ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF PSYCHOLOGY

THE SITUATION OF PERCEIVED PARENT-CHILD COMMUNICATION ABOUT SEXUALITY AND ITS RELATIONSHIP WITH ADOLESCENTS' SEXUAL BEHAVIOR

Getinet Ashenafi

May 2007

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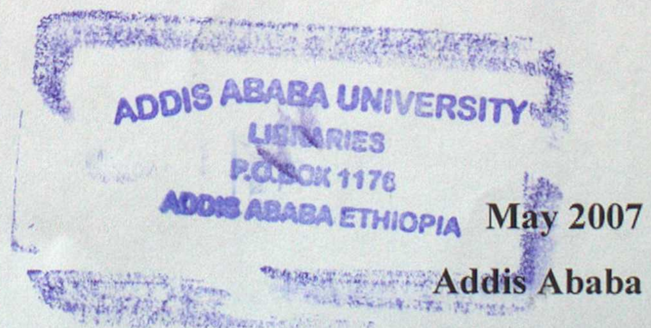

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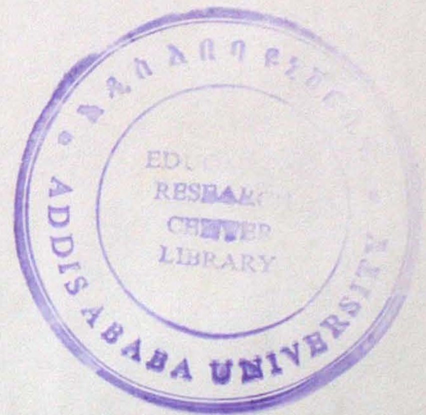
THE SITUATION OF PERCEIVED PARENT-CHILD COMMUNICATION ABOUT SEXUALITY AND ITS RELATIONSHIP WITH ADOLESCENTS' SEXUAL BEHAVIOR

A Thesis Submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Developmental Psychology.

Getinet Ashenafi



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Getinet Ashenafi

May 2007

ACRONYMS

- AIDS - Acquired Immune Deficiency Syndrome
- ANOVA - Analysis of Variance
- CDC - Centers for Disease Control and Prevention
- CSA - Central Statistics Authority
- FMOH - Federal Ministry of Health
- HAPCO - HIV/AIDS Prevention and Control Office
- HIV - Human Immunodeficiency Virus
- NCPTP - National Campaign to Prevent Teen Pregnancy
- SPSS - Statistical Package for Social Science
- STDs - Sexually Transmitted Diseases
- UNAIDS - United Nations Program on HIV/AIDS
- WHO - World Health Organization
- YRBSS - Youth Risk Behavior Surveillance Survey

Abstract

This study was conducted on 365 high school students in the age range 15-19 (mean age=16.73, SD=1.20) to investigate the situation of parent-child sexual communication and its relationship with adolescents' sexual behavior. A 20 item parent-child communication scale was administered to collect data on father-child and mother-child communication separately. To obtain data on adolescents' sexual behavior, a seven item close-ended questionnaire was employed. Interview was also held with five students to get supplementary information. The data obtained on parent-child communication showed a medium level of communication. There was significant difference observed between mothers and fathers in communicating about sexuality with their children. Mothers were found to communicate more frequently than were fathers. Sex difference was also observed among adolescents. Females reported significantly more frequent communication with their mothers than did boys. Parents' education was positively associated with parent-child sexual communication. Significant negative correlation was found between perceived parent-child communication and sexual behavior of adolescents. Better communication was significantly associated with lower sexual risk behavior. Implications of parent-child sexual communications for adolescents' healthy sexual behavior are discussed.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Population growth in Ethiopia, particularly the country's youthful population, has been increasing since the turn of the century, which is one of the highest rates in the world (World Health Organization [WHO], 1999). Along with the increasing number of adolescents in the country, these days, they are found to be at risk due to different environmental, psychological, and developmental (age–related) factors.

Among many adolescents risk behaviors, which lead them to reproductive health problems and even to death, are sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV) infection (Centers for Disease Control and prevention [CDC], 2006). This is because the prevailing mode of transmission of HIV/AIDS and other STDs is through heterosexual intercourse which accounted for about 87% of all infections in Ethiopia (HIV/AIDS Prevention and Control Office [HAPCO], 2006). The health of adolescents is greatly determined by their behavior and, an important and complex area of adolescent behavioral health is sexuality (Meschke, Bartholomae, & Zentall, 2000).

HIV/AIDS remained the most striking threat to the health and socio-economic development of sub-Saharan African countries in general (Federal Ministry of Health [FMOH], 2004) and Ethiopia in particular (Central Statistics Authority [CSA], 2005). Sub-Saharan Africa remains the worst affected region in the world (United Nations program on HIV/AIDS [UNAIDS], 2006). This UNAIDS (2006) report on HIV/AIDS epidemic further indicated that in 2005, there were 24.5 million people in Sub-Saharan Africa living with HIV. That is, globally, 64% of all people living with HIV are found in this region.

Ethiopia is among the first countries hard hit by this epidemic (HAPCO, 2006). According to the fifth report of the Federal Ministry of Health, FMOH (2004), the number of people living with HIV/AIDS in 2003 was 1.5 million and is estimated to be 1.7 million in 2005. In the FMOH (2004) report, it is shown that the HIV prevalence in the age range of 15 to 24 is 8.6% and the highest incidence still occurs in this age group.

Among the identified risk groups, the youth especially teenagers from 15 to 19 are particularly vulnerable to STDs including HIV infection, unwanted pregnancy (UNAIDS, 2006; Getnet, et al., 2002) and unsafe abortion (WHO, 1999). Most endangered are teenagers who started sexual activity early, who have multiple sex partners, who do not use contraceptives, and who have inadequate information about sex (Papalia, Olds, & Feldman, 2001).

According to Ethiopian HIV/AIDS Behavioral Surveillance Survey conducted by Getnet, et al. (2002), amongst all youth, 17.4% reported having had risky sex with a commercial sex worker or non-commercial partner in the previous months of that study. Male youth were engaged more in risk sex behavior than female youth (19.4% of males and 16.1% of females).

Moreover, in its report, HAPCO (2006) identified major risk sexual behaviors that most Ethiopian young people are experiencing nation wide. These include, premarital early sex, having had frequent sexual activity with different non-marital or non-cohabiting partners and inconsistent use of condom.

Investigations in different parts of Ethiopia found out that significant number of both in-school youth and out-of-school youth of age 15-19 had experienced sexual intercourse before and at 15 years of age, had multiple sex partners and unprotected sex. A study conducted by Shabir, Habteab, and Kahsu (1997) among high school students in rural town, north western Ethiopia, indicates that, 31.9% of the students were sexually active and 9.3% had sex with commercial sex workers. The total number of sex partners they had on average was two, and only 45.9% had used condoms.

Another cross-sectional survey by Nigussie (1998) on sexual activity of out-of-school youth in southern Ethiopia, Awasa, showed that 49% of the

respondents (mean age 17 years) had started sex before the study date. Of those, only 27.6% used condom and 36% had had more than one sex partner.

According to the results of Getnet, et al. (2002), level of sexual activity amongst the youth was increasing. Due to the combination use of drugs (*"Chat and "Shisha"*) and alcohol, adolescents were found to be engaged in an unprotected sex. Greater proportion of those youth reported that they had more than one sexual partner.

Moreover, overall contraceptive use prevalence in Ethiopia is still low (WHO, 1999; CSA, 2005). Young adolescents who enter into sexual relationship for the first time are less likely to use condoms and any other forms of contraception which in turn lead them to unintended pregnancy, infections of HIV/AIDS or other STDs and of other negative social and psychological outcomes (O'Donnell, O'Donnell, & Stueve, 2001; Moore & Miller, 1990). Having sexual relationship with more than one sex partner and unprotected sex is, therefore, the most risk behavior that exposes adolescents to serious and fatal reproductive health problems.

Given the significant figure of adolescent population in Ethiopia found at higher risk, especially of contracting HIV/AIDS and other STDs, it is crucial that a lot has to be done to ensure that they could be able to protect

themselves. This involves providing them with access to information and resources, as well as promoting a climate to understand young people's sexual and reproductive health. Concept of reproductive health according to WHO (1999), implies that people could be able to have a satisfying and safe sex life, the right of access to appropriate health care service, information and support.

Special attention should be given to the discussion and provision of information on adolescents' sexuality since their cognitive and emotional development often lags behind their biological development (Moore & Miller, 1990). That is, teens who look matured physically for sexual and reproductive activities may lack the cognitive skills necessary to choose a responsible sexual behavior and understand its long-term consequences.

The source of this information and support for adolescents' sexual and reproductive health could be many. However, different studies pointed out that parents are primary and effective sex educators for their children (Meschke, Bartholomae, & Zentall, 2000).

Parents are in a unique and powerful position to shape attitudes and behaviors of young people and to socialize them to become sexually healthy adults (Miller, Forehand, & Kotchick, 1999). They can do this, as Miller,

Forehand, and Kotchick (1999) noted, by providing accurate information about sex and its risks, consequences and responsibilities.

The role of parents' open and positive communication with their teenage sons and daughters about HIV and other sex-related matters in reducing risks of adolescents' sexual behaviors is also strongly supported by different researches. For example, Fox (1981), (cited in Hutchinson & Cooney, 1998), reported that parent-child sexual communications were associated with lower rates of sexual risk behaviors among adolescents.

Adolescents who discussed about HIV with their parents were significantly less likely to have had unprotected sexual intercourse, less likely to have multiple sex partners (Holtzman & Rubinson, 1995). Similarly, higher levels of condom use self-efficacy, greater sexual communication with partner, and asking sex partner about STDs and previous sex history are found to be significantly attributed to parent-teen sexual communication (Hutchinson & Cooney, 1998).

Moreover, Blake, Simkin, Ledsky, Perkins, and Calabrese (2001) stated that children whose parents talk with them about sexual matters or provide sexuality education or contraceptive information at home are more likely than others to postpone sexual activity. And in effect, when these adolescents become sexually active, they would have fewer sexual partners

and more likely to use contraceptives and condoms than young people who do not discuss sexual matters with their parents and, therefore, are at reduced risk for pregnancy, HIV and other STDs.

In line with this, sexual socialization theory suggests that adolescents who talk with their parents about sexual issues will be able to form judgments about their sexual behaviors (Rodgers, 1999). Hence, they are likely to know parental expectations regarding sexual responsibility as well as specific ways to minimize sexual risk, such as, use of contraceptives, reducing number of sex partners, delaying sex, resisting partners' pressure to have unsafe and early sex.

Parent-teenager communication promotes teenagers' healthy sexuality and reduces their risk-taking behaviors only if parents are skilled, comfortable, and open in discussions about sexuality and risks related to sexual behavior (Whitaker, Miller, May, & Levin, 1999). Likewise, the positive effects of parent-child communications, as Blake et al. (2001) discussed, appear to depend on the frequency and specificity of the communications, the quality and nature of exchange, parental knowledge, beliefs and comfort with the subject matter. It is also important to take into consideration contents and timing of communications. That is, whether they take place before the young person initiates sexual activity. In other words, sexuality education by parents should begin early as part of a life long process of

acquiring information and forming attitudes, beliefs, and values, rather than just only the "talk".

Accordingly, comprehensive discussion topics include sexual decision making, menstruation, reproduction, physical/sexual development, when to start having sex, birth control, consistent and effective use of condoms and other contraceptives, choosing sexual partners, postponing sex, HIV/AIDS and other STDs (CDC, 1998).

Moreover, CDC (1998) listed some characteristics related to parental skills and sensitivity during discussing about sexuality issues with adolescents. This may include having accurate information about the topics, talking openly and freely rather than lecturing or threatening or warning, welcoming questions from adolescents, and listening to the adolescents' concerns and feelings about the topics.

However, parents of both sexes (fathers and mothers) might not be equally active or good at communicating sexual matters with their children. There are some differences among them as to how they approach to girls and boys. Sometimes, some findings conveyed mothers discuss more with daughters, and fathers with sons (Miller, Kotchick, Dorsey, Forehand, & Ham, 1998); sometimes both boys and girls discuss more with mothers than fathers (Rodgers, 1999).

Having discussed all these facts however, in our country, Ethiopia, recent HIV/AIDS and other STDs, and youth reproductive health problems prevention programs rely more on mass media campaign, written or documented warnings of the risks of these pandemics and promoting condom use. Most of the youth in the country are having got information on STDs including HIV/AIDS and other sexual matters from their friends whom, in fact, might be uninformed or wrongly informed (Nigussie, Rahel, Selamu, Alemayehu, & Kedir, 1999). In the studies conducted on the knowledge and awareness of the youth about these sexual and reproductive health problems, parents' involvement has not been given due attention even both by the youth themselves and by the HIV/AIDS prevention and controlling agencies.

In the studies of the area, young people of reproductive age (15-24) are found to be sexually active and have been engaged in risk sexual behaviors (Getnet, et. al, 2002; Nigussie, et. al, 1999; Shabir, Habteab, & Kahsu, 1997). The cumulative prevalence of consistent and effective use of condoms and other contraceptives, having had limited sexual partners is very low (CSA, 2005; WHO, 1999).

Talking about sexual matters in Ethiopian culture has long been seen as taboo and shameful, especially discussion between children and their parents. The cultural taboo and secrecy nature of sexuality seriously

affected open discussions with people and educating boys and girls about adolescent physical/ sexual development and subsequent risks of unsafe sex. That is why many teenagers are becoming vulnerable to reproductive health problems like too early or unintended pregnancy and unsafe abortion, contracting HIV/AIDS and other STDs.

In sum, what makes worth conducting this research is, therefore, the inadequate attention given to parents despite that they are in a powerful position to reduce risk sexual behaviors and to promote sexual and reproductive health among adolescents; high prevalence of the HIV/AIDS epidemic among the youth; low prevalence of contraceptive use including condoms; adolescents' incomplete understanding of comprehensive reproductive health, unsafe sex and its long-term effect.

