

Addis Ababa University

College of Social Science

School of Social Work

**ADOLESCENT AND YOUTH-PARENT COMMUNICATION ON SEXUAL AND
REPRODUCTIVE HEALTH ISSUES: THE CASE OF FUTURE HOPES
INTEGRATED DEVELOPMENT ORGANIZATION, ARADA SUB-CITY OF
ADDIS ABABA, ETHIOPIA**

By: Tewedaj Abayneh Mebratu

**A Thesis Submitted to Addis Ababa University School of Social Work in Partial
Fulfillment of the Requirements for for the Master's Degree in Social Work**

**June, 2024
Addis Ababa, Ethiopia**

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This is to certify that the thesis prepared by **Tewedaj Abayneh**, entitled: “*Adolescent and Youth-Parent Communication on Sexual and reproductive Health Issues: The Case of Future Hopes Integrated Development Organization, Arada Sub- City of Addis Ababa, Ethiopia*” in Partial Fulfillment of the Requirements for the Degree of Master of Social Work complies with the Regulations of the University and meets the accepted standards with respect to its originality and quality.

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Abstract

Adolescents and young people in Ethiopia are increasingly experiencing issues related to their sexual and reproductive health. This could be linked to poor communication and early sexual initiation. A delay in sexual activity has been favorably correlated with effective family communication on sexual risk behavior. Various aspects impact the communication between parents and adolescents and youth on SRH in different ways. The study aims to analyze the communication between adolescents and youth and parents on sexual and reproductive health issues focusing on a case of FHIDO, Arada Sub-city, Addis Ababa, Ethiopia. To attain this, a cross-sectional mixed descriptive study was conducted involving 347 randomly selected students from the FHIDO's sponsorship youth development program. A pre-tested, structured anonymous questionnaire was used to collect quantitative data, which was entered, cleaned, and analyzed using the SPSS version 23 statistical package. Qualitative data were also obtained from through FGD and KII interviews with adolescents' fathers and Woreda health professionals. The bivariate, multivariate logistic regression analysis was used to assess the contribution of determinants. Results indicated that one hundred eighty-nine (54.5%) of the students discussed with either of their parents at least on two topics of SRH. However, rather than talking to their parents about the SRH issue, the majority of respondents said that they would rather talk to their classmates or friends. It was also demonstrated that having a literate mother reduced the likelihood of believing in importance of parents and adolescents and youth on SRH issues by 72% [AOR = 0.28; 95%CI (0.13,0.61)]. Adolescents and youth knowing STIs increase the odds by threefold [AOR = 3.73; 95% CI (1.48, 9.43)] compared to other SRH issues. The most reported factors that affect communication between parents and adolescents on SRH issues are shamefulness, parents' lack of knowledge, and not being good listeners and this factors also revealed in the FGD discussants. As the study confirmed, there is a lack of communication on various SRH issues between parents and adolescents, with several causes given for this lack of communication. Thus, to facilitate effective communication on SRH issues, it is advised that sexual and reproductive health education should commence for adolescents and parents and kids in schools, homes, religious institutions, and health facilities based on the study's findings. To determine what influences, how well, and when parent-adolescent communication on sexuality occurs, further research needs to be done.

Key words: Adolescents, youth, reproductive health, parent- adolescent/youth communication

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Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
AYSRH	Adolescent-Youth Sexual & Reproductive Health
CSW	Commercial Sex Worker
FHIDO	Future Hopes Integrated Development Organization
FGD	Focus Group Discussion
HIV	Human Immune Virus
HRSB	High Risk Sexual Behavior
KII	Key Informant Interview
NGO	Non-Governmental Organization
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Right
STI	Sexually Transmitted Infection
SNNPR	Southern Nations, Nationalities, and Peoples' Region
SPSS	Statistical Package for the Social Sciences
UNESCO	United Nations Educational, Scientific and Cultural Organization
UN	United Nations
UNFPA	United Nations Population Fund

CHAPTER ONE

1. INTRODUCTION

1.1. Background of the Study

With approximately 37.4 million individuals in Ethiopia between the ages of 10 and 24, and this made Ethiopia has the second-largest youth population in all of Africa. Adolescent and youth health (AYH) initiatives, which focused on sexual and reproductive health (SRH) and youth development, have gained popularity in Ethiopia over the past 20 years to address the needs of this demographic, particularly after the country's election in 2005. However, several factors, such as teenage pregnancy, unintended pregnancies, poor nutrition, HIV and STIs, unsafe abortions, early and child marriage, and unmet family planning needs, continue to place a heavy burden of morbidity and mortality on Ethiopia's adolescents and youth (Admassu et al., 2022 p.1). This also concides with study conducted in Ethiopia by Muntean and her colleagues (2015); argues that Young people in Ethiopia suffer a multitude of risks to their sexual and reproductive health, including adolescent pregnancy, sexual abuse, and unmet need for family planning.

More than one of every four Ethiopians is an adolescent 10 to 19 years of age while one in three is a young person aged 10 to 24 years (UNFPA, World Population Dashboard, 2020; cited in Admassu et al., p.1). Youth and adolescents between the ages of 10 and 29 are estimated to make up 42% of the population. (CSA and ICF, 2016). In principle, the right investments should be made to this segment of the population in order to contribute to the development of the country. (Admassie et al., 2015; cited in Admassu et al., 2022).

Recently, the global youth population aged between 15 and 24 was accounts for 15.5 percent (UN World Youth Report, 2020, p. 19). Projections suggest that the youth cohort will reach 1.29 billion, which is 15.1 percent of the world total, with more concentrations in Sub-Saharan Africa (20%) and Asia accounting for around 17% to19% (UN World Youth Report, 2018, pp. 28–29). By the year 2030, and it will reach 1.34 billion and account for 13.8 percent of the general population by 2050 (UN World Youth Report, 2020, p. 19). As a result, between 2015 and 2020, the least developed countries' average annual growth rate was 2.3 percent, which is 2.5 times faster than the global population (UN World Youth Report, 2020, p. 19).

The Ethiopian National Adolescent and Youth Health Strategy (2016, p.1) also stated that, Ethiopia's population is young, with 33.8% of people being adolescents and youth (10 to 24 years). SRH, malnourishment, substance abuse, non-communicable diseases, mental illness, injuries, and violence are among the difficulties in the state's adolescents' health issues (Abraham et al., 2019). As a result, there are numerous causes of morbidities and mortalities that Ethiopian teenagers must deal with. Approximately 64% of adolescent females in the nation begin having sex before the age of 18, with 26% beginning before the age of 15 (Abraham et al., 2019, p.50). Moreover, Ethiopian adolescents and young people remained burdened by a high rate of morbidity and mortality associated with consequences for their reproductive health (Admassu et al. 2022). Ethiopia has the fourth-highest percentage of women globally married or in a union before the age of 18 years.

(Girls not Brides, Ethiopia. 2021; cited in Admassu et al., 2022, p.2).

The United Nations Population Fund (2020, p. 7) also asserts that to achieve the Sustainable Development Goal by 2030, unnecessary legal, medical, clinical, and regulatory barriers to the utilization of sexual and reproductive health services must be removed. Sexual and Reproductive Health and Rights (SRHR), including family planning, are a critical component of leaving no one behind. Without them, the attainment of the Sustainable Development Goals (SDGs) will be delayed (UNESCO, 2021, p. 6). Providing SRHR information and services helps adolescents and youth avoid adolescent pregnancy and allows them to remain in school, stay engaged, maintain the quality of their learning, and complete their education (UNESCO, 2021, p. 7). However, different challenges, such as socioeconomic and cultural barriers, significantly affect the achievement of universal coverage of sexual and reproductive health services in developing countries, including Ethiopia. Subsequently, “due to a lack of adolescent/youth-friendly services, many adolescents are reported to die hastily because of accidents, suicide, violence, pregnancy-related problems, and other reproductive health disorders that are either preventable or treatable” (Mekie et al., 2020, p. 2).

The inclusive SRHR definition proposed by the Guttmacher-Lancet Commission (Starrs and others, 2018; cited in UNFPA, 2019, p. 8) covers:

Sexual health, sexual rights, reproductive health, and reproductive rights, and reflects an emerging consensus on the services and interventions needed to address the sexual and reproductive health needs of all individuals. It also tackles topics like violence, stigma, and respect for one's own body, all of which have a significant impact on people's social, psychological, and emotional wellbeing UNFPA, 2019 UNFPA, p. 8).

Thus, realizing the rights of SRH and the provision of such services for this huge population remains a challenge for Ethiopia.

Moreover, the UN defines youth as the life period during which individuals reach sexual maturity. However, the National Youth Policy of Ethiopia states that the age of youth covers the age groups between 15 and 29 years (Ethiopian National Youth Policy 2004), which shows that countries have their own specific age range determination for youth. However, in this study, youth implies a segment of people that fall in the age range of 15 to 24 years. This is to accommodate the youth who are included in the organization, the subject of the study, and to align with the age range that is determined to support the youth in the SRH intervention or project.

Communication on SRH between youth and parents appears to be one of the key strategies to enhance positive SRH behaviors in youth. It is a simple interactive discussion between youth and parents on issues like HIV and AIDS, sexual intercourse, menarche, unplanned pregnancy, and the use of contraceptives. Communication about sexuality and sexual matters is more important for youth than at any other stage of life. Because of this, youth are highly affected by the burden of unplanned pregnancy and its complications, unsafe abortion, HIV and AIDS, STIs, hemorrhage, and other sexual and reproductive health problems (Wachamo et al., 2020, p. 1). Concerning this, the study conducted by UNFPA notes that “the number of preventable maternal deaths in Ethiopia remained high until the first half of 2000 (there were 687 maternal deaths per 100,000 live births in 2005), with unsafe abortion accounting for nearly one-third of all maternal deaths” (UNFPA, 2019, p. 35).

Parent-youth communication regarding sexuality is perceived by many to be an effective means of encouraging youths to adopt responsible sexual behaviors (Usonwu et al., 2021, p. 1). As Nurachmah and her colleagues (2018, p. 172) underscore, “Several publications showed that parents are among the preferred sources for adolescents’ SRH education; therefore, risky behaviors, such as early sexual initiation and unprotected sexual activity, can protect adolescents and youth by improving the quality of communication between parents and adolescents and youth.” Accordingly, this particular study analyzes parent-youth communication regarding SRH issues, with an implication of its importance for youth’s healthy sexual behavior and better sexual and reproductive health interventions for SRH service providers, including FHIDO and beyond.

Considering the above background information, this research will study youth-parent communications regarding sexual and reproductive health issues in Future Hopes Integrated

Development Organization (FHIDO), ‘Arada’ Sub-city of Addis Ababa City Administration. The organization has supported youth empowerment and sponsorship programs for more than 30 years with the support of Child Fund Ethiopia (NGO). Specific to adolescent and youth empowerment on issues related to SRH, FHIDO has the experience of supporting young people such as secondary school students, TVET students, college students, and university students in four project areas such as the ‘Afinchober’ site, ‘Atkiltera’ site, Piassa (‘Doromanekiya’) site, and ‘Kelifa’ site. A total of 1235 youth beneficiaries have participated in the youth development sponsorship program, and SRH is one of the main parts of the program. The SRH support program includes peer education among school and out-of-school youth, the provision of sanitary pads for girls, and awareness-raising programs among parents for better and healthier SRH behavior among the youth. Therefore, the study explores youth-parent communications related to SRH issues in FHIDO in the ‘Arada’ Sub-city of Addis Ababa City Administration.

1.2. Statement of the Problem

Nowadays, there has been a growing interest in the sexual and reproductive health of adolescents and youth all over the world. The United Nations Population Fund (2019, p. 5) states that “SRHR are essential to human life and overall health and well-being over the life course, and, therefore, SRHR should be part of public health and development strategies. In order to strengthen families, investing in SRHR is beneficial to societies.” However, because of cultural and political sensitivities, SRHR often gets little attention in public policy discussions (Yohannes and Tsegaye, 2015). Due to the changing conditions of lifestyle, civilization, and urbanization, the health of adolescents and youth has become increasingly at risk. For instance, STIs, HIV and AIDS, and other reproductive health problems are the greatest threats to youth’s well-being. Additionally, despite the growing SRH-related needs of youth, there is no adequate or separate room for the provision of youth-friendly SRH services specifically suitable for this specific age group (Fikre, 2009). In addressing gaps in the delivery of SRHR interventions, it is relevant to consider the political, social, cultural, gender, economic, and financial barriers that prevent young people from fully achieving their sexual and reproductive health and rights (UNFPA, 2019, p. 6).

Although adolescents and youth constitute one of the most dynamic human resource bases and one of the healthiest groups in most populations, their potentials are often negated by the poor choices they make, which translate to risky behaviors and eventually ill health (Adeokun et. al., 2009, p. 38). Adolescents and youths often engage in a wide range of high-risk sexual behaviors that can result in adverse health, social, and economic consequences for themselves and their families.

Early sexual intercourse is a severe adolescent risk behavior. Moreover, early initiation of sexual intercourse is associated with other behaviors that increase risks, including more frequent intercourse, multiple sexual partners, and a low probability of contraceptive use during the adolescent years. Individuals who initiate sexual intercourse relatively in their early adolescence age are at high risk for STIs (Fikre, 2009).

As one of the strategies to reduce SRH-related risks on adolescents and youth, communication between youth and parents is essential. In this respect, Sagnia, Gharoro, and Isara, (2020) argue that effective and positive communication between parents and their children about sexual and reproductive health issues helps adolescents to establish individual values and make sexually healthy decisions. They further explain that good adolescent–parent communication promotes healthy sexual development and reduces sexual risks in adolescents. Supporting this idea, (Bikila et al., 2021, p.2), articulates that parent communication with adolescents regarding sexuality is regarded as critical for informing adolescents of risks and protective behaviors, providing guidelines on values and standards of behavior, and decreasing the likelihood of youth’s engagement in risk behaviors.

Nevertheless, regarding youth-parent communication related to SRH issues, the research findings in the Ethiopian context reveal that the communication between youth and parent is not as needed. For instance, Mekie, and his colleagues (2020, p.12) argue that in Ethiopia, the prevalence of parent-adolescent communication on SRH issues was low. Similarly, the finding of the study conducted in Yirgalem town reveals that parent-adolescent communication on sexual and reproductive health issues was low due to a lack of communication skills, shame, embarrassment, and cultural taboo to discuss the SRH issues (Yohannes and Tsegaye, 2015). Even though, adolescents/youth have aware of sexual & reproductive health services, the study conducted in Hadiya Zone, SNNPR also stated that “adolescents were not communicating much with parents about sexual and reproductive health issues” (Kusheta et al., 2019, p.1). Another study conducted in the Benishangul Gumuz region also underlines, “Adolescents/youth preferred their friends/peers of similar sex for the communication of on sexual and reproductive health issues than parents” (Yesus and Fantahun, 2010). Parental and cultural factors, fear, shyness, ignorance, and lack of communication skills among youth and parents were among the key reasons for poor youth-parent communication on SRH issue (Yohannes and Tsegaye, 2015; Sagnia, Gharoro and Isara, 2020). To improve the unpleasant SRH problems, several strategies need to be employed, such as providing adolescents and youth with knowledge enhancing positive attitudes, and skills to prevent

HIV infection and other SRH risks and also establishing counseling service outlets, media campaigns, and family communication about SRH (Fikre, 2009, p.11).

Thus, as the earlier discussions revealed, adolescents and youth and parent communications about SRH issues are regarded as an effective way to reduce risky sexual behavior and HIV infection among adolescents. However, its practice in Ethiopia and other parts of Africa is low. In doing so, the researcher of this study believes that the health and well-being of young people will improve through conducting in-depth and context-based research since people's perceptions and experiences on SRH and their socio-economic and cultural backgrounds vary from area to area or from context to context. It also requires forwarding specific and context-based recommendations for better SRH behaviors of the youth.

Considering the above discussions, this research aims to explore parent-youth communication concerning SRH issues in Future Hopes Integrated Development Organization. Future Hopes Integrated Development Organization (FHIDO) has been working since 1986 on supporting the right of sexual and reproductive health to youth and empowering them towards this. The researcher decided to do this research because no research has been done on parent-youth communication on SRH issues in the organization (FHIDO) as well as in its project sites in Arada Sub-city of City Administration of Addis Ababa (as far as the researcher knowledge is concerned); believing in conducting a tailored study and implementation of evidence-based SRH interventions contribute to the effectiveness of the program and delivery of better results for youth's wellbeing; and undertaking institutional and specific research enables to explore in-depth SRH problems and suggest workable recommendations for program improvement and knowledge generation. My study will also be specific in dealing with the situations of youth-parent communication on SRH provided their engagement in different organizational SRH interventions along with urban context/culture, Arada sub city, Addis Ababa's residents who are assumed to have relatively better information than the rural context. It allows exploring whether such a context might contribute to or hinder youth-parent communications on SRH issues.

Moreover, the researcher's experience while working as a development worker in FHIDO for eight years also shows that the youth who are participating in the FHIDO SRH program have no mention of any experience of discussion with their parents about SRH matters and raised my curiosity to study their communications on SRH issues. Through communication with social worker colleagues in FHIDO, the researcher also learned that there are some cases of SRH problems that beneficiary youth encounter (e.g., unplanned and early pregnancy) that need more systematic and

evidence-based support for the well-being of disadvantaged youth. Additionally, FHIDO has no research-supported projects' intervention on SRH, as it became an issue of concern for its management and program staff, and this study will be a contribution to the organization in introducing evidence-based development work. Therefore, considering the background of and acknowledging the research problem as it deserves an in-depth study to support the well-being of youth, this research will explore parent-youth communication concerning SRH issues in Future Hopes Integrated Development Organization in Arada Sub-city of City Administration of Addis Ababa. Eventhough, so many related research conducted in Ethiopia and still the research gap is the same and the researcher was aspired to explore the specific situation of parent-adoscent/youth communication on SRH issues in FHIDO project intervention Woredas located in Arada subcity. Since, there was no research conducted in the stated subcity. Towards achieving this aim, the study focuses on the practice of youth-parent communication concerning SRH issues, SRH's knowledge and attitudes of parents and youth, and factors negatively and positively affecting youth-parent communication and suggestions to promote healthy SRH behavior for adolescents and youth.

1.3. Research Objectives

1.3.1. General Objective

The general aim of this study is to explore parent-youth communication concerning sexual and reproductive health issues in Youth Development Sponsorship Program in Future Hopes Integrated Development Organization, Arada sub-city, Addis Ababa.

1.3.2. Specific Objectives

- To describe the practice of adolescents and youth-parent communication concerning SRH issues.
- To identify the knowledge of parents on SRH towards discussion with their youth on the SRH issues.
- To identify the attitude of parents on SRH towards discussion with their youth on the SRH issues.
- To identify the knowledge of the youth on SRH towards discussion with their parents on the SRH issues.

- To identify the attitude of the youth on SRH towards discussion with their parents on the SRH issues.
- To find out the major factors that affect communication between youth and parents concerning SRH issues.
- To find out the influence of parent-youth communication on youth's SRH understanding and practices.

1.4. Research Questions

- What are the socio-demographic characteristics of youth's parents in FHIDO, and how it affects the communication between youth and parents on SRH issues?
- Does the knowledge of parents on SRH issues directly affect the positive SRH behavior of the youth on and how?
- Does the attitude of parents towards discussion on SRH issues directly affect the positive SRH behavior of the youth on and how?
- Does the knowledge of youths concerning SRH issues directly relate to the communication between parents and youths on SRH issues?
- Does the attitude of youths towards discussion on SRH issues directly affect the communication with their parents concerning SRH issues?
- What are the major factors that negatively affect the communication between parents and youth on SRH issues (e.g. social, culture, economic, education background)?
- What are the major factors that positively influence the communication between youth and parents on SRH issues?
- Do the youth practice a healthy SRH life and what encourages them to do so?

1.5. Significance of the Study

The study explores parent-youth communication concerning SRH issues in Future Hopes Integrated Development Organization in Arada Sub-city of Addis Ababa City Administration. In doing so, the study will have the following significance:

- It generates knowledge on youth-parent communication on SRH issues and contribute to the existing knowledge in the area.
- It informs the Future Hopes Integrated Development Organization, its management bodies, experts and community development workers to plan and implement evidence-based SRH programs and provide better services for the healthy, wellbeing and positive behavior of youth in the organization and other NGOs working on SRH.
- It provides information for the researchers who want to conduct a study on youth-parent communication on SRH and related issues.

CHAPTER TWO

2. LITERATURE REVIEW

In this section, there were about nine issues stated to contribute to the aforementioned research questions. These are general overview of sexual and reproductive health, parent-youth communication on SRH issues, knowledge and attitude of parents and youth on SRH, sexual behavior of adolescent and youth, risky sexual behavior of adolescents, gender preference to discuss SRH issues, SRH services for adolescents/youth, factors affecting parent-youth communication on SRH, and benefits of parent-adolescent/youth communication on SRH issues. The detailed literature was reviewed as follows:

2.1. An Overview of Sexual and Reproductive Health

Adolescent and youth sexual and reproductive health has emerged as an area of major concern in the world, including in Ethiopia. Under universal health coverage (UHC), sexual and reproductive health and rights (SRHR) are an essential part. As they progress toward UHC, nations must take into account how to meet the SRHR needs of their citizens at every stage of life, from early childhood and adolescence to adulthood and old age (UNFPA, 2018, p. 3). WHO defined “adolescents ”and ”young people “as the age groups 10–19 years and 10–24 years, respectively. Young people cover over one-quarter of the world’s population. Thus, overlooking this population has a major impact on sexual and reproductive behaviors as they develop into adults (Gebre Yesus and Fantahun, 2010). Reiterating the importance of SRH, the World Health Organization (2017) articulates that:

For the sustainable and equitable development of societies, improved sexual and reproductive health is a key pillar of the overall health, empowerment, and human rights of individuals. Sexual and reproductive health-related problems, including too many, too early, and too frequent pregnancies, remain a major cause of mortality and disability among women and girls, particularly among the most vulnerable, marginalized, and underserved. Poor sexual and reproductive health has a significant contribution to poverty, thus limiting socio-economic development. Conversely, achieving sexual and reproductive health allows individuals and communities to

contribute to economic development. (World Health Organization cited in Ussher, Chrisler, and Perz, 2020, p.1).

As a global agenda, Reproductive Health emerged following the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994. ICPD also heralded Women's Sexual and Reproductive Rights, and constituted the framework for the development of the United Nations Millennium Development Goals (MDGs) in 2000 (cited in Adinma and Adinma, 2011, p.9). Since then, there has been a growing interest in the sexual and reproductive health of adolescents all over the world.

Furthermore, according to Maria (2007, p. 15), "the HIV and AIDS pandemic, growing rates of other sexually transmitted infections, and complications of early, unplanned, or unplanned pregnancy" make young people's sexual and reproductive health issues of international and national significance.

However, adolescents and youth constitute one of the most dynamic human resource bases and one of the healthiest groups in most populations; their potential is often negated by the poor choices they make, which translate to risky behaviors and eventual ill health (Adeokun et al. 2009, p. 38). Furthermore, despite their extreme importance, there has not been sufficient funding to increase access to sexual and reproductive health (SRH) services for most people across the globe. This is even more pronounced in lower- and middle-income countries where funding for sexual and reproductive health and rights (SRHR) is largely donor-driven (Akazili et al., 2020, p. 2). In addition to a lack of funding and appropriate information, "young people may also find it difficult to access sexual and reproductive health services. A major obstacle for many young people is the discrimination they face by some health service staff in accessing contraceptive and STI services in primary health care settings" (Wood and Aggleton, 2004, p. 1). Considering the challenges discussed above, enhancing parents-adolescents' and youth communication on SRH issues hugely helps to improve the better and healthier sexual behavior of the youth.

2.2. Parents-Youth Communication on SRH Issues

Although sexual and reproductive health are the most fundamental parts of life, because of cultural and political sensitivities, they often get little attention in public policy discussions. Parents are the potential source of sexual and reproductive health information for adolescents and youth, and a lack of communication among them is a serious problem, particularly in developing countries,

which results in emotional distress, lower self-esteem, school problems, drug use, and sexual risk behaviors (Tegegne et al., 2019, p. 2).

