringing up your child and directing him or her on all issues of puberty?
Why do you decide it to be like that?

Do you think the one you assign the task is very capable than you? (This question will be posed if the respondent say he or she assign someone for directing his or her child on issues of puberty)

Do you see changes concerning on what is aimed to be attained?

2. How do parents communicate you with their child on issues concerning sexually transmitted diseases?

Probe: Do parents or students communicate with you about Sexual and Reproductive health Issues? Why if not? If they come what was there talking points?

3. How does your current level of education help you in discussing with your students and parents about early pregnancy and methods to use to prevent it?

4. Whom do you think is responsible for discussing with the students about HIV and AIDS in your School?

Probe: Why?

What is mostly discussed? The causes or its effects?

5. Does any discussion concerning sexual risk behaviors need you to have enough wealth?

Probe: Why do you think so?

6. Is there any SRH educations in your School? If yes what kind of...? Why?

7. Does the school facilitate any discussion between parents and their adolescents in School?

Why