1.2 Statement of the Problem

In Ethiopia, the new generation entering to the youth population is becoming greater. With this increasing number, they are found to be at a higher risk for HIV infection and other sexual and reproductive health problems. According to Zubeida (1992), premarital sexual activity, though a recent phenomena in Ethiopia, is believed to be on the rise and, an increasing number of adolescents particularly in urban areas are sexually active before marriage. Despite widespread knowledge of contraception, Zubeida (1992) added, unprotected sex is high among these adolescents.

Communicating or discussing all their sexual developments and related issues with their parents has not been practiced due to cultural barriers. Parents and adults, on the other hand, might be unsure of the best way of handling and unprepared to discuss sexuality with children and adolescents. They might, or else, feel uncomfortable that they disapprove youngsters who express interests in sexuality.

Given these trends, therefore, it is time to conduct a research to examine the sexual and reproductive health problems of adolescents. In line with this intention, Rodgers (1999) asserts that, rather than continuing to examine factors associated to sexual initiation or why adolescents become sexually active, it is important to shift the question to more constructive way how they become at a safer (healthy) sexual behavior. In pursuing this, the present study is intended to address parent-child communication role in reducing adolescents' sexual risk-taking behaviors. To this end, the following research questions were formulated to be answered by the study.

1. What is the situation of parent-child communication regarding sexuality?
2. Is there any significant gender difference among parents and adolescents in communication about sexual issues?
3. Is there any association between parental education and parent-child communication about sexual issues?
4. Is there any association between drug/alcohol use and sexual behavior of adolescents?

5. Is there any association between parent-child communication about sexuality and adolescents' sexual behavior?
6. Does parent-child communication have significant role in promoting healthy sexual behavior among adolescents?

1.3 Objectives of the Study

The main objective of the present study is to investigate whether parental communication with their teenage children and socializing them sexually has significant role on promoting adolescents' reproductive health and reducing HIV-related sexual risk behaviors. The study specifically is targeted to:

1. examine how often parents communicate with their children about sexuality, reproductive health and associated risk behaviors before the onset of sexual activity.
2. find out whether these communications about sexuality could be associated to adolescents' sexual behaviors.
3. detect as to how these communications contribute to the promotion of healthy adolescent sexuality and how they are used as intervention for the reduction of HIV and other sexual related problems.
4. inform responsible bodies to design programs that facilitate open communication between parents and their children in such a way to minimize adolescent risk-taking sexual behavior.

1.4 Significance of the Study

In the study of human life-span development, adolescence is a period when drastic biological (physical), mental and socio-emotional changes occur on the subjects whom they have not yet been ready for, such as menarche, heterosexual desires, etc. They might, therefore, be driven biologically to get involved in early sexual risk activities.

Hence, these young uninformed people should get information about the biological and psychosocial reality of sexuality and its risks in an open manner. This discussion would be productive if adolescents do it with someone closer and significant to them in line with the developmental needs of the stage they are found in. For this, the family, parents in particular, should be recognized as a potentially important institution for the prevention programs in the reduction of sexual risks among young people.

This study will, therefore, be supposed to have the following contributions.

1. It will bring the role of parent-child communication to the floor in the promotion of healthy adolescent sexuality and risk prevention programs.
2. It will give insights about and inform some opportunities as well as ways for parents to be assisted in examining their own values, knowledge and communication skills that enable them to promote adolescents' individual responsibility for protecting their own

sexual and reproductive health.

3. The study will open tracks for further research on the area and on related topics that are not addressed by the present study.

1.5 Delimitation of the Study

The scope of this study was limited to the investigation of the association of parent-child communication with adolescents' sexual behavior and its implication to the sexual and reproductive health of adolescents. The study encompassed only the investigation of the issue among secondary school students of Awasa, regional city of Southern Nations, Nationalities and Peoples. It would have been very generalizeable, however, had it been a comprehensive study including participants from all or different parts of the nations of the country.

The analysis was also limited to reports of adolescents of age 15-19, and did not include reports from parents. Basically, what is assumed to be important is what adolescents think and perceive about the quality of communication they have with their parents and its effect on their own sexual behavior, though the importance of having information from parents too was unquestionable.

1.6 Operational Definition of Terms

1. Parent-Child Sexual Communication:

A process by which adolescents gain information and develop attitudes and values through interpersonal interaction with parents (father and mother) about human sexuality, condom use and other birth control methods, sexually transmitted diseases (STDs), proper dating, safer sex to prevent HIV infection, how to resist partners' pressure to have unprotected and early sex.

2. Sexual Risk Behaviors:

Sexual behaviors such as unprotected sexual relations, premarital (early) sex, and having sex with multiple sex partners which are likely to expose adolescents to unintended pregnancy, HIV/AIDS and other STDs. Ideally, the most responsible behavior of a sexually active adolescent would include the consistent use of condoms and other contraceptives with a one-to-one committed relationship.

3. Adolescent Reproductive Health:

A health condition in which adolescents are found to manage their sex life by protecting themselves from unwanted and unplanned pregnancy, unsafe abortion, as well as STDs including HIV/AIDS.

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CHAPTER TWO

LITERATURE REVIEW

2.1. Adolescence: Definition and its Concepts

Though adolescence has different connotations by different psychologists, most agree that it is a period of transition from childhood years to adulthood years. As it is generally used today, adolescence refers to the period of life between childhood and adulthood – roughly corresponding to the teenage years (Kimmel & Wiener, 1995). Steinberg (1993) defines it as a time of growing up, of moving from the immaturity of childhood to the maturity of adulthood.

Both Kimmel and Wiener (1995) and Steinberg (1993) agreed that adolescence is a period of transition. It is a time when individuals become biologically interested in sex and capable of having children; psychologically, they become wiser, more sophisticated and better able to make their own decisions; socially, they are permitted to work, to get married; financially, they are expected to support themselves (Steinberg, 1993).

These transitions, though positive and successful to some adolescents, due to the rapid biological, psychological and social changes put a complex menu of life situations on too large group of adolescents (Santrock, 2002).

Social scientists who study adolescence usually classified it in to three periods. These are:

1. Early adolescence (approximately 11-15 years of age)
2. Middle adolescence (approximately 15-18 years of age)
3. Late adolescence (sometimes known as youth) covers 18-21 years of age (Steinberg, 1993). These periods of classification correspond to the way young people are grouped in to educational institutions: junior high school, high school, and college years, respectively

2.2. Sexuality in Adolescence

Adolescence is a time of exploration and experimentation of sexual fantasies and sexual realities (Santrock, 2002). Though not an entirely new issue that surfaces for the first time during adolescence, sexuality is one of the major aspects of psychosocial development (Steinberg, 1993). This means, sexual activity and sexual development occur in childhood years and continue after adolescence. According to Steinberg (1993), however, if not the most important time in the life cycle, adolescence is a fundamentally important time for the development of sexuality. This is in part because there is a link between adolescent sexuality and puberty. There is an increase in the sex drive in early adolescence as a result of hormonal changes (Udry, 1978, cited in Kimmel & Wiener, 1995). Moreover, Steinberg (1993) added, it is not until puberty that individuals become capable of sexual reproduction.

2.2.1. Adolescent Risk Sexual Behaviors

According to Steinberg (1993), adolescence is an exciting time of life that individuals become interested in sex and capable of having children. However, it is perceived on the other hand as a period of vulnerability and stress (Kimmel & Weiner, 1995). This might be attributed to the fact that in this period, though an individual's immaturity of childhood is being left behind, the challenges and potentials of adulthood have not yet been completed.

Human sexuality reflects the influences of hormones, cognitive development, social learning, one's culture, the peer group and the family (Kimmel & Weiner, 1995). An adolescent's level of cognitive development, for example, may inhibit planning for the possibility of intercourse. That is, as Kimmel and Weiner noted, adolescent egocentrism can interfere with contraception because the imaginary audience is watching, and the personal fable implies that bad things like unintended pregnancy will not happen to oneself.

Most adolescents have sexual relations. Research results in the United States (Kimmel & Weiner, 1995) and in Ethiopia (Getnet, et al., 2002) indicated that majority of male and female age 15-19 years had experienced heterosexual intercourse at least once. The risk of HIV infection and unintended pregnancy is associated with sexual intercourse, and therefore

sexually active adolescents are at the forefront of the battle of AIDS (Steinberg, 1993). In other words, this implies that though sexuality is normal aspect of adolescent development (Santrock, 2002), there are risks associated with sexual behavior of adolescents that lead them to reproductive health problems. The major sexual risk behaviors are discussed below.

1. *Unsafe or Unprotected Sex*

It is sexual irresponsible behavior exercised by an individual with the inconsistent and ineffective use of condoms and other contraceptives. Sexual activity, though a normal life phenomenon, involves considerable risks if appropriate safeguards are not taken (Santrock, 2002). A research finding (cited in Santrock, 2002) noted that a sexually active adolescent who does not use contraceptive has a 90 percent chance of pregnancy. According to Kimmel and Weiner (1995), use of condom is not only a form of contraception but also a means of preventing infection with HIV/AIDS and other STDs. In short, proper and consistent use of condom (and other contraceptives) prevents from contacting STDs and from getting unintended pregnancy.

2. *Having Multiple Sex Partners*

Compared to other age groups, teens are more likely to have multiple sex partners, engage in unprotected sex and choose higher risk sex partner

(CDC, 1998; Getnet, et al., 2002). One may have all the sex one desires in a mutually exclusive (monogamous) relationship without increasing the risk of disease. However, if one's exclusive partner has other partners, each of whom may have also different sexual partners, then the risk of HIV/AIDS and other STDs increases greatly (Kimmel & Weiner, 1995). Kimmel and Weiner (1995) strongly noted that the more sexual partners one has, the greater the risk of STDs (including HIV/AIDS). Jones (1996) (cited in Santrock, 2002) also stated that the risk of AIDS might be increasing among heterosexual individuals who have multiple sex partners.

3. *Early Premarital Sex*

Another sexual behavior of adolescents is their engagement in sex in their earlier ages. Premarital coitus and pregnancy have long been recognized as sexual risks being unwanted and undesirable outcomes of premarital sexual activity among adolescents and young adults

While most adolescents become sexually active at some point during adolescence, some of them engage in sex at early ages (before 16) and experience a number of partners over time (Santrock, 2002). These adolescents are the least effective users of contraceptives and are at risk for early unintended pregnancy and for STDs. Moreover, according to O'Donnell, O'Donnell, and Stueve (2001), early initiation of sexual intercourse places younger adolescents, particularly females, at an elevated

risk of being involved in unintended pregnancy, of acquiring HIV or other STDs. In sum, early sexual activity makes a young adolescent susceptible to less and inconsistent use of condoms and other contraceptives which in turn lead them to total reproductive health problems (Santrock, 2002).

2.2.2. Sexual and Reproductive Health Problems

The consequences of high risk sexual behaviors undoubtedly are negative and life long (Rodgers, 1999). Adolescents who unknowingly are getting in to risk sexual behaviors face sexual and reproductive health problems- contracting sexually transmitted diseases (including HIV/AIDS) and adolescent pregnancy. These problems range from the milder STDs and giving unintended birth to a child, to fatal health problems of HIV/AIDS infection and unsafe abortion.

1. Sexually Transmitted Diseases

Sexual relations usually involve considerable intimate contact with another person. Thus, a variety of diseases may be passed from an infected person, who may or may not have symptoms of the disease, to his/her sex partner. These diseases are known as STDs – which are caused by bacteria, viruses, and other organisms that one may be exposed to during sexual contact (Kimmel & Weiner, 1995).

According to Steinberg (1993), adolescents usually contract an STD before graduating from high school. The most common STDs experienced by adolescents are gonorrhea (caused by a bacteria), chlamydia (caused by a parasite), and herpes (caused by a virus). Steinberg (1993) further stated that because of risk factors like having unprotected sex, having many sexual partners and use of drugs, which are more common among young people, the risk of HIV infection among adolescents is substantial. HIV/AIDS is thus a seriously devastating pandemic that today's adolescents are coming of age (Kimmel & Weiner, 1995).

2. *Unintended Pregnancy*

Among the adolescents' sexual and reproductive health problems, unintended and premarital adolescent pregnancy is the one that needs great attention. According to Santrock (2002), it creates health risks for the offspring and the mother. Infants born to adolescent mothers under the age of 18 are more likely to have low birth weights – a prominent factor in infant mortality – than children of mothers over the age of 18 (Kimmel & Weiner, 1995). However, all pregnancies do not end in child bearing. According to Kimmel and Weiner (1995), accidental conception during the teen years also often results in unsafe abortion which leads them to fatal health problems.

Because of the physical and hormonal changes as well as cognitive characteristics of adolescents, young people become sensitive to sexual

problems. From adolescents' cognitive perspective, for example, Steinberg (1993) noted the following.

> *The limited ability of young adolescents to engage in long-term, hypothetical thinking, and their occasionally egocentric tendency to believe that they are immuned from the forces that affect others, may impede their consideration of pregnancy as a likely outcome of sexual activity (P.374).*

2.2.3. Factors Associated with Adolescents' Sexual Risk Behaviors

Sexual risk taking behaviors among adolescents have been discussed so far as having multiple sex partners, inconsistent and ineffective use of condoms and other contraceptives, and engaging in early premarital sexual activity. These behaviors are more likely to occur in adolescents due to several factors including both developmental (age–related) and environmental or social factors.

1. Developmental (age-related) Factors

Problem factors attributed to adolescent development are their biological and psychological developments. There is substantial evidence, as Moore and Miller (1990) noted, that precocious pubertal development is associated with early initiation of sexual activity. This is because, according to Kimmel and Weiner (1995), sex feelings increase in intensity after puberty, reflecting the greater amount of sex hormones circulating in the body for both females

and males. Steinberg (1993) added on the sexual maturation of adolescents that younger boys who were more matured biologically were more likely to be sexually active than older ones whose hormone levels were lower.

Besides the physical and hormonal changes related to adolescence period, young people's psychological feature tends to have strong influence on their sexual behaviors. Adolescents seem to have a feeling of invulnerability (Moore & Miller, 1990), and their egocentric tendency to believe that they are more immuned not to be affected by sexually transmitted infections and pregnancy (Steinberg, 1993) makes them more prone to risk taking behaviors.