Focusing on young women, SRH also continues to pose a tremendous challenge for policymakers and health care providers. Many young women often lack basic information, knowledge, and access to reproductive health services (Wong, 2012, p. 1). To promote adolescents' and youth's healthy sexual and reproductive behavior, parent-child communication on SRH issues is critical in informing youth about risk and protective behaviors, which in turn decreases the likelihood of involvement in risky sexual behaviors (Mekie et al., 2020). However, due to the social restrictions in many traditional communities, parent-adolescent discussion regarding sexual matters is still difficult in Ethiopia (Yohannes and Tsegaye 2015).

Regarding parent-child communication on SRH issues, Motsomi (2016, p. 5) asserts that:

Parent-adolescent communication about sexual and reproductive health issues is important in reducing risky sexual behaviors and the consequences associated with such behaviors among adolescents. By taking the roles and responsibilities of parents and adolescents into account, there is a need to modify interventions to accommodate both worlds, find the middle ground between parents, and promote cultural integration of traditional and western norms as a way of encouraging effective parent-child communication (Motsomi, 2016, p. 5).

Access to reproductive health services, knowledge, and basic information are lacking for many young women. The first and primary sexual educators of children are parents. On the contrary, because of cultural taboos, many adolescents and youth do not feel comfortable discussing sex-related issues with their parents (Wong, 2012, p. 1). Early childhood experiences are also central in the patterning of an individual's emotions' development, and therefore, the absence of such an experience brings youth and adults' behavioral problems throughout their lives (Hutchison, 2015). Thus, early years' parent-child communication on SRH issues improves children's connectedness to the family, which is also a protective factor in reducing adolescents' risk-taking behavior (Holloman, 2021, p. 12).

Although parents often have difficulty communicating about sex, positive communication between parents and children greatly helps young people establish individual values and make healthy decisions on SRH matters (Whittaker, 2010, p. 1). When young people experience feelings of not being connected to home, family, and school, they may be involved in activities that put their health and lives at risk (Holloman, 2021, p. 13). Teachers and medical professionals are also hesitant to tell young, single people about sex issues. The reasons for the reluctance were discomfort discussing the issues or erroneous beliefs that providing the information would encourage sexual activity (Wong, 2012, p. 1).

The study conducted in Ethiopia, Sawla town, and Gofa Zone revealed that 485 (74.27%) of parents and youth did not have any discussion on SRH issues. The remaining research participants were able to discuss SRH issues: puberty 54 (8.3%), sexual intercourse 156 (23.9%), contraceptive 46 (7.0%), condom use 24(3.7%), STI 138 (21.1%), and unintended pregnancy 120 (18.4%), respectively, were the topics of discussion between parents and adolescents about SRH issues (Malango et al., 2021, p. 10).

Lastly, they have concluded that parent-[adolescents/youth] communication on sexual and reproductive health matters is uncommon based on "several studies in developing countries that have focused on the nature and influence of parent-[adolescents/youth] communication on these matters" (Biddlecom, Awusabo-Asare, and Bankole, 2009; Kiragu et al., 2007, cited in Svodziwa et al., 2016, p. 63).

2.3. Knowledge and Attitude of Parents and Youth on Sexual and Reproductive Health Issues

Although almost all adolescents have some information about sexually transmitted infections, they lack adequate knowledge about transmission and presentation (Adeokun et al., 2009, p. 38). Kusheta and his colleagues (2019, p. 2) also say that adolescents in sub-Saharan Africa were not well informed about sexual and reproductive health matters because their major sources of information were friends (Kusheta et al., 2019, p. 2). Researchers have demonstrated that parental knowledge and attitudes influence adolescents in terms of health behavior, including early sexual initiation. There is also "growing evidence showing that various parenting dimensions like connectedness, love, material support, behavioral control, monitoring, and parent-adolescent communication are positively associated with reduced levels of risk-taking among adolescents" (Muhwezi et al., 2015, p. 2).

With regard to the knowledge and attitude of parents and youth on SRH, research findings suggest that “in South Africa, the knowledge of adolescents and youth regarding pregnancy and other reproductive health issues was limited, and moreover, with their repeated pregnancy, adolescents were noticeably having no better information about pregnancy and other sexual and reproductive health matters (Govender et al., 2019, p. 1). According to the findings, 79 (24.2%) of the 326 participants felt that having sex before getting married is appropriate, while 87 (26.7%) felt that it is impossible to avoid having sex while a teenager. According to Govender et al. (2019, p. 8), only sixty-one individuals (18.7%) believed that a female who chooses to be a virgin during her adolescent years is old-fashioned.

Regarding parents’ perceptions of SRH, some parents felt that they were neither educated nor trained to discuss SRH issues with their children at home. The majority of the parents mentioned in the FGD that they had no knowledge of which issues were related to SRH (Ram et al., 2020, p. 3). Besides, parents mentioned that issues around SRH were not discussed openly since it is still considered taboo, and thus, they felt that the schools were a good opportunity to teach young people about SRH issues (Ram et al., 2020, p. 3).

The study conducted at Ebony state Nigeria also mentioned that, when it comes to sex-related issues, some parents reported that they do not want to discuss them with their adolescents. Some parents also stated in the FGD that having discussions about sex with their adolescents does not make them feel comfortable. Parents are also restricted by religious and cultural norms from having sex-related discussions with their children (Mbachu et al., 2020, p. 8).

In the Ethiopian context, the study conducted at Benishangul Gumuz Bullen woreda revealed that most mothers in the FGD had little or no discussion with their adolescents on reproductive health issues such as menses and sexual intercourse because it was culturally unacceptable and created awkwardness. Some thought that talking about this issue in detail might rather encourage or remind adolescents to be engaged in sex (Yesus & Fantahun, 2010). The study conducted on Metu secondary and preparatory school students also indicated that out of 361 respondents, 75.9% of them have awareness about risky sexual behaviors, and about 76.5% of them have awareness of the consequences of unsafe sex. However, among the total study participants, about 22.7% of them had previously practiced sexual activity; of these, 61.7% of respondents had more than one sexual partner. Among the respondents who had practiced sex during sexual intercourse with their partners, 19.8% of them always used condoms, while 58% of them never used condoms during sexual intercourse (Keto et al., 2020, p. 1).

Further research at Ambo University also showed that although students were aware of STIs, they did not put their knowledge into practice, which led to SRH and STI problems among the student body (Yared et al., 2017, p. 6). Thus, a Western Ethiopian study likewise found that 50 individuals (10.32%) out of 771 who had visited health facilities for any kind of care had ever encountered adolescent and youth SRH services. Teenagers and young adults who were utilizing sexual and reproductive health services were therefore few in number (Tilahun et al., 2021, p. 2).

Girls between the ages of 20 and 24 account for 37% of unintended pregnancies due to inadequate access to reproductive health information and education, restricted usage of contraceptives, and ignorance of sexual physiology. Despite this, adolescents believe that using contraceptives other than condoms causes infertility (Feyissa et al., 2020, p. 2). Furthermore, 318 (84.1%) of the 394 participants in the study which was carried out in secondary and preparatory schools in Fiche Town reported having ever heard of sexual and reproductive health issues. According to them, schools accounted for 238 (74.8%) of the information sources in this regard, while the media accounted for 64 (20.1%). Additionally, 370 individuals, or 97.9%, stated that they were aware of one or more STIs. With 364 (98.3%) respondents knowing about HIV, it was the most common STI, followed by gonorrhea with 235 (63.5%) (Feyissa et al., 2020, p. 4).

2.4. Sexual Behavior of Adolescents and Youth

People who engage in sexual behavior do so in order to satisfy their sexual urge, one of their basic needs. The method by which sexual activity is performed can often have negative consequences. However, the age, gender, and culture all influence what constitutes dangerous sexual conduct (Chawla and Sarkar, 2019, p. 26). Adolescents engage in a variety of sexual activities as a means of experimenting and proving to be adults. Sexual behavior is defined as any action that satisfies one's sexual urges. Teenage sexual behavior is influenced by a complex interaction of factors, such as personal perspectives, personality traits, biology and genetics, and sociocultural norms and values (Kato, 2021, p. 5). Although sexuality and its expression are normal, the circumstances in which they are manifested might make them dangerous or aberrant (Chawla and Sarkar, 2019, p. 27). For example, 196 (33.22%) secondary and preparatory students in Ambo Town, Ethiopia, participated in a survey wherein it was found that having sexual feelings during adolescence was normal and acceptable. In terms of their behavior, 76 students (12.88%) reported having had sex in the past, with 30 of them (39.48%) having had many partners. 49 (64.47%) of the individuals with a history of sexual activity engaged in non-condom-using sex (Bikila et al., 2021, p. 6). These

seem to be dangerous sexual activities that put young people at risk of STIs, including HIV, and have an impact on their lives and health.

2.5. Risky Sexual Behavior of Adolescents and Youth

High-risk behaviors are those that have the potential to negatively impact teenagers' general development and well-being or to prevent them from achieving success and developing in the future. These include actions that result in immediate bodily harm (like fighting) as well as actions that have long-term detrimental impacts (like drug use) (Guzaman, 2014, p. 1). High-risk activities can profoundly damage the lives of youth and those around them. Because of this, it is crucial that parents, teachers, and other concerned adults learn about the frequency of these behaviors, the circumstances that make them more likely, and the steps that may be taken to reduce or eliminate the hazards involved (Guzaman, 2014, p. 1).

The risky behaviors of adolescents and young adults are defined as follows: using tobacco products, abusing alcohol, using other illegal drugs, or driving while intoxicated (Jessor, 1991; Arnett, 2000); engaging in unprotected sex (Arnett, 2000; Lerner, 2002); acting aggressively during early sexual encounters; engaging in violent dating situations; abusing drugs or alcohol (Lerner, 2002); engaging in delinquent behavior (Jessor, 1991; Arnett, 2000; Lerner, 2002); dropping out of school and failing grades; and crime/violence (Lerner, 2002) (quoted in Savi-Cakar, Tagay, and Ikiz, 2015, p. 9). Adolescents and young people who engage in sexual activity are therefore among the most high-risk behaviors because many of them do not follow safe sexual practices and may not be prepared for the social and emotional ramifications of doing so (Guzaman, 2014, p. 2).

Unprotected sex, sex while under the influence of drugs, sex with people who inject drugs, having several partners, starting sex at a young age, sex with female sex workers, paid sex, or casual sex are all examples of risky sexual conduct. STIs, HIV, unplanned pregnancies, teenage pregnancies, and abortions are the negative consequences of high-risk sexual behavior (HRSB) (Chawla and Sarkar, 2019, p. 30). Risky sexual behaviors, including early sexual debuts, multiple sexual engagements, and condom-free sexual encounters, have also been documented among young people in the African Region, according to Ali and his colleagues (2021, p. 2). For example, HIV is highly prevalent in Sub-Saharan Africa, where heterosexual acts are the primary mode of transmission.

As a result, more young people in Sub-Saharan Africa than in other nations are affected by half of all new HIV infections. In addition to HIV/STIs, unplanned pregnancies are a significant adverse consequence of risky sexual behavior that may have a particularly strong effect on the health of young women as well as increase their likelihood of poverty and social exclusion in the future (Ali et al., 2021, pp. 5–6).

In the Ethiopian context, 221 (27.4%) of the 806 respondents in the survey carried out in the Mecha district and Bahir Dar city stated that they had ever engaged in sexual activity, with a mean age of 16.2 for first sexual activity. Of the adolescents who reported being sexually active, over 60% reported having had sex in the 12 months prior to the study; nearly half (48.5%) reported having numerous partners; and 66% reported not always using a condom during sex. 13.2% of all the study participants, who were adolescents, engaged in risky sexual conduct (Asrese and Mekonnen, 2018, p. 5).

Additionally, 306 (38.5%) of research participants in a school-based survey performed in Wolaita Sodo reported having ever engaged in sexual activity with them; 202 (66.0%) of the individuals were males, and 104 (34.0%) were females; 196 (24.7%) of them participated in unsafe sexual activities (Azeze et al., 2021, p. 1). The first sexual experience might occur anywhere between the ages of 14 and 27. Among the respondents, the most common motivations for engaging in sex were alcohol and/or drug usage (43.3%), sex for enjoyment (57%), and peer pressure (60.8%) (Azeze et al., 2021, p. 5).

2.6. Gender Preferences to Discuss SRH Issues between Parents and Adolescents and Youth

Parents are in a unique position to influence young people's health, personal development, and their transition to sexual life. Parents are the first socializing agents for children. The family plays a significant role in the lives of young people. Family environment plays a key role in the timing of sexual and reproductive health transitions in adolescents (Svodziwa, Kurete, and Ndlovu, 2016, p. 62). In terms of discussion on SRH issues, Motsomi et al. (2016, p. 5) argue that:

Sensitive issues such as explanations of condom use, the acquisition of HIV and AIDS and STIs, and the child's physical development are rarely discussed because of a lack of knowledge and cultural norms that restrict

interaction between opposite sexes. When SRH discussions occur, they are mainly on a same-sex basis (Motsomi et al., 2016, p. 5).

Within the context of limited parent-youth communication, mothers communicate more often with girls than boys, and fathers very rarely communicate with boys than girls. The major reason is that both parents feel shy and, hence, find it difficult to openly talk to their children (Kamangu et al., 2017, p. 2). The same study found that teenage girls' propensity for communication is trending in the same direction. According to Kurniawati et al. (2021, p.3), stigma and taboos rooted in sociocultural factors are the cause of this. On the other hand, research indicates that parent-child discussion about sex-related issues is uncommon. Communication with fathers in Sub-Saharan Africa is very uncomfortable most of the time (Awusabo-Asare, Bankole, & Kumi-Kyereme, 2008, quoted in Syodziwa Kurete, and Ndlovu, 2016, p. 63).

Gender differences exist in parent-adolescent communication with SRH difficulties, according to Sierra (2013, p. 5). Mothers were noted as having the confidence to speak to their daughters, and fathers were mentioned as having the same faith in their sons. Despite mentioning talking about the same or related topics, each parent spoke to the youngster in a gender-specific manner. This is supported by a study done in Asella, Ethiopia, which found that most female parents prefer to talk to their daughters (50.7%), whereas male parents talk to their sons and daughters (53.1%) (Bekele et al., 2022, p. 5). Furthermore, a comparable survey among secondary school students in Woreta Town revealed that, of 360 respondents, 169 (46.9%) talked about SRH difficulties mostly with their mother, with brothers and sisters coming in second with 150 (41.7%) (Wudineh et al., 2021, p. 3).

2.7. Sexual and Reproductive Health Services for Adolescents and Youth

A reproductive health service is one that health professionals provide to adolescent/young girls at government or private health centers, health posts, and hospitals. These services may include information about sexually transmitted infections and how to manage them, short-acting family planning to avoid unintended pregnancies, and abortion care and management (Negash, 2016, p. 5). In order to promote excellent health through preventive and curative care, health services are essential. More precisely, family planning, including infertility services, abortion, STI/HIV treatment and care, information, and counseling are all included in the category of sexual and reproductive health services (WHO, 2004; cited in Warenius, 2008, p. 3). Reproductive health

treatments have historically been reserved for married, older women in many low-income nations. Reproductive health care was not anticipated to be necessary for young, single individuals (Hughes and MacCauley 1998; Senanayake et al., 2001, cited in Warenius, 2008, p. 3).

A variety of SRH services are needed to address the requirements of adolescents and youth in all of their diversity if SRH outcomes are to be effective. But every service provided in a single location or every customer interaction is not expected. Based on the knowledge and resources the clinic has on hand as well as an awareness of the requirements of the community it serves, the service mix should be developed. The supplier then provides the required services in accordance with the most recent national standards or makes appropriate referrals, either to another facility or within the facility (IPPF and UNFPA, 2017, p. 23). "For the implementation of SRH services including maternal and child health, safe abortion and post-abortion care, and GBV, lack of adequate funding for the implementation and sustaining of these activities in countries is one of the biggest challenges," (Akazili and his colleagues, 2022, p. 7).

Thus, all adolescents and young adults should have access to youth-friendly services, regardless of their age, marital status, HIV status, sexual orientation, gender identity, employment, social standing, location, or financial situation. Private, judgment-free, stigma-free, and confidential services are what people should expect (IPPF and UNFPA, 2017, pp. 23-57).

2.8. Factors Affecting Parents- Adolescents/Youth Communication

Adolescent sexual and reproductive health (ASRH) outcomes have been demonstrated to be significantly influenced by parent-adolescent/youth communication. Nonetheless, a number of factors influence the communication on sexual and reproductive health issues between parents and adolescents or children. Additionally, there are elements that support parent-youth dialogue about SRH matters. Good, respectful communication, accountability, showing unity, and enjoyment were some of the positive behaviors seen in teenagers and young adults (Sierra, 2013, p. 8). However, intergenerational disparities, a lack of understanding of SRH concerns, and a lack of trust between parents and adolescents and youth are some of the main obstacles to successful communication between parents and youth regarding SRH issues, according to Sierra (2013, pp. 10–12).

According to Motsomi et al. (2016, p. 2), youth and parent-adolescent communication about sexual and reproductive health issues raises knowledge of these issues and safeguards the sexual and reproductive health of adolescents. Regarding this, they said that lower levels of risk-taking among

adolescents are positively correlated with stronger bonds and communication between parents and their kids. On the other hand, parents avoid talking to their kids about some subjects a lot because they find it embarrassing and uncomfortable. For example, compared to 90% of parents in the USA, "studies conducted in Lesotho and Ethiopia report that as few as 20% of parents discussed sexual matters with their adolescent children" (Motsomi et al., 2016, p. 2).

Furthermore, as stated in Bisika, 2008, p. 80, "cultural practices, religion, and beliefs combine to prevent people from adopting protective behaviors and put men, women, boys, and girls at risk of HIV and AIDS, STIs, and unplanned pregnancy." Effective parent-teen and youth communication about sexual and reproductive health issues is hampered by gender disparities and traditional or cultural norms, despite the fact that parent-child communication is crucial to lowering risky sexual behaviors (Motsomi et al., 2016, p. 2). According to parental perspectives, parents are worried about their children's transition into the sexual world, but they are also limited by cultural norms, a lack of knowledge, and their own limited abilities to interact with them and create the kind of supportive environment they need (Svodziwa, Kurete, and Ndlovu, 2016, p. 69).

Additionally, parents thought about having a conversation with their kids and teenagers about sexuality since it discourages them from having hazardous sexual behavior and early sex, which can lead to teenage pregnancy and STIs (Klu et al., 2022, p. 14). According to the results of the Ethiopian study, fear of parents (68.9%) and shame (126, 35.0%) are two of the main variables that have a negative impact on parents and youth's ability to have an open talk about SRH concerns (Wudineh et al., 2021, pp. 3-4). According to a study done in the Wogdie district of North Ethiopia, the main things preventing parent-adolescent communication are ignorance of SRH, fear, cultural taboos against discussing SRH with teenagers, which make them rude, and religious taboos against discussing SRH, which predispose teenagers to sin (Ewnetu et al., 2021, p. 17).

2.9. Benefits of Parents-Adolescents and Youth Communication

In order to lower risky sexual behaviors and their associated effects, it is essential that parents and young people communicate about SRH issues. It is the essential process by which parents teach their kids sexual norms, knowledge, expectations, and beliefs in an effort to shape their sexual attitudes, behaviors, and decision-making (Abdissa & Sileshi, 2021, p. 3). Research has examined and emphasized the protective role that parent-child communication about sexuality plays in assisting adolescents in making responsible sexual behavior decisions. Young people who feel safe

in their family and community are less likely to participate in high-risk sexual practices when their parents are involved and communicate with them (Holloman, 2021, p. 18).

Additionally, talking about sexual and reproductive health (SRH) issues with parents and adolescents lowers risky behaviors in teenagers, raises understanding of reproductive health issues, and helps to prevent unfavorable reproductive health outcomes (Malango et al., 2021, p. 2). Reducing adolescent risk-taking sexual behaviors and delaying early sexual activity and contraceptive use are two outcomes of effective parent-child communication about SRH issues (Bekele et al., 2021, pp. 3-4).

According to a qualitative study done in the USA on middle school-aged children, kids who had good communication from their parents regarding sex, birth control, and STIs were twice as likely to have used condoms as kids who didn't have those talks (Holloman, 2021, p. 4). Students at government public schools were less likely than those in private schools to speak about SRH issues, according to a study done in Ambo town among secondary and preparatory students. This might be the result of socioeconomic disparities, parental educational backgrounds, and parental access to SRH information, all of which could have an impact on how parents and teenagers communicate (Bikila et al., 2021, p. 9).

Svodziwa, Kurete, and Ndlovu (2016, pp. 69–70) recommended that to enhance parent-youth communication as well as adolescents' and youths' healthy sexual and reproductive behavior: parents should start early conversations with their adolescents/youth children about sexuality before they engage in sexual activity, parents should also discuss with their children on physical and psychological change on puberty, and there is need to implement and test the effectiveness of interventions designed to improve parental- adolescents communication and interaction. Moreover, according to (Svodziwa et al., 2016, p. 70); parent- adolescent communication on sexuality should be supported through various mechanisms. Among these is promoting school sex education homework assignments designed to be completed by both parents and adolescents to improve parent-adolescent communication. In doing so, the media should keep encouraging parents to get involved in their children's sex education, in order to reduce the cultural barriers associated with sexuality education.

In general, raising awareness among parents and adolescents/youth about sexual and reproductive health issues is necessary and providing training for parents on how to interact with their children

of the opposite sex and the mentioned ideas will narrow the communication gaps and in turn enhancing the healthy parent-adolescent/youth communication on sexual and reproductive health issues (Svodziwa, Kurete, and Ndlovu, 2016, p. 70).

2.10. Conceptual Framework

After examining the pertinent literature articles, a conceptual framework was created for this work, as shown in Figure 1. As the image illustrates, communication on SRH concerns between parents and adolescents/youth is influenced by socio-demographic characteristics, parents' perceived openness, and understanding of SRH. This communication may be further linked to sexual behavior and decision-making in youth. It is also evident that adolescents' and young people's sexual conduct is closely related to sociodemographic traits and level of knowledge about SRH.

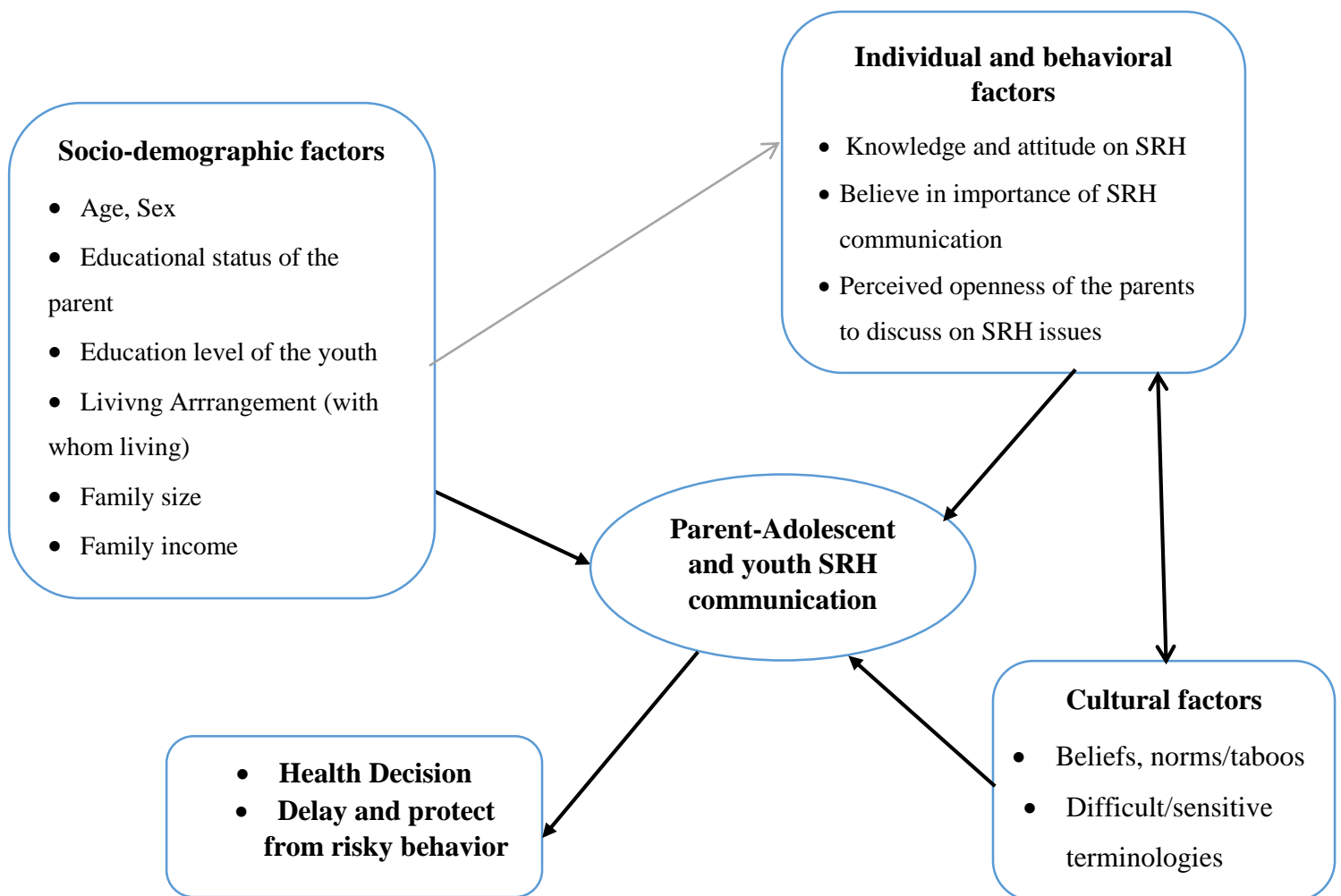


Figure 1 Conceptual framework Framework of communication between parents and adolescents on SRH, (Feyissa et al., 2020, p.419).

CHAPTER THREE

3. RESEARCH METHODS

3.1. Study Design

A descriptive mixed-methods approach was employed to undertake this study. This mainly includes quantitative surveys and qualitative interviews and FGDs. Quantitative data collected from youth and qualitative data collected from parents via FGDs and key informants from fathers and Woreda Health Offices. This research method is selected as it helps to adequately respond to the research questions and address both quantitative and qualitative issues related to SRH.

3.2. Study Setting and Areas

The study was conducted in Addis Ababa City Administration, Arada Sub-City, and focuses on Future Hopes Integrated Development Organization Youth Development Program beneficiaries as a case study. Future Hopes Integrated Development Organization (FHIDO) is located in Addis Ababa City Administration Arada Sub-city, and the project sites are located around Afinchober, Doro Manekia, Atkiltera, and Kelifa. The total number of beneficiaries under the youth development program among the four project sites is 1235 (627 girls and 608 boys).

3.3. Study Population

The study population for this particular study was all youth beneficiaries who are participating in youth development sponsorship programs found in all project offices. These subjects were selected from the study population using systematic probability sampling. A considerable number of parents also participated in the focus group discussion (FGD) and fathers and Woreda health officials from key informant interview (KII).

3.4. Sample Size

To determine the sample size for the study of 1235, a single population technique was used by considering the following assumptions: Level of confidence: 95% ($Z_{\alpha/2}$)² = 1.96, 5% margin of error ($d = 0.05$), and a 10% non-response rate ($p = 28.9\%$) proportion of adolescents communicating on reproductive issues among youths with their parents. Calculation was done using the assumption that the proportion of parent-adolescent communication in a previous study was 28.9% (Shewasinad et al., 2016 and cited by Abdissa & Sileshi, 2021 p. 4).

$$n = \frac{(z_{\alpha/2})^2 * P(1-P)}{d^2} = \frac{(1.96)^2 * 0.289(1-0.289)}{(0.05)^2} = 315.7$$

Where n = required sample size

Z = Percentiles of the standard normal distribution corresponding to 95% confidence level assumption

$z^{\alpha/2}$ = Coefficient at level of significance = 1.96

p = 28.9% proportion of parent young communication

d = Margin of error = 0.05

By taking into consideration 10% non-response rate, the final sample size was $315.7 + 31.57 = 347$

3.5. Sampling Procedures

The sampling frame of the study populations was obtained from the master list of youth prepared by the project offices. The required sample size from each group was allocated proportionally to the number of youths within each age group. Finally, a systematic random sampling technique was applied to select eligible respondents by calculating the “ K ” value (every K^{th} = total youths at each project site/sample size). The first youth to be selected was chosen by the lottery method, and the rest were selected every K^{th} value until the required sample size was reached. For those respondents with no eligible candidates, the selection moved to the next respondents based on the project master list. During data collection, candidates who were not found were revisited in order to enhance the response rate.

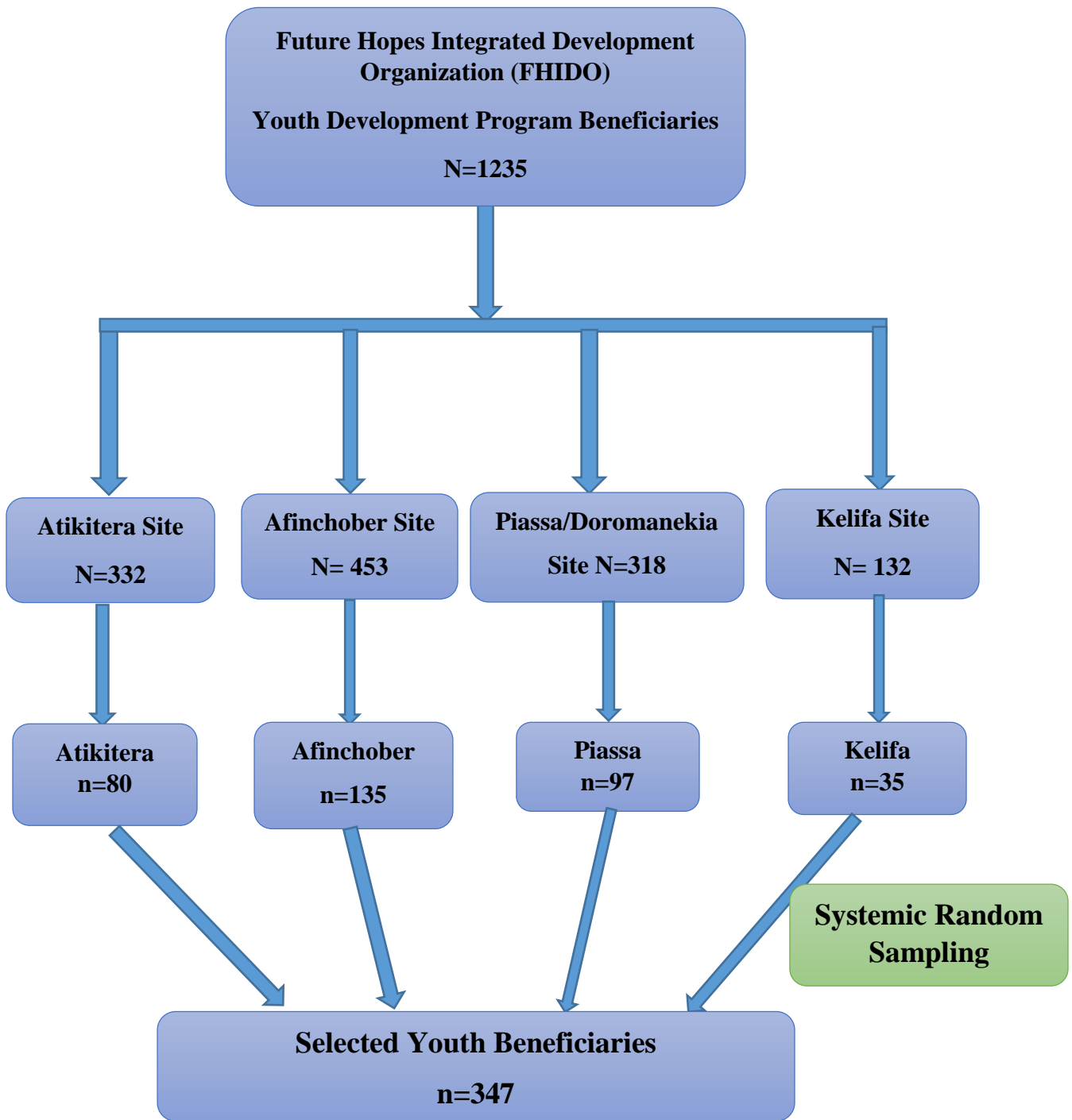


Figure 2 Schematic representation of sampling procedure for selecting participants at Future Hopes Integrated Development Organization (FHIDO), Youth Development Program

3.6. Variables

Dependent Variable: Communication between parent-adolescent/youth on SRH

Independent Variables:

- The socio-demographic characteristics of parents are similar to age, sex, religion, occupation, educational level of adolescent/youth, education status of the family, family size, and family income.
- Knowledge of parents concerning SRH issues
- Knowledge of youths concerning SRH issues.
- Perceived parental monitoring.
- Perceived openness of the parents

3.7. Data Collection Method

3.7.1. Quantitative Data Collection Method and Process

A structured or closed-ended questionnaire was developed by revising relevant literature, standard questionnaire design procedures, and questionnaires developed for similar studies were adapted with modifications so as to meet the objectives of this particular study. Because of the sensitive nature of the issues under study, a self-administered questionnaire is preferred for this kind of study to minimize the bias and distortion that often result from the use of face-to-face interviews. The questionnaire was designated in English and translated into Amharic and back to English to validate that it maintained its original meaning. Finally, a structured, self-administered, closed-ended questionnaire was distributed in Amharic to the respondents.

Six data collectors who are working as community development facilitators were trained on the questionnaire, data collection, and interviewing methods. Data collection took place from May 2022 to June 2022. The data collectors have distributed the questionnaire to youth beneficiaries of the organization at four project sites. The researcher supervised the data collectors throughout the data collection process.

The main contents of the questionnaire include socio-demographic characteristics, knowledge of youths towards selected SRH issues, parent and youth communication concerning SRH issues,

sexual behavior, and parental monitoring. The questionnaire comprises ninety-seven questions, and out of these twelve items were socio-demographic characteristics of adolescent/youth, nine were on the knowledge of youth towards selected SRH issues, fourteen were on the sexual attitude and behavior of respondents, seven were on parental monitoring, and fifty-five were on parent-and-youth communication concerning SRH issues. Then the researcher collected appropriate data from the respondent by using FHIDO's volunteers and community development facilitators to minimize cost and use time properly.

Pretesting Quantitative Data Collection Tool

The questionnaire was pretested prior to actual data collection in a similar setting among youths not selected for the study to ensure the understandability and consistency of the questions for respondents. The clarity of the questionnaire was discussed with the participants in the pretesting process. Thus, the finalization of the questionnaire was considered one of the points that arose during pretesting. In addition to substantial corrections, necessary changes were made to make the questionnaire clear and understandable for respondents.

3.7.2. Qualitative Data Collection Method and Process

Focus Group Discussion

Four focused group discussions were conducted among 40 purposefully selected parents or mothers who have youth children in the age range of 15 to 24 years. Moreover, the features of the focus group discussion participants were similar in terms of socio-demographic characteristics like age, sex, etc. The researcher moderated all the focus group discussions, and the focus group discussions were carried out with mothers only, and fathers participated in the key informant interviews since their numbers were not allowed to conduct focus group discussions. A tape recorder was used in order to capture their opinion fully after they had been told about the objective of the study and upon receiving verbal and written consent. There were ten participants in each group. A semi-structured interview questions was used to lead the discussion.

Key Informant Interview

Key informant interviews were also conducted with the fathers of the youth selected based on purposive sampling. And considering their knowledge and experience on, direct relationship with, and job responsibilities in managing, implementing, and supporting the SRH issues, Woreda health

office representatives also participated in the key informant interviews. A key informant interview was conducted with four purposively selected fathers from respective project sites and with four Woreda's health office representatives. A pre-tested interview guideline was used to lead the interview.

3.8. Data Analysis Procedure

3.8.1. Quantitative Data Analysis Procedure

The researcher used SPSS version 23 to enter, clean, and analyze the data. The quantitative data collected through questionnaires was checked for completeness and consistency. The data was cleaned and inserted to SPSS for analysis. In the analysis process, frequency distributions, percentages, and various figures of variables were presented. Univariate, bivariate and multivariate analyses were carried out to examine the relationship between the outcome variables and selected determinant factors. Chi-square was also used as appropriate.

In order to determine the strengths of association between dependent and independent variables, an odds ratio with a 95% confidence interval was calculated. A multiple-variable analysis has been employed by logistic regression in an attempt to identify the relative effects of independent variables on the dependent variable.

3.8.2. Qualitative Data Analysis Procedure

The qualitative data analysis was started by reviewing the notes taken and audiotape records conducted during focus group discussions (FGD) and key informant interview sessions. The audio tape response was transcribed manually. The themes developed by considering the objective of this particular study in line with the questions included in the interview guide. Finally, the qualitative data was described in a narrative way. All focus group discussions and key informant interviews were taped and transcribed. The analysis of the qualitative data was accomplished based on the predetermined themes and the context of additional information provided by the respondents. The data was then organized, and each issue was discussed independently.

3.9.Data quality control

The researcher performed the supervision of the data collection procedure daily. Then, they checked each and every completed form. Additionally, the researcher provided on-site technical assistance and guidance. When inconsistency and incompleteness of answers were encountered, the questionnaire excluded from entry and in this study all samples were taken to analysis.

3.10. Operational Definitions

Parents: Parents in this study mean biological parents, stepparents, or foster parents of the youth population under this study.

Youths: In this study, the youth implies a segment of the people who are unmarried and whose age falls in the age range between 15 and 24.

Risky sexual behavior:

Sexual act with more than one partner, casual partner, and CSWs, and having sex with somebody else other than one's boyfriend or girlfriend without the use of a condom.

Early sexual practice:

A sexual act performed by a 15-year-old or younger

3.11. Ethical Consideration

Since this study was conducted on human subjects, ethical approval and clearances were obtained from Addis Ababa University, the School of Social Work. The study area officials at all levels were contacted, and permission was obtained. The respondents' verbal and written consent was obtained after important explanations about the purpose of the study, its procedures, and the confidentiality of the information delivered. The study units also have the information that they have the right to decide whether or not to participate in the study. The questionnaires were filled out by each respondent in a separate place, thereby ensuring the privacy of participants and the confidentiality of the information. For this study purpose, a one-page translated consent letter was attached to the cover page of each questionnaire, focus group discussion and key informant interview stated the general purpose of the study and issues of confidentiality that were discussed by the data collectors before proceeding with the interview.

CHAPTER FOUR

4. FINDINGS AND RESULTS

4.1. Socio-demographic characteristics of the Respondents

The study involved 347 (150 males and 197 females) adolescents and young people in total, meaning that 100% of the participants responded. 197 (56.8%) female and 150 (43.2%) male of the 347 young people who answered the questionnaire. The respondents' ages ranged from 15 to 24 years old, with a mean age of 18.69 ± 2.26 SD years. 226 (65.1%) of the young people attending secondary school which is made up the majority. The next highest percentage of adolescents attending primary and TVET were 18 (5.2%) and 85 (24.5%) were university/college, respectively. Furthermore, 257 (74.1%) of the respondents identified as Orthodox Christians, followed by 68 (19.6%) Muslims and 22 (6.3%) Protestants. One hundred sixty-two respondents (46.7%) were living with both parents, followed by 140 (40.4%) who live with only one parent, and the rest, 45 (13%), live with other relatives (**Table 1**).

Out of the youth, 152 (43.8%) said their family size is fewer than five, while the remaining 135 (56.2%) said their family size is five or more. As responded by the discussants regarding mothers' educational status, 113 (32.6%) could read and write at their level. The remaining 18 (5.2%) respondent's mothers were not alive. And the rest, seventy-two (20.2%) had completed their primary education, sixty-six (18.7%) had completed their secondary school, and 57 (16.4%) were illiterate. Fathers' educational status is as follows: 55 (15.9%) only read and write, 13 (3.7%) are illiterate, 94 (27.1%) have a secondary education, 42 (12.1%) have a primary education, 40 (11.5%) have a higher education, and the remaining 103 (29.7%) are deceased. Out of the total, 122 (52.4%) of the mothers of the respondents were housewives, 83 (23.9%) worked for the government or for private companies, 55 (15.9%) were merchants with their own businesses, and nine (2.6%) were workers on a daily basis. Seventy-three (49.8%) of the respondents' fathers worked for the government or for private companies; these were followed by 54 (15.67%) fathers who were merchants operating their own companies; seventeen (4.9%) fathers were employed as day laborers, brokers, priests, or retirees. In comparisons, most respondents' fathers were employed (49.8%) and most respondents' mothers were housewives (52.4%) (**Table 2**).

Table 1 Socio-demographic characteristics of adolescents and youth in FHIDO, 2022(n=347)

Variables	Number	Percent (%)
Age		
15-17	113	32.6
18-20	165	47.5
21-24	69	19.9
Sex		
Male	150	43.2
Female	197	56.8
Level of Education		
Primary Education	18	5.2
Secondary Education	226	65.1
TVET	18	5.2
University/College	85	24.5
Others	-	-
Religion		
Orthodox Christian	257	74.1
Muslim	68	19.6
Protestant	22	6.3
Others	-	-
Living arrangement		
With both parents	162	46.7
With mother only	120	34.6
With father only	20	5.8
Others**	45	13

**** Others indicate those who live alone, with their relatives or other than their parents**

Table 2 Socio-demographic characteristics of the parents in FHIDO 2022 (n=347)

Variables	Number	Percent (%)
Mother's Edu. Status		
Not read and write	57	16.4
Read and write	113	32.6
Primary School	65	18.7
Secondary School	70	20.2
Tertiary Level	24	6.9
Not Alive	18	5.2
Father's Edu. Status		
Not read and write	13	3.7
Read and write	55	15.9
Primary School	42	12.1
Secondary School	94	27.1
Tertiary Level	40	11.5
Not Alive	103	29.7
Mother's Occupation		
Housewife	182	52.4
Employee (Gov. & Pvt.)	83	23.9
Merchant	55	15.9
Not Alive	18	5.2
Others*	9	2.6
Father's Occupation		
Employee (Gov. & Pvt.)	173	49.8
Merchant	54	15.6
Not Alive	103	29.7
Others*	17	4.9
Family Size		
<5	152	43.8
5 and above	195	56.2
Family Monthly Income		
1000-2000	44	12.7
2500-3500	26	7.5
>3500	11	3.2
Not Known	266	76.7

***Others indicate daily laborers, broker, priest, and pensioners**

4.2. Communication of adolescents and youth and parents on different sexual and reproductive health issues

Two hundred ninety-five (85%) respondents reported that it is important to discuss sexual and reproductive health issues with parents. And most female respondents, 95 (48.2%), preferred to discuss SRH issues with their mothers, while 39 (26%) of male respondents preferred their mothers to discuss SRH issues. Most male respondents 71 (47.3%) had preferred both parents to discuss about SRH, followed by 80 (40.6%) of female respondents preferred both parents to discuss about SRH. Moreover, 13 (8.7%) male respondents preferred their fathers to discuss about SRH and 3(1.5%) of female respondents preferred their fathers to discuss about SRH. There is an association between gender and discussion preference on SRH. There is a significant association across genders in being comfortable discussing with mothers more females than males [OR=0.689; 95% CI (0.566, 0.838)] with $X^2 = 25.686$, p-value = 0.000 (**Table 3**).

Respondents also reported that they had discussed with their parent's on puberty, STIs/HIV, avoiding premarital sex, abortion, unplanned pregnancy, contraceptives, sexual intercourse, and condoms; each encountered 192 (55.3%), 189 (54.5%), 93 (26.8%), 90 (25.9%), 71 (20.5%), 55 (15.9%), 49 (14.1%), and 41 (11.8%), respectively. Moreover, regarding chi-square and p-value calculations, there is an association and statistical significance between sex and the importance of SRH discussion, discussion on contraceptives, STIs/HIV, sexual intercourse, unplanned pregnancy, abortion, and avoiding premarital sex with p-values of 0.024, 0.000, 0.035, 0.025, 0.000, 0.003, and 0.000. However, in the case of the discussion about condoms and puberty, there is no association between sexes (p-value = 0.151 and 0.191, respectively). Thus, sex is independent of the discussion about condoms and puberty (**Table 3**).

Table 3 SRH topics discussed between parents and adolescents and youth by gender in FHIDO, 2022 (n=347)

SRH topics discussed b/n parents and youth	Male	Female	Total
	Ferq. (%)	Ferq. (%)	Ferq. (%)
Importance of discussing about SRH with parents			
Yes	120 (80%)	175 (88.8%)	295 (85%)
No	30 (20%)	22 (11.2)	52 (15%)
$X^2= 5.215$			
(p-value)= 0.024**			
[OR=0.503;95%CI(0.277, 0.914)]			
Discussion preference about SRH			
Mother	39 (26.0%)	95 (48.2%)	134 (38.6%)
Father	13 (8.7%)	3 (1.5%)	16 (4.6%)
Both	7 (47.3%)	80 (40.6%)	151 (43.5%)
Not Known	27 (18%)	19 (9.6%)	46 (13.3%)
$X^2=25.686$			
(p-value)= 0.000**			
[OR=0.689;95%CI(0.566, 0.838)]			
Discussion on at least two topics of SRH			
Yes	72 (48%)	122 (61.9%)	194 (55.9%)
No	78 (52%)	75 (38.1%)	153 (44.1%)
Discussion on Contraceptives			
Yes	12 (8%)	43 (21.8%)	55 (15.9%)
No	138 (92%)	154 (78.2%)	292 (84.1%)
$X^2=12.207$			
(p-value)= 0.000**			
[OR=0.311;95%CI(0.158, 0.615)]			
Discussion on STI/HIV			
Yes	72 (48%)	117 (59.4%)	189 (54.5%)
No	78 (52%)	80 (40.6%)	292 (54.5%)
$X^2=4.455$			
(p-value)= 0.035**			
[OR=0.631;95%CI(0.411, 0.969)]			
Discussion on Sexual Intercourse			
Yes	14 (9.3%)	35 (17.8%)	49 (14.1%)
No	136 (90.7%)	162 (82.2%)	298 (85.9%)
$X^2=4.994$			
(p-value)= 0.025**			
[OR=0.476;95%CI(0.246, 0.922)]			
Discussion on Unplanned Pregnancy			
Yes	12 (8%)	59 (29.9%)	71 (20.5%)
No	138 (92%)	138 (70.1%)	276 (79.5%)
$X^2=25.209$			
(p-value)= 0.000**			
[OR=0.203;95%CI(0.105, 0.395)]			

Table 3 cont.....