2. Environmental or Social Factors

Adolescent sexual involvement and pregnancy are also related to other social factors like family antecedents, peer influence, and drug and alcohol use. Regarding this, Steinberg (1993) stated: "It does seem to be the case that early sexual activity is associated with being from a lower socioeconomic class and with a more general attitude and behavioral profile that includes involvement with drugs and alcohol...which are likely to lead to earlier sexual activity" (P. 367).

Family Antecedents: With regard to family economic background, Moore and Miller (1990) indicated that living in poverty is associated with both

early sexual activity and early pregnancy. This is to say that as socioeconomic status decreases, rates of sexual activity and early pregnancy rises perhaps with the perceived lack of options and desirable alternative for the future.

Peer Pressure: Peer influence on the one hand can affect many behaviors of teenagers, including drug abuse, sexuality, delinquency and others (Moore & Miller, 1990). Research results supported the notion that adolescents are more likely to be influenced by the peer group value to have sexual intercourse when their peers are sexually active (Holtzman & Rubinson, 1995; Steinberg, 1993). High peer involvement tends to work against and sometimes overrides the effect of parental involvement (Moore & Miller, 1990). Moreover, Holtzman and Rubinson (1995) concluded in their study that adolescents' communication with peers tends to increase the likelihood that they will engage in risky sexual behaviors as opposed to the effect of parent–adolescent communication.

Drug and Alcohol Use: Use of drugs and alcohol is another contributing factor which is related to risk of HIV infection, because responsible decisions are more likely to be made when one is not drunk (Kimmel & Weiner, 1995). In other words, drugs and alcohol have inherent potential to initiate (provoke) the youth to practice unprotected sex. In the research conducted by Getnet, et al. (2002) nationwide in Ethiopia, it has been

reported that after taking drugs or alcohol, the youth specially males were often 'out of their minds' that they might not be able to remember to use condoms during sexual intercourses. The research further indicated that drugs were said to prompt males to visit female sex workers and predisposed them to have sex with out condom.

2.3. Parent–Child Communications about Sex–Related Matters

Adolescents' overall health and optimum development can be shaped by many factors, of which communicating with them about sexuality and sexual development is one. In the studies made on adolescent sexuality, it has been reported that today's adolescents are engaged in behaviors which are considered risky or unsafe that may expose them to HIV, other STDs or may result in unintended pregnancy (Hughes & McCauley, 1998; Miller, Forehand, & Kotchick, 1999).

To alleviate this sexual problem, young people need expanded information, skills, and services concerning sexual and reproductive health despite their near universal adult discomfort with the subject (Hughes & McCauley, 1998). One factor that consistently plays an important role in the sexual socialization of young people is the family context (Miller, Forehand, & Kotchick, 1999).

According to Miller, Forehand, and Kotchick (1999), familial influences can be categorized as *family structure variables* and *family process variables.* Family structure variables (such as single parenting or absence of father, educational attainment of parents and low socioeconomic status of parents), though cannot be ignored, are not as such important in understanding adolescent sexual behavior and in practical efforts to change risky adolescent sexual behaviors. This is because the variables are static and are not immediately susceptible to change through intervention.

Family process variables, as Miller, Forehand, and Kotchick (1999) discussed, on the other hand, include monitoring children's activities and communication (both parent–child general communications and communication about sex) which are important in affecting behavior.

Considerable research has addressed whether parents communication with their children about sex actually impacts adolescent sexual activity. Most of this research has been correlational in nature. Some early studies tended to find no significant association between parent-child communication and sexual behavior, whereas more recent studies have observed such links. The general finding in more recent studies has indicated that higher levels of parent child communication are associated with reduced sexual risk taking on the part of the adolescent. For example, adolescents who describe their parents as attentive and supportive communicators report less sexual

activity during their junior high school and high school years (Rodgers, 1999; Hutchinson & Cooney, 1998). Other research findings cited in Miller, Forehand, and Kotchick (1999) showed that parent–adolescent communication about sexual behavior and HIV/AIDS has been found to facilitate young people's knowledge about sex and their subsequent reduction in risk.

Despite this fact, on the other hand, Newcomer and Udry (1985) have come up with contradicting result which states that neither parental attitudes toward premarital sex nor parent–child communication about sex and contraception appear to affect teenagers' subsequent sexual and contraceptive behavior. Other small groups of studies found that higher levels of communication are associated with higher levels of adolescent sexual activity (Darling & Hicks, 1982; Widner, 1997; cited in Jaccard, 2006). These findings explained that such discussions encourage subsequent adolescent sexual risk taking anticipating sexual activity on the part of the child.

2.3.1. Framework and Nature of the Communication

Regardless of the controversial results reported in several studies, parents with open, supportive and skilful approach have been found to be the primary sex educators for their sons and daughters (Rodgers, 1999;

Whitaker, et, al., 1999). In order for this communication to be effective, there are certain components and conditions to be considered.

2.3.1.1. Components of Communication

Jaccard (2006) distinguished five core components of communication. These are:

1. the source of communication (the parent)
2. the message or the content
3. the medium or channel through which the message is transmitted
4. the recipient of the message (the child), and
5. the context in which the communication occurs

According to Jaccard (2006), the variations in these five components affect how adolescents respond to the parental communications. Thus, the nature of the communication and impact of a parental message on adolescents' sexual risk taking may vary as a function of characteristics of the parent, of the message that the parent conveys, of the channel through which the message is delivered, of the adolescent, and of the context in which the communication occurs.

Source of Communication: Studies of the effects of parental variables have focused most often on how the gender, expertise (education), and trustworthiness of parent affect communication. Regarding gender of

parents, studies have revealed that mothers are more likely than fathers to talk about sexuality and birth control with their children (e.g., Rodgers, 1999). Feldman and Rosenthal (2000) (cited in Jaccard, 2006) reported that adolescent evaluations of their parents as sex educators tend to vary as a function of the gender of the parent, with mother being evaluated more positively than fathers.

Other important dimensions of parent variables in parent-child sexual communication are perceived expertise, and perceived trustworthiness of the parent. Expertise refers to knowledge, expert status, and familiarity with the topic, whereas trustworthiness refers to sincerity, honesty, and good intentions or attitude (Jaccard, 2006). This writer further noted that adolescents tend to see parents as being out of touch with current adolescent life styles and pressures, for they lack up-to-date knowledge about adolescent sexual behavior. Moreover, Whitaker, et al. (1999) claimed that when parents are knowledgeable about the issue a bit better than their children, there will be a more likelihood for adolescents to be responsible in their sexual behavior.

Message of Communication: The message refers to the content that parents and adolescents talk when they engage in conversations about sex (Jaccard, 2006). Focuses of such discussions tend to differ depending on the relative importance of the issue. For example, some studies suggest that

parent-child discussions about sex should emphasize on physical development and maturation as well as the dangers associated with STDs and the occurrence of unintended pregnancy (Miller, et al., 1998; Whitaker, et al., 1999). Other studies have found that discussions should address sensitive topics such as premarital sex, abstinence or delay of sexual activity, and the right time to have sex (Getnet, et al., 2002). On the other hand, Hutchinson and Cooney (1998); Kimmel & Weiner (1995) emphasized on topics such as ways of transmission and long term effect of HIV/AIDS and other STDs; effective and consistent use of condoms and other contraceptives as a means of protection from the infection; about selecting a mate (girlfriend or boyfriend); age-related sexual characteristics (for example, menstruation); risks of having multiple sex partners and unsafe sex in contracting HIV, other STDs and unintended pregnancy.

Channel of Communication: Channel refers to the medium used to convey a message and how this affects message exposure, attention, comprehension, acceptance, retention and retrieval (e.g., face-to-face, written materials, recorded messages). Most of the time, parents use verbal communication through face-to-face interaction when they discuss about sex-related matters (Jaccard, 2006).

Recipient of Communication: Recipient variables focus on characteristics of the child or adolescent which influence the communication. Among the

most extensively studied recipient characteristic in research on parent-child sexual communication is the gender of the child. Although there are exceptions, discussions about sex are more frequent and extensive with daughters as compared to sons. Moreover, daughters tend to evaluate mothers more positively as sex educators than do sons. Sons and daughters, however, have been found to have comparable evaluations of fathers (Feldman & Rosenthal, 2000; cited in Jaccard, 2006).

Another variable attached to the recipient in parent-adolescent communication is the developmental status of the adolescent (i.e., early adolescence, middle adolescence, and late adolescence). Analyses of adolescent development typically focus on three broad areas: physical development, cognitive development, and socio-emotional development (Santrock, 2002). Adolescents' experiences in each of these domains differ for early, middle, and late adolescence. For example, during early adolescence, most adolescents undergo their most dramatic physical changes during the adolescent growth spurt. Most of these changes have transpired by late adolescence. The physical changes during early adolescence often are accompanied by heightened sensitivity to physical appearance which, in turn, influences the kinds of information and arguments that an adolescent is receptive to (Jaccard, 2006). With respect to cognitive development, early adolescents tend to exhibit more concrete thinking. They have difficulty thinking abstractly. This is less true for older

adolescents. Memory processes are still developing in adolescence, with older adolescents exhibiting more efficient strategies for storing and retrieving information from memory than early adolescents. Socially, early adolescents are less prone to see things from other people's point of view and tend to have difficulty imagining different perspectives for solving social problems (Papalia, Olds, & Feldman, 2001).

Context of Communication Variables: Contexts in communication includes family structure (one versus two parent families, blended families, presence of grandparents or other relatives in the household), social class, marital status, presence of siblings, and psychosocial characterizations of the family (Jaccard, 2006).

2.3.1.2. Points to be Considered by Parents during Communication

Initiating conversations about sexuality might be difficult for some parents because they did not grow up in an environment where the issue was discussed. Some parents may be afraid for they do not know the appropriate response or feel confused about the proper topics to be discussed. Hence, to help these parents, Advocates for Youth (2004) recommended the following points to be considered. Parents should:

1. encourage communication by reassuring kids that they can talk to them about anything.

2. take advantage of teachable moments. For example, a friend's pregnancy, news article, or a TV show can help start a conversation.
3. listen more than they talk. It is good for them to think about what they are being asked.
4. not jump to conclusions. The fact that a teen asks about sex does not mean that he/she is having or thinking about having sex.
5. answer questions simply and directly. They have to give factual, honest, short, and simple answers.

In addition to the advises provided by the Advocates for Youth (2004), the United States National Campaign to Prevent Teen Pregnancy (NCPTP) (1997) has developed 10 tips to help parents communicate with their children about sex and presented them as follows. Parents should:

1. be clear about their own sexual values before they talk to their children about sex.
2. talk to their children early and often about sex.
3. be sure to have a two-way discussion and not a lecture.
4. supervise and monitor their children.
5. know their children's friends and their families.
6. discourage early, frequent, and steady dating in favor of group activities.

7. discourage dating where the age difference is large, especially for young girls.
8. know what programs their children are watching on television, listening to on the radio, and what they are reading.
9. let their children know that they value education.
10. let their children know that they value (adore) them.

Most researchers agree that communication between parents and children should begin early so that it can evolve comfortably as the child matures (NCPTP, 1997). Moreover, communication about sex is most effective when it is continuous. Having a single talk about sex suggests that sexuality is not a fundamental part of life and talking about it is uncomfortable, inappropriate, or forbidden (Raboni, 2006).

2.3.2. Barriers of Communication between Parents and Children

One of the important issues in parent-child communication is determining why parents fail to engage in meaningful discussions with children. For a variety of reasons, parents are not comfortable talking about sexuality with their children. Other adults including teachers, religious leaders, even doctors and health professionals may not be comfortable in discussing sexuality with adolescents neither do adolescents (Kimmel & Weiner, 1995). Some of these barriers are discussed below.

1. Parents' Attitudes and Values

Several studies have noted complaints by adolescents that their parents are not sufficiently open, supportive, trusty, and empathic, nor do parents sufficiently respect adolescents' privacy (Neer & Warren, 1988; Nolin & Peterson, 1992; Warren, 1995; cited in Jaccard, 2006). Parents and other adults' attitudes and behaviors concerning adolescent sexuality are often the greatest barriers to have sexual communication with young people (Hughes & McCauley, 1998). For example, some parents worry that acknowledging teen's sexual feelings or giving them "too much" information about sex "too soon" will encourage them to become sexually active (Raboni, 2006).

2. Lack of Knowledge/Skills on the Part of Parents

A number of studies have shown that parental sexual communication is completely insufficient due to their lack of knowledge about sexual issues (Hurrelmann & Engel, 1989). A study conducted by Nigussie, et al., (1999) in a rural town of Ethiopia indicated that parents had a partial knowledge regarding adolescent sexual maturation and behavior or complication of teenage pregnancy. Adolescents sometimes feel that their parents do not treat them as equals and that parents fail to have adequate knowledge about current life styles and peer pressures (Jaccard, 2006). In other words, when parents' knowledge regarding adolescent sexuality and development does not fit to the current needs and status of the teenagers, there may

appear a generation gap (in communication with different morals and social outlooks) that would negatively affect communication (Stodghill, 2000; Conger, 1991).

In developing countries, specially in rural areas, parents often are less educated than their children and worry that they lack the knowledge to talk with them about sex (Nsamenang, 2002). For example, In Kenya, as Nsamenang observed, many parents know little about HIV/AIDS and worry that they do not have the information to give their children. Similar findings were reported in some parts of Ethiopia that most parents were not knowledgeable about the existing HIV/ADIS pandemic, its nature, protection and exact transmission as compared to their children (Nigussie, 1998; Getnet, et al., 2002). Hence, young people could not trust the information they might obtain from their parents and they might no more seek such incomplete information.