SRH topics discussed b/n parents and youth	Male	Female	Total
	Ferq. (%)	Ferq. (%)	Ferq. (%)
Discussion on Abortion			
Yes	27 (18%)	63 (32%)	90 (25.9%)
No	123 (82%)	134 (68%)	257 (74.1%)
X ² =8.664			
(p-value)= 0.003**			
[OR=0.467;95%CI(0.280, 0.780)]			
Discussion on avoiding premarital sex			
Yes	22 (14.7%)	71 (36%)	93 (26.8%)
No	128 (85.3%)	126 (64%)	254 (73.2%)
X ² =19.831			
(p-value)= 0.000**			
[OR=0.305;95%CI(0.837, 3.098)]			
Discussion on condom			
Yes	22 (14.7%)	19 (9.6%)	41 (11.8%)
No	128 (85.3%)	178 (90.4%)	306 (88.2%)
X ² =2.061			
(p-value)= 0.151			
[OR=0.610;95%CI(0.837, 3.098)]			
Discussion on puberty			
Yes	77 (51.3%)	115 (58.4%)	192 (55.3%)
No	73 (48.7%)	82 (41.6%)	155 (44.7%)
X ² =1.709			
(p-value)= 0.191			
[OR=0.752;95%CI(0.490, 1.153)]			

**** P-value= ≤ 0.05 α -value, there is an association between variables, the result is significant**

4.3. Reasons for no communication between parents and adolescent and youth on SRH Issues

Of the 292 (84.1%) respondents who had not talked about contraception, 58 (19.8%) gave the reason that it is embarrassing to talk about such matters with parents, and 55 (18.8%) gave no explanation at all. The reason why the teenagers and young adults had not talked about STIs or HIV was because, according to 36 (22.8%) of them, their parents were not good listeners and did not know enough about the topics to bring up. Once more, it was embarrassing to talk about sexual activity with parents because they are shameful to discuss, poor listeners, and lack of knowledge. Table 4 shows that parents made up 78 (26.2%), 43 (14.4%), and 41 (13.8%) of the total, respectively.

The most often cited reasons for not discussing unplanned pregnancy with their parents were shame to talk about (67, 24.3%) and lack of information on the subject of SRH (47, 17%). In the case of discussing abortion and its complications, the most frequently reported reason for which they didn't discuss it with their parents was shameful to discuss (56, 21.8%), followed by parents' lack of knowledge (54, 21%) and unknown reasons (46, 17.9%) (**Table 4**).

The most common excuses given for avoiding participating in premarital sex were that it was taboo to talk about, that one lacked knowledge, and that one's parents were poor listeners (66 (26%), 41 (16.1%), and 35 (13.8%), respectively. Furthermore, of those who had not talked to their parents about condoms, 107 (35%) felt that it was embarrassing to bring up the topic, followed by parents who are poor listeners, 38 (12.4%), and 43 (14.1%) who felt that it was culturally inappropriate. The most commonly cited reasons among those who had not talked about puberty were that, 21 (13.5%) parents were embarrassed to talk about the physical and psychological changes that come with puberty, 54 (34.8%) parents are not good listeners, and 22 (14.2%) parents lack information (**Table 4**).

Table 4 Major Reasons for not discussing about SRH with parents in FHIDO 2022 (n=347)

Discussion Topics	Reasons for not discussing								N(%) not discussing
	Culturally unacceptable	Shame	Lack of knowledge	Parents are not good listners	Lack of communication skill	Embrassing	Not known	Others	
Contraceptives	34(11.6%)	58 (19.8)	48 (16.4%)	42 (14.3%)	37 (12.6%)	18 (6.1%)	55 (18.8%)	-	292 (84.1%)
STIs/HIV	5 (3.2%)	18 (11.4%)	36 (22.8%)	29 (19.4%)	17 (10.8%)	9 (5.7%)	44 (27.8%)	-	158 (45.5%)
Sexual Intercourse	35 (11.7%)	78 (26.2%)	41 (13.8%)	43 (14.4%)	18 (6%)	22 (7.4%)	60 (20.1%)	1 (0.3%)	298 (85.9%)
Unplanned Pregnancy	27 (9.8%)	67(24.3%)	47 (17%)	43 (15.6%)	12 (4.3%)	22 (8%)	57 (20.7%)	1 (0.4%)	276 (79.5%)
Abortion	28 (10.9%)	56 (21.8%)	54 (21%)	23 (8.9%)	18 (7%)	31 (12.1%)	46 (17.9%)	1 (0.4%)	257 (74.1%)
Avoiding premarital sex	17 (6.7%)	66 (26%)	41 (16%)	35 (13.8)	16 (6.3%)	27 (10.6%)	51 (20.1%)	1 (0.4%)	254 (73.2%)
Condom	43 (14.1%)	107 (35%)	26 (8.5%)	38 (12.4%)	18 (5.9%)	20 (6.5%)	53 (17.3%)	1 (0.3%)	306 (88.2%)
Puberty	6 (3.9%)	21 (13.5%)	22 (14.2%)	54 (34.8%)	15 (9.7%)	5 (3.2%)	31 (20%)	1 (0.6%)	155 (44.7%)

***others mentioned for respondents who lost both parents**

4.4. Adolescents and youth preference for discussing SRH issues other than their parents

Among those adolescents and youth who have discussed different SRH issues other than those of their parents, such as contraceptives, STIs and HIV, sexual intercourse, unplanned pregnancy, abortion, avoiding premarital sex, condoms, and puberty, 191 (55%), 229 (66%), 204 (58.8%), 211 (60.8%), 193 (55.6%), 217 (62.5%), 186 (53.6%), and 247 (71.2%) have discussed them with their friends, respectively. Adolescents and youth also prefer to discuss different SRH issues other than those of their parents with their sisters. And hence, each issue accounted for 39 (11.2%) for contraceptives, 43 (12.4%) for STIs and HIV, 32 (9.2%) for sexual intercourse, 21 (6.1%) for unplanned pregnancy, 37 (10.7%) for abortion, 22 (6.3%) for avoiding premarital sex, 19 (5.65%) for condoms, and 30 (8.6%) for pubertal changes (Table 5).

Table 5 Proportion of Adolescents and Youth who have discussed on SRH issues other than their parents in FHIDO (n=347)

Discussion Topics	With whom they had discussed				N(%) Discussed
	Peers	Sister	Brother	No discussion at all (Others)	
Contraceptives	191 (55%)	39 (11.2%)	9(2.6%)	108(31.1%)	239(68.9%)
STIs/HIV	229(66%)	43(12.4%)	12(3.7%)	62(17.9%)	285(82.1%)
Sexual Intercourse	204(58.8%)	32(9.2%)	5(1.4%)	106(30.5%)	241(69.5%)
Unplanned Pregnancy	211(60.8%)	21(6.1%)	4(1.2%)	111(32%)	236(68%)
Abortion	193(55.6%)	37(10.7%)	4(1.2%)	113(32.6%)	234(67.4%)
Avoiding premarital sex	217(62.5%)	22(6.3%)	8(2.3%)	100(28.8%)	247(71.2%)
Condom	186(53.6%)	19(5.5%)	10(2.9%)	132(38%)	215(62%)
Puberty	247(71.2%)	30(8.6%)	9(2.6%)	61(17.6%)	286(82.4%)

*others mentioned for respondents who had no discussion at all

4.4.1. Adolescents and youth gender preference for discussing on SRH issue with their parents

Out of those who had discussed different topics of SRH, those who had discussed mostly with their mother about the different topics had accounted for: contraceptive 40 (72.7%), STI/HIV 99 (52.4%), sexual intercourse 30 (61.2%), unplanned pregnancy 52 (73.2%), abortion 61 (67%), avoiding premarital sex 56 (60.9%), condom 24 (57.1%), and puberty 114 (59.4%), respectively. The rest are discussed with their father and both of their parents (Table 6). As seen in Table 6, the proportion of mothers who have communicated with their female adolescents is higher than with their male adolescents, and, in turn, the proportion of fathers who have discussed with their male adolescents is higher than with their female adolescents on each SRH topic except discussions on unplanned pregnancy, as fathers prefer with their female adolescents or youth. There are also adolescents, in which male adolescents discuss more with their fathers and female adolescents discuss more with their mothers. As a result of p-values, SRH topics such as sexual intercourse, abortion, avoiding premarital sex, and puberty showed that there is an association between variables and significance as their alpha values were less than 0.05. However, topics such as contraceptives, STI/HIV, unplanned pregnancy, and condoms showed that there is no association between variables and that their p-values are greater than 0.05 alpha values.

Table 6 Proportion of Adolescents and youth who have discussed on SRH issues with preferred parents by gender in FHIDO 2022 (n=347)

Topics communicated between parents and youth	With whom they had discussed			
	Mother	Father	Both	Others
Contraceptives				
Male	6(50%)	1(8.3%)	5(41.7%)	-
Female	34(79.1%)	-	8 (18.6%)	1(2.3%)
Total	40 (72.7%)	1 (1.8%)	13 (23.6%)	1 (1.8%)
$X^2(p\text{-value}) = 7.06 (0.070)$				
STI/HIV				
Male	31 (43.1%)	8 (11.1%)	33(45.8%)	-
Female	68 (58.1%)	7(6%)	41(35%)	1(0.9%)
Total	99 (52.4%)	15 (7.9%)	74 (39.2%)	1(0.5%)
$X^2(p\text{-value}) = 5.35 (0.148)$				
Sexual intercourse				
Male	3 (21.4%)	5 (35.7%)	6(42.9%)	-
Female	27 (77.1%)	-	8(22.9%)	-
Total	30(61.2%)	5 (10.2%)	14(28.6%)	-
$X^2(p\text{-value}) = 18.97(0.000) *$				
Unplanned pregnancy				
Male	8 (66.7%)	-	4(33.3%)	-
Female	44 (74.6%)	3(5.1%)	12(20.3%)	-
Total	52(73.2%)	3(4.2%)	16 (22.5%)	-
$X^2(p\text{-value}) = 1.44(0.486)$				
Abortion				
Male	18 (66.7%)	4 (14.8%)	5(18.5%)	-
Female	43 (67.2%)	-	20(31.3%)	1(1.6%)
Total	61 (67.0%)	4 (4.4%)	25(27.5%)	1 (1.1%)
$X^2(p\text{-value}) = 11.024 (0.012) *$				
Avoiding premarital sex				
Male	10 (45.5%)	5 (22.7%)	7(31.8%)	-
Female	46 (65.7%)	3(4.3%)	21(30%)	-
Total	56(60.9%)	8(8.7%)	28(30.4%)	-
$X^2(p\text{-value}) = 7.694 (0.021) *$				
Condom				
Male	11 (50%)	5(22.7%)	6(27.3%)	-
Female	13 (65%)	2(10%)	4(20%)	1(0.5%)
Total	24(57.1%)	7(16.7%)	10(23.8%)	1(2.4%)
$X^2(p\text{-value}) = 2.763(0.430)$				
Puberty				
Male	37 (48.1%)	11 (14.3%)	29(37.7%)	-
Female	77(67%)	6(5.2%)	32(27.8%)	-
Total	114(59.4%)	17(8.9%)	61(31.8%)	-
$X^2(p\text{-value}) = 8.464(0.015) *$				

*= there is significant association

Others indicated that discussion made with grandmothers, aunts

4.5. Importance of Parent- adolescent/youth communication on sexual and reproductive health issues

As shown in Table 7, bivariate and multivariate logistic regressions were done to assess factors related to communication between parents and adolescents and youth on SRH issues. Among the sociodemographic variables, male respondents were shown to decrease the odds of communication between parents and adolescents on SRH by 47% [AOR = 0.53; 95% CI (0.28, 0.99)]. Therefore, female respondents were more open to discussing SRH issues with their parents than male respondents. Moreover, from the sociodemographic variables, respondents whom have literate mothers were less likely to believe in importance of discussing on SRH issues than respondents who has illiterate mothers & their mothers not alive, and decrease the odds 72% [AOR= 0.28; 95%CI (0.13,0.61)]. On the other hand, communication between parents and adolescents and youth on SRH significantly associated; adolescents' and youth having knowledge on different SRH issues, such as knowledge on STI [AOR= 3.73; 95% CI (1.48, 9.43)] than other SRH issues, or respondents who have knowledge on STI increase the odds of communication between parents on SRH by three folds than other variables. If age increases, there is less likely chance to communicate about SRH issues with parents or decrease by 18% [AOR = 0.82; 95% CI (0.71,0.95)]. Moreover, respondents whose parents are not open to discuss were more likely to believe in importance of discussing on SRH issues than perceived openness of parents or it shows a significant association and increase the odds by three folds [AOR = 3.12; 95% CI (1.54, 6.30)] (Table 7)

Table 7 Communication on sexual and reproductive health issues across different variables, FHIDO 2022 (n=347)

Variables	Importance of SRH Communication between parents and youth		OR	AOR	P-value
	Yes	No			
Sex					
Male n=150	114	36	0.50[0.28,0.91]	0.53[0.28,0.99] *	0.045*
Female n=197	174	23	1		
Age of respondents (continuous)	295	52	0.80[0.69,0.93]	0.82[0.71,0.95] *	0.01*
Age of respondents (categorical)					
15-19 n=238	198	40	0.16[0.31,1.22]	0.68[0.31,1.42]	0.304
20-24 n=109	97	12	1		
Educational Level					
Primary n=17	14	3	0.81[0.23,2.94]	1.12[0.29,4.29]	0.869
Secondary n=330	281	49	1		
Living arrangement					
Both parents	127	35	1		
Single parents	122	18	0.58[0.30,1.12]	0.62[0.31,1.21]	0.161
Others	39	6	0.67[0.26,1.71]	0.79[0.30,2.13]	0.653
Mothers Education					
Not read and write	39	18	1		
Literate	243	30	0.27[0.14,0.53]	0.28[0.13,0.61]	0.001*
Have no mother	13	4	0.67[0.19,2.33]	0.98[0.19,4.94]	0.988
Fathers Educaion					
Not read and write	10	3	1		
Literate	188	43	0.76[0.20,2.88]	2.37 [0.54,10.36]	0.953
Have no father	97	6	0.21[0.05,0.95]	0.53 [0.09,2.81]	0.452
Perceived openness of parents					
Yes, open	151	13	1		
No, not open	137	38	3.22[1.65,6.30]	3.12 [1.54,6.30] *	0.002*
Have no parents	7	1	1.66[0.19,14.54]	2.07 [0.13,33.14]	0.608
Knowledge on STI					
Yes	278	43	3.42[1.44,8.17]	3.73 [1.48,9.43] *	0.005*
No	17	9	1		

*= there is significant association

Others indicated that respondents living with other relatives (grandmother, aunt....)

4.6. Perception and behavior of study groups about sexuality

4.6.1. Perception of study groups about sexuality

One hundred sixteen (33.4%) of the students believed that it is normal and acceptable to have sexual feelings during adolescence, while 200 (57.6%) do not accept and 31 (8.9%) do not know about the issue. Most students who do not accept to have sexual feelings during adolescence were twofold greater than students who believed to have sexual feelings during adolescents [OR = 2.12; 95% CI (1.33, 3.38)], and students who do not know about the issue were again twofold greater than the students who believed to have sexual feelings during adolescents [OR=2.68; 95% CI (1.16, 6.19)]. Hence, it is evident that the association is significant. More males (43.3%) believe that it is normal and acceptable to have sexual feelings during adolescence than females (25.9%). Moreover, the majority of the respondents, 295 (85%), disapprove of premarital sex. More males (23.3%) approve of premarital sex than females (8.6%), and it is seen that the association is significant and it increase the odd ratio by threefolds [OR=3.22; 95%CI (1.73, 6.02)]. Most students, 318 (91.6%), agree about the importance of educating students on sexuality; 185 (58.2%) preferred schools to be sites for sex education. Students who preferred home to be the site for sexuality education were fourfold greater than students who preferred school to be the site for sexuality education [OR = 4.09; 95% CI (1.79, 9.37)], and students who preferred all (school, home, peers & religious institutions) to be the site for sexuality education again were threefold greater than those who preferred school only [OR=2.94; 95% CI (1.49, 5.77)]. And it was seen that the association is significant (Table 8).

Table 8 Perception of adolescents on sexuality in Addis Ababa, FHIDO (n=347)

Variables	Male	Female	OR	P-value
	Freq (%)	Freq (%)		
Sexual feeling during adolescents				
Agree	65 (43.3%)	51(25.9%)	1	
Disagree	75 (50%)	125 (63.5%)	2.12 [1.33,3.38] *	0.002*
Not known	10 (6.7%)	21 (10.7%)	2.68 [1.16,6.19] *	0.021*
Approval of premarital sex				
Yes	35 (23.3%)	17(8.6%)	3.22 [1.73,6.02] *	0.000*
No	115(76.7%)	180 (91.4%)	1	
Importance of sexuality education (SRH)				
Yes	140 (93.3%)	178 (90.4%)	1.49 [0.67,3.32]	0.323
No	10(6.7%)	19 (9.6%)	1	
Preference of sexuality education				
School	95(67.9%)	90(50.6%)	1	
Home	8(5.7%)	31(17.4%)	4.09 [1.79,9.37] *	0.001*
Peers/friends	4(2.9%)	5(2.8%)	1.32 [0.34,5.07]	0.686
Religious Institutions	10(7.1%)	6(3.4%)	0.63[0.22,1.81]	0.395
School, home, peers	7(5.0%)	6(3.4%)	0.91[0.29,2.79]	0.862
All	14(10%)	39(21.9%)	2.94 [1.49,5.77] *	0.002*
Others	2(1.4%)	1(0.6%)	0.53[0.05,5.92]	0.604

***= there is significant association**

Otherrs indicated that respondents living with other relatives (grandmother, aunt...)

Out of 197 female students, 94 (47.7%) felt fear and 45 (22.8%) felt tension with regards to feeling of female students for their first menses (figure 3).

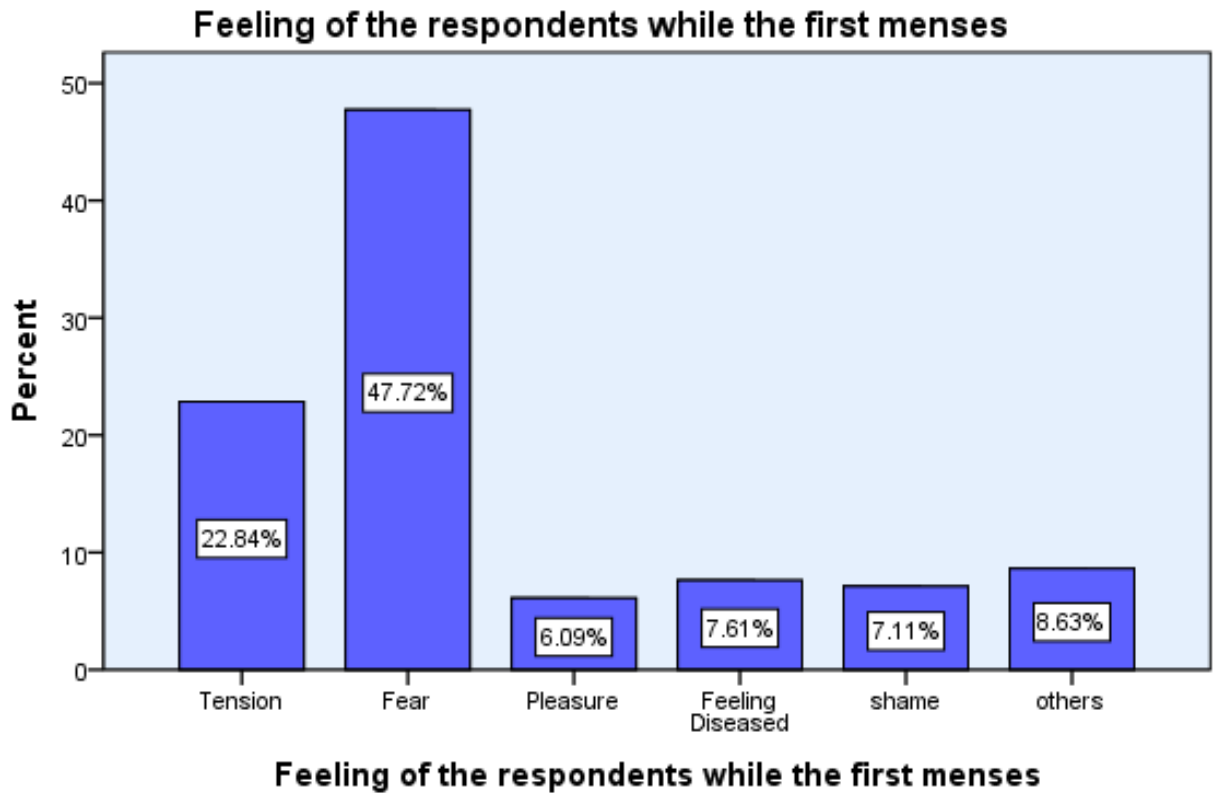


Figure 3 *Feeling of female respondents during their first menses in Addis Ababa, FHIDO, 2022.*

Out of 347 respondents, mass media was the dominant source of information regarding sexuality, mentioned by 113 (32.6%) of students, followed by school, friends, and home, each counting 81 (23.3%), 17 (4.9%), and 7 (2.0%), respectively, and the rest 129 (37.2%) of the respondents mentioned 61 (17.6%) school and media, 7 (2.0%) media and peers, 56 (16.2%) from all means, and 5 (1.4%) others, like religious institutions and hospitals (**Figure 4**). Moreover, out of 237 respondents' whom chose media as a source of information, internet was the vital source of information regarding sexuality, mentioned by 165 (69.6%) of students, followed by television, radio, and newspapers, each counting 47 (19.8%), 23 (9.7%), and 2 (0.8%), respectively (**Figure 5**)

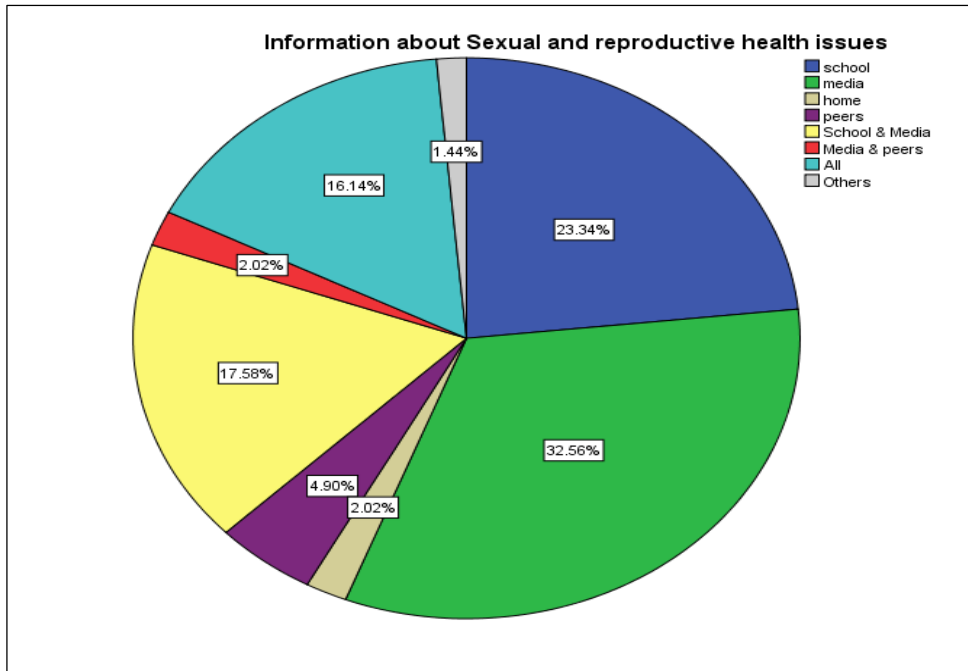


Figure 4 Percentage of source of information regarding sexuality cited by respondents in Addis Ababa, FHIDO, 2022.

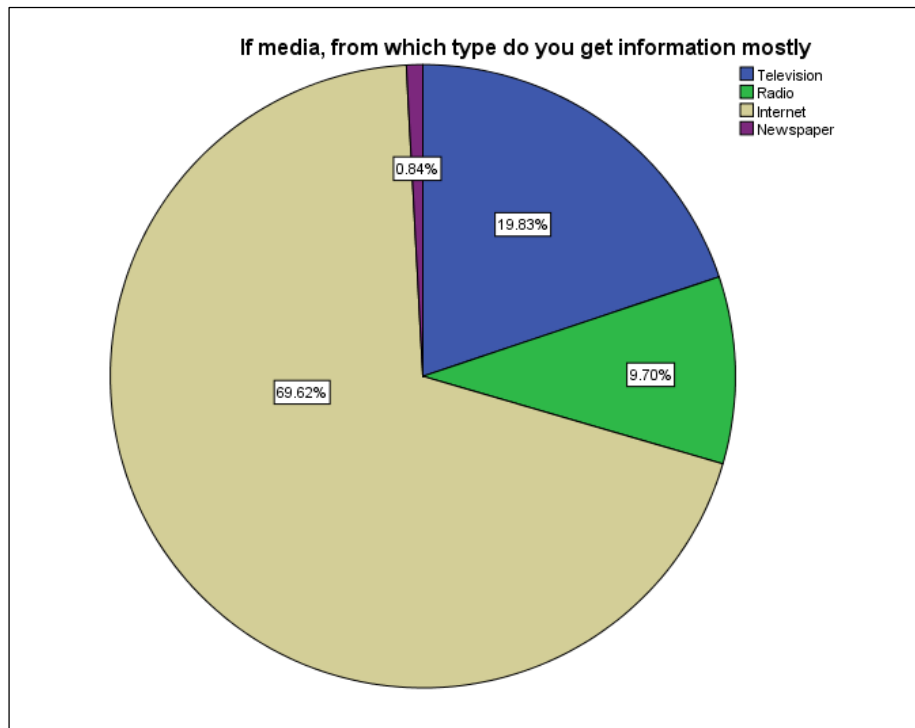


Figure 5 Percentage of media as source of information regarding sexuality cited by respondents in Addis Ababa, FHIDO, 2022.

4.6.2. Sexual behavior of the study group

In general, 78 (22.5%) respondents reported that had sexual intercourse at least once, and the mean age of sexual commencement was 18.75 ± 2.02 SD, and the median was 18 years old. More girls (23.4%) than boys (21.3%) reported having had sex with a p-value greater than 0.05 [OR= 0.89; 95%CI (0.53, 1.47)] Hence, there is no significant association between gender and sexual initiation.

Among those who are sexually active respondents, 52 (69.65%) made their sexual debut at the age of eighteen or older, and 25 (30.35%) were between the age of twenty and twenty three during their first sexual commencement. More females 46 (59.7%) than males 31 (40.3%) initiate sexual intercourse with in the age of thirteen to nineteen, [OR = 3.05; 95% CI (1.05, 8.84)] with a p-value less than 0.05 and it has a significant association. Moreover, out of 16 experienced unplanned pregnancies, 14 (87.5%) were falls the age between thirteen to nineteen and the rest 2 (12.5%) falls the age of twenty to twenty-three; [$X^2 = 8.396$; $P < 0.05$] and [OR = 9.15; 95% CI (1.76, 47.6)] and it had an association (**Table 9.1**).

Sixty-eight (88.3%) of sexually active students reported that their first sexual partner was a boy or girlfriend, 4 (5.2%) an unknown person, 2 (2.6%) a housemaid, 2 (2.6%) a relative, and 1 (1.3%) a neighbor, respectively. Sixty-nine (89.6%) students reported having had one sexual partner in their lifetime. Having one sexual partner is not significantly associated with gender [$X^2 = 0.352$; p-value >0.05 ; OR = 0.79; 95% CI (0.35, 1.78)]. Out of the sexually active female students, 16 (29.1%) experienced unplanned pregnancy, out of which 15 (93.8%) ended with abortion and 1 (6.3%) delivered the baby.

Among the 78 students who had experienced sexual intercourse, 50 (64.9%) did ever use a condom, out of which 20 (40%) were using them consistently and the rest 30 (60%) were using them inconsistently. Using a condom at least once during sexual intercourse by adolescents was seen more in males than females, and not associated with gender [OR = 1.57; 95% CI (0.48, 4.69)]. Consistent condom use was reported by 10 (45.5%) of males and 10 (35.7%) of females (**Table 9**).

Table 9 Perception of students on sexuality in Addis Ababa, FHIDO, 2022 (n=347)

Variables	Male	Female	OR	P-value
	Freq (%)	Freq (%)		
Sexual initiation				
Yes	32 (21.3%)	46(23.4%)	0.89[0.53, 1.49]	0.656
No	118 (78.7%)	151 (76.6%)	1	
Age of sexual initiation				
13-19	26 (81.3%)	27(58.7%)	3.05 [1.05, 8.84]	0.040*
20-23	6(18.8%)	19 (41.3%)	1	
First sexual partner				
Boy/girl friend	26 (83.9%)	42 (91.3%)	1	
Relative	1 (3.2%)	1 (2.2%)	0.62 [0.04,10.33]	0.738
Housemaid	2 (6.5%)	0(0%)	0.00 [0.00, ----]	0.999
Neighbor	0 (0%)	1 (2.2%)	1000[0.000, ---]	1
Not recognized	2 (6.5%)	2 (4.3%)	0.62 [0.08, 4.67]	0.642
Number of sexual partner				
One	27(87.1%)	42(91.3%)	1	
Two and above	1(3.2%)	1(2.2%)	0.64 [0.04,10.72]	0.758
Have no sex the last six months	3(9.7%)	3(6.5%)	0.64 [0.12,3.42]	0.604
Ever use condom				
Yes	22(71.0%)	28 (60.9%)	1.57 [0.59, 4.17]	0.364
No	9 (29.0%)	18 (39.1%)	1	
Frequency of condom use				
Consistently	10 (45.5%)	10 (35.7%)	1.50 [0.48, 4.69]	0.486
Inconsistently	12 (54.5%)	18 (64.3%)	1	
Experienced unplanned pregnancy				
Yes	0	16 (29.1%)		
No	0	39 (70.9%)		
Management of unplanned pregnancy				
Delivered the baby	0	1 (6.25%)		
Made an abortion	0	15 (93.75%)		

*= there is significant association

--- = not adjusted because it has no effect due to small size

Table 9.1. Perception of female adolescents on unplanned pregnancy in Addis Ababa, FHIDO

Variables	Experienced unplanned pregnancy		OR	P-value
	Yes	No		
Age of Sexual Debut				
13-19	14 (87.5%)	13(43.3%)	9.15[1.76, 47.6] *	0.008*
20-23	2 (12.5%)	17(56.7%)	1	
X²=8.396, p-value < 0.05				

*= there is significant association

4.6.3. Factors related to sexual activity

Based on the conceptual framework, factors deemed to be related to sexual activity were grouped and analyzed using univariate and multivariate analysis, which is presented in Table 10. Male students were 62% less likely to initiate sex as compared to female students [AOR=0.38; 95%CI (0.15, 0.96)]. The proportion of sexually active adolescents rose from 9.7% among the age group 15 - 19 to 50.5% in the age group 20–24 years. It means that students whose age falls between 15 - 19 years were 87% less likely to initiate sex as compared to students whose age falls between 20 - 24 years [AOR = 0.13; 95% CI (0.06, 0.29)]. Regarding the educational level of parents, students who have literate fathers were 14.51 times more likely to initiate sex than students who have illiterate fathers [AOR=14.51; 95%CI (1.65, 127.8)].

Students who do not have knowledge on contraceptives and emergency contraceptives were 5.55 and 2.91 times more likely to initiate sex as compared to students who have knowledge of contraceptives and emergency contraceptives [AOR = 5.55; 95% CI (1.53, 20.1)] and [AOR = 2.91; 95% CI (1.27, 6.64)], respectively. Moreover, students who appreciate premarital sex were 50.06 times more likely to initiate sex as compared to students who do not accept premarital sex [AOR=50.06;95%CI (15.39, 162.9)].

In general, variables like sex, age, fathers' education status, knowledge on contraceptive and emergency contraceptive and respondents who appreciates premarital sex have an association with sexual initiation (Table 10).

Table 10 Correlates of sexual activity of the study group in Addis Ababa, FHIDO, 2022 (n=347)

Variables	Sexual Initiation				
	Yes	No	OR	AOR	P-value
Sex					
Male	32(21.3%)	118(78.7%)	0.89[0.53,1.49]	0.38[0.15, 0.96] *	0.040*
Female	46 (23.4%)	151(76.6%)		1	
Age Group					
15-19	23 (9.7%)	215 (90.3%)	0.11[0.06,0.17]	0.13[0.06,0.29]*	0.000*
20-24	55 (50.5%)	54 (49.5%)		1	
Living Arrangement					
Both Parents	33(20.2%)	130 (79.8%)		1	
Single Parents	34 (24.6%)	104 (75.4%)	0.76[0.45, 1.34]	1.27[0.46, 3.45]	0.645
Others	11 (23.9%)	35 (76.1%)	0.81[0.37, 1.78]	2.16[0.47, 9.92]	0.322
Religion					
Orthodox	61 (23.7%)	196 (76.3%)		1	
Muslim	16 (23.5%)	52 (76.5%)	1.01[0.54, 1.89]	0.38[0.14, 1.05]	0.062
Protestant	1 (4.5%)	21 (95.5%)	6.54[0.86, 49.59]	5.04[0.56, 45.74]	0.151
Education Level					
Primary	3 (16.7%)	15 (83.3%)	0.68[0.19, 2.40]	2.69[0.42, 17.23]	0.298
Secondary and above	75 (22.8%)	254 (77.2%)		1	
Mother's Education Status					
Illiterate	11 (19.3%)	46 (80.7%)		1	
Literate	61 (22.3%)	212 (77.7%)	0.83[0.41,1.70]	0.32[0.08,1.28]	0.107
Have no mother	6 (35.3%)	11 (64.7%)	0.44[0.13, 1.45]	0.43[0.05, 3.79]	0.451
Father's Education Status					
Illiterate	4 (30.8%)	9 (69.2%)		1	
Literate	44 (19.0%)	187 (81.0%)	1.89[0.56, 6.42]	14.51[1.65, 127.8]	0.016*
Have no father	30(29.1%)	73 (70.9%)	1.08[0.31, 3.78]	6.07[0.64, 57.7]	0.117
Parental Monitoring					
Strongly Disagree	3 (75.0%)	1 (25.0%)		1	
Disagree	10 (33.3%)	20 (66.7%)	0.67[0.29, 1.61]	5.40[0.32, 92.7]	0.245
Neutral	2 (10.0%)	18 (90.0%)	3.09[0.68, 13.99]	13.18[0.59, 291.7]	0.103
Agree	28 (17.9%)	128 (82.1%)	1.57[0.89, 2.75]	9.21[0.65, 131.2]	0.101
Strongly Agree	35 (25.5%)	102 (74.5%)	0.11[0.01, 1.14]	5.29[0.37, 75.1]	0.218
Knowledge on contraceptive					
Yes	71 (26.1%)	201 (73.9%)		1	
No	7 (9.3%)	68 (90.7%)	3.43[1.51, 7.82]	5.55[1.53, 20.1]	0.009*
Knowledge on emergency contraceptive					
Yes	47(38.2%)	76 (61.8%)		1	
No	31 (13.8%)	198 (86.2%)	3.85[2.28, 6.51]	2.91[1.27, 6.64]	0.011*
Premarital Sex					
Yes	39 (75.0%)	13 (25.0%)	19.69[9.66, 40.15]	50.06[15.39, 162.9]	0.000*
No	39 (13.2%)	256 (86.8%)		1	

Table 10 Cont...

Discussion Preference about SRH					
Mother	23(17.2%)	111 (82.8%)	1		
Father	4 (25%)	12 (75%)	0.62[0.18, 2.10]	3.05[0.49, 18.99]	0.232
Both	43 (28.5%)	108 (71.5%)	0.52[0.29, 0.92]	0.42[0.18, 1.01]	0.054
Not known	8 (17.4%)	38 (82.6%)	0.98[0.41, 2.38]	1.02[0.27, 3.87]	0.973
Perceived Openness (Parents)					
Yes, open	34(20.7%)	130(79.3%)	1		
No, not open	40(22.9%)	135(77.1%)	0.88[0.53, 1.48]	0.88[0.45, 1.72]	0.698
Have no parent	4(50%)	4(50%)	0.26[0.06, 1.10]	0.35[0.02, 7.01]	0.493

*= there is significant association

4.7. Focus Group Discussion

The focus group discussion was done among parents of adolescents (15 to 24 years of age) enrolled in the study. The discussion was conducted in four groups among four project sites. In each FGD, ten parents participated, and a total of 40 mothers were participated in the FGDs. The FGD was done to identify the ideas of parents on parent-adolescent/youth communication on SRH issues. In doing so, 4 fathers were participated in the key informant interview via FGD data collection tool.

Table 11 Socio-demographic of the mothers in FGD, FHIDO 2022 (n=40)

Table 11 Socio-demographic of the fathers in KII, FHIDO 2022 (n=4)

Parents	Number	Percent (%)	Parents	Number	Percent (%)
Age of mothers			Age of fathers		
35-40	25	62.5	35-40	-	-
41 and above	15	37.5	41 and above	4	100%
Mother's Edu. Status			Father's Edu. Status		
Illiterate	10	25	Illiterate	0	-
Read & write	8	20	Read & write	0	-
Primary School	13	32.5	Primary School	1	25
Secondary School	9	22.5	Secondary School	3	75
Tertiary Level	-	-	Tertiary Level	0	-
Mother's Religion					
Orthodox	26	65	Orthodox	3	75
Muslim	14	35	Muslim	1	25
Protestant	0	0	Protestant	0	-
Family size (# of children)					

Less than five	28	70	Less than five	2	50
More than five	12	30	More than five	2	50
Monthly Income			Monthly Income		
Less than 3000	33	82.5	Less than 3000	3	75
More than 3000	0	0	More than 3000	1	25
No Income	3	7.5	No Income	0	-
Not Known	4	10	Not Known	0	-
Marital status					
Married	23	57.5	Married	4	100
Divorced	7	17.5	Divorced	0	-
Widowed/widower	10	25	Widowed	0	-

Knowledge of parents on selected reproductive health (contraceptives, STIs, HIV & AIDS & puberty)

Most of the FGD participants knew and explained about HIV and AIDS transmission and prevention; they also had good information about sexually transmitted infections, including HIV and AIDS. In addition, two male parents disclosed their HIV status and shared their life experiences, and they mentioned the importance of doing regular testing and knowing the status. They do have sufficient knowledge on reproductive health especially, HIV and STIs.

A few FGD participants were explained that even though they do have a good understanding of HIV and unplanned pregnancy, they don't know that much about sexually transmitted infections.

One female parent explained that, in addition to HIV and AIDS, *'unplanned pregnancy is also an important issue that we should discuss with both male and female children, since teenage pregnancies are commonly seen in our areas.'*

One female parent also explained, *'I have a 15-year-old girl, and she saw her first menses at the age of 9 years, so at that time I didn't have that much knowledge about SRH issues to discuss with my daughter, and she added as a tip that parents should know about the different SRH issues to teach and protect their children's from unforeseen events and complications'.*

Regarding knowledge of puberty, most parents know about puberty and its physical changes in both girls and boys. For instance, changing in voice and becoming muscular in boys and menstrual initiation and breast enlargement among girls.

The physical and psychological changes that occur during this period stress the entire group of FGD participants because, at this stage, children do not listen to their parents, which may expose them to different problems like HIV and unplanned pregnancies.

One male parent explained that *'this stage is a very difficult and dangerous time to handle; it puts adolescents' and youth in bad situations.'*

One female parent also explained that *'problems related to reproductive health are related to unwise use of social media and drug addiction.'*

Perception of parents on different SRH issues

Perception of parents on premarital sex

The majority of parents disapprove of premarital sex because it is culturally unacceptable and strictly forbidden in any religion, apart from the dangerous consequences and complications that may occur.

One father from key informant interview stated that *'the impact of globalization leads our youth to change our traditional value of marriage. There are many chances that lead them to spend private time together with the opposite sex, so they will start premarital sex. The government is not working on this topic, so it is spread in the fastest way.'*

One female parent also explained that *'premarital sex is the major cause of STIs, unplanned pregnancy, and illegal abortion. This situation is exposed to HIV and AIDS. Illegal abortion is the cause of younger girls' deaths, so the government, the community, and FBOs should work together in order to protect the youth.'*

Another female parent said that *'if they are not willing to marry, we should inform them to use contraceptives. If they are not willing to talk with us, we should also give them directions to go to the health centers and take professional advice from health workers.'*

Perception of parents on adolescent sexuality

Some participants shared their opinions that it is improper or abnormal for adolescents to experience sexual feelings.

According to a parent, "*adolescents do not have sexual feelings at this stage if they are not triggered by different sexually related issues.*"

Some female parents refute the aforementioned theory by stating that "*it is normal to have sexual feelings during the adolescent period, as adolescents now start to see their first menses at an early age.*"

Perception of parents on the importance of sex education

The participants entirely agreed with the importance of giving sex education because it will protect their children from different reproductive health problems like unsafe sex, unplanned pregnancy, abortion, gender-based violence (GBV), and even death. Moreover, they are the most productive portion of the entire population. A very few participants put their ideas in opposition to the aforementioned ideas: '*giving sex education to our children may exacerbate their desire to engage in sexual activity.*'

Those who agreed on the importance of sex education said it should be given at home, school, health facilities, religious places, police stations, and the like. And they also mentioned that sex education should be age-appropriate.

One female parent stated that '*peer education plays a great role in educating adolescents and youth, since I witnessed that permitting my daughter to participate in peer education made her alert and sensitive about sexuality.*'

Discussion on SRH issues between parents and adolescents and youth

All FGD participants agreed on the importance of discussing SRH issues with their children. We can protect them from different consequences and give them a direction in life. However, they are not discussing SRH issues with their adolescents.

One female parent mentioned that *'my parents were reluctant and considered it taboo to discuss SRH issues; as a result, I became pregnant at an early age and faced complicated labor and delivery.'* Hence, I always discuss SRH issues with my children to protect them from different SRH-related problems.

Another FGD participant said that *'most of the time, our children are not willing to discuss SRH issues with us; rather, they want to discuss them with their friends.'*

One female parent also mentioned that, *'if we impose and forbid them, they will be eager to engage in sexual activity.'* So we have to openly discuss SRH issues with our children.

Suggested age by parents to discuss on SRH issues

It was suggested that the entire family start a discussion on SRH issues with their children between the ages of 10 - 15 years, as puberty starts at these ages and the generation is very fast and has access to different information. Moreover, they also mentioned that the discussion should be age-appropriate.

One female parent said that *'the SRH discussion should start at the age of 5 to protect them from different GBVs since there are GBV reported cases at and below the aforementioned age'* and it would also be easy to talk when they grow up on different topics.

SRH topics discussed & viewed by parents

Discussion on contraceptive

Most of the FGD participants mentioned that they do not discuss contraceptives with their adolescents or youth because they think it is not important, and they also said that their children couldn't hear them. Few of the parents said that they discuss contraceptives only with their female adolescent's because they think this discussion concerns only female adolescents and youth, and the discussion is not detailed and not friendly.

One female parent mentioned that '*she openly discusses the importance of contraceptives like preventing unplanned pregnancy, spacing childbirth, and avoiding abortion,*' because she lacked discussion on SRH with her parents and became the victim of unplanned pregnancy, abortion, and its complications.

Another female parent mentioned the '*importance of openly discussing with her children as it keeps close and the children become open; if not, they will be distant and choose an outsider for discussion.*'

Discussion on condom

The entire FGD participants said that they do not discuss condoms with their adolescents or youth; rather, they mentioned condoms as a prevention mechanism for HIV.

Discussion on unplanned pregnancy

Most of the female parents and a few of the male parents mentioned that they raise the issue of unplanned pregnancy with their female adolescents. The reason mentioned for raising the issue of unplanned pregnancy was when their female adolescents started to interact with boys, and they also said that females are more active and vulnerable to GBV than boys. Their discussion focused only on the consequences of unplanned pregnancy and was not friendly. Most FGD participants mentioned that their discussion was aggressive, so their children are not willing to listen to their parents.

One female parent mentioned, "Sometimes, *when female adolescents showed unique behavior and started frequent interaction with boys, some mothers would say “diqalashen endatamechibign” [take care not to be a mother of unplanned illegitimate child] but parents are not communicating with their children in appropriate manner.*

Male parents do not discuss unplanned pregnancies because they think that it is the responsibility of mothers to protect their daughters from sexually related problems. In addition to this, all of the FGD participants do not discuss unplanned pregnancy with their male children, as they think unplanned pregnancy is the only problem for female children.

Discussion on puberty

The majority of female parents communicate with their female adolescents about the physical and psychological changes that occur during puberty. The discussion was made with girls after the commencement of the first menses, and most of the discussion focused on how to change the sanitary pads and maintain hygiene during, after, and before menstruation.

The male parents from the key informant interview said that they are uncomfortable discussing menses with their daughters, as they think it is a female-to-female discussion.

Parents' reasons not to discuss on SRH with adolescents/youth

Most of the FGD participants mentioned that their reason not to discuss with their adolescents SRH matters was culturally unacceptable. They said it is an intergenerational gap '*since we had been growing up in a culture where talking about SRH was considered taboo*, so we passed this on to our children. Low economic status was another major barrier to not discussing with their adolescents or youth; as a result, they don't have time to talk with their children. Embarrassment and lack of knowledge were other reasons mentioned by parents. They said that because of our insufficient knowledge, we could not provide adequate information on SRH-related issues.

Another identified reason by the parents was the unwillingness of adolescents and youth to discuss with their parents because they think they know everything (overconfident), choose their friends, and do not respect our ideas. Moreover, nowadays our children are technology dependent (daily

mobile usage); as a result, our children isolate themselves and choose manipulating their mobile phones rather than discussing with us.

Lack of open and interactive discussion in the family was mentioned by some of the participants. They said most of the parents, especially fathers, communicate with our sons and daughters in an aggressive way by saying ‘do this’ and ‘do not do that’ but not listening to what their adolescents or youth have to say. As a result of this, our children became distant and chose their friends for the discussion. In general, the aggressive behavior of parents does not incite children to have an open discussion with their parents.

4.8. Key Informant Interview

The key informant interview was done among Woreda health officials to assess the communication on sexual and reproductive health matters between adolescents and parents. The KII was conducted with two health professionals, one female and one male, and they represented the Arada subcity of Woreda 2 and 3, and Woreda 5 and 10, respectively.

Table 12 Socio-demographic of the health professionals in KII, FHIDO 2022

Health professionals	Number	Percent (%)
Age		
30-40	1	50
41 and above	1	50
Educational Level		
Diploma	1	50
Degree and above	1	50
Orthodox	2	100
Muslim	0	-
Protestant	0	-
Family size (# of children)		
Less than five	2	100
More than five	0	-
Marital status		
Married	2	100
Divorced	0	-
Widowed	0	-

Types of service provided in the health institutions under SRH component

Both respondents agreed that various SRH-related services are provided in their respective health institutions for youth. The services are counseling and testing, STI treatment, family planning, abortion services, etc. And the male respondent from Woreda 2 and 3 mentioned that there is a separate room for the provision of youth-friendly SRH services in their health center.

Adolescent and youth discussion on SRH issues with their parents

Again the respondents mentioned adolescent/youth do not discuss on SRH issues with their parents, because the parents had lack of knowledge on SRH, culturally unacceptable and considered as a taboo, and parents are aggressive to discuss with their children as the youth mentioned while they are receiving SRH related services at the health institutions. As a result, adolescents and youth preferred to discuss SRH issues with their friends rather than with their parents.

Major SRH related problems in the Woreda

The male respondent mentioned that the major problems related to SRH are *‘psychological problems that youths face due to conflict with their partner or boyfriend*, which results in absenteeism. Depression is a serious and adverse effect of such a problem. Such a problem appears three to four times a year. Due to this problem, school-going youth drop out of school.

The female respondent’s mentioned the major SRH problems in their Woreda are sexually transmitted infections with the symptoms of vaginal and urethral discharge and irritation while urinating and unplanned pregnancy. As she said, *‘majority of the adolescents and youth who came with the diagnosis of an unplanned pregnancy want an abortion.’* Most of the time reported cases of *‘unplanned pregnancy is between the ages of 18 and 24. She also said that most of the reported cases come from out of the catchment areas because the issues are sensitive and there a fear of stigma and discrimination.’*

She also mentioned that ‘if we refuse to conduct an abortion, they will go and perform a backyard or unsafe abortion or will commit suicide.’ Because of this, to prevent maternal mortality, they perform safe abortion care for needy adolescents and youth.