3. Cultural Influences

Communication is mainly hindered because of the cultural taboo and secrecy surrounding sexuality. In many cultures parents traditionally do not discuss about sexuality with their children. For instance, Rivers and Aggeleton (1999) found out that in conservative families of the United States, having too much knowledge about sex is a sign of easy virtue, whereas ignorance of sexual matters is often viewed as a sign of purity and

innocence. Nsamenang (2002) reported situations of communication in different cultures in Africa. For example, in South Africa, adolescent women are afraid of talking to their parents about sex. In Zimbabwe, young people's communication with parents about sex was often one-sided, with the parents mainly warning about the dangers of sex. In Ethiopia, there is no adequate literature that explores how the different cultural settings affect sexual communication. A research conducted by Nigussie, et al. (1999) indicated only the embarrassment of cultural taboo on parent-child sexual communication.

From experience, however, the researcher of the present study could learn that in most societies of the country, social sanctions put on sexuality strictly forbid open discussions between parents and children in the family, and even among adults. This is mainly because discussing explicitly on sexuality is considered to be sinful or awkwardness or indicating someone's extreme sex-oriented feelings. Premarital sexual activity and having multiple sex partners are usually disapproved by the parents and the society at large simply for the reasons mentioned than their negative consequences on adolescents' reproductive health.

2.4. Theoretical Approaches on Parent-Child Communication

The role of parents in bringing healthy adolescent sexual behavior through communication could be explained by different theoretical perspectives. For the purpose of this study, Ecological and Socialization approaches are considered to explain parent-child sexual communication in shaping sexual behavior of adolescents.

2.4.1. Ecological Approach

Ecological theory, the Bronfenbruener's approach, describes the influence of multiple interlocking contextual systems (the micro-, meso-, exo-, macro-, and chrono-systems) on a person's behavior and the reciprocal reactions of the person. Among these contextual systems, a micro system is a pattern of activities, roles, and relationships within a setting, such as the home, peer group, school or neighborhood in which a person functions on a first hand, day-to-day basis (Papalia, Olds, & Feldman, 2001).

The ecological approach emphasizes that the most proximal influences, such as family and peers, may have the greatest effects on developmental outcomes (Henrich, Brookmeyer, Shrier, & Shahar, 2006). This study, espousing a micro system of an ecological approach, investigates the role of supportive relationships with parents as a potential protective factor against adolescent sexual risk behavior. According to Henrich, et al., (2006),

parent-child communication in the family represents interacting social system related to adolescents' sexual risk.

2.4.2. Socialization Approach

Socialization, in its broad sense, is defined as the process by which children develop habits, skills, and motives that make them responsible and productive members of the society (Papalia, Olds, & Feldman, 2001). Among the many activities involving in the socialization process, sexual socialization is one. In specific terms, children can be socialized sexually to be responsible in their sexual behavior.

Sexual socialization is thus one area in which children gain information and develop attitude about sexuality through interpersonal communication. The family is one of the earliest and the most important influences on adolescent sexual development and sexual socialization, and it plays an important role in sexual risk reduction among adolescents (Wilson & Donenberg, 2004). The socialization approach suggests that the quantity and quality of parent communication plays a crucial role in the extent that parents influence their children and bears great potential for reducing adolescent risky sexual behavior by fostering responsible sexual decision making (Rodgers, 1999).

CHAPTER THREE

METHODS

In this section, sample and sampling techniques, instruments used to collect the data, and procedures of data collection are presented. Methods of data analysis are also specified for each segment of the analysis.

3.1. Sample and Sampling Techniques

Adolescents in the age range of 15-19 years participated in the study (Mean age=16.73, SD=1.20). All were high school students in Awasa town. The research was conducted in Awasa town for two reasons. First, because of the beautiful nature of the area, many people including foreign visitors come from different areas for recreation and stay there for some time. During his stay for the last one year in Awasa for work, the researcher observed that many young people were easily attracted by different incentives of (financial gains from) these visitors for sexual activities. Second, drugs (e.g. 'Chat' and 'Shisha') and alcohol use among the youth is common in the area. For these and other reasons, adolescents engage in sexual relations with different sexual partners. They might also involve in unprotected sex.

The study had been carried out in two government high schools in the town. These schools were Tabor Secondary School and Addis Ketema Secondary School. These schools were selected using convenience sampling technique.

That is, because of the researcher's acquaintance with teachers and principals of the schools, data were collected in a relatively short period of time and without difficulty.

Profiles of students (name, sex, and roll number) in each grade were obtained from the record offices of the schools. During the time the data were collected, the total number of students from grades nine to 12 in 2006/2007 was 6,858 and 6,100 in Tabor Secondary School and Addis Ketema Secondary School, respectively. To have proportional number of male and female students from each grade level, proportionate stratified random sampling technique was employed. Students were stratified first by grade level and then by sex.

Initially, 400 students were selected from the two high schools; that is, 212 students (129 males and 83 females) from Tabor secondary school and 188 students (100 males and 88 females) from Addis Ketema secondary school. During data analysis, however, instruments completed by 35 (29 male and 6 female) students were excluded for different reasons. Some to the respondents were found to be out of the predetermined age range for the research (i.e., below age 15 or above age 19). Some others had been living with only one parent for different reasons (e.g., because of the death of the other parent, separation). Thus, the final sample included 365 (200 male and 165 female) participants. Demographic characteristics of the sample are shown in Table 1 below.

Table 1: Demographic characteristics of the participants

Variable	Level	Frequency	Percent
Sex	Male	200	54.8
	Female	165	45.2
Grade	9	156	42.7
	10	127	34.8
	11	50	13.7
	12	32	8.8
Father's Education	No Education	28	7.7
	Reading and Writing	52	14.2
	Elementary Education	99	27.1
	Secondary Education	77	21.1
	College Diploma	82	22.5
	First Degree and above	27	7.4
Mother's Education	No Education	66	18.1
	Reading and Writing	59	16.2
	Elementary Education	127	34.8
	Secondary Education	78	21.4
	College Diploma	30	8.2
	First Degree and above	5	1.4
	Total	365	100

3.2. Instruments

The main variables of this study are parent-child sexual communication and adolescent sexual behavior. Data on parent-child sexual communication were collected using a self-administered scale in which respondents rated the frequency of information they might have shared with their father and mother separately. Parents could be biological, adoptive or step-parents. The scale was adapted from Hutchinson and Cooney (1998) and Miller, et al. (1998). Six questions were taken from Hutchinson and Conney's (1998) scale, whereas three questions were from Miller, et al's (1998) scale. The remaining seven items were commonly used by both sources. Thus, a total of 16 items were used to assess the level of communication between adolescents and their parents. For each item, participants were supposed to rate the extent to which the statement was true about their sexual communication with their parents. The scale was used to ascertain the frequency with which teens had communicated with each parent about sex-related issues.

The 16 items were presented in the form of a three-point rating scale (1=Never, 2= Sometimes, and 3=Always). Two sets of the same 16 items were presented for the participants; one set was concerned with father-child communication whereas the other dealt with mother-child communication. This was done to examine father-child and mother-child communication clearly and separately.

Contents of the scale included the frequency of communication adolescents might have had with their parents about when to start having sex, about use of condoms and other contraceptives, HIV/AIDS and other STDs, menstruation, postponing or delaying sex, choosing partner or dating, risks of unprotected sex, and resisting peer or partner's pressure to have sex.

This Likert type parent-child communication scale was then pilot tested on 40 high school students. Participants filled separate scales for father- child and mother-child sexual communication. Reliability of the scales was calculated using Cronbach alpha to be 0.82 for father-child, and 0.78 for mother-child communication.

In an attempt to increase the reliability of the scales (coefficient alpha), four items that measure the same underlying construct had been added to the 16 items. The 20 item scale had a reliability coefficient of alpha=0.91 for father-child and 0.93 for mother-child communication when calculated after the administration of the scale on the main sample.

In determining the level of adolescents' sexual risk behavior, a self-administered questionnaire was employed. The questionnaire consisted of seven close-ended items. The items were adapted from the Youth Risk Behavioral Surveillance Survey (YRBSS) conducted by Centers for Disease Control and Prevention (CDC) (2005). The same participants who filled in

the parent-child sexual communication scale were asked if they had sexual intercourse, how many people they had sexual intercourse with, whether they had used condoms during sexual intercourses, and whether they had consumed alcohol or drugs before having sex. One item was included in the questionnaire to secure information about the most important source of information for the participants concerning sexuality.

To get supplementary information on both parent-child communication and adolescents' sexual behavior, a 12–item semi-structured interview was developed. The interview was conducted with five students (3 males and 2 females) in a one-to-one situation. The students were identified by their teachers on the basis of their ability to express their ideas and the rich (in-depth) information they had on the issue. The interview included items that help to examine whether participants and their parents were comfortable with discussing sexual related issues, how they evaluated the knowledge and understanding level of their parents about adolescents and their sexual behavior, and others. The researcher conducted the interviews with the selected participants.

Before administration, both the scale and the questionnaire were translated into Amharic for ease of understanding for the participants. The translation was done by the researcher and another language postgraduate student independently. After examining the two versions of translated instruments

together, minor differences in grammar and word usage were found and corrected. Items which seemed vague were made simple and easily comprehensible; words which held a sense of taboo for Ethiopian culture were made less taboo and socially accepted.

3.3. Procedures of Data Collection

After the researcher contacted the respective principals of the schools, he informed them about the purpose of the research and secured their full consent to conduct the study. The principals and vice principals assigned teachers to facilitate the data collection.

Having proportional number of male and female students in each of the selected class at hand, administration of the instruments was possible whenever the students did not have classes. Separate sheets of the parent-child sexual communication scale together with adolescents' sexual behavior questionnaire were attached and given to each participant. Respondents were closely supervised to complete every item accurately. On average, each student spent 10-15 minutes to complete the instruments.

3.4. Methods of Data Analysis

The statistical analysis of the data was performed using SPSS version 13.0 for windows after the data were coded and entered to the SPSS program. T-test was employed to see significant differences between boys and girls in

their communication with their fathers and mothers separately. Comparison was also made between fathers and mothers to see whether there was any gender difference in communicating with their children about sexuality. The difference was examined using paired sample t-test.

To examine whether parental education had any association with parent child communication, Spearman's correlation coefficient (*rho*) was used. To examine the status of sexual communication among parents and their children, communication scores were trichotomized and labeled high, medium, or low levels. Total scores on the 20 item scale ranged from 20 to 60 (mean score= 33.52, SD= 9.13 for father-child, and 34.93, SD= 9.96 for mother-child). Total scores less than or equal to 30 were categorized as showing low level of communication, and total scores between 30 and 50 were labeled as representing medium level of communication. Total scores greater than or equal to 50 were categorized as showing high level of communication. This was made considering the responses for the scale as 3 (Always), 2 (sometimes), or 1 (Never). That is, responses in between 1 and 1.5 were considered to be low, whereas responses indicating more or less frequent communication (fewer scores of 'sometimes' and most 'always') were said to be higher. The remaining scores (between 1.5 and 2.5) were indicating occasional communications and were labeled medium.

With respect to Adolescents' sexual behavior, participants were again classified into three groups: sexually not active, low risk, or high risk

groups. Sexually not active adolescents were those who reportedly did not start sex at all. On the other hand, those who had sex with one partner and used condom always, had never been pregnant and did not attempt to abort were classified in the lower risk group. Respondents who either had sexual intercourse with one or more sexual partner without condom, or who had been pregnant unintentionally or attempted to abort were classified in the high risk group. Gender differences between boys and girls in their sexual activity and risk level were then examined using Chi-square test.

Adolescents' age at which they had sexual contact the first time was also correlated with their condom use habit. Correlation was computed using Spearman's *rho*. Besides, to examine if drug or alcohol use had any association with adolescents' sexual risk behavior, chi-square was used. The association between sources of information for adolescents and their sexual behavior was further examined using chi-square test.

Finally, to determine whether parent-child sexual communication had any relationship with the subsequent adolescents' sexual behavior, Spearman's correlation coefficient was used. One way ANOVA was also employed to examine possible mean differences in parent-child communication scores for each level of adolescents' sexual behavior (sexually not active, low risk, and high risk).

The data obtained through interviews were categorized into pertinent themes and excerpts were quoted directly or paraphrased and possible explanations were given whenever necessary. This was, of course, possible to do only for some of the items of the semi-structured interview. Participants of the interview felt shy and ashamed of responding directly to some other items because of the sensitive nature of sexuality as well as the face-to-face situation of the interview. The discussion section, therefore, did not include those unsatisfactory and unrelated responses to the items.

CHAPTER FOUR

RESULTS

The main purpose of the present study was to examine parent-child communication about sexuality and the association of this communication with adolescents' subsequent sexual behavior. In this section, data obtained from 365 high school students are analyzed and reported.

4.1. Situation of Parent-Child Sexual Communication

The levels of communication between fathers and children, and mothers and children are tabulated. Gender differences between mothers and fathers as well as between male and female students in sexual communications are also examined.

As to the level of communication how often children communicated with their parents about sexuality, the researcher attempted to categorize communication scores into low, medium, and high level (scores less than or equal to 30, between 30 and 50, and greater than or equal to 50, respectively). This is made only for the purpose to describe what the current parent-child communication looks like. Based on this, the frequency counts on each category of father-child and mother-child communication are presented in Table 2.

Table 2: Levels of parent-child communication

Levels	Father-child	Mother child
	N (%)	N (%)
Low	154(42.2)	147(40.3)
Medium	199(54.5)	195(53.4)
High	12(3.3)	23(6.3)
Total	365(100)	365(100)
$\chi^2 = 7.67$, df=2, $p<0.05$		

As shown in Table 2, the majority of both father-child and mother-child communication was found to be of medium level (54.5% and 53.4%, respectively). Only few adolescents reported a high level of communication with their fathers (3.3%) and with their mothers (6.3%).

In order to examine gender differences among parents and adolescents in communication, it was possible to compute the differences on the category of communication indicated in Table 2. However, because of the limitation of using categorical data for generalization, overall scores (continuous data) were used in examining gender difference using parametric tests.

Table 3: Gender difference among parents in communicating about sexuality with their children

Communication	N	Mean	SD	df	t-value
Father-child	365	33.52	9.13	364	4.162***
Mother-child	365	34.93	9.96		

***P<0.001

Comparison between communication with fathers and mothers was made irrespective of the sex of respondents. As indicated in Table 3, there was significant difference observed between father-child and mother-child communication about sexuality (t=4.162, p<0.001). Total scores of adolescents' communication with mothers (mean=34.93, SD=9.96) was found to be greater than communication with fathers (mean=33.52, SD=9.13).

Differences between boys and girls in communicating with their fathers and mothers were also examined. Mean differences and tests of statistical significance are presented in Table 4 below.

Table 4: Gender difference among adolescents in their communications with their fathers and mothers

Communication	Sex (of adolescents)	N	Mean	SD	df	t-value
Father-child	Male	200	33.34	8.93	363	0.43
	Female	165	33.75	9.38		
Mother-child	Male	200	32.41	8.87	363	5.55***
	Female	165	37.99	10.36		

*** P<0.001

As indicated in Table 4, there was no significant difference observed between boys and girls in communicating about sexuality with fathers ($t=0.43$, $P>0.05$). However, a statistically significant difference was observed between boys and girls when communicating with their mothers ($t=5.55$, $P<0.001$). Girls communicated more frequently about sex-related matters with their mothers (mean= 37.99, SD= 10.36) than boys did (mean= 32.41, SD= 8.87).

An attempt was also made to see who (boys or girls) communicates more with whom (fathers or mothers). Table 5 shows the mean scores of boys and girls in their preferences for communication with father or mother.

Table 5: Parental preferences of adolescents to communicate with

Communication	N	Mean	SD	df	t-value
Boys with fathers	200	33.34	8.93	199	2.86*
Boys with mothers	200	32.41	9.38		
Girls with fathers	165	33.75	8.87	164	7.53***
Girls with mothers	165	37.99	10.36		

* $p<0.05$ *** $p<0.001$

As indicated in Table 5, the communication boys had with their fathers was significantly more frequent than the one they had with mothers ($t=2.86$, $p<0.05$). The reverse was true for female adolescents. Unlike boys, girls

reported to have significantly more frequent communication with their mothers than with their fathers ($t=7.53$, $P<0.001$).

4.2. Association of Parental Education with Parent-Child Communication

The association between parent-child communication and education of parents was examined. The data revealed that both father's and mother's education was positively correlated with parent-child communication in general ($r=0.35$, $p<0.001$ for father, and $r=0.27$, $p< 0.001$ for mothers). This means, higher level of education of parents is associated with better communication between parents and their children on sexuality. Although the correlations in both cases were statistically significant, the magnitude of the correlation of father's education with father-child communication was greater than the correlation of mother's education with mother-child communication.

Separate examination of the correlations for males and females as shown in Table 6 indicates that, father's education was positively correlated with father-son communication ($r=0.39$, $p<0.001$) and father-daughter communication ($r=0.31$, $p<0.001$). Though mother's education had lower magnitude of correlation, it was significantly and positively correlated with mother-daughter ($r=0.27$, $p<0.001$) and mother-son communication ($r=0.19$, $p<0.001$).

Table 6: Correlation of parent-child communication with parents' education as a function of adolescents' sex

Parent-child Communication	Fathers' Education	Mothers' Education
Father-son	0.39***	
Father-daughter	0.31***	
Mother-son		0.19***
Mother-daughter		0.27***

*** P< 0.001; Females (N) = 165, Males (N) = 200

4.3. Sexual Behavior of Adolescents

In this sub-section, data on the sexual behavior of respondents is presented by their sex. The associations of drug and alcohol use, age of young people when they started sex for the first time, and sources of information about sexuality with respondents' sexual behavior are examined.

In the sexual behavior questionnaire, adolescents were asked if they had sexual intercourse in their life time to know whether they were sexually active or not. The responses are summarized in Table 7.

Table 7: Sexual activity (experience) of respondents by sex (N=365)

Sex	Sexual Activity		
	Yes	No	Total
	N (%)	N (%)	N (%)
Male	132(55)	68(54.4)	200(55)
Female	108(45)	57(45.6)	165(45)
Total	240(100)	125(100)	365(100)
$\chi^2 = 0.01$, df=1, p> 0.05			

The data in Table 7 show that from the total participants, 240 (65.8%) respondents reported having had sexual intercourse at least once. Out of those sexually active adolescents, 55% were males and 45% were females. In their sexual activities, however, there was no significant difference observed between males and females ($\chi^2 = 0.01$, P>0.05).

Sexually active adolescents were asked how many sexual partners they had, whether they had used condom during sexual intercourse, whether they had experienced pregnancy to know their risk level in their sex life. Those who either had sexual relation with more than one partner, use condoms inconsistently or not at all, or had ever had unintended pregnancy and attempted to abort were separated and labeled as high-risk individuals. On the other hand, those who had sexual relation with only one partner, who always used condoms and never had unintended pregnancy were labeled

low risk. Table 8 summarizes the classification of sexually active adolescents by their sex and risk level.

Table 8: Adolescents' sexual risk behaviors by sex (N=240)

Sex	Risk Levels		
	Low Risk N (%)	High Risk N (%)	Total N (%)
Male	42(49.4)	90(58.1)	132(55)
Female	43(50.6)	65(41.9)	108(45)
Total	85(100)	155(100)	240(100)
$\chi^2 = 1.52$, df =1, p>0.05			

Among 240 sexually active adolescents, the majority (64.6%) was found to be at a higher sexual risk and the remaining 35.4% were sexually at a lower risk. Among the high-risk taking adolescents, males constituted 58.1% and females 41.9%. There is, however, no significant difference observed between the two sexes ($\chi^2 = 1.52$, $p>0.05$).

4.4. Drug/Alcohol use and Adolescents' Sexual Risk Behavior

Drug and alcohol use is generally assumed to have negative contribution to adolescents' sexual behavior. Sexually active participants were asked as to whether they had consumed drug and/or alcohol before having sex. The

response to this question and its association with their sexual risk behavior is shown in Table 9 below.

Table 9: Association of drug and/or alcohol use with sexual risk behavior (N= 240)

Risk Level	Drug and/or Alcohol Use		
	Yes N (%)	No N (%)	Total N (%)
Low risk	7(8.2)	76(49.0)	83(34.6)
High risk	78(91.8)	79(51.0)	157(65.4)
Total	85(100)	155(100)	240(100)
$\chi^2 = 40.76$, df=1, p<0.001			

As shown in Table 9, 85 (out of 240) sexually active adolescents reported that they had used drug or alcohol before having sex. Among those who used drug and/or alcohol, 78 (91.8%) were high risk-taking adolescents. Only minority (8.2%) of them were at a lower risk. The results indicate that sexual risk behavior is significantly associated with drug and alcohol use (χ^2 =40.76, p<0.001). More specifically, adolescents who use drug and alcohol before sexual intercourse were more likely to involve in high risk sexual activity than adolescents who did not use drug or alcohol before sexual intercourse.

4.5. Age at First Sexual Contact and Adolescents' Sexual Risk Behavior

An attempt was also made to see whether age at which boys and girls started sexual intercourse had relation with the use of condom or other contraceptives. The minimum age respondents started sex was 13, and the maximum age was 19 (mean age=15.7, SD=1.11). There was significant positive correlation between age of first sexual contact and condom use ($r=0.35$, $p<0.001$). This indicates that the earlier the age adolescents started sex, the less likely they used condoms. In other words, those who started sex as late as 19 are more likely to engage in safer or protected sex than those who started as early as the age of 13.

4.6. Sources of Information about Sexual Matters and Sexual Behavior of Adolescents

In this study, parent-child communication on sexuality generally was not frequent. Besides parents, different options were provided for participants to select from whom they were obtaining information about sex-related matters mostly. The responses were cross-tabulated with adolescents' sexual behavior in Table 10.

Table 10: Sources of information about sexuality and sexual behavior of adolescents (N= 365)

Sources of Information	Sexual Behavior			
	Sexually not Active	Low Risk	High Risk	Total
	N (%)	N (%)	N (%)	N (%)
Parent	29(23.2)	35(41.2)	10(6.5)	74(20.3)
Peers	10(8.0)	9(10.6)	98(63.2)	117(32.1)
Mass Media	51(40.8)	24(28.2)	42(27.1)	117(32.1)
School	35(28.0)	17(20.0)	5(3.2)	57(15.6)
Total	125(100)	85(100)	155(100)	365(100)
$\chi^2 = 118.96$, df=6, P<0.001				

Table 10 shows that peers and mass media were potential sources of information about sexual issues for most adolescents. Parents and schools ranked third and fourth as sources of information. Out of those high risk-taking adolescents, 63.2% preferred peers as the most important source of information about sexuality. Those who delayed their sexual coitus (sexually not active) and who were at a lower risk reported that they obtained information mostly from parents and from mass media than those who were at a higher risk. Association between these sources of information and sexual behavior of adolescents was found to be significant ($\chi^2 = 118.96$, $p<0.001$).

4.7. Relationship between Parent-Child Communication about Sexuality and Sexual Behavior of Adolescents

The primary reason for examining parent-child sexual communication was that such communication may influence the subsequent sexual behavior of adolescents. In this section, therefore, the potential association of such communication with adolescents' sexual behavior is examined.

One way ANOVA was employed to see whether the three risk groups had different communication patterns with their parents. Table 11 shows the means and standard deviations of the parent-child communication across different levels of sexual behavior of adolescents.

Table 11: Means and standard deviations of communication scores by level of sexual behavior

Parent-child communication	Sexual Behavior	N	Mean	SD	df	F-value
Father-child	Sexually not active	125	34.21	8.40	2	60.1***
	Low risk	85	40.69	9.37		
	High risk	155	29.03	6.56		
	Total	365	33.52	9.13		
Mother-child	Sexually not active	125	36.16	9.52	2	58.83***
	Low risk	85	42.35	8.92		
	High risk	155	29.86	7.77		
	Total	365	34.93	9.96		

*** $p<0.001$

The data presented in Table 11 indicate that there is significant difference among the three risk groups of adolescents in their communication scores with fathers and mothers ($F=60.1$, $p<0.001$ for father-child, and $F=58.83$, $p<0.001$ for mother-child communication).

The mean difference of communication scores among the three groups was compared as to which group significantly differs from which group in a paired comparison. For this, Post-Hoc comparison test (Tukey test) was employed.

The pair-wise comparison of communication scores with both parents indicated a significant mean difference among the three sexual risk levels ($p<0.001$). There is a marked difference in communication between adolescents in the low risk group and high risk group. Those who were at a lower risk had better communication scores with both their fathers and mothers as compared to those who were sexually at a higher risk. In other words, adolescents in the high risk group had significantly lower communication with their parents. Those with better communication were found to be sexually at a lower risk and preferred to delay their sexual activity as compared to adolescents with lower communication about sexuality. Sexually not active adolescents, when compared to those at a high risk group, on the other hand, had better communication scores with both parents.

The association of these communications with sexual behavior of adolescents was further examined using Spearmen's correlation coefficient as shown in Table 12 (for the total sample) and in Table 13 (for males and females separately).

Table 12: Correlation of parent-child sexual communication with adolescents' sexual behavior (for the total sample)

Parent-child communication	N	Sexual Behavior
Father-child	365	-0.29***
Mother-child	365	-0.31***

*** p<0.001

For the total sample, parent-child sexual communication was significantly correlated with sexual behavior of adolescents irrespective of the sex of respondents (r=-0.29, p<0.001 for father-child, and r=-0.31, p<0.001 for mother-child communication). Because the correlation was negative, high level communication was associated with lower risk sexual behavior. Besides, mother-child communication had better correlation coefficient with adolescents' sexual behavior than did father-child communication.

Table 13: Correlation of parent-child sexual communication with adolescents' sexual behavior by sex of respondents

Parent-child Communication	N	Sexual Behavior
Father–son	200	-0.23***
Father–daughter	165	-0.38***
Mother–son	200	-0.24***
Mother–daughter	165	-0.39***

*** $p<0.001$

Separate analysis of the correlations for boys and girls indicate that both boys' and girls' sexual communication with both parents were significantly correlated with their sexual behavior. The correlation in all cases was negative in that, better communication between adolescents and their parents is associated with lower risk sexual behavior. Those who often communicate with their parents about sexuality were more likely to be at a lower sexual risk or delay their early sexual activity.

The magnitude of the correlation coefficient for mother-child communication was greater than the one for father-child communication in general. Mother-daughter communication was highly correlated with girls' sexual behavior as compared to father-daughter communication. Boys reported better communication with their fathers than with their mothers. However, communication between boys and mothers was found to be highly correlated with their sexual behavior as compared to the communication they had with their fathers.

CHAPTER FIVE

DISCUSSION

This study was designed to explore the situation of sexual communication among parents and their children, and the relationship of this communication with sexual behavior of adolescents. To achieve this objective, the following basic research questions were formulated.

1. What does the situation of parent-child communication about sexual issues look like?
2. Is there any significant gender difference among parents and adolescents in communication about sexual issues?
3. Is there any association between parental education and parent-child communication about sexual issues?
4. Is there any association between drug/alcohol use and sexual behavior of adolescents?
5. Is there any association between parent-child communication about sexuality and adolescents' sexual behavior?
6. Does parent-child communication have significant role in promoting healthy sexual behavior among adolescents?

Results pertaining to the status of sexual communication between adolescents and their parents, gender differences observed among parents and adolescents in communication, association of parental education with

parent-child communication, prevalence of adolescents' sexual risk behavior, and the relationship of parent-child communication with adolescents' sexual behavior are discussed below.

5.1. The Situation of Parent-Child Sexual Communication

Regarding parent-child sexual communication, higher scores of the communication (maximum score=60) indicate frequent (high level) communication, and lower scores (minimum score=20) indicate low level communication. Based on this, 42.5% and 40.3% of the respondents reported lower level of communication with their fathers and mothers, respectively. In contrast, only 3.3 % of father-child and 6.3% of mother-child communications were at a higher level. The remaining 54.5% of father-child and 53.4% of mother child communications were at a medium level.

The results indicated that there exists sexual communication between parents and children in a family. However, the communication held between parents and children about the issue is not as such frequent. Only few adolescents reported relatively better (frequent) communication.