Health professionals’ communication on SRH issues with their families

The female respondent mentioned that ‘she does not discuss SRH with her daughter because she is 3 years old; hence, in the future, she will have a plan to discuss SRH at the appropriate time and age. Currently, she is discussing with her husband the menstrual cycle and sexual intercourse.

The male respondent mentioned, ‘No matter how difficult it might be to deal with these issues, I do discuss SRH issues with my daughter.’ ‘I used to advise her not to be influenced by peer pressure to engage in undesirable sexual activities. I also accept her feedback and discuss positive issues with her. He also explained that the discussion was not regularly conducted with his daughter. ‘until his daughter reached 13 years old, she attentively listened to me’, and after that, she totally refused to listen.’ Because, in my opinion, during this time, adolescents and youth are intimate with their friends, and their technological know-how is also high.

Age preference to discuss on SRH with adolescents and youth

The male respondent mentioned that it depends on the understanding and psychological capacity of participants and the level of awareness of families. These days, everyone is very close to information due to the advancement of technology. The generation is also very fast. If possible, I suggest the discussion start at the age of 10. ‘I used to discuss this with my daughter when she was 12 years old.’ Children are very active when they reach grades 7 and 8. The SRH issue is expected to be advocated by the government so that adolescents and youth might be aware of it.

The female respondent mentioned that ‘the appropriate age for discussing on SRH is 10 years’, because if the discussion does not start at this age, it will be difficult to capture our children. But the discussion topics should range from simple to complex; they should be age-appropriate. For instance, if we choose to discuss sexual intercourse with a 10-year-old child, it will not be appropriate. And the appropriate topics could be discussions about menstruation, and for 14-year-olds, sexual intercourse, family planning, HIV and AIDS, STIs, hepatitis, and the like.

Government future direction adolescents/youth SRH

There are so many beginnings regarding adolescents and youth SRH, such as preparing separate policies for AYSRH, because the productive age groups are mainly affected by HIV, teenage pregnancy, and related complications. So, the government, in collaboration with other concerned stakeholders, is protecting the future leaders of the country, as the male respondent mentioned.

The female informant also mentioned that the future direction of the government is to expand SRH-friendly service provision outlets; '*currently, we provide SRH service for adolescents and youth on regular hours; hence, the future direction will be to provide the service for 24 hours.*'

In general, she mentioned that the predisposing factors for unplanned pregnancy are '*peer pressure*', '*lack of open discussion with parents*', and '*schools unable to provide intensive sexuality education*' for adolescents and youth. Finally, she recommended that schools should work closely in collaboration with health institutions.

CHAPTER FIVE

5. DISCUSSION

The study analyses communication between parents and adolescents/youth on SRH and also attempts to reveal whether there is any association between parent-adolescent/youth communications and adolescent sexuality, including other reproductive health issues in Addis Ababa, Arada Subcity, at the Future Hopes Integrated Development Organization.

Parent-adolescents' and youth communication about sexual and reproductive health issues is important in reducing risky sexual behaviors and the consequences associated with such behaviors among adolescents. As a result, in order to foster effective parent-child communication, interventions must be specifically designed to take into account the roles and responsibilities of parents and their adolescent children while also promoting the cultural integration of traditional and culturally appropriate Western norms. This will allow for the accommodation of both worlds' experiences and the finding of a middle ground between parents and children (Motsomi, 2016, p. 5)

Parents are the potential source of sexual and reproductive health information for adolescents and youth, and a lack of communication among them is a serious problem, particularly in developing countries, which results in emotional distress, lower self-esteem, school problems, drug use, and sexual risk behaviors (Tegegne et al., 2019, p. 2). Similarly, this study illustrates that the majority of the respondents, that is, two hundred ninety-five (85%), believe that it is important to discuss SRH issues with parents. Out of these, 54.5% of the study participants have discussed at least two SRH issues. In terms of discussing SRH issues, this study is higher than the study conducted in Ambo Town (37.6%), Dire Dawa (37%), Hadiya Zone (35%) (Bikila et al., 2021; Ayalew et al., 2014; Kusheta et al., 2019), and this study lower than studies conducted in Ghana (72.8%), Alamata (68.2%), & Jimma Agaro-zone (61.3%) (Manu et al., 2015; Abebe et al., 2013; Abdissa et al., 2021). These disparities may result from variations in SRH information access as well as demographic and sociocultural differences. The research also differs in terms of time periods.

This also coincides with the FGD discussion, that majority of the discussants believed on the importance of parent-adolescent/youth communication on SRH issues.

Researchers have demonstrated that parental knowledge and attitudes influence adolescents in terms of health behavior, including early sexual initiation. There is also “growing evidence showing that various parenting dimensions like connectedness, love, material support, behavioral control, monitoring, and parent-adolescent communication are positively associated with reduced levels of risk-taking among adolescents” (Muhwezi et al., 2015, p. 2). This is consistent with the finding because there is an association between parent-adolescent discussion on SRH and adolescents/youth having knowledge on STI, [AOR= 3.73; 95% CI (1.48, 9.43)]. Or respondents who have knowledge on STI increase the odds of communication between parents on SRH by three folds than other variables. However, as many previous studies showed, there is no association between parent-adolescent communication and SRH issues in this study.

The study revealed, respondents whom have literate mothers', are less likely to believe in the importance of discussing different SRH issues and it decrease the odds of communication by 72% [AOR = 0.28; 95% CI (0.13, 0.61)]. In contrast, the study conducted in Oromia regional state at Fiche town with secondary and preparatory school students, revealed that literate mothers were more likely to discuss on SRH issues with their children and increased the odds of communication [AOR=3.52, 95%CI (1.13-10.95)], (Feyissa et al., 2020, p. 8). The reason might be, because of the difference in study population, study areas urban vs. rural and period of the study.

Regarding different SRH topics communicated among parents and adolescents, according to this study, communication on contraceptives is a protective factor for females against unplanned pregnancy, consistent with our findings from a study done in Hawassa town, Sub-Saharan Africa, and Sawla town, Gofa Zone (Fikre, M., 2009; Usonwu et al., 2021; Malango et al., 2022), and shows consistent users of contraception, which prevent unplanned pregnancy, are more likely to report conversation with parents about contraception; communication on STI/HIV is associated with adolescents' having knowledge on STI/HIV; communication on sexual intercourse is more common among age groups 20 to 24 years than 15 to 19 years. This finding coincides with other studies (Fikre, M., 2009; Abdissa et al., 2021; Motsomi et al., 2016) showing older adolescents talk to their mothers more about sexual topics than do younger adolescents. This also coincides

with the FGD, as the parents in the FGD explained that they believe older adolescents acquire sexual feelings and engage in sexual activity, so they need discussion on SRH issues; communication on condoms is significantly associated with adolescents' consistent use of condoms; this is also true in other studies (Fikre, M., 2009; Kamangu et al., 2017). This also coincides with finding in the present study more males using condom than female adolescents. This implies that parents had discussed on condom less with female, so more female than male adolescents are exposed for unsafe sexual practice.

Moreover, studies done in Ebonyi State, Nigeria, East Africa (Kenya, Uganda, Rwanda and Tanzania), and in Ethiopia, Oromia-Ambo town, E/Wollega zone, and Hawassa indicate that the content of parent-adolescent's conversation seemed to focus more on the negative outcomes of sexual intercourse and sexuality and less on what adolescents should know to more completely understand how they are growing and developing (Mbachu et al., 2020; Kamangu et al., 2017; Bikila et al., 2021; Tesso et al., 2012; Fikre M., 2009). This finding is also consistent with the FGD and KII conducted in this study, which may indicate that there is a gap in discussing the positive aspects of adolescent sexuality-related issues. Thus, if adolescents discuss only a negative outcome of sexuality with their parents, they will be highly unlikely to turn to their parents to discuss sexual matters as they get older. However, when children are young and have pleasant conversations regarding sexual information, feelings, attitudes, beliefs, and conduct, these conversations often continue as they get older. It is therefore crucial to create an atmosphere that encourages honest and relaxed conversation.

In this study, adolescents and young adults felt more at ease talking about SRH concerns with mothers than fathers. Research conducted in Ethiopia's Ambo and Yirgalem towns, Jordan and Syria, Vientiane Prefecture, Lao PDR, Ebonyi State-Nigeria, and Ghana, revealed that teenagers, both male and female, were more comfortable to discuss SRH issues with their mothers than with fathers (Othman et al., 2020; Vongsavanh et al., 2020; Mbachu et al., 2020; Manu et al., 2015; Bikila et al., 2021; Yohannes et al., 2015). This might be because mothers were also considered to be better at listening than fathers (Bikila et al., 2021), and it may also be because mothers create faith and certainty with children, as previous studies showed (Fikre M. 2009).

Conversely, a research conducted in Dera woreda, north west Ethiopia found that husbands were 2.78 times more likely than wives to talk to young people about sexual and reproductive health issues [AOR = 2.78; 95% CI (1.26, 6.13)]. This is due to the fact that they are not equally able to access and talk to their children about sexual and reproductive health issues. In addition, mothers are in charge of looking after all families and are occupied with domestic duties (Tegegne et al., 2019).

In addition, in this study, both female and male adolescents prefer their peers for discussion on SRH issues than their parents. Similarly, studies in Ethiopia and Sub-Saharan Africa showed that both male and female adolescents would be most comfortable discussing sexual matters with their friends of the same sex (Eshete et al., 2020; Kusheta et al., 2019; Mekonnen et al., 2018; and Usonwu et al., 2021). Discussing a number of sex-based topics with friends rather than parents may have a negative impact on adolescents' sexuality and sexual behavior if their peer is not equipped with appropriate information on sexuality. The FGD discussant also stated that because of a lack of open discussion and fathers' aggressive behavior, adolescents and youth become reluctant and prefer their friends to discuss SRH-related issues.

Based on the findings, more female adolescents prefer to discuss with mothers, and more male adolescents prefer to discuss with fathers. This difference was significant; this was consistent with other studies in East Africa, Jordan, and Syria, and in Ethiopia, Asella town and Awabel woreda (Kamangu et al., 2017; Othman et al., 2020; Bekele et al., 2022; and Ayehu et al., 2016) showing a similar finding. This may suggest that there is sex preference in discussing sexually related issues, which may indicate that discussing sexual issues with someone of similar sex is comfortable. This may also be due to the sensitive issues, where adolescents preferred to have someone with whom they could discuss these issues and not feel shy when discussing sexual matters.

The FGD discussants mentioned that there is a difference in which topics mothers and fathers are comfortable communicating with their adolescents, and it was seen that fathers were uncomfortable talking about menses and unplanned pregnancy with their girl adolescent because they thought it was a female-to-female discussion and the responsibility of mothers. This was comparable to another study done in Jordan and Syria (Othman et al., 2020), in which fathers were

found not to have discussions relating to menstruation and other reproductive health issues with their daughters. Fathers believed that talking about these issues would be harmful on the private lives of their daughters (Kamangu et al. 2017, p.47). This role was reserved for mothers because they are of the same gender. Fathers were more comfortable communicating in an aggressive way by saying ‘do this’ and ‘do not do that’ but not listening to what their adolescents or youth had to say. As a result of this, adolescents/youth became distant and chose their friends for the discussion.

In this study, the majority of the female respondents feeling towards first menses reported that feeling fear (47.7%), followed by feeling tension (22.8%). This may be explained by the results on FGD of the present study, in which the majority of female parents communicate the physical and psychological changes that occur during puberty with their female adolescents. The discussion was made with girls after the commencement of the first menses, and similar to other studies, pubertal changes lead to discussions. In a study done in East Africa (Kenya, Uganda, Rwanda, and Tanzania) (Kamangu et al., 2017), none of them reported communication with parents about sexuality prior to first menses, and another study in Ebonyi State, Nigeria (Mbachu et al., 2020) showed the initiation of discussion on pubertal change was menstrual initiation in their female adolescents.

In this study, many adolescents and youth received information on sexual and reproductive issues from media (34.6%), like the internet (69.6%), followed by school (23.1%), which was preferred by most of them. According to the findings, adolescents and youth who were in favor of premarital sex and gender were associated with sexual activity. Finding of the current study, coincides with different findings (Asrese et al., 2018) showing sexual initiation is related to unsafe sexual practice and females are more likely to start sex than males, and other findings (Fikre, M. 2009) show not living with at least one of the parents is associated with sexual activity.

The mean age of sexual initiation in this study is 18.5 which is higher from other studies done in Hawassa 15.2, North East Ethiopia 16.8, Bahir Dar & Mecha district 16.2 and it coincides with Wolaita Sodo town 18.2 years (Fikre, M. 2009, Mazengia, F. 2008, Asrese et al., 2018 and Azeze et al., 2021) adolescents/youth in Ethiopia this is may be due to the difference in the growth of the town, since changing conditions due to civilization, urbanization and life style, makes adolescents/youth to engage in risky behavior.

The study revealed females engage in more early sexual activity than males, and this finding coincides with a study conducted in Sub-Saharan Africa, Ghana (Bankole et al., 2007). In contrast, different study revealed different results in different parts of Ethiopia: males engage in more early sexual activity than males (Fikre, M. 2009; Mazengia, F. 2008; Asrese et al., 2018; Azeze et al., 2021). This may be due to the period of the study conducted, sample size, and geographic location. In line with other studies (Nkata et al., 2019) that indicate people who start sexual activity relatively early in adolescence are at high risk for STIs and pregnancy, females who engage in sexual activity at an early age in this study were more likely to become unintentionally pregnant. In addition, parental monitoring is an important parental factor associated with the early sexual activity of adolescents; this result is consistent with studies done in different European countries (Lenciauskiene et al., 2008). However, in the key informant interviews, the informant revealed that most reported cases of unplanned pregnancies are between the age of 18 to 24, where as, the study revealed that 87.5% of unplanned pregnancies occurred between the age of 13 to 19. This may be due to adolescents preferred to conduct unsafe abortion than youth, and fear of stigma and discrimination

Contrary to their premarital sexual activity, the majority of adolescents and youth disapprove of premarital sex. This is a similar finding from other studies done in South Africa, Ugu, KwaZulu-Natal, Ethiopia, and the west Gojjam zone in Shendi town (Govender et al., 2019; Bogale et al., 2014). The majority of the respondents in this study approved the introduction of sexual and reproductive health education in school, which is comparable to a study done in Hawassa town, Benishangul Gumuz-Bullen woreda, Vientiane Prefecture, Lao PDR, Sub-Saharan Africa, and Fiji, in which the majority of students approved the introduction of sexual and reproductive health education in school (Fikre, M. 2009; Yesus et al., 2010; Vongsavanh et al., 2020; Usonwu et al., 2021; Ram et al., 2020). Moreover, this result also aligned with the FGD participants of this study and stated that sexual and reproductive health education should be given at schools. In studies done abroad with parents of Fiji, Jordan, and Syria, and in a local study at Hawassa, the results showed that parents were very supportive of the school sexuality education program, which is in agreement with the present study conducted on parents (FGD) and health professionals (KII) (Ram et al., 2020; Othman et al., 2020; Fikre, M. 2009). This is an encouraging finding, given the fact that the introduction of sexual and reproductive health education in school by both respondents could possibly create a conducive environment for effective communication between parents and

adolescents on sexuality issues because this raises the knowledge and confidence of adolescents to discuss SRH. Similarly, approving the introduction of sexual and reproductive health education in schools and disapproving premarital sex could have an encouraging impact on the prevention of sexual and reproductive health problems that may occur due to early sexual intercourse.

6. Conclusions and Implications for Social Work

6.1. Conclusions

According to the study's findings, both the study population's attitudes regarding the importance of communication on SRH were positive (students and parents). But there wasn't much communication about issues related to sexual and reproductive health. The most common reasons for low communication were shame, limited knowledge, parents not being good listeners, and a lack of communication skills to discuss the issue.

Parental education is a significant factor for parent-adolescent and youth communication on SRH issues, and parent-adolescent communication is a predictor factor for adolescents' knowledge of different sexual and reproductive health issues. Moreover, there was an association between parental preference and adolescent and youth communication on SRH and sexual activity/initiation.

Concerning different SRH topics communicated among parents and adolescents/youth:

- Communication on contraceptives is a protective factor for females against unplanned pregnancy.
- Communication on STI/HIV is associated with adolescents' knowing about STI/HIV;
- Communication on sexual intercourse, condoms, contraceptives, unplanned pregnancy, and puberty is more common among older adolescents and their parents.
- Communication on condoms is not significantly associated with adolescents' consistent use of condoms.

There is a preference among adolescents of the same sex to discuss with their parents, with males preferring their fathers and females preferring their mothers. Furthermore, they chose their peers rather than parents to discuss SRH.

Based on the focus group discussion of this study, there is a difference between mothers and fathers on how to communicate with their adolescents. In addition, the content of parent-adolescent and youth discussions focuses more on the undesirable outcomes of sexuality, and they initiate the

discussion after changes occur in adolescents. According to the findings of the present study, a substantial number of adolescents whose age falls between 20 and 24 are sexually active. In addition, parental monitoring has a significant association with the initiation of sexual activity among adolescents. More females than males engage in sexual activity early (in the age range of thirteen and below) and have had more than one sexual partner in their lifetime. A substantial proportion of female adolescents experienced unplanned pregnancy, and early sexual activity among females is a determinant factor for unplanned pregnancy, and the majority of them ended up with abortion. More males than females are consistent condom users.

There was a positive attitude towards avoiding premarital sex, both in the students' responses and in the focus group discussion with the parents. Furthermore, adolescents and parents have a positive attitude towards commencing the SRH program in schools. Generally, the study concluded that parent-adolescent communication on SRH promotes healthy behaviors, but there is low communication due to reasons shameful, lack of knowledge, parents are not good listeners, and lack of communication skills.

6.2. Implication for Social Work

This research shows that better result on the importance of parent-adolescent and youth SRH communication. Thus, the following suggestions made in light of the major findings and aligning with the social work implications:

6.2.1. Implication for Policy and Program

- Adolescents should receive sexual and reproductive health education from an early age, preferably in school. Policymakers should also collaborate with various sectors, such as youth services, education, and health, to provide a means of information and help parents overcome their issues about SRH communication with their teenagers.
- It is crucial to support and empower parents to have conversations with their kids about sexual issues when the kids are still in their late childhood or early adolescent years before they start engaging in sexual activity

6.2.2. Implication for practice

- It is necessary to provide parents with adequate IEC materials and communication skills on sexuality and RH-related issues to equip and educate them on various SRH issues.
- Different intergenerational dialogues related to SRH issues should organize for adolescents, youth and their parents to narrow the generation gaps.
- Parents should also talk to their young children about SRH difficulties because it will be their responsibility to deal with them.
- Parents must be given the authority and encouragement to become positive role models and mentors for their male and female teenagers. It ensures by capacitating the parents on communication skills and awareness raising trainings.
- Healthcare professionals and other responsible bodies should work on developing a culture of discussion on sexual and reproductive health issues.

6.2.3. Implication for Social Work Education

- School of social work education should prepare training manual in collaboration with concerned stakeholders.
- Regarding parental education, the school of social work should prepare context-based training manuals.
- Provide intensive trainings related to sexual and reproductive health
- Organizing continuous panel discussions with elites, adolescents, youth, parents, health professionals, CBOs, FBOs. These will have a tendency to narrow the generation gaps related to sexual and reproductive health.

6.2.4. Implication for Research

From the research findings, out of sixteen experienced unplanned pregnancies, 15 (93.8%) ended up with an abortion. Hence, government, schools, parents, and health institutions should work collaboratively, since abortion complications are the leading factors for maternal mortality rates.

- Government should earmark appropriate budget for the provision of youth friendly sexual and reproductive health services and capacity building.
- Schools should provide age appropriate sexual and reproductive health education for children, adolescents and youth.
- Parents should openly discuss on sexual and reproductive health issues with their children
- Health institutions vigorously work on awareness raising via health education platforms and provision of youth friendly SRH services separate with adult clients.
- NGOs should work on awareness raising and constructing youth friendly SRH rooms in the health institutions.
- Social workers should lobby and advocate the policy makers

Finally, more researches have to be conducted to find out what causes, how well, and when parent-adolescent communication about sexuality and issues connected to reproductive health occurs, as well as how communication affects safe sexual practices. Age- and context-specific communication obstacles ought to be identified.

7. Strength and limitation of the Study

7.1. Strengths of the study

- The large sample size, appropriate sampling procedures, and analysis methods utilized were appropriate to the study and considered one of its strengths.
- Inclusion of respondents of both sexes, use of questionnaire items from validated survey instruments, and adaptation of materials to the Ethiopian context.
- The participation of respondents was also generally satisfactory.
- The survey results were supplemented with qualitative data.

7.2. Limitations of the study

- The basis for communication about SRH, sexual activities, and attitude consequences is self-reported data, which is prone to biases, reporting errors, and missed values.
- It is impossible to completely rule out the chance of being underestimated because the study deals with delicate and private subjects. Even in cases where an anonymous survey is conducted, it might be affected by some degree of social desirability bias because of its sensitive nature and cultural barriers to open discussion.
- Unable to conduct separate FGDs with fathers, since majority of them were the source of income of the family and their availability were low. Thus, few fathers were participated in KII, and this may hinder a thorough discussion and capture their ideas. Additionally, since it excludes youths' who are out of school, it cannot be generalized.
- Due to the cross-sectional nature of the data used in this study, it is not always possible to determine the direction that causal relationships.

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8. ANNEXES

ANNEX I: INFORMED CONSENT AGREEMENT FOR QUESTIONNAIRE

Study participant's consent form

Greetings! My name is _____. I'm coming from Addis Ababa University School of Social Work. I am a Masters student and currently, am on thesis work. The purpose of this study is to assess the communication between adolescent/youth and parents on sexual and reproductive issues and the study is solely an academic. The questionnaire will be filled based on your free will and consent and Your answers are completely confidential, your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer and you may end filling of the questionnaire at any time you want to. However, your genuine answers to these questions will help us better understand about parent and adolescent communication on sexual and reproductive matters. Therefore, I kindly ask genuine resposns for the questions that will be presenting for you.

If you agree, please put your signature _____

If you disagree, please write your reasons in short

Thank you in advance!

Data collector's

Name _____

Signature _____

Date _____

ANNEX II: QUESTIONNAIRE

English Questionnaire

Addis Ababa University, School of Social Work

Questionnaire to Study Adolescents-Youth and parent communication on SRH issues in Addis Ababa, Arada Sub city; the case of Future Hopes Integrated Development Organization (FHIDO).

INSTRUCTION TO THE RESPONDENT

The survey's questions cover a broad range of experiences and worries that adolescent and youth are facing, with regard to sexual and reproductive health in particular, please read carefully each question and the instructions. Some of the questions may not be applicable to participants. Try to ask only those questions which are applicable to participants as indicated by supplementing instructions i.e. you may need to skip some questions. Never be afraid to ask the supervisors questions if you have any. Making clear that participants must provide honest answers to all of the questions is crucial.

Thank You again for your participation!

Part I. Respondents Background Information			
S.no	Questions	Alternatives	Code
1	Age	_____	
2	Level of Education	1. Primary Education 2. Secondary Education 3. TVET 4. University/College 5. Others Specify _____	
3	Sex	1. Male 2. Female	
4	Religion	1. Orthodox Christian 2. Muslim 3. Protestant 4. Others Specify _____	
5	With whom are you living?	1. Living with both parents 2. Living with single parents 3. Others Specify _____	
6	Family Size	_____	
7	Parents monthly income	1. _____ 2. I don't know	
8	Mother's educational status	1. Illiterate 2. Read and write only 3. Primary School 4. Secondary School 5. Diploma 6. Degree 7. Masters & above 8. Have no mother	
9	Father's educational status	1. Illiterate	

		2. Read and write only 3. Primary School 4. Secondary School 5. Diploma 6. Degree 7. Masters & above 8. Have no father	
10	Occupation of mother	1. House wife 2. Employed (private) 3. Employed (gov't) 4. Merchant running own business 5. Have no mother 6. Others Specify _____	
11	Occupation of father	1. Employed (private) 2. Employed (gov't) 3. Merchant running own business 4. Have no father 5. Others Specify _____	

Part II. Knowledge of the youth and Adolescent on major selected Reproductive Health Issues			
S.no	Questions	Alternatives	Code
1	Do you know when menstruation starts?	1. Yes 2. No	
2	If yes at what age it starts?	_____years	
3	What was your feeling when the first menses comes (for girls only)?	1. Tension 2. Fear 3. Pleasure 4. Feeling diseased 5. Shame	

		6. Others Specify _____	
4	Do you know about Sexually Transmitted Infections?	1. Yes 2. No	
5	If yes for question # 4, which one do you know? (Multiple Response Possible)	1. Chancroid 2. Syphilis 3. Gonorrhea 4. Lympho Granuloma Venerum 5. HIV & AIDS 6. Genital Herpes 7. Others Specify _____	
6	Do you know about contraceptive methods?	1. Yes 2. No	
7	If yes for question # 6, which one do you know? (Multiple Response Possible)	1. Pills 2. Injectable 3. Norplant 4. IUD 5. Condom 6. Abstinence 7. Using safe period/calendar method 8. All 9. Others Specify _____	
8	Do you know what emergency contraceptive means?	1. Yes 2. No	
9	Do you know the likely date of pregnancy between menstruation?	1. Yes 2. No	

Part III. Sexual and Reproductive Health Attitude and Behavior of Adolescents and youth			Code
S.no	Questions	Alternatives	
1	Is it normal and acceptable to have sexual feeling during adolescent?	1. Yes 2. No 3. I don't know	
2	Have you ever started sexual intercourse? If your answer is No, please skip to question # 10?	1. Yes 2. No → to Q 10	
3	If yes for question # 2, at what age was your first sexual act/ debut?	_____ years	
4	With whom have you made your first sex?	1. Boy/girlfriend 2. Relative 3. House maid 4. Neighbor 5. Commercial Sex Worker 6. Not recognized	
5	With how many partner have you made sex with in the last six months?	1. One 2. Two and above 3. Have no sex with in the last six months	
6	Have you ever used condom during sex?	1. Yes 2. No → to Q 8	
7	If yes for question # 6, do you use consistently?	1. Yes, consistently 2. Yes, but on and off	
8	Have you ever experienced unplanned pregnancy? (for girls only) If your answer is No, please skip to question # 10	1. Yes 2. No → to Q 10	
9	If yes for question # 8, how did you managed it?	1. Delivered the baby 2. Made an Abortion	

10	Do you accept premarital sex?	1. Yes 2. No	
11	Do you think sexual & reproductive health education is necessary for adolescent/youth If your answer is No, please skip to question # 13	8.1. Yes 8.2. No → to Q 13	
12	Where do you prefer sexual & reproductive health education to be given? (Multiple Response Possible)	1. School 2. Home 3. By friends/peers 4. Religious institution 5. School, home and friends/peers 6. All 5. Other Specify _____	
13	Where did you get information about sexual matters? (Multiple Response Possible)	1. School 2. Media 3. Home 4. Peers 5. School and media 6. Media and peers 7. All 5. Other Specify _____	
14	If your answer for question # 13 is media, what are your source of information mostly?	1. Television 2. Radio 3. Internet 4. Newspaper 5. Others Specify _____	

Part IV. Adolescent and youth perception of parental monitoring						
S.no	Parental monitoring	Strongly disagree	Agree	Neutral	Agree	Strongly Agree
1	What is your view to parental monitoring on adolescents and youth?	1	2	3	4	5
S.no	Questions		Alternatives		Code	
2	(For male only), did your parents ever forbid to play with females?		1. Yes 2. No			
3	If yes for question # 2, at what age did they forbid you?		_____ years			
4	(For female only), did your parents ever forbid to play with males?		1. Yes 2. No			
5	If yes for question # 4, at what age did they forbid you?		_____ years			
6	Do your parents know with whom where you are outside home/school?		1. Yes 2. No 3. I don't know			
7	Do your parents know with whom are you when outside home/school?		1. Yes 2. No 3. I don't know			

Part V. Communication of adolescent/youth and parents on sexual and reproductive health

S.no	Questions	Alternatives	Code
1	Is it important to discuss/communicate on sexual and reproductive health issues with parents?	1. Yes 2. No	
2	Which parent do you prefer to discuss with on sexual and reproductive health issue?	1. Mother 2. Father 3. Both 4. I don't know	
3	Have you ever discussed on contraceptive issues with parents?	1. Yes 2. No	
4	If yes for question # 3, with whom you discussed mostly?	1. Mother 2. Father 3. Both 4. Other Specify _____	
5	If you do not discuss on contraceptive issues with parents, what do you think the reasons? (Multiple Response Possible)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6. Difficult and embarrassing 7. I don't know 8. Others Specify _____	
6	How frequent you have discussed about contraceptive?	1. Very often 2. Often 3. Sometimes 4. Not at all	
7	With whom have you discussed about contraceptives other than parents?	1. Peers 2. Sisters 3. Brothers	

		4. Others Specify _____	
8	How frequent have you discussed about contraceptive other than parents?	1. Very often 2. Often 3. Sometimes 4. Not at all	
9	Have you ever discussed on STIs/HIV with parents?	1. Yes 2. No	
10	If yes for question # 9 with whom did you discussed mostly?	1. Mother 2. Father 3. Both 4. Other Specify _____	
11	If you do not discuss on HIV/STI with parents, What are the reasons? (Multiple Response Possible)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6. Difficult and embarrassing 7. I don't know 8. Others Specify _____	
12	How frequent you have discussed with parents about HIV/STI?	1. Very often 2. Often 3. Sometimes 4. Not at all	
13	With whom have you discussed other than parents regarding HIV/STI?	1. Peers 2. Sisters 3. Brothers 4. Others Specify _____	
14	How frequent have you discussed about HIV/STI other than parents?	1. Very often 2. Often	

		3. Sometimes 4. Not at all	
15	Have you ever discussed with parents on sexual intercourse?	1. Yes 2. No	
16	If yes for question # 15, with whom have you discussed mostly?	1. Mother 2. Father 3. Both 4. Others Specify _____	
17	If you do not discuss on sexual intercourse with parents, what are the reasons? (Multiple Response Possible)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6. Difficult and embarrassing 7. I don't know 8. Others Specify _____	
18	How frequent have you discussed with parents about sexual intercourse?	1. Very often 2. Often 3. Sometimes 4. Not at all	
19	With whom have you discussed about sexual intercourse other than parents?	1. Peers 2. Sisters 3. Brothers 4. Others Specify _____	
20	How frequent have you discussed about sexual intercourse other than parents?	1. Very often 2. Often 3. Sometimes 4. Not at all	

21	Have you ever discussed about unplanned pregnancy with parents?	1. Yes 2. No	
22	If yes for question # 21, with whom do you discuss mostly?	1.Mother 2.Father 3.Both 4.Others Specify _____	
23	If you do not discuss about unplanned pregnancy with your parents, what are the reasons? (Multiple Response Possible)	1.Culturally unacceptable 2.Shame 3.Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6.Difficult and embarrassing 7. I don't know 8. Others Specify _____	
21	How frequent have you discussed with your parents about unplanned pregnancy?	1. Very often 2. Often 3. Sometimes 4. Not at all	
25	With whom have you discussed about unplanned pregnancy other than parents?	1. Peers 2. Sisters 3. Brothers 4. Others Specify _____	
26	How frequent have you discussed about unplanned pregnancy other than parents?	1. Very often 2. Often 3. Sometimes 4. Not at all	
27	Have you ever discussed about abortion and its complications with parents?	1. Yes 2. No	

28	If yes for question # 27, with whom did you discuss mostly?	<ul style="list-style-type: none"> 1 Mother 2. Father 3. Both 4. Others Specify _____ 	
29	If you do not discuss about abortion and its complications with parents, what are the reasons? (Multiple Response Possible)	<ul style="list-style-type: none"> 1.Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6.Difficult and embarrassing 7. I don't know 8. Others Specify _____ 	
30	How frequent have you discussed with your parents about abortion and its complications?	<ul style="list-style-type: none"> 1. Very often 2. Often 3. Sometimes 4. Not at all 	
31	With whom have you discussed about abortion and its complications other than parents?	<ul style="list-style-type: none"> 1. Peers 2. Sisters 3. Brothers 4. Others Specify _____ 	
32	How frequent have you discussed about abortion and its complications other than parents?	<ul style="list-style-type: none"> 1. Very often 2. Often 3. Sometimes 4. Not at all 	
33	Have you ever discussed on not having sex before marriage with parents?	<ul style="list-style-type: none"> 1. Yes 2. No 	
34	If yes for question # 33, with whom did you discuss mostly?	<ul style="list-style-type: none"> 1 Mother 2. Father 	

		3. Both 4. Others Specify _____	
35	If you do not discuss on not having sex before marriage with parents, what are the reasons? (Multiple Response Possible)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6. Difficult and embarrassing 7. I don't know 8. Others Specify _____	3.
36	How frequent have you discussed with your parents on not having sex before marriage?	1. Very often 2. Often 3. Sometimes 4. Not at all	
37	With whom have you discussed on not having sex before marriage other than parents?	1. Peers 2. Sisters 3. Brothers 4. Others Specify _____	
38	How frequent have you discussed on not having sex before marriage other than parents?	1. Very often 2. Often 3. Sometimes 4. Not at all	
39	Have you ever discussed about condom with parents?	1. Yes 2. No	

40	If yes for question # 39, with whom do you discuss mostly?	<ol style="list-style-type: none"> 1. Mother 2. Father 3. Both 4. Others Specify _____ 	
41	If you do not discuss about condom with parents, what are the reasons? (Multiple Response Possible)	<ol style="list-style-type: none"> 1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6. Difficult and embarrassing 7. I don't know 8. Others Specify _____ 	
42	How frequent have you discussed with your parents about condom?	<ol style="list-style-type: none"> 1. Very often 2. Often 3. Sometimes 4. Not at all 	
43	With whom have you discussed about condom other than parents?	<ol style="list-style-type: none"> 1. Peers 2. Sisters 3. Brothers 4. Others Specify _____ 	
44	How frequent have you discussed about condom other than parents?	<ol style="list-style-type: none"> 1. Very often 2. Often 3. Sometimes 4. Not at all 	
45	Have you ever discussed on physical and psychological change on puberty with parents?	<ol style="list-style-type: none"> 1. Yes 2. No 	
46	If yes for question # 45, with whom do you discuss mostly?	<ol style="list-style-type: none"> 1. Mother 2. Father 	

		3. Both 4. Others Specify _____	
47	If you do not discuss on physical and psychological change on puberty, what are the reasons? (Multiple Response Possible)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6. Difficult and embarrassing 7. I don't know 8. Others Specify _____	
48	How frequent have you discussed with your parents on physical and psychological change on puberty?	1. Very often 2. Often 3. Sometimes 4. Not at all	
49	With whom have you discussed on physical and psychological change on puberty other than parents?	1. Peers 2. Sisters 3. Brothers 4. Others Specify _____	
50	How frequent have you discussed about on physical and psychological change on puberty other than parents?	1. Very often 2. Often 3. Sometimes 4. Not at all	
51	If you have ever discussed at least one of the above issues with your parents, at what age have you started discussing it?	_____ years of age	
52	At what age do you think sexual and reproductive health related issues discussion should be started?	_____ years of age	
53	Do you currently discussing on sexual and reproductive health issues with your parents?	1. Yes 2. No	

54	Is your mother or father open to discuss about sexual and reproductive health?	1. Yes, mother 2. Yes, father 3. Both are open 4. Both are not open 5. I don't know 6. Have no parents					
S.no	Parent's communication skill	Very low	Low	Medium	High	Very high	
55	How do you rate your parents' communication skill about sexual and reproductive health matters?	1	2	3	4	5	

ANNEX III: AMHARIC INFORMED CONSENT AGREEMENT FOR QUESTIONNAIRE

በጥናቱ ለመሳተፍ የስምምነት መግለጫ ቅጽ

ጤና ይስጥልኝ! ስሜ _____ ይባላል። የመጣሁት ከአዲስ አበባ ዩኒቨርሲቲ ሲሆን በሶሻል ወርክ ትምህርት ቤት የሁለተኛ ዲግሪ ተማሪ ነኝ። በአሁኑ ሰአት የመመረቂያ ጥናቱን እየሰራሁ እገኛለሁ።

የጥናቱም ዓላማ ጎረምሶች ብሎም ወጣቶች ከቤተሰቦቻቸው ጋር በግብረሰጋ ግንኙነት ጉዳይና በስነ-ተዋልዶ ጤና ዙሪያ የሚያደርጉት ውይይትና ተግባራት ምን ይመስላል ያሉትን መሰረተዊ ችግሮች ምን ይመስላሉ የሚለውን ለማጥናት እና ጥናቱም ሙሉ በሙሉ ትምህርታዊ ብቻነው።

መጠይቁ በአንተ/አንች ሙሉ ፈቃደኝነት ላይ የተመሰረተ ሲሆን በማንኛውም ሁኔታ ጥሩ ያልሆነ ስሜት ከተሰማህ/ሽ ጥያቄውን ያለመመለስ መብትህ/ሽ የተጠበቀነው። ነገር ግን ለጥያቄዎቹ የምትሰጡት ትክክለኛ ምላሽ ጥናቱን በአግባቡ እንድናጠና ወሳኝነት አላቸው። ማናቸውም የምታነሳቸው/ሻቸው ነጥቦች እና ምላሾች እንዲሁም የምንጠቀምባቸው መሳሪያዎች በሚስጥራዊነት ይቀመጣል። ለዚህም ሲባል ስማችሁን ወይም ሌላ መለያ ማስቀመጥ አያስፈልግም። ስለዚህ በጥናቱ ለመሳተፍ ፍቃደኛ ነህ/ነሽ፡-

አዎ እሳተፋለሁ _____

አልሳተፍም ካልህ/ሽ ምክንያቱን ባጭሩ ብትገልፅልኝ/ጩልኝ

በቅድሚያ እናመሰግናለን!

ስምምነቱን ያስፈረመው መረጃ ሰብሳቢ

ስም _____

ፊርማ _____

ቀን _____

ክፍል 1. አጠቃላይ መረጃ			
ተ.ቁ	ጥያቄ	አማራጭ	ኮድ
1	እድሜ	_____	
2	የትምህርት ደረጃ	1. የመጀመሪያ ደረጃ 2. ሁለተኛ ደረጃ 3. ቴክኒክ እና ሞያ 4. ዩኒቨርሲቲ/ኮሌጅ 5. ሌላ ካለ ይገለጽ _____	
3	ፆታ	1. ወንድ 2. ሴት	
4	ሀይማኖት	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ሌላ ካለ ይገለጽ _____	
5	የምትኖረው/ሪውከማንጋርነው?	1. ከእናት እና ከአባት ጋር 2. ከእናት/ከአባት ጋር 3. ሌላ ካለ ይገለጽ _____	
6	የቤተሰብ ብዛት	_____	
7	የወላጆች የገቢ መጠን	1. _____ 2. አላውቅም	
8	የእናት የትምህርት ደረጃ	1. ያልተማረች 2. ማንበብ እና መጻፍ 3. የመጀመሪያ ደረጃ 4. ሁለተኛ ደረጃ 5. ዲፕሎማ 6. ዲግሪ 7. ማስተርስ እና ከዚያ በላይ 8. እናት በህይወት የለችም	

9	የአባት የትምህርት ደረጃ	<ol style="list-style-type: none"> 1. ያልተማረ 2. ማንበብ እና መጻፍ 3. የመጀመሪያ ደረጃ 4. ሁለተኛ ደረጃ 5. ዲፕሎማ 6. ዲግሪ 7. ማስተርስ እና ከዚያ በላይ 8. አባት በህይወት የለም 	
10	የእናት የስራ ሁኔታ	<ol style="list-style-type: none"> 1. የቤት እመቤት 2. ተቀጣሪ (የግል) 3. ተቀጣሪ (የመንግስት) 4. ነጋዴ 5. እናት በህይወት የለችም 6. ሌላ ካለ ይገለጽ _____ 	
11	የአባት የስራ ሁኔታ	<ol style="list-style-type: none"> 1. ተቀጣሪ (የግል) 2. ተቀጣሪ (የመንግስት) 3. ነጋዴ 4. አባት በህይወት የለም 5. ሌላ ካለ ይገለጽ _____ 	

ክፍል 2. በተመረጡ ዋና ዋና የስነ-ተዋልዶ ጤና ዙሪያ ለጎረምቶች/ወጣቶች የተዘጋጁ የእውቀት ጥያቄዎች

ተ.ቁ	ጥያቄ	አማራጭ	ኮድ
1	የወር አበባ የሚጀምርበትን እድሜታው ታለህ/ሽ?	1. አዎ 2. አላውቅም	
2	አዎካልክ/ሽ የመጀመሪያ የወር አበባ በስንት ዓመት ይጀምራል?	_____ ዓመት	
3	ለመጀመሪያ ጊዜ የወር አበባ ስታዩ ምን ተሰማሽ (ለሴቶች-ብቻ)?	1. ጭንቀት 2. ፍርሃት 3. ደስታ 4. በበሽታ የተያዘኩ መሰለኝ 5. እፍረት 6. ሌላ ካለ ይገለጽ _____	
4	በግብረሰጋ ግንኙነት ስለሚመጡ በሽታዎች ታውቃለህ/ሽ?	1. አዎ 2. አላውቅም	
5	ለጥያቄ ቁጥር 4 መልስህ/ሽ አዎ ከሆነ የትኛውን ታውቃለህ/ሽ? (ከአንድ በላይ መመለስ ይቻላል)	1. ክርክር 2. ጨብጥ 3. ቁጥኝ 4. ባምቡሌ 5. ኤች ኤ ቪ ኤድስ 6. የብልት ሽፌ 7. ሌላ ካለ ይገለጽ _____	
6	የወሊድ መቆጣጠሪያ ዘዴዎችን ታውቃለህ/ሽ?	1. አዎ 2. አላውቅም	
7	If yes for question # 6, which one do you know? (ከአንድ በላይ መመለስ ይቻላል)	1. የወሊድ መቆጣጠሪያ ክኒን 2. መርፌ 3. በክንድ ላይ የሚቀበር 4. በማህፀን ውስጥ የሚቀመጥ 5. ኮንዶም 6. መታቀብ 7. በካላንደር መጠቀም	

		8. ሁሉም 9. ሌላ ካለ ይገለጽ _____	
8	ድንገተኛ የወሊድ መቆጣጠሪያን ታውቃለህ/ሽ?	1. አዎ 2. አላውቅም	
9	በወር አበባዎቻቸው መካከል እርግዝና ሊከሰት የሚችልበትን ጊዜ ታውቃለህ/ሽ?	1. አዎ 2. አላውቅም	

ክፍል 3. ጎረቤቶች እና ወጣቶች በግብረሰጋ ግንኙነት እና በስነተዋልዶ ጤና ዙሪያ ላይ ያላቸው አመለካከትና ባህሪ			
ተ.ቁ	ጥያቄ	አማራጭ	ኮድ
1	በጉርምስና ጊዜ የግብረሰጋ ግንኙነት ለማድረግ መፈለግ ጤናማና ተቀባይነት አለው?	1. አዎ 2. አይ 3. አላውቅም	
2	የግብረሰጋ ግንኙነት መፈፀም ጀምረሃል/ሻል? መልስ/ህ አልጀመርኩም ከሆነ ወደጥያቄቁጥር 10 እለፍ/ፊ	1. አዎ 2. አልጀመርኩም → ወደ ጥ.ቁ.10	
3	አዎ ካልክ/ሽ በስንት ዓመት እድሜ ፈፀምሽ/ክ?	_____ ዓመት	

4	ለመጀመሪያ ጊዜ ከማን ጋር ፈፀምሽ/ክ?	<ol style="list-style-type: none"> 1. ከወንድ/ሴት ጓደኛ 2. ከዘመድ 3. ከሴት ሰራተኛ 4. ከጎረቤት 5. ከሴተኛ አዳሪ 6. አላስታውስም 	
5	ባለፉት 6 ወራት ጊዜ ውስጥ የግብረሰጋ ግንኙነት ከስንት ሰው ጋር ፈፀምሽ/ህ ታውቋልሽ/ህ?	<ol style="list-style-type: none"> 1. አንድ 2. ሁለት እና ከዚያ በላይ 3. ባለፉት 6 ወራት ውስጥ ግንኙነት አልፈፀምኩም 	
6	በግብረሰጋ ግንኙነት ወቅት ኮንዶም ትጠቀማለህ/ሽ?	<ol style="list-style-type: none"> 1. አዎ 2. አልጠቀምም → ወደ ጥ.ቁ. 8 	
7	ለጥያቄ ቁጥር 6 ምላሽዎ አዎ እጠቀማለሁ ከሆነ, አጠቃቀምዎን ይግለፁ	<ol style="list-style-type: none"> 1. ሁልጊዜና በአግባቡ እጠቀማለሁ 2. አንዳንድ ጊዜ እጠቀማለሁ 	
8	ያልታቀደ እርግዝና ገጥሞሽ ያውቃል? (ለሴት-ብቻ) መልስዎ አያውቅም ከሆነ ወደ ጥያቄቁጥር 10 ይለፉ	<ol style="list-style-type: none"> 1. አዎ 2. አያውቅም → ወደ ጥ.ቁ.10 	
9	ለጥያቄ ቁጥር 8 መልስሽ አዎ አጋጥሞኝ ነበር ከሆነ እንዴት አድርገሽ አለፍሽው?	<ol style="list-style-type: none"> 1. ወለድኩ 2. ፅንሰ አቋረጥኩ 	
10	ከጋብቻ በፊት የግብረሰጋ ግንኙነት ማድረግን ትቀበላለህ/ያለሽ?	<ol style="list-style-type: none"> 1. አዎ 2. አልቀበልም 	
11	ተማሪዎቻችን ስለ ስነ ተዋልዶ ጤና /ግብረሰጋ ግንኙነት ማስተማር አስፈላጊ ይመስልህል/ሻል? መልስሽ/ህ አይ ከሆነ ወደ ጥያቄቁጥር 13 እለፍ/ፊ	<ol style="list-style-type: none"> 1. አዎ 2. አይ → ወደ ጥ.ቁ. 13 	

12	ልጆች ስለ ስነ ተዋልዶ ጤና/ግብረሰጋ ግንኙነት የት ቢማሩ ይሻላል ብለህ/ሽ ታስባለህ/ሽ? (ከአንድ በላይ መመለስ ይቻላል)	<ol style="list-style-type: none"> 1. ትምህርት ቤት 2. ቤት 3. ጓደኛ 4. የሀይማኖት ተቋም 5. ት/ቤት፣ ቤት እና ጓደኛ 6. ሁሉም 7. ሌላ ካለ ይገለጽ _____ 	
13	ስለ ስነ ተዋልዶ ጤና/ ግብረሰጋ ግንኙነት መረጃዎችን ከየት ታገኛለህ/ሽ? (ከአንድ በላይ መመለስ ይቻላል)	<ol style="list-style-type: none"> 1. ትምህርት ቤት 2. መገናኛ ብዙኃን 3. ቤት 4. ጓደኛ 5. ት/ቤት እና መገናኛ ብዙኃን 6. መገናኛ ብዙኃን እና ጓደኛ 7. ሁሉም 8. ሌላ ካለ ይገለጽ _____ 	
14	ለጥያቄ ቁጥር 13 መልስዎ ከመገናኛ ብዙሃን ከሆነ በአብዛኛው ከየትኛው አይነት ያገኛሉ?	<ol style="list-style-type: none"> 1. ቴሌቪዥን 2. ራዲዮ 3. ኢንተርኔት 4. ጋዜጣ 5. ሌላ ካለ ይገለጽ _____ 	