This finding is some how comparable to the findings of Nigussie, et al. (1999). The study by Nigussie and his associates, conducted in a rural town of Ethiopia, indicated that explicit discussions about sexual matters among adolescents and their parents were rare as a result of cultural taboo on

discussing sex-related topics. What adolescents wished they had from their fathers and mothers but did not get was, however, open discussion about sexual issues that recognize their age. They wanted their parents to listen to them and their feelings. A 17 year old grade 10 female adolescent noted the following during the interview.

> *I wish my father had asked me about my boy friend, told me how to lead my sexual life, and listen to my opinions on any issue including sexuality. But in reality, he seemed not to raise even a topic on such areas most of the time than a mere supervisory question where I have been and how my schooling is going.*

One possible explanation why parents frequently do not raise issues of sexuality to their children at home might be because of the assumption that if they do so, it would initiate the children's sexual desire and encourage them to be sexually active. In addition, in Ethiopia and some other developing countries, bringing sexual topics to a stage even among adults is considered shameful and taboo (Nigussie, et al., 1999). Furthermore, the negative attitude parents had towards sexuality may be explained by lack of awareness about the importance of discussing with adolescents on the topic for their healthy sexual behavior.

5.2. Parent-Child Sexual Communication as a Function of Sex of the Parent and the Adolescent

Comparing the total communication scores of adolescents on the given situation of parent-child communication, there was statistically significant difference observed between their communication with fathers and mothers. Mothers were found to communicate more frequently on sexual issues with their children than did fathers irrespective of the sex of respondents. This result is consistent with the findings of other studies (e.g., Hutchinson & Cooney, 1998; Miller, et al., 1998). The studies indicated that mothers were the primary communicators for adolescents regarding sexual behavior and related topics. An explanation for this is possibly that, it might be associated with the mother-child connectedness for the primary care mothers provide to their children. This close relationship and protective nature of mothers for their children that extended from childhood might create opportunities to communicate on sexuality issues. With regard to this, Jaccard (2006) ascertained that mothers are better at communicating because they are the agents of intimacy and/or because they can discuss sexual matter more safely than fathers.

When it comes to the sex difference of adolescents in sexual communication, the gender of adolescents was related to the gender of the parent with whom discussion took place. That is, female adolescents reported more frequent communication with their mothers than with their

fathers, whereas boys with their fathers than with their mothers. Moreover, girls reported communicating significantly more frequently with their mothers than did boys. This result is consistent with the finding of Jaccard (2006) which states that mother-child discussions about sexuality are extensive and more likely to occur with daughters than with sons. Furthermore, daughters tend to prefer mothers for their sex information than boys do. One possible explanation for this might be that, girls commonly pass through similar experiences of the adolescence period as mothers do (such as, menarche) and tend to consult their mothers than their fathers about such experiences.

Significantly more frequent discussion between same gender (father with son, and mother with daughter), on the other hand, could be attributed to the same sex role identification. That is, there would be a tendency for male adolescents to identify with the values, roles and expectations of fathers, and for girls to identify with the values, roles and exercises of mothers which could likely bring opportunities to go together and discuss on sexuality.

The degree to which adolescents got frequent instruction (discussion) was found to be associated with the education level of both parents. The result shows that better level of fathers' education was correlated with better communication for boys and girls. Correlation was also significant for

mothers' education with mother-child communication though the magnitude of the correlation coefficient is lesser as compared to fathers'. Boys and girls would benefit from the education of their parents. This result is, however, different from that of the finding of Hutchinson and Cooney (1998), which states that both parents' and adolescents' education has not any relationship with sexual communication. This might probably be because in the United States, level of parents' understanding about sexuality may not need further education. In Ethiopian families, however, it is not surprising to find that communication about sex-related topics is related to and supported by education. That is, the skills and resources gained through education are more likely to help them to develop positive attitude towards discussing sexuality with children and to overcome cultural influences or the secrecy surrounding sexuality.

Regarding the knowledge and attitude of parents about sex topics, an 18 years old male adolescent who participated in the interview noted:

> *I hope they know something about sexuality better than I do even from their own experience. But the bad thing is not the high or low level of knowledge they had on sexuality, rather the attitude they have towards telling us what they actually know. They often avoid topics of sexuality and raise other topics which do not concern us.*

This might be possibly the case for those parents who were hampered by the conservative attitude towards sexuality, or who lacked basic skills and knowledge in communicating with their children.

5.3. Sexual Behavior of Adolescents

As far as adolescents' sexual activity is concerned, results of the present study show that 65.8% of high school students reported having had sexual intercourse at least once. This proportion of young people who admitted having had sexual intercourse seem to be higher compared to previous research findings conducted in different parts of Ethiopia at different times. For example, Shabir, Habteab, and Kahsu (1997) found out that 31.9% of high school students were sexually active. Nigussie (1998), on the one hand, came up with 49% and Getnet, et al. (2002) with 64% sexually active adolescents.

It is argued that young people in this generation are becoming increasingly sexually active (Getnet, et al., 2002). It was also reported that teens in other countries were likely to engage in sexual activity before finishing high school (Rodgers, 1999, Miller, Forehand, & Kotchick, 1999). This increasing trend of sexual activity among the adolescents could be attributed to the increased use of drug and alcohol, the expansion of illegal video houses showing pornographic films, and possibly pressures from peers.

Among those sexually active high school students, there was no significant difference between males and females in their sexual activity and risk level. This result is not consistent with findings of other studies (e.g., Niguissie, 1998; Getnet, et al., 2002; O'Donnell, O'Donnell, & Stueve, 2001). The studies indicated that male adolescents were more prone to have sexual activity than females. One possible explanation for this may be that, both male and female adolescents were exposed to the same environment (such as, peer pressure, media-like pornographic films, and others). In Awasa it is common to see both male and female adolescents watching films, consuming local drugs and doing other activities that possibly lead them towards sexual relationships.

Adolescents' age at first sexual contact was found to be correlated with condom use. Those who started sex early were less likely to use condoms and were at a higher sexual risk (of contracting STDs including HIV/AIDS and unintended pregnancy) than those who started sex late. This result agrees with the literature which stated that young adolescents who enter into sexual relationships in their earlier ages are less likely to use condom or other forms of contraceptives (Moore & Miller, 1990; O'Donnell, O'Donnell, & Stueve, 2001). One possible explanation for this is that young adolescents in their earlier years may not have adequate knowledge or understanding about the use of condom or other contraceptive in that

incident. They may not imagine the negative consequences of unprotected sex because of their mental immaturity and psychological readiness.

Among the factors that most likely contribute to the early initiation of sexual activity and having unprotected sex is the use of drugs and alcohol (Getnet, et al., 2002). In the present study, it was found that 83 (34.6%) of the 240 sexually active adolescents used drugs/alcohol before having sex. Among those who used drugs/alcohol, 91.8% of them were at a higher sexual risk. That is, they either had unprotected sex or had sexual relations with multiple sex partners. Consistent with this, association of the use of drugs and alcohol with adolescents' sexual risk behavior was significant. Consuming drugs (specially 'Chat' and 'Shisha'–the local drugs) is widespread among young people in Awasa. It is not also uncommon to see female high school students drinking alcohol with different people in bars and restaurants even during school hours with their uniforms.

Another finding of the present study was that institutions like schools, mass media, and peers were also serving as sources of information for adolescents on sexual issues. Each source of information had its own contribution in providing information about sex-related matters. One hundred and seventeen (32.1%) out of 365 participants reported that they obtained information mostly from peers. Equal proportion of the participants got information mostly from mass media. The remaining 20.3% and 15.6% got

information on sexuality from parents and schools, respectively. Similar results were reported by previous researches. For example, Holtzman and Rubinson (1995) found that adolescents in general were more likely to report having communicated about sexuality with their peers than their parents or other adults in the family.

The consistency of the result in the present study to the Holtzman and Rubinson's finding was because adolescents in the Ethiopian context were not comfortable to discuss with their parents about sexuality. The students were asked during the interview how comfortable they and their parents were while talking about sexuality. Most of them complained that the environment at home (with parents) was neither comfortable nor inviting. They indicated that they would be more comfortable (more free) to talk to their friends/peers what they feel about sexuality than to talk to their parents. The result of the present study shows, in effect, that significantly more adolescents who received information mostly from peers were more likely to be sexually at a higher risk than those who received mostly from parents, schools or mass media.

Adolescents, during the interview, confirmed that the information they obtained from parents was informative and helped them to lead appropriate sex life. In contrast, much of the information they received from peers and media clips (such as, channels which broadcast sex-initiating lyrics and

films) was sexually unhealthy and was more likely to direct them to practice sexual activity. That is, though adolescents feel free in discussing about sexuality with peers who can fill the gap in adolescents' knowledge about sexual matters, they may not get adequate information from their peers since they themselves may not have accurate information on such issues.

5.4. The Relationship between Parent-Child Communication about Sexuality and Sexual Behavior of Adolescents

The intention of this study was to examine whether the communication among children and their parents about sexuality has any association with the changes in adolescents' sexual behavior. The findings of the present study show that parent-child communication on sexual topics was significantly negatively correlated with adolescents' sexual behavior. The direction of the correlation was negative to show reverse association. That is, better communication with both parents was associated with lower sexual risk or delaying early sexual activity. Similar results were reported by previous studies indicating that adolescents who communicated with their parents about sexuality were more likely to delay/postpone early initiation of sex and to be at a lower risk (Rodgers, 1998; Whitaker, et al., 1999; and Hutchinson & Cooney, 1998).

Mother-child communication was found to be highly correlated with adolescents' sexual behavior as compared to father-child. Consistent with

this finding, previous research by Jaccard (2006) showed that communication held between adolescents and their mothers was supportive and made teenagers responsible for their sexual behavior when they become sexually active. An open and supportive mother-daughter relationship promotes the delay of coitus and reduces the likelihood that adolescent females will experience unintended pregnancies. In other words, well informed adolescents will plan ahead and make responsible decisions on their sexual behavior. This idea is supported by Stodghill (2000) that most adolescents seek attention and orientation from their parents since they are identified figures for their children and considered to be the most accurate source of information.

CHAPTER SIX

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

6.1. Summary

The present study was conducted to investigate the current situation of sexual communication between parents and their children. In this effort, the following research questions were formulated to be addressed.

1. What is the situation of parent-child communication regarding sexuality?
2. Is there any significant gender difference among parents and adolescents in communication about sexual issues?
3. Is there any association between parental education and parent-child communication about sexual issues?
4. Is there any association between drug/alcohol use and sexual behavior of adolescents?
5. Is there any association between parent-child communication about sexuality and adolescents' sexual behavior?
6. Does parent-child communication have significant role in promoting healthy sexual behavior among adolescents?

To attain the objective of the study, samples were drawn from high schools in the age range of 15-19 in Awasa. Two government high schools, Tabor high school and Addis ketema high school, were selected using convenience

sampling technique, and 365 (200 male and 165 female) students participated in the study.

A 20 item three-point Likert communication scale and an eight item questionnaire were used to collect necessary information on parent-child sexual communication and on sexual behavior of adolescents, respectively. Semi-structured interview was also conducted with five (3 male and 2 female) students to supplement the data on parent-child communication and adolescent sexual behavior.

Analysis of the data was performed using SPSS version 13.0 for windows, and both parametric and non parametric tests were used in accordance with the nature of the data. T-test was employed to examine gender differences among parents and adolescents in communicating about sexuality.

To examine whether adolescents of different sexual behavior (risk level) had different communication patterns with their parents, one way ANOVA was employed. Spearman's correlation coefficient (*rho*) was used to examine the relationship between parent-child communication and education of parents, between adolescents' age they started sex and condom use, and between parent-child sexual communication and adolescents' sexual behavior. Chi-square test was also employed whether drugs/alcohol use and sources of information had any association with adolescents' sexual behavior. Based on the analysis of the data the following results were obtained.

1. The frequency at which parents and children communicate about sexuality was found to be at a medium level.
2. Gender difference was observed among parents and adolescents in discussing about sexual issues. Mothers were more likely to communicate with their children than were fathers irrespective of the sex of respondents. Female adolescents significantly differed from male adolescents when communicating with their mothers. That is, girls communicated more often with mothers than did boys. However, there was no significant difference observed between boys and girls in communicating with their fathers.
3. Communication about sexuality was found to be supported by education. Parental education was positively correlated with perceived parent-child sexual communication. Parents with better education level were relatively good at discussing topics of sexuality with their sons and daughters.
4. Regarding adolescents' sexual activity and risk behavior, more than half of the adolescents reported that they were sexually active and reported a higher sexual risk behavior.
5. Drug and alcohol use was found to have significant association with adolescents' sexual behavior. Adolescents who use drugs ('Chat' and 'Shisha') and alcoholic drinks before having sexual intercourse were more likely to have unprotected sex with multiple sex partners.

6. Early sexual initiation (as early as age 13) was relatively common among teenagers and tended to be associated with inconsistent use of condom. Those who started sex in their earlier ages were more likely to have unprotected sex which in turn could make them to be at a higher risk of acquiring STDs including HIV/AIDS and unintended pregnancy.
7. These days, mass media and peers are in the lead to provide information on the area of sexuality for the young people. However, the data obtained from the participants on their sexual communication revealed that there was statistically significant negative correlation between parent-child communication and adolescents' sexual behavior. Better communication was found to be associated with lower risk sexual behavior. There is likelihood for adolescents either to delay/postpone early sexual activity or to have protected sex in a one-to-one sexual relationship. On the contrary, adolescents with lower communication were found to be at a higher risk sexual activity. They reported having had sexual relations with multiple sex partners with inconsistent use of condoms or other contraceptives which might expose them to unintended pregnancy and abortion as well as acquiring HIV/AIDS and other STDs.

6.2. Conclusion

The present study attempted to examine the situation of parent-child sexual communication and its relationship with adolescents' sexual behavior. It further examined gender differences among parents and adolescents in communicating about sexuality.

From the results obtained, it could be concluded that parent-child communication about sexual issues was generally considered to be of medium level. That is, parents and children discuss on some topics more frequently and on some others less frequently or not at all. Uniformly frequent communication on the issue is almost non-existent. This could be attributable to different factors which needs further investigation.

Given this communication, however, there was gender difference among parents when communicating with their children. Mothers communicated more often with their children than did fathers. Regarding adolescents, girls were found to communicate more frequently with their mothers than were boys.

The communication held between parents and their children was significantly associated with sexual behavior of adolescents. Well informed adolescents were more likely to be at a lower sexual risk than their counterparts (non-informed ones). The former either kept on abstaining or

maintained a monogamous (one-to-one) sexual relationship and protect themselves from HIV/AIDS and other STDs. This seems to imply that when parents are perceived as friendly, attentive and open in discussing about sexuality more frequently, adolescents will develop responsible and healthy sexual behavior.

6.3. Recommendations

Better communication about sexuality between parents and their children was found to be associated with reduced sexual risk behavior of adolescents. This implies that parental involvement in the provision of information about sexuality has positive contribution for the development of healthy sexual behavior among adolescents. However, such communication held between parents and children in general was not often. To enhance (improve) the condition and frequency of parent-child communication for intervention in the sexual and reproductive health problems, a lot has to be done and the following points are recommended.

1. Parents have to be assisted to acquire basic skills and positive attitude necessary to communicate with their children about sexual issues. They also need to understand the physical and sexual developments and associated behavioral changes observed during adolescence. This could be addressed through different responsible agencies. Government bodies and other community based organizations (such as, Health centers, Family Guidance

Associations, Churches, Mosques, etc), who are directly working with parents, need to develop strategies or extend family education programs. These programs should be designed in such a way that they facilitate positive parent-child relationships, empower parents to break the secrecy surrounding communication about sexuality. Such programs can help parents to evaluate their own values and knowledge related to sexuality so that they avoid discomforts (create conducive environments) among themselves and their children in discussing the issue.

2. Mass media (printed and electronic) and other public programs (talk shows and conferences) are working extensively on the awareness formation about the transmission and protection of HIV/AIDS. Little is done on parent-child sexual communication. They are in a potential position to play vital role in the promotion of open, friendly and supportive parent-child discussions and to help to get attention its contribution in bringing healthy adolescent sexual behavior.
3. Further research is also needed to extend the results of the present study by addressing and including what parents say and what attitudes they do have towards adolescent sexuality from parents' perspective.

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APPENDICES

Appendix A

Parent-Child Sexual Communication Scale and Adolescent Sexual Behavior Questionnaire

Addis Ababa University

School of Graduate Studies

Department of Psychology

The purpose of this Instrument is to gather information on the level of sexual communications among children/adolescents and their parents, and on sexual behavior of adolescents. The items in the questionnaire may involve personal privacy of the participants; however, the information obtained will be used only for the research purpose and, the secrecy of the information you give will also be fully maintained. For this, you are not expected to write your name, address, or any information that may express your identity, except your age, sex, grade level, and parental background which is universal to everyone.

Your genuine and appropriate responses are very essential for the research. I, therefore, kindly request you to respond to each item genuinely and carefully.

Thank you in advance

Instruction:

The instrument has three sections. The first section consists of items on the background information of respondents. The second one is a scale designed to measure the level of sexual communications among parents and children/adolescents. The third section is a questionnaire aimed at generating ideas on the present sexual behavior of adolescents.

Section I – Demographic characteristics of respondents

In this section, you are requested to encircle or write a letter, a word or phrase appropriate to you.

1. Name of the school you are attending: ________________________________
2. Age: ____
3. Sex: M F
4. Grade level: 9th 10th 11th 12th
5. Parental background:

5.1. Education

Father	**Mother**
1. No Education (cannot read and write)	**1.** No Education (cannot read and write)
2. Reading and Writing	2. Reading and Writing
3. Elementary Education	3. Elementary Education
4. Secondary Education	4. Secondary Education
5. College Diploma	5. College Diploma
6. First degree and above	6. First degree and above
7. Other, specify ____________	7. Other, specify ____________

5.2. Monthly Income (in Eth. Birr)

Father	**Mother**
1. Less than 300.00	1. Less than 300.00
2. 301.00 – 600.00	2. 301.00 – 600.00
3. 601.00 – 900.00	3. 601.00 – 900.00
4. 901.00 and above	4. 901.00 and above

Section II – Parent-Child Sexual Communication Scale

Put a "✓" or "**X**" mark corresponding to each item, where it is true for the frequency of your communications with your father/mother about sexuality, under the columns of 'Never', 'Sometimes', or 'Always'.

2.1 Father – Child Communication

Items	Never (1)	Sometimes (2)	Always (3)
How often have your father 1.talked to you about human sexuality in general?			
2.discussed with you about reproduction/ how babies are made?			
3.talked to you about appropriate time to start having sex?			
4.discussed with you about early premarital sexual relationship?			
5.discussed with you about contraceptives/birth control?			
6.discussed with you about transmission of STDs and HIV?			
7.told you about protection from STDs and HIV?			
8.discussed with you about effective and consistent use of condoms?			
9.told you the risks of having sex without condom?			
10. discussed with you about sexual development?			
11. talked to you about when and how unintended adolescent pregnancy happens?			
12. discussed with you about age-related physical changes and sexual characteristics during adolescence?			
13. instructed you about menstruation? (male participants can jump this item)			
14. shared his/her own past dating and sexual experiences?			
15. told you about how he/she felt you should behave sexually?			
16. informed you how to handle/resist sexual pressure by your friends?			
17. informed you how to handle/resist sexual pressure from your sex partner?			
18. talked to you about choosing sexual partner (boyfriend or girlfriend)?			
19. discussed with you about risks of multiple sexual partners?			
20. discussed with you about postponing/delaying sex?			

2.2 Mother – Child Communication

Items	Never (1)	Sometimes (2)	Always (3)
How often have your mother 1. talked to you about human sexuality in general?			
2. discussed with you about reproduction/ how babies are made?			
3. talked to you about appropriate time to start having sex?			
4. discussed with you about early premarital sexual relationship?			
5. discussed with you about contraceptives/birth control?			
6. discussed with you about transmission of STDs and HIV?			
7. told you about protection from STDs and HIV?			
8. discussed with you about effective and consistent use of condoms?			
9. told you the risks of having sex with out condom?			
10. discussed with you about sexual development?			
11. talked to you about when and how unintended adolescent pregnancy happens?			
12. discussed with you about age-related physical changes and sexual characteristics during adolescence?			
13. instructed you about menstruation? (male participants can jump this item)			
14. shared his/her own past dating and sexual experiences?			
15. told you about how he/she felt you should behave sexually?			
16. informed you how to handle/resist sexual pressure by your friends?			
17. informed you how to handle/resist sexual pressure from your sex partner?			
18. talked to you about choosing sexual partner (boyfriend or girlfriend)?			
19. discussed with you about risks of multiple sexual partners?			
20. discussed with you about postponing/delaying sex?			

Section III – A questionnaire on adolescents' sexual behavior

Please encircle a letter which holds a word or phrase that is true for your sexual behavior among the given alternatives.

NB. *For item 2 only, write the age at which you had started sex.*

1. Have you had sexual intercourse?

   1. Yes 2. No

2. If yes, at what age have you had sex the first time?

   At age _______

3. How many people have you had sexual intercourse with during the previous six months?

   1. One 4. Four
   2. Two 5. Five or more
   3. Three

4. The last time you had sexual intercourse, did you or your partner/s use a condom?

   1. Never 2. Sometimes . 3. Always

5. Have you ever been pregnant unintentionally? (For male participant he may think of his sex partner)

   1. Yes 2. No

6. If you had been pregnant, have you ever got abortion or attempt to abort?

   1. Yes 2. No

7. In the previous three months, have you ever drunk alcohol or used drugs (like *Chat* or *Shisha*) before having sexual intercourse?

   1. Yes 2. No

8. Which one of the following is the most important source of information for you about sexuality?

   1. Parent 2. Mass media
   2. Peers/friends 3. School

Appendix B

Parent-Child Sexual Communication Scale and Adolescent Sexual Behavior Questionnaire (Amharic Version)

አዲስ አበባ ዩኒቨርሲቲ

ድህረ ምረቃ ትምህርት ቤት

የሳይኮሎጂ ትምህርት ክፍል

የዚህ መጠይቅ አላማ ፆታዊ ጉዳዮችን በተመለከተ በወላጆችና በልጆቻቸው መካከል ስለሚኖረው ግልጽ ውይይት መጠንና ስለ ወጣት ልጆች ወሲባዊ ባህርያት መረጃ ለመሰብሰብ ነው። በመጠይቁ ውስጥ የተካተቱት ጥያቄዎች የተሳታፊዎችን የግል ሕይወት የሚዳስሱ ቢሆኑም የተገኘው መረጃ ግን ለጥናት አገልግሎት ብቻ የሚውልና ሚስጥርነቱም ሙሉ በሙሉ የተጠበቀ ነው። ስለሆም የጥናቱ ተሳታፊ ከዕድሜ፣ ፆታ፣የትምህርት ደረጃና የቤተሰብ ሁኔታ በቀር ስምና አድራሻ ወይም ማንነቱን የሚገልጽ ምንም ዓይነት መረጃ በፁሑፍ አያስፈልገውም።

የአንተ/ቺ ግልጽና ሐቀኝነት የተሞላበት ምላሽ ለጥናቱ መሳካት አጅግ ወሳኝ ነው። በመሆኑም የዚህ ጥናት አጥኚ ለያንዳንዱ ጥያቄ ተገቢውን ምላሽ እንድትሰጥለት/እንድትሰጪለት መልካም ትብበርህን/ሽን ይጠይቃል።

ስለትብብርህ/ሽ በቅድሚያ አመሰግናለሁ

መመሪያ፣

መጠይቁ ሶስት ክፍሎች ያሉት ሲሆን፣ የመጀመሪያው ክፍል ስለጥናቱ ተሳታፊዎች ሁኔታ መረጃ የሚሰጡ ጥያቄዎችን የያዘ ነው። ሁለተኛው ክፍል በወላጆችና በልጆቻቸው መካከል ስለሚኖረው ፃታዊ የውይይት መጠን ማወቅ የሚያስችል መለኪያ አካቷል። በሶስተኛው ክፍል የሚገኘው ደግሞ የወጣቶችን ወሲባዊ ባህሪ በተመለከተ መረጃ የሚሰጥ መጠይቅ ነው።

ክፍል 1: የተሳታፊዎች ሁኔታ መግለጫ

ሬደሳትን፣ ቃላትን፣ቁጥሮችን ወይም ሐረጋትን በመጻፍ ወይም በማክበብ ምላሽ ስጥ/ጪ

1. በአሁኑ ሰዓት በመማር ላይ የምትገኝበት/የምትገኚበት ት/ቤት ስም____________________

2. ዕድሜ _______

3. ፃታ ወ ሴ

4. የክፍል ደረጃ 9ኛ 10ኛ 11ኛ 12ኛ

5. የወላጆችህ/ሽ ሁኔታ

1. **የትምህርት ደረጃ**

የአባትህ/ሽ

1. ያልተማሩ (ማንበብና መጻፍ የማይችሉ)
2. ማንበብና መጻፍ የሚችሉ
3. የመጀመሪያ ደረጃ ትምህርት
4. የሁለተኛ ደረጃ ትምህርት
5. ኮሌጅ ዲፕሎማ
6. የመጀመሪያ ዲግሪና ከዚያ በላይ
7. ሌላ ካለ ይገለጽ___________

የእናትህ/ሽ

1. ያልተማሩ (ማንበብና መጻፍ የማይችሉ)
2. ማንበብና መጻፍ የሚችሉ
3. የመጀመሪያ ደረጃ ትምህርት
4. የሁለተኛ ደረጃ ትምህርት
5. ኮሌጅ ዲፕሎማ
6. የመጀመሪያ ዲግሪና ከዚያ በላይ
7. ሌላ ካለ ይገለጽ ___________

2. ወርሃዊ የገቢ መጠን (የኢት.ብር)

የአባትህ/ሽ

1. ከ300 ብር በታች
2. ከ301 — 600 ብር
3. ከ601 — 900 ብር
4. 901 ብር እና ከዚያ በላይ

የእናትህ/ሽ

1. ከ300 ብር በታች
2. ከ301 — 600 ብር
3. ከ601 — 900 ብር
4. 901 ብር እና ከዚያ በላይ

ክፍል 2: የወላጆች - ልጆች ፆታዊ ውይይት መለኪያ

በእያንዳንዱ ጥያቄ ትይዩ በአንተ/ቺና በወላጆችህ/ሽ መካከል ስላለው ፆታዊ ውይይት የሚገልጸውን የጊዜ መጠን 'በፍጹም'፣ 'አንዳንድ ጊዜ' ወይም 'ሁል ጊዜ' በሚሉት አምዶች ስር የ '✓' ወይም 'X' ምልክት አስቀምጥ/ጪ።

2.1 የአባት - ልጅ ውይይት

ጥያቄ	በፍጹም (1)	አንዳንድ ጊዜ (2)	ሁልጊዜ (3)
አባትህ/ሽ ምን ያህሉን ጊዜ			
1. ስለ ሰው ልጅ አጠቃላይ ፆታዊ ግንኙነት አውርተውሃል/አውርተውሻል?			
2. ከአንተ/ቺ ጋር ስለ ስነ ተዋልዶ/ልጅ እንዴት እንደሚፈጠር ተወያይተው ያውቃሉ?			
3. ግብረ ስጋ ግንኙነት ለመጀመር ተገቢው ወቅት መቼ ስለ መሆኑ አውርተውህ/አውርተውሽ ያውቃሉ?			
4. ከጋብቻ በፊት ያለጊዜው ስለሚደረግ ፆታዊ ግንኙነት አወያይተውህ/ሽ ያውቃሉ?			
5. ስለ ወሊድ መቆጣጠሪያ አስረድተውሃል/አስረድተውሻል?			
6. ከአንተ/ቺ ጋር ስለ ኤች.አይ.ቪ./ኤድስና ሌሎች የአባለዘር በሽታዎች መተላለፊያ መንገድ ተወያይተዋል?			
7. ስለ ኤች.አይ.ቪ./ኤድስና ሌሎች የአባለዘር በሽታዎች መከላከያ ሁኔታስ ነግረውሃል/ነግረውሻል?			
8. ኮንዶምን በአግባቡና ሁልጊዜ ስለመጠቀም አስረድተውህ/ሽ ያውቃሉ?			
9.. ያለ ኮንዶም ግብረ ስጋ ግንኙነት መፈፀም ስለሚኖረው አደጋ ይነግሩሽ ነበር?			
10. ስግብረ ስጋ ግንኙነት ስለ መድረስ/ስለ መጎልበት ከአንተ/ቺ ጋር ተወያይተዋል?			
11. ያልተጠበቀ እርግዝና እንዴትና መቼ እንደሚከሰት አውርተውሽ ያውቃሉ?			
12. በወጣትነት ጊዜ ከዕድሜ ጋር ተያይዘው ስለሚከሰቱ አካላዊ ለውጦችና ወሲባዊ ባህርያት ከአንተ/ቺ ጋር ተወያይተው ያውቃሉ?			
13. ስለ ወር አበባ ነግረውሃል/ነግረውሻል? (የወንድ ተሳታፊዎች ይህን ጥያቄ ማለፍ ይችላሉ)			
14. ስለ ራሳቸው ወሲባዊ የሕይወት ልምድ/ገጠመኝ አካፍለውህ/ሽ ያውቃሉ?			
15. ወሲባዊ ባህሪህ/ሽ ምን መልክ መያዝ እንዳለበት ያሰቡትን/የተሰማቸውን ነገር ነግረውህ/ሽ ያውቃሉ?			