ክፍል 4. በቤተሰብ ቁጥጥር ዙሪያ ላይ የጎረምቶች እና ወጣቶች አመለካከት

ተ.ቁ	የቤተሰቦች ቁጥጥር	በጣም አልስማማም	አልስማማም	እርግጠኛ አይደለሁም	እስማማለሁ	በጣም እስማማለሁ
1	የጎረምቶች እና የወጣቶች በቤተሰብ ቁጥጥር ዙሪያ ያላቸው አመለካከት ምን ይመስላል?	1	2	3	4	5

ተ.ቁ	ጥያቄ	አማራጭ	ኮድ
2	(ለወንዶች ብቻ) ወላጆችህ ከሌቶች ጋር እንዳትጫወት ከልክለውህ ያውቃሉ?	1. አዎ 2. አይ	
3	ለጥያቄ ቁ.2 መልስዎ አዎ ከሆነ በስንት ዓመት እንዳትጫወት ከለክሉህ?	_____ ዓመት	
4	(ለሌቶች ብቻ) ወላጆችሽ ከወንዶች ጋር እንዳትጫወቱ ከልክለውሽ ያውቃሉ?	1. አዎ 2. አይ	
5	ለጥያቄ ቁ.4 መልስዎ አዎ ከሆነ በስንት ዓመት እንዳትጫወት/ቱ ከለክሉሽ?	_____ ዓመት	
6	ወላጆችህ/ሽ ከቤት/ትምህርት ቤት ውጭ የትና ከማን ጋር እንደምትሆን/ኒ ያውቃሉ?	1.አዎ 2. አይ 3. አላውቅም	
7	ወላጆችህ/ሽ ከቤት/ትምህርት ቤት ውጭ መቼና ከማን ጋር እንደምትሆን/ኒ ያውቃሉ?	1.አዎ 2. አይ 3. አላውቅም	

ክፍል 5. በወላጆችና በጎረቤቶች/ወጣቶች መካከል በግብረሰጋ ግንኙነት እና በስነተዋልዶ ጤና ዙሪያ ላይ የሚደረጉ ውይይቶች

ተ.ቁ	ጥያቄ	አማራጭ	ኮድ
1	በወላጆችና በጎረቤቶች/ወጣቶች መካከል በግብረሰጋ ግንኙነት ላይ ባሉ ሁኔታዎች ዙሪያ መወያየት አስፈላጊ ይመስልህል/ሻል?	1.አዎ 2. አይ	
2	ከየትኛው ወላጅ ጋር መወያየቱን ትመርጣለህ/ሽ?	1.እናት 2. አባት 3. ሁለቱም 4. አላውቅም	
3	ስለወሊድ መቆጣጠሪያ ቤተሰቦችህ/ሽ አወያይተውህ/ሽ ያውቃሉ?	1. አዎ 2. አይ	
4	ለጥያቄ ቁጥር 3 መልስህ/ሽ አዎ ከሆነ ውይይቱን አብዛኛውን ጊዜ ከማን ጋር ታደርጋለህ/ሽ?	1. እናት 2. አባት 3. ሁለቱም 5. ሌላ ካለ ይገለጽ _____	
5	ስለወሊድ መቆጣጠሪያ የማትወያዩ ከሆነ ምክንያቱ ምንድንው ብለህ/ሽ ታስቢያለሽ/ህ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ክልጆች ጋር የመግባባት ችግር አለባቸው 6. ርዕሶቹ ከባድ እና የሚያበሳጩ ናቸው 7. አላውቅም 8. ሌላ ካለ ይገለጽ _____	
6	በምን ያህል ጊዜ ስለወሊድ መቆጣጠሪያ ከወላጆችህ/ሽ ጋር ትወያያለሽ/ህ?	1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4- በጭራሽ አንነጋገርም	

7	ከወላጆች ውጪ ስለወሊድ መቆጣጠሪያ ከማን ጋር ትወያያለህ/ለሽ?	<ol style="list-style-type: none"> 1. ከንደኛ 2. ከእህት 3. ወንድም 4. ሌላ ካለ ይገለጽ _____ 	
8	በምን ያህል ጊዜ ስለወሊድ መቆጣጠሪያ ከወላጆችህ/ሽ ውጪ ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4- በጭራሽ አንነጋገርም 	
9	ስለኤች አይ ቪ/ኤድስ / አባላዘር በሽታ ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ?	<ol style="list-style-type: none"> 1. አዎ 2. አይ 	
10	ለጥያቄ ቁጥር 9 መልስህ/ሽ አዎከሆነውይይቱን አብዛኛውንጊዜከማንጋርታደርጋለህ/ሽ?	<ol style="list-style-type: none"> 1. እናት 2. አባት 3. ሁለቱም ሌላ ካለ ይገለጽ _____ 	
11	ስኤች አይ ቪ/አባላዘር በሽታ የማትወያዩ ከሆነ ምክንያቱ ምንድንው ብለህ/ሽ ታስቢያለሽ/ህ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	<ol style="list-style-type: none"> 1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችግር አለባቸው 6. ርዕሶቹ ከባድ እና የሚያበሳጩ ናቸው 7. አላውቅም 8. ሌላ ካለ ይገለጽ _____ 	
12	በምን ያህል ጊዜ ስለስኤች አይ ቪ/አባላዘር በሽታ ከወላጆችህ/ሽ ጋር ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4- በጭራሽ አንነጋገርም 	

13	ከወላጆች ውጪ ስለ ኤች አይ ቪ/አባላዘር በሽታ ከማን ጋር ትወያያለህ/ለሽ?	<ol style="list-style-type: none"> 1. ከጓደኛ 2. ከእህት 3. ወንድም 4. ሌላ ካለ ይገለጽ_____ 	
14	በምን ያህል ጊዜ ስለኤች አይ ቪ/አባላዘር በሽታ ከወላጆችህ/ሽ ውጪ ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4. በጭራሽ አንነጋገርም 	
15	ስለግብረ ስጋ ግንኙነት ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ?	<ol style="list-style-type: none"> 1. አዎ 2. አይ 	
16	ለጥያቄ ቁጥር 15 መልስህ/ሽ አዎከሆነውይይቱን አብዛኛውንጊዜከማንጋርታደርጋለህ/ሽ?	<ol style="list-style-type: none"> 1. እናት 2. አባት 3. ሁለቱም 4. ሌላ ካለ ይገለጽ _____ 	
17	ስለግብረ ስጋ ግንኙነት የማትወያዩ ከሆነ ምክንያቱ ምንድንው ብለህ/ሽ ታስቢያለሽ/ህ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	<ol style="list-style-type: none"> 1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችግር አለባቸው 6. ርዕሶቹ ከባድ እና የሚያበሳጩ ናቸው 7. አላውቅም 8. ሌላ ካለ ይገለጽ_____ 	
18	በምን ያህል ጊዜ ስለግብረ ስጋ ግንኙነት ከወላጆችህ/ሽ ጋር ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4. በጭራሽ አንነጋገርም 	
19	ከወላጆች ውጪ ስለግብረ ስጋ ግንኙነት ከማን ጋር ትወያያለህ/ለሽ?	<ol style="list-style-type: none"> 1. ከጓደኛ 2. ከእህት 	

		3. ወንድም 4. ሌላ ካለ ይገለጽ _____	
20	በምን ያህል ጊዜ ስለግብረ ስጋ ግንኙነት ከወላጆችህ/ሽ ውጪ ትወያያለሽ/ለህ?	1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4- በጭራሽ አንነጋገርም	
21	ስለያልተፈለገ እርግዝና ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ?	1. አዎ 2. አይ	
22	ለጥያቄ ቁጥር 21 መልስህ/ሽ አዎ ከሆነ ውይይቱን አብዛኛውን ጊዜ ከማን ጋር ታደርጋለህ/ሽ?	1. እናት 2. አባት 3. ሁለቱም 4. ሌላ ካለ ይገለጽ _____	
23	ስለ ያልታቀደ እርግዝና የማትወያዩ ከሆነ ምክንያቱ ምንድን ነው ብለህ/ሽ ታስቢያለሽ/ህ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችግር አለባቸው 6. ርዕሶቹ ከባድ እና የሚያበሳጩ ናቸው 7. አላውቅም 8. ሌላ ካለ ይገለጽ _____	
21	በምን ያህል ጊዜ ስለ ያልታቀደ እርግዝና ከወላጆችህ/ሽ ጋር ትወያያለሽ/ለህ?	1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4- በጭራሽ አንነጋገርም	
25	ከወላጆች ውጪ ስለ ያልታቀደ እርግዝና ከማን ጋር ትወያያለህ/ለሽ?	1. ከጓደኛ 2. ከእህት 3. ወንድም 4. ሌላ ካለ ይገለጽ _____	

26	በምን ያህል ጊዜ ስለያልታቀደ እርግዝና ከወላጆችህ/ሽ ውጪ ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4. በጭራሽ አንነጋገርም 	
27	ስለውርጃ እና ስለሚያስከትለው ጉዳት ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ?	<ol style="list-style-type: none"> 1. አዎ 2. አይ 	
28	ለጥያቄ ቁጥር 27 መልስህ/ሽ አዎ ከሆነ ውይይቱን አብዛኛውን ጊዜ ከማን ጋር ታደርጋለህ/ሽ?	<ol style="list-style-type: none"> 1. እናት 2. አባት 3. ሁለቱም 4. ሌላ ካለ ይገለጽ _____ 	
29	ስለውርጃ እና ስለሚያስከትለው ጉዳት የማትወያዩ ከሆነ ምክንያቱ ምንድንው ብለህ/ሽ ታስቢያለሽ/ህ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	<ol style="list-style-type: none"> 1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችግር አለባቸው 6. ርዕሶቹ ከባድ እና የሚያበሳጩ ናቸው 7. አላውቅም 8. ሌላ ካለ ይገለጽ _____ 	
30	በምን ያህል ጊዜ ስለውርጃ እና ስለሚያስከትለው ጉዳት ከወላጆችህ/ሽ ጋር ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4. በጭራሽ አንነጋገርም 	
31	ከወላጆች ውጪ ስለውርጃ እና ስለሚያስከትለው ጉዳት ከማን ጋር ትወያያለህ/ለሽ?	<ol style="list-style-type: none"> 1. ከጓደኛ 2. ከእህት 3. ወንድም 4. ሌላ ካለ ይገለጽ _____ 	
32	በምን ያህል ጊዜ ስለውርጃ እና ስለሚያስከትለው ጉዳት ከወላጆችህ/ሽ ውጪ ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 	

		3. አንዳንዴ 4- በጭራሽ አንካጋገርም	
33	ከጋብቻ በፊት የግብረሰጋ ግንኙነት ስለ ያለማድረግ ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ?	1. አዎ 2. አይ	
34	ለጥያቄ ቁጥር 33 መልስህ/ሽ አዎ ከሆነ ውይይቱን አብዛኛውን ጊዜ ከማን ጋር ታደርጋለህ/ሽ?	1. እናት 2. አባት 3. ሁለቱም 4. ሌላ ካለ ይገለጽ _____	
35	ከጋብቻ በፊት የግብረሰጋ ግንኙነት ስለ ያለማድረግ የማትወያዩ ከሆነ ምክንያቱ ምንድንው ብለህ/ሽ ታስቢያለሽ/ህ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችግር አለባቸው 6. ርዕሶቹ ከባድ እና የሚያበሳጩ ናቸው 7. አላውቅም 8. ሌላ ካለ ይገለጽ _____	
36	በምን ያህል ጊዜ ከጋብቻ በፊት የግብረሰጋ ግንኙነት ስለ ያለማድረግ ከወላጆችህ/ሽ ጋር ትወያያለሽ/ለህ?	1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4- በጭራሽ አንካጋገርም	
37	ከወላጆች ውጪ ከጋብቻ በፊት የግብረሰጋ ግንኙነት ስለ ያለማድረግ ከማን ጋር ትወያያለህ/ለሽ?	1. ከጓደኛ 2. ከእህት 3. ወንድም 4. ሌላ ካለ ይገለጽ _____	
38	በምን ያህል ጊዜ ከጋብቻ በፊት የግብረሰጋ ግንኙነት ስለ ያለማድረግ ከወላጆችህ/ሽ ውጪ ትወያያለሽ/ለህ?	1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ	

		4- በጭራሽ አንካጋገርም	
39	ስለ ኮንዶም ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ?	1. አዎ 2. አይ	
40	ለጥያቄ ቁጥር 39 መልስህ/ሽ አዎ ከሆነ ውይይቱን አብዛኛውን ጊዜ ከማን ጋር ታደርጋለህ/ሽ?	1. እናት 2. አባት 3. ሁለቱም 4. ሌላ ካለ ይገለጽ _____	
41	ስለ ኮንዶም የማትወያዩ ከሆነ ምክንያቱ ምንድንው ብለህ/ሽ ታስቢያለሽ/ህ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችግር አለባቸው 6. ርዕሶቹ ከባድ እና የሚያበሳጩ ናቸው 7. አላውቅም 8. ሌላ ካለ ይገለጽ _____	
42	በምን ያህል ጊዜ ስለኮንዶም ከወላጆችህ/ሽ ጋር ትወያያለሽ/ለህ?	1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4- በጭራሽ አንካጋገርም	
43	ከወላጆች ውጪ ስለኮንዶም ከማን ጋር ትወያያለህ/ለሽ?	1. ከንደኛ 2. ከእህት 3. ወንድም 4. ሌላ ካለ ይገለጽ _____	
44	በምን ያህል ጊዜ ስለኮንዶም ከወላጆችህ/ሽ ውጪ ትወያያለሽ/ለህ?	1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4- በጭራሽ አንካጋገርም	

45	ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነልቦና ለውጦች ከወላጆችህ/ሽ ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ?	<ol style="list-style-type: none"> 1. አዎ 2. አይ 	
46	ለጥያቄ ቁጥር 45 መልስህ/ሽ አዎ ከሆነ ውይይቱን አብዛኛውን ጊዜ ከማን ጋር ታደርጋለህ/ሽ?	<ol style="list-style-type: none"> 1. እናት 2. አባት 3. ሁለቱም 4. ሌላ ካለ ይገለጽ _____ 	
47	ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነልቦና ለውጦች የማትወያዩ ከሆነ ምክንያቱ ምንድን ነው ብለህ/ሽ ታስቢያለሽ/ህ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	<ol style="list-style-type: none"> 1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችግር አለባቸው 6. ርዕሶቹ ከባድ እና የሚያበሳጩ ናቸው 7. አላውቅም 8. ሌላ ካለ ይገለጽ _____ 	
48	በምን ያህል ጊዜ ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነልቦና ለውጦች ከወላጆችህ/ሽ ጋር ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4. በጭራሽ አንነጋገርም 	
49	ከወላጆች ውጪ ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነልቦና ለውጦች ከማን ጋር ትወያያለህ/ለሽ?	<ol style="list-style-type: none"> 1. ከጓደኛ 2. ከእህት 3. ወንድም 4. ሌላ ካለ ይገለጽ _____ 	
50	በምን ያህል ጊዜ ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነልቦና ለውጦች ከወላጆችህ/ሽ ውጪ ትወያያለሽ/ለህ?	<ol style="list-style-type: none"> 1. በጣም በብዛት 2. በብዛት 3. አንዳንዴ 4. በጭራሽ አንነጋገርም 	

51	ከወላጆችህ/ሽ ጋር ከላይ ከተጠቀሱት ጉዳዮች ዙሪያ ቢያንስ በአንዱ ላይ ውይይት አድርገህ/ሽ ከሆነ ውይይቱን በስንተኛው እድሜህ/ሽ ላይ ጀመርህ/ሽ?	_____ ዓመት				
52	ስለ ግብረሰጋ ግንኙነትና ስነተዋልዶ ጤና ውይይት በስንተኛው እድሜ መጀመር አለበት ትላለህ/ያለሽ?	_____ ዓመት				
53	በአሁኑ ወቅት ከወላጆችህ/ሽ ጋር ስለ ግብረሰጋ ግንኙነትና ስነተዋልዶ ጤና ውይይት ታደርጋለህ/ሽ?	1. አዎ 2. አይ				
54	እናትሽ/ህ ወይስ አባትህ/ሽ ስለግብረሰጋ ግንኙነትና ስነተዋልዶ ጤና ውይይት ለማድረግ ግልፅ ነው/ች?	1. እናት 2. አባት 3. ሁለቱም ግልጽ ናቸው 4. ሁለቱም ግልጽ አይደሉም 5. አላውቅም 6. ወላጅ በህይወት የሉም				
ተ.ቁ	የወላጆች የመግባባት ችሎታ ልኬት	በጣም ዝቅተኛ	ዝቅተኛ	እርግጠኛ አይደለሁም	ከፍተኛ	በጣም ከፍተኛ
55	የወላጆችህ/ሽን በግብረሰጋ ግንኙነት እና በስነተዋልዶ ጤና ጉዳዮች ዙሪያ ላይ ለመወያየት ያላቸውን ችሎታ ምን ያህል ነው ብለህ/ሽ ታስቢያለሽ/ህ?	1	2	3	4	5

ANNEX IV: INFORMED CONSENT AGREEMENT FOR DISCUSSION/INTERVIEW

Discussion/ Interview participant’s consent form

Greetings! My name is _____. I’m coming from Addis Ababa University School of Social Work Masters student and currently, am on thesis work. The purpose of this study is to assess the communication between adolescent/youth and parents on sexual and reproductive issues and the study is solely an academic. The interview/ discussion will be undertaken based on your free will and consent and Your answers are completely confidential, your name will not be written on this form, and will never be used in connection with any of the information you tell me. So that if you feel discomfort you can discontinue whenever you want. All the private issues you disclose and the instruments we use such as records will be kept permanently as a secret for the seek of your safety. And your genuine answers to these questions will help us better understand about parent and adolescent communication on sexual and reproductive matters, and it would eventually help us in designing appropriate intervention programs. Therefore, I kindly ask genuinely respond for the questions that will be presented for you.

If you agree, please put your signature _____

If you disagree, please write your reasons in short

Thank you in advance!

Data collector’s

Name _____

Signature _____

Date _____

ANNEX V: AMHARIC INFORMED CONSENT AGREEMENT FOR DISCUSSION/INTERVIEW

በውይይቱ/ቃለመጠይቁ ለመሳተፍ የስምምነት መግለጫ ቅጽ

ጤና ይስጥልኝ! ስሜ _____ ይባላል። የመጣሁት ከአዲስ አበባ ዩኒቨርሲቲ ሲሆን በሶሻል ወርክ ትምህርት ቤት የሁለተኛ ዲግሪ ተማሪ ነኝ። በአሁኑ ሰአት የመመረቄያ ጥናቴን እየሰራሁ እገኛለሁ።

የጥናቴም ዓላማ ጎረቤቶች ብሎም ወጣቶች ከቤተሰቦቻቸው ጋር በግብረሰጋ ግንኙነት ጉዳይና በስነ-ተዋልዶ ጤና ዙሪያ የሚያደርጉት ውይይትና ተግባራት ምን ይመስላል ያሉትን መሰረተዊ ችግሮች ምን ይመስላሉ የሚለውን ለማጥናት እና ጥናቴም ሙሉ በሙሉ ትምህርታዊ ብቻ ነው።

ቃለመጠይቁ/ውይይቱ በእርስዎ ሙሉ ፈቃደኝነት ላይ የተመሰረተ ሲሆን በማንኛውም ሁኔታ ጥሩ ያልሆነ ስሜት ከተሰማዎ ጥያቄውን ያለመመለስ መብትዎ የተጠበቀ ነው። ነገር ግን ለጥያቄዎቹ የምትሰጡት ትክክለኛ ምላሽ ጥናቴን በአግባቡ እንድናጠና እንዲሁም ለወደፊት የተሻለ ፕሮግራም ለመቅረጽ ወሳኝነት አላቸው። ማናቸውም የምታነሷቸው ነጥቦች እና ምላሾች እንዲሁም የምንጠቀምባቸው መሳሪያዎች ለምሳሌ እንደመቅረጻ ድምጽ በሚስጥራዊነት ይቀመጣል። ለዚህም ሲባል ስማችሁን ወይም ሌላ መለያ ማስቀመጥ አያስፈልግም።

ስለዚህ በውይይቱ/ቃለመጠይቁ ለመሳተፍ ፍቃደኛ ከሆኑ በፊርማዎ ያረጋግጡልን፡-

ፍቃደኛ ነኝ _____

ፍቃደኛ ካልሆኑ ምክንያቱን ባጭሩ ብትገልፅልኝ/ጨልኝ

በቅድሚያ እናመሰግናለን!

ስምምነቱን ያስፈረመው መረጃ ሰብሳቢ

ስም _____

ፊርማ _____

ቀን _____

ANNEX VI: GUIDE TO FOCUS GROUP DISCUSSION

I. Socio-demographic characteristics of parents

1. Age _____ years

2. Level of Education

1. Primary Education 2. Secondary Education 3. TVET 4. University/College
5. Reading & Writing only 6. Illiterate 7. Other Specify _____

3. Sex 1. Male 2. Female

4. Religion

1. Orthodox Christian 2. Muslim 3. Protestant 4. Others _____

5. Family Size/ # of children _____

6. Parents monthly income

1. _____ 2. I don't know 3. No Income

7. Marital status

1. Married 2. Divorced 3. Widowed/Widower 4. Separated 5. Deceased

Focus Group Discussion Guide

Discussion to parents on level of communication, parents with their adolescent/youth on sexual matters and factors affecting communication.

- Greeting
- Ask the willingness of the parents for participating in the discussion.
- Explain the objective of the study and focus group discussion.
- Telling the participants that confidentiality will be maintained and using tape recorder.

My name is _____. My colleague near to me is called _____. We came from Addis Ababa University

Read the following as it is:

“We will discuss the communication between parents and youth around sexual and reproductive health after a quick introduction. The study will be useful in evaluating how parents communicate with adolescents and young people about sexual and reproductive health, and other related aspects will aid in the development of services and educational initiatives. At the end of the session, we will ask for your suggestions on how to improve parent-youth communication regarding sexual and reproductive health and how to build specific suitable interventions. These recommendations will essentially be ascribed to your comments and suggestions.

Topics to be discussed:

1. What do you think the knowledge of parents on reproductive health? (Contraceptive, STIs, HIV& AIDS, and puberty)
2. What are the feeling of parents on premarital sex and unplanned pregnancy in adolescents/youth?
3. What are the feeling of parents on adolescent sexuality?
4. What is your suggestion for sex education? First do you agree? (Why and why not), if you agree where to be given?

5. Is it important to discuss on sexual matters with adolescents and youth? (Why and why not)?
6. If you suggest discussion on sexual and reproductive health matters, at what age the discussion should be started? Justify your response with reasons?
7. What are the topics discussed with your adolescents/youth?
8. Do you think parent and adolescents and youth communicate on different sexual and reproductive matters? Tell me about your observations?
9. What are the reasons (barriers for not communicating/discussing on sexual matters)?

Thank you very much for your participation in the discussion!

ANNEX VII: GUIDE TO KEY INFORMANT INTERVIEW

In-depth interview for Woreda health officials-on assessment of communication on sexual and reproductive health matters between adolescents/youth and parents.

Date of interview: _____ position of the interviewee: _____

1. What kinds of services are provided in the health sectors under sexual and reproductive health component?
2. Are adolescents/youth can openly discuss about sexual and reproductive health issues? If yes, would you please mention the main topics being discussed between/among adolescents/youth and parents?
3. If not, what are the reasons for not discussing about sexual and reproductive health? Please explain.
4. What are the major problems of sexual and reproductive health among adolescents/youth in your Woreda's?

5. Are you communicating freely on SRH issues with your families? If yes, what are the major topics that are you discussing with? If not, what are the major reasons that hinder to openly communicating on SRH issues?
6. At what age adolescent/youth parent discussion on SRH issues should start? Please explain your answer with justification.
7. What are government future directions about sexual and reproductive health especially for adolescents/youth?

Thank you very much for your participation in the interview session!

ANNEX VIII: DECLARATION

I, the undersigned, declared that this is my original work, has not been presented for a degree in this or any other University, and that all sources of materials used for this thesis has been fully acknowledged.

Name_____

Signature_____

Place_____

Date of Submission_____

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

Name_____

Signature_____