16. ከዕድሜ ጓደኞች/ሽ የሚመጣብህን/የሚመጣብሽን ወሲባዊ ጫና እንዴት እንደምትቋቋመው/እንደምትቋቋሚው ቀድመው ያሳውቁሃል/ያሳውቁሻል?			
17. ከሴት/ከወንድ ጓደኛህ/ሽ የሚመጣብህን/የሚመጣብሽን ወሲባዊ ጫናስ እንዴት እንደምትቋቋመው/ እንደምትቋቋሚው ቀድመው ያሳውቁሃል/ያሳውቁሻል?			
18. የሴት/የወንድ ጓደኛ ስለመያዝ ወይም ስለመምረጥ አውርተውልህ/አውርተውልሽ ያውቃሉ?			
19. ከአንድ በላይ የወሲብ ጓደኛ መያዝ ስለሚኖረው አደጋ አስረድተውሃል/አስረድተውሻል?			
20. የግብረ ስጋ ግንኙነት ሳይፈጽሙ ስለመቆየት ከአንተ/ቺ ጋር ተወያይተዋል?			

2.1 የእናት - ልጅ ውይይት

ጥያቄ	በፍጹም (1)	አንዳንድ ጊዜ (2)	ሁልጊዜ (3)
እናትህ/ሽ ምን ያህሉን ጊዜ			
1. ስለ ሰው ልጅ አጠቃላይ ፆታዊ ግንኙነት አውርተውሃል/አውርተውሻል?			
2. ከአንተ/ቺ ጋር ስለ ስነ ተዋልዶ/ልጅ እንዴት እንደሚፈጠር ተወያይተው ያውቃሉ?			
3. ግብረ ስጋ ግንኙነት ለመጀመር ተገቢው ወቅት መቼ ስለ መሆኑ አውርተውህ/አውርተውሽ ያውቃሉ?			
4. ከጋብቻ በፊት ያለጊዜው ስለሚደረግ ፆታዊ ግንኙነት አወያይተውህ/ሽ ያውቃሉ?			
5. ስለ ወሊድ መቆጣጠሪያ አስረድተውሃል/አስረድተውሻል?			
6. ከአንተ/ቺ ጋር ስለ ኤች.አይ.ቪ./ኤድስና ሌሎች የአባለዘር በሽታዎች መተላለፊያ መንገድ ተወያይተዋል?			
7. ስለ ኤች.አይ.ቪ./ኤድስና ሌሎች የአባለዘር በሽታዎች መከላከያ ሁኔታስ ነግረውሃል/ነግረውሻል?			
8. ኮንዶምን በአግባቡና ሁልጊዜ ስለመጠቀም አስረድተውህ/ሽ ያውቃሉ?			
9. ያለ ኮንዶም ግብረ ስጋ ግንኙነት መፈፀም ስለሚኖረው አደጋ ይነግሩሽ ነበር?			
10. ስግብረ ስጋ ግንኙነት ስለ መድረስ/ስለ መጎልበት ከአንተ/ቺ ጋር ተወያይተዋል?			
11. ያልተጠበቀ እርግዝና እንዴትና መቼ እንደሚከሰት አውርተውሽ ያውቃሉ?			
12. በወጣትነት ጊዜ ከዕድሜ ጋር ተያይዘው ስለሚከሰቱ አካላዊ ለውጦችና ወሲባዊ ባህርያት ከአንተ/ቺ ጋር ተወያይተው ያውቃሉ?			
13. ስለ ወር አበባ ነግረውሃል/ነግረውሻል? (የወንድ ተሳታፊዎች ይህን ጥያቄ ማለፍ ይችላሉ)			
14. ስለ ራሳቸው ወሲባዊ የሕይወት ልምድ/ገጠመኝ አካፍለውህ/ሽ ያውቃሉ?			
15. ወሲባዊ ባህሪህ/ሽ ምን መልክ መያዝ እንዳለበት ያሰቡትን/የተሰማቸውን ነገር ነግረውህ/ሽ ያውቃሉ?			
16. ከዕድሜ ጓደኞች/ሽ የሚመጣብህን/የሚመጣብሽን ወሲባዊ ጫና እንዴት እንደምትቋቋመው/እንደምትቋቋሚው ቀድመው ያሳውቁሃል/ያሳውቁሻል?			
17. ከሴት/ከወንድ ጓደኛህ/ሽ የሚመጣብህን/የሚመጣብሽን ወሲባዊ ጫናስ እንዴት እንደምትቋቋመው/ እንደምትቋቋሚው ቀድመው ያሳውቁሃል/ያሳውቁሻል?			
18. የሴት/የወንድ ጓደኛ ስለመያዝ ወይም ስለመምረጥ አውርተውልህ/አውርተውልሽ ያውቃሉ?			
19. ከአንድ በላይ የወሲብ ጓደኛ መያዝ ስለሚኖረው አደጋ አስረድተውሃል/አስረድተውሻል?			
20. የግብረ ስጋ ግንኙነት ሳይፈጽሙ ስለመቆየት ከአንተ/ቺ ጋር ተወያይተዋል?			

ክፍል 3: የወጣት ልጆችን ወሲባዊ ባህሪ የሚያሳይ መጠይቅ

ከቀረቡት አማራጮች መካከል ስለአንተ/ቺ ወሲባዊ ባህሪ የሚገልጽ ሃሳብ የያዘውን ቁጥር አክብብ/ቢ

*ለ2ኛው ጥያቄ ብቻ ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት ስትፈጽም/ሚ ዕድሜህ/ሽ ስንት እንደነበር ጻፍ/ፊ

1. የግብረ ስጋ ግንኙነት አድርገህ/ሽ ታውቃለህ/ታውቂያለሽ?
    1. አዎን
    2. አላውቅም
2. መልስህ/ሽ አዎን ከሆነ፣ ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት ስትፈጽም/ሚ ዕድሜህ/ሽ ስንት ነበር?_
3. ባለፉት ስድስት ወራት ውስጥ ከስንት ሰዎች ጋር የግብረ ስጋ ግንኙነት ፈጽመሃል/ፈጽመሻል?
    1. አንድ
    2. ሁለት
    3. ሶስት
    4. አራት
    5. አምስት ወይም ከዚያ በላይ
4. አንተም/አንቺም ሆንክ/ሽ የወሲብ ጓደኛህ/ሽ የግብረ ስጋ ግንኙነት ባደረጋችሁባቸው ጊዜያት ኮንዶም የምትጠቀሙበት ጊዜ ነበር?
    1. በፍጹም
    2. አንዳንድ ጊዜ
    3. ሁል ጊዜ
5. ያልታሰበ/ያልተፈለገ እርግዝና አጋጥሞሽ ያውቃል? (ለወንድ ተሳታፊ የሴት ጓኛውን ማሰብ ይችላል)
    1. አዎን
    2. አያውቅም
6. ያልተፈለገ እርግዝና ካጋጠመሽ ጽንሱን አስወርደሽ ወይም ለማስወረድ ሞክረሽ ነበር?
    1. አዎን
    2. አልሞከርኩም
7. ባለፉት ሶስት ወራት ውስጥ የግብረ ስጋ ግንኙነት ከማድረግህ/ሽ በፊት የአልኮል መጠጥ ወይም አደንዛዥ ዕጽ (እንደ ጫትና ሺሻ የመሳሰሉትን) ተጠቅመህ/ሽ ታውቃለህ/ታውቂያለሽ?
    1. አዎን
    2. አላውቅም
8. ከሚከተሉት መካከል ወሲብ ነክ ለሆኑ ጉዳዮች የበለጠ መረጃ የሚሰጥህ/ሽ የትኛው ነው?
    1. ወላጅ
    2. የዕድሜ እኩዮች
    3. መገናኛ ብዙሀን
    4. ትምህርት ቤት

Appendix-C

Semi-Structured Interview Guide

1. What issues or topics do you wish your father had discussed with you but didn't?
2. What issues or topics do you wish your mother had discussed with you but didn't?
3. How much comfortable are you and your parents while discussing sex-related issues?
4. How do you evaluate the Knowledge and understanding level of your parents about sexual topics?
5. How related are those communications you made with your parents to your sexual behavior?
6. How much impact does mass media and peer group have on your sexual behavior relative to the communication you have with your parents?
7. What is the most serious challenge you faced in relation to sexual matters?
8. What is the most important step you took to avoid/overcome any sexual problem?
9. Who is the person you remember most as a role model in relation to your sexuality?
10. Who is the person you do not want to remember most when sexual issues are raised?
11. What should the role of parents (mothers and fathers) be in relation to their children's sexual behavior?
12. Do you have any suggestions that would help to alleviate problems pertaining to sexuality (for example, roles of government, community, parents, mass media, schools, and peers)?

Appendix-D

Semi-Structured Interview Guide (Amharic Version)

ቃለ መጠይቅ

1. አባትህ/ሽ እንዲያወሩልህ/ሽ ወይም እንዲያስረዱህ/ሽ የምትፈልገው/የምትፈልጊው ነገር ግን ከእርሳቸው ያላገኘኻቸው/ያላገኘሻቸው ርዕሰ-ጉዳዮች ምንድናቸው?
2. እናትህ/ሽ እንዲያወሩልህ/ሽ ወይም እንዲያስረዱህ/ሽ የምትፈልገው/የምትፈልጊው ነገር ግን ከእርሳቸው ያላገኘኻቸው/ያላገኘሻቸው ርዕሰ-ጉዳዮች ምንድናቸው?
3. አንተም/አንቺም ሆንክ/ሽ ወላጆችህ/ሽ ወሲብ ነክ በሆኑ ጉዳዮችላይ በምትወያዩበት ጊዜ ምን ያህል ነጻ ትሆናላችሁ?
4. ወሲብ ነክ ስለሆኑ ጉዳዮች የወላጆችህን/ሽን እውቀትና የግንዛቤ ደረጃ እንዴት ትመዝነዋለህ/ትመዝኚዋለሽ?
5. ከወላጆችህ/ሽ ጋር የምታደርጋቸው/የምታደርጊያቸው እነዚህ ውይይቶች ከራስህ/ሽ ወሲባዊ ባህሪ ጋር ምን ያህል ተያያዥነት/ግንኙነት አላቸው?
6. መገናኛ ብዙሃንና የዕድሜ እኩዮችህ/ሽ በወሲባዊ ባህሪህ/ሽ ላይ የሚያሳድሩብህ/ሽ ተጽዕኖ ከወላጆችህ/ሽ ጋር ስትወያይ/ዪ ከምታገኘው/ከምታገኚው እውቀት አንጻር ምን ያህል ክብደት አለው ትላለህ/ትያለሽ?
7. ወሲብ ነክ ከሆነ ጉዳይ ጋር በተያያዘ አጋጥሞኛል የምትለው/የምትዪው እጅግ ፈታኝ ነገር ምንድነው?
8. ወሲብ ነክ ከሆነ ጉዳይ ጋር በተያያዘ ያጋጠሙህን/ሽን ችግሮች ለመፍታት/ለማስወገድ የወሰድከው/የወሰድሽው ጠቃሚ እርምጃ ምንድነው?
9. አሁን ላለህ/ሽ ወሲባዊ ባህሪ እንደ አርአያ የምትወስደው/የምትወስጂው ሰው ማንን ነው?
10. ወሲብ ነክ ጉዳዮች ሲነሱ ስለሱ ማስታወስ/ማሰብ የማትፈልገው/የማትፈልጊው ሰው ማነው?
11. ወላጆች (እናቶችና አባቶች) የልጆቻቸውን ወሲባዊ ባህርያት በተመለከተ ሊኖራቸው የሚገባ ሚና/ድርሻ ምንድነው ትላለህ/ትያለሽ?
12. በወጣቶች ላይ ያነጣጠረውን ወሲባዊ ችግር ለመቅረፍ ሊረዳ የሚችል ምን አስተያየት አለህ (ለምሳሌ ያህል፣ የወላጆች፣ የመገናኛ ብዙሀን፣ የት/ቤቶችና የዕድሜ እኩዮችን ሚና በተመለከተ)?

DECLARATION

I, the undersigned, declare that this thesis is my original work and all the resources used for the thesis are duly acknowledged.

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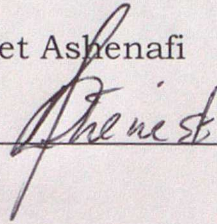
Signature: 

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